DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 409, 410, 411, 413, 414, 415, and 424

[CMS–1503–P]

RIN 0938–AP79

Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011

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

ACTION: Proposed rule.

SUMMARY: This proposed rule addresses proposed changes to the physician fee schedule and other Medicare Part B payment policies to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. It also addresses, implements or discusses certain provisions of both the Affordable Care Act and the Medicare Improvements for Patients and Providers Act of 2008. In addition, this proposed rule discusses payments under the Ambulance Fee Schedule, Clinical Laboratory Fee Schedule, payments to ESRD facilities, and payments for Part B drugs. Finally, the proposed rule includes a discussion regarding the Chiropractic Services Demonstration program, the Competitive Bidding Program for Durable Medical Equipment and Provider and Supplier Enrollment Issues associated with Air Ambulances. (See the Table of Contents for a listing of the specific issues addressed in this proposed rule.)

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on August 24, 2010.

ADDRESSES: In commenting, please refer to file code CMS–1503–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the instructions for "submitting a comment."

2. *By regular mail.* You may mail written comments to the following address only:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1503–P, P.O. Box 8013, Baltimore, MD 21244–8013.

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

3. *By express or overnight mail.* You may send written comments to the following address only:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1503–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

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

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

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

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

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

FOR FURTHER INFORMATION CONTACT:

Rebecca Cole, (410) 786–4497, for issues related to physician payment and for all other issues not identified below.

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

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

Glenn McGuirk, (410) 786–5723, for clinical laboratory issues.

Randall Ricktor, (410) 786–4632, for Federally Qualified Health Center Issues.

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

Troy Barsky, (410)786–8873, or Kristin Bohl, (410)786–8680, for issues related to physician self-referral.

Troy Barsky, (410)786–8873, or Fred Grabau (410)786–0206, for issues related to timely filing rules.

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

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

Sheila Roman, 410–786–6004, or Pamela Cheetham, 410–786–2259, for issues related to the Physician Resource Use Feedback Program and value-based purchasing.

Joel Kaiser, (410)786–4499, for issues related to the DME provisions.

Jim Bossenmeyer, (410)786–9317, for issues related to provider and supplier enrollment issues.

SUPPLEMENTARY INFORMATION:

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

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

Table of Contents

To assist readers in referencing sections contained in this preamble, we are providing a table of contents. Some of the issues discussed in this preamble affect the payment policies, but do not require changes to the regulations in the *Code of Federal Regulations* (CFR). Information on the regulation's impact appears throughout the preamble, and therefore, is not discussed exclusively in section V. of this proposed rule.

Acronyms

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

AA Anesthesiologist assistant
AACVPR American Association of Cardiovascular and Pulmonary Rehabilitation
AANA American Association of Nurse Anesthetists
ABMS American Board of Medical Specialties
ABN Advanced Beneficiary Notice
ACA "Affordable Care Act"
ACC American College of Cardiology
ACGME Accreditation Council on Graduate Medical Education
ACLS Advanced cardiac life support
ACR American College of Radiology
AED Automated external defibrillator
AFROC Association of Freestanding Radiation Oncology Centers
AHA American Heart Association
AHFS–DI American Hospital Formulary Service—Drug Information
AHRQ [HHS'] Agency for Healthcare Research and Quality
AMA American Medical Association
AMA–DE American Medical Association Drug Evaluations
AMP Average manufacturer price
AO Accreditation organization
AOA American Osteopathic Association
APA American Psychological Association
APTA American Physical Therapy Association
ARRA American Recovery and Reinvestment Act (Pub. L. 111–5)
ASC Ambulatory surgical center
ASP Average sales price
ASRT American Society of Radiologic Technologists
ASTRO American Society for Therapeutic Radiology and Oncology
ATA American Telemedicine Association
AWP Average wholesale price
BBA Balanced Budget Act of 1997 (Pub. L. 105–33)
BBRA [Medicare, Medicaid and State Child Health Insurance Program] Balanced Budget Refinement Act of 1999 (Pub. L. 106–113)
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement Protection Act of 2000 (Pub. L. 106–554)
BLS Basic Life support
BN Budget neutrality
BPM Benefit Policy Manual
CABG Coronary artery bypass graft
CAD Coronary artery disease
CAH Critical access hospital
CAHEA Committee on Allied Health Education and Accreditation
CAP Competitive acquisition program
CBIC Competitive Bidding Implementation Contractor
CBP Competitive Bidding Program
CBSA Core-Based Statistical Area
CF Conversion factor
CfC Conditions for Coverage
CFR Code of Federal Regulations
CKD Chronic kidney disease
CLFS Clinical laboratory fee schedule
CMA California Medical Association
CMHC Community mental health center
CMP Civil money penalty
CMS Centers for Medicare & Medicaid Services
CNS Clinical nurse specialist
CoP Condition of participation
COPD Chronic obstructive pulmonary disease
CORF Comprehensive Outpatient Rehabilitation Facility
COS Cost of service
CPEP Clinical Practice Expert Panel
CPI Consumer Price Index
CPI–U Consumer price index for urban customers
CPR Cardiopulmonary resuscitation
CPT [Physicians'] Current Procedural Terminology (4th Edition, 2002, copyrighted by the American Medical Association)
CR Cardiac rehabilitation
CRNA Certified registered nurse anesthetist
CRP Canalith repositioning
CRT Certified respiratory therapist
CSW Clinical social worker
CY Calendar year
DEA Drug Enforcement Agency
DHS Designated health services
DME Durable medical equipment
DMEPOS Durable medical equipment, prosthetics, orthotics, and supplies
DOQ Doctor's Office Quality
DOS Date of service
DRA Deficit Reduction Act of 2005 (Pub. L. 109–171)
DSMT Diabetes self-management training
E/M Evaluation and management
EDI Electronic data interchange
EEG Electroencephalogram
EHR Electronic health record
EKG Electrocardiogram
EMG Electromyogram
EMTALA Emergency Medical Treatment and Active Labor Act
EOG Electro-oculogram
EPO Erythopoeitin
ESRD End-stage renal disease
FAX Facsimile
FDA Food and Drug Administration (HHS)
FFS Fee-for-service
FR **Federal Register**
GAF Geographic adjustment factor
GAO General Accounting Office
GEM Generating Medicare [Physician Quality Performance Measurement Results]
GFR Glomerular filtration rate
GPO Group purchasing organization
GPCI Geographic practice cost index
HAC Hospital-acquired conditions
HBAI Health and behavior assessment and intervention
HCPAC Health Care Professional Advisory Committee
HCPCS Healthcare Common Procedure Coding System
HCRIS Healthcare Cost Report Information System
HDRT High dose radiation therapy
HH PPS Home Health Prospective Payment System
HHA Home health agency
HHRG Home health resource group
HHS [Department of] Health and Human Services
HIPAA Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191)
HIT Health information technology
HITECH Health Information Technology for Economic and Clinical Health Act (Title IV of Division B of the Recovery Act, together with Title XIII of Division A of the Recovery Act)
HITSP Healthcare Information Technology Standards Panel
HIV Human immunodeficiency virus
HOPD Hospital outpatient department
HPSA Health Professional Shortage Area
HRSA Health Resources Services Administration (HHS)
IACS Individuals Access to CMS Systems
ICD International Classification of Diseases

ICF Intermediate care facilities
ICR Intensive cardiac rehabilitation
ICR Information collection requirement
IDTF Independent diagnostic testing facility
IFC Interim final rule with comment period
IMRT Intensity-Modulated Radiation Therapy
IPPE Initial preventive physical examination
IPPS Inpatient prospective payment system
IRS Internal Revenue Service
ISO Insurance services office
IVD Ischemic Vascular Disease
IVIG Intravenous immune globulin
IWPUT Intra-service work per unit of time
JRCERT Joint Review Committee on Education in Radiologic Technology
KDE Kidney disease education
LCD Local coverage determination
MA Medicare Advantage
MA–PD Medicare Advantage—Prescription Drug Plans
MAV Measure Applicability Validation
MCMP Medicare Care Management Performance
MDRD Modification of Diet in Renal Disease
MedCAC Medicare Evidence Development and Coverage Advisory Committee (formerly the Medicare Coverage Advisory Committee (MCAC))
MedPAC Medicare Payment Advisory Commission
MEI Medicare Economic Index
MIEA–TRHCA Medicare Improvements and Extension Act of 2006 (that is, Division B of the Tax Relief and Health Care Act of 2006 (TRHCA)) (Pub. L. 109–432)
MIPPA Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275)
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173)
MMSEA Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173)
MNT Medical nutrition therapy
MOC Maintenance of certification
MP Malpractice
MPPR Multiple procedure payment reduction
MQSA Mammography Quality Standards Act of 1992 (Pub. L. 102–539)
MRA Magnetic resonance angiography
MRI Magnetic resonance imaging
MSA Metropolitan statistical area
NBRC National Board for Respiratory Care
NCD National Coverage Determination
NCQDIS National Coalition of Quality Diagnostic Imaging Services
NDC National drug code
NF Nursing facility
NISTA National Institute of Standards and Technology Act
NP Nurse practitioner
NPI National Provider Identifier
NPP Nonphysician practitioner
NQF National Quality Forum
NRC Nuclear Regulatory Commission
OACT [CMS'] Office of the Actuary
OBRA Omnibus Budget Reconciliation Act
ODF Open door forum
OGPE Oxygen generating portable equipment
OIG Office of Inspector General
OMB Office of Management and Budget
ONC [HHS'] Office of the National Coordinator for Health IT
OPPS Outpatient prospective payment system
OSCAR Online Survey and Certification and Reporting
PA Physician assistant
PAT Performance assessment tool
PC Professional component
PCI Percutaneous coronary intervention
PDP Prescription drug plan
PE Practice expense
PE/HR Practice expense per hour
PEAC Practice Expense Advisory Committee
PERC Practice Expense Review Committee
PFS Physician Fee Schedule
PGP [Medicare] Physician Group Practice
PHI Protected health information
PHP Partial hospitalization program
PIM [Medicare] Program Integrity Manual
PLI Professional liability insurance
POA Present on admission
POC Plan of care
PPI Producer price index
PPIS Physician Practice Information Survey
PPS Prospective payment system
PPTA Plasma Protein Therapeutics Association
PQRI Physician Quality Reporting Initiative
PR Pulmonary rehabilitation
PRA Paperwork Reduction Act
PSA Physician scarcity areas
PT Physical therapy
PTCA Percutaneous transluminal coronary angioplasty
PVBP Physician and Other Health Professional Value-Based Purchasing Workgroup
RA Radiology assistant
RBMA Radiology Business Management Association
RFA Regulatory Flexibility Act
RHC Rural health clinic
RIA Regulatory impact analysis
RN Registered nurse
RNAC Reasonable net acquisition cost
RPA Radiology practitioner assistant
RRT Registered respiratory therapist
RUC [AMA's Specialty Society] Relative (Value) Update Committee
RVU Relative value unit
SBA Small Business Administration
SGR Sustainable growth rate
SLP Speech-language pathology
SMS [AMA's] Socioeconomic Monitoring System
SNF Skilled nursing facility
SOR System of record
SRS Stereotactic radiosurgery
STARS Services Tracking and Reporting System
TC Technical Component
TIN Tax identification number
TRHCA Tax Relief and Health Care Act of 2006 (Pub. L. 109–432)
TTO Transtracheal oxygen
UPMC University of Pittsburgh Medical Center
USDE United States Department of Education
USP–DI United States Pharmacopoeia-Drug Information
VBP Value-based purchasing
WAMP Widely available market price

I. Background

Since January 1, 1992, Medicare has paid for physicians' services under section 1848 of the Social Security Act (the Act), "Payment for Physicians' Services." The Act requires that payments under the physician fee schedule (PFS) are based on national uniform relative value units (RVUs) based on the relative resources used in furnishing a service. Section 1848(c) of the Act requires that national RVUs be established for physician work, practice expense (PE), and malpractice expense. Before the establishment of the resource-based relative value system, Medicare payment for physicians' services was based on reasonable charges. We note that throughout this proposed rule, unless otherwise noted, the term "practitioner" is used to describe both physicians and eligible nonphysician practitioners (such as physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, psychologists, or social workers) that are permitted to furnish and bill Medicare under the PFS for the services under discussion.

A. Development of the Relative Value System

1. Work RVUs

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

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

Section 1848(b)(2)(B) of the Act specifies that the RVUs for anesthesia services are based on RVUs from a uniform relative value guide, with appropriate adjustment of the

conversion factor (CF), in a manner to assure that fee schedule amounts for anesthesia services are consistent with those for other services of comparable value. We established a separate CF for anesthesia services, and we continue to utilize time units as a factor in determining payment for these services. As a result, there is a separate payment methodology for anesthesia services.

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

2. Practice Expense Relative Value Units (PE RVUs)

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

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

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

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

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

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

In the calendar year (CY) 2007 PFS final rule with comment period (71 FR 69624), we revised the methodology for calculating direct PE RVUs from the top-down to the bottom-up methodology beginning in CY 2007 and provided for a 4-year transition for the new PE RVUs under this new methodology. This transition ended in CY 2010 and direct PE RVUs are calculated in CY 2011 using this methodology, unless otherwise noted.

In the CY 2010 PFS final rule with comment period, we updated the PE/hour (HR) data that are used in the calculation of PE RVUs for most specialties (74 FR 61749). For this update, we used the Physician Practice Information Survey (PPIS) conducted by the AMA. The PPIS is a multispecialty, nationally representative, PE survey of both physicians and nonphysician practitioners (NPPs) using a survey instrument and methods highly consistent with those of the SMS and the supplemental surveys used prior to CY 2010. We note that in CY 2010, for oncology, clinical laboratories, and independent diagnostic testing facilities (IDTFs), we continued to use the supplemental survey data to determine PE/HR values (74 FR 61752).

3. Resource-Based Malpractice (MP) RVUs

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

4. Refinements to the RVUs

Section 1848(c)(2)(B)(i) of the Act requires that we review all RVUs no less often than every 5 years. The first Five-Year Review of the physician work RVUs was published on November 22, 1996 (61 FR 59489) and was effective in 1997. The second Five-Year Review was published in the CY 2002 PFS final rule with comment period (66 FR 55246) and was effective in 2002. The third Five-Year Review of physician work RVUs was published in the CY 2007 PFS final rule with comment period (71 FR 69624) and was effective on January 1, 2007. (**Note:** Additional codes relating to the third Five-Year Review of physician work RVUs were addressed in the CY 2008 PFS final rule with comment period (72 FR 66360).) The fourth Five-Year Review of physician work RVUs was initiated in the CY 2010 PFS final rule with comment period where we solicited candidate codes from the public for this review (74 FR 61941). Changes due to the fourth Five-Year Review of physician work RVUs will be effective January 1, 2012.

In 1999, the AMA's RUC established the Practice Expense Advisory Committee (PEAC) for the purpose of refining the direct PE inputs. Through March 2004, the PEAC provided recommendations to CMS for over 7,600 codes (all but a few hundred of the codes currently listed in the AMA's Current Procedural Terminology (CPT) codes). As part of the CY 2007 PFS final rule with comment period (71 FR 69624), we implemented a new bottom-up methodology for determining resource-based PE RVUs and transitioned the new methodology over a 4-year period. A comprehensive review of PE was undertaken prior to the 4-year transition period for the new PE methodology from the top-down to the bottom-up methodology, and this transition was completed in CY 2010. In

CY 2010, we also incorporated the new PPIS data to update the specialty-specific PE/HR data used to develop PE RVUs. Therefore, the next Five-Year Review of PE RVUs will be addressed in CY 2014.

In the CY 2005 PFS final rule with comment period (69 FR 66236), we implemented the first Five-Year Review of the MP RVUs (69 FR 66263). Minor modifications to the methodology were addressed in the CY 2006 PFS final rule with comment period (70 FR 70153). The second Five-Year Review and update of resource-based malpractice RVUs was published in the CY 2010 PFS final rule with comment period (74 FR 61758) and was effective in CY 2010.

5. Adjustments to RVUs Are Budget Neutral

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

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

For CY 2010, we adopted a number of new payment policies for which we estimated the potential for a redistributive effect under the PFS, including the use of the new PPIS data to develop the specialty-specific PE/HR used for the PE RVUs (74 FR 61749 through 61752) and the elimination of the reporting of all CPT consultation codes in order to allow for correct and consistent coding and appropriate payment for evaluation and management services under the PFS (74 FR 61767 through 61775). We recognize that clinical experience with these new PFS policies has been growing over the first 6 months of CY 2010 and, as we seek to improve future PFS payment accuracy for services, we are interested in public comments on the perspectives of physicians and nonphysician practitioners caring for Medicare beneficiaries under the current PFS coding and payment methodologies for physicians' services.

B. Components of the Fee Schedule Payment Amounts

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

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

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

$$\text{Payment} = [(\text{RVU work} \times \text{GPCI work}) + (\text{RVU PE} \times \text{GPCI PE}) + (\text{RVU malpractice} \times \text{GPCI malpractice})] \times \text{CF}$$

C. Most Recent Changes to the Fee Schedule

The CY 2010 PFS final rule with comment period (74 FR 61738) implemented changes to the PFS and other Medicare Part B payment policies. It also finalized some of the CY 2009 interim RVUs and implemented interim RVUs for new and revised codes for CY 2010 to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. The CY 2010 PFS final rule with comment period also addressed other policies, as well as certain provisions of the MIPPA.

As required by the statute at the time of its issuance on October 30, 2009, the CY 2010 PFS final rule with comment period announced the following for CY 2010: The PFS update of −21.2 percent; the initial estimate for the sustainable growth rate of −8.8 percent; and the CF of $28.4061.

On December 10, 2009, we published a correction notice (74 FR 65449) to correct several technical and typographical errors that occurred in the CY 2010 PFS final rule with comment period. This correction notice announced a revised CF for CY 2010 of $28.3895.

On December 19, 2009, the Department of Defense Appropriations Act, 2010 (Pub. L. 111–118) was signed into law. Section 1011 of Pub. L. 111–118 provided a 2-month zero percent update to the CY 2010 PFS effective only for dates of service from January 1, 2010 through February 28, 2010.

On March 2, 2010, the Temporary Extension Act of 2010 (Pub. L. 111–144) was signed into law. Section 2 of Pub. L. 111–144 extended the zero percent update to the PFS through March 31, 2010 that was in effect for claims with dates of service from January 1, 2010 through February 28, 2010.

In addition, on April 15, 2010, the Continuing Extension Act of 2010 (Pub. L. 111–157) was signed into law. Section 4 of Public Law 111–157 extended through May 31, 2010 the zero percent update to the PFS that was in effect for claims with dates of services from January 1, 2010 through March 31, 2010. The law is retroactive to April 1, 2010.

In the May 11, 2010 **Federal Register** (75 FR 26350), we published a subsequent correction notice to correct several technical and typographical errors that occurred in the CY 2010 PFS final rule with comment period and the December 10, 2009 correction notice. The May 11, 2010 correction notice announced a revised CF for CY 2010 of $28.3895.

Finally, on March 23, 2010 the Patient Protection and Affordable Care Act (Pub. L. 111–148) was signed into law. Shortly thereafter, on March 30, 2010, the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) was signed into law. These two laws are discussed in this proposed rule and are collectively referred to as the "Affordable Care Act" (ACA) throughout this proposed rule.

II. Provisions of the Proposed Rule for the Physician Fee Schedule

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

1. Overview

Practice expense (PE) is the portion of the resources used in furnishing the service that reflects the general categories of physician and practitioner expenses, such as office rent and personnel wages but excluding malpractice expenses, as specified in section 1848(c)(1)(B) of the Act. Section 121 of the Social Security Amendments of 1994 (Pub. L. 103–432), enacted on October 31, 1994, required CMS to develop a methodology for a resource-based system for determining PE RVUs for each physician's service. We develop PE RVUs by looking at the direct and indirect physician practice resources involved in furnishing each service. Direct expense categories include clinical labor, medical supplies and medical equipment. Indirect expenses include administrative labor, office expense, and all other expenses. The sections that follow provide more

detailed information about the methodology for translating the resources involved in furnishing each service into service-specific PE RVUs. In addition, we note that section 1848(c)(2)(B)(ii)(II) of the Act provides that adjustments in RVUs for a year may not cause total PFS payments to differ by more than $20 million from what they would have been if the adjustments were not made. Therefore, if revisions to the RVUs cause expenditures to change by more than $20 million, we make adjustments to ensure that expenditures do not increase or decrease by more than $20 million. We refer readers to the CY 2010 PFS final rule with comment period (74 FR 61743 through 61748) for a more detailed history of the PE methodology.

2. Practice Expense Methodology

a. Direct Practice Expense

We use a bottom-up approach to determine the direct PE by adding the costs of the resources (that is, the clinical staff, equipment, and supplies) typically required to provide each service. The costs of the resources are calculated using the refined direct PE inputs assigned to each CPT code in our PE database, which are based on our review of recommendations received from the American Medical Association's (AMA's) Relative Value Update Committee (RUC). For a detailed explanation of the bottom-up direct PE methodology, including examples, we refer readers to the Five-Year Review of Work Relative Value Units Under the PFS and Proposed Changes to the Practice Expense Methodology proposed notice (71 FR 37242) and the CY 2007 PFS final rule with comment period (71 FR 69629).

b. Indirect Practice Expense per Hour Data

We use survey data on indirect practice expenses incurred per hour worked (PE/HR) in developing the indirect portion of the PE RVUs. Prior to CY 2010, we primarily used the practice expense per hour (PE/HR) by specialty that was obtained from the AMA's Socioeconomic Monitoring Surveys (SMS). These surveys were conducted from 1995 through 1999. For several specialties that collected additional PE/HR data through supplemental surveys, we incorporated these data in developing the PE/HR values used annually.

While the SMS was not specifically designed for the purpose of establishing PE RVUs, we found these data to be the best available at the time. The SMS was a multispecialty survey effort conducted using a consistent survey instrument and method across specialties. The survey sample was randomly drawn from the AMA Physician Masterfile to ensure national representativeness. The AMA discontinued the SMS survey in 1999. As required by the Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113), we also established a process by which specialty groups could submit supplemental PE data. In the May 3, 2000 **Federal Register**, we issued the Medicare Program; Criteria for Submitting Supplemental Practice Expense Survey Data interim final rule (65 FR 25664) in which we established criteria for acceptance of supplemental data. The criteria were modified in the CY 2001 and CY 2003 PFS final rules with comment period (65 FR 65380 and 67 FR 79971, respectively). In addition to the SMS, we previously used supplemental survey data for the following specialties: Cardiology; dermatology; gastroenterology; radiology; cardiothoracic surgery; vascular surgery; physical and occupational therapy; independent laboratories; allergy/immunology; independent diagnostic testing facilities (IDTFs); radiation oncology; medical oncology; and urology.

Because the SMS data and the supplemental survey data were from different time periods, we historically inflated them by the Medicare Economic Index (MEI) to put them on as comparable a time basis as we could when calculating the PE RVUs. This MEI proxy was necessary in the past due to the lack of contemporaneous, consistently collected, and comprehensive multispecialty survey data.

The AMA administered a new survey in CY 2007 and CY 2008, the Physician Practice Expense Information Survey (PPIS), which was expanded (relative to the SMS) to include nonphysician practitioners (NPPs) paid under the PFS. The PPIS was designed to update the specialty-specific PE/HR data used to develop PE RVUs. The AMA and the CMS contractor, The Lewin Group (Lewin), analyzed the PPIS data and calculated the PE/HR for physician and nonphysician specialties, respectively. The AMA's summary worksheets and Lewin's final report are available on the CMS Web site at *http://www.cms.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=4&sortOrder=descending&itemID=CMS1223902&intNumPerPage=10*. (*See* downloads labeled AMA PPIS Worksheets 1–3 and Physician Practice Expense non MDDO Final Report)

The PPIS is a multispecialty, nationally representative, PE survey of both physicians and NPPs using a consistent survey instrument and methods highly consistent with those used for the SMS and the supplemental surveys. The PPIS gathered information from 3,656 respondents across 51 physician specialty and healthcare professional groups.

We believe the PPIS is the most comprehensive source of PE survey information available to date. Therefore, we used the PPIS data to update the PE/HR data for almost all of the Medicare-recognized specialties that participated in the survey for the CY 2010 PFS. When we changed over to the PPIS data beginning in CY 2010, we did not change the PE RVU methodology itself or the manner in which the PE/HR data are used in that methodology. We only updated the PE/HR data based on the new survey. Furthermore, as we explained in the CY 2010 PFS final rule with comment period (74 FR 61751), because of the magnitude of payment reductions for some specialties resulting from the use of the PPIS data, we finalized a 4-year transition (75/25 for CY 2010, 50/50 for CY 2011, 25/75 for CY 2012, and 0/100 for CY 2013) from the previous PE RVUs to the PE RVUs developed using the new PPIS data.

Section 303 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) added section 1848(c)(2)(H)(i) of the Act, which requires us to use the medical oncology supplemental survey data submitted in 2003 for oncology drug administration services. Therefore, the PE/HR for medical oncology, hematology, and hematology/oncology reflects the continued use of these supplemental survey data.

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

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

developed from their supplemental survey data.

Finally, consistent with our past practice, the previous indirect PE/HR values from the supplemental surveys for medical oncology, independent laboratories, and IDTFs were updated to CY 2006 using the MEI to put them on a comparable basis with the PPIS data. In the CY 2010 PFS final rule with comment period (74 FR 61753), we miscalculated the indirect PE/HR for IDTFs as part of this update process. Therefore, for CY 2011, we are proposing to use a revised indirect PE/HR of $479.81 for IDTFs, consistent with our final policy to update the indirect PE/HR values from prior supplemental survey data that we are continuing to use in order to put these data on a comparable basis with the PPIS data. This revision changes the IDTF indirect percentage from 51 percent to 50 percent.

Previously, CMS has established PE/HR values for various specialties without SMS or supplemental survey data by crosswalking them to other similar specialties to estimate a proxy PE/HR. For specialties that were part of the PPIS for which we previously used a crosswalked PE/HR, we instead use the PPIS-based PE/HR. We continue previous crosswalks for specialties that did not participate in the PPIS. However, beginning in CY 2010 we changed the PE/HR crosswalk for portable x-ray suppliers from radiology to IDTF, a more appropriate crosswalk because these specialties are more similar to each other with respect to physician time.

In the CY 2010 PFS final rule with comment period (74 FR 61752), we agreed that, under the current PE methodology, the PPIS data for registered dieticians should not be used in the calculation of PE RVUs since these dieticians are paid 85 percent of what a physician would be paid for providing the service. To include their survey data in the PE calculation would influence the ratesetting by incorporating what the services would be paid if performed by registered dieticians and not strictly what the payment rates would be if provided by physicians. We further stated that we would utilize the "All Physicians" PE/HR, as derived from the PPIS, in the calculation of resource-based PE RVUs in lieu of the PE/HR associated with registered dieticians. In the resource-based PE methodology for CY 2010, while we removed the specialty of registered dieticians from the ratesetting step we did not assign the "All Physicians" PE/HR to services furnished by registered dieticians. Instead, we allowed the PE/HR for those services to be generated by a weighted average of all the physician specialties that also furnished the services. This method was consistent with our policy to not use the registered dietician PPIS PE/HR in calculating the PE RVUs for services furnished by registered dieticians but we did not actually crosswalk the specialty of registered dietician to the "All Physicians" PE/HR data as we had intended according to the final policy. Nevertheless, we are affirming for CY 2011 that the proposed resource-based PE RVUs have been calculated in accordance with the final policy adopted in the CY 2010 PFS final rule with comment period (74 FR 61752) for registered dietician services that crosswalks the specialty to the "All Physicians" PE/HR data.

As provided in the CY 2010 PFS final rule with comment period (74 FR 61751), CY 2011 is the second year of the 4-year transition to the PE RVUs calculated using the PPIS data. Therefore, in general, the CY 2011 PE RVUs are a 50/50 blend of the previous PE RVUs based on the SMS and supplemental survey data and the new PE RVUS developed using the PPIS data as described above. Note that the reductions in the PE RVUs for expensive diagnostic imaging equipment attributable to the change to an equipment utilization rate assumption of 75 percent (*see* 74 FR 61753 through 61755 and section II.A.3. of this proposed rule) are not subject to the transition.

c. Allocation of PE to Services

To establish PE RVUs for specific services, it is necessary to establish the direct and indirect PE associated with each service.

(i) *Direct costs.* The relative relationship between the direct cost portions of the PE RVUs for any two services is determined by the relative relationship between the sum of the direct cost resources (that is, the clinical staff, equipment, and supplies) typically required to provide the services. The costs of these resources are calculated from the refined direct PE inputs in our PE database. For example, if one service has a direct cost sum of $400 from our PE database and another service has a direct cost sum of $200, the direct portion of the PE RVUs of the first service would be twice as much as the direct portion of the PE RVUs for the second service.

(ii) *Indirect costs.* Section II.A.2.b. of this proposed rule describes the current data sources for specialty-specific indirect costs used in our PE calculations. We allocate the indirect costs to the code level on the basis of the direct costs specifically associated with a code and the greater of either the clinical labor costs or the physician work RVUs. We also incorporate the survey data described earlier in the PE/HR discussion. The general approach to developing the indirect portion of the PE RVUs is described below.

- For a given service, we use the direct portion of the PE RVUs calculated as described above and the average percentage that direct costs represent of total costs (based on survey data) across the specialties that perform the service to determine an initial indirect allocator. For example, if the direct portion of the PE RVUs for a given service were 2.00 and direct costs, on average, represented 25 percent of total costs for the specialties that performed the service, the initial indirect allocator would be 6.00 since 2.00 is 25 percent of 8.00.
- We then add the greater of the work RVUs or clinical labor portion of the direct portion of the PE RVUs to this initial indirect allocator. In our example, if this service had work RVUs of 4.00 and the clinical labor portion of the direct PE RVUs was 1.50, we would add 6.00 plus 4.00 (since the 4.00 work RVUs are greater than the 1.50 clinical labor portion) to get an indirect allocator of 10.00. In the absence of any further use of the survey data, the relative relationship between the indirect cost portions of the PE RVUs for any two services would be determined by the relative relationship between these indirect cost allocators. For example, if one service had an indirect cost allocator of 10.00 and another service had an indirect cost allocator of 5.00, the indirect portion of the PE RVUs of the first service would be twice as great as the indirect portion of the PE RVUs for the second service.
- We next incorporate the specialty-specific indirect PE/HR data into the calculation. As a relatively extreme example for the sake of simplicity, assume in our example above that, based on the survey data, the average indirect cost of the specialties performing the first service with an allocator of 10.00 was half of the average indirect cost of the specialties performing the second service with an indirect allocator of 5.00. In this case, the indirect portion of the PE RVUs of the first service would be equal to that of the second service.

d. Facility and Nonfacility Costs

For procedures that can be furnished in a physician's office, as well as in a hospital or facility setting, we establish two PE RVUs: facility and nonfacility.

The methodology for calculating PE RVUs is the same for both the facility and nonfacility RVUs, but is applied independently to yield two separate PE RVUs. Because Medicare makes a separate payment to the facility for its costs of furnishing a service, the facility PE RVUs are generally lower than the nonfacility PE RVUs.

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

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

f. Alternative Data Sources and Public Comments on Final Rule for 2010.

In the CY 2010 PFS final rule with comment period (74 FR 61749 through 61750), we discussed the Medicare Payment Advisory Commission's (MedPAC's) comment that in the future, "CMS should consider alternatives to collecting specialty-specific cost data or options to decrease the reliance on such data." We agreed with MedPAC that it would be appropriate to consider the future of the PE RVUs moving forward. We sought comments from other stakeholders on the issues raised by MedPAC for the future. In particular, we requested public comments regarding MedPAC's suggestion that we consider alternatives for collecting specialty-specific cost data or options to decrease the reliance on such data. We noted MedPAC's comment that, "CMS should consider if Medicare or provider groups should sponsor future data collection efforts, if participation should be voluntary (such as surveys) or mandatory (such as cost reports), and whether a nationally representative sample of practitioners would be sufficient for either a survey or cost reports." MedPAC also stated that one option for decreasing the reliance on specialty-specific cost data would be the elimination of the use of indirect PE/HR data in the last step of establishing the indirect cost portion of the PE RVUs as described previously.

Almost all of the commenters on the CY 2010 PFS final rule with comment period that addressed this issue expressed a general willingness to work with CMS on methodological improvements or future data collection efforts. Although no commenters detailed a comprehensive overall alternative methodology, several commenters did provide suggestions regarding future data collection efforts and specific aspects of the current methodology.

The commenters that addressed the issue of surveys supported the use of surveys if they yielded accurate PE information. The few commenters that addressed the issue of cost reports were opposed to physician cost reports. The commenters varied with respect to their opinions regarding whether data collection efforts should be led by organized medicine, individual specialty societies, or CMS. Several commenters that addressed the issue of voluntary versus mandatory data collection efforts supported voluntary data collection efforts and opposed mandatory data collection efforts.

Some commenters recommended no changes to the methodology or PE data in the near future. Other commenters indicated that the methodology and data changes needed to be made for CY 2011. Although most commenters did not directly address the use of the indirect PE/HR data, those that did predominately opposed the elimination of the use of these data.

Many commenters addressed specifics of the PE methodology (as further described in section II.A.2.c. of this proposed rule). Some were opposed to the scaling factor applied in the development of the direct PE portion of the PE RVUs so that in the aggregate the direct portion of the PE RVUs do not exceed the proportion indicated by the survey data (*See* Step 4 in g.(ii) below). Several of these commenters advocated the elimination of this direct scaling factor, while others indicated that the issue should be examined more closely.

A few commenters recommended that physician work not be used as an allocator in the development of the indirect portion of the PE RVUs as described earlier in this section. A few indicated that physician time, but not physician work, should be used in the allocation. Other commenters suggested that indirect costs should be allocated solely on the basis of direct costs.

We note that many of the issues raised by commenters on the CY 2010 PFS final rule with comment period are similar to issues raised in the development of the original resource-based PE methodology and in subsequent revisions to the methodology, including the adoption of the bottom-up methodology. While we are not proposing a broad methodological change or broad data collection effort in this CY 2011 PFS proposed rule, we invite comments on our summary of the issues raised by the commenters on the CY 2010 PFS final rule with comment period, as presented above. The complete public comments on that final rule are available for public review at *http://www.regulations.gov* by entering "CMS–1413–FC" in the search box on the main page.

g. PE RVU Methodology

For a more detailed description of the PE RVU methodology, we refer readers to the CY 2010 PFS final rule with comment period (74 FR 61745 through 61746).

(i) Setup File

First, we create a setup file for the PE methodology. The setup file contains the direct cost inputs, the utilization for each procedure code at the specialty and facility/nonfacility place of service level, and the specialty-specific PE/HR data from the surveys.

(ii) Calculate the Direct Cost PE RVUs

Sum the costs of each direct input.

Step 1: Sum the direct costs of the inputs for each service. Apply a scaling adjustment to the direct inputs.

Step 2: Calculate the current aggregate pool of direct PE costs. This is the product of the current aggregate PE (aggregate direct and indirect) RVUs, the CF, and the average direct PE percentage from the survey data.

Step 3: Calculate the aggregate pool of direct costs. This is the sum of the product of the direct costs for each service from Step 1 and the utilization data for that service.

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

Step 5: Convert the results of Step 4 to an RVU scale for each service. To do this, divide the results of Step 4 by the CF. Note that the actual value of the CF used in this calculation does not influence the final direct cost PE RVUs, as long as the same CF is used in Step 2 and Step 5. Different CFs will result

in different direct PE scaling factors, but this has no effect on the final direct cost PE RVUs since changes in the CFs and changes in the associated direct scaling factors offset one another.

(iii) Create the Indirect Cost PE RVUs

Create indirect allocators.

Step 6: Based on the survey data, calculate direct and indirect PE percentages for each physician specialty.

Step 7: Calculate direct and indirect PE percentages at the service level by taking a weighted average of the results of Step 6 for the specialties that furnish the service. Note that for services with TCs and PCs, the direct and indirect percentages for a given service do not vary by the PC, TC, and global components.

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

For most services the indirect allocator is:

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

There are two situations where this formula is modified:

- If the service is a global service (that is, a service with global, professional, and technical components), then the indirect allocator is: indirect percentage * (direct PE RVUs/direct percentage) + clinical PE RVUs + work RVUs.
- If the clinical labor PE RVUs exceed the work RVUs (and the service is not a global service), then the indirect allocator is: indirect percentage * (direct PE RVUs/direct percentage) + clinical PE RVUs.

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

For presentation purposes in the examples in the Table 2, the formulas were divided into two parts for each service. The first part does not vary by service and is the: indirect percentage * (direct PE RVUs/direct percentage). The second part is either the work RVUs, clinical PE RVUs, or both depending on whether the service is a global service and whether the clinical PE RVUs exceed the work RVUs (as described earlier in this step).

Apply a scaling adjustment to the indirect allocators.

Step 9: Calculate the current aggregate pool of indirect PE RVUs by multiplying the current aggregate pool of PE RVUs by the average indirect PE percentage from the survey data.

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

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

Calculate the indirect practice cost index.

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

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

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

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

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

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

(iv) Calculate the Final PE RVUs

Step 18: Add the direct PE RVUs from Step 6 to the indirect PE RVUs from Step 17 and apply the final PE budget neutrality (BN) adjustment, MEI rebasing adjustment, and multiple procedure payment reduction (MPPR) adjustment.

The final PE BN adjustment is calculated by comparing the results of Step 18 (prior to the MEI rebasing and MPPR adjustments) to the current pool of PE RVUs. This final BN adjustment is required primarily because certain specialties are excluded from the PE RVU calculation for ratesetting purposes, but all specialties are included for purposes of calculating the final BN adjustment. (*See* "Specialties excluded from ratesetting calculation" below in this section.)

As discussed in section II.E.1. of this proposed rule, we are proposing to rebase and revise the Medicare Economic Index (MEI) for CY 2011. As discussed in section II.C.4. of this proposed rule, section 1848(c)(2)(K) of the Act (as added by section 3134 of the ACA) specifies that the Secretary shall identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service. There is inherent duplication in the PE associated with those services which are frequently furnished together, so reducing PFS payment for the second and subsequent services to account for the efficiencies in multiple service sessions may be appropriate. Consistent with this provision of the ACA, we are proposing a limited expansion of the current MPPR policy for imaging services for CY 2011 and a new MPPR policy for therapy services.

(v) Setup File Information

- Specialties excluded from ratesetting calculation: For the purposes of calculating the PE RVUs, we exclude certain specialties, such as certain nonphysician practitioners paid at a percentage of the PFS and low volume specialties, from the calculation. These specialties are included for the purposes of calculating the BN adjustment. They are displayed in Table 1.

TABLE 1—SPECIALTIES EXCLUDED FROM RATESETTING CALCULATION

Specialty code	Specialty description
42	Certified nurse midwife.
49	Ambulatory surgical center.
50	Nurse practitioner.
51	Medical supply company with certified orthotist.
52	Medical supply company with certified prosthetist.
53	Medical supply company with certified prosthetist-orthotist.
54	Medical supply company not included in 51, 52, or 53.
55	Individual certified orthotist.
56	Individual certified prosthetist.
57	Individual certified prosthetist-orthotist.
58	Individuals not included in 55, 56, or 57.
59	Ambulance service supplier, *e.g.,* private ambulance companies, funeral homes, etc.
60	Public health or welfare agencies.
61	Voluntary health or charitable agencies.
73	Mass immunization roster biller.
74	Radiation therapy centers.
87	All other suppliers (*e.g.,* drug and department stores).
88	Unknown supplier/provider specialty.
89	Certified clinical nurse specialist.
95	Competitive Acquisition Program (CAP) Vendor.
96	Optician.
A0	Hospital.
A1	SNF.
A2	Intermediate care nursing facility.
A3	Nursing facility, other.
A4	HHA.
A5	Pharmacy.
A6	Medical supply company with respiratory therapist.
A7	Department store.
1	Supplier of oxygen and/or oxygen related equipment.
2	Pedorthic personnel.
3	Medical supply company with pedorthic personnel.

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

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

• Identify professional and technical services not identified under the usual TC and 26 modifiers: Flag the services that are PC and TC services, but do not use TC and 26 modifiers (for example, electrocardiograms). This flag associates the PC and TC with the associated global code for use in creating the indirect PE RVUs. For example, the professional service, CPT code 93010 (Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only), is associated with the global service, CPT code 93000 (Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report).

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

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

(vi) Equipment Cost per Minute

The equipment cost per minute is calculated as:

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

Where:

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

usage = equipment utilization assumption; 0.75 for certain expensive diagnostic imaging equipment (*see* 74 FR 61753 through 61755 and section II.A.3. of this proposed rule) and 0.5 for others.

price = price of the particular piece of equipment.

interest rate = 0.11.

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

maintenance = factor for maintenance; 0.05.

Note: The use of any particular conversion factor (CF) in Table 2 to illustrate the PE calculation has no effect on the resulting RVUs.

TABLE 2—CALCULATION OF PE RVUS UNDER METHODOLOGY FOR SELECTED CODES

	Step	Source	Formula	99213 Office visit, est nonfacility	33533 CABG, arterial, single facility	71020 Chest x-ray nonfacility	71020–TC Chest x-ray nonfacility	71020–26 Chest x-ray nonfacility	93000 ECG, complete nonfacility	93005 ECG, tracing nonfacility	93010 ECG, report nonfacility
(1) Labor cost (Lab)	Step 1	AMA		13.32	77.52	5.74	5.74	0.00	6.12	6.12	0.00
(2) Suppy cost (Sup)	Step 1	AMA		2.98	7.34	3.39	3.39	0.00	1.19	1.19	0.00
(3) Equipment cost (Eqp).	Step 1	AMA		0.19	0.65	8.17	8.17	0.00	0.12	0.12	0.00
(4) Direct cost (Dir)	Step 1		=(1)+(2)+(3)	16.50	85.51	17.31	17.31	0.00	7.43	7.43	0.00
(5) Direct adjustment (Dir Adj).	Steps 2–4	See footnote*		0.484	0.484	0.484	0.484	0.484	0.484	0.484	0.484
(6) Adjusted labor	Steps 2–4	=Lab * Dir Adj	=(1) * (5)	6.45	37.52	2.78	2.78	0.00	2.96	2.96	0.00
(7) Adjusted supplies	Steps 2–4	=Sup * Dir Adj	=(2) * (5)	1.44	3.55	1.64	1.64	0.00	0.58	0.58	0.00
(8) Adjusted equipment	Steps 2–4	=Eqp * Dir Adj	=(3) * (5)	0.09	0.32	3.96	3.96	0.00	0.06	0.06	0.00
(9) Adjusted direct	Steps 2–4		=(6)+(7)+(8)	7.99	41.39	8.38	8.38	0.00	3.60	3.60	0.00
(10) Conversion Factor (CF).	Step 5	PFS		36.0791	36.0791	36.0791	36.0791	36.0791	36.0791	36.0791	36.0791
(11) Adj. labor cost converted.	Step 5	=(Lab * Dir Adj)/CF	=(6)/(10)	0.18	1.04	0.08	0.08	0.00	0.08	0.08	0.00
(12) Adj. supply cost converted.	Step 5	=(Sup * Dir Adj)/CF	=(7)/(10)	0.04	0.10	0.05	0.05	0.00	0.02	0.02	0.00
(13) Adj. equip cost converted.	Step 5	=(Eqp * Dir Adj)/CF	=(8)/(10)	0.00	0.01	0.11	0.11	0.00	0.00	0.00	0.00
(14) Adj. direct cost converted.	Step 5		=(11)+(12)+(13)	0.22	1.15	0.23	0.23	0.00	0.10	0.10	0.00
(15) Wrk RVU	Setup File	PFS		0.97	33.75	0.22	0.00	0.22	0.17	0.00	0.17
(16) Dir_pct	Steps 6, 7	Surveys		25.5%	18.0%	28.9%	28.9%	28.9%	29.0%	29.0%	29.0%
(17) Ind_pct	Steps 6, 7	Surveys		74.5%	82.0%	71.2%	71.2%	71.2%	71.1%	71.1%	71.1%
(18) Ind. Alloc. formula (1st part).	Step 8	See Step 8		((14)/(16)) * (17)	((14)/(16)) * (17)	((14)/(16)) * (17)	((14)/(16)) * (17)	((14)/(16)) * (17)	((14)/(16)) * (17)	((14)/(16)) * (17)	((14)/(16)) * (17)
(19) Ind. Alloc. (1st part).	Step 8		See (18)	0.65	5.23	0.57	0.57	0.00	0.24	0.24	0.00
(20) Ind. Alloc. formulas (2nd part).	Step 8	See Step 8		(15)	(15)	(15)+(11)	(11)	(15)	(15)+(11)	(11)	(15)
(21) Ind. Alloc. (2nd part).	Step 8		See (20)	0.97	33.75	0.30	0.08	0.22	0.25	0.08	0.17
(22) Indirect Allocator (1st+2nd).	Step 8		=(19)+(21)	1.62	38.98	0.87	0.65	0.22	0.50	0.33	0.17
(23) Indirect Adjustment (Ind Adj).	Steps 9–11	See footnote**		0.369	0.369	0.369	0.369	0.369	0.369	0.369	0.369
(24) Adjusted Indirect Allocator.	Steps 9–11	=Ind Alloc * Ind Adj		0.60	14.37	0.32	0.24	0.08	0.18	0.12	0.06
(25) Ind.Practice Cost Index (PCI).	Steps 12–16	See Steps 12–16		1.104	0.831	0.852	0.852	0.852	0.926	0.926	0.926
(26) Adjusted Indirect	Step 17	= Adj. Ind Alloc * PCI	=(24) * (25)	0.66	11.95	0.27	0.20	0.07	0.17	0.11	0.06
(27) MEI Rebasing Adjustment.	Step 18	PFS		1.168	1.168	1.168	1.168	1.168	1.168	1.168	1.168
(28) MPPR Adjustment	Step 18	PFS		1.011	1.011	1.011	1.011	1.011	1.011	1.011	1.011
(29) PE RVU	Step 18	=(Adj Dir+Adj Ind) * budn * MEI Adj * MPPR Adj.	=((14)+(26)) * budn * (27) * (28).	1.03	15.36	0.59	0.51	0.08	0.32	0.25	0.07

Note: PE RVUs in Table 2, row 27, may not match Addendum B due to rounding.
* The direct adj = [current pe rvus * CF * avg dir pct]/[sum direct inputs] = [Step 2]/[Step 3].
** The indirect adj = [current pe rvus * avg ind pct]/[sum of ind allocators] = [Step 9]/[Step 10].

3. Proposed PE Revisions for CY 2011

a. Equipment Utilization Rate

As part of the PE methodology associated with the allocation of equipment costs for calculating PE RVUs, we currently use an equipment utilization rate assumption of 50 percent for most equipment, with the exception of expensive diagnostic imaging equipment (which is equipment priced at over $1 million, for example, computed tomography (CT) and magnetic resonance imaging (MRI) scanners), for which we adopted a 90 percent utilization rate assumption and provided for a 4-year transition beginning in CY 2010 (74 FR 61755). Therefore, CY 2010 is the first transitional payment year. Payment is made in CY 2010 for the diagnostic services listed in Table 3 (those that include expensive diagnostic imaging equipment in their PE inputs) based on 25 percent of the new PE RVUs and 75 percent of the prior PE RVUs for those services.

Section 1848(b)(4)(C) of the Act (as added by section 3135(a) of the ACA) requires that with respect to fee schedules established for CY 2011 and subsequent years, in the methodology for determining PE RVUs for expensive diagnostic imaging equipment under the CY 2010 PFS final rule with comment period, the Secretary shall use a 75 percent assumption instead of the utilization rates otherwise established in that rule. The provision also requires that the reduced expenditures attributable to this change in the utilization rate for CY 2011 and subsequent years shall not be taken into account when applying the budget neutrality limitation on annual adjustments described in section 1848(c)(2)(B)(ii)(II) of the Act.

As a result, the 75 percent equipment utilization rate assumption will be applied to expensive diagnostic imaging equipment in a nonbudget neutral manner for CY 2011, and the changes to PE RVUs will not be transitioned over a period of years. We will apply the 75 percent utilization rate assumption in CY 2011 to all of the services to which we currently apply the transitional 90 percent utilization rate assumption in CY 2010. These services are listed in a file on the CMS Web site that is posted under downloads for the CY 2010 PFS final rule with comment period at: (*http://www.cms.gov/physicianfeesched/downloads/CODES_SUBJECT_TO_90PCT_USAGE_RATE.zip*). These codes are also displayed in Table 3.

TABLE 3—CURRENT CPT CODES SUBJECT TO FIRST YEAR (CY 2010) OF 4-YEAR TRANSITION TO 90 PERCENT EQUIPMENT UTILIZATION RATE ASSUMPTION AND THAT WILL BE SUBJECT TO THE 75 PERCENT EQUIPMENT UTILIZATION RATE ASSUMPTION IN CY 2011

CPT code	Short descriptor
70336	Mri, temporomandibular joint(s).
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.
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.
70554	Fmri brain by tech.
71250	Ct thorax w/o dye.
71260	Ct thorax w/dye.
71270	Ct thorax w/o & w/dye.
71550	Mri chest w/o dye.
71551	Mri chest w/dye.
71552	Mri chest w/o & w/dye.
72125	CT neck spine w/o dye.
72126	Ct neck spine w/dye.
72127	Ct neck spine w/o & w/dye.
72128	Ct chest spine w/o dye.
72129	Ct chest spine w/dye.
72130	Ct chest spine w/o & w/dye.
72131	Ct lumbar spine w/o dye.
72132	Ct lumbar spine w/dye.
72133	Ct lumbar spine w/o & w/dye.
72141	Mri neck spine w/o dye.
72142	Mri neck spine w/dye.
72146	Mri chest spine w/o dye.
72147	Mri chest spine w/dye.
72148	Mri lumbar spine w/o dye.
72149	Mri lumbar spine w/dye.
72156	Mri neck spine w/o & w/dye.
72157	Mri chest spine w/o & w/dye.
72158	Mri lumbar spine w/o & w/dye.
72192	Ct pelvis w/o dye.
72193	Ct pelvis w/dye.
72194	Ct pelvis w/o & w/dye.
72195	Mri pelvis w/o dye.
72196	Mri pelvis w/dye.
72197	Mri pelvis w/o & w/dye.
73200	Ct upper extremity w/o dye.
73201	Ct upper extremity w/dye.
73202	Ct upper extremity w/o & w/dye.
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.
73700	Ct lower extremity w/o dye.
73701	Ct lower extremity w/dye.
73702	Ct lower extremity w/o & w/dye.
73718	Mri lower extremity w/o dye.
73719	Mri lower extremity w/dye.
73720	Mri lower ext w/dye & w/o dye.
73721	Mri joint of lwr extr w/o dye.
73722	Mri joint of lwr extr w/dye.
73723	Mri joint of lwr extr w/o & w/dye.
74150	Ct abdomen w/o dye.
74160	Ct abdomen w/dye.
74170	Ct abdomen w/o & w/dye.
74181	Mri abdomen w/o dye.
74182	Mri abdomen w/dye.
74183	Mri abdomen w/o and w/dye.
74261	Ct colonography, w/o dye.
74262	Ct colonography, w/dye.
75557	Cardiac mri for morph.
75559	Cardiac mri w/stress img.
75561	Cardiac mri for morph w/dye.
75563	Cardiac mri w/stress img & dye.
75571	Ct hrt w/o dye w/ca test.
75572	Ct hrt w/3d image.
75573	Ct hrt w/3d image, congen.
77058	Mri, one breast.
77059	Mri, both breasts.
77078	Ct bone density, axial.
77084	Magnetic image, bone marrow.

Additionally, for CY 2011, we are proposing to expand the list of services to which the higher equipment utilization rate assumption applies to all other diagnostic imaging services that utilize similar expensive CT and MRI scanners. The additional 24 CPT codes (listed in Table 4) to which we are proposing to apply the 75 percent equipment utilization rate assumption also have expensive diagnostic imaging equipment (priced at over $1 million) included in their PE inputs. These services are predominantly diagnostic computed tomographic angiography (CTA) and magnetic resonance angiography (MRA) procedures that include similar expensive CT and MRI scanners in their direct PE inputs. We indicated in the CY 2010 PFS final rule with comment period (74 FR 61754) that we were persuaded by PPIS data on angiography that the extrapolation of MRI and CT data (and their higher equipment utilization rate) may be inappropriate. However, this reference was limited to those procedures that include an angiography room in the direct PE inputs, such as CPT code 93510 (Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous). In contrast, CTA and MRA procedures include a CT room or

MRI room, respectively, in the direct PE inputs, and the PPIS data confirm that a higher assumed utilization rate than 50 percent would be appropriate. The PPIS angiography room data that reflected a 56 percent equipment utilization rate would not specifically apply to CTA and MRA procedures. Thus, on further review, we believe it is appropriate to include CTA and MRA procedures in the list of procedures for which we assume a 75 percent equipment utilization rate, and we are proposing to do so beginning in CY 2011.

Consistent with section 1848(c)(2)(B)(v)(III) of the Act (as amended by section 3135 of the ACA), the reduced expenditures attributable to this change in the utilization rate assumption applicable to CY 2011 shall not be taken into account when applying the budget neutrality limitation on annual adjustments described in section 1848(c)(2)(B)(ii)(III) of the Act.

As provided in the CY 2010 PFS final rule with comment period (74 FR 61751), CY 2011 is the second year of the 4-year transition to the PE RVUs calculated using the PPIS data. The reductions in the PE RVUs for expensive diagnostic imaging equipment attributable to the change to an equipment utilization rate assumption of 75 percent for CY 2011 are not subject to the transition.

TABLE 4—PROPOSED CPT CODE ADDITIONS TO THE 75 PERCENT EQUIPMENT UTILIZATION RATE ASSUMPTION CY 2011

CPT code	Short descriptor
70496	Ct angiography, head.
70498	Ct angiography, neck.
70544	Mr angiography head w/o dye.
70545	Mr angiography head w/dye.
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.
71275	Ct angiography, chest.
71555	Mri angio chest w/ or w/o dye.
72159	Mr angio spone w/o & w/dye.
72191	Ct angiography, pelv w/o & w/ dye.
72198	Mri angio pelvis w/ or w/o dye.
73206	Ct angio upper extr w/o & w/dye.
73225	Mr angio upr extr w/o & w/dye.
73706	Ct angio lower ext w/o & w/dye.
73725	Mr angio lower ext w/ or w/o dye.
74175	Ct angiography, abdom w/o & w/ dye.
74185	Mri angio, abdom w/ or w/o dye.
75565	Card mri vel flw map add-on.
75574	Ct angio hrt w/3d image.
75635	Ct angio abdominal arteries.
76380	CAT scan follow up study.
77079	Ct bone density, peripheral.

b. HCPCS Code-Specific PE Proposals

In this section, we discuss other specific CY 2011 proposals and changes related to direct PE inputs. The proposed changes that follow are included in the proposed CY 2011 direct PE database, which is available on the CMS Web site under the downloads for the CY 2011 PFS proposed rule at *http://www.cms.gov/PhysicianFeeSched/.*

(1) Biohazard Bags

We have identified 22 codes for which the supply item "biohazard bag" (SM004) is currently considered a direct PE input. The item is already properly accounted for in the indirect PE because it is not attributable to an individual patient service. Therefore, we are proposing to remove the biohazard bag from the CY 2011 direct PE database and the changes in direct PE inputs for the associated services are reflected in the proposed CY 2011 direct PE database.

(2) PE Inputs for Professional Component (PC) Only and Technical Component (TC) Only Codes Summing to Global Only Codes

In the case of selected diagnostic tests, different but related CPT codes are used to describe global, professional, and technical components of a service. These codes are unlike the majority of other diagnostic test CPT codes where modifiers may be used in billing a single CPT code in order to differentiate professional and technical components. When different but related CPT codes are used to report the components of these services, the different CPT codes are referred to as "global only," "professional (PC) only," and "technical (TC) only" codes. Medicare payment systems are programmed to ensure that the PE RVUs for global only codes equal the sum of the PE RVUs for the PC and TC only codes. However, it has come to our attention that the direct PE inputs for certain global only codes do not reflect the appropriate summation of their related TC only and PC only component code PE inputs as they appear in the direct PE database. While the PFS payment calculations have been programmed to apply the correct PE RVUs for the global only code based on a summation of component code PE RVUs, the direct PE database has reflected incorrect inputs that are overridden by the payment system. Therefore, we are proposing to correct the direct PE inputs for the global only codes so that the inputs reflect the appropriate summing of the PE inputs for the associated PC only and TC only codes. The proposed CY 2011 direct PE database includes PE corrections to the 14 CPT codes listed in Table 5.

TABLE 5—GROUPS OF RELATED CPT CODES WITH PROPOSED CHANGES TO PE INPUTS SO THAT INPUTS FOR PROFESSIONAL COMPONENT (PC) ONLY AND TECHNICAL COMPONENT (TC) ONLY CODES SUM TO GLOBAL ONLY CODES

CPT code	Long descriptor
93224	Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous original waveform recording and storage, with visual superimposition scanning; includes recording, scanning analysis with report, physician review and interpretation.
93225	Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous original waveform recording and storage, with visual superimposition scanning; recording (includes connection, recording, disconnection).
93226	Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous original waveform recording and storage, with visual superimposition scanning; scanning analysis with report.
93230	Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous original waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; including recording, microprocessor-based analysis with report, physician review and interpretation.
93231	Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous original waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; recording (includes connection, recording, and disconnection.

TABLE 5—GROUPS OF RELATED CPT CODES WITH PROPOSED CHANGES TO PE INPUTS SO THAT INPUTS FOR PROFESSIONAL COMPONENT (PC) ONLY AND TECHNICAL COMPONENT (TC) ONLY CODES SUM TO GLOBAL ONLY CODES—Continued

CPT code	Long descriptor
93232	Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous original waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; microprocessor-based analysis with report.
93268	Wearable patient activated electrocardiographic rhythm derived event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; includes transmission, physician review and interpretation.
93270	Wearable patient activated electrocardiographic rhythm derived event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; recording (includes connection, recording, and disconnection).
93271	Wearable patient activated electrocardiographic rhythm derived event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; monitoring, receipt of transmissions, and analysis.
93720	Plethysmography, total body; with interpretation and report.
93721	Plethysmography, total body; tracing only, without interpretation and report.
93784	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report.
93786	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; recording only.
93788	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report.

(3) Equipment Time Inputs for Certain Diagnostic Tests

We have recently identified incorrect equipment time inputs for four CPT codes associated with certain diagnostic tests (each is displayed in Table 5):

- CPT code 93225 is the TC only code that includes the connection, recording, and disconnection of the holter monitor (CMS Equipment Code EQ127) used in 24 hour continuous electrocardiographic rhythm derived monitoring. The current equipment time input for the holter monitor is 42 minutes, which parallels the intra-service clinical labor input time for the CPT code. However, the equipment time should reflect the 24 hours of continuous monitoring in which the device is used exclusively by the patient. Therefore, we are proposing to change the monitor equipment time for CPT code 93225 to 1440 minutes, the number of minutes in 24 hours.
- CPT code 93226 is the TC only code that includes the scanning analysis with report. The number of minutes the monitor (CMS Equipment Code EQ127) is used in this service should parallel the intra-service clinical labor input time of 52 minutes during which the monitor is in use, instead of the current equipment time of 1440 minutes, because this code does not represent 24 hours of device use. Therefore, we are proposing to change the monitor equipment time for CPT code 93226 to 52 minutes.
- CPT 93224 is the global only code that includes the connection, recording, and disconnection of the monitor (CMS Equipment Code EQ127) and the scanning analysis with report, as well as the physician review and interpretation. Under our proposal, its direct PE inputs have been appropriately summed to include the 1492 total minutes of time for the holter monitor that are included in CPT codes 93225 and 93226.
- CPT code 93788 is the TC only code that describes the scanning analysis with report for ambulatory blood pressure monitoring. The equipment time input for the blood pressure monitor should parallel the 10 minutes of clinical labor input for the CPT code since that is the time during which the monitor is in use. Currently, the equipment time input for the monitor is 1440 minutes, which is appropriate only for CPT code 93786, the code that describes the 24 hours of ambulatory blood pressure monitoring recording. In this case, CPT code 93786's direct PE inputs are correct. Therefore, we are proposing to correct the equipment time input for the ambulatory blood pressure monitor in CPT code 93788 to 10 minutes.
- CPT code 93784 is the global only code that includes the recording, the scanning analysis with report, and the physician interpretation and report for ambulatory blood pressure monitoring. Under our proposal, its direct PE inputs have been appropriately summed to include the 1450 total minutes of time for the ambulatory blood pressure monitor that are included in CPT codes 93786 and 93788.

We have modified the proposed CY 2011 direct PE database to reflect these changes.

(4) Cobalt-57 Flood Source

Stakeholders have requested that CMS reevaluate the useful life of the Cobalt-57 flood source (CMS Equipment Code ER001), given their estimate of approximately 271 days for the source's half-life. The current useful life input for the Colbalt-57 flood source is 5 years. Using publicly available catalogs, we found that the Cobalt-57 flood source is marketed with a useful life of 2 years. Therefore, we are proposing to change the useful life input from the current 5 years to 2 years. The Cobalt-57 flood source is included with the revised useful life input for 96 HCPCS codes in the proposed CY 2011 direct PE database.

(5) Venom Immunotherapy

One stakeholder provided updated price information for the venoms used for the five venom immunology CPT codes, specifically 95145 (Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); single stinging insect venom); 95146 (Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 2 single stinging insect venoms); 95147 (Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 3 single stinging insect venoms); 95148 (Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 4 single stinging insect venoms); 95149 (Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 5 single stinging insect venoms).

In the CY 2004 PFS final rule with comment period (68 FR 63206), we

adopted a pricing methodology that utilizes the average price of a 1 milliliter dose of venom and adds that price per dose as direct PE inputs for CPT codes 95145 and 95146. When a patient requires three stinging insect venoms, as for CPT code 95147, the price input for a 3-vespid mix is used. This 3-vespid mix price is also used to value CPT codes 95148 (four venoms) and 96149 (five venoms), with the single venom price added once to CPT code 97148 and twice to CPT code 97149.

As requested by the stakeholder, we are updating the price inputs for the 1-milliliter dose of venom to $16.67 and for the 3-vespid mix to $30.22 in the proposed CY 2011 direct PE database.

(6) Equipment Redundancy

Stakeholders have recently brought to our attention that the ECG, 3-channel (with SpO2, NIBP, temp, resp) (CMS Equipment Code EQ011) incorporates all of the functionality of the pulse oximeter with printer (CMS Equipment Code EQ211). Therefore, in HCPCS codes where CMS Equipment Code EQ011 is present, CMS Equipment Code EQ211 is redundant. On this basis, we are proposing to remove the pulse oximeter with printer (CMS Equipment Code EQ211) as an input for the 118 codes that also contain the ECG, 3-channel (with SpO2, NIBP, temp, resp) (CMS Equipment Code EQ011). We have made these adjustments in the proposed CY 2011 direct PE database.

(7) Equipment Duplication

We recently identified a number of CPT codes with duplicate equipment inputs in the PE database. We are proposing to remove the duplicate equipment items and have modified the proposed CY 2011 direct PE database accordingly as detailed in Table 6.

TABLE 6—CPT CODES WITH PROPOSED REMOVAL OF DUPLICATE EQUIPMENT ITEMS IN THE DIRECT PE DATABASE

CPT code		CMS equipment code for duplicate equipment	Description of equipment
19302	P-mastectomy w/ln removal	EF014	light, surgical.
19361	Breast reconstr w/lat flap	ED005	camera, digital system, 12 megapixel (medical grade).
		EF031	table, power.
		EQ168	light, exam.
44157	Colectomy w/ileoanal anast	EF031	table, power.
		EQ168	light, exam.
44158	Colectomy w/neo-rectum pouch	EF031	table, power.
		EQ168	light, exam.
56440	Surgery for vulva lesion	EF031	table, power.
		EQ170	light, fiberoptic headlight w-source.
57296	Revise vag graft, open abd	EF031	table, power.
		EQ170	light, fiberoptic headlight w-source.
58263	Vag hyst w/t/o & vag repair	EF031	table, power.
59610	Vbac delivery	EF031	table, power.
67228	Treatment of retinal lesion	EL005	lane, exam (oph).
		EQ230	slit lamp (Haag-Streit), dedicated to laser use.
76813	Ob us nuchal meas, 1 gest	ED024	film processor, dry, laser.
77371	Srs, multisource	EQ211	pulse oximeter w-printer.
93540	Injection, cardiac cath	ED018	computer workstation, cardiac cath monitoring.
		EL011	room, angiography.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).
		EQ032	IV infusion pump.
		EQ088	contrast media warmer.
		EQ211	pulse oximeter w-printer.
93542	Injection for heart x-rays	ED018	computer workstation, cardiac cath monitoring.
		EL011	room, angiography.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).
		EQ032	IV infusion pump.
		EQ088	contrast media warmer.
		EQ211	pulse oximeter w-printer.

(8) Establishing Overall Direct PE Supply Price Inputs Based on Unit Prices and Quantities

We have identified minor errors in total price inputs for a number of supply items due to mathematical mistakes in multiplying the item unit price and the quantity used in particular CPT codes for the associated services. We are proposing to modify the direct PE database to appropriately include the overall supply price input for a supply item as the product of the unit price and the quantity of the supply item used in the CPT code. Most of the overall supply price input changes are small, and we have adjusted the proposed CY 2011 direct PE database accordingly. The CPT and Level II HCPCS codes and associated supplies for nonfacility and facility settings that are subject to these corrections are displayed in Tables 7 and 8, respectively.

TABLE 7—OVERALL SUPPLY PRICE CALCULATION CORRECTIONS FOR NONFACILITY SETTINGS

CPT/HCPCS code	Short descriptor	CMS Supply code with overall price corrections	Description of supply
11952	Therapy for contour defects	SC029	needle, 18–27g.
11954	Therapy for contour defects	SC029	needle, 18–27g.
15820	Revision of lower eyelid	SA082	pack, ophthalmology visit (w-dilation).

TABLE 7—OVERALL SUPPLY PRICE CALCULATION CORRECTIONS FOR NONFACILITY SETTINGS—Continued

CPT/HCPCS code	Short descriptor	CMS Supply code with overall price corrections	Description of supply
15821	Revision of lower eyelid	SA082	pack, ophthalmology visit (w-dilation).
15822	Revision of upper eyelid	SA082	pack, ophthalmology visit (w-dilation).
17311	Mohs, 1 stage, h/n/hf/g	SG078	tape, surgical occlusive 1in (Blenderm).
17312	Mohs addl stage	SG078	tape, surgical occlusive 1in (Blenderm).
17313	Mohs, 1 stage, t/a/l	SG078	tape, surgical occlusive 1in (Blenderm).
17314	Mohs, addl stage, t/a/l	SG078	tape, surgical occlusive 1in (Blenderm).
21011	Exc face les sc < 2 cm	SH046	lidocaine 1% w-epi inj (Xylocaine w-epi).
21013	Exc face tum deep < 2 cm	SH046	lidocaine 1% w-epi inj (Xylocaine w-epi).
21073	Mnpj of tmj w/anesth	SG079	tape, surgical paper 1in (Micropore).
21076	Prepare face/oral prosthesis	SL047	dental stone powder.
21081	Prepare face/oral prosthesis	SK024	film, dental.
21310	Treatment of nose fracture	SB034	mask, surgical, with face shield.
23075	Exc shoulder les sc < 3 cm	SG056	gauze, sterile 4in x 4in (10 pack uou).
		SH021	bupivacaine 0.25% inj (Marcaine).
24075	Exc arm/elbow les sc < 3 cm	SG056	gauze, sterile 4in x 4in (10 pack uou).
		SH021	bupivacaine 0.25% inj (Marcaine).
25075	Exc forearm les sc < 3 cm	SG056	gauze, sterile 4in x 4in (10 pack uou).
		SH021	bupivacaine 0.25% inj (Marcaine).
26115	Exc hand les sc < 1.5 cm	SG056	gauze, sterile 4in x 4in (10 pack uou).
		SH021	bupivacaine 0.25% inj (Marcaine).
27327	Exc thigh/knee les sc < 3 cm	SG056	gauze, sterile 4in x 4in (10 pack uou).
27618	Exc leg/ankle tum < 3 cm	SG056	gauze, sterile 4in x 4in (10 pack uou).
28039	Exc foot/toe tum sc > 1.5 cm	SG056	gauze, sterile 4in x 4in (10 pack uou).
28043	Exc foot/toe tum sc < 1.5 cm	SG056	gauze, sterile 4in x 4in (10 pack uou).
28045	Exc foot/toe tum deep < 1.5cm	SG056	gauze, sterile 4in x 4in (10 pack uou).
28306	Incision of metatarsal	SA048	pack, minimum multi-specialty visit.
28307	Incision of metatarsal	SA048	pack, minimum multi-specialty visit.
28310	Revision of big toe	SA048	pack, minimum multi-specialty visit.
28312	Revision of toe	SA048	pack, minimum multi-specialty visit.
28313	Repair deformity of toe	SA048	pack, minimum multi-specialty visit.
28315	Removal of sesamoid bone	SA048	pack, minimum multi-specialty visit.
28340	Resect enlarged toe tissue	SA048	pack, minimum multi-specialty visit.
28344	Repair extra toe(s)	SA048	pack, minimum multi-specialty visit.
28345	Repair webbed toe(s)	SA048	pack, minimum multi-specialty visit.
28496	Treat big toe fracture	SA048	pack, minimum multi-specialty visit.
28755	Fusion of big toe joint	SA048	pack, minimum multi-specialty visit.
28820	Amputation of toe	SA048	pack, minimum multi-specialty visit.
28890	High energy eswt, plantar f	SC051	syringe 10–12ml.
29870	Knee arthroscopy, dx	SG079	tape, surgical paper 1in (Micropore).
32553	Ins mark thor for rt perq	SB034	mask, surgical, with face shield.
36475	Endovenous rf, 1st vein	SC074	iv pressure infusor bag.
36592	Collect blood from picc	SG050	gauze, non-sterile 2in x 2in.
41530	Tongue base vol reduction	SD009	canister, suction.
41805	Removal foreign body, gum	SD134	tubing, suction, non-latex (6ft) with Yankauer tip (1).
41806	Removal foreign body, jawbone	SD134	tubing, suction, non-latex (6ft) with Yankauer tip (1).
42107	Excision lesion, mouth roof	SD009	canister, suction.
46505	Chemodenervation anal musc	SD009	canister, suction.
49411	Ins mark abd/pel for rt perq	SB034	mask, surgical, with face shield.
49440	Place gastrostomy tube perc	SK089	x-ray developer solution.
49441	Place duod/jej tube perc	SK089	x-ray developer solution.
49442	Place cecostomy tube perc	SK089	x-ray developer solution.
49446	Change g-tube to g-j perc	SK089	x-ray developer solution.
49450	Replace g/c tube perc	SK089	x-ray developer solution.
49451	Replace duod/jej tube perc	SK089	x-ray developer solution.
49452	Replace g-j tube perc	SK089	x-ray developer solution.
49460	Fix g/colon tube w/device	SK089	x-ray developer solution.
49465	Fluoro exam of g/colon tube	SK089	x-ray developer solution.
50382	Change ureter stent, percut	SB034	mask, surgical, with face shield.
50384	Remove ureter stent, percut	SB034	mask, surgical, with face shield.
50385	Change stent via transureth	SB034	mask, surgical, with face shield.
50386	Remove stent via transureth	SB034	mask, surgical, with face shield.
50387	Change ext/int ureter stent	SB034	mask, surgical, with face shield.
50389	Remove renal tube w/fluoro	SB034	mask, surgical, with face shield.
51100	Drain bladder by needle	SH047	lidocaine 1%–2% inj (Xylocaine).
51101	Drain bladder by trocar/cath	SH047	lidocaine 1%–2% inj (Xylocaine).
51727	Cystometrogram w/up	SC051	syringe 10–12ml.
51728	Cystometrogram w/vp	SC051	syringe 10–12ml.
51729	Cystometrogram w/vp&up	SC051	syringe 10–12ml.
52649	Prostate laser enucleation	SA048	pack, minimum multi-specialty visit.
53855	Insert prost urethral stent	SB024	gloves, sterile.

TABLE 7—OVERALL SUPPLY PRICE CALCULATION CORRECTIONS FOR NONFACILITY SETTINGS—Continued

CPT/HCPCS code	Short descriptor	CMS Supply code with overall price corrections	Description of supply
59300	Episiotomy or vaginal repair	SG062	packing, gauze plain 0.25–0.50in (5 yd uou).
59812	Treatment of miscarriage	SA052	pack, post-op incision care (staple).
64490	Inj paravert f jnt c/t 1 lev	SK025	film, dry, radiographic, 8in x 10in.
64493	Inj paravert f jnt l/s 1 lev	SH021	bupivacaine 0.25% inj (Marcaine).
		SK025	film, dry, radiographic, 8in x 10in.
65272	Repair of eye wound	SA082	pack, ophthalmology visit (w-dilation).
65286	Repair of eye wound	SA082	pack, ophthalmology visit (w-dilation).
66250	Follow-up surgery of eye	SA082	pack, ophthalmology visit (w-dilation).
67031	Laser surgery, eye strands	SA082	pack, ophthalmology visit (w-dilation).
67105	Repair detached retina	SA082	pack, ophthalmology visit (w-dilation).
67110	Repair detached retina	SA082	pack, ophthalmology visit (w-dilation).
67120	Remove eye implant material	SA082	pack, ophthalmology visit (w-dilation).
67228	Treatment of retinal lesion	SA082	pack, ophthalmology visit (w-dilation).
67901	Repair eyelid defect	SA048	pack, minimum multi-specialty visit.
75571	Ct hrt w/o dye w/ca test	SJ019	electrode adhesive disk.
75572	Ct hrt w/3d image	SJ019	electrode adhesive disk.
75573	Ct hrt w/3d image, congen	SJ019	electrode adhesive disk.
75574	Ct angio hrt w/3d image	SJ019	electrode adhesive disk.
75960	Transcath iv stent rs&i	SK034	film, x-ray 14in x 17in.
76821	Middle cerebral artery echo	SM013	disinfectant, surface (Envirocide, Sanizide).
77371	Srs, multisource	SG079	tape, surgical paper 1in (Micropore).
77372	Srs, linear based	SG079	tape, surgical paper 1in (Micropore).
77373	Sbrt delivery	SG079	tape, surgical paper 1in (Micropore).
78452	Ht muscle image spect, mult	SC051	syringe 10–12ml.
		SK092	x-ray fixer solution
78454	Ht musc image, planar, mult	SK092	x-ray fixer solution.
88125	Forensic cytopathology	SL026	clearing agent (Histo-clear).
88355	Analysis, skeletal muscle	SK073	skin marking ink (tattoo).
		SL061	embedding paraffin.
		SL078	histology freezing spray (Freeze-It).
		SL201	stain, eosin.
88356	Analysis, nerve	SB023	gloves, non-sterile, nitrile.
		SK073	skin marking ink (tattoo).
		SL061	embedding paraffin.
		SL078	histology freezing spray (Freeze-It).
		SL108	pipette.
		SL201	stain, eosin.
88365	Insitu hybridization (fish)	SF004	blade, microtome.
		SL179	1.0N NaOH.
		SL183	slide, organosilane coated.
		SL189	ethanol, 100%.
		SL190	ethanol, 70%.
		SL194	Hemo-De.
		SM016	eye shield, splash protection.
88367	Insitu hybridization, auto	SC057	syringe 5–6ml.
		SF004	blade, microtome.
		SL030	cover slip, glass.
		SL085	label for microscope slides.
		SL178	0.2N HCL.
		SL179	1.0N NaOH.
		SL181	pipette tips, sterile.
		SL183	slide, organosilane coated.
		SL189	ethanol, 100%.
		SL190	ethanol, 70%.
		SL191	ethanol, 85%.
		SL194	Hemo-De.
		SM016	eye shield, splash protection.
88368	Insitu hybridization, manual	SF004	blade, microtome.
		SL179	1.0N NaOH.
		SL183	slide, organosilane coated.
		SL189	ethanol, 100%.
		SL190	ethanol, 70%.
		SL194	Hemo-De.
		SM016	eye shield, splash protection.
88385	Eval molecul probes, 51–250	SL207	air, filtered, compressed.
		SL218	DNA, Versagene, blood kit.
		SL220	ethanol, 200%.
		SL225	gas, nitogen, ultra-high purity (compressed), grade 5.0.
88386	Eval molecul probes, 251–500	SL207	air, filtered, compressed.
		SL218	DNA, Versagene, blood kit.

TABLE 7—OVERALL SUPPLY PRICE CALCULATION CORRECTIONS FOR NONFACILITY SETTINGS—Continued

CPT/HCPCS code	Short descriptor	CMS Supply code with overall price corrections	Description of supply
	.....	SL220	ethanol, 200%.
	.....	SL225	gas, nitogen, ultra-high purity (compressed), grade 5.0.
90470	Immune admin H1N1 im/nasal	SB036	paper, exam table.
91065	Breath hydrogen test	(blank)	Sivrite-4.
91132	Electrogastrography	SD062	electrode, surface.
91133	Electrogastrography w/test	SD062	electrode, surface.
92550	Tympanometry & reflex thresh	SK059	paper, recording (per sheet).
92597	Oral speech device eval	SB022	gloves, non-sterile.
92610	Evaluate swallowing function	SB022	gloves, non-sterile.
92626	Eval aud rehab status	SK008	audiology scoring forms.
92627	Eval aud status rehab add-on	SK008	audiology scoring forms.
92640	Aud brainstem implt programg	SK068	razor.
95004	Percut allergy skin tests	SC023	multi-tine device.
95024	Id allergy test, drug/bug	SA048	pack, minimum multi-specialty visit.
	.....	SG050	gauze, non-sterile 2in x 2in.
95027	Id allergy titrate-airborne	SA048	pack, minimum multi-specialty visit.
	.....	SC052	syringe 1ml.
95044	Allergy patch tests	SK087	water, distilled.
95052	Photo patch test	SK087	water, distilled.
95148	Antigen therapy services	SH009	antigen, venom.
95805	Multiple sleep latency test	SK094	x-ray marking pencil.
96040	Genetic counseling, 30 min	SK062	patient education booklet.
96102	Psycho testing by technician	SK057	paper, laser printing (each sheet).
96360	Hydration iv infusion, init	SC018	iv infusion set.
	.....	SC051	syringe 10–12ml.
	.....	SG050	gauze, non-sterile 2in x 2in.
96365	Ther/proph/diag iv inf, init	SC018	iv infusion set.
	.....	SC051	syringe 10–12ml.
	.....	SG050	gauze, non-sterile 2in x 2in.
96366	Ther/proph/diag iv inf addon	SB022	gloves, non-sterile.
96367	Tx/proph/dg addl seq iv inf	SB022	gloves, non-sterile.
96369	Sc ther infusion, up to 1 hr	SC013	infusion pump cassette-reservoir.
96371	Sc ther infusion, reset pump	SC013	infusion pump cassette-reservoir.
96372	Ther/proph/diag inj, sc/im	SB022	gloves, non-sterile.
96374	Ther/proph/diag inj, iv push	SB022	gloves, non-sterile.
	.....	SC051	syringe 10–12ml.
	.....	SG050	gauze, non-sterile 2in x 2in.
96375	Tx/pro/dx inj new drug addon	SB022	gloves, non-sterile.
	.....	SC051	syringe 10–12ml.
96401	Chemo, anti-neopl, sq/im	SC051	syringe 10–12ml.
	.....	SG050	gauze, non-sterile 2in x 2in.
96402	Chemo hormon antineopl sq/im	SC051	syringe 10–12ml.
	.....	SG050	gauze, non-sterile 2in x 2in.
96409	Chemo, iv push, sngl drug	SC018	iv infusion set 22.
	.....	SC051	syringe 10–12ml.
96411	Chemo, iv push, addl drug	SC018	iv infusion set.
	.....	SC051	syringe 10–12ml.
96413	Chemo, iv infusion, 1 hr	SC018	iv infusion set.
	.....	SC051	syringe 10–12ml.
96417	Chemo iv infus each addl seq	SC018	iv infusion set.
96445	Chemotherapy, intracavitary	SC018	iv infusion set.
	.....	SH069	sodium chloride 0.9% irrigation (500–1000ml uou).
96542	Chemotherapy injection	SC018	iv infusion set.
99366	Team conf w/pat by hc pro	SK062	patient education booklet.
G0270	MNT subs tx for change dx	SK057	paper, laser printing (each sheet).
	.....	SK062	patient education booklet.
G0271	Group MNT 2 or more 30 mins	SK057	paper, laser printing (each sheet).

TABLE 8—OVERALL SUPPLY PRICE CALCULATION CORRECTIONS FOR FACILITY SETTINGS

CPT/HCPCS Code	Short descriptor	CMS supply code with overall price corrections	Description of supply
15738	Muscle-skin graft, leg	SG017	bandage, Kling, non-sterile 2in.
15820	Revision of lower eyelid	SA082	pack, ophthalmology visit (w-dilation).
15821	Revision of lower eyelid	SA082	pack, ophthalmology visit (w-dilation).
15822	Revision of upper eyelid	SA082	pack, ophthalmology visit (w-dilation).
19303	Mast, simple, complete	SB006	drape, non-sterile, sheet 40in x 60in.
20900	Removal of bone for graft	SA054	pack, post-op incision care (suture).

TABLE 8—OVERALL SUPPLY PRICE CALCULATION CORRECTIONS FOR FACILITY SETTINGS—Continued

CPT/HCPCS Code	Short descriptor	CMS supply code with overall price corrections	Description of supply
21011	Exc face les sc < 2 cm	SA048	pack, minimum multi-specialty visit.
21013	Exc face tum deep < 2 cm	SA048	pack, minimum multi-specialty visit.
21193	Reconst lwr jaw w/o graft	SJ061	tongue depressor.
21194	Reconst lwr jaw w/graft	SJ061	tongue depressor.
21240	Reconstruction of jaw joint	SJ061	tongue depressor.
21366	Treat cheek bone fracture	SJ061	tongue depressor.
21435	Treat craniofacial fracture	SJ061	tongue depressor.
21555	Exc neck les sc < 3 cm	SA048	pack, minimum multi-specialty visit.
21930	Exc back les sc < 3 cm	SA048	pack, minimum multi-specialty visit.
22902	Exc abd les sc < 3 cm	SA048	pack, minimum multi-specialty visit.
23075	Exc shoulder les sc < 3 cm	SA048	pack, minimum multi-specialty visit.
24075	Exc arm/elbow les sc < 3 cm	SA048	pack, minimum multi-specialty visit.
25075	Exc forearm les sc < 3 cm	SA048	pack, minimum multi-specialty visit.
26115	Exc hand les sc < 1.5 cm	SA048	pack, minimum multi-specialty visit.
27047	Exc hip/pelvis les sc < 3 cm	SA048	pack, minimum multi-specialty visit.
27327	Exc thigh/knee les sc < 3 cm	SA048	pack, minimum multi-specialty visit.
27618	Exc leg/ankle tum < 3 cm	SA048	pack, minimum multi-specialty visit.
28307	Incision of metatarsal	SA048	pack, minimum multi-specialty visit.
28340	Resect enlarged toe tissue	SA048	pack, minimum multi-specialty visit.
28345	Repair webbed toe(s)	SA048	pack, minimum multi-specialty visit.
28820	Amputation of toe	SA048	pack, minimum multi-specialty visit.
33516	Cabg, vein, six or more	SA052	pack, post-op incision care (staple).
34510	Transposition of vein valve	SA054	pack, post-op incision care (suture).
35013	Repair artery rupture, arm	SA048	pack, minimum multi-specialty visit.
41150	Tongue, mouth, jaw surgery	SA048	pack, minimum multi-specialty visit.
41153	Tongue, mouth, neck surgery	SA048	pack, minimum multi-specialty visit.
41155	Tongue, jaw, & neck surgery	SA048	pack, minimum multi-specialty visit.
41805	Removal foreign body, gum	SD134	tubing, suction, non-latex (6ft) with Yankauer tip (1).
41806	Removal foreign body, jawbone	SD134	tubing, suction, non-latex (6ft) with Yankauer tip (1).
42160	Treatment mouth roof lesion	SD122	suction tip, Yankauer.
51925	Hysterectomy/bladder repair	SB006	drape, non-sterile, sheet 40in x 60in.
56620	Partial removal of vulva	SA048	pack, minimum multi-specialty visit.
57284	Repair paravag defect, open	SA051	pack, pelvic exam.
		SB006	drape, non-sterile, sheet 40in x 60in.
57285	Repair paravag defect, vag	SA051	pack, pelvic exam.
		SB006	drape, non-sterile, sheet 40in x 60in.
57423	Repair paravag defect, lap	SA051	pack, pelvic exam.
		SB006	drape, non-sterile, sheet 40in x 60in.
58660	Laparoscopy, lysis	SB006	drape, non-sterile, sheet 40in x 60in.
58662	Laparoscopy, excise lesions	SJ046	silver nitrate applicator.
58670	Laparoscopy, tubal cautery	SJ046	silver nitrate applicator.
58940	Removal of ovary(s)	SA052	pack, post-op incision care (staple).
58952	Resect ovarian malignancy	SB006	drape, non-sterile, sheet 40in x 60in.
64632	N block inj, common digit	SA048	pack, minimum multi-specialty visit.
65112	Remove eye/revise socket	SA050	pack, ophthalmology visit (no dilation).
65114	Remove eye/revise socket	SA050	pack, ophthalmology visit (no dilation).
65235	Remove foreign body from eye	SA082	pack, ophthalmology visit (w-dilation).
65265	Remove foreign body from eye	SA082	pack, ophthalmology visit (w-dilation).
65272	Repair of eye wound	SA082	pack, ophthalmology visit (w-dilation).
65273	Repair of eye wound	SA082	pack, ophthalmology visit (w-dilation).
65280	Repair of eye wound	SA082	pack, ophthalmology visit (w-dilation).
65285	Repair of eye wound	SA082	pack, ophthalmology visit (w-dilation).
65286	Repair of eye wound	SA082	pack, ophthalmology visit (w-dilation).
65290	Repair of eye socket wound	SA082	pack, ophthalmology visit (w-dilation).
65770	Revise cornea with implant	SA050	pack, ophthalmology visit (no dilation).
65850	Incision of eye	SA082	pack, ophthalmology visit (w-dilation).
65865	Incise inner eye adhesions	SA082	pack, ophthalmology visit (w-dilation).
65870	Incise inner eye adhesions	SA082	pack, ophthalmology visit (w-dilation).
66180	Implant eye shunt	SA082	pack, ophthalmology visit (w-dilation).
66185	Revise eye shunt	SA082	pack, ophthalmology visit (w-dilation).
66220	Repair eye lesion	SA082	pack, ophthalmology visit (w-dilation).
66250	Follow-up surgery of eye	SA082	pack, ophthalmology visit (w-dilation).
66500	Incision of iris	SA082	pack, ophthalmology visit (w-dilation).
66600	Remove iris and lesion	SA082	pack, ophthalmology visit (w-dilation).
66605	Removal of iris	SA082	pack, ophthalmology visit (w-dilation).
66625	Removal of iris	SA082	pack, ophthalmology visit (w-dilation).
66630	Removal of iris	SA082	pack, ophthalmology visit (w-dilation).
66635	Removal of iris	SA082	pack, ophthalmology visit (w-dilation).
66682	Repair iris & ciliary body	SA082	pack, ophthalmology visit (w-dilation).
66820	Incision, secondary cataract	SA082	pack, ophthalmology visit (w-dilation).

TABLE 8—OVERALL SUPPLY PRICE CALCULATION CORRECTIONS FOR FACILITY SETTINGS—Continued

CPT/HCPCS Code	Short descriptor	CMS supply code with overall price corrections	Description of supply
66850	Removal of lens material	SA082	pack, ophthalmology visit (w-dilation).
66852	Removal of lens material	SA082	pack, ophthalmology visit (w-dilation).
66930	Extraction of lens	SA082	pack, ophthalmology visit (w-dilation).
66940	Extraction of lens	SA082	pack, ophthalmology visit (w-dilation).
66983	Cataract surg w/iol, 1 stage	SA082	pack, ophthalmology visit (w-dilation).
67015	Release of eye fluid	SA082	pack, ophthalmology visit (w-dilation).
67031	Laser surgery, eye strands	SA082	pack, ophthalmology visit (w-dilation).
67036	Removal of inner eye fluid	SA082	pack, ophthalmology visit (w-dilation).
67040	Laser treatment of retina	SA082	pack, ophthalmology visit (w-dilation).
67105	Repair detached retina	SA082	pack, ophthalmology visit (w-dilation).
67107	Repair detached retina	SA082	pack, ophthalmology visit (w-dilation).
67110	Repair detached retina	SA082	pack, ophthalmology visit (w-dilation).
67115	Release encircling material	SA082	pack, ophthalmology visit (w-dilation).
67120	Remove eye implant material	SA082	pack, ophthalmology visit (w-dilation).
67228	Treatment of retinal lesion	SA082	pack, ophthalmology visit (w-dilation).
67400	Explore/biopsy eye socket	SA082	pack, ophthalmology visit (w-dilation).
67412	Explore/treat eye socket	SA082	pack, ophthalmology visit (w-dilation).
67440	Explore/drain eye socket	SA082	pack, ophthalmology visit (w-dilation).
67908	Repair eyelid defect	SG008	applicator, cotton-tipped, non-sterile 6in.
88356	Analysis, nerve	SL108	pipette.

c. AMA RUC Recommendations in CY 2010 for Changes to Direct PE Inputs

In a March 2010 letter, the AMA RUC made specific PE recommendations that we consider below. As stated earlier, the proposed changes that follow are included in the proposed CY 2011 direct PE database, which is available on the CMS Web site under the downloads for the CY 2011 PFS proposed rule at *http://www.cms.gov/PhysicianFeeSched/*.

(1) Electrogastrography and Esophageal Function Test

We are accepting the AMA RUC recommendations for the CY 2011 PE inputs for the following CPT codes: 91132 (Electrogastrography, diagnostic, transcutaneous); 91133 (Electrogastrography, diagnostic, transcutaneous; with provocative testing); 91038 (Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)). For CPT code 91038, we have assumed a useful life of 5 years for the equipment item "ZEPHR impedance/pH reflux monitoring system with data recorder, software, monitor, workstation and cart," based on its entry in the AHA's publication, "Estimated Useful Lives of Depreciable Hospital Assets," which we use as a standard reference. The proposed CY 2011 direct PE database has been changed accordingly.

(2) 64-Slice CT Scanner and Software

The AMA RUC submitted an updated recommendation regarding the correct pricing of the 64-slice CT scanner and its accompanying software. Based on the documentation accompanying the recommendation, we are accepting this recommendation and updating the price input for the 64-slice scanner and software. This affects the following four CPT codes that use either the scanner, the software, or both: 75571 (computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium); 75572 (Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)); 75573 (Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)); and 75574 (Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structure, if performed)). The proposed CY 2011 direct PE database has been modified accordingly.

(3) Cystometrogram

The AMA RUC recently identified a rank order anomaly regarding CPT code 51726 (Complex cystometrogram (i.e., calibrated electronic equipment)). Currently, this procedure has higher PE RVUs, despite being less resource-intensive than the three CPT codes for which it serves as the base: 51727 (Complex cystometrogram *(i.e.,* calibrated electronic equipment); with urethral pressure profile studies (*i.e.,* urethral closure pressure profile), any technique); 51728 (Complex cystometrogram (*i.e.,* calibrated electronic equipment); with voiding pressure studies (*i.e.,* bladder voiding pressure), any technique); and 51729 (Complex cystometrogram (*i.e.,* calibrated electronic equipment); with voiding pressure studies (*i.e.,* bladder voiding pressure) and urethral pressure profile studies (*i.e.,* urethral closure pressure profile), any technique).

Since usual AMA RUC policy is that CPT codes with a 0-day global period do not have pre-service time associated with the code, the AMA RUC recommended removing the nonfacility pre-service clinical staff time from the PE inputs for 51726. Additionally, the AMA RUC recommended that the nonfacility clinical intra-service staff time for CPT code 51276 be reduced from the 118 minutes of intra-service clinical staff time currently assigned to the code to 85 minutes of intra-service clinical staff time. These changes would resolve the rank order anomaly and bring the PE inputs for CPT code 51726 into alignment with the other three codes. Finally, and for the reasons

stated above, the AMA RUC recommended that CMS remove the 23 minutes of pre-service nonfacility clinical staff time from CPT code 51725 (Simple cystometrogram (CMG) (*e.g.,* spinal manometer)). We are accepting these recommendations and, therefore, have changed the direct PE inputs for CPT codes 51725 and 51726 in the nonfacility setting in the proposed CY 2011 direct PE database.

(4) Breath Hydrogen Test

The AMA RUC provide recommendations regarding the PE inputs for CPT code 91065 (breath hydrogen test (*e.g.,* for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit). We are accepting the recommendations with two modifications. We have folded the two pieces of equipment listed as "quinGas Table-Top Support Stand, 3 Tank" and "Drying Tube, Patient Sample" into the "BreathTrackerDigital SC Instrument" and summed their inputs into one equipment line-item, since these equipment items are used together specifically for the service in question. We have increased the useful life input of the "BreathTrackerDigital SC Instrument" from 7 to 8 years based on our use of the American Hospital Association (AHA)'s publication entitled, "Estimated Useful Lives of Depreciable Hospital Assets" as a standard reference. Additionally, because the AMA RUC did not include equipment times in their recommendations for this CPT code, we have used 53 minutes as the total time for all equipment items based on the total intra-service period for the clinical labor, consistent with our general policy for establishing equipment times. These modifications are reflected in the proposed CY 2011 direct PE database.

(5) Radiographic Fluoroscopic Room

A recent AMA RUC review of services that include the radiographic fluoroscopic room (CMS Equipment Code EL014) as a direct PE revealed that the use of the item is no longer typical for certain services in which it is specified within the current direct cost inputs. The AMA RUC recommended to CMS that the radiographic fluoroscopic room be deleted from CPT codes 64420 (Injection, anesthetic agent; intercostal nerve, single); 64421 (Injection, anesthetic agent; intercostal nerves, multiple, regional block); and 64620 (Destruction by neurolytic agent, intercostal nerve).

We are accepting these recommendations and, therefore, these changes are included in the proposed CY 2011 direct PE database.

The AMA RUC also informed us that it has convened a workgroup to examine the inclusion of the fluoroscopic room across a broader range of codes. We will consider any future recommendations from the AMA RUC on this topic when they are submitted.

d. Referral of Existing CPT Codes for AMA RUC Review

As part of our review of high cost supplies, we conducted a clinical review of the procedures associated with high cost supplies to confirm that those supplies currently are used in the typical case described by the CPT codes. While we confirmed that most high cost supplies could be used in the procedures for which they are currently direct PE inputs, we noted that one of the high cost supplies, fiducial screws (CMS Supply Code SD073) with a current price of $558, is included as a direct PE input for two CPT codes, specifically 77301 (Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications) and 77011 (Computed tomography guidance for stereotactic localization). The documentation used in the current pricing of the supply item describes a kit that includes instructions, skull screws, a drill bit, and a collar for the TALON® System manufactured by Best nomos. Best nomos' literature describes the insertion of the screws into the patient's skull to ensure accurate set-up. When CPT codes 77301 and 77011 were established in CY 2002 and CY 2003, respectively, we accepted the AMA RUC recommendations to include fiducial screws in the PE for these services. Upon further review, while we understand why this supply may be considered a typical PE input for CPT code 77011, we do not now believe that fiducial screws, as described in the Best nomos literature, would typically be used in CPT code 77301, where the most common clinical scenario would be treatment of prostate cancer.

Therefore, in order to ensure that CPT codes 77301 and 77011 are appropriately valued for CY 2011 through the inclusion or exclusion of fiducial screws in their PE, we are asking the AMA RUC to review these CPT codes with respect to the inclusion of fiducial screws in their PE. We are requesting that the AMA RUC make recommendations to us regarding whether this supply should be included in the PE or removed from the PE for CPT codes 77301 and 77011 in a timeframe that would allow us to adopt interim values for these codes for CY 2011, should the AMA RUC recommend a change. If the AMA RUC continues to recommend the inclusion of fiducial screws in the PE for CPT code 77301 and/or 77011 for CY 2011, we are requesting that the AMA RUC provide us with a detailed rationale for the inclusion of this specialized supply in the PE for the typical case reported under the relevant CPT code. We would also request that the AMA RUC furnish updated pricing information for the screws if they continue to recommend the screws as a PE input for one or both of these CPT codes in CY 2011.

e. Updating Equipment and Supply Price Inputs for Existing Codes

Historically, we have periodically received requests to change the PE price inputs for supplies and equipment in the PE database. In the past, we have considered these requests on an *ad hoc* basis and updated the price inputs as part of quarterly or annual updates if we believed them to be appropriate. In this proposed rule, we are proposing to establish a regular and more transparent process for considering public requests for changes to PE database price inputs for supplies and equipment used in existing codes.

We are proposing to act on public requests to update equipment and supply price inputs annually through rulemaking by following a regular and consistent process as discussed in the following paragraphs. We are proposing to use the annual PFS proposed rule released in the summer and the final rule released on or about November 1 each year as the vehicle for making these changes.

We will accept requests for updating the price inputs for supplies and equipment on an ongoing basis; requests must be received no later than December 31 of each CY to be considered for inclusion in the next proposed rule. In that next proposed rule, we would present our review of submitted requests to update price inputs for specific equipment or supplies and our proposals for the subsequent calendar year. We would then finalize changes in the final rule for the upcoming calendar year. Our review of the issues and consideration of public comments may result in the following outcomes that would be presented in the final rule with comment period:

- Updating the equipment or supply price inputs, as requested.
- Updating the equipment or supply price inputs, with modifications.
- Rejecting the new price inputs.

• Declining to act on the request pending a recommendation from the AMA RUC.

To facilitate our review and preparation of issues for the proposed rule, at a minimum, we would expect that requesters would provide the following information:

• Name and contact information for the requestor.

• The name of the item exactly as it appears in the direct PE file under downloads for the most recent PFS final rule with comment period, available on the CMS Web site at *http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage*.

In order to best evaluate the requests in the context of our goal of utilizing accurate market prices for these items as direct PE inputs, we also would expect requestors to provide multiple invoices from different suppliers/manufacturers. In some cases, multiple sources may not be available, whereupon a detailed explanation should be provided to support the request. When furnishing invoices, requestors should take into consideration the following parameters:

++ May be either print or electronic but should be on supplier and/or manufacturer stationery (for example, letterhead, billing statement, *etc.*)

++ Should be for the typical, common, and customary version of the supply or equipment that is used to furnish the services.

++ Price should be net of typical rebates and/or any discounts available, including information regarding the magnitude and rationale for such rebates or discounts.

++ If multiple items are presented on the same invoice, relevant item(s) should be clearly identified.

We are soliciting public comments on this proposed process, including the information that requestors should furnish to facilitate our full analysis in preparation for the next calendar year's rulemaking cycle.

B. Malpractice Relative Value Units (RVUs)

1. Background

Section 1848(c) of the Act requires that each service paid under the PFS be comprised of three components: work, PE, and malpractice. From 1992 to 1999, malpractice RVUs were charge-based, using weighted specialty-specific malpractice expense percentages and 1991 average allowed charges. Malpractice RVUs for new codes after 1991 were extrapolated from similar existing codes or as a percentage of the corresponding work RVU. Section 4505(f) of the BBA required us to implement resource-based malpractice RVUs for services furnished beginning in 2000. Therefore, initial implementation of resource-based malpractice RVUs occurred in 2000.

The statute also requires that we review, and if necessary adjust, RVUs no less often than every 5 years. The first review and update of resource-based malpractice RVUs was addressed in the CY 2005 PFS final rule with comment period (69 FR 66263). Minor modifications to the methodology were addressed in the CY 2006 PFS final rule with comment period (70 FR 70153). In the CY 2010 PFS final rule with comment period, we implemented the second review and update of malpractice RVUs. For a discussion of the second review and update of malpractice RVUs see the CY 2010 PFS proposed rule (74 FR 33537) and final rule with comment period (74 FR 61758).

2. Malpractice RVUs for New and Revised Services Effective Before the Next 5-Year Review

Currently, malpractice RVUs for new and revised codes effective before the next 5-Year Review (for example, effective CY 2011 through CY 2014) are determined by a direct crosswalk to a similar "source" code or a modified crosswalk to account for differences in work RVUs between the new/revised code and the source code. For the modified crosswalk approach, we adjust the malpractice RVUs for the new/revised code to reflect the difference in work RVUs between the source code and the AMA RUC's recommended work value (or the work value we are applying as an interim final value under the PFS) for the new code. For example, if the interim final work RVUs for the new/revised code are 10 percent higher than the work RVUs for the source code, the malpractice RVUs for the new/revised code would be increased by 10 percent over the source code RVUs. This approach presumes the same risk factor for the new/revised code and source code but uses the work RVUs for the new/revised code to adjust for risk-of-service. The assigned malpractice RVUs for new/revised codes effective between updates remain in place until the next 5-Year Review.

We will continue our current approach for determining malpractice RVUs for new/revised codes that become effective before the next 5-Year Review and update. Under this approach we will crosswalk the new/revised code to the RVUs of a similar source code and adjust for differences in work (or, if greater, the clinical labor portion of the fully implemented PE RVUs), between the source code and the new/revised code. Additionally, we will publish a list of new/revised codes and the analytic crosswalk(s) used for determining their malpractice RVUs in the final rule with comment period, which we have not previously done. The CY 2011 malpractice RVUs for new/revised codes will be implemented as interim final values in the CY 2011 PFS final rule with comment period, where they will be subject to public comment. They will then be finalized in the CY 2012 PFS final rule with comment period.

3. Revised Malpractice RVUs for Selected Disc Arthroplasty Services

As discussed in the CY 2010 PFS proposed rule (74 FR 33539), we assign malpractice RVUs to each service based upon a weighted average of the risk factors of all specialties that furnish the service. For the CY 2010 review of malpractice RVUs, we used CY 2008 Medicare payment data on allowed services to establish the frequency of a service by specialty. CPT code 22856 (Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical) had zero allowed services for CY 2008. Therefore, our contractor initially set the level of services to 1, and assigned a risk factor according to the average risk factor for all services that do not explicitly have a separate technical or professional component. We proposed to adopt our contractor's initial malpractice RVUs for CPT code 22856 in the CY 2010 proposed rule. Application of the average physician risk factor would have resulted in a significant decrease in malpractice RVUs for CPT code 22856 in CY 2010.

Several commenters on the CY 2010 PFS proposed rule expressed concern regarding the proposed malpractice RVUs for CPT code 22856, which represented a proposed reduction of more than 77 percent. The commenters stated that this service is predominantly furnished by neurosurgeons and orthopedic surgeons. Given the high risk factors associated with these specialty types and the changes in malpractice RVUs for comparable services, the commenters stated that a reduction in the malpractice RVUs of this magnitude for CPT code 22856 could not be correct.

After consideration of the public comments, for CY 2010, we set the risk factor for CPT code 22856 as the weighted average risk factor of six comparable procedures mentioned by

the commenters: CPT code 22554 (Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2); CPT code 22558 (Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar); CPT code 22857 (Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar); CPT code 22845 (Anterior instrumentation; 2 to 3 vertebral segments (list separately in addition to code for primary procedure)); CPT code 63075 (Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace); and CPT code 20931 (Allograft for spine surgery only; structural (list separately in addition to code for primary procedure)). The weighted average risk factor for these services is 8.4.

Since publication of the CY 2010 PFS final rule with comment period, stakeholders have mentioned that we made significant changes to the malpractice RVUs for CPT code 22856 in CY 2010. The commenters also brought to our attention that other services are clinically similar to CPT code 22856 and have similar work RVUs, and therefore, some stakeholders believe these services should all have similar malpractice RVUs. Services mentioned by the stakeholders that are clinically similar to CPT code 22856 include CPT code 22857; CPT code 22861 (Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical); CPT code 22862 (Revision including replacement of total disc arthroplasty (artificial disc) anterior approach, lumbar); CPT code 22864 (Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical); and CPT code 22865 (Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar).

After further review of this issue, we are proposing to apply the same risk factor used for CPT code 22856 to certain other services within this family of services (CPT codes 22857 through 22865) for which there were no allowed services in CY 2008. CPT codes 22861 and 22864 had zero allowed services in CY 2008 and our contractor initially set their malpractice RVUs in the same way as it did for CPT code 22856. Therefore, we will assign the weighted average risk factor we use for CPT code 22856 (that is, the weighted average of the risk factors for CPT codes 20931, 22554, 22558, 22845, 22857, and 63075) to CPT codes 22861 and 22864. However, CPT codes 22857, 22862, and 22865 are low volume services (allowed services under 100). Our policy for low volume services is to apply the risk factor of the dominant specialty as indicated by our claims data. We will continue to apply our policy for low volume services to CPT codes 22857, 22862, and 22865.

C. Potentially Misvalued Services Under the Physician Fee Schedule

1. Valuing Services Under the PFS

As discussed in section I. of this proposed rule, in order to value services under the PFS, section 1848(c) of the Act requires the Secretary to determine relative values for physicians' services based on three components: the work, practice expense (PE), and malpractice components. Section 1848(c)(1)(A) of the Act defines the work component to include "the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service." Additionally, the statute provides that the work component shall include activities that occur before and after direct patient contact. Furthermore, the statute specifies that with respect to surgical procedures, the valuation of the work component for the code would reflect a "global" concept in which pre-operative and post-operative physicians' services related to the procedure would also be included.

In addition, section 1848(c)(2)(C)(i) of the Act specifies that "the Secretary shall determine a number of work relative value units (RVUs) for the service based on the relative resources incorporating physician time and intensity required in furnishing the service." As discussed in detail in sections I.A.2. and I.A.3 of this proposed rule, the statute also defines the PE and malpractice components and provides specific guidance in the calculation of the RVUs for each of these components. Section 1848(c)(1)(B) of the Act defines the PE component as "the portion of the resources used in furnishing the service that reflects the general categories of expenses (such as office rent and wages of personnel, but excluding malpractice expenses) comprising practice expenses."

Section 1848(c)(2)(C)(ii) of the Act specifies that the "Secretary shall determine a number of practice expense relative value units for the services for years beginning with 1999 based on the relative practice expense resources involved in furnishing the service." Furthermore, section 1848(c)(2)(B) of the Act directs the Secretary to conduct a periodic review, not less often than every 5 years, of the RVUs established under the PFS. Finally, on March 23, 2010, the Affordable Care Act was enacted, further requiring the Secretary to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of those services identified as being potentially misvalued. Section 3134(a) of the ACA added a new section 1848(c)(2)(K) of the Act which requires the Secretary to periodically identify potentially misvalued services using certain criteria, and to review and make appropriate adjustments to the relative values for those services. Section 3134(a) of the ACA also added a new section 1848(c)(2)(L) which requires the Secretary to develop a validation process to validate the RVUs of potentially misvalued codes under the PFS and make appropriate adjustments.

As discussed in section I.A.1. of this proposed rule, we establish physician work RVUs for new and revised codes based on our review of recommendations received from the AMA RUC. The AMA RUC also provides recommendations to CMS on the values for codes that have been identified as potentially misvalued. To respond to concerns expressed by MedPAC, the Congress, and other stakeholders regarding accurate valuation of services under the PFS, the AMA RUC created the Five-Year Review Identification Workgroup. In addition to providing recommendations to CMS for work RVUs, the AMA RUC's Practice Expense Subcommittee reviews direct PE (clinical labor, medical supplies, and medical equipment) for individual services and examines the many broad and methodological issues relating to the development of PE RVUs.

In accordance with section 1848(c) of the Act, we determine appropriate adjustments to the RVUs, taking into account the recommendations provided by the AMA RUC and MedPAC, and publish the explanation for the basis of these adjustments in the PFS proposed and final rules. We note that section 1848(c)(2)(A)(ii) of the Act authorizes the use of extrapolation and other techniques to determine the RVUs for physicians' services for which specific data are not available, in addition to taking into account the results of consultations with organizations representing physicians.

2. Identifying, Reviewing, and Validating the RVUs of Potentially Misvalued Services Under the PFS

a. Background

In its March 2006 Report to Congress, MedPAC noted that "misvalued services can distort the price signals for physicians' services as well as for other health care services that physicians order, such as hospital services." In that same report MedPAC postulated that physicians' services under the PFS can become misvalued over time for a number of reasons: "For example, when a new service is added to the physician fee schedule, it may be assigned a relatively high value because of the time, technical skill, and psychological stress that are required to perform it. Over time, skill, and stress involved may decline as physicians become more familiar with the service and more efficient at providing it. The amount of physician work needed to furnish an existing service may decrease when new technologies are incorporated. Services can also become overvalued when practice expenses decline. This can happen when the costs of equipment and supplies fall, or when equipment is used more frequently, reducing its cost per use. Likewise, services can become undervalued when physician work increases or practice expenses rise." In the ensuing years since MedPAC's 2006 report, additional groups of potentially misvalued services have been identified by Congress, CMS, MedPAC, the AMA RUC, and other stakeholders.

In recent years CMS and the AMA RUC have taken increasingly significant steps to address potentially misvalued codes. As MedPAC noted in its March 2009 Report to Congress, in the intervening years since MedPAC made the initial recommendations, "CMS and the AMA RUC have taken several steps to improve the review process." Most recently, section 1848(c)(2)(K)(ii) of the Act (as added by section 3134 of the ACA) directed the Secretary to specifically examine potentially misvalued services in seven categories.

(1) Codes and families of codes for which there has been the fastest growth.

(2) Codes or families of codes that have experienced substantial changes in practice expenses.

(3) Codes that are recently established for new technologies or services.

(4) Multiple codes that are frequently billed in conjunction with furnishing a single service.

(5) Codes with low relative values, particularly those that are often billed multiple times for a single treatment.

(6) Codes which have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes').

(7) Other codes determined to be appropriate by the Secretary.

Section 1848(c)(2)(K)(iii) of the Act (as added by section 3134 of the ACA) also specifies that the Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services. In addition, the Secretary may conduct surveys, other data collection activities, studies, or other analyses as the Secretary determines to be appropriate to facilitate the review and appropriate adjustment of potentially misvalued services. This section authorizes the use of analytic contractors to identify and analyze potentially misvalued codes, conduct surveys or collect data, and make recommendations on the review and appropriate adjustment of potentially misvalued services. Finally, section 1848(c)(2)(K)(iii)(V) of the Act (as added by section 3134 of the ACA) specifies that the Secretary may make appropriate coding revisions (including using existing processes for consideration of coding changes) which may include consolidation of individual services into bundled codes for payment under the physician fee schedule.

b. Progress in Identifying and Reviewing Potentially Misvalued Codes

Over the last several years, CMS, in conjunction with the AMA RUC, has identified and reviewed numerous potentially misvalued codes in all seven of the categories specified in section 1848(c)(2)(K)(ii) (as added by section 3134 of the ACA), and we plan to continue our work examining potentially misvalued codes in these areas over the upcoming years, consistent with the new legislative mandate on this issue. In the current process, the AMA RUC reviews potentially misvalued codes that are identified either by CMS or through its own processes and recommends revised work RVUs and/or direct PE inputs for those codes to CMS. CMS then assesses the recommended revised work RVUs and/or direct PE inputs and, in accordance with section 1848(c) of the Act, we determine if the recommendations constitute appropriate adjustments to the RVUs under the PFS. Since CY 2009, CMS and the AMA RUC have identified over 700 potentially misvalued codes.

For example, in regards to the first category (codes and families of codes for which there has been the fastest growth), for CY 2009 CMS identified over 100 potentially misvalued codes for which an analysis of the utilization data showed an annual growth in allowed services of 10 percent (or more) for 3 consecutive years (73 FR 38586). Each of these codes had allowed charges of $1 million or more in CY 2007. We published this list in the CY 2009 proposed rule (73 FR 38586 through 38589) and requested that the AMA RUC immediately begin a review of the codes on this list. Meanwhile, in parallel with CMS' efforts, the AMA RUC also initiated processes to identify and review potentially misvalued codes on an ongoing basis using certain screens, including screens for "CMS fastest growing procedures" and "high volume growth." Both of these AMA RUC screens are applicable to the first category of potentially misvalued codes specified in ACA. We plan to continue to analyze Medicare claims data over future years to identify additional services that exhibit rapid growth and high Medicare expenditures for referral to the AMA RUC for review as potentially misvalued codes.

Pertaining to the second category specified in section 1848(c)(2)(K)(ii) of the Act (as added by section 3134 of ACA) (codes or families of codes that have experienced substantial changes in practice expenses), in CY 2009 we requested that the AMA RUC continue its review of direct PE inputs, focusing particularly on high-volume codes where the PE payments are increasing significantly under the transition to the new PE methodology (73 FR 38589). The AMA RUC has responded by sending CMS recommendations for revised direct PE inputs for codes identified for PE review on an ongoing basis.

Additionally in CY 2009, we began an initiative to review and update the prices for high-cost supplies in order to ensure the accuracy and completeness of the direct PE inputs. We discuss our most recent efforts in refining the process to update the prices of high-cost supplies in section II.C.5. of this proposed rule.

For the third category of potentially misvalued codes identified in section 1848(c)(2)(K)(ii) (as added by section 3134 of the ACA) (codes that are recently established for new technologies or services), the AMA RUC routinely identifies such codes through a screen based on 3 years of Medicare claims data, and sends CMS recommendations for revised work RVUs and/or direct PE inputs for these codes on an ongoing basis. The AMA RUC may determine that a code for a new service requires reevaluation or does not require reevaluation, or it may conclude, on a case-by-case basis, that more than 3 years of claims data are

necessary before the code can be reviewed. In that case, it would determine the appropriate future timeframe for review.

We also note that in its June 2008 Report to Congress entitled "Reforming the Health Care System" and in the context of a discussion about primary care, MedPAC acknowledges, "* * * Efficiency can improve more easily for other types of services, such as procedures, with advances in technology, technique, and other factors. Ideally, when such efficiency gains are achieved, the fee schedule's relative value units (RVUs) for the affected services should decline accordingly, while budget neutrality would raise the RVUs for the fee schedule's primary care services." (page 27). Section III.C.5. of this proposed rule includes a discussion regarding periodic updates to the costs of high cost supplies. This discussion is highly relevant to new technology services, where growth in volume of a service as it diffuses into clinical practice may lead to a decrease in the cost of expensive supplies. We also expect that other efficiencies in physician work and PE may be achieved after an initial period of relative inefficiency that reflects the "learning curve." We plan to pay particular attention to the work values and direct PE inputs for these new services and the AMA RUC's periodic review process to ensure that any efficiencies are captured under the PFS over time, recognizing that the appropriate timing for revaluing these services needs to be considered on a case-by-case basis depending on the growth rate in service volume.

We have also addressed the fourth category (multiple codes that are frequently billed in conjunction with furnishing a single service) in rulemaking prior to the enactment of the ACA. As discussed in the CY 2009 PFS proposed rule (73 FR 38586), we have a longstanding policy of reducing payment for multiple surgical procedures performed on the same patient, by the same physician, on the same day. Over the ensuing years, the multiple procedure payment reduction (MPPR) policy has been extended to a number of nuclear diagnostic and diagnostic imaging procedures. We continue our work to recognize efficiencies in this area with a proposal to expand the MPPR policy to additional combinations of imaging services and to therapy services for CY 2011 as described in section II.C.4. of this proposed rule.

We note the AMA RUC has also established a screen to identify services performed by the same physician on the same date of service 95 percent of the time or more. Over the past 2 years, the CPT Editorial Panel has established new bundled codes to describe a comprehensive service for certain combinations of these existing services that are commonly furnished together, and the AMA RUC has recommended work values and direct PE inputs to CMS for these comprehensive service codes that recognize the associated efficiencies. CMS looks forward to working with the AMA RUC in this joint effort to examine codes commonly reported together and more appropriately value common combinations services.

We address the fifth category of potentially misvalued codes (codes with low relative values, particularly those that are often billed multiple times for a single treatment) in section II.C.3.b. of this proposed rule. That is, we are providing a list of services with low work RVUs that are commonly reported with multiple units in a single encounter and requesting that the AMA RUC review these codes that we have identified as potentially misvalued.

The sixth category (codes which have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes')) also continues to be addressed by CMS and the AMA RUC on an ongoing basis. As we noted in the CY 2009 PFS proposed rule (73 FR 38589), there were at that time approximately 2900 codes, representing $5 billion in annual spending, that were originally valued using Harvard data and have not subsequently been evaluated by the AMA RUC. Consequently, in CY 2009, we requested that the AMA RUC engage in an ongoing effort to review the remaining Harvard-valued codes, focusing first on the high-volume, low intensity codes (73 FR 38589). In response to our request, the AMA RUC initially conducted an analysis of Harvard-valued services with utilization above 10,000 services per year, which resulted in a list of 296 distinct services (73 FR 69883). The AMA RUC, in its public comment on the CY 2009 proposed rule, stated that it believes it would be effective to limit any review to these 296 services and also noted that of the 296 services identified, 23 had already been identified by another screen and were in the process of being reviewed (73 FR 69883). To date, the AMA RUC has reviewed and submitted to CMS recommendations for revised work RVUs and/or direct PE inputs for a number of Harvard-valued codes, prioritizing those codes with utilization of over 1 million services. The AMA RUC and CMS intend to continue our ongoing assessment of Harvard-valued codes, next targeting codes with utilization of over 100,000 services.

Finally, the seventh category of potentially misvalued codes mentioned in section 1848(c)(2)(K)(ii) (as added by section 3134 of the ACA) is all other codes determined to be appropriate by the Secretary. In this category, CMS has previously proposed policies and requested that the AMA RUC review codes for which there have been shifts in the site-of-service (site-of-service anomalies), as well as codes that qualify as "23-hour stay" outpatient services. The policies for valuation of both the site-of-service anomaly codes and the "23-hour stay" codes are developed further in sections II.C.3.d. and e., respectively, of this proposed rule. For CY 2011, we are also identifying codes with low work RVUs but are high volume based on claims data as another category of potentially misvalued codes and are referring these codes to the AMA RUC for review, as discussed in section II.C.3.b. of this proposed rule. In addition, for CY 2011 we are newly targeting key codes that the AMA RUC uses as reference services for valuing other services, termed "multispecialty points of comparison" services, and referring these to the AMA RUC for review as potentially misvalued codes as described in section II.C.3.a. of this proposed rule. Finally, we note the AMA RUC has also established screens to identify potentially misvalued codes in additional categories, including codes with a high intra-service work per unit of time (IWPUT) and codes representing services that had been surveyed by one specialty, but are now performed by a different specialty. We will continue to review AMA RUC recommendations for revised work RVUs and/or direct PE inputs for codes that fall into these categories.

As a result of the combined efforts of CMS and the AMA RUC to address potentially misvalued codes, for CY 2009 the AMA RUC recommended revised work values and/or PE inputs for 204 misvalued services (73 FR 69883). For CY 2010, an additional 113 codes were identified as misvalued and the AMA RUC provided new recommendations for revised work RVUs and/or PE inputs to CMS as discussed in the CY 2010 PFS final rule with comment period (74 FR 61778). Upon review of the AMA RUC-recommended work RVUs, CMS accepted the majority of the values as appropriate adjustments to the RVUs under the PFS, in accordance with section 1848(c) of the Act. However, for a number of codes, mainly the site-of-service anomaly codes, we indicated

that although we would accept the AMA RUC valuations for these site-of-service anomaly codes on an interim basis through CY 2010, we had ongoing concerns about the methodology used by the AMA RUC to review these services (73 FR 69883 and 74 FR 61776 through 61778, respectively). In the CY 2010 PFS final rule with comment period, we requested that the AMA RUC reexamine the site-of-service anomaly codes and use the building block methodology to revalue the services (74 FR 61777). In that same rule, we also stated that we would continue to examine these codes and consider whether it would be appropriate to propose additional changes in future rulemaking. We discuss our CY 2011 proposal with respect to these codes in section II.C.3.d. of this proposed rule.

c. Validating RVUs of Potentially Misvalued Codes

In addition to identifying and reviewing potentially misvalued codes, section 1848(c)(2)(L) (as added by section 3134 of the ACA) specifies that the Secretary shall establish a formal process to validate relative value units under the PFS. The validation process may include validation of work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and may include validation of the pre, post, and intra-service components of work. The Secretary is directed to validate a sampling of the work RVUs of codes identified through any of the seven categories of potentially misvalued codes specified by section 1848(c)(2)(K)(ii) (as added by section 3134 of the ACA). Furthermore, the Secretary may conduct the validation using methods similar to those used to review potentially misvalued codes, including conducting surveys, other data collection activities, studies, or other analyses as the Secretary determines to be appropriate to facilitate the validation of RVUs of services. Currently, while CMS does assess the AMA RUC- recommended work RVUs to determine if the recommendations constitute appropriate adjustments to the RVUs under the PFS, we intend to establish a more extensive validation process of RVUs in the future in accordance with the requirements of section 1848(c)(2)(L) (as added by section 3134 of the ACA). Therefore, we are soliciting public comments on this proposed rule on possible approaches and methodologies that we should consider for a validation process. We are especially interested in public comments regarding approaches, including the use of time and motion studies, to validate estimates of physician time and intensity that are factored into the work RVUs for services with rapid growth in Medicare expenditures, one of the categories that the statute specifically directs CMS to examine. We plan to discuss the validation process in a future PFS rule once we have considered the matter further in conjunction with any public comments and other input from stakeholders that we receive.

3. CY 2011 Identification and Review of Potentially Misvalued Services

In this section, we discuss codes that may be misvalued according to five different criteria:

- Codes on the multi-specialty points of comparison list;
- Codes with low work RVUs commonly billed in multiple units per single encounter;
- Codes with high volume and low work RVUs;
- Codes with site-of-service anomalies; and
- Codes that qualify as "23-hour stay" outpatient services.

a. Codes on the Multispecialty Points of Comparison List

The AMA RUC uses a scale referred to as the multispecialty points of comparison (MPC) to evaluate the reasonableness of a specialty society's recommended RVU value for a service. The MPC list contains reference codes of established comparison services that are used in the valuation of new codes. The current MPC list consists of 316 codes which the AMA RUC may use to compare and contrast the relativity of codes under review to existing relative values. Since the AMA RUC may use the values on the MPC list as a basis for relativity when determining the values for new, revised, and newly reviewed codes (including potentially misvalued codes), it is essential that the services on the MPC list be appropriately valued since any codes misvalued on the MPC list could contribute to the misvaluing of other codes under review. While we believe that the entire MPC list should be assessed to ensure that services are paid appropriately under the PFS, we have prioritized the review of the MPC list, ranking the codes by allowed service units and charges based on CY 2009 claims data. We are proposing to refer the codes in Table 9 to the AMA RUC for review.

TABLE 9—CODES ON THE MPC LIST REFERRED FOR AMA RUC REVIEW

CPT Code	Short descriptor
66984	Cataract surg w/iol, 1 stage.
97110	Therapeutic exercises.
43239	Upper GI endoscopy, biopsy.
20610	Drain/inject, joint/bursa.
78815	Pet image w/ct, skull-thigh.
45385	Lesion removal colonoscopy.
45380	Colonoscopy and biopsy.
11721	Debride nail, 6 or more.
17000	Destruct premalg lesion.
92980	Insert intracoronary stent.
74160	Ct abdomen w/dye.
71020	Chest x-ray.
11100	Biopsy, skin lesion.
66821	After cataract laser surgery.
52000	Cystoscopy.
92083	Visual field examination(s).
73721	Mri jnt of lwr extre w/o dye.
93010	Electrocardiogram report.
77334	Radiation treatment aid(s).
92250	Eye exam with photos.
95810	Polysomnography, 4 or more.
77003	Fluoroguide for spine inject.
11056	Trim skin lesions, 2 to 4.
76700	Us exam, abdom, complete.
77290	Set radiation therapy field.
77300	Radiation therapy dose plan.
43235	Uppr gi endoscopy, diagnosis.
71275	Ct angiography, chest.
95900	Motor nerve conduction test.
31231	Nasal endoscopy, dx.
95165	Antigen therapy services.
94060	Evaluation of wheezing.
31575	Diagnostic laryngoscopy.

b. Codes With Low Work RVUs Commonly Billed in Multiple Units per Single Encounter

Consistent with section 1848(c)(2)(K)(ii) (as added by section 3134 of the ACA) which identifies categories of potentially misvalued codes for our review, we believe services with low work RVUs that are commonly billed with multiple units in a single encounter are an additional appropriate category for identifying potentially misvalued codes. An example of a high multiple/low work RVU service is CPT code 95004 (Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests). For purposes of compiling a list of the high multiple/low work RVU services, we defined a high multiple service as one that is commonly performed in multiples of 5 or more per day. Then, we selected from high multiple services with work RVUs of less than or equal to 0.5 RVUs. We note that in selecting 5 per day as the minimum threshold for the number of common services performed in a multiple service encounter, we intended to establish a meaningful threshold which, in conjunction with the

threshold for work RVUs of 0.5 RVUs or less, would produce a reasonable number of services for the RUC to review that have substantial total work RVUs for the comprehensive service furnished during a single treatment. That is, as a general example, with a work RVU threshold of 0.5 RVUs and a multiple threshold of 5 per day, the total work RVUs for a typical treatment would equate to 2.5 RVUs, which is approximately comparable to a high level office visit, an interpretation of a complex imaging procedure, or a minor surgical procedure.

We are asking the AMA RUC to review the codes in Table 10.

TABLE 10—CODES WITH LOW WORK RVUS THAT ARE COMMONLY BILLED IN MULTIPLE UNITS REFERRED FOR AMA RUC REVIEW

CPT Code	Short descriptor
95904	Sense nerve conduction test.
17003	Destruct premalg les, 2–14.
95004	Percut allergy skin tests.
11101	Biopsy, skin add-on.
95024	Id allergy test, drug/bug.
76000	Fluoroscope examination.
95144	Antigen therapy services.
95010	Percut allergy titrate test.
88300	Surgical path, gross.
95027	Id allergy titrate-airborne.
95015	Id allergy titrate-drug/bug.
95148	Antigen therapy services.

c. Codes With High Volume and Low Work RVUs

We believe that codes that have low work RVUs but are high volume based on claims data are another category of potentially misvalued codes. Although these codes have low work RVUs (less than or equal to 0.25 RVUs), the high utilization of these codes represents significant expenditures under the PFS such that their appropriate valuation is especially important. Table 11 contains a list of such codes and we are requesting that the AMA RUC review these codes.

TABLE 11—CODES WITH LOW WORK RVUS THAT ARE HIGH VOLUME REFERRED FOR AMA RUC REVIEW

CPT Code	Short descriptor
71010	Chest x-ray.
73510	X-ray exam of hip.
97035	Ultrasound therapy.
88313	Special stains group 2.
73630	X-ray exam of foot.
72100	X-ray exam of lower spine.
73030	X-ray exam of shoulder.
73562	X-ray exam of knee, 3.
73560	X-ray exam of knee, 1 or 2.
94010	Breathing capacity test.
77052	Comp screen mammogram add-on.
88304	Tissue exam by pathologist.
73564	X-ray exam, knee, 4 or more.
72170	X-ray exam of pelvis.
74000	X-ray exam of abdomen.
73610	X-ray exam of ankle.
11719	Trim nail(s).
73620	X-ray exam of foot.
92567	Tympanometry.
73110	X-ray exam of wrist.
73130	X-ray exam of hand.
93701	Bioimpedance, cv analysis.
72040	X-ray exam of neck, spine.
92543	Caloric vestibular test

d. Codes With Site-of-Service Anomalies

In previous years, we requested that the AMA RUC review codes that, according to the Medicare claims database, have experienced a change in the typical site of service since the original valuation of the code. For example, we have found services that originally were provided in the inpatient setting but for which current claims data show the typical case has shifted to being furnished outside the inpatient setting. Since the procedures were typically performed in the inpatient setting when the codes were originally valued, the work RVUs for these codes would have been valued to include the inpatient physician work provided, as well as to reflect the intensive care and follow-up normally associated with an inpatient procedure. If the typical case for the procedure has shifted from the inpatient setting to an outpatient or physician's office setting, it is reasonable to expect that there have been changes in medical practice, and that such changes would represent a decrease in physician time or intensity or both. The AMA RUC reviewed and recommended to CMS revised work RVUs for 29 codes for CY 2009 and 11 codes for CY 2010 that were identified as having site-of-service anomalies.

In the CY 2010 PFS proposed and final rules with comment period (74 FR 33556 and 74 FR 61777, respectively), we encouraged the AMA RUC to utilize the building block methodology when revaluing services with site-of-service anomalies. Specifically, where the AMA RUC has determined in its review that changes in the inclusion of inpatient hospital days, office visits, and hospital discharge day management services (that is, the "building blocks" of the code) are warranted in the revaluation of the code, we asked the AMA RUC to adjust the site-of-service anomaly code for the work RVUs associated with those changes.

Additionally, we suggested that in cases where the AMA RUC has adjusted the pre-service, intra-service and post-service times of the code under review, the AMA RUC should also make associated work RVU adjustments to account for those changes. However, we remain concerned that in the AMA RUC's recommendations of the work RVUs for the CYs 2009 and 2010 site-of-service anomaly codes, the AMA RUC may have determined that eliminating or reallocating pre-service and post-service times, hospital days, office visits, and hospital discharge day management services was appropriate to reflect the typical case that is now occurring in a different setting, but the work RVUs associated with those changes may not have been systematically extracted or reallocated from the total work RVU value for the service.

In the CYs 2009 and 2010 PFS final rules with comment period (73 FR 69883 and 74 FR 61776 through 61778, respectively), we indicated that although we would accept the AMA RUC valuations for these site-of-service anomaly codes on an interim basis through CY 2010, we had ongoing concerns about the methodology used by the AMA RUC to review these services. We requested that the RUC reexamine the site-of-service anomaly codes and use the building block methodology to revalue the services (74 FR 61777). We also stated that we would continue to examine these codes and consider whether it would be appropriate to propose additional changes in future rulemaking.

Accordingly, in preparation for CY 2011 rulemaking, we conducted a comprehensive analysis of the codes that the AMA RUC reviewed for CYs 2009 and 2010 due to site-of-service anomaly concerns. We systematically applied the reverse building block methodology to the 29 codes from CY 2009 and 11 codes from CY 2010 as follows:

- First, we obtained the original work RVU value assigned to the code (this is the "starting value") and made a list of the building block services with RVUs that were originally associated with the code (that is, before the AMA RUC reviewed the code for site-of-service anomalies).
- Next, we examined the AMA RUC-recommended changes to the building blocks of the code.

• We then deducted the RVUs associated with the AMA RUC's recommended eliminations from the code's starting RVU value.

Generally, the AMA RUC eliminated inpatient hospital visit building blocks from the value of the code since the site-of-service for the code has shifted from the inpatient setting to another setting. We note in some cases, the AMA RUC left an inpatient hospital visit in the valuation of the code. We believe this is inconsistent with the change in the site of service to non-inpatient settings. Accordingly, we adhered to the methodology and deducted the RVUs associated with all inpatient hospital visits from the starting value. In cases where the AMA RUC recommended adding or substituting outpatient visits, we also added or substituted the RVUs associated with those changes to the starting value. If the AMA RUC recommended changes to the pre-, intra-, or post-service times, we calculated the incremental change in RVUs associated with that time and either added or deducted that RVU amount from the starting value. We note that the RVU values associated with the incremental time change are calculated using the intensity associated with the particular pre-, intra-, or post period. For the intensity of the intra-service period, we utilized the original IWPUT associated with the code. The AMA RUC generally recommended allowing only half of a hospital discharge day management service for the site-of-service anomaly codes. That is, CPT code 99238 (Hospital discharge day management; 30 minutes or less) has a work RVU value of 1.28; therefore, half the value associated with CPT code 99238 is 0.64. Accordingly, if a code had one CPT code 99238 listed as part of the original valuation, we deducted 0.64 RVUs from the starting value.

We standardized the methodology so that each of the site-of-service anomaly codes has half of a hospital discharge day management service value accounted in the valuation. Finally, we note that while we eliminated the RVUs associated with all inpatient hospital visits built into the code's starting value, because the typical case no longer occurs in the inpatient setting, we allowed for the possibility that in some cases, some part of the work which had been performed in the inpatient setting may continue to be provided even in the outpatient setting. Therefore, to be conservative in our deductions of work RVUs associated with the inpatient hospital codes from the starting values, we allowed the intra-time of any inpatient hospital visits included in the original valuation to migrate to the post-service period of the code. Accordingly, while we deducted the full RVUs of an inpatient hospital visit from the starting value, we added the intra-service time of the inpatient hospital visit to the post-service time of the code and accounted for the incremental change in RVUs. The following description provides an example of our methodology.

CPT code 21025 (Excision of bone (*e.g.,* for osteomyelitis or bone abscess); mandible) has a starting value of 11.07 RVUs. Table 12 shows the building blocks that are included in the original valuation of the code.

TABLE 12

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213	Original IWPUT
75 min	120 min	43 min	1 visit (0.76 RVUs).	1 visit (1.39 RVUs).	1 visit (1.28 RVUs).	2 visits (0.36 RVUs).	2 visits (0.96 RVUs).	2 visits (1.94 RVUs).	0.0145

The AMA RUC removed two inpatient hospital visits and reduced the outpatient visits from 6 to 4 visits. Table 13 shows the building blocks that were recommended for CY 2009 by the AMA RUC after its review of the code for site-of-service anomalies.

TABLE 13

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213	Revised IWPUT
85 min	90 min	30 min	.....	.....	.....	.....	2 visits	2 visits	0.0530

Next we calculated the RVUs associated with the changes to the building blocks recommended by the AMA RUC. We note that the immediate post-service value of 0.38 RVUs (Table 14) includes 30 minutes of intra-service time from inpatient hospital CPT code 99231 (Level 1 subsequent hospital care, per day). Also, the median intra-service value of 0.44 RVUs (Table 14) was determined using the starting IWPUT value of 0.0145. Additionally, our methodology accounted for a half of a hospital discharge day management service (CPT code 99238) for the site-of-service anomaly code. Table 14 shows the RVU changes to the building blocks that were calculated based on the methodology discussed above.

TABLE 14

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213
0.22 RVUs	−0.44 RVUs	0.38 RVUs ...	−0.76 RVUs	−1.39 RVUs	−0.64 RVUs	−0.36 RVUs.		

In the final step, the RVUs associated with the changes to the building blocks recommended by the AMA RUC (Table 14) were deducted from or added to the starting value of 11.07 RVUs, which resulted in the CY 2011 reverse building

block value of 8.08 RVUs (11.07+0.22 − 0.44+0.38 − 0.76 − 1.39 − 0.64 − 0.36=8.08).

The methodology discussed above was applied to each of the site-of-service anomaly codes from CYs 2009 and 2010 and the results are summarized in Tables 15 and 16.

TABLE 15—CY 2009 SITE-OF-SERVICE ANOMALY CODES [1]

CPT code	Short descriptor	CY 2008 RVUs ("starting value")	RUC Recommended value for CY 2009	CY 2011 Reverse building block value
21025	Excision of bone, lower jaw	11.07	9.87	8.09
23415	Release of shoulder ligament	10.09	9.07	10.63
25116	Remove wrist/forearm lesion	7.38	7.38	7.21
42440	Excise submaxillary gland	7.05	7.05	6.52
52341	Cysto w/ureter stricture tx	6.11	5.35	5.62
52342	Cysto w/up stricture tx	6.61	5.85	6.20
52343	Cysto w/renal stricture tx	7.31	6.55	5.90
52344	Cysto/uretero, stricture tx	7.81	7.05	5.58
52345	Cysto/uretero w/up stricture	8.31	7.55	5.76
52346	Cystouretero w/renal strict	9.34	8.58	6.05
52400	Cystouretero w/congen repr	10.06	8.66	7.00
52500	Revision of bladder neck	9.39	7.99	8.72
52640	Relieve bladder contracture	6.89	4.73	5.01
53445	Insert uro/ves nck sphincter	15.21	15.21	11.72
54410	Remove/replace penis prosth	16.48	15.00	14.00
54530	Removal of testis	9.31	8.35	8.88
57287	Revise/remove sling repair	11.49	10.97	10.20
62263	Epidural lysis mult sessions	6.41	6.41	6.99
62350	Implant spinal canal cath	8.04	6.00	0.41
62355	Remove spinal canal catheter	6.60	4.35	-0.43
62360	Insert spine infusion device	3.68	4.28	-3.14
62361	Implant spine infusion pump	6.59	5.60	-0.92
62362	Implant spine infusion pump	8.58	6.05	-0.51
62365	Remove spine infusion device	6.57	4.60	-0.35
63650	Implant neuroelectrodes	7.57	7.15	4.25
63685	Insrt/redo spine n generator	7.87	6.00	4.80
64708	Revise arm/leg nerve	6.22	6.22	6.17
64831	Repair of digit nerve	10.23	9.00	8.87
65285	Repair of eye wound	14.43	14.43	13.52

[1] We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

TABLE 16—CY 2010 SITE-OF-SERVICE ANOMALY CODES [2]

CPT code	Short descriptor	CY 2009 RVUs ("starting value")	RUC Recommended value for CY 2010	CY 2011 Reverse building block value
28120	Part removal of ankle/heel	5.64	8.08	6.03
28122	Partial removal of foot bone	7.56	7.56	6.79
28725	Fusion of foot bones	11.97	11.97	12.41
28730	Fusion of foot bones	12.21	12.21	10.06
36825	Artery-vein autograft	10.00	15	13.12
42415	Excise parotid gland/lesion	17.99	17.99	15.17
42420	Excise parotid gland/lesion	20.87	20.87	17.80
49507	Prp i/hern init block >5 yr	9.97	9.97	9.37
49521	Rerepairing hernia, blocked	12.36	12.36	11.59
49587	Rpr umbil hern, block > 5 yr	7.96	7.96	7.19
61885	Insrt/redo neurostim 1 array	7.37	7.57	3.22

[2] We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

For most codes in Tables 15 and 16, the CY 2011 reverse building block methodology produced a value that is somewhat lower than the AMA RUC-recommended value. While our results suggest that the majority of the codes with site-of-service anomalies continue to be overvalued under the AMA RUC's most recent recommendations, we also found that the methodology may produce a result that is considerably reduced or, in several cases, a negative value. We understand that in previous years, stakeholders have expressed confusion as to why the application of a building block methodology would produce negative values. We believe in some cases, the starting value, that is,

the original work RVU, may have been misvalued using building block inputs that were not consistent with the service, although the overall work value of the code may have been consistent with the values for other similar services. Moreover, a number of these services are the Harvard-valued codes, for which the RVUs were established many years ago based on historical inputs that may no longer be appropriate for the code. An attempt to extract the RVUs associated with these inappropriate inputs through the reverse building block methodology could produce aberrant results. Furthermore, in some cases, we noticed that the original IWPUT of the code was negative even before the code was reviewed by the AMA RUC for a site-of-service anomaly. A negative value for the IWPUT is counterintuitive to the IWPUT concept, indicating that the code was originally misvalued at the building block level. At a minimum, we believe that in cases where the reverse building block methodology produces aberrant results, and where clinical review indicates a need for further analysis, the codes should be referred back to the AMA RUC for review and new valuation should be performed based on the building block methodology.

We note the application of the reverse building block methodology is an objective way to account for changes in the resources resulting from the change in the site-of-service in which the typical service is provided. However, because relative values under the PFS are "relative," that is, where work relative value units for a code are established relative to work relative value units for other codes, the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion. For example, we recognize that the AMA RUC looks at families of codes and may assign RVUs based on a particular code ranking within the family. This method of valuing services preserves relativity within the relative value scale for that code family. However, we have stated that we believe the relative value scale requires each service to be valued based on the resources used in furnishing the service as specified in section 1848(c)(1)(A) of the Act, which defines the physician work component to include "the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service." Furthermore, section 1848(c)(2)(C)(i) of the Act specifies that "the Secretary shall determine a number of work relative value units (RVUs) for the service based on the relative resources incorporating physician time and intensity required in furnishing the service." Read together, these two sections of the statute support our intention to rely on the building block methodology to determine appropriate work RVUs for codes.

We note that we continue to rely on the extensive expertise provided by the AMA RUC to recommend appropriate input building blocks for codes. Additionally, the AMA RUC's unique infrastructure and broad perspective permits the valuation of a code within the context of relativity to the entire relative value system. Therefore, we believe that the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion.

Accordingly, we are requesting that the AMA RUC review the CPT codes displayed in Tables 15 and 16. In addition, where the application of the CY 2011 reverse building block methodology produces an aberrant result that is clearly not a reflection of physician work for the service, we are requesting that the AMA RUC review the input building blocks and recommend an appropriate RVU value that is both consistent with the building blocks of the code and appropriate relative to the values for other codes in the family. For other codes where the application of the CY 2011 reverse building block methodology produces a result that is consistent with the physician work for the service, we encourage the AMA RUC to confirm the values and recommend these work values for CY 2011. In this way, we would hope to receive new AMA RUC recommendations for all of the codes in Tables 15 and 16 for CY 2011. Furthermore, if the recommendations that we receive from the AMA RUC are not consistent with the building block methodology and not appropriate relative to the values of other services, and the application of the CY 2011 reverse building block methodology produces a result that CMS medical advisors believe is consistent with the work for the service, we are proposing to adopt the CY 2011 reverse building block methodology values that are listed in Tables 15 and 16 for CY 2011. In cases where the reverse building block methodology produces a negative work value, we are suggesting that the AMA RUC review and revise the building blocks of the code so that a new valuation can be determined based on the building block methodology. For such codes, if the revised recommendations that we would hope to receive from the AMA RUC are still not consistent with the building block methodology upon revision, because we cannot pay for these services based on negative work RVUs, we are proposing to modify the AMA RUC-recommended values for these codes as CMS determines clinically appropriate and adopt the CMS-modified RVUs on a interim final basis for CY 2011.

In their future work, we urge the AMA RUC to use the building block methodology when valuing services or provide CMS with extensive rationale for cases where the AMA RUC believes the building block methodology is inappropriate for a specific code. Since section 1848(c)(2)(L) (as added by section 3134 of the ACA) specifies that the Secretary shall establish a process to validate work RVUs of potentially misvalued codes under the PFS, as we have discussed earlier in this section, we believe codes that are valued using the building block methodology would be more likely to meet the standards of a systematic RVU validation process that could be developed in accordance with the requirements of the statute.

e. Codes With "23-hour" Stays

In the CY 2010 PFS proposed rule (74 FR 33557), we requested that the AMA RUC review services that are typically performed in the outpatient setting and require a hospital stay of less than 24 hours. We stated in the proposed rule that we believed these to be primarily outpatient services and expressed concern that the value of evaluation and management (E/M) visits for inpatients was inappropriately included in the valuation of codes that qualify as "23-hour stay" outpatient services.

We received a number of comments in response to the discussion in the CY 2010 proposed rule. The AMA RUC stated that it already values stays of less than 23 hours appropriately by reducing the hospital discharge day management service (that is, CPT code 99238), from 1 day to a half day. The AMA RUC also explained that when the AMA RUC refers to 23-hour stay services in discussions at AMA RUC meetings, it is referring primarily to services that are reported in the Medicare claims database as typically outpatient services, but where the patient is kept overnight and, on occasion, even longer in the hospital. Because the AMA RUC believes the patient stays overnight in the hospital, it believes the inclusion of inpatient E/M visits to be appropriate in the valuation of this category of codes.

We believe that the 23-hour stay issue encompasses several scenarios. The typical patient is commonly in the

hospital for less than 24 hours, which often means the patient may indeed stay overnight in the hospital. On occasion, the patient may stay longer than a single night in the hospital; however, in both cases, the patient is considered for Medicare purposes to be a hospital outpatient, not an inpatient, and our claims data support that the typical 23-hour stay service is billed as an outpatient service. Accordingly, we believe that the valuation of the codes that fall into the 23-hour stay category should not reflect work that is typically associated with an inpatient service. For example, inpatient E/M visit codes such as CPT codes 99231 (Level 1 subsequent hospital care, per day); 99232 (Level 2 subsequent hospital care, per day); and 99233 (Level 3 subsequent hospital care, per day), should not be included at the full value in the valuation of 23-hour stay services.

Currently, the valuation of 23-hour stay services is conducted in a nonuniform manner by the AMA RUC. The AMA RUC has indicated that it currently includes a half hospital discharge day management service and no hospital inpatient visits for outpatient services with expected hospital stays of 23 hours or less. In contrast, for those outpatient services where the AMA RUC believes that the recovery period could be longer than 23 hours, the AMA RUC stated in its comment on the CY 2010 PFS proposed rule that it currently includes a full hospital discharge day management service and one or more inpatient E/M visits in the code's value. However, we note the typical 23-hour stay service is billed as an outpatient service and so long as the typical case continues to be billed as an outpatient service, we believe the code should not incorporate physician work values for services that are typically associated with an inpatient service. In the 2010 PFS proposed and final rule with comment period (74 FR 33556 and 74 FR 61777, respectively), we stated that we believed the use of inpatient E/M visit codes for services rendered in the post-service period for outpatient 23-hour stay procedures would result in overpayment for pre- and post-service work that would not be provided. Accordingly, we proposed in the CY 2010 proposed rule (74 FR 33556 through 33557) not to allow any additional inpatient E/M service to be billed for care furnished during the post-procedure period when care is furnished for an outpatient service requiring less than a 24-hour hospital stay.

However, we find it is plausible that while the patient receiving the 23-hour stay service remains a hospital outpatient, the patient would typically be cared for by the physician furnishing the procedure during that post-procedure period. While we do not believe that post-procedure hospital "visits" would be at the inpatient level since the typical case is an outpatient who would be ready to be discharged from the hospital in 23 hours or less, we agree that the intra-service time of the inpatient hospital visit may be included in the valuation for the 23-hour stay code.

Accordingly, we are modifying our proposed CY 2010 approach and suggesting that in the future, when the AMA RUC reviews new and potentially misvalued codes that are identified as 23-hour stay services, the AMA RUC would apply the following methodology:

(1) Begin with the starting RVU value of the 23-hour stay code under review and decrease the hospital discharge day management service from one day to a half day.

(2) Deduct the RVUs of inpatient hospital visits from the starting RVU value.

(3) Reallocate the time associated with the intra-service portion of the inpatient hospital visits to the immediate post-service time of the 23-hour stay code under review.

Example: A 23-hour stay code is currently valued at 15 RVUs and has 1 hospital discharge day management service and 1 level 3 subsequent hospital care visit incorporated in this value.

- Applying step (1): $15 - 0.64^{*} = 14.36$
- Applying step (2): $14.36 - 2^{**} = 12.36$
- Applying step (3): $12.36 + (30 \text{ minutes} \times 0.0224)^{***} = 13.032$ RVUs

*Value associated with ½ hospital discharge day management service.

**Value associated with an inpatient hospital visit, CPT code 99233.

***Value associated with the reallocated intra-service time multiplied by the post-service intensity of the 23-hour stay code.

Finally, we note that since work relative value units are established by the Secretary in the context of relativity to other codes in the system, the recommended methodology for the evaluation of 23-hour stay codes is best applied within the context of relativity. We appreciate that the AMA RUC has the ability to assess the 23-hour stay code after application of the recommended methodology to ensure appropriate relativity of this code and other codes within the system. We strongly encourage the AMA RUC to apply the recommended methodology to ensure the consistent and appropriate valuation of the physician work for these services.

4. Expanding the Multiple Procedure Payment Reduction (MPPR) Policy to Additional Nonsurgical Services

a. Background

Medicare has a longstanding policy to reduce payment by 50 percent for the second and subsequent surgical procedures furnished to the same patient by the same physician on the same day, largely based on the presence of efficiencies in the PE and pre- and post-surgical physician work. Effective January 1, 1995, the multiple procedure payment reduction (MPPR) policy, with the same percentage reduction, was extended to nuclear medicine diagnostic procedures (CPT codes 78306, 78320, 78802, 78803, 78806, and 78807). In the CY 1995 PFS final rule with comment period (59 FR 63410), we indicated that we would consider applying the policy to other diagnostic tests in the future.

Consistent with recommendations of MedPAC in its March 2005 Report to Congress on Medicare Payment Policy, under the CY 2006 PFS, the MPPR policy was extended to the technical component (TC) of certain diagnostic imaging procedures performed on contiguous areas of the body in a single session (70 FR 70261). The reduction recognizes that, for the second and subsequent imaging procedures, there are some efficiencies in clinical labor, supplies, and equipment time. In particular, certain clinical labor activities and supplies are not duplicated for subsequent procedures and, because equipment time and indirect costs are allocated based on clinical labor time, those would also be reduced accordingly.

The imaging MPPR policy currently applies to computed tomography (CT) and computed tomographic angiography (CTA), magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA), and ultrasound services within 11 families of codes based on imaging modality and body region. When we adopted the policy in CY 2007, we stated that we believed efficiencies were most likely to occur 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 (70 FR 45850). Therefore, the MPPR policy currently applies only to procedures involving contiguous body

areas within a family of codes, not across families, and to those procedures that are provided in a single session. Additionally, while the MPPR policy applies to TC-only services and to the TC of global services, it does not apply to professional component (PC) services.

Under the current imaging MPPR policy, full payment is made for the TC of the highest-paid procedure, and payment is reduced by 25 percent of the TC for each additional procedure when an MPPR scenario applies. We had originally planned to phase in the MPPR policy over a 2-year period, with a 25 percent reduction in CY 2006 and a 50 percent reduction in CY 2007 (70 FR 70263). However, the Deficit Reduction Act of 2005 (Pub. L. 109–171) (DRA) capped the PFS payment amount for most imaging procedures at the amount paid under the hospital Outpatient Prospective Payment System (OPPS). In view of the DRA, we determined that it would be prudent to retain the MPPR at 25 percent while we continued to examine the appropriate payment levels (71 FR 69659). The DRA also exempted reduced expenditures attributable to the MPPR policy from the PFS budget neutrality provision. Most recently, effective July 1, 2010, section 3135(b) of the ACA increased the MPPR on the TC of imaging services under the policy established in the CY 2006 PFS final rule with comment period from 25 to 50 percent and exempted the reduced expenditures attributable to this further change from the PFS budget neutrality provision.

In the July 2009 GAO report entitled, "Medicare Physician Payments: Fees Could Better Reflect Efficiencies Achieved when Services are Provided Together," the GAO recommended that we take further steps to ensure that fees for services paid under the PFS reflect efficiencies that occur when services are performed by the same physician on the same beneficiary on the same day. The GAO recommended the following: (1) Expanding the existing MPPR policy to the PC to reflect efficiencies in physician work for certain imaging services; and (2) expanding the MPPR to reflect PE efficiencies that occur when certain nonsurgical, nonimaging services are provided together. The GAO also encouraged us to focus on service pairs that have the most impact on Medicare spending.

In the March 2010 report, MedPAC noted its concerns about mispricing of services under the PFS. MedPAC indicated that it would explore whether expanding the unit of payment through packaging or bundling would improve payment accuracy and encourage more efficient use of services.

In the CYs 2009 and 2010 PFS proposed rules (73 FR 38586 and 74 FR 33554, respectively), we stated that we planned to analyze nonsurgical services commonly furnished together (for example, 60 to 75 percent of the time) to assess whether an expansion of the MPPR policy could be warranted. MedPAC encouraged us to consider duplicative physician work, as well as PE, in any expansion of the MPPR policy.

b. Proposed CY 2011 Expansion of the Imaging Technical Component MPPR Policy to Additional Combinations of Imaging Services

Over the past 2 years, the AMA RUC has examined several services billed 90 percent or more of the time together as part of the potentially misvalued service initiative and, in several cases, created one code to describe the complete service, with a value that reflects the expected efficiencies. Notwithstanding the bundling work of the RUC, there may be additional imaging and other diagnostic services that are furnished together less than 90 percent of the time where we could still expect efficiencies in the TC, and in some cases in the PC, resulting in potential overpayment for these services under current policy when furnished together.

Section 1848(c)(2)(K) of the Act (as added by section 3134 of the ACA) specifies that the Secretary shall identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service, and review and make appropriate adjustments to their relative values. As a first step in applying this provision, we are proposing a limited expansion of the current imaging MPPR policy for CY 2011. We will continue to review other possible expansions of the MPPR policy to the TC and/or PC of imaging procedures or other diagnostic tests for the future. Any further changes would be addressed in future rulemaking.

In a related policy for hospital outpatient payment of imaging services, in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68559 through 68569), the OPPS adopted a policy to pay for two or more CT and CTA, MRI and MRA, or ultrasound procedures furnished in the same session through a single composite ambulatory payment classification (APC) group. These composite APC payments were based on the 11 families of codes subject to the MPPR under the PFS that were collapsed into 3 imaging families for the OPPS according to their modality—1 for ultrasound, 1 for CT and CTA, and 1 for MRI and MRA services.

At that time, we stated our belief that the contiguous body area concept that was incorporated in the PFS imaging families was not necessary for potential efficiencies to be achieved in an imaging session. We provided examples to illustrate that we would not expect second and subsequent imaging services of the same modality involving noncontiguous body areas to require duplicate facility resources (comparable to the TC under the PFS) for clinical labor activities such as greeting the patient, providing education and obtaining consent, retrieving prior exams, setting up an intravenous infusion, and preparing and cleaning the room, any more than second and subsequent imaging procedures of the same modality involving contiguous body areas. While we noted that multiple imaging claims under the OPPS are generally within the same imaging modality and involve contiguous body areas the vast majority of the time, we estimated that the collapsed 3 families, as opposed to the 11 PFS families, would add 12 percent additional claims to those eligible for a single composite APC payment under the OPPS based on the provision of 2 or more imaging services in a single session, allowing us to capture additional claims with efficiencies.

Taking into consideration the OPPS policy that was adopted in the CY 2009 OPPS/ASC final rule with comment period, in this proposed rule, we are proposing to apply the MPPR regardless of family, that is, the policy would apply to multiple imaging services furnished within the same family of codes or across families. This proposal would simplify the current imaging MPPR policy in a way that is consistent with the standard PFS MPPR policy for surgical procedures that does not group procedures by body region. Therefore, the MPPR would apply to CT and CTA, MRI and MRA, and ultrasound procedures services furnished to the same patient in the same session, regardless of the imaging modality, and not limited to contiguous body areas.

Because of the different pieces of equipment used for CT/CTA, MRI/MRA, and ultrasound procedures, it would be highly unlikely that a single practitioner would furnish more than one imaging procedure involving 2 different modalities to one patient in a single session where the proposed MPPR policy would apply. On the other hand, while most multiple procedures furnished with a single modality in one session would involve procedures currently assigned to one of the 11

imaging families, it would not be uncommon for more than one imaging procedure of the same modality to be furnished across families and, like the scenario for hospital outpatient imaging services, we would expect efficiencies to occur in these cases. Therefore, we believe that an expansion of the current imaging MPPR policy to account for efficiencies in such situations would allow us to pay more appropriately for these multiple imaging procedure sessions, consistent with our ongoing efforts to address misvalued services.

The proposed expansion of the imaging MPPR policy to include all of the current codes in a single family to which the standard 50 percent reduction for second and subsequent procedures would apply would reduce payment for 20 percent more services than the current MPPR policy under the PFS. Thus, under the CY 2011 proposal, we would capture additional efficiencies and pay more appropriately in these cases. We note that, as indicated above, section 3135(b)(2) of the ACA specifies that reduced expenditures attributable to the increase in the imaging MPPR from 25 to 50 percent in CY 2011 are excluded from the PFS budget neutrality adjustment. However, the reduced payment for code combinations that would newly be subject to the imaging MPPR policy under this proposal would be made in a budget neutral manner under the PFS, as these new combinations are not included under section 1848(b)(4)(D) (added by section 3135(b) of the ACA), which addresses "single-session imaging to consecutive body parts" under the established imaging MPPR policy.

Finally, we are also proposing to add the codes displayed in Table 17 to the list of imaging services subject to the MPPR policy in CY 2011. These codes were newly created for CY 2010 and are similar to codes currently in imaging family 2, titled CT and CTA (Chest/Thorax/Abdomen/Pelvis).

We further note that new CY 2010 CPT codes 74261 (Computed tomography (CT) colonography, diagnostic, including image postprocessing; without contrast material) and 74262 (Computed tomography (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed) were added to the CY 2010 MPPR policy through the July 2010 PFS quarterly update, with a retroactive effective date of January 1, 2010. These codes replaced CPT code 0067T (Computed tomographic (CT) colonography (*i.e.,* virtual colonoscopy); diagnostic) in CY 2010, which was on the list of procedures subject to the imaging MPPR policy prior to CY 2010.

As discussed earlier in this section, reduced expenditures attributable to the increase in the MPPR for multiple imaging procedures to consecutive body parts (that is, those previously designated in the same family of codes) are exempt from the budget neutrality provision of the PFS. However, the reduced expenditures attributable to the MPPR for combinations of multiple imaging procedures that we are proposing for CY 2011 (the MPPR for multiple imaging procedures not involving consecutive body parts) would be subject to budget neutrality adjustment under the PFS. We note that this formulation for whether reduced expenditures are exempt from budget neutrality applies both to procedures currently subject to the imaging MPPR and to new codes that are subject to the policy in CY 2011 and in future years. To the extent that imaging procedures described by the new codes are furnished in combination with other procedures that are subject to the imaging MPPR on consecutive body areas, the reduced expenditures attributable to the MPPR for these combinations would be exempt from the PFS budget neutrality adjustment.

The complete list of codes subject to the proposed CY 2011 MPPR policy for diagnostic imaging services is included in Addendum F to this proposed rule.

TABLE 17—PROPOSED CPT CODE ADDITIONS TO THE DIAGNOSTIC IMAGING MPPR POLICY FOR CY 2011

CPT code	Short descriptor
75571	Ct hrt w/o dye w/ca test.
75572	Ct hrt w/3d image.
75573	Ct hrt w/3d image, congen.
75574	Ct angio hrt w/3d image.

c. Proposed CY 2011 Expansion of the MPPR Policy to Therapy Services

In the July 2009 GAO report entitled, "Medicare Physician Payments: Fees Could Better Reflect Efficiencies Achieved when Services are Provided Together," the GAO found efficiencies when multiple physical therapy services were furnished in one session and concluded that an MPPR policy could be appropriate for these services. In the report, the GAO noted that officials from the AMA RUC explained that time spent on pre-service and post-service therapy activities is spread across the number of services in a typical session in order to avoid duplication of the PE for the services. Nevertheless, the GAO found that there was duplication of certain activities in the intra-service period, and provided the example of time spent testing range of motion or muscle flexibility that was duplicated in commonly observed code pairs.

In the typical clinical scenario for therapy services, we believe that therapy services are misvalued for PFS payment when multiple services are furnished to a patient in a single session because duplicate clinical labor and supplies are included in the PE of the services furnished. We believe this duplication should be accounted for under the PFS, as we currently account for efficiencies in multiple surgical and multiple diagnostic imaging procedures furnished in a single session. Over the past 2 years, the AMA RUC has examined several services billed 90 percent or more of the time together as part of its potentially misvalued service initiative and, in several cases, created one code to describe the complete service, with a value that reflects the expected efficiencies. Notwithstanding the AMA RUC's analyses, in most cases it has not created one code to describe a complete therapy service, in part because many of the core therapy CPT codes are timed codes based on increments of treatment time.

Therefore, we are proposing a further step to implement section 1848(c)(2)(K) of the Act (as added by section 3134 of the ACA) that specifies that the Secretary shall identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service. For CY 2011 we are proposing an MPPR policy for the HCPCS codes listed in Table 18, specifically the separately payable "always therapy" services that are only paid by Medicare when furnished under a therapy plan of care. These services are designated "always therapy" services regardless of who furnishes them and always require therapy modifiers to be reported, specifically –GP (Services rendered under outpatient physical therapy plan of care); –GO (Services rendered under outpatient occupational therapy plan of care); or –GN (Services rendered under outpatient speech pathology plan of care). The therapy codes are available in a file on the CMS Web site at: *http://www.cms.gov/TherapyServices/.* We have excluded both contractor-priced and bundled codes from Table 18 because, under our proposal, an MPPR would not be applicable for "always therapy" services furnished in combination with these codes. In the case of bundled codes that are not separately paid, there are no explicit efficiencies in the direct PE to be reflected in payment for the second and subsequent therapy services furnished

to the patient on the same day. In the case of contractor-priced codes, there is no nationally established pricing that could be uniformly adjusted to reflect the expected efficiencies when multiple therapy services are furnished.

TABLE 18—SEPARATELY PAYABLE "ALWAYS THERAPY" SERVICES SUBJECT TO THE PROPOSED CY 2011 MPPR POLICY*

CPT/ HCPCS code	Short descriptor
92506	Speech/hearing evaluation.
92507	Speech/hearing therapy.
92508	Speech/hearing therapy.
92526	Oral function therapy.
92597	Oral speech device eval.
92607	Ex for speech device rx, 1hr.
92608	Ex for speech device rx addl.
92609	Use of speech device service.
96125	Cognitive test by hc pro.
97001	Pt evaluation.
97002	Pt re-evaluation.
97003	Ot evaluation.
97004	Ot re-evaluation.
97010	Hot or cold packs therapy.
97012	Mechanical traction therapy.
97016	Vasopneumatic device therapy.
97018	Paraffin bath therapy.
97022	Whirlpool therapy.
97024	Diathermy eg, microwave.
97026	Infrared therapy.
97028	Ultraviolet therapy.
97032	Electrical stimulation.
97033	Electric current therapy.
97034	Contrast bath therapy.
97035	Ultrasound therapy.
97036	Hydrotherapy.
97110	Therapeutic exercises.
97112	Neuromuscular reeducation.
97113	Aquatic therapy/exercises.
97116	Gait training therapy.
97124	Massage therapy.
97140	Manual therapy.
97150	Group therapeutic procedures.
97530	Therapeutic activities.
97533	Sensory integration.
97535	Self care mngment training.
97537	Community/work reintegration.
97542	Wheelchair mngment training.
97750	Physical performance test.
97755	Assistive technology assess.
97760	Orthotic mgmt and training.
97761	Prosthetic training.
97762	C/o for orthotic/prosth use.
G0281	Elec stim unattend for press.
G0283	Elec stim other than wound.
G0329	Electromagntic tx for ulcers.

*Excludes contractor-priced and bundled codes.

At this time, we are not proposing an MPPR policy for "sometimes therapy" services, specifically those services that may be furnished under a therapy plan of care or otherwise by physicians or NPPs as medical services. We believe that the care patterns are different for the latter group of services that may sometimes be furnished as therapy services, and note that they are less commonly furnished with multiple services in a single session than the "always therapy" services. In the discussion that follows, our reference to therapy services means those HCPCS codes designated annually as "always therapy" services by CMS.

Based on CY 2009 PFS claims data, we identified over 500 therapy service code pairs billed for the same patient in a single session. We then reviewed a sample of the most common therapy code pairs, specifically those high volume code pairs with more than 250,000 combined services per year, to examine the potential for duplication in the PE. These codes pairs represented more than half of the occurrences of therapy services billed together. While we acknowledge that the PE inputs per service for some therapy services were included in the direct PE database based on one-half of the total PE inputs required for two services provided in a single session, which would account for some duplication, this was not the case for all combinations of therapy services. Of the high volume therapy services examined, approximately one-fourth of the code pairs were not valued based on two services. In addition, we note that the CY 2009 PFS claims data show that when multiple therapy services are billed on a claim for the same date of service, the median number is four services per day. Therefore, even for those clinical labor times that may reflect the allocation of total time across two units of therapy services, we believe that some elements of the current PE inputs are duplicated based on current patterns of therapy service delivery where most multiple service claims involve delivery of more than 2 services in a session.

Duplicate labor activities currently included in the PE for the service period for these high volume pairs of therapy services are as follows: clean room/equipment; education/instruction/counseling/coordinating home care; greet patient/provide gowning; obtain measurements, for example, ROM/strength/edema; and post-treatment patient assistance. The most common duplicate supply item included in the PE was the multispecialty visit pack. Examples of duplicated and unduplicated labor activities and supplies for two sample therapy code pairs and our estimates of potential clinically appropriate time and quantity reductions for multiple service sessions are displayed in Table 19. We note that CY 2009 PFS claims data for these sample code pairs include over 3.4 million pairs of CPT codes 97112 (Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities) and 97110 (Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility) furnished by the same practitioner on the same day and over 500,000 pairs of CPT codes 97001 (Physical therapy evaluation) and 97140 (Manual therapy techniques (*e.g.,* mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes).

Table 19: Examples of Duplicate PE Inputs for Therapy Services That Should Be Accounted for When Multiple Services Are Furnished in One Session

Example 1: CPT code 97112 (Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities) and CPT code 97110 (Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility)

Staff description	Labor task description	Time period	Code A 97112 labor task time	Code B 97110 labor task time	Total minute reduction
Physical Therapy Aide	Clean room/equipment	Service Period, Post-Service.	1	1	1

Staff description	Labor task description	Time period	Code A 97112 labor task time	Code B 97110 labor task time	Total minute reduction
Physical Therapy Assistant.	Education/instruction/counseling/coord home care.	Service Period, Post-Service.	2.5	2.5	2.5
Physical Therapy Aide	Greet patient/provide gowning	Service Period, Pre-Service.	1.5	1.5	1.5
Physical Therapy Assistant.	Obtain measurements, *e.g.,* ROM/strength/edema.	Service Period, Pre-Service.	1.5	1.5	1.5
Physical Therapy Assistant.	Obtain vital signs	Service Period, Pre-Service.	1	1	1
Physical Therapy Assistant.	Phone calls between visits with patient, family	Post-Service Period	1	1	1
Physical Therapy Aide	Post treatment patient assistance	Service Period, Post-Service.	1	1	1
Physical Therapy Assistant.	Review/read documentation, plan of care, treatment goals.	Pre-Service Period	1.5	1.5	1.5
Physical Therapy Aide	Verify/Coordinate availability of resources/equip.	Pre-Service Period	1.5	1.5	1.5

Supply description	Price	Code A 97112 quantity	Code B 97110 quantity	Code B 97110 quantity reduction
pack, minimum multi-specialty visit	$1.14	0.5	0.5	0
Thera-bands (6in width)	0.06	1.5	1.5	1.5

Example 2: CPT code 97001 (Physical therapy evaluation) and CPT Code 97140 (Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes)

Staff description	Labor task description	Time period	Code A 97001 labor task time	Code B 97140 labor task time	Total minute reduction
Physical Therapy Aide	Clean room/equipment	Service Period, Post-Service.	3	1	1
Physical Therapy Assistant.	Education/instruction/counseling/coord home care.	Service Period, Post-Service.	2	1	1
Physical Therapy Aide	Greet patient/provide gowning	Service Period, Pre-Service.	3	1.5	1.5
Physical Therapy Assistant.	Obtain measurements, *e.g.,* ROM/strength/edema.	Service Period, Pre-Service.	8	1.5	1.5
Physical Therapy Assistant.	Obtain vital signs	Service Period, Pre-Service.	3	1	1
Physical Therapy Assistant.	Phone calls between visits with patient, family	Post-Service Period	2	1	1
Physical Therapy Assistant.	Review/read documentation, plan of care, treatment goals.	Pre-Service Period	1	.5	.5
Physical Therapy Aide	Verify/Coordinate availability of resources/equip.	Pre-Service Period	3	1.5	1.5
Physical Therapy Aide	Prep and position patient	Service Period, Pre-Service.	2	0	0
Physical Therapy Aide	Prepare room, equipment, supplies	Service Period, Pre-Service.	2	0	0
Physical Therapy Aide	Post treatment assistance	Service Period, Post-Service.	0	1	0

Supply description	Price	Code A 97001 quantity	Code B 97140 quantity	Code B 97140 quantity reduction
pack, minimum multi-specialty visit	$1.14	1	0.5	0.5
lotion, message, unscented	0.158	0	0.5	0

We did not remove minutes for clinical labor tasks that were not duplicated. For example, for CPT code pair 97001 and 97140 the following tasks were not duplicated: Post treatment patient assistance; prep and position patient; and prepare room, equipment, and supplies. In addition, we did not remove any supply items that would be required for only one of the separate services because these would not be duplicated in the PE applicable to the combination of services. We estimated no reduction for equipment time, even though efficiencies would be expected for equipment that is used in both services when they are furnished together. Finally, a corresponding reduction to the indirect expenses is appropriate since indirect costs are allocated partially based on direct costs. For five high volume therapy code pairs that each occur over 2 million time in PFS claims for multiple therapy services and account for almost half of such claims, we estimated that the resulting reduction in the PE for the lower paying code would range from 28 to 56 percent.

In summary, given the duplicative clinical labor activities and supplies as shown in the code combination examples, we believe it would be appropriate to extend the 50 percent MPPR policy that is currently applied to surgical services and the TC of imaging services, to the PE component of certain therapy services. Specifically, we are proposing to apply a 50 percent payment reduction to the PE component of the second and subsequent therapy services for multiple "always therapy" services furnished to a single patient in a single day. Because it would be difficult to determine the precise beginning and end of therapy sessions and we do not believe that beneficiaries would typically have more than one therapy session in a single day, we are proposing to apply the 50 percent MPPR policy to the PE component of subsequent therapy services provided to the same patient on the same day, rather than in the same session.

We note that many therapy services are time-based CPT codes, so multiple units of a single code may be billed for a single session that lasts for a longer period of time than one unit of the code. The proposed MPPR policy would apply to multiple units of the same therapy service, as well as to multiple different services, when furnished to the same patient on the same day. Full payment would be made for the service or unit with the highest PE and payment would be made at 50 percent of the PE component for the second and subsequent procedures or units of the service. The work and malpractice components of the therapy service payment would not be reduced. For therapy services furnished by a group practice or "incident to" a physician's service, the MPPR would apply to all "always therapy" services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, for example, physical therapy, occupational therapy, or speech-language pathology. The proposed CY 2011 MPPR policy would apply to both those services paid under the PFS that are furnished in the office setting and those services paid at the PFS rates that are furnished by outpatient hospitals, home health agencies, comprehensive outpatient rehabilitation facilities (CORFs), and other entities that are paid by Medicare for outpatient therapy services. Table 20 provides a sample calculation of the current and proposed CY 2011 payment for multiple therapy services furnished on the same day. For those services paid under the PFS, the PFS budget neutrality provision would apply so that the estimated reduced expenditures for therapy services would be redistributed to increase payment for other PFS services.

TABLE 20—SAMPLE PROPOSED PAYMENT CALCULATION FOR MULTIPLE THERAPY SERVICES FURNISHED TO A SINGLE PATIENT ON THE SAME DAY

	Procedure 1 Unit 1	Procedure 1 Unit 2	Procedure 2	Current total payment	Proposed CY 2011 total payment	Proposed payment calculation
Work	$7.00	$7.00	$11.00	$25.00	$25.00	no reduction.
PE	10.00	10.00	8.00	28.00	19.00	$10 + (0.5 × $10) + (0.5 × $8).
Malpractice	1.00	1.00	1.00	3.00	3.00	no reduction.
Total	18.00	18.00	20.00	56.00	47.00	$18 + $7 + (0.5 × $10) + $1 + $11 + (0.5 × $8) + $1.

We believe this proposed therapy MPPR policy would provide more appropriate payment for therapy services that are commonly furnished together by taking into account the duplicative clinical labor activities and supplies in the PE that are not furnished more than once in the single therapy session. This approach is consistent with the statutory requirement for the Secretary to identify, review, and adjust the relative values of potentially misvalued services under the PFS as specified by section 3134 of the ACA. We also believe this proposed policy is responsive to Congressional concerns about significant growth in therapy spending and to MedPAC and GAO recommendations regarding the expansion of MPPR policies under the PFS to account for additional efficiencies. We note that paying more appropriately for therapy services based on PE relative values that are adjusted for the clinical scenario under which the services are furnished would result in reduced therapy expenditures, and beneficiaries would be able to receive more medically necessary outpatient therapy services before reaching the therapy cap. For a further discussion of potential alternatives to the therapy caps, we refer readers to section III.A.2. of this proposed rule.

5. High Cost Supplies

a. Background

MedPAC and the AMA RUC have long recommended that CMS establish a frequent price update process for high-cost supplies that are direct PE inputs in the PE database for services paid under the PFS because of their speculation that prices for these items may decrease over time as competition increases and new technologies disseminate into medical practice. MedPAC in particular has perennially noted that it is important for CMS to update the prices of high-priced supplies on a regular basis as inaccurate prices can distort PE RVUs over time,

contributing to the misvaluing of established services under the PFS.

Most of the current prices for high-cost supplies included in the direct PE database are from 2004 or earlier. There are currently 62 unique supplies with prices of $150 or more in the proposed CY 2011 PE database, which is available on the CMS Web site under the supporting data files for the CY 2011 PFS proposed rule at *http://www.cms.gov/PhysicianFeeSched/.* Finally, we note that we do not actually pay the supply prices included in the PE database but, instead, use them to develop the PE RVUs according to our standard PE methodology as described in section II.A.2. of this proposed rule. Payment for a procedure that uses a supply is based upon the PE RVUs that result from the PE methodology, and supplies are among the direct PE inputs for procedures. Therefore, it is the relativity of high-cost supply prices to prices for other PE items (equipment, low-cost supplies, and clinical labor) that is important.

Accordingly, in the CY 2009 PFS proposed rule (73 FR 38582), we proposed a process to update the prices for high-cost supplies priced at $150 or more that are included in the PE inputs for procedures paid under the PFS PE methodology. The CY 2009 proposed rule described a publicly transparent process in which CMS would publish a list of the high-cost supplies in the PFS proposed rule (65 supplies were included in the CY 2009 PFS proposed rule), and specialty societies or other relevant organizations would provide acceptable documentation supporting the pricing for the supplies during the 60-day public comment period. Furthermore, in that same proposed rule (73 FR 38582), we provided guidance on what constitutes valid, reliable documentation that reflects the typical price of the high-cost item in the marketplace. We outlined examples of acceptable documentation, such as a detailed description (including system components), sources, and current pricing information, confirmed by copies of catalog pages, invoices, and quotes from manufacturers, vendors, or distributors. We indicated that documentation that does not include specific pricing information such as phone numbers and addresses of manufacturers, vendors, or distributors or Web site links without pricing information would not be acceptable. We also noted that if acceptable documentation was not received within the proposed rule's 60-day public comment period, we would use prices from the Internet, retail vendors, and supply catalogs to determine the appropriate cost, and that we would use the lowest price identified by these sources (73 FR 38582). Finally, we solicited public comments on alternatives that could be used to update pricing information in the absence of acceptable documentation provided by specialty societies or other interested organizations.

In the CY 2009 PFS final rule with comment period (73 FR 69882), we indicated that we received many comments on the proposed process and, while some commenters expressed support, others believed the proposed process was flawed and burdensome. Moreover, although we received some data in response to our request for information on the 65 high-cost supplies with prices of $150 or more, much of what we received was not complete or did not represent typical market prices. In particular, we expressed concern that the submitted data often represented manufacturer list prices for the premier models of many supplies, while we believed there were less expensive alternatives. Therefore, we were unable to determine the most appropriate, typical supply prices for our PFS payment methodology that prices the typical service described by a HCPCS code. Rather than finalizing the proposed process for updating high-cost supplies and revising the prices for the 65 supplies based on inadequate pricing information, we stated in the CY 2009 PFS final rule with comment period (73 FR 69882) that we would research the possibility of using an independent contractor to assist us in obtaining accurate pricing information. Furthermore, we informed the public that we planned to study the limitations of available pricing data and determine how to revise our proposed process to elicit better data.

In the CY 2010 PFS proposed rule and final rule with comment period (74 FR 33554 and 61776, respectively), we stated that we were continuing to examine ways to obtain accurate pricing information for high-cost supplies. We noted again in the CY 2010 PFS proposed rule that we would depend upon the cooperation of the medical community to obtain typical prices in the marketplace, and we provided stakeholders with another opportunity to submit public comments on the process. In the CY 2010 PFS final rule with comment period, we acknowledged commenters' general support for an initiative to ensure accurate pricing of high-cost supplies. In general, the commenters strongly preferred a transparent and public process, and we stated that we would consider this perspective as we explore the best way to ensure that accurate supply pricing information is used in the PFS payment methodology.

b. Future Updates to the Prices of High-Cost Supplies

In working towards refining a process to update the prices of high-cost supplies and consistent with our intention expressed in the CY 2009 PFS final rule with comment period (73 FR 69882), we contracted with an independent contractor during CY 2009 to help us study the availability of accurate pricing information. We requested that the independent contractor, L&M Policy Research, research pricing information for the 65 high-cost supplies listed in the CY 2009 proposed rule (73 FR 38583 through 38585) and determine what, if any, pricing information reflecting typical market prices could be obtained for these high-cost supplies.

We first requested that the contractor explore publicly available sources to obtain typical market prices for these supplies. The contractor utilized supply vendor catalogs and Web sites and directly contacted vendors, manufacturers, group purchasing organizations (GPOs), and any other suppliers that the contractor identified in their research in order to identify prices for each of the supplies. Where more than one version of a supply item appeared to match a description of a high-cost supply and/or more than one possible vendor or manufacturer was identified, the contractor attempted to obtain prices from the multiple sources.

Upon review of the high-cost supply list, the contractor refined the list to 62 unique high-cost items with prices of $150 or more for the study. The original list only consisted of 64 items but included one item inadvertently listed twice (CMS Supply Code SD207 (suture device for vessel closure (Perclose A–T)) and one item (CMS Supply Code SH079 (collagen implant)) that was deleted from the PE database after CY 2007 because it was no longer used as an input for any codes. While the contractor was able to obtain prices for 37 of the 62 unique supplies, the contractor was unable to obtain pricing information for the remaining 25 supplies. Documentation of these prices, a requirement we discussed in the CY 2009 PFS proposed rule (73 FR 38582), was only obtained for 25 of the 36 supplies with new pricing information. For the remainder, while the contractor was given price quotes over the phone, the sales agents or customer service representatives declined to provide any form of written documentation, in some cases because company policies

restricted providing pricing documentation to prospective customers without an account. Moreover, information on typical discounts was obtained for only seven products, and only one discount was documented. In the case of these products, companies disclosed the maximum available discounts, ranging from 18 percent to 45 percent. Relative to prices currently included in the PE database, the contractor found higher prices for the majority of the medical supplies that were researched, specifically 23 supplies with higher prices, 8 with lower prices, and 3 with the same price. The high-cost supplies studied by the contractor and their current database prices are displayed in Table 20.

TABLE 20—HIGH-COST SUPPLIES WITH PRICES OF $150 OR GREATER IN THE PFS DIRECT PE DATABASE THAT WERE STUDIED BY THE CMS CONTRACTOR

CMS supply code	Supply description	Current database unit price	Associated CPT codes
	stent, ureteral, wguidewire, 3cm flexible tip	$235	52332
	probe, cryoablation, renal	1,175	50593
	catheter, intradiscal (spineCATH)	1,380	22526, 22527
	probe, cryoablation (Visica ICE 30 or 40)	1,589	19105
	kit, capsule, ESO, endoscopy w-application supplies (ESO)	450	91111
	catheter, balloon, lacrimal	306	68816
	catheter, CVA, system, tunneled w-port, dual (LifeSite)	1,750	36566
	stent, vascular, deployment system, Cordis SMART	1,645	37205, 37206
	agent, embolic, 2 ml uou	258	37210
	tube, jejunostomy	195	49441, 49446, 49451, 49452
SA005	kit, capsule endoscopy w-application supplies (M2A)	450	91110
SA010	kit, CVA catheter, tunneled, without portpump	308	36557, 36558, 36581
SA011	kit, CVA catheter, tunneled, with subcut port	495	36560, 36561, 36563, 36582, 36583
SA015	kit, for percutaneous thrombolytic device (Trerotola)	488	36870, 37184, 37186, 37187, 37188
SA020	kit, loop snare (Microvena)	275	36595, 37203
SA022	kit, percutaneous neuro test stimulation	305	63610, 64561
SA024	kit, photopheresis procedure	858	36522
SA025	kit, PICC with subcut port	586	36570, 36571, 36585
SA036	kit, transurethral microwave thermotherapy	1,149	53850
SA037	kit, transurethral needle ablation (TUNA)	1,050	53852
SA038	kit, transurethral waterinduced thermotherapy	650	53853
SA039	kit, vertebroplasty (LP2, CDO)	696	22520, 22521
SA074	kit, endovascular laser treatment	519	36478
SA075	kit, hysteroscopic tubal implant for sterilization	1,245	58565
SA077	kit, pleural catheter insertion	329	32550, 96440
SA087	tray, RTS applicator (Mammosite)	2,550	19296
SA091	tray, scoop, fast track system	750	31730
SA092	kit, gene, MLL fusion	1,395	88385
SA093	kit, priming, random	[1] 463	88385, 88386
SC085	tubing set, plasma exchange	173	36514
SD018	catheter, balloon, thermal ablation (Thermachoice)	727	58353
SD019	catheter, balloon, ureteral-GI (strictures)	166	43456, 45303, 45340, 45386, 46604
SD020	catheter, CVA, tunneled, dual (Tesio)	355	36565
SD023	catheter, enteroclysis	183	74251, 74260, 89100, 89105, 89130, 89132, 89135, 89136, 89140, 89141
SD058	electrode, grid	475	95829
SD072	eyelid weight implant, gold	218	67912
SD073	fiducial screws (set of 4)	[2] 558	77011, 77301
SD094	mammotome probe	200	19103
SD109	probe, radiofrequency, 3 array (StarBurstSDE)	1,995	20982, 32998, 41530, 50592
SD151	catheter, balloon, low profile PTA	432	35470, 35471, 35474
SD152	catheter, balloon, PTA	244	35472, 35473, 35475, 35476, G0392, G0393
SD154	catheter, microcatheter (selective 3rd order)	338	36217, 36247, 36481, 37183, 37210

TABLE 20—HIGH-COST SUPPLIES WITH PRICES OF $150 OR GREATER IN THE PFS DIRECT PE DATABASE THAT WERE STUDIED BY THE CMS CONTRACTOR—Continued

CMS supply code	Supply description	Current database unit price	Associated CPT codes
SD155	catheter, RF endovenous occlusion	725	36475
SD175	guidewire, steerable (Transcend)	180	36217, 36247, 36481, 37183, 37205, 37206, 37210, 49440, 49441, 49442, 49446, 49450, 49451, 49452, 49460
SD177	hysteroscope, ablation device	1,146	58563
SD185	plasma antibody adsorption column (Prosorba)	1,150	36515
SD186	Plasma LDL adsorption column (Liposorber)	1,380	36516
SD189	plate, surgical, mini-compression, 4 hole	226	21208
SD191	plate, surgical, reconstruction, left, 5 × 16 hole	719	21125, 21127, 21215
SD193	plate, surgical, rigid comminuted fracture	389	21461, 21462
SD204	sensor, pH capsule (Bravo)	225	91035
SD205	sheath, endoscope ultrasound balloon	154	31620
SD207	suture device for vessel closure (Perclose A–T)	225	35470, 35471, 35472, 35473, 35474, 35475, 37184, 37187, 37188, 37205, G0392
SD215	probe, endometrial cryoablation (Her Option)	1,250	58356
SD216	catheter, balloon, esophageal or rectal (graded distention test)	165	91040, 91120
SD218	stent, ureteral, without guidewire	162	50382, 50384, 50385
SF028	laser tip (single use)	290	30117, 52214, 52224, 52317
SF029	laser tip, bare (single use)	150	46917, 46924
SF030	laser tip, diffuser fiber	850	52647, 52648
SL055	DNA stain kit (per test)	[3] 150	88358
SL209	array kit, Genosensor	2,121	88386
SL225	gas, nitogen, ultra-high purity (compressed) grade 5.0	190	88385, 88386

[1] Six pack.
[2] Set of 4.
[3] 10 pack.

Next, we directed the contractor to access the United States General Services Administration (GSA) medical supply schedule to augment the results obtained through review of vendor materials and direct contact with vendors, manufacturers, and GPOs. We note that the GSA establishes long-term government-wide contracts with commercial firms for many products, negotiating contracts and determining prices to be fair and reasonable prior to placing them on schedule. Included on the schedule are thousands of medical supplies at prices that, in most cases, are established through competition. The GSA schedule is an open solicitation and a business of any size, if it is stable and financially sound, can request to be included on the schedule. GSA's vendors usually are nationwide vendors with substantial non-government sales, and products on the schedule must be manufactured in the U.S. or in a nation with a trade agreement with the United States. Submissions for the schedule are received 365 days per year, vendor contracts can be of varying lengths, and vendors can add or delete products from the schedule. Depending on the aggregate cost estimate associated with the vendor's supply items, the time to achieve inclusion on the schedule can vary from as short as several months to as long as 2 years. The GSA has delegated authority to the Department of Veterans Affairs (VA) to procure medical supplies under the VA Federal Supply Schedules Program.

Using the GSA general search engine under the category "Laboratory, Scientific, & Medical" available at *https://www.gsaadvantage.gov/advgsa/advantage/main/start_page.do* the contractor obtained nine prices for items similar to the high-cost supplies in the PE database and that are displayed in Table 20 from the publicly available information on the Internet, including pricing for one product for which its prior work did not yield an updated price. We believe that additional items that are similar to the high-cost supplies in the PE database and that may be used with the same procedures may be on the GSA schedule but we are still working through the crosswalk between our supplies and the way the supplies are presented on the GSA schedule. Examples of high-cost supplies in the PE database that the contractor located on the GSA schedule include: (1) Kit, capsule, ESO, endoscopy w-application supplies (ESO), priced at $450 in the PE database and $444 on the GSA schedule; and (2) tube, jejunostomy, priced at $195 in the PE database and $60 to $83 on the GSA schedule, depending on the characteristics of the tube.

Since the GSA medical supply schedule is a source for pricing information that is public and transparent and reflects the best government contract price for a product, we believe it is a desirable resource for us to use in a refined process for updating the prices of high-cost

supplies. For historical context, CMS has previously proposed to use VA prices that result from the competitive marketplace as comparison points to limit the Medicare prices for oxygen and certain items of durable medical equipment and prosthetic devices (62 FR 38100 through 38107, and 64 FR 44227 through 44231) in 1997 and 1999, respectively. These prior proposals were based on our determination that the Medicare payment amounts for these items as durable medical equipment or prosthetics (not as physicians' services) were not inherently reasonable. We note, however, that our current interest in the GSA schedule for pricing high-cost supplies for payment of physicians' services is not based on considerations of inherent reasonableness, and we do not actually pay the prices in the PE database for supplies under the PFS.

We further note that public commenters on pricing high-cost supplies have consistently requested that CMS ensure that the pricing information used to update the prices is provided publicly. The commenters have observed that this transparency would enable stakeholders to evaluate and provide feedback to the agency on pricing accuracy (74 FR 61776). We also acknowledge that our past attempts over several years to identify typical market prices for the high-cost supplies have been inhibited by the limited availability of public data that meet the documentation requirements we have previously established. Individual vendors do not always publish their product prices or provide typical discounts. Moreover, discounts may vary depending on suppliers and the volume of supplies purchased. Our understanding of the GSA medical supply schedule is that the publicly listed fair and reasonable prices on the schedule generally do not include volume and or certain other discounts that may be subsequently negotiated by the buyer. Consequently, we would consider the prices available on the GSA schedule to represent the "individual item ceiling" price for a single item purchase, which we believe would be appropriate to estimate the high-cost supply prices for physicians' office purchases. We are soliciting public comments regarding the high-cost supplies in the direct PE database for the CY 2011 PFS proposed rule, available on the CMS Web site as noted earlier in this section, and the corresponding supplies or alternative items that could be used for the same function that are currently on the GSA supply schedule. We encourage commenters to provide a detailed analysis of the current relationships between the items in the PE database and those on the GSA schedule.

At this time, we would like to describe a refined process for regularly updating prices for high-cost supplies under the PFS and solicit comments on how we could improve on this process. The process could occur every 2 years beginning as soon as CY 2013, although we note that we would propose the refined process through rulemaking before revising the prices for any high-cost supply item based on the GSA schedule. We could also consider establishing a different price update period depending on whether a high-cost supply was a new supply in the PE database or had been in use for some time, in which case we might expect that the price would have stabilized and, therefore, could be updated less frequently. In general, we would expect that the periodicity of updating prices for high-cost supplies that we eventually adopted would balance the associated administrative burden with the rate of price changes, to ensure that the associated procedures remain appropriately valued, rather than increasingly misvalued, over time.

We envision that we would base high-cost supply price inputs on the publicly available price listed on the GSA medical supply schedule. Since the medical community would have several years to examine the GSA medical supply schedule before the refined process would be adopted, and we have found no apparent limitations on vendors placing products on the GSA schedule, beyond the schedule's interest in competitive, best value procurements, stakeholders would have the opportunity to ensure that any high-cost direct PE input for a PFS service that may currently be missing from the GSA medical supply schedule would be included before CMS needs to access the publicly available price for the item. If a supply price were not publicly available on the GSA medical supply schedule by the time CMS needs to access the price, we would propose to reduce the current price input for the supply by a percentage that would be based on the relationship between GSA prices at that time and the existing PE database prices for similar supplies (currently an average 23 percent reduction). We believe that this refined process is desirable because it is consistent with commenters' repeated requests for the updating methodology to be transparent and predictable.

Moreover, the VA (with responsibility delegated by the GSA) determines whether prices are fair and reasonable by comparing the prices and discounts that a company offers the government with the prices and discounts that the company offers to commercial customers. Therefore, using the GSA medical supply schedule as a source for publicly available prices would also better account for product-specific market dynamics than the alternative of an across-the-board percentage reduction for supplies not on the GSA schedule based on general price trends for the high-cost supplies on the schedule. That is, if the market price of a particular supply were not to drop according to broad trends for other high-cost supplies, suppliers would have the opportunity to provide their price to the public on the GSA schedule in order to preclude any reduction in Medicare payment for procedures associated with that supply.

Finally, we would like to reiterate that we are interested in receiving detailed public comments on the refined process discussed above, including all aspects of the price update methodology that we have presented. Moreover, we believe a similar approach could potentially be appropriate to update the prices for other supplies in the PE database that would not fall under our definition of high-cost supplies, and we welcome further public comments on that possible extension. We also invite further suggestions for alternative approaches to updating high-cost supply prices, specifically those that would result in a predictable, public, and transparent methodology that would ensure that the prices in the PE database reflect typical market prices. These principles are particularly important in order to ensure that the services that utilize the high-cost supplies when provided in the physician's office are appropriately valued under the PFS and continue to be appropriately valued over time.

D. Geographic Practice Cost Indices (GPCIs)

1. Background

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

permanent 1.5 work GPCI floor in Alaska for services furnished beginning January 1, 2009. Section 1848(e)(1)(C) of the Act requires us to review and, if necessary, adjust the GPCIs at least every 3 years. This section also specifies that if more than 1 year has elapsed since the last GPCI revision, we must phase in the adjustment over 2 years, applying only one-half of any adjustment in each year. As discussed in the CY 2009 PFS final rule with comment period (73 FR 69740), the CY 2009 adjustment to the GPCIs reflected the fully implemented fifth comprehensive GPCI update. CY 2010 would have typically included no adjustments to the GPCIs. However, section 3102(a) of the ACA amends section 1848(e)(1)(E) of the Act to extend the 1.0 work GPCI floor for services furnished through December 31, 2010. Additionally, section 3102(b) of the ACA adds a new subparagraph 1848(e)(1)(H) to the Act, which specifies that for CY 2010 and CY 2011, the employee compensation and rent portions of the PE GPCI must reflect only one-half of the relative cost differences for each locality compared to the national average. The new subparagraph also includes a "hold harmless" provision for CY 2010 and CY 2011 for any PFS locality that would otherwise receive a reduction to its PE GPCI resulting from the limited recognition of cost differences. Additionally, section 1848(e)(1)(I) of the Act (as added by section 10324(c) of ACA) establishes a 1.0 PE GPCI floor for services furnished in frontier States effective January 1, 2011. In May 2010, we provided our Medicare contractors with an updated CY 2010 payment file that included the 1.0 work GPCI floor and the PE GPCIs calculated according to the methodology required by section 1848(e)(1)(H) of the Act (as added by section 3102(b) of ACA) for CY 2010, to be used for payment of services furnished on or after January 1, 2010.

For the CY 2011 PFS proposed rule, we have completed the sixth review of the GPCIs and are proposing new GPCIs. We note that section 1848(e)(1)(E) of the Act (as amended by section 3102(a) of ACA) extends the 1.0 work GPCI floor only through December 31, 2010. Under current statute, the 1.0 work GPCI floor will expire on January 1, 2011. Therefore, the CY 2011 physician work GPCIs and summarized geographic adjustment factors (GAFs) do not reflect the 1.0 work floor. However, section 1848(e)(1)(G) of the Act (as amended by section 134(b) of the MIPPA) set a permanent 1.5 work GPCI floor in Alaska for services furnished beginning January 1, 2009; and, as noted above, section 1848(e)(1)(I) of the Act (as added by section 10324(c) of ACA) provides for a permanent 1.0 PE GPCI floor for frontier States effective January 1, 2011. Therefore, as required by the statute, the 1.5 work GPCI floor for Alaska and the 1.0 PE GPCI floor for frontier States will be in effect for CY 2011. In addition to the limited recognition of certain cost differences for the PE GPCIs, section 1848(e)(1)(H) of the Act (as added by section 3102(b) of ACA) also requires us to complete an analysis of the data sources used and cost share weights assigned to the PE GPCIs. Implementation of ACA provisions related to the CY 2011 PE GPCIs is discussed in more detail in the GPCI update section below.

See Addenda D and E to this proposed rule for the proposed CY 2011 GPCIs and summarized GAFs.

2. GPCI Update

The proposed updated GPCI values were developed by Acumen, LLC (Acumen) under contract to CMS. As mentioned above, there are three GPCI components (physician work, PE, and malpractice), and all GPCIs are developed through comparison to a national average for each component. Additionally, each of the three GPCIs relies on its own data source(s) and methodology for calculating its value as described below.

a. Physician Work GPCIs

The physician work GPCIs are designed to capture the relative cost of physician labor by Medicare PFS locality. Previously, the physician work GPCIs were developed using the median hourly earnings from the 2000 Census of workers in seven professional specialty occupation categories which we used as a proxy for physicians' wages and calculated to reflect one-quarter of the relative cost differences for each locality compared to the national average. Physicians' wages are not included in the occupation categories because Medicare payments are a key determinant of physicians' earnings. Including physicians' wages in the physician work GPCIs would, in effect, have made the indices dependent upon Medicare payments.

The physician work GPCIs were updated in CYs 2001, 2003, 2005, and 2008 using professional earnings data from the 2000 Census. However, wage and earnings data are no longer available from the Census long form and the 2000 data are outdated. Therefore, for the proposed sixth GPCI update, we used the 2006 through 2008 Bureau of Labor Statistics (BLS) Occupational Employment Statistics (OES) data as a replacement for the 2000 Census data. The use of BLS OES data as a replacement for the 2000 Census data is discussed in more detail in the update of the PE GPCIs section. As noted above, the 1.0 work GPCI floor is set to expire under current statute on December 31, 2010. Therefore, the CY 2011 proposed physician work GPCIs reflect the removal of this floor.

b. Practice Expense GPCIs

(1) The Affordable Care Act Requirements for PE GPCIs

General Methodology for the CY 2011 GPCIs

ACA added a new subparagraph 1848(e)(1)(H) to the Act which revises the methodology for calculating the PE GPCIs for CY 2010 and CY 2011 so that the employee compensation and rent portions of the PE GPCIs reflect only one-half of the relative cost differences for each locality compared to the national average. Additionally, under section 1848(e)(1)(H)(iii) of the Act (as added by section 3102(b) of the ACA), each PFS locality is held harmless so that the PE GPCI will not be reduced as a result of the change in methodology for PE GPCIs. In accordance with section 1848(e)(1)(H)(ii) of the Act (as added by section 3102(b) of ACA), the employee compensation and rent components of the proposed CY 2011 PE GPCIs were calculated to reflect one-half of the cost differences for each PFS locality relative to the national average cost. Additionally, as required by the statute, physicians' services furnished in each PFS locality would be adjusted by the higher of the locality's PE GPCI calculated with the limited recognition of employee compensation and rent cost differences or the PE GPCI calculated without the limited recognition of cost differences.

Phase-In of PE GPCIs

Section 1848(e)(1)(C) of the Act requires us to phase in GPCI adjustments over 2 years if there was more than 1 year between GPCI adjustments. In accordance with the statute, we are proposing to phase in the updated PE GPCIs using one-half of the CY 2010 values and one-half of the fully implemented values (as described in this section). To apply the phase-in and hold harmless provisions of the Act, we calculated transitional PE GPCIs based on two scenarios. Under the first scenario, we calculated transitional CY 2011 PE GPCIs using the full recognition of employee compensation and rent cost differences for each locality as compared to the national average. The

CY 2011 transitional PE GPCI values with full recognition of cost differences were calculated using one-half of the CY 2010 PE GPCI values *with* full recognition of cost differences and one-half of the updated PE GPCIs with full recognition of cost differences. The first scenario represents the transitional PE GPCI values prior to the limited recognition of cost differences. In other words, this scenario does not include the effects of sections 1848(e)(1)(H)(i) and (ii) of the Act (as added by section 3102(b) of ACA).

For the second scenario, we calculated transitional CY 2011 PE GPCIs with the limited recognition of cost differences for the employee compensation and rent components (as required by sections 1848(e)(1)(H)(i) and (ii) of the Act (as added by section 3102(b) of ACA)). The CY 2011 transitional PE GPCI values with the limited recognition of cost differences were calculated using one-half of the CY 2010 PE GPCIs with the limited cost differences and one-half of the updated PE GPCIs with the limited cost differences. The hold harmless provision under section 1848(e)(1)(H)(iii) of the Act (as added by section 3102(b) of ACA) was applied by selecting the greater of the CY 2011 transitional PE GPCI value calculated with the limited recognition of cost differences or the CY 2011 transitional PE GCPI value calculated *with full recognition of cost differences*. The phase-in of the CY 2011 PE GPCIs and application of the hold harmless provision are illustrated in Table 21 below.

TABLE 21—PHASE-IN OF THE CY 2011 PE GPCIS

	CY 2010	Updated GPCIs	CY 2011 (transitional year)	Hold harmless
File 1				
PE GPCI *Without* 3102(b) of ACA.	Without ACA ..	Without ACA (Updated Data)	(½ of 2010) + (½ Updated GPCI).	Greater of File 1 Transitional Value.
File 2				
PE GPCI *With* 3102(b) of ACA.	With ACA	With ACA (Updated Data)	(½ of 2010 w/ACA) + (½ Updated GPCI w/ACA).	or File 2 Transitional Value.

*ACA in this table means the Affordable Care Act.

Data Analysis

Section 1848(e)(1)(H)(iv) of the Act (as added by section 3102(b) of ACA) also requires the Secretary to "analyze current methods of establishing practice expense adjustments under subparagraph (A)(i) and evaluate data that fairly and reliably establishes distinctions in the cost of operating a medical practice in different fee schedule areas." This section also requires the Secretary to make appropriate adjustments to the PE GPCIs no later than by January 1, 2012. To implement this statutory requirement, we are proposing to implement changes in PE data sources and cost share weights discussed herein effective beginning in CY 2011.

In accordance with section 1848(e)(1)(H)(iv) of the Act (as added by section 3102(b) of ACA), we have analyzed the current methods and data sources used in the establishment of the PE GPCIs. With respect to the method used, we began with a review of the GAO's March 2005 Report entitled, "MEDICARE PHYSICIAN FEES: Geographic Adjustment Indices Are Valid in Design, but Data and Methods Need Refinement" (GAO–05–119). While we have raised concerns in the past about some of the GAO's GPCI recommendations, we note that with respect to the PE GPCIs, the GAO did not indicate any significant issues with the *methods* underlying the PE GPCIs. Rather, the report focused on some of the *data* sources used in the method. For example, the GAO stated that the wage data used for the PE GPCIs are not current. Similarly, upon our reexamination of public comments we have received on the PE GPCIs for previous updates, we note that the commenters predominately focused on either the data sources used in the method or raised issues such as incentivizing the provision of care in different geographic areas. However, the latter issue (incentivizing the provision of care) is outside the scope of the statutory requirement that the PE GPCIs reflect the relative costs of the mix of goods and services comprising practice expenses in the different fee schedule areas relative to the national average.

One key component of the PE GPCI method that our analysis identified involved the office expense portion of the PE GPCIs and the cost share weight assigned to this component. Most significantly, we are proposing that the weight for the office rent component be revised from 12.209 percent to 8.410 percent to reflect our more detailed breakout of the types of office expenses that are determined in local markets instead of national markets. For example, for previous GPCI updates, we used the office expenses cost category as the cost share weight for office rent and, therefore, all individual components previously included in the office expenses category were adjusted for local area cost differences by the GPCIs. As discussed in section II.E.1. of this proposed rule, we are proposing to disaggregate the broader office expenses component into 9 new cost categories as part of the proposed CY 2011 MEI rebasing. The disaggregation of the office expenses category indicates that the fixed capital cost category, for which the consumer price index (CPI) for owner's equivalent rent is the price proxy, is the office expense category applicable to the office rent component of the PE GPCI. Therefore, the fixed cost capital cost category is the only component of office expenses that we are proposing to adjust for local area cost differences beginning in CY 2011. We are proposing to assign other newly defined components of the office expenses category (for example, utilities, chemicals, paper, rubber and plastics, telephone, postage, and moveable capital) to the medical equipment, supplies, and other miscellaneous expenses cost component of the PE GPCIs. As discussed later in this section, the medical equipment, supplies, and other miscellaneous expenses component of the PE GPCIs is assumed to have a national market and, therefore, this component is not adjusted for local area cost differences.

The proposed expense categories for the PE GPCIs, along with their respective cost share weights, are primarily derived from the 2006 American Medical Association (AMA) Physician Practice Information Survey (PPIS) for self-employed physicians and selected self-employed non-medical doctor specialties. The PPIS is the most comprehensive, multispecialty, contemporaneous, and consistently collected PE data source available. It

was developed by medical organizations and captures the costs of operating a medical practice, including office rents and nonphysician staff wages.

Moreover, we also examined the feasibility of using the American Community Survey (ACS) and the Bureau of Labor and Statistics (BLS) Occupational Employment Statistics (OES) data for the employee compensation component of the PE GPCI. For previous updates, the employee compensation component was based on the 2000 Decennial Census long form data. Since the Census data are significantly outdated and the 2010 Census no longer includes occupational wage data, we believed the ACS or BLS OES data might be viable alternatives. While the ACS 3-year public use microsample (PUMS) is currently available, it reflects only about 3 percent of households and the data exhibit significant variation due to the small sample. In particular, the ACS PUMS has fewer than 10 observations of pharmacists in the Manhattan, Beaumont Texas, and Southern Maine localities. Therefore, we believe it would be premature to use the ACS data for determining GPCI values. The 2006, 2007, and 2008 panels from the BLS OES represent a larger sample than the ACS PUMS and more recent data than the 2000 Census. As such, we are proposing to use the BLS OES data for updating the GPCIs. We look forward to exploring the use of the full ACS data when they become available.

Additionally, we explored other sources of rent data (including commercial rental data and survey data) for use in calculating the PE GPCIs. We could not identify a reliable alternative rental data source available on a national basis with coverage of non-metropolitan areas.

We do not believe there is a national data source better than the Housing and Urban Development (HUD) data for determining the relative cost differences in office rents. Therefore, based on our review of the available data sources, we are proposing to use the 2010 apartment rental data produced by HUD at the 50th percentile as a proxy for the relative cost difference in physician office rents.

We believe our analysis of the current methods of establishing PE GPCIs and our evaluation of data that fairly and reliably establish distinctions in the cost of operating a medical practice in the different fee schedule areas meet the statutory requirements of section 1848(e)(1)(H)(iv) of the Act (as added by section 3102(b) of ACA). A more detailed discussion of our analysis of current methods of establishing PE GPCIs and evaluation of data sources is included in Acumen's draft report. Acumen's draft report and associated analysis of the sixth GPCI update, including the PE GPCIs, will be posted on the CMS Web site after display of this CY 2011 PFS proposed rule. The draft report may be accessed from the PFS Web site at: *http://www.cms.gov/PhysicianFeeSched/* under the "Downloads" section of the CY 2011 PFS proposed rule web page.

Determining the Proposed PE GPCI Cost Share Weights

To determine the cost share weights for the proposed CY 2011 GPCIs, we used the proposed 2006-based Medicare Economic Index (MEI) as discussed in section II.E.1. of this proposed rule. The proposed MEI was rebased and revised to reflect the weighted-average annual price change for various inputs needed to provide physicians' services. As discussed in detail in that section, the proposed expense categories in the MEI, along with their respective weights, are primarily derived from data collected in the 2006 AMA PPIS for self-employed physicians and selected self-employed non-medical doctor specialties.

For the cost share weight for the PE GPCIs, we used the 2006-based MEI weight for the PE category of 51.734 percent minus the professional liability insurance category weight of 4.295 percent. Therefore, the proposed cost share weight for the PE GPCIs is 47.439 percent. For the employee compensation portion of the PE GPCIs, we used the nonphysician employee compensation category weight of 19.153 percent. The fixed capital category weight of 8.410, for which the CPI for owner's equivalent rent is the price proxy, was used for the office rent component. To determine the medical equipment, supplies, and other miscellaneous expenses component, we removed professional liability (4.295 percent), nonphysician employee compensation (19.153 percent), and fixed capital (8.410 percent) from the PE category weight (51.734 percent). Therefore, the proposed cost share weight for the medical equipment, supplies, and other miscellaneous expenses component is 19.876 percent.

Furthermore, the physician compensation cost category and its weight of 48.266 percent reflect the proposed work GPCI cost share weight and the professional liability insurance weight of 4.295 percent was used for the malpractice GPCI cost share weight. We believe our analysis and evaluation of the weights assigned to each of the categories within the PE GPCIs meets the statutory requirements of section 1848(e)(1)(H)(iv) of the Act (as added by section 3102(b) of ACA).

The proposed cost share weights for the CY 2011 GPCIs are displayed in Table 22 below.

TABLE 22—PROPOSED COST SHARE WEIGHTS FOR CY 2011 GPCI UPDATE

Expense category	Current cost share weight (percent)	Proposed cost share weight (percent)
Physician Work	52.466	48.266
Practice Expense	43.669	47.439
—Employee Compensation	18.654	19.153
—Office Rent	12.209	8.410
—Equipment, Supplies, Other	12.806	19.876
Malpractice Insurance	3.865	4.295
Total	100	100

PE GPCI Floor for Frontier States

Section 10324(c) of ACA added a new subparagraph (I) under section 1848(e)(1) of the Act to establish a 1.0 PE GPCI floor for physicians' services furnished in frontier States. In accordance with section 1848(e)(1)(I) of the Act (as added by section 10324(c) of ACA), beginning in CY 2011, we will apply a 1.0 PE GPCI floor for physicians' services furnished in States determined to be frontier States. The statute requires us to define any State as a frontier State if at least 50 percent of the State's counties are determined to be frontier

counties, which the statute defines as counties that have a population density less than 6 persons per square mile. However, section 1848(e)(1)(I) of the Act (as added by section 10324(c) of ACA) also specifies that this provision shall not apply to States receiving a non-labor related share adjustment under section 1886(d)(5)(H) of the Act (which excludes Alaska and Hawaii from qualifying as a frontier State).

Consistent with the proposed FY 2011 hospital inpatient prospective payment system (IPPS) 1.0 wage index floor for frontier States (as required by section 10324(a) of the ACA) (75 FR 30920 through 30921), we are proposing to identify frontier counties by analyzing population data and county definitions based upon the most recent annual population estimates published by the U.S. Census Bureau. We divide each county's population total by each county's reported land area (according to the decennial census) in square miles to establish population density. We also are proposing to update this analysis from time to time, such as upon publication of a subsequent decennial census, and if necessary, add or remove qualifying States from the list of frontier States based on the updated analysis.

For a State that qualifies as a frontier State, in accordance with section 1848(e)(1)(I) of the Act (as added by section 10324(c) of the ACA), we are proposing that physicians' services furnished within that State would receive the higher of the applicable PE GPCI value calculated according to the standard CY 2011 methodology or a minimum value of 1.00. Furthermore, in accordance with section 1848(e)(1)(I) of the Act (as added by section 10324(c) of the ACA), the frontier State PE GPCI floor is not subject to budget neutrality and would only be extended to physicians' services furnished within a frontier State.

For determining the proposed CY 2011 PFS PE GPCI values, the frontier States are the following: Montana; Wyoming; North Dakota; Nevada; and South Dakota (as reflected in Table 23).

TABLE 23—FRONTIER STATES UNDER SECTION 1848(E)(1)(I) OF THE ACT (AS ADDED BY SECTION 10324(c) OF THE AFFORDABLE CARE ACT)

State	Total counties	Frontier counties	Percent frontier counties
Montana	56	45	80
Wyoming	23	17	74
North Dakota	53	36	68
Nevada	17	11	65
South Dakota	66	34	52

(2) Summary of CY 2011 Proposed PE GPCIs

The PE GPCIs include three components: employee compensation, office rent, and medical equipment, supplies and miscellaneous expenses as discussed below:

(i) Employee Compensation: We used the 2006 through 2008 BLS OES data to determine the proposed employee compensation component of the PE GPCIs. Employee compensation accounts for 40.4 percent of the total PE GPCIs.

(ii) Office Rents: Consistent with the previous GPCI update, we used the most recent residential apartment rental data produced by HUD (2010) at the 50th percentile as a proxy for the relative cost differences in physician office rents. Office rent accounts for 17.7 percent of the PE GPCIs.

(iii) Medical Equipment, Supplies, and other Miscellaneous Expenses: We assumed that items such as medical equipment and supplies have a national market and that input prices do not vary among geographic areas. As discussed in previous GPCI updates in the CY 2005 and CY 2008 PFS proposed rules, specifically the fourth GPCI update (69 FR 47503) and fifth GPCI update (72 FR 38138), respectively, some price differences may exist, but we believe these differences are more likely to be based on volume discounts rather than on geographic market differences. Medical equipment, supplies, and miscellaneous expenses are factored into the PE GPCIs with a component index of 1.000. The medical equipment, supplies, and other miscellaneous expense component are 41.9 percent of the PE GPCIs.

c. Malpractice GPCIs

The malpractice GPCIs are calculated based on insurer rate filings of premium data for $1 million to $3 million mature claims-made policies (policies for claims made rather than services furnished during the policy term). The proposed CY 2011 malpractice GPCI update reflects 2006 and 2007 premium data.

d. General GPCI Update Process

The periodic review and adjustment of GPCIs is mandated by section 1848(e)(1)(C) of the Act. At each update, the proposed GPCIs are published in the PFS proposed rule the year before they would take effect in order to provide an opportunity for public comment and further revisions in response to comments prior to implementation. As mentioned above, the proposed CY 2011 updated GPCIs for the first year of the 2-year transition and summarized GAFs are displayed in Addenda D and E to this proposed rule.

3. Payment Localities

The current PFS locality structure was developed and implemented in 1997. There are currently 89 localities; 34 localities are Statewide areas. There are 52 localities in the other 18 States, with 10 States having 2 localities, 2 States having 3 localities, 1 State having 4 localities, and 3 States having 5 or more localities. The District of Columbia, Maryland, and Virginia suburbs, Puerto Rico, and the Virgin Islands are additional localities that make up the remainder of the total of 89 localities. The development of the current locality structure is described in detail in the CY 1997 PFS proposed rule (61 FR 34615) and the subsequent final rule with comment period (61 FR 59494).

As we have previously noted in the CYs 2008 and 2009 proposed rules (72 FR 38139 and 73 FR 38513), any changes to the locality configuration must be made in a budget neutral manner within a State and can lead to significant redistributions in payments. For many years, we have not considered making changes to localities without the support of a State medical association in order to demonstrate consensus for the change among the professionals whose payments would be affected (with some increasing and some decreasing). However, we have recognized that, over time, changes in demographics or local economic conditions may lead us to conduct a more comprehensive

examination of existing payment localities.

For the past several years, we have been involved in discussions with physician groups and their representatives about recent shifts in relative demographics and economic conditions, most notably within the current California payment locality structure. We explained in the CY 2008 PFS final rule with comment period that we intended to conduct a thorough analysis of potential approaches to reconfiguring localities and would address this issue again in future rulemaking. For more information, we refer readers to the CY 2008 PFS proposed rule (72 FR 38139) and subsequent final rule with comment period (72 FR 66245).

As a follow-up to the CY 2008 PFS final rule with comment period, we contracted with Acumen to conduct a preliminary study of several options for revising the payment localities on a nationwide basis. The contractor's interim report was posted on the CMS Web site on August 21, 2008, and we requested comments from the public. The report entitled, "Review of Alternative GPCI Payment Locality Structures," remains accessible from the CMS PFS Web page under the heading "Interim Study of Alternative Payment Localities under the PFS." The report may also be accessed directly from the following link: *http://www.cms.hhs.gov/PhysicianFeeSched/10_Interim_Study.asp#TopOfPage.*

We accepted public comments on the interim report through November 3, 2008. The alternative locality configurations discussed in the report are described briefly below in this section.

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

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

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

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

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

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

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

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

As discussed in Acumen's interim report, all four studied alternative locality configurations would increase the number of localities and separate higher cost areas from rural "rest of state" areas. As a result, payments to urban areas would increase, while rural areas would see a decrease in payment because they would no longer be grouped with higher cost "urbanized" areas. A number of public commenters on the draft report expressed support for Option 3 (separate MSAs from Statewide localities) because the commenters believed this alternative would improve payment accuracy over the current locality configuration and could mitigate possible payment reductions to rural areas as compared to Option 1 (CMS CBSAs). Therefore, Acumen is conducting a more in-depth analysis of the dollar impacts that would result from the application of Option 3.

For a detailed discussion of the public comments on the contractor's interim locality study report, we refer readers to the CY 2010 PFS proposed rule (74 FR 33534) and subsequent final rule with comment period (74 FR 61757).

E. PFS Update for CY 2010

1. Rebasing and Revising of the Medicare Economic Index (MEI)

a. Background

The Medicare Economic Index (MEI) is required by section 1842(b)(3) of the Act, which states that prevailing charge levels beginning after June 30, 1973 may not exceed the level from the previous year except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by year-to-year economic changes. Beginning July 1, 1975, and continuing through today, the MEI has met this requirement by reflecting the weighted-average annual price change for various inputs needed to provide physicians' services. The MEI is a fixed-weight input price index, with an adjustment for the change in economy-wide, private nonfarm business multifactor productivity. This index is comprised of two broad categories: (1) Physician's own time; and (2) physician's practice expense (PE).

The current form of the MEI was detailed in the November 25, 1992 **Federal Register** (57 FR 55896) and was based in part on the recommendations of a Congressionally-mandated meeting of experts held in March 1987. Since that time, the structure of the MEI has remained essentially unchanged, with three exceptions. First, the MEI was rebased in 1998 (63 FR 58845), which moved the cost structure of the index from 1992 data to 1996 data. Second, the methodology for the productivity adjustment was revised in the CY 2003 PFS final rule (67 FR 80019) to reflect the percentage change in the 10-year moving average of economy-wide private nonfarm business multifactor productivity. Third, the MEI was rebased in 2003 (68 FR 63239), which moved the cost structure of the index from 1996 data to 2000 data.

We are proposing to rebase and revise the MEI and incorporate it into the CY 2011 PFS update. The terms "rebasing" and "revising", while often used interchangeably, actually denote different activities. Rebasing refers to moving the base year for the structure of costs of an input price index, while revising relates to other types of changes such as changing data sources, cost categories, or price proxies used in the input price index. As is always the case with a rebasing and revising exercise, we have attempted to use the most recently available, relevant, and appropriate information to develop the proposed MEI cost category weights and price proxies. In the following sections

of this proposed rule, we detail our proposals regarding the updated cost weights for the MEI expense categories, our rationale for selecting the price proxies in the MEI, and the results of the proposed rebasing and revising of the MEI.

b. Use of More Current Data

The MEI was last rebased and revised in 2003 in the CY 2004 PFS final rule with comment period (68 FR 63239). The current base year for the MEI is 2000, which means that the cost weights in the index reflect physicians' expenses in 2000. However, we believe it is desirable to periodically rebase and revise the index so that the expense shares and their associated price proxies reflect more current conditions. For this reason, we propose to rebase the MEI to reflect appropriate physicians' expenses in 2006.

We are proposing several changes to the expenses that are eligible to be included in the MEI. For instance, we are proposing to remove all costs related to drug expenses as drugs are not paid for under the PFS nor are they included in the definition of "physicians' services" for purposes of the Sustainable Growth Rate (SGR) system that is used to update the PFS. The details of the decision regarding the removal of physician-administered drugs from the SGR system can be found in the CY 2010 PFS proposed rule and finalized in the CY 2010 final rule with comment period (74 FR 33651 and 74 FR 61961, respectively). Additionally, we are proposing to remove costs associated with separately billable supplies. The rationale for removing the separately billable supplies is discussed further below in section III.E.1.X of this proposed rule.

We are proposing to revise the cost categories in the MEI by expanding the Office Expense category into nine detailed categories with additional price proxies associated with these categories. Additionally, we will continue to adjust the MEI for economy-wide multifactor productivity based on the 10-year moving average of total private nonfarm business multi-factor productivity.

c. Rebasing and Revising Expense Categories in the MEI

The MEI is used in conjunction with the SGR system to update the PFS and represents the price component of that update. The proposed expense categories in the index, along with their respective weights, are primarily derived from data collected in the 2006 AMA Physician Practice Information Survey (PPIS) for self-employed physicians and selected self-employed non-Medical Doctor (non-MD) specialties. We included data from the following specialties in the MEI cost weight calculations (optometrists, oral surgeons, podiatrists, and chiropractors) consistent with the definition of the term "physician" in section 1861(r) of the Act. In summary, the term "physician" when used in connection with the performance of functions or actions an individual is legally authorized to perform means the following: (1) A doctor of medicine or osteopathy; (2) a doctor of dental surgery or of dental medicine; (3) a doctor of podiatric medicine; (4) a doctor of optometry; or (5) a chiropractor. For a complete definition, please see section 1861(r) of the Act. We weighted the expense data from the above-referenced specialties with the self-employed physician expense data using physician counts by specialty.

The AMA data from the PPIS were used to determine expenditure weights for total expenses, physicians' earnings, physicians' benefits, employed physician payroll, nonphysician compensation, office expenses, professional liability insurance (PLI), medical equipment, medical supplies, and all other expenses. To further disaggregate into subcategories reflecting more detailed expenses, we used data from the 2002 Bureau of Economic Analysis (BEA) Benchmark Input-Output table (I/O), the 2006 Bureau of the Census Current Population Survey (CPS), the 2006 Bureau of Labor Statistics (BLS) Occupational Employment Survey (OES) and Employment Cost for Employee Compensation Survey (ECEC), and the 2006 Internal Revenue Service (IRS) Statistics of Income (SOI) data. The development of each of the cost categories using these sources is described in detail below.

(1) Developing the Weights for Use in the MEI

Developing a rebased and revised MEI requires selecting a base year and determining the appropriate expense categories. We are proposing to rebase the MEI to CY 2006. We choose CY 2006 as the base year for two primary reasons: (1) CY 2006 is the most recent year for which data were available; and (2) we believe that the CY 2006 data provide a representative distribution of physicians' compensation and PEs.

Compared to the 2000-based MEI, we are proposing to include 9 new cost categories (along with their respective weights) that disaggregate the costs under the broader Office Expenses cost category. The 2000-based MEI did not break these expenses into individual categories. A more detailed discussion is provided below in this section. In addition, we are proposing to exclude the Pharmaceutical cost category as pharmaceuticals are neither paid for under the PFS nor are they included in the definition of "physicians' services" for purposes of calculating the physician update via the SGR system (for more details see the CY 2010 PFS final rule with comment period (74 FR 61961 through 61962)). Lastly, we are proposing to exclude the expenses associated with separately billable supplies since these items are not paid for under the PFS.

We determined the number and composition of expense categories based on the criteria used to develop the current MEI and other CMS input price index expenditure weights. These criteria are timeliness, reliability, relevance, and public availability. Table 24 lists the set of mutually exclusive and exhaustive cost categories that make up the proposed rebased and revised MEI.

TABLE 24—PROPOSED 2006 MEI COST CATEGORIES, WEIGHTS, AND PRICE PROXIES COMPARED TO THE 2000 MEI COST CATEGORIES AND WEIGHTS

Cost category	Proposed 2006–expense weights [1] [2]	2000 Expense weights	Proposed 2006 price proxies
Total	100.00	100.000	
Physician's Own Time [3]	48.266	52.466	
Wages and Salaries	43.880	42.730	AHE Total Nonfarm Private.[5]

TABLE 24—PROPOSED 2006 MEI COST CATEGORIES, WEIGHTS, AND PRICE PROXIES COMPARED TO THE 2000 MEI COST CATEGORIES AND WEIGHTS—Continued

Cost category	Proposed 2006–expense weights [1] [2]	2000 Expense weights	Proposed 2006 price proxies
Benefits [3] [4]	4.386	9.735	ECI–Benefits Total Nonfarm Private.[6]
Physician's Practice Expense	51.734	47.534	
Nonphysician Employee Compensation	19.153	18.654	
Nonphysician Employee Wages and Salaries	13.752	13.809	
Prof/Tech Wages	6.006	5.887	ECI–Wages/Salaries: Private Professional &Technical.
Managerial Wages	1.446	3.333	ECI–Wages/Salaries: Private Managerial.
Clerical Wages	4.466	3.892	ECI–Wages/Salaries: Private Clerical.
Services Wages	1.834	0.696	ECI–Wages/Salaries: Private Service.
Nonphysician Employee Benefits [4]	5.401	4.845	ECI–Ben: Private Blend.
Office Expenses	20.035	12.209	
Utilities	1.139	.....	CPI Fuel & Utilities.[7]
Chemicals	0.679	.....	PPI for Other Basic Organic Chemical Manufacturing PPI325190.[8]
Paper	0.616	.....	PPI for converted paper.
Rubber & Plastics	0.563	.....	PPI for rubber and plastics.
Telephone	1.415	.....	CPI for Telephone Services.
Postage	0.661	.....	CPI for Postage.
All Other Labor-Related	4.718	.....	ECI Compensation Services Occupations (ECIPCSONS).
Fixed Capital	8.410	.....	CPI for Owner's Equivalent Rent.
Moveable Capital	1.834	.....	PPI for Machinery and Equipment.
PLI	4.295	3.865	CMS–Prof. Liab. Phys. Premiums.
Medical Equipment	1.978	2.055	PPI–Medical Instruments & Equip.
Pharmaceuticals and Medical Materials and Supplies	1.760	4.320	
Pharmaceuticals	.....	2.309	
Medical Materials and Supplies	1.760	2.011	PPI Surg. Appliances and Supplies/CPI(U) Med Supplies.
Other Professional Expenses	4.513	6.433	CPI–U All Items Less Food and Energy.

(1) Due to rounding, weights may not sum to 100.000 percent.
(2) Sources: 2006 Physician Practice Information Survey (PPIS), Center for Health Policy Research, American Medical Association; 2006 Employment Cost for Employee Compensation, U.S. Department of Labor, Bureau of Labor Statistics; 2006 Occupational Employment Statistics (OES), BLS; U.S. Department of Commerce, Bureau of Economic Analysis 2002 Benchmark Input Output Tables, and U.S. Department of Commerce, Bureau of the Census, 2006 Current Population Survey.
(3) Includes employed physician payroll.
(4) Includes paid leave.
(5) Average Hourly Earnings (AHE).
(6) Employment Cost Index (ECI).
(7) Consumer Price Index (CPI).
(8) Producer Price Index (PPI).

The development of each of the cost categories in the proposed 2006 MEI is described, in detail, below.

(2) Physician's Own Time

The component of the MEI that reflects the physician's own time is represented by the net income portion of business receipts. The proposed 2006 cost weight associated with the physician's own time (otherwise referred to as the Physician's Compensation cost weight) is based on 2006 AMA PPIS data for mean physician net income (physician compensation) for self-employed physicians and for the selected self-employed specialties referenced previously in this rule.

We are proposing to continue to add employed physician compensation to self-employed physician compensation in order to calculate an aggregate Physician Compensation cost weight. By including the compensation of employed physicians in the physician compensation expense category, these expenses will be adjusted by the appropriate price proxies for a physician's own time. The proposed 2006 Physician Compensation cost weight is 48.266 percent as compared to a 52.466 percent share in the 2000-based MEI. We split the physician compensation component into subcategories: Wages & Salaries and Benefits. For Physician Compensation, the ratio for Wages & Salaries and Benefits was calculated using data from the PPIS. Self-employed physician wages & salaries accounted for 92.3 percent of physician earnings while physician benefits accounted for the remaining 7.8 percent. For employed physician payroll, the distribution for wages & salaries and benefits for 2006 was 85.8 percent and 14.2 percent, respectively. This ratio was determined by calculating a weighted average of available SOI data for partnerships, corporations, and S-corporations specific to physicians and outpatient care centers. Based on these proposed methods, the proposed 2006 Physician Wages & Salaries cost weight is 43.880 percent and the proposed 2006

Physician Benefits cost weight is 4.386 percent.

(3) Physician's Practice Expenses

To determine the remaining individual Practice Expenses cost weights, we use mean expense data from the 2006 PPIS survey. The detailed explanations for the derivation of the individual weights under Practice Expenses are listed below.

(A) Nonphysician Employee Compensation

The cost weight for Nonphysician Employee Compensation was developed using the 2006 AMA PPIS mean expenses for these costs. We further divided this cost share into Wages & Salaries and Benefits using 2006 BLS Employer Costs for Employee Compensation (ECEC) data for the Health Care and Social Assistance (private industry). Although this survey does not contain data specifically for offices of physicians, data are available to help determine the shares associated with wages & salaries and benefits for private industry health care and social assistance services (which include hospitals, nursing homes, offices of physicians, and offices of dentists). We believe these data provide a reasonable estimate of the split between wages and benefits for employees in physicians' offices. Data for 2006 in the ECEC for Health Care and Social Assistance indicate that wages and benefits are 71.8 percent and 28.2 percent of compensation, respectively. The 2000-based MEI included a wage and benefit split of 74.0 percent and 26.0 percent of compensation.

As in the 2000-based MEI, we are proposing to use 2006 Current Population Survey (CPS) data and 2006 BLS Occupational Employment Statistics (OES) data to develop cost weights for wages for nonphysician occupational groups. We determined total annual earnings for offices of physicians using employment data from the CPS and mean annual earnings from the OES. To arrive at a distribution for these separate categories, we determined annual earnings for each of the four categories (which are Professional & Technical workers, Managers, Clerical workers, and Service workers), using the Standard Occupational Classification (SOC) system. We then determined the overall share of the total for each. The proposed distribution, as well as the distribution from the 2000-based MEI are presented in Table 25.

TABLE 25—PERCENT DISTRIBUTION OF NONPHYSICIAN PAYROLL EXPENSE BY OCCUPATIONAL GROUP: 2006 AND 2000

BLS Occupational Group	2006 Expenditure shares	2000 Expenditure shares
Total	100.000	100.000
Professional & Technical Workers	43.671	42.635
Managers	10.517	24.138
Clerical Workers	32.477	28.187
Service Workers	13.336	5.040

Values may not sum to 100 due to rounding.

The decrease in the Management expenditure share is directly related to a decrease in the total number of employees in Management occupations in physicians' offices, in particular, "Medical and health service managers." The decrease in expenditure share may also be due, in part to the methods used in this rebasing. That is, for the 2006-based MEI, we are using data limited to "Offices of physicians." In the 2000-based version of the index, the only data that were available to inform these estimates were inclusive of physician offices and clinics ("Offices of physicians and clinics"). An examination of 2006 CPS and OES data comparing "Outpatient care centers" to "Offices of physicians" indicates that there is a higher share of management occupations in the "Outpatient care centers" than in "Offices of physicians."

The increase in the Service Workers expenditures share is attributable to a substantive increase in the number of employees in service occupations, particularly, "Medical assistants and other health care support occupations".

(B) Office Expenses

The aggregate Office Expenses cost weight was derived using the 2006 AMA PPIS and is explained in more detail below in this section. This calculation resulted in a 20.035 percent share of total costs in 2006 compared to a 12.209 percent share in the 2000-based index.

For the 2006-based MEI, we propose to further disaggregate the Office Expenses into more detailed cost categories using the BEA 2002–Benchmark I/O data for Offices of physicians, dentists, and other health practitioners (NAICS 621A00). We used this data to develop the nine detailed 2002 costs weights as a percent of total office expenses, as measured by the BEA I/O data. The total Office Expenses cost category was calculated by matching the BEA I/O data as closely as possible to the AMA survey data, the latter of which defined office expenses as "office (non-medical) equipment and office (non-medical) supplies, as well as rent, mortgage, interest, maintenance, refrigeration, storage, security, janitorial, depreciation on medical buildings used in your practice, utilities, or other office computer systems (including information management systems/electronic medical record systems) and telephone."

We then aged the 2002 weights forward to 2006 to derive the 2006 detailed office expense cost weights as a percent of total Office Expenses. The methodology we used to age the data forward involved applying the annual price changes from each respective price proxy to the appropriate cost categories. We repeated this practice for each year of the interval. We then applied the resulting 2006 distributions to the aggregate 2006 AMA Office Expenses weight to yield the detailed 2006 Office Expenses' weights as a percent of total expenses.

We are proposing to introduce these new, more detailed weights for the 2006-based index based on our intent to derive an increased level of precision while maintaining appropriate levels of aggregation in the market basket. The proposed proxies are described in section X. of this proposed rule. The following is a description of what is included in each of the detailed cost categories.

- *Utilities:* The Utilities cost weight includes expenses classified in the fuel,

oil and gas, water and sewage, and electricity industries. The proposed cost weight for utilities is 1.139 percent.

• *Paper:* The Paper cost weight includes expenses classified in the paper (including but not limited to paper, paperboard, and sanitary paper products) and printing industries. The proposed cost weight for paper is 0.616 percent.

• *Chemicals:* The Chemicals cost weight includes expenses classified in the basic organic and inorganic chemical manufacturing industry (accounting for about 45 percent of the chemical expenses), as well as other chemical industries including but not limited to industrial gas manufacturing and all other chemical product manufacturing. The proposed cost weight for chemicals is 0.679 percent.

• *Rubber and Plastics:* The Rubber and Plastics cost weight includes expenses classified in the rubber and plastic industries, including but not limited to, urethane and other foam product manufacturing and other plastic and rubber manufacturing industries. The proposed cost weight for Rubber and Plastics is 0.563 percent.

• *Telephone:* The telephone cost weight includes expenses classified in the telecommunications (accounting for the majority of the telephone expenses) and cable industries. The proposed cost weight for Telephone services is 1.415 percent.

• *Postage:* The Postage cost weight includes postal service expenses. The proposed cost weight for Postage is 0.661 percent.

• *All Other Services:* The All Other Services cost weight includes other service expenses including, but not limited to, nonresidential maintenance and repair, machinery repair, janitorial, and security services. This cost weight does not include expenses associated with professional services such as accounting, billing, legal and marketing which are included in the All Other Expenses cost weight derived using the AMA PPIS survey. The proposed cost weight for All Other Services is 4.718 percent.

• *Fixed Capital:* The Fixed Capital cost weight includes expenses for building leases and depreciation. The proposed cost weight for Fixed Capital is 8.410 percent.

• *Moveable Capital:* The Moveable Capital cost weight includes expenses for non-medical equipment including but not limited to, computer equipment and software, as well as the rental and leasing of automotive and industrial machinery equipment. The proposed cost weight for Moveable Capital is 1.834 percent.

(C) Professional Liability Insurance (PLI) Expense

The weight for PLI expense was derived from the 2006 AMA survey and was calculated as the mean PLI expense expressed as a percentage of total expenses. This calculation resulted in a 4.513 percent share of total costs in 2006 compared to a 3.865 percent share in the 2000-based index. The increase in the weight for PLI reflects the current prices of premiums, as well as an update to the level of coverage purchased by physicians in 2006 compared to 2000.

(D) Medical Equipment Expenses

The proposed weight for Medical Equipment was calculated using the 2006 AMA PPIS mean expense data. This calculation resulted in a 1.978 percent share of total costs in 2006 compared to a 2.055 percent share in the 2000-based index. By definition, this category includes the expenses related to depreciation, maintenance contracts, leases/rental of medical equipment used in diagnosis or treatment of patients. The category would also include the tax-deductible portion of the purchase price or replacement value of medical equipment, if not leased.

(E) Medical Supplies Expenses

The proposed weight for Medical Supplies was calculated using the 2006 AMA PPIS mean expense data. This calculation resulted in a 1.760 percent share of total costs in 2006 compared to a 2.011 percent share in the 2000-based index. By definition, this category includes the expenses related to medical supplies such as sterile gloves, needles, bandages, specimen containers, and catheters. Additionally, we are proposing to exclude the expenses related to separately billable supplies as these expenses are not paid for under the PFS. The Medical Supply cost category does not include expenses related to drugs.

(F) All Other Professional Expenses

The proposed weight for All Other Professional expenses was calculated using the 2006 AMA PPIS mean expense data. This calculation resulted in a 4.513 percent share of total costs in 2006 compared to a 6.433 percent share in the 2000-based index. By definition, this category includes the expenses related to tax-deductible expenses for any other expenses not reported in another category from the PPIS. These expenses would include fees related to legal, marketing, accounting, billing, office management services, professional association memberships, maintenance of certification or licensure, journals and continuing education, professional car upkeep and depreciation, and any other professional expenses not reported elsewhere on the PPIS.

d. Selection of Price Proxies for Use in the MEI

After the proposed 2006 cost weights for the rebased and revised MEI were developed, we reviewed all of the price proxies to evaluate their appropriateness. As was the case in the development of the 2000-based MEI (68 FR 63239), most of the proxy measures we considered are based on BLS data and are grouped into one of the following five categories:

• *Producer Price Indices (PPIs):* PPIs measure price changes for goods sold in markets other than retail markets. These fixed-weight indexes are a measure of price change at the intermediate or final stage of production. They are the preferred proxies for physician purchases as these prices appropriately reflect the product's first commercial transaction.

• *Consumer Price Indices (CPIs):* CPIs measure change in the prices of final goods and services bought by consumers. Like the PPIs, they are fixed-weight indexes. Since they may not represent the price changes faced by producers, CPIs are used if there are no appropriate PPIs or if the particular expenditure category is likely to contain purchases made at the final point of sale.

• *Average Hourly Earnings (AHEs):* AHEs are available for production and nonsupervisory workers for specific industries, as well as for the nonfarm business economy. They are calculated by dividing gross payrolls for wages & salaries by total hours. The series reflects shifts in employment mix and, thus, is representative of actual changes in hourly earnings for industries or for the nonfarm business economy.

• *ECIs for Wages & Salaries:* These ECIs measure the rate of change in employee wage rates per hour worked. These fixed-weight indexes are not affected by employment shifts among industries or occupations and thus, measure only the pure rate of change in wages.

• *ECIs for Employee Benefits:* These ECIs measure the rate of change in employer costs of employee benefits, such as the employer's share of Social Security taxes, pension and other retirement plans, insurance benefits (life, health, disability, and accident), and paid leave. Like ECIs for wages & salaries, the ECIs for employee benefits are not affected by employment shifts among industries or occupations.

When choosing wage and price proxies for each expense category, we evaluate the strengths and weaknesses of each proxy variable using the following four criteria.

- *Relevance:* The price proxy should appropriately represent price changes for specific goods or services within the expense category. Relevance may encompass judgments about relative efficiency of the market generating the price and wage increases.
- *Reliability:* If the potential proxy demonstrates a high sampling variability, or inexplicable erratic patterns over time, its viability as an appropriate price proxy is greatly diminished. Notably, low sampling variability can conflict with relevance—since the more specifically a price variable is defined (in terms of service, commodity, or geographic area), the higher the possibility of high sampling variability. A well-established time series is also preferred.
- *Timeliness of actual published data:* For greater granularity and the need to be as timely as possible, we prefer monthly and quarterly data to annual data.
- *Public availability:* For transparency, we prefer to use data sources that are publicly available.

The BLS price proxy categories previously described meet the criteria of relevance, reliability, timeliness, and public availability. Below we discuss the proposed price-wage proxies for the rebased and revised MEI (as shown in Table 23).

(1) Expense Categories in the MEI

(A) Physician's Own Time (Physician Compensation)

In the proposed revised and rebased MEI, we are using the AHE for the private nonfarm economy as the proxy for the Physician Wages & Salaries component (BLS series code: CEU0500000008).

As discussed extensively in the November 2, 1998 final rule (63 FR 58848), and again in the December 31, 2002 final rule (67 FR 80019), we believe that this price proxy represents the most appropriate proxy for use in the MEI. The AHE for the nonfarm business economy reflects the impacts of supply, demand, and economy-wide productivity for the average worker in the economy. As such, use of this proxy is consistent with the original legislative intent that the change in the physicians' earnings portion of the MEI follow the change in general earnings for the economy. Since earnings are expressed per hour, a constant quantity of labor input per unit of time is reflected. Finally, the use of the AHE data is also consistent with our using the BLS economy-wide private nonfarm business sector multifactor productivity measures since economy-wide wage increases reflect economy-wide productivity increases.

The current 2000-based MEI uses the ECI for Total Benefits (BLS series code: CIU2030000000000I) for total private industry as the price proxy for Physician Benefits. We are proposing to use the same proxy for the 2006-based MEI. This means that both the wage and benefit proxies for physician earnings are derived from the private nonfarm business sector and are computed on a per-hour basis.

(B) Nonphysician Employee Compensation

For the 2006-based MEI, we are proposing to use Current Population Survey (CPS) data on employment by occupation and earnings from the BLS Occupational Employment Statistics for NAICS 6211, Office of Physicians, to develop labor cost shares for the nonphysician occupational groups shown in Table 23. The 2000-based MEI was based on CPS data for the Standard Industrial Classification 801 and 803, which included both office of physicians and outpatient care centers. Beginning in 2003, BLS began publishing CPS data on a NAICS basis which provided data for office of physicians (NAICS 6211)and outpatient care centers (NAICS 6214) separately. We believe using data for office of physicians is appropriate for the 2006-based MEI. The BLS maintains an ECI for each selected industry group. We propose to use these ECIs as price proxies for nonphysician employee wages in the same manner they are used in the current MEI.

As described in the CY 2008 PFS proposed rule (72 FR 38190), as a result of the discontinuation of the White Collar Benefit ECI for private workers, we are currently using a composite ECI benefit index. We are proposing to continue to use the composite ECI for nonphysician employees in the proposed rebased and revised MEI; however, we are proposing to revise the weights within that blend in order to reflect the more recent 2006 data. Table 26 lists the four ECI series and corresponding weights used to construct the 2006 composite benefit index.

TABLE 26—CMS COMPOSITE PRICE INDEX FOR NONPHYSICIAN EMPLOYEE BENEFITS

ECI series	2006 Weight (%)
Benefits, Private, Professional & Related	44
Benefits, Private, Management, Business, Financial	11
Benefits, Private, Office & Administrative Support	32
Benefits, Private, Service Occupations	13

(C) Utilities

For the 2006-based MEI, we are proposing to use the CPI for Fuel and Utilities (BLS series code #CUUR0000SAH2) to measure the price growth of this cost category. This cost category was not broken-out separately in the 2000-based MEI.

(D) Chemicals

For the 2006-based MEI, we are proposing to use the PPI for Other Basic Organic Chemical Manufacturing (BLS series code #PCU32519–32519) to measure the price changes of this cost category. We are proposing this industry-based PPI because BEA's 2002 benchmark I/O data show that the majority of the office of physicians' chemical expenses are attributable to Other Basic Organic Chemical Manufacturing (NAICS 32519). This cost category was not broken-out separately in the 2000-based MEI.

(E) Paper

For the 2006-based MEI, we are proposing to use the PPI for Converted Paper and Paperboard (BLS series code #WPU0915) to measure the price growth of this cost category. This cost category was not broken-out separately in the 2000-based MEI.

(F) Rubber and Plastics

For the 2006-based MEI, we are proposing to use the PPI for Rubber and Plastic Products (BLS series code #WPU07) to measure the price growth of this cost category. This cost category was not broken-out separately in the 2000-based MEI.

(G) Telephone

For the 2006-based MEI, we are proposing to use the CPI for Telephone Services (BLS series code #CUUR0000SEED) to measure the price growth of this cost category. This cost category was not broken-out separately in the 2000-based MEI.

(H) Postage

For the 2006-based MEI, we are proposing to use CPI for Postage (BLS series code #CUUR0000SEEC01) to measure the price growth of this cost category. This cost category was not broken-out separately in the 2000-based MEI.

(I) All Other Services

For the 2006-based MEI, we are proposing to use the ECI for Compensation for Service Occupations (private industry) (BLS series code #CIU2010000300000I) to measure the price growth of this cost category. This cost category was not broken-out separately in the 2000-based MEI.

(J) Fixed Capital

For the 2006-based MEI, we are proposing to use the CPI for Owner's Equivalent Rent (BLS series code #CUUS0000SEHC) to measure the price growth of this cost category. This price index represents about 50 percent of the CPI for Housing which was used to in the 2000-based MEI to proxy total office expenses.

(K) Moveable Capital

For the 2006-based MEI, we are proposing to use the PPI for Machinery and Equipment (series code #WPU11) to measure the price growth of this cost category. This cost category was not broken-out separately in the 2000-based MEI.

(L) Professional Liability Insurance

In order to accurately reflect the price changes associated with PLI, each year, we solicit PLI premium data for physicians from a sample of commercial carriers. This information is not collected through a survey form, but instead is requested directly from, and provided by (on a voluntary basis), several national commercial carriers. As we require for our other price proxies, the professional liability price proxy is intended to reflect the pure price change associated with this particular cost category. Thus, it does not include changes in the mix or level of liability coverage. To accomplish this result, we obtain premium information from a sample of commercial carriers for a fixed level of coverage, currently $1 million per occurrence and a $3 million annual limit. This information is collected for every State by physician specialty and risk class. Finally, the State-level, physician-specialty data are aggregated by effective premium date to compute a national total, using counts of physicians by State and specialty as provided in the AMA publication, *Physician Characteristics and Distribution in the U.S.*

The resulting data provide a quarterly time series, indexed to a base year consistent with the MEI, and reflect the national trend in the average professional liability premium for a given level of coverage, generally $1 million/$3 million of claims-made mature policies. From this series, quarterly and annual percent changes in PLI are estimated for inclusion in the MEI.

The most comprehensive data on professional liability costs are held by the State insurance commissioners, but these data are available only with a substantial time lag and hence, the data currently incorporated into the MEI are much timelier. We believe that, given the limited data available on professional liability premiums, the information and methodology described above adequately reflect the PLI price trends facing physicians.

(M) Medical Equipment

The Medical Equipment cost category includes depreciation, leases, and rent on medical equipment. We are proposing to use the PPI for Medical Instruments and Equipment (BLS series code: WPU1562) as the price proxy for this category, consistent with the price proxy used in the 2000-based MEI and other CMS input price indexes.

(N) Medical Materials and Supplies

As is used in the 2000-based MEI, we are proposing to use a blended index comprised of 50/50 blend of the PPI Surgical Appliances (BLS series code: WPU156301) and the CPI–U for Medical Equipment and Supplies (BLS series code: CUUR0000SEMG). We believe physicians purchase the types of supplies contained within these proxies, including such items as bandages, dressings, catheters, I.V. equipment, syringes, and other general disposable medical supplies, via wholesale purchase, as well as at the retail level. Consequently, we are proposing to combine the two aforementioned indexes to reflect those modes of purchase.

(O) Other Professional Expenses

This category includes the residual subcategory of other professional expenses such as accounting services, legal services, office management services, continuing education, professional association memberships, journals, professional car expenses, and other professional expenses. Given this heterogeneous mix of goods and services, we are proposing to use the CPI–U for All Items Less Food and Energy, consistent with the price proxy used in the 1996 and 2000-based MEI.

(2) Productivity Adjustment to the MEI

The MEI has been adjusted for changes in productivity since its inception. In the CY 2003 PFS final rule (67 FR 80019), we implemented a change in the way the MEI was adjusted to account for those changes in productivity The MEI used for the 2003 physician payment update incorporated changes in the 10-year moving average of private nonfarm business (economy-wide) multifactor productivity that were applied to the entire index. Previously, the index incorporated changes in productivity by adjusting the labor portions of the index by the 10-year moving average of economy-wide private nonfarm business labor productivity.

We are proposing to continue to use the current method for adjusting the full MEI for multifactor productivity in the rebased and revised MEI.

As described in the CY 2003 PFS final rule, we believe this adjustment is appropriate because it explicitly reflects the productivity gains associated with all inputs (both labor and non-labor). We believe that using the 10-year moving average percent change in economy-wide multifactor productivity is appropriate for deriving a stable measure that helps alleviate the influence that the peak (or a trough) of a business cycle may have on the measure. The adjustment will be based on the latest available historical economy-wide nonfarm business multifactor productivity data as measured and published by BLS.

e. Results of Rebasing

Table 27 illustrates the results of updating the MEI from the following changes to the weights for the Physician Compensation, Practice Expenses (excluding PLI), and PLI.

TABLE 27—PERCENT DISTRIBUTION OF SELECTED PHYSICIAN EXPENSES USED TO CALIBRATE RVUS: CYS 2006 AND 2000

	CY 2006 weight (%)	CY 2000 weight (%)
Physician Compensation (Own Time)	48.266	52.466
Practice Expenses (less PLI)	47.439	43.669
PLI	4.295	3.865

The rebased and revised MEI has several differences as compared to the 2000-based MEI; these changes have been discussed in detail in prior

sections of this rule. Table 28 shows the average calendar year percent change from CY 2004 to CY 2011 for both the 2000- and 2006-based MEIs. The 2006-based MEI annual percent changes differ from the 2000-based MEI annual percent changes by 0.0 to 0.8 percentage point. In the 5 most recent years (CYs 2007–2011), the annual percent change in the rebased and revised MEI was within 0.3 percentage point of the percent change in the 2000-based MEI. In the earlier years, there were bigger differences between the annual percent change in the rebased and revised MEI and the 2000-based MEI. The majority of these differences can be attributed to the lower benefit cost weight, as measured by the 2006 AMA data, and the exclusion of the drug cost weight. The remaining differences are attributable to the higher cost weight for PLI, as measured by the 2006 AMA data.

TABLE 28—ANNUAL PERCENT CHANGE IN THE CURRENT AND PROPOSED REVISED AND REBASED MEI

Update year [A]	Proposed 2006-based MEI	Current 2000-based MEI
CY 2004	2.4	2.7
CY 2005	2.1	2.9
CY 2006	2.0	2.5
CY 2007	1.7	2.0
CY 2008	1.9	1.8
CY 2009	1.7	1.7
CY 2010	1.4	1.2
CY 2011 [B]	0.3	0.3
Avg. Change for CYs 2004–2011	1.7	1.9

[A] Update year based on historical data through the second quarter of the prior calendar year. For example, the 2010 update is based on historical data through the second quarter 2009.

[B] Based on the 1st quarter 2010 forecast by HIS Global Insight. With historical data through the 4th quarter 2009.

As shown in Table 29, the projection of the proposed rebased and revised MEI for the CY 2011 PFS proposed rule is an increase of 0.3 percent, identical to the projected increase using the 2000-based MEI. In the CY 2011 PFS final rule, we will incorporate historical data through the second quarter of 2010; therefore, the current estimated increase of 0.3 percent for 2011 may differ in the final rule.

TABLE 29—FORECASTED ANNUAL PERCENT CHANGE IN THE CURRENT AND PROPOSED REVISED AND REBASED MEI FOR CY 2011

	Proposed 2006-based MEI	2000-based MEI
CY 2011	0.3	0.3

TABLE 30—FORECASTED ANNUAL PERCENT CHANGE IN THE PROPOSED REVISED AND REBASED MEI CY 2011, ALL CATEGORIES [1]

Cost categories	2006 Weight [2] (%)	Projected CY 2011 percent changes
MEI Total, productivity adjusted	100.000	0.3
Productivity: 10-year moving average of MFP	N/A	1.3
MEI Total, without productivity adjustment	100.000	1.6
Physician Compensation (Own Time) [3]	48.266	2.4
Wages and Salaries	43.880	2.5
Benefits	4.386	1.5
Practice Expenses	51.734	0.9
Nonphysician Compensation	19.153	1.5
Nonphysician Wages	13.752	1.5
P&T	6.006	1.2
Management	1.446	1.0
Clerical	4.466	1.8
Services	1.834	2.0
Nonphysician Benefits	5.401	1.4
Other Practice Expenses	26.308	0.4
Office Expenses	20.035	0.8
Utilities	1.139	−3.0
Chemicals	0.679	−1.1
Paper	0.616	−1.0
Rubber & Plastics	0.563	−0.7
Telephone	1.415	1.1
Postage	0.661	5.5
All Other Services	4.718	2.0

TABLE 30—FORECASTED ANNUAL PERCENT CHANGE IN THE PROPOSED REVISED AND REBASED MEI CY 2011, ALL CATEGORIES [1]—Continued

Cost categories	2006 Weight [2] (%)	Projected CY 2011 percent changes
Fixed Capital	8.410	0.9
Moveable Capital	1.834	−0.1
PLI [4]	4.295	−2.2
Medical Equipment	1.978	0.8
Medical supplies	1.760	0.5
All Other Expenses	4.513	1.4

[1] The forecasts are based upon the latest available Bureau of Labor Statistics data as of December 2009.
[2] The weights shown for the MEI components are the 2006 base-year weights, which may not sum to subtotals or totals because of rounding. The MEI is a fixed-weight, Laspeyres-type input price index whose category weights indicate the distribution of expenditures among the inputs to physicians' services for CY 2006. To determine the MEI level for a given year, the price proxy level for each component is multiplied by its 2006 weight. The sum of these products (weights multiplied by the price index levels) overall cost categories yields the composite MEI level for a given year. The annual percent change in the MEI levels is an estimate of price change over time for a fixed market basket of inputs to physicians' services.
[3] The measures of productivity, average hourly earnings, Employment Cost Indexes, as well as the various Producer and Consumer Price Indexes can be found on the Bureau of Labor Statistics Web site at *http://stats.bls.gov*.
[4] Derived from a CMS survey of several major commercial insurers N/A Productivity is factored into the MEI categories as an adjustment to the price variables; therefore, no explicit weight exists for productivity in the MEI.

In addition to the proposed revisions to the MEI mentioned earlier in this section, we are also proposing to convene a technical advisory panel later this year to review all aspects of the MEI, including the inputs, input weights, price-measurement proxies, and productivity adjustment. We will ask the panel to assess the relevance and accuracy of these inputs to current physician practices. The panel's analysis and recommendations will be considered in future rule making to ensure that the MEI accurately and appropriately meets its intended statutory purpose. We are requesting comments from the physician community and other interested members of the public on any other specific issues that should be considered by the technical panel.

f. Adjustments to the RVU Shares To Match the Proposed Rebased MEI Weights

As described in the previous section, we are proposing to rebase the MEI for CY 2011 based on the most current data and establish new weights for physician work, PE, and malpractice under the MEI. As stated in the previous section, the MEI was rebased to a CY 1996 base year beginning with the CY 1999 MEI (63 FR 58845), and to a CY 2000 base year beginning with the CY 2004 MEI (68 FR 63239). For both the CY 1999 and CY 2004 rebasing, we made adjustments to ensure that our estimates of aggregate PFS payments for work, PE, and malpractice were in proportion to the weights for these categories in the rebased MEI (63 FR 58829 and 69 FR 1095).

Consistent with our past practice when the MEI has been rebased, we are proposing to make adjustments to ensure that estimates of aggregate CY 2011 PFS payments for work, PE, and malpractice are in proportion to the weights for these categories in the rebased CY 2011 MEI.

Our proposal would necessitate increasing the proportion of aggregate CY 2011 PFS payments for PE and malpractice and decreasing the proportion for work. This could be accomplished by applying adjustments directly to the work, PE, and malpractice RVUs. However, we are cognizant of the public comments made during prior rulemaking on issues related to scaling the work RVUs. Many commenters have indicated a preference for the work RVUs to remain stable over time and for any necessary adjustments that would otherwise be made broadly to the work RVUs to be accomplished in an alternative manner. For example, in past 5-Year Reviews of the work RVUs, many commenters have cited stability in the work RVUs, among other reasons, in their requests that any required budget neutrality adjustments not be made directly to the work RVUs. Given these prior comments, we are proposing to make the necessary MEI rebasing adjustments without adjusting the work RVUs. Instead, we are proposing to increase the PE RVUs by an adjustment factor of 1.168 and the malpractice RVUs by an adjustment factor of 1.413. The RVUs in Addendum B to this proposed rule reflect the application of these adjustment factors. We note that an application of the 1.413 adjustment factor to the malpractice RVUs for services with malpractice RVUs of 0.01 will, due to rounding, result in malpractice RVUs of 0.01.

Section 1848(c)(2)(B)(ii)(II) of the Act requires that changes to RVUs cannot cause the amount of expenditures for a year to differ by more than $20 million from what expenditures would have been in the absence of the changes. Therefore, as required by section 1848(c)(2)(B)(ii) of the Act, we are proposing to make an adjustment of 0.921 to the CY 2011 conversion factor to ensure that the 1.168 adjustment to the PE RVUs and the 1.413 adjustment to the malpractice RVUs do not cause an increase in CY 2011 PFS expenditures. The current law estimate of the CY 2011 CF is $26.6574.

III. Code-Specific Issues for the PFS

A. Therapy Services

1. Outpatient Therapy Caps for CY 2011

Section 1833(g) of the Act applies an annual, per beneficiary combined cap on expenses incurred for outpatient physical therapy and speech-language pathology services under Medicare Part B. A similar separate cap for outpatient occupational therapy services under Medicare Part B also applies. The caps do not apply to expenses incurred for therapy services furnished in an outpatient hospital setting. The caps were in effect during 1999, from September 1, 2003 through December 7, 2003, and beginning January 1, 2006. The caps are a permanent provision, that is, there is no end date specified in the statute for therapy caps. Beginning January 1, 2006, the Deficit Reduction Act (Pub. L. 109–171) (DRA) provided for exceptions to the therapy caps until December 31, 2006. The exceptions

process for therapy caps has been extended through December 31, 2009 pursuant to three subsequent amendments (in MEIA–TRHCA, MMSEA, and MIPPA).

Section 1833(g)(5) of the Act (as amended by section 3103 of the ACA) extended the exceptions process for therapy caps through December 31, 2010. We will announce the amount of the therapy cap for CY 2011 in the CY 2011 PFS final rule with comment period. The annual change in the therapy cap is computed by multiplying the cap amount for CY 2010, which is $1,860, by the MEI for CY 2011, and rounding to the nearest $10. This amount is added to the CY 2010 cap to obtain the CY 2011 cap. The agency's authority to provide for exceptions to therapy caps (independent of the outpatient hospital exception) will expire on December 31, 2010, unless the Congress acts to extend it. If the current exceptions process expires, the caps will be applicable in accordance with the statute, except for services furnished and billed by outpatient hospitals.

2. Alternatives to Therapy Caps

a. Background

In section 4541 of the Balanced Budget Act of 1997 (Pub. L. 105–33) (BBA), the Congress enacted the financial limitations on outpatient therapy services (the "therapy caps" discussed above for physical therapy, occupational therapy, and speech-language pathology). At the same time, the Congress requested that the Secretary submit a Report to Congress that included recommendations on the establishment of a revised coverage policy for outpatient physical therapy services and outpatient occupational therapy services under the statute. The Balanced Budget Refinement Act of 1999 (Pub. L. 106–113) (BBRA) placed the first of a series of moratoria on implementation of the limits. In addition, it required focused medical review of claims and revised the report requirements in section 4541(d)(2) of the BBA to request a report that included recommendations on the following: (A) The establishment of a mechanism for assuring appropriate utilization of outpatient physical therapy services, outpatient occupational therapy services, and speech-language pathology services; and (B) the establishment of an alternative payment policy for such services based on classification of individuals by diagnostic category, functional status, prior use of services (in both inpatient and outpatient settings), and such other criteria as the Secretary determines appropriate, in place of the limits.

In 1999, therapy services were not defined, but services documented as therapy were billed and reported when furnished by a variety of individuals in many different settings. These services were not identified in a way that would allow analysis of utilization or development of alternative payment policies.

We have studied therapy services with the assistance of a number of contractors over the past 11 years. Reports of these projects are available on the CMS Web site at *http://www.cms.gov/TherapyServices/*. On November 9, 2004, we delivered the Report to Congress, Number 137953, "Medicare Financial Limitations on Outpatient Therapy Services" that referenced two utilization analyses. We periodically updated the utilization analyses and posted other contracted reports in order to further respond to the requirements of the BBRA. Subsequent reports highlighted the expected effects of limiting services in various ways and presented plans to collect data about patient condition using available tools. The general belief was that if patient condition could be reliably determined, an objective payment policy could be developed that would ensure appropriate payment for appropriately utilized services.

Over the past decade, significant progress has been made in identifying the outpatient therapy services that are billed to Medicare, the demographics of the beneficiaries who utilize those services, the types of services, the HCPCS codes used to bill the services, the allowed and paid amounts of the services, and the settings, geographic locations, and provider types where services are furnished.

Some of the information that is necessary to ensure appropriate utilization and develop objective and equitable payment alternatives to therapy caps based on patient condition has proven difficult to develop. The influence of prior use of inpatient services on outpatient use of therapy services was not accessible due to systems issues and differences in the policies, billing, and reporting practices for inpatient and outpatient therapy services. The weakness of the ICD–9–CM diagnostic codes in describing the condition of the rehabilitation patient obscured analyses of claims to assess the need for therapy services. The primary diagnosis on the claim is a poor predictor for the type and duration of therapy services required, which complicates assignment of patient cohorts for analysis. Although changes to the guidance in the Medicare Benefit Policy Manual (Pub. 100–02) on documentation of therapy services in 2005 improved the consistency of records and facilitated chart review, it became increasingly obvious that neither claims analysis nor chart review could serve as a reliable and valid method to determine a patient's need for services or to form the basis for equitable payment. We concluded that in order to develop alternative payment approaches to the therapy caps, we needed a method to identify patients with similar risk-adjusted conditions (cohorts) and then we would identify the therapy services that are necessary for the patients to attain the best outcomes with the most efficient use of resources.

While we studied therapy utilization, a number of proprietary tools were developed by researchers in the professional community to assess the outcomes of therapy. Some tool sponsors collected sufficient information to predict with good reliability the amount or length of treatment that would result in the best expected outcomes. We encouraged the use of these proprietary tools in manual instructions, but proprietary tools do not serve CMS' purposes because modification of proprietary tools may only be done by the tool sponsor. There now are some versions of the tools in the public domain and they are being utilized widely to identify patient conditions and, by some insurers, to pay for efficient and effective treatment. Examples of such tools including the National Outcomes Measurement System (NOMS) by the American Speech-Language Hearing Association and Patient Inquiry by Focus On Therapeutic Outcomes, Inc. (FOTO).

In 2006, Focus on Therapeutic Outcomes, Inc. delivered to CMS a report titled, "Pay for Performance for Physical Therapy and Occupational Therapy," which is also available on the CMS Web site at *http://www.cms.gov/TherapyServices*. The purpose of this project was to simulate a pay-for-performance implementation, designed to align financial incentives with the achievement of better clinical outcomes from services that were delivered efficiently. The project, funded by HHS/CMS Grant #18–P–93066/9–01, demonstrated the predictive validity of the risk-adjusted pay-for-performance model and the feasibility of reducing payments without affecting services to beneficiaries who need them.

b. Current Activities

The Tax Relief and Health Care Act of 2006 (TRHCA) extended the therapy cap

exceptions process through December 31, 2007 and provided funds used for two CMS projects related to developing alternative payment approaches for therapy services that are based on beneficiary needs. A 5-year project titled "Development of Outpatient Therapy Alternatives" (DOTPA), awarded to RTI International, was initiated in order to develop a comprehensive and uniform therapy-related data collection instrument, assess its feasibility, and determine the subset of the measures that we could routinely and reliably collect in support of payment alternatives. While DOTPA will identify measurement items relevant to payment, the project will not deliver a standardized measurement tool. We may either develop a tool or allow other tools to be used for payment purposes when they include those items that identify the following: (a) Beneficiary need; and (b) outcomes (that is effectiveness of therapy services). In addition to therapy caps, the DOTPA project addresses our interest in value-based purchasing by identifying components of value, including beneficiary need and the effectiveness of therapy services.

The DOTPA project reports are available on the contractor's Web site at *http://optherapy.rti.org/*. The data collection design and instrument development have been completed, and a Paperwork Reduction Act (PRA) package was submitted for approval of the data collection forms by the Office of Management and Budget (OMB). The **Federal Register** notice for the second round of public comment on this package was published on April 23, 2010 (75 FR 21296). Once the PRA package is approved, the contractor will begin data collection. While approval is pending, the contractor is recruiting potential participants in the data collection, developing training materials for participants, and updating the project web site. We are not seeking public comments on the DOTPA project in this proposed rule.

The TRCHA also funded the 2-year project contracted to Computer Sciences Corporation (CSC) titled "Short Term Alternatives for Therapy Services" (STATS). STATS will provide recommendations regarding alternative payment approaches to therapy caps that could be considered before completion of the DOTPA project. The STATS project draws upon the analytical and clinical expertise of contractors and stakeholders to consider policies, measurement tools, and claims data that are currently available to provide further information about patient condition and the outcomes of therapy services. The final report, due in the fall of CY 2010, will include recommended actions we could take within 2 or 3 calendar years to replace the current cap limits on therapy services with a policy that pays appropriately for necessary therapy services.

c. Potential Short-Term Approaches to Therapy Caps

On June 30, 2009, we received a draft of the CSC report titled "STATS Outpatient Therapy Practice Guidelines," a summary of expert workgroup discussions, and several short-term payment alternatives for consideration. CSC discussed options based on the assumption that short-term policy changes should facilitate the development of adequate function and/or outcomes reporting tools. In the long-term, CSC recommended that payment be based on function or quality measurements that adequately perform risk adjustment for episode-based payment purposes.

Based on the draft report, additional stakeholder input, and subsequent communications with the contractor, in this proposed rule we are discussing several potential alternatives to the therapy caps that could lead to more appropriate payment for medically necessary and effective therapy services that are furnished efficiently. We are soliciting public comments on this proposed rule regarding all aspects of these alternatives, including the potential associated benefits or problems, clinical concerns, practitioner administrative burden, consistency with other Medicare and private payer payment policies, and claims processing considerations. We are not proposing either short-term or long-term payment alternatives to the therapy caps at this time. However, we refer readers to section II.C.4.(c) of this proposed rule for our CY 2011 proposal to expand the MPPR policy to "always therapy" services furnished in a single session in order to pay more appropriately for therapy services, taking into consideration the expected efficiencies when services are furnished together. While we are not proposing the adoption of an MPPR policy for therapy services specifically as an alternative to the therapy caps, we acknowledge that by paying more appropriately for combinations of therapy services that are commonly furnished in a single session, practitioners would be able to furnish more medically necessary therapy services to a given beneficiary before surpassing the caps. This proposed policy would have the potential to reduce the number of beneficiaries impacted by the therapy caps in a given year.

The three specific short-term options that we are discussing in this proposed rule would not require statutory changes. Some would require moderate reporting changes that would yield more detailed information about patient function and progress to inform future payment approaches and facilitate the medical review of services above the therapy caps at the present time. Others require new coding and bundled per-session payment that would be a first step toward episode-based payment. They are not necessarily independent of each other. Under each of these alternatives, administrative simplification with respect to current policies, such as HCPCS code edits and "ICD–9–CM to HCPCS code" crosswalk edits that serve to limit utilization without regard to the patient's clinical presentation, could be pursued in the context of these options.

The first option would modify the current therapy caps exceptions process to capture additional clinical information regarding therapy patient severity and complexity in order to facilitate medical review. This approach would complement the DOTPA project, which is identifying items to measure patient condition and outcomes. We believe the first option may have the greatest potential for rapid implementation that could yield useful information in the short-term. We are especially interested in detailed public comments on this option that could inform a potential proposal to adopt such an alternative through future rulemaking. The second option would involve introducing additional claims edits regarding medical necessity, in order to reduce overutilization. The third option would be to adopt a per-session bundled payment that would vary based on patient characteristics and the complexity of evaluation and treatment services furnished in the session. Each option would require significant provider and contractor education, and all would necessitate major claims processing systems changes. Moreover, some of the options may affect beneficiaries by changing the type or amount of services covered by Medicare or the beneficiary's cost sharing obligations.

Option (1): Revise therapy caps exceptions process by requiring the reporting of new patient function-related Level II HCPCS codes and severity modifiers.

This option would require that clinicians submit beneficiary function-related nonpayable HCPCS codes to replace the –KX modifier (Specific

required documentation on file). Codes would not be submitted on every claim, but at episode onset and at periodic intervals (for example, progress report intervals of 12 sessions or 30 days—whichever is less). Codes would be submitted for all patients in order for the claims to be paid and not only those claims approaching or surpassing the therapy caps. The current –KX modifier is not useful to identify claims exceeding therapy caps, because it is used for services both before and after the caps are exceeded, and it must be used on the entire claim for facilities. New codes also would not identify claims above the cap, but they would perform the same function as the current –KX modifier to signal that documentation in the medical record supported medical necessity that should lead to an exception to the therapy caps. The codes would also provide more information for medical review.

Six Level II HCPCS G-codes representing functions addressed in the plan of care and 5 (or 7) modifiers representing severity/complexity would be utilized to report information on the claim.

Examples of six new function-related G-codes:

- GXXXU—Impairments to body functions and/or structures—current.
- GXXXV—Impairments to body functions and/or structures—goal.
- GXXXW—Activity limitations and/or participation restrictions—current.
- GXXXX—Activity limitations and/or participation restrictions—goal.
- GXXXY—Environmental barriers—current.
- GXXXZ—Environmental barriers—goal.

Two potential severity/complexity scales have been suggested that would require the adoption of 5 or 7 new severity modifiers, respectively. Under one scenario, modifiers based on the International Classification of Function could identify severity as follows:

- None (0 to 4 percent);
- MILD (5 to 24 percent);
- MODERATE (25 to 49 percent);
- SEVERE (50 to 95 percent); or
- COMPLETE (96 to 100 percent).

Alternatively, a proportional severity/complexity scale would use 7 modifiers to describe impairments, limitations, or barriers:

- 0 percent;
- 1 to 19 percent;
- 20 to 39 percent;
- 40 to 59 percent;
- 50 to 79 percent;
- 80 to 99 percent; or
- 100 percent.

Implementation of this general approach would require 6 months to 2 years to modify claims processing for the current therapy caps and exceptions processing of claims, and to develop, pilot test, and refine coding before applying the approach nationally. While therapists initially would need to learn the new codes and update their billing systems, ultimately their reporting burden would be reduced because the –KX modifier would not be required on each claim line for patients with expenditures approaching or exceeding the therapy caps. This option could potentially result in a small reduction in outpatient therapy expenditures due to increased Medicare contractor scrutiny of episodes where functional severity scores did not change over time, or to other atypical reporting patterns associated with the new codes.

In the long-term, these codes and modifiers could be mapped to reliable and validated measurement tools (either currently available tools in the public domain or newly developed tools from items on the DOTPA instrument or the Continuity Assessment Record and Evaluation (CARE) tool). When statistically robust patient condition information has been collected from claims data, it may be possible to develop Medicare payment approaches for outpatient therapy services that would pay appropriately and similarly for efficient and effective services furnished to beneficiaries with similar conditions who have good potential to benefit from the services furnished. At a minimum, the new codes would allow contractors to more easily identify and limit the claims for beneficiaries that show no improvement over reasonable periods of time.

Option (2): Enhance existing therapy caps exceptions process by applying medical necessity edits when per-beneficiary expenditures reach a predetermined value.

The existing automatic process for exceptions, and the revised exceptions process described in Option 1 above, pay practitioners indefinitely for services if they attest on the claim by appending a specific modifier to therapy HCPCS codes that the services being furnished are medically necessary and that supporting documentation is included in the medical record. Unless the contractor uses claims edits or does post payment review, these processes do not identify or limit unusually high annual per-beneficiary utilization. High utilization is not limited to beneficiaries with multiple or complex conditions. We could use existing therapy utilization data to develop annual per-beneficiary medical necessity payment edits, such as limits to the number of services per session, per episode, or per diagnostic grouping, for exceptions to the therapy caps which could be set at benchmark payment levels that only a small percentage of beneficiaries would surpass in a single year. Once these levels were reached, additional claims would be denied and practitioners would need to appeal those denials if they wished to challenge Medicare's nonpayment.

This alternative would require 1 to 2 years to implement as an expansion of existing policy, and its effects could be anticipated by analysis of the current utilization of therapy services. Additional practitioner burden would be incurred in the small number of cases exceeding the per-beneficiary expenditure edits when the practitioner chooses to appeal the medical necessity denial.

Option (3): Introduce per-session "Evaluation/Assessment and Intervention" (E&I) codes to bundle payment for groups of current therapy HCPCS codes into a single per-session payment.

As discussed in section II.C.4.(c) of this proposed rule, multiple therapy services are often furnished in a single session, and we are proposing to expand the MPPR policy to "always therapy" services in CY 2011 in order to take into consideration the efficiencies that occur when multiple services (the typical therapy scenario) are furnished in one session to a beneficiary. Furthermore, we note that section 1848(c)(2)(K) of the Act (as added by section 3134 of the ACA) regarding potentially misvalued codes under the PFS specifies that the Secretary may make appropriate coding changes, which may include consolidation of individual services into bundled codes for payment under the PFS, as part of her review and adjustment of the relative values for services identified as potentially misvalued.

This option would require that practitioners submit a single new Level II HCPCS code to represent all the therapy services currently reported and paid separately for an outpatient therapy session. Payment for the HCPCS code would be based on patient characteristics (as identified through prior CMS contractor analyses) and the complexity of the evaluation/assessment and intervention services furnished during the session. The new coding requirements would not disrupt the current exceptions process or the revised exceptions process described in Option (1) above. Approximately 12 E&I codes would be needed, taking into consideration the basic algorithm shown in Table 31.

TABLE 31—EVALUATION/ASSESSMENT & INTERVENTION LEVEL II HCPCS CODES

	Evaluation/Assessment complexity		
	Minimal	Moderate	Significant
Intervention Level:			
None	E&I Code #1	E&I Code #2	E&I Code #3.
Minimal	E&I Code #4	E&I Code #5	E&I Code #6.
Moderate	E&I Code #7	E&I Code #8	E&I Code #9.
Significant	E&I Code #10	E&I Code #11	E&I Code #12.

We would need to develop and test operational definitions for each E&I code so that practitioners would be able to properly report services and appropriate relative values could be established for each per-session code. We believe that a pilot study might reveal that the different practice patterns for the three therapy professions (physical therapy, occupational therapy, and speech-language pathology) could necessitate separate relative value determinations for each E&I code by type of therapy service furnished. As a result, up to 36 total new Level II HCPCS codes could be needed (12 per discipline).

We anticipate that the definitions of E&I codes 1 through 3 and 7 through 12 would describe services that may only be furnished by a "clinician" (therapist, physician, or nonphysician practitioner). E&I codes 1 through 3 would be reported for sessions that consisted only of evaluations. In addition, the definitions of E&I codes 4 through 6 would describe services that could be furnished by or under the permissible supervision of all qualified outpatient therapy professionals. Based upon historical therapy utilization patterns, the vast majority of E&I codes submitted would likely fall in the 4 through 9 code range. We would expect the RVUs under the PFS for all E&I codes to take into consideration the efficiencies when multiple services (those that would be currently reported under multiple CPT codes) are furnished.

This option would require 2 to 4 years to add new codes and conduct a short-term pilot study to refine coding and value the 12 new HCPCS codes (or 36 if they are specific to each therapy discipline). There would be significant initial practitioner administrative burden to learn new codes and update billing systems. However, ultimately, with elimination of the practitioner's reporting of 76 different codes and many of the associated claims processing edits, the administrative burden of reporting therapy services to Medicare would be minimized. This bundled approach to reporting and payment could result in more appropriate valuation of therapy services that reflects efficiencies when individually reported services are furnished in the same session. As a result, it could lead to reduced therapy expenditures, as well as a reduction in the number of beneficiaries affected by the therapy caps in a given year.

In conclusion, we emphasize that we continue to be committed to developing alternatives to the therapy caps that would provide appropriate payment for medically necessary and effective therapy services furnished to Medicare beneficiaries based on patient needs, rather than the current therapy caps which establish financial limitations on Medicare payment for therapy services in some settings regardless of medical necessity. The Congress has repeatedly intervened to allow exceptions to these caps for certain time periods, and the current exceptions are automatically processed based on a practitioner's attestation that medical necessity is documented in the chart for an individual patient. We believe that, ultimately, payment for therapy services should incentivize the most effective and efficient care, consistent with Medicare's focus on value in its purchasing.

Therefore, we are soliciting public comments on potential alternatives to the therapy caps, including those discussed in this section of this proposed rule. The STATS contractor has worked closely with a broad variety of clinicians, administrators, scientists, researchers, and other contractors to develop the 3 alternatives presented this discussion. We welcome all public comments on this propose rule from interested stakeholders, including individual therapists from both facility and nonfacility settings treating Part B (outpatient) beneficiaries. Among the topics of interest to us are the following:

- Recommendations for alternative payment policies (options discussed in this proposed rule or others) that address patient needs, while minimizing payment for inefficient services or those of limited patient benefit;
- Assessment of the practitioner burden associated with the recommended policies;
- Likelihood that recommended changes would minimize fraud, abuse, and waste;
- Whether the recommendations could assist CMS in obtaining meaningful information on patient function and how that information could be utilized;
- Whether measurement tools relevant to assessing the need for therapy services exist in the public domain and how they might be utilized;
- What function information should be collected and how it could be utilized to ensure necessary care, while minimizing payment for inefficient services or those of limited patient benefit; and
- How therapist behavior, plans of care, or patient scheduling would be affected by the recommended alternatives.

We are committed to finding alternatives to the current therapy cap limitations on expenditures for outpatient therapy services that will ensure that beneficiaries continue to receive those medically necessary therapy services that maximize their health outcomes. We continue to dedicate our resources to identifying alternatives that would encourage the most efficient and cost-effective treatments. We believe motivated therapists, with attention to the most cost-effective practices, can incorporate practice efficiencies that benefit patients by achieving the best possible results at the lowest cost.

Our STATS and DOTPA projects, which are currently engaged in data collection and analysis to inform short-term and long-term alternatives to the therapy caps, respectively, lay the foundation for future payment alternatives for outpatient therapy services. We are optimistic that the STATS project will identify short-term, feasible alternatives that may be tested in the future. The DOTPA project will create a tool and test its use to collect patient condition information that can then be applied to identify patient need

for therapy services. Together, these projects may provide the basis for a long-term plan to reshape Medicare's payment policy for outpatient therapy services to align with the value-based purchasing principles that are now guiding principles of the Medicare program. We encourage the public to provide comments so that we may consider all perspectives as we continue our work in this important area.

B. Diabetes Self-Management Training (DSMT) Services (HCPCS Codes G0108 and G0109)

1. Background

Section 4105(a) of BBA provided coverage for DSMT in outpatient settings without limiting this coverage to hospital outpatient departments. DSMT services consist of educational and training services furnished to an individual with diabetes by a certified provider in an outpatient setting.

Section 4105(a) of the BBA stipulated that training would be furnished by a "certified provider" which is a physician or other individual or entity that also provides other items or services for which payment may be made under Medicare. This program is intended to educate beneficiaries in the successful self-management of diabetes. The program includes instructions in self-monitoring of blood glucose; education about diet and exercise; an insulin treatment plan developed specifically for the patient who is insulin-dependent; and motivation for patients to use the skills for self-management. DSMT services are reported under HCPCS codes G0108 (Diabetes outpatient self-management training services, individual, per 30 minutes) and G0109 (Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes).

2. Proposed Payment for DSMT Services

In accordance with section 4105(a) of the BBA, Medicare payment for outpatient DSMT services is made under the PFS as specified in § 414.1 through § 414.48. When we created HCPCS codes G0108 and G0109, the only direct costs included in the PE were registered nurse labor. Section 410.144(a)(4)(a) states that the DSMT team includes at least a registered dietitian and a certified diabetes educator. We did not establish work RVUs for DSMT services because we believed training would typically be performed by individuals other than a physician, such as a registered nurse (65 FR 83130). However, since that time, we have received requests from a number of stakeholders, including the American Association of Clinical Endocrinologists (AACE), the American Association of Diabetes Educators (AADE), and the Juvenile Diabetes Research Foundation, to include physician work in valuing DSMT services that is similar to the physician work that has been included in medical nutrition therapy (MNT) services since CY 2007 and kidney disease education (KDE) services since CY 2010. The stakeholders argued that because physicians coordinate DSMT programs, provide patient instruction, and communicate with referring physicians, physician work should be included in the RVUs for DSMT services. The stakeholders also requested that we reconsider the direct PE inputs for DMST services and include clinical labor for diabetes educators at a higher hourly rate instead of registered nurse labor. In addition, they stated that the supplies and equipment in the PE for DSMT services should be the same as for KDE services, with additional direct PE inputs for a diabetic educator curriculum, data tracking software, and DSMT program accreditation.

For CY 2011, we are proposing to assign physician work RVUs to DSMT services that are comparable, as adjusted for the service times of the HCPCS codes, to the work RVUs for MNT services. We are proposing that HCPCS G0108 for 30 minutes of individual DSMT services would be crosswalked to CPT code 97803 (Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes) for purposes of assigning work RVUs, with the physician work RVUs for CPT code 97803 multiplied by two to account for the greater time associated with HCPCS code G0108 (that is, 30 minutes). We are also proposing that HCPCS G0109 for 30 minutes of group DSMT services would be crosswalked to CPT code 97804 (Medical nutrition therapy; group (2 or more individuals(s)), each 30 minutes) for purposes of assigning work RVUs. The rationale for the proposed work RVUs for the DSMT HCPCS G-codes is based on the similarity of DSMT services to MNT services in the individual (CPT code 97803) and group (CPT code 97804) setting.

For CY 2011, we are also proposing to modify the PE inputs for DSMT services to reflect the current equipment and supplies for the KDE HCPCS G-codes implemented in the CY 2010 PFS final rule with comment period (74 FR 61901) (that is, HCPCS codes G0420 (Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour) and G0421 (Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour)), based on the similarity in the equipment and supplies necessary for DSMT and KDE services. We have made adjustments to some of the equipment times for the 30 minute DSMT individual and group services as compared to the 1 hour individual and group KDE services. We are also including a diabetic educator curriculum and data tracking software in the PE inputs for DSMT services, but it is our general practice not to include program accreditation costs in those PE inputs. With respect to clinical labor, rather than changing the current labor type for DSMT services, we are proposing to utilize the same approach as we adopted for MNT services when we provided physician work RVUs for those services in CY 2007 (71 FR 69645). Specifically, we are removing all of the clinical labor from the group DSMT code and most of the clinical labor from the individual DSMT code, given that we are proposing work RVUs for both DSMT codes for CY 2011.

We believe these proposals would value DSMT services more consistently with other similar services that are paid under the PFS. As a result of our proposed CY 2011 changes, the proposed work RVUs for HCPCS codes G0108 and G0109 are 0.90 and 0.25, respectively. As described above, we are also proposing to modify the direct PE inputs for these codes for CY 2011.

C. End-Stage Renal Disease Related Services for Home Dialysis (CPT Codes 90963, 90964, 90965, and 90966)

1. End-Stage Renal Disease Home Dialysis Monthly Capitation Payment Services (CPT Codes 90963, 90964, 90965, and 90966)

In the CY 2004 PFS final rule with comment period (68 FR 63216), we established new Level II HCPCS G-codes for end-stage renal disease (ESRD) monthly capitation payment (MCP) services. For center-based patients, payment for the G-codes varied based on the age of the beneficiary and the number of face-to-face visits furnished each month (for example, 1 visit, 2–3 visits and 4 or more visits). Under the MCP methodology, the lowest payment applied when a physician provided one visit per month; a higher payment was provided for two to three visits per month. To receive the highest payment, a physician would have to provide at least four ESRD-related visits per month. However, payment for home dialysis MCP services only varied by the age of beneficiary. Although we did not initially specify a frequency of required

visits for home dialysis MCP services, we stated that we "expect physicians to provide clinically appropriate care to manage the home dialysis patient" (68 FR 63219).

Effective January 1, 2009, the CPT Editorial Panel created new CPT codes to replace the G-codes for monthly ESRD-related services, and we accepted the new codes for use under the PFS in CY 2009. The CPT codes for monthly ESRD-related services for home dialysis patients include the following, as displayed in Table 32: 90963, 90964, 90965, and 90966. In addition, the clinical vignettes used for the valuation of CPT codes 90963, 90964, 90965, and 90966 include scheduled (and unscheduled) examinations of the ESRD patient.

Given that we pay for a physician (or practitioner) to evaluate the ESRD patient over the course of an entire month under the MCP, we believe that it is clinically appropriate for the physician (or practitioner) to have at least one in-person, face-to-face encounter with the patient per month. Therefore, we are proposing to require the MCP physician (or practitioner) to furnish at least one in-person patient visit per month for home dialysis MCP services (as described by CPT codes 90963 through 90966). This requirement would be effective for home dialysis MCP services beginning January 1, 2011. We believe this requirement reflects appropriate, high quality medical care for ESRD patients being dialyzed at home and generally would be consistent with the current standards of medical practice.

2. Daily and Monthly ESRD–Related Services (CPT Codes 90951 through 90970)

In CY 2008, the AMA RUC submitted recommendations for valuing the new CY 2009 CPT codes displayed in Table 32 that replaced the MCP HCPCS G-codes for monthly ESRD-related services. We accepted these codes for use under the PFS.

TABLE 32—MCP CODES RECOGNIZED UNDER THE PFS

MCP code	Long descriptor
90951	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month.
90952	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2–3 face-to-face physician visits per month.
90953	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month.
90954	End-stage renal disease (ESRD) related services monthly, for patients 2–11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month.
90955	End-stage renal disease (ESRD) related services monthly, for patients 2–11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2–3 face-to-face physician visits per month.
90956	End-stage renal disease (ESRD) related services monthly, for patients 2–11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month.
90957	End-stage renal disease (ESRD) related services monthly, for patients 12–19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month.
90958	End-stage renal disease (ESRD) related services monthly, for patients 12–19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2–3 face-to-face physician visits per month.
90959	End-stage renal disease (ESRD) related services monthly, for patients 12–19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month.
90960	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face physician visits per month.
90961	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2–3 face-to-face physician visits per month.
90962	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face physician visit per month.
90963	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.
90964	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2–11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.
90965	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12–19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.
90966	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older.

There are four additional CPT codes for ESRD-related services that are reported on a per-day basis. These daily CPT codes are: 90967 (End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age); 90968 (End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 2–11 years of age); 90969 (End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12–19 years of age); and 90970 (End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older).

For the MCP codes displayed in Table 32, the AMA RUC initially

recommended 36 minutes of clinical labor time for the pre-service period. They also recommended an additional 6 minutes in the post-period for CPT codes 90960, 90961, 90962, and 90966. For the four codes describing daily services (CPT codes 90967 through 90970), the AMA RUC recommended including 1.2 minutes of clinical labor per day, which is the prorated amount of pre-service clinical labor included in the monthly codes. The AMA RUC also recommended that CPT codes 90952 and 90953 be contractor-priced.

In the CY 2009 PFS final rule with comment period (73 FR 69898), we asked the AMA RUC to reconsider their recommended PE inputs in the interest of making certain that they accurately reflected the typical direct PE resources required for these services. In addition, we asked the AMA RUC to review the physician times for CPT codes 90960 and 90961 that are used in the calculation of the PE RVUs. We accepted the work values for the new CPT codes for ESRD-related services that were recommended by the AMA RUC.

Since CY 2009, we have continued to calculate the PE RVUs for the entire series of MCP codes displayed in Table 32 by using the direct PE inputs from the predecessor HCPCS G-codes, except for CPT codes 90952 and 90953 which are contractor-priced. We have also continued to use the physician time associated with the predecessor HCPCS G-codes for CPT codes 90960 and 90961 for purposes of calculating the PE RVUs.

In CY 2009, the AMA RUC submitted new recommendations for CPT codes 90951 and 90954 through 90970. For each of the MCP codes (CPT code 90951 and CPT codes 90954 through 90966), the AMA RUC recommended an increased pre-service clinical staff time of 60 minutes. For each of the daily dialysis service codes (CPT codes 90967 through 90970), the AMA RUC recommended an increased clinical labor time of two minutes, which is the prorated amount of clinical labor included in the monthly codes. The AMA RUC also recommended an additional 38 minutes of physician time for CPT codes 90960 and 90961. This resulted in a total physician time of 128 minutes and 113 minutes, respectively, for these codes. The AMA RUC continued to recommend that CPT codes 90952 and 90953 be contractor-priced.

For CY 2011, we are proposing to accept these AMA RUC recommendations as more accurate reflections of the typical direct PE resources required for these services. Therefore, we are proposing to develop the PE RVUs for CPT code 90951 and CPT codes 90954 through 90970 using the direct PE inputs as recommended by the AMA RUC and reflected in the proposed CY 2011 PE database, which is available on the CMS Web site under the supporting data files for the CY 2011 PFS proposed rule at: *http://www.cms.gov/PhysicianFeeSched/.* We are also proposing to use the AMA RUC-recommended physician times for CPT codes 90960 and 90961. Consistent with the AMA RUC's recommendations, we are proposing to continue to contractor-price CPT codes 90952 and 90953.

D. Portable X-Ray Set-Up (HCPCS Code Q0092)

When a portable x-ray is furnished to a single patient, as many as four component HCPCS codes may be billed and paid for the service, including the portable x-ray transportation (HCPCS code R0070 (Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen)); the portable x-ray set-up (HCPCS code Q0092 (Set-up of portable x-ray equipment)); and the professional and technical components of the x-ray service itself (CPT 70000 series). Currently, the direct PE database contains x-ray equipment in both the radiology codes in the 70000 series of CPT and HCPCS code Q0092, the code for the set-up of a portable x-ray. In the technical component of the x-ray service is the direct PE input of a radiology room which contains x-ray equipment for the various radiology codes in the 70000 series of CPT. In addition, portable x-ray equipment is included as a direct PE input for HCPCS code Q0092. Thus, x-ray equipment currently is recognized within the direct PE values for two of the HCPCS codes that would be reported for the portable x-ray service, resulting in an overvaluation of the comprehensive portable x-ray service.

Therefore, for CY 2011 we are proposing to remove portable x-ray equipment as a direct PE input for HCPCS code Q0092, in order to pay more appropriately for the x-ray equipment used to furnish a portable x-ray service. We believe the resulting payment for the comprehensive portable x-ray service would more appropriately reflect the resources used to furnish portable x-ray services by providing payment for the x-ray equipment solely through payment for the technical component of the x-ray service that is furnished.

E. Pulmonary Rehabilitation Services (HCPCS Code G0424)

In the CY 2010 PFS proposed rule (74 FR 33614), we proposed to create new HCPCS G-code G0424 (Pulmonary rehabilitation, including aerobic exercise (includes monitoring), per session, per day) to describe the services of a pulmonary rehabilitation (PR) program as specified in section 144(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Using CPT code 93797 (Cardiac rehab without telemetry) as a reference code, we proposed to assign 0.18 work RVUs and 0.01 malpractice RVUs to G0424. To establish PE RVUs, we reviewed the PE inputs of similar services, particularly those of the respiratory therapy HCPCS codes G0237 (Therapeutic procedures to increase strength or endurance or respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring)) and G0238 (Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes (includes monitoring)), as well as the cardiac rehabilitation codes, CPT codes 93797 and 93798 (Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)). In the CY 2010 PFS final rule with comment period (74 FR 61886), we finalized our proposal with modifications to the code descriptor and PE inputs, as recommended by some commenters.

Based on commenters' recommendations from the CY 2010 PFS final rule with comment period and further information furnished by stakeholders, we are proposing to increase the work RVUs for HCPCS code G0424 to 0.28 for CY 2011 to be comparable to the work RVUs for cardiac rehabilitation with monitoring (CPT code 93798) in view of the monitoring required for HCPCS code G0424.

In addition, we are also proposing to increase the clinical labor time for the respiratory therapist from 15 minutes to 30 minutes and to crosswalk the PE equipment inputs for HCPCS code G0424 to those for respiratory treatment services (HCPCS code G0238), which include a 1-channel ECG and a pulse oximeter. We would retain the treadmill currently assigned to HCPCS code G0424 and adjust the equipment time to 45 minutes. While several public commenters recommended this equipment, these commenters also requested a full 60 minutes of respiratory therapist time be included in the PE for HCPCS code G0424, comparable to the 15 minutes of

respiratory therapist time included in the one-on-one codes for 15 minutes of respiratory treatment services (HCPCS codes G0237 and G0238). However, because PR services reported under HCPCS code G0424 can be furnished either individually or in groups, we believe that 30 minutes of respiratory therapist time would be more appropriate for valuing the typical PR service.

F. Application of Tissue-Cultured Skin Substitutes to Lower Extremities (HCPCS Codes GXXX1 and GXXX2)

There are currently two biological products, Apligraf and Dermagraft, which are FDA-approved for the treatment of diabetic foot ulcers. While commonly used by podiatrists for this purpose, these products are also used by other specialists in the treatment of other clinical conditions, such as burns.

Many Medicare contractors have established local coverage determinations specifying the circumstances under which these services are covered. In the case of diabetic foot ulcers, clinical studies of Apligraf weekly application were based on up to 5 treatments over a 12-week period. In contrast, Dermagraft was applied weekly, up to 8 treatments over a 12-week period.

The skin substitute CPT codes were reviewed and new codes were last created by the CPT Editorial Panel for CY 2006. There are currently 2 skin repair CPT codes that describe Apligraf application, one primary code, CPT code 15340 (Tissue cultured allogeneic skin substitute; first 25 sq cm or less) and one add-on code, CPT code 15341 (Tissue cultured allogeneic skin substitute; each additional 25 sq cm, or part thereof (List separately in addition to code for primary procedure)) and 4 codes that describe Dermagraft application, two initial codes based on body area, CPT codes 15360 (Tissue cultured allogeneic dermal substitute, trunk, arms, legs; first 100 sq cm or less, or 1 percent of body area of infants and children) and 15365 (Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1 percent of body area of infants and children) and two add-on codes, CPT codes 15361 (Tissue cultured allogeneic dermal substitute, trunk, arms, legs; each additional 100 sq cm, or each additional 1 percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)) and 15366 (Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1 percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)).

Several stakeholders have expressed concern about the appropriateness and equity of the coding and payment for these services, given their similar uses and the office resources required when the products are applied repeatedly over a number of weeks for treatment of lower extremity ulcers. They are concerned that current coding, with the associated payment policies and relative values, does not provide for appropriate payment for the services based on how they are furnished. In addition, some stakeholders believe that the current coding and payment provides a financial incentive for the selection of one tissue-cultured product over another, rather than facilitating clinical decisionmaking based solely on the most clinically appropriate product for the patient's case. For example, the Dermagraft and Apligraf application codes have 90-day and 10-day global periods, respectively, and their current values include several follow-up office visits. When patients are treated periodically with repeated applications of the products over several weeks, the patients may be seen in follow-up by the physician. However, those encounters would not be evaluation and management visits but, instead, would be procedural encounters that would typically be valued differently under the PFS than the follow-up office visits currently included in the values for the Dermagraft and Apligraf application codes. Furthermore, while different stakeholders have indicated that debridement and site preparation are variably performed when these products are applied, the CPT codes for Dermagraft application allow separate reporting of these preparation services when they are performed, while the Apligraf application codes bundle these services. Since CY 2006, the PFS has accepted the RUC work and PE recommendations for the Dermagraft and Apligraf application codes and has paid accordingly.

With respect to Medicare payment policy, some Medicare contractors allow the use of modifier -58 (Staged or related procedure or service by the same physician during the postoperative period) to be reported with the skin substitute application codes and provide full payment for the service each time it is performed, even if the subsequent application(s) is within the global period of the service. Other contractors do not allow the use of modifier -58, and therefore, provide a single payment for a series of applications over 90 days or 10 days, as applicable to the particular code reported for the product's initial application.

Because of the current inconsistencies in valuing similar skin substitute application services and the common clinical scenarios for their use for Medicare beneficiaries, we believe that it would be appropriate to temporarily create Level II HCPCS G-codes to report application of tissue-cultured skin substitutes applied to the lower extremities in order to provide appropriate and consistent payment for the services as they are commonly furnished. Therefore, we are proposing to create two new HCPCS G-codes for CY 2011, GXXX1 (Application of tissue cultured allogeneic skin substitute or dermal substitute; for use on lower limb, includes the site preparation and debridement if performed; first 25 sq cm or less) and GXXX2 (Application of tissue cultured allogeneic skin or dermal substitute; for use on lower limb, includes the site preparation and debridement if performed; each additional 25 sq cm), that would be recognized for payment under the PFS for the application of Apligraf or Dermagraft to the lower limb. These codes would not allow separate reporting of CPT codes for site preparation or debridement. We emphasize that we would expect that the use of these HCPCS G-codes for payment under Medicare would be temporary, while stakeholders work through the usual channels to establish appropriate coding for these services that reflects the current common clinical scenarios in which the skin substitutes are applied. Furthermore, we would expect to receive recommendations from the AMA RUC for appropriate work values and direct practice expense inputs for the applicable codes, according to the usual process for new or revised codes.

Under the PFS, as a temporary measure, the HCPCS G-codes would be assigned a 0-day global period so payment would be made each a time a covered service was furnished. We are proposing to base payment on the physician work relative values and the direct PE inputs for the existing CPT codes for Apligraf application, with adjustments for the global period differences because the HCPCS G-codes and the Apligraf application CPT codes. These CPT codes resemble the new HCPCS G-codes in terms of wound size description and the inclusion of site preparation and debridement in their current values so we believe they

appropriately represent the physician work involved in the proposed HPCPCS G-codes. However, we would adjust the work RVUs of the Apligraf application codes to derive the HCPCS G-code proposed CY 2011 work values by extracting the values for any office visits and discharge day management services because the HCPCS G-codes have a 0-day global period. In addition, we would adjust the direct PE inputs of the Apligraf application codes to develop the proposed CY 2011 direct PE inputs of the HPCPS G-codes that have a 0-day global period.

Our crosswalks and adjustments result in proposed CY 2011 work RVUs of 2.22 for HPCPCS code GXXX1 and 0.50 for HCPCPS GXXX2. The proposed direct PE inputs for HCPCS codes GXXX1 and GXXX2 are included in the direct PE database for the CY 2011 proposed rule that is posted on the CMS Web site at *http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp.*

We note that many Medicare contractors currently have local coverage policies that specify the circumstances under which Medicare covers the application of skin substitutes. The local coverage policies may include diagnostic or prior treatment requirements, as well as frequency limitations on the number and periodicity of treatments. We expect that these policies would be updated in the context of the temporary new HCPCS G-codes that we are proposing for use in CY 2011 to report the application of tissue cultured allogeneic skin or dermal substitutes. We are proposing to establish the HCPCS G-codes for temporary use in CY 2011 in order to improve the consistency and resource-based nature of PFS payments for skin substitute application services that require similar resources. However, we note our continued interest in ensuring that skin substitutes are properly utilized for Medicare beneficiaries who will benefit from that treatment. We will continue to monitor the utilization of these services and plan to identify any concerning trends in utilization that contractors may want to examine further through medical review or other approaches.

G. Canalith Repositioning (CPT Code 95992)

For CY 2009, CPT created a new code for canalith repositioning, specifically CPT code 95992 (Canalith repositioning procedure(s) (*e.g.,* Epley maneuver, Semont maneuver), per day). This service may be furnished by both physicians and therapists. Although we accepted the RUC-recommended work RVUs and PE inputs, we initially bundled this procedure on an interim basis in the CY 2009 PFS final rule with comment period (73 FR 69896), indicating that we believed it would be paid through the E/M service that it would accompany. Subsequently, in view of concerns from therapists who cannot furnish E/M services, we clarified that therapists could report one of the generally defined therapy CPT codes when canalith repositioning was furnished. In the CY 2010 PFS final rule with comment period (74 FR 61766), we changed the code's status under the PFS to "not recognized for payment under Medicare," consistent with our expectation that another payable code would be reported when the service was furnished.

Based on further information from stakeholders regarding the distinct and separate nature of this procedure from an E/M service and their request that we recognize this CPT code for payment, similar to our separate payment for most other procedures commonly furnished in association with an E/M service, we are proposing to recognize CPT code 95992 for payment under the CY 2011 PFS, consistent with our typical treatment of most other codes for minor procedures. In doing so, we are proposing to change the code's status to "A" and utilize the CY 2009 RUC recommendations for work RVUs (0.75) and PE inputs for establishing its payment in CY 2011. (That is, status "A" means Active code. These codes are separately payable under the PFS if covered.) Because canalith repositioning (CPT code 95992) can be furnished by physicians or therapists as therapy services under a therapy plan of care or by physicians as physicians' services outside of a therapy plan of care, we would add CPT code 95992 to the "sometimes therapy" list on the therapy code abstract file.

H. Intranasal/Oral Immunization Codes (CPT Codes 90467, 90468, 90473, and 90474)

To ensure that the PE RVUs are consistent between the intranasal/oral and injectable immunization administration CPT codes that describe services that utilize similar PE resources, we are proposing to crosswalk the PE values for CPT code 90471 (Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)) to CPT codes 90467 (Immunization administration younger than age 8 years (includes intranasal or oral routes of administration) when the physician counsels the patient/family; first administration (single or combination vaccine/toxoid), per day) and 90473 (Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)).

Similarly, we are also proposing to crosswalk the PE values for CPT code 90472 (Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)) to CPT codes 90468 (Immunization administration younger than age 8 years (includes intranasal or oral routes of administration) when the physician counsels the patient/family; each additional administration (single or combination vaccine/toxoid), per day (List separately in addition to code for primary procedure)) and 90474 (Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)).

I. Refinement Panel Process

As discussed in the November 25, 1992 PFS final rule (57 FR 55938), we adopted a refinement panel process to assist us in reviewing the public comments on interim physician work RVUs for CPT codes with that status in each year and developing final work values for the subsequent year. Our decision to convene multispecialty panels of physicians was based on our need to balance the interests of those who commented on the work RVUs against the budgetary and redistributive effects that could occur if we accepted extensive increases in work RVUs across a broad range of services. The refinement panel reviews and discusses the work involved in each procedure and then each member individually rates the work of the procedure. Since 1992, the refinement panels' recommendation to change a work value or to retain the interim value has hinged solely on the outcome of a statistical test on the ratings (an F-test).

Depending on the number and range of codes that public commenters, typically specialty societies, request be subject to refinement, we establish refinement panels with representatives from 4 groups of physicians: Clinicians representing the specialty most identified with the procedures in question; physicians with practices in related specialties; primary care physicians; and contractor medical directors (CMDs). Typically the refinement panels meet in the summer prior to the promulgation of the final rule finalizing the RVUs for the codes.

Typical panels have included 8 to 10 physicians across the 4 groups. Over time, the statistical test used to evaluate the RVU ratings of individual panel members have become less reliable as the physicians in each group have tended to select a previously discussed value, rather than independently evaluating the work. In addition, the resulting RVUs have occasionally exhibited rank order anomalies (that is, a more complex procedure is assigned lower RVUs than a less complex procedure).

Most recently, section 1848(c)(2)(K) of the Act (as added by section 3134 of the ACA) authorizes the Secretary to review potentially misvalued codes and make appropriate adjustments to the relative values. In addition, MedPAC has encouraged CMS to critically review the values assigned to the services under the PFS. MedPAC has stated its belief that CMS has historically relied too heavily on specialty societies to identify services that are misvalued by accepting so many recommendations of the RUC.

We believe the refinement panel process continues to provide stakeholders with a meaningful opportunity for review and discussion of the interim work RVUs with a clinically diverse group of experts that then provides informed recommendations to CMS. Therefore, we would like to continue the refinement process, including the established composition that includes representatives from the 4 groups of physicians, but with administrative modification and clarification. Specifically, for refinement panels beginning in CY 2011 (that is, for those codes with CY 2011 interim values that would be subject to refinement during CY 2011), we are proposing to eliminate the use of the F-test and instead base revised RVUs on the median work value of the panel members' ratings. We believe this approach will simplify the refinement process administratively, while resulting in a final panel recommendation that reflects the summary opinion of the panel members based on a commonly used measure of central tendency that is not significantly affected by outlier values. In addition, we are clarifying that we have the final authority to set the RVUs, and therefore, may make adjustments to the work RVUs resulting from refinement if policy concerns warrant their modification.

J. Remote Cardiac Monitoring Services (CPT Codes 93012, 93229, 93268, and 93271)

In the CY 2010 PFS final rule with comment period (74 FR 61755), we indicated that we continued to have concerns about the issue of developing PE RVUs for services that are utilized 24 hours a day, 7 days a week (24/7), such as those that require certain monitoring system equipment. The PE equipment methodology was developed for equipment that is in use during standard physician's office business hours and not this type of 24/7 equipment. We stated that we would conduct further analysis of this issue. Services that were contractor-priced in CY 2009 remained contractor-priced in CY 2010. We also indicated that any proposed changes will be communicated through future rulemaking.

Since publication of the CY 2010 PFS final rule with comment period, we have focused our additional analysis on four of the CPT codes that commenters have brought to our attention because they involve concurrent, remote, 24/7 attended monitoring of multiple patients from a central location: CPT code 93012 (Telephonic transmission of post-symptom electrocardiogram rhythm strip(s); 24-hour attended monitoring, per 30 day period of time; tracing only); CPT code 93229 (Wearable mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and physician prescribed transmission of daily and emergent data reports); CPT code 93268 (Wearable patient activated electrocardiographic rhythm derived event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; includes transmission, physician review and interpretation); and CPT 93271 code (Wearable patient activated electrocardiographic rhythm derived event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; monitoring, receipt of transmissions, and analysis).

Of these four codes, CPT code 93229 is currently contractor-priced in CY 2010, meaning that the local Medicare contractors determine payment rates for the service within the PFS geographic areas in their jurisdiction. The three services that are currently nationally-priced on the PFS are in the first year of a 4-year transition to lower payment rates based on the use of the PPIS data adopted in the CY 2010 PFS final rule with comment period. We refer readers to section II.A.2. of this proposed rule for a description of the general PFS PE methodology that is the basis for the following discussion of approaches to establishing PE RVUs for these four CPT codes.

We examined several alternative methods for developing PE RVUS upon which PFS payment rates for these four CPT codes could be based. Each of these services involves transmission of information from multiple patients who wear individual monitoring devices that transmit patient-specific information to centralized equipment that is simultaneously in use for multiple patients. We believe it would be most consistent with the principles underlying the PFS PE methodology to classify the centralized monitoring equipment as an indirect cost since it is servicing multiple patients at the same time. After classifying this equipment as an indirect cost, we used our standard methodology to calculate an indirect practice cost index value for each code based on the PE/HR survey data of the historical mix of specialties providing these services. Establishing payment rates for these codes based on this approach would result in decreases in the payment rates for these services, including the typical contractor's price for CPT code 93229. For the three services that are nationally priced, these decreases would be relative to the lower payment rates based on the use of the PPIS data after the 4-year transition.

We also received PE/HR data from the Remote Cardiac Services Provider Group (RCSPG), a group of IDTF suppliers of these types of services. For sensitivity analysis purposes, we substituted these data for the PE/HR data of the specialties performing these services, while continuing to treat the centralized monitoring equipment as an indirect cost. We found that establishing payment rates for these codes based on the approach of using the submitted RCSPG PE/HR data would again result in decreases in the payment rates for these services, including the typical contractor's price for CPT code 93229. As in the prior alternative, the decreases for the nationally priced codes would be relative to the payment rates reflecting the 4-year transition to the PPIS data.

Although we believe that it would be most consistent with the principles underlying the PE methodology to classify the centralized monitoring equipment as an indirect cost, we also performed a sensitivity analysis of the payment rates if the centralized monitoring equipment were classified as a direct cost. In this simulation, we

assumed that the centralized monitoring equipment was in year-round use, 7 days per week for 24 hours per day. We found that establishing payment rates for these codes based on the approach of classifying the centralized monitoring equipment as a direct cost would again result in decreases in the payment rates for the nationally priced services relative to their payment rates after the 4-year transition to the use of the PPIS data, as well as to the typical current contractor's price for CPT code 93229.

Finally, we considered proposing contractor-pricing for all four of these services for CY 2011. However, we are cognizant of past public comments on this issue that have requested that all of these services be priced nationally on the PFS, including the one service (CPT code 93229) that is currently contractor-priced.

We also considered that the services currently priced nationally on the PFS are scheduled to receive lower payment rates under the 4-year transition to the PPIS data and that the contractor's price for CPT 93229 was recently reduced in the area where the majority of the billings for this service currently occur.

After taking all these factors into consideration, we are not proposing CY 2011 methodological or direct cost input changes for CPT codes 93012, 93268, or 93271—the services that are currently nationally priced under the PFS. We are also proposing to continue contractor-pricing for CPT 93229 for CY 2011. We continue to be interested in public comments on this issue, including responses to our analysis of alternative approaches to establishing PE RVUs for 24/7 services, and further discussion of the issues we have identified in our alternative pricing methodologies. In addition, while we have focused the 24/7 services analysis to date on developing the PE RVUs for remote cardiac monitoring services, there may be 24/7 services in other areas of medicine, either currently paid under the PFS or in development for the future. Therefore, we are also interested in public comments on these current or emerging 24/7 services, including descriptions of the similarities or differences between these other services and remote cardiac monitoring services, particularly with respect to the issues we have identified in our analysis of alternative approaches to establishing PE RVUs for remote cardiac monitoring services under the PFS.

IV. Medicare Telehealth Services for the Physician Fee Schedule

A. Billing and Payment for Telehealth Services

1. History

Prior to January 1, 1999, Medicare coverage for services delivered via a telecommunications system was limited to services that did not require a face-to-face encounter under the traditional model of medical care. Examples of these services included interpretation of an x-ray or electrocardiogram or electroencephalogram tracing, and cardiac pacemaker analysis.

Section 4206 of the BBA provided for coverage of, and payment for, consultation services delivered via a telecommunications system to Medicare beneficiaries residing in rural health professional shortage areas (HPSAs) as defined by the Public Health Service Act. Additionally, the BBA required that a Medicare practitioner (telepresenter) be with the patient at the time of a teleconsultation. Further, the BBA specified that payment for a teleconsultation had to be shared between the consulting practitioner and the referring practitioner and could not exceed the fee schedule payment which would have been made to the consultant for the service provided. The BBA prohibited payment for any telephone line charges or facility fees associated with the teleconsultation. We implemented this provision in the CY 1999 PFS final rule with comment period (63 FR 58814).

Effective October 1, 2001, section 223 of the Medicare, Medicaid and SCHIP Benefits Improvement Protection Act of 2000 (Pub. L. 106–554) (BIPA) added a new section 1834(m) to the Act which significantly expanded Medicare telehealth services. Section 1834(m)(4)(F)(i) of the Act defines Medicare telehealth services to include consultations, office visits, office psychiatry services, and any additional service specified by the Secretary, when delivered via a telecommunications system. We first implemented this provision in the CY 2002 PFS final rule with comment period (66 FR 55246). Section 1834(m)(4)(F)(ii) required the Secretary to establish a process that provides for annual updates to the list of Medicare telehealth services. We established this process in the CY 2003 PFS final rule with comment period (67 FR 79988).

As specified in regulations at § 410.78(b), we generally require that a telehealth service be furnished via an interactive telecommunications system. Under § 410.78(a)(3), an interactive telecommunications system is defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and the practitioner at the distant site. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system. An interactive telecommunications system is generally required as a condition of payment; however, section 1834(m)(1) of the statute does allow the use of asynchronous "store-and-forward" technology in delivering these services when the originating site is a Federal telemedicine demonstration program in Alaska or Hawaii. As specified in regulations at § 410.78(a)(1), store and forward means the asynchronous transmission of medical information from an originating site to be reviewed at a later time by the practitioner at the distant site.

Medicare telehealth services may be provided to an eligible telehealth individual notwithstanding the fact that the individual practitioner providing the telehealth service is not at the same location as the beneficiary. An eligible telehealth individual means an individual enrolled under Part B who receives a telehealth service furnished at an originating site. As specified in BIPA, originating sites are limited under section 1834(m)(3)(C) of the statute to specified medical facilities located in specific geographic areas. The initial list of telehealth originating sites included the office of a practitioner, a critical access hospital (CAH), a rural health clinic (RHC), a federally qualified health center (FQHC) and a hospital. More recently, section 149 of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275) (MIPPA) expanded the list of telehealth originating sites to include hospital-based renal dialysis centers, skilled nursing facilities (SNFs), and community mental health centers (CMHCs). In order to serve as a telehealth originating site, these sites must be located in an area designated as a rural health professional shortage area (HPSA), in a county that is not in a metropolitan statistical area (MSA), or must be an entity that participates in a Federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary of Health and Human Services as of December 31, 2000. Finally, section 1834(m) of the statute does not require the eligible telehealth individual to be

presented by a practitioner at the originating site.

2. Current Telehealth Billing and Payment Policies

As noted above, Medicare telehealth services can only be furnished to an eligible telehealth beneficiary in an originating site. An originating site is defined as one of the specified sites where an eligible telehealth individual is located at the time the service is being furnished via a telecommunications system. In general, originating sites must be located in a rural HPSA or in a county outside of an MSA. The originating sites authorized by the statute are as follows:

- Offices of a physician or practitioner
- Hospitals
- CAHs
- RHCs
- FQHCs
- Hospital-Based or Critical Access Hospital-Based Renal Dialysis Centers (including Satellites)
- SNFs
- CMHCs

Currently approved Medicare telehealth services include the following:

- Initial inpatient consultations
- Follow-up inpatient consultations
- Office or other outpatient visits
- Individual psychotherapy
- Pharmacologic management
- Psychiatric diagnostic interview examination
- End Stage Renal Disease (ESRD) related services
- Individual medical nutrition therapy (MNT)
- Neurobehavioral status exam
- Individual health and behavior assessment and intervention (HBAI)

In general, the practitioner at the distant site may be any of the following, provided that the practitioner is licensed under State law to furnish the service being furnished via a telecommunications system:

- Physician
- Physician assistant (PA)
- Nurse practitioner (NP)
- Clinical nurse specialist (CNS)
- Nurse midwife
- Clinical psychologist
- Clinical social worker
- Registered dietitian or nutrition professional

Practitioners furnishing Medicare telehealth services are located at a distant site, and they submit claims for telehealth services to the Medicare contractors that process claims for the service area where their distant site is located. Section 1834(m)(2)(A) of the Act requires that a practitioner who furnishes a telehealth service to an eligible telehealth individual be paid an amount equal to the amount that the practitioner would have been paid if the service had been furnished without the use of a telecommunications system. Distant site practitioners must submit the appropriate HCPCS procedure code for a covered professional telehealth service, appended with the –GT (Via interactive audio and video telecommunications system) or –GQ (Via asynchronous telecommunications system) modifier. By reporting the –GT or –GQ modifier with a covered telehealth procedure code, the distant site practitioner certifies that the beneficiary was present at a telehealth originating site when the telehealth service was furnished. The usual Medicare deductible and coinsurance policies apply to the telehealth services reported by distant site practitioners.

Section 1834(m)(2)(B) of the Act provides for payment of a facility fee to the originating site. To be paid the originating site facility fee, the provider or supplier where the eligible telehealth individual is located must submit a claim with HCPCS code Q3014 (Telehealth originating site facility fee), and the provider or supplier is paid according to the applicable payment methodology for that facility or location. The usual Medicare deductible and coinsurance policies apply to HCPCS code Q3014. By submitting HCPCS code Q3014, the originating site authenticates that it is located in either a rural HPSA or non-MSA county or is an entity that participates in a Federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary of Health and Human Services as of December 31, 2000 as specified in section 1834(m)(4)(C)(i)(III) of the Act.

As described above, certain professional services that are commonly furnished remotely using telecommunications technology, but that do not require the patient to be present in-person with the practitioner when they are furnished, are covered and paid in the same way as services delivered without the use of telecommunications technology when the practitioner is in-person at the medical facility furnishing care to the patient. Such services typically involve circumstances where a practitioner is able to visualize some aspect of the patient's condition without the patient being present and without the interposition of a third person's judgment. Visualization by the practitioner can be possible by means of x-rays, electrocardiogram or electroencephalogram tracings, tissue samples, *etc.* For example, the interpretation by a physician of an actual electrocardiogram or electroencephalogram tracing that has been transmitted via telephone (that is, electronically, rather than by means of a verbal description) is a covered physician's service. These remote services are not Medicare telehealth services as defined under section 1834(m). Rather, these remote services that utilize telecommunications technology are considered physicians' services in the same way as services that are furnished in-person without the use of telecommunications technology; they are paid under the same conditions as in-person physicians' services (with no requirements regarding permissible originating sites), and should be reported in the same way (that is, without the –GT or –GQ modifier appended).

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

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

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

Since establishing the process to add or remove services from the list of approved telehealth services, we have added the following to the list of Medicare telehealth services: Individual HBAI services; psychiatric diagnostic interview examination; ESRD services with 2 to 3 visits per month and 4 or more visits per month (although we require at least 1 visit a month to be furnished in-person by a physician, CNS, NP, or PA in order to examine the vascular access site); individual MNT; neurobehavioral status exam; and initial and follow-up inpatient telehealth consultations for beneficiaries in hospitals and skilled nursing facilities (SNFs).

Requests to add services to the list of Medicare telehealth services must be submitted and received no later than December 31 of each calendar year to be considered for the next rulemaking cycle. For example, requests submitted before the end of CY 2010 are considered for the CY 2012 proposed rule. Each request for adding a service to the list of Medicare telehealth services must include any supporting documentation the requester wishes us to consider as we review the request. Because we use the annual PFS rulemaking process as a vehicle for making changes to the list of Medicare telehealth services, requestors should be advised that any information submitted is subject to public disclosure for this purpose. For more information on submitting a request for an addition to the list of Medicare telehealth services, including where to mail these requests, we refer readers to the CMS Web site at *http://www.cms.gov/telehealth/.*

C. Submitted Requests for Addition to the List of Telehealth Services for CY 2011

We received requests in CY 2009 to add the following services as Medicare telehealth services effective for CY 2011: (1) Individual kidney disease education (KDE) services; (2) individual diabetes self-management training (DSMT) services; (3) group KDE, DSMT, MNT, and HBAI services; (4) initial, subsequent, and discharge day management hospital care services; (5) initial, subsequent, discharge day management, and other nursing facility care services; (6) neuropsychological testing services; (7) speech-language pathology services; and (8) home wound care services. The following presents a discussion of these requests, including our proposals for additions to the CY 2011 telehealth list.

1. Individual KDE Services

The American Society of Nephrology, Dialysis Patient Citizens, AMGEN, and Kidney Care Partners submitted requests to add individual KDE services, reported by HCPCS code G0420 (Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour), to the list of approved telehealth services for CY 2011 on a category 1 basis.

Individual KDE services, covered under the new Medicare KDE benefit effective for services furnished beginning in CY 2010, are defined as face-to-face educational services provided to a patient with stage IV chronic kidney disease (CKD). We believe the interaction between a practitioner and a beneficiary receiving individual KDE services is similar to the education, assessment, and counseling elements of individual MNT services, reported by HCPCS code G0270 (Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes); CPT code 97802 (Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes); and CPT code 97803 (Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes), all services that are currently on the telehealth list.

Therefore, we are proposing to add HCPCS code G0420 to the list of telehealth services for CY 2011 on a category 1 basis. Consistent with this proposal, we are also proposing to revise our regulations at § 410.78(b) and § 414.65(a)(1) to include individual KDE as a Medicare telehealth service.

2. Individual DSMT Services

The Tahoe Forest Health System and the Marshfield Clinic submitted requests to add individual DSMT services, reported by HCPCS code G0108 (Diabetes outpatient self-management training services, individual, per 30 minutes), to the list of telehealth services for CY 2011 on a category 1 basis. In the CY 2009 PFS final rule with comment period (73 FR 69743), we stated that we believe individual DSMT services are not analogous to individual MNT services because of the element of skill-based training that is encompassed within individual DSMT services that is not an aspect of individual MNT services (or any other services currently approved for telehealth). Due to the statutory requirement that DSMT services include teaching beneficiaries the skills necessary for the self-administration of injectable drugs, we have stated our belief that DSMT, whether provided to an individual or a group, must be evaluated as a category 2 service as specified in the CY 2009 PFS proposed rule (73 FR 38516). We have considered several previous requests to add DSMT to the list of Medicare telehealth services. We have not added individual DSMT to the list of telehealth services because we believe that skill-based training, such as teaching patients how to inject insulin, would be difficult to accomplish effectively without the physical presence of the teaching practitioner (70 FR 45787 and 70157, and 73 FR 38516 and 69743).

In considering the new request to add individual DSMT services to the list of telehealth services in CY 2011, we have taken into account requestors' argument that individual DSMT services are highly similar to individual MNT services and that injection training constitutes just a small proportion of DSMT services. Except for the component of individual DSMT services that involves instruction in self-administration of injectable drugs for eligible beneficiaries, we agree with the requestors that individual DSMT services are similar to individual MNT services, which are currently on the list of Medicare telehealth services. We note that Medicare coverage of DSMT services was initially authorized in the Balanced Budget Act of 1997. After more than a decade of Medicare coverage, the most recent information shows that DSMT continues to be significantly underutilized in the context of the eligible population of Medicare beneficiaries. While we are uncertain to what extent geographic barriers to care contribute to this underutilization, given the morbidity associated with poorly managed diabetes and the growing evidence-base regarding effective DSMT services, we believe it is very important to facilitate Medicare beneficiary access to these underutilized services. While we have previously been concerned about treating the components of DSMT services differently in the context of considering DSMT services for the telehealth list, we believe that our concern regarding the skill-based injection training component of DSMT services can be addressed by imposing a requirement that a minimum portion of the training be furnished in-person.

We note that for beneficiaries who meet the coverage criteria, Medicare covers 10 hours of DSMT services in the year following the initial training, as described in the Medicare Benefit Policy Manual (Pub. 100–02, Chapter 15, Section 300.3). Taking into consideration the initial year coverage of DSMT services, we are proposing that a minimum of 1 hour of instruction in injection training must be furnished in-person during the year following the initial DSMT service. Imposing this condition would allow us to expand access to DSMT services by adding individual DSMT services to the list of telehealth services, while ensuring effective injection training for beneficiaries.

Therefore, we are proposing to add HCPCS code G0108 to the list of telehealth services beginning in CY 2011. We are also proposing that, as a condition of payment for individual DSMT services furnished as telehealth services to an eligible telehealth individual, a minimum of 1 hour of in-person instruction in the self-administration of injectable drugs must be furnished to the individual during the year following the initial DSMT service. The injection training may be furnished through either individual or group DSMT services. By reporting the –GT or –GQ modifier with HCPCS code G0108 as a telehealth service, the distant site practitioner would certify that the beneficiary has received or will receive 1 hour of in-person DSMT services for purposes of injection training during the year following the initial DSMT service. Consistent with this proposal, we are proposing to revise our regulations at § 410.78(b) and § 414.65(a)(1) to include individual DSMT services as a Medicare telehealth service, with the exception of 1 hour of in-person instruction in self-administration of injectable drugs which must be furnished to the eligible telehealth individual as individual or group DSMT services during the year following the initial DSMT service.

We note that, as specified in § 410.141(e), individual DSMT services may be furnished by a physician, individual, or entity that furnishes other services for which direct Medicare payment may be made and that submits necessary documentation to, and is accredited by, an accreditation organization approved by CMS. However, consistent with the statutory requirements of section 1834(m)(1) of the Act and as provided in § 410.78(b)(1) and (b)(2) of our regulations, Medicare telehealth services, including individual DSMT furnished as a telehealth service, could only be furnished by a licensed PA, NP, CNS, certified nurse-midwife, clinical psychologist, clinical social worker, or registered dietitian or nutrition professional.

3. Group KDE, MNT, DSMT, and HBAI Services

The American Society of Nephrology, Dialysis Patient Citizens, AMGEN, Tahoe Forest Health Systems, Kidney Care Partners, the American Telemedicine Association, and the Marshfield Clinic submitted requests to add one or more of the following group services to the telehealth list for CY 2011:

- Group KDE services, reported by HCPCS code G0421 (Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour);
- Group MNT services, reported by CPT code 97804 (Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes);
- Group DSMT services, reported by HCPCS code G0109 (Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes); and/or
- Group HBAI services, reported by CPT code 96153 (Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)) and 96154 (Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)).

When furnished as individual services, HBAI and MNT services are currently on the list of Medicare telehealth services. Furthermore, we are proposing to add individual KDE and DSMT services to the list of Medicare telehealth services beginning in CY 2011 as described above.

In the CY 2007 and CY 2010 PFS rulemaking cycles (70 FR 45787 and 70157, and 74 FR 33543 and 61764), we stated that we did not believe that group services could be appropriately delivered through telehealth. We have observed that currently there are no group services approved as Medicare telehealth services and that there is a different interactive dynamic between the practitioner and his or her patients in group services as compared to individual services. We previously have considered requests to add various group services to the list of Medicare telehealth services on a category 2 basis because we have believed that, especially given the interactive dynamic between practitioners and their patients, group services are not similar to other services on the list of Medicare telehealth services. Therefore, we have maintained that it is necessary to evaluate the addition of group services by comparing diagnostic findings or therapeutic interventions when services are furnished via telehealth versus when services are furnished in-person.

We continue to believe that the group dynamic may be a critical and defining element for certain services, and that this characteristic precludes many group services from being considered on a category 1 basis for addition to the list of Medicare telehealth services. For example, we believe that due to the therapeutic nature of the group dynamic that is integral to group psychotherapy, group psychotherapy is fundamentally different from other Medicare telehealth services and, therefore, could not be considered on a category 1 basis for addition to the telehealth services list. For the same reason, in the absence of evidence to the contrary, we do not believe group psychotherapy services could be appropriately delivered through telehealth.

However, upon further consideration, with regard to the particular group education and training services for which we received requests for addition to the Medicare telehealth services list, we believe the group dynamic is not central to the core education and training components of these particular services, specifically DSMT, MNT, KDE, and HBAI services. We believe that these group services are sufficiently similar to the individual, related services that are already on the telehealth services list or are proposed for addition beginning in CY 2011. Specifically, we believe that for these group services, which consist principally of an information exchange for the purpose of education and training, the roles of, and interactions between, the patients and the practitioner are sufficiently similar to the related individual education and training services that the services can be furnished appropriately as a telehealth service.

Therefore, we are proposing to add HCPCS code G0421 for group KDE services, CPT code 97804 for group MNT services, HCPCS code G0109 for group DSMT services, and CPT codes 96153 and 96154 for group HBAI services to the Medicare telehealth services list on a category 1 basis. Furthermore, because the concerns we raised above regarding adequate injection training with the addition of individual DSMT are also present for group DSMT, we are proposing to require the same minimum of 1 hour of in-person instruction for injection training within the year following the initial DSMT service for any beneficiary that receives DSMT services via

telehealth. By reporting the –GT or –GQ modifier with HCPCS code G0109, the distant site practitioner would certify that the beneficiary has received or will receive 1 hour of in-person DSMT services for purposes of injection training during the year following the initial DSMT service. Consistent with this proposal to add these group education and training services, we are also proposing to revise our regulations at § 410.78(b) and § 414.65(a)(1) to include group KDE, MNT, DSMT, and HBAI services as Medicare telehealth services, with the exception of 1 hour of in-person instruction of individual or group DSMT services in the year following the initial DSMT service.

As described above for individual DSMT services, we note that group DSMT services may be furnished by a physician, individual, or entity that furnishes other services for which direct Medicare payment may be made and that submits necessary documentation to, and is accredited by, an accreditation organization approved by CMS, as specified in § 410.141(e) for DSMT services. However, consistent with the statutory requirements of section 1834(m)(1) of the Act and as provided in § 410.78(b)(1) and (b)(2) of our regulations, Medicare telehealth services, including group DSMT furnished as a telehealth service, could only be furnished by a licensed PA, NP, CNS, certified nurse-midwife, clinical psychologist, clinical social worker, or registered dietitian or nutrition professional.

4. Initial, Subsequent, and Discharge Day Management Hospital Care Services

The University of Louisville School of Medicine, the American Telemedicine Association, and Mille Lacs Health System submitted various requests to add initial hospital care services (reported by CPT codes 99221 (Level 1 initial hospital care), 99222 (Level 2 initial hospital care), and 99223 (Level 3 initial hospital care)); subsequent hospital care services (reported by CPT codes 99231 (Level 1 subsequent hospital care), 99232 (Level 2 subsequent hospital care), and 99233 (Level 3 subsequent hospital care)); and/or hospital discharge day management services (reported by CPT codes 99238 (Hospital discharge day management; 30 minutes or less) and 99239 (Hospital discharge day management; more than 30 minutes) to the Medicare telehealth services list beginning in CY 2011, generally on a category 1 basis. Some of the requestors also recommended that we limit the delivery of these services through telehealth to the provision of services to patients with a psychiatric diagnosis or to those treated in a psychiatric hospital or licensed psychiatric bed.

We appreciate the recommendations of the requestors to substantially expand the list of Medicare telehealth services. The requestors submitted a number of studies regarding the outcomes of telehealth services in caring for patients with psychiatric diagnoses. However, we note that the CPT codes for hospital care services are used to report care for hospitalized patients with a variety of diagnoses, including psychiatric diagnoses. We do not believe it would be appropriate to add services to the telehealth list only for certain diagnoses because the service described by a HCPCS code is essentially the same service, regardless of the patient's diagnosis. When evaluating the addition of services for telehealth on a category 1 basis, our focus is on the roles of, and interactions among, the beneficiary, the physician or practitioner, and the telepresenter (if applicable), which generally are similar across diagnoses for services that may be reported with the same HCPCS codes. Even in the unique case of certain ESRD services, we limited additions to the list of Medicare telehealth services based on the appropriateness of certain specific codes, taking into consideration the full service descriptions (69 FR 47511). Therefore, we continue to believe that it is most appropriate to consider additions to the list of telehealth services based on the overall suitability of the services described by the relevant HCPCS codes to delivery through telehealth.

In the CY 2005, CY 2008, and CY 2009 PFS rulemakings (69 FR 47510 and 66276, 72 FR 38144 and 66250, and 73 FR 38517 and 69745, respectively), we did not add initial, subsequent, or discharge day management hospital care services to the list of approved telehealth services because of our concern regarding the use of telehealth for the ongoing evaluation and management (E/M) for the generally high acuity of hospital inpatients. While we continue to have some concern in this area, we also share the requestors' interest in improving access for hospitalized patients to care furnished by treating practitioners. Therefore, we have reevaluated these services in the context of the CY 2011 requests, including considering the possibility that these services could be added on a category 1 basis based on their resemblance to services currently on the telehealth list, such as initial and follow-up inpatient telehealth consultations. The following presents a discussion of our review of the subcategories of hospital care services included in these requests.

Currently, one of the three codes for an initial hospital care service (specifically CPT codes 99221, 99222, or 99223) is reported for the first hospital inpatient E/M visit to the patient by the admitting or a consulting practitioner when that visit is furnished in-person. In addition, we note that currently there are several HCPCS G-codes on the Medicare telehealth services list that may be reported for initial and follow-up inpatient consultations through telehealth, specifically HCPCS codes G0406 (Follow-up inpatient telehealth consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth); G0407 (Follow-up inpatient telehealth consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth); G0408 (Follow-up inpatient telehealth consultation, complex, physicians typically spend 35 minutes or more communicating with the patient via telehealth); G0425 (Initial inpatient telehealth consultation, typically 30 minutes communicating with the patient via telehealth); G0426 (Initial inpatient telehealth consultation, typically 50 minutes communicating with the patient via telehealth); and G0427 (Initial inpatient telehealth consultation, typically 70 minutes or more communicating with the patient via telehealth).

While initial inpatient consultation services are currently on the list of approved telehealth services, there are no services on the current list of telehealth services that resemble initial hospital care for an acutely ill patient by the admitting practitioner who has ongoing responsibility for the patient's treatment during the hospital course. Therefore, we are unable to consider initial hospital care services on a category 1 basis for the telehealth list.

We have reviewed the documentation submitted in support of adding the initial hospital care codes to the Medicare telehealth services list as category 2 requests. Most of the studies provided by the requestors were specific to the treatment of patients with particular diagnoses. Additionally, the studies were not specific to initial hospital care visits by admitting practitioners. Finally, most of the studies concluded that more research was required in order to establish medical equivalence between telehealth and in-person services. Therefore, we received no information that provides robust support for the addition of initial hospital care services to the approved telehealth list on a category 2 basis. The

initial hospital care codes describe the first visit to the hospitalized patient by the admitting practitioner who may or may not have seen the patient in the decision-making phase regarding hospitalization. We believe it is critical that the initial hospital visit by the admitting practitioner be conducted in-person to ensure that the practitioner with ongoing treatment responsibility comprehensively assesses the patient's condition upon admission to the hospital through a thorough in-person examination. Therefore, we are not proposing to add initial hospital care services to the Medicare telehealth services list for CY 2011.

We have again considered adding subsequent hospital care services reported by CPT codes 99231 through 99233 to the telehealth list for CY 2011 on a category 1 basis. In the CY 2005 and CY 2008 PFS proposed rules (69 FR 47511 and 72 FR 38155), we stated that the potential acuity of patients in the hospital setting precludes consideration of subsequent hospital visits as similar to existing telehealth services. However, as stated earlier, we also note that HCPCS codes for initial and follow-up inpatient consultation services are on the list of telehealth services. These E/M services are furnished to high acuity hospitalized patients, although not by the admitting practitioner himself or herself. However, in light of the increasingly prevalent care model that entails multidisciplinary team care for patients with complex medical illnesses that involve multiple body systems, consulting practitioners may often play a key, intensive, and ongoing role in caring for hospitalized patients. Therefore, we believe that subsequent hospital care visits by a patient's admitting practitioner may sufficiently resemble follow-up inpatient consultation services to consider these subsequent hospital care services on a category 1 basis for the telehealth list. While we still believe the potential acuity of hospital inpatients is greater than those patients likely to receive currently approved Medicare telehealth services, we also believe that it would be appropriate to permit some subsequent hospital care services to be furnished through telehealth in order to ensure that hospitalized patients have frequent encounters with their admitting practitioner. However, we also continue to believe that the majority of these visits should be in-person to facilitate the comprehensive, coordinated, and personal care that medically volatile, acutely ill patients require on an ongoing basis.

Therefore, we are proposing that subsequent hospital care services, specifically CPT codes 99231, 99232, and 99233, be added to the list of telehealth services on a category 1 basis for CY 2011, but with some limitations on the frequency that these services may be furnished through telehealth. Because of our concerns regarding the potential acuity of hospital inpatients, we are proposing to limit the provision of subsequent hospital care services through telehealth to once every 3 days. We are confident that admitting practitioners will continue to make appropriate in-person visits to all patients who need such care during their hospitalization. Consulting practitioners should continue to use the inpatient telehealth consultation HCPCS G-codes, specifically G0406, G0407, G0408, G0425, G0426, or G0427 when reporting consultations furnished to inpatients via telehealth.

Consistent with this proposal, we are proposing to revise § 410.78(b) and § 414.65(a)(1) to include subsequent hospital care services as Medicare telehealth services, with the limitation of one telehealth subsequent hospital care service every 3 days.

We also considered adding hospital discharge day management services to the list of telehealth services. These services, reported by CPT codes 99238 and 99239, include the final examination of the patient, discussion of the hospital stay, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions, and referral forms. These services are furnished when a practitioner deems it medically reasonable and necessary to assess a patient's readiness for discharge and to prepare a patient for discharge from an acute care environment to a less intensive setting. There are no services on the current list of telehealth services that resemble such preparation of a patient for discharge. We believe it is especially important that, if a practitioner furnishes a discharge day management service, the service be furnished in-person in order to allow the practitioner to comprehensively assess the patient's status in preparation for discharge so that the patient will have a higher likelihood of making a successful transition to the less intensive setting. Therefore, we are not considering hospital discharge day management services for addition to the Medicare telehealth services list on a category 1 basis.

We have reviewed the documentation submitted by requestors in support of adding these codes to the Medicare telehealth services list on a category 2 basis. Most of the submitted studies were specific to the treatment of patients with specific diagnoses and were not specific to discharge services. Additionally, most of the studies concluded that more research was required in order to establish medical equivalence between telehealth and in-person services. The submitted documentation did not provide the necessary evidence to alter our previous conclusion that hospital discharge day management services should be provided in-person in light of the acuity of hospitalized patients, their typically complex post-hospitalization care needs, and the importance of patient education by the admitting practitioner who had ongoing responsibility for the patient's treatment during the hospital stay. Therefore, we are not proposing to add hospital discharge day management services to the list of telehealth services for CY 2011.

5. Initial, Subsequent, Discharge Day Management, and Other Nursing Facility Care Services

The American Telemedicine Association and the Marshfield Clinic submitted requests to add nursing facility care codes, covering the spectrum of initial (reported by CPT codes 99304 (Level 1 initial nursing facility care), 99305 (Level 2 initial nursing facility care) and 99306 (Level 3 initial nursing facility care)); subsequent (reported by CPT codes 99307 (Level 1 subsequent nursing facility care), 99308 (Level 2 subsequent nursing facility care), 99309 (Level 3 subsequent nursing facility care), and 99310 (Level 4 subsequent nursing facility care)); discharge day management (reported by CPT codes 99315 (Nursing facility discharge day management; 30 minutes or less) and 99316 (Nursing facility discharge day management; more than 30 minutes)); and other (reported by CPT code 99318 (Evaluation and management of a patient involving an annual nursing facility assessment)) services, to the Medicare telehealth services list beginning in CY 2011. The requests for the addition of these services expressed concerns regarding limited access to care if we do not allow these services to be furnished through telehealth, and requested that CMS acknowledge the recent Congressional inclusion of nursing facilities as telehealth originating sites by adding these codes to the list of Medicare telehealth services.

In the CY 2010 PFS proposed and final rules (74 FR 33544 and 74 FR 61762), we discussed concerns about potential disparities in patient acuity between nursing facility services and the current list of Medicare telehealth

services. We have also declined to add HCPCS codes to the Medicare telehealth services list that are used exclusively to describe Federally-mandated nursing facility visits. As discussed in the CY 2010 PFS proposed rule (74 FR 33543), the long-term care regulations at § 483.40(c) require that residents of SNFs receive initial and periodic personal visits. These regulations ensure that at least a minimal degree of personal contact between a practitioner and a SNF resident is maintained, both at the point of admission to the facility and periodically during the course of the resident's stay. We continue to believe that these federally-mandated visits should be conducted in-person, and not as Medicare telehealth services. Therefore, in the CY 2010 PFS final rule with comment period, we revised § 410.78 to preclude physicians and other practitioners from furnishing the physician visits required under § 483.40(c) through telehealth.

We reviewed the use of telehealth for each of the subcategories of nursing facility services included in the requests for CY 2011. We identified the E/M services that fulfill Federal requirements for personal visits under § 483.40(c), and we are not proposing for CY 2011 to add any HCPCS codes to the Medicare telehealth services list that are used exclusively to describe these Federally-mandated visits. These codes include the CPT codes for initial nursing facility care (CPT codes 99304 through 99306) that are used to report the initial E/M visit that fulfills Federally-mandated requirements under § 483.40(c) and other nursing facility service (CPT code 99318) that is only payable by Medicare if the visit is substituted for a federally-mandated visit under § 483.40(c).

The nursing facility discharge day management services reported under CPT code 99315 and 99316 are E/M visits that prepare a nursing facility resident for discharge from the facility. There are no Medicare requirements that such a service be furnished. If a practitioner chooses to furnish this service, we continue to believe that an in-person visit is most appropriate in order to ensure the resident is prepared for discharge from the nursing facility. These services are furnished when a practitioner deems it medically reasonable and necessary to assess a patient's readiness for and to prepare a patient being discharged from the monitored nursing facility environment to another typically less intensive setting. There are no services on the current list of telehealth services that resemble such preparation of a patient for discharge. As in the case of hospital discharge day management services, we believe it is especially important that, if a practitioner furnishes a nursing facility discharge day management service, the service be furnished in-person. The practitioner must be able to comprehensively assess the patient's status in preparation for discharge so that the patient will have a higher likelihood of making a successful transition from the nursing facility to another setting. Therefore, we are not considering nursing facility discharge day management services for addition to the Medicare telehealth services list on a category 1 basis. When we considered the addition of these services under category 2, we had no evidence that nursing facility discharge services furnished through telehealth are equivalent to in-person discharge services. Therefore, we are not proposing to add nursing facility discharge day management services to the CY 2011 telehealth list.

Subsequent nursing facility services, reported by CPT codes 99307 through 99310, may be used to report either a federally-mandated periodic visit under § 483.40(c) or another E/M visit, prior to or after the initial nursing facility care visit, as long as the subsequent nursing facility care visit is medically reasonable and necessary for the resident's care. While we continue to believe that many SNF residents have complex medical care needs, we believe that it is appropriate to consider the addition of these codes to the telehealth list on a category 1 basis. As we state above in the context of our discussion of subsequent hospital care services, the HCPCS codes for initial and follow-up inpatient consultation services for nursing facility patients are on the list of Medicare telehealth services, and subsequent nursing facility services are similar to those services. These E/M services are furnished to high acuity, complex SNF patients, although not by the admitting practitioner himself or herself. Therefore, we believe that subsequent nursing facility visits by a patient's admitting practitioner sufficiently resemble follow-up inpatient consultation services to consider them on a category 1 basis for the telehealth list. We have concluded that it would be appropriate to permit some subsequent nursing facility care services to be furnished through telehealth to ensure that complex nursing facility patients have frequent encounters with their admitting practitioner, although we continue to believe that the federally-mandated visits should be in-person to facilitate the comprehensive, coordinated, and personal care that these complex patients require on an ongoing basis.

Therefore, we are proposing that subsequent nursing facility care services, specifically CPT codes 99307, 99308, 99309 and 99310, be added to the list of Medicare telehealth services on a category 1 basis beginning in CY 2011, with some limitations on furnishing these services through telehealth. Because of our concerns regarding the potential acuity and complexity of SNF inpatients, we are proposing to limit the provision of subsequent nursing facility care services furnished through telehealth to once every 30 days. We are especially interested in public comments, including any evidence regarding patterns of high quality care and clinical outcomes, regarding this proposal to limit the provision of subsequent nursing facility care services furnished through telehealth to once every 30 days. We remain committed to ensuring that SNF inpatients receive appropriate in-person visits and that Medicare pays only for medically reasonable and necessary care. Currently and continuing in CY 2011, an unlimited number of initial and follow-up consultation services may be furnished through telehealth to these patients so we believe that only a limited number of subsequent nursing facility care services by the admitting practitioner would be appropriate for SNF inpatients. Finally, we are specifying that subsequent nursing facility care services reported for a Federally-mandated periodic visit under § 483.40(c) may not be furnished through telehealth. In light of this proposal for CY 2011, we remain confident that admitting practitioners will continue to make appropriate in-person visits to all patients who need such care during their SNF stay.

Consistent with this proposal, we are proposing to revise § 410.78(b) and § 414.65(a)(1) to include subsequent nursing facility care services as Medicare telehealth services, with the limitation of one telehealth subsequent nursing facility care service every 30 days. Federally-mandated periodic visits may not be furnished through telehealth, as specified currently in § 410.78(e)(2).

6. Neuropsychological Testing

The American Telemedicine Association submitted a request to add neuropsychological testing services, described by CPT codes 96119 (Neuropsychological testing (*e.g.,* Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour

of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report); and 96119 (Neuropsychological testing (*e.g.,* Halstead-Reitan Neuropsychological Battery, Wechsler Memory scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face), to the list of telehealth services for CY 2011 based on their similarity to other telehealth services.

In the CY 2008 PFS final rule with comment period (72 FR 66251), we stated that we have received conflicting comments and data regarding the appropriateness of furnishing neuropsychological testing via telehealth. While we appreciate the recent request for addition of these same services to the Medicare telehealth services list, we do not believe that these services are similar to services currently on the Medicare telehealth services list and, therefore, we conclude that they would not be appropriate for consideration or addition under category 1. In this year's request for the addition of the these services, we received no information to indicate that the diagnostic findings of neuropsychological testing through telehealth are similar to those based upon in-person testing, and therefore, that testing through telehealth does not affect the patient's diagnosis. Therefore, we are not proposing to add neuropsychological testing services to the list of approved Medicare telehealth services for CY 2011.

7. Speech-Language Pathology Services

The Marshfield Clinic submitted a request to add various speech-language pathology services to the list of approved telehealth services for CY 2011. Speech-language pathologists are not permitted under section 1842(b)(18)(C) of the Act to furnish and receive payment for Medicare telehealth services. Therefore, we are not proposing to add any speech-language pathology services to the list of Medicare telehealth services for CY 2011. For further discussion of these services in the context of telehealth, we refer readers to the CY 2005 and CY 2007 PFS proposed and final rules with comment period (69 FR 47512 and 66276, and 71 FR 48995 and 69657).

8. Home Wound Care Services

Wound Care Associates, LLC, submitted a request to add wound care in the home setting to the list of Medicare telehealth services. A patient's home is not permitted under current statute to serve as an originating site for Medicare telehealth services. Therefore, we are not proposing to add home wound care services to the list of Medicare telehealth services for CY 2011.

D. Summary of CY 2011 Telehealth Proposals

In summary, we are proposing to add the following requested services to the list of Medicare telehealth services for CY 2011:

- Individual and group KDE services (HCPCS codes G0420 and G0421, respectively);
- Individual and group DSMT services, with a minimum of 1 hour of in-person instruction to be furnished in the year following the initial DSMT service to ensure effective injection training (HCPCS codes G0108 and G0109, respectively);
- Group MNT and HBAI services (CPT codes 97804, and 96153 and 96154, respectively);
- Subsequent hospital care services, with the limitation for the patient's admitting practitioner of one telehealth visit every 3 days (CPT codes 99231, 99232, and 99233); and
- Subsequent nursing facility care services, with the limitation for the patient's admitting practitioner of one telehealth visit every 30 days (CPT codes 99307, 99308, 99309, and 99310).

Furthermore, we are proposing to revise § 410.78(b) and § 414.65(a)(1) accordingly. Specifically, we are proposing to add individual and group KDE services, individual and group DSMT services, group MNT services, group HBAI services, and subsequent hospital care and nursing facility care services to the list of telehealth services for which payment will be made at the applicable PFS payment amount for the service of the practitioner. In addition, we have reordered the listing of services in these two sections and removed "initial and follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals and SNFs" in § 410.78(b) because these are described by the more general term "professional consultations" that is in the same section. Finally, we are continuing to specify that the physician visits required under § 483.40(c) may not be furnished as telehealth services.

V. Provisions of the Patient Protection and Affordable Care Act of 2010

The following section addresses certain provisions of the Patient Protection and Affordable Care Act (Pub. L. 111–148), enacted on March 23, 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) enacted on March 30, 2010 (collectively known as the Affordable Care Act (ACA)).

A. Section 3002: Improvements to the Physician Quality Reporting System

Section 3002 of ACA makes a number of changes to the Physician Quality Reporting Initiative (PQRI), including authorizing incentive payments through 2014, and requiring a penalty beginning in 2015, for eligible professionals who do not satisfactorily submit quality data. For a more detailed discussion of the provisions of section 3002 of the ACA, please refer to section VI.G.1. of this proposed rule.

B. Section 3003: Improvements to the Physician Feedback Program and Section 3007: Value-based Payment Modifier Under the Physician Fee Schedule

1. Background

As required under section 1848(n) of the Act, as added by section 131(c) of MIPPA, we established and implemented by January 1, 2009, the Physician Resource Use Measurement & Reporting (RUR) Program for purposes of providing confidential reports to physicians that measure the resources involved in furnishing care to Medicare beneficiaries. Section 1848(n) of the Act also authorizes CMS to include information on the quality of care furnished to Medicare beneficiaries by a physician or group of physicians.

We are continuing a phased implementation of the program. Phase I was discussed in the CY 2010 proposed and final rules (74 FR 33589, and 74 FR 61844, respectively), and has been completed. Phase I consisted of several activities including extensive data analysis to inform decisions about topics such as measures, attribution, and risk adjustment and formative testing of report design with practicing physicians. We concluded Phase I by sending to individual practicing physicians in 12 geographic areas [1] several hundred reports that contained per capita and episode-based cost information.

Phase I of the Program focused on providing confidential feedback on resource use measures. Section 1848(n)(1)(A)(iii) of the Act states that the Secretary may also include information on the quality of care

[1] The 12 geographic areas are: Boston, MA, Syracuse, NY, Northern New Jersey, Greenville, SC, Miami, FL, Little Rock, AR, Indianapolis, IN, Cleveland, OH, Lansing, MI, Phoenix, AZ, Seattle, WA, and Orange County, CA.

furnished to Medicare beneficiaries by physicians (or groups of physicians) in the feedback reports. We believe that providing physicians with feedback on both quality and cost is consistent with the direction of other CMS value based purchasing (VBP) initiatives. As a result, we decided to include quality measures in Phase II of the program and, in particular, we considered measures used in PQRI and claims-based measures such as GEM measures (74 FR 61846).

Section 1848(n)(1)(A)(ii) also states that the Secretary may provide reports at the physician group level. Accordingly, as part of Phase II of the program, we will also include reporting to group practices, defined as more than one physician practicing medicine together (74 FR 61846). In addition, we noted that the definition applies to the following types of physician groups: (1) Formally established single or multi-specialty group practices; (2) physicians practicing in defined geographic regions; and (3) physicians practicing within facilities or larger systems of care (74 FR 61846). As we continue with Phase II, we plan to report to both physician group practices and their affiliated practitioners, recognizing that many physicians practice in arrangements other than solo practices. We believe that using both group and individual level reporting will also allow us to gain experience with the sample size issues that arise when individual physicians have too few Medicare beneficiaries with specific conditions to generate reliable information. (*See* the CY 2010 final rule with comment period (74 FR 61844) for a detailed discussion of plans for Phase II.)

2. Effect of the ACA of 2010 on the Program

The ACA contains two provisions relevant to the RUR program. Section 3003 continues the confidential feedback program and requires the Secretary, beginning in 2012, to provide reports that compare patterns of resource use of individual physicians to other physicians. In addition, section 3007 of the ACA requires the Secretary to apply a separate, budget-neutral payment modifier to the Fee-For-Service physician fee schedule payment formula. The payment modifier, which will be phased in beginning January 1, 2015 through January 1, 2017, will provide for differential payment under the fee schedule to a physician or groups of physicians, and later, possibly to other eligible professionals, based upon the relative quality and cost of care of their Medicare beneficiaries. Accordingly, our goal is to have Medicare physicians receive a confidential feedback report prior to implementation of the payment modifier. We view these two provisions as complementary, as we expect the work done for the confidential feedback program under section 3003 of the ACA will inform our implementation of the payment modifier under section 3007 of the ACA. The approach used in the confidential feedback reports will serve as the foundation for implementing the payment modifier. Specifically, throughout future phases of reports under the RUR program, we will continue to enhance our measures and methods and improve the content of the reports based on both our research and the feedback of stakeholders before the payment modifier begins to affect physician payments in 2015.

We plan to engage in a large-scale effort to garner widespread stakeholder involvement with regard to how we continue to build and expand the confidential feedback program and transition to implementation of the payment modifier. We recognize that such a payment modifier may have an impact on the delivery of care to Medicare beneficiaries. Reports that will be produced in the future based on changes as a result of section 3003 of the ACA will contain both cost and quality data, and work done to improve these reports with regard to fair and actionable measures in each of these domains will aid our decision making in how to apply the payment modifier. We intend to seek stakeholder input on various aspects of program design, including cost and quality measures, methodologies for compositing measures, and feedback report content and delivery. Such feedback may be gathered through rulemaking, open door forums, or other mechanisms.

3. Phase II Proposed Changes

We anticipate that reports in Phase II of the RUR Program will be distributed in the fall of 2010. We are proposing, however, several changes to the program parameters for Phase II that were finalized in prior rules. First, we plan to discontinue our use of commercially-available proprietary episode grouping software. In particular, section 3003 of the ACA requires that the Secretary develop a Medicare-specific episode grouper by January 1, 2012, the details of which must be made public. This grouper will address the limitations found in the proprietary software.

We recognize that episode-specific cost information is meaningful and actionable for physicians, and we plan to provide such information in feedback reports after the public grouper software is developed. Prior to that, we may consider other potential interim options for grouping to provide such information. We believe that our use of proprietary episode grouping software in previous phases of the program had limitations. These software products were not intended for use with Medicare claims data, and we discovered several problems with the data outputs. Specifically, the groupers do not work well to create episodes for beneficiaries with multiple chronic conditions, which is a significant portion of Medicare beneficiaries.

For example, when a beneficiary with a chronic disease is hospitalized for an acute condition, that beneficiary most likely also receives treatments unrelated to the condition for which he or she is hospitalized, but related to the chronic disease. The groupers, which are proprietary and often referred to as "black boxes," do not enable users to understand the coding to determine how to accomodate these issues. Therefore, CMS had to make several decisions about how to pre-process the claims data so that the groupers could recognize and attempt to deal with these issues in the clinical grouping logic. After report production in Phase I, we discovered several problems with the pre-processing, which resulted in inaccurate episode cost information being disseminated.

Until a Medicare-specific episode grouping software is developed, we plan to produce reports for Phase II that contain per capita cost information. More specifically, instead of episode-specific cost information, we plan to provide overall per capita cost information, as well as per capita cost information for those beneficiaries with five common chronic diseases: (1) Diabetes, (2) congestive heart failure, (3) coronary artery disease, (4) chronic obstructive pulmonary disease, and (5) prostate cancer. This information will not be specific to the cost of treating the disease itself, but will provide total Part A/B per capita cost information, as well as service category breakdowns, for treating the subset of attributed beneficiaries with that disease.

Second, while commenters have been generally supportive of including PQRI measures in the reports, we propose not including data from PQRI in the reports. The current support contractor for this program has only 2007 PQRI data. This was the first year of PQRI, and participation was still quite low. Because of the low number of physicians reporting under PQRI, and because providers have the flexibility to choose which measures to report under

PQRI, we believe it would be difficult to make meaningful peer comparisons for purposes of these reports. Instead, for Phase II, we propose using the claims-based measures developed by CMS in the Generating Medicare Physician Quality Performance Measurement Results (GEM) project.[2] This is a core set of 12 process quality measures that can be calculated using only administrative claims data. However, in future phases of the program, we intend to explore the possibility of linking this program to the HITECH incentive program for meaningful use of electronic health records, and the group practice reporting option in PQRI. Both of these programs offer measures and measure sets, as well as methods of reporting data which may be more conducive to meaningful peer comparisons among physicians.

Third, we propose to distribute reports electronically in Phase II, by leveraging the infrastructure used to distribute PQRI feedback reports. This infrastructure will enable groups to utilize an electronic portal to download their Phase II reports. Individual practitioners will be able to contact their MACs/fiscal intermediaries to receive an e-mailed copy of their reports. We have received feedback from physicians that the reports distributed in Phase I were too long and cumbersome to manage in hard copy. Our intent is a condensed report with electronic dissemination that allows for easier navigation. We are seeking public comment on the above proposals.

4. Implementation of Sections 3003 and 3007 of the ACA

The Affordable Care Act provisions that we mention above contain several important implementation dates. In addition to developing an episode grouper by January 1, 2012, we are required to publish the cost and quality measures we intend to use in determining the payment modifier to be effective on January 1, 2012. We are also required to begin implementing the program parameters through rulemaking in 2013. The payment modifier is effective on January 1, 2015, with a phased implementation so that all physicians paid under the physician fee schedule will be subject to the modifier by January 1, 2017. On or after January 1, 2017, we have the authority to also apply the payment modifier to other eligible professionals.

In anticipation of implementing sections 3003 and 3007 of the ACA, we intend to perform extensive data analysis and research, and to seek stakeholder input on issues related to cost and quality measures so that we can be prepared to publish, by January 1, 2012, those measures we intend to use for the payment modifier. We intend for the work done in determining measures for use in the payment modifier to inform the continued dissemination of confidential feedback reports to both individual physicians and physician groups. Specifically, the measures chosen for use in the payment modifier will be candidates for inclusion in future phases of the confidential feedback reports.

As mentioned above, Phase I included reports to several hundred physicians. In Phase II we anticipate disseminating reports to about 40 large physician groups and the approximately 2,000 physicians affiliated with those groups. We anticipate future phases of the reports to include additional dissemination to increasing numbers of practitioners and groups such that virtually every applicable Medicare practitioner receives a report prior to implementation of the payment modifier.

5. Comments Sought on Specific Statistical Issues Related to the ACA Sections 3003 and 3007

We recognize that there are many important decisions to be made when implementing a program that compares physicians to their peers, especially when such information can lead to differential payment. Since the inception of the RUR program, all data have been price standardized which includes accounting for geographic adjustments. We have identified important statistical issues in previous rules, and as we have done in previous rules, CMS seeks input on several of these topics as they relate to future phases of reports. These include, but are not limited to: risk adjustment; attribution; benchmarking; peer groups; minimum case sizes; cost and quality measures; and compositing methods. To date, the public comments we have received have not led us to a single methodology to propose for dealing with any of these issues. Therefore, we do not make formal proposals in this proposed rule. Specific parameters of the RUR program are based on the most current information we have available to us. These parameters will continue to evolve and we will continue to evaluate them as the state of the art in these areas continues to improve. Therefore, we seek public comment on these issues.

a. Risk Adjustment

The cost data used in Phase I will be risk adjusted. For the per capita costs, we used the Hierarchical Condition Categories (HCC) model developed for risk adjustment in Medicare Advantage plans. This model takes into account beneficiary characteristics such as age, sex, and Medicaid status, and then predicts costs for beneficiaries based on their unique mix of health conditions. Several other socioeconomic factors, such as the median income per capita in the county where the physician practices, were used. For the episode costs, we used the risk adjustment/severity levels in the proprietary grouper software.

The cost data in Phase II are risk adjusted using the HCC model, but excluding the additional socioeconomic factors such as the median income per capita in the county where the physician practices, as mentioned above. Regression analyses indicated that these additional socioeconomic factors did little to improve the fit of the model, so we will not include them. And since there are no episode-based costs in Phase II—only annual per capita costs—the HCC model will be the only method used. Other methods of risk adjustment exist that we have not used, such as the CC (complications and comorbidities) and MCC (major complications and comorbidities) indicators implemented in the 2008 MS–DRG system.

The quality data included in Phase II will not be risk adjusted because the GEM measures are all clinical process measures, and it is generally accepted that such measures need not be risk adjusted. Beneficiaries should receive the indicated preventive services (for example, breast cancer screening) regardless of their demographic characteristics or presence or absence of health conditions.

We seek comment on the appropriate method for risk adjusting cost data, as well as our reasoning for not risk adjusting clinical process quality measures.

b. Attribution

Deciding which physician(s) is/are responsible for the care of which beneficiaries is an important aspect of measurement. CMS must strike a balance between only attributing cost information to physicians for the services they personally delivered, and attributing costs to physicians based on a more encompassing view of the services provided to each beneficiary so as to encourage better care coordination and accountability for patient outcomes.

There are several methods that are generally used for attributing beneficiaries' costs to physicians for the purposes of measuring and comparing

[2] *http://www.cms.gov/GEM.*

performance. In Phase I, we used two different attribution methodologies. Half of the reports used the "multiple-proportional" attribution, in which a beneficiary's costs were summed, and then divided among the physicians who treated that beneficiary in the same proportion as their share of evaluation and management (E&M) services provided. The other half of the reports used the "plurality-minimum" method, in which a beneficiary's entire cost (either for the episode or for the year) was attributed to the physician who performed the plurality of the E&M services, subject to a minimum percentage (in that case, 10 percent).

In Phase II reports, we plan to use the "plurality-minimum" method with a minimum percentage threshold of E&M services of 20 percent for individual physicians and a minimum percentage threshold of E&M services of 30 percent of the E&M services for physician group level reports. These minimum threshold determinations were based on our analysis of the claims data. We recognize that other attribution methods exist, which may be either more or less appropriate given the aspect of care one is measuring. For example, it may be desirable to attribute the entire cost of a surgical episode to the performing surgeon. Another method for attributing costs is referred to as "multiple-even," in which the entire beneficiary's cost is attributed to multiple physicians who treated the beneficiary.

We seek comment on the topic of attribution methodologies, including both of those we have already used in the program, as well as others that may or may not be mentioned here.

c. Benchmarking and Peer Groups

Determining the relevant comparisons to make among physicians is also an important policy aspect of the program. CMS' research conducted in Phase I of the program indicated that physicians prefer to be compared only to those physicians most like them (that is, the narrowest peer group). We recognize the importance of fair comparison, but are also faced with the challenge that very narrow peer groups are most often not large enough to make statistically significant comparisons.

The individual-level reports in both phases of the program have contained, or will contain, two peer group comparisons: (1) Physicians in the same specialty in the same geographic area; and (2) physicians in the same specialty across all 12 geographic areas. In each of these peer groups, a physician is shown where he or she falls on a distribution that specifically identified the 10th, 50th, and 90th percentiles. These benchmarks were finalized on an interim basis in the CY 2010 proposed rule (74 FR 33589).

In determining applicability for episode measures in Phase I, we used a statistical reliability test. For per capita measures in Phase I, a physician had to have 20 or more beneficiaries to be measured and compared. There was no minimum peer group size requirement.

The original MIPPA mandate requires CMS to make comparisons among physicians on cost, and gives the Secretary the authority to include comparisons on quality. The use of quality measures in the program was finalized in the CY 2010 final rule (74 FR 61846). In Phase II, comparisons with appropriate peer groups will be made for both cost and quality. Phase II reports will be provided only to those physicians that have 30 or more patients for each of the cost measures. For the quality measures, we plan to use the measure specifications in the GEM project to define minimum case sizes, which are at least 11 beneficiaries. We also plan to impose a minimum peer group size of 30 in Phase II for both the cost and quality measures. A minimum sample size of 30 is generally accepted in the research community as the minimum sample size to represent a group and make comparisons.

We seek comment on the most appropriate and relevant peer groups for comparison, including the appropriate minimum case sizes and minimum peer group sizes. We are also interested in methodologies that can account for small case sizes.

d. Cost and Quality Measures and Compositing Methods

As mentioned above, and in previous rules, section 1848(n)(1)(A)(ii) of the Act gives the Secretary the authority to include both cost and quality information in the feedback reports. In Phase I, we chose to use only cost information, and used both per capita and episode cost measurements. As mentioned above, we previously finalized the use of quality measures in Phase II (74 FR 61846), but propose to discontinue our use of episode cost measurements. We have yet to include any composite measures of cost or quality in the feedback reports.

Section 3007 of the ACA requires CMS to pay physicians differentially based on a modifier derived with composites of both quality and cost measures. Accordingly, we will need to devise a methodology in the future for compositing cost measures and quality measures, including considering, among other things, possible methodologies to develop a single score. In the future, episode-based cost measures developed using the public Medicare-specific episode grouper software also may be considered in developing a composite score. Other domains of measures that may be considered include patient-level utilization statistics (for example, emergency department visits per 1,000 patients) and structural measures such as whether a provider has adopted an electronic health record. We recognize that measure composites are methodologically and operationally complex and, therefore, we are seeking comment on this topic.

We plan to continue a phased approach in the future. Although we will continue to move from phase-to-phase, any substantive changes to the RUR program will be implemented through rulemaking. We also anticipate continuing to gather feedback from stakeholders about the important data-driven policy topics that affect the feedback reports.

C. Section 3102: Extension of the Work Geographic Index Floor and Revisions to the Practice Expense Geographic Adjustment Under the Medicare Physician Fee Schedule, and Protections for Frontier States as Amended by Section 10324

Section 1848(e)(1)(E) of the Act (as amended by section 3102(a) of the ACA) extends application of the 1.0 work GPCI floor for services furnished through December 31, 2010. In addition, section 1848(e)(1) of the Act (as amended by section 3102(b) of the ACA) specifies that for CY 2010 and CY 2011, the employee wage and rent portions of the PE GPCI must reflect only one-half of the relative cost differences for each locality compared to the national average and includes a "hold harmless" provision for any PFS locality that would receive a reduction to its PE GPCI resulting from the limited recognition of cost differences. Section 1848(e)(1) of the Act (as amended by section 3102(b) of the ACA) also requires an analysis of the current methods and data sources used to determine the relative cost differences in office rent and employee wages compared to the national average and the cost share weights assigned to each PE GPCI component: Employee wages, office rent, and supplies. Finally, section 1848(e)(1) of the Act (as amended by section 3102(b) of the ACA) requires the Secretary to make appropriate adjustments to the PE GPCI by no later than January 1, 2012. In addition, section 1848(e)(1) of the Act (as amended by section 10324(c) of the ACA) establishes a 1.0 PE GPCI floor for services furnished in frontier states effective January 1, 2011. The

provisions of the ACA related to the GPCIs are discussed in detail in section II.D. of this proposed rule.

D. Section 3103: Extension of Exceptions Process for Medicare Therapy Caps

Section 1833(g)(5) of the Act (as amended by section 3103 of the ACA) extends the exceptions process for therapy caps through December 31, 2010. Therapy caps are discussed in detail in section III.A. of this proposed rule.

E. Section 3104: Extension of Payment for Technical Component of Certain Physician Pathology Services

Section 542(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554), as amended by section 732 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173), section 104 of division B of the Tax Relief and Health Care Act of 2006 (MIEA–TRHCA) (Pub. L. 109–432), section 104 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (Pub. L. 110–173), and section 136 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110–275) is amended by section 3104 of the ACA to continue payment to independent laboratories for the TC of physician pathology services for fee-for-service Medicare beneficiaries who are inpatients or outpatients of a covered hospital through CY 2010. The technical component (TC) of physician pathology services refers to the preparation of the slide involving tissue or cells that a pathologist interprets. The professional component (PC) of physician pathology services refers to the pathologist's interpretation of the slide.

When the hospital pathologist furnishes the PC service for a hospital patient, the PC service is separately billable by the pathologist. When an independent laboratory's pathologist furnishes the PC service, the PC service is usually billed with the TC service as a combined service.

Historically, any independent laboratory could bill the Medicare contractor under the PFS for the TC of physician pathology services for hospital patients even though the payment for the costs of furnishing the pathology service (but not its interpretation) was already included in the bundled inpatient stay payment to the hospital. In the CY 2000 PFS final rule with comment period (64 FR 59408 through 59409), we stated that this policy has contributed to the Medicare program paying twice for the TC service: (1) To the hospital, through the inpatient prospective payment rate, when the patient is an inpatient; and (2) to the independent laboratory that bills the Medicare contractor, instead of the hospital, for the TC service. While the policy also permits the independent laboratory to bill for the TC of physician pathology services for hospital outpatients, in this case, there generally would not be duplicate payment because we would expect the hospital to not also bill for the pathology service, which would be paid separately to the hospital only if the hospital were to specifically bill for it. We further indicated that we would implement a policy to pay only the hospital for the TC of physician pathology services furnished to its inpatients.

Therefore, in the CY 2000 PFS final rule with comment period, we revised § 415.130(c) to state that for physician pathology services furnished on or after January 1, 2001 by an independent laboratory, payment is made only to the hospital for the TC furnished to a hospital inpatient. Ordinarily, the provisions in the PFS final rule with comment period are implemented in the following year. However, the change to § 415.130 was delayed 1 year (until January 1, 2001), at the request of the industry, to allow independent laboratories and hospitals sufficient time to negotiate arrangements.

Full implementation of § 415.130 was further delayed by section 542 of the BIPA and section 732 of the MMA, which directed us to continue payment to independent laboratories for the TC of physician pathology services for hospital patients for a 2-year period beginning on January 1, 2001 and for CYs 2005 and 2006, respectively.

In the CY 2007 MPFS final rule with comment period (71 FR 69624 and 69788), we amended § 415.130 to provide that, for services furnished after December 31, 2006, an independent laboratory may not bill the carrier for the TC of physician pathology services furnished to a hospital inpatient or outpatient. However, section 104 of the MIEA–TRHCA continued payment to independent laboratories for the TC of physician pathology services for hospital patients through CY 2007, and section 104 of the MMSEA further extended such payment through the first six months of CY 2008.

Section 136 of the MIPPA extended the payment through CY 2009. Most recently, section 3104 of the ACA amended the prior legislation to extend the payment through CY 2010.

Consistent with this legislative change, we are proposing to revise § 415.130(d) to: (1) Amend the effective date of our payment policy to reflect that for services furnished after December 31, 2010, an independent laboratory may not bill the Medicare contractor for the TC of physician pathology services furnished to a hospital inpatient or outpatient; and (2) reformat this subsection into subparagraphs.

F. Sections 3105 and 10311: Extension of Ambulance Add-Ons

1. Amendment to Section 1834(l)(13) of the Act

Section 146(a) of the MIPPA amended section 1834(l)(13)(A) of the Act to specify that, effective for ground ambulance services furnished on or after July 1, 2008 and before January 1, 2010, the ambulance fee schedule amounts for ground ambulance services shall be increased as follows:

- For covered ground ambulance transports which originate in a rural area or in a rural census tract of a metropolitan statistical area, the fee schedule amounts shall be increased by 3 percent.
- For covered ground ambulance transports which do not originate in a rural area or in a rural census tract of a metropolitan statistical area, the fee schedule amounts shall be increased by 2 percent.

Sections 3105(a) and 10311(a) of the ACA further amend section 1834(l)(13)(A) of the Act to extend the payment add-ons described above for an additional year, such that these add-ons also apply to covered ground ambulance transports furnished on or after January 1, 2010 and before January 1, 2011. We are revising § 414.610(c)(1)(i) to conform the regulations to this statutory requirement. This statutory requirement is self-implementing. A plain reading of the statute requires only a ministerial application of the mandated rate increase, and does not require any substantive exercise of discretion on the part of the Secretary. For further information regarding the extension of these payment add-ons, please see Transmittal 706 (Change Request 6972) dated May 21, 2010.

2. Amendment to Section 146(b)(1) of MIPPA

Section 146(b)(1) of the MIPPA amended the designation of rural areas for payment of air ambulance services. The statute specified that any area that was designated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished on December 31, 2006, shall continue to be

treated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished during the period July 1, 2008 through December 31, 2009. Sections 3105(b) and 10311(b) of the ACA amend section 146(b)(1) of MIPPA to extend this provision for an additional year, through December 31, 2010. Accordingly, for areas that were designated as rural on December 31, 2006, and were subsequently re-designated as urban, we have re-established the "rural" indicator on the ZIP Code file for air ambulance services, effective January 1, 2010 through December 31, 2010. We are revising § 414.610(h) to conform the regulations to this statutory requirement. This statutory requirement is self-implementing. A plain reading of the statute requires only a ministerial application of a rural indicator, and does not require any substantive exercise of discretion on the part of the Secretary. For further information regarding the extension of this MIPPA provision, please see Transmittal 706 (Change Request 6972) dated May 21, 2010.

3. Amendment to Section 1834(l)(12) of the Act

Section 414 of the MMA added paragraph (12) to section 1834(l) of the Act, which specified that in the case of ground ambulance services furnished on or after July 1, 2004, and before January 1, 2010, for which transportation originates in a qualified rural area (as described in the statute), the Secretary shall provide for a percent increase in the base rate of the fee schedule for such transports. The statute requires this percent increase to be based on the Secretary's estimate of the average cost per trip for such services (not taking into account mileage) in the lowest quartile of all rural county populations as compared to the average cost per trip for such services (not taking into account mileage) in the highest quartile of rural county populations. Using the methodology specified in the July 1, 2004 interim final rule (69 FR 40288), we determined that this percent increase was equal to 22.6 percent. As required by the MMA, this payment increase was applied to ground ambulance transports that originated in a "qualified rural area"; that is, to transports that originated in a rural area included in those areas comprising the lowest 25th percentile of all rural populations arrayed by population density. For this purpose, rural areas included Goldsmith areas (a type of rural census tract). Sections 3105(c) and 10311(c) of the ACA amend section 1834(l)(12)(A) of the Act to extend this rural bonus for an additional year through December 31, 2010. Therefore, as directed by the ACA, we are continuing to apply the rural bonus described above (in the same manner as in previous years), to ground ambulance services with dates of service on or after January 1, 2010 and before January 1, 2011 where transportation originates in a qualified rural area.

We are revising § 414.610(c)(5)(ii) to conform the regulations to this statutory requirement. This statutory requirement is self-implementing. The statute requires a one-year extension of the rural bonus (which was previously established by the Secretary), and does not require any substantive exercise of discretion on the part of the Secretary. For further information regarding the extension of this rural bonus, please see Transmittal 706 (Change Request 6972) dated May 21, 2010.

G. Section 3107: Extension of Physician Fee Schedule Mental Health Add-On

Section 3107 of the ACA amends section 138(a)(1) of the MIPPA to continue the 5 percent increase in Medicare payment for specified mental health services through December 31, 2010. This payment increase was originally authorized under section 138 of the MIPPA from July 1, 2008 until December 31, 2009. Accordingly, payment for the 24 psychiatry CPT codes in Table 33, representing "specified services," remains increased by 5 percent until December 31, 2010.

TABLE 33—SPECIFIED MENTAL HEALTH SERVICES SUBJECT TO THE FIVE PERCENT INCREASE IN MEDICARE PAYMENT THROUGH DECEMBER 31, 2010

Office or Other Outpatient Facility **Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy**
90804 (Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient).
90805 (Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services).
90806 (Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient).
90807 (Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services).
90808 (Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient).
90809 (Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services).
Interactive Psychotherapy
90810 (Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient).
90811 (Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services).
90812 (Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient).
90813 (Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services).
90814 (Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient).

TABLE 33—SPECIFIED MENTAL HEALTH SERVICES SUBJECT TO THE FIVE PERCENT INCREASE IN MEDICARE PAYMENT THROUGH DECEMBER 31, 2010—Continued

90815	(Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services).
	Inpatient Hospital, Partial Hospital or Residential Care Facility Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy
90816	(Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient).
90817	(Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services).
90818	(Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient).
90819	(Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services).
90821	(Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient).
90822	(Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services).
	Interactive Psychotherapy
90823	(Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient).
90824	(Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services).
90826	(Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient).
90827	(Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services).
90828	(Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient).
90829	(Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services).

H. Section 3108: Permitting Physician Assistants To Order Post-Hospital Extended Care Services

The ACA included a self-implementing provision relating to SNFs. Section 3108 adds physician assistants (PAs) to the list of practitioners (that is, physicians, nurse practitioners (NPs), and clinical nurse specialists) that can perform the required initial certification and periodic recertifications under section 1814(a)(2)(B) of the Act with respect to the SNF level of care. Accordingly, we are proposing to make appropriate revisions to include PAs in § 424.20(e)(2), in which we refer to NPs, clinical nurse specialists, and PAs collectively as "physician extenders."

I. Section 3111: Payment for Bone Density Tests

Section 1848(b) of the Act (as amended by section 3111 of the ACA) changes the payment calculation for dual-energy X-ray absorptiometry (DXA) services described by two specified DXA CPT codes for CYs 2010 and 2011. This provision requires payment for these services at 70 percent of the product of the CY 2006 RVUs for these DXA codes, the CY 2006 conversion factor (CF), and the geographic adjustment for the relevant payment year.

Effective January 1, 2007, the CPT codes for DXA services were revised. The former DXA CPT codes 76075 (Dual energy X-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton (*e.g.,* hips, pelvis, spine)); 76076 (Dual energy X-ray absorptiometry (DXA), bone density study, one or more sites; appendicular skeleton (peripheral) (*e.g.,* radius, wrist, heel)); and 76077 (Dual energy X-ray absorptiometry (DXA), bone density study, one or more sites; vertebral fracture assessment) were deleted and replaced with new CPT codes 77080, 77081, and 77082 that have the same respective code descriptors as the predecessor codes. Section 1848(b) of the Act (as amended by section 3111 of the ACA) specifies that the revised payment applies to two of the predecessor codes (CPT codes 76075 and 76077) and "any succeeding codes," which are, in this case, CPT codes 77080 and 77082.

Section 1848(b) (as amended by section 3111 of the ACA) revises the payment for CPT codes 77080 and 77082 during CY 2010 and CY 2011. We have provided payment in CY 2010 under the PFS for CPT codes 77080 and 77082 at the specified rates. We note that the RVUs included in Addendum B to this proposed rule reflect the RVUs that result from application of this statutory provision and the proposed CY 2011 conversion factor. Because the statute specifies a payment amount for these services as described previously, we imputed RVUs for CY 2011 to include in Addendum B that would provide the specified payment amount for these services when multiplied by the CY 2011 CF. Specifically, we divided the payment amount based on the statutory requirements by the CY

2011 CF for this proposed rule, and distributed the imputed total RVUs across the work, PE, and malpractice components proportionately to their CY 2006 distribution. Therefore, these imputed RVUs for CPT codes 77080 and 77082 are displayed in Addendum B to this proposed rule.

J. Section 3114: Improved Access for Certified Nurse-Midwife Services

Section 1833(a)(1)(K) of the Act (as amended by section 3114 of the ACA) increases the amount of Medicare payment made under the PFS for certified nurse-midwife (CNM) services. Currently, section 1833(a)(1)(K) of the Act specifies that the payment amount for CNM services is 80 percent of the lesser of the actual charge or 65 percent of the PFS amount. Under section 1833(a)(1)(K) of the Act (as amended by section 3114 of the ACA), effective for services furnished on or after January 1, 2011, Medicare payment for CNM services is increased to 100 percent of the PFS amount (or 80 percent of the actual charge if that is less). We are proposing to revise our regulations at § 414.54 (Payment for certified nurse-midwives' services) accordingly to reflect the increased payment for CNM services effective for services furnished on or after January 1, 2011.

Although CNMs are currently paid under Medicare Part B for their professional services, there is no mention of CNMs under the regulatory provision that lists the providers and suppliers of services to whom payment is made under the Medicare Part B program. Accordingly, we are proposing to make a technical revision to § 410.150 (To whom payment is made) to specify that Medicare Part B pays CNMs for professional services in all settings, as well as services and supplies furnished incident to those services.

CNMs are authorized under the statute to be paid directly for services that they are legally authorized to furnish under State law and that are of the type that would otherwise be covered if furnished by a physician or incident to a physician's services. Additionally, there is no requirement under the CNM benefit for physician oversight or supervision. Accordingly, CNMs are authorized to personally furnish diagnostic tests that fall under their State scope of practice without regard to the levels of physician supervision required under the diagnostic tests benefit. Therefore, we are amending § 410.32(b)(2) (Exceptions to the levels of physician supervision required for diagnostic tests) to include CNMs who furnish diagnostic tests that fall within their State scope of practice.

K. Section 3122: Extension of Medicare Reasonable Costs Payments for Certain Clinical Diagnostic Laboratory Tests Furnished to Hospital Patients in Certain Rural Areas

Section 416 of the MMA established a reasonable cost payment for outpatient clinical diagnostic laboratory tests furnished by hospitals with fewer than 50 beds that are located in qualified rural areas for cost reporting periods beginning during the 2-year period beginning on July 1, 2004.

Section 105 of the Tax Relief and Health Care Act of 2006 (Pub. L. 109–432) (TRHCA) extended the 2-year period in section 416(b) of the MMA for an additional cost-reporting year.

Section 107 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173) (MMSEA) extended the time period for cost reporting periods beginning on July 1, 2004, and ending on June 30, 2008. For some hospitals with cost reports that began as late as June 30, 2008, this extension affected services performed as late as June 29, 2009, because this was the date those cost reports would have closed.

Section 3122 of the ACA reinstitutes reasonable cost payment for clinical diagnostic laboratory tests performed by hospitals with fewer than 50 beds that are located in qualified rural areas as part of their outpatient services for cost reporting periods beginning on or after July 1, 2010, through June 30, 2011. For some hospitals with cost reports that begin as late as June 30, 2011, this reinstitution of reasonable cost payment could affect services performed as late as June 29, 2012, because this is the date those cost reports will close.

L. Section 3134: Misvalued Codes Under the Physician Fee Schedule

Section 1848(c)(2)(K) of the Act (as added by section 3134 of the ACA) requires the Secretary to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of those services identified as being potentially misvalued. Section 1848(c)(2)(K) of the Act (as added by section 3134 of the ACA) further specifies that the Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services, as well as conduct surveys or implement other data collection activities, studies, or other analyses as the Secretary determines to be appropriate to facilitate the review and appropriate adjustment of the relative values of potentially misvalued codes. Finally, section 1848(c)(2)(L) of the Act (as added by section 3134 of the ACA) provides that the Secretary shall establish a process to validate relative value units under the PFS.

We note that over the past several years, we have been working with the AMA RUC to identify approaches to addressing the issue of potentially misvalued services. Our proposed CY 2011 approaches to categories of potentially misvalued codes are discussed in section II.C. of this proposed rule.

M. Section 3135: Modification of Equipment Utilization Factor for Advanced Imaging Services

1. Adjustment in Practice Expense To Reflect Higher Presumed Utilization

Section 1848(b)(4)(C) of the Act (as added by section 3135(a) of the ACA) adjusts the utilization rate for expensive diagnostic imaging equipment to 75 percent in the methodology for establishing the PE of the associated procedures. As discussed further in section II.A.3.a. of this proposed rule, effective January 1, 2011, we are proposing to assign a 75 percent equipment utilization rate assumption to expensive diagnostic imaging equipment used in services described by the HCPCS codes displayed in Table 4.

In the CY 2010 PFS final rule with comment period (74 FR 61755), we finalized a policy to increase the utilization rate to 90 percent for expensive diagnostic equipment priced at more than $1 million (CT and MRI scanners), providing for a 4-year transition to the 90 percent utilization rate from the CY 2009 utilization rate of 50 percent. Therefore, in CY 2010 we were transitioning to a 90 percent equipment utilization rate assumption, applying a 25/75 blend of the new and old PE RVUs, respectively, for the associated procedures. Section 1848(b)(4)(C) of the Act (as added by section 3135(a) of the ACA) does not provide for any further transition and, therefore, we are assigning a 75 percent equipment utilization rate assumption to CT and MRI scanners, effective January 1, 2011. Under section 1848(b)(4) of the Act (as amended by section 3135(a) of the ACA), this change in the equipment utilization rate assumption from CY 2010 to CY 2011 is not budget neutral under the PFS. The equipment utilization rate assumption remains at 50 percent for all other equipment included in the PFS PE methodology.

2. Adjustment in Technical Component "Discount" on Single-Session Imaging to Consecutive Body Parts

Section 1848(b)(4)(D) of the Act (as added by section 3135(a) of the ACA) increases the established PFS multiple procedure payment reduction (MPPR) for the technical component (TC) of certain single-session imaging services to consecutive body areas from 25 to 50 percent, effective July 1, 2010, and section 1848(c)(2)(B)(v)(VI) of the Act (as added by section 3135(b) of the ACA) exempts this change from the PFS budget neutrality provision. This policy is discussed in detail in section II.C.4 of this proposed rule.

Effective January 1, 2006, we adopted an MPPR of 25 percent for the technical component (TC) of certain diagnostic imaging procedures, applied to the second and subsequent services when more than one service in one of 11 imaging families, defined by imaging modality and contiguous body area, is furnished in a single session (70 FR 70261 through 70263). The established imaging MPPR applies to TC-only services and to the TC of global services. It does not apply to professional component (PC) services. Under this policy, full payment was made for the TC of the highest priced procedure, while payment was made at 75 percent of the TC for each additional procedure. As of July 1, 2010, and continuing in CY 2011, payment is made at 50 percent of the TC for each additional procedure, consistent with the statutory provision.

N. Section 3136: Revision for Payment for Power-Driven Wheelchairs

1. Payment Rules for Power Wheelchairs

Durable medical equipment (DME) is defined at section 1861(n) of the Act and includes wheelchairs necessary for use in the patient's home. Section 1861(n) provides that wheelchairs included in the definition of DME "may include a power-operated vehicle that may be appropriately used as a wheelchair, but only where the use of such a vehicle is determined to be necessary on the basis of the individual's medical and physical condition." The general Medicare payment rules for DME are set forth in section 1834(a) of the Act and 42 CFR part 414, subpart D of our regulations. Section 1834(a)(1) of the Act and § 414.210(a) of our regulations establish that the Medicare payment for a DME item is generally equal to 80 percent of either the lower of the actual charge or the fee schedule amount for the item. The beneficiary coinsurance is generally equal to 20 percent of either the lower of the actual charge or the fee schedule amount for the item once the deductible is met.

For Medicare payment purposes, power wheelchairs or power-driven wheelchairs are classified under various codes in the Healthcare Common Procedure Coding System (HCPCS) based on the level of performance and functional characteristics of each power wheelchair that accommodate the specific needs of patients. Power wheelchairs classified under performance Groups 1 through 3 are covered under Medicare for use in the patient's home. Power wheelchair groups were established in 2006 with the release of the Power Mobility Device Coding Guidelines published by the Durable Medical Equipment Regional Carriers (DMERCs) currently called the Durable Medical Equipment Medicare Administrative Contractors (DME MACs). The DMEPOS quality standards define certain power wheelchairs falling as "complex, rehabilitative" power wheelchairs, and these "complex, rehabilitative" power wheelchairs are treated as a separate product category for the purpose of implementing the DMEPOS Competitive Bidding Program (CBP) mandated by section 1847(a) of the Act. In both the quality standards and the DMEPOS competitive bidding program, complex, rehabilitative power wheelchairs are defined or identified as power wheelchairs classified as Group 2 power wheelchairs with power options that can accommodate rehabilitative features (for example, tilt in space) or Group 3 power wheelchairs.

With the exception of power wheelchairs furnished during calendar year 1990, power wheelchairs have been paid under the capped rental category of DME since January 1, 1989. The payment rules for capped rental DME are provided at section 1834(a)(7) of the Act and § 414.229 of our regulations. Payment for these items is generally on a monthly rental basis, with rental payments capped at 13 months. After a 13-month period of continuous use during which rental payments are made, the statute and regulations require that the supplier transfer title to the wheelchair to the beneficiary. In addition, effective for power wheelchairs furnished on or after January 1, 1***, section 1834(a)(7) of the Act, as amended by section 4152(c)(2) (D) of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101–508), mandates that the supplier of the power wheelchair offer the patient the option to purchase rather than rent the item. Since 1991, over 95 percent of Medicare beneficiaries have exercised this lump-sum purchase option for power wheelchairs.

Consistent with payment for other DMEPOS items, § 414.210(f)(1) permits payment for replacement of capped rental DME if the item has been in continuous use for the equipment's reasonable useful lifetime or is lost, stolen, or irreparably damaged. Section 414.210(f)(1) states the reasonable useful lifetime for equipment is determined through program instructions. In the absence of CMS program instructions, the carrier may determine the reasonable useful lifetime for equipment, but in no case can it be less than 5 years. Computation is based on when the equipment is delivered to the beneficiary, not the age of the equipment. If the beneficiary elects to obtain a new capped rental item after the reasonable useful lifetime, a new 13-month rental payment period would begin for the new equipment in accordance with the requirements of § 414.229.

Section 1834(a)(7)(A) of the Act, § 414.229(b) and (c) set forth the current fee schedule amounts for capped rental items. Pursuant to section 1834(a)(7)(A)(i)(II) of the Act and § 414.229(b), the current rental fee schedule amounts for months 1 thru 3 of the 13-month capped rental period are calculated to pay 10 percent of the average of allowed purchase price for the item. The rental fee schedule amounts for months 4 thru 13 of the 13-month capped rental period are calculated to pay 7.5 percent of the average of allowed purchase price for the item. The purchase price is determined consistent with section 1834(a)(8) of the Act and § 414.229(c) and § 414.220(e) and (f) and is updated by the covered item update, as required by section 1834(a)(14) of the Act and § 414.229(d). The current purchase price amount for power wheelchairs acquired on a lump sum purchase basis is 100 percent of the purchase price calculated for the item when rented, as discussed above.

2. Revision of Payment Amounts for Power Wheelchairs

Section 3136(a) of the ACA made several changes to section 1834(a)(7)(A) of the Act. Section 3136(a)(1) of the ACA amends section 1834(a)(7)(A) of the Act by adding a new subclause (III) to section 1834(a)(7)(A)(i) of the Act. Subclause (III) revises the capped rental fee schedule amounts for all power wheelchairs, modifying the current payment structure of 10 percent of the purchase price for months 1 thru 3 and 7.5 percent of that purchase price for months 4 through 13 that was discussed above. The rental fee schedule amount for months 1 thru 3 of the 13-month

capped rental period for power wheelchairs is revised to 15 percent of the purchase price for the item. The rental fee schedule amounts for months 4 thru 13 of the 13-month capped rental period for power wheelchairs is revised to 6 percent of the purchase price for the item. The statutory provision does not change the methodologies used to calculate and subsequently update of the purchase price of power wheelchairs. Therefore, the methodology described above for determining the purchase price amounts will continue to apply.

Pursuant to section 3136(c) of the ACA, the changes made by section 3136(a) of the ACA apply to power-driven wheelchairs furnished on or after January 1, 2011.

Furthermore, as discussed above, section 3136(c)(2) of the ACA states that the changes made by section 3136(a), including the new payment structure for power wheelchairs, do not apply to payment made for items and services furnished pursuant to contracts entered into under section 1847 of the Act for the DMEPOS CBP prior to January 1, 2011 which applies to the implementation of the first round of the DMEPOS CBP. As a result, contract suppliers furnishing power wheelchairs in competitive bidding areas (CBA) pursuant to contracts entered into prior to January 1, 2011 as part of Round 1 of the DMEPOS CBP will continue to be paid based under the current regulations using 10 percent of the purchase price for months 1 through 3 and 7.5 percent for each of the remaining months. As a result, we are proposing to make changes to §§ 414.202, 414.229 and 414.408 to reflect these statutory requirements.

3. Elimination of Lump Sum Payment for Standard Power Wheelchairs

Section 3136(a)(2) of the ACA further amends section 1834(a)(7)(A)(iii) by inserting the term "complex rehabilitative" before the term "power-driven wheelchairs." As a result, section 1834(a)(7)(A)(iii) of the Act now extends the lump sum purchase option only to complex rehabilitative power wheelchairs. As discussed above, "complex rehabilitative power wheelchairs are power wheelchairs that are classified as: (1) Group 2 power wheelchairs with power options that can accommodate rehabilitative features (for example, tilt in space), or (2) Group 3 power wheelchairs. We consider all other power wheelchairs to be standard power wheelchairs. Therefore, we propose to interpret the language "complex rehabilitative" in section 1834(a)(7)(A) of the Act consistent with this longstanding classification. As a result, the changes made by section 3136 to section 1834(a)(7)(A)(iii) eliminate the lump sum purchase option for standard power wheelchairs.

Pursuant to section 3136(c) of the ACA, the changes made to section 1834(a)(7)(A)(iii) of the Act apply to power-driven wheelchairs furnished on or after January 1, 2011. The lump sum purchase payment option will no longer extend to standard power driven wheelchairs furnished on or after January 1, 2011.

Furthermore, section 3136(c)(2) of the ACA states that the changes made by section 3136(a), including the limitation of the lump sum purchase payment option to complex, rehabilitative power wheelchairs, do not apply to payment made for items and services furnished pursuant to contracts entered into under section 1847 of the Act for the DMEPOS CBP prior to January 1, 2011 pursuant to the implementation of the first round of the DMEPOS CBP. As a result, contract suppliers furnishing power wheelchairs in CBAs pursuant to contracts entered into prior to January 1, 2011 as part of Round 1 of the DMEPOS CBP must continue to offer beneficiaries the lump sum purchase option for all power wheelchairs.

We are proposing changes to §§ 414.229 and 414.408 to reflect our interpretation of these statutory requirements.

O. Section 3139: Payment for Biosimilar Biological Products

Section 3139 of the ACA amends section 1847A of the Act to provide for Medicare payment of biosimilar biological products using the average sale price (ASP) methodology.

Section 1847A of the Act, as amended by the ACA, defines a biosimilar biological product as a biological product approved under an abbreviated application for a license of a biological product that relies in part on data or information in an application for another biological product licensed under section 351 of the Public Health Service Act (PHSA). The reference biological product for a biosimilar biological product is defined by the statute as the biological product licensed under such section 351 of the PHSA that is referred to in the application of the biosimilar biological product.

The ACAct also amends section 1847A of the Act to specify that the payment amount for a biosimilar biological product will be the sum of the following two amounts: the ASP of all NDCs assigned to the biosimilar biological drug product determined using the methodology in section 1847A(b)(6) of the Act, and 6 percent of the payment amount determined using the methodology in section 1847A(b)(4) of the Act for the corresponding reference biological product. Sections 7001 to 7003 of the ACA also established a licensing pathway for biosimilar biological products, and in accordance with the statute, the effective date for Medicare ASP statutory provisions is July 1, 2010. We are proposing conforming regulation text changes at § 414.902 and § 414.904 and we welcome comments on these conforming changes.

We anticipate that as biosimilar biological drug products are approved, we will receive ASP sales data through the ASP data submission process and publish national payment amounts in a manner that is consistent with our current approach to other drugs and biologicals that are paid under section 1847A of the Act and set forth in 42 CFR part 414 subpart J. Until we have collected sufficient sales data, as reported by manufacturers, payment limits will be determined in accordance with the provisions in section 1847A(c)(4) of the Act. If no manufacturer data is collected, prices will be determined by local contractors using any available pricing information, including provider invoices. More information about the ASP payment methodology and the data submission process may be found on the CMS Web site at *http://www.cms.gov/McrPartBDrugAvgSalesPrice/01_overview.asp* and in this rule, in the section VI.A.1. of this proposed rule, "Carry Over" ASP.

P. Section 3401: Revision of Certain Market Basket Updates and Incorporation of Productivity Improvements Into Market Basket Updates That Do Not Already Incorporate Such Improvements.

1. ESRD Market Basket Discussion

Section 3401(h) of the ACA amended section 1881(b)(14)(F) of the Act and directs the Secretary to annually increase payment amounts established under the ESRD market basket. Please see section VI.E. of this proposed rule for a detailed description of these provisions.

2. Productivity Adjustment Regarding Ambulatory Surgical Center, Ambulance, Clinical Laboratory and DMEPOS Fee Schedules

Section 3401 of the ACA requires that the update factor under certain payment systems be annually adjusted by changes in economy-wide productivity.

The year that the productivity adjustment is effective varies by payment system. Specifically, section 3401 of the ACA requires that in CY 2011 (and in subsequent years) update factors under the ambulatory surgical center (ASC) payment system, the ambulance fee schedule (AFS), and the clinical laboratory fee schedule (CLFS) be adjusted by changes in economy-wide productivity. Section 3401(a) amends section 1886(b)(3)(B) of the Act to add clause (xi)(II) which sets forth the definition of this productivity adjustment. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP) (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period) (the "MFP adjustment"). Please see *http://www.bls.gov/mfp* for more information on MFP. This is the link to the Bureau of Labor Statistics (BLS) historical published data on the measure of MFP.

The projection of MFP will be produced by an economic forecasting firm, currently HIS Global Insight (IGI). In order to generate a forecast of MFP, IGI would replicate the MFP measure calculated by the BLS using a series of proxy variables derived from the IGI US Macro-economic models. These models take into account a very broad range of factors that influence the total US economy. IGI forecasts the underlying proxy components such as Gross Domestic Product (GDP), capital, and labor inputs required to estimate MFP, and will combine those projections according to the BLS methodology. For more information on the BLS measure of MFP, including technical notes, visit: *http://www.bls.gov/mfp/*. Table 34 lists the MFP component series employed by the BLS and the corresponding concepts estimated by IGI.

TABLE 34—MULTIFACTOR PRODUCTIVITY COMPONENT SERIES EMPLOYED BY THE BUREAU OF LABOR STATISTICS AND HIS GLOBAL INSIGHT

BLS Series	IGI Series
Real value-added output, constant 2000 dollars	Real gross non-farm value added output, chained 2005 dollar billions.
Private non-farm business sector labor input; 2000=100.00	Hours of all persons-private nonfarm business sector; 1992=1.0.
Aggregate capital inputs; 2000=100.00	Real effective capital stock used for full employment GDP, chained 2005 dollar billions.

To identify the appropriate proxy variables, IGI compared the historical growth rates of the BLS and IGI components listed above and found they were consistent across all series and therefore suitable proxies for calculating MFP. IGI would use the growth rates of the forecasted IGI concepts to project BLS' components of MFP, and derive the MFP adjustment that would be used under section 3401 to adjust the updates for the ASC payment system, the AFS, and the CLFS.

As discussed below, for each of these payment systems, the update factor is the percentage increase (or percentage decrease for the CLFS) in the consumer price index for all urban consumers (CPI–U) (referred to as the "CPI–U update factor").

The statute for all three payment systems generally states that the Secretary shall reduce the CPI–U adjustment by the MFP adjustment. In order to calculate the MFP-adjusted updates to these payment systems, the MFP percentage adjustment would be subtracted from the CPI–U update factor (for the most recent 12-month period beginning with July 1 of the previous year and ending with June 30 of the current year). For example, if the update factor (CPI–U) is 4.0 percent, and the projected MFP is 1.3 percent, the MFP–Adjusted update factor (or MFP–Adjusted CPI–U for these payment systems) would be a 2.7 percent increase.

The period on which the CPI–U is calculated is for the most recent 12-month period beginning with July 1 of the previous year and ending with June 30 of the current year, and we propose that the end of the 10-year moving average of changes in the MFP should coincide with the end of this CPI–U timeframe. Since the CPI–U update factor is reduced by the MFP adjustment to determine the annual update for these payment systems, we believe it is appropriate for the numbers associated with both parts of the calculation to be projected as of the same end date (in this case, the end date of the time frame for both estimates would be June 30th of the year preceding the update year itself). In this way, changes in market conditions are aligned. We will round the final annual adjustment to the one-tenth of one percentage point level up or down as applicable according to conventional rounding rules (that is, if the number we are rounding is followed by 5, 6, 7, 8, or 9, we will round the number up; if the number we are rounding is followed by 0, 1, 2, 3, or 4, we will round the number down).

Below, we provide more information on the statutory requirements and proposals for each of the three payment systems. The statutory requirements for the ASC payment system will also be addressed in the CY 2011 OPPS/ASC proposed rule. We note that, in this proposed rule, we are describing the legislative provision and outlining the methodology we propose to use to calculate and apply the MFP adjustment to determine the annual updates for ASCs, the AFS, and the CLFS for CY 2011 and each subsequent year. We will set forth the final MFP adjustment for CY 2011 in the CY 2011 PFS final rule. Once we finalize the methodology for determining and applying the MFP adjustment to the CPI–U update factors for these payment systems, for subsequent calendar years, as we have done in the past, we intend to notify the general public of the annual update to the AFS and CLFS via CMS instruction and on the CMS Web site. These notifications would set forth both the CPI–U percentage increase or decrease and the MFP adjustment for the applicable year. For ASCs, for subsequent calendar years, as we have done in the past, we would continue to notify the general public of the annual update to the ASC payment amount via OPPS/ASC rulemaking.

We welcome comments on these proposals.

a. Ambulatory Surgical Centers (ASCs)

Section 1833(i)(2)(C) of the Act requires that, if the Secretary has not updated the ASC payment amounts in a calendar year, the payment amounts shall be increased by the percentage increase in the CPI–U as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved. Because the Secretary does update the ASC payment amounts annually, we adopted a policy, which we codified at § 416.171(a)(2)(ii), to update the ASC conversion factor using the CPI–U for CY 2010 and subsequent calendar years. Therefore, the annual

update to the ASC payment system is the CPI–U (referred to as the CPI–U update factor). Section 3401(k) of the ACA amends section 1833(i)(2)(D) of the Act by adding a new clause (v) which requires that "any annual update under [the ASC payment] system for the year * * * shall be reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II)" (which we refer to as the MFP adjustment) effective with the calendar year beginning January 1, 2011. Section 3401(k) of the ACA states that application of the MFP adjustment to the ASC payment system may result in the update to the ASC payment system being less than zero for a year and may result in payment rates under the ASC payment system for a year being less than such payment rates for the preceding year.

In accordance with section 1833(i)(2)(C)(i) of the Act, before applying the MFP adjustment, the Secretary first determines the "percentage increase" in the CPI–U, which we interpret cannot be a negative number. Thus, in the instance where the percentage change in the CPI–U for a year is negative, we propose to hold the CPI–U update factor for the ASC payment system to zero. Section 1833(i)(2)(D)(v) of the Act, as added by section 3401(k) of the ACA, then requires that the Secretary reduce the CPI–U update factor (which would be held to zero if the CPI–U percentage change is negative) by the MFP adjustment, and states that application of the MFP adjustment may reduce this percentage change below zero. If the application of the MFP adjustment to the CPI–U percentage increase would result in a MFP-adjusted CPI–U update factor that is less than zero, then the annual update to the ASC payment rates would be negative and payments would decrease relative to the prior year.

Table 35 provides illustrative examples of how the MFP would be applied to the ASC payment system. These examples show the implication of a positive CPI–U update factor with a smaller MFP, a positive CPI–U update factor with a large MFP, and a CPI–U update factor of 0. We discuss the application of the MFP to the CPI–U update factor for the ASC payment system under the OPPS/ASC CY 2001 proposed rule (1504–P), which will be published around the same time as this proposed rule. Comments on the specific mathematical calculation of the MFP should be made to this PFS proposed rule. Comments on the application of the MFP to the CPI–U update factor under the ASC payment system should be made to the OPPS/ASC CY 2011 proposed rule (1504–P).

TABLE 35—MULTIFACTOR PRODUCTIVITY ADJUSTED PAYMENT UPDATE: ILLUSTRATIVE EXAMPLE

CPI–U (percent)	MFP (percent)	MFP–Adjusted CPI–U update factor (percent)
4.0	1.3	2.7
4.0	4.7	−0.7
0.0	0.2	−0.2

b. Ambulance Fee Schedule (AFS)

In accordance with section 1834(l)(3)(B) of the Act, the AFS is required to be increased each year by the percentage increase in the CPI–U (U.S. city average) for the 12-month period ending with June of the previous year. We refer to this update as the Ambulance Inflation Factor (AIF). Section 3401(j) of the ACA amends section 1834(l)(3) of the Act to add a new subparagraph (C) which states that, for CY 2011 and each subsequent year, after determining the percentage increase under section 1834(l)(3)(B) (that is, the CPI–U percentage increase, or AIF), the Secretary shall reduce such percentage increase by the MFP adjustment described in section 1886(b)(3)(B)(xi)(II) (as discussed above). Section 3401(j) further amends section 1834(l)(3) to state that the application of subparagraph (C) (that is, the reduction of the CPI–U percentage increase by the MFP adjustment) may result in that percentage increase being less than zero for a year, and may result in payment rates for a year being less than such payment rates for the preceding year.

In accordance with section 1834(l)(3) of the Act as amended by section 3401(j) of the ACA, before applying the MFP adjustment, the Secretary first determines the "percentage increase" in the CPI–U, which we interpret cannot be a negative number. Thus, in the instance where the percentage change in the CPI–U for a year is negative, we propose to hold the AIF to zero. The statute then requires that the Secretary reduce the CPI–U percentage increase (which would be held to zero if the CPI–U percentage change is negative) by the MFP adjustment, and states that application of the MFP adjustment may reduce this percentage increase below zero. If the application of the MFP adjustment to the CPI–U percentage increase would result in an MFP-adjusted AIF that is less than zero, then the annual update to the AFS would be negative and payments would decrease relative to the prior year.

Table 36 provides illustrative examples of how the MFP would be applied to the AFS. Finally, we propose to revise § 414.610(f) to require that the AIF be reduced by the MFP adjustment as required by the statute in determining the annual update under the ambulance fee schedule for CY 2011 and each subsequent year, and to revise § 414.620 to state that changes in payment rates resulting from the incorporation of the AIF and the MFP adjustment will be announced by CMS by instruction and on the CMS Web site, as we discussed above.

TABLE 36—EXAMPLES OF THE APPLICATION OF THE MULTIFACTOR PRODUCTIVITY ADJUSTMENT TO THE AMBULANCE FEE SCHEDULE

A CPI–UA	B AIF	C MFP	D Final update rounded
2.0%	2.0%	1.3%	0.7%
0.0%	0.0%	1.3%	−1.3%
−2.0%	0.0%	1.3%	−1.3%
1.0%	1.0%	1.3%	−0.3%

c. Clinical Laboratory Fee Schedule

Section 1833(h)(2)(A)(i) of the Act, as amended by section 3401(l) of the ACA, requires the Secretary to annually adjust the CLFS "by a percentage increase or decrease equal to the percentage increase or decrease in the Consumer Price Index for All Urban Consumers (United States city average minus, for each of the years 2009 through 2010, 0.5 percentage points." Therefore, the

adjustment to the fee schedule can be an increase or a decrease.

Section 3401(l) of the ACA also adds new clause (iv) that applies in CY 2011 and each subsequent year. This clause requires the Secretary to reduce the adjustment in clause (i): (1) By the MFP adjustment described in section 1886(b)(3)(B)(xi)(II) for 2011 and each subsequent year and (2) by 1.75 percentage points for each of 2011 through 2015 (the "percentage adjustment"). However, section 3401(l) of the ACA states that the MFP adjustment will not apply in a year where the adjustment to the fee schedule determined under clause (i) is zero or a percentage decrease for a year. Further, the application of the MFP adjustment may not result in an adjustment to the fee schedule under clause (i) of less than zero for a year.

Therefore, we are proposing to apply the MFP adjustment as follows:

- If the CPI–U update factor is positive, it would be reduced by the MFP. However, if application of the MFP would result in a negative update, the update would be held to zero.
- If the CPI–U update factor is zero or negative, the MFP adjustment would not be applied.

Section 3401(l) of the ACA also states that the application of the percentage adjustment may result in an adjustment to the fee schedule under clause (i) being less than zero for a year and may result in payment rates for a year being less than such payment rates for the preceding year. Therefore, we are proposing to apply the percentage reduction of 1.75 percentage points to any adjustment to the fee schedule under the CLFS as directed by Section 3401(l) of the ACA.

Table 37 provides illustrative examples of how these adjustments would be applied to fees under the CLFS.

TABLE 37—EXAMPLES OF THE APPLICATION OF THE MULTIFACTOR PRODUCTIVITY ADJUSTMENT TO THE CLINICAL LAB FEE SCHEDULE

CPI–U	MFP	Productivity adjusted update	(−1.75%) Percentage point reduction	Resultant change to CLFS
		Greater of 0.0% or (Col.A) − (Col.B)		Col.C − Col.D
A	B	C	D	E
2.0%	1.3%	0.7%	−1.75%	−1.05%
0.0%	N/A	0.0%	−1.75%	−1.75%
−2.0%	N/A	0.0%	−1.75%	−1.75%

d. DMEPOS Fee Schedule

Sections 1834(a)(14), 1834(h)(4), and 1842(s)(1) of the Act mandate annual updates to the fee schedule amounts established in accordance with these respective sections for covered items of durable medical equipment defined in section 1834(a)(13) of the Act, prosthetic devices, orthotics, and prosthetics defined in section 1834(h)(4)(B) and (C) of the Act, and parenteral and enteral nutrients, equipment, and supplies described in section 1842(s)(2)(D) of the Act. The annual updates for 2011 for these sections are based on the percentage increase in the CPI–U for the 12-month period ending with June 2010. The annual updates for years subsequent to 2011 are based on the percentage increase in the CPI–U for the 12-month period ending with June of the previous year (that is, June 2011 for 2012, June 2011 for 2013, *etc.*). Since 1990 for durable medical equipment, prosthetic devices, orthotics, and prosthetics and 2003 for parenteral and enteral nutrients, equipment, and supplies, these annual fee schedule updates have been implemented on an annual basis through program instructions.

Section 3401(m) of the ACA amends section 1834(a)(14) of the Act to add a new subparagraph (L) which provides that, for CY 2011 and each subsequent year, the fee schedule update factor based on the CPI–U for the 12-month period ending with June of the previous year is to be reduced by the MFP adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act (as discussed above). Section 3401(m) of the ACA further amends section 1834(a)(14) of the Act to state that the application of subparagraph (L) (that is, the reduction of the CPI–U percentage increase by the MFP adjustment) may result in that percentage increase being less than zero for a year, and may result in payment rates for a year being less than such payment rates for the preceding year.

Section 3401(n) of ACA amends section 1834(h)(4)(A) of the Act to add a new clause (xi) which provides that, for CY 2011 and each subsequent year, the fee schedule update factor based on the CPI–U for the 12-month period ending with June of the previous year is to be reduced by the MFP adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act (as discussed above). Section 3401(n) of the ACA further amends section 1834(h)(4) of the Act to state that the application of subparagraph (A)(xi) (that is, the reduction of the CPI–U percentage increase by the MFP adjustment) may result in that percentage increase being less than zero for a year, and may result in payment rates for a year being less than such payment rates for the preceding year.

Section 3401(o) of ACA amends section 1842(s)(1) of the Act to add a new subparagraph (B) and clause (ii) which provides that, for CY 2011 and each subsequent year, the fee schedule update factor based on the CPI–U for the 12-month period ending with June of the previous year is to be reduced by the MFP adjustment described in section 1886(b)(3)(B)(xi)(II) (as discussed above). Section 3401(o) further amends section 1842(s)(1) to state that the application of subparagraph (B)(ii) (that is, the reduction of the CPI–U percentage increase by the MFP adjustment) may result in that percentage increase being less than zero for a year, and may result in payment rates for a year being less than such payment rates for the preceding year.

The MFP adjustments to the CPI–U percentage increases used in calculating the fee schedule adjustment factors for these DMEPOS items and services as mandated by sections 3401(m), (n), and (o) of ACA are simple mathematical calculations and are ministerial in nature. Therefore, we plan to implement these adjustments for 2011 and subsequent years as part of the annual program instructions related to the DMEPOS fees schedule updates.

Q. Section 4103: Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan

1. Background

a. Medicare Coverage of Preventive Physical Examinations and Routine Checkups

Section 1862(a)(7) of the Act explicitly prohibits Medicare payment for routine physical checkups with certain exceptions. One exception is for the Initial Preventive Physical Exam (also referred to as the "Welcome to Medicare" exam) established for new beneficiaries effective for services furnished on or after January 1, 2005. Section 4103 of the ACA has provided another exception to section 1862(a)(7). Congress has expanded Medicare coverage under part B to include an Annual Wellness Visit Providing Personalized Prevention Plan Services (hereinafter referred to as the annual wellness visit) in sections 1861(s)(2)(FF) and 1861(hhh) of the Act. This expanded benefit will be effective on January 1, 2011. Preventive care has become an increasing focus of the Medicare program. For instance, section 101 of the MIPPA expanded Medicare's authority to establish coverage for preventive services that meet specified criteria. Among other things, the annual wellness visit will encourage beneficiaries to obtain the preventive services already covered by Medicare, and that are appropriate for each individual beneficiary.

b. Requirements for Coverage of an Annual Wellness Visit

Section 4103 of the ACA provides for coverage of an annual wellness visit, which includes and/or takes into account a health risk assessment (HRA), and creates a personalized prevention plan for beneficiaries, subject to certain eligibility and other limitations. Section 4103 of the ACA also requires the identification of elements that must be provided to a beneficiary as part of the first visit for personalized prevention plan services and requires the establishment of a yearly schedule for appropriate provision of such elements thereafter.

The Affordable Care Act specifies elements that may be included in a personalized prevention plan, including establishment of, or update to, the individual's medical and family history, a list of the individual's current providers and suppliers and medications prescribed for the individual; measurement of height, weight, body-mass index (BMI) or waist circumference, and blood pressure; detection of any cognitive impairment; establishment or update of an appropriate screening schedule for the next 5 to 10 years; establishment or update of a list of risk factors and conditions (including any mental health conditions) for which interventions are recommended or underway; and furnishing of personalized health advice and referral, as appropriate, to health education or preventive counseling services or programs. The Affordable Care Act also permits the Secretary to add other elements to the annual wellness visit determined to be appropriate.

2. Proposed Revisions

a. Proposed Revisions to § 411.15, Particular Services Excluded From Coverage

To conform the regulations to the statutory requirements of the ACA, we are proposing to revise § 411.15 by specifying an exception to the routine physical checkups exclusion from coverage in § 411.15(a)(1) and modifying § 411.15(k)(15). We would add a provision to permit coverage of annual wellness visits that meet the eligibility limitation and the conditions for coverage we are specifying in § 410.15 (Annual Wellness Visit Providing Personalized Prevention Plan Services). Coverage of the annual wellness visit is furnished under Medicare Part B only. As provided in the statute, this new coverage allows payment for an annual wellness visit if provided after January 1, 2011 for an individual who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage period, and has not received either an IPPE or an annual wellness visit within the past 12 months.

b. Proposed Revisions to Part 410, Subpart B—Medical and Other Health Services

We propose to add § 410.15(a), Condition for Coverage of Annual Wellness Visits Providing Personalized Prevention Plan Services, and § 410.15(b), Limitation on Coverage of Annual Wellness Visits Providing Personalized Prevention Plan Services, to codify the coverage of the annual wellness visit providing personalized prevention plan services.

We are proposing to define several terms in § 410.15. These include the following terms: (1) Detection of any cognitive impairment; (2) Review of the individual's functional ability and level of safety; (3) Health professional; (4) Establishment of, or update to the individual's medical and family history; (5) Eligible beneficiary; (6) First annual wellness visit providing personalized prevention plan services; and (7) Subsequent annual wellness visit providing personalized prevention plan services.

Further, the ACA allows the addition of any other element determined appropriate by the Secretary for inclusion in an annual wellness visit. We reviewed the relevant medical literature, current clinical practice guidelines, and the recommendations of the United States Preventive Services Task Force (USPSTF). Pursuant to that review, we propose to add depression screening and functional status screening as elements of the first annual wellness visit only. In their December 2009 Recommendation Statement, the U.S. Preventive Services Task Force (USPSTF) recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment and follow-up (Grade: B recommendation). That is, the USPSTF recommends the service; and there is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

The USPSTF is currently updating its 1996 recommendation regarding screening for hearing impairment in older adults as well as its recommendation on falls in the elderly. Until those recommendations can be published, functional status screening (including assessment of hearing impairment, ability to successfully perform activities of daily living, fall risk and home safety) appears supportable by evidence only for the first annual wellness visit.

We also are proposing that the definition of the term "Establishment of, or an update to the individual's medical and family history" include more than a list of all of an individual's prescribed medications as provided in the statute, but also supplements such as vitamins and calcium that an individual may use or be exposed to. Supplements such as these are commonly used by many beneficiaries and the medical literature supports that their use be closely monitored by health professionals because they can interact with prescribed medications and may result in unintended medical problems in individual cases. The statute expressly permits the Secretary to add other elements such as this to the annual wellness visits.

(1) Definitions

We are proposing to add the following definitions to § 410.15:

• *Detection of any cognitive impairment,* for purposes of this section, means assessment of an individual's cognitive function by direct observation, with due consideration of information obtained by way of patient report, concerns raised by family members, friends, caretakers, or others.

• *Review of the individual's functional ability and level of safety,* for purposes of this section includes, at a minimum, assessment of the following topics:

++ Hearing impairment;
++ Ability to successfully perform activities of daily living;
++ Fall risk;
++ Home safety.

• *Health professional,* for purposes of this section means:

++ A physician who is a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act); or
++ A practitioner as described in clause (i) of section 1842(b)(18)(C) of the Act, that is, a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5) of the Social Security Act); or
++ A medical professional (including a health educator, registered dietitian, or nutritionist) or a team of medical professionals, who are working under the supervision of a physician as defined in this definition.

• *Establishment of, or an update to the individual's medical and family history,* for purposes of this section, means at a minimum the collection and documentation of the following:

++ Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments.
++ Use or exposure to medications and supplements, including calcium and vitamins.
++ Medical events experienced by the beneficiary's parents and any siblings and children, including diseases that may be hereditary or place the individual at increased risk.

• *Eligible beneficiary,* for purposes of this section, means an individual who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage period, and has not received either an initial preventive physical examination or an annual wellness visit providing a personalized prevention plan within the past 12 months.

(2) Requirements of the First Visit for Personalized Prevention Plan Services

We are proposing that the first annual wellness visit for purposes of this benefit include the following:

• Establishment of the individual's medical and family history;

• Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual;

• Measurement of the individual's height, weight, body mass index (or waist circumference, if appropriate), blood pressure, and other routine measurements as deemed appropriate, based on the individual's medical and family history;

• Detection of any cognitive impairment that the individual may have;

• Review of the individual's potential (risk factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional as defined in this section may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations;

• Review of the individual's functional ability and level of safety, based on direct observation or the use of appropriate screening questions or a screening questionnaire, which the health professional as defined in this section may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations;

• Establishment of the following:

++ A written screening schedule, such as a checklist, for the next 5 to 10 years as appropriate, based on recommendations of the USPSTF and the Advisory Committee on Immunization Practices, and the individual's health status, screening history, and age-appropriate preventive services covered by Medicare; and
++ A list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway, including any mental health conditions or any such risk factors or conditions that have been identified through an initial preventive physical examination (as described under § 410.16), and a list of treatment options and their associated risks and benefits;

• Furnishing of personalized health advice and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition; and

• Any other element determined appropriate by the Secretary through the National Coverage Determination process.

(3) Requirements of Subsequent Visits for Personalized Prevention Plan Services

We are proposing that subsequent annual wellness visits providing personalized prevention plan services for purposes of this benefit include the following:

• An update of the individual's medical and family history;

• An update of the list of current providers and suppliers that are regularly involved in providing medical care to the individual, as that list was developed for the first annual wellness visit providing personalized prevention plan services;

• Measurement of an individual's weight, blood pressure, and other routine measurements as deemed appropriate, based on the individual's medical and family history;

• Detection of any cognitive impairment, as that term is defined in this section, that the individual may have;

• An update to the following:

++ The written screening schedule for the individual as that schedule was developed at the first annual wellness visit providing personalized prevention plan services; and
++ The list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway for the individual as that list was developed at the first annual wellness visit providing personalized prevention plan services;

• Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs as that advice and related services are defined in paragraph (a) of this section;

• Any other element determined appropriate by the Secretary through the National Coverage Determination process. Body-mass index (BMI) should be calculated at the first annual wellness visit and may be recalculated at subsequent visits, if indicated. Given

the general stability of adult height, we would not expect the BMI to meaningfully change in the absence of significant weight change. We have not in the definition of the subsequent annual visit required measurement of the individual's height.

We are proposing to add two distinct elements to the definition of the first annual wellness visit only: depression screening and functional status assessment. Our review of the medical literature and the USPSTF recommendations indicates that the optimum frequency for those services is unknown. Thus we believe it would be premature and beyond the current evidence to require that they be included in the definition of subsequent visits, but they may be performed at these visits, if indicated.

In addition, to facilitate future consideration of coverage of additional elements in the definitions of the first and subsequent annual wellness visits in § 410.15(a), we are proposing that the determination of other required elements for those purposes will be made through the National Coverage Determination (NCD) process. The NCD process is evidence based, transparent and furnishes the opportunity for public comment, and is described in sections 1862(l) of the Act.

While section 4103 of the ACA ultimately requires that an HRA be included in the new annual wellness visit benefit beginning January 1, 2011, the HRA guidelines (with standards for interactive telephonic and web-based HRAs) and the model HRA tool also required by section 4103 are not yet available. As a result, we have not included requirements related to the HRA in this proposed rule. When HRA guidelines and standards have been established, and a model HRA instrument is available and determined by the Secretary to be appropriate for the Medicare population, we will revise these regulations to include the HRA as an element in the definition of the annual wellness visit.

We are requesting public comments on the components of both the first and subsequent annual wellness visits, as well as the definitions of related terms in the document. We ask that commenters making specific recommendations on this or any related issue provide documentation from the medical literature, current clinical practice guidelines, or the USPSTF or Advisory Committee on Immunization Practices recommendations.

3. Payment for the Annual Wellness Visit Providing Personalized Prevention Plan Services (PPPS)

Section 4103 of the ACA created a new benefit for the "annual wellness visit" with personalized prevention plan services. The Affordable Care Act amends section 1861(s)(2) of the Act by adding a new subsection (FF) to provide for coverage of the annual wellness visit beginning January 1, 2011. Section 4103 also adds new subsection (hhh) to section 1861 of the Act to define "personalized prevention plan services" and to specify who may furnish these services. Finally, section 4103 amends section 1848(j)(3) of the Act to provide for payment of annual wellness visits under the PFS, and specifically excludes the annual wellness visit from the hospital outpatient prospective payment system (OPPS). Therefore, a single payment under the PFS will be made when an annual wellness visit is furnished by a physician, physician assistant, nurse practitioner, or clinical nurse specialist, or by a medical professional or team of medical professionals, as determined appropriate by the Secretary, under the supervision of a physician.

To allow for Medicare reporting and payment of the annual wellness visit, we are proposing to create two new HCPCS G-codes for reporting the first wellness visit and creation of the PPPS and the subsequent visits available to the beneficiary every 12 months. Specifically, we are proposing to establish the following two new HCPCS codes for CY 2011: GXXXA (Annual wellness visit; includes a personalized prevention plan of service (PPPS), first visit) and GXXXB (Annual wellness visit; includes a personalized prevention plan of service (PPPS), subsequent visit). A beneficiary's first annual wellness visit to a practitioner would be reported to Medicare under HCPCS code GXXXA, even if the beneficiary had previously received an initial preventive physical examination (IPPE) that was covered by Medicare. Beneficiaries, in their first 12 months of Part B coverage, will continue to be eligible only for an IPPE. After the first 12 months of Part B coverage, on and after January 1, 2011, beneficiaries will be eligible for an annual wellness visit described by HCPCS code GXXXA or GXXXB, provided that the beneficiary has not received an IPPE or annual wellness visit within the preceding 12-month period.

A beneficiary would be eligible for one initial annual wellness visit covered by Medicare that must include all of the required elements that we are proposing for the first visit as described in the preceding section. All other annual wellness visits that would include the required elements for those visits would be reported as subsequent visits, even if a different practitioner furnished the subsequent annual wellness visit. We would expect there to be continuity and communication among the practitioners caring for beneficiaries over time with respect to the PPPS, and that would include the case where a different practitioner furnishing a subsequent annual wellness visit would update the information in the patient's medical record based on the patient's interval history since the previous annual wellness visit.

The first wellness visit described by HCPCS code GXXXA is similar to the IPPE that is currently reported with HCPCS code G0402 (Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment). We believe that the physician work and nonfacility PE of the IPPE and the first annual wellness visit are very similar, given that both represent an initial beneficiary visit focused on prevention. In the CY 2010 PFS final rule with comment period discussion of payment for the IPPE (74 FR 61767), we noted that in the context of physician work and intensity, HCPCS code G0402 was most equivalent to CPT code 99204 (Level 4 new patient office or other outpatient visit). Therefore, for CY 2011, we are proposing to crosswalk the same physician work RVUs of 2.43 from CPT code 99204 to HCPCS codes G0402 and GXXXA. Similarly, we believe the direct PE inputs for all of these services are similar and, therefore, we are proposing to assign the same direct PE inputs to HCPCS codes G0402 and GXXXA as are included for CPT code 99204. We note that currently, the direct PE inputs for HCPCS code G0402 also include preventive assessment forms, and we are proposing to add this supply to the PE for HCPCS code GXXXA as well because we believe it would be used in the first wellness visit. The proposed CY 2011 PE and malpractice RVUs for HCPCS code GXXXA are displayed in Addendum B to this proposed rule. We also note that we are proposing no facility PE RVUs for HCPCS code GXXXA because only a single payment will be made under the PFS when this service is furnished. There is no separate facility payment for GXXXA when a practitioner furnishes this service in the facility setting.

Moreover, we believe that a subsequent annual wellness visit described by HCPCS code GXXXB is most similar, from the perspectives of

physician work and PE, to CPT code 99214 (Level 4 established patient office or other outpatient visit). The subsequent annual wellness visit is a patient visit for PPPS that includes certain required elements, such as updating information regarding the patient's history, risk factors, and regular medical care providers and suppliers since the prior annual visit, and obtaining routine measurements. We believe the physician work and direct PE of a subsequent annual wellness visit are similar, in terms of evaluation and management (E/M) visit level, to the first wellness visit, which we are proposing to value like a level 4 new patient office or other outpatient visit, as we have previously valued the IPPE. However, the subsequent annual wellness visit would typically be for an established patient and, as described earlier in this section, we are proposing that certain wellness visit elements only must be furnished in the first wellness visit. As a result, we believe it would be most appropriate to value the subsequent annual wellness visit based upon an E/M visit for an established patient. Therefore, for CY 2011 we are proposing to crosswalk the same physician work RVUs of 1.50 from CPT code 99214 to HCPCS code GXXXB. Furthermore, we believe the direct PE inputs for these two services are also similar and, therefore, we are proposing to assign the same direct PE inputs to HCPCS code GXXXB as are assigned to CPT code 99214. We note that we are also proposing to add the same preventive assessment forms to the PE for HCPCS code GXXXB as we are proposing to add for HCPCS code GXXXA because we believe this supply would be used in both the first and subsequent annual wellness visits. The proposed CY 2011 PE and malpractice RVUs for HCPCS code GXXXB are displayed in Addendum B to this proposed rule. Similar to our treatment of HCPCS code GXXXA for the first wellness visit, we are proposing no facility PE RVUs for HCPCS code GXXXB as only a single payment will be made under the PFS when this service is furnished. There is no separate facility payment for GXXXB when a practitioner furnishes this service in the facility setting.

While we believe there could be overlap in the direct PE, malpractice expense, and physician work in both history taking and examination of the patient in the context of the initial or subsequent wellness visit and another E/M service, we are not proposing to limit the level of a medically necessary E/M visit when furnished and billed with a wellness visit. As we stated in the CY 2005 PFS final rule with comment period with respect to the IPPE (69 FR 66289 through 66290), we do not want to prohibit the reporting of an appropriate level of service when it is necessary to evaluate and treat the beneficiary for acute and chronic conditions. However, at the same time, we believe the practitioner is better able to discuss health promotion, disease prevention, and the educational opportunities available with beneficiaries when their health status has been stabilized and the beneficiary is physically receptive. Therefore, depending on the clinical circumstances, a CPT code for a medically necessary E/M visit may be reported and appended with CPT modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to designate the E/M visit as a separately identifiable service from the initial or subsequent wellness visit. However, we believe this scenario would be uncommon, and we expect that no components of an encounter attributable to the annual wellness visit would be used in determining the level of a separate E/M visit that would also be reported.

With respect to beneficiary cost-sharing, section 4103(c) of the ACA amends section 1833(a)(1) of the Act by adding subparagraph (X), referring to the PPPS to state that the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under the payment basis determined under section 1848 of the Act, thereby eliminating coinsurance for the annual wellness visit. Finally, section 4103(b)(4) of the ACA amends section 1833(b) of the Act to specify that the Part B deductible does not apply to the annual wellness visit. We expect that practitioners will work to ensure that this valuable new Medicare benefit is furnished to the beneficiaries that they care for in their practices, effective January 1, 2011.

R. Section 4104: Removal of Barriers to Preventive Services in Medicare

1. Definition of "Preventive Services"

Section 4104 of the ACA revises section 1861(ddd) of the Act to add paragraph (3), which defines the term "preventive services" as follows:

- The specific services currently listed in section 1861(ww)(2) of the Act with the explicit exclusion of electrocardiograms (as specified in section 1861(ww)(2)(M) of the Act);
- The initial preventive physical examination (IPPE) established by section 611 of the MMA and defined in section 1861(ww)(1) of the Act; and
- The annual wellness visit, as specified by section 1861(hhh) of the Act as added by section 4103 of the ACA. We refer readers to section V.Q. of this proposed rule for the proposed provisions related to the coverage of and payment for the annual wellness visit. The regulations regarding coverage of the IPPE are specified in § 410.16 and remain unchanged by the ACA.

The specific preventive services included in the definition of "preventive services" in section 1861(ddd)(3)(A) of the Act as cross-referenced to section 1861(ww)(2) of the Act, excluding electrocardiograms, include the following:

- Pneumococcal, influenza, and hepatitis B vaccine and administration.
- Screening mammography.
- Screening pap smear and screening pelvic exam.
- Prostate cancer screening tests.
- Colorectal cancer screening tests.
- Outpatient diabetes self-management training (DSMT).
- Bone mass measurement.
- Screening for glaucoma.
- Medical nutrition therapy (MNT) services.
- Cardiovascular screening blood tests.
- Diabetes screening tests.
- Ultrasound screening for abdominal aortic aneurysm (AAA).
- Additional preventive services identified for coverage through the national coverage determination (NCD) process.

We note that currently the only additional preventive service identified for coverage through the NCD process is HIV testing. A proposed NCD for smoking cessation services for asymptomatic patients was released in May 2010 on the CMS Web site at: *http://www.cms.gov/mcd/index_list.asp?list_type=nca.* We will address the applicability of section 1861(ddd)(3)(A) of the Act (as added by section 4104 of the ACA) to these services if an NCD establishing them as additional preventive services is finalized.

We are proposing to add the definition of "preventive services" in § 410.2 to implement the provisions of section 1861(ddd)(3) of the Act (as amended by section 4104 of the ACA).

2. Deductible and Coinsurance for Preventive Services

Section 4104(b)(4) of the ACA amends section 1833(a)(1) of the Act by requiring 100 percent Medicare

payment for the IPPE and for those preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual. This provision waives any coinsurance that would otherwise be applicable under section 1833(a)(1) of the Act for those items and services listed in section 1861(ww)(2) of the Act (excluding electrocardiograms) to which the USPSTF has given a grade of A or B. In addition, section 4103(c)(1) of the ACA amends section 1833(c)(1) of the Act to waive the coinsurance for the annual wellness visit. The coinsurance represents the beneficiary's share of the payment to the provider or supplier for furnished services. Coinsurance generally refers to a percentage (for example, 20 percent) of the Medicare payment rate for which the beneficiary is liable and is applicable under the PFS, while copayment generally refers to an established amount that the beneficiary must pay that is not necessarily related to a particular percentage of the Medicare payment, and is applicable under the hospital Outpatient Prospective Payment System (OPPS). We refer readers to the CY 2011 OPPS/ASC proposed rule for proposed provisions related to payment for preventive services, including waiver of the deductible and copayment, under the OPPS.

Section 4104(c) of the ACA amends section 1833(b)(1) of the Act to waive the Part B deductible for preventive services described in subparagraph (A) of section 1861(ddd)(3) of the Act that have a grade of A or B from the USPSTF. In addition, section 1833(b)(1) of the Act (as amended by section 4103(c)(4) of the ACA) waives the Part B deductible for the annual wellness visit. These provisions are effective for services furnished on and after January 1, 2011. Section 101(b)(2) of the MIPPA amended section 1833(b) of the Act to waive the deductible for the IPPE effective January 1, 2009.

Not all preventive services described in subparagraph (A) of section 1861(ddd)(3) are recommended by the USPSTF with a grade of A or B and, therefore, some of the preventive services do not meet the criteria in sections 1833(a)(1) and (b)(1) of the Act for the waiver of the deductible and coinsurance. However, with certain exceptions noted below, the changes made by section 4104 of the ACA do not affect most of the preexisting specific provisions in sections 1833(a) and 1833(b) of the Act (that are codified in regulations in § 410.160(b) and § 410.152) that waive the deductible and coinsurance for specific services. For example, section 1833(a)(1)(D) of the Act already waives the coinsurance and section 1833(b)(3) of the Act waives the deductible for clinical laboratory tests (including tests furnished for screening purposes). Section 4104 of the ACA does not change this provision and, therefore, the waiver of both the deductible and coinsurance remains in place for all laboratory tests, regardless of whether the particular clinical laboratory test meets the USPSTF grading criteria specified in sections 1833(a)(1) and 1833(b)(1) of the Act (as amended by section 4104 of the ACA) for waiver of the deductible and coinsurance as a preventive service.

The following preventive services listed in section 1833(ddd)(3)(A) of the Act are not recommended by the USPSTF with a grade of A or B for any indication or population: digital rectal examination furnished as a prostate cancer screening service; glaucoma screening; DSMT services; and barium enema furnished as a colorectal cancer screening service.

Specifically, HCPCS code G0102 (Prostate cancer screening; digital rectal exam), which does not have a grade of A or B from the USPSTF for any indication or population, will continue to be subject to the deductible and coinsurance as there is no statutory provision to the contrary. However, the deductible and coinsurance for HCPCS code G0103 (Prostate cancer screening; prostate specific antigen test (PSA)) will continue to be waived in accordance with section 1833(a)(1)(D) of the Act, even though this service also does not have a grade of A or B from the USPSTF.

Glaucoma screening services, described by HCPCS codes G0117 (Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist) and G0118 (Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist), will continue to be subject to the deductible and coinsurance because these services are not recommended with a grade of A or B by the USPSTF for any indication or population and there is no other statutory provision to except them. Similarly, DSMT services are currently not rated by the USPSTF, and there is no other statutory provision to except them from applicability of the deductible and coinsurance. Therefore the deductible and coinsurance requirements will continue to apply.

Barium enemas furnished as colorectal cancer screening tests, described by HCPCS codes G0106 (Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema) and G0120 (Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema), do not have a grade of A or B from the USPSTF for any indication or population. However, the deductible does not apply to barium enemas furnished as colorectal cancer screening tests, because colorectal cancer screening tests are explicitly excluded from the deductible in section 1833(b)(8) of the Act. However, there is no specific exclusion of barium enemas from the coinsurance requirement in section 1833(b)(1) of the Act and, therefore, this requirement, as applicable, continues to apply to barium enemas. We note that the USPSTF has given a grade of A to screening colonoscopy, screening flexible sigmoidoscopy, and fecal occult blood screening tests, and that, as a result, these colorectal cancer screening tests are subject to the statutory waiver of both the deductible and coinsurance.

We note also that the USPSTF ceased to make recommendations with regard to vaccines and vaccine administration after CY 1996, so as not to conflict with the recommendations of the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. However, the USPSTF's most recent vaccine recommendations gave a grade of B to influenza and pneumococcal vaccines and their administration and a grade of A to hepatitis B vaccine and its administration. While sections 1833(a)(1) and 1833(b)(1) of the Act require that the preventive services receive a grade of A or B from the USPSTF for the coinsurance and deductible to be waived, the statute does not specify that the recommended grade must be furnished by the USPSTF within any given timeframe. The USPSTF grades for these preventive services are the most current USPSTF grade and have never been withdrawn. Therefore, we believe that these preventive services meet the requirements of the statute for the waiver of the deductible and coinsurance. We also note that the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices currently recommends influenza, pneumococcal, and hepatitis B vaccines.

We are proposing to update § 410.160(b), which lists the services for which expenses incurred are not subject to the Part B annual deductible and do not count toward meeting that deductible. Specifically, we are proposing to revise § 410.160(b)(2) to include influenza and hepatitis B

vaccines and their administration, in addition to pneumococcal vaccine and its administration. In addition, in § 410.160(b), we are also proposing to add exceptions for bone mass measurement, MNT services, and the annual wellness visit.

In § 410.152, we are proposing to revise paragraph (l) to establish the amount of payment under the applicable payment system for providers and suppliers of the services listed in the paragraph and displayed in Table 38. Table 38 displays the HCPCS codes that we are proposing as "preventive services" under section 1861(ddd)(3)(A) of the Act and identifies the HCPCS codes for the IPPE and the annual wellness visit. Table 38 also indicates the most recent USPSTF grade, if any, that is the basis for our proposed policy with regard to waiver of the deductible and coinsurance, as applicable, and the Medicare payment system under which the HCPCS code would be paid when furnished outside of the facility setting. We note that the changes made by section 4104 of the ACA with respect to the deductible and coinsurance apply in all settings in which the services are furnished.

In developing recommendations regarding preventive services, we recognize that the USPSTF may make recommendations that are specific to an indication or population, at times including characteristics such as gender and age in its recommendations. While we are proposing to waive the deductible and coinsurance for any Medicare covered preventive service recommended with a grade of A or B for any indication or population, with no limits on the indication or population as long as the USPSTF has recommended the preventive service for at least one indication and/or population with a grade of A or B, we note that all existing Medicare coverage policies for such services, including any limitations based on indication or population, continue to apply. In some cases, national coverage policies may currently limit Medicare coverage based on the indication or population, consistent with the USPSTF recommendations with a grade of A or B for the indication or population. In other cases where Medicare does not explicitly noncover preventive services for a specific population or indication, we would expect that, particularly in those cases where the USPSTF recommendation grade is a D (that is, the USPSTF recommends against the service because there is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits), practitioners would only order those preventive services that are clinically appropriate for the beneficiary. If we have concerns in the future about the appropriateness of preventive services for an indication or population in light of the USPSTF's recommendations, we may consider using our authority under section 1834(n)(1) of the Act (as added by section 4105 of the ACA) to modify Medicare coverage of any preventive service to be consistent with the recommendations of the USPSTF.

Section 10501(i)(2) of the ACA amended the definition of Federally Qualified Health Center (FQHC) services as defined in section 1861(aa)(3)(A) of the Act by replacing the specific references to services provided under section 1861(qq) and (vv) of the Act (diabetes outpatient self-management training services and medical nutrition therapy services, respectively) with preventive services as defined in section 1861(ddd)(3) of the Act, as established by section 4014(a)(3) of the ACA. These changes are effective for services provided on or after January 1, 2011. Accordingly, we are proposing to conform the regulations to the new statutory requirement by adding a new section § 405.2449 which would add the new preventive services definition to the definition of FQHC services effective for services provided on or after January 1, 2011.

Section 1861(ddd)(3) of the Act defines "preventive services" as consisting of the following three components:

- Screening and preventive services described in section 1861(ww)(2) of the Act (other than electrocardiograms described in subparagraph (M) of that same subsection).
- An initial preventive physical examination, as defined in section 1861(ww) of the Act.
- Personalized prevention plan services as defined in section 1861(hhh)(1) of the Act.

We are proposing to add each of these three components into the new Medicare FQHC preventive services definition in a new § 405.2449.

Section 4104(b)(1) of the ACA, as amended by section 10406 of the same Act, waives coinsurance for preventive services by adding section 1833(a)(1)(Y) to the Act to require, essentially, waiver of coinsurance for preventive services that are recommended with a grade of A or B by the USPSTF for any indication or population. This provision is specifically designed to remove barriers to affording and obtaining such preventive services under Medicare.

In addition, section 10501(i)(3)(B)(ii) of the ACA added section 1833(a)(1)(Z) to the Act to require a 20-percent copay on all FQHC services after implementation of the FQHC prospective payment system. We believe we can give both section 1833(a)(1)(Y) and (Z) of the Act, and the definition of FQHC services (revised to include the broader scope of preventive services) their best effect by permitting a 100 percent reimbursement rate for preventive services as defined at section 1861 (ddd)(3) of Act, effective January 1, 2011.

Section 1833(b)(4) of the Act stipulates that the Medicare Part B deductible shall not apply to Federally qualified health center services. The ACA makes no change to this provision, therefore Medicare shall continue to waive the Part B deductible for all federally qualified health center services, including preventive services added by the ACA.

TABLE 38—PROPOSED CY 2011 DEDUCTIBLE AND COINSURANCE FOR PREVENTIVE SERVICES UNDER SECTION 1861(ddd)(3)(A) OF THE ACT (INCLUDES THE IPPE AND THE ANNUAL WELLNESS VISIT)

Preventive service	CPT/ HCPCS Code	Long descriptor	USPSTF rating [1]	Payment method	CY 2010 coins./ deductible	CY 2011 coins./ deductible
Initial Preventive Physical Examination, IPPE.	G0402	Initial preventive physical examination; face to face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment.	* Not Rated.	PFS	Coins. applies and ded. is waived.	WAIVED.
	G0403	Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report.	.....	PFS	Not Waived	Not Waived.

TABLE 38—PROPOSED CY 2011 DEDUCTIBLE AND COINSURANCE FOR PREVENTIVE SERVICES UNDER SECTION 1861(ddd)(3)(A) OF THE ACT (INCLUDES THE IPPE AND THE ANNUAL WELLNESS VISIT)—Continued

Preventive service	CPT/ HCPCS Code	Long descriptor	USPSTF rating [1]	Payment method	CY 2010 coins./ deductible	CY 2011 coins./ deductible
	G0404	Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination.	.....	PFS	Not Waived	Not Waived.
	G0405	Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination.	.....	PFS	Not Waived	Not Waived.
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA).	G0389	Ultrasound, B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) ultrasound screening.	B	PFS	Coins. applies and ded. is waived.	WAIVED.
Cardiovascular Disease Screening.	80061	Lipid panel	A	CLFS	WAIVED	WAIVED.
	82465	Cholesterol, serum or whole blood, total ..	.....	CLFS	WAIVED	WAIVED.
	83718	Lipoprotein, direct measurement; high density cholesterol (hdl cholesterol).	.....	CLFS	WAIVED	WAIVED.
	84478	Triglycerides	.....	CLFS	WAIVED	WAIVED.
Diabetes Screening Tests.	82947	Glucose; quantitative, blood (except reagent strip).	B	CLFS	WAIVED	WAIVED.
	82950	Glucose; post glucose dose (includes glucose).	.....	CLFS	WAIVED	WAIVED.
	82951	Glucose; tolerance test (gtt), three specimens (includes glucose).	* Not Rated.	CLFS	WAIVED	WAIVED.
Diabetes Self-Management Training Services. (DSMT)	G0108	Diabetes outpatient self-management training services, individual, per 30 minutes.	* Not Rated.	PFS	Not Waived	Not Waived.
	G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes.	.....	PFS	Not Waived	Not Waived.
Medical Nutrition Therapy (MNT) Services.	97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.	B	PFS	Not Waived	WAIVED.
	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes.	.....	PFS	Not Waived	WAIVED.
	97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes.	.....	PFS	Not Waived	WAIVED.
	G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes.	B	PFS	Not Waived	WAIVED.
	G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes.	.....	PFS	Not Waived	WAIVED.

TABLE 38—PROPOSED CY 2011 DEDUCTIBLE AND COINSURANCE FOR PREVENTIVE SERVICES UNDER SECTION 1861(ddd)(3)(A) OF THE ACT (INCLUDES THE IPPE AND THE ANNUAL WELLNESS VISIT)—Continued

Preventive service	CPT/ HCPCS Code	Long descriptor	USPSTF rating [1]	Payment method	CY 2010 coins./ deductible	CY 2011 coins./ deductible
Screening Pap Test.	G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision.	A	CLFS	WAIVED	WAIVED.
	G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician.		PFS	Coins. applies and ded. is waived.	WAIVED.
	G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician.	A	PFS	Coins. applies and ded. is waived.	WAIVED.
	G0143	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision.	A	CLFS	WAIVED	WAIVED.
	G0144	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision.	A	CLFS	WAIVED	WAIVED.
	G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision.	A	CLFS	WAIVED	WAIVED.
	G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision.	A	CLFS	WAIVED	WAIVED.
	G0148	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening.	A	CLFS	WAIVED	WAIVED.
	P3000	Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision.		CLFS	WAIVED	WAIVED.
	P3001	Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician.		PFS	Coins. applies & ded. is waived.	WAIVED.
	Q0091	Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory.		PFS	Coins. applies & ded. is waived.	WAIVED.
Screening Pelvic Exam.	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination.	A	PFS	Coins. applies and ded. is waived.	WAIVED.
Screening Mammography.	77052	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure).	B	PFS	Coins. applies and ded. is waived.	WAIVED.
	77057	Screening mammography, bilateral (2-view film study of each breast).	B	PFS	Coins. applies and ded. is waived.	WAIVED.
	G0202	Screening mammography, producing direct digital image, bilateral, all views.		PFS	Coins. applies & ded. is waived.	WAIVED.
Bone Mass Measurement.	G0130	Single energy x-ray absorptiometry (sexa) bone density study, one or more sites; appendicular skeleton (peripheral) (*e.g.,* radius, wrist, heel).	B	PFS	Not Waived	WAIVED.

TABLE 38—PROPOSED CY 2011 DEDUCTIBLE AND COINSURANCE FOR PREVENTIVE SERVICES UNDER SECTION 1861(ddd)(3)(A) OF THE ACT (INCLUDES THE IPPE AND THE ANNUAL WELLNESS VISIT)—Continued

Preventive service	CPT/ HCPCS Code	Long descriptor	USPSTF rating [1]	Payment method	CY 2010 coins./ deductible	CY 2011 coins./ deductible
	77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (*e.g.,* hips, pelvis, spine).	.....	PFS	Not Waived	WAIVED.
	77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (*e.g.,* radius, wrist, heel).	.....	PFS	Not Waived	WAIVED.
	77080	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (*e.g.,* hips, pelvis, spine).	.....	PFS	Not Waived	WAIVED.
	77081	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; appendicular skeleton (peripheral) (*e.g.,* radius, wrist, heel).	.....	PFS	Not Waived	WAIVED.
	77083	Radiographic absorptiometry (*e.g.,* photodensitometry, radiogrammetry), 1 or more sites.	.....	PFS	Not Waived	WAIVED.
	76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method.	B	PFS	Not Waived	WAIVED.
Colorectal Cancer Screening.	G0104	Colorectal cancer screening; flexible sigmoidoscopy.	A	PFS	Coins. applies and ded. is waived.	WAIVED.
	G0105	Colorectal cancer screening; colonoscopy on individual at high risk.	.....	PFS	Coins. applies and; ded. is waived.	WAIVED.
	G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema.	* Not Rated.	PFS	Coins. applies and ded. is waived.	Coins. applies and ded. is waived.
	G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema..	.....	PFS	Coins. applies and ded. is waived.	Coins. applies and ded. is waived.
	G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk.	A	PFS	Coins. applies and ded. is waived.	WAIVED.
	82270	Blood, occult, by peroxidase activity (*e.g.,* guaiac), qualitative; feces, consecutive.	.....	CLFS	WAIVED	WAIVED.
	G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, 1–3 simultaneous.	.....	CLFS	Coins. applies and ded. is waived.	WAIVED.
Prostate Cancer Screening.	G0102	Prostate cancer screening; digital rectal examination.	D	PFS	Not Waived	Not Waived.
	G0103	Prostate cancer screening; prostate specific antigen test (PSA).	.....	CLFS	WAIVED	WAIVED.
Glaucoma Screening.	G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist.	I	PFS	Not Waived	Not Waived.
	G0118	Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist.	.....	PFS	Not Waived	Not Waived.
Influenza Virus Vaccine.	90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6–35 months of age, for intramuscular use.	B	Drug Pricing File.	WAIVED	WAIVED.
	90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use.	.....	Drug Pricing File.	WAIVED	WAIVED.
	90657	Influenza virus vaccine, split virus, when administered to children 6–35 months of age, for intramuscular use.	.....	Drug Pricing File.	WAIVED	WAIVED.
	90658	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use.	.....	Drug Pricing File.	WAIVED	WAIVED.
	90660	Influenza virus vaccine, live, for intranasal use.	.....	Drug Pricing File.	WAIVED	WAIVED.

TABLE 38—PROPOSED CY 2011 DEDUCTIBLE AND COINSURANCE FOR PREVENTIVE SERVICES UNDER SECTION 1861(ddd)(3)(A) OF THE ACT (INCLUDES THE IPPE AND THE ANNUAL WELLNESS VISIT)—Continued

Preventive service	CPT/ HCPCS Code	Long descriptor	USPSTF rating [1]	Payment method	CY 2010 coins./ deductible	CY 2011 coins./ deductible
	90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use.	.....	Drug Pricing File.	WAIVED	WAIVED.
	G0008	Administration of influenza virus vaccine	.....	PFS	WAIVED	WAIVED.
	G9141	Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family).	.....	PFS	WAIVED	WAIVED.
	G9142	Influenza A (H1N1) vaccine, any route of administration.	.....	Drug Pricing File (if not supplied at no cost).	WAIVED	WAIVED.
Pneumococcal Vaccine.	90669	Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use.	B	Drug Pricing File.	WAIVED	WAIVED.
	90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use..	.....	Drug Pricing File.	WAIVED	WAIVED.
	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use.	.....	Drug Pricing File.	WAIVED	WAIVED.
	G0009	Administration of pneumococcal vaccine	.....	PFS	WAIVED	WAIVED.
Hepatitis B Vaccine.	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use.	A	Drug Pricing File.	Not Waived	WAIVED.
	90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use.	.....	Drug Pricing File.	Not Waived	WAIVED.
	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use.	.....	Drug Pricing File.	Not Waived	WAIVED.
	90746	Hepatitis B vaccine, adult dosage, for intramuscular use.	.....	Drug Pricing File.	Not Waived	WAIVED.
	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use.	.....	Drug Pricing File.	Not Waived	WAIVED.
	G0010	Administration of hepatitis B vaccine	A	PFS	Not Waived	WAIVED.
HIV Screening	86689	HTLV or HIV antibody, confirmatory test (*e.g.,* Western Blot).	A	CLFS	WAIVED	WAIVED.
	G0432	Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-qualitative, multiple-step method, HIV–1 or HIV–2, screening.	.....	CLFS	WAIVED	WAIVED.
	G0433	Infectious agent antigen detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV–1 or HIV–2, screening.	.....	CLFS	WAIVED	WAIVED.
	G0435	Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV–1 or HIV–2, screening.	.....	CLFS	WAIVED	WAIVED.
Annual Wellness Visit.	GXXXA	Annual wellness visit, including PPPS, first visit.	* Not Rated.	PFS	N/A	WAIVED.
	GXXXB	Annual wellness visit, including PPPS, subsequent visit.	.....	PFS	N/A	WAIVED.

[1] U.S. Preventive Services Task Force Recommendations.

A—The USPSTF strongly recommends that clinicians routinely provide [the service] to eligible patients. (The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.)

B—The USPSTF recommends that clinicians routinely provide [the service] to eligible patients. (The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.)

C—The USPSTF makes no recommendation for or against routine provision of [the service]. (The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.)

D—The USPSTF recommends against routinely providing [the service] to asymptomatic patients. (The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.)

I—The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. (Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.)

4. Extension of Waiver of Deductible to Services Furnished in Connection With or in Relation to a Colorectal Cancer Screening Test That Becomes Diagnostic or Therapeutic

Section 4104(c) of the ACA amends section 1833(b) of the Act to waive the Part B deductible for colorectal cancer screening tests that become diagnostic. Specifically, section 1833(b)(1) of the Act (as amended by section 4104(c)(2) of the ACA) waives the deductible with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as a screening test. We are proposing that all surgical services furnished on the same date as a planned screening colonoscopy, planned flexible sigmoidoscopy, or barium enema be considered to be furnished in connection with, as a result of, and in the same clinical encounter as the screening test. In the event of a legislative change to this policy (for example, a statutory change that would waive the coinsurance for these related services in addition to the deductible), we would reassess the appropriateness of this proposed definition of services that are furnished in connection with, as a result of, and in the same clinical encounter as the colorectal cancer screening test that becomes diagnostic. We also note that the beneficiary's annual deductible would likely be met when any surgical procedure (related or not) is furnished on the same day as the scheduled screening test.

We are proposing to implement this provision by creating a HCPCS modifier that providers and practitioners would append to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code or as a result of the barium enema when the screening test becomes a diagnostic service. The claims processing system would respond to the modifier by waiving the deductible for all surgical services on the same date as the diagnostic test. Coinsurance would continue to apply to the diagnostic test and to other services furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

S. Section 5501: Expanding Access to Primary Care Services and General Surgery Services

1. Section 5501(a): Incentive Payment Program for Primary Care Services

a. Background

Section 5501(a) of the ACA revises section 1833 of the Act by adding a new paragraph (x), "Incentive Payments for Primary Care Services." Section 1833(x) of the Act states that in the case of primary care services furnished on or after January 1, 2011 and before January 1, 2016 by a primary care practitioner, there shall also be paid on a monthly or quarterly basis an amount equal to 10 percent of the payment amount for such services under Part B.

Section 1833(x)(2)(A) of the Act (as added by section 5501(a) of the ACA) defines a primary care practitioner as: (1) A physician, as described in section 1861(r)(1) of the Act, who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or (2) a nurse practitioner, clinical nurse specialist, or physician assistant as defined in section 1861(aa)(5) of the Act, and in all cases, for whom primary care services accounted for at least 60 percent of the allowed charges under Part B for the practitioner in a prior period as determined appropriate by the Secretary.

Section 1833(x)(2)(B) (as added by section 5501(a)(2)(B) of the ACA) defines primary care services as those services identified by the following HCPCS codes as of January 1, 2009 (and as subsequently modified by the Secretary, as applicable):

- 99201 through 99215 for new and established patient office or other outpatient evaluation and management (E/M) visits;
- 99304 through 99340 for initial, subsequent, discharge, and other nursing facility E/M services; new and established patient domiciliary, rest home (*e.g.,* boarding home), or custodial care E/M services; and domiciliary, rest home (*e.g.,* assisted living facility), or home care plan oversight services; and
- 99341 through 99350 for new and established patient home E/M visits.

These codes are displayed in Table 39. All of these codes remain active in CY 2010 and there are no other codes used to describe these services.

TABLE 39—PRIMARY CARE SERVICES ELIGIBLE FOR PRIMARY CARE INCENTIVE PAYMENTS IN CY 2011

CPT codes	Description
99201	Level 1 new patient office or other outpatient visit.
99202	Level 2 new patient office or other outpatient visit.
99203	Level 3 new patient office or other outpatient visit.
99204	Level 4 new patient office or other outpatient visit.
99205	Level 5 new patient office or other outpatient visit.
99211	Level 1 established patient office or other outpatient visit.
99212	Level 2 established patient office or other outpatient visit.
99214	Level 4 established patient office or other outpatient visit.
99215	Level 5 established patient office or other outpatient visit.
99304	Level 1 initial nursing facility care.
99305	Level 2 initial nursing facility care.
99306	Level 3 initial nursing facility care.
99307	Level 1 subsequent nursing facility care.
99308	Level 2 subsequent nursing facility care.
99309	Level 3 subsequent nursing facility care.
99310	Level 4 subsequent nursing facility care.
99315	Nursing facility discharge day management;. 30 minutes.
99316	Nursing facility discharge day management; more than 30 minutes.
99318	Other nursing facility services; evaluation and management of a patient involving an annual nursing facility assessment.
99324	Level 1 new patient domiciliary, rest home, or custodial care visit.

TABLE 39—PRIMARY CARE SERVICES ELIGIBLE FOR PRIMARY CARE INCENTIVE PAYMENTS IN CY 2011—Continued

CPT codes	Description
99325	Level 2 new patient domiciliary, rest home, or custodial care visit.
99326	Level 3 new patient domiciliary, rest home, or custodial care visit.
99327	Level 4 new patient domiciliary, rest home, or custodial care visit.
99328	Level 5 new patient domiciliary, rest home, or custodial care visit.
99334	Level 1 established patient domiciliary, rest home, or custodial care visit.
99335	Level 2 established patient domiciliary, rest home, or custodial care visit.
99336	Level 3 established patient domiciliary, rest home, or custodial care visit.
99337	Level 4 established patient domiciliary, rest home, or custodial care visit.
99339	Individual physician supervision of a patient in home, domiciliary or rest home recurring complex and multidisciplinary care modalities; 30 minutes.
99340	Individual physician supervision of a patient in home, domiciliary or rest home recurring complex and multidisciplinary care modalities; 30 minutes or more.
99341	Level 1 new patient home visit.
99342	Level 2 new patient home visit.
99343	Level 3 new patient home visit.
99344	Level 4 new patient home visit.
99345	Level 5 new patient home visit.
99347	Level 1 established patient home visit.
99348	Level 2 established patient home visit.
99349	Level 3 established patient home visit.
99350	Level 4 established patient home visit.

b. Proposed Primary Care Incentive Payment Program (PCIP)

For primary care services furnished on or after January 1, 2011 and before January 1, 2016, we are proposing to provide a 10 percent incentive payment to primary care practitioners, identified as the following: (1) In the case of physicians, enrolled in Medicare with a primary specialty designation of 08—family practice, 11—internal medicine, 37—pediatrics, or 38—geriatrics; or (2) in the case of nonphysician practitioners (NPPs), enrolled in Medicare with a primary care specialty designation of 50—nurse practitioner, 89—certified clinical nurse specialist, or 97—physician assistant; and (3) for whom the primary care services displayed in Table 39 accounted for at least 60 percent of the allowed charges under Part B for such practitioner during the time period that is specified by the Secretary, and proposed in this section.

We are proposing to use the most current full year of claims data to identify primary care practitioners eligible for the PCIP for a CY based on the practitioner's primary specialty (as identified on claims) and the practitioner's percentage of all allowed charges for the primary care services displayed in Table 39. We commonly use the most recent full year of claims data for purposes of establishing annual payment amounts under a number of Medicare's fee-for-service programs. A practitioner with a primary care specialty designation would be eligible for the PCIP in a CY if the percentage of his or her allowed charges for primary care services (identified in Table 39) on claims where the practitioner is identified as one of the primary care specialties described above meets or exceeds the 60 percent threshold. We note that the practitioner's specialty is applied to the claim by the claims processing system and reflects the physician's primary specialty designation for purposes of Medicare enrollment on the date the claim is processed, which would usually be close to the date on which the service was actually furnished to the beneficiary. We would identify primary care practitioners eligible for the PCIP for a year by the individual physician/practitioner national provider identifier (NPI) number using the most current full year of claims data available.

Therefore, for determining PCIP practitioner eligibility for CY 2011, we would use CY 2009 PFS claims data, processed through June 30, 2010. This would ensure analysis of about 99 percent of CY 2009 claims to determine practitioner eligibility for PCIP payment beginning January 2011. We note that the MMA changed the requirements for critical access hospital (CAH) billing for practitioners' professional services and, therefore, modifications were made to the Medicare claims processing system to require CAHs to identify the practitioner furnishing a service on the CAH claim for that professional service. However, because the rendering practitioner has only been identified on CAH claims since July 1, 2009, for the first year of the PCIP we are proposing to identify eligible practitioners using only 6 months of CAH data for those CAHs paid under the optional method. Thereafter, we would update the list of practitioners eligible for the PCIP annually based on the most recent available full year of PFS and CAH claims data.

To the extent practitioners were paid under the PFS during the historical claims data year for some primary services and, for other services, CAHs were paid under the optional method for those same practitioners' professional services, we would aggregate the historical claims data from all settings by the practitioner's NPI in order to determine whether the practitioner is eligible for PCIP payments. We note that for all practitioners (both practitioners paid under the PFS and practitioners for whose professional services CAHs are paid under the optional method), the period of claims data used for the annual determination of the primary care service percentage of allowed charges with a practitioner specialty of primary care would lag the PCIP payment year by 2 years (for example, CY 2010 claims data would be used for the CY 2012 PCIP). This 2-year lag is consistent with other areas of the Medicare program where we rely on information from claims data to inform payment in a future year, such as the use of CY 2009 PFS utilization data in the establishment of certain aspects of CY 2011 PFS payment rates.

Under the proposed PCIP eligibility determination method, it would be necessary to revise the list of eligible practitioners based on updated claims data regarding primary specialty designation and the percentage of a practitioner's allowed charges for primary care services each year. The

revised list of practitioners developed prior to the beginning of the next CY would establish a practitioner's eligibility for PCIP payments for the full next CY. That is, once eligible for the PCIP for a given CY, the practitioner would receive PCIP payments for primary care services furnished throughout that full CY until we reassess the practitioner's PCIP eligibility for the next year's payments. As a result, a practitioner newly enrolling in Medicare during a CY would not be eligible for the PCIP until Medicare claims data reflecting the practitioner's primary care specialty and a percentage of allowed charges for primary care services that equals or exceeds the 60 percent threshold were available to establish the practitioner's eligibility for the next PCIP year. Similarly, an enrolled practitioner's change in primary specialty designation (either to or from a primary care specialty) would not affect that practitioner's eligibility for the PCIP until the practitioner's claims reflecting the change were available for analysis in preparation for the next applicable CY PCIP. Given the statutory requirement that a practitioner's primary care services account for at least 60 percent of the allowed charges under Part B for the practitioner in a prior period as determined by the Secretary, we see no clear alternative methodologies that would allow PCIP payments to be made to those practitioners newly enrolling in Medicare without the 2-year lag in eligibility determination that was described previously. However, given our general interest in supporting primary care practitioners and entry into primary care practice by new physicians and NPPs in order to ensure that Medicare beneficiaries have access to these important services, we are seeking public comments on alternative approaches for establishing PCIP eligibility for newly enrolled practitioners that would be consistent with the statutory requirement.

We plan to monitor changes in the primary specialties of enrolled practitioners over time and would expect not to see significant changes in the specialties of currently enrolled practitioners as a result of the PCIP payments. We would expect that physicians changing their primary specialty to one of the primary care specialties of family medicine, internal medicine, geriatric medicine, or pediatric medicine and who would be newly eligible for the PCIP would be furnishing primary care services to the patients in their practices. Consistent with our past policies, we would expect that physicians changing their primary specialty designation under Medicare would make such changes only so that their primary specialty designation is fully consistent with the specific or unique type of medicine they practice. If we find that physicians are changing their specialty designations (for example, cardiologists who designate their primary specialty as internal medicine, although they practice cardiology) in order to take advantage of the PCIP payments, we would considering making future revisions to eliminate such an outcome.

Consistent with the established Medicare HPSA physician bonus program (Medicare Claims Processing Manual, Pub. 100–04, Chapter 12, Section 90.4.4) and the proposed Health Professional Shortage Area Surgical Incentive Payment Program (HSIP) described in section III.S.2. of this proposed rule, we are proposing that PCIP payments would be calculated by the Medicare contractors and made quarterly on behalf of the eligible primary care practitioner for the primary care services furnished by the practitioner in that quarter. The primary care practitioners' professional services may be paid under the PFS based on a claim for professional services or, where the practitioner has reassigned his or her benefits to a CAH paid under the optional method, to the CAH based on an institutional claim.

As discussed above, eligible primary care practitioners would be identified on a claim based on the NPI of the rendering practitioner. If the claim is submitted by a practitioner's group practice or a CAH, the rendering practitioner's NPI must be included on the line-item for the primary care service (identified in Table 39 above) in order for a determination to be made regarding whether or not the service is eligible for payment of the PCIP. We note that, in order to be eligible for the PCIP, physician assistants, clinical nurse specialists, and nurse practitioners must be billing for their services under their own NPI and not furnishing services incident to physicians' services. Regardless of the specialty area in which they may be practicing, these specific NPPs would be eligible for the PCIP based on their specialty if their historical percentage of allowed charges for primary care services equals or exceeds the 60 percent threshold.

We note that section 1833(x)(4) of the Act (as added by section 5501(a) of the ACA) specifies "there shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting the identification of primary care practitioners." We believe that the inclusion of this language is intended to provide a means for the practical implementation of this provision. That is, because we must develop a process and identify primary care practitioners before we can make payment under the PCIP to the eligible primary care practitioners, the statute gives CMS the authority to make final determinations of eligible primary care practitioners that are not subject to appeal through the various channels normally available to practitioners, in order for the timely payments under the PCIP to occur. In contrast, if the determinations that CMS must make under this provision were subject to appeal, the timely implementation of this provision could be jeopardized and payments under the PCIP could be significantly delayed. However, we do not believe that the "no administrative or judicial review" clause precludes CMS from correcting errors resulting from clerical or mathematical mistakes. Therefore, we note that practitioners would have the opportunity to notify CMS of clerical or mathematical errors that may have occurred during the process of identifying eligible primary care practitioners for PCIP payment, and which could result in a mistaken eligibility determination for the PCIP.

In summary, under the PCIP beginning in CY 2011, we are proposing to identify primary care practitioners based on their primary specialty and percentage of allowed charges for primary care services that equals or exceeds the 60 percent threshold based upon the most current full year of Medicare claims data, which would be the claims data for 2 years prior to the incentive payment year (for example, CY 2009 claims data processed through June 2010 would be used to identify primary care practitioners for the CY 2011 PCIP). Practitioners identified as eligible for the PCIP immediately prior to the PCIP payment year would then receive quarterly incentive payments during the PCIP year equal to 10 percent of the payment amount for their primary care services under Part B, in addition to the amount the primary care practitioner would otherwise be paid for their professional services under Part B for furnishing the primary care services. For example, primary care practitioners identified in late CY 2010 for the CY 2011 PCIP would receive quarterly PCIP payments in CY 2011 that equal 10 percent of the Part B payment for the primary care services those practitioners furnish during CY 2011.

We further note that section 1833(x)(3) of the Act (as added by section 5501(a) of the ACA) authorizes

payment under the PCIP as an additional payment amount for specified primary care services without regard to any additional payment for the service under section 1833(m) of the Act. Therefore, an eligible primary care physician furnishing a primary care service in a HPSA may receive both a HPSA physician bonus payment under the established program and a PCIP payment under the new program beginning in CY 2011, but the PCIP payment is made without regarding to the HPSA physician bonus payment amount. In addition, payments for outpatient CAH services under section 1834(g)(2)(B) of the Act (as amended by section 5501(a) of the ACA) are not affected by the PCIP payment amounts made to the CAH on behalf of the primary care practitioner.

Accordingly, for CY 2011, we are proposing to add a new § 414.80 to our regulations to specify the requirements of the PCIP. Proposed § 414.80(a) would define primary care practitioners and primary care services. Proposed § 414.80(b) would provide eligible primary care practitioners a 10 percent incentive payment with respect to primary care services, in addition to the amount that would otherwise be paid for their professional services under Part B. Quarterly PCIP payments would be made to eligible practitioners or to CAHs paid under the optional method that are billing on behalf of practitioners for their professional services for identified primary care services.

2. Section 5501(b): Incentive Payment Program for Major Surgical Procedures Furnished in Health Professional Shortage Areas

a. Background

Section 1833(m) of the Act provides for an additional 10 percent incentive payment for physicians' services furnished to a covered individual in an area that is designated as a geographic Health Professional Shortage Area (HPSA) as identified by the Secretary prior to the beginning of such year. Section 5501(b) of the ACA revises section 1833 of the Act by adding the new subparagraph (y), "Incentive Payments for Major Surgical Procedures Furnished in Health Professional Shortage Areas."

In the case of major surgical procedures furnished by a general surgeon on or after January 1, 2011 and before January 1, 2016, in an area designated under section 332(a)(1)(A) of the Public Health Service Act as a geographic HPSA, there shall be paid on a monthly or quarterly basis, an amount equal to 10 percent of the payment amount for eligible services under Part B. Section 1833(y)(2)(A) of the Act (as added by section 5501(b) of the ACA) defines a general surgeon as a physician who is described in section 1861(r)(1) of the Act and who has designated a CMS specialty code of 02—General Surgery as his or her primary specialty code in the physician enrollment under section 1866(j) of the Act.

Section 1833(y)(2)(B) of the Act (as added by section 5501(b) of the ACA) defines major surgical procedures as surgical procedures for which a 10-day or 90-day global period is used for payment under the PFS in section 1848(b) of the Act. In Addendum B to the CY 2010 PFS final rule with comment period (74 FR 62017 through 62143), as corrected in the correction notice (74 FR 65455 through 65457), we identified 489 10-day global procedure codes and 3,796 90-day global procedure codes for a total of 4,285 surgical procedure codes that would have met the surgical procedure criteria for the incentive payment if it were applicable in CY 2010.

b. Proposed HPSA Surgical Incentive Payment Program (HSIP)

For services furnished on or after January 1, 2011 and before January 1, 2016, we are proposing to provide a 10 percent incentive payment to general surgeons, identified by their enrollment in Medicare with a primary specialty code of 02—general surgery, in addition to the amount they would otherwise be paid for their professional services under Part B, when they furnish a major surgical procedure in a location that was defined by the Secretary as of December 31 of the prior year as a geographic HPSA. As with the PCIP described above, we do not believe that surgeons will change their Medicare specialty designation in order to take advantage of the HSIP payments. However, we will monitor the specialty designations of enrolled physicians, and if we find that surgeons are changing their primary specialty designation to general surgery in order to take advantage of the HSIP payments, we would consider making future revisions to eliminate such an outcome.

Consistent with the established Medicare HPSA physician bonus program, we are proposing that these HSIP payments would be calculated by the Medicare contractors based on the criteria for payment that we have established as discussed earlier in this section, and payments would be made quarterly on behalf of the qualifying general surgeon for the qualifying major surgical procedures. The surgeons' professional services may be paid under the PFS based on a claim for professional services or, where the physician has reassigned his or her benefits to a critical access hospital (CAH) paid under the optional method, to the CAH based on an institutional claim.

Qualifying general surgeons would be identified on a claim for a major surgical procedure based on the primary specialty of the rendering physician, identified by his or her NPI, of 02—general surgery. If the claim is submitted by a physician's group practice or a CAH, the rendering physician's NPI must be included on the line-item for the major surgical procedure in order for a determination to be made regarding whether or not the procedure is eligible for payment under the HSIP.

For HSIP payment to be applicable, the major surgical procedure must be furnished in an area designated by the Secretary as of December 31 of the prior year as a geographic HPSA. We would provide HSIP payments for major surgical procedures furnished by general surgeons in the same HPSAs as we currently recognize for purposes of payment of all physicians under the established Medicare HPSA physician bonus program under section 1833(m) of the Act.

Each year, we publish a list of zip codes eligible for automatic payment of the HPSA physician bonus payment at: *http://www.cms.gov/hpsapsaphysicianbonuses/01_overview.asp.* We are proposing to use the same list of zip codes for automatic payment of the bonus for eligible services furnished by general surgeons. We are also proposing to create a new HCPCS code modifier to identify circumstances when general surgeons furnish services in areas that are designated as HPSAs as of December 31 of the prior year, but that are not on the list of zip codes eligible for automatic payment. The new modifier would be appended to the major surgical procedure on claims submitted for payment, similar to the current process for payment of the Medicare HPSA physician bonus when the geographic HPSA is not a HPSA identified for automatic payment.

Consistent with the statutory requirement, we are proposing to define major surgical procedures as those for which a 10-day or 90-day global period is used for payment under the PFS. For CY 2011, approximately 4,300 10-day and 90-day global surgical procedures codes are identified in Addendum B to this proposed rule under the far right column labeled "Global" and designated with "010" or "090," respectively.

We further note that section 1833(y)(3) of the Act (as added by section 5501(b)(1) of the ACA) authorizes payment under the HSIP as an additional payment amount for specified surgical services without regard to any additional payment for the service under section 1833(m) of the Act. Therefore, a general surgeon may receive both a HPSA physician bonus payment under the established Medicare HPSA physician bonus program and an HSIP payment under the new program beginning in CY 2011, but the HSIP payment is made without regarding to the HPSA physician bonus payment amount. In addition, payments for outpatient CAH services under section 1834(g)(2)(B) of the Act (as amended by section 5501(b) of the ACA) are not affected by the HSIP payment amounts made to the CAH on behalf of the general surgeon.

Accordingly, for CY 2011, we are proposing to amend § 414.2 by adding the definitions of "HPSA" and "major surgical procedure." We are also proposing to revise § 414.67 to move the existing provisions to paragraph (a) to be grouped as the "Health Professional Shortage Area (HPSA) physician bonus program" and adding a new paragraph (b) for the "HPSA surgical incentive payment program" provisions. Proposed § 414.67(b) would state that general surgeons who furnish identified 10-day and 90-day global period surgical procedures in an area designated by the Secretary as of December 31 of the prior year as a geographic HPSA that is recognized by Medicare for the HPSA physician bonus program as specified under renumbered § 414.67(a)(1) would receive a 10 percent incentive payment in addition to the amount that would otherwise be paid for their professional services under Part B. Physicians furnishing services in areas that are designated as geographic HPSAs prior to the beginning of the year but not included on the published list of zip codes for which automated HPSA surgical bonus payments are made should report a specified HCPCS code modifier to receive the HSIP payment. Quarterly incentive payments would be made to physicians or to CAHs paid under the optional method that are billing on behalf of physicians for their professional services.

3. Sections 5501(a) and (b) of the ACA and Payment for Critical Access Hospital Professional Services Under the Optional Method

Section 1834(g) of the Act establishes the payment rules for outpatient services furnished by a CAH. In 1999, section 403(d) of the Balanced Budget Refinement Act of 1999 (Pub. L. 106–113) (BBRA) amended section 1834(g) of the Act to provide for two methods of payment for outpatient services furnished by a CAH. Specifically, section 1834(g)(1) of the Act, as amended by the BBRA, specifies that the amount of payment for outpatient services furnished by a CAH is equal to the reasonable costs of the CAH in furnishing such services. (The physician or other practitioner furnishing the professional service receives payment under the PFS.) In the alternative, the CAH may make an election, under section 1834(g)(2) of the Act, to receive amounts that are equal to "the reasonable costs" of the CAH for facility services plus, with respect to the professional services, the amount otherwise paid for professional services under Medicare, less the applicable Medicare deductible and coinsurance amount. The election made under section 1834(g)(2) of the Act is sometimes referred to as "method II" or "the optional method." Throughout this section of this preamble, we refer to this election as "the optional method."

In 2000, section 202 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000) (Pub. L. 106–554) (BIPA) amended section 1834(g)(2)(B) of the Act to increase the payment for professional services under the optional method to 115 percent of the amount otherwise paid for professional services under Medicare. In addition, in 2003 section 405(a)(1) of the MMA amended section 1834(g)(l) of the Act by inserting the phrase "equal to 101 percent of" before the phrase "the reasonable costs." However, section 405 of the MMA did not make a corresponding change to section 1834(g)(2)(A) of the Act regarding the amount of payment for facility services under the optional method. In 2010, Section 3128 of the ACA amended section 1834(g)(2)(A) of the Act by inserting the phrase "101 percent of" before "the reasonable costs."

Section 5501(a) of the ACA amends section 1833 of the Act by adding a new paragraph (x), "Incentive Payments for Primary Care Services," that authorizes additional Part B payments to primary care practitioners for primary care services. Section 5501(b) of the ACA further amends section 1833 of the Act by adding new paragraph (y), "Incentive Payments for Major Surgical Procedures Furnished in Health Professional Shortage Areas," that authorizes additional Part B payments for major surgical procedures furnished by general surgeons in HPSAs. Sections 5501(a)(3) and 5501(b)(3) of the ACA make conforming amendments to section 1834(g)(2)(B) of the Act, which refers to payment to the CAH for professional services under the optional method, by adding at the end of section 1834(g)(2)(B) the following phrase, "Subsections (x) and (y) of 1833 shall not be taken into account in determining the amounts that would otherwise be paid pursuant to the preceding sentence." As such, section 1834(g)(2)(B) of the Act (as amended by sections 5501(a)(2) and 5501(b)(2) of the ACA) requires that under the optional method, the 115 percent adjustment payment to the CAH for professional services is calculated without considering the incentive payments for primary care services furnished by primary care practitioners and major surgical procedures furnished by general surgeons in HPSAs as these terms are defined under sections 1833(x) and (y) of the Act.

The regulations implementing section 1834(g)(2)(B) of the Act, payment to the CAH for professional services under the optional method, are in § 413.70(b)(3)(ii)(B). In order to implement the amendments to section 1834(g)(2)(B) of the Act as specified by sections 5501(a)(2) and 5501(b)(2) of the ACA, we are proposing to amend the regulations in § 413.70(b)(3)(ii)(B) to state that, effective for primary care services furnished by primary care practitioners and major surgical procedures furnished by general surgeons in HPSAs on or after January 1, 2011 and before January 1, 2016, the additional incentive payment amounts as specified in § 414.67 and § 414.80 are not included in the determination of the payment for professional services made to the CAH under the optional method. Accordingly, we are proposing that payment for professional services to the CAH at 115 percent of the PFS amount under the optional method would not take into account the additional Part B incentive payments for primary services furnished by primary care practitioners and major surgical procedures furnished by general surgeons in HPSAs as provided in § 414.67 and § 414.80.

T. Section 6003: Disclosure Requirements for In-Office Ancillary Services Exception to the Prohibition on Physician Self-Referral for Certain Imaging Services

1. Background

Section 1877 of the Act also known as the physician self-referral law: (1) Prohibits a physician from making referrals for certain "designated health services" (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a

financial relationship (ownership or compensation), unless an exception applies; and (2) prohibits the entity from filing claims with Medicare (or billing another individual, entity, or third party payer) for those DHS rendered as a result of a prohibited referral. The statute establishes a number of specific exceptions and grants the Secretary the authority to create regulatory exceptions that pose no risk of program or patient abuse.

Section 1877(b)(2) of the Act, entitled "In-office Ancillary Services" sets forth the exception that permits a physician in a solo or group practice to order and provide designated health services (DHS), other than most durable medical equipment and pretrial and enteral nutrients, in the office of the physician or group practice, provided that certain specific criteria are met. Under this exception, the statute limits who can furnish the service, designates where the service must be performed, and limits who can bill for the service. As explained at the end of the statutory exception, the service may also be subject to "such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse." The in-office ancillary services exception is interpreted at § 411.355(b).

Section 6003 of the ACA amends section 1877(b)(2) of the Act by creating a new disclosure requirement for the in-office ancillary services exception to the prohibition on physician self-referral. Specifically, section 6003 provides that, with respect to referrals for magnetic resonance imaging (MRI), computed topography (CT), positron emission topography (PET), and any other DHS specified under section 1877(h)(6)(D) that the Secretary determines appropriate, we must promulgate a requirement that the referring physician inform a patient in writing at the time of the referral that the patient may obtain the service from a person other than the referring physician or someone in the physician's group practice and provide the patient with a list of suppliers who furnish the service in the area in which the patient resides.

2. Proposed Disclosure Requirement

We are proposing to implement section 6003 of the ACA by amending § 411.355(b) to add new paragraph (b)(7). We describe below our proposal for the new disclosure requirement.

a. Services That Trigger the Disclosure Requirement

Section 6003(a) of the ACA requires that the new disclosure requirement apply to MRI, CT, and PET services as well as such other radiology or imaging services included in the DHS category specified in section 1877(h)(6)(D) of the Act that the Secretary determines appropriate. We are considering whether to expand this disclosure requirement to other radiology and imaging services. We are not inclined to expand the disclosure requirement but we solicit comments regarding whether other radiology or imaging services that fall under section 1877(h)(6)(D) of the Act should be included in this requirement, and if so, which services, and the purpose served by extending the disclosure requirement to additional radiology or imaging services.

b. General Disclosure Requirements

In § 411.355(b)(7), we are proposing that the disclosure notice should be written in a manner sufficient to be reasonably understood by all patients and must, as the ACA requires, be given to the patient at the time of the referral. This notice must indicate to the patient that the services may be obtained from a person other than the referring physician or his or her group practice and include a list of other suppliers who provide the service being referred (MRI, CT, or PET).

We believe one purpose of the disclosure requirement is to inform a patient's decision-making regarding his or her own care. The list of suppliers provided to the patient by the physician is meant to serve as a resource for the patient. Nothing on the disclosure notice or list of suppliers may indicate to the patient that he or she must receive imaging from a supplier on the list if not receiving the service from the referring physician. The patient may receive the imaging service from the referring physician, from a supplier identified on the notice, or from another supplier of the patient's choice. The patient is free to choose the supplier of the service.

c. List of Alternate Suppliers

Section 6003(a) of the ACA specifies that the referring physician must provide a written list of "suppliers (as defined in section 1861(d))." Section 1861(d) of the Act defines supplier as "a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this title." We are proposing that only suppliers be included on the written list. We are not proposing to permit or require the list to include "providers of services", which is defined in section 1861(u) of the Act to include hospitals and critical access hospitals, among other facilities. We are soliciting comments regarding whether inclusion of providers of services on the written notice would benefit patients in choosing an alternate entity for an imaging service by providing more, and varied, options.

Section 6003(a) of the ACA also requires that the alternate suppliers specified in the notice provided to the patient must furnish the relevant services "in the area in which [the patient] resides." We are aware that a patient may travel outside the area in which he or she resides in order to receive medical care. We believe that requiring an original written notice for each patient based upon a certain distance from the patient's residence could place a significant administrative burden on physicians practicing in a solo or group practice. It would be impractical for a physician to prepare a separate list for every area in which his or her patients reside. Additionally, we believe that if a patient has traveled to see the referring physician, the physician is located in an area convenient to the patient and therefore, a referral within a certain distance of this location would also be convenient for the patient.

In order to ease the administrative burden of creating multiple lists while still implementing the requirements of the statute, we are proposing that the suppliers included in this notice should be located within a 25-mile radius of the physician's office location at the time of the referral. We believe that a 25-mile radius is large enough in most areas to generate a list of suppliers that will be useful to patients. We note that we have used a 25-mile radius in other physician self-referral exceptions, including the intra-family rural referrals exception (§ 411.355(j)) and the physician recruitment exception (§ 411.357(e)). Even if a patient resides more than 25 miles away, we are proposing that it will be sufficient to provide a list of suppliers located within a 25-mile radius of the physician's office location at the time the referral is made. As discussed above, we believe that measuring the distance from the physician's office location will better serve patients who have perhaps traveled from long distances to receive specialized treatment.

We are soliciting comments regarding the proposed 25-mile radius requirement. In attempting to minimize confusion and burden related to implementing this provision, we have proposed the same standard for both urban and rural areas. We realize that in some areas 25 miles may be too small to generate a sufficient list of other suppliers. We are interested in hearing whether an alternative distance may be

more effective for urban or rural areas as well as what other criteria should be considered in finalizing regulations for physicians in both urban and rural areas.

In order to help a patient make an informed decision regarding other options for the recommended imaging services, we propose that the written notice include no fewer than 10 other suppliers. We considered proposing that the list include the 10 closest suppliers, but we want to allow physicians some flexibility in drafting the list of suppliers. On the other hand, we are concerned that physicians located in large metropolitan areas will draft a list that includes suppliers located mostly at the edges of the 25-mile radius, thereby increasing the chances that the patient will choose to receive imaging services from the referring physician's practice. We are soliciting comments regarding whether providing a list of 10 suppliers is sufficient or too burdensome or susceptible to abuse and whether there are alternate criteria we should use that would result in an adequate list of convenient suppliers that does not impose an undue burden on physician practices or a risk of abuse.

We recognize that there may be fewer than 10 other suppliers within a 25-mile radius of the referring physician's office location. We propose that, under these circumstances, the physician shall list all of the other suppliers of the particular imaging service that are present within a 25-mile radius of the referring physician's office location, including up to 10 suppliers as required by these regulations. If no other suppliers of the imaging services ordered exist within the 25-mile radius of the physician's office location, the physician need not provide a list of alternative suppliers, but must still disclose to his or her patients that the patients may receive the imaging services from another supplier. In this last situation, simply providing this disclosure statement will satisfy the disclosure requirement of this provision even though alternative suppliers are not listed. The physician must maintain documentation of the disclosure.

We are proposing that the written notice be required to include certain information about the listed suppliers in order to satisfy this disclosure requirement. The list must include the name, address, phone number, and distance from the physician's office location at the time of the referral. We propose to require inclusion of the distance from the physician's location to the other suppliers in order to emphasize to the patient the relative convenience of the listed suppliers.

We are not proposing an exception to the disclosure requirement for MRI, CT, or PET services furnished on an emergency or time-sensitive basis. We are soliciting comments related to whether there are other procedures or circumstances in which it may be difficult or impractical to provide the written disclosure prior to provision of the imaging services.

This proposal sets forth criteria that apply to the disclosure requirement and list of alternative suppliers. These criteria are intended to provide clear guidance as to how physicians may comply with the new requirement of the in-office ancillary services exception. We understand that there may be alternative ways to implement these statutory requirements. One possible alternative is to only require a "reasonable" list of other suppliers with general requirements for the disclosure to patients, while providing that if the physician meets the more specific requirements set forth in this proposal, he or she will be deemed to have a "reasonable" disclosure. We seek comments on this specific alternative and any other alternative methods of compliance that still satisfy the statutory requirements.

d. Documentation of Disclosure

In order to document that this disclosure requirement has been satisfied, we propose that a record of the patient's signature on the disclosure notification must be maintained as an element of the patient's medical record. We are soliciting comments regarding the burden of this recordkeeping requirement. We are also interested in comments that suggest alternative means of recording that the disclosure was made to the patient at the time of referral.

e. Effective Date

As discussed above, section 6003(a) of the ACA amends section 1877(b)(2) of the Act by instructing that the new disclosure requirement be added as one of the additional requirements of the in-office ancillary services exception. The last sentence of the statutory exception preceding this amendment authorizes the Secretary to impose "such other requirements * * * *by regulation* as needed to protect against program or patient abuse" (*emphasis added*). The amendment specifies that "[s]uch requirements shall * * * include a [disclosure] requirement * * *" In reading the last sentence of section 1877(b)(2) together with the amendment, we do not believe that the amendment is self-effectuating. Instead, the new disclosure requirement of section 6003 must be promulgated by regulation. Therefore, we believe that a correct reading of section 6003(a) is that this amendment shall not be effective until the Secretary promulgates a final regulation implementing this new requirement and the regulation becomes effective.

We considered whether, pursuant to section 6003 of the ACA, the final rule setting forth the disclosure requirement should apply retroactively to all services furnished on or after January 1, 2010. Given the structure of the amended in-office ancillary services exception and the statute as a whole, however, we believe that retroactive rulemaking is not required. Therefore, we are proposing that the new disclosure requirement shall apply only to services furnished on or after the effective date of the final regulation implementing section 6003 of the ACA. We are proposing an effective date of January 1, 2011 for the regulation implementing this provision.

U. Section 6404: Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months

1. Background

Sections 1814(a)(1), 1835(a), and 1842(b)(3)(B) of the Act establish time limits for filing Medicare Part A and B claims. Prior to the enactment of the ACA, under sections 1814(a)(1) and 1835(a) of the Act, providers could file for Part A and Part B claims, respectively, "* * * no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that, where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year * * *". Prior to the enactment of the ACA, CMS was authorized to establish a minimum time limit for provider-submitted Part A and Part B claims of at least 1 calendar year from the date of service, and a maximum time limit not to exceed 4 years and 3 months after the date of service.

Additionally, prior to the enactment of the ACA, under section 1842(b)(3)(B) of the Act, Part B claims for physician and other supplier services could be filed with Medicare "* * * no later than the close of the calendar year following the year in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to have been furnished in

the succeeding calendar year) * * *". Therefore, prior to the enactment of the ACA, CMS was authorized to establish a minimum time limit for filing Part B claims of 15 months and a potential maximum of 27 months after the service was furnished, depending on what month of the year the service was furnished.

Section 424.44 implements sections 1814(a)(1), 1835(a), and 1842(b)(3)(B) of the Act. In order to effectively administer the Medicare Program, CMS, through regulations, modified the potential minimum and maximum time periods for filing Part A claims so that Part A claims would have the same time limits as Part B claims. At § 424.44(a), CMS adopted the minimum time limit of 15 months and potential maximum of 27 months after the service was furnished that was permitted under section 1842(b)(3)(B) of the Act for Part B claims and uniformly applied that 15 to 27 month time limit to both Part A and B claims. Also, under § 424.44(b), CMS allowed providers and suppliers the opportunity to file claims after the 15 to 27 month deadline for filing claims expired when the failure to file "* * * was caused by error or misrepresentation of an employee, intermediary, carrier, or agent of the Department that was performing Medicare functions and acting within the scope of its authority."

2. Provisions of the ACA

Section 6404 of the ACA amended sections 1814(a)(1), 1835(a), and 1842(b)(3)(B) of the Act regarding Medicare fee-for-service (FFS) claims for services furnished on or after January 1, 2010. Under section 6404(b)(1) of the ACA, all claims for services furnished on or after January 1, 2010 must be filed within 1 calendar year after the date of service. The provisions of the ACA did not amend these sections of the Act for services furnished before January 1, 2010. However, section 6404(b)(2) of the ACA created a new requirement that claims for services furnished before January 1, 2010 must be filed on or before December 31, 2010. Thus, the statutory provisions prior to the enactment of the ACA remain in effect for pre-2010 services, subject to this new requirement. The practical effect of this change is that any claims for services furnished before October 1, 2009 will follow the current existing regulations. But for any services furnished during the last three months of 2009, those claims must be filed no later than December 31, 2010. For services furnished between October 1, 2009 and December 31, 2009, providers and suppliers will only have 12–15 months to file a claim, whereas before the ACA amendments, they would have had an additional year to file their claims, or 24 to 27 months. Therefore, in order to effectuate the changes made by the ACA, we are proposing to amend § 424.44 so that it is consistent with the amended statutory provisions.

We are proposing to amend § 424.44(a) by replacing the current text with the requirement that claims for services provided on or after January 1, 2010 must be submitted no later than the close of the period ending 1 calendar year after the date of service. As noted above, any services furnished before January 1, 2010 will still be subject to the pre-existing statutory provisions. Therefore, we are proposing that for pre-2010 services, the pre-existing regulatory structure will continue to apply. For those services furnished before January 1, 2010, claims must be filed on or before December 31 of the following year for services that were furnished during the first 9 months of a calendar year, and on or before December 31st of the second following year for services that were furnished during the last 3 months of the calendar year. However, for those services provided in the last three months of 2009, we propose that all claims for those services must be filed no later than December 31, 2010.

Section 6404 of the ACA also gives the Secretary authority to create exceptions to the 1 year timely filing period. In addition to the existing exception to the timely filing requirement due to error or misrepresentation by CMS, our contractors or agents, we propose to create two new exceptions. First, we are proposing to create an exception for those situations where a beneficiary becomes retroactively entitled to Medicare benefits, but was not entitled at the time the services were furnished. Second, we are proposing to permit providers and suppliers to file claims after the time limit for filing claims has expired in limited dual eligible Medicare/Medicaid beneficiary situations.

The first new proposed exception at § 424.44(b)(2) will permit providers and suppliers to file claims after the time limit for filing claims expires when CMS or our contractors determines that the following conditions have been met:

- At the time the service was furnished the beneficiary was not entitled to Medicare; and
- The beneficiary subsequently received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.

In these situations, if CMS or one of our contractors determines that both of the conditions in § 424.44(b)(2) are met, then the time to file a claim will be extended through the last day of the 6th calendar month following the month in which the beneficiary received notification of Medicare entitlement effective retroactively to or before the date of the furnished service. Therefore, instead of the beneficiary having to pay out of his or her own pocket for the service or instead of the beneficiary's other insurance or some other payer that is secondary to Medicare having to pay primary for the service, Medicare may pay primary (or secondary or tertiary) for the service since the beneficiary was entitled to Medicare (although retroactively) at the time the service was furnished. All of Medicare's payment rules including Medicare's Secondary Payer rules still apply in these retroactive entitlement situations.

The second proposed new exception at § 424.44(b)(3) will permit providers and suppliers to file claims for dually-eligible beneficiaries after the time limit for filing claims expires when CMS or our contractors determine that all of the following conditions have been met:

- At the time the service was furnished the beneficiary was not entitled to Medicare;
- The beneficiary subsequently received notification of Medicare entitlement effective retroactively to or before the date of the furnished service; and
- A State Medicaid agency recovered the Medicaid payment for the furnished service from the provider or supplier 11 months or more after the date of service.

This proposed exception applies to situations where a provider or supplier bills (and receives payment from) Medicaid for the services that a dual eligible Medicare/Medicaid beneficiary receives from the provider or supplier. However, at the time the services were furnished, the patient was not a dual eligible Medicare/Medicaid beneficiary yet because Medicare entitlement was granted to the individual retroactively after the service was actually furnished to the individual. In addition, after the State Medicaid Program discovers that the individual was granted Medicare entitlement retroactively, the State Medicaid Program recovers its payments from the provider or supplier for that individual's services instructing the provider or supplier that Medicare should be billed for the services (not Medicaid). If all three of the conditions outlined above occur within 11 months of the date the service was furnished, then the provider or supplier will have enough time to bill Medicare for the

service. However, if Medicaid recovers their incorrect payment 11 months or more after the date the service was furnished, then the provider or supplier will not have enough time to file a claim with Medicare for the covered services because the time limit for filing claims expires 1 calendar year after the date of service. In these situations, if CMS or one of our contractors determines that all of the conditions at § 424.44(b)(3) are met, then the time to file a claim will be extended through the last day of the 6th calendar month following the month in which the State Medicaid agency recovered the Medicaid payment for the furnished service from the provider or supplier. Therefore, we are proposing that this exception along with the aforementioned retroactive entitlement exception be added to § 424.44.

We are proposing that for the one existing exception due to error or misrepresentation by CMS, our contractors or agents (*see* § 424.44(b)(1)) that no extension of time will be granted beyond 4 years from the date of service. Limiting the exception for this timely filing extension is consistent with current CMS policy. Moreover, we believe that limiting this exception to 4 years after the date of service strikes an appropriate balance between fairness and equity for providers, suppliers, and beneficiaries and administrative finality for the Medicare program. We recognize that limiting the exceptions process could have potential impacts on those that wish to avail themselves of this exception. Therefore, we are soliciting comments on how this proposed four year limitation on the exception at § 424.44(b)(1) will impact providers, suppliers and beneficiaries and the frequency of such occurrences. In addition, we are soliciting comments on whether the proposed four year limitation for this particular exception is appropriate, or what changes, if any, should be made to the limitation on the exceptions process, including a rationale or justification for an alternative time limitation.

CMS is not proposing a definition of the term "date of service" in this regulation. Yet we recognize that the definition of this term is very important to providers, suppliers, and beneficiaries because the "date of service" will ultimately determine when the claim has to be filed in order to meet the new 1 calendar year requirement. In most cases the "date of service" will be the date that the item or service is actually furnished to the beneficiary; however, we recognize that for many Part A and B services it is difficult to craft a uniform rule that will apply a consistent date of service standard. It is our intention to provide sub-regulatory guidance on what constitutes the date of service for different Part A and B services. We are soliciting comments regarding whether CMS should provide a regulatory definition of "date of service" and, if so, how should it define this term.

We are also clarifying the exception that appears at § 424.44(e). We are making clear that this regulation does not supersede the restriction on retrospective billing that appears in §§ 424.520 and 424.521. Under these provisions certain newly-enrolled suppliers, such as physicians, non-physician practitioners, physician or non-physician practitioner organizations and IDTFs, have only a limited ability to submit claims for items or services furnished prior to the effective date of their Medicare billing privileges even if these claims would otherwise be considered timely. In addition, we want to make clear that the one calendar year timely filing limit in section 424.44(a) does apply to any retrospective claims permitted by sections 424.520 and 424.521 and to claims for items or services furnished after the effective date of the supplier's billing privileges.

V. Section 6410 and MIPPA: Adjustments to the Metropolitan Statistical Areas (MSA) for Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Acquisition Program

We are proposing a number of revisions to the DMEPOS CBP as a result of changes to the statute made by both the Medicare Improvements for Patients and Provider Act of 2008 (MIPPA) and the ACA. Since both MIPPA and the ACA specify requirements for MSA selection for round 2 and beyond we are outlining our proposals for implementing the statutory requirements related to MSA selection in both MIPPA and the ACA in this section. First, we propose to use the authority provided by the statute at section 1847(a)(1)(D)(ii) of the Act, as amended by MIPPA to subdivide Metropolitan Statistical Areas (MSAs) with populations of greater than 8,000,000 under Round 2 of the DMEPOS CBP. Second, we propose to exclude certain areas from competitive bidding after round 2 as mandated by section 1847(a)(1)(D)(iii) of the Act, as amended by MIPPA. Third, we propose to implement the requirement of section 6410 of the ACA to expand Round 2 of the program by adding 21 of the largest MSAs based on total population to the original 70 already selected for round 2.

1. Background

Section VI.H of this proposed rule provides background on the DMEPOS CBP, including a description of many of the changes made to the program by section 154 of MIPPA. In this section, we provide additional information regarding changes made by both MIPPA and Section 6410 of the ACA. In addition to the changes discussed previously in this proposed rule, MIPPA also added subparagraph (D) to section 1847(a)(1) of the Act. Section 1847(a)(1)(D)(ii), as added by MIPPA, addresses Round 2 of the DMEPOS CBP, and section 1847(a)(1)(D)(iii) addresses subsequent rounds of the Program.

Section 1847(a)(1)(D)(ii)(II) of the Act specifies that the Secretary shall implement DMEPOS competitive bidding in the areas previously selected for round 2 of the program and also allows the Secretary, in implementing round 2 of the program, to subdivide metropolitan statistical areas (MSAs) with populations of greater than 8,000,000 into separate CBAs. Previously, we believe the statute could have been interpreted to allow CMS to subdivide large MSAs but MIPPA gave CMS the explicit authority to subdivide large MSAs. Section 1847(a)(1)(D)(iii) imposes new requirements on the Secretary for competitions occurring before 2015 in subsequent rounds of the program. For such competitions (other than national mail order), the following areas are to be excluded from the program: (I) Rural areas; (II) MSAs not selected under Round 1 or 2 with a population of less than 250,000; and (III) certain areas with low population density within a selected MSA. These requirements do not apply to a national mail order program.

Finally, MIPPA required that we implement Round 2 of the DMEPOS CBP in the same MSAs that were designated as of June 1, 2008. In 2010, section 6410(a) of the ACA amended sections 1847(a)(1)(B)(i)(II) and (D)(ii) of the Act to expand Round 2 of the program from 70 MSAs to 91 MSAs by adding the next 21 largest MSAs by total population not already selected for Rounds 1 or 2.

2. Subdividing Large MSAs Under Round 2

We have selected MSAs for Round 1 and for Round 2 consistent with MIPPA's requirement. For round 1 CBAs generally were comparable to MSAs, however, for round 2 we are proposing to subdivide MSAs of 8,000,000 or more in population. The authority to subdivide MSAs into separate areas for competitive bidding

purposes is set forth in section 1847(a)(1)(D)(ii)(II) of the Act which states, "[t]he Secretary may subdivide metropolitan statistical areas with populations (based upon the most recent data from the Census Bureau) of at least 8,000,000 into separate areas for competitive acquisition purposes." We have identified three MSAs which, based on the 2009 estimate from the Census Bureau data, could be subdivided under section 1847(a)(1)(D)(ii)(II): (1) Chicago-Naperville-Joliet, Illinois-Indiana-Wisconsin (IL-IN-WI) MSA with a population of 9,569,624; (2) Los Angeles-Long Beach-Santa Ana, California (CA) MSA with a population of 12,872,808; and (2) New York-Northern New Jersey-Long Island, New York-New Jersey-Pennsylvania (NY-NJ-PA) MSA with a population of 19,006,798. We are proposing to divide these MSAs into separate CBAs because we believe this approach would create more manageable CBAs for contract suppliers to serve and allow more small suppliers to be considered for participation in the program.

We considered certain factors when considering whether to propose subdividing the MSAs with populations of at least 8,000,000. We considered the geographic, social, and economic integration of each of the MSAs. We apply all of these factors when grouping counties into CBAs considered at a county level in each MSA and we believe it is also appropriate to use these factors to determine: (1) Whether or not to subdivide an MSA into separate CBAs, and (2) once the decision is made to subdivide the MSA, how to subdivide the MSA. We considered the following factors, generally in the order in which they are listed:

- Geographic size of the MSA and the location of the counties within each MSA compared to neighboring counties;
- The driving distances from north to south and east to west within each MSA and county;
- The total population and the population of FFS Medicare beneficiaries using DMEPOS items subject to competitive bidding;
- The DMPOS allowed charges for items subject to competitive bidding;
- Comparably sized Round 1 and Round 2 MSAs based on beneficiary counts and allowed charges for competitive bid items;
- The interstate highway infrastructures of the MSAs; and
- The current service patterns of suppliers in each county of the MSA.

We used each of the factors to the extent practical to develop initial proposals for reasonable and workable subdivisions of these highly and densely populated MSAs. We believe consideration of these factors will help us meet our goal of subdividing large and densely populated MSAs and creating CBAs that are attractive to suppliers and incentivize them to bid competitively for a contract. With this goal in mind, we are trying to establish CBAs that provide for a good volume of DMEPOS business for winning bidders, avoid obvious geographic obstacles, mimic existing supplier service patterns, and, to the extent possible, do not cross State lines. We believe the factors we have selected will achieve those objectives.

We found that counties clearly delineate areas within a MSA, and as we have done for Round 1 by identifying CBAs by counties and zip codes, we are proposing to subdivide the MSAs at a county level. Since the Office of Management and Budget (OMB) defines the MSAs by counties and county-based subdivisions are stable, we use counties to subdivide CBAs. When subdividing an MSA into counties, we consider counties that share social, economic and geographic integration. The Chicago-Naperville-Joliet IL-IN-WI MSA comprises 14 counties within 3 States: Illinois, Indiana, and Wisconsin. This MSA has 207,106 beneficiaries and $218,161,562 of DMEPOS allowed charges subject to the DMEPOS CBP. Using the factors that we indentified, we would subdivide the Chicago-Naperville-Joliet, IL-IN-WI MSA into four separate CBAs: Indiana-Chicago Metro CBA; South-West-Chicago-Metro CBA; Central-Chicago Metro CBA; and Northern-Chicago Metro CBA. The counties, DMEPOS allowed charges, and the number of beneficiaries subject to competitive bidding, and the general population that comprise each of these proposed CBAs are shown in Table 40.

TABLE 40—CHICAGO-NAPERVILLE-JOLIET, IL-IN-WI

CBA name/County	DMEPOS allowed Charles*	DMEPOS beneficiary count subject to competitive bidding*	General population **
Indiana-Chicago Metro CBA:			
Lake, IN	$18,600,917	16,637	493,800
Jasper, IN	1,238,119	1,191	32,544
Newton, IN	580,842	393	13,933
Porter, IN	4,856,838	4,526	162,181
CBA TOTAL	25,276,716	22,747	702,458
South-West-Chicago-Metro CBA:			
Will, IL	13,523,185	12,522	681,097
Grundy, IL	1,417,511	1,405	47,958
Kendall, IL	978,215	1,052	103,460
DeKalb, IL	2,358,319	2,323	106,321
Kane, IL	9,273,504	9,082	507,579
CBA TOTAL	27,550,734	26,384	1,446,415
Central-Chicago Metro CBA:			
Cook, IL	124,854,279	116,360	5,294,664
DuPage, IL	16,945,135	18,492	930,528
CBA TOTAL	141,799,414	134,852	6,225,192
Northern-Chicago Metro CBA:			

TABLE 40—CHICAGO-NAPERVILLE-JOLIET, IL-IN-WI—Continued

CBA name/County	DMEPOS allowed Charles*	DMEPOS beneficiary count subject to competitive bidding*	General population**
Lake, IL	12,352,802	12,482	712,453
McHenry, IL	7,020,768	6,852	318,641
Kenosha, WI	4,161,128	3,789	164,465
CBA TOTAL	23,534,698	23,123	1,195,559
MSA TOTAL	218,161,562	207,106	9,569,624

* Source: Medicare claims from 10/1/08 to 9/30/09 for items subject to competitive bidding.
** Source: U.S. Census Bureau 2009 population estimates.

Figure 1 shows the boundaries of each proposed CBA.

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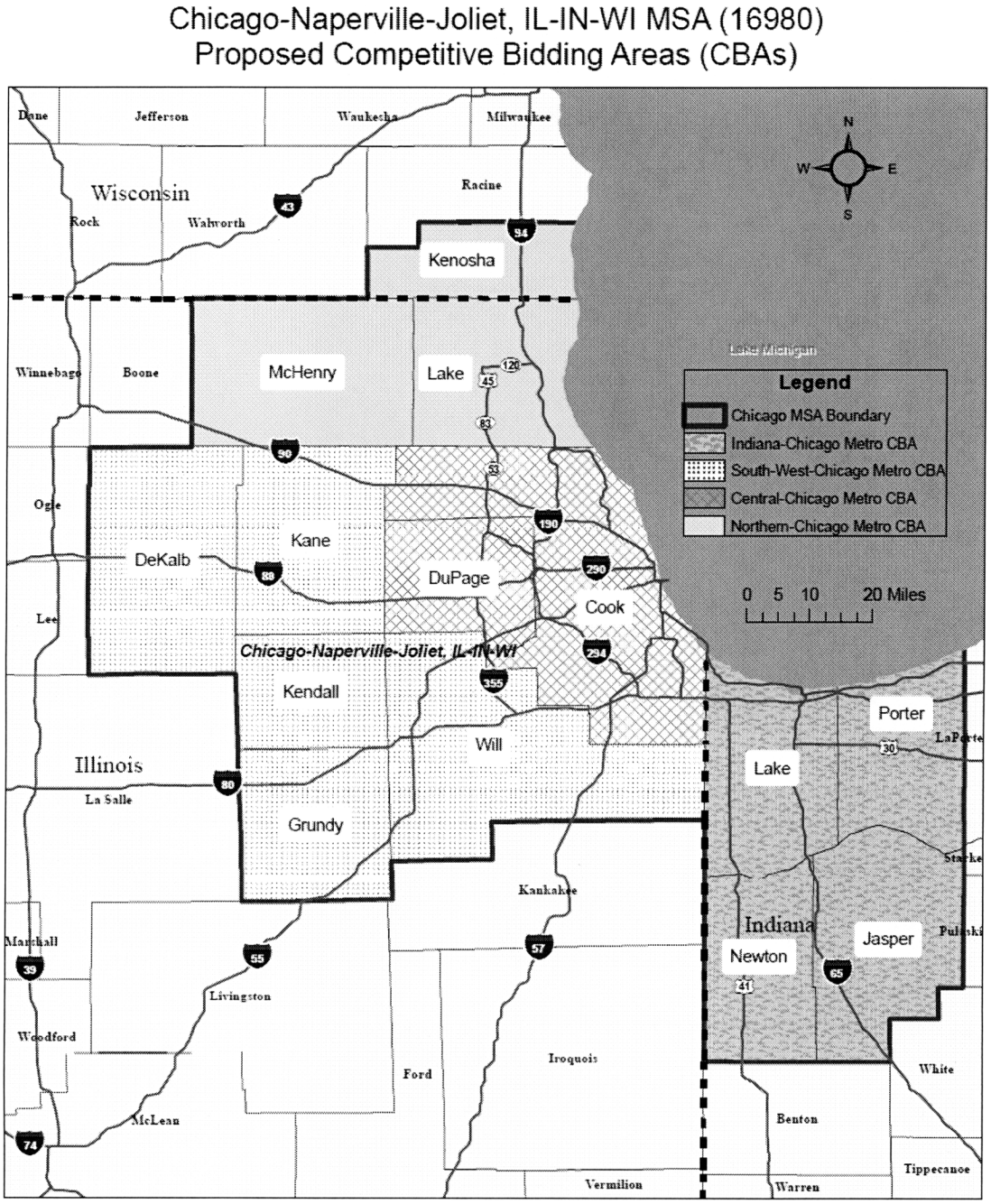
FIGURE 1:



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The Indiana-Chicago Metro CBA would include all four of the Indiana counties that are part of the MSA. The other CBAs in the MSA would be as follows:

- The South-West-Chicago Metro CBA would include counties in Illinois located to the south and west of the Central-Chicago Metro CBA.
- The Central-Chicago Metro CBA would include the city of Chicago covering both Cook and DuPage counties.
- The Northern-Chicago Metro CBA which is north of the Central-Chicago Metro CBA subdivision that encompasses the city of Chicago.

The Los Angeles-Long Beach-Santa Ana, CA MSA comprises two counties: Los Angeles County and Orange County. The MSA has 173,631 fee-for-service beneficiaries receiving DMEPOS subject to competitive bidding and $244,523,957 in DMEPOS allowed charges subject to the DMEPOS CBP. We propose to subdivide the Los Angeles-Long Beach-Santa Ana, CA MSA into two CBAs: Los Angeles County CBA and Orange County CBA. The DMEPOS allowed amount and beneficiary count subject to competitive bidding, and the general population that comprises these two proposed CBAs are shown in Table 41.

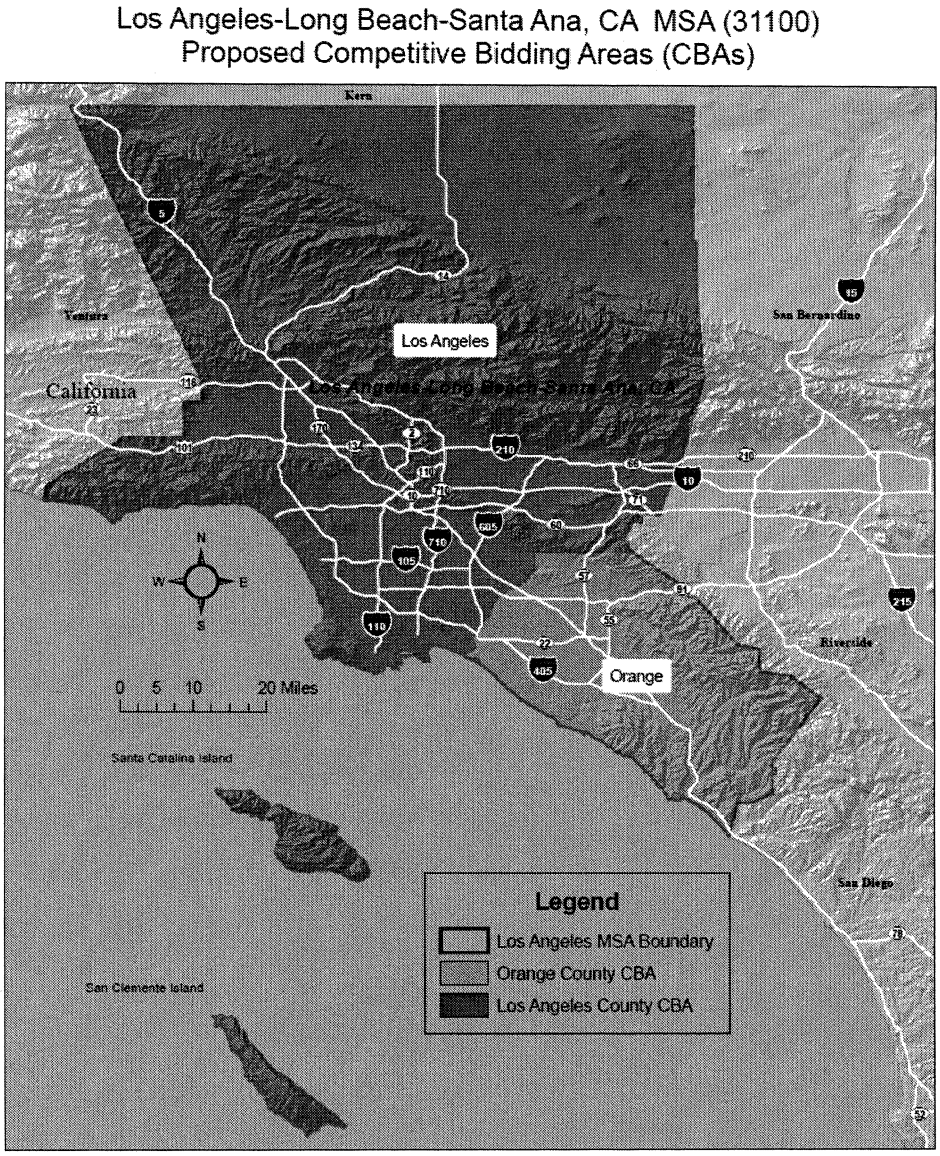
TABLE 41—LOS ANGELES-LONG BEACH-SANTA ANA, CA

CBA name	DMEPOS allowed amount *	DMEPOS beneficiary count *	General population **
Los Angeles County CBA	$201,244,121	137,408	9,862,049
CBA Total	201,244,121	137,408	* 9,862,049
Orange County CBA	43,279,836	36,223	3,010,759
CBA Total	43,279,836	36,223	3,010,759
MSA Total	244,523,957	173,631	12,872,808

*Source: Medicare claims from 10/1/08 to 9/30/09 for items subject to competitive bidding.
**Source: U.S. Census Bureau 2009 population estimates.

Figure 2 shows the boundaries of each proposed CBA.

FIGURE 2:



As mentioned earlier, we propose to subdivide MSAs using counties, and since the Los Angeles-Long Beach-Santa Ana, CA MSA only has two counties, it offers only one subdivision along the county lines. Hence, we have proposed to divide the MSA by the two counties creating two CBAs.

We also propose to use the authority in section 1847(a)(3)(A) of the Act to exclude certain areas within the Los Angeles-Long Beach-Santa Ana, CA MSA. We believe these areas meet the requirement of section 1847(a)(3)(A); they are rural areas with a low population density within an urban area that are not competitive. In the final rule CMS–1270 F § 414.410(c) published in April 2007, we defined the factors we consider when determining an area is considered a low population density area or an area that would not be competitive. Based on our review of the County Subdivision Population from the 2000 Census from the U.S. Census Bureau, and using the factors set forth in the April 2007 proposed rule, we propose to exclude the area of Los Angeles County north of the San Gabriel mountains. This large geographic area has a population of about 357,000, which is only 4 percent of the total population of Los Angeles County, and is separated from the rest of the county by the San Gabriel Mountains. The area north of the San Gabriel Mountains has one major road and many terrains which make this area remote. The majority of the population in LA County lives south of the San Gabriel Mountains.

We believe that excluding this area will create a more manageable CBA that still provides sufficient volume of DMEPOS items while avoiding the geographic obstacle of the mountains. We believe including this area in the DMEPOS CBP would result in fewer small suppliers being considered for participation under the program, because we would not expect small suppliers to have the resources to serve these more remote areas. As a result, we expect that if this proposal is finalized it will increase the number of bids submitted for the CBAs within the Los Angeles-Long Beach-Santa Ana, CA MSA.

The Los Angeles County includes the two islands of Santa Catalina and San Clemente off the west coast. We are proposing that the two islands be included as a part of the Los Angeles County CBA in order to ensure that

beneficiaries presently residing on these islands or who move to these islands in the future are ensured access to competitively bid items by contract suppliers. San Clemente Island is a military base with a current population of zero, and therefore, the inclusion of this area in the CBA would not result in an increase in the supplier service area at this time.

We also propose to subdivide the New York-Northern New Jersey-Long Island, NY–NJ–PA MSA into five CBAs. This MSA comprises 23 counties in three States: New York, New Jersey and Pennsylvania. The MSA has 344,879 FFS beneficiaries receiving DMEPOS subject to the DMEPOS CBP and $350,449,795 in allowed charges for DMEPOS items subject to competitive bidding. The counties, DMEPOS allowed amount and beneficiary count subject to competitive bidding and the general populations that comprise each of these proposed CBAs are shown in Table 42.

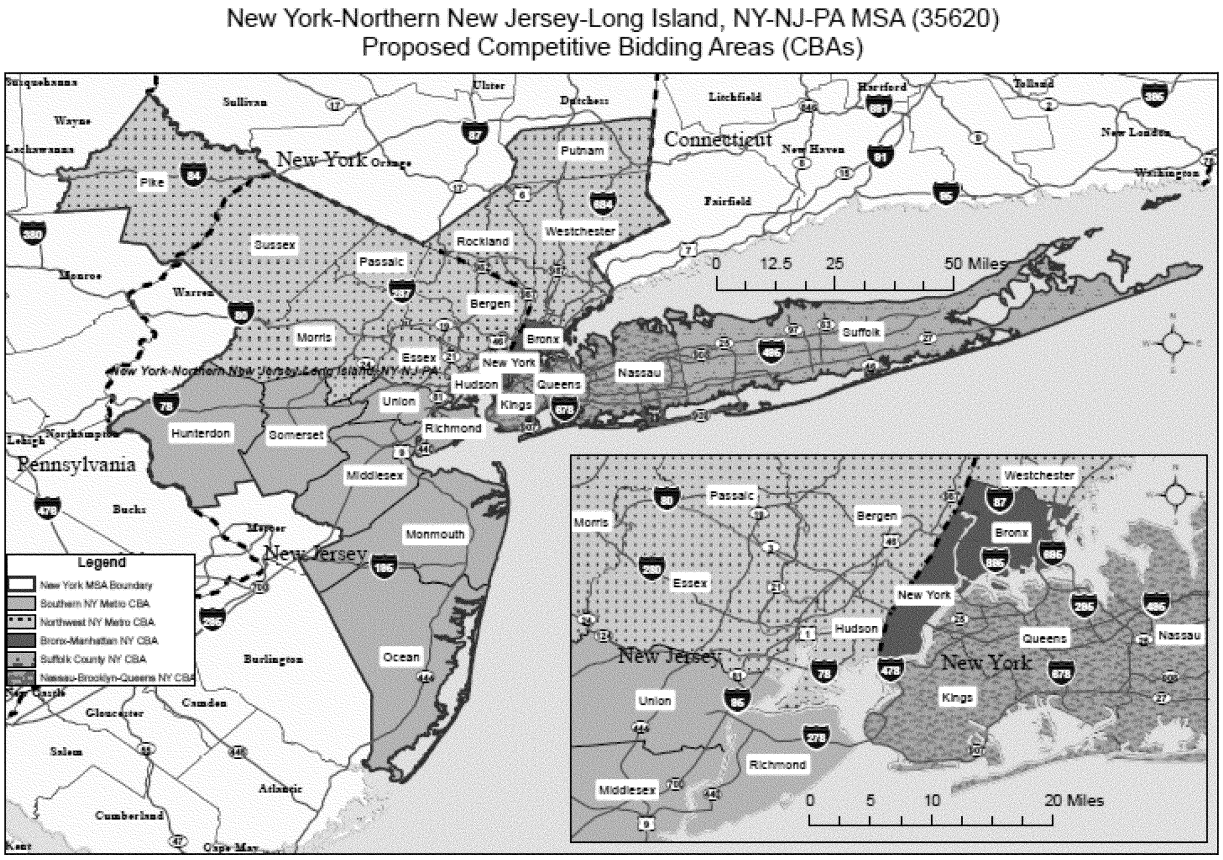
TABLE 42—NEW YORK-NORTHERN NEW JERSEY-LONG ISLAND, NY-NJ-PA

CBA name/County	DMEPOS allowed amount *	DMEPOS beneficiary count *	General population **
Nassau-Brooklyn-Queens County Metro CBA:			
Nassau, NY	$30,888,889	29,857	1,351,625
Kings, NY	47,044,915	44,893	2,556,598
Queens, NY	33,406,236	32,798	2,293,007
CBA TOTAL	111,340,040	107,548	6,201,230
Suffolk County CBA:			
Suffolk, NY	31,950,806	31,476	1,512,224
CBA TOTAL	31,950,806	31,476	1,512,224
Bronx-Manhattan NY CBA:			
Bronx, NY	19,791,646	17,002	1,391,903
New York, NY	26,483,792	26,414	1,634,795
CBA TOTAL	46,275,438	43,416	3,026,698
North-West NY Metro CBA:			
Hudson, NJ	13,622,910	12,644	595,419
Bergen, NJ	19,948,837	20,278	894,840
Passaic, NJ	10,266,137	10,233	490,948
Putnam, NY	1,997,668	1,876	99,244
Rockland, NY	6,421,317	6,265	298,545
Essex, NJ	1,392,770	1,379	770,675
Morris, NJ	9,094,758	9,830	487,548
Sussex, NJ	2,905,240	2,819	150,909
Pike, PA	1,393,003	1,475	59,664
Westchester, NY	16,971,210	17,220	953,943
CBA TOTAL	84,013,850	84,019	4,801,735
Southern NY Metro CBA:			
Hunterdon, NJ	2,709,880	2,356	129,031
Richmond, NY	7,054,863	6,626	487,407
Union, NJ	10,466,838	10,654	523,249
Middlesex, NJ	15,803,473	16,649	789,102
Monmouth. NJ	14,979,747	15,110	642,448
Ocean, NJ	20,913,022	21,600	569,111
Somerset, NJ	4,941,838	5,425	324,563
CBA TOTAL	76,869,661	78,420	3,464,911
MSA TOTAL	350,449,795	344,879	19,006,798

* Source: Medicare claims from 10/1/08 to 9/30/09 for items subject to competitive bidding.
** Source: U.S. Census Bureau 2009 population estimates.

Figure 3 shows the boundaries of each proposed CBA.

FIGURE 3:



The Nassau-Brooklyn-Queens CBA would be contiguous to Suffolk County and would consist of the western part of Long Island and extend to the eastern part of New York City. The Suffolk County CBA would consist of the eastern part of Long Island and would encompass most of Long Island. The Bronx-Manhattan NY CBA would include the entire area of Manhattan and the Bronx. The North-West NY Metro CBA would be situated north and west of New York City and would extend into New Jersey and Pennsylvania. The Southern NY Metro CBA would include Staten Island and would extend south to Ocean County, New Jersey.

At the March 17, 2010 meeting of the Program Advisory and Oversight Committee (PAOC), we presented these proposals for subdividing these three large MSAs. Various members of the PAOC had the following suggestions for subdividing these MSAs:

- Draw the boundaries of CBAs using the interstate highways rather than the divisions by County;
- Determine the current servicing areas of suppliers by MSA and product category by using a scatter plot;
- Use the Hudson River to divide the CBAs for the New York MSA;
- Carve out Pike and Putnam Counties from the New York MSA due to their location and their low population density;
- Include Manhattan as a separate CBA, due to its unique nature as a self contained area;
- Consider State licensure requirements when we divide the MSAs into CBAs;
- In the LA County CBA, exclude the area north of the San Gabriel Mountains from the CBA; and
- Consider traffic patterns when dividing the Los Angeles MSAs into CBAs.

We are considering the PAOC's advice and recommendations and invite further comments on the proposed subdivisions and PAOC's advice of these three MSAs.

3. Exclusions of Certain Areas After Round 2 and Prior to 2015

The MIPPA amended the statute by requiring that competition under Round 2 takes place in 2011 and by adding section 1847(a)(1)(D)(iii) that requires CMS to exclude the following areas from the competitive bid program for competitions after Round 2 of the program and before 2015:

- Rural Areas;
- Metropolitan Statistical Areas not selected under Round 1 or Round 2 with a population of less than 250,000; and
- Areas with a low population density within a MSA that is otherwise selected consistent with section 1847(a)(3)(A).

We propose to incorporate these requirements and timeframes in proposed § 414.410(c).

4. Expansion of Round 2

Section 6410(a) of the ACA expanded the areas to be included in Round 2 of the program. As amended by section 6410(a) of the ACA, section 1847(a)(1)(B)(i)(II) requires that the competition for Round 2 of the program occur in 91 of the largest MSAs in 2011. Prior to this change, Round 2 was to include 70 MSAs. Section 1847(a)(1)(D)(ii)(II), as added by section 6410(a), specifies that the additional 21 MSAs to be included in Round 2 "include the next 21 largest metropolitan statistical areas by total population" (after those already selected Round 2). The 2009 annual population estimates from the U.S. Census Bureau

are the most recent estimates of population that will be available prior to the Round 2 competition mandated to take place in 2011. We therefore propose to use these estimates to determine the additional 21 MSAs to be included in Round 2 of the program. Table 43 is a list of the additional 21 MSAs added to Round 2.

TABLE 43—ADDITIONAL 21 MSAS ADDED TO ROUND 2

21 Additional MSAs	2009 Total population
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	5,968,252
Washington-Arlington-Alexandria, DC-VA-MD-WV	5,476,241
Boston-Cambridge-Quincy, MA-NH	4,588,680
Phoenix-Mesa-Scottsdale, AZ	4,364,094
Seattle-Tacoma-Bellevue, WA	3,407,848
St. Louis, MO-IL	2,828,990
Baltimore-Towson, MD	2,690,886
Portland-Vancouver-Beaverton, OR-WA	2,241,841
Providence-New Bedford-Fall River, RI-MA	1,600,642
Buffalo-Niagara Falls, NY	1,123,804
Rochester, NY	1,035,566
Tucson, AZ	1,020,200
Honolulu, HI	907,574
Albany-Schenectady-Troy, NY	857,592
Worcester, MA	803,701
Oxnard-Thousand Oaks-Ventura, CA	802,983
Springfield, MA	698,903
Bradenton-Sarasota-Venice, FL	688,126
Poughkeepsie-Newburgh-Middletown, NY	677,094
Stockton, CA	674,860
Boise City-Nampa, ID	606,376

W. Section 10501(i)(3)—Proposed Collection of HCPCS Data for Development and Implementation of a Prospective Payment System for the Medicare Federally Qualified Health Center Program

The Omnibus Budget Reconciliation Act (OBRA) of 1989 amended the Social Security Act by creating new FQHC benefit programs under both Medicare and Medicaid. The Medicare FQHC benefit provides coverage for a full range of primary care services, including physician and certain nonphysician services (PAs, NPs), clinical social worker, psychologist services, and preventive services. FQHCs are "safety net" providers (for example, community health centers and programs serving migrants, the homeless, public housing centers, and tribal groups). The main purpose of the FQHC program is to enhance the provision of primary care services in underserved urban and rural communities. FQHCs typically enhance the availability of care to vulnerable populations, including Medicare, Medicaid, SCHIP, and the uninsured. Most of these health centers receive HRSA grants for services to the uninsured.

Medicare pays FQHCs on the basis of reasonable cost, subject to an upper payment limit on the reasonableness of incurred cost. Actual Medicare reasonable cost is determined based upon a Medicare cost report filed by the FQHC after the end of its fiscal year. Prior to the start of the year, an interim all-inclusive per-visit payment amount, based upon an estimate of Medicare reasonable costs, is calculated for each Medicare FQHC. During the year, this interim all-inclusive per-visit payment amount is paid for each covered visit between a Medicare beneficiary and an FQHC health professional. After the end of the Medicare FQHC's cost reporting year, interim per-visit payments are reconciled to actual Medicare reasonable costs based upon the Medicare cost report filed by the FQHC. Section 10501(i)(3) of the ACA now amends this current Medicare FQHC payment policy with an entirely different payment system, effective with cost reporting periods beginning on or after October 1, 2014.

Section 10501(i)(3)(A) of the ACA amended section 1834 of the Act by adding a new subsection (o), Development and Implementation of Prospective Payment System. This subsection provides the statutory framework for development and implementation of a prospective payment system for Medicare FQHCs. Section 1834(o)(1)(B) of the Act, as established by the ACA, addresses collection of data necessary to develop and implement the new Medicare FQHC prospective payment system. Specifically, section 1834(o)(1)(B) of the Act, Collection of Data and Evaluation, grants the Secretary of HHS the authority to require FQHCs to submit such information as may be required in order to develop and implement the Medicare FQHC prospective payment system, including the reporting of services using HCPCS codes. Section 1834(o)(1)(B) of the Act requires that the Secretary impose this data collection submission requirement no later than January 1, 2011. Accordingly, we are proposing to add a new paragraph (d) to § 405.2470 to require Medicare FQHCs to begin reporting all services furnished and using HCPCS codes for these services starting January 1, 2011. Beginning January 1, 2011, the Medicare FQHC would be required to report on Medicare FQHC claims all pertinent service(s) provided for each Medicare FQHC visit (defined in § 405.2463). This additional reporting would include the information needed to develop and implement a PPS for FQHCs. For example, corresponding HCPCS code(s) would be required to be reported along with the presently required Medicare revenue code(s) for the Medicare FQHC visit(s). CMS' Medicare FQHC claims processing system would be revised to accept the addition of the new reporting requirements effective January 1, 2011. The proposed new data collection effort would be for informational and data gathering purposes only, and would not be utilized to determine Medicare payment to the FQHC. Until the FQHC prospective payment system is implemented in 2014 and the Medicare claims processing system is revised to reflect such a system, Medicare FQHC

payment would continue in the current manner (utilizing revenue codes and the interim per-visit payment rate methodology).

We further note that Medicare FQHCs would be required to adhere to the information collection requirements in accordance with the content and terms of their Medicare agreement as stipulated at § 405.2434. Failure to do so could result in the termination of the FQHC's Medicare agreement in accordance with § 405.2436 of the Medicare FQHC regulations.

At this time, we do not foresee additional claims or other information collection needs beyond collection of HCPCS codes. Accordingly, we are not proposing additional information collection requirements at this time. However, we invite public comment on any additional information FQHCs believe may be necessary in order to develop and implement a prospective payment system for Medicare FQHCs.

VI. Other Provisions of the Proposed Regulation

A. Part B Drug Payment: Average Sales Price (ASP) Issues

1. "Carry Over" ASP

The ASP payment methodology is authorized under section 303(c) of the MMA which amends Title XVIII of the Act by adding section 1847A of the Act. This section establishes the use of the ASP methodology for payment for drugs and biologicals described in section 1842(o)(1)(C) of the Act furnished on or after January 1, 2005. For purposes of this part, the term "drugs" will hereafter refer to both drugs and biologicals. The ASP methodology applies to most drugs furnished incident to a physician's service, drugs furnished under the durable medical equipment (DME) benefit, certain oral anti-cancer drugs, and oral immunosuppressive drugs.

Sections 1847A and 1927(b) of the Act specify quarterly ASP data reporting requirements for manufacturers. Specific ASP reporting requirements are set forth in section 1927(b) of the Act. Although delays in reporting have been uncommon, they create a risk that: (1) Could result in the publication of payment limits which do not reflect prices for drug products, and (2) could result in inaccurate payments, the need for correction of files and unintentional ASP payment limit variability.

As a result of these concerns, we are seeking to establish a process for addressing situations where manufacturers fail to report manufacturer ASP data in a timely fashion. This proposal is intended to allow us to calculate and report ASP payment limits for a given quarter within the existing timelines and does not affect the CMS or OIG's authority to assess civil monetary penalties associated with untimely or false ASP reporting. Manufacturers who misrepresent or fail to report manufacturer ASP data will remain subject to civil monetary penalties, as applicable and described in sections 1847A and 1927(b) of the Act.

For the purposes of reporting under section 1847A of the Act, the term manufacturer is defined in section 1927(k)(5) of the Act and means any entity engaged in the following: production, preparation, propagation, compounding, conversion or processing of prescription drug product, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis; or packaging, repackaging, labeling, relabeling, or distribution of prescription drug products. The term manufacturer does not include a wholesale distributor of drugs or a retail pharmacy licensed under State law. However, manufacturers that also engage in certain wholesaler activities are required to report ASP data for those drugs that they manufacture. Note that the definition of manufacturers for the purposes of ASP data reporting includes repackagers.

In accordance with section 1847A of the Act, manufacturers are required to report data on the NDC level, which include the following elements: the manufacturer ASP for drugs; the Wholesale Acquisition Cost (WAC) in effect on the last day of the reporting period; the number of ASP units sold; and the NDC. Currently, when manufacturer ASP data or specific data elements are not available, we calculate an ASP price for a billing code based on other applicable and available pricing data from manufacturers for that drug. This includes WAC prices from compendia if manufacturer data are not available for a billing code. WAC prices tend to be higher than manufacturer ASP prices.

Although problems with reporting have been uncommon, we have recently encountered situations where delays in manufacturer ASP reporting could have led to significant ASP payment limit fluctuations for highly utilized HCPCS codes. The greatest potential impact occurs when data for high volume drug products within a HCPCS code that is represented by a limited number of NDCs have not been reported and cannot be included in the ASP volume weighted calculations described in section 1847A(b) of the Act. For multisource drugs, such a situation is likely to artificially increase or decrease Medicare ASP payment limits, which in turn would affect beneficiary cost sharing amounts. Such artificial fluctuations of the ASP payment limit could provide the appearance of instability unrelated to market forces and could also create access issues for providers and beneficiaries and confusion that could ultimately affect product demand in the marketplace.

In order to minimize the possibility of ASP payment limit fluctuations due to missing data, we are proposing a process, consistent with our authority in section 1847A(c)(5)(B), to update ASPs, based on the manufacturer's ASP calculated for the most recent quarter for which data is available. Specifically, we are proposing to carry over the previously reported manufacturer ASP for an NDC(s) when missing manufacturer ASP and/or WAC data could cause significant changes or fluctuations in ASP payment limits, and efforts by us to obtain manufacturer reported ASP before Medicare ASP payment limits publication deadlines have not been successful. For example, the most recently reported manufacturer ASP prices for products on the market would be carried over to the next quarter if an entire manufacturer's submission was not received, manufacturer ASP price data for specific NDCs has not been reported, or only WAC data has been reported; however, NDCs that have zero sales or are no longer being manufactured will not be subjected to this process. Also, we are proposing to apply the carryover process only in cases where missing data results in a 10 percent or greater change in the ASP payment limit compared to the previous quarter. Based on experience with ASP methodology since 2006, we believe that this percentage threshold meets the definition of significant. We are specifically seeking comments on our use of 10 percent as the threshold amount. In order to better represent actual market trends, that is actual increases or decreases in manufacturer reported ASP for the group of NDCs that represent the HCPCS code, we are proposing that the manufacturer ASP payment amounts for the individual NDCs that are carried over will be adjusted by the weighted average of the change in the manufacturer ASP for the NDCs that were reported during both the most recently available quarter and the current quarter. We would appreciate comments about whether other methods to account for

marketplace price trends to the carried over NDCs could be a better substitute for applying the weighted average change. The previous quarter's sales volumes will be carried over. An example of the proposed process appears in Table 44.

We propose to apply this process to both single source drugs and multiple source drugs. However, we are concerned that including single source drugs in the carry over process could create an incentive for non-reporting in situations where ASP prices for a single source drug are falling and the manufacturer stops reporting ASP in an effort to preserve a higher payment amount despite the risk of significant statutory penalties for such an action. Therefore, we are specifically requesting comments on this option and the effect of limiting this proposal to multiple source drugs only. We will consider these comments carefully before including both single source and multisource drugs in this process.

TABLE 44—PROPOSED ASP CARRYOVER EXAMPLE FOR NDCS IN A SPECIFIC HCPCS CODE

Previous quarter reported NDCs	Previous Qtr reported volume	Previous Qtr ASP price	Current Qtr reported NDCs	Current Qtr reported volume	Current Qtr ASP price	Current Qtr NDCs for calculation	Current Qtr volume for calculation	Current Qtr price for calculation
12345–6789–10	2000	$1.000	12345–6789–10	2500	$0.980	12345–6789–10	2500	$0.980
12345–6789–11	3000	1.000	12345–6789–11	1700	0.980	12345–6789–11	1700	0.980
12345–6789–12	5000	1.000	12345–6789–12	5500	0.980	12345–6789–12	5500	0.980
45678–1234–90	9000	1.100	(**)	(**)	(**)	45678–1234–90	9000	*1.078
45678–1234–99	27000	1.100	(**)	(**)	(**)	45678–1234–99	27000	*1.078

*This result is obtained by calculating the weighted average price change in NDCs available (that is, 12345–6789–10 thru 12345–6789–12) in both the previous and current quarters, which is −2% [(0.98–1.00)*100], and applying that change to the previous quarter's manufacturer ASP for the missing NDCs (that is, 45678–1234–90 and 45678–1234–99). The last two columns on the right would be used to calculate the weighted ASP and payment limits for the 5 NDCs as a HCPCS code and accounts for missing prices for two high volume NDCs that represent most of the units sold within the HCPCS code and therefore heavily influence the price calculation for the HCPCS code.

** Missing.

Our proposed approach is intended to establish a straightforward and transparent solution that minimizes the effect of missing manufacturer ASP data on Medicare ASP payment limits. We believe that the availability of a mechanism to minimize non-market related price fluctuations is desirable when efforts to obtain manufacturer's ASP data by deadlines have not been successful. Our proposed mechanism is not intended to alter or adjust reported prices and will not be used to do so, but instead is intended to more accurately represent prices in the marketplace if manufacturer ASP data for particular drug product(s) is missing. Based on our experience with ASP reporting since 2004, we do not believe that this process will be used frequently. However, as we stated previously, recent concerns with delays in reporting of manufacturer ASP data have led to this proposal.

We also remind manufacturers that significant civil monetary penalties for not reporting or misrepresenting manufacturer ASP data are authorized under sections 1847A(d)(4) and 1927(b)(3)(C) of the Act and codified in regulations at § 414.806. This proposal should not be interpreted to mean that CMS and the OIG will refrain from collecting such penalties for ASP reporting violations. Late or missing reports will not be tolerated. This proposed policy would be implemented regardless of any efforts by the OIG to enforce Civil Monetary Penalties for non-reporting.

We would also like to remind manufacturers that additional specific information about reporting ASP data to us is available. (See for example.: 69 FR 17936, 69 FR 66299, 70 FR 70215, 71 FR 69665, 72 FR 66256, 73 FR 69751, and 74 FR 61904.) Also, Frequently Asked Questions are posted in the Related Links Inside CMS Section of the ASP Overview Web page at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01_overview.asp#TopOfPage*, and the Downloads section of the same webpage contains a link to the ASP Data Form (addendum A), which includes examples of how ASP data must be reported and formatted for submission. In particular, we would like to remind manufacturers to report sales volume in quantities of NDC units sold (not vials or other units of sale), and to use a zero (that is the character "0") instead of a blank when reporting items that did not have any sales in a particular quarter. In addition, manufacturers should report both the ASP and the WAC for each NDC, the expiration date for the last lot sold, if applicable, and the date of first sale for an NDC.

In summary, in situations where any current quarter's manufacturer ASP data is unavailable, we are proposing, consistent with our authority in section 1847A(c)(5)(B), to use the most recent data available in the ASP payment limit calculation for single source and multiple source drugs. We look forward to comments on this proposal and the proposed changes to § 414.904(i).

2. Partial Quarter ASP Data

Section 1847A(c)(4) of the Act states that "In the case of a drug or biological during an initial period (not to exceed a full calendar quarter) in which data on the prices for sales for the drug or biological is not sufficiently available from the manufacturer to compute an average sales price for the drug or biological, the Secretary may determine the amount payable under this section for the drug or biological based on—(A) the wholesale acquisition cost; or (B) the methodologies in effect under this part on November 1, 2003, to determine payment amounts for drugs or biological."

When a new drug product enters the market, the first date of sale rarely coincides with the beginning of a calendar quarter. Therefore, the ASP data for many new drug products falls into partial quarter status during the first quarter of sales. We are taking this opportunity to describe our policy regarding how reported data is used in the calculation of ASP payment limits during the first quarter of sales for single source and multiple source drugs.

In accordance with section 1847A(c)(4)(A) of the Act, it has been our policy to price new single source drugs at WAC for the first quarter (unless the date of first sale is on the first day of the quarter), and to add new

NDCs for multi source drugs and product line expansions of single source drugs to the ASP calculation for a quarter as soon as these products are reported.

We believe that the approaches for both single source and multi source drugs are consistent with the statute, particularly section 1847A(c)(4) of the Act, and we intend to continue this policy.

3. Determining the Payment Amount for Drugs and Biological Which Include Intentional Overfill

The methodology for developing Medicare drug payment allowances based on the manufacturers' submitted ASP data is specified in 42 CFR part 414, subpart K. We initially established this regulatory text in the CY 2005 PFS final rule with comment period (69 FR 66424). We further described the formula we use to calculate the payment amount for each HCPCS billing code in the CY 2006 PFS proposed rule (70 FR 45844) and final rule with comment period (70 FR 70217). With the enactment of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) (Pub. L. 110–173), the formula we use changed beginning April 1, 2008. Section 112(a) of the MMSEA requires us to calculate payment amounts using a specified volume-weighting methodology. In addition, section 112(b) of the MMSEA sets forth a special rule for determining the payment amount for certain drugs and biological. We addressed these changes in the CY 2009 PFS proposed and final rules (73 FR 38520 and 69571, respectively). For each billing code, we calculate a volume-weighted, ASP-based payment amount using the ASP data submitted by manufacturers. Manufacturers submit ASP data to us at the 11-digit National Drug Code (NDC) level, including the number of units of the 11-digit NDC sold and the ASP for those units. We determine the number of billing units in an NDC based on the amount of drug in the package.

For example: A manufacturer sells a box of 4 vials of a drug. Each vial contains 20 milligrams (mg); the billing code is per 10 MG. The number of billing units in this NDC for this billing code is (4 vials × 20mg)/10mg = 8 billable units.

Beginning April 1, 2008, we use a two-step formula to calculate the payment amount for each billing code. We sum the product of the manufacturer's ASP and the number of units of the 11-digit NDC sold for each NDC assigned to the billing and payment code, and then divide this total by the sum of the product of the number of units of the 11-digit NDC sold and the number of billing units in that NDC for each NDC assigned to the billing and payment code.

The provisions in section 112 of the MMSEA were self-implementing for services on and after April 1, 2008. Because of the limited time between enactment and the implementation date, it was not practical to undertake and complete rulemaking on this issue prior to implementing the required changes. As a result of the legislation, we revised § 414.904 to codify the changes to the determination of payment amounts consistent with section 112 of the MMSEA.

Since that time, we have become aware of situations where manufacturers, by design, include a small amount of "intentional overfill" in containers of drugs. We understand that this "intentional overfill" is intended to compensate for loss of product when a dose is prepared and administered properly. For instance, a hypothetical drug is intended to be delivered at a 0.5 mg dose which must be drawn into a syringe from a vial labeled for single use only. The vial is labeled to contain 0.5 mg of product but actually contains 1.5 mg of product. The additional 1.0 mg of product is included, by design, and is intended to be available to the provider so as to ensure a full 0.5 mg dose is administered to the patient.

Our ASP payment calculations are based on data reported to us by manufacturers. This data includes the "volume per item." In our "Appendix A—Average Sales Price Reporting Data Elements" available on our Web site at *http://www.cms.gov/McrPartBDrugAvgSalesPrice/,* we define "volume per item" as "The amount in one item. (ex., 10 ml in one vial, or 500 tablets in one bottle) Enter "1" for certain forms of drugs (for example, powders and sheets) when "Strength of the Product" indicates the amount of the product per item." In order to accurately calculate Medicare ASP payment limits under section 1847A, we interpret "the amount in one item" to be the amount of product in the vial or other container as indicated on the FDA-approved label.

It has been longstanding Medicare policy that in order to meet the general requirements for coverage under the "incident to" provision, services or supplies should represent an expense incurred by the physician or entity billing for the services or supplies (See Medicare Benefit Policy Manual (Publication #100–02), Chapter 15, Sections 50.3, 60.1.A). Such physicians' services and supplies include drugs and biological under section 1861(s)(2)(A). In accordance with this policy, providers may only bill for the amount of drug product actually purchased and that the cost of the product must represent an expense to the physician.

We further understand that when a provider purchases a vial or container of product, the provider is purchasing an amount of drug defined by the product packaging or label. Any excess, free product (that is, overfill) is provided without charge to the provider. In accordance with our policy, providers may not bill Medicare for overfill harvested from containers, including overfill amounts pooled from more than one container, because that overfill does not represent a cost to the provider. Claims for drugs and biological that do not represent a cost to the provider are not reimbursable, and providers who submit such claims may be subject to scrutiny and follow up action by CMS, its contractors, and OIG.

Because such overfill is not included in the calculation of payment limits under the methodology in section 1847A of the Act and does not represent an incurred cost to a provider, we are proposing to update our regulations at 42 CFR part 414 subpart J to clearly state that Medicare ASP payment limits are based on the amount of product in the vial or container as reflected on the FDA-approved label. We are also proposing to update our regulations to clearly state that payment for amounts of free product, or product in excess of the amount reflected on the FDA-approved label, will not be made under Medicare.

4. WAMP/AMP

Section 1847A(d)(1) of the Act states that "the Inspector General of HHS shall conduct studies, which may include surveys to determine the widely available market prices (WAMP) of drugs and biologicals to which this section applies, as the Inspector General, in consultation with the Secretary, determines to be appropriate." Section 1847A (d)(2) of the Act states that, "Based upon such studies and other data for drugs and biologicals, the Inspector General shall compare the ASP under this section for drugs and biologicals with—

- The widely available market price (WAMP) for these drugs and biologicals (if any); and
- The average manufacturer price (AMP) (as determined under section 1927(k)(1) of the Act) for such drugs and biologicals."

Section 1847A(d)(3)(A) of the Act states that, "The Secretary may disregard the ASP for a drug or biological that exceeds the WAMP or the AMP for such drug or biological by the applicable

threshold percentage (as defined in subparagraph (B)).'' Section 1847A(d)(3)(C) of the Act states that if the OIG finds that the ASP for a drug or biological is found to have exceeded the WAMP or AMP by this threshold percentage, the OIG ''shall inform the Secretary (at such times as the Secretary may specify to carry out this subparagraph) and the Secretary shall, effective as of the next quarter, substitute for the amount of payment otherwise determined under this section for such drug or biological, the lesser of—(i) the widely available market price for the drug or biological (if any); or (ii) 103 percent of the average manufacturer price * * *.''

The applicable threshold percentage is specified in section 1847A(d)(3)(B)(i) of the Act as 5 percent for CY 2005. For CY 2006 and subsequent years, section 1847A(d)(3)(B)(ii) of the Act establishes that the applicable threshold percentage is ''the percentage applied under this subparagraph subject to such adjustment as the Secretary may specify for the WAMP or the AMP, or both.'' In the CY 2006 (70 FR 70222), CY 2007 (71 FR 69680), CY 2008 (72 FR 66258), CY 2009 (73 FR 69752), and CY 2010 (74 FR 61904) PFS final rules with comment period, we specified an applicable threshold percentage of 5 percent for both the WAMP and AMP. We based this decision on the fact that data was too limited to support an adjustment to the current applicable threshold percentage.

For CY 2011, we are proposing to specify two separate adjustments to the applicable threshold percentages. When making comparisons to the WAMP, we propose the applicable threshold percentage to remain at 5 percent. The applicable threshold percentage for the AMP is addressed below in this section of the preamble. Although the latest WAMP comparison was published in 2008, the OIG is continuing to perform studies comparing ASP to WAMP. Based on available OIG reports that have been published comparing WAMP to ASP, we do not have sufficient information to determine that the 5 percent threshold percentage is inappropriate. As a result, we believe that continuing the 5 percent applicable threshold percentage for the WAMP is appropriate for CY 2011. Therefore we are proposing to revise § 414.904(d)(3) to include the CY 2011 date.

As we noted in the CY 2010 PFS final rule with comment period (74 FR 61904), we understand that there are complicated operational issues associated with this policy. We continue to proceed cautiously in this area. We remain committed to providing stakeholders, including providers and manufacturers of drugs impacted by potential price substitutions with adequate notice of our intentions regarding such, including the opportunity to provide input with regard to the processes for substituting the WAMP for the ASP.

We welcome comments on our proposal to continue the applicable threshold percentage at 5 percent for the WAMP for 2011.

5. AMP Threshold and Price Substitutions

a. AMP Threshold

As mentioned elsewhere in this proposal, when making comparisons of ASP to AMP, the applicable threshold percentage for CY 2005 was specified in statute as 5 percent. Section 1847A(d)(3) of the Act allows the Secretary to specify adjustments to this threshold percentage for years subsequent to 2005, and to specify the timing for any price substitution. For CY 2006 (70 FR 70222), CY 2007 (71 FR 69680), CY 2008 (72 FR 66258), CY 2009 (73 FR 69752), and CY 2010 (74 FR 61904), the Secretary made no adjustments to the threshold percentage; it remained at 5 percent.

For CY 2011, we are proposing with respect to AMP substitution to apply the applicable percentage subject to certain adjustment such that comparisons of ASP to AMP will only be made when the ASP exceeds the AMP by 5 percent in two consecutive quarters immediately prior to the current pricing quarter, or three of the previous four quarters immediately prior to the current quarter.

In general, the ASP methodology reflects average market prices for Part B drugs for a quarter. The ASP is based, in part, on the average sales price to all purchasers for a calendar quarter; the AMP, in turn, represents the average price paid by certain wholesalers. Accordingly, while the ASP payment amount for a billing code may exceed its AMP for that billing code for any given quarter, this may only reflect a temporary fluctuation in market prices that would be otherwise corrected in a subsequent quarter. We believe this fluctuation is demonstrated by how few billing codes exceed the applicable threshold percentage over multiple quarters. For example, in the Inspector General's report ''Comparison of Average Sales Prices and Average manufacturer Prices: An Overview of 2008'', only 33 of 482 examined billing codes exceeded the applicable threshold percentage over multiple quarters. This figure also included billing codes that exceeded the threshold based on partial price comparisons (OEI–03–09–00350). We are concerned that comparisons of a single quarter's ASP to AMP will not adequately account for these temporary fluctuations and underlying market trends. We believe that applying this threshold percentage adjusted to reflect data from multiple quarters will account for continuing differences between ASP and AMP, and allow us to better identify those drugs that consistently trigger the substitution threshold.

We further propose to apply the applicable AMP threshold percentage only for those situations where AMP and ASP comparisons are based on the same set of NDCs for a billing code (that is, ''complete'' AMP data). Prior to 2008, the OIG calculated a volume-weighted AMP and made ASP and AMP comparisons for only billing codes with such ''complete'' AMP data. In such comparisons, a volume-weighted AMP for a billing code was calculated when NDC-level AMP data was available for the same NDCs used by us to calculate the volume-weighted ASP. Beginning in the first quarter of 2008, the OIG also began to make ASP and AMP comparisons based on ''partial'' AMP data (that is, AMP data for some, but not all NDCs in a billing code). For these comparisons, the volume-weighted AMP for a billing code is calculated even when only such limited AMP data is available. That is, the volume-weighted AMP calculated by the Inspector General is based on fewer NDCs than the volume-weighted ASP calculated by CMS. Moreover, volume-weighted ASPs are not adjusted by the Inspector General to reflect the fewer number of NDCs in the volume-weighted AMP.

Because the OIG's partial AMP data comparison does not reflect all the NDCs used in our volume-weighted ASP calculations, we have some concerns using the volume-weighted AMP. We believe that such AMP data may not adequately account for market-related drug price changes and may lead to the substitution of incomplete and inaccurate volume-weighted prices. Such substitutions may impact physician and beneficiary access to drugs. Therefore, in accordance with our authority as set forth in section 1847A(d)(1) and (3) of the Act, we are proposing the substitution of 103 percent of AMP for 106 percent of ASP should be limited to only those drugs with ASP and AMP comparisons based on the same set of NDCs. We are proposing to revise § 414.904(d)(3) to reflect corresponding regulatory text changes, and we welcome comments on all aspects of this proposal.

b. AMP Price Substitution

(1) Inspector General Studies

Section 1847A(d) of the Act requires the Inspector General to conduct studies of the widely available market price for drugs and biological to which section 1847A of the Act applies. However, it does not specify the frequency of when such studies should be conducted. The Inspector General has conducted studies comparing AMP to ASP for essentially each quarter since the ASP system has been implemented. Since 2005, the OIG has published 18 reports pertaining to the price substitution issue (see Table 45), of which 16 have identified billing codes with volume-weighted ASPs that have exceeded their volume-weighted AMPs by the applicable threshold percentage.

TABLE 45—PUBLISHED OIG REPORTS ON PRICE SUBSTITUTIONS

Date	Report title
7/2008	A Comparison of Average Sales Price to Widely Available Market Prices for Inhalation Drugs (OEI–03–07–00190).
6/2006	A Comparison of Average Sales Price to Widely Available Market Prices: Fourth Quarter 2005 (OEI–03–05–00430).
4/2010	Comparison of Third-Quarter 2009 Average Sales Price and Average Manufacturer Prices: Impact on Medicare Reimbursement for First Quarter 2010 (OEI–03–10–00150).
2/2010	Comparison of Average Sales Prices and Average Manufacturer Prices: An Overview of 2008 (OEI–03–09–00350).
1/2010	Comparison of Second-Quarter 2009 Average Sales Price and Average Manufacturer Prices: Impact on Medicare Reimbursement for Fourth Quarter 2009 (OEI–03–09–00640).
8/2009	Comparison of First-Quarter 2009 Average Sales Price and Average Manufacturer Prices: Impact on Medicare Reimbursement for Third Quarter 2009 (OEI–03–09–00490).
8/2009	Comparison of Fourth-Quarter 2008 Average Sales Price and Average Manufacturer Prices: Impact on Medicare Reimbursement for Second Quarter 2009 (OEI–03–09–00340).
4/2009	Comparison of Third-Quarter 2008 Average Sales Prices and Average Manufacturer Prices: Impact on Medicare Reimbursement for First Quarter 2009 (OEI–03–09–00150).
2/2009	Comparison of Second-Quarter 2008 Average Sales Prices and Average Manufacturer Prices: Impact on Medicare Reimbursement for Fourth Quarter 2008 (OEI–03–09–00050).
12/2008	Comparison of First-Quarter 2008 Average Sales Price and Average Manufacturer Prices: Impact on Medicare Reimbursement for Third Quarter 2008 (OEI–03–08–00530).
12/2008	Comparison of Average Sales Prices and Average Manufacturer Prices: An Overview of 2007 (OEI–03–08–00450).
8/2008	Comparison of Fourth-Quarter 2007 Average Sales Price and Average Manufacturer Prices: Impact on Medicare Reimbursement for Second Quarter 2008 (OEI–03–08–00340).
5/2008	Comparison of Third-Quarter 2007 Average Sales Price and Average Manufacturer Prices: Impact on Medicare Reimbursement for First Quarter 2008 (OEI–03–08–00130).
12/2007	Comparison of Second-Quarter 2007 Average Sales Price and Average Manufacturer Prices: Impact on Medicare Reimbursement for Fourth Quarter 2007 (OEI–03–08–00010).
9/2007	Comparison of First-Quarter 2007 Average Sales Price and Average Manufacturer Prices: Impact on Medicare Reimbursement for Third Quarter 2007 (OEI–03–07–00530).
7/2007	Comparison of Third-Quarter 2006 Average Sales Price and Average Manufacturer Prices: Impact on Medicare Reimbursement for First Quarter 2007 (OEI–03–07–00140).
7/2006	Comparison of Fourth-Quarter 2005 Average Sales Price and Average Manufacturer Prices: Impact on Medicare Reimbursement for Second Quarter 2006 (OEI–03–06–00370).
4/2006	Monitoring Medicare Part B Drug Prices: A Comparison of Average Sales Price to Average Manufacturer Prices (OEI–03–04–00430).

For example, in their latest report comparing AMP to ASP entitled "Comparison of Third-Quarter 2009 Average Sales Price and Average Manufacturer Prices: Impact on Medicare Reimbursement for First Quarter 2010" (OEI–03–10–00150), the Inspector General found that of 356 billing codes with complete AMP data in the third quarter of 2009, 16 met the 5 percent threshold, that is, ASP exceeded AMP by at least 5 percent. Eight of these 16 billing codes were also eligible for price adjustments in one or more of the previous four quarters, with three drugs meeting the 5-percent threshold in all five quarters under review. This Inspector General report further indicates that, "If reimbursement amounts for all 16 drugs had been based on 103 percent of the AMPs, we estimate that Medicare expenditures would have been reduced by over half a million dollars in the first quarter of 2010." These drugs and the savings found by the Inspector General constitute potential savings for the Medicare program and beneficiaries.

(2) Regulatory, Judicial, and Legislative Changes

Since 2005, regulatory and legislative changes, as well as litigation, have had a direct impact on this price substitution issue. In 2007, we published a final rule that, in accordance with section 6001(c) of the Deficit Reduction Act, was designed to clarify the definition of AMP (72 FR 39142). On December 19, 2007, the United States District Court for the District of Columbia issued a preliminary injunction in *National Association of Chain Drug Stores et al.* v. *Health and Human Services,* Civil Action No. 1:07-cv-02017(RCL) that enjoins CMS, in part, from posting any AMP data on a public Web site or otherwise disclosing any AMP data to certain individuals or entities, including, but not limited to, States or their representatives. (For additional information on this injunction, please see our Web site at *http://www.cms.hhs.gov/DeficitReductionAct/Downloads/AMPPIOrder.pdf).*

In 2010, section 2503 of ACA amended the definition of AMP, in part, to reflect the average price paid for covered outpatient drugs: (1) By wholesalers for drugs distributed to retail community pharmacies; and (2) by retail community pharmacies that purchase drugs directly from the manufacturer. The statute defines retail community pharmacies, in part, as independent, chain, and supermarket pharmacies.

(3) Proposal

Overall, we are cognizant that any policy must reflect market-related pricing changes. Additionally, we continue to recognize the need, in light of the statute, to implement a price substitution policy.

As discussed previously, section 1847A(d)(3) of the Act provides authority for us to determine the applicable percentage subject to "such adjustment as the Secretary may specify for the widely available market price or the average manufacturer price, or both." We also have authority to specify the timing of any ASP substitution. Consistent with this authority, we are proposing a policy to substitute 103 percent of AMP for 106 percent of ASP where the applicable percentage has been satisfied for a number of calendar quarters, as discussed elsewhere in this rule. This policy would apply to both single source and multiple source drugs and biologicals as defined respectively at section 1847A(c)(6)(C) and (D) of the Act.

We acknowledge the limitation of the preliminary injunction on our ability to publicly disclose AMP data and until that injunction is modified, we will not implement this price substitution policy.

Because of the lack of data regarding WAMP to ASP comparisons, we are explicitly excluding WAMP from this price substitution proposal though we are proposing to maintain the WAMP threshold at 5 percent for CY 2011 in a separate section of this rule. Overall, we are interested in implementing a price substitution policy that reflects market-related pricing changes and which focuses on those drugs that consistently exceed the price substitution threshold over multiple quarters. Unlike the OIG's AMP studies, the published WAMP studies have recommended price substitutions based on specific timeframes that do not illustrate whether such pricing discrepancies are singular or consistent across multiple quarters. We will reconsider proposing a policy for the substitution of WAMP at a later date.

(4) Timeframe for and Duration of Price Substitutions

As stated in § 414.804(a)(5), a manufacturer's average sales price must be submitted to CMS within 30 days of the close of the quarter. We then calculate an ASP for each billing code as per the process outlined at § 414.904. Then, as per our CY 2005 PFS final rule (69 FR 66300), we implement these new prices through program instructions or otherwise at the first opportunity after we receive the data, which is the calendar quarter after receipt.

Section 1847A(d)(3)(C) of the Act indicates that a price substitution would be implemented "effective as of the next quarter" after the OIG has informed us that the ASP for a drug or biological exceeds its AMP by the applicable percentage threshold. The OIG does not receive new ASP prices for a given quarter until after we have finalized them. Also, the results of their pricing comparisons are not available until after the ASP prices for a given quarter have gone into effect. Therefore, we anticipate that there will be a three quarter lag for substituted prices from the quarter in which manufacturer sales occurred, though this will depend in great part upon the timeframe in which we obtain comparison data from the OIG. Table 46 provides an example of this timeframe.

TABLE 46—EXAMPLE PRICE SUBSTITUTION TIMEFRAME

	Q2–10	Q3–10	Q4–10	Q1–11
ASP Process	Manufacturer sells drug.	Manufacturer submits Q2–10 pricing data. CMS calculates ASP payment limits for Q4–10.	CMS publishes Q4–10 payment limits.	
.....	.....	.....	CMS calculates ASP payment limits for Q1–11. Compares calculated payment limits to OIG substitute prices. Publishes Q1–11 prices that may include OIG substitute prices.	
OIG Process	.....	.....	OIG receives Q4–10 pricing from CMS and compares it to Q2–10 volume-weighted AMP data. Notifies CMS of eligible HCPCS for substitution.	

Given this lag in time, the ASP price for a billing code may have decreased since the OIG's comparison. Therefore, consistent with our authorities in section 1847A(d)(3) of the Act and our desire to provide accurate payments consistent with these provisions, we believe that the timing of any substitution policy should permit a final comparison between the OIG's volume-weighted 103 percent AMP for a billing code (calculated from the prior quarter's data) and the billing code's volume-weighted 106 percent ASP, as calculated by CMS, for the current quarter. This final comparison would assure the Secretary that the 106 percent ASP payment limit continues to exceed 103 percent of the OIG's calculated AMP in order to avoid a situation in which the Secretary would inadvertently raise the Medicare payment limit through this price substitution policy. We specifically request comments on this proposal.

ASP payment limits are calculated on a quarterly basis as per section 1847A(c)(5)(A) of the Act, and we are particularly mindful that the ASP-based payment allowance for a billing code may change from quarter to quarter. As such, we propose that any price substitution would last for one quarter.

Overall, we believe that our proposal as outlined above to substitute 103 percent of AMP for 106 percent of ASP provides us with a viable mechanism for generating savings for the Medicare program and its beneficiaries since it will allow Medicare to pay based off lower market prices for those drugs and biologicals that consistently exceed the applicable threshold percentage. Moreover, it will enable us to address a programmatic vulnerability identified by the OIG. We welcome comments on all aspects of our proposal.

We are also seeking comment on other issues related to the comparison between ASP and AMP, such as—

- Any effect of definitional differences between AMP and ASP, particularly in light of the revised definition of AMP per ACA;
- The impact of any differences in AMP and ASP reporting by manufacturers on price substitution comparisons; and
- Whether and/or how general differences and similarities between AMP and manufacturer's ASP would affect comparisons between these two.

B. Ambulance Fee Schedule Issue: Policy for Reporting Units When Billing for Ambulance Fractional Mileage

Under the ambulance fee schedule, the Medicare program pays for transportation services for Medicare beneficiaries when other means of transportation are contraindicated and all other applicable medical necessity requirements are met. Ambulance services are classified into different levels of ground (including water) and air ambulance services based on the medically necessary treatment provided during transport. These services include the following levels of service:

- For Ground—

++ Basic Life Support (BLS) (emergency and nonemergency).

++ Advanced Life Support, Level 1 (ALS1) (emergency and nonemergency).

++ Advanced Life Support, Level 2 (ALS2).

++ Specialty Care Transport (SCT).

++ Paramedic ALS Intercept (PI).

- For Air—

++ Fixed Wing Air Ambulance (FW).

++ Rotary Wing Air Ambulance (RW).

1. History of Medicare Ambulance Services

a. Statutory Coverage of Ambulance Services

Under sections 1834(l) and 1861(s)(7) of the Act, Medicare Part B (Supplementary Medical Insurance) covers and pays for ambulance services, to the extent prescribed in regulations, when the use of other methods of transportation would be contraindicated by the beneficiary's medical condition. The House Ways and Means Committee and Senate Finance Committee Reports that accompanied the 1965 Social Security Amendments suggest that the Congress intended that—

- The ambulance benefit cover transportation services only if other means of transportation are contraindicated by the beneficiary's medical condition; and

- Only ambulance service to local facilities be covered unless necessary services are not available locally, in which case, transportation to the nearest facility furnishing those services is covered (H.R. Rep. No. 213, 89th Cong., 1st Sess. 37 and Rep. No. 404, 89th Cong., 1st Sess. Pt 1, 43 (1965)).

The reports indicate that transportation may also be provided from one hospital to another, to the beneficiary's home, or to an extended care facility.

b. Medicare Regulations for Ambulance Services

Our regulations relating to ambulance services are set forth at 42 CFR part 410, subpart B, and 42 CFR part 414, subpart H. Section 410.10(i) lists ambulance services as one of the covered medical and other health services under Medicare Part B. Therefore, ambulance services are subject to basic conditions and limitations set forth at § 410.12 and to specific conditions and limitations as specified in § 410.40 and § 410.41. Part 414, subpart H, describes how payment is made for ambulance services covered by Medicare.

2. Mileage Reporting

a. Background and Current Process for Reporting Ambulance Mileage

Historically, the Medicare fee-for-service (FFS) claims processing system lacked the capability to accept and process fractional unit amounts reported in any claim format. Therefore, the standard for reporting units for ambulance mileage was to bill in whole number increments. Thus, if the total units of service for ambulance mileage included a fractional amount, providers and suppliers of ambulance services (hereafter referred to collectively as "providers and suppliers") were instructed to round the fraction up to the next whole number. Claims billed with fractional units of service were, at that time, returned as unprocessable as CMS' claims processing systems could not accept nor adjudicate fractional unit amounts properly.

Consequently, in Change Request (CR) 1281 (Transmittal AB–00–88, issued on September 18, 2000), we instituted an operational procedure requiring whole-unit reporting of mileage on ambulance claims. Specifically, we instructed providers and suppliers that "If mileage is billed, the miles must be whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number." Our instructions also stated that "1" should be reported for trips totaling less than a single mile. This was an operational instruction based on Medicare's FFS system limitations and capabilities at the time, as our claims processing systems were not capable of accepting and processing claims submitted with fractional units of service. Since then, our claims processing system functionality has evolved to the point where this rounding process is no longer necessary for most ambulance transports, as it is now possible for our FFS systems to capture and accurately process fractional units on both paper and electronic forms.

Under our current instructions, providers and suppliers continue to report loaded mileage as whole-number units on both paper and electronic claims. Providers and suppliers utilize the appropriate Healthcare Common Procedure Coding System (HCPCS) code for ambulance mileage to report the number of miles traveled during a Medicare-covered trip rounded up to the nearest whole mile at a minimum of 1 unit for the purpose of determining payment for mileage. Transmittal AB–00–88 established a list of HCPCS codes accepted by Medicare for the purpose of billing mileage. Providers and suppliers were instructed to use these specific HCPCS codes and enter the total number of covered miles in the "units" field of the claim form. For example, if a covered trip from the point of pickup (POP) to the Medicare-approved destination (see § 414.40 for a list of approved destinations) totaled 9.1 miles, the provider would enter the appropriate HCPCS code for covered mileage and a "10" in the units field. Providers and suppliers billing for trips totaling, for example, 0.5 covered miles, would enter "1" in the units field along with the appropriate HCPCS code for mileage.

b. Concerns Regarding the Potential for Inaccuracies in Reporting Units and Associated Considerations

Often an ambulance provider will transport a distance that is either not an exact whole number of miles or less than one whole mile during a covered trip. Currently, providers and suppliers billing for ambulance services must round up the total billable mileage to the nearest whole mile for trips that include a fraction of a mile or less than one whole mile. Under our current instructions, a provider or supplier is required to bill as much as .9 of a mile more than what was actually traveled.

We have been contacted by suppliers on several occasions with concerns regarding our current instructions for reporting ambulance mileage. Certain suppliers believe that our instructions require them to bill inaccurately. One company in particular stated that they routinely need to bill for trips totaling less than 1 mile. The beneficiaries that are being transported by this company live in the immediate vicinity of the facility to which they are being transported, and therefore, the number of loaded miles for each trip totals approximately one half of a mile. The company was concerned that since Medicare requires that they enter a "1" in the units field of their claims for mileage, they are being overpaid by

Medicare for mileage based on the service they actually provided.

However, the company's main concern revolved around the risk of creating an appearance of impropriety. Although our instructions clearly state that providers and suppliers should, as a matter of procedure, round up fractional mileage amounts to the nearest whole mile, some providers and suppliers indicated that they wanted to bill as accurately as possible and that they only wanted to be paid for the service they actually provided. We thoroughly considered these concerns while reevaluating the procedure for reporting units for fractional mileage amounts.

Our first priority in considering the issues raised by ambulance providers and suppliers was to ascertain the basis for the current mileage reporting instructions. As previously discussed, the original instructions for reporting fractional mileage were published in Transmittal AB–00–88, issued on September 18, 2000. We instructed providers and suppliers to round fractional mileage amounts "up to the nearest whole mile" and to enter "1" for fractional mileage totaling less than one mile. This particular process had also been in place prior to issuance of the transmittal. The reason for the procedure was that our claims processing systems were not capable of accepting and processing claims submitted with fractional units of service—even if the service was commonly measured in fractional amounts, as with ambulance mileage.

We then explored whether a change in our procedure would be: (a) Appropriate, (b) possible considering our current system capabilities and industry standards of measurement, and (c) applicable to any service other than ambulance mileage. As to the appropriateness of changing the procedure for reporting units of service on provider claims for fractional ambulance mileage, we believe that we should make every effort to create and implement policies and processes that create the best opportunity for accuracy in billing. It is not our intention to put providers and suppliers in a position where they are required to bill inaccurately for the service they provide. We continue to strive toward ensuring that providers and suppliers bill and are paid only for services actually provided. We believe that changing our current procedure for reporting units of service to require reporting of fractional mileage will help to ensure that providers and suppliers can submit claims that more precisely reflect actual mileage, and are reimbursed more accurately for the services they actually provided. We originally instituted a policy of accepting and processing only whole units because at that time, system limitations prevented us from accepting and processing fractional ambulance mileage.

Second, we considered whether it is currently possible for our claims processing systems to accept and process fractional unit amounts on both paper and electronic claims. Upon reevaluating our system capabilities, we found that technological advancements in Optical Character Recognition (OCR) and electronic claim submission have made it possible for our FFS systems to capture and accurately process fractional units on both paper and electronic claims. We note that our systems currently have the capability to accept fractional units with accuracy up to as much as one thousandth of a unit (that is, to 3 decimal places).

We also considered whether ambulance providers and suppliers have the capability to measure fractional mileage. This was an important point because if providers and suppliers are not able to measure mileage with any more specificity than the nearest whole number mile, then there would be no need to modify the current procedure for billing fractional mileage. In that case, providers and suppliers would continue to report mileage as whole numbers since they could measure no more accurately than that. However, both analog and digital motor vehicle odometers are designed to measure mileage accurately to within a minimum of a tenth of a mile. While we found that some vehicle odometers measure mileage more accurately than a tenth of a mile, most odometers are accurate to the nearest tenth of a mile. Additionally, aircraft geographic positioning system (GPS) technology provides the means to accurately determine billable mileage to the tenth of a mile.

Third, we considered whether a policy of billing fractional units would be applicable to any other service besides ambulance mileage. The units of service field on both the electronic and paper claim is used to report the quantity of services or supplies provided to Medicare beneficiaries and is used to report a wide range of services and supplies including, but not limited to: Number of office visits; anesthesia minutes; quantity of drugs administered; covered miles. Although Medicare currently makes payment based on fractional units for some services (for example, calculation of payment after conversion of anesthesia time reported in minutes to time units), there is currently no requirement that providers bill fractional units on the claim. If we were to implement a policy of requiring reporting of fractional units for other types of services or supplies we would first need to evaluate whether it is possible to do so considering industry standards of measurement. As previously discussed, providers and suppliers of ambulance services have the capability to determine fractional mileage using standard onboard equipment, that is, an odometer, GPS, and/or other similar equipment used to measure distance traveled. This would enable us to readily implement a fractional unit billing policy for ambulance mileage; whereas applicability to other areas (such as anesthesia, drugs, *etc.*) would require more analysis to determine whether a fractional unit billing policy is feasible, efficacious, and cost effective. Additionally, this issue was first raised by ambulance suppliers who were concerned about overbilling and being overpaid by Medicare. Therefore, we believe it is most reasonable to first address the area where concerns have been raised (that is, ambulance mileage) and consider applicability of this procedure to other types of services and items in the future.

Finally, and perhaps most importantly, we considered that our claims processing system should be configured to process claims as accurately as possible so as to provide for more accurate payments and to safeguard Medicare dollars. As previously discussed, ambulance providers and suppliers currently have the capability to measure mileage accurately to within a minimum of a tenth of a mile using devices (for example, odometers, GPS technology, etc.) already equipped onboard their vehicles. We believe that requiring ambulance providers and suppliers to round (and report) fractional ambulance mileage up to the next tenth of a mile strikes a proper balance between ensuring that the claims processing system adjudicates a claim as accurately as the system will permit without unduly burdening the ambulance community.

Based on all of the above considerations, we have decided that our claims processing instructions for submission of claims for ambulance mileage should be revised to reflect the current functionality of our claims processing systems so as to maximize the accuracy of claims payment, as further discussed below in this section.

c. Billing of Fractional Units for Mileage

It is both reasonable and prudent that, in order to ensure accuracy of payment, we facilitate and allow submission of the most accurate information on all Medicare ambulance claims. Furthermore, since our claims processing systems are currently capable of accepting and processing fractional units of service, we believe that ambulance mileage should be billed to and paid by Medicare in fractional amounts to enhance payment accuracy. Based on all the considerations discussed above, we are proposing to require that claims for mileage submitted by ambulance providers and suppliers for an ambulance transport (ground and air) be billed in fractional units, by rounding up to the nearest tenth of a mile (with the exception discussed below). As discussed above, we believe that requiring ambulance providers and suppliers to round (and report) fractional mileage up to the next tenth of a mile would allow us to provide for more accurate claims payment without unduly burdening the ambulance community.

Therefore, we are proposing that, effective for claims with dates of service on and after January 1, 2011, ambulance providers and suppliers would be required to report mileage rounded up to the nearest tenth of a mile for all claims for mileage totaling up to 100 covered miles. Providers and suppliers would submit fractional mileage using a decimal in the appropriate place (for example, 99.9). Since standard vehicle mileage (analog, digital, and GPS) is or can be calculated accurately to the nearest tenth of a mile, we are proposing that the mileage billed to Medicare by ambulance providers and suppliers be reported by rounding up to the next tenth of a mile.

Although the electronic claim formats can accommodate fractional mileage when mileage is equal to or greater than 100 covered miles (for example, 100.0), the paper claim cannot. Because the Form CMS–1500 paper claim currently only supports four characters (including the decimal point) in the units field (Item 24G), we also propose that mileage equal to or greater than 100 covered miles continue to be reported in whole number miles on both paper and electronic claims. We propose that providers and suppliers would round up fractional mileage to the next whole number for mileage that exceeds 100 covered miles and report the resulting whole number in the units' field. We would revise the instructions set forth in our Claims Processing Manual to reflect the revised procedures for submitting and paying claims for fractional ambulance.

C. Clinical Laboratory Fee Schedule: Signature on Requisition

In the March 10, 2000 **Federal Register**, we published the "Medicare Program; Negotiated Rulemaking: Coverage and Administrative Policies for Clinical Diagnostic Laboratory Services" proposed rule (65 FR 13082) announcing and soliciting comments on the results of our negotiated rulemaking committee tasked to establish national coverage and administrative policies for clinical diagnostic laboratory tests under Part B of Medicare. In our final rule published in the November 23, 2001 **Federal Register** (66 FR 58788), we explained our policy on ordering clinical diagnostic laboratory services and amended § 410.32 to make our policy more explicit. Our regulation at § 410.32(a) states the requirement that "[a]ll diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary." In the November 23, 2001 final rule, we added paragraph (d)(2) to § 410.32 to require that the physician or qualified nonphysician practitioner (NPP) (that is, clinical nurse specialists, clinical psychologists, clinical social workers, nurse-midwives, nurse practitioners (NPs), and physician assistants (PAs)) who orders the service must maintain documentation of medical necessity in the beneficiary's medical record (66 FR 58809). In the preamble discussions to the March 10, 2000 proposed rule and November 23, 2001 final rule (65 FR 13089 and 66 FR 58802, respectively), we noted that "[w]hile the signature of a physician on a requisition is one way of documenting that the treating physician ordered the test, it is not the only permissible way of documenting that the test has been ordered." In those preambles, we described the policy of not requiring physician signatures on requisitions for clinical diagnostic laboratory tests, but implicitly left in place the existing requirements for a written order to be signed by the ordering physician or NPP for clinical diagnostic laboratory tests, as well as other types of diagnostic tests. We further stated in the preambles of the proposed and final rules that we would publish an instruction to Medicare contractors clarifying that the signature of the ordering physician is not required for Medicare purposes on a requisition for a clinical diagnostic laboratory test (65 FR 13089 and 66 FR 58802).

On March 5, 2002, we published a program transmittal implementing the administrative policies set forth in the final rule, including the following instruction: "Medicare does not require the signature of the ordering physician on a laboratory service requisition. While the signature of a physician on a requisition is one way of documenting that the treating physician ordered the service, it is not the only permissible way of documenting that the service has been ordered. For example, the physician may document the ordering of specific services in the patient's medical record." (Transmittal AB–02–030, Change Request 1998, dated March 5, 2002).

On January 24, 2003, we published a program transmittal in order to manualize the March 5, 2002 Transmittal. (Transmittal 1787, Change Request 2410, dated January 24, 2003). The cover note to the transmittal states, "Section 15021, Ordering Diagnostic Tests, manualizes Transmittal AB–02–030, dated March 5, 2002. In accordance with negotiated rulemaking for outpatient clinical diagnostic laboratory services, no signature is required for the ordering of such services or for physician pathology services." In the manual instructions in that transmittal in a note, we stated: "No signature is required on orders for clinical diagnostic services paid on the basis of the physician fee schedule or for physician pathology services." The manual instructions did not explicitly reference clinical diagnostic laboratory tests as the cover note did. Rather, the transmittal seemed to extend the policy set forth in the **Federal Register** (that no signature is required on requisitions for clinical diagnostic laboratory tests paid under the Clinical Laboratory Fee Schedule (CLFS)) to also apply to clinical diagnostic tests paid on the basis of the Physician Fee Schedule (PFS) and physician pathology services. In addition, the manual instructions used the term "order" instead of "requisition," which some members of the industry have asserted caused confusion.

When we transitioned from paper manuals to the current electronic Internet Only Manual system, these manual instructions were inadvertently omitted from the new Benefit Policy Manual (BPM).

In August 2008, we issued a program transmittal (Transmittal 94, Change Request 6100, dated August 29, 2008) to update the BPM to incorporate language that was previously contained in section 15021 of the Medicare Carriers Manual. The reissued language states, "No signature is required on orders for clinical diagnostic tests paid on the basis of the clinical laboratory fee schedule, the physician fee schedule, or

for physician pathology services." Based on further review, we have determined that there are no clinical diagnostic laboratory tests paid under the PFS. After Transmittal 94 was published, we received numerous inquiries from laboratory, diagnostic testing, and hospital representatives who had questions about whether the provision applied to all diagnostic services, including x-rays, MRIs, and other nonclinical laboratory fee schedule diagnostic services.

To resolve any existing confusion surrounding the implementation of the policy in 2001 and subsequent transmittals, we restated and solicited public comments on our policy in the CY 2010 PFS proposed rule (74 FR 33641). Our current policy is that a physician's signature is not required on a requisition for clinical diagnostic laboratory tests paid on the basis of the CLFS; however, it must be evident, in accordance with our regulations at § 410.32(d)(2) and (3), that the physician ordered the services.

We note that we solicited and received comments on this signature requirement during the notice and comment period for the March 10, 2000 proposed rule in the context of our proposal to add paragraph (d)(2)(i) to § 410.32 to require that the practitioner who orders a diagnostic laboratory test must maintain documentation of medical necessity in the beneficiary's medical record. The majority of comments supported the adoption of a policy that the signature of the practitioner on a requisition for a clinical diagnostic laboratory test paid under the CLFS is not the only way of documenting that the test has been ordered and, thus, should not be required provided such documentation exists in an alternate form.

This policy regarding requisitions for clinical diagnostic laboratory tests does not supersede other applicable Medicare requirements (such as those related to hospital Conditions of Participation (CoPs)) which require the medical record to include an order signed by the physician who is treating the beneficiary. Nor do we believe that anything in our policy regarding signatures on requisitions for clinical diagnostic laboratory tests supersedes other requirements mandated by professional standards of practice or obligations regarding orders and medical records promulgated by Medicare, the Joint Commission, or State law; nor do we believe the policy would require providers to change their business practices.

We also restated and solicited public comment on our long-standing policy consistent with the principle in § 410.32(a) that a written order for diagnostic tests including those paid under the CLFS and those that are not paid under the CLFS (for example, that are paid under the PFS or under the OPPS), such as X-rays, MRIs, and the TC of physician pathology services, must be signed by the ordering physician or NPP. That is, the policy that signatures are not required on requisitions for clinical diagnostic laboratory tests paid based on the CLFS applies only to requisitions (as opposed to written orders) (74 FR 33642).

Additionally, we solicited public comments about the distinction between an order and a requisition (74 FR 33642). We note that an "order" as defined in our IOM, 100–02, Chapter 15, Section 80.6.1, is a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. The order may conditionally request an additional diagnostic test for a particular beneficiary if the result of the initial diagnostic test ordered yields to a certain value determined by the treating physician/practitioner (for example, if test X is negative, then perform test Y). As set forth in the CY 2010 MPFS final rule (FR 74 61930), an order may be delivered via any of the following forms of communication:

- A written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility.
- A telephone call by the treating physician/practitioner or his or her office to the testing facility.
- An electronic mail, or other electronic means, by the treating physician/practitioner or his or her office to the testing facility.

If the order is communicated via telephone, both the treating physician/practitioner, or his or her office, and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records.

In the proposed rule (74 FR 33642), we defined a "requisition" as the actual paperwork, such as a form, which is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient. It may contain patient information, ordering physician information, referring institution information, information about where to send reports, billing information, specimen information, shipping addresses for specimens or tissue samples, and checkboxes for test selection. We believe it is ministerial in nature, assisting laboratories with billing and handling of results, and serves as an administrative convenience to providers and patients. We believe that a written order, which may be part of the medical record, and the requisition are two different documents, although a requisition that is signed may serve as an order. We welcomed comments from the public about the distinction between requisitions and orders.

During the proposed and final rulemaking process for CY 2010, we received numerous comments on these issues, including, among others: Expressions of continued confusion over the difference between an "order" and a "requisition"; requests that CMS develop a single policy for all outpatient laboratory services, without the distinction for those paid under the CLFS or the PFS; and concerns about reference laboratory technicians who felt compelled to perform a test in order to protect the viability of the specimen although they did not have the proper documentation. See 74 FR 61930–32 for a complete discussion of the comments received and responses to these issues. In the CY 2010 PFS final rule with comment period (74 FR 61931), we stated that, in light of the issues and concerns raised during the comment period, and our desire to create policy that will address the concerns in a meaningful, clear and thoughtful way, we would continue to carefully consider the issues of physician signatures on requisitions and orders and that we plan to revisit these issues in the future paying particular attention to the definitions of order and requisition.

Since the publication of the CY 2010 PFS final rule with comment period, we have considered an approach that would address the concerns raised. We are proposing to require a physician's or NPP's signature on requisitions for clinical diagnostic laboratory tests paid on the basis of the CLFS.

We believe that this policy would result in a less confusing process. We believe that it would be less confusing because a physician's signature would then be required for all requisitions and orders, eliminating uncertainty over whether the documentation is a requisition or an order, whether the type of test being ordered requires a signature, or which payment system does or does not require a physician or NPP signature. We also believe that it would not increase the burden on physicians because it is our understanding that, in most instances, physicians are annotating the patient's medical record with either a signature or an initial (the "order"), as well as providing a signature on the paperwork that is provided to the clinical diagnostic laboratory that identifies the

test or tests to be performed for a patient (the "requisition") as a matter of course. Further, this policy would make it easier for the reference laboratory technicians to know whether a test is appropriately requested, and potential compliance problems would be minimized for laboratories during the course of a subsequent Medicare audit because a signature would be consistently required. As already discussed, this minimizes confusion and provides a straightforward directive for laboratories to meet.

We welcome comments on this proposal.

D. Discussion of Chiropractic Services Demonstration

Section 651 of MMA requires the Secretary to conduct a 2-year demonstration to evaluate the feasibility and advisability of expanding coverage for chiropractic services under Medicare. Medicare coverage for chiropractic services is limited to manual manipulation of the spine to correct a subluxation described in section 1861(r)(5) of the Act. The demonstration expanded current Medicare coverage to include "care for neuromusculoskeletal conditions typical among eligible beneficiaries and diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is provided" and was conducted in four geographically diverse sites, two rural and two urban regions, with each type including a Health Professional Shortage Area (HPSA). The two urban sites were 26 counties in Illinois and Scott County, Iowa, and 17 counties in Virginia. The two rural sites were the States of Maine and New Mexico. The demonstration, which ended on March 31, 2007, was required to be budget neutral as section 651(f)(1)(B) of MMA mandates the Secretary to ensure that "the aggregate payments made by the Secretary under the Medicare program do not exceed the amount which the Secretary would have paid under the Medicare program if the demonstration projects under this section were not implemented."

In the CY 2006, 2007, and 2008 PFS final rules with comment period (70 FR 70266, 71 FR 69707, 72 FR 66325, respectively), we included a discussion of the strategy that would be used to assess budget neutrality (BN) and the method for adjusting chiropractor fees in the event the demonstration resulted in costs higher than those that would occur in the absence of the demonstration. We stated BN would be assessed by determining the change in costs based on a pre-post comparison of Medicare costs for beneficiaries in the demonstration and their counterparts in the control groups and the rate of change for specific diagnoses that are treated by chiropractors and physicians in the demonstration sites and control sites. We also stated that our analysis would not be limited to only review of chiropractor claims because the costs of the expanded chiropractor services may have an impact on other Medicare costs.

In the CY 2010 PFS final rule with comment period (74 FR 61926), we discussed the evaluation of this demonstration conducted by Brandeis University and the two sets of analyses used to evaluate budget neutrality. In the "All Neuromusculoskeletal Analysis," which compared the Medicare costs of *all* beneficiaries who received services for a neuromusculoskeletal condition in the demonstration areas with those of beneficiaries with similar characteristics from similar geographic areas that did not participate in the demonstration, the total effect of the demonstration to Medicare was $114 million. In the "Chiropractic User Analysis," which compared the Medicare costs of beneficiaries who used expanded chiropractic services to treat a neuromusculoskeletal condition in the demonstration areas, with those of beneficiaries with similar characteristics who used chiropractic services as currently covered by Medicare to treat a neuromusculoskeletal condition from similar geographic areas that did not participate in the demonstration, the total effect of the demonstration to Medicare was $50 million.

As explained in the CY 2010 PFS final rule, we based the BN estimate on the "Chiropractic User Analysis" because of its focus on users of chiropractic services rather than all Medicare beneficiaries with neuromusculoskeletal conditions, including those who did not use chiropractic services and who would not have become users of chiropractic services even with expanded coverage for them (74 FR 61926 through 61927). Users of chiropractic services are most likely to have been affected by the expanded coverage provided by this demonstration. Cost increases and offsets, such as reductions in hospitalizations or other types of ambulatory care, are more likely to be observed in this group.

As explained in the CY 2010 PFS final rule (74 FR 61927), because the costs of this demonstration were higher than expected and we did not anticipate a reduction to the PFS of greater than 2 percent per year, we finalized a policy to recoup $50 million in expenditures from this demonstration over a 5-year period, that is, CYs 2010 through 2014 (74 FR 61927). Specifically, we are recouping $10 million for each such year through adjustments to the chiropractic CPT codes. Payment under the PFS for these codes will be reduced by approximately 2 percent. We believe that spreading this adjustment over a longer period of time will minimize its potential negative impact on chiropractic practices.

We are continuing the implementation of the required budget neutrality adjustment by recouping $10 million in CY 2011. Our Office of the Actuary estimates chiropractic expenditures in CY 2011 to be approximately $524 million based on actual Medicare spending for chiropractic services for the most recent available year. To recoup $10 million in CY 2011, the payment amount under the PFS for the chiropractic CPT codes (that is, CPT codes 98940, 98941, and 98942) will be reduced by approximately 2 percent. We are reflecting this reduction only in the payment files used by the Medicare contractors to process Medicare claims rather than through adjusting the RVUs. Avoiding an adjustment to the RVUs would preserve the integrity of the PFS, particularly since many private payers also base payment on the RVUs.

E. Provisions Related to Payment for Renal Dialysis Services Furnished by End-Stage Renal Disease (ESRD) Facilities

Since August 1, 1983, payment for dialysis services furnished by ESRD facilities has been based on a composite rate payment system that provides a fixed, prospectively determined amount per dialysis treatment, adjusted for geographic differences in area wage levels. The composite rate is designed to cover a package of goods and services needed to furnish dialysis treatments that include, but not be limited to, certain routinely provided drugs, laboratory tests, supplies, and equipment. Unless specifically included in the composite rate, other injectable drugs and laboratory tests medically necessary for the care of patients on dialysis are separately billable.

Other than periodic updates, there were no significant changes to the composite rate payment system until the implementation of the basic case-mix adjusted composite rate payment system beginning January 1, 2005. The Congress has enacted a number of adjustments to the composite rate since that time. As a result of the July 15, 2008 enactment of MIPPA, we are required to implement an end-stage renal disease (ESRD)

bundled prospective payment system effective January 1, 2011 (referred to as the "ESRD PPS"). Below we briefly discuss the ESRD PPS, the basic case-mix composite payment system, as well as our proposed updates to the composite rate portion of the blended payment for CY 2011.

a. MIPPA—The ESRD PPS

On September 29, 2009, we published in the **Federal Register** a proposed rule entitled "End-Stage Renal Disease Prospective Payment System" (74 FR 49922). In that rule, we proposed to implement a case-mix adjusted bundled PPS for renal dialysis services beginning January 1, 2011, in accordance with the statutory provisions set forth in section 153(b) of MIPPA. The ESRD PPS would replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD services.

As explained in the ESRD PPS proposed rule (74 FR 50019), section 1881(b)(14)(E)(i) of the Act requires a 4-year transition (phase-in) from the current composite payment system to the ESRD PPS, and section 1881(b)(14)(E)(ii) of the Act allows ESRD facilities to make a one-time election to be excluded from the transition. Electing to be excluded from the 4-year transition means that the ESRD facility receives payment for renal dialysis services based on 100 percent of the payment rate established under the ESRD PPS, rather than a blended rate under each year of the transition based in part on the payment rate under the current payment system and in part on the payment rate under the ESRD PPS. As of January 1, 2011, ESRD facilities that elect to go through the transition would be paid in the first year a blended amount that will consist of 75 percent of the basic case-mix adjusted composite payment system and the remaining 25 percent would be based on the ESRD PPS payment. Thus, we must continue to update the basic case-mix composite payment system for purposes of determining the composite rate portion of the blended payment amount during the ESRD PPS 4-year transition (CYs 2011 through 2013.) Accordingly, in this proposed rule, we are proposing the composite rate portion of the blend, which includes an update to the drug add-on and the application of the wage index, as well as the payment amount for the first-year (CY 2011) of the ESRD PPS transition. We anticipate that the final rule for the ESRD PPS will be published this summer.

b. Medicare Modernization Act (MMA)—The Basic Case-Mix Adjusted Composite Payment System

Section 623 of the MMA amended section 1881 of the Act to require changes to the composite rate payment methodology, as well as to the pricing methodology for separately billable drugs and biologicals furnished by ESRD facilities. Section 1881(b)(12) of the Act, as added by section 623(d) of the MMA, requires the establishment of a basic case-mix adjusted composite payment system that includes services comprising the composite rate and an add-on to the composite rate component to account for the difference between current payments for separately billed drugs and the revised drug pricing specified in the statute. In addition, section 1881(b)(12)(A) of the Act requires that the composite rate be adjusted for a number of patient characteristics (case-mix) and section 1881(b)(12)(D) of the Act gives the Secretary discretion to revise the wage indices and the urban and rural definitions used to develop them. Finally, section 1881(b)(12)(E) of the Act imposed a budget neutrality (BN) requirement, so that aggregate payments under the basic case-mix adjusted composite payment system equal the aggregate payments for the same period if section 1881(b)(12) of the Act did not apply.

1. CY 2005 Revisions

In the CY 2005 PFS final rule with comment period (69 FR 66319 through 66334), we implemented section 1881(b)(12) of the Act, as added by section 623 of the MMA, and revised payments to ESRD facilities. These revisions that were effective January 1, 2005, included an update of 1.6 percent to the composite rate component of the payment system; a drug add-on adjustment of 8.7 percent to the composite rate to account for the difference between pre-MMA payments for separately billable drugs and payments based on revised drug pricing for 2005 which used acquisition costs.

Also, to implement section 1881(b)(13) of the Act, we revised payments for drugs billed separately by independent ESRD facilities, paying for the top 10 ESRD drugs based on acquisition costs (as determined by the OIG) and for other separately billed drugs at the average sales price +6 percent (ASP+6).

In addition, effective April 1, 2005, we implemented the case-mix adjustments to the composite rate for certain patient characteristics (that is, age, low body mass index, and body surface area). For further explanation of the development of the basic case-mix adjusted composite payment system, see the CY 2005 PFS final rule with comment period (69 FR 66319 through 66334).

2. CY 2006 Revisions

In the CY 2006 PFS final rule with comment, we implemented additional revisions to payments to ESRD facilities required under section 623 of the MMA. We revised the drug payment methodology applicable to drugs furnished by ESRD facilities. Effective January 1, 2006, all separately billed drugs and biologicals furnished by both hospital-based and independent ESRD facilities were paid based on ASP+6 percent. The drug add-on adjustment was updated to 14.5 percent to reflect the expected growth in expenditures for separately billable drugs in CY 2006.

We also implemented a revised geographic adjustment authorized by section 1881(b)(12)(D) of the Act. This adjustment revised the labor market areas to incorporate the Core-Based Statistical Area (CBSA) designations established by the Office of Management and Budget (OMB) by providing a 4-year transition from the previous wage-adjusted composite rates. Effective January 1, 2006, 25 percent of the payment was based on the revised geographic adjustments, and the remaining 75 percent of payment was based on the metropolitan statistical area-based (MSA-based) adjustments. Other adjustments included the elimination of the wage index ceiling, and reducing the wage index floor to 0.8500, as well as a revised labor portion of the composite rate to which the geographic adjustment is applied.

In addition, section 5106 of the DRA (Pub. L. 109–171) provided for a 1.6 percent update to the composite rate component of the basic case-mix adjusted composite payment system, effective January 1, 2006. For further explanation of the revisions to the basic case-mix adjusted composite payment system, see the CY 2006 PFS final rule with comment period (70 FR 70161 through 70771).

3. CY 2007 Revisions

In the CY 2007 PFS final rule with comment period, we implemented a method to annually calculate the growth update to the drug add-on adjustment required by section 1881(b)(12) of the Act, as well as a growth update of 0.5 percent to the drug add-on adjustment. Also, section 103 of the MIEA–TRHCA (Pub. L. 109–432) established a 1.6 percent update to the composite rate portion of the payment system, effective

April 1, 2007. The effect of this increase in the composite rate was a reduction in the drug add-on adjustment to 14.9 percent, effective April 1, 2007. As a result, the drug add-on adjustment to the composite rate increased from 14.5 to 15.1 percent. Since we compute the drug add-on adjustment as a percentage of the weighted average base composite rate, increases in the composite rate portion of the payment reduce the drug add-on percentage.

We provided an update to the wage index adjustments to reflect the latest hospital wage data, including a BN adjustment factor. We also implemented the second year of the transition to the CBSA-based wage index, where 50 percent of the payment was based on the CBSA-based geographic adjustments, and the remaining 50 percent of payment was based on the MSA-based adjustments. In addition, we reduced the wage index floor 0.85 to 0.80.

For further explanation of the development of the basic case-mix adjusted composite payment system, see the CY 2007 PFS final rule with comment period (71 FR 69681 through 69688).

4. CY 2008 Revisions

In the CY 2008 PFS final rule with comment period (72 FR 66280), we implemented a growth update to the drug add-on adjustment of 0.5 percent. As a result, the drug add-on adjustment to the composite payment rate increased from 14.9 percent to 15.5 percent. In addition, we updated the wage index adjustments to reflect the latest hospital wage data, including a wage index BN adjustment of 1.055473 to the wage index for CY 2008, and finally, for CY 2008, we implemented the third year of the transition to the CBSA-based wage index, where 75 percent of the payment was based on the the CBSA-based adjustments and the remaining 25 percent of payment was based on the MSA-based adjustments. In addition, we reduced the wage index floor from 0.80 to 0.75.

5. CY 2009 Revisions

For CY 2009, section 153(a) of the MIPPA updated sections 1881(b)(12)(G) and 1881(b)(12)(A) of the Act to revise payments to ESRD facilities effective for services furnished on or after January 1, 2009 and January 1, 2010. The revisions included an update of 1 percent to the composite rate, and the establishment of a site neutral composite rate to both hospital-based and independent dialysis facilities that reflects the labor share applicable to independent dialysis facilities (53.711). The 1 percent increase to the independent dialysis facility's CY 2008 composite rate of $132.49 resulted in a CY 2009 base composite rate for hospital-based and independent dialysis facilities of $133.81. The one percent increase in the composite rate portion of the payment system effective January 1, 2009, reduced the drug add-on adjustment from 15.5 to 15.2 percent.

Also, we updated the wage index adjustments to reflect the latest available wage data, including a wage index BN adjustment of 1.056672 to the wage index for CY 2009. Finally, we completed the 4-year transition to the CBSA-based geographic adjustments and reduced the wage index floor from 0.7500 to 0.700. For further detail, regarding the ESRD provisions, see the 2008 PFS final rule with comment period (73 FR 61921 through 61926).

6. CY 2010 Revisions

For CY 2010, we updated the case-mix adjusted composite rate payment system by updating the drug add-on component of the composite rate system, as well as the wage index values used to adjust the labor component of the composite rate. Specifically, to update the drug add-on adjustment, we conducted a trend analysis of CY 2006 through 2008, we implemented a zero growth update to the drug add-on adjustment to the composite rates for 2010 required by section 1881(b)(12)(F) of the Act.

Also, section 1881(b)(12)(G)(iv) of the Act, as added by section 153(a)(1) of the MIPPA, increased the composite rate by 1.0 percent for ESRD services furnished on or after January 1, 2010. The 1.0 percent increase resulted in a base composite rate of $135.15 per treatment and reduced the drug add-on adjustment from 15.2 to 15.0 percent.

Lastly, we updated the wage index to reflect the latest available wage data, including a revised BN adjustment factor of 1.057888. We applied a reduction to the wage index floor from 0.700 to 0.6500.

For further detail, regarding the ESRD provisions, see the 2009 final rule with comment period (74 FR 33634 through 33639).

7. CY 2011 Proposals

For purposes of establishing the composite rate portion of the blended payments under the ESRD PPS for those facilities electing to go through the transition in CY 2011, CMS is proposing the following:

- An update to the drug add-on adjustment to the composite rate, using a refined methodology for projecting growth in drug expenditures; and
- An update to the wage index adjustment to reflect the latest available wage data, including a revised BN adjustment.
- A reduction in the ESRD wage index floor from 0.6500 to 0.600.

8. The Affordable Care Act

Section 1881(b)(14)(F) of the Act, as added by section 153(b) of MIPPA and amended by section 3401(h) of ACA, governs the ESRD market basket increase factor (that is, the ESRD market basket). As explained in the ESRD PPS proposed rule (74 FR 4997), we described how the ESRD Bundled market basket would be used to update the composite rate portion of the ESRD payments during the PPS transition.

Ordinarily in updating the composite payment system, we discuss any updates to the composite rate. However, beginning in 2011, the composite payment would be used as part of the blended payments during the ESRD PPS transition. Since the publication of the ESRD PPS proposed rule, and as explained in the ESRD PPS final rule, which we anticipate will be published this summer, we interpret this provision as requiring that the composite rate portion of the blended payment amount be increased in CY 2011 by the ESRD market basket percentage increase factor (the "ESRD market basket").

For purposes of this proposed rule, for CY 2011, we anticipate an estimate of a 2.5 percent increase to the ESRD composite rate portion of the blended payment amount, resulting in a CY 2011 composite rate of $138.53 ($135.15*1.025). This 2.5 percent increase does not apply to the drug add-on adjustment to the composite rate. Also, we note that the drug add-on percentage would be reduced from 15.0 to 14.7 as a result of the proposed increase to the composite rate in CY 2011. (A detailed explanation of the reduction to the drug add-on adjustment is discussed below).

9. Proposed Update to the Drug Add-on Adjustment to the Composite Rate

a. Estimating Growth in Expenditures for Drugs and Biologicals in CY 2011

Section 1881(b)(12)(F) of the Act specifies that the drug add-on increase must reflect "the estimated growth in expenditures for drugs and biologicals (including erythropoietin) that are separately billable * * *." By referring to "expenditures," we believe the statute contemplates that the update would account for both increases in drug prices, as well as increases in utilization of those drugs.

Since we now have 4 years of drug expenditure data based on ASP pricing,

we propose to continue estimating growth in drug expenditures based on the trends in available data. Therefore, for CY 2011, we are proposing to use trend analysis from drug expenditure data to update the per treatment drug add-on adjustment. We then removed growth in enrollment for the same time period from the expenditure growth so that the residual reflects per patient expenditure growth (which includes price and utilization combined).

We further propose to use the per patient growth update to the drug add-on adjustment for CY 2011. To estimate drug expenditure growth using trend analysis, we looked at the average annual growth in total drug expenditures between 2006 and 2009. First, we estimated the total drug expenditures for all ESRD facilities in CY 2009. For this proposed rule, we used the final CY 2006, through CY 2008 ESRD claims data and the latest available CY 2009 ESRD facility claims, updated through December 31, 2009 (that is, claims with dates of service from January 1 through December 31, 2009, that were received, processed, paid, and passed to the National Claims History File as of December 31, 2009). For the CY 2011 PFS final rule, we plan to use additional updated CY 2009 claims with dates of service for the same timeframe. This updated CY 2009 data file will include claims received, processed, paid, and passed to the National Claims History File as of June 30, 2010.

While the CY 2009 claims file used in this proposed rule is the most current available, we recognize that it does not reflect a complete year, as claims with dates of service towards the end of the year have not all been processed. To more accurately estimate the update to the drug add-on, aggregate drug expenditures are required. Based on an analysis of the 2008 claims data, we are proposing to inflate the CY 2009 drug expenditures to estimate the June 30, 2010 update of the 2009 claims file. We used the relationship between the December 2008 and the June 2009 versions of 2008 claims to estimate the more complete 2009 claims that will be available in June 2010 and applied that ratio to the 2009 claims data from the December 2009 claims file. The net adjustment to the CY 2009 claims data is an increase of 12.22 percent to the 2009 expenditure data. This adjustment allows us to more accurately compare the 2008 and 2009 drug expenditure data to estimate per patient growth. As stated earlier in this section, we plan to use additional updated CY 2009 claims in the CY 2011 PFS final rule.

Using the full-year 2009 drug expenditure figure, we calculated the average annual change in drug expenditures from 2006 through 2009. This average annual change showed an increase of 2.1 percent for this timeframe. We propose to use this 2.1 percent increase to project drug expenditures for both 2010 and 2011.

b. Estimating Per Patient Growth

Once we had the projected growth in drug expenditures from 2010 to 2011, which is what we believe that section 1881(b)(12)(F) of the Act requires us to use to update the drug add-on adjustment. To calculate the per patient growth between CYs 2010 and 2011, we removed the enrollment component by using the estimated growth in enrollment data between CY 2010 and CY 2011. This was approximately 3.6 percent. To do this, we divided the total drug expenditure change between 2010 and 2011 (1.021) by enrollment growth of 3.6 percent (1.036) for the same timeframe. The result is a per patient growth factor equal to 0.986 (1.021/1.036 = 0.986). Thus, we are projecting a 1.4 percent decrease in per patient growth in drug expenditures between 2010 and 2011.

c. Applying the Proposed Growth Update to the Drug Add-On Adjustment

In CY 2006, we applied the projected growth update percentage to the total amount of drug add-on dollars established for CY 2005 to establish a dollar amount for the CY 2006 growth update. In addition, we projected the growth in dialysis treatments for CY 2006 based on the projected growth in ESRD enrollment. We divided the projected total dollar amount of the CY 2006 growth by the projected growth in total dialysis treatments to develop the per treatment growth update amount. This growth update amount, combined with the CY 2005 per treatment drug add-on amount, resulted in an average drug add-on amount per treatment of $18.88 (or a 14.5 percent adjustment to the composite rate) for CY 2006.

In the CY 2007 PFS final rule with comment period (71 FR 69684), we revised our update methodology by applying the growth update to the per treatment drug add-on amount. That is, for CY 2007, we applied the growth update factor of 4.03 percent to the $18.88 per treatment drug add-on amount for an updated amount of $19.64 per treatment (71 FR 69684). For CY 2008, the per treatment drug add-on amount was updated to $20.33. In the CY 2009 and 2010 PFS final rule with comment period (73 FR 69755 through 69757 and 74 FR 61923), we applied a zero update to per treatment drug add-on amount which left it at $20.33. As discussed in detail below, for CY 2011, we are again proposing no update to the per treatment drug add-on amount of $20.33 established in CY 2008.

d. Proposed Update to the Drug Add-On Adjustment

As discussed previously in this section, we estimate a 2.1 percent increase in drug expenditures between CY 2010 and CY 2011. Combining this reduction with a 3.6 percent increase in enrollment, as described above, we are projecting a 1.4 percent decrease in per patient growth of drug expenditures between CY 2010 and CY 2011. Therefore, we are projecting that the combined growth in per patient utilization and pricing for CY 2011 would result in a negative update equal to 0.2 percent. However, similar to last year and as indicated above, we are proposing a zero update to the drug add-on adjustment. We believe this approach is consistent with the language under section 1881(b)(12)(F) of the Act which states in part that "the Secretary shall annually increase" the drug add-on amount based on the growth in expenditures for separately billed ESRD drugs. Our understanding of the statute contemplates "annually increase" to mean a positive or zero update to the drug add-on. Therefore, we propose to apply a zero update, and to maintain the $20.33 per treatment drug add-on amount for CY 2011.

e. Proposed Update to the Geographic Adjustments to the Composite Rate

The purpose of the wage index is to adjust the composite rates for differing wage levels covering the areas in which ESRD facilities are located. The wage indexes are calculated for each urban and rural area.

In addition, we generally have followed wage index policies related to these definitions as used under the inpatient hospital prospective payment system (IPPS), but without regard to any approved geographic reclassification authorized under sections 1886(d)(8) and (d)(10) of the Act or other provisions that only apply to hospitals paid under the IPPS (70 FR 70167). For purposes of the ESRD wage index methodology, the hospital wage data we use is pre-classified, pre-floor hospital data and unadjusted for occupational mix.

f. Proposed Updates to Core-Based Statistical Area (CBSA) Definitions

In the CY 2006 PFS final rule with comment period (70 FR 70167), we announced our adoption of the OMB's

CBSA-based geographic area designations to develop revised urban/rural definitions and corresponding wage index values for purposes of calculating ESRD composite rates. The CBSA-based geographic area designations are described in OMB Bulletin 03–04, originally issued June 6, 2003, and is available online at *http://www.whitehouse.gov/omb/bulletins/b03-04.html.* In addition, OMB has published subsequent bulletins regarding CBSA changes, including changes in CBSA numbers and titles. We wish to point out that this and all subsequent ESRD rules and notices are considered to incorporate the CBSA changes published in the most recent OMB bulletin that applies to the hospital wage index used to determine the current ESRD wage index. The OMB bulletins may be accessed online at *http://www.whitehouse.gov/omb/bulletins/index.html.*

g. Updated Wage Index Values

In the CY 2007 PFS final rule with comment period (71 FR 69685), we stated that we intended to update the ESRD wage index values annually. The ESRD wage index values for CY 2011 were developed from FY 2007 wage and employment data obtained from the Medicare hospital cost reports. As we indicated, the ESRD wage index values are calculated without regard to geographic classifications authorized under sections 1886(d)(8) and (d)(10) of the Act and utilize pre-floor hospital data that is unadjusted for occupational mix. We propose to use the same methodology for CY 2011, with the exception that FY 2007 hospital data would be used to develop the CY 2011 wage index values. For a detailed description of the development of the proposed CY 2011 wage index values based on FY 2007 hospital data, see the FY 2011 IPPS proposed rule (75 FR 23944). Section III.G, of the preamble to the FY 2011 IPPS proposed rule, "Method for Computing the Proposed FY 2011 Unadjusted Wage Index," describes the cost report schedules, line items, data elements, adjustments, and wage index computations. The wage index data affecting the ESRD composite rate for each urban and rural locale may also be accessed on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp.* The wage data are located in the section entitled, "FY 2011 Proposed Rule Occupational Mix Adjusted and Unadjusted Average Hourly Wage and Pre-reclassified Wage Index by CBSA."

i. Reduction to the ESRD Wage Index Floor

In the CY 2010 PFS final rule with comment period, we stated our intention to continue to reassess the need for a wage index floor (74 FR 61924). We also stated that a gradual reduction in the floor is needed to support continuing patient access to dialysis in areas that have low wage index values, especially in Puerto Rico where the wage index values are below the current wage index floor.

In the ESRD PPS proposed rule (74 FR 49968), we stated our intent to continue to reduce the wage index floor to the composite rate during the transition. For CY 2011, we propose that the ESRD wage index floor would be reduced from 0.65 to 0.60.

j. Proposed Wage Index Values for Areas With No Hospital Data

As discussed in the CY 2010 PFS final rule (74 FR 61925), and the ESRD PPS proposed rule (74 FR 49969) we have a methodology for identifying the small number of ESRD facilities in both urban and rural geographic areas where there are no hospital wage data from which to calculate ESRD wage index values. At that time those rules were published, the affected areas were rural Puerto Rico, and the urban area Hinesville-Fort Stewart, GA (CBSA 25980), and rural Massachusetts.

In the case of Massachusetts, the entire rural area consists of Dukes and Nantucket Counties. We determined that the borders of Dukes and Nantucket counties are contiguous with CBSA 12700, Barnstable Town, MA, and CBSA 39300, Providence-New Bedford-Fall River, RI–MA. We intend to use the same methodology for CY 2011. Under this methodology, this results in a proposed CY 2011 wage index value of 1.3577 for the composite rate portion of the blend, and a wage index value of 1.2844 for the ESRD PPS portion of the blend for Barnstable Town, MA (CBSA 12700) and also results in a proposed CY 2011 wage index value of 1.1343 for the composite rate portion of the blend, and a wage index value of 1.0731 for the ESRD PPS portion of the blend for (Providence-New Bedford-Fall River, RI–MA (CBSA 39300). These averages result in an imputed proposed wage index value of 1.2460 for rural Massachusetts in CY 2011, for the composite rate portion of the blend, and a wage index value of 1.1788 for the ESRD PPS portion of the blend.

For Hinesville-Fort Stewart, GA (CBSA 25980), which is an urban area without specific hospital wage data, we propose to apply the same methodology used to impute a wage index value that we used in CYs 2006 through 2010. Specifically, we compute the average wage index value of all urban areas within the State of Georgia. This results in a CY 2011 wage index value of 0.9465 for the composite rate portion of the blend, and a wage index value of 0.8954 for the ESRD PPS portion of the blend for Hinesville-Fort Stewart, GA (CBSA 25980).

For CY 2011, there is an additional urban area—Anderson, SC—with no hospital data. For this urban area, Anderson, SC (CBSA 11340), we propose to use the same methodology we have used for the other urban area with no hospital data, that is, Hinesville-Fort Stewart, GA (CBSA 25980). Under the methodology used for that area, we compute the average of all urban areas within the State of South Carolina. This approach would result in a CY 2011 wage index value of 0.9480 for the composite rate portion of the blend, and a wage index value of 0.8839 for the ESRD PPS portion of the blend for the Anderson, SC CBSA (CBSA 11340).

For Puerto Rico, because all geographic areas in Puerto Rico were subject to the wage index floor in CYs 2006 through 2010, we applied the ESRD wage index floor to rural Puerto Rico as well. Therefore, for CY 2011, all urban areas in Puerto Rico that have a wage index are eligible for the ESRD wage index floor of 0.60. Currently there are no ESRD facilities located in rural Puerto Rico, however, should any facilities open in rural Puerto Rico, we intend to apply the CY 2011 proposed wage index floor of 0.60 to facilities that are located in rural Puerto Rico. The proposed reduction to the wage index floor of 0.60 remains higher than the actual wage index values for ESRD facilities located in Puerto Rico, which currently range from 0.3674 to 0.4828. Also, in the CY 2010 PFS final rule with comment period (74 FR 61925), we stated that we would continue to evaluate existing hospital wage data and possibly wage data from other sources such as the Bureau of Labor Statistics, to determine if other methodologies might be appropriate for imputing wage index values for areas without hospital wage data for CY 2011 and subsequent years. To date, no data from other sources, superior to that currently used in connection with the IPPS wage index has emerged. For ESRD purposes, we continue to believe this is an appropriate policy.

Finally, for CY 2011, we are proposing to use the FY 2011 wage index data (collected from cost reports submitted by hospitals for cost reporting

periods beginning FY 2007) to compute the ESRD composite payment rates effective beginning January 1, 2011.

k. Budget Neutrality Adjustment

We have previously interpreted the statute as requiring that the geographic adjustment be made in a budget neutral manner. Given our application of the ESRD wage index, this means that aggregate payments to ESRD facilities in CY 2011 would be the same as aggregate payments that would have been made if we had not made any changes to the geographic adjusters. We note that this BN adjustment only addresses the impact of changes in the geographic adjustments. A separate BN adjustment was developed for the case-mix adjustments required by the MMA.

As we are not proposing any changes to the case-mix measures for CY 2011, the current case-mix BN adjustment of 0.9116 would remain in effect for CY 2011. Consistent with prior rulemaking, For CY 2011, we propose to apply the wage-index BN adjustment factor of 1.057057 directly to the ESRD wage index values to the composite rate portion of the blend. Because the ESRD wage index is only applied to the labor-related portion of the composite rate, we computed the BN adjustment factor based on that proportion (53.711 percent).

To compute the proposed CY 2011 wage index BN adjustment factor (1.057057), we used the FY 2007 pre-floor, pre-reclassified, non-occupational mix-adjusted hospital data to compute the wage index values, 2009 outpatient claims (paid and processed as of December 31, 2009), and geographic location information for each facility which may be found through Dialysis Facility Compare Web page on the CMS Web site at *http://www.cms.hhs.gov/DialysisFacilityCompare/.* The FY 2011 hospital wage index data for each urban and rural locale by CBSA may also be accessed on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp.* The wage index data are located in the section entitled, "FY 2011 Proposed Rule Occupational Mix Adjusted and Unadjusted Average Hourly Wage and Pre-Reclassified Wage Index by CBSA."

Using treatment counts from the 2009 claims and facility-specific CY 2010 composite rates, we computed the estimated total dollar amount each ESRD provider would have received in CY 2010. The total of these payments became the target amount of expenditures for all ESRD facilities for CY 2011. Next, we computed the estimated dollar amount that would have been paid for the same ESRD facilities using the proposed ESRD wage index for CY 2011. The total of these payments becomes the new CY 2011 amount of wage-adjusted composite rate expenditures for all ESRD facilities.

After comparing these two dollar amounts (target amount divided by the new CY 2011 amount), we calculated an adjustment factor that, when multiplied by the applicable CY 2011 ESRD wage index value, would result in aggregate payments to ESRD facilities that would remain within the target amount of composite rate expenditures. When making this calculation, the ESRD wage index floor value of 0.6000 is applied whenever appropriate. The proposed wage BN adjustment factor for CY 2011 is 1.057057.

To ensure BN, we also must apply the BN adjustment factor to the wage index floor of 1.057057 which results in an adjusted wage index floor of 0.6343 (0.6000 x 1.057057) for CY 2011. This budget neutrality factor is not applied to the wage index values for the ESRD PPS portion of the blend.

l. ESRD Wage Index Tables

The CY 2011 ESRD proposed wage index tables are located in Addenda K and L of this proposed rule. The wage index tables lists two separate columns of wage index values. The first column lists the wage index values will be applied under the composite rate portion and includes the budget neutrality adjustment of 1057057. The second column lists the wage index values that will be applied under the ESRD PPS.

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

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

a. Program Background and Statutory Authority

The Physician Quality Reporting Initiative (PQRI) is a voluntary reporting program, first implemented in 2007, that provides an incentive payment to identified EPs (EPs) who satisfactorily report data on quality measures for covered professional services furnished during a specified reporting period. We propose to add § 414.90 to title 42 of the Code of Federal Regulations to implement the provisions of the PQRI discussed in this section of the proposed rule.

Under section 1848(k)(3)(B) of the Act, the term "EP" means any of the following: (1) A physician; (2) a practitioner described in section 1842(b)(18)(C); (3) a physical or occupational therapist or a qualified speech-language pathologist; or (4) a qualified audiologist. The PQRI was first implemented in 2007 as a result of section 101 of Division B of the Tax Relief and Health Care Act of 2006—the Medicare Improvements and Extension Act of 2006 (Pub.L. 109–432) (MIEA–TRHCA), which was enacted on December 20, 2006. The PQRI was extended and further enhanced as a result of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173) (MMSEA), which was enacted on December 29, 2007, and the MIPPA, which was enacted on July 15, 2008. Changes to the PQRI as a result of these laws, as well as information about the PQRI in 2007, 2008, 2009, and 2010 are discussed in detail in the CY 2008 PFS proposed and final rules (72 FR 38196 through 38204 and 72 FR 66336 through 66353, respectively), CY 2009 PFS proposed and final rules (73 FR 38558 through 38575 and 73 FR 69817 through 69847, respectively), and CY 2010 PFS proposed and final rules (74 FR 33559 through 33600 and 74 FR 61788 through 61861, respectively). Further detailed information, about the PQRI program, related laws, and help desk resources, is available on the CMS Web site at *http://www.cms.gov/PQRI.*

The ACA makes a number of changes to the PQRI, including authorizing incentive payments through 2014, and requiring a penalty beginning in 2015 for EPs who do not satisfactorily report data on quality measures in the applicable reporting period for the year. The various provisions of the ACA, with respect to PQRI, are further discussed in sections VI.F.1.b., VI.F.1.k., and VI.F.1.l. of this proposed rule.

Prior to the enactment of the ACA, PQRI incentive payments were only authorized through 2010. As discussed further in sections VI.F.1.b. and VI.F.1.l. below, under section 1848(m)(1)(A) of the Act, as amended by section 3002(a) of the ACA, PQRI incentive payments are extended through 2014 for EPs that satisfactorily report data on PQRI quality measures for the applicable reporting period. Section 1848(m)(1)(B) of the Act, as amended by section 3002(a) of the ACA, authorizes a 1.0 percent incentive payment for program year 2011 and a 0.5 percent incentive payment for program years 2012 through 2014 for qualified EPs who satisfactorily submit PQRI quality measures data. Beginning in 2015, an incentive payment adjustment will be implemented for EPs who do not satisfactorily report quality measures as required by section 1848(a)(8) of the Act

and added by section 3002(b) of the ACA.

Section 3002(e) of the ACA amends section 1848(m)(5) of the Act to require the Secretary to provide timely feedback to EPs on the performance of the EP with respect to satisfactorily submitting data on quality measures. This is discussed further in section VI.F.1.l.(4) below.

Section 3002(f)(2) amends section 1848(m)(5) of the Act by adding a requirement with respect to an informal appeals process. Specifically, section 1848(m)(5)(I) of the Act, as discussed further in section VI.F.1.l.(5) below, requries that the Secretary establish and have in place an informal process by January 1, 2011, whereby EPs may seek a review of the determination that an EP did not satisfactorily submit data on quality measures for purposes of qualifying for a PQRI incentive payment.

Section 1848(m)(7) of the Act ("Additional Incentive Payment"), as added by section 10327(a) of the ACA, provides that for years 2011 through 2014, the applicable quality percent under PQRI for EPs satisfactorily reporting PQRI quality measures data will be increased by 0.5 percentage points, if the EP also meets certain requirements, including satisfactorily reporting data on quality measures for a year and having such data submitted on their behalf through a Maintenance of Certification Program (MOCP) (as defined under section 1848(m)(7) of the Act) and participating in an MOCP practice assessment more frequently than is required to qualify for or maintain board certification status. Section 1848(m)(7) of the Act ("Additional Incentive Payment") is discussed in more detail in section VI.F.1.l.(2). Furthermore, section 3002(c) of the ACA, as amended by section 10327(b) of the ACA authorizes the Secretary to incorporate participation and successful completion in an MOCP and successful completion of a qualified MOCP practice assessment into the composite of measures of quality of care furnished under the PFS payment modifier.

Also discussed further in section VI.F.1.k. below, section 10331 of the ACA requires the Secretary to develop a Physician Compare Internet web site by January 1, 2011, on which information on physicians enrolled in the Medicare program and other EPs who participate in the PQRI program would be posted. With respect to measures collected under the PQRI program, to the extent practicable, the Secretary will implement a plan by January 1, 2013, to report 2012 PQRI information on the Physician Compare Web site.

Finally, section 1848(m)(7) of the Act ("Integration of Physician Quality Reporting and EHR Reporting"), as added by section 3002 of the ACA requires that not later than January 1, 2012, the Secretary shall develop a plan to integrate reporting on quality measures under subsection (o) relating to the meaningful use of electronic health records (EHRs), as discussed further in section VI.F.1.l.(3) below.

b. Incentive Payments for the 2011 PQRI

As stated above, for years 2011 through 2014, section 3002(a) of the ACA extends the opportunity for EPs to earn a PQRI incentive payment for satisfactorily reporting PQRI quality measures. For 2011 PQRI, section 1848(m)(2)(B) of the Act, as amended by section 3002(a) of the ACA, authorizes a 1.0 percent incentive, and for 2012 through 2014, a 0.5 percent incentive, for qualified EPs who satisfactorily submit PQRI quality measures data. Regardless of the reporting mechanism, and/or the associated reporting period (both discussed in detail below) an EP chooses to report quality data for purposes of PQRI, if the EP meets the respective criteria for satisfactory reporting, the EP may receive a 1.0 percent incentive.

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

As mentioned above, we are proposing a number of reporting mechanisms that EPs may choose in order to participate in PQRI. Our proposals for claims-based reporting, registry-based reporting, and EHR-based reporting are discussed below with respect to the opportunity for individual EPs to participate in PQRI. For satisfactory reporting at the individual level in 2011, 1.0 percent of qualified charges would be paid at the TIN/NPI level. These proposed reporting mechanisms are addressed in section G.1.d. below. Our proposed criteria for satisfactorily reporting using the various reporting mechanisms are discussed in further detail in sections VI.F.1.e. and VI.F.1.f. below. Our proposals with respect to the reporting mechanisms and criteria for satisfactorily reporting for group practices are also addressed below, in section VI.F.1.g. Those group practices that satisfactorily report will also be paid a 1.0 percent incentive payment based upon the qualified charges for the group practice TIN.

c. Proposed 2011 Reporting Periods for Individual EPs

Under section 1848(m)(6)(C) of the Act, the "reporting period" for the 2008 PQRI and subsequent years is defined to be the entire year, but the Secretary is authorized to revise the reporting period for years after 2009 if the Secretary determines such revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden. For the 2011 PQRI, we propose the following reporting periods: (1) 12-month reporting period for claims-based reporting and registry-based reporting (that is, January 1, 2011 through December 31, 2011); (2) 12-month reporting period for EHR-based reporting (that is, January 1, 2011 through December 31, 2011; and (3) 6-month reporting period for claims-based reporting and registry-based reporting (that is, July 1, 2011 through December 31, 2011). Additionally, as discussed further below in their respective sections, we propose the 12-month reporting period for the group practice reporting option (GPRO) for both PQRI and the eRx Prescribing Incentive Program (January 1, 2011 through December 31, 2011).

The proposed 2011 PQRI reporting periods are consistent with the 2010 reporting periods. In addition, in prior program years, we received input from stakeholders in support of partial year reporting for all reporting mechanisms, to give more EPs the opportunity to begin reporting later in the year. We agree that having the same reporting periods for all mechanisms may be less complex, and may facilitate participation in 2011 PQRI for certain EPs. In an effort to be consistent with prior program years, and move in the direction of maintaining program

stability and continuing program flexibility, while increasing successful reporting of 2011 PQRI measures, we propose to retain 2010 PQRI reporting periods as described above. We invite comments on the proposed reporting periods for 2011 PQRI.

d. Proposed 2011 PQRI Reporting Mechanisms for Individual EPs

When the PQRI was first implemented in 2007, there was only 1 reporting mechanism available to submit data on PQRI quality measures. For the 2007 PQRI, EPs had to submit quality data codes (QDCs) on Medicare Part B claims (claims-based reporting). QDCs are Current Procedural Terminology (CPT) Category II codes or G-codes (where CPT Category II codes are not yet available). CPT Category II codes and G-codes are Healthcare Common Procedure Coding System (HCPCS) codes for reporting quality data. For the 2008 PQRI, we added registry-based reporting as an alternative reporting mechanism as required by section 1848(k)(4) of the Act. Under this option, EPs may submit data on PQRI quality measures to a qualified PQRI registry and request the registry to submit PQRI quality measures results and numerator and denominator data on the 2008 PQRI quality measures or measures groups. For the 2009 PQRI, we retained the 2 reporting mechanisms used in the 2008 PQRI (that is, claims-based reporting and registry-based reporting) for reporting individual PQRI quality measures and for reporting measures groups.

Finally, to promote the adoption of EHRs, and to facilitate quality measure data reporting, we sought to establish an EHR reporting option by conducting limited testing of EHR reporting for the 2008 and 2009 PQRI. This involved the submission of clinical quality data extracted from an EHR, or the EHR-based reporting mechanism. No incentive payment was available to those EPs who participated in testing the EHR-based reporting mechanism.

For the 2010 PQRI, we retained the claims-based reporting mechanism, the registry-based reporting mechanism, and established EHR reporting for a limited subset of the 2010 PQRI quality measures, as identified in Table 14 of the CY 2010 PFS final rule with comment period (74 FR 61831), contingent upon the successful completion of our 2009 EHR data submission testing process and a determination based on that testing process that accepting data from EHRs on quality measures for the 2010 PQRI was practical and feasible. In the 2010 PQRI, following the successful completion of the 2009 EHR data submission testing process, it was determined that it is practical and feasible to accept data from EHRs on quality measures for the 2010 PQRI.

For the 2011 PQRI, we are proposing to retain the claims-based reporting mechanism and the registry-based reporting mechanism. We also propose to retain the 2010 EHR-based reporting mechanism, by which we will continue to accept quality measures data extracted from a qualified EHR product for a limited subset of the proposed 2011 PQRI quality measures, as identified in Tables 55 and 56. Under the 2011 PQRI, we propose that the EHR submission is optional.

For the 2011 PQRI, we are not proposing to offer additional reporting options for individual EPs beyond those discussed above. In contrast to prior program years (2008 PQRI, 2009 PQRI, and 2010 PQRI), we believe that other options would not facilitate reporting of quality data for PQRI by EPs. However, we seek public comment on these proposals and invite suggestions as to other options that could be included in the PQRI.

We recognize that there continues to be a number of limitations associated with claims-based reporting since the claims processing system was developed for billing purposes and not for the submission of quality data. Claims submission, however, is available to all EPs. We have observed that only about half of those EPs who participated in PQRI via the claims-based reporting mechanism satisfied the criteria for satisfactory reporting (that is, reported at least 3 PQRI measures or 1–2 measures if there were fewer than 3 applicable measures, for at least 80 percent of the EP's Medicare Part B FFS patients for whom services were furnished during the reporting period to which the measure applies) and qualified for the incentive. We have also found that measures with complex specifications, such as those that require multiple diagnosis codes are not as conducive to claims-based reporting and may be associated with a greater number of invalidly reported QDCs. Similarly, when multiple measures share the same codes it may be difficult to determine which measure(s) the EP intended to report through claims. Finally, for pragmatic efficiency it is not practical to allow resubmission of claims for the sole purpose of adding QDCs. This means that claims-based reporting must be concurrent with billing.

By contrast, our experience with the registry-based reporting mechanism continues to be a favorable option, as the drawbacks discussed above do not apply. Data has shown that not only have the participation rates for registry-based reporting increased, but also satisfactory reporting, resulting in an incentive payment for EPs, has also increased. Furthermore, the available number of qualified registries has also increased since 2008, and we expect additional registries to become qualified in future years. For these reasons, we maintain that the registry-based reporting option remains viable, and furthermore, we anticipate continuing to expand this option in future years.

We also believe that EHR-based reporting continues to be a viable option for overcoming the limitations associated with claims-based reporting of quality measures, as clinical quality data is extracted from the EHR for submission. We believe further that retaining the EHR-based reporting mechanism for 2011 PQRI will continue to promote the adoption and use of EHRs and further align with the provision in the ACA related to the integration of PQRI EHR measures and the EHR incentive program measures in years after 2011, which is discussed in further detail in section VI.F.1.l.(3) below.

In summary, we propose that for 2011, an EP may choose to report data on PQRI quality measures through claims, a qualified registry (for the proposed qualification requirements for registries, see section VI.F.1.d.(4) of this proposed rule), or through a qualified EHR product (for the proposed qualification requirements for the EHR vendors and their products, see section VI.F.1.d.(5) of this proposed rule). As in previous years, depending on which PQRI individual quality measures or measures groups an EP selects, one or more of the proposed reporting mechanisms may not be available for reporting a particular 2011 PQRI individual quality measure or measures group. For example, the EHR reporting mechanism currently is not available for reporting measures groups and specifications for the electronic transmission of a measure via an EHR are not available for all of the individual PQRI measures. In addition, as discussed previously the specifications for some measures are too complex for claims-based reporting. The proposed 2011 reporting mechanisms through which each proposed 2011 PQRI individual quality measure and measures group could be reported are identified in Tables 47 and 48. We invite comments on our proposal for the 2011 reporting mechanisms.

While we propose to retain the claims-based reporting mechanism for 2011, we note that we continue to

consider significantly limiting the claims-based mechanism of reporting clinical quality measures in future program years. This limitation continues to be contingent upon there being an adequate number and variety of registries available and/or the continuation and/or expansion of the EHR reporting option. Potentially, we would continue to retain claims-based reporting in years after 2011 principally for the reporting of structural measures, such as Measure #124 Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR), and in circumstances where claims-based reporting is the only available mechanism for certain categories of EPs to report on PQRI quality measures.

Continuing to reduce our reliance on the claims-based reporting mechanism after 2011 would allow us and EPs to continue to devote available resources towards maximizing the potential of registries and EHRs for quality measurement reporting. Both mechanisms hold the promise of more sophisticated and timely reporting of clinical quality measures. Clinical data registries allow the collection of more detailed data, including outcomes, without the necessity of a single submission contemporaneously with claims billing, which overcomes some of the limitations of the claims-based reporting mechanism. Registries can also provide feedback and quality improvement information based on reported data. Finally, clinical data registries can also receive data from EHRs, and therefore, serve as an alternative means to reporting clinical quality data extracted from an EHR. As we continue to qualify additional registries (qualified registries are listed on the CMS PQRI Web site *http://www.cms.gov/PQRI/20_AlternativeReportingMechanisms.asp#TopOfPage*), we believe there may be a sufficient number of registries by 2012 to make it possible to reduce the claims-based reporting mechanism for many measures after 2011. We again invite comments on our intent to lessen our reliance on the claims-based reporting mechanism for the PQRI program beyond 2011.

As in previous years, regardless of the reporting mechanism chosen by an EP, there is no requirement for the EP to sign up or register to participate in the PQRI. However, there may be some requirements for participation through a specific reporting mechanism that are unique to that particular reporting mechanism. In addition to the proposed criteria for satisfactory reporting of individual measures and measures groups described in section VI.F.1.e. and section VI.F.1.f., respectively, of this proposed rule, EPs must ensure that they meet all requirements for their chosen reporting mechanism for 2011.

(1) Proposed Requirements for Individual EPs Who Choose the Claims-Based Reporting Mechanism

For EPs who choose to participate in the 2011 PQRI by submitting data on individual quality measures or measures groups through the claims-based reporting mechanism, we propose the EP would be required to submit the appropriate PQRI QDCs on the professionals' Medicare Part B claims. QDCs for the EP's selected individual PQRI quality measures or measures group may be submitted to CMS at any time during 2011. Please note, however, that as required by section 1848(m)(1)(A) of the Act, all claims for services furnished between January 1, 2011 and December 31, 2011, would need to be processed by no later than February 28, 2012, to be included in the 2011 PQRI analysis.

(2) Proposed Requirements for Individual EPs Who Choose the Registry-Based Reporting Mechanism

We propose that in order to report quality data on the 2011 PQRI individual quality measures, or measures groups, through a qualified clinical registry, an EP must enter into and maintain an appropriate legal arrangement with a qualified 2011 PQRI registry. Such arrangements would provide for the registry's receipt of patient-specific data from the EP and the registry's disclosure of quality measures results and numerator and denominator data on PQRI quality measures or measures groups on behalf of the EP to CMS. Thus, the registry would act as a Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191) (HIPAA) Business Associate and agent of the EP. Such agents are referred to as "data submission vendors." The "data submission vendors" would have the requisite legal authority to provide clinical quality measures results and numerator and denominator data on individual quality measures or measures groups on behalf of the EP for the PQRI. We propose that the registry, acting as a data submission vendor, would submit CMS-defined registry-derived measures information to our designated database for the PQRI, using a CMS-specified record layout, which would be provided to the registry by CMS.

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

We propose that EPs choosing to participate in PQRI through the registry-based reporting mechanism for 2011 would need to select a qualified PQRI registry and submit information on PQRI individual quality measures or measures groups to the selected registry in the form and manner and by the deadline specified by the registry.

We propose to post on the PQRI section of the CMS Web site at *http://www.cms.gov* a list of qualified registries for the 2011 PQRI, including the registry name, contact information, and the 2011 measure(s) and/or measures group(s) and eRx reporting (if qualified) for which the registry is qualified and intends to report. As in the 2010 PQRI, we propose for the 2011 PQRI to post the names of the 2011 PQRI qualified registries in 3 phases, which are discussed below. In any event, even though a registry is listed as "qualified," we cannot guarantee or assume responsibility for the registry's successful submission of the required PQRI quality measures results or measures group results or required data elements submitted on behalf of a given EP.

In the first phase, we propose to post, by December 31, 2010, a list of those registries qualified for the 2011 PQRI based on the following: (1) Being a qualified registry for a prior PQRI program year that successfully submitted 2008 and/or 2009 PQRI quality measures results and numerator and denominator data on the quality measures; (2) having received a letter indicating their continued interest in being a PQRI registry for 2011 by October 31, 2010; and (3) the registry's compliance with the 2011 PQRI registry requirements. This list may be modified if any given registry fails to meet any new requirement(s) proposed for 2011. The testing of any additional requirements will be completed as soon as possible but by the end of the first quarter of 2011 at the latest. By posting this first list of qualified registries for the 2011 PQRI, we seek to make available the names of registries that can be used at the start of the 2011 reporting period.

We propose in the second phase, to add the names of the registries that were initially qualified in 2010 and submitted actual quality data on behalf of their EPs to CMS for the first time in early 2011. Successful submission of data to CMS

for the year in which a registry is qualified is the final step in the qualification process and a necessary requirement if the registry desires to continue to participate in PQRI in subsequent years. We propose that these registries also must meet any new 2011 requirements and will also undergo testing, which will be completed by the end of the first quarter of 2011 at the latest.

In the third phase, we propose to complete posting of the list of qualified 2011 registries as soon as we have completed vetting the additional registries interested in and capable of participating in the 2011 PQRI. We anticipate this will be completed no later than the summer of 2011. An EP's ability to report PQRI quality measures data and numerator and denominator data on PQRI quality measures or measures groups using the registry-based reporting mechanism should not be impacted by the complete list of qualified registries for the 2011 PQRI being made available after the start of the reporting period. First, registries would not begin submitting EPs' PQRI quality measures results and numerator and denominator data on the quality measures or measures groups to CMS until 2012. Second, if an EP decides that he or she is no longer interested in submitting quality measures data and numerator and denominator data on PQRI individual quality measures or measures group through the registry-based reporting mechanism after the complete list of qualified registries becomes available, this would not preclude the EP from attempting to meet the criteria for satisfactory reporting through another 2011 PQRI reporting mechanism, such as claims or EHR-based data submission.

In addition to meeting the above proposed requirements specific to registry-based reporting, we propose that EPs who choose to participate in PQRI through the registry-based reporting mechanism would need to meet the relevant criteria proposed for satisfactory reporting of individual measures or measures groups that all EPs must meet in order to satisfactorily report for PQRI 2011. However, in 2011, we propose not to count measures that are reported through a registry or EHR that have a zero percent performance rate. That is, if the recommended clinical quality action is not performed on at least 1 patient for a particular measure or measures group reported by the EP via a registry or EHR, we will not count the measure (or measures groups) as a measure (or measures group) reported by an EP. We propose to disregard measures (or measures groups) that are reported through a registry or EHR that have a zero percent performance rate in the 2011 PQRI because we are assuming that the measure was not applicable to the EP and was likely reported from EHR-derived data (or from data mining) and was unintentionally submitted from the registry or EHR to CMS. We also seek to avoid the possibility of intentional submission of spurious data solely for the purpose of receiving an incentive payment for reporting.

(3) Proposed Requirements for Individual EPs Who Choose the EHR-Based Reporting Mechanism

For 2011, in addition to meeting the criteria for satisfactory reporting of at least 3 individual measures, we propose the following requirements associated with EHR-based reporting: (1) Selection of a PQRI qualified EHR product; and (2) submission of clinical quality data extracted from the EHR to a CMS clinical data warehouse in the CMS-specified manner and format. These proposed requirements are identical to the 2010 requirements for individual EPs who choose the EHR-based requirements. We are proposing to retain the 2010 requirements because results from 2010 EHR data submission will not be available until 2011. A test of quality data submission from EPs who wish to report 2010 quality measure data directly from their qualified EHR product will be required and occur in early 2011 immediately followed by the submission of the EP's actual 2010 PQRI data. This entire final test/production 2010 data submission timeframe is expected to be January 2011 through March 2011. As discussed in the CY 2010 PFS final rule with comment period (74 FR 61800), throughout most of 2010, we will continue to vet newly self-nominated EHR vendor products for possible qualification for the 2011 PQRI program year. We expect to list any additional PQRI qualified EHR products by January 2011. It is expected that these newly qualified products would be able to submit 2011 PQRI data in early 2012.

Measures group reporting is not an option for EHR based quality measure reporting for 2010. We propose to continue this policy for 2011 and therefore, propose not to include measures group reporting via EHRs for the 2011 PQRI. We will receive 2010 production data in early 2011 and since this will be the first time we have an opportunity to receive direct EHR data submission for quality reporting and to calculate the results, we believe it is best not to add another reporting option using EHRs at this time. We propose that EPs who choose the EHR-based reporting mechanism for the 2011 PQRI would be required to (in addition to meeting the criteria for satisfactory reporting of individual measures)—

- Have a qualified EHR product;
- Have an active Individuals Authorized Access to CMS Computer Services (IACS) user account with a data submission role or be able to use the surrogate data submission method (if one exists) that will be used to submit clinical quality data extracted from the EHR to a CMS clinical data warehouse or another CMS approved means of securely transmitting the quality measures data to CMS such as a CMS/OCSQ approved HIE (health information exchange) if we are able to collect data from HIEs in 2012 using the NHIN (national health information network) or NHIN direct network;
- Submit a test file containing real or test clinical quality data extracted from the EHR to a CMS clinical data warehouse via an approved data submission method such as IACS, an HIE, or the NHIN between July 1, 2011 and September 30, 2011 (if technically feasible); and
- Submit a file containing the EP's 2011 PQRI clinical quality data extracted from the EHR for the entire reporting period (that is January 1, 2011 through December 31, 2011) via IACS or an acceptable surrogate (if technically feasible) between January 1, 2012, through February 28, 2012.

However, as stated above, the 2010 EHR Testing Program is still ongoing. Since we are proposing that only EHR vendors that self-nominated to participate in the 2011 EHR Testing Program and successfully complete the 2011 EHR Testing Program would be considered qualified EHR vendors for the 2011 PQRI, there is no guarantee that there will be any additionally qualified EHR vendors available for the 2011 PQRI. In addition, as we complete the 2010 EHR Testing Program and are better able to determine what is technically feasible, the actual dates on which EPs are required to submit their test files and/or to begin submitting their actual 2011 PQRI data are subject to change.

We cannot assume responsibility for the successful submission of data from an EP's EHR. Any EP who chooses to submit PQRI data extracted from an EHR should contact the EHR product's vendor to determine if the product is qualified and has been updated to facilitate PQRI quality measures data submission. Such professionals also should begin attempting submission soon after the opening of the clinical data warehouse in order to assure the

professional has a reasonable period of time to work with his or her EHR and/or its vendor to correct any problems that may preclude successful quality measures data submission through that EHR. As we indicated above, we are proposing that data submission for the 2011 PQRI would need to be completed by February 28, 2012.

The specifications for the electronic transmission of the 2011 PQRI measures, identified in Tables 55 and 56 of this proposed rule as being available for EHR-based reporting in 2011, will be posted on the Alternative Reporting Mechanisms page of the PQRI section of the CMS Web site during the summer of 2010.

(4) Proposed Qualification Requirements for Registries

In order to be "qualified" to submit quality measures results and numerator and denominator data on PQRI quality measures and measures groups on behalf of EPs pursuing a PQRI incentive for the 2008, 2009, and 2010 PQRI, we required registries to complete a self-nomination process and to meet certain technical and other requirements. For the 2010 PQRI, registries that were qualified for 2009 did not need to be "re-qualified" for 2010 unless they were unsuccessful at submitting 2009 PQRI data (that is, failed to submit 2009 PQRI data per the 2009 PQRI registry requirements). Registries that were "qualified" for 2009 and wished to continue to participate in 2010 were only required to communicate their desire to continue participation for 2010 by submitting a letter to CMS indicating their continued interest in being a PQRI registry for 2010 and their compliance with the 2010 PQRI registry requirements by March 31, 2010.

For the 2011 PQRI, we are proposing to require a self-nomination process for registries wishing to submit 2011 PQRI quality measures or measures groups on behalf of EPs for services furnished during the applicable reporting periods in 2011. We propose that the registry self-nomination process for the 2011 PQRI would be based on a registry meeting specific technical and other requirements, as discussed below.

To be considered a qualified registry for purposes of submitting individual quality measures and measures groups on behalf of EPs who choose to report using this reporting mechanism under the 2011 PQRI, we propose that all registries (new to PQRI and those previously qualified) must:

- Be in existence as of January 1, 2011;
- Have at least 25 participants by January 1, 2011;
- Provide at least 1 feedback report per year to participating EPs;
- Not be owned and managed by an individual locally-owned single-specialty group (in other words, single-specialty practices with only 1 practice location or solo practitioner practices would be prohibited from self-nominating to become a qualified PQRI registry);
- Participate in ongoing 2011 PQRI mandatory support conference calls hosted by CMS (approximately 1 call per month), including an in-person registry kick-off meeting to be held at CMS headquarters in Baltimore, MD. Registries that miss more than one meeting will be precluded from submitting PQRI data for the reporting year (2011);
- Be able to collect all needed data elements and transmit to CMS the data at the TIN/NPI level for at least 3 measures in the 2011 PQRI program (according to the posted 2011 PQRI Measure Specifications);
- Be able to calculate and submit measure-level reporting rates or the data elements needed to calculate the reporting rates by TIN/NPI;
- Be able to calculate and submit, by TIN/NPI, a performance rate (that is, the percentage of a defined population who receive a particular process of care or achieve a particular outcome) for each measure on which the TIN/NPI reports or the data elements needed to calculate the reporting rates;
- Be able to separate out and report on Medicare Part B FFS patients;
- Provide the name of the registry;
- Provide the reporting period start date the registry will cover;
- Provide the reporting period end date the registry will cover;
- Provide the measure numbers for the PQRI quality measures on which the registry is reporting;
- Provide the measure title for the PQRI quality measures on which the registry is reporting;
- Report the number of eligible instances (reporting denominator);
- Report the number of instances of quality service performed (numerator);
- Report the number of performance exclusions;
- Report the number of reported instances, performance not met (EP receives credit for reporting, not for performance);
- Be able to transmit this data in a CMS-approved XML format. We expect that this CMS-specified record layout will be substantially the same as for the 2008, 2009, and 2010 PQRI if aggregate level data is continued but will likely change if individual data elements are required, as discussed below. This layout will be provided to registries in 2011;
- Comply with a CMS-specified secure method for data submission, such as submitting the registry's data in an XML file through an IACS user account or another approved method such as over the NHIN (national health information network) if technically feasible;
- Submit an acceptable "validation strategy" to CMS by March 31, 2011. A validation strategy ascertains whether EPs have submitted accurately and on at least the minimum number (80 percent) of their eligible patients, visits, procedures, or episodes for a given measure. Acceptable validation strategies often include such provisions as the registry being able to conduct random sampling of their participant's data, but may also be based on other credible means of verifying the accuracy of data content and completeness of reporting or adherence to a required sampling method;
- Perform the validation outlined in the strategy and send the results to CMS by June 30, 2012 for the 2011 reporting year's data;
- Enter into and maintain with its participating professionals an appropriate Business Associate agreement that provides for the registry's receipt of patient-specific data from the EPs, as well as the registry's disclosure of quality measure results and numerator and denominator data on behalf of EPs who wish to participate in the PQRI program;
- Obtain and keep on file signed documentation that each holder of an NPI whose data are submitted to the registry has authorized the registry to submit quality measures and numerator and denominator data to CMS for the purpose of PQRI participation. This documentation must be obtained at the time the EP signs up with the registry to submit PQRI quality measures data to the registry and must meet any applicable laws, regulations, and contractual business associate agreements;
- Provide CMS access (if requested for validation purposes) to review the Medicare beneficiary data on which 2011 PQRI registry-based submissions are founded or provide to CMS a copy of the actual data (if requested);
- Provide the reporting option (reporting period and reporting criteria) that the EP has satisfied or chosen;
- Provide CMS a signed, written attestation statement via mail or e-mail which states that the quality measure results and any and all data including numerator and denominator data

provided to CMS are accurate and complete;

• Indicate the reporting period chosen for each EP who chooses to submit data on measures groups;

• Base reported information on measures groups only on patients to whom services were furnished during the 12-month reporting period of January through December 2011 or the 6-month reporting period of July 1, 2011 through December 31, 2011;

• Agree that the registry's data may be inspected or a copy requested by CMS and provided to CMS under our oversight authority;

• Be able to report data on all applicable measures in a given measures group on either 30 or more Medicare Part B FFS patients from January 1, 2011 through December 31, 2011, or on 80 percent of applicable Medicare Part B FFS patients for each EP (with a minimum of 15 patients during the January 1, 2011, through December 31, 2011, reporting period or a minimum of 8 patients during the July 1, 2011, through December 31, 2011, reporting period).

These proposed qualification requirements for 2011 registries are similar to the PQRI qualification requirements for registries for previous years. However, we note, that registries would no longer be permitted to include non-Medicare patients for measures group reporting (*see* section VI.F.1.f. of this proposed rule for further discussion of the criteria for satisfactory reporting of measures groups by individual EPs).

In addition, in prior years registries were permitted to develop their own algorithms to calculate measure results (that is, reporting and performance rates) from the data provided to them from their EP members. For the 2011 PQRI, we propose that all current and future registries would have to meet the following new requirements proposed for 2011:

• Use PQRI measure specifications and the CMS provided measure calculation algorithm to calculate reporting rates or performance rates unless otherwise stated if aggregated measures data is continued for 2011 PQRI registry reporting. CMS will provide registries a calculation algorithm for each measure and/or measures group they intend to report in 2011.

• Provide a calculated result using the CMS supplied algorithm and XML file for each measure that the registry intends to calculate (as described below). This applies to all registries; those that are new to the program, and those that were previously qualified. The registries will be required to show that they can calculate the proper measure results (that is, reporting and performance rates) using the CMS-supplied algorithm and send the calculated data back to CMS in the specified format.

• Provide us the individual data elements used to calculate the measures if so requested by CMS for validation purposes, if aggregated data submission is still the selected method of data collection. Registries that are subject to validation will be asked to send discrete data elements for a measure (determined by CMS) in the required data format for us to recalculate the registries' reported results. Validation will be conducted for several measures at a randomly selected sample of registries in order to validate their data submissions.

While registries allow EPs to collect data over a broader timeframe enabling us to implement more sophisticated measures in PQRI and despite their apparent success as a vehicle for quality reporting (over 90.0 percent of EPs who participated in the 2008 PQRI through registry-based reporting were incentive eligible), registry data results have been inconsistent when we have validated the registry data against claims. Even though qualified registries go through a thorough vetting and testing process, we have found differences in measure results (that is, performance rates) reported by the registries when compared to measure results calculated from claims data for the same EP. This makes it difficult for EPs to analyze their performance results for practice improvement in that the information may not be reliable and reproducible from registry to registry. This also makes possible physician comparison difficult and inconsistent. We believe there are likely several reasons for these inconsistencies, including the fact that some registries are getting their data from an EP's EHR, the use of non-Medicare patients by registries for measures groups, and the use of different algorithms by registries to calculate measures. We believe the proposed new requirements for registries discussed above will help us in validating the registry data we receive by addressing some of the reasons leading to the inconsistencies. The proposal for 2011 to retain many of the 2010 requirements while introducing some new requirements is intended to improve the registry-based reporting mechanism by capitalizing on some of the registry's existing quality improvement functions, maximizing the registry's ability to successfully submit EP's quality measure results and numerator and denominator data on PQRI individual quality measures or measures groups to CMS, and discouraging small physicians' offices or an individual EP from self-nominating to become a qualified registry. We continue to be concerned that an individual EP or a small practice does not have either the resources, or the capabilities, to successfully submit quality measures results and numerator and denominator data on PQRI individual measures or measures groups through the registry data submission process. We invite comments on the process and requirements that we propose to use to determine whether a registry is qualified to submit quality measures results (performance rates and reporting rates) and numerator and denominator data on PQRI quality measures or measures groups on an EP's behalf.

As stated previously, registries currently calculate the measure results (that is reporting and performance rates) from the data submitted to them by their EP members and send us the measure results for each participating EP, which are aggregated, nonpatient identifiable data. An advantage of this approach is that less data will need to be transmitted to CMS (since we only receive aggregated data), which means there is less data for CMS to analyze.

Another option that we considered was changing the requirements with respect to the type of data that registries send us. For 2011, we considered requiring registries, instead, to send discrete data elements for a measure (as determined by CMS) in the required data format for us to calculate the EP's measure results. Thus, the registry would be required to send CMS beneficiary-level data provided to the registry by the EP and CMS would use the data to calculate the EP's measure results (that is, reporting and performance rates). This approach is similar to the approach that was contemplated when registry data submission began in 2008 and was referred to as "Option 2" in the CY 2008 PFS proposed rule (72 FR 38203). An advantage of this approach is that it allows us to calculate the measure results and reduces the variation that occurs when registries try to aggregate their data and calculate the measure results themselves. Reducing the variation would facilitate comparison of EPs' results should we move towards public reporting of performance results in the future. Also, if the measure specifications change from year to year, this approach would require the registry to make fewer systems changes. The registry would not need to update the algorithms used to calculate the

measure's results. We invite comments on this alternative that was considered.

We propose to post the final 2011 PQRI registry requirements, including the exact date by which registries that wish to qualify for 2011 must submit a self-nomination letter and instructions for submitting the self-nomination letter, on the PQRI section of the CMS Web site at *http://www.cms.gov/PQRI* by November 15, 2010. We anticipate that new registries that wish to self-nominate for 2011 would be required to do so by January 31, 2011.

Similar to 2010 PQRI, we propose that registries that were "qualified" for 2010 and wish to continue to participate in 2011 will not need to be "re-qualified" for 2011 except to the extent that the requirements change for 2011 (as proposed above). If this occurs, we propose that all previously qualified registries would need to demonstrate that they can meet the new 2011 data submission requirements. Additionally, we propose that registries that are unsuccessful submitting 2010 PQRI data (that is, fail to submit 2010 PQRI data per the 2010 PQRI registry requirements) will need to go through a full self-nomination vetting process for 2011. Successful 2010 PQRI registries that choose to report on new or different 2011 PQRI measures would also need to qualify for these additional measures and/or methods. We also propose that registries that are "qualified" for 2010, who were successful in submitting 2010 PQRI data, and wish to continue to participate in 2011 would need to indicate their desire to continue participation for 2011 by submitting a letter to CMS indicating their continued interest in being a PQRI registry for 2011 and their compliance with the 2011 PQRI registry requirements by no later than October 31, 2010. Instructions regarding the procedures for submitting this letter will be provided to qualified 2010 PQRI registries on the 2010 PQRI registry support conference calls.

Similar to 2010 PQRI, we propose that if a qualified 2010 PQRI registry fails to submit 2010 PQRI data per the 2010 PQRI registry requirements, the registry would be considered unsuccessful at submitting 2010 PQRI data and would need to go through the full self-nomination process again to participate in the 2011 PQRI. By March 31, 2011, registries that are unsuccessful at submitting quality measures results and numerator and denominator data for 2010 would need to be able to meet the 2011 PQRI registry requirements and go through the full vetting process again. This would include CMS receiving the registry's self-nomination by March 31, 2011. As discussed further under section VI.F.2. of this proposed rule, we propose that the above registry requirements would apply not only for the purpose of a registry qualifying to report 2011 PQRI quality measure results and numerator and denominator data on PQRI individual quality measures or measures groups, but also for the purpose of a registry qualifying to submit the proposed electronic prescribing measure for the 2011 Electronic Prescribing Incentive Program. We invite comments on the proposed qualification requirements for registries for the 2011 PQRI.

(5) Proposed Qualification Requirements for EHR Vendors and Their Products

In 2010 PQRI, EHR products were listed on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* as a "qualified" EHR product (that is, the name of the vendor software product and the version that was qualified), and were available for the product's users to submit quality data on Medicare beneficiaries to CMS directly from their system for the 2010 PQRI. This list of qualified EHR vendors and products was posted upon completion of the 2009 EHR Testing Program in January 2010.

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

The EHR vendor qualification process for the 2011 PQRI was finalized in the 2010 PFS final rule with comment period (74 FR 61800 through 61802) and is currently underway. We anticipate the EHR vendor vetting process for the 2011 PQRI will be complete in early 2011. At the conclusion of the 2011 PQRI EHR vendor vetting process, those EHR products that meet all of the 2011 EHR vendor requirements will be listed on the PQRI section of the CMS Web site as a "qualified" PQRI EHR product, which indicates that the product's users may submit quality data to CMS for the 2011 PQRI. We continue to caution there is no guarantee that there will be any qualified EHR vendors available for the 2011 PQRI. However, since seven EHR vendors and their programs were "qualified" to submit quality data to CMS directly from their EPs for 2010 PQRI reporting, we are optimistic that for 2011 PQRI and subsequent years there will continue to be multiple "qualified" EHR vendors available for EPs.

During 2011, we propose to use the same self-nomination process described in the "Requirements for Electronic Health Record (EHR) Vendors to Participate in the 2011 PQRI EHR Testing Program" posted on the PQRI section of the CMS Web site at *http://www.cms.gov/PQRI/20_AlternativeReportingMechanisms.asp#TopOfPage,* to qualify additional EHR vendors and their EHR products to submit quality data extracted from their EHR products to the CMS clinical quality data warehouse for 2012 PQRI. We propose that any EHR vendor interested in having one or more of their EHR products "qualified" to submit quality data extracted from their EHR products to the CMS clinical quality data warehouse for 2012 and subsequent years will be required to submit their self-nomination letter by January 31, 2011. Instructions for submitting the self-nomination letter will be provided in the 2012 EHR vendor requirements, which we expect to post in the 4th quarter of CY 2010. Specifically, for the 2012 PQRI, we propose that only EHR vendors that self-nominate to participate in the 2012 EHR Test Program will be considered qualified EHR vendors for the 2012 PQRI. We propose that the 2011 PQRI EHR test vendors, who, if their testing is successful, may report 2012 PQRI data to CMS, must meet the following requirements:

- Be able to collect and transmit all required data elements according to the 2012 EHR Specifications.
- Be able to separate out and report on Medicare Part B FFS patients only.
- Be able to include TIN/NPI information submitted with an EP's quality data.
- Be able to transmit this data in the CMS-approved format.
- Comply with a secure method for data submission.
- Not be in a beta test form.
- Have at least 25 active users.

Additionally, we propose that previously qualified PQRI EHR vendors and 2012 EHR test vendors must also

participate in ongoing PQRI mandatory support conference calls hosted by CMS (approximately one call per month). These requirements would apply not only for the purpose of a vendor's EHR product being qualified so that the product's users may submit data extracted from the EHR for the 2012 PQRI in 2013, but also for the purpose of a vendor's EHR product being qualified so that the product's users may electronically submit data extracted from the EHR for the electronic prescribing measure for the 2012 eRx Incentive Program in 2013. We propose that if a vendor misses more than one mandatory support call or meeting, the vendor and their product would be disqualified for the PQRI reporting year, which is covered by the call.

We propose that previously qualified vendors and new vendors will need to incorporate any new EHR measures (measures electronically-specified) added to PQRI for the reporting year they wish to maintain their PQRI qualification, as well as update their electronic measure specifications and data transmission schema should either or both change. This proposed requirement ensures that all PQRI qualified EHR products can be used by EPs to report any PQRI EHR measure. We invite comments on the proposed qualification requirements for EHR Vendors and their products for the 2012 PQRI.

e. Proposed Criteria for Satisfactory Reporting of Individual Quality Measures for Individual EPs

Section 1848(m)(3)(A) of the Act established the criteria for satisfactorily submitting data on individual quality measures as at least 3 measures in at least 80 percent of the cases in which the measure is applicable. If fewer than 3 measures are applicable to the services of the professional, the professional may meet the criteria by submitting data on 1 or 2 measures for at least 80 percent of applicable cases where the measures are reportable. This section establishes the presumption that if an EP submits quality data codes for a particular measure the measure applies to the EP.

For years after 2009, section 1848(m)(3)(D) of the Act provides additional authority to the Secretary, in consultation with stakeholders and experts, to revise the criteria for satisfactorily reporting data on quality measures. Based on this authority and the input we have previously received from stakeholders, we propose, for 2011, the following 2 criteria for claims-based reporting of individual measures by individual EPs:

- Report on at least 3 measures that apply to the services furnished by the professional; and
- Report each measure for at least 50 percent of the EP's Medicare Part B FFS patients for whom services were furnished during the reporting period to which the measure applies.

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

- Report on all measures that apply to the services furnished by the professional (that is 1 to 2 measures); and
- Report each measure for at least 50 percent of the EP's Medicare Part B FFS patients for whom services were furnished during the reporting period to which the measure applies.

We also propose for 2011 the requirement that an EP who reports on fewer than 3 measures through the claims-based reporting mechanism may be subject to the Measure Applicability Validation (MAV) process, which would allow us to determine whether an EP should have reported quality data codes for additional measures. This process was applied in prior years. Under the proposed MAV process, when an EP reports on fewer than 3 measures, we propose to review whether there are other closely related measures (such as those that share a common diagnosis or those that are representative of services typically provided by a particular type of EP). We further propose that if an EP who reports on fewer than 3 measures in 2011 reports on a measure that is part of an identified cluster of closely related measures and did not report on any other measure that is part of that identified cluster of closely related measures, then the EP would not qualify as a satisfactory reporter in 2011 PQRI or earn an incentive payment. In 2011, we propose that these criteria for satisfactorily reporting data on fewer than 3 individual quality measures would apply for the claims-based reporting mechanism only.

We note that the proposed 2011 criteria for satisfactory reporting of individual quality measures through claims submission are different from the 2010 criteria, which required reporting on at least 80 percent of the EP's Medicare Part B FFS patients for whom services were furnished during the reporting period to which the measure applies.

The rationale for an 80 percent reporting rate is that this sample size would prevent selective reporting to achieve higher performance rates. However, we now have experience with claims based reporting, which has proved challenging for EPs, as discussed above. In 2007, approximately half of PQRI participants (defined as submitting at least one QDC), qualified for the PQRI incentive payment. Following the 2007 program completion, we performed an extensive review and made a number of analytic changes that we detailed in our 2007 PQRI Experience Report. For 2008, the analytic changes that we made following the completion of the 2007 program resulted in substantial increases in valid QDC reporting and the number of professionals qualifying for an incentive payment. However, the number who qualified for the incentive for the 2008 program year remained at about half of those who participated. A major reason for this was reporting at less than the required 80 percent reporting requirement. As a result of our review of the 2007 and 2008 program results, we believe that we can reduce the reporting sample requirement to 50 percent for claims-based submission without increasing the likelihood that professionals will selectively report based on whether the performance expectation of a measure is met for that particular patient. Inasmuch as we do not allow resubmission of a claim solely for the purpose of resubmission of a QDC, EPs will still need to submit QDCs contemporaneously with the claim. Therefore, we believe that even at a 50 percent reporting it would be difficult to selectively report for the purpose of better performance. Based on our review, we further believe that by reducing the reporting sample, there will be substantial increases in the portion of participating professionals who qualify for the PQRI incentive. Thus, we believe we can encourage significantly broader participation which otherwise might be deterred if physicians and other EPs do not believe that they are likely to qualify for the incentive.

As previously stated, we propose that the 50 percent reporting sample would apply only to the 2011 PQRI claims-based reporting mechanism available for reporting individual PQRI quality measures and not registry-based reporting or EHR-based reporting.

For the 2011 PQRI, we propose the following 2 criteria for satisfactory reporting of data on individual PQRI quality measures for registry-based and EHR-based reporting:

- Report on at least 3 measures that apply to the services furnished by the professional; and

• Report each measure for at least 80 percent of the EP's Medicare Part B FFS patients for whom services were furnished during the reporting period to which the measure applies.

We do not believe that reducing the reporting sample to 50 percent for registry-based reporting or EHR-based reporting would substantially impact the portion of participating professionals who qualify for the PQRI incentive. As stated previously, over 90.0 percent of EPs submitting data through registries were incentive eligible.

The proposed 2011 criteria for satisfactory reporting of data on individual PQRI quality measures are summarized in Table 47 and are arranged by reporting mechanism and reporting period. We seek public comment on these proposed reporting criteria. We are particularly interested in receiving comments on our proposal to lower the reporting criteria for claims-based reporting of individual measures from 80 percent to 50 percent. We seek input on whether 50 percent is an appropriate threshold or if another threshold would be more appropriate. We had considered lowering the reporting criteria to a higher threshold (such as 60 percent or 75 percent) but we found that differences in the performance rates at 50 percent and 80 percent reporting were not substantial while differences in the proportion of EPs satisfactorily reporting at the two different thresholds were substantial.

TABLE 47—PROPOSED 2011 CRITERIA FOR SATISFACTORY REPORTING OF DATA ON INDIVIDUAL PQRI QUALITY MEASURES, BY REPORTING MECHANISM AND REPORTING PERIOD

Reporting mechanism	Reporting criteria	Reporting period
Claims-based reporting	• Report at least 3 PQRI measures, or 1–2 measures if less than 3 measures apply to the EP; and • Report each measure for at least 50% of the EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies.	January 1, 2011–December 31, 2011.
Claims-based reporting	• Report at least 3 PQRI measures, or 1–2 measures if less than 3 measures apply to the EP; and • Report each measure for at least 50% of the EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies.	July 1, 2011–December 31, 2011.
Registry-based reporting	• Report at least 3 PQRI measures; and • Report each measure for at least 80% of the EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies.	January 1, 2011–December 31, 2011.
Registry-based reporting	• Report at least 3 PQRI measures; and • Report each measure for at least 80% of the EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies.	July 1, 2011–December 31, 2011.
EHR-based reporting	• Report at least 3 PQRI measures; and • Report each measure for at least 80% of the EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies.	January 1, 2011–December 31, 2011.

Table 47 illustrates that there are a total of 5 proposed reporting options for 2011, or ways in which an EP may meet the criteria for satisfactorily reporting on individual quality measures for the 2011 PQRI. Each proposed reporting option consists of the criteria for satisfactorily reporting such data and results on individual quality measures relevant to a given reporting mechanism and reporting period. EPs may potentially qualify for an incentive as satisfactorily reporting individual quality measures under more than one of the proposed reporting criteria, proposed reporting mechanism, and or for more than one proposed reporting period; however, only one incentive payment will be made to an EP based on the longest reporting period for which the EP satisfactorily reports.

f. Proposed Criteria for Satisfactory Reporting Measures Groups for Individual EPs

We also propose that individual EPs have the option to report measures groups instead of individual quality measures to qualify for the 2011 PQRI incentive, using claims or registries. As stated previously, we do not propose to make the EHR-based reporting mechanism available for reporting on measures groups in 2011. The criteria that we propose for 2011 for satisfactory reporting of measures groups through claims-based or registry-based reporting for either the 12-month or 6-month reporting period are as follows: (1) For claims-based reporting, the reporting of at least 1 measures group for at least 50 percent of patients to whom the measures group applies, during the reporting period; or (2) for registry-based reporting, the reporting of at least 1 measures group for at least 80 percent of patients to whom the measures group applies during the reporting period. EPs, for both claims-based and registry-based reporting under these criteria, would be required to submit data on a minimum of 15 unique Medicare Part B FFS patients for the 12-month reporting period and a minimum of 8 Medicare Part B FFS patients for the 6-month reporting period. We note that the proposed criteria for 2011 are the same criteria as for 2010 PQRI reporting on measures groups, with the exception of our reducing the reporting sample from 80 percent to 50 percent for claims-based submission of measures groups. We propose to reduce the reporting sample requirement for claims-based submission of measures groups for the same reasons discussed in section VI.F.1.e. of this proposed rule for claims-based submission of individual measures. In other words, we believe that reducing the reporting sample from 80 percent to 50 percent will substantially increase the portion of participating EPs who qualify for a 2011 PQRI incentive without encouraging EPs to selectively report only those cases that will increase their performance rates. Additionally for 2011, we propose to retain the criteria, available only for the 12-month reporting period, based on reporting on at least 1 measures group for at least 30 patients for whom

services were furnished between January 1, 2011, and December 31, 2011, to whom the measures group applies. We also propose that the 30 patients on which an EP would need to report a measures group for 2011 would not need to be consecutive patients. We propose that the EP may report on any 30 unique patients seen during the reporting period to which the measures group applies. As in previous years, we propose that for 2011, the patients, for claims-based reporting, would be limited to Medicare Part B FFS patients.

Finally, for registry-based reporting in 2011, in contrast to prior program years, we propose to require that the minimum patient numbers or percentages must be met by Medicare Part B FFS patients exclusively and not non-Medicare Part B FFS patients. The reason for this is the difficulty of analyzing data we receive from registries, where patients other than Medicare Part B FFS patients are included. For example, under our proposal we would be able to compare claims data with registry submitted data to compare patients in the denominator of the measure for validation. The proposed 2011 criteria for satisfactory reporting of data on measures groups are summarized in Table 48 and are arranged by reporting mechanism and reporting period.

TABLE 48—PROPOSED 2011 CRITERIA FOR SATISFACTORY REPORTING ON MEASURES GROUPS, BY REPORTING MECHANISM AND REPORTING PERIOD

Reporting mechanism	Reporting criteria	Reporting period
Claims-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 30 Medicare Part B FFS patients.	January 1, 2011–December 31, 2011.
Claims-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 50% of the EP's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	January 1, 2011–December 31, 2011.
Claims-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 50% of the EP's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 8 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	January 1, 2011–December 31, 2011.
Registry-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 30 Medicare Part B FFS patients.	January 1, 2011–December 31, 2011.
Registry-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 80% of the EP's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	January 1, 2011–December 31, 2011.
Registry-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 80% of the EP's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 8 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	January 1, 2011–December 31, 2011.

As illustrated in Table 48, there are a total of 6 proposed reporting options, or ways in which EPs may meet the criteria for satisfactory reporting of measures groups for the 2011 PQRI. Each proposed reporting option consists of the criteria for satisfactory reporting relevant to a given reporting mechanism and reporting period. As stated previously, EPs may potentially qualify as satisfactorily reporting for 2011 PQRI on measures groups under more than one of the reporting criteria, reporting mechanisms, and/or for more than one reporting period; however, only one incentive payment will be made to an EP based on the longest reporting period for which the EP satisfactorily reports. Similarly, an EP could also potentially qualify for the PQRI incentive payment by satisfactorily reporting both individual measures and measures groups. However, only one incentive payment will be made to the EP based on the longest reporting period for which the EP satisfactorily reports. We invite comments on the proposed criteria for satisfactory reporting measures groups for individual EPs.

g. Proposed Reporting Option for Satisfactory Reporting on Quality Measures by Group Practices

(1) Background and Authority

Section 1848(m)(3)(C)(i) of the Act requires the Secretary to establish and have in place a process by January 1, 2010 under which EPs in a group practice (as defined by the Secretary) shall be treated as satisfactorily submitting data on quality measures

under PQRI if, in lieu of reporting measures under PQRI, the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time specified by the Secretary. Section 1848(m)(3)(C)(ii) of the Act requires that this process provide for the use of a statistical sampling model to submit data on measures, such as the model used under the Medicare Physician Group Practice (PGP) demonstration project under section 1866A of the Act. A group practice reporting option (GPRO) was established for the 2010 PQRI in the CY 2010 PFS final rule with comment period (74 FR 61807 through 61811).

In addition, payments to a group practice under section 1848(m) of the Act by reason of the process proposed herein shall be in lieu of the PQRI incentive payments that would otherwise be made to EPs in the group practice for satisfactorily submitting data on quality measures (that is, prohibits double payments). Therefore, for the 2011 PQRI, we propose to continue to allow a group practice, as a whole (that is, for the TIN(s)), to participate in 2011 PQRI and to submit PQRI quality measures for 2011 and qualify to earn an incentive. If, however, an individual EP is affiliated with a group practice participating in the GPRO and the group practice satisfactorily reports under the GPRO, the EP will be considered as satisfactorily reporting PQRI quality measures data at the individual level under that same TIN(s) (that is, for the same TIN/NPI combination).

(2) Definition of "Group Practice"

As stated above, section 1848(m)(3)(C)(i) of the Act authorizes the Secretary to define "group practice." For purposes of determining whether a group practice satisfactorily submits PQRI quality measures data, we propose that for the 2011 PQRI a "group practice" would consist of a physician group practice, as defined by a TIN, with 2 or more individual EPs (or, as identified by NPIs) who have reassigned their billing rights to the TIN. This proposed definition for group practice is different from the 2010 PQRI definition of group practice in that we propose to change the minimum group size from 200 to 2 to enable more group practices to participate in the PQRI GPRO in 2011.

Generally, our intent continues to be to build on an existing quality reporting program that group practices may already be familiar with by modeling some aspects of the the PQRI GPRO after the PGP demonstration while concurrently expanding the availability of the GPRO to more group practices. Since the PGP demonstration is a demonstration program for large group practices, one of the requirements for group practices participating in the PGP demonstration is for each practice to have 200 or more members. To be consistent with the PGP demonstration, we propose one GPRO process, which we refer to as "GPRO I" that would be available only to similar large group practices. For group practices that have fewer than 200 members, we propose, if technically feasible, an alternative GPRO process which we refer to as "GPRO II". We invite comments on the proposed definition of "group practice" and our proposal to expand the definition of group practice to include groups with 2 or more members.

In order to participate in the 2011 PQRI through the GPRO, we propose to require group practices to complete a self-nomination process and to meet certain technical and other requirements. The proposed self-nomination process and participation requirements for GPRO I and GPRO II are separately discussed below.

As discussed further in section VI.F.2. of this proposed rule, participation in the Electronic Prescribing (eRx) Incentive Program is voluntary for group practices selected to participate in the PQRI group practice reporting option. However, for 2011, we propose that group practices must participate in the PQRI group practice reporting option in order to be eligible to participate in the eRx group practice reporting option for 2011 PQRI. This is the current requirement under the 2010 PQRI and ERx Incentive programs. Therefore, we propose that a group practice that wishes to participate in both the PQRI group practice reporting option and the electronic prescribing group practice reporting option must notify CMS of its desire to do so at the time that it self-nominates to participate in the PQRI group practice reporting option.

In addition, we propose that group practices that are participating in Medicare demonstration projects, as approved by the Secretary, would also be considered group practices for purposes of the 2011 PQRI GPRO. Specifically, for the 2011 PQRI we propose to deem group practices participating in the PGP, Medicare Care Management Performance (MCMP), and EHR demonstrations to be participating in the PQRI GPRO since many of the measures being reported under these demonstration programs are similar to PQRI measures. As a result, such practices do not need to separately self-nominate to participate in the PQRI GPRO, although it would be necessary for such groups to meet the requirements for incentive qualification under their respective approved demonstration project. For example, the MCMP demonstration sites would be required to meet the requirements for earning a PQRI incentive specified under the MCMP demonstration.

For purposes of the 2011 eRx Incentive Program, however, we propose that group practices participating in CMS-approved demonstration projects discussed above would be required to meet the proposed 2011 eRx Incentive Program GPRO requirements or the proposed 2011 eRx Incentive Program requirements for individual EPs in order to qualify for a 2011 eRx incentive. Such group practices would not be able to qualify for a 2011 eRx incentive via participation in an approved demonstration project since there is no eRx requirement under these demonstrations.

(3) Proposed Process for Physician Group Practices To Participate as Group Practices and Criteria for Satisfactory Reporting

(i) Group Practice Reporting Option for Physician Group Practices With 200 or More NPIs–GPRO I

As stated above, we propose that group practices interested in participating in GPRO I must self-nominate to do so. Specifically, we propose that the 2011 PQRI self-nomination letter for group practices interested in participating in the 2011 PQRI through the GPRO I must be accompanied by an electronic file submitted in a format specified by CMS (such as, a Microsoft Excel file) that includes the group practice's TIN(s) and name of the group practice, the name and e-mail address of a single point of contact for handling administrative issues, as well as the name and e-mail address of a single point of contact for technical support purposes. This information was also required as part of the self-nomination process for the 2010 PQRI GPRO.

One change that we propose from the 2010 PQRI GPRO is that we propose for 2011 PQRI GPRO I to validate that the group practice consists of a minimum of 200 NPIs and we will supply group practices with this list. We invite comment on this proposed change for self nomination criteria. In addition, we propose that the self-nomination letter must also indicate the group practice's compliance with the following requirements:

- Have an active IACS user account;

- Agree to attend and participate in all mandatory GPRO training sessions; and
- Have billed Medicare Part B on or after January 1, 2010 and prior to October 29, 2010.

We propose to post the final 2011 PQRI participation requirements for group practices, including instructions for submitting the self-nomination letter and other requested information, on the PQRI section of the CMS Web site at *http://www.cms.gov/PQRI* by November 15, 2010. Group practices that wish to self-nominate for 2011 would be required to do so by January 31, 2011. Upon receipt of the self-nomination letters we propose to assess whether the participation requirements were met by each self-nominated group practice using 2010 Medicare claims data. We do not propose to preclude a group practice from participating in the GPRO I if we discover, from analysis of the 2010 Medicare claims data, that there are some EPs (identified by NPIs) that are not established Medicare providers (that is, have not billed Medicare Part B on or after January 1, 2010 and prior to October 29, 2010) as long as the group has at least 200 established Medicare providers. NPIs who are not established Medicare providers, however, would not be included in our incentive payment calculations. We propose that group practices that were selected to participate in the 2010 PQRI GPRO would automatically be qualified to participate in the 2011 PQRI GPRO I and would not need to complete the 2011 PQRI GPRO I self-nomination process.

For physician groups selected to participate in the PQRI GPRO I for 2011, we propose to retain the existing 12-month reporting period beginning January 1, 2011. We propose that group practices participating in GPRO I submit information on these measures using a data collection tool based on the GPRO Tool used in 2010 PQRI GPRO by 36 participating group practices to report quality measures under PQRI. The 2010 PQRI GPRO Tool will be updated as needed to include the 2011 PQRI GPRO I measures. We believe that use of the GPRO data collection tool allows group practices the opportunity to calculate their own performance rates for reporting quality measures. We propose that physician groups selected to participate in the 2011 PQRI through the GPRO I report on a proposed common set of 26 NQF-endorsed quality measures that are based on measures currently used for 2010 PQRI GPRO. We believe these measures target high-cost chronic conditions and preventive care. The proposed quality measures are identified in Table 71.

The proposed 2011 PQRI GPRO I quality measures are based on a subset of the Doctor's Office Quality (DOQ) quality measures set developed under the direction of CMS and were used in the PGP and/or MCMP demonstration programs, and have subsequently been used in 2010 PQRI GPRO. Contributors to the development of the DOQ measures set included the American Medical Association's Physician Consortium for Performances Improvement (AMA–PCPI), the American College of Cardiology (ACC), the American Heart Association (AHA), the National Diabetes Quality Improvement Alliance, the National Committee for Quality Assurance (NCQA), and the Veterans Health Administration (VA). In most instances, these measures overlap with the proposed 2011 PQRI measures for reporting by individual EPs, however, there are some measures proposed for GPRO I that are not proposed for individual EPs.

These quality measures are grouped into four disease modules: coronary artery disease; diabetes; heart failure; and preventive care services. On February 2, 2010, we hosted a 2011 PQRI listening session to solicit input on a number of aspects of the PQRI, including measures for the 2011 PQRI GPRO. Since we received no suggestions for additional disease modules for the GPRO I from this listening session, we are not proposing any additional measures for the 2011 PQRI GPRO I. We invite comments on our proposal to use the 26 measures identified in Table 71 for inclusion in 2011 PQRI GPRO I. We specifically request comments on whether these measures can and/or should be expanded for the group practice reporting option for future program years. Disease modules and measures should address high cost conditions and/or a gap in care. Further detail on criteria for measure selection can be found in section VI.F.1.h. below.

The proposed process that group practices will be required to use to report data on quality measures for the 2011 PQRI GPRO I and the proposed associated criteria for satisfactory reporting of data on quality measures by group practices, are summarized in Table 49. Under our proposed 2011 program, group practices participating in PQRI GPRO I as a group practice would be required to report on all of the measures listed in Table 71.

As part of the data submission process for 2011 GPRO I, we propose that during 2012, each group practice would be required to report quality measures with respect to services furnished during the 2011 reporting period (that is, January 1, 2011, through December 31, 2011) on an assigned sample of Medicare beneficiaries. We propose to analyze the January 1, 2011 through October 31, 2011 (that is, the last business day of October 2011) National Claims History (NCH) file to assign Medicare beneficiaries to each physician group practice using a patient assignment methodology modeled after the patient assignment methodology used in the PGP demonstration. Based on our desire to model the PQRI GPRO I after the PGP demonstration, we will also consider applying any refinements made to the patient assignment methodology used in the PGP demonstration prior to January 1, 2011 to the 2011 PQRI GPRO I. Assigned beneficiaries would be limited to those Medicare FFS beneficiaries with Medicare Parts A and B for whom Medicare is the primary payer. Assigned beneficiaries would not include Medicare Advantage enrollees. A beneficiary would be assigned to the physician group that provides the plurality of a beneficiary's office or other outpatient evaluation and management allowed charges (based on Medicare Part B claims submitted for the beneficiary for dates of services between January 1, 2011, and October 31, 2011). Beneficiaries with only 1 visit to the group practice between January 1, 2011 and October 31, 2011, would be eliminated from the group practice's assigned patient sample for purposes of 2011 PQRI GPRO I. For inclusion in the sample, assigned beneficiaries would be required to have at least 2 visits to the group practice between January 1, 2011, and October 31, 2011.

Once the beneficiary assignment has been made for each physician group during the fourth quarter of 2011, we propose to provide each physician group selected to participate in the PQRI GPRO I with access to a database (that is, a data collection tool) that will include the group's assigned beneficiary samples and the quality measures listed in Table 71. We propose to pre-populate the data collection tool with the assigned beneficiaries' demographic and utilization information based on all of their Medicare claims data. We intend to provide the selected physician groups with access to this pre-populated database by no later than the first quarter of 2012. The physician group would be required to populate the remaining data fields necessary for capturing quality measure information on each of the assigned beneficiaries. Numerators for each of the quality measures would include all

beneficiaries in the denominator population who also satisfy the quality performance criteria for that measure. Denominators for each quality measure would include a sample of the assigned beneficiaries who meet the eligibility criteria for that disease module or each preventive care quality measure. All of the assigned patients' inpatient, outpatient, and physician claims would be used in determining clinical eligibility for each module, regardless if they were submitted by the group practice or other providers. Identical to the sampling method used in the PGP demonstration, we propose that the random sample must consist of at least 411 assigned beneficiaries. If the pool of eligible assigned beneficiaries is less than 411, then the group practice must report on 100 percent, or all, of the assigned beneficiaries to satisfactorily participate in the group practice reporting option. For each disease module or preventive care measure, the physician group would be required to report information on the assigned patients in the order in which they appear in the group's sample (that is, consecutively). These proposed reporting criteria are identical to the reporting criteria used in the PGP demonstration and in the 2010 PQRI GPRO. By building on an existing demonstration program that large group practices may already have experience with, we hope to minimize burden on both group practices and CMS.

TABLE 49—2011 PROPOSED PROCESS FOR PHYSICIAN GROUP PRACTICES TO PARTICIPATE AS GROUP PRACTICES AND CRITERIA FOR SATISFACTORY REPORTING OF DATA ON QUALITY MEASURES BY GROUP PRACTICES FOR GPRO I

Reporting mechanism	Reporting criteria	Reporting period
A pre-populated data collection tool provided by CMS.	• Report on all measures included in the data collection tool (26 measures); and • Complete the tool for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each disease module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100% of assigned beneficiaries.	January 1, 2011–December 31, 2011.

For 2011, we propose an exclusive reporting mechanism for EPs identified as part of the group practice with respect to the group as identified by the TIN. However, EPs who are part of the group practice, and who separately practice with respect to another TIN to which the EP has reassigned benefits, could separately qualify as individual EPs with respect to the other practice (TIN). As discussed above, we propose that each physician group selected to participate in the PQRI GPRO I would have access to a data base (that is a data collection tool) that would include the assigned beneficiary sample and the quality measures. This data collection tool was originally developed for use in the PGP demonstration, updated for use in the MCMP demonstration, and will continue to be updated as needed for use in the PQRI. The assigned beneficiaries' demographic and utilization information is pre-populated based on claims data. We anticipate being able to provide the selected physician groups with access to this pre-populated database by the first quarter of 2012. The physician group would be required to populate the remaining data fields necessary for capturing quality measure information on each of the assigned beneficiaries. Numerators for each of the quality measures would include all beneficiaries in the denominator population who also satisfy the quality performance criteria for that measure. Denominators for each quality measure would include a sample of the assigned beneficiaries who meet the eligibility criteria for that quality measure module or preventive care measure.

We expect that use of the PQRI GPRO I data collection tool allows group practices the opportunity to calculate their own performance rates for reporting quality measures. This provides group practices with the chance to preview their information prior to the public posting of performance data should we choose to do so in future program years.

We invite comment on our proposal for 2011 to retain 200 as the number of NPIs for a TIN required for each group practice under the GPRO I. We also invite comment on our proposal to allow those "qualified" for 2010 GPRO to be rolled over for automatic qualification for 2011 GPRO I.

(ii) Group Practice Reporting Option for Group Practices of 2—199 NPIs—GPRO–II

As discussed previously, section 1848(m)(3)(C) of the Act authorizes us to define the term "group practice" and requires us to establish a process under which EPs in group practices shall be treated as satisfactorily submitting data on PQRI quality measures, but is not prescriptive with regard to the characteristics of this process. Although for 2010 we did not provide a process for groups of less than 200 NPIs to report under the GPRO, we believe that there are significant potential benefits to allowing reporting at the group level generally. At present, for example, where more than one individual professional sees the same patient, each may have to report separately with respect to the patient even for processes of care that do not need to be repeated at each visit. Thus, there is significant duplication of reporting. Additionally, while we are not proposing to report performance information with respect to the 2011 PQRI GPRO, the public reporting of performance information at the group level raises substantially fewer issues, such as privacy, and the potential adverse impact of public reporting on the individual physician, and the lack of sufficient numbers of patients for any one physician to meaningfully differentiate performance results. Finally, we believe that many process-of-care measures depend on general functioning of the practice, such as in coordinating and tracking care, as opposed to a quality of a particular professional in the group, particularly for measures related to prevention and care of chronic illnesses.

As a result, based on our authority under section 1848(m)(3)(C) of the Act to establish a process for group practices and our discretion to define "group practice" under this section we are proposing multiple processes for reporting at the group level for groups of EPs of all sizes for purposes of qualifying for a PQRI incentive payment. The proposed process for groups of 200 or more EPs, known as GPRO I, was discussed above. If technically feasible, we propose a new group practice reporting option (GPRO

II) for groups of 2–199 NPIs in a TIN for 2011. For GPRO II in 2011, we propose to require groups of EPs who decide to report as a group to self-nominate. The self-nomination process would consist of sending a letter with the name of the group, the TIN, an e-mail address of the contact person, and the names and NPIs of all of the EPs practicing under that group's TIN. We do not propose to preclude a group practice from participating in the GPRO II if we discover, from analysis of the 2010 Medicare claims data, that there are some EPs (identified by NPIs) that are not established Medicare providers (that is, have not billed Medicare Part B on or after January 1, 2010 and prior to October 29, 2010) as long as the group has at least 2 established Medicare providers. NPIs who are not established Medicare providers, however, would not be included in our incentive payment calculations.

We also propose that self-nominating groups would need to indicate in this letter if the group intends to report as a group for the eRx Incentive Program and the reporting mechanism the group intends to use to report as a group for the eRx Incentive Program. We would require that this information be sent to: GPRO II, c/o CMS, 7500 Security Blvd., Mail Stop S3–02–01, Baltimore, MD 21244, and must be postmarked by January 31, 2011, for consideration in the program.

Since GPRO II would be a new process available to groups in 2011, we propose to initially pilot the GPRO II process with a limited number of groups. We propose to select the first 500 groups that meet the proposed eligibility requirements to participate in the 2011 GPRO II. We propose to use the postmark to determine the order in which groups self-nominated for GPRO II. We propose to consider only self-nomination letters postmarked between January 3, 2011 and January 31, 2011. We do not propose to consider letters postmarked prior to January 3, 2011 to prevent groups from self-nominating before the GPRO II requirements are finalized and to discourage groups from self-nominating for GPRO II prior to reviewing the final GPRO II requirements.

For purposes of quality data submission, we propose, for the GPRO II, to allow EPs to submit their data through claims or through a qualified GPRO registry to the extent registries are technically capable of collecting, calculating and transmitting the required data to CMS and that we are able to accept such data from registries.

For GPRO II, as discussed in greater detail below, we propose that in addition to reporting a specific number of individual measures, the group would have to report one or more proposed 2011 PQRI measures groups identified in Tables 57 through 70 of this proposed rule depending on the size of the group practice. In this way we seek to address a concern expressed regarding PQRI for individual reporting that EPs are able to select any three of a large array of measures making comparison data difficult whether for the same individual or among professionals. We believe that by having a smaller set of measures to choose from, we hope to focus on topics of major significance, and make the information obtained with respect to quality more meaningful.

For purposes of satisfying the requirements under section 1848(m)(3)(C)(i) of the Act for groups of 2–199 NPIs, we propose that in order to be treated as satisfactorily reporting under GPRO II, the group practice would be required to report on 50 percent or more (if submitting through claims) of all Medicare Part B patients who fit into the measures group denominator or 80 percent or more of Medicare patients if using a registry to report.

Additionally, to earn a PQRI incentive payment for all allowed Medicare Part B services that are provided by the TIN, we propose that a group practice must report on three to six individual 2011 PQRI measures, depending on the size of the group. We propose that the group practice may select from among any of the 2011 PQRI measures on which to submit data, provided the measures selected are not duplicated in the measures group(s) reported.

We propose that, to satisfactorily report individual PQRI measures, a group must report each measure at the same rate (percentage) as determined by the method of submission as individual EPs. For example, if reporting via claims, to satisfactorily report individual measures, each measure would need to be reported on at least 50 percent of eligible Medicare Part B FFS patients.

An alternative which we considered was to require that the individual measures be selected from a more limited set of measures, such as measures closely linked to improved population health, or other measures perceived to address the greatest potential benefit from improved performance. While there are potential benefits to this approach of encouraging broad reporting of a more limited set of measures, we are concerned that any limited measures set may not be applicable to all groups, such as single specialty groups. Further we are concerned that this would diminish an important strength of the overall PQRI measures set, which is its broad applicability. We invite comments on the potential benefits of a core measures set, as opposed to allowing groups to select from among the array of PQRI measures, what measures should be included in that set, whether there are any PQRI measures that all professionals in group practices should report, where the measure applies to patients of the group.

A second alternative that we considered was to require group practices, as part of the self-nomination process, to designate whether they were a multispecialty group with primary care, a multispecialty group without primary care, or a single specialty group, and if so, the specialty. Depending on what type of specialty the group is, we would identify a set of PQRI measures pertaining to the group's specialty and require the group practice to report on the identified set of specialty-specific PQRI measures. We invite comments on the potential benefits of this approach as opposed to allowing groups to select from among the array of PQRI measures or requiring all groups, regardless of specialty, to report on the same core set of measures.

Table 50 sets forth the proposed criteria for satisfactory reporting under the 2011 PQRI GPRO II and requirements for each group based on their respective group size (number of EPs).

If a group does not satisfactorily report as a GPRO II group, we propose to analyze the individual professional's data to see if they satisfactorily reported at the individual TIN/NPI level. If the EP satisfactorily reported at the individual level, he or she would receive a PQRI incentive, which is calculated using the EP's TIN/NPI Medicare Part B allowed charges.

If a group practice participating in the 2011 PQRI GPRO II wants to also participate in the 2011 eRx Incentive Program as a small group, we propose that the group would need to indicate that preference in their self-nomination letter and would need to report on the number of unique encounters based on their group size as listed in Table 50 below. For the 2011 eRx reporting for GPRO II, we propose the following reporting mechanisms: claims, a GPRO eRx qualified registry or a GPRO qualified EHR. As with the 2011 eRx Incentive Program for individual EPs and the 2011 eRx GPRO I, at least 10 percent of a GPRO II group's charges would need to be comprised of codes in the denominator of the electronic

prescribing measure and the group would need to use an electronic prescribing system that meets the requirements of the 2011 eRx measure. Similar to proposed GPRO I, if a GPRO II group self-nominates to report the eRx measure as a group, we propose that all members of the group practicing under the group's TIN would be ineligible to report as an individual electronic prescriber.

TABLE 50—2011 PROPOSED PROCESS FOR PHYSICIAN GROUP PRACTICES TO PARTICIPATE AS GROUP PRACTICES AND CRITERIA FOR SATISFACTORY REPORTING OF DATA ON QUALITY MEASURES BY GROUP PRACTICES FOR GPRO II

Group size (number of EPs)	Number of MGs required to be reported	Percent of Medicare Pt B patients in denominator for successful reporting via claims	Percent of Medicare Pt B patients in denominator for successful reporting via registries	Minimum number of patients in each measures group	Number of required individual measures to report	Required number of unique visits where an e-prescription was generated to be a successful electronic prescriber
2–10	1	50%	80%	35	3	75
11–25	1	50%	80%	50	3	225
26–50	2	50%	80%	50	4	475
51–100	3	50%	80%	60	5	925
101–199	4	50%	80%	100	6	1875

The required number of unique visits where an electronic prescription was generated to be a successful electronic prescriber was determined by taking the midpoint of the group size range and multiplying the number by 12.5 and then rounding this number to the nearest multiple of 5. This is consistent with how the 2010 eRx GPRO requirements, which requires that the group practice report that at least 1 prescription during an encounter was generated and transmitted using a qualified electronic prescribing system in at least 2,500 instances during the reporting period, were derived. For the 2010 eRx Incentive Program, we assumed that half the members of an average sized-group (which we assumed to be 200 EPs) do not furnish the services represented by the electronic prescribing measure's denominator codes, and thus, would not have an opportunity to report the electronic prescribing measure. For the remaining EPs within the group who do have an opportunity to report the electronic prescribing measure, we sought to hold those EPs to the same standard as individual EPs. Thus, for an average 200 EP group, each of the 100 EPs with an opportunity to report the electronic prescribing measure would be expected to have 25 unique electronic prescribing events for a total of 2,500 unique electronic prescribing events for the group.

We propose posting the information required by section 1848(m)(5)(G) of the Act for those group practices that are selected to participate in the 2011 PQRI under the GPRO II. That is, we propose to post the names of group practices that satisfactorily report under GPRO II as we propose to do for group practices that satisfactorily report under the 2011 PQRI GPRO I.

We invite comment on our proposal to add this second option (GPRO II) for group practices to report PQRI quality data measures and the GPRO II process. We also invite comments regarding our proposal to publicly report GPRO II information with respect to satisfactory PQRI participation.

(iii) Alternatives Considered for Expanding the GPRO in 2011

In addition to the GPRO II, another option that we considered for expanding the GPRO for 2011 was to expand GPRO I to include smaller group practices. Specifically, we considered allowing groups of 100 or more EPs to participate in the PQRI under GPRO using the same reporting mechanism and reporting criteria required under the 2010 PQRI GPRO and proposed for the 2011 PQRI GPRO I. We also considered modifying the definition of "group practice" to include groups that have and use multiple TINs. We invite comments on these alternatives.

h. Statutory Requirements and Other Considerations for 2011 PQRI Measures

(1) Statutory Requirements for 2011 PQRI Measures

Under section 1848(k)(2)(C)(i) of the Act, the PQRI quality measures shall be such measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under subsection 1890(a) of the Act (that is, the National Quality Forum, or NQF). However, in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the NQF, section 1848(k)(2)(C)(ii) of the Act authorizes the Secretary to specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary, such as the AQA alliance. In light of these statutory requirements, we believe that, except in the circumstances specified in the statute, each proposed 2011 PQRI quality measure would need to be endorsed by the NQF. The NQF endorsement status of each of the proposed measures is identified for each measure. The basis for including certain measures that are not endorsed by NQF is discussed further below.

Additionally, section 1848(k)(2)(D) of the Act requires that for each 2011 PQRI quality measure, "the Secretary shall ensure that EPs have the opportunity to provide input during the development, endorsement, or selection of measures applicable to services they furnish." We believe that this requirement is met for all proposed measures in several ways. Measure developers generally include a public comment phase in their measure development process. As part of the measures development process, measures developers typically solicit public comments on measures that they are testing in order to determine whether additional refinement of the measure(s) is needed prior to submission for consensus endorsement. For example, information on the measure development process, employed by us when CMS or our contractor is the measure developer, is available in the "Measures Management System Blueprint" found on the CMS Web site at *http://www.cms.gov/apps/QMIS/mmsBlueprint.asp*. EPs also have the opportunity to provide input on a measure as the measure is being vetted

through the NQF consensus endorsement process. The NQF employs a public comment period for measures vetted through its consensus endorsement process (and previously, for the AQA consensus adoption process). Additionally, we have invited suggestions for measures during the last 3 years, including most recently via the Listening Session held at CMS on February 2, 2010. The goal of the Listening Session was to discuss and solicit feedback on suggestions received on individual quality measures and measures groups for possible inclusion in the proposed set of quality measures for use in the 2011 PQRI program. Finally, as in previous program years, EPs also have an opportunity to provide input on the measures proposed for inclusion in the 2011 PQRI through this proposed rule, which provides a 60-day comment period. Accordingly, with regard to the 2011 PQRI, we believe we have satisfied this requirement in multiple ways.

The statutory requirements under section 1848(k)(2)(C) of the Act, subject to the exception noted above, require only that the measures be selected from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a) (that is, the NQF) and are silent with respect to how the measures that are submitted to the NQF for endorsement were developed. The basic steps for developing measures applicable to physicians and other EPs prior to submission of the measures for endorsement may be carried out by a variety of different organizations. We do not believe there needs to be any special restrictions on the type or make up of the organizations carrying out this basic development of physician measures, such as restricting the initial development to physician-controlled organizations. Any such restriction would unduly limit the basic development of quality measures and the scope and utility of measures that may be considered for endorsement as voluntary consensus standards.

(2) Other Considerations for Measures Proposed for Inclusion in the 2011 PQRI

As stated previously, in addition to reviewing the 2010 PQRI measures for purposes of developing the proposed 2011 PQRI measures, we reviewed and considered measure suggestions including comments received in response to the CY 2010 PFS proposed rule and final rule with comment period. Additionally, suggestions and input received through other venues, such as an invitation for measures suggestions via the Listening Session held February 2, 2010, were also reviewed and considered for purposes of our development of the list of proposed 2011 PQRI quality measures. A summary of the measures suggestions received via the Listening Session is included in the background paper that was provided to Listening Session participants. The Listening Session background paper is posted on CMS Sponsored Calls page of the PQRI section of the CMS Web site at: *http://www.cms.gov/PQRI/04_CMSSponsoredCalls.asp#TopOfPage*.

With respect to the selection of new measures (that is, measures that have never been selected as part of a PQRI quality measure set for 2010 or any prior year), we propose to apply the following considerations, which include many of the same considerations applied to the selection of 2009 and 2010 PQRI quality measures for inclusion in the 2011 PQRI quality measure set described above:

- High Impact on Healthcare.

++ Measures that are high impact and support CMS and HHS priorities for improved quality and efficiency of care for Medicare beneficiaries. These current and long-term priority topics include the following: Prevention; chronic conditions; high cost and high volume conditions; elimination of health disparities; healthcare-associated infections and other conditions; improved care coordination; improved outcomes; improved efficiency; improved patient and family experience of care; improved end-of-life/palliative care; effective management of acute and chronic episodes of care; reduced unwarranted geographic variation in quality and efficiency; and adoption and use of interoperable HIT.

- Measures that are included in, or facilitate alignment with, other Medicare, Medicaid, and CHIP programs in furtherance of overarching healthcare goals.

- NQF Endorsement.

++ Measures must be NQF-endorsed by June 1, 2010, in order to be considered for inclusion in the 2011 PQRI quality measure set except as provided under section 1848(k)(2)(C)(ii) of the Act.

++ Section 1848(k)(2)(C)(ii) of the Act provides an exception to the requirement that the Secretary select measures that have been endorsed by the entity with a contract under section 1890(a) of the Act (that is, the NQF). As long as an area or medical topic for which a feasible and practical NQF-endorsed measure is not available has been identified and due consideration has been given to measures that have been adopted by the AQA or other consensus organization identified by Secretary. As discussed above, we anticipate not including measures which only have AQA adoption for future program years.

++ The statutory requirements under section 1848(k)(2)(C) of the Act, subject to the exception noted above, require only that the measures be selected from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a) (that is, the NQF) and are silent with respect to how the measures that are submitted to the NQF for endorsement are developed. The basic steps for developing measures applicable to physicians and other EPs prior to submission of the measures for endorsement may be carried out by a variety of different organizations. We do not believe there needs to be any special restrictions on the type or makeup of the organizations carrying out this basic development of physician measures, such as restricting the initial development to physician-controlled organizations. Any such restriction would unduly limit the basic development of quality measures and the scope and utility of measures that may be considered for endorsement as voluntary consensus standards. The requirements under section 1848(k)(2)(C) of the Act pertain only to the selection of measures and not to the development of measures.

- Address Gaps in PQRI Measure Set.

++ Measures that increase the scope of applicability of the PQRI measures to services furnished to Medicare beneficiaries and expand opportunities for EPs to participate in PQRI. We continue to seek the broad ability to assess the quality of care furnished to Medicare beneficiaries, and ultimately to compare performance among professionals. We seek to increase the circumstances where EPs have at least three measures applicable to their practice and measures that help expand the number of measures groups with at least four measures in a group.

- Measures of various aspects of clinical quality including outcome measures, where appropriate and feasible, process measures, structural measures, efficiency measures, and measures of patient experience of care.

Other considerations that we propose to apply to the selection of measures for 2011, regardless of whether the measure was a 2010 PQRI measure or not, were:

• Measures that are functional, which is to say measures that can be technically implemented within the capacity of the CMS infrastructure for data collection, analysis, and calculation of reporting and performance rates. This leads to preference for measures that reflect readiness for implementation, such as those that are currently in the 2010 PQRI program or have been through testing. The purpose of measure testing is to reveal the measure's strengths and weaknesses so that the limitations can be addressed and the measure refined and strengthened prior to implementation. For any new measures considered for 2011 PQRI, preference is given to those that can be most efficiently implemented for data collection and submission. Therefore, any measures that have previously been found to be technically impractical to report because they are analytically challenging due to any number of factors, including those that are claims-based, will again not been included for 2011 PQRI. For example, in some cases, we are proposing to replace existing 2010 PQRI measures with updated and improved measures that are less technically challenging to report. For example, we are proposing to replace existing 2010 PQRI measures #114 and #115 with updated and improved measure #TBD (Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention), which is less technically challenging to report.

• In 2011 PQRI, as in 2010 PQRI, for some measures that are useful, but where data submission is not feasible through all otherwise available PQRI reporting mechanisms, a measure may be included for reporting solely through specific reporting mechanism(s) in which its submission is feasible. For the 2011 PQRI, we propose to retain those measures that had previously been available for claims-based reporting and registry-based reporting, which were changed for 2010 PQRI to registry-based reporting only because they were technically challenging to report and/or analyze through the claims-based reporting mechanism.

We welcome comments on the implication of including or excluding any given measure or measures for our proposed 2011 PQRI quality measure set, as well as feedback relative to our proposed approach in selecting measures. We recognize that some commenters may also wish to recommend additional measures for inclusion in the 2011 PQRI measures that we are not proposing. While we welcome all constructive comments and suggestions, and may consider such recommended measures for inclusion in future measure sets for PQRI and/or other programs to which such measures may be relevant, we will not be able to consider such additional measures for inclusion in the final 2011 measure set.

As discussed above, section 1848(k)(2)(D) of the Act requires that the public have the opportunity to provide input during the selection of measures. We also are required by other applicable statutes to provide opportunity for public comment on provisions of policy or regulation that are established via notice and comment rulemaking. Measures that were not included in this proposed rule for inclusion in the 2011 PQRI that are recommended to CMS via comments on this proposed rule cannot be included in the 2011 measure set.

As discussed above, section 1848(k)(2)(D) of the Act requires that the public have the opportunity to provide input during the selection of measures. We also are required by other applicable statutes to provide opportunity for public comment on provisions of policy or regulation that are established via notice and comment rulemaking. Measures that were not included in this proposed rule for inclusion in the 2011 PQRI that are recommended to CMS via comments on this proposed rule have not been placed before the public to comment on the selection of those measures within the rulemaking process. Even when measures have been published in the **Federal Register**, but in other contexts and not specifically proposed as PQRI measures, such publication does not provide true opportunity for public comment on those measures' potential inclusion in PQRI. Thus, such additional measures recommended for selection for the 2011 PQRI via comments on this proposed rule cannot be included in the 2011 measure set. However, as discussed above, we will consider comments and recommendations for measures, which may not be applicable to the final set of 2011 PQRI measures, for purposes of identifying measures for possible use in future years' PQRI or other initiatives to which those measures may be pertinent.

In addition, as in prior years, we again note that we do not use notice and comment rulemaking as a means to update or modify measure specifications. Quality measures that have completed the consensus process have a designated party (usually, the measure developer/owner) who has accepted responsibility for maintaining the measure. In general, it is the role of the measure owner, developer, or maintainer to make changes to a measure. Therefore, comments requesting changes to a specific proposed PQRI measure's title, definition, and detailed specifications or coding should be directed to the measure developer identified in Tables 52 through 70. Contact information for the 2010 PQRI measure developers is listed in the "2010 PQRI Quality Measures List," which is available on the PQRI section of the CMS Web site at *http://www.cms.gov/PQRI*.

However, we stress that inclusion of measures that are not NQF endorsed or AQA adopted is an exception to the requirement under section 1848(k)(2)(C)(i) of the Act that measures be endorsed by the NQF. We may exercise this exception authority in a specified area or medical topic for which a feasible and practical measure has not been endorsed by NQF, so long as due consideration is given to measures that have been endorsed by the NQF.

i. Proposed 2011 PQRI Quality Measures for Individual EPs

As in 2010 PQRI, individual EPs have the choice of reporting PQRI quality measures data on either individual quality measures or on measures groups for 2011 PQRI.

Consistent with statutory requirements for identifying and including measures for 2011 PQRI, the individual quality measures identified for use in the 2011 PQRI will be selected from those we propose in this rule and will ultimately be finalized as of the date the CY 2011 PFS final rule with comment period is available for public inspection at the Office of the Federal Register. No changes (that is, additions or deletions of measures) will be made after publication of the CY 2011 PFS final rule with comment period. However, as was the case in previous program years, we may make modifications or refinements, such as revisions to measures titles and code additions, corrections, or revisions to the detailed specifications for the 2011 measures until the beginning of the reporting period. The 2011 measures specifications for individual quality measures will be available on the PQRI section of the CMS Web site at *http://www.cms.gov/PQRI* when they are sufficiently developed or finalized. We are targeting finalization and publication of the detailed specifications for all 2011 PQRI measures on the PQRI section of the CMS Web site by November 15, 2010 and will, in no event, publish these specifications later than December 31, 2010. The detailed specifications will include instructions for reporting and will identify the circumstances in which each measure is applicable. For 2011,

we are proposing that for the most part, final PQRI quality measures will be selected from the 2010 PQRI measures.

In response to the February 2, 2010 Listening Session, CMS received 146 individual measure suggestions and 9 measures groups suggestions, one of which included modifications to an existing measures group, for possible inclusion in the 2011 PQRI.

We propose to include a total of 198 measures (this includes both individual measures and measures that are part of a proposed 2011 measures group) on which individual EPs can report for the 2011 PQRI. The individual PQRI quality measures proposed for the 2011 PQRI are listed in Tables 52 through 56 and fall into four broad categories as set forth below. The four categories are the following:

- Proposed 2011 Individual Quality Measures Selected From the 2010 PQRI Quality Measures Set Available for Claims-Based Reporting and Registry-Based Reporting;
- Proposed 2011 Individual Quality Measures Selected From the 2010 PQRI Quality Measures Set Available for Registry-Based Reporting Only;
- New Individual Quality Measures Proposed for 2011; and
- Proposed 2011 Measures Available for EHR-Based Reporting.

In addition, we are also proposing the inclusion of 1 new measures group for 2011 PQRI. The measures proposed for 2011 measures groups are listed in Tables 57 through 70. Please note Table 51 includes 2010 PQRI measures that are not proposed for inclusion in 2011 PQRI.

TABLE 51—2010 PQRI QUALITY MEASURES NOT PROPOSED FOR INCLUSION IN THE 2011 PQRI

Measure No.	Measure title
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use.
115	Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit.
135	Chronic Kidney Disease (CKD): Influenza Immunization.
136	Melanoma: Follow-Up Aspects of Care.
139	Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement.

After careful consideration of 2010 PQRI measures, we propose to retire these 5 measures because they did not meet one or more of the considerations for selection of proposed 2011 measures discussed in section VI.F.1.h. above. Specifically, we are proposing to retire PQRI measures #135, #136, and #139, for 2011 because they have been considered by NQF for possible endorsement but ultimately were not NQF-endorsed. In addition we propose to replace existing 2010 PQRI measures #114 and #115 with an updated and improved measure (#TBD "Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention"), which is less technically challenging to report. We invite comments on our proposal to retire the 2010 measures listed in Table 51 for the 2011 PQRI.

(1) Proposed 2011 Individual Quality Measures Selected From the 2010 PQRI Quality Measures Set Available for Claims-Based Reporting and Registry-Based Reporting

For 2011, we propose to retain 170 measures currently used in the 2010 PQRI. These 170 proposed measures include 45 registry-only measures currently used in the 2010 PQRI, but do not include any measures that are proposed to be included as part of the 2011 Back Pain measures group (*see* section VI.F.1.i.(5) of this proposed rule). Similar to the 2010 PQRI, for 2011, we propose that any 2011 PQRI measures that are included in the Back Pain measures group would not be reportable as individual measures through claims-based reporting or registry-based reporting.

The 125 individual 2010 PQRI measures proposed for inclusion in the 2011 PQRI quality measure set as individual quality measures for either claims-based reporting or registry-based reporting are listed by their Measure Number and Title in Table 52, along with the name of the measure's developer/owner, and the NQF measure number, if applicable. The PQRI Measure Number is a unique identifier assigned by CMS to all measures in the PQRI measure set. Once a PQRI Measure Number is assigned to a measure, it will not be used again to identify a different measure, even if the original measure to which the number was assigned is subsequently retired from the PQRI measure set. A description of the measures listed in Table 52 can be found in the "2010 PQRI Quality Measures List," which is available on the Measures and Codes page of the PQRI section of the CMS Web site at *http://cms.gov/PQRI.*

The 2010 measures that are proposed to be available for registry-based reporting only for the 2011 PQRI are discussed and identified in section VI.F.1.i.(2) of this proposed rule.

TABLE 52—PROPOSED 2011 MEASURES SELECTED FROM THE 2010 PQRI QUALITY MEASURE SET AVAILABLE FOR EITHER CLAIMS-BASED REPORTING OR REGISTRY-BASED REPORTING

Measure No.	Measure title	Measure developer	NQF Measure No.
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus.	NCQA	0059.
2	Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control in Diabetes Mellitus.	NCQA	0064.
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus.	NCQA	0061.
6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD.	AMA–PCPI	0067.
9	Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD.	NCQA	0105.
10	Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports.	AMA–PCPI/NCQA	0246.

TABLE 52—PROPOSED 2011 MEASURES SELECTED FROM THE 2010 PQRI QUALITY MEASURE SET AVAILABLE FOR EITHER CLAIMS-BASED REPORTING OR REGISTRY-BASED REPORTING—Continued

Measure No.	Measure title	Measure developer	NQF Measure No.
12	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation.	AMA–PCPI/NCQA	0086.
14	Age-Related Macular Degeneration (AMD): Dilated Macular Examination.	AMA–PCPI/NCQA	0087.
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy.	AMA–PCPI/NCQA	0088.
19	Diabetic Retinopathy: Communication with the Physician Managing On-Going Diabetes Care.	AMA–PCPI/NCQA	0089.
20	Perioperative Care: Timing of Antibiotic Prophylaxis—Ordering Physician.	AMA–PCPI/NCQA	0270.
21	Perioperative Care: Selection of Prophylactic Antibiotic—First OR Second Generation Cephalosporin.	AMA–PCPI/NCQA	0268.
22	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures).	AMA–PCPI/NCQA	0271.
23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients).	AMA–PCPI/NCQA	0239.
24	Osteoporosis: Communication with the Physician Managing On-Going Care Post-Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older.	AMA–PCPI/NCQA	0045.
28	Aspirin at Arrival for Acute Myocardial Infarction (AMI)	AMA–PCPI/NCQA	0092.
30	Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics.	AMA–PCPI/NCQA	0270.
31	Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage.	AMA–PCPI/NCQA	0240
32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy.	AMA–PCPI/NCQA	0325.
35	Stroke and Stroke Rehabilitation: Screening for Dysphagia	AMA–PCPI/NCQA	0243.
36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services.	AMA–PCPI/NCQA	0244.
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older.	AMA–PCPI/NCQA	0046.
40	Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older.	AMA–PCPI/NCQA	0045.
41	Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older.	AMA–PCPI/NCQA	0049.
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery.	Society of Thoracic Surgeons (STS).	0516 or 0134.
44	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery.	STS	0127 or 0236.
45	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures).	AMA–PCPI/NCQA	0637.
46	Medication Reconciliation: Reconciliation After Discharge From an Inpatient Facility.	AMA–PCPI/NCQA	0097.
47	Advance Care Plan	AMA–PCPI/NCQA	0326.
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older.	AMA–PCPI/NCQA	0098.
49	Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older.	AMA–PCPI/NCQA	0099.
50	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older.	AMA–PCPI/NCQA	0100.
51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation.	AMA–PCPI	0091.
52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy.	AMA–PCPI	0102.
53	Asthma: Pharmacologic Therapy	AMA–PCPI	0047.
54	12–Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain.	AMA–PCPI/NCQA	0090.
55	12–Lead Electrocardiogram (ECG) Performed for Syncope	AMA–PCPI/NCQA	0093.
56	Community-Acquired Pneumonia (CAP): Vital Signs	AMA–PCPI/NCQA	0232
57	Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation.	AMA–PCPI/NCQA	0094.
58	Community-Acquired Pneumonia (CAP): Assessment of Mental Status.	AMA–PCPI/NCQA	0234.
59	Community-Acquired Pneumonia (CAP): Empiric Antibiotic	AMA–PCPI/NCQA	0096.
64	Asthma: Asthma Assessment	AMA–PCPI	0001.

TABLE 52—PROPOSED 2011 MEASURES SELECTED FROM THE 2010 PQRI QUALITY MEASURE SET AVAILABLE FOR EITHER CLAIMS-BASED REPORTING OR REGISTRY-BASED REPORTING—Continued

Measure No.	Measure title	Measure developer	NQF Measure No.
65	Treatment for Children With Upper Respiratory Infection (URI): Avoidance of Inappropriate Use.	NCQA	0069.
66	Appropriate Testing for Children With Pharyngitis	NCQA	0002.
67	Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow.	AMA–PCPI/American Society of Hematology (ASH).	0377.
68	Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy.	AMA–PCPI/ASH	0378.
69	Multiple Myeloma: Treatment With Bisphosphonates	AMA–PCPI/ASH	0380.
70	Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry.	AMA–PCPI/ASH	0379.
71	Breast Cancer: Hormonal Therapy for Stage IC–IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer.	AMA–PCPI/American Society of Clinical Oncology (ASCO)/National Comprehensive Cancer Network (NCCN).	0387.
72	Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients.	AMA–PCPI/ASCO/NCCN	0385.
76	Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol.	AMA–PCPI	0464.
79	End-Stage Renal Disease (ESRD): Influenza Immunization in Patients with ESRD.	AMA–PCPI	0227.
84	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment.	AMA–PCPI	0395.
85	Hepatitis C: HCV Genotype Testing Prior to Treatment	AMA–PCPI	0396.
86	Hepatitis C: Antiviral Treatment Prescribed	AMA–PCPI	0397.
87	Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment.	AMA–PCPI	0398.
89	Hepatitis C: Counseling Regarding Risk of Alcohol Consumption.	AMA–PCPI	0401.
90	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy.	AMA–PCPI	0394.
91	Acute Otitis Externa (ACE): Topical Therapy	AMA–PCPI	AQA adopted Currently under NQF review.
92	Acute Otitis Externa (ACE): Pain Assessment	AMA–PCPI	AQA adopted Currently under NQF review.
93	Acute Otitis Externa (ACE): Systemic Antimicrobial Therapy—Avoidance of Inappropriate Use.	AMA–PCPI	AQA adopted Currently under NQF review.
94	Otitis Media with Effusion (OME): Diagnostic Evaluation—Assessment of Tympanic Membrane Mobility.	AMA–PCPI	AQA adopted Currently under NQF review.
99	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) With Histologic Grade.	AMA–PCPI/College of American Pathologists (CAP).	0391.
100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) With Histologic Grace.	AMA–PCPI/CAP	0392.
102	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients.	AMA–PCPI	0389.
104	Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients.	AMA–PCPI	0390.
105	Prostate Cancer: Three-Dimensional (3D) Radiotherapy	AMA–PCPI	0388.
106	Major Depressive Disorder (MDD): Diagnostic Evaluation	AMA–PCPI	0103.
107	Major Depressive Disorder (MDD): Suicide Risk Assessment.	AMA–PCPI	0104.
108	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy.	NCQA	0054.
109	Osteoarthritis: Function and Pain Assessment	AMA–PCPI	0050.
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old.	AMA–PCPI	0041.
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older.	NCQA	0043.
112	Preventive Care and Screening: Screening Mammography	NCQA	0031.
113	Preventive Care and Screening: Colorectal Cancer Screening.	NCQA	0034.
116	Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use.	NCQA	0058.
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	NCQA	0055.
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients.	NCQA	0062.

TABLE 52—PROPOSED 2011 MEASURES SELECTED FROM THE 2010 PQRI QUALITY MEASURE SET AVAILABLE FOR EITHER CLAIMS-BASED REPORTING OR REGISTRY-BASED REPORTING—Continued

Measure No.	Measure title	Measure developer	NQF Measure No.
121	Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorous, Intact Parathyroid Hormone (iPTH) and Lipid Profile).	AMA–PCPI	Combined: 0570, 0571, 0572, 0626.
122	Chronic Kidney Disease (CKD): Blood Pressure Management.	AMA–PCPI	AQA adopted.
123	Chronic Kidney Disease (CKD): Plan of Care—Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA).	AMA–PCPI	AQA adopted.
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR).	CMS/Quality Insights of Pennsylvania (QIP).	0488.
126	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy—Neurological Evaluation.	American Podiatric Medical Association (APMA).	0417.
127	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention—Evaluation of Footwear.	APMA	0416.
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up.	CMS/QIP	0421.
130	Documentation and Verification of Current Medications in the Medical Record.	CMS/QIP	0419.
131	Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up.	CMS/QIP	0420.
134	Screening for Clinical Depression and Follow-Up Plan	CMS/QIP	0418.
140	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement.	AMA–PCPI/NCQA	0566.
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of Plan of Care.	AMA–PCPI/NCQA	0563.
142	Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications.	AMA–PCPI	0051.
145	Radiology: Exposure Time Reported for Procedures Using Fluoroscopy.	AMA–PCPI/NCQA	0510.
146	Radiology: Inappropriate Use of “Probably Benign” Assessment Category in Mammography Screening.	AMA–PCPI/NCQA	0508.
147	Nuclear Medicine: Correlation With Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy.	AMA–PCPI	0511.
153	Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula.	AMA–PCPI	AQA adopted.
154	Falls: Risk Assessment	AMA–PCPI/NCQA	AQA adopted.
155	Falls: Plan of Care	AMA–PCPI/NCQA	AQA adopted.
156	Oncology: Radiation Dose Limits to Normal Tissues	AMA–PCPI	0382
157	Thoracic Surgery: Recording of Clinical Stage for Lung Cancer and Esophageal Cancer Resection.	STS	0455.
158	Carotid Endarterectomy: Use of Patch During Conventional Carotid Endarterectomy.	Society of Vascular Surgeons (SVS).	0466.
163	Diabetes Mellitus: Foot Exam	NCQA	0056.
172	Hemodialysis Vascular Access Decision-Making by Surgeon To Maximize Placement of Autogenous Arterial Venous (AV) Fistula.	SVS	0259.
173	Preventive Care and Screening: Unhealthy Alcohol Use—Screening.	AMA–PCPI	AQA adopted.
175	Pediatric End-Stage Renal Disease (ESRD): Influenza Immunization.	AMA–PCPI	AQA adopted.
176	Rheumatoid Arthritis (RA): Tuberculosis Screening	AMA–PCPI/NCQA	AQA adopted.
177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity.	AMA–PCPI/NCQA	AQA adopted.
178	Rheumatoid Arthritis (RA): Functional Status Assessment	AMA–PCPI/NCQA	AQA adopted.
179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis.	AMA–PCPI/NCQA	AQA adopted.
180	Rheumatoid Arthritis (RA): Glucocorticoid Management	AMA–PCPI/NCQA	AQA adopted.
181	Elder Maltreatment Screen and Follow-Up Plan	CMS/QIP	AQA adopted.
182	Functional Outcome Assessment in Chiropractic Care	CMS/QIP	AQA adopted.
183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV	AMA–PCPI	0399.
184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV	AMA–PCPI	0400.
185	Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients With a History of Adenomatous Polyps—Avoidance of Inappropriate Use.	AMA–PCPI/NCQA	AQA adopted Currently under NQF review.
186	Wound Care: Use of Compression System in Patients With Venous Ulcers.	AMA–PCPI/NCQA	AQA adopted.
188	Referral for Otologic Evaluation for Patient With Congenital or Traumatic Deformity of the Ear.	Audiology Quality Consortium (AQC).	Not applicable.

TABLE 52—PROPOSED 2011 MEASURES SELECTED FROM THE 2010 PQRI QUALITY MEASURE SET AVAILABLE FOR EITHER CLAIMS-BASED REPORTING OR REGISTRY-BASED REPORTING—Continued

Measure No.	Measure title	Measure developer	NQF Measure No.
189	Referral for Otologic Evaluation for Patient With History of Active Drainage From the Ear Within the Previous 90 days.	AQC	Not applicable.
190	Referral for Otologic Evaluation for Patient With a History of Sudden or Rapidly Progessive Hearing Loss.	AQC	Not applicable.
193	Perioperative Temperature Management	AMA–PCPI	0454.
194	Oncology: Cancer Stage Documented	AMA–PCPI/ASCO	0386.
195	Stenosis Measurement in Carotid Imaging Studies	AMA–PCPI/NCQA	0507.
201	Ischemic Vascular Disease (IVD): Blood Pressure Management Control.	NCQA	0084.
202	Ischemic Vascular Disease (IVD): Complete Lipid Profile	NCQA	0073.
203	Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL–C) Control.	NCQA	0075.
204	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Anti-thrombotic.	NCQA	0068

It is our understanding that measures #188, #189, and #190 were considered by NQF for possible endorsement but were not ultimately NQF-endorsed. However, since we are not aware of any other NQF-endorsed measures that are available to audiologists, we propose to exercise our exception authority under section 1848(k)(2)(C)(ii) of the Act. Therefore, we propose to use measures #188, #189, and #190 for the 2011 PQRI despite the fact that they are neither NQF-endorsed nor AQA adopted.

Please note that detailed measure specifications, including the measure's title, for 2010 individual PQRI quality measures may have been updated or modified during the NQF endorsement process or for other reasons prior to 2011. The 2011 PQRI quality measure specifications for any given individual quality measure may, therefore, be different from specifications for the same quality measure used for 2010. Specifications for all 2011 individual PQRI quality measures, whether or not included in the 2010 PQRI program, must be obtained from the specifications document for 2011 individual PQRI quality measures, which will be available on the PQRI section of the CMS Web site on or before December 31, 2010.

(2) Proposed 2011 Individual Quality Measures Selected From the 2010 PQRI Quality Measures Set Available for Registry-Based Reporting Only

For the 2011 PQRI, we propose to include 45 registry-only individual measures from the 2010 PQRI. As in 2010 PQRI, we are proposing to designate these measures as registry-only measures for 2011 to relieve ongoing analytical difficulties encountered with claims-based reporting of these measures in prior program years. We encourage comments on our proposal to designate these 45 2010 measures as registry-only measures for the 2011 PQRI.

Although we are proposing to designate certain measures as registry-only measures for 2011, we cannot guarantee that there will be a registry qualified to submit each registry-only measure for 2011. We rely on registries to self-nominate and identify the types of measures for which they would like to be qualified to submit quality measures results and numerator and denominator data on quality measures. If no registry self-nominates to submit measure results and numerator and denominator data on a particular type of measure for 2011, then an EP would not be able to report that particular measure type via a registry. The Measure Number and Measure Title for these proposed registry-only measures are listed in Table 53 along with the NQF measure number, if applicable, and the name of the measure's developer/owner. As mentioned above, a description of the measures listed in Table 53 can be found in the "2010 PQRI Quality Measures List," which is available on the Measures and Codes page of the PQRI section of the CMS Web site at *http://www.cms.gov/PQRI.*

TABLE 53: 2011 PROPOSED MEASURES SELECTED FROM THE 2010 PQRI QUALITY MEASURE SET AVAILABLE FOR REGISTRY-BASED REPORTING ONLY

Measure No.	Measure title	Measure developer	NQF Measure No.
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD).	AMA–PCPI	0081.
7	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients With Prior Myocardial Infarction (MI).	AMA–PCPI	0070.
8	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD).	AMA–PCPI	0083.
33	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge.	AMA–PCPI/NCQA	0241.
81	End-Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis in ESRD Patients.	AMA–PCPI	0323.
82	End-Stage Renal Disease (ESRD): Plan of Care for Inadequate Peritoneal Dialysis.	AMA–PCPI	0321
83	Hepatitis C: Testing for Chronic Hepatitis C—Confirmation of Hepatitis C Viremia.	AMA–PCPI	0393.

TABLE 53: 2011 PROPOSED MEASURES SELECTED FROM THE 2010 PQRI QUALITY MEASURE SET AVAILABLE FOR REGISTRY-BASED REPORTING ONLY—Continued

Measure No.	Measure title	Measure developer	NQF Measure No.
118	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients With CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LSVD).	AMA–PCPI	0066.
137	Melanoma: Continuity of Care—Recall System	AMA–PCPI/NCQA	0650.
138	Melanoma: Coordination of Care	AMA–PCPI/NCQA	0561.
143	Oncology: Medical and Radiation—Pain Intensity Quantified	AMA–PCPI	0384.
144	Oncology: Medical and Radiation—Plan of Care for Pain	AMA–PCPI	0383.
159	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage	AMA–PCPI/NCQA	0404.
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis.	AMA–PCPI/NCQA	0405.
161	HIV/AIDS: Adolescent and Adult Patients With HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy.	AMA–PCPI/NCQA	0406.
162	HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy.	AMA–PCPI/NCQA	0407.
164	Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation).	STS	0129.
165	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate.	STS	0130.
166	Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA).	STS	0131.
167	Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency.	STS	0114.
168	Coronary Artery Bypass Graft (CABG): Surgical Re-Exploration.	STS	0115.
169	Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge.	STS	0116.
170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge.	STS	0117.
171	Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling.	STS	0118.
174	Pediatric End-Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis.	AMA–PCPI	AQA adopted Currently under NQF review.
187	Stroke and Stroke Rehabilitation: Thrombolytic Therapy	AHA/ASA/ TJC	0437.
191	Cataracts: 20/40 or Better Visual Acuity Within 90 Days Following Cataract Surgery.	AMA–PCPI/NCQA	0565.
192	Cataracts: Complications Within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures.	AMA–PCPI/NCQA	0564.
196	Coronary Artery Disease (CAD): Symptom and Activity Assessment.	AMA–PCPI	0065.
197	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL–Cholesterol.	AMA–PCPI	0074.
198	Heart Failure: Left Ventricular Function (LVF) Assessment	AMA–PCPI	0079.
199	Heart Failure: Patient Education	AMA–PCPI	0082.
200	Heart Failure: Warfarin Therapy Patients With Atrial Fibrillation.	AMA–PCPI	0084.
205	HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea.	AMA–PCPI/NCQA	0409.
206	HIV/AIDS: Screening for High Risk Sexual Behaviors	AMA–PCPI/NCQA	0413.
207	HIV/AIDS: Screening for Injection Drug Use	AMA–PCPI/NCQA	0415.
208	HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis.	AMA–PCPI/NCQA	0410.
209	Functional Communication Measure—Spoken Language Comprehension.	American Speech Language Haring Association (ASHA).	0445.
210	Functional Communication Measure—Attention	ASHA	0449.
211	Functional Communication Measure—Memory		0448.
212	Functional Communication Measure—Motor Speech	ASHA	0447.
213	Functional Communication Measure—Reading	ASHA	0446.
214	Functional Communication Measure—Spoken Language Expression.	ASHA	0444.
215	Functional Communication Measure—Writing	ASHA	0442.
216	Functional Communication Measure—Swallowing	ASHA	0443.

Please note, as previously discussed above, detailed measure specifications, including a measure's title, for 2010 PQRI quality measures may be updated or modified during the NQF endorsement process or for other reasons during 2010. Therefore, the 2011 PQRI quality measure specifications for any given quality measure may be different from specifications for the same quality measure used for 2010. Specifications

for all 2011 individual PQRI quality measures, whether or not included in the 2010 PQRI program, must be obtained from the specifications document for 2011 individual PQRI quality measures, which will be available on the PQRI section of the CMS Web site on or before December 31, 2010.

(3) New Individual Quality Measures Proposed for 2011

We propose to include in the 2011 PQRI quality measure set 20 measures that were not included in the 2010 PQRI quality measures set provided that each measure obtains NQF endorsement by June 1, 2010 and its detailed specifications are completed and ready for implementation in PQRI by August 15, 2010. Besides having NQF endorsement, we again propose that the development of a measure is considered complete for the purposes of the 2011 PQRI if by August 15, 2010: (1) The final, detailed specifications for use in data collection for PQRI have been completed and are ready for implementation, and (2) all of the Category II Current Procedural Terminology (CPT II) codes required for the measure have been established and will be effective for CMS claims data submission on or before January 1, 2011. The titles of these proposed additional, or new, measures are listed in Table 54 along with the name of the measure developer and the proposed reporting mechanism (that is, whether the measure is proposed to be reportable using claims, registries, or both). For these 20 proposed measures, a PQRI Measure Number will be assigned to a measure if and when the measure is included in the final set of 2011 PQRI measures.

Due to the complexity of their measure specifications, we propose that 8 of these 20 measures would be available as registry-only measures for the 2011 PQRI. The remaining 15 measures are proposed to be available for reporting through either claims-based reporting or registry-based reporting.

TABLE 54—NEW INDIVIDUAL QUALITY MEASURES PROPOSED FOR 2011

Measure title	NQF Measure number	Measure developer	Reporting mechanism(s)
Change in Risk-Adjusted Functional Status for Patients With Knee Impairments.	0422	FOTO	Registry.
Change in Risk-Adjusted Functional Status for Patients With Hip Impairments.	0423	FOTO	Registry.
Change in Risk-Adjusted Functional Status for Patients With Lower Leg, Foot or Ankle Impairments.	0424	FOTO	Registry.
Change in Risk-Adjusted Functional Status for Patients With Lumbar Spine Impairments.	0425	FOTO	Registry.
Change in Risk-Adjusted Functional Status for Patients With Shoulder Impairments.	0426	FOTO	Registry.
Change in Risk-Adjusted Functional Status for Patients With Elbow, Wrist or Hand Impairments.	0427	FOTO	Registry.
Change in Risk-Adjusted Functional Status for Patients With a Functional Deficit of the Neck, Cranium, Mandible, Thoracic Spine, Ribs or Other General Orthopedic Impairment.	0428	FOTO	Registry.
Care Transitions: Reconciled Medication List Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care).	Currently under NQF review	Society of Hospital Medicine (SMH) AMA–PCPI/NCQA.	Claims, Registry.
Care Transitions: Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care).	Currently under NQF review	Society of Hospital Medicine (SMH) AMA–PCPI/NCQA.	Claims, Registry.
Care Transitions: Timely Transmission of Transition Record (Inpatient Discharges to Home/Self Care or Any Other Site of Care).	Currently under NQF review	Society of Hospital Medicine (SMH) AMA–PCPI/NCQA.	Claims, Registry.
Care Transitions: Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care).	Currently under NQF review	Society of Hospital Medicine (SMH) AMA–PCPI/NCQA.	Claims, Registry.
Hypertension (HTN): Plan of Care	0017	AMA–PCPI	Claims, Registry.
Heart Failure (HF): Left Ventricular Function (LVF) Testing	79	CMS	Registry.
Melanoma: Overutilization of Imaging Studies in Stage 0–IA Melanoma.	0562	AMA–PCPI	Claims, Registry.
Radiology: Reminder System for Mammograms	0509	AMA–PCPI	Claims, Registry.
Asthma: Assessment of Asthma Risk—Emergency Department/Inpatient Setting.	Currently under NQF review	AMA–PCPI	Claims, Registry.
Asthma: Discharge Plan—Emergency Department/Inpatient Setting.	Currently under NQF review	AMA–PCPI	Claims, Registry.
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.	0028	AMA–PCPI	Claims, Registry.
Recording of Performance Status Prior to Lung or Esophageal Cancer Resection.	0457	Society of Thoracic Surgery (STS).	Claims, Registry.
Pulmonary Function Tests Before Major Anatomic Lung Resection.	0458	Society of Thoracic Surgery (STS).	Claims, Registry.

These measures are being proposed for the 2011 PQRI because they meet one or more of the considerations for measure selection discussed in section VI.F.1.h. of this proposed rule.

(4) Proposed 2011 Measures Available for EHR-Based Reporting

For 2011, we propose to again accept PQRI data from EHRs for a limited subset of the proposed 2011 PQRI quality measures, contingent upon the successful completion of our 2010 EHR data submission process and a determination that accepting data from EHRs on quality measures for the 2011 PQRI continues to be practical and feasible.

We propose to make a total of 22 measures available for EHR-based reporting in the 2010 PQRI. These include the 10 measures available for EHR-based reporting in the 2010 PQRI, which are identified in Table 55 and 12 additional measures identified in Table 56 that overlap with the clinical quality measures used in the EHR incentive program established by the American Recovery and Reinvestment Act (ARRA). Again, this year, we propose to make these measures available for electronic submission via an EHR because these measures target preventive care or common chronic and high-cost conditions.

TABLE 55—PROPOSED 2011 MEASURES AVAILABLE FOR EHR-BASED REPORTING FROM 2010 PQRI

Measure No.	Measure title	Measure developer	NQF Measure No.
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus.	NCQA	0059.
2	Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control in Diabetes Mellitus.	NCQA	0064.
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	NCQA	0061.
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD).	AMA–PCPI	0081.
7	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI).	AMA–PCPI	0070.
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old.	AMA–PCPI	0041.
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older.	NCQA	0043.
112	Preventive Care and Screening: Screening Mammography	NCQA	0031.
113	Preventive Care and Screening: Colorectal Cancer Screening	NCQA	0034.
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR).	CMS/QIP	0488.

TABLE 56: PROPOSED 2011 MEDICARE ARRA—HITECH MEASURES AVAILABLE FOR EHR-BASED REPORTING

Measure No.	Measure title	Measure developer	NQF Measure No.
TBD	Hypertension (HTN): Blood Pressure Measurement	AMA–PCPI	0013.
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up.	CMS/Quality Insights of Pennsylvania.	0421.
TBD	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.	AMA–PCPI	0028.
TBD	Childhood Immunization Status	NCQA	0038.
TBD	Body Mass Index (BMI) 2 Through 18 Years of Age	National Initiative for Children's Healtcare Quality.	0024.
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older.	AMA–PCPI/NCQA	0046.
47	Advance Care Plan	AMA–PCPI/NCQA	0326.
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older.	AMA–PCPI/NCQA	0098.
173	Preventive Care & Screening: Unhealthy Alcohol Use—Screening ..	AMA–PCPI	AQA Adopted.
TBD	Drugs To Be Avoided in the Elderly	NCQA	0022.
41	Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older.		0049.
142	Osteoarthritis: Assessment of Use of Anti-Inflammatory or Analgesic OTC Meds.	AMA–PCPI	0051.

(5) Measures Proposed for Inclusion in 2011 Measures Groups

We propose to retain the following 13 2010 PQRI measures groups for the 2011 PQRI: (1) Diabetes Mellitus; (2) CKD; (3) Preventive Care; (4) CABG; (5) Rheumatoid Arthritis; (6) Perioperative Care; (7) Back Pain; (8) CAD; (9) Heart Failure; (10) IVD; (11) Hepatitis C; (12) HIV/AIDS; and (13) CAP. We are proposing to include these measures groups in 2011 PQRI because they each contain at least 4 PQRI quality measures that share a common denominator definition.

For 2011, we propose that the CABG, CAD, Heart Failure, HIV/AIDS measures groups continue to be reportable through the registry-based reporting mechanism only, while the remaining Diabetes Mellitus, CKD, Preventive Care, Rheumatoid Arthritis, Perioperative Care, Back Pain, IVD, Hepatitis C, and CAP measures groups will continue to be reportable through either claims-based reporting or registry-based reporting for the 2011 PQRI. The 4 2011 proposed measures groups reportable via registry-based reporting only are identified with an asterisk (*) below.

For 2010, the 13 measures groups that we propose to retain in the 2011 PQRI, combined with the one additional measures group we are proposing for 2011, makes a total of 14 measures groups for the 2011 PQRI. The 1 additional measures group we propose for the 2011 PQRI, identified in Table 70, is an Asthma Measures Group. The Asthma Measures Group is proposed to be reportable through either claims-based reporting or registry-based reporting.

We believe that the measure groups proposed for the 2011 PQRI address gaps in quality reporting and are those that have a high impact on HHS and CMS priority topics for improved quality and efficiency for Medicare beneficiaries (such as prevention, chronic conditions, improved care coordination, improved efficiency, improved patient and family experience of care, and effective management of acute and chronic episodes).

Finally, as in previous program years, for 2011, we continue to propose that except for the measures included in the Back Pain measures group, the measures included in any proposed 2011 measures group be reportable either as individual measures or as part of a measures group. For 2011, we propose that the measures proposed for inclusion in the Back Pain measures group will continue to be reportable only as part of a measures group and not as individual measures in 2011. We propose that measures selected for inclusion in all 2011 PQRI measures groups (except for the Back Pain measures group) are reportable either as individual measures or as part of a measures group.

The measures proposed for inclusion in each of the 2011 measures groups are identified in Tables 57 through 70. As stated previously, the PQRI Measure Number is a unique identifier assigned by CMS to all measures in the PQRI measure set. Once a PQRI Measure Number is assigned to a measure, it will not be used again, even if the measure is subsequently retired from the PQRI measure set. Measures that are not preceded by a number (in other words, those preceded by "TBD") in Tables 57 through 71 were never part of a PQRI measure set prior to 2011. A number will be assigned to such measures for 2011, if we finalize inclusion of the measures in the 2011 PQRI.

As with measures group reporting in the 2008, 2009, and 2010 PQRI, we propose that each EP electing to report a group of measures for 2011 must report all measures in the group that are applicable to each patient or encounter to which the measures group applies at least up to the minimum number of patients required by the applicable reporting criteria.

TABLE 57—MEASURES PROPOSED FOR 2011 DIABETES MELLITUS MEASURES GROUP

Measure No.	Measure Title	NQF Measure No.	Measure developer
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus.	0059	NCQA.
2	Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control in Diabetes Mellitus.	0064	NCQA.
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	0061	NCQA.
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	0055	NCQA.
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients.	0062	NCQA.
163	Diabetes Mellitus: Foot Exam	0056	NCQA.

TABLE 58—MEASURES PROPOSED FOR 2011 CKD MEASURES GROUP

Measure No.	Measure Title	NQF Measure No.	Measure developer
121	Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile).	0570, 0571, 0572, 0626	AMA–PCPI.
122	Chronic Kidney Disease (CKD): Blood Pressure Management	AQA adopted	AMA–PCPI.
123	Chronic Kidney Disease (CKD): Plan of Care—Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA).	AQA adopted	AMA–PCPI.
153	Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula.	AQA adopted	AMA–PCPI.

TABLE 59—MEASURES PROPOSED FOR 2011 PREVENTIVE CARE MEASURES GROUP

Measure No.	Measure title	NQF Measure No.	Measure developer
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older.	0046	AMA–PCPI/NCQA.
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older.	0098	AMA–PCPI/NCQA.
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old.	0041	AMA–PCPI.
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older.	0043	NCQA.
112	Preventive Care and Screening: Screening Mammography	0031	NCQA.
113	Preventive Care and Screening: Colorectal Cancer Screening	0034	NCQA.
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up.	0421	CMS/QIP.
173	Preventive Care and Screening: Unhealthy Alcohol Use—Screening.	AQA adopted	AMA–PCPI.

TABLE 59—MEASURES PROPOSED FOR 2011 PREVENTIVE CARE MEASURES GROUP—Continued

Measure No.	Measure title	NQF Measure No.	Measure developer
TBD	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.	0028	AMA–PCPI.

TABLE 60—MEASURES PROPOSED FOR 2011 CABG MEASURES GROUP *

Measure No.	Measure title	NQF Measure No.	Measure developer
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery.	0516, 0134	Society of Thoracic Surgeons (STS).
44	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery.	0127, 0236	STS.
164	Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation).	0129	STS.
165	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate.	0130	STS.
166	Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA).	0131	STS.
167	Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency.	0114	STS.
168	Coronary Artery Bypass Graft (CABG): Surgical Re-exploration	0115	STS.
169	Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge.	0116	STS.
170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge.	0117	STS.
171	Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling.	0118	STS.

* This measures group is reportable through registry-based reporting only.

TABLE 61—MEASURES PROPOSED FOR 2011 RHEUMATOID ARTHRITIS MEASURES GROUP

Measure No.	Measure title	NQF Measure No.	Measure developer
108	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy.	0054	NCQA.
176	Rheumatoid Arthritis (RA): Tuberculosis Screening	AQA adopted	AMA–PCPI/NCQA.
177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity	AQA adopted	AMA–PCPI/NCQA.
178	Rheumatoid Arthritis (RA): Functional Status Assessment	AQA adopted	AMA–PCPI/NCQA.
179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis.	AQA adopted	AMA–PCPI/NCQA.
180	Rheumatoid Arthritis (RA): Glucocorticoid Management	AQA adopted	AMA–PCPI/NCQA.

TABLE 62—MEASURES PROPOSED FOR 2011 PERIOPERATIVE CARE MEASURES GROUP

Measure No.	Measure title	NQF Measure No.	Measure developer
20	Perioperative Care: Timing of Antibiotic Prophylaxis—Ordering Physician.	0270	AMA–PCPI/NCQA.
21	Perioperative Care: Selection of Prophylactic Antibiotic—First OR Second Generation Cephalosporin.	0268	AMA–PCPI/NCQA.
22	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures).	0271	AMA–PCPI/NCQA.
23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients).	0239	AMA–PCPI/NCQA.

TABLE 63—MEASURES PROPOSED FOR 2011 BACK PAIN MEASURES GROUP

Measure No.	Measure title	NQF Measure No.	Measure developer
148	Back Pain: Initial Visit	0322	NCQA.
149	Back Pain: Physical Exam	0319	NCQA.
150	Back Pain: Advice for Normal Activities	0315	NCQA.
151	Back Pain: Advice Against Bed Rest	0313	NCQA.

TABLE 64—MEASURES PROPOSED FOR 2011 CAD MEASURES GROUP*

Measure No.	Measure title	NQF Measure No.	Measure developer
6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD.	0067	AMA–PCPI.
196	Coronary Artery Disease (CAD): Symptom and Activity Assessment	0065	AMA–PCPI.
197	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL–Cholesterol.	0074	AMA–PCPI.
TBD	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.	0028	AMA–PCPI.

*This measures group is reportable through registry-based reporting only.

TABLE 65—MEASURES PROPOSED FOR 2011 HEART FAILURE MEASURES GROUP*

Measure No.	Measure title	NQF Measure No.	Measure developer
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD).	0081	AMA–PCPI.
8	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD).	0083	AMA–PCPI.
198	Heart Failure: Left Ventricular Function (LVF) Assessment	0079	AMA–PCPI.
199	Heart Failure: Patient Education	0082	AMA–PCPI.
TBD	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.	0028	AMA–PCPI.

*This measures group is reportable through registry-based reporting only.

TABLE 66—MEASURES PROPOSED FOR 2011 IVD MEASURES GROUP

Measure No.	Measure title	NQF Measure No.	Measure developer
201	Ischemic Vascular Disease (IVD): Blood Pressure Management Control.	0073	NCQA.
202	Ischemic Vascular Disease (IVD): Complete Lipid Profile	0075	NCQA.
203	Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL–C) Control.	0075	NCQA.
204	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic.	0068	NCQA.
TBD	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.	0028	AMA–PCPI.

TABLE 67—MEASURES PROPOSED FOR 2011 HEPATITIS C MEASURES GROUP

Measure No.	Measure title	NQF Measure No.	Measure developer
84	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment.	0395	AMA–PCPI.
85	Hepatitis C: HCV Genotype Testing Prior to Treatment	0396	AMA–PCPI.
86	Hepatitis C: Antiviral Treatment Prescribed	0397	AMA–PCPI.
87	Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment.	0398	AMA–PCPI.
89	Hepatitis C: Counseling Regarding Risk of Alcohol Consumption	0401	AMA–PCPI.
90	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy.	0394	AMA–PCPI.
183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV	0399	AMA–PCPI.
184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV	0400	AMA–PCPI.

TABLE 68—MEASURES PROPOSED FOR 2011 HIV/AIDS MEASURES GROUP*

Measure No.	Measure title	NQF Measure No.	Measure developer
159	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage	0404	AMA–PCPI/NCQA.
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	0405	AMA–PCPI/NCQA.
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy.	0406	AMA–PCPI/NCQA.
162	HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy.	0407	AMA–PCPI/NCQA.
205	HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea.	0409	AMA–PCPI/NCQA.
206	HIV/AIDS: Screening for High Risk Sexual Behaviors	0413	AMA–PCPI/NCQA.
207	HIV/AIDS: Screening for Injection Drug Use	0415	AMA–PCPI/NCQA.

TABLE 68—MEASURES PROPOSED FOR 2011 HIV/AIDS MEASURES GROUP*—Continued

Measure No.	Measure title	NQF Measure No.	Measure developer
208	HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis	0410	AMA–PCPI/NCQA.

*This measures group is selected to be reportable through registry-based reporting only.

TABLE 69—MEASURES PROPOSED FOR 2011 CAP MEASURES GROUP

Measure No.	Measure title	NQF Measure No.	Measure developer
56	Community-Acquired Pneumonia (CAP): Vital Signs	0232	AMA–PCPI/NCQA.
57	Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation.	0094	AMA–PCPI/NCQA.
58	Community-Acquired Pneumonia (CAP): Assessment of Mental Status.	0234	AMA–PCPI/NCQA.
59	Community-Acquired Pneumonia (CAP): Empiric Antibiotic	0096	AMA–PCPI/NCQA.

TABLE 70—MEASURES PROPOSED FOR 2011 ASTHMA MEASURES GROUP

Measure No.	Measure title	NQF Measure No.	Measure developer
53	Asthma: Pharmacologic Therapy	0047	AMA–PCPI.
64	Asthma: Asthma Assessment	0001	AMA–PCPI.
TBD	Asthma: Assessment of Asthma Risk—Emergency Department/Inpatient Setting.	Currently under NQF review	AMA–PCPI.
TBD	Asthma: Discharge Plan-Emergency/Inpatient Setting	Currently under NQF review	AMA–PCPI.

We note that the specifications for measures groups do not necessarily contain all the specification elements of each individual measure making up the measures group. This is based on the need for a common set of denominator specifications for all the measures making up a measures group in order to define the applicability of the measures group. Therefore, the specifications and instructions for measures groups will again be provided separately from the specifications and instructions for the individual 2011 PQRI measures. We will post the detailed specifications and specific instructions for reporting measures groups on the PQRI section of the CMS Web site at *http://www.cms.gov/PQRI* by no later than December 31, 2010.

Additionally, the detailed measure specifications and instructions for submitting data on those 2011 measures groups that were also included as 2010 PQRI measures groups may be updated or modified prior to 2011. Therefore, the 2011 PQRI measure specifications for any given measures group could be different from specifications and submission instructions for the same measures group used for 2010. These measure specification changes are not expected to materially impact the intended meaning of the measures or the strength of the measures.

j. Proposed 2011 PQRI Quality Measures for Physician Groups Selected To Participate in the Group Practice Reporting Option (GPRO I)

As discussed in section VI.F.1.g.(3).(i) of this proposed rule, we propose that physician groups selected to participate in the 2011 PQRI GPRO I would be required to report on 26 proposed measures. We are proposing these measures because they are NQF-endorsed measures currently collected as part of the PGP and/or MCMP demonstrations and in the 2010 PQRI GPRO. These proposed measures are listed in Table 71. To the extent that a measure is an existing PQRI measure available for reporting by individual EPs, the Measure Title is preceded by the measure's PQRI Measure Number. If there is no number in the PQRI Measure Number column of the table, then the measure is not an existing PQRI measure and will be added to the 2011 PQRI for purposes of the GPRO I. Measures proposed for GPRO II are discussed in section VI.F.1.g.(3).(ii) of this proposed rule.

As in the 2010 PQRI, a separate measures specifications manual and other supporting documents will be available for group practices participating in the 2011 PQRI GPRO I. We anticipate that the group practice measures specifications manual will be available by November 15, 2010 on the PQRI section of the CMS Web site at *http://www.cms.gov/PQRI.*

TABLE 71—MEASURES FOR PHYSICIAN GROUPS PARTICIPATING IN THE 2011 PQRI GROUP PRACTICE REPORTING OPTION (GPRO I)

PQRI measure No.	Measure title	Measure developer	NQF No.
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus.	NCQA	0059
2	Diabetes Mellitus: Low Density Lipoprotein (LDL–C)Control	NCQA	0064
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	NCQA	0061
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD).	AMA–PCPI	0081
6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD.	AMA–PCPI	0067

TABLE 71—MEASURES FOR PHYSICIAN GROUPS PARTICIPATING IN THE 2011 PQRI GROUP PRACTICE REPORTING OPTION (GPRO I)—Continued

PQRI measure No.	Measure title	Measure developer	NQF No.
7	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI).	AMA–PCPI	0070
8	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD).	AMA–PCPI	0083
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old.	AMA–PCPI	0041
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older.	NCQA	0043
112	Preventive Care and Screening: Screening Mammography	NCQA	0031
113	Preventive Care and Screening: Colorectal Cancer Screening	NCQA	0034
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	NCQA	0055
118	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD).	AMA–PCPI	0066
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients.	NCQA	0062
163	Diabetes Mellitus: Foot Exam	NCQA	0056
GPRO DM–1	Diabetes Mellitus: Hemoglobin A1c Testing	NCQA	0057
GPRO DM–9	Diabetes Mellitus: Lipid Profile	NCQA	0063
GPRO HF–2	Heart Failure: Left Ventricular Function (LVF) Testing	CMS.	
198	Heart Failure: Left Ventricular Function (LVF) Assessment	AMA–PCPI	0079
GPRO HF–3	Heart Failure: Weight Measurement	CMS AMA–PCPI not maintaining	0085
199	Heart Failure: Patient Education	AMA–PCPI	0082
200	Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation	AMA–PCPI	0084
197	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL–Cholesterol.	AMA–PCPI	0074
GPRO HTN–1	Hypertension: Blood Pressure Measurement	AMA–PCPI	0013
GPRO HTN–2	Hypertension (HTN): Blood Pressure Control	NCQA	0018
GPRo HTN–3	Hypertension (HTN): Plan of Care	AMA–PCPI	0017

k. Public Reporting of PQRI Data

Section 1848(m)(5)(G) of the Act requires the Secretary to post on the CMS Web site, in an easily understandable format, a list of the names of EPs (or group practices) who satisfactorily submitted data on quality measures for the PQRI and the names of the EPs (or group practices) who are successful electronic prescribers. In addition, section 10331(a)(1) of the ACA, requires the Secretary to develop a Physician Compare Internet Web site by January 1, 2011, on which information on physicians enrolled in the Medicare program and other EPs who participate in the PQRI program would be posted.

To meet the ACA deadline of January 1, 2011, with respect to establishing the Physician Compare Web site, we propose, for 2011 PQRI, to use the current Physician and Other Health Care Professional Directory as a foundation for the Physician Compare Web site. As in 2010 PQRI, we propose to continue to make public the names of EPs and group practices that satisfactorily submit quality data for the 2011 PQRI. Previously, this was posted on the Physician and Other Health Care Professionals Directory. Our intent for the 2011 PQRI is to post the information on the Physician Compare Web site that must be developed by January 1, 2011. Specifically, we propose to post the names of EPs who: (1) Submit data on the 2011 PQRI quality measures through one of the reporting mechanisms available for the 2011 PQRI; (2) meet one of the proposed satisfactory reporting criteria of individual measures or measures groups for the 2011 PQRI as described above; and (3) qualify to earn a PQRI incentive payment for covered professional services furnished during the applicable 2011 PQRI reporting period, for purposes of satisfying the requirements under section 1848(m)(5)(G)(i) of the Act, on the Physician Compare Web site.

Similarly, for purposes of publicly reporting the names of group practices, on the Physician Compare Web site, for 2011, we propose to post the names of group practices that: (1) Submit data on the 2011 PQRI quality measures through one of the proposed group practice reporting options; (2) meet the proposed criteria for satisfactory reporting under the respective group practice reporting option; and (3) qualify to earn a PQRI incentive payment for covered professional services furnished during the applicable 2011 PQRI reporting period for purposes of satisfying the requirements under section 1848(m)(5)(G)(i) of the Act.

We do not propose to require as a condition of participation in the 2011 PQRI that performance information be made publicly available at either the group practice or individual level for 2011 PQRI. However, we note that section 10331 of the ACA requires that not later than January 1, 2013, and with respect to reporting periods that begin no earlier than January 1, 2012, we implement a plan for making publicly available through Physician Compare, information on physician performance, including measures collected under PQRI. Consistent with section 10331 of the ACA, we expect, in the future, to publicly report performance information based on PQRI.

We will be working on a plan to expand the information that is publicly posted on the Physician Compare in future years. This will be further described in future rulemaking. We solicit comments on our plan for implementation of a Physician Compare Web site for 2011.

l. Other Relevant ACA Provisions

(1) Section 3002 (b)—Incentive Payment Adjustment for Quality Reporting

Beginning 2015, a payment adjustment will apply under the PQRI. Specifically, under section 1848(a)(8) of the Act, as added by section 3002(b) of the ACA, with respect to covered professional services furnished by an EP during 2015 or any subsequent year, if the EP does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year, the fee schedule amount for services furnished by such professionals during the year shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services. The applicable percent for 2015 is 98.5 percent and for 2016 and each subsequent year it is 98.0 percent.

We will address this provision of the ACA in future notice and comment rulemaking.

(2) Section 3002(c)—Maintenance of Certification Programs and Section 10327 Improvements to the Physician Quality Reporting System

Section 3002(c) of the ACA amends section 1848(k)(4) of the Act to require a mechanism whereby an EP may provide data on quality measures through an MOCP operated by a specialty body of the American Board of Medical Specialties (ABMS). In addition, section 1848(m)(7)of the Act ("Additional Incentive Payment"), as added by section 10327(a) of the ACA, provides for an additional 0.5 percent incentive payment for years 2011 through 2014 if certain requirements are met. In accordance with section 1848(m)(7)(B) of the Act, in order to qualify for the additional incentive payment, an EP must—

- Satisfactorily submit data on quality measures under PQRI for a year and have such data submitted—

++ On their behalf through an MOCP that meets the criteria for a registry under PQRI (see section VI.F.1.d.(4) of this proposed rule); or

++ In an alternative form and manner determined appropriate by the Secretary; and

- More frequently than is required to qualify for or maintain board certification status—

++ Participate in such an MOCP for a year; and

++ Successfully completes a qualified MOCP for such year.

Section 1848(m)(7)(C)(i) of the Act defines "Maintenance of Certification Program" as a continuous assessment program, such as a qualified ABMS MOCP, or an equivalent program (as determined by the Secretary), that advances quality and the lifelong learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communications skills and professionalism. Such a program shall require a physician to do the following:

- Maintain a valid, unrestricted medical license in the United States.
- Participate in educational and self-assessment programs that require an assessment of what was learned.
- Demonstrate, through a formalized, secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty.
- Successful completion of a qualified MOCP practice assessment.

As defined in section 1848(m)(7)(C)(ii) of the Act, a "qualified Maintenance of Certification Program practice assessment" means an assessment of a physician's practice that—

(1) Includes an initial assessment of an EP's practice that is designed to demonstrate the physician's use of evidence-based medicine;

(2) Includes a survey of patient experience with care; and

(3) Requires a physician to implement a quality improvement intervention to address a practice weakness identified in the initial assessment and then to remeasure to assess performance after such intervention.

To qualify for the additional incentive payment, section 1848(m)(7)(B)(iii) of the Act also requires the MOCP Program to submit to CMS, on behalf of the EP, information:

(1) In a form and manner specified by the Secretary, that the EP has successfully completed a qualified MOCP practice assessment for such year;

(2) If requested by the Secretary, information on the survey of patient experience with care; and

(3) As the Secretary may require, on the methods, measures, and data used under the MOCP and the qualified MOCP practice assessment.

Section 10327(b) of the ACA amends section 3002(c) of the ACA further to specify that the additional 0.5 percent incentive payment is available only for years 2011, 2012, 2013, and 2014. For years after 2014, if the Secretary determines it to be appropriate, the Secretary may incorporate participation in an MOCP and successful completion of a qualified MOCP practice assessment into the composite of measures of quality for care furnished pursuant to the physician fee schedule payment modifier.

To implement the provisions under sections 3002(c) and 10327 of the ACA, CMS proposes for 2011 to require the following:

- An EP wishing to be eligible for the additional PQRI incentive payment of 0.5 percent must meet the proposed requirements for satisfactory PQRI reporting, for program year 2011, based on the 12-month reporting period. We propose to require that EPs seeking the additional PQRI incentive payment satisfactorily report for a 12-month reporting period rather than only a 6 month reporting period, based on the statutory language that the EP must satisfactorily report "for a year." For purposes of satisfactory reporting under PQRI, we propose that the EP may participate as an individual EP using either individual PQRI measures or measures groups and submitting the PQRI data via claims, a registry, or an her or participate under one of the GPRO options (I or II),. Alternatively, EPs may satisfactorily report under PQRI based on submission of PQRI data by an MOCP, provided that the MOCP has qualified as a PQRI registry for 2011. As indicated previously, an EP would not necessarily have to qualify for PQRI through an MOCP serving as a registry. Rather, we propose that an EP may qualify for the additional incentive, without reqard to the method by which the EP has met the basic requirement of satisfactory reporting under PQRI.
- In addition to meeting the proposed requirements for satisfactory reporting under PQRI for program year 2011, the EP must have data submitted on his or her behalf through an MOCP, for the MOCP in which the EP participates. Although the MOCP need not become a qualified registry for data submission for PQRI purposes, the MOCP must meet the criteria for a registry for submission of the MOCP data as specified below.
- An EP must, more frequently than is required to qualify for or maintain board certification, participate in an MOCP for a year and successfully complete a qualified MOCP practice assessment for such year. We believe that the "more frequently" requirement applies both to the elements of the MOCP itself and the requirement to successfully complete a qualified MOCP practice assessment. With regard to the elements other than completing a qualified MOCP practice assessment, we propose to require that the MOCP certify that the EP has "more frequently" than is required to qualify for or maintain

board certification "participated in a MOCP for a year" as required by section 10327 of the ACA. We do not propose to specify with respect to participation how an EP must meet the more frequently requirement, but rather that the MOCP so certify that EP has met this requirement. We note that we do not believe that the "more frequently" requirement is applicable to the licensure requirement, given that one cannot be licensed "more frequently" than is required. However, we do believe that the "more frequently" requirement applies to the required elements under sections 1848(m)(7)(C)(i)(II) and 1848(m)(7)(C)(i)(III) of the Act. In other words, we believe that the EP must "more frequently" than is required to qualify for or maintain board certification, participate in educational and self-assessment programs that require an assessment of what was learned; demonstrate, through a formalized, secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty; and successfully complete a qualified MOCP practice assessment.

With respect to the MOCP practice assessment, which is specifically delineated in section 1848(m)(7)(B)(ii) of the Act as being required more often than is necessary to qualify for or maintain board certification, we believe we need to be more specific regarding our interpretation of the phrase "more frequently." Additionally, we are aware that some specialty boards have varying MOCP requirements for physicians to maintain board certification, based on the date of original certification. Some, we believe, may not be required to participate in an MOCP program at all in order to maintain board certifications. Accordingly, we recognize that "more often" may vary among physicians certified by the same specialty board. We interpret the statutory provisions as requiring participation in and successful completion of at least one MOCP practice assessment. Therefore, we propose, as a basic requirement, participation in and successful completion in at least one MOCP practice assessment. For physicians who are not required to participate in an MOCP to maintain board certification, "more often" would be more than 0, and therefore only once. For physicians, however, who are otherwise required by the specialty board to participate in an MOCP to maintain board certification status, these physicians would need to complete the MOCP practice assessment a second time in order to qualify for the additional incentive payment. If an MOCP practice assessment were required more than once during a particular cycle, the EP would be required to complete the MOCP practice assessment a third time in order to qualify for the additional incentive.

We are also aware that ABMS boards are at various stages in implementing the practice assessment modules, and some may not have such assessment modules in place. However, inasmuch as we interpret the statute to require an MOCP practice assessment at least once as part of the MOCP, EPs who do not have available, through their boards or otherwise, an MOCP practice assessment are not eligible for the 0.5 percent incentive.

- We believe that the experience of care survey provides particularly valuable information and propose that a qualified MOCP practice assessment must include a survey of patient experience with care. The Secretary may request information on the survey of patient experience with care, under section 1848(m)(7)(B)(iii) of the Act. In view of the importance of this information, and the lack of readily available alternative sources, we propose to require that MOCPs submit information as to the survey of patient experience with care for the EP regarding whom information is being submitted by the MOCP.

We propose that MOCPs, who wish to enable their members to be eligible for an additional PQRI incentive payment for the 2011 PQRI, will need to go through a self-nomination process by January 31, 2011. We propose the board will need to include all of the following information in their self-nomination letter to CMS:

- Provide detailed information regarding the MOCP with reference to the statutory requirements for such program.
- Indicate the organization sponsoring the MOCP, and whether the MOCP is sponsored by an ABMS board. If not an ABMS board, indicate whether the program is substantially equivalent to the ABMS MOCP process.
- The frequency of a cycle of MOC for the specific MOCP of the sponsoring organization; including what constitutes "more frequently" for the MOCP practice assessment for the specific MOCP of the sponsoring organization.
- What was, is, or will be the first year of availability of the MOCP practice assessment for completion by an EP.
- What data is collected under the patient experience of care survey and how this information would be provided to CMS.
- How the MOCP monitors that an EP has implemented a quality improvement process for their practice.
- Describe the methods, and data used under the MOCP, and provide a list of all measures used in the MOCP for 2010 and to be used for 2011, including the title and descriptions of each measure, the owner of the measure, whether the measure is NQF endorsed, and a link to a Web site containing the detailed specifications of the measures, or an electronic file containing the detailed specifications of the measures.

We propose that sponsoring organizations who desire to participate as an MOCP will need to be able to provide CMS the following information in a CMS-specified file format by no later than the end of the first quarter of 2012:

- The name, NPI and applicable TIN(s) of the EP who would like to participate in this process;
- Attestation from the board that the information provided to CMS is accurate and complete;
- The board has signed documentation from the EP that the EP wishes to have their information released to CMS; Information from the experience of care survey;
- Information certifying that the EP has participated in an MOCP for a year, more frequently than is required to qualify for or maintain board certification status, including the year that the physician met the board certification requirements for the MOCP, and the year the EP participated in an MOCP "more frequently" than is required to maintain or qualify for board certification; and
- Information certifying that the EP has completed the MOCP practice assessment one additional time more than is required to qualify for or maintain board certification, including the year of the original MOCP practice assessment or that an MOCP practice assessment is not required for the EP, and the year of the additional MOCP practice assessment completion.

We propose that specialty boards that also desire to send PQRI information to CMS on behalf of their EP should be able to meet the requirements for registry data submission proposed in section VI.F.1.d.(4) of this rule and should follow the directions for self-nomination to become a qualified registry. Boards may also participate as registries for PQRI data provided that they meet the registry requirements.

As an alternative to requiring boards to either operate a qualified PQRI registry or to self-nominate to submit MOCP data to CMS on behalf of their members, we also considered having the

various boards submit the MOCP data to the ABMS and having ABMS channel the information from the various boards to CMS. We invite comments on the proposed mechanism for receiving MOCP data from the specialty boards as well as on the alternative mechanism that we considered.

(3) Section 3002(d)—Integration of PQRI and EHR Reporting

Section 1848(m)(7) of the Act ("Integration of Physician Quality Reporting and EHR Reporting), as added by section 3002(d) of the ACA requires us to move towards the integration of EHR measures with respect to the PQRI program. Section 1848(m)(7) of the Act specifies that by no later than January 1, 2012, the Secretary shall develop a plan to integrate reporting on quality measures under PQRI with reporting requirements under subsection (o) relating to the meaningful use of EHRs. Such integration shall consist of the following:

(A) The selection of measures, the reporting of which would both demonstrate—

(i) Meaningful use of an EHR for purposes of the EHR incentive program; and

(ii) Quality of care furnished to an individual; and

(B) Such other activities as specified by the Secretary.

In an effort to align PQRI with the EHR incentive program, we propose to include many ARRA core clinical quality measures in the PQRI program, to demonstrate meaningful use of EHR and quality of care furnished to individuals. We propose the selection of these measures to meet the requirements of planning the integration of PQRI and EHR reporting. We are working towards a plan to integrate reporting on quality measures to make available by January 1, 2012.

We solicit comments on this approach to integrate PQRI EHR measures with the clinical quality measures adopted for the EHR incentive program. Specifically, we encourage comments on how CMS plans to align the measures, and how the plan for integration will optimally improve quality of care for individuals and provide meaningful use of EHRs.

(4) Section 3002(e)—Feedback

Section 3002 (e) of the ACA amends section 1848(m)(5) of the Act by adding subparagraph (H), which requires the Secretary to provide timely feedback to EPs on the performance of the EP with respect to satisfactorily submitting data on quality measures. Since the inception of the program in 2007, the PQRI program has provided EPs who have reported PQRI data on quality measures feedback reports at the TIN/NPI level detailing participation in PQRI, including reporting rate and performance rate information. For 2008, we improved the format and content of feedback reports based on stakeholder input. We also developed an alternate report distribution method whereby each EP can directly request and receive a feedback report. We will continue to provide feedback reports to individuals and group practices that satisfactorily submit PQRI quality measure and thus qualify to earn a PQRI incentive.

We believe that the requirements under section 1848(m)(5)(H) of the Act, as added by section 3002(e) of the ACA, for "timely" feedback reports with respect to satisfactorily submitting data on quality measures is met by providing the feedback reports on or about the time of issuance of the incentive payments. Thus, we propose to provide 2011 feedback reports on or about the time of issuance of the 2011 incentive payments, consistent with our current practice.

In addition, we also propose to provide interim feedback reports for EPs reporting 2011 measures groups through the claims-based reporting mechanism. Specifically, we propose to develop interim feedback reports that are similar in content and format to the reports that we currently provide for such EPs using claims for dates of service between January 1, 2011 and February 28, 2011. We expect that we would be able to make these interim feedback reports available to EPs in June 2011. We believe interim feedback reports would be particularly valuable to EPs reporting measures group because, unlike with individual measures reporting, EPs would not be required to report on a certain percentage of eligible cases to satisfactorily report the 2011 PQRI measures groups. EPs could just report on 30 eligible cases to satisfactorily report using measures groups. Interim feedback regarding the number of cases reported as of February 28, 2011 would be valuable since an EP would know how many more cases he or she needs to report to satisfy the criteria for satisfactory reporting for claims-based reporting of measures groups.

We also intend to continue to explore methods to facilitate PQRI feedback report distribution. Additionally, based on feedback from the 2011 PQRI Listening Session that was held on February 2, 2010, we are considering a process by which we could respond to interim feedback report requests at the individual level for claims-based submission, based upon first quarter claims data for the applicable program year. The goal of this would be to provide information to EPs as to errors in claims-based QDC submission while the reporting period is ongoing and prior to the start of the 6-month reporting period. We welcome comments with respect to our proposal to provide timely feedback reports for PQRI.

(5) Section 3002(f)—Appeals

Section 1848(m)(5)(I) of the Act, as amended and added by section 3002(f)(2) of the ACA, requires an informal review process. Specifically, the statute requires that the Secretary establish and have in place, no later than January 1, 2011, an informal process for EPs to seek a review of the determination that an EP did not satisfactorily submit data on quality measures under the PQRI.

We note that except as provided under the informal process under section 1848(m)(5)(I) of the Act, section 1848(m)(5)(E) of the Act, as amended by section 3002(f) of the ACA, specifies that, with respect to the PQRI, there shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of:

(1) The determination of measures applicable to services furnished by EPs under PQRI;

(2) The determination of satisfactory reporting under PQRI; and

(3) The determination of any PQRI incentive payment and PQRI payment adjustment.

We propose to base the informal process on our current inquiry process whereby an EP can contact the Quality Net Help Desk (via phone or e-mail) for general PQRI and eRx Incentive Program information, information on PQRI feedback report availability and access, and/or information on PQRI Portal password issues. We believe that the current inquiry process provides a good basis for an informal review process because EPs currently can utilize the inquiry process if they have questions on whether they qualified for an incentive. However, the current inquiry process does not have timelines nor is it restricted to questions solely on whether the EP qualified for an incentive. Thus, for purposes of the informal process required under section 1848(m)(5)(E) of the Act, we propose the following process:

- An EP electing to utilize the informal process must request an informal review within 90 days of the release of his or her feedback report.
- An EP can request the informal review by notifying the Quality Net Help Desk via e-mail at

qnetsupport@sdps.org. The e-mail requesting the initiation of the informal review process should summarize the concern(s) of the EP and the reason(s) for requesting an informal review.

- We propose to provide the EP with a response to his or her request for an informal review within 60 days of receiving the original request.
- As this process is informal and the statute does not require a formal appeals process, we will not include a hearing or evidence submission process, although the EP may submit information to assist in the review.
- Based on our informal review, we will provide a written response. Where we find that the EP did satisfactorily report, we propose to provide the applicable incentive payment.
- Given that this is an informal review process and given the limitations on review under section 1848(m)(5)(E) of the Act, decisions based on the informal review will be final, and there will be no further review or appeal.
- By December 31, 2011, we propose to post on the CMS PQRI Web site, further information regarding the operational aspects of the informal review process for 2011 PQRI. We invite public comment on this proposed process.

2. Section 132: Incentives for Electronic Prescribing (eRx)— The Electronic Prescribing Incentive Program

a. Program Background and Statutory Authority

As defined in § 423.159(a), eRx is the transmission using electronic media, of prescription or prescription-related information between prescriber, dispenser, pharmacy benefit manager (PBM), or health plan, either directly or through an intermediary, including an eRx network. Included in eRx, but not limited to, are two-way transmissions between the point of care and the dispenser.

Section 1848(m)(2) of the Act promotes the use of electronic prescribing by authorizing incentive payments to EPs or group practices who are "successful electronic prescribers." The intention of the 2011 eRx Incentive Program, which is separate from, and in addition to, any incentive payment that EPs may earn through the PQRI program, is to continue to encourage significant expansion of the use of electronic prescribing by authorizing a combination of financial incentives and payment adjustments. Individual EPs do not have to participate in PQRI in order to participate in the eRx Incentive Program (and vice versa). We propose to add § 414.92 to title 42 of the Code of Federal Regulations to implement the provisions of the eRx Incentive Program discussed in this section of the proposed rule.

For 2011, which is the third year of the eRx Incentive Program, the Secretary is authorized to provide successful electronic prescribers, as defined in section 1848(m)(3)(B) of the Act and further discussed below in this section, an incentive payment equal to 1.0 percent of the total estimated Medicare Part B PFS allowed charges (based on claims submitted not later than 2 months after the end of the reporting period) for all covered professional services furnished during the 2011 reporting period. Covered professional services are defined under the statute to be services for which payment is made under, or is based on, the PFS and which are furnished by an EP. The applicable electronic prescribing percent (1.0 percent) authorized for the 2011 eRx Incentive Program is different from that authorized for the 2009 and 2010 eRx Incentive Program.

Under section 1848(m)(2)(C) of the Act, the incentive payments for successful electronic prescribers for future years are authorized as follows:

- 1.0 percent for 2012.
- 0.5 percent for 2013.

However, section 1848(m)(2)(D) of the Act, as added by section 4101(f)(2)(B) of Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (Pub.L. 111–5) (ARRA–HITECH), specifies that the eRx incentive does not apply to an EP (or group practice), if, for the EHR reporting period, the EP (or group practice) earns an incentive payment under the Medicare EHR incentive program. The Medicare EHR incentive program begins in 2011. Therefore, EPs who earn an incentive under the Medicare EHR Incentive Program, with respect to certified EHR technology that has eRx capabilities, will not be eligible to earn a separate incentive payment for being a successful electronic prescriber under the eRx Incentive Program.

For eRx, when reporting any of the G-codes for purposes of qualifying for the incentive payment for electronic prescribing in 2011, we propose that the professional must have and regularly use a "qualified" electronic prescribing system, as defined in the electronic prescribing measure specifications. If the professional does not have general access to an eRx system in the practice setting, as cited in the hardship exception as stated by the secretary, there is nothing to report.

In addition, under section 1848(a)(5)(A) of the Act, a PFS payment adjustment applies beginning in 2012 to those who are not successful electronic prescribers. Specifically, for 2012, 2013, and 2014, if the EP is not a successful electronic prescriber for the reporting period for the year, the PFS amount for covered professional services furnished by such professionals during the year as referenced above shall be less than the PFS amount that would otherwise apply over the next several years by:

- 1.0 percent for 2012.
- 1.5 percent for 2013.
- 2.0 percent for 2014.

We believe that the criteria for determination of successful electronic prescriber proposed herein for the eRx incentive payment are not required to be identical to the criteria that will be used to determine the applicability of the payment adjustment that begins in 2012. Policy considerations underlying the application of the incentive payment are not necessarily the same as those in applying a payment adjustment. In general, we believe that an incentive should be broadly available to encourage the widest possible adoption of eRx, even for low volume prescribers. On the other hand, we believe that a payment adjustment should be applied primarily to assure that those who have a large volume of prescribing do so electronically, without penalizing those for whom the adoption and use of an electronic prescribing system may be impractical given the low volume of prescribing. The 2011 eRx incentive and the application of the payment adjustment for 2012 will be addressed separately below.

Under section 1848(m)(6)(A) of the Act, the definition of "EP" for purposes of eligibility for the eRx Incentive Program is identical to the definition of "EP" for the PQRI under section 1848(k)(3)(B) of the Act. In other words, EPs include physicians, other practitioners as described in section 1842(b)(18)(C) of the Act, physical and occupational therapists, qualified speech-language pathologists, and qualified audiologists. However, as we have noted in prior years, for purposes of the eRx Incentive Program, eligibility is further restricted by scope of practice to those professionals who have prescribing authority. Detailed information about the types of professionals that are eligible to participate in the eRx Incentive Program is available on the Electronic Prescribing Incentive Program section of the CMS Web site at *http://www.cms.gov/ERXIncentive.*

As in the 2010 eRx Incentive Program, we propose in 2011 that the eRx Incentive Program continue to be an incentive program in which determination of whether an EP is a

successful electronic prescriber will be made at the individual professional level, based on the NPI. Inasmuch as some individuals (identified by NPIs) may be associated with more than one practice or TIN, the determination of whether an EP is a successful electronic prescriber will be made to the holder of each unique TIN/NPI combination. Then, as in previous years, payment will be made to the applicable holder of the TIN. For 2011, the determination of whether an EP is a successful electronic prescriber will continue to be made for each unique TIN/NPI combination. However, section 1848(m)(3)(C) of the Act required the Secretary by January 1, 2010 to establish and have in place a process under which EPs in a group practice (as defined by the Secretary) would be treated as meeting the requirements for submitting data on electronic prescribing quality measures for covered professional services for a reporting period (or, for purposes of the payment adjustment under section 1848(a)(5) of the Act, for a reporting period for a year) if, in lieu of reporting the electronic prescribing measure, the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time specified by the Secretary. Therefore, in addition to making incentive payments for 2011 to individual EPs based on separately analyzing whether the individual EPs are successful electronic prescribers, we propose to also make incentive payments to group practices based on the determination that the group practice, as a whole, is a successful electronic prescriber in accordance with section 1848(m)(3)(C) of the Act.

b. The 2011 eRx Incentive

(1) The 2011 Reporting Period for the eRx Incentive Program

Section 1848(m)(6)(C)(i)(II) of the Act defines "reporting period" for the 2011 eRx Incentive Program to be the entire year. Section 1848(m)(6)(C)(ii) of the Act, however, authorizes the Secretary to revise the reporting period if the Secretary determines such revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden. We propose the 2011 eRx Incentive Program reporting period to be the entire calendar year (January 1, 2011 through December 31, 2011) based on the definition of "reporting period" specified under section 1848(m)(6)(C)(i)(II) of the Act. We believe that keeping the 2011 eRx Incentive Program reporting period consistent with 2009 and 2010 eRx Incentive Program reporting periods will help to further maintain program stability and be less confusing for EPs.

Accordingly, we propose that successful electronic prescribers would be eligible to receive an incentive payment equal to 1.0 percent of the total estimated allowed Medicare Part B charges (based on claims submitted by no later than February 28, 2012) for all covered professional services furnished January 1, 2011 through December 31, 2011.

(2) Proposed Criteria for Determination of Successful Electronic Prescriber for EPs

Under section 1848(m)(3)(B) of the Act, in order to qualify for the incentive payment, an EP must be a "successful electronic prescriber," which the Secretary is authorized to identify using 1 of 2 possible criteria. One criterion, under section 1848(m)(3)(B)(ii) of the Act, is based on the EP's reporting, in at least 50 percent of the reportable cases, on any electronic prescribing quality measures that have been established under the physician reporting system, under subsection 1848(k) of the Act (which, as noted previously, we have named "PQRI" for ease of reference) and are applicable to services furnished by the EP during a reporting period. We applied this criterion in 2009. However, for years after 2009, section 1848(m)(3)(D) of the Act permits the Secretary in consultation with stakeholders and experts to revise the criteria for submitting data on electronic prescribing measures under section 1848(m)(3)(B)(ii) of the Act.

The second criterion, under section 1848(m)(3)(B)(iii) of the Act, is based on the electronic submission by the EP of a sufficient number (as determined by the Secretary) of prescriptions under Part D during the reporting period. If the Secretary decides to use the latter standard, then, in accordance with section 1848(m)(3)(B)(iv) of the Act, the Secretary is authorized to use Part D drug claims data to assess whether a "sufficient" number of prescriptions have been submitted by EPs. However, under section 1848(m)(3)(B)(i) of the Act, if the standard based on a sufficient number (as determined by the Secretary) of electronic Part D prescriptions is applied for a particular reporting period, then the standard based on the reporting on electronic prescribing measures would no longer apply.

For 2011, we propose to continue to require EPs to report on the electronic prescribing measure used in the 2009 and 2010 eRx Incentive Program to determine whether an EP is a successful electronic prescriber, but we are proposing to again use modified measure specifications and to use modified reporting criteria based on the authority provided under section 1848(m)(3)(D) of Act, as discussed below.

As we stated in prior years, we are still considering the use of a certain number of Part D prescribing events as the basis for the incentive payment. We propose to continue to require EPs to report on the electronic prescribing measure used in the 2009 and 2010 eRx Incentive Program because we believe that the accuracy and completeness of the Part D data with respect to whether a prescription was submitted electronically is unknown. In 2010, information on whether a prescription was submitted electronically by an individual EP began to be collected on the Part D claims and/or Prescription Drug Event (PDE) data. Also, since April 1, 2009, prescription drug plan sponsors are required to send PDE data with an individual prescriber's NPI. We currently have limited information on the accuracy and completeness of NPI data that is submitted with the PDE data. The NPI is needed in order for CMS to be able to link an EP's PDE data to his or her Medicare Part B claims to calculate the incentive payment amount. During 2010, we continue to evaluate the adequacy of Part D data to determine the feasibility of its use for determining whether an EP qualifies as a successful electronic prescriber. The use of Part D data for correlation has not yet shown to be possible due to NPI and other issues. Part D data is supplied by the pharmacy and not the EP. We are in the process of writing and will publish an evaluation of the PQRI reporting experience. The experience report will include an evaluation of the eRx Incentive Program.

(i) Reporting the Electronic Prescribing Measure

For 2011, we propose to retain the 3 reporting mechanisms available to individual EPs to report the electronic prescribing measure in 2010 to maintain program stability. First, we propose to again retain the claims-based reporting mechanism that is used in the 2009 and 2010 eRx Incentive Program. In addition, similar to the PQRI, for the eRx Incentive Program, we propose to continue the registry-based reporting mechanism and, we also propose that the EHR-based reporting mechanism be available for the electronic prescribing measure for 2011.

We propose that only registries qualified to submit quality measure results and numerator and denominator data on quality measures on behalf of EPs for the 2011 PQRI would be qualified to submit measure results and numerator and denominator data on the electronic prescribing measure on behalf of EPs for the 2011 eRx Incentive Program. As in 2010, not all registries qualified to submit quality measures on behalf of EPs for the 2011 PQRI would be qualified to submit quality measures results and numerator and denominator data on the eRx measure. The electronic prescribing measure is reportable by an EP any time he or she bills for one of the procedure codes for Part B services included in the measure's denominator. Some registries who self-nominate to become a qualified registry for PQRI may not choose to self-nominate to become a qualified registry for submitting measures that require reporting at each eligible visit. Registries need to indicate their desire to qualify to submit measure results and numerator and denominator data on the electronic prescribing measure for the 2011 eRx Incentive program at the time that they submit their self-nomination letter for the 2011 PQRI. In addition, we propose that registries that want to be qualified to submit measure results and numerator and denominator data on the electronic prescribing measure for the 2011 eRx Incentive Program would be required to transmit 2011 eRx measure results and numerator and denominator data on the electronic prescribing measure to CMS in two separate transmissions. In addition to submitting 2011 measure results and numerator data on the electronic prescribing measure in 2012 as described in section VI.F.1. above, such registries would need to submit 2011 measure results and numerator and denominator data on the electronic prescribing measure between July 1, 2011 and August 19, 2011 for purposes of the eRx penalty described in section VI.F.2.c. below. The self-nomination process and requirements for registries for the PQRI, which also would apply to the registries for the 2011 eRx Incentive Program, are discussed previously in section VI.F.1. of this proposed rule. We will post a final list of qualified registries for the 2011 eRx Incentive Program on the Electronic Prescribing Incentive Program section of the CMS Web site at *http://www.cms.gov/ERXIncentive* when we post the final list of qualified registries for the 2011 PQRI on the PQRI section of the CMS Web site.

Similarly, we continue to propose that only EHR products "qualified" to potentially be able to submit clinical quality data extracted from the EHR to CMS for the 2011 PQRI would be considered "qualified" for the purpose of an EP potentially being able to submit data on the electronic prescribing measure for the 2011 eRx Incentive Program. The self-nomination process and requirements for EHR vendors for the PQRI, which would apply to the EHR vendors for the 2011 eRx Incentive Program were discussed in the CY 2010 PFS final rule with comment period (74 FR 61801 through 61802). EHR vendors were required to indicate their desire to have one or more of their EHR products qualified for the purpose of an EP potentially being able to submit data on the electronic prescribing measure for the 2011 eRx Incentive Program at the time that they submitted their self-nomination letter for the 2011 PQRI. A list of qualified EHR vendors and their products (including the version that is qualified) for the 2011 eRx Incentive Program will be posted on the eRx Incentive Program section of the CMS Web site at *http://www.cms.gov/ERXIncentive* when we post the list of qualified EHR products for the 2011 PQRI on the PQRI section of the CMS Web site. We propose that EPs who want to use a qualified EHR to submit the electronic prescribing measure for the 2011 eRx Incentive Program would be required to transmit 2011 eRx data to CMS in two separate transmissions. In addition to submitting 2011 data on the electronic prescribing measure in 2012, as described in section VI.F.1. above, such EPs would need to submit 2011 data on the electronic prescribing measure between July 1, 2011 and August 19, 2011 for purposes of the eRx penalty described in section VI.F.2.c. below.

(ii) The Reporting Denominator for the Electronic Prescribing Measure

The electronic prescribing measure, similar to the PQRI measures, has 2 basic elements, which include: (1) A reporting denominator that defines the circumstances when the measure is reportable; and (2) a reporting numerator.

The denominator for the electronic prescribing measure consists of specific billing codes for covered professional services. The measure becomes reportable when any one of these procedure codes is billed by an EP for Part B covered professional services. As initially required under section 1848(k)(2)(A)(ii) of the Act, and further established through rulemaking and under section 1848(m)(2)(B) of the Act, we may modify the codes making up the denominator of the electronic prescribing measure. As such, we expanded the scope of the denominator codes for 2010 to covered professional services outside the professional office and outpatient setting, such as professional services furnished in skilled nursing facilities or the home care setting.

We propose to retain the following CPT codes in the denominator of the electronic prescribing measure for 2011: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109. In 2010, the expansion of the electronic prescribing measure denominator was expected to provide more EPs the opportunity to report the measure, and thus, provide more opportunities for EPs to participate in the eRx Incentive Program. Thus far, our experience in the 2010 eRx Incentive Program has been positive and we do not see a need to change the denominator codes for 2011. We invite comments on our proposal to retain the denominator codes from the 2010 electronic prescribing measure denominator.

There are no diagnosis codes in the measure's denominator and there are no age/gender requirements in order for a patient to be included in the measure's denominator (that is, reporting of the electronic prescribing measure is not further limited to certain ages or a specific gender). EPs are not required to report this measure in all cases in which the measure is reportable. EPs who do not bill for one of the procedure codes for Part B covered professional services included in the measure's denominator will have no occasion to report the electronic prescribing measure.

We further propose that by December 31, 2010, we will post the final specifications of the measure on the "eRx Measure" page of the eRx Incentive Program section of the CMS Web site at *http://www.cms.gov/ERXIncentive.*

(iii) Qualified Electronic Prescribing System—Required Functionalities and Part D eRx Standards

To report the electronic prescribing measure in 2011, we again propose that the EP must report one of the measure's numerator "G" codes, as will be discussed below. However, when reporting any of the G-codes for purposes of qualifying for the incentive

payment for electronic prescribing in 2011, we propose that the professional must have and regularly use a "qualified" electronic prescribing system, as defined in the electronic prescribing measure specifications. If the professional does not have general access to an eRx system in the practice setting, the EP does not have any data to report for purposes of the incentive payment.

Required Functionalities for a "Qualified" Electronic Prescriber System.

For 2011, we propose to retain what constitutes a "qualified" electronic prescribing system as a system based upon certain required functionalities that the system can perform. We propose that for 2011, a "qualified" electronic prescribing system would be one that can—

- Generate a complete active medication list incorporating electronic data received from applicable pharmacies and PBMs, if available.
- Allow EPs to select medications, print prescriptions, electronically transmit prescriptions, and conduct alerts (written or acoustic signals to warn the prescriber of possible undesirable or unsafe situations including potentially inappropriate dose or route of administration of a drug, drug-drug interactions, allergy concerns, or warnings and cautions). This functionality must be enabled.
- Provide information related to lower cost, therapeutically appropriate alternatives (if any). The ability of an electronic prescribing system to receive tiered formulary information, if available, would again suffice for this requirement for 2011 and until this function is more widely available in the marketplace.
- Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan (if available).

Part D Electronic Prescribing Standards. Section 1848(m)(3)(B)(v) of the Act specifies that to the extent practicable, in determining whether an EP is a successful electronic prescriber, "the Secretary shall ensure that EPs utilize electronic prescribing systems in compliance with standards established for such systems pursuant to the Part D Electronic Prescribing Program under section 1860D–4(e)" of the Act. The Part D standards for electronic prescribing systems establish which electronic standards Part D sponsors, providers, and dispensers must use when they electronically transmit prescriptions and certain prescription related information for Part D covered drugs that are prescribed for Part D eligible individuals. To be a qualified electronic prescribing system under the current eRx Incentive Program, electronic systems must convey the information listed above under (a) through (d) using the standards currently in effect for the Part D electronic prescribing program. Additional Part D electronic prescribing standards were implemented April 1, 2009. These latest Part D electronic prescribing standards, and those that had previously been adopted, can be found on the CMS Web site at *http://www.cms.gov/eprescribing.*

To ensure that EPs utilize electronic prescribing systems that meet these requirements, the electronic prescribing measure requires that those functionalities required for a "qualified" electronic prescribing system utilize the adopted Part D electronic prescribing standards. The Part D electronic prescribing standards relevant to the four functionalities for a "qualified" system in the electronic prescribing measure described above and listed as (a), (b), (c), and (d), currently are as follows:

(a) Generate medication list—Use the National Council for Prescription Drug Programs (NCPDP) Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide, Version 8, Release 1, October 2005 (hereinafter "NCPDP SCRIPT 8.1") Medication History Standard.

(b) Transmit prescriptions electronically—Use the NCPDP SCRIPT 8.1 for the transactions listed at § 423.160(b)(2).

(c) Provide information on lower cost alternatives—Use the NCPDP Formulary and Benefits Standard, Implementation Guide, Version 1, Release 0 (Version 1.0), October 2005 (hereinafter "NCPDP Formulary and Benefits 1.0").

(d) Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan—use—

(1) NCPDP Formulary and Benefits 1.0 for communicating formulary and benefits information between prescribers and plans;

(2) Accredited Standards Committee (ASC) X12N 270/271–Health Care Eligibility Benefit Inquiry and Response, Version 4010, May 2000, Washington Publishing Company, 004010X092 and Addenda to Health Care Eligibility Benefit Inquiry and Response, Version 4010A1, October 2002, Washington Publishing Company, 004010X092A1 for communicating eligibility information between the plan and prescribers; and

(3) NCPDP Telecommunication Standard Specification, Version 5, Release 1 (Version 5.1), September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1, Release 1 (Version 1.1), January 2000 for communicating eligibility information between the plan and dispensers.

However, there are Part D electronic prescribing standards that are in effect for functionalities that are not commonly utilized at this time. Such functionalities are not currently required for a "qualified" system under the eRx Incentive Program. One example is Rx Fill Notification, which is discussed in the Part D electronic prescribing final rule (73 FR 18918, 18926). For purposes of the 2011 Electronic Prescribing Program, we again are not proposing to require that an electronic prescribing system contain all functionalities for which there are available Part D electronic prescribing standards. For those required functionalities described above, we propose that a "qualified" system must use the adopted Part D electronic prescribing standards for electronic messaging.

There are other aspects of the functionalities for a "qualified" system that are not dependent on electronic messaging and are part of the software of the electronic prescribing system, for which Part D standards for electronic prescribing do not pertain and are not required for purposes of the eRx Incentive Program. For example, the requirements in qualification (b) listed above that require the system to allow professionals to select medications, print prescriptions, and conduct alerts are functions included in the particular software, for which Part D standards for electronic messaging do not apply.

We are aware that there are significant numbers of EPs who are interested in participating in the eRx Incentive Program, but currently do not have an electronic prescribing system. The electronic prescribing measure does not require the use of any particular system or transmission network; only that the system be a "qualified" system having the functionalities described above based on Part D electronic prescribing standards. As in 2010, if the professional does not have general access to an electronic prescribing system in the practice setting, the EP does not have any data to report for purposes of the incentive payment and would not be able to participate in the 2011 eRx Incentive Program. If an EP does not participate in the 2011 eRx Incentive Program he or she may be subject to the 2012 eRx penalty

discussed in section VI.F.2.c. of this proposed rule.

(iv) The Reporting Numerator for the Electronic Prescribing Measure

The proposed criteria for reporting for purposes of being a 2011 successful electronic prescriber are designed to reward those EPs who demonstrate that they have adopted a qualified electronic prescribing system and actually used the system in a substantial way to electronically prescribe. In this context, the reporting of information in circumstances where a professional did not electronically prescribe is not pertinent. Additionally, although it may be of interest to measure the proportion of prescribing events that are electronic, we do not believe such detail at the individual or group practice level is of sufficient value to warrant the high burden of reporting such information. We do note that in the future the use of Part D claims data may allow this information to be collected without the necessity for professionals to specifically report such details.

Accordingly, for the 2011 electronic prescribing measure, we propose to retain the following numerator G-code from the 2010 electronic prescribing measure's numerator: G8553 (At least 1 prescription created during the encounter was generated and transmitted electronically using a qualified electronic prescribing system.)

We propose to post the final 2011 electronic prescribing measure specifications on the "eRx Measure" page of the eRx Incentive Program section of the CMS Web site at *http://www.cms.gov/ERXIncentive*. We propose to post the final 2011 electronic prescribing measure specifications by no later than December 31, 2010.

Because the electronic prescribing quality measure will apply only when an EP furnishes services indicated by one of the codes included in the measure's denominator, for claims-based reporting, for example, it will not be necessary for an EP to report G-codes for the electronic prescribing measure on claims not containing one of the denominator codes. However, if reporting a G-code, the G-code data submission will only be considered valid if it appears on the same Medicare Part B claim containing one of the electronic prescribing quality measure's denominator codes.

In addition, if the EP submits a Medicare Part B claim containing one of the electronic prescribing measure's denominator codes, he or she can report the numerator G-code only when the EP furnishes services indicated by the G-code included in the measure's numerator. That is, only when at least 1 prescription created during the encounter is generated and transmitted electronically using a qualified electronic prescribing system.

(v) Criteria for Successful Reporting of the Electronic Prescribing Measure

As discussed above, section 1848(m)(3)(D) of the Act authorizes the Secretary to revise the criteria for submitting data on the electronic prescribing measure from the criteria specified under section 1848(m)(3)(B)(ii) of the Act, which requires the measure to be reported in at least 50 percent of the cases in which the measure is reportable. In 2010, we revised the criteria for successful electronic prescriber such that an EP shall be treated as a successful electronic prescriber for a reporting period based on the EP's reporting of the electronic prescribing measure by generating and reporting one or more prescriptions associated with a patient visit electronically, a minimum of 25 unique visits per year in 2010 of applicable cases in the denominator of the eRx measure. For 2011, we again propose to make the determination of whether an EP is a successful electronic prescriber based on a count of the number of times (minimum threshold of 25) an EP reports that at least one prescription created during the encounter is generated using a qualified electronic prescribing system (that is, reports the G8553 code).

As in 2010, we believe these criteria will bring us closer to our intention to transition to using a certain number of electronic Part D prescribing events as the basis for the incentive payment in future years. In proposing these criteria again for 2011 eRx, we continue to assume that once an EP has invested in an eRx system, integrated the use of the eRx system into the practice's work flows, and has used the system to some extent, he or she is likely to continue to use the eRx system for most of the prescriptions he or she generates.

For structural measures such as the electronic prescribing measure, once an EP has demonstrated that he or she has integrated use of an eRx system into his or her practice's work flow, we believe that requiring the EP to continue to report the measure represents an administrative burden with little added benefit to the reliability and validity of the data being reporting. In contrast, for clinical quality measures, we believe that the reliability and validity of the performance rates depends on the adequacy of the sample. Therefore, we propose that an EP would be required to report that at least 1 prescription for a Medicare Part B FFS patient created during an encounter that is represented by 1 of the codes in the denominator of the electronic prescribing measure was generated and transmitted electronically using a qualified eRx system for at least 25 times during the 2011 reporting period.

The reporting threshold of 25 also takes into consideration that prescriptions are not generated with every Medicare Part B FFS patient encounter, some prescriptions, such as narcotics, cannot be prescribed electronically, and that not all Medicare Part B FFS encounters are represented by the electronic prescribing measure's denominator codes.

As stated previously, we propose that by December 31, 2010, we will post the final specifications of the measure on the "eRx Measure" page of the eRx Incentive Program section of the CMS Web site at *http://www.cms.gov/ERXIncentive*.

(3) Determination of the 2011 Incentive Payment Amount for Individual EPs Who Are Successful Electronic Prescribers

Section 1848(m)(2)(B) of the Act imposes a limitation on the electronic prescribing incentive payment. The Secretary is authorized to choose 1 of 2 possible criteria for determining whether or not the limitation applies to a successful electronic prescriber. The first criterion, under section 1848(m)(2)(B)(i) of the Act, is based upon whether the Medicare Part B allowed charges for covered professional services to which the electronic prescribing quality measure applies are less than 10 percent of the total Medicare Part B PFS allowed charges for all covered professional services furnished by the EP during the reporting period. The second criterion, under section 1848(m)(2)(B)(ii) of the Act, is based on whether the EP submits (both electronically and non-electronically) a sufficient number (as determined by the Secretary) of prescriptions under Part D (which can, again, be assessed using Part D drug claims data). If the Secretary decides to use the latter criterion, then, in accordance with section 1848(m)(2)(B) of the Act, the criterion based on the reporting on electronic prescribing measures would no longer apply. The statutory limitation also applies with regard to the application of the payment adjustment.

Based on our proposal to make the determination of whether an EP is a "successful electronic prescriber" based on submission of the electronic prescribing measure, we propose to

again apply the criterion under section 1848(m)(2)(B)(i) of the Act for the limitation for the 2011 eRx Incentive Program.

Since, as discussed above, we are retaining for 2011 our proposal to make the determination of whether an EP is a "successful electronic prescriber" based on submission of the electronic prescribing measure, we also are proposing to retain the requirement to analyze the claims submitted by the EP at the TIN/NPI level to determine whether the 10 percent threshold is met in determining the receipt of an electronic prescribing incentive payment for 2011 by an EP. This calculation is expected to take place in the first quarter of 2012 and will be performed by dividing the EP's total 2011 Medicare Part B PFS allowed charges for all such covered professional services submitted for the measure's denominator codes by the EP's total Medicare Part B PFS allowed charges for all covered professional services (as assessed at the TIN/NPI level). If the result is 10 percent or more, then the statutory limitation will not apply and a successful electronic prescriber will qualify to earn the electronic prescribing incentive payment. If the result is less than 10 percent, then the statutory limitation will apply and the EP will not earn an electronic prescribing incentive payment even if he or she electronically prescribes and reports a G-code indicating that he or she generated and transmitted a prescription electronically at least 25 times for those eligible cases that occur during the 2011 reporting period. Although an individual EP may decide to conduct his or her own assessment of how likely this statutory limitation is expected to apply to him or her before deciding whether or not to report the electronic prescribing measure, an individual EP may report the electronic prescribing measure without regard to the statutory limitation for the incentive payment.

(4) Proposed Reporting Option for Satisfactory Reporting of the Electronic Prescribing Measure by Group Practices

In 2010 eRx Incentive Program, we were required by section 1848(m)(3)(C) of the Act to establish a process under which EPs in a group practice shall be treated as a successful electronic prescriber. In addition, section 1848(m)(3)(C)(iii) of the Act requires that payments to a group practice by reason of the process established under section 1848(m)(3)(C)(i) of the Act shall be in lieu of the payments that would otherwise be made under this subsection to EPs in the group practice for being a successful electronic prescriber. In 2011, we propose to retain the requirements from 2010 eRx Incentive Program with respect to making incentive payments to group practices based on the determination that the group practice, as a whole, is a successful electronic prescriber for 2011. An individual EP who is affiliated with a group practice participating in the group practice reporting option that successfully meets the proposed requirements for group practices would not be eligible to earn a separate eRx incentive payment for 2011 on the basis of his or her successfully reporting the electronic prescribing measure at the individual level.

(i) Definition of "Group Practice"

Section 1848(m)(3)(C)(i) of the Act authorizes the Secretary to define "group practice." For purposes of determining whether a group practice is a successful electronic prescriber for 2011, we propose that consistent with the definition of group practice proposed for the PQRI group practice reporting option (GPRO) discussed in section VI.F.1. of this proposed rule, a "group practice" would be defined as a single Taxpayer Identification Number (TIN) with 2 or more EPs, as identified by their individual National Provider Identifier (NPI), who have reassigned their Medicare billing rights to the TIN. "Group practice" would also include group practices participating in Medicare demonstration projects approved by the Secretary, as described in section VI.F.1.g.(2) of this proposed rule.

In addition, we propose to restrict participation in the 2011 eRx GPRO to group practices participating in the 2011 PQRI GPRO (either through GPRO I or GPRO II) or group practices that are deemed to be participating in the 2011 PQRI GPRO (that is, group practices participating in a CMS-approved Medicare demonstration) that have indicated their desire to participate in the 2011 eRx GPRO.

Therefore, unlike individual EPs who are not required to participate in the PQRI, to be eligible to earn an electronic prescribing incentive in 2011, group practices that wish to participate in the electronic prescribing group practice reporting option will be required to participate in the PQRI group practice reporting option or be deemed to be participating in the PQRI group practice reporting option based on the practice's participation in an approved Medicare demonstration project. Participation in the eRx Incentive Program, including participation in the electronic prescribing group practice reporting option is, however, optional for group practices that are participating in PQRI under the group practice reporting option. If a group practice wishes to participate in the 2011 eRx Incentive Program under the group practice reporting option, it must indicate its desire to do so at the time that the group practice self-nominates to participate in the 2011 PQRI group practice reporting option. There is no need for group practices to indicate their intent to participate in the 2011 eRx Incentive Program as individual EPs when the group practice self-nominates to participate in the 2011 PQRI group practice reporting option.

Group practices interested in participating in the 2011 PQRI through the group practice reporting option will be required to submit a self-nomination letter to CMS, requesting to participate in the 2011 PQRI group practice reporting option. Instructions for submitting the self-nomination letter will be posted on the PQRI section of the CMS Web site by November 15, 2010. A group practice that wishes to participate in the eRx Incentive Program group practice reporting option will be notified of the selection decision to participate in the eRx Incentive Program at the same time that it is notified of the selection decision for the PQRI group practice reporting option.

In addition to meeting the proposed eligibility requirements discussed in section VI.F.1.g. of this proposed rule, we propose that a group practice that wishes to participate in the 2011 eRx Incentive Program under the group practice reporting option will also have to indicate how it intends to report the electronic prescribing measure. That is, the group practice will need to indicate in its self-nomination letter which reporting mechanism the group practice intends to use for purposes of participating in the 2011 eRx Incentive Program group practice reporting option.

(2) Process for Group Practices to Participate as Group Practices and Criteria for Successful Reporting of the Electronic Prescribing Measure by Group Practices

For group practices selected to participate in the electronic prescribing group practice reporting option for 2011, we propose the reporting period would be January 1, 2011, to December 31, 2011.

We propose that physician groups selected to participate in the 2011 eRx Incentive Program through the group practice reporting option would be able to choose to report the electronic prescribing measure through the claims-

based, the registry-based, or, the EHR-based reporting mechanism.

In order for a group practice participating in the PQRI GPRO I to be considered a successful electronic prescriber, we propose that the group practice would have to report that at least 1 prescription during an encounter was generated and transmitted electronically using a qualified electronic prescribing system in at least 2,500 instances during the reporting period. In order for a group practice participating in the PQRI GPRO II to be considered a successful electronic prescriber, we propose that the group practice would have to report that at least 1 prescription during an encounter was generated and transmitted electronically using a qualified electronic prescribing system for the number of instances specified in Table 50 (see section VI.F.1.g.(3).(ii). of this proposed rule). In other words, a group of 2–10 NPIs would need to report the 2011 electronic prescribing measure for at least 75 denominator eligible patient encounters during 2011, 225 instances for groups of 11–25 NPIs, 475 instances for groups of 26–50 NPIs, 925 instances for groups of 51–100, and 1,875 instances for groups of 101–199.

Section 1848(m)(2)(B) of the Act specifies that the limitation on the applicability of the electronic prescribing incentive applies to group practices as well as individual EPs. Therefore, in determining whether a group practice will receive an electronic prescribing incentive payment for 2011 by meeting the proposed reporting criteria described above, we would determine whether the 10 percent threshold is met based on the claims submitted by the group practice.

This calculation is expected to take place in the first quarter of 2012 and will be determined by dividing the group practice's total 2011 Medicare Part B PFS allowed charges for all covered professional services submitted for the measure's denominator codes by the group practice's total Medicare Part B PFS allowed charges for all covered professional services. If the result is 10 percent or more, then the statutory limitation would not apply and a group practice that is determined to be a successful electronic prescriber would qualify to earn the electronic prescribing incentive payment. If the result is less than 10 percent, then the statutory limitation would apply and the group practice would not qualify to earn the electronic prescribing incentive payment.

c. The 2012 eRx Penalty

As stated previously, section 1848(a)(5) of the Act requires that beginning with respect to covered professional services furnished by an EP in 2012, if the EP is not a successful electronic prescriber for the reporting period for the year, the fee schedule amount for such services furnished by such professional during 2012 shall be equal to 99 percent of the fee schedule amount that would otherwise apply to such PFS services. As noted previously, we do not believe that the criteria that will be used to determine the applicability of the payment adjustment, or penalty, for 2012 need to be identical to the criteria for determination of successful electronic prescriber.

We note also that although earning an incentive payment under the EHR incentive payment program precludes an EP from earning an eRx incentive payment, it does not preclude the EP from being subject to the eRx penalty. In order to avoid the eRx penalty, an EP participating in the Medicare EHR incentive program still must meet the relevant eRx penalty criteria for being a successful electronic prescriber.

(1) The eRx Penalty Reporting Period

For purposes of the 2012 eRx penalty, we propose to make a determination of whether an EP or a group practice is a successful electronic prescriber based on the reporting period that begins January 1, 2011 through June 30, 2011. We are proposing a 6-month reporting period for the 2012 penalty rather than a 12-month reporting period so that we may be able to complete the analysis of 2011 data to determine whether an EP or group practice is a successful electronic prescriber prior to January 1, 2012. In order to apply the penalty in 2012 concurrently with claims submission, we will need to make a determination of whether the penalty applies sufficiently in advance of 2012. We believe that establishing a 6-month reporting period for the first year of the penalty will provide administrative efficiencies and avoid the need to apply a retroactive penalty or to make retroactive payments based on application of a penalty.

For EPs and group practices using the claims-based reporting mechanism, we propose that all claims for services furnished between January 1, 2011 and June 30, 2011 must be processed by no later than July 31, 2011 for the claim to be included in our data analysis. This is in contrast to the incentive, where we allow 2 months for claims to be processed. In order to be able to make a determination of whether the penalty applies sufficiently in advance of 2012, we will need to begin our analysis of the claims shortly after June 30, 2011. We invite comments on the proposed reporting period for the 2012 penalty and our proposal to require claims to be submitted by no later than 1 month after the reporting period.

(2) Criteria for Determining Applicability of the 2012 eRx Penalty to Individual EPs

Based on the authority under section 1848(m)(3)(D) of the Act, we propose that the 2012 eRx penalty would apply to an individual EP unless one of the following conditions is met:

- The EP is not a physician (includes MDs, DOs, and podiatrists), nurse practitioner, or physician assistant as of June 30, 2011. We believe that it is appropriate to limit the application of the penalty to those professionals who generally have prescribing privileges nationwide. Other EPs not listed above may have prescribing privileges in some states but not others. Therefore, we propose to exempt EPs who do not generally have prescribing privileges from being subject to the penalty.
- The EP does not have at least 100 cases (that is, claims for patient services) containing an encounter code that falls within the denominator of the eRx measure for dates of service between January 1, 2011 through June 30, 2011. We seek to apply the penalty only to EPs who have a sufficient number of cases between January 1, 2011 and June 30, 2011 to meet the criteria for successful electronic prescribing for purposes of the penalty. We believe that, on average, for every 10 eligible cases, there will be at least one electronic prescribing opportunity, which provides a sufficient number of cases to allow EPs to meet the criteria for being a successful electronic prescriber. In addition, we seek to prevent EPs who are new to Medicare from being subject to the eRx penalty.
- The EP is a successful electronic prescriber for the January 1, 2011 through June 30, 2011 reporting period. Specifically, we propose that the EP must report that at least 1 prescription for Medicare Part B FFS patients created during an encounter that is represented by 1 of the codes in the denominator of the 2011 electronic prescribing measure was generated and transmitted electronically using a qualified eRx system at least 10 times during the 2012 eRx penalty reporting period (that is, January 1, 2011 through June 30, 2011). We propose reporting criteria that are lower for the 2012 eRx penalty than for the 2011 eRx incentive because EPs will only have 6 months to satisfy the

criteria for the 2012 penalty but have a full year to satisfy the criteria for the 2011 incentive.

The limitation with respect to the electronic prescribing measures required under section 1848(m)(2)(B)(i) of the Act also applies to the penalty. Therefore, we propose that if less than 10 percent of the EP's estimated total allowed charges for the January 1, 2011 through June 30,2011 reporting period are comprised of services which appear in the denominator of the 2011 electronic prescribing measure, then the EP would not be subject to the eRx penalty.

We invite comments on the proposed conditions under which we would prospectively apply the 1.0 percent reduction in PFS charges for services furnished January 1, 2012 through December 31, 2012. We specifically invite comments on our proposals to exempt certain types of EPs and EPs who do not have a certain number of cases from the penalty as well as the proposed criteria for successful reporting of the electronic prescribing measure for individual EPs with respect to the penalty.

As with the 2011 incentive payment, we propose that the determination of whether an EP is subject to the penalty will be made at the individual professional level, based on the NPI and for each unique TIN/NPI combination.

(3) Criteria for Determining Applicability of the 2012 eRx Penalty to Group Practices

As required by section 1848(m)(3)(C) of the Act, we are also required to establish and have in place a process under which EPs in a group practice shall be treated as a successful electronic prescriber for purposes of the eRx penalty. Thus, we propose that for purposes of the 2012 eRx penalty, a payment adjustment would not be applied to a a group practice participating in the 2011 eRx GPRO if the group practice is participating in either the 2011 PQRI GPRO I or the 2011 PQRI GPRO II and meets the proposed 2011 criteria for successful electronic prescribing described in sections VI.F.2.b.(4).(ii). (with respect to the eRx requirements for GPRO I participants who wish to participate in the 2011 eRx GPRO) and VI.F.1.g.(3).(ii). of the preamble to this proposed rule (with respect to the eRx requirements for GPRO II participants who wish to participate in the 2011 eRx GPRO) for the 2011 eRx incentive.

For purposes of the 2012 eRx penalty, we propose that the proposed 2011 criteria for successful electronic prescribing would need to be satisfied during the 2012 eRx penalty reporting period of January 1, 2011 through June 30, 2011 for the same operational reasons that we are proposing a 6-month reporting period for the penalty for individual EPs. Furthermore, we do not believe that group practices would be disadvantaged by having to satisfy the proposed criteria for being a successful electronic prescriber for the 2011 incentive in 6 months rather than 12 months to avoid the penalty. When compared to the criteria for individual EPs, the proposed criteria for being a successful electronic prescriber for the 2011 eRx incentive payment for group practices enable group practices, on average, to earn the incentive by electronically prescribing a fewer number of prescriptions per EP than what individual EPs are required to do.

For purposes of determining whether the eRx penalty applies to a group practice, we propose to conduct our analysis for each unique TIN/NPI combination so as not to disadvantage EPs who may have joined the group practice after January 1, 2011.

In addition, in accordance with section 1848(m)(2)(B)(i) of the Act, we also propose that the 2012 eRx penalty would not apply to an eRx GPRO in which less than 10 percent of the group practice's estimated total allowed charges for the January 1, 2011 through June 30, 2011 reporting period are comprised of services which appear in the denominator of the 2011 electronic prescribing measure. To be consistent with how this limitation is applied to group practices for purposes of the incentive, we propose to determine whether this limitation applies to a group practice for the penalty at the TIN level.

For the same reasons that we are proposing a 6-month reporting period for the 2012 eRx penalty for group practices, we also propose that we will use only claims processed by July 31, 2011 in our analysis. This is consistent with our proposed approach for analyzing individual EP claims. Similarly, we propose that registries would need to submit eRx data for services furnished January 1, 2011 through June 30, 2011 to CMS between July 1, 2011 and August 19, 2011 so that we may include registry data in our analysis. We propose also that group practices participating in the eRx group practice reporting option via EHR-based reporting would be required to submit eRx data for services furnished January 1, 2011 through June 30, 2011 to CMS between July 1, 2011 and August 19, 2011.

We invite comments on the proposed criteria for determining applicability of the 2012 eRx penalty to group practices, including the proposed criteria for successful reporting of the electronic prescribing measure for group practices, and our proposed analytical approach.

(4) Significant Hardship Exemption

Section 1848(a)(5)(B) of the Act provides that the Secretary may, on a case-by-case basis, exempt an EP from the application of the payment adjustment, or penalty, if the Secretary determines, subject to annual renewal, that compliance with the requirement for being a successful electronic prescriber would result in a significant hardship, such in the case of an EP who practices in a rural area without sufficient Internet access. Therefore, we propose that in addition to meeting the criteria for successful electronic prescriber described in sections VI.F.2.(c).(2) and VI.F.2.(c).(3) of the preamble to this proposed rule, an EP or group practice may also be exempt from application of the 2012 eRx penalty, if during the 2012 eRx penalty reporting period (that is, January 1, 2011 through June 30, 2011), one of the following circumstances applies to the EP or group practice:

- The EP or group practice practices in a rural area with limited high speed Internet access.
- The EP or group practice practices in an area with limited available pharmacies for electronic prescribing.

We propose to add two additional "G" codes to the 2011 electronic prescribing measure's specifications describing these 2 circumstances. EPs or group practices to whom one or more of these circumstances apply would be required to report the appropriate G-code at least once between January 1, 2011 and June 30, 2011 using their selected 2011 eRx reporting mechanism. Reporting of one of these two G-codes prior to June 30, 2011 will indicate to us that the EP or group practice would like to be considered for an exemption from the 2012 penalty under the significant hardship exception. We invite comments on the proposed process for the significant hardship exception as well as comments regarding other circumstances that should be considered a significant hardship.

d. The 2013 eRx Penalty

Section 1848(a)(5) of the Act also requires that with respect to covered professional services furnished by an EP in 2013, if the EP is not a successful electronic prescriber for the reporting period for the year, the fee schedule amount for such services furnished by such professional during 2013 shall be equal to 98.5 percent of the fee schedule

amount that would otherwise apply to such PFS services. Under section 1848(m)(3)(C) of the Act, we are also required to establish and have in place a process under which EPs in a group practice shall be treated as a successful electronic prescriber for purposes of the eRx penalty.

For purposes of the 2013 eRx penalty, we propose to use the proposed 2011 criteria for successful electronic prescriber to determine whether an EP or a group practice is a successful electronic prescriber for purposes of the 2013 eRx penalty. In addition, we propose that the reporting period for the 2013 eRx penalty would be the 2011 eRx incentive reporting period of January 1, 2011 through December 31, 2011. We believe that matching the criteria that will be applied for the 2013 penalty with the criteria that will be applied for the incentive in an earlier year would be the most effective means of encouraging EPs and group practices to adopt and use electronic prescribing systems since anyone who does not qualify for an incentive in 2011 would be subject to a payment adjustment in 2013. We invite comments on this proposal.

e. Public Reporting of Names of Successful Electronic Prescribers

Section 1848(m)(5)(G) of the Act requires the Secretary to post on the CMS Web site, in an easily understandable format, a list of the names of EPs (or group practices) who satisfactorily submit data on quality measures for the PQRI and the names of the EPs (or group practices) who are successful electronic prescribers. As required by section 1848(m)(5)(G) of the Act, we are proposing to make public the names of EPs and group practices who are successful electronic prescribers for the 2011 eRx Incentive Program on the Physician Compare Web site that we are required to establish by January 1, 2011 under section 10331 of the ACA. As stated under section VI.F.1.k. of this proposed rule, we plan to use the existing Physician and Other Health Care Professionals directory as the foundation for the Physician Compare Web site.

We anticipate that the names of individual EPs and group practices who are successful electronic prescribers for the 2011 eRx Incentive Program will be available in 2012 after the 2011 incentive payments are paid.

To comply with section 1848(m)(5)(G) of the Act, we specifically propose to post the names of individual EPs who report the electronic prescribing measure at least 25 times during the 2011 reporting period for patient encounters included in the measure's denominator, without regard to whether the limitation under section 1848(m)(2)(B) of the Act applies to the EP and without regard to whether the EP actually qualifies to earn an incentive payment. In addition, since the PQRI and the eRx Incentive Program are two separate incentive programs and individual EPs are not required to participate in both programs to earn an incentive under either program, we point out that it is possible for an EP who participates in both incentive programs to be listed both as an individual EP who satisfactorily submits data on quality measures for the PQRI and is a successful electronic prescriber under the eRx Incentive Program. Likewise, an individual EP may be listed as an individual EP who satisfactorily submits data on quality measures for the PQRI but not as a successful electronic prescriber under the eRx Incentive Program (or vice versa) even if he or she participated in both incentive programs.

Similarly, for purposes of publicly reporting the names of group practices, on the Physician Compare Web site, we intend to post the names of group practices that report the electronic prescribing measure the required number of times during the 2011 reporting period for patient encounters included in the measure's denominator without regard to whether the limitation under section 1848(m)(2)(B) of the Act applies to the group practice or whether the group practice actually qualifies to earn an incentive payment. Although any group practice participating in the eRx Incentive Program under the group practice reporting option would also have to participate in a PQRI group practice reporting option, the criteria for satisfactory reporting of PQRI measures for group practices are different from the criteria for successful reporting of the electronic prescribing measure by group practices. Therefore, it is possible for a group practice to be listed as a group practice that satisfactorily submits data on quality measures for the PQRI but not as a successful electronic prescriber under the eRx Incentive Program, or vice versa.

G. DMEPOS Provisions

1. Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP)

a. Legislative and Regulatory History of DMEPOS CBP

Medicare pays for most DMEPOS furnished after January 1, 1989 pursuant to fee schedule methodologies set forth in section 1834 of the Act, as added by section 4062 of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) (Pub. L. 100–203). Specifically, sections 1834(a)(1)(A) and (B), and 1834 (h)(1)(A) of the Act provide that Medicare payment for these items is equal to 80 percent of the lesser of the actual charge for the item or the fee schedule amount for the item. We implemented this payment methodology at 42 CFR part 414, subpart D of our regulations. Sections 1834(a)(2) through (a)(5) and 1834(a)(7) of the Act, and implementing regulations at § 414.200 through § 414.232 (with the exception of § 414.228), set forth separate payment categories of durable medical equipment (DME) and describe how the fee schedule for each of the following categories is established:

- Inexpensive or other routinely purchased items (section 1834(a)(2) of the Act and § 414.220 of the regulations);
- Items requiring frequent and substantial servicing (sections 1834(a)(3) of the Act and § 414.222 of the regulations);
- Customized items (section 1834(a)(4) of the Act and § 414.224 of the regulations);
- Oxygen and oxygen equipment (section 1834(a)(5) of the Act and § 414.226 of the regulations);
- Other items of DME (section 1834(a)(7) of the Act and § 414.229 of the regulations).

For a detailed discussion of payment for DMEPOS under fee schedules, see the final rule published in the April 10, 2007 **Federal Register** (72 FR 17992).

Blood glucose testing strips or diabetic testing strips are covered under the Medicare DME benefit in accordance with section 1861(n) of the Act. Other supplies that are necessary for the effective use of DME are also covered under the Medicare DME benefit in accordance with longstanding program instructions at section 110.3 of chapter 15 of the Medicare Benefit Policy Manual.

Section 1847 of the Act, as amended by section 302(b)(1) of the MMA, requires the Secretary to establish and implement a DMEPOS CBP. Under the DMEPOS CBP, Medicare sets payment amounts for selected DMEPOS items and services furnished to beneficiaries in competitive bidding areas (CBAs) based on bids submitted by qualified suppliers and accepted by Medicare. For competitively bid items, these new payment amounts, referred to as "single payment amounts (SPA)," replace the fee schedule payment methodology. Section 1847(b)(5) of the Act provides that Medicare payment for these

competitively bid items and services is made on an assignment-related basis equal to 80 percent of the applicable SPA, unless any unmet Part B deductible described in section 1833(b) of the Act. Section 1847(b)(2)(A)(iii) of the Act prohibits the awarding of contracts to any entity unless the total amounts to be paid to contractors in a CBA are expected to be less than the total amounts that would otherwise be paid under the fee schedule methodologies set forth in section 1834(a) of the Act. This requirement guarantees savings to both the Medicare program and beneficiaries under the program. The fee schedule methodologies will continue to set payment amounts for noncompetitively bid DMEPOS items and services. The program also includes provisions to ensure beneficiary access to quality DMEPOS items and services. Section 1847 of the Act limits participation in the program to suppliers who have met applicable quality and financial standards and requires the Secretary to maintain beneficiary access to multiple suppliers.

When first enacted by the Congress, section 1847(a)(1)(B) of the Act required the Secretary to phase in the DMEPOS CBP in a manner so that the competition under the program occurred in 10 of the largest metropolitan statistical areas (MSAs) in 2007. The program was to be expanded into 70 additional MSAs in 2009, and then into additional areas after 2009.

In the May 1, 2006 **Federal Register** (72 FR 25654), we issued a proposed rule that would implement the DMEPOS CBP for certain DMEPOS items and services and solicited public comment on our proposals. In the April 10, 2007 **Federal Register** (72 FR 17992), we issued a final rule addressing the comments on the proposed rule and establishing the regulatory framework for the DMEPOS CBP in accordance with section 1847 of the Act.

Consistent with the requirements of section 1847 of the Act and the competitive bidding regulations, we began implementation of the program by conducting the first round of competition in 10 of the largest MSAs in 2007. We limited competition during this first round of the program to DMEPOS items and services included in 10 selected product categories, including mail order diabetic supplies. The bidding window opened on May 15, 2007 and was extended to allow bidders adequate time to prepare and submit their bids. We then evaluated each submission and awarded contracts consistent with the requirements of section 1847(b)(2) of the Act and § 414.414. Following the bid evaluation process, we awarded over 329 contracts to qualified suppliers.

The DMEPOS CBP was effective on July 1, 2008. Beginning on that date, Medicare coverage for competitively bid DMEPOS items and services furnished in the first 10 CBAs was limited to items and services furnished by contract and grandfathered suppliers of oxygen and oxygen equipment and rented DME, and payment to these suppliers was based on the SPA, as determined under the competitive bidding regulations. For further discussion of the DMEPOS CBP and the bid evaluation process, see the final rule published in the April 10, 2007 **Federal Register** (72 FR 17992).

On July 15, 2008, the MIPPA was enacted. Section 154 of the MIPPA amended section 1847 of the Act to make certain limited changes to the DMEPOS CBP. Section 154(a) of the MIPPA delayed competition under the program and amended section 1847(a)(1)(D)(i) of the Act to terminate the competitive bidding contracts effective June 30, 2008 and prohibit payment based on the contracts.

Section 154(a) of the MIPPA required the Secretary to conduct a second competition to select suppliers for Round 1 in 2009 ("Round 1 Rebid"). The Round 1 Rebid includes the "same items and services" and is to be conducted in the "same areas" as the 2007 Round 1 competition, with certain limited exceptions. Specifically, we were required to exclude the product category of negative pressure wound therapy (NPWT) items and services and the San Juan, Puerto Rico CBA from the Round 1 Rebid. In addition, section 154(a) of the MIPPA permanently excluded group 3 complex rehabilitative wheelchairs from the DMEPOS CBP by amending the definition of "items and services" in section 1847(a)(2) of the Act. Section 154(a) of the MIPPA delayed competition for Round 2 of the DMEPOS CBP from 2009 to 2011, and subsequent competitions under the program to after 2011. Finally, section 154(a) of the MIPPA specifically addresses the phase in of a competition for national mail order items and services by specifying that such competitions may be phased in after 2010.

b. Implementation of a National Mail Order DMEPOS Competitive Bidding Program (CBP) for Diabetic Testing Supplies

We conducted competitions for mail order diabetic testing supplies in the 10 CBAs selected for Round 1. In the Round 1 rebid we conducted competition for mail order diabetic testing supplies in 9 of the 10 CBAs selected in Round 1. These competitions were limited to diabetic testing supplies furnished by mail order contract suppliers, as defined in the April 10, 2007 DMEPOS Competitive Bidding final rule (72 FR 17992) to individuals located in those CBAs. As defined in the final rule, a mail order contract supplier is "a contract supplier that furnishes items through the mail to beneficiaries who maintain a permanent residence in a CBA". We clarified in program instructions that "mail order" means items ordered remotely (that is, by phone, e-mail, Internet, or mail) and delivered to a beneficiary's residence by common carriers (for example, U.S. Postal Service, Federal Express, United Parcel Service, or other shipping or courier service companies) but not items obtained by beneficiaries from local retail storefronts.

Due to the inclusion of mail order diabetic supplies as a product category in Round 1 of the program, Medicare beneficiaries in a CBA who obtain diabetic testing supplies through mail order must purchase these supplies from a mail order contract supplier in order for Medicare to pay for these items. Payment for these items will be at the SPA determined consistent with the program's regulations. Beneficiaries who do not obtain their testing supplies through mail order may purchase these products from any enrolled Medicare supplier and Medicare payment for these items will be at the fee schedule amount. The home blood glucose monitor (diabetic testing equipment) itself is not included in the Round 1 DMEPOS CBP for mail order diabetic supplies. This allows the beneficiary to go to any enrolled supplier to obtain the glucose monitor that the beneficiary and their clinician believes best meets their medical needs. The supplier of the glucose monitor is responsible for training the beneficiary on how to use the monitor and for answering all follow up questions and providing all services required by the DMEPOS quality standards and supplier standards, found in § 424.57, related to the glucose monitoring system selected by the beneficiary and their clinician. The beneficiary then has the choice of obtaining the replacement diabetic testing supplies that work with their purchased monitoring system from any local, non-mail order supplier (typically a pharmacy) or from a mail order supplier whose contract requires them to ship the replacement diabetic supplies directly to the beneficiary's home. If the beneficiary wants to continue receiving their replacement

supplies from a local pharmacy because that is their preference or because they want to have face-to-face access to a local pharmacist who, in addition to the supplier of the glucose monitoring system, can answer questions about the use of their system in testing their blood glucose levels, this choice is preserved. However, if they choose the convenience and savings associated with having their replacement supplies shipped directly to their home, the beneficiary can decide to obtain their supplies from a mail order contract supplier.

The SPA was on average 43 percent lower than the fee schedule amount for diabetic testing supplies during the Round 1 of DMEPOS CBP. This reduction in payment would have resulted in a reduction of the beneficiary's co-insurance payment. The contracts and SPAs for the Round 1 Rebid for mail order diabetic testing supplies are scheduled to be effective for diabetic supplies furnished on a mail order basis to beneficiaries in the 9 CBAs from January 1, 2011, through December 31, 2012.

(1) National Mail Order DMEPOS CBP

As part of our rulemaking implementing the DMEPOS CBP, we established regulations to implement competitions on a regional or national level for certain items such as diabetic testing supplies that are furnished on a mail order basis. We explained our rationale for establishing a national DMEPOS CBP for items furnished on a mail order basis in the **Federal Register** in the May 1, 2006 proposed rule (71 FR 25669) and April 10, 2007 final rule (72 FR 18018). A national mail order program would generate immediate national savings at a magnitude that may not be possible with local competitions among suppliers that are not able to obtain the type of volume purchasing discounts from manufacturers that are available to large, national mail order suppliers. In a September 2004 report (GAO–04–765), the Government Accountability Office (GAO) recommended that we consider using mail delivery for items that can be provided directly to beneficiaries in the home as a way to implement a DMEPOS competitive bidding strategy. In the case of diabetic supplies and other items furnished by local neighborhood pharmacies, establishing a competition for items furnished on a mail order basis would exempt local pharmacies from competing with national mail order suppliers while preserving the choice of the beneficiary to go to any local pharmacy to pick up their diabetic supplies. Manufacturers and suppliers have stated to CMS at different meetings on numerous occasions that the choice for beneficiaries to obtain diabetic supplies from local pharmacies with licensed pharmacists in house who can provide instructions and guidance to beneficiaries related to their testing needs is important and needs to be preserved.

(2) DMEPOS CBP for National Mail Order Diabetic Supplies

In the January 16, 2009 **Federal Register**, we published an interim final rule (IFC) (74 FR 2873) implementing certain changes to the DMEPOS CBP. Specifically, the rule implemented certain MIPPA provisions that delayed implementation of Round 1 of the program; required CMS to conduct a second Round 1 competition in 2009, and mandated certain changes for both the Round 1 Rebid and subsequent rounds of the program. In the January 16, 2009 IFC preamble, we indicated that we would be considering alternatives for competition of diabetic testing supplies in future notice and comment rulemaking. We explained that we believed it was consistent with section 1847(a) to employ competitive bidding for diabetic suppliers in both the mail order and traditional retail markets, in part due to concerns raised about the bifurcation of the method of delivery of diabetic supplies and the difficulty in defining what constitutes "mail order" for purposes of competition.

(3) Overview of Proposed Rule

As part of the phase in of the DMEPOS CBP, we are proposing to implement a national mail order DMEPOS CBP for diabetic testing supplies. Under the proposed mail order DMEPOS CBP, we would award contracts to suppliers to furnish these items across the nation to beneficiaries who elect to have replacement diabetic testing supplies delivered to their residence. Suppliers wishing to furnish these items through mail order to Medicare beneficiaries would be required to submit bids to participate in any DMEPOS CBP implemented for the furnishing of mail order items. In accordance with the DMEPOS CBP final rule, payment for mail order diabetic supplies would be based on the SPA determined from the bids submitted and accepted for the furnishing of diabetic testing supplies by mail order throughout the national CBA.

As part of our proposal to implement the national mail order DMEPOS CBP, we are also proposing a revised definition in regulation of "mail order" so that there would be a clear distinction between mail order items and non-mail order items. This revised definition would apply to all future competitions for mail order items and services. We are also proposing to implement the special rule mandated by section 1847(b)(10)(A) of the Act for competitions for diabetic testing strips following the Round 1 Rebid. Section 1847(b)(10)(A) requires suppliers bidding in competitions to furnish diabetic testing strips after the Round 1 Rebid to demonstrate that their bid covers at least 50 percent of all types of diabetic testing strips furnished by suppliers. If the supplier is not able to satisfy this requirement, the Secretary must reject that bid. Finally, we are proposing to include an additional term in contracts of mail order suppliers of diabetic testing supplies following the Round 1 Rebid. The proposed term would prohibit suppliers from influencing or incentivizing beneficiaries to change their brand of glucose monitor and test strips.

(4) Future Competitions for Diabetic Testing Supplies

Section 1847(a)(1)(A) of the Act mandates the establishment of DMEPOS CBP for items described in section 1847(a)(2)(A) of the Act, including diabetic testing supplies. Section 1847(a)(1)(B)(ii) of the Act authorizes the phase in of items and services under these programs beginning with the highest cost and highest volume items and services or those items and services that are determined to have the largest savings potential. Current Medicare claims data from fiscal year 2009 shows that over 62 percent of beneficiaries currently receive their replacement diabetic testing supplies from mail order suppliers. Mail order diabetic testing supplies account for approximately one billion dollars in allowed charges per year and are therefore high volume items. We believe that a national mail order CBP for diabetic testing supplies would result in large savings as a result of competition between entities that would factor into their bids savings from volume discount purchasing of quantities of supplies needed on a national rather than local basis. Therefore, we believe that implementing a national mail order DMEPOS CBP for diabetic testing supplies is the best option for meeting the requirements of the statute referenced above as long as certain refinements discussed below are made to the program to address concerns about the mail order/non-mail order bifurcation.

We have heard from industry groups and suppliers that furnish diabetic testing supplies on a national mail order

basis of their concerns that national chain pharmacies that furnish diabetic testing supplies through both a national mail order business and local retail pharmacies will encourage beneficiaries to obtain these items from local retail locations by inappropriately offering certain incentives to Medicare beneficiaries such as coupons for other store items. Based on our experience from Round 1, we believe DMEPOS CBP for mail order diabetic testing supplies would be subject to manipulation without a clearer definition of what we mean by mail order. We agree with the industry groups and suppliers that have indicated that this practice will harm businesses that only furnish diabetic testing supplies on a mail order basis. In order to address these concerns, we are proposing to add to § 414.402 a definition of "National mail order DMEPOS CBP." We propose to define that term as a program whereby contracts are awarded to suppliers for the furnishing of mail order items across the nation. We believe that implementing a national competitive bidding program for diabetic supplies would preserve beneficiary choice to purchase testing supplies in person from any local pharmacy that is an enrolled Medicare supplier that furnishes diabetic supplies, while clarifying the definition of mail order will provide significant savings potential for beneficiaries and the program. Savings would be generated in the near future from national SPAs for supplies furnished on a mail order or home delivery basis and on a long term basis for all diabetic supplies as a result of the requirement of section 1834(a)(1)(F) of the Act to either competitively bid in all areas or adjust prices in all areas by January 1, 2016. We believe that more beneficiaries will elect to choose the mail order/home delivery option, thereby further increasing short term savings under the program. Even if this is not the case, and the percentage of beneficiaries choosing the mail order/home delivery option remains at the current rate of 62 percent, savings for the remaining 38 percent must be achieved by no later than January 1, 2016, as a result of the requirements of section 1834(a)(1)(F) of the Act.

We considered other alternatives for establishing DMEPOS CBP for diabetic testing supplies that would eliminate the mail order/non-mail order bifurcation and associated concerns. These alternatives include:

- A national competition among all types of suppliers for all replacement diabetic supplies. Under this alternative, all beneficiaries would receive their replacement diabetic supplies from contract suppliers responsible for furnishing diabetic supplies throughout the nation using any method of delivery as long as the supplies are delivered on a timely basis.
- Competitions in regional CBAs among all types of suppliers for all replacement diabetic supplies. Under this alternative, all beneficiaries would receive their replacement diabetic supplies from contract suppliers responsible for furnishing diabetic supplies throughout a designated region of the country using any method of delivery to a beneficiary home as long as the supplies are delivered on a timely basis.
- Competitions in local CBAs among all types of suppliers for all replacement diabetic supplies. Under this alternative, all beneficiaries would receive their replacement diabetic supplies from contract suppliers responsible for furnishing diabetic supplies throughout the local area using any method of delivery to a beneficiary as long as the supplies are delivered on a timely basis.

We believe that the first option to bid on a national basis for all diabetic supplies, would result in most beneficiaries using mail order and might generate more savings than a national competition for diabetic supplies furnished on a mail order basis only. However, this first option would likely eliminate the beneficiary choice to obtain replacement diabetic supplies on a non-mail order basis from any enrolled supplier that is a pharmacy or other local supplier storefront where a licensed pharmacist is on hand to offer guidance and consultation to the beneficiary. We believe the other two options would also diminish this choice. In addition, the alternatives of regional or local competitions are not likely to result in savings at or above the level that can be generated from a national competition for mail order supplies. Suppliers participating in a national program may be able to obtain volume purchasing discounts for the quantities of supplies needed nationwide. Therefore, we are not proposing any of these alternatives at this time. However, we are specifically requesting public comments on these and other alternatives for establishing DMEPOS CBP for diabetic supplies.

In § 414.411, we are proposing to establish a national mail order DMEPOS CBP with competitions taking place after 2010 for the purpose of awarding contracts to suppliers to furnish replacement diabetic testing supplies across the nation, with additional program refinements described below. We note that the decision to proceed with a national mail order competition after 2010 does not prevent us from phasing in competitions for non-mail order diabetic supplies or from conducting competitions for diabetic supplies in general in the future consistent with section 1847(a)(1) of the Act.

(5) Definition of Mail Order Item

We are proposing to define "mail order item" in 42 CFR 414.402 to mean any item (for example, diabetic testing supplies) shipped or delivered to the beneficiary's home, regardless of the method of delivery. We are also proposing to define "non-mail order item" as any item (for example, diabetic testing supplies) that a beneficiary or caregiver picks up in person at a local pharmacy or supplier storefront. Therefore, the only items excluded from the mail order definition and mail order competition would be those that a beneficiary or caregiver picks up in person at a local pharmacy or other local supplier storefront. These revised definitions of mail order item and non-mail order item are intended to clearly identify which items are truly mail order. In addition, we believe this definition will preserve the choice of the beneficiary to obtain replacement diabetic supplies in person from a local pharmacy and eliminate the circumvention of the mail order program.

As discussed above, for Round 1 and the Round 1 Rebid of the DMEPOS CBP, we defined mail order contract supplier in our regulations at § 414.402 to mean a contract supplier that furnishes items through the mail. We further defined mail order in program instructions to mean "items ordered remotely (that is, by telephone, e-mail, Internet or mail) and delivered to beneficiary's residence by common carriers (for example, U.S. Postal Service, Federal Express, United Parcel Service) and does not include items obtained by beneficiaries from local storefronts." The intent of the Round 1 definition was to distinguish between mail order supplies (supplies furnished directly to the beneficiary's home) and non-mail order supplies (supplies picked up at a local pharmacy). Manufacturers and suppliers of blood glucose monitors and test strips have expressed on numerous occasions the importance of maintaining the patient option of obtaining diabetic testing supplies from a local pharmacy that provides full time access to a licensed pharmacist who can provide instructions and guidance to the beneficiary or caregiver related to the use of the diabetic supplies (the

pharmacy pickup option). This is the "non-mail order" option we attempted to separate from the mail order option with the Round 1 definition of mail order.

During implementation of Round 1 of the program, we discovered that suppliers that did not successfully compete and win a contract under the program tried to adopt certain approaches to circumvent the mail order definition. In the first round of competitive bidding, suppliers that lost their bid to be a contract supplier for mail order diabetic testing supplies considered ways to change their delivery methods to circumvent the mail order DMEPOS CBP. For example, some mail order suppliers considered purchasing a fleet of cars to deliver these items to the beneficiary's home so as not to be considered a mail order supplier. Other suppliers attempted to enter into special "private" arrangements with well known delivery services and claimed that because of such arrangements they should not be considered mail order suppliers. These alternative home delivery methods do not provide any benefits to the patient beyond what the traditional mail order home delivery method offers. They are simply ways to continue furnishing diabetic supplies on a home delivery basis after submitting a bid for mail order that does not result in the award of a contract under the DMEPOS CBP. Without a clear distinction between mail order (home delivery option) and non-mail order (pharmacy pickup option), suppliers could continue to attempt to make arrangements as they did in the initial Round 1 competition to circumvent the DMEPOS CBP. We consider these practices to be inconsistent with the DMEPOS CBP statute and regulations currently in effect, and our proposal is intended to further clarify the existing definition of mail order. Such arrangements prevent beneficiaries and the Medicare program from realizing savings afforded by the mail order DMEPOS CBP and is unfair to winning suppliers who bid in good faith for a contract for furnishing supplies to the home delivery market.

This proposed definition of mail order item would not apply to the Round 1 competition because of the specific requirement of MIPPA to rebid Round 1 in 2009 for the same items and services included in the initial Round 1 competition. However, for a national competition, it is imperative that the new definition of mail order item be in place because of the implications such a program would have on the entire mail order delivery market in the United States. In these future competitions, we would continue to emphasize in our educational efforts the basic distinction between mail order (home delivery) and non-mail order (pharmacy pickup). In addition, we will continue to take appropriate and necessary action against suppliers that do not comply with the revised definition.

As mentioned above, an alternative DMEPOS CBP for replacement diabetic supplies would be to hold a national competition among all types of suppliers for all replacement diabetic supplies. One benefit to this approach is that it would eliminate the need to differentiate between mail order and non-mail order supplies; however, it would likely eliminate the pharmacy pickup choice since most local pharmacies would not be able to service the entire CBA if they did not also operate a national mail order service.

We invite comments on our proposed definition of "mail order" and its impact on future rounds of bidding.

(6) Special Rule in Case of Competition for Diabetic Testing Strips

Following Round 1 of the program, any competition for diabetic testing strips, such as the national mail order program for diabetic testing supplies proposed in this rule, must include the special rule set forth in section 1847(b)(10)(A) of the Act. Under that section, a supplier must demonstrate that their bid to furnish diabetic testing strips covers the furnishing of a sufficient number of different types of diabetic testing strip products that, in the aggregate and taking into account volume for the different products, to account for at least 50 percent of all such types of products on the market. Section 1847(a)(10)(A) also specifies that the volume for the different products may be determined in accordance with data (which may include market based data) recognized by the Secretary. When a beneficiary needs to obtain replacement test strips, they must obtain the specific brand of test strips products that work with their brand and model of blood glucose monitor. The test strips are not manufactured in a way that allows use of different brands of test strips in different brands of monitors. Therefore, when replacement test strips are furnished, the supplier must ensure that the specific brand and model of test strips that the patient requires for use with their purchased monitor is furnished.

Section 1847(b)(10)(B) of the Act mandates the Office of Inspector General (OIG) of the Department to conduct a study before 2011 to generate volume data for the various products that could be used for this purpose.

Under the DMEPOS CBP, bidding suppliers are required to provide information on the products they plan to furnish if awarded a contract. We propose to use this information and information on the market share (volume) of the various diabetic testing strip products to educate suppliers on meeting the requirements of this special rule. In addition, it may be necessary to obtain additional information from suppliers such as invoices or purchase orders to verify that the requirements in the statute have been met.

We are proposing that suppliers be required to demonstrate that its bid covers the minimum 50 percent threshold provided in the statute, but we invite comments on whether a higher threshold should be used. We have proposed the 50 percent threshold in part because we believe that all suppliers have an inherent incentive to furnish a wide variety of types of diabetic testing products to generate a wider customer referral base. The 50 percent threshold would ensure that beneficiaries have access to mail order delivery of the top-selling diabetic test strip products. In addition, as explained below, we are proposing an "anti-switching provision" that we believe should obviate the need to establish a threshold of greater than 50 percent for the purpose of implementing this special rule because the contract suppliers would not be able to carry a limited variety of products and switch beneficiaries to those products.

For purposes of implementing the special rule in section 1847(b)(10)(A), we are proposing to define "diabetic testing strip product" as a specific brand and model of test strip, as that is the best way to distinguish among different products. Therefore, we plan to use market based data for specific brands and models of diabetic test strips to determine the relative market share or volume of the various products on the market that are available to Medicare beneficiaries. We plan to review a variety of data, including but not limited to data furnished in the OIG report, to determine the market share of the various products. The special rule mandated by section 1847(b)(10)(A) of the Act applies to all competitions for diabetic testing strips after the first round of the DMEPOS CBP. Therefore, we would apply this rule to non-mail order competitions and/or local competitions conducted for diabetic testing strips after Round 1 of the DMEPOS CBP.

(7) Anti-Switching Rule in Case of Competition for Diabetic Test Strips

We do not believe that we can effectively apply the 50 percent rule, as required by section 1847(b)(10)(A) of the Act, if we do not establish an anti-switching rule to prevent suppliers from influencing beneficiaries to switch monitors. We have heard concerns from beneficiary advocacy groups, as well as industry representatives, that contract suppliers furnishing diabetic testing supplies in the first round encouraged beneficiaries to switch to a different brand of blood glucose monitor and testing supplies than they and/or their physician or clinician previously selected. Suppliers attempted to switch beneficiaries to the less expensive monitor or the monitor that provided them with the most profit rather than the monitor that was most suitable for them. Without the anti-switching rule, suppliers may offer 50 percent of the brands on the market but continue to switch beneficiaries to the least expensive brands so that the requirement to offer at least 50 percent of the brands on the market rather than a few specific brands becomes meaningless.

We are proposing to prohibit suppliers awarded contracts for diabetic testing supplies from influencing or incentivizing the beneficiary in any way to switch the brand of glucose monitor and testing supplies they are currently using. We would propose that contract suppliers continue to furnish the brand of testing supplies that work with the monitor currently in use by the beneficiary. In the case where the beneficiary is receiving a monitor for the first time or a replacement monitor, the contract supplier would be subject to the requirements of § 414.420 in order to protect beneficiaries from feeling forced or incentivized to use a particular type or brand of monitor We continue to believe the proper role of the contract supplier is to furnish diabetic testing strips and other supplies to beneficiaries, not to interfere with the beneficiary's selection of the type of monitor and supplies. This requires the supplier to furnish the brand of testing supplies that work with the blood glucose monitor product that the beneficiary and/or clinician, and not the supplier of the testing supplies, selects. If the beneficiary needs a blood glucose monitor for the first time, or needs to replace their existing blood glucose monitor, and neither the beneficiary nor their physician has determined which brand or type of monitor to obtain, the beneficiary may continue to ask for assistance from the supplier to select a monitor and the supplier should show them the full range of products. However, if the beneficiary has already selected a monitor and simply needs replacement diabetic testing supplies, the supplier must furnish the brands of testing supplies that work with the brand monitor that the beneficiary has selected. We believe this proposal would preserve the integrity of the clinical decision regarding choice of glucose monitoring system and would result in contract suppliers offering a wide variety of diabetic testing supply products.

We are proposing to amend § 414.422 to add the anti-switching requirement to the terms of the contract for a supplier of diabetic testing supplies. A supplier would be in breach of their contract and subject to the sanctions set forth under § 414.423(g), including termination, if they violate this term. We welcome comments on this proposal.

c. Off-the-Shelf (OTS) Orthotics Exemption

In the April 10, 2007 final rule (72 FR 17992), we established § 414.404(b)(1), which sets forth several exemptions to the DMEPOS CBP. These exceptions are applicable to providers, physicians, and treating practitioners that furnish certain DMEPOS items under Medicare Part B. The exempted items are limited to crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps that are DME. For an explanation as to why these items were exempt see the DMEPOS Competitive Bidding final rule (CMS–1270–F) published April 10, 2007, (72 FR 17992). For the exemptions to apply, the items must be furnished by a physician or treating practitioner to his or her own patients as part of his or her professional service. The items are to be billed under a billing number assigned to the physician, the treating practitioner (if possible), or a group practice to which the physician or treating practitioner has reassigned the right to receive Medicare payment.

The April 10, 2007 final rule also established an exemption for a physical therapist in private practice (as defined in § 410.60(c)) or an occupational therapist in private practice (as defined in § 410.59(c)) to furnish competitively bid OTS orthotics without submitting a bid and being awarded a contract under the DMEPOS CBP, provided that the items are furnished only to the therapist's own patients as part of a physical or occupational therapy service.

Section 154(d) of MIPPA amended section 1847(a) of the Act by adding paragraph (7), which expands the exemptions from the DMEPOS CBP for certain OTS orthotics to physicians or other practitioners (as defined by the Secretary) if furnished to their own patients as part of their professional service. Section 1847(a)(7) of the Act, as added by MIPPA, also expanded the exemption from the program to hospitals for certain OTS orthotics, crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps if these items are furnished to the hospital's own patients during an admission or on the date of discharge.

The DMEPOS CBP Round 1 Rebid interim final rule with comment period (IFC) included the expanded exemption for certain DMEPOS items as provided by MIPPA for hospitals. We noted in the IFC that we would address the expanded exemption of OTS orthotics for hospitals, physicians and other practitioners in future rulemaking.

In this proposed rule, we are proposing to revise current provisions at § 414.404(b)(1)(i) to incorporate the provision of section 1847(a)(7)(A)(i) and (ii) of the Act that exempts from the program OTS orthotics furnished by physicians and other practitioners to their own patients as part of their professional service or by hospitals to the hospital's own patients during an admission or on the date of discharge.

d. Grandfathering Rules Resulting in Additional Payments To Contract Suppliers Under the DMEPOS Competitive Bidding Program (CBP)

Section 1847(a)(4) of the Act requires that in the case of rented DME and oxygen and oxygen equipment, the Secretary shall establish a "grandfathering" process. This requirement was implemented through regulations at § 414.408(j) that were published in the April 10, 2007 **Federal Register** (72 FR 17992). The grandfathering process allows beneficiaries who were renting DME items or receiving oxygen and oxygen equipment prior to the start of a DMEPOS CBP from a supplier who did not win a contract to continue to rent the equipment from that noncontract supplier if that supplier chooses to become a grandfathered supplier. Under § 414.408(i)(2), when the beneficiary decides to use a contract supplier instead of a grandfathered supplier to receive their oxygen equipment and supplies, the contract supplier receives a minimum of 10 monthly payments for taking over the furnishing of oxygen and oxygen equipment. When a beneficiary decides to use a contract supplier to furnish capped rental DME, section § 414.408(h)(2) restarts the 13-month

capped rental period. These rules were established, in part, based on advice from the Program Advisory and Oversight Committee (PAOC) and are intended to give bidding suppliers an assurance that they would be compensated in these situations and would not have to factor into their bids the cost of receiving as few as one monthly payment for beneficiaries near the end of the 13-month cap for capped rental items and 36-month cap for oxygen equipment.

At the time these rules were developed, the supplier was mandated by the statute to transfer title to the equipment to the beneficiary after the both the 13-month cap for capped rental items and the 36-month cap for oxygen equipment. Section 144(b) of the MIPPA repealed the transfer of title requirement for oxygen equipment, as established by Deficit Reduction Act of 2005, replacing that requirement with the 36-month rental cap. Under the revised oxygen payment provisions, suppliers now get the equipment back when the beneficiary no longer needs it. Also, at the time these rules were developed, the beneficiary had the option to acquire standard power wheelchairs on a lump sum purchase basis, an option which greater than 95% of the beneficiaries selected, based upon historic claims data. Therefore, those items generally would not be affected by the grandfathering rules. However, as discussed in section 3136 of this proposed rule, section 3136 of the ACA eliminates the lump sum purchase option for standard power wheelchairs. This new policy applies to items furnished under the DMEPOS CBP beginning with Round 2 of the program. Over 200,000 beneficiaries received standard power wheelchairs nationwide in 2009, and the Medicare allowed charges for these wheelchairs was over $650 million, including both rental and purchase options. Therefore, this large volume of capped rental items will be subject to the grandfathering rules effective with Round 2 of the DMEPOS CBP, thus increasing the overall magnitude of the effect these rules have on the program and beneficiaries.

In some cases, the grandfathering rules described above place a financial burden on beneficiaries who are near the end of the 13 or 36-month rental cap periods. If a beneficiary's existing supplier chooses not to be a grandfathered supplier, the beneficiary will be required to switch to a contract supplier in order for Medicare to continue to pay for the furnishing of the rental equipment. In such cases, the beneficiary will be responsible for additional co-insurance amounts. Based on experience from the initial Round 1 competition in 2008, we believe that most suppliers will choose to grandfather and therefore these rules will have no impact on these situations. However, in those limited situations in which the beneficiary does not use a grandfathered supplier and the beneficiary is near the end of the 13 or 36-month rental cap period, the impact on the beneficiary could be significant. As mentioned above, our current grandfathering rules will result in a limited number of beneficiaries facing additional co-insurance payments. To illustrate the impact some beneficiaries may face as a result of these rules, a beneficiary who has already made 12 coinsurance payments for a capped rental item could make as many as 12 additional copayments as a result of restarting the capped rental period when they transition from a noncontract supplier to a contract supplier at the beginning of a DMEPOS CBP. In another example, a beneficiary who has already made 35 coinsurance payments for oxygen and oxygen equipment could make as many as 9 additional copayments as a result of the rule that provides a minimum of 10 monthly payments when they transition from a noncontract supplier to a contract supplier at the beginning of a DMEPOS CBP. As stated above, we expect that most noncontract suppliers will choose to become grandfathered suppliers, therefore limiting the number of instances where these rules would apply. However, in light of the beneficiary impact in the those extreme cases illustrated above, and in light of the recent legislative changes by the MIPPA and the ACA as explained above, we are reevaluating whether or not changes to these grandfathering rules are necessary. As discussed above, as a result of the MIPPA, suppliers of oxygen equipment no longer lose title to the equipment after receiving the 36th payment and this may warrant reconsideration of the minimum number of payments they should receive as contract suppliers when a beneficiary transitions to them from a noncontract supplier at the beginning of a DMEPOS CBP. In addition, we believe it is important to reevaluate the policy that restarts the 13-month capped rental period in situations where a beneficiary transitions from a noncontract supplier to a contract supplier at the beginning of a DMEPOS CBP. Therefore, we are soliciting public comments on whether or not the current rules should be changed to reduce the number of payments the contract supplier would receive in these situations above the 13 and 36-month limits set forth under the standard payment rules in section 1834(a) of the Act. We also plan to solicit advice from the PAOC on this subject at a future committee meeting.

e. Appeals Process

The DMEPOS CBP final rule issued on April 10, 2007 includes § 414.422(g)(1), which states that "any deviation from contract requirements, including a failure to comply with governmental agency or licensing organization requirements, constitutes a breach of contract." In the event we determine that a contract supplier's actions constitute a breach of contract, § 414.422(g)(2) authorizes us to take one or more of the following actions:

- Require the contract supplier to submit a corrective action plan;
- Suspend the contract supplier's contract;
- Terminate the contract;
- Preclude the contract supplier from participating in the DMEPOS CBP;
- Revoke the supplier number of the contract supplier; or
- Avail itself of other remedies allowed by the statute.

Proposed Appeals Process

We are proposing to add a new § 414.423 to establish an appeals process for contracts terminated under section 1847(a) and (b) of the Act. Section § 414.423, as proposed in this rule, would set forth policies and procedures relating to our determinations of a breach of contract and the appeals process for contract suppliers that are considered to be in breach of contract. In addition, we are proposing to add new definitions to § 414.402 that are used in the proposed § 414.423.

Given the impact that termination has on a contract supplier, we believe it is appropriate for contract suppliers whose contract(s) may be terminated due to a breach of contract to have access to an appeal process that will reconsider that termination. In establishing this process we reviewed other appeals processes, such as the appeals process under Part D located at 42 CFR 423.641 through 423.668, Subpart N—Medicare Contract Determinations and Appeals, to consider essential steps to ensure suppliers have access to an appropriate review of certain CMS decisions. We chose to propose a simplified process that would not result in disruption to the program by having suppliers going in and out of the program. For this reason, we propose a process for review and reconsideration before the contract is actually terminated. This proposal would avoid the necessity to reinstate

retroactively suppliers because the contracts would generally not be terminated before the full review process has occurred. This would protect the supplier because we generally would not terminate a supplier until a final decision is made. Another feature of this process that may be beneficial to some suppliers is allowing them to submit a corrective action plan (CAP) depending upon the nature of the breach. We believe our proposal would allow most suppliers to correct identified deficiencies.

(1) Purpose and Definitions: (§ 414.402)

We are proposing to amend § 414.402 to define the following terms:

- *Affected party* means a contract supplier that has been notified that their DMEPOS CBP contract would be terminated for a breach of contract.
- *Breach of contract* means any deviation from contract requirements, including a failure to comply with a governmental agency or licensing organization requirements.
- *Corrective Action Plan (CAP)* means a contract supplier's written document with supporting information that describes the actions the contract supplier would take within a specified timeframe to remedy the breach of contract.
- *Competitive Bidding Implementation Contractor (CBIC) Hearing Officer (HO)* means an individual, who was not involved with the CBIC recommendation to terminate a DMEPOS CBP contract, who is designated by CMS to review and make an unbiased and independent determination from the CBIC's recommendation to terminate a DMEPOS CBP contract.
- *Parties to the Hearing* means the DMEPOS contract supplier and CMS.

(2) Applicability

The appeals process proposed in this regulation would allow contract suppliers the opportunity for a review of the following:

- A CMS determination under § 414.422(g)(1) that the contract supplier breached its contract entered into as part of the DMEPOS CBP; and
- Certain agency actions taken under § 414.422(g)(2).

The proposed appeals process would not apply to any other actions made by CMS, nor would the existence of other appeals processes preclude us from terminating a DMEPOS CBP contract. In other words, the proposed appeals process would be in addition to—and would not replace—existing CMS regulations regarding other appeals mechanisms. For example, a contract may be terminated because a supplier's National Supplier Clearinghouse (NSC) number has been revoked or inactivated. In this case, the supplier would not appeal the decision to inactive or revoke its number through this appeals process. Instead, the supplier would continue to appeal the inactivation or revocation of its supplier number through the NSC's appeals process, and we would postpone the termination decision until the supplier completes the NSC appeals process.

Under our proposal, when we issue a termination decision, it would be final and binding unless a postponement of the termination decision is allowed by proposed § 414.423. We welcome comments on the scope of the proposed appeals process.

(3) Contract Termination

We are proposing that this appeals process applies in situations where the supplier has received a notice that we have determined that they are in breach of contract and that their contract is therefore subject to termination. A contract may be terminated for any violation of the terms of the contract. Examples of violations include, but are not limited to, situations where the contract supplier—

- Has committed or participated in false, fraudulent, or abusive activities affecting the Medicare program, including the submission of false or fraudulent data or claims;
- Experiences financial difficulties so that they are unable to effectively provide the necessary services to a Medicare beneficiary; or
- Fails to meet the non-discrimination policy and provides different items to beneficiaries located in a competitive bidding area (CBA) than it provides to its non-Medicare beneficiaries at § 414.422(c).

We welcome comments on our proposed termination process.

(4) Notice of Termination

Under the proposed rule, the CBIC would work with suppliers to informally resolve performance deficiencies under its DMEPOS CBP contract prior to sending a recommendation to CMS that the supplier's contract be terminated. If the CBIC cannot informally resolve the supplier's deficiencies and recommends that we terminate the contract, we would review the CBIC's recommendation to terminate the supplier's contract. If we find that a breach occurred, we would begin the contract termination process by sending out a notice of termination to the supplier.

We also propose requirements for the notice of termination so that suppliers are informed of the basis for CMS's action as well as their options to respond to this action. The notice would explain all actions we plan to take in response to the supplier's breach, such as the ability to submit a CAP or our determination to preclude a supplier from participating in future rounds of competitive bidding if found in breach of contract. If the supplier decides to appeal any of these decisions the supplier would submit an appeal in response to the notice to terminate. If we consider a supplier to be in breach of its contract, either in part or in whole, we would notify the contract supplier of the termination by certified mail. The notice would indicate that the contract supplier has been found to be in breach of contract and that the supplier's contract would be terminated within 45 calendar days of the date of the notification of termination. The notice would be sent by the CBIC using certified mail on the same date as the date on the notification of termination. The date of the notification of termination is the date that the notification is signed. The notification will be mailed on the date that it is signed. This date will be indicated on the notification.

The proposed rule requires the notice to include, at a minimum, the following information:

- The reasons for the termination in sufficient detail to allow the contract supplier to understand the nature of its breach of contract;
- Depending on the nature of the breach, whether the supplier may be allowed to submit a CAP in lieu of requesting a hearing by the HO;
- The right to request a hearing by the HO;
- The address to which the written request for a hearing must be mailed;
- The address to which the CAP must be mailed; and
- The effective date of the termination of the contract, if a CAP is not submitted or if a request for a hearing has not been filed timely.

We believe that this information would be sufficient to provide the supplier with the basis for CMS's action, as well as their options in responding to our decision. We welcome comments on our proposal regarding the contents of the notice.

In addition, our proposed rule requires the notice to indicate any additional penalties that may result from the termination, such as not being eligible to bid in future rounds of competitive bidding. An appeal of the termination would include the appeal of

any other results from the termination that are permissible under § 414.423, such as preclusion from participation in future rounds of the DMEPOS CBP. We believe this information may help the supplier to decide whether to appeal the notice of termination.

(5) Corrective Action Plan

We are also proposing a process by which a contract supplier may be able to submit a CAP to address the breach of contract. Depending on the nature of the breach of contract, we propose that the notice to the supplier would indicate whether a contract supplier would be allowed to provide the CBIC with a written CAP instead of submitting a request for a hearing by a HO. For example, under this proposal we would not allow a CAP if the supplier has been excluded, debarred or convicted of a health care related crime. We may also not allow a CAP that would result in negative consequences to the beneficiaries or the program caused by delaying the termination of the contract.

We are proposing timelines related to the CAP. Under the proposed rule, if the supplier decides to submit a CAP, the CAP must be received by the CBIC within 30 calendar days from the date on the notice of termination. If the supplier decides not to submit a CAP, the supplier retains the right to request a review by a HO within 30 days from the date of the notice for termination. While the CAP is being evaluated, the termination determination would be postponed. We believe that 30 days is a sufficient amount of time for suppliers to prepare and submit a CAP and this would also ensure that there are no unnecessary delays in the appeals process.

Under the proposed rule, we would require the CAP to demonstrate that the contract supplier has a plan to remedy all of the deficiencies that were identified in its notice of termination and must specify the timeframes for correcting these deficiencies. The CBIC would review the CAP to ensure that the contract supplier would be taking the appropriate measures in a timely manner to remedy the breach of contract. What constitutes a timely manner is dependent on the type of deficiency that is being corrected. Once the nature of the deficiency is identified the CBIC and CMS would make a case-by-case determination concerning what constitutes a timely manner for correcting the deficiency. However, we expect most deficiencies to be corrected within 90 days or less. Further guidance of what constitutes a timely manner would be communicated to the contract supplier by the CBIC as part of the review process.

As part of the review process, the CBIC would provide guidance, in accordance with CMS instructions, regarding the type of documentation that the CAP and the follow-up report must provide to substantiate that the deficiencies have been corrected. To make a determination if a CAP would be considered acceptable, we may discuss the CAP with the supplier, and as a result of these discussions, the CBIC will allow a supplier to make revisions to its CAP during the review process. Suppliers may only revise their CAP one time during the review process. The timeframe for the review process would vary upon the circumstances for each case. If the supplier does not submit an acceptable CAP during the review process, the supplier would receive a new notice that their CAP is not acceptable or has not been implemented consistent with the supplier's original submission and its contract would be terminated within 45 calendar days. Every supplier would have a one time opportunity to revise their CAP based upon deficiencies identified by the CBIC. Failure to develop and implement an approved CAP would result in a new notice to the supplier of the termination of the DMEPOS CBP contract and provide notice that the supplier may request a hearing on this termination. Under the proposed rule, once an acceptable CAP has been completed the contract supplier must provide a follow-up report within 5 days of the agreed upon date for the completion of the CAP to verify that all of the deficiencies identified in the CAP have been corrected consistent with the timeframes specified in the CAP, as approved by the CMS. We believe that 5 days is sufficient time for a supplier to submit a report to CBIC outlining all steps that have been completed to correct the identified deficiencies.

We welcome comments on our proposals relating to the option for a CAP.

(6) Right To Request a Hearing by the CBIC Hearing Officer (HO)

We propose that a contract supplier that has received a notice that we consider the supplier in breach of contract has the right to request a hearing before a HO who was not involved with the original breach of contract determination. We consider this process to be a reconsideration of the original decision, and consistent with other Medicare appeals provisions, we believe it is important that an individual not involved in making the initial recommendation conduct the reconsideration of the initial decision. As mentioned previously, the HO would be an individual who is designated by CMS to review and to make an unbiased and independent recommendation of whether to terminate the supplier's DMEPOS CBP contract. The notice to the contract supplier would also identify the location to which a request for hearing must be sent.

Under the proposed rule, a contract supplier may appeal the notice of termination by submitting a written request to the CBIC for a hearing by a HO. The written request should include any evidence to support its appeal. The HO is not required to allow evidence submitted in addition to the evidence submitted along with the written request. The hearing request must be received by the CBIC within 30 calendar days from the date of the termination letter. A request for a hearing must be sent to the address identified on the notice. Failure to request a hearing within the allotted 30 calendar days would result in a termination of the supplier's contract, as of the effective date of termination identified in the notice to the supplier. There would be no extensions to this 30-day timeframe. We believe suppliers have sufficient time to decide whether or not to request a hearing and the deficiencies identified in the notice may pose a risk to the DMEPOS CBP. The date the request is received by the CBIC determines if the hearing request was timely filed.

We would require that the request for hearing be filed by a supplier's authorized official, because an authorized official of the company signed the contract and this ensures the validity of the request. The authorized official must be an official of the company who is identified on the supplier's CMS 855–S form as an authorized official of the supplier. A supplier may appoint someone other than the authorized official to be a representative for them at the hearing. However, the representative may not be an individual who has been disqualified or suspended from acting as a representative by the Secretary or otherwise prohibited by law. The request for a hearing must be filed with the CBIC at the address identified on the notice of termination.

We welcome comments on our proposed process for requesting a hearing by a HO.

(7) Scheduling of the Hearing

The proposed rule also addresses scheduling the hearing. We propose that within 30 calendar days from the receipt of a supplier's timely hearing request the HO would contact the parties to

schedule a hearing. The request for a hearing would result in the postponement of the date of the contract termination. The only exception to this rule is when a supplier has been excluded, debarred or convicted of a health care related crime; in that situation the supplier's contract would be terminated immediately. In the hearing request the contract supplier may ask for the hearing to be held in person or by telephone. The HO would send a notice to the parties to the hearing indicating the time and place for the hearing at least 30 days before the date of the hearing. The HO may, on his or her own motion, or at the request of a party, change the time and place for the hearing, but must give the parties to the hearing a 30-day notice of the change.

The proposed rule would require that the HO's notice scheduling the hearing must provide, at a minimum, the following information:

- Date, time, and location of the scheduled hearing;
- Description of the hearing procedure;
- Issues to be resolved;
- Requirement that the contract supplier bears the burden of proof to demonstrate that it is not in breach of contract; and
- Provide an opportunity for the supplier to submit evidence to support its appeal. We believe this information provides the supplier with sufficient information regarding the hearing date, time, and matters that would be addressed at that time. We welcome comments on the content of this notice and the procedures for scheduling a hearing.

(8) Burden of Proof

We propose that the contract supplier would present to the HO the basis for its disagreement with the termination notice and would have the burden of proof to demonstrate to the HO with supporting evidence that it is not in breach of its contract and that the termination action is not appropriate. The supplier's supporting evidence must be submitted with its request for a hearing. The supporting evidence and the request for a hearing must be submitted together and received by the HO within 30 calendar days from the date identified on the notice of termination. In the absence of good cause, the HO may not allow evidence to be submitted in addition to the evidence submitted along with the written request. We also have the opportunity to submit evidence to the HO within 30 days of receiving the notice announcing the hearing. The HO will share all evidence submitted, both from the supplier and CMS, in preparation for the hearing with all affected parties within 15 days prior to the scheduled date of the hearing.

We welcome comments on our proposal regarding the burden of proof.

(9) Role of the Hearing Officer (HO)

Our proposal requires that the HO conduct a thorough and independent review. Such a review requires the consideration of all information and documentation relevant to the hearing and submitted consistent with this proposal. Consistent with this goal, we propose that the HO is responsible for all of the following:

- Sharing all evidence submitted, both from supplier and CMS, in preparation for the hearing with all affected parties within 15 days prior to the scheduled date of the hearing.
- Conducting the hearing and deciding the order in which the evidence and the arguments of the parties would be presented.
- Determining the rules on admissibility of the evidence.
- Examining the witnesses, in addition to the examinations conducted by CMS and the contract supplier.
- Determining the rules for requesting documents and other evidence from other parties.
- Ensuring a complete recording of the hearing is available and provided to all parties to the hearing and the CBIC.
- Preparing a file of the record of the hearing which includes all evidence submitted as well as any relevant documents identified by the HO and considered as part of the hearing.
- Complying with all applicable provisions of 42 U.S.C. Title 18 and related provisions of the Act, the applicable regulations issued by the Secretary, and manual instructions issued by CMS.

The HO would make a recommendation based on the information presented and submitted. The HO would issue a written recommendation to CMS within 30 days of the close of the hearing, unless the HO requests an extension from CMS and demonstrates to CMS that he or she needs an extension due to complexity of the matter or heavy work load. The HO's recommendation would include the rationale for his or her recommendation regarding the termination of the supplier's contract and the HO would submit this recommendation to CMS for its determination.

We welcome comments on the role of the CBIC HO in our proposed rule.

(10) CMS's Final Determination

Under the proposed rule, the HO's recommendation is submitted to CMS, and the agency would make the final determination regarding whether the supplier's contract would be terminated. Our determination would be based upon on the record of the hearing, evidence, and documents considered by the HO as part of the HO recommendation. Information submitted after the hearing would not be considered. Our decision would be made within 30 days of the receipt of the HO's recommendation. If our decision is to terminate the contract, the supplier would be notified of the effective date of termination by certified mail. Our decision regarding the termination of the contract is final and binding.

We welcome comments on our proposal relating to CMS's final determination of a supplier's contract termination.

(11) Effective Date of the Contract Termination

Under the proposed rule, suppliers who submit a CAP or request a hearing would have the termination date identified on the notice delayed. The only exception to this rule is when a supplier has been excluded, debarred or convicted of a health care related crime; in that situation the contract would be terminated immediately. For terminations that do not meet these exceptions, the effective date of a final termination would be determined as follows:

- The termination of a supplier's DMEPOS CBP contract is effective on the date specified in the initial notice of termination, which will be 45 days from the date of the notice, unless the supplier request a hearing with the HO or the supplier submits an acceptable CAP.
- After reviewing the HO recommendation, if we terminate a supplier's contract the effective date of the termination would be the date specified in the post-hearing notice sent to the supplier indicating CMS's final determination to terminate the contract.

We welcome comments on our proposals related to the effective date of contract termination.

(12) Effect of Contract Termination

Under our proposal, once a supplier's contract is terminated for breach of contract under the DMEPOS CBP, the contract supplier is no longer a DMEPOS CBP contract supplier for any DMEPOS CBP product category for which it was awarded a contract. This termination applies to all areas and

product categories because there is only one contract that encompasses all CBAs and product categories for which the supplier was awarded a contract. We would not make payment and would reject claims for DMEPOS competitive bid items and services furnished by a supplier whose contract has been terminated after the effective date of the termination for the remainder of the contract period.

We recognize that a supplier's termination would impact beneficiaries within the CBA. Therefore, we therefore propose that terminated suppliers must notify all beneficiaries within the CBA who are receiving rented competitively bid items of the termination of their contract status so that the beneficiaries can make arrangements to receive equipment and suppliers through other contract suppliers. After we have made our final determination and sent notification to the supplier, the supplier must notify beneficiaries within 5 days of receipt of the contract supplier's final notice of termination. This notice must inform beneficiaries that they would have to select a new contract supplier to furnish their DMEPOS items in order for Medicare to pay for these items. For beneficiary protection, we also propose that contract suppliers who fail to give proper notification to beneficiaries may be prevented from participating in future rounds of DMEPOS CBP. We also propose that rental items may not be picked up from the beneficiary's home until after the last day of the rental month for which the supplier has already received payment. We are proposing both of these policies to protect the beneficiary and to ensure that suppliers do not pick up equipment from a beneficiary for a time period for which they have already been paid to provide the service.

2. Changes to Payment Rules for Oxygen and Oxygen Equipment

a. Background

The general Medicare payment rules for DME are set forth in section 1834(a) of the Act and 42 CFR part 414, subpart D of our regulations. Section 1834(a)(1) of the Act and § 414.210(a) of our regulations establish the Medicare payment for a DME item as equal to 80 percent of either the lower of the actual charge or the fee schedule amount for the item. The beneficiary coinsurance is equal to 20 percent of either the lower of the actual charge or the fee schedule amount for the item once the deductible is met.

The specific payment rules for oxygen and oxygen equipment under the existing fee schedules are set forth in section 1834(a)(5) of the Act and § 414.226 of our regulations. Suppliers are paid a monthly payment amount for furnishing medically necessary oxygen contents (for both stationary and portable) and stationary oxygen equipment described under the class described in § 414.226(c)(1)(i). Equipment in the stationary class includes stationary oxygen concentrators, which concentrate oxygen from room air; stationary liquid oxygen systems, which use oxygen stored as a very cold liquid in cylinders and tanks; and gaseous oxygen systems, which administer compressed oxygen directly from cylinders.

A monthly add-on payment is also made to suppliers furnishing medically necessary portable oxygen equipment falling under one of two classes described in § 414.226(c)(1)(ii) and (iii). Equipment in these classes includes traditional portable equipment, that is, portable liquid oxygen systems and portable gaseous oxygen systems, and oxygen generating portable equipment (OGPE), that is, portable oxygen concentrators and oxygen transfilling equipment used to fill portable tanks or cylinders in the home. Both the liquid and gaseous oxygen systems (for stationary and traditional portable systems) require on-going delivery of oxygen contents.

Section 1834(a)(5)(F) of the Act, as amended by section 144(b) of MIPPA, limits the monthly rental payments to suppliers for oxygen equipment to 36 months of continuous use, although monthly payments for furnishing gaseous or liquid oxygen contents continue after the 36-month equipment rental cap is reached for gaseous or liquid systems. In the CY 2009 PFS final rule with comment period (73 FR 69875 through 69876), we discussed section 144(b) of MIPPA and included a detailed discussion of how section 5101(b) of the Deficit Reduction Act of 2005 (DRA) previously required suppliers to transfer title to oxygen equipment to the beneficiary at the end of the 36-month rental period. Section 144(b) of the MIPPA repealed this requirement to transfer title to the oxygen equipment to the beneficiary and allows suppliers to retain title to the oxygen equipment after 36 monthly rental payments are made for the equipment.

Section 414.210 establishes the requirements for the replacement of DME, including oxygen equipment. Section 414.210(f)(1) states that if an item of DME, which includes oxygen equipment, has been in continuous use by the patient for the equipment's reasonable useful lifetime or if the original equipment is lost, stolen, or irreparably damaged, the patient may elect to obtain a new piece of equipment. In such circumstances, § 414.420(f)(2) authorizes payment for the new oxygen equipment in accordance with § 414.226(a). Section 414.210(f)(1) states that the reasonable useful lifetime for DME, which includes oxygen equipment, is determined through program instructions. In the absence of CMS program instructions, the carrier may determine the reasonable useful lifetime for equipment, but in no case can it be less than 5 years. Computation is based on when the equipment is delivered to the beneficiary, not the age of the equipment. If the beneficiary elects to obtain new oxygen equipment after the reasonable useful lifetime, the payment is made for a new 36-month rental period in accordance with § 414.226(a).

We are proposing to revise the payment rule for oxygen and oxygen equipment at § 414.226(g)(1) to address situations where beneficiaries relocate outside the service area of a supplier during the 36-month rental payment cap period for the oxygen equipment. Beneficiaries are experiencing great difficulties in finding suppliers willing to furnish oxygen equipment in situations where only a few months are left in the 36-month rental payment period at the time they relocate. For example, if a beneficiary is in the 30th rental month, the new supplier would be entitled to only 6 months of rental payments and then would have to continue to furnish the oxygen and oxygen equipment during any period of medical need for the remainder of the reasonable useful lifetime of the equipment. This creates a financial disincentive for oxygen suppliers to furnish oxygen and oxygen equipment to beneficiaries in these situations.

The proposed changes to the payment rules for oxygen and oxygen equipment would apply to oxygen and oxygen equipment furnished under Part B and would also apply to oxygen and oxygen equipment furnished under programs implemented in accordance with section 1847(a) of the Act.

b. Furnishing Oxygen Equipment after the 36-Month Rental Period (Cap)

In the CY 2010 PFS final rule with comment period (74 FR 61887 through 61890), we finalized § 414.226(g)(1) which, in accordance with section 1834(a)(5)(F)(ii)(I) of the Act, requires the supplier that furnishes oxygen equipment during the 36-month rental period to continue furnishing the oxygen equipment after the 36-month rental period. The supplier is required

to continue to furnish the equipment during any period of medical need for the remainder of the reasonable useful lifetime of the equipment. As we noted when finalizing this rule, section 1834(a)(5)(F)(ii)(I) does not provide any exceptions to this requirement. If the beneficiary relocates outside the supplier's normal service area at some time after the 36-month rental period but before the end of the reasonable useful lifetime of the equipment, the supplier must make arrangements for the beneficiary to continue receiving the equipment at his or her new place of residence. This responsibility for furnishing the equipment does not transfer to another supplier.

We revised § 414.226(f) to conform our regulations to this new MIPPA requirement. We deleted the transfer of ownership requirement and added the new requirement that the supplier must continue furnishing the oxygen equipment after the 36-month rental period during any period of medical need for the remainder of the reasonable useful lifetime of the equipment. It is important to note that § 414.226(g)(1)(ii) does not apply this same requirement in situations where the beneficiary relocates outside of the supplier's normal service area during the 36-month rental period.

c. Furnishing Oxygen Equipment during the 36-Month Rental Period (Cap)

Section § 414.226(g)(1) contains the requirement that the supplier that furnishes oxygen and oxygen equipment for the first month of the 36th month of the rental cap period must continue to furnish the equipment for the entire 36-month period of continuous use, with limited exceptions. One exception at § 414.226(g)(1)(ii) applies when a beneficiary permanently relocates his or her residence during the 36-month rental period outside of the current supplier's normal service area. This exception was proposed in the "Home Health Prospective Payment System Rate Update for Calendar Year 2007 and Deficit Reduction Act of 2005 Changes to Medicare Payment for Oxygen Equipment and Capped Rental Durable Medical Equipment; Proposed Rule" published in the August 3, 2006 **Federal Register** (71 FR 44094) and was intended to reduce the burden on the supplier in these situations. This approach is also consistent with the regulations addressing capped rental items described in § 414.229. We addressed this issue in the capped rental context in the July 10, 1995 **Federal Register** (60 FR 35494) in response to comments. The discussion states that since the implementation of the capped rental payment methodology on January 1, 1989, we received no reports of beneficiaries having difficulty obtaining access to capped rental DME after relocating outside the supplier's service area. Since enactment of the capped rental DME payment category in section 4062 of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100–203), representatives of the DME industry indicated that suppliers would be able to accommodate beneficiaries in these situations, and this has proven to be true for capped rental items. In fact, we have found this to be the case to this day.

For this reason, we believed that beneficiaries would not encounter problems obtaining access to oxygen and oxygen equipment in similar situations, that is, following the 36-month cap imposed by section 144(b) of MIPPA. However, since the changes to the payment rules for oxygen and oxygen equipment mandated by the DRA became effective in 2006 and the 36-month rental cap imposed by MIPPA was reached for the first time in January 2009, we have received many reports of beneficiaries relocating prior to the end of the 36-month rental payment cap period and having difficulty finding an oxygen supplier in the new location. We have learned that many suppliers are unwilling to provide services in situations where there are a few number of months left in the 36-month rental payment period.

We do not believe that beneficiaries have encountered similar issues following the 36-month rental cap, which most likely is the result of different statutory requirements for these two periods (that is, during and after the 36-month rental period). Section 1834(a)(5)(F)(ii) of the Act requires the supplier that furnishes the oxygen equipment during the 36-month rental payment period to continue furnishing the equipment after the 36-month rental payment period. Consistent with this requirement, we established regulations at § 414.226(f)(1) that require the supplier to furnish the equipment or make arrangements for furnishing the equipment in situations where the beneficiary relocates outside the supplier's normal service area. Since no such requirement currently applies in situations where the beneficiary relocates prior to the end of the 36-month rental payment period, and in fact current regulations at § 414.226(g)(1)(ii) absolve the supplier of the obligation to continue furnishing oxygen equipment in these situations, beneficiaries are experiencing difficulties finding suppliers of oxygen equipment in their new locations that are willing to accommodate them. As noted above, we have not seen this problem in the capped rental DME context. The requirement at § 414.226(g)(1) to furnish oxygen equipment for the entire 36 month rental cap period was established in the course of implementing section 5101(b) of the DRA in order to safeguard the beneficiary from situations where suppliers might discontinue service and pick up oxygen equipment prior to the end of the 36-month rental cap in order to avoid losing title to the equipment. As mentioned earlier, the transfer of title of oxygen and oxygen equipment after the 36th paid rental month was repealed. The exception to this rule at § 414.226(g)(1)(ii) was established based on our experience that suppliers of capped rental DME have accommodated beneficiaries in these situations, which, unfortunately, has not been our experience in the context of oxygen equipment.

In order to address this vulnerability facing beneficiaries as a result of regulations currently in effect, we are proposing to revise the exception at § 414.226(g)(1)(ii) to apply only to situations where the beneficiary relocates before the 18th paid rental month to an area that is outside the normal service area of the supplier that initially furnished the equipment. We are proposing to revise the regulation to require the supplier that furnishes the oxygen equipment and receives payment for month 18 or later to either furnish the equipment for the remainder of the 36-month rental payment period or, in the case where the beneficiary has relocated outside the service area of the supplier, make arrangements for furnishing the oxygen equipment with another supplier for the remainder of the 36-month rental payment period. The supplier that is required to furnish the equipment on the basis of this requirement must also furnish the equipment after the 36-month rental payment period in accordance with the requirements of section 1834(a)(5)(F)(ii) and § 414.226(f).

The proposed revision would mean that a supplier does not have to continue to furnish the oxygen equipment if the beneficiary relocates outside the normal service area before the 18th paid rental month during a period of continuous use. Under the current rule, a supplier does not have to furnish the oxygen equipment if the beneficiary relocated before the 36th paid rental month during a period of continuous use. The current rule was established based on the long term, demonstrated ability of suppliers of capped rental DME to accommodate

beneficiaries in situations where they relocate near the end of a capped rental payment period. With regard to oxygen equipment, suppliers in general have not demonstrated a willingness to accommodate beneficiaries in similar situations. Therefore, it is necessary to revisit this rule in order to protect beneficiaries in these situations. This proposal would allow either a new supplier in the beneficiary's new service area or a supplier in the old service area to receive at least half of the 36 monthly payments allowed for under the current statutory payment rule for oxygen equipment. We believe this approach would be fair to suppliers in either scenario since the same minimum number of payments applies. Based on current 2010 Medicare allowed fee schedule amounts for stationary oxygen equipment, total payments for 18 months is $3,117.06. We believe this new rule would provide greater financial incentive to suppliers in areas where beneficiaries relocate to furnish oxygen equipment in these situations. We also believe that this proposal would not disadvantage suppliers required to continue furnishing oxygen equipment or make arrangements for furnishing oxygen equipment to beneficiaries that relocate outside their normal service area since these suppliers would receive 18 or more monthly payments. Most of the cases that have been reported regarding problems encountered by beneficiaries in obtaining access to oxygen equipment after relocating during the 36-month rental cap period have been situations where the beneficiary has relocated during the second half of the 36-month rental cap period. Therefore, we believe that this rule would largely address access problems associated with relocations during the 36-month rental cap period because the supplier that received payments during the first half of the 36-month rental cap period would be obligated to continuing furnishing the equipment during the second half of the 36-month rental cap period.

H. Provider and Supplier Enrollment Issue: Air Ambulance Provision

The National Transportation Safety Board (NTSB) is an independent Federal agency charged by the Congress with investigating transportation accidents, determining their probable cause and making recommendations to prevent similar accidents from occurring. Based on information derived from testimony provided at the NSTB public hearing and investigations into recent Helicopter Emergency Medical Services (HEMS) accidents, the NTSB made several specific recommendations to the Secretary of Health and Human Services on September 24, 2009.

Specifically, the NTSB recommended that the Secretary develop minimum safety accreditation standards for HEMS operators that augment the operating standards of 14 CFR part 135 by including for all fights with medical personnel on board: (a) Scenario-based pilot training; (b) implementation of preflight risk evaluation programs; and (c) the installation of FAA-approved terrain awareness warning systems, night vision imaging systems, flight data recording systems for monitoring and autopilots if a second pilot is not used.

In response to the NTSB concerns, the Secretary noted that the recommendations to CMS were similar to those being made to the Federal Aviation Administration (FAA). While we have expertise to regulate health and safety requirements that suppliers and providers of healthcare should meet, we do not have the expertise to determine aircraft safety requirements. The Secretary stated that, "we believe the FAA should determine the minimum level of safety that HEMS operators should meet and CMS should adopt regulations that require any HEMS operator that enrolls in Medicare to meet those requirements." The Secretary also added that, "while we do not believe CMS should augment FAA regulations, we do believe that CMS' regulations should ensure that only those HEMS operators that maintain the minimum level of requirements established by the FAA through its regulations are enrolled or maintain enrollment in the Medicare program."

In the April 21, 2006 **Federal Register**, we published the "Requirements for Providers and Suppliers to Establish and Maintain Medicare Enrollment" final rule. This final rule implemented section 1866(j)(1)(A) of the Act. In this final rule, we required that all providers and suppliers (other than physicians or practitioners who have elected to "opt-out" of the Medicare program) must complete an enrollment form and submit specific information to CMS in order to obtain Medicare billing privileges. Section 424.515 required that ambulance service providers continue to resubmit enrollment information in accordance with § 410.41(c)(2), which states, "Upon a carrier's request, complete and return the ambulance supplier form designated by CMS and provide Medicare carrier with documentation of compliance with emergency vehicle and staff licensure and certification requirements in accordance with State and local laws." This final rule also established § 424.510(d)(2)(iii) which states, "Submission of all documentation, including all applicable Federal and State licensure and regulatory requirements that apply to the specific provider or supplier type that related to providing health care services, required by CMS under this or other statutory or regulatory authority, or under the Paperwork Reduction Act of 1995, to establish the provider or supplier's eligibility to furnish Medicare covered items or services to beneficiaries in the Medicare program."

While the Airline Deregulation Act (Pub. L. 95–504) preempts a State, political subdivision of a State, or political authority of at least 2 States from enacting or enforcing a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier that may provide air transportation, air ambulances remain subject to Federal laws and regulations. In accordance with § 424.516(a)(2), providers and suppliers must adhere to all Federal regulations and State laws and regulations, as required, based on the type of services or supplies the provider or supplier type will furnish and bill Medicare.

In § 424.510(d)(iii), we are proposing to clarify that ambulance suppliers and other providers and suppliers include documentation regarding all applicable Federal and State certifications. Accordingly we are propsing to revise § 424.510(d)(iii) from "Submission of all documentation, including all applicable Federal and State licenses and regulatory requirements that apply to the specific provider or supplier type that relate to providing health care service, required by CMS under this or other statutory or regulatory authority, or under the Paperwork Reduction Act of 1995, to establish the provider or supplier's eligibility to furnish Medicare covered items or services to beneficiaries in the Medicare program," to "Submission of all documentation, including all applicable Federal and State licenses, certifications (including, but not limited to Federal Aviation Administration and Clinical Laboratory Improvement Act certifications), and regulatory requirements that apply to the specific provider or supplier type that relate to providing health care service, required by CMS under this or other statutory or regulatory authority, or under the Paperwork Reduction Act of 1995, to establish the provider or supplier's eligibility to furnish Medicare covered items or services to beneficiaries in the Medicare program."

We are also proposing to revise § 424.516(e)(2) and add new paragraph

(e)(3) to clarify that Medicare enrolled providers and suppliers must report a revocation or suspension of a Federal or State license or certification, including but not limited to FAA and Clinical Laboratory Improvement Act (CLIA) certifications. This revision will clarify that fixed-wing ambulance operators and HEMS operators are responsible for notifying the designated Medicare contractor for their State when FAA revokes or suspends any license or certification. Moreover, fixed-wing ambulance operators and HEMS operators must maintain all requirements as specified in 14 CFR part 135.

We believe that requiring fixed-wing ambulance and HEMS operators to notify their Medicare contractor of a suspension or revocation of a license or certification will ensure that any action taken by the FAA or other regulating authority will have a direct linkage to the operator's ability to maintain their Medicare enrollment. We believe that such a policy will help improve aircraft safety for operators that are enrolled in Medicare and providing services to Medicare beneficiaries. In addition, since the FAA is responsible for the issuance and enforcement of regulations and minimum standards covering manufacturing, operating, and maintaining aircraft, we will work with the FAA to confirm that fixed-wing ambulance operators and HEMS operators remain in compliance with FAA safety regulations (including, but not limited to Federal Aviation Administration and certifications) to the Medicare contractor within 30 days of the revocation or suspension of the license or certification, the provider or supplier is making the decision to voluntarily terminate its Medicare billing privileges because the provider or supplier is no longer in compliance with the applicable licensing or certification requirements for their provider or supplier type. We believe that allowing providers and suppliers to self-report licensure or certification revocations and suspensions within a 30 day period via the Medicare enrollment application (such as, the Internet-based Provider Enrollment Chain and Ownership System (PECOS) or the paper CMS–855) promotes compliance with the Medciare reporting requirements found in § 424.516. In addition, by reporting a licensure or certification revocation or suspension within 30 days, the provider or supplier avoids the Medicare contractor bringing an action to revoke its Medicare billing privileges and establishing and Medicare enrollment bar, see § 424.535(c). Thus, by complying with the reporting responsibilities found in § 424.516 and voluntarily terminating from the Medicare program, the air ambulance supplier can submit an initial application to enroll in the Medicare program as soon as the licensure or certification revocation or suspension action is resolved with the applicable licensing or certification organization.

In § 424.502, we are proposing to define the term, "voluntary termination" as it is currently used in the Medicare program and throughout this regulation in the context of the provider enrollment requirements: We are proposing that the term, "voluntary termination" to mean an air ambulance supplier, that submits written confirmation to CMS of its decision to discontinue enrollment in the Medicare program.

Futhermore, we belive that an air ambulance supplier, can make the decision to voluntary terminate their business relationship with the Medicare program at any time, including when the provider or supplier makes the decision that they will no longer furnish services to Medicare beneficiaries.

In those situations, where an air ambulance supplier does not meet their reporting responsibilities and notify the Medicare program of a Federal or State licensure or certification revocation or suspension within 30 days of the reportable event, we believe that it is appropriate to that CMS or the Medicare contractor revoke the supplier's Medicare billing privileges using § 424.535(a)(1). We believe that this change will clarify that CMS or our Medicare contractor may revoke Medicare billing privileges when these types of suppliers do not report a revocation or suspension of a Federal or State license or certification.

I. Technical Corrections

1. Physical Therapy, Occupational Therapy and Speech-language Pathology

We are proposing to revise § 409.23(c) by making a minor technical correction to remove an extraneous cross-reference which was initially proposed in the CY 2008 PFS proposed rule (72 FR 38122, 72 FR 38193, and 72 FR 38221). This cross-reference refers the reader to "paragraph (c)(1)(ii) of this section," a paragraph also proposed in the CY 2008 PFS proposed rule, but never finalized. In the CY 2008 PFS final rule with comment period, we inadvertently neglected to remove the associated cross-reference from the regulations text. Accordingly, we now propose to rectify that oversight by making an appropriate correction in the regulations text, along with other minor formatting revisions. We are also proposing to make a minor clarification to the section heading and introductory text of § 409.23 (along with a conforming revision to the corresponding regulations text at § 409.20(a)(3)) by revising the existing phrase "speech therapy" to read "speech-language pathology services," so that it more accurately reflects the currently used terminology for this type of therapeutic treatment.

In addition, we are also proposing to make a minor wording change in the provision at § 409.17(d) (which is incorporated by reference in § 409.23(c)(2)), in order to clarify that the former provision's reference to "hospital" policies and procedures can alternatively refer, depending on the particular context, to SNF policies and procedures.

2. Scope of Benefits

In § 410.3, we are proposing a technical correction to paragraph (b)(2). Currently, § 410.3(b)(2) states that the specific rules on payment are set forth in subpart E of part 410. However, the specific payment rules are actually listed in subpart I of part 410. Therefore, we are proposing to correct § 410.3(b)(2) in this proposed rule.

VII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

A. ICRs Regarding Diagnostic X-ray Tests, Diagnostic Laboratory Tests, and Other Diagnostic Tests: Conditions (§ 410.32)

Proposed § 410.32(d)(2)(i) would require the physician or qualified non physician practitioner (as defined in § 410.32(a)(2)) who orders the service must maintain documentation of medical necessity in the beneficiary's medical record. In addition, both the medical record and the laboratory requisition (or order) would be required to be signed by the physician or qualified non physician practitioner (as defined in § 410.32(a)(2) of this section) who orders the service. The burden associated with these requirements would be the time and effort necessary for a physician or qualified nonphysician practitioner to sign the medical record or laboratory requisition (or order). There would also be a recordkeeping requirement associated with maintaining the documentation of medical necessity in the beneficiary medical record. While these requirements are subject to the PRA, we believe the associated burden is exempt from the PRA in accordance with 5 CFR 1320.3(b)(2). We believe that the time, effort, and financial resources necessary to comply with the aforementioned information collection requirements would be incurred by persons in the normal course of their activities and therefore considered to be usual and customary business practices.

B. ICRs Regarding General Exceptions to the Referral Prohibition Related to Both Ownership/Investment and Compensation (§ 411.355)

Proposed § 411.355(b)(7)(i) states that with respect to magnetic resonance imaging, computed tomography, and positron emission tomography, the referring physician shall provide written notice to the patient at the time of the referral that the patient may receive the same services from a person other than one described in § 411.355(b)(1). The written notice shall include a list of other suppliers (as defined in § 400.202 of this title) that provide the services for which the individual is being referred. The list shall include a minimum of 10 suppliers within a 25-mile radius of the referring physician's office location at the time of the referral. The notice should be written in a manner sufficient to be reasonably understood by all patients and should include for each supplier on the list, at a minimum, the supplier's name, address, telephone number, and distance from the referring physician's office. A record of the disclosure notification, signed by the patient, shall be maintained as a part of the patient's medical record.

Section 411.355(b)(7)(ii) proposes that if the referring physician makes a referral within an area with fewer than 10 other suppliers within the 25-mile radius of the physician's office location at the time of the referral, the physician shall list all of the other suppliers of the imaging service that are present within a 25-mile radius of the referring physician's office location, including up to 10 suppliers. Provision of the written list of alternate suppliers will not be required if no other suppliers provide the services for which the individual is being referred within the 25-mile radius. These physicians must still disclose to the patient that the patient may receive these services from a person other than one described in § 411.355(b)(1) in a manner sufficient to reasonably be understood by all patients. A record of the disclosure notification, signed by the patient and the referring physician, shall be maintained as a part of the patient's medical record.

The burden associated with the requirements contained in this section would be the time and effort necessary for a physician to develop a standard disclosure. There would also be burden associated with the time and effort necessary for a physician to provide the disclosure to the patient, to obtain the patient's signature, and to record the paper as part of the patient's medical record. We estimate that it would take 1 hour for a physician's office to develop a standard disclosure. We further estimate that 71,000 physicians will be required to comply with these requirements. The total burden associated with the development of the standard disclosure is 71,000 hours at a cost of $1,042,280. Similarly, we estimate that it will take each physician 1 minute to provide the disclosure to the patient, to obtain the patient's signature, and to record the paper as part of the patient's medical record. We believe that each provider will make approximately 106 disclosures. The total estimated annual for this requirement is 125,433 hours at a cost of $10,536,400.

C. ICRs Regarding Appeals Process for Termination of Competitive Bidding Contract (§ 414.423)

Proposed § 414.423(c)(1)(i) states that CMS has the option to allow a DMEPOS supplier to provide a written CAP to remedy the deficiencies identified in the notice, when CMS determines that the delay in the termination date caused by allowing a CAP will not cause harm to beneficiaries. As stated in proposed § 414.423(c)(2)(i) a CAP must be submitted within 30 calendar days from the date on the notification letter. If the supplier decides not to submit a CAP the supplier may within 30 days of the date on the termination letter request a hearing by a CBIC hearing officer.

The burden associated with this requirement is the time and effort necessary for a supplier that has received a termination notice to develop and submit a CAP. We estimate that 10 suppliers will need to comply with this requirement annually. Similarly, we estimate that it will take a supplier an average of 3 hours to develop a CAP. The total estimated annual burden associated with this requirement is 30 hours at a cost of $2,250.

Proposed § 414.423(e)(2) would require that if CMS accepts the CAP, including supplier's designated timeframe for its completion, the supplier must provide a follow-up report within 5 days after the supplier has fully implemented the CAP that verifies that all of the deficiencies identified in the CAP have been corrected in accordance with the timeframes accepted by CMS. The burden associated with this requirement is the time and effort necessary for a supplier to develop and submit a follow-up report. While this requirement is subject to the PRA, we believe the associated burden is exempt under 5 CFR 1320.3(h)(6). In accordance with 5 CFR 1320.3(h)(6), a request for facts or opinions addressed to a single person is not defined as information collection requirements and is therefore exempt from the PRA.

Proposed § 414.423(f)(1) states that a supplier who has received a notice that CMS considers them in breach of contract or that their CAP is not acceptable has the right to request a hearing before a CBIC HO who was not involved with the original determination. Section 414.423(f)(2) further proposes that a supplier who wishes to appeal the termination notice must submit a written request to the CBIC. The request for a hearing must be received by the CBIC within 30 calendar days from the date of the notice to terminate.

The burden associated with this section is the time and effort necessary for a supplier to develop and submit a written request for a hearing by a CBIC Hearing Officer. We estimate that it will take a supplier 8 hours to develop and submit a request for a hearing. We believe 5 suppliers will be subject to this requirement on an annual basis. The total estimated annual burden associated with developing and submitting a written request for a

hearing by a CBIC Hearing Officer is 40 hours at a cost of $3,000.

Proposed § 414.423 would require a contract suppliers whose contract has been terminated to notify all beneficiaries who are receiving rented competitive bid items or competitive bid items received on a recurring basis, of the termination of their contract. The notice to the beneficiary from the supplier whose contract was terminated must be provided within 5 days of receipt of the notice of termination. The notification to the beneficiaries must inform the beneficiaries that they are going to have to select a new contract supplier for these items.

The burden associated with this section is the time and effort necessary for a supplier to develop and distribute notification of its termination to all beneficiaries receiving rented competitive bid items or competitive bid items received on a recurring basis. We estimate that it will take a supplier 3 hours to develop and distribute a notice announcing its termination to all of its beneficiaries receiving rented competitive bid items or competitive bid items received on a recurring basis. We believe 2 suppliers will be subject to this requirement on an annual basis. The total estimated annual burden associated with this requirement is 6 hours at a cost of $450.

D. ICRs Regarding Additional Provider and Supplier Requirements for Enrolling and Maintaining Active Enrollment Status in the Medicare Program (§ 424.516)

Proposed § 424.516(e)(2) would require a provider or supplier to report a revocation or suspension to the applicable Medicare contractor within 30 days any revocation or suspension of a Federal or State license or certification. Similarly, proposed § 424.516(e)(2) states that within 30 days of voluntary withdrawal or involuntary termination from the Medicare program, the provider or supplier must report voluntary withdraw or involuntary termination to the applicable Medicare contractor. The burden associated with the requirements in § 424.516(e)(2) and (3) is the time and effort necessary for a provider or supplier to report the required information to the applicable Medicare contractor. While these requirements are subject to the PRA, each submission will be evaluated on a case-by-case basis.

E. ICRs Regarding Additional Provider and Supplier Requirements for Enrolling and Maintaining Active Enrollment Status in the Medicare Program (§ 424.516)

Proposed § 424.516(e)(2) would require a provider or supplier to report a revocation or suspension to the applicable Medicare contractor within 30 days any revocation or suspension of a Federal or State license or certification. Similarly, proposed § 424.516(e)(2) states that within 30 days of voluntary withdrawal or involuntary termination from the Medicare program, the provider or supplier must report voluntary withdraw or involuntary termination to the applicable Medicare contractor. The burden associated with the requirements in § 424.516(e)(2) and (3) is the time and effort necessary for a provider or supplier to report the required information to the applicable Medicare contractor. While these requirements are subject to the PRA, each submission will be evaluated on a case-by-case basis.

TABLE 72—ESTIMATED ANNUAL RECORDKEEPING AND REPORTING BURDEN

Regulation section(s)	OMB Control No.	Respondents	Responses	Burden per response (hours)	Total annual burden (hours)	Hourly labor cost of reporting (in $)	Total labor cost of reporting (in $)	Total capital/maintenance costs (in $)	Total cost (in $)
§ 411.355	0938–New	71,000	71,000	1	71,000	14.68	1,042,280	0	1,042,280
		71,000	7,454,760	0.0167	125,433	83.79	10,536,400*	0	10,536,400
§ 414.423	0938–New	10	10	3	30	75.00	2,250	0	2,250
		5	5	8	40	75.00	3000		3000
		2	2	3	6	75.00	450		450
Total		71,017	7,525,777		196,509				11,584,380

* The annual cost burden for this provision was calculated by taking 106 disclosures per year per physician × $1.40 per disclosure = $148.40 a year per physician × 71,000 physicians = $10,536,400.

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: CMS Desk Officer, [CMS–1503–P] Fax: (202) 395–6974; or E-mail: *OIRA_submission@omb.eop.gov.*

F. Additional Information Collection Requirements

This proposed rule imposes collection of information requirements as outlined in the regulation text and specified above. However, this proposed rule also makes reference to several associated information collections that are not discussed in the regulation text contained in this document. The following is a discussion of these information collections, some of which have already received OMB approval.

1. Part B Drug Payment

The discussion of average sales price (ASP) issues in section VI.A.1 of this proposed rule does not contain any new information collection requirements with respect to payment for Medicare Part B drugs and biologicals under the ASP methodology. Drug manufacturers are required to submit ASP data to us on a quarterly basis. The ASP reporting requirements are set forth in section 1927(b) of the Act. The burden associated with this requirement is the time and effort required by manufacturers of Medicare Part B drugs and biologicals to calculate, record, and submit the required data to CMS. While the burden associated with this requirement is subject to the PRA, it is currently approved under OMB control number 0938–0921.

3. Physician Quality Reporting Initiative (PQRI)

Section VI.F.1. of this proposed rule discusses the background of the PQRI, provides information about the proposed measures and reporting mechanisms to be available to eligible professionals (EPs) and group practices who choose to participate in the 2011 PQRI, and the proposed criteria for satisfactory reporting in 2011.

With respect to satisfactory submission of data on quality measures by EPs, EPs include physicians, other practitioners as described in section 1842(b)(18)(c) of the Act, physical and occupational therapists, qualified speech-language pathologists, and qualified audiologists. EPs may choose whether to participate and, to the extent they satisfactorily submit data on quality measures for covered professional services, they can qualify to receive an incentive payment. To qualify to receive an incentive payment for 2011, the EP (or group practice) must meet one of the proposed criteria for satisfactory reporting described in sections VI.F.1.e. or VI.F.1.f. of this proposed rule (or section VI.F.1.g. for group practices).

Because this is a voluntary program, it is difficult to accurately estimate how many EPs will opt to participate in the PQRI in CY 2011. Information from the "PQRI 2007 Reporting Experience Report," which is available on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI,* indicates that nearly 110,000 unique TIN/NPI combinations attempted to submit PQRI quality measures data via claims for the 2007 PQRI. Therefore, for purposes of conducting a burden analysis for the 2011 PQRI, we will assume that all EPs who attempted to participate in the 2007 PQRI will also attempt to participate in the 2011 PQRI. Furthermore, we believe that the burden for EPs who are participating in the PQRI for the first time in 2011 will be considerably higher than the burden for EPs who have participated in PQRI in prior years.

For individual EPs, the burden associated with the requirements of this reporting initiative is the time and effort associated with EPs identifying applicable PQRI quality measures for which they can report the necessary information, collecting the necessary information, and reporting the information needed to report the EP's or group practice's measures. We believe it is difficult to accurately quantify the burden because EPs may have different processes for integrating the PQRI into their practice's work flows. Moreover, the time needed for an EP to review the quality measures and other information, select measures applicable to his or her patients and the services he or she furnishes to them, and incorporate the use of quality data codes into the office work flows is expected to vary along with the number of measures that are potentially applicable to a given professional's practice. Since EPs are generally required to report on at least 3 measures to earn a PQRI incentive, we will assume that each EP who attempts to submit PQRI quality measures data is attempting to earn a PQRI incentive payment and reports on an average of 3 measures for this burden analysis.

Because we anticipate even greater participation in the 2011 PQRI than in previous years, including participation by EPs who are participating in PQRI for the first time in 2011, we will assign 5 hours as the amount of time needed for EPs to review the 2011 PQRI Measures List, review the various reporting options, select the most appropriate reporting option, identify the applicable measures or measures groups for which they can report the necessary information, review the measure specifications for the selected measures or measures groups, and incorporate reporting of the selected measures or measures groups into the office work flows. This estimate is based on our assumption that an EP will need up to 2 hours to review the 2011 PQRI Measures List, review the reporting options, and select a reporting option and measures on which to report and 3 hours to review the measure specifications for up to 3 selected measures or up to 1 selected measures group and to develop a mechanism for incorporating reporting of the selected measures or measures group into the office work flows.

Information from the Physician Voluntary Reporting Program (PVRP), which was a predecessor to the PQRI, indicated an average labor cost of $50 per hour. To account for salary increases over time, we will use an average practice labor cost of $58 per hour in our estimates based on an assumption of an average annual increase of approximately 3 percent. Thus, we estimate the cost for EP associated with preparing to report PQRI quality measures would be approximately $290 per EP ($58 per hour x 5 hours).

We continue to expect the ongoing costs associated with PQRI participation to decline based on an EP's familiarity with and understanding of the PQRI, experience with participating in the PQRI, and increased efforts by CMS and stakeholders to disseminate useful educational resources and best practices.

We believe the burden associated with actually reporting the PQRI quality measures will vary depending on the reporting mechanism selected by the EP. For claims-based reporting, EPs must gather the required information, select the appropriate quality data codes (QDCs), and include the appropriate QDCs on the claims they submit for payment. The PQRI will collect QDCs as additional (optional) line items on the existing HIPAA transaction 837–P and/or CMS Form 1500 (OCN: 0938–0999). We do not anticipate any new forms and no modifications to the existing transaction or form. We also do not anticipate changes to the 837–P or CMS Form 1500 for CY 2011.

Based on our experience with the PVRP, we continue to estimate that the time needed to perform all the steps necessary to report each measure (that is, reporting the relevant quality data code(s) for a measure) on claims ranges from 15 seconds (0.25 minutes) to over 12 minutes for complicated cases and/or measures, with the median time being 1.75 minutes. At an average labor cost of $58 per hour per practice, the cost associated with this burden ranges from $0.24 in labor to about $11.60 in labor time for more complicated cases and/or measures, with the cost for the median practice being $1.69.

The total estimated annual burden for this requirement will also vary along with the volume of claims on which quality data is reported. In previous years, when we required reporting on 80 percent of eligible cases for claims-based reporting, we found that on average, the median number of reporting instances for each of the PQRI measures was 9. Since we propose to reduce the required reporting rate by over one-third to 50 percent, then for purposes of this burden analysis we will assume that an EP will need to report each selected measure for 6 reporting instances. The actual number of cases on which an eligible professional would be required to report quality measures data will vary, however, with the EP's patient population and the types of measures on which the EP chooses to report (each measure's specifications includes a required reporting frequency).

Based on the assumptions discussed above, we estimate the total annual reporting burden per EP associated with claims-based reporting to range from 4.5 minutes (0.25 minutes per measure $\times$ 3 measures $\times$ 6 cases per measure) to 180 minutes (12 minutes per measure $\times$ 3 measures $\times$ 6 cases per measure), with the burden to the median practice being 31.5 minutes (1.75 minutes per measure $\times$ 3 measures $\times$ 6 cases). We estimate the total annual reporting cost per EP associated with claims-based reporting to range from $4.32 ($0.24 per measure $\times$ 3 measures $\times$ 6 cases per measure) to $208.80 ($11.60 per measure $\times$ 3 measures $\times$ 6 cases per measure), with the cost to the median practice being $30.42 per EP ($1.69 per measure $\times$ 3 measures $\times$ 6 cases per measure).

For registry-based reporting, there would be no additional time burden for EP to report data to a registry as EP

opting for registry-based reporting would more than likely already be reporting data to the registry for other purposes. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2011 PQRI. However, EPs would need to authorize or instruct the registry to submit quality measures results and numerator and denominator data on quality measures to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes per EP.

Registries interested in submitting quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf in 2011 would need to complete a self-nomination process in order to be considered "qualified" to submit on behalf of EPs unless the registry was qualified to submit on behalf of EPs for prior years and did so successfully. We estimate that the self-nomination process for qualifying additional registries to submit on behalf of EPs for the 2011 PQRI involves approximately 1 hour per registry to draft the letter of intent for self-nomination. It is estimated that each self-nominated entity will also spend 2 hours for the interview with CMS officials and 2 hours calculating numerators, denominators, and measure results for each measure the registry wishes to report using a CMS-provided measure flow. However, the time it takes to complete the measure flow could vary depending on the registry's experience and the number and type of measures for which the registry wishes to submit on behalf of EPs. Additionally, part of the self-nomination process involves the completion of an XML submission by the registry, which is estimated to take approximately 5 hours, but may vary depending on the registry's experience. We estimate that the registry staff involved in the registry self-nomination process have an average labor cost of $50 per hour. Therefore, assuming the total burden hours per registry associated with the registry self-nomination process is 10 hours, we estimate the total cost to a registry associated with the registry self-nomination process to be approximately $500 ($50 per hour × 10 hours per registry).

The burden associated with the registry-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the registry calculating quality measure results from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on quality measures to CMS on behalf of their participants. The time needed for a registry to review the quality measures and other information, calculate the measures results, and submit the measures results and numerator and denominator data on the quality measures on their participants behalf is expected to vary along with the number of EPs reporting data to the registry and the number of applicable measures. However, we believe that registries already perform many of these activities for their participants. The number of measures that the registry intends to report to CMS and how similar the registry's measures are to CMS' PQRI measures will determine the time burden to the registry.

For EHR-based reporting, the EP must have an IACS account, which we believe takes less than 1 hour to obtain. Once an EP has an IACS account, he or she must extract the necessary clinical data from his or her EHR, and submit the necessary data to the CMS-designated clinical data warehouse. With respect to our proposal to require an EP to submit a test file, we believe that doing so would take less than 1 hour. With respect to submitting the actual 2011 data file in 2012, we believe that this would take an EP no more than 2 hours, depending on the number of patients on which the EP is submitting. We believe that once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the EP associated with submission of data on PQRI quality measures should be minimal. Because this manner of reporting quality data to CMS was new to PQRI for 2010 and no EHR data submissions have taken place yet, it is difficult to estimate how many EPs will opt to participate in the PQRI through the EHR mechanism in CY 2011.

An EHR vendor interested in having their product(s) be used by EPs to submit PQRI quality measures data to CMS were required to complete a self-nomination process in order for the vendor's product(s) to be considered "qualified" for 2011. It is difficult to accurately quantify the burden associated with the EHR self-nomination process as there is variation regarding the technical capabilities and experience among vendors. For purposes of this burden analysis, however, we estimate that the time required for an EHR vendor to complete the self-nomination process will be similar to the time required for registries to self-nominate that is approximately 10 hours at $50 per hour for a total of $500 per EHR vendor ($50 per hour x 10 hours per EHR vendor).

The burden associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the EP needs to submit to CMS for purposes of reporting 2010 PQRI quality measures will be dependent on the EHR vendor's familiarity with PQRI, the vendor's system capabilities, as well as the vendor's programming capabilities. Some vendors already have these necessary capabilities and for such vendors, we estimate the total burden hours to be 40 hours at a rate of $50 per hour for a total burden estimate of $2,000 ($50 per hour x 40 hours per vendor). However, given the variability in the capabilities of the vendors, those vendors with minimal experience would have a burden of approximately 200 hours at $50 per hour, for a total estimate of $10,000 per vendor ($50 per hour x 200 hours per EHR vendor).

With respect to the process for group practices to be treated as satisfactorily submitting quality measures data under the 2011 PQRI discussed in section VI.F.1. of this proposed rule, group practices interested in participating in the 2011 PQRI through one of the proposed group practice reporting options would need to complete a self-nomination process similar to the self-nomination process required of registries and EHR vendors. Therefore, assuming 2 hours for a group practice to decide whether to participate as a group or individually, approximately 2 hours per group practice to draft the letter of intent for self-nomination, gather the requested information, and provide this requested information, and an additional 2 hours undergoing the vetting process with CMS officials, we estimate a total of 6 hours associated with the self-nomination process. Assuming that the group practice staff involved in the group practice self-nomination process have the same average practice labor cost as the average practice labor cost estimates we used for individual EPs of $58 per hour, we estimate the total cost to a group practice associated with the group practice self-nomination process to be approximately $348 ($58 per hour x 6 hours per group practice).

The burden associated with the group practice reporting requirements of this voluntary reporting initiative is the time and effort associated with the group practice submitting the quality measures data. For practices participating under the proposed GPRO I process, this would be the time associated with the physician group completing the data collection tool. The information collection components of this data collection tool have been reviewed by OMB and are currently approved under

OMB control number 0938–0941, with an expiration date of December 31, 2011, for use in the Physician Group Practice, Medicare Care Management Performance (MCMP), and EHR demonstrations. Based on burden estimates for the PGP demonstration, which uses the same data submission methods, we estimate the burden associated with a physician group completing the data collection tool would be approximately 79 hours per physician group. Based on an average labor cost of $58 per physician group, we estimate the cost of data submission per physician group associated with participating in the proposed PQRI GPRO I would be $4,582 ($58 per hour x 79 hours per group practice).

For group practices participating under the proposed GPRO II process, the burden associated with submitting the PQRI quality measures data would be the time associated with the group practice submitting the required data to CMS via claims or a registry. We would expect that data submission under GPRO II would take no more time than the time it would take an individual EP to submit via claims or registry. We believe it would be appropriate to multiply the appropriate burden estimates for each reporting mechanism for individual EPs by the number of EPs in a group to obtain the burden estimates for data submission under GPRO II. For example, based on our estimate of 15.75 minutes per EP under claims-based reporting, we would expect that a 2-person group would have a burden of 31.50 minutes for claims-based submission under GPRO II.

We invite comments on this burden analysis, including the underlying assumptions used in developing our burden estimates.

3. Electronic Prescribing (eRx) Incentive Program

We believe it is difficult to accurately estimate how many EPs will opt to participate in the eRx Incentive Program in CY 2011. Final participation numbers from the first year of the eRx Incentive Program (2009) are not available. Information from the "PQRI 2007 Reporting Experience Report," which is available on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI,* however, indicates that nearly 110,000 unique TIN/NPI combinations attempted to submit PQRI quality measures data via claims for the 2007 PQRI. Therefore, for purposes of conducting a burden analysis for the 2011 eRx Incentive Program, we will assume that as many EPs who attempted to participate in the 2007 PQRI will attempt to participate in the 2011 eRx Incentive Program. As such, we can estimate that nearly 110,000 unique TIN/NPI combinations will participate in the 2011 eRx Incentive Program.

Section VI.F.2 of this proposed rule discusses the background of the eRx Incentive Program. Section VI.F.2.b.(2) of this proposed rule provides information on how we propose EPs and group practices can qualify to be considered a successful electronic prescriber in 2011 in order to earn an incentive payment. For 2011, EPs and group practices may choose whether to participate and, to the extent they meet— (1) certain thresholds with respect to the volume of covered professional services furnished; and (2) the criteria to be considered a successful electronic prescriber described in section VI.F.2.b.(2) of this proposed rule, they can qualify to receive an incentive payment for 2011 and/or avoid being subject to a penalty that goes into effect in 2012.

For the 2011 eRx Incentive Program, as discussed in section VI.F.2. of this proposed rule, we propose that each EP would need to report the G-code indicating that at least one prescription generated during an encounter was electronically submitted at least 25 instances during the reporting period. We expect the ongoing costs associated with participation in the eRx Incentive Program to decline based on an EP's familiarity with and understanding of the eRx Incentive Program, experience with participating in the eRx Incentive Program, and increased efforts by CMS and stakeholders to disseminate useful educational resources and best practices.

Similar to PQRI, one factor in the burden to individual EPs would be the time and effort associated with individual EPs reviewing the electronic prescribing measure to determine whether it is applicable to them, reviewing the available reporting options (we propose this measure would be reportable through claims-based reporting, registry-based reporting, or through EHRs) and selecting one, gathering the required information, and incorporating reporting of the measure into their office work flows. Since the eRx Incentive Program consists of only 1 measure to report, we estimate 2 hours as the amount of time needed for individual EPs to prepare for participation in the eRx Incentive Program. At an average cost of approximately $58 per hour per practice, we estimate the total preparation costs to individual EPs to be approximately $116 (2 hours × $58 per hour).

Another factor that influences the burden to EPs is how they choose to report the electronic prescribing measure. For EPs who choose to do so via claims, we estimate that the burden associated with the requirements of this incentive program is the time and effort associated with gathering the required information, selecting the appropriate quality data codes (QDCs), and including the appropriate QDCs on the claims they submit for payment. For claims-based reporting, the QDCs will be collected as additional (optional) line items on the existing HIPAA transaction 837–P and/or CMS Form 1500. We do not anticipate any new forms and no modifications to the existing transaction or form. We also do not anticipate changes to the 837–P or CMS Form 1500 for CY 201.

Based on the information from the PVRP described above for the amount of time it takes a median practice to report one measure one time on claims (1.75 minutes) and our proposal to require EPs to report the measure 25 times, we estimate the burden associated with claims-based data submission to be 43.75 minutes (1.75 minutes per case × 1 measure × 25 cases per measure). This equates to a cost of approximately $42.29 (1.75 minutes per case × 1 measure × 25 cases per measure × $58 per hour) per individual EP.

Because registry-based reporting of the electronic prescribing measure to CMS was added to the eRx Incentive Program for 2010 and EPs are not required to indicate to us how they plan to report the electronic prescribing measure each year, it is difficult to accurately estimate how many EPs will opt to participate in the eRx Incentive Program through the registry-based reporting mechanism in CY 2011. We do not anticipate, however, any additional burden for EPs to report data to a registry as EPs opting for registry-based reporting would more than likely already be reporting data to the registry for other purposes. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2011 eRx Incentive Program. However, EPs would need to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each EP that wishes to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic

prescribing measure to CMS on their behalf.

Based on our proposal to consider only registries qualified to submit PQRI quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf for the 2010 PQRI to be qualified to submit results and numerator and denominator data on the electronic prescribing measure for the 2010 eRx Incentive Program, there would be no need for a registry to undergo a separate self-nomination process for the eRx Incentive Program and therefore, no additional burden associated with the registry self-nomination process.

There would also be a burden to the registry associated with the registry calculating results for the electronic prescribing measure from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on the electronic prescribing quality measure to CMS on behalf of their participants. The time needed for a registry to review the electronic prescribing measure and other information, calculate the measure's results, and submit the measure's results and numerator and denominator data on the measure on their participants behalf is expected to vary along with the number of EPs reporting data to whom the measure applies. However, we believe that registries already perform many of these activities for their participants. Since the E–Prescribing Incentive Program consists of only one measure, we believe that the burden associated with the registry reporting the measure's results and numerator and denominator to CMS on behalf of their participants would be minimal.

For EHR-based reporting, the EP must extract the necessary clinical data from his or her EHR and submit the necessary data to the CMS-designated clinical data warehouse. Because this manner of reporting quality data to CMS was first added to the eRx Incentive Program in 2010 and EPs are not required to indicate to us how they intend to report the electronic prescribing measure, it is difficult to estimate how many EPs will opt to participate in the eRx Incentive Program through the EHR-based reporting mechanism in CY 2011. We believe that once an EP's EHR is programmed by the vendor to allow data submission to CMS, the burden to the EP associated with submission of data on the electronic prescribing measure should be minimal.

Since we are considering only EHR products qualified for the 2010 PQRI to be qualified for the 2011 eRx Incentive Program, there would be no need for EHR vendors to undergo a separate self-nomination process for the 2011 eRx Incentive Program and therefore, no additional burden associated with the self-nomination process.

There would also be a burden to the EHR vendor associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the EP needs to submit to CMS for purposes of reporting the proposed 2011 electronic prescribing measure. The time needed for an EHR vendor to review the measure and other information and program each qualified EHR product to enable EPs to submit data on the measure to the CMS-designated clinical data warehouse will be dependent on the EHR vendor's familiarity with the electronic prescribing measure, the vendor's system capabilities, as well as the vendor's programming capabilities. Since only EHR products qualified for the 2011 PQRI would be qualified for the 2011 eRx Incentive Program and the eRx Incentive Program consists of only one measure, we believe that any burden associated with the EHR vendor to program its product(s) to enable EPs to submit data on the electronic prescribing measure to the CMS-designated clinical data warehouse would be minimal.

Finally, with respect to the process for group practices to be treated as successful electronic prescribers under the 2011 eRx Incentive Program discussed in section VI.F.2. of this proposed rule, we propose that group practices would have the same options as individual EPs in terms of the form and manner for reporting the electronic prescribing measure (that is, group practices would have the option of reporting the measure through claims, a qualified registry, or a qualified EHR product). There are only 2 differences between the proposed requirements for an individual EP and a group practice: (1) The fact that a group practice would have to self-nominate; and(2) the number of times that a group practice would be required to report the electronic prescribing measure.

We do not anticipate any additional burden associated with the group practice self-nomination practice since we propose to limit the group practices to those selected to participate in the 2011 PQRI GPRO I or PQRI GPRO II. The practice only would need to indicate their desire to participate in the eRx GPRO at the same time they self-nominate for either PQRI GPRO I or PQRI GPRO II and indicate how they intend to report the electronic prescribing measure.

In terms of the burden to group practices associated with submission of the electronic prescribing measure, we believe that this would be similar to the burden to individual EPs for submitting the electronic prescribing measure. In fact, overall, there could be less burden associated with a practice participating as a group rather than as individual EPs because the total number of reporting instances required by the group could be less than the total number of reporting instances that would be required if each member of the group separately reported the electronic prescribing measure. Thus, we believe that the burden to a group practice associated with reporting the electronic prescribing measure could range from almost no burden (for groups who choose to do so through a qualified EHR or registry) to 72.92 hours (1.75 minutes per measure $\times$ 1 measure $\times$ 2,500 cases per measure) for a GPRO I group who chooses to report the electronic prescribing measures through claims submission. Consequently, the total estimated cost per group practice to report the electronic prescribing measure could be as high as $4,225 ($1.69 per measure $\times$ 1 measure $\times$ 2,500 cases per measure).

As with individual EPs, we believe that group practices that choose to participate in the 2011 eRx GPRO through registry-based reporting of the electronic prescribing measure would more than likely already be reporting data to the registry. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2011 eRx Incentive Program beyond authorizing or instructing the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each group practice that wishes to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf.

For group practices that choose to participate in the 2011 eRx Incentive Program through EHR-based reporting of the electronic prescribing measure, once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the group practice associated with submission of data on the electronic prescribing measure should be minimal.

We invite comments on this burden analysis, including the underlying

assumptions used in developing our burden estimates.

VIII. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

IX. Regulatory Impact Analysis

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We estimate, as discussed below in this section, that the PFS provisions included in this proposed rule will redistribute more than $100 million in 1 year. Therefore, we estimate that this rulemaking is "economically significant" as measured by the $100 million threshold, and hence also a major rule under the Congressional Review Act. Accordingly, we have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the rulemaking.

The RFA requires agencies to analyze options for regulatory relief of small businesses, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, we estimate that most hospitals and most other providers are small entities as that term is used in the RFA (including small businesses, nonprofit organizations, and small governmental jurisdictions). The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the SBA definition of a small business (having revenues of less than $34.5 million in any 1 year) (for details see the SBA's Web site at *http://sba.gov/idc/groups/public/documents/sba_homepage/serv_sstd_tablepdf.pdf* (refer to the 620000 series). Individuals and States are not included in the definition of a small entity. The RFA requires that we analyze regulatory options for small businesses and other entities. We prepare a regulatory flexibility analysis unless we certify that a rule would not have a significant economic impact on a substantial number of small entities. The analysis must include a justification concerning the reason action is being taken, the kinds and number of small entities the rule affects, and an explanation of any meaningful options that achieve the objectives with less significant adverse economic impact on the small entities.

For purposes of the RFA, physicians, NPPs, and suppliers including IDTFs are considered small businesses if they generate revenues of $10 million or less based on SBA size standards. Approximately 95 percent of physicians are considered to be small entities. There are over 1 million physicians, other practitioners, and medical suppliers that receive Medicare payment under the PFS.

For purposes of the RFA approximately 85 percent of suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) are considered small businesses according to the SBA size standards. Our most recent claims information includes 47,000 entities billing Medicare for DMEPOS each year. Total annual estimated Medicare expenditures for DMEPOS suppliers are approximately $10.1 billion in CY 2009, for which $8.1 billion was fee-for-service (FFS) and $2 billion was for managed care.

For purposes of the RFA, approximately 80 percent of clinical diagnostic laboratories are considered small businesses according to the SBA size standards.

Ambulance providers and suppliers for purposes of the RFA are also considered to be small entities.

In addition, most ESRD facilities are considered small entities for purposes of the RFA, either based on nonprofit status or by having revenues of $34.5 million or less in any year. We note that a considerable number of ESRD facilities are owned and operated by large dialysis organizations (LDOs) or regional chains, which would have total revenues more than $34.5 million in any year if revenues from all locations are combined. However, the claims data we use to estimate payments for this RFA and RIA does not identify which dialysis facilities are parts of an LDO, regional chain, or other type of ownership. Each individual dialysis facility has its own provider number and bills Medicare using this number. Therefore, we consider each ESRD facility to be a small entity for purposes of the RFA. We consider a substantial number of entities to be significantly affected if the proposed rule has an annual average impact on small entities of 3 to 5 percent or more. The majority of ESRD facilities will experience impacts of approximately 2 percent of total revenues. There are 954 nonprofit ESRD facilities with a combined increase of 2.1 percent in overall payments relative to current overall payments. We note that although the overall effect of the wage index changes is budget neutral, there are increases and decreases based on the location of individual facilities. The analysis and discussion provided in this section and elsewhere in this proposed rule complies with the RFA requirements.

Because we acknowledge that many of the affected entities are small entities, the analysis discussed throughout the preamble of this proposed rule constitutes our regulatory flexibility analysis for the remaining provisions and addresses comments received on these issues.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis, if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. Any such regulatory impact analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. We do not believe this proposed rule has impact on significant operations of a substantial number of small rural hospitals because most dialysis facilities are freestanding. While there are 184 rural hospital-based dialysis facilities, we do not know how many of them are based at hospitals with fewer than 100 beds. However, overall, the 184 rural hospital-based dialysis facilities will experience an estimated 2.1 percent increase in payments. As a result, this rule will not have a significant impact on small rural hospitals. Therefore, the Secretary has determined that this proposed rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2010, that threshold is approximately $135 million. This proposed rule will not mandate any requirements for State, local, or tribal governments in the aggregate, or by the private sector, of $135 million. Medicare beneficiaries are considered to be part of the private sector and as a result a more detailed discussion is presented on the Impact of Beneficiaries in section IX.G. of this regulatory impact analysis.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have examined this proposed rule in accordance with Executive Order 13132 and have determined that this regulation would not have any substantial direct effect on State or local governments, preempt States, or otherwise have a Federalism implication.

We have prepared the following analysis, which together with the information provided in the rest of this preamble, meets all assessment requirements. The analysis explains the rationale for and purposes of this proposed rule; details the costs and benefits of the rule; analyzes alternatives; and presents the measures we will use to minimize the burden on small entities. As indicated elsewhere in this rule, we are implementing a variety of changes to our regulations, payments, or payment policies to ensure that our payment systems reflect changes in medical practice and the relative value of services. We provide information for each of the policy changes in the relevant sections of this proposed rule. We are unaware of any relevant Federal rules that duplicate, overlap, or conflict with this proposed rule. The relevant sections of this rule contain a description of significant alternatives if applicable.

A. RVU Impacts

1. Resource-Based Work, PE, and Malpractice RVUs

Section 1848(c)(2)(B)(ii) of the Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, we make adjustments to preserve budget neutrality.

Our estimates of changes in Medicare revenues for PFS services compare payment rates for CY 2010 with proposed payment rates for CY 2011 using CY 2009 Medicare utilization for all years. To the extent that there are year-to-year changes in the volume and mix of services provided by physicians, the actual impact on total Medicare revenues will be different than those shown in Table 73. The payment impacts reflect averages for each specialty based on Medicare utilization. The payment impact for an individual physician would be different from the average, based on the mix of services the physician furnishes. The average change in total revenues would be less than the impact displayed here because physicians furnish services to both Medicare and non-Medicare patients and specialties may receive substantial Medicare revenues for services that are not paid under the PFS. For instance, independent laboratories receive approximately 85 percent of their Medicare revenues from clinical laboratory services that are not paid under the PFS.

Table 73 shows only the payment impact on PFS services. We note that these impacts do not include the effect of the current law −6.1 percent CY 2011 PFS update. The following is an explanation of the information represented in Table 73:

- *Column A (Specialty):* The Medicare specialty code as reflected in our physician/supplier enrollment files.
- *Column B (Allowed Charges):* The aggregate estimated PFS allowed charges for the specialty based on CY 2009 utilization and CY 2010 rates. That is, allowed charges are the PFS amounts for covered services and include coinsurance and deductibles (which are the financial responsibility of the beneficiary). These amounts have been summed across all services furnished by physicians, practitioners, or suppliers within a specialty to arrive at the total allowed charges for the specialty.
- *Column C (Impact of Work and Malpractice (MP) RVU Changes):* This column shows the estimated CY 2011 impact on total allowed charges of the changes in the work and malpractice RVUs.
- *Column D (Impact of PE RVU and Multiple Procedure Payment Reduction Changes—Full):* This column shows the estimated CY 2011 impact on total allowed charges of the changes in the PE RVUs if there were no remaining transition to the full use of the new PPIS data. This column also includes the impact of the various MPPR and imaging equipment utilization policies.
- *Column E (Impact of PE RVU and MPPR Changes—Tran):* This column shows the estimated CY 2011 impact on total allowed charges of the changes in the PE RVUs under the second year of the 4-year transition to the full use of the new PPIS data. This column also includes the impact of the various MPPR and imaging equipment utilization policies.
- *Column F (Impact of MEI Rebasing):* This column shows the estimated CY 2011 impact on total allowed charges of the proposed CY 2011 rescaling of the RVUs so that the proportions of total payments based on the work, PE, and malpractice RVUs match the proportions proposed in the rebased CY 2006 MEI.
- *Column G (Combined Impact—Full):* This column shows the estimated CY 2011 combined impact on total allowed charges of all the changes in the previous columns if there were no remaining transition to the new PE RVUs using the PPIS data.
- *Column H (Combined Impact—Tran):* This column shows the estimated CY 2011 combined impact on total allowed charges of all the changes in the previous columns under the second year of the 4-year transition to the new PE RVUs using the PPIS data.

TABLE 73—CY 2011 PFS PROPOSED RULE TOTAL ALLOWED CHARGE ESTIMATED IMPACT FOR RVU, MPPR, AND MEI REBASING CHANGES*

Specialty	Allowed charges (mil)	Impact of work and MP RVU changes	Impact of PE RVU and MPPR changes		Impact of MEI re-basing	Combined impact	
			Full	Tran		Full	Tran
(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
TOTAL	$79,731	0%	0%	0%	0%	0%	0%
01—ALLERGY/IMMUNOLOGY	$176	0%	0%	0%	4%	4%	4%
02—ANESTHESIOLOGY	$1,729	0%	3%	1%	−3%	0%	−2%
03—CARDIAC SURGERY	$373	0%	−1%	0%	0%	−1%	0%
04—CARDIOLOGY	$6,801	0%	−5%	−2%	0%	−5%	−2%
05—COLON AND RECTAL SURGERY	$134	0%	4%	1%	0%	4%	1%
06—CRITICAL CARE	$233	0%	2%	1%	−2%	0%	−1%
07—DERMATOLOGY	$2,678	0%	1%	1%	2%	3%	3%
08—EMERGENCY MEDICINE	$2,527	0%	1%	1%	−3%	−2%	−2%
09—ENDOCRINOLOGY	$382	0%	3%	1%	−1%	2%	0%
10—FAMILY PRACTICE	$5,351	0%	3%	1%	0%	3%	1%
11—GASTROENTEROLOGY	$1,752	0%	2%	1%	−1%	1%	0%
12—GENERAL PRACTICE	$704	0%	2%	1%	0%	2%	1%
13—GENERAL SURGERY	$2,221	0%	3%	1%	0%	3%	1%
14—GERIATRICS	$182	0%	5%	2%	−2%	3%	0%
15—HAND SURGERY	$100	0%	3%	1%	2%	5%	3%
16—HEMATOLOGY/ONCOLOGY	$1,870	0%	−5%	−2%	1%	−4%	−1%
17—INFECTIOUS DISEASE	$567	0%	4%	2%	−2%	2%	0%
18—INTERNAL MEDICINE	$10,381	0%	3%	1%	−1%	2%	0%
19—INTERVENTIONAL PAIN MGMT	$379	0%	4%	2%	1%	5%	3%
20—INTERVENTIONAL RADIOLOGY	$222	0%	−9%	−4%	0%	−9%	−4%
21—MULTISPECIALTY CLINIC/OTHER	$44	0%	−5%	−4%	1%	−4%	−3%
22—NEPHROLOGY	$1,891	0%	0%	0%	−1%	−1%	−1%
23—NEUROLOGY	$1,415	0%	4%	1%	0%	4%	1%
24—NEUROSURGERY	$622	0%	2%	1%	1%	3%	2%
25—NUCLEAR MEDICINE	$57	0%	−7%	−4%	1%	−6%	−3%
27—OBSTETRICS/GYNECOLOGY	$649	0%	1%	0%	1%	2%	1%
28—OPHTHALMOLOGY	$5,154	0%	7%	3%	1%	8%	4%
29—ORTHOPEDIC SURGERY	$3,339	0%	2%	1%	1%	3%	2%
30—OTOLARNGOLOGY	$915	0%	3%	1%	1%	4%	2%
31—PATHOLOGY	$1,040	0%	−1%	0%	−1%	−2%	−1%
32—PEDIATRICS	$65	0%	2%	1%	0%	2%	1%
33—PHYSICAL MEDICINE	$868	0%	4%	1%	−1%	3%	0%
34—PLASTIC SURGERY	$306	0%	4%	2%	1%	5%	3%
35—PSYCHIATRY	$1,105	0%	1%	1%	−3%	−2%	−2%
36—PULMONARY DISEASE	$1,736	0%	2%	1%	−1%	1%	0%
37—RADIATION ONCOLOGY	$1,889	0%	−5%	−2%	4%	−1%	2%
38—RADIOLOGY	$4,975	0%	−12%	−6%	0%	−12%	−6%
39—RHEUMATOLOGY	$496	0%	0%	0%	1%	1%	1%
40—THORACIC SURGERY	$388	0%	−1%	0%	0%	−1%	0%
41—UROLOGY	$1,909	0%	−6%	−2%	1%	−5%	−1%
42—VASCULAR SURGERY	$702	0%	−2%	−1%	2%	0%	1%
43—AUDIOLOGIST	$52	0%	−7%	−2%	1%	−6%	−1%
44—CHIROPRACTOR	$732	0%	3%	1%	−2%	1%	−1%
45—CLINICAL PSYCHOLOGIST	$557	0%	−6%	−2%	−5%	−11%	−7%
46—CLINICAL SOCIAL WORKER	$376	0%	−5%	−2%	−5%	−10%	−7%
47—DIAGNOSTIC TESTING FACILITY	$851	0%	−26%	−13%	6%	−20%	−7%
48—INDEPENDENT LABORATORY	$1,009	0%	−6%	−2%	4%	−2%	2%
49—NURSE ANES/ANES ASST	$706	0%	2%	2%	−3%	−1%	−1%
50—NURSE PRACTITIONER	$1,175	0%	4%	1%	−1%	3%	0%
51—OPTOMETRY	$937	0%	7%	3%	1%	8%	4%
52—ORAL/MAXILLOFACIAL SURGERY	$38	0%	3%	2%	2%	5%	4%
53—PHYSICAL/OCCUPATIONAL THERA	$2,138	0%	−7%	−11%	−1%	−8%	−12%
54—PHYSICIAN ASSISTANT	$868	0%	3%	1%	0%	3%	1%
55—PODIATRY	$1,738	0%	4%	2%	1%	5%	3%
56—PORTABLE X-RAY SUPPLIER	$91	0%	3%	2%	6%	9%	8%
57—RADIATION THERAPY CENTERS	$69	0%	−9%	−3%	8%	−1%	5%
OTHER	$67	0%	2%	1%	−1%	2%	2%

* Does not include the impact of the current law −6.1 percent CY 2011 update.

2. CY 2011 PFS Impact Discussion

a. Changes in RVUs

The most widespread specialty impacts of the RVU changes are generally related to two factors. First, as discussed in section II.A.2. of this proposed rule, we are currently implementing the second year of the 4-year transition to new PE RVUs using the new PPIS data that were adopted in the CY 2010 PFS final rule with comment period (74 FR 61751). The impacts of using the new PPIS data are generally consistent with the impacts discussed in the CY 2010 PFS final rule with comment period (74 FR 61983 through 61984).

The second general factor contributing to the CY 2011 impacts shown in Table 73 is the proposed CY 2011 rescaling of the RVUs so that in the aggregate they match the proposed work, PE, and malpractice proportions in the rebased CY 2006 MEI. That is, as discussed in section II.E.1. of this proposed rule, the proposed rebased MEI has a greater proportion attributable to malpractice and PE and, correspondingly, a lesser proportion attributable to work. Specialties that have a high proportion of total RVUs attributable to work, such as anesthesiology, are estimated to experience a decrease in aggregate payments as a result of this rescaling, while specialties that have a high proportion attributable to PE, such as radiation oncology, are estimated to experience an increase in aggregate payments. Malpractice generally represents a small proportion of total payments and the rescaling of the malpractice RVUs is not the primary driver of the specialty impacts. As discussed in section II.E.1. of this proposed rule, the proposed rescaling of the RVUs to match the proposed rebased MEI is budget neutral overall.

Table 73 also includes the impacts resulting from our proposed regulatory change to apply the current 50 percent MPPR policy to therapy services. Under the PFS, we estimate that this change would primarily reduce payments to the specialties of physical therapy and occupational therapy. In order to maintain budget neutrality, we are proposing to redistribute the PFS savings back into other services paid under the PFS by increasing all PE RVUs by approximately 1 percent.

Because providers in settings outside of the PFS, such as outpatient hospital departments, are also paid using the PFS payment rates and policies for physical therapy services, we estimate that this proposal would reduce (not redistribute) payments in those settings for therapy services by approximately 13 percent in CY 2011.

In addition, Table 73 includes the impacts resulting from the proposed regulatory change to the scope of the current contiguous body area MPPR policy for imaging services from contiguous body areas to include noncontiguous body areas. We estimate that this change would primarily reduce payments to the specialties of IDTF and radiology. In order to maintain budget neutrality, we are proposing to redistribute these savings back into other services paid under the PFS by increasing all PE RVUs by approximately 0.1 percent.

Table 73 also reflects the impacts resulting from certain ACA provisions, including section 3135 that amends section 1848(b)(4) of the Act to reduce the payment for expensive diagnostic imaging equipment, and, effective July 1, 2010, increases the level of the MPPR for contiguous body areas from 25 percent to 50 percent. The proposed expansion of the MPPR policy is further discussed in section II.C.4. of this proposed rule, while the discussions of the provisions of section 3135 of the ACA are found in sections V.M. and II.A.3.a. of this proposed rule. As required by sections 1848(c)(2)(B)(v)(V) and (VI) of the Act (as added by sections 3135(a) and (b) of the ACA), these changes are not budget neutral and result in program savings. See section IX.D below for a discussion of the budget impacts of the ACA provisions.

We note that the payment impact for an individual physician may be different from the average, based on the mix of services the physician furnishes.

b. Combined Impact

Column H of Table 73 displays the estimated CY 2011 combined impact on total allowed charges by specialty of all the proposed RVU and MPPR changes. These impacts range from an increase of 8 percent for portable x-ray suppliers, to a decrease of 12 percent for physical/occupational therapy. There is generally a slightly positive net effect of our proposals on primary care specialties, such as family practice, internal medicine, and geriatrics. Again, these impacts are estimated prior to the application of the negative CY 2011 CF update specified under the current statute.

Table 74 shows the estimated impact on total payments for selected high-volume procedures of all of the changes discussed previously, including the effect of the CY 2011 negative PFS CF update. We selected these procedures because they are the most commonly furnished by a broad spectrum of physician specialties. There are separate columns that show the change in the facility rates and the nonfacility rates. For an explanation of facility and nonfacility PE, we refer readers to Addendum A of this proposed rule.

TABLE 74.—IMPACT OF PROPOSED RULE AND ESTIMATED PHYSICIAN UPDATE ON CY 2011 PAYMENT FOR SELECTED PROCEDURES

CPT [1]HCPCS Code	MOD	Short descriptor	Facility			Nonfacility		
			CT 2010 [2]	CY 2011 [3]	Percent change	CY 2010 [2]	CY 2011 [3]	Percent change
11721		Debride nail, 6 or more	$20.72	$18.41	−11	$31.23	$29.71	−5
17000		Destruct premalg lesion	40.88	39.04	−4	57.91	55.98	−3
27130		Total hip arthroplasty	1,084.09	1,005.16	−7	NA	NA	NA
27244		Treat thigh fracture	918.31	854.90	−7	NA	NA	NA
27447		Total knee arthroplasty	1,159.32	1,074.64	−7	NA	NA	NA
33533		CABG, arterial, single	1,536.01	1,374.42	−11	NA	NA	NA
35301		Rechanneling of artery	869.49	783.95	−10	NA	NA	NA
43239		Upper GI endoscopy, biopsy	133.42	122.76	−8	256.05	243.80	−5
66821		After cataract laser surgery	216.59	210.41	−3	228.80	222.69	−3
66984		Cataract surg w/iol, 1 stage	549.57	524.43	−5	NA	NA	NA
67210		Treatment of retinal lesion	479.17	457.89	−4	494.21	473.12	−4
71010		Chest x-ray	NA	NA	NA	18.17	16.94	−7
71010	26	Chest x-ray	7.10	6.38	−10	7.10	6.38	−10

TABLE 74.—IMPACT OF PROPOSED RULE AND ESTIMATED PHYSICIAN UPDATE ON CY 2011 PAYMENT FOR SELECTED PROCEDURES—Continued

CPT [1] HCPCS Code	MOD	Short descriptor	Facility			Nonfacility		
			CT 2010 [2]	CY 2011 [3]	Percent change	CY 2010 [2]	CY 2011 [3]	Percent change
77056		Mammogram, both breasts	NA	NA	NA	82.61	78.08	−5
77056	26	Mammogram, both breasts	34.63	30.69	−11	34.63	30.69	−11
77057		Mammogram, screening	NA	NA	NA	61.60	57.45	−7
77057	26	Mammogram, screening	27.82	24.80	−11	27.82	24.80	−11
77427		Radiation tx management, ×5	153.00	141.17	−8	153.00	141.17	−8
88305	26	Tissue exam by pathologist	28.67	26.03	−9	28.67	26.03	−9
90801		Psy dx interview	100.21	88.14	−12	120.93	109.75	−9
90862		Medication management	35.77	32.16	−10	44.28	41.00	−7
90935		Hemodialysis, one evaluation	53.08	48.37	−9	NA	NA	NA
92012		Eye exam established pat	38.32	36.09	−6	58.48	56.96	−3
92014		Eye exam & treatment	58.48	55.00	−6	85.44	82.74	−3
92980		Insert intracoronary stent	689.80	608.64	−12	NA	NA	NA
93000		Electrocardiogram, complete	NA	NA	NA	15.61	14.24	−9
93010		Electrocardiogram report	7.10	6.38	−10	7.10	6.38	−10
93015		Cardiovascular stress test	NA	NA	NA	72.67	66.29	−9
93307	26	Echo exam of heart	38.32	34.13	−11	38.32	34.13	−11
93510	26	Left heart catheterization	198.71	174.81	−12	198.71	174.81	−12
98941		Chiropractic manipulation	24.13	21.85	−9	27.25	25.29	−7
99203		Office/outpatient visit, new	57.34	52.79	−8	76.93	72.67	−6
99213		Office/outpatient visit, est	38.04	35.11	−8	51.38	48.86	−5
99214		Office/outpatient visit, est	58.48	53.77	−8	76.93	72.43	−6
99222		Initial hospital care	101.62	93.54	−8	NA	NA	NA
99223		Initial hospital care	149.60	137.25	−8	NA	NA	NA
99231		Subsequent hospital care	29.81	27.25	−9	NA	NA	NA
99232		Subsequent hospital care	53.93	49.35	−9	NA	NA	NA
99233		Subsequent hospital care	77.50	70.96	−8	NA	NA	NA
99236		Observ/hosp same date	166.06	151.73	−9	NA	NA	NA
99239		Hospital discharge day	77.78	71.94	−8	NA	NA	NA
99283		Emergency dept visit	48.26	43.21	−10	NA	NA	NA
99284		Emergency dept visit	91.41	81.76	−11	NA	NA	NA
99291		Critical care, first hour	170.04	153.94	−9	203.25	187.33	−8
99292		Critical care, add'l 30 min	85.16	77.09	−9	91.97	83.97	−9
99348		Home visit, est patient	NA	NA	NA	63.59	58.19	−8
99350		Home visit, est patient	NA	NA	NA	130.58	120.30	−8
G0008		Admin influenza virus vac	NA	NA	NA	16.75	16.45	−2

[1] CPT codes and descriptions are copyright 2010 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] Payments based upon corrected CY 2010 conversion factor of $28.3868 under the statute as of October 30, 2009 that would be in effect on December 31, 2010 under current law.
[3] Payments based upon the projected CY 2011 conversion factor of $26.6574 adjusted by the proposed MEI rescaling factor of 0.921.

B. Geographic Practice Cost Indices (GPCIs)

As discussed in section II.D. of this proposed rule, we are required to update the GPCI values at least every 3 years and phase in the adjustment over 2 years (if there has not been an adjustment in the past year). For CY 2011, we are proposing new GPCIs for each Medicare locality. The updated GPCIs reflect the first year of the 2-year phase in. The new GPCIs rely upon the 2010 HUD data for determining the relative cost differences in the office rent component of the PE GPCIs, as well as the 2006 through 2007 professional malpractice premium data for determining the malpractice GPCIs. The 2006 through 2008 Bureau of Labor and Statistics (BLS) Occupational Employment Statistics (OES) data were used as a replacement for 2000 Census data for determining the physician work GPCIs and the employee compensation component of the PE GPCIs. As discussed in section II.D. of this proposed rule, the cost share weights for each GPCI value, that is, work, PE, and malpractice, reflect the same proportions determined for the proposed 2006-based MEI.

Additionally, the proposed GPCIs reflect several provisions required by the ACA. Section 1848(e)(1)(H) of the Act (as added by section 3102(b) of the ACA) specifies that for CY 2010 and CY 2011, the employee wage and rent portions of the PE GPCIs reflect only one-half of the relative cost differences for each locality compared to the national average and includes a "hold harmless" provision for any PFS locality that would receive a reduction to its PE GPCI resulting from the limited recognition of cost differences. Section 1848(e)(1)(E) of the Act (as amended by section 3102(a) of the ACA) extends the 1.000 work GPCI floor only through December 31, 2010. Therefore, the proposed CY 2011 GPCIs reflect the sunset of the 1.000 work GPCI floor. Section 1848(e)(1)(G) of the Act (as amended by section 134(b) of the MIPPA) established a permanent 1.500 work GPCI floor in Alaska, beginning January 1, 2009 and, therefore, the 1.500 work GPCI floor in Alaska will remain in place for CY 2011. Moreover, section 1848(e)(1)(I) of the Act (as added by section 10324(c) of the ACA) establishes a 1.000 PE GPCI floor for services furnished in frontier states effective January 1, 2011. OACT estimates the combined impact of these provisions on a fiscal year cash basis as $580 million for FY 2011.

As required by the statute, the updated GPCIs would be phased in over a 2-year period. Addendum D to this proposed rule shows the estimated effects of the revised GPCIs on locality

GAFs for the transitional year (CY 2011) in descending order. The GAFs reflect the use of updated underlying GPCI data, updated cost share weights, and the ACA provisions. The GAFs are a weighted composite of each area's work, PE, and malpractice GPCIs using the national GPCI cost share weights. While we do not actually use the GAFs in computing the PFS payment for a specific service, they are useful in comparing the estimated overall costs and payments for different localities. The actual effect on payment for any specific service would deviate from the estimated payment based on the GAF to the extent that the proportions of work, PE, and malpractice expense RVUs for the specific service differ from those of the GAF. The most significant changes would occur in 12 payment localities, where the GAF increases by more than 1 percent or decreases by more than 2 percent. The cumulative effects of all of the GPCI revisions, including the updated underlying GPCI data, updated cost share weights, and provisions of the ACA, are reflected in the CY 2012 GPCI values that are displayed in Addendum E to this proposed rule.

C. Rebasing and Revising of the MEI

As discussed in section II.E.1. of this proposed rule, we are proposing to rebase and revise the MEI for the CY 2011 PFS. Substituting the proposed 2006 MEI weights in place of the 2000 weights and implementing the proposed revisions to the MEI has no impact on the projected MEI increase for CY 2011. The projected MEI update for CY 2011 is 0.3 percent under both the 2000-based and 2006-based MEI. After CY 2011, the MEI updates are slightly higher (0.1 percentage point) in the early part of the forecast, unchanged in the medium term, and slightly lower in the long term (between 0.1 to 0.2 percentage points).

D. The Affordable Care Act Provisions

1. Section 3103: Extension of Exceptions Process for Medicare Therapy Caps

This provision extends the exceptions process for therapy caps through December 31, 2010. Therapy caps are discussed in detail in section III.A.1. of this proposed rule. OACT estimates the impact on a fiscal year cash basis as $1.16 billion for FY 2011.

2. Section 3104: Extension of Payment for Technical Component of Certain Physician Pathology Services

As discussed in section V.E. of this proposed rule, this provision continues payment to independent laboratories for the TC of physician pathology services for fee-for-service Medicare beneficiaries who are inpatients or outpatients of a covered hospital through CY 2010. OACT estimates the impact on a fiscal year cash basis as $80 million for FY 2011.

3. Sections 3105 and 10311: Extension of Ambulance Add-Ons

As discussed in section V.F. of this proposed rule, these provisions require the extension of certain add-on payments for ground ambulance services, and the extension of certain rural area designations for purposes of air ambulance payment. As further discussed in section V.F., we are amending the Medicare program regulations to conform the regulations to these provisions of the ACA. These statutory provisions are essentially prescriptive and do not allow for discretionary alternatives on the part of the Secretary.

As discussed in the July 1, 2004 interim final rule (69 FR 40288), in determining the super-rural bonus amount under section 1834(l)(12) of Act, we followed the statutory guidance of using the data from the Comptroller General (GAO) of the U.S. We obtained the same data as the data that were used in the GAO's September 2003 Report titled "Ambulance Services: Medicare Payments Can Be Better Targeted to Trips in Less Densely Populated Rural Areas" (GAO report number GAO–03–986) and used the same general methodology in a regression analysis as was used in that report. The result was that the average cost per trip in the lowest quartile of rural county populations was 22.6 percent higher than the average cost per trip in the highest quartile. As required by section 1834(l)(12) of the Act, this percent increase is applied to the base rate for ground ambulance transports that originate in qualified rural areas, which were identified using the methodology set forth in the statute. Payments for ambulance services under Medicare are determined by the point of pick-up (by zip code area) where the beneficiary is loaded on board the ambulance. We determined that ground ambulance transports originating in 7,842 zip code areas (which were determined to be in "qualified rural areas") out of 42,879 zip code areas, according to the July 2010 zip code file, will realize increased base rate payments under this provision; however, the number and level of services that might occur in these areas for CY 2011 is unknown at this time. While many elements may factor into the final impact of sections 3105(a), (b), and (c) and 10311(a), (b), and (c) of the ACA, our Office of the Actuary (OACT) estimates the impact of all these provisions to be $10 million for FY 2011.

4. Section 3107: Extension of Physician Fee Schedule Mental Health Add-On

As discussed in section V.G. of this proposed rule, this provision extends the period of time for the five percent increase in Medicare payment for specified mental health services through CY 2010. OACT estimates the impact on a fiscal year cash basis as $20 million for FY 2011.

5. Section 3111: Payment for Bone Density Tests

As discussed in section V.I. of this proposed rule, this provision restores payment for dual-energy x-ray absorptiometry (DXA) services furnished during CYs 2010 and 2011 to 70 percent of the Medicare rate paid in CY 2006. OACT estimates the impact on a fiscal year cash basis as $60 million for FY 2011.

6. Section 3122: Extension of Medicare Reasonable Costs Payments for Certain Clinical Diagnostic Laboratory Tests Furnished to Hospital Patients in Certain Rural Areas

As discussed in section V.K. of this proposed rule, this provision reinstitutes reasonable cost payment for clinical diagnostic laboratory tests performed by hospitals with fewer than 50 beds that are located in qualified rural areas as part of their outpatient services for cost reporting periods beginning on or after July 1, 2010 through June 30, 2011. For some hospitals with cost reports that begin as late as June 30, 2011, this reinstitution of reasonable cost payment could affect services performed as late as June 29, 2012, because this is the date those cost reports will close.

7. Section 3135: Modification of Equipment Utilization Factor For Advanced Imaging Services

As discussed in section V.M. of this proposed rule, for services furnished on or after July 1, 2010, section 1848(b)(4)(D) of the Act (as added by section 3135(b) of the ACA) adjusts the technical component MPPR for multiple imaging studies provided in a single imaging session on contiguous body parts within families of codes from 25 percent to 50 percent as of July 1, 2010. For services furnished on or after January 1, 2011, section 1848(b)(4)(C) of the Act (as added by section 3135(a) of the ACA) increases the equipment utilization rate to 75 percent for expensive diagnostic imaging equipment, changing the CY 2011 transitional utilization rate adopted in

the CY 2010 PFS final rule with comment period to the 75 percent rate. Both of these provisions are not budget neutral. OACT estimates the impact on a fiscal year cash basis to be savings to the Medicare program of $160 million for FY 2011.

8. Section 3136: Revisions in Payments for Power Wheelchairs

As discussed in section V.N. of this proposed rule, this provision requires the Secretary to revise the capped rental fee schedule amounts for all power wheelchairs effective for power wheelchairs furnished on or after January 1, 2011. Under the monthly capped rental payment structure, the fee schedule will pay 15 percent (instead of 10 percent) of the purchase price for the first three months and 6 percent (instead of 7.5 percent) for the remaining rental months not to exceed 13 months. In addition, the lump sum (up front) purchase payment will be eliminated for standard power-driven wheelchairs. For complex rehabilitative power-driven wheelchairs, the provision permits payment to be made on a lump sum purchase method or a monthly rental method. These changes are prescriptive in the statute and does not allow for discretionary alternatives.

We expect the changes mandated by section 3136 of the ACA as a whole to achieve program savings as a result of total payments per standard power wheelchair being less than 100 percent of the purchase fee schedule amount. This decrease in expenditures is expected for two reasons. Primarily, the provision will eliminate the lump sum payment method for standard power-driven wheelchairs and instead payment will be made under the monthly rental method resulting in lower aggregate payments because many beneficiaries who use standard power wheelchairs do not use them for as long as 13 months. In addition, we note that currently a significantly lower volume of power-driven wheelchairs are paid under the monthly payment method. The payment impact of increasing monthly rental payments in the initial 3 months will be offset both by the savings achieved from eliminating the lump sum payment method for standard power-driven wheelchairs and by decreasing payments for the remaining months of rental from 7.5 percent to 6 percent of the purchase price for all power-driven wheelchairs. We compared the estimates of current payments for power-driven wheelchairs to estimates of payments resulting from the changes which showed an estimated payment impact of a decrease in expenditures of approximately $780 million over a 5-year period. The FY 2011 cash savings was $120 million.

9. Section 3401: Revisions of Certain Market Basket Updates and Incorporation of Productivity Adjustments

As discussed in section V.P. of this proposed rule, section 3401 of the ACA incorporates a productivity adjustment into the update factors for certain payment systems. Specifically, section 3401 requires that in CY 2011 (and in subsequent years), update factors under the ambulatory surgical center payment system, the ambulance fee schedule, and the clinical laboratory fee schedule be adjusted by the productivity adjustment. OACT estimates the impact to be savings to the Medicare program of $20 million, $30 million, and $50 million for the ambulatory surgical center payment system, the ambulance fee schedule, and the clinical laboratory fee schedule, respectively, for FY 2011. Furthermore section 3401 changed the 2011 ESRD composite rate Market Basket minus one increase to a Market Basket increase. This provision would be a cost to the Medicare program of $40 million (does not include coinsurance).

10. Section 4103: Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan

As discussed in section V.Q. of this proposed rule, for services furnished on or after January 1, 2011, section 1861(s)(2)(FF) of the Act (as added by section 4103 of the ACA) provides Medicare coverage, with no coinsurance or deductible, for an annual wellness visit. The annual wellness visit entails the creation of a personalized prevention plan for an individual that includes a health risk assessment and may include other elements, such as updating the family history, identifying providers that regularly provide medical care to the individual, body mass index measurement, development of a screening service schedule, and identification of risk factors. OACT estimates the impact on a fiscal year cash basis to be $110 million for FY 2011.

11. Section 4104: Removal of Barriers to Preventive Services in Medicare

As discussed in section V.R. of this proposed rule, for services furnished on or after January 1, 2011, sections 1833(a)(1) and 1833(b) of the Act (as amended by section 4104 of the ACA) waive the deductible and coinsurance requirements for most preventive services, and waive the deductible for colorectal cancer screening tests that are reported with other codes. Services to which no coinsurance or deductible would be applied are the annual wellness visit, the initial preventive physical examination, and any covered preventive service if it is recommended with a grade of A or B by the United States Preventive Services Task Force. We estimate that this new benefit will result in an increase in Medicare payments. OACT estimates the impact on a fiscal year cash basis to be $110 million for FY 2011.

12. Section 5501: Expanding Access to Primary Care Services and General Surgery Services

As discussed in section V.S. of this proposed rule, for services furnished on or after January 1, 2011 and before January 1, 2016, sections 1833(x) and (y) of the Act (as added by section 5501 of the ACA) provide primary care practitioners, as well as general surgeons practicing in geographic health professional shortage areas, with 10 percent incentive payments based on their provision of primary care or major surgical services, respectively. OACT estimates the impact on a fiscal year cash basis to be $170 million for FY 2011.

13. Section 6003: Disclosure Requirements for In-office Ancillary Services Exception to the Prohibition of Physician Self-Referral for Certain Imaging Services

In section V.T of the preamble of this proposed rule, we propose to amend § 411.355(b)(2) to include a new disclosure requirement created by section 6003 of the ACA and related to the in-office ancillary services exception to the physician self-referral prohibition. Specifically, the statute requires that, with respect to magnetic resonance imaging, computed tomography, and positron emission tomography, the referring physician must inform the patient in writing at the time of the referral that the patient may obtain the same imaging services from another supplier. In addition, the statute requires physicians to provide a written list of other suppliers who furnish the same imaging services in the area in which the patient resides.

We propose that the written notice shall include a list of at least 10 other suppliers who provide the services for which the individual is being referred and which are located within a 25-mile radius of the referring physician's office location. If there are fewer than 10 other suppliers located within a 25-mile radius of the physician's office location, the physician shall list all of the other suppliers of the imaging service that are present within a 25-mile radius of the

referring physician's office location, including up to 10 suppliers. Provision of the written list of alternate suppliers will not be required if no other suppliers provide the services for which the individual is being referred within a 25-mile radius. We also propose that the notice should be written in a manner sufficient to be reasonably understood by all patients and should include for each supplier on the list, at a minimum, the supplier's name, address, telephone number, and distance from the referring physician's office location. A record of the disclosure notification, signed by the patient, shall be maintained as a part of the patient's medical record.

Our proposal minimizes the administrative burden for the physician by requiring the development of only one list of alternative suppliers for each office location, rather than multiple lists targeting the various areas in which the physician's patients reside.

We do not anticipate that our proposals in section V.T. of the preamble of this proposed rule would have a significant economic impact on a substantial number of physicians, other health care providers and suppliers, or the Medicare or Medicaid programs and their beneficiaries. Specifically, we believe that this proposed rule would affect only those physicians who provide MRI, CT, PET services under the in-office ancillary services exception and beneficiaries receiving those services. We are uncertain of the number of physicians who will have to comply with this disclosure requirement. Using data from the 2009 CMS Statistics booklet, we propose an estimate of 71,000 Medicare enrolled physicians would have to comply with this new requirement. This figure represents 20 percent of primary care and medical specialty physicians enrolled in Medicare Part B. In order to ensure accuracy of the effect of this provision on physician practices, we are soliciting comments regarding the appropriateness of this estimate. The burden associated with disclosing the information, receiving the patient's signature on the form and maintaining a record of such disclosure will be de minimis for the individual physician.

Our proposed criteria for the new disclosure requirement would present a negligible economic impact on the physician or group practice required to create the disclosure notice. The physician or group practice would incur only a one-time cost associated with developing a disclosure notice that informs patients that they may receive the same imaging services from another supplier and also lists other suppliers located within a 25-mile radius of the physician's office location at the time of the referral. We believe it would take an individual 1 hour to create the notice informing patients that they may receive imaging services from another supplier as well as to compile the list of 10 other suppliers. In addition, we believe it would require a negligible amount of time to provide the notice and list of suppliers to the patient and to maintain a copy of the notice in the patient's medical record.

We believe that beneficiaries would be impacted positively by this new provision. The disclosure that the patient may receive the referred imaging services from another supplier contributes to informed decision-making about the availability of such imaging services from other suppliers. We also believe that furnishing a list of other suppliers who provide the same services in the vicinity of the referring physician serves patient convenience. The proposed regulation makes no significant changes that would impede patient access to health care services, and it will likely improve patients' awareness of options in deciding where to receive imaging services.

14. Section 6404: Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months

As discussed in section V.U. of this proposed rule, section 6404 of the ACA reduces the maximum time period for filing Medicare claims to no more than 12 months after the date of service. Under the new law, claims for services furnished on or after January 1, 2010, must be filed within 1 calendar year after the date of service. In addition, section 6404 of the ACA provides that claims for services furnished before January 1, 2010, must be filed no later than December 31, 2010.

Section 6404 of the ACA also permits the Secretary to make certain exceptions to the 1-year filing deadline. This proposed rule would create two new exceptions to the 1-year filing deadline.

The first exception would permit the time limits for filing claims to be extended where a beneficiary becomes retroactively entitled to Medicare benefits, but was not entitled to Medicare benefits at the time the services were furnished. Under this exception, the time to file a claim would be extended through the last day of the sixth month following the month in which the beneficiary received notification of the retroactive Medicare entitlement to the date of the furnished service.

The second exception would permit the time limits for filing claims to be extended where: (1) At the time the service was furnished, the beneficiary was not entitled to Medicare; (2) subsequently, the beneficiary received notification of Medicare entitlement, retroactively effective to the date of the furnished service; and (3) subsequently the State Medicaid agency recovered the Medicaid payment for the furnished service from a provider or supplier 11 months or more after date the service was furnished. Under this exception, the time to file a claim would be extended through the last day of the sixth month following the month in which the State recovered the Medicaid payment from the provider or supplier.

The budgetary impact related to this provision is significant as future payment of claims for services incurred will now be made at an earlier date, relative to the 12-month submission expiration. This is reflected by the Part A and Part B payment amounts of $60 and $50 million for FY 2011. However, for purposes of the Regulatory Impact Analysis, the economic impact of this provision is non-economically significant, as to the interest lost on money now required to pay claims prior to the 12-month submission expiration is minimal.

Providers and suppliers have established billing practices for the submission of claims for payment to the Medicare program. Although this proposed rule would require providers and suppliers to submit Medicare fee-for-service claims within 12 months from the date of service, we believe providers and suppliers would easily revise their billing practices on a one-time basis, and suffer no economic impact. In fact, analysis of Medicare claims data shows that more than 99 percent of Part A and Part B claims are filed in 12 months or less. In addition, some providers and suppliers will receive payment and interest on claims that are filed at an earlier date.

Lastly, providers, suppliers, or the small number of beneficiaries that occasionally submit claims may benefit from the availability of the two proposed new exceptions to the timely filing rule; however, we believe the impact on program costs would be negligible.

E. Other Provisions of the Proposed Regulation

1. Part B Drug Payment: ASP Issues

Application of our proposed policies for "Carry Over ASP" and "Partial Quarter ASP Data," as discussed in section VI.A. of this proposed rule, are dependent on the status and quality of quarterly manufacturer data

submissions, so we cannot quantify associated savings.

Furthermore, we do not expect that our proposed policy for determining the payment amount for drugs and biologicals which include intentional overfill, as discussed in section VI.A of this proposed rule, will impact payments made by the Medicare program.

Finally, as discussed in section VI.A of this proposed rule, we are proposing to provide for appropriate price substitutions that account for market-related pricing changes and would allow Medicare to pay based off lower market prices for those drugs and biologicals that consistently exceed the applicable threshold percentage. We believe that this proposal will generate some savings for the Medicare program and its beneficiaries since any substituted prices would be for amounts less than the calculated 106 percent of the ASP.

2. Ambulance Fee Schedule: Proposed Policy for Reporting Units When Billing for Ambulance Fractional Mileage

As discussed in section VI.B. of this proposed rule, we are proposing to implement fractional mileage billing for all providers and suppliers of ambulance services. For all claims for mileage totaling up to 100 covered miles, we are proposing to require all providers and suppliers of ambulance services to bill mileage rounded up to the nearest tenth of a mile rather than the nearest whole mile and are proposing to pay based on that amount. By requiring that providers and suppliers round up to the nearest tenth of a mile rather than the nearest whole mile, providers and suppliers would be submitting claims for anywhere between 0.1 and 0.9 of a mile less per claim and Medicare would pay based on that amount. We anticipate that requiring greater accuracy in billing for ambulance mileage will generate modest cost savings for the Medicare program. Based on our rough estimates using CY 2008 claims data, Medicare could potentially save at least $45 million per year in payments for base mileage billed by suppliers, and perhaps as much as $80 million per year when considering other types of ambulance mileage payments such as those for rural mileage and those made to institutional providers.

3. Chiropractic Services Demonstration

As discussed in section VI.D. of this proposed rule, we are continuing the recoupment of the $50 million in expenditures from this demonstration in order to satisfy the budget neutrality requirement in section 651(f)(1)(b) of the MMA. We initiated this recoupment in CY 2010 and this will be the second year. As discussed in the CY 2010 PFS final rule with comment period, we finalized a policy to recoup $10 million each year through adjustments to the PFS for all chiropractors in CYs 2010 through 2014. To implement this required budget neutrality adjustment, we are recouping $10 million in CY 2011 by reducing the payment amount under the PFS for the chiropractic CPT codes (that is, CPT codes 98940, 98941, and 98942) by approximately 2 percent.

4. Renal Dialysis Services Furnished by ESRD Facilities

The ESRD related provisions are discussed in sections V.P. and VI.E. of this proposed rule. To understand the impact of the changes affecting payments to different categories of ESRD facilities, it is necessary to compare estimated payments under the current year (CY 2010 payments) to estimated payments under the revisions to the composite rate payment system (CY 2011 payments) as discussed in section VI.E. of this proposed rule. To estimate the impact among various classes of ESRD facilities, it is imperative that the estimates of current payments and estimates of proposed payments contain similar inputs. Therefore, we simulated payments only for those ESRD facilities for which we are able to calculate both current CY 2010 payments and proposed CY 2011 payments.

Also, as explained in the ESRD PPS proposed rule (74 FR 50019), section 1881(b)(14)(E)(i) of the Act requires a 4-year transition (phase-in) from the current composite payment system to the ESRD PPS, and section 1881(b)(14)(E)(ii) allows ESRD facilities to make a one-time election to be excluded from the transition. As of January 1, 2011, ESRD facilities that elect to go through the transition would be paid a blended amount that will consist of 75 percent of the basic case-mix adjusted composite payment system and the remaining 25 percent would be based on the ESRD PPS payment. Therefore, these proposed rates listed in the impact table below reflect only the composite rate portion of the blended payment amounts for facilities going through the first year of the 4-year transition under the new ESRD PPS. A full analysis of the projected impact of the ESRD PPS will be addressed in the ESRD PPS final rule which will be published in the summer.

ESRD providers were grouped into the categories based on characteristics provided in the Online Survey and Certification and Reporting (OSCAR) file and the most recent cost report data from the Healthcare Cost Report Information System (HCRIS). We also used the December 2009 update of CY 2009 National Claims History file as a basis for Medicare dialysis treatments and separately billable drugs and biologicals. Since the December 2009 update of the CY 2009 National Claims History File is incomplete, we updated the data. The description of the updates for the separately billable drugs is described in section IV.E. of this proposed rule. To update the treatment counts we used the ratio of the June 2009 to the December 2008 updates of the CY 2008 National Claims History File figure for treatments. This was an increase of 12.4 percent. Due to data limitations, we are unable to estimate current and proposed payments for 32 of the 5318 ESRD facilities that bill for ESRD dialysis treatments.

Table 75 shows the impact of this year's proposed changes to CY 2011 payments to hospital-based and independent ESRD facilities. The first column of Table 75 identifies the type of ESRD provider, the second column indicates the number of ESRD facilities for each type, and the third column indicates the number of dialysis treatments. The fourth column shows the effect of all proposed changes to the ESRD wage index for CY 2011 as it affects the composite rate payments to ESRD facilities. The fourth column compares aggregate ESRD wage-adjusted composite rate payments in CY 2011 to aggregate ESRD wage-adjusted composite rate payments in CY 2010. In CY 2010, ESRD facilities receive 100 percent of the CBSA wage-adjusted composite rate. The overall effect to all ESRD providers in aggregate is zero because the CY 2011 ESRD wage index has been multiplied by a budget neutrality adjustment factor to comply with the statutory requirement that any wage index revisions be done in a manner that results in the same aggregate amount of expenditures as would have been made without any changes in the wage index. The fifth column shows the effect of proposed changes to the ESRD wage index in CY 2011 and the effect of section 3401(h) of the ACA, which amends section 1881(b)(14)(F) of the Act to revise the ESRD market basket increase factor. Effective January 1, 2011, there is a full ESRD bundled market basket update to the composite rate component of the blended payment amount under the payment system. We anticipate an estimated ESRD market basket increase factor of 2.5 percent for those facilities

electing to go through the ESRD PPS transition. The sixth column shows the overall effect of the proposed changes in composite rate payments to ESRD providers, including the drug add-on. The overall effect is measured as the difference between the proposed CY 2011 payment with all changes as proposed in this rule and current CY 2010 payment. This payment amount is computed by multiplying the wage-adjusted composite rate with the drug add-on for each provider times the number of dialysis treatments from the CY 2009 claims. The CY 2011 proposed payment is the composite rate for each provider (with the proposed 14.7 percent drug add on) times dialysis treatments from CY 2009 claims. The CY 2010 current payment is the composite rate for each provider (with the current 15.0 percent drug add on) times dialysis treatments from CY 2009 claims.

The overall impact to ESRD providers in aggregate is 2.2 percent as shown in Table 75. Most ESRD facilities will see an increase in payments as a result of the ACA provision. While section 3401(h) of the ACA modifies the ESRD bundled market basket, which we anticipate will be a 2.5 percent increase to the ESRD composite rate portion of the blended payment amount, this 2.5 percent increase does not apply to the drug add-on to the composite rate. For this reason, the impact of all changes in this proposed rule is a 2.2 percent increase for all ESRD providers. Overall, payments to independent ESRD facilities will increase by 2.2 percent and payments to hospital-based ESRD facilities will increase by 2.1 percent.

TABLE 75—IMPACT OF CY 2012 CHANGES IN PAYMENTS TO HOSPITAL-BASED AND INDEPENDENT ESRD FACILITIES

[Percent change in composite rate payments to ESRD facilities]

1	2	3	4	5	6
	Number of facilities	Number of dialysis treatments (in millions)	Effect of changes in wage index [1]	Effect of changes in wage index and of affordable care act provision [2]	Overall effect of wage index affordable care act & drug add-on [3]
All Providers	5,286	38.8	0.0%	2.5%	2.2%
Independent	4,715	35.1	0.0%	2.5%	2.2%
Hospital Based	571	3.7	−0.1%	2.4%	2.1%
By Facility Size					
Less than 5000 treatments	1,973	5.6	0.1%	2.6%	2.3%
5000 to 9999 treatments	2,042	14.8	0.1%	2.6%	2.3%
Greater than 9999 treatments	1,271	18.3	−0.1%	2.4%	2.1%
Type of Ownership					
Profit	4,332	32.1	0.0%	2.5%	2.3%
Nonprofit	954	6.7	−0.1%	2.4%	2.1%
By Geographic Location					
Rural	1,167	6.3	0.2%	2.7%	2.4%
Urban	4,119	32.5	0.0%	2.5%	2.2%
By Region					
New England	163	1.3	−0.6%	1.9%	1.6%
Middle Atlantic	591	4.8	−0.4%	2.1%	1.8%
East North Central	869	6.0	0.2%	2.7%	2.4%
West North Central	397	2.1	−0.1%	2.4%	2.2%
South Atlantic	1,188	8.8	0.0%	2.5%	2.2%
East South Central	415	2.9	0.0%	2.5%	2.3%
West South Central	712	5.6	0.4%	2.9%	2.7%
Mountain	310	1.8	0.2%	2.7%	2.4%
Pacific	603	5.1	0.0%	2.5%	2.3%
Puerto Rico & Virgin Islands	38	0.4	−2.4%	0.0%	−0.2%

Notes: Payments have been adjusted to reflect budget neutrality. 2010 includes the MIPPA 1 percent increase and site neutral rates. 2010 & 2011 are 100 percent new CBSA wage adjusted compsite rate.

[1] This column shows the overall effect of wage index changes on ESRD providers. Composite rate payments are computed using the proposed CY 2011 wage indexes which are compared to composite rate payments using the current CY 2010 wage indexes.

[2] This column shows the effect of the changes in the Wage Indexes and the ACA provision which includes an ESRD Bundled Market Basket (anticipated 2.5 percent) increase to the composite rate. This provision is effective January 1, 2011.

[3] This column shows the percent change between CY 2011 and CY 2010 composite rate payments to ESRD facilities.

[4] The CY 2011 payments include the CY 2011 wage adjusted composite rate, an anticipated 2.5 percent increase due to the ACA effective January 1, 2011, and the drug add-on of 14.7 percent. The CY 2010 payments include the CY 2010 wage adjusted composite rate, a 1 percent increase and site neutral rates effective January 1, 2009, and the drug add-on of 15.0 percent. This column shows the effect of wage index, ACA, and drug add-on changes. Although as a result of the ACA provision we anticipate a 2.5 percent increase to the composite rate in CY 2011, this increase does not apply to the drug add-on to the composite rate. For this reason, the impact of all changes in this proposed rule is a 2.2 percent increase for all ESRD providers.

5. Section 131(b) of the MIPPA: Physician Payment, Efficiency, and Quality Improvements—Physician Quality Reporting Initiative (PQRI)

As discussed in section VI.F.1 of this proposed rule, we propose several different reporting options for EPs who wish to participate in the 2011 PQRI. Although there may be some cost incurred in the PQRI and their associated code sets, and for expanding an existing clinical data warehouse to accommodate registry-based reporting and EHR-based reporting for the PQRI, we do not anticipate a significant cost impact on the Medicare program.

Participation in the CY 2011 PQRI by individual EPs is voluntary and individual EPs and group practices may have different processes for integrating the PQRI into their practice's work flows. Given this variability and the multiple reporting options that we propose to provide, it is difficult to accurately estimate the impact of the PQRI on providers. Furthermore, we believe that costs for EPs who are

participating in the PQRI for the first time in 2011 will be considerably higher than the cost for EPs who participated in PQRI in prior years. In addition, for many EPs, the cost of participating in the PQRI is offset by the incentive payment received.

With respect to the potential incentive payment that will be made for the 2011 PQRI, we estimate this amount to be approximately $100 million. This estimate is derived from looking at our 2008 incentive payment of more than $93 million and then accounting for the fact that the 2008 incentive payment was 1.5 percent of an EP's total estimated Medicare Part B PFS allowed charges for all covered professional services furnished during the 2008 reporting period. For 2011, the incentive payment is 1.0 percent of an EP's total estimated Medicare Part B PFS allowed charges for all covered professional services furnished during the 2011 reporting period. Although we expect that the lower incentive payment amount for 2011 would reduce the total outlay by approximately one-third, we also expect more EPs to participate in the 2011 PQRI as there are more methods of data submission and additional alternative reporting periods.

One factor that influences the cost to individual EPs is the time and effort associated with individual EPs identifying applicable PQRI quality measures and reviewing and selecting a reporting option. This burden will vary with each individual EP by the number of applicable measures, the EP's familiarity and understanding of the PQRI, experience with PQRI participation, and the method(s) selected by the EP for reporting of the measures, and incorporating the reporting of the measures into the office work flows. Information obtained from the Physician Voluntary Reporting Program (PVRP), which was a predecessor to the PQRI and was the first step for the reporting of physician quality of care through certain quality metrics, indicated an average labor cost per practice of approximately $50 per hour. To account for salary increases over time, we will use an average practice labor cost of $58 per hour for our estimates, based on an assumption of an average annual increase of approximately 3 percent. Therefore, assuming that it takes an individual EP approximately 5 hours to review the PQRI quality measures, review the various reporting options, select the most appropriate reporting option, identify the applicable measures for which they can report the necessary information, and incorporate reporting of the selected measures into their office work flows, we estimate that the cost to EPs associated with preparing to report PQRI quality measures would be approximately $290 per individual EP ($58 per hour × 5 hours).

Another factor that influences the cost to individual EPs is how they choose to report the PQRI measures (that is, whether they select the claims-based, registry-based or EHR-based reporting mechanism). For claims-based PQRI reporting, estimates from the PVRP indicate the time needed to perform all the steps necessary to report quality data codes (QDCs) for 1 measure on a claim ranges from 15 seconds (0.25 minutes) to 12 minutes for complicated cases or measures. In previous years, when we required reporting on 80 percent of eligible cases for claims-based reporting, we found that on average, the median number of reporting instances for each of the PQRI measures was 9. Since we propose to reduce the required reporting rate by over one-third to 50 percent, then for purposes of this impact analysis we will assume that an EP will need to report each selected measure for 6 reporting instances, or 6 cases. Assuming that an EP, on average, will report 3 measures and that an EP reports on an average of 6 reporting instances per measure, we estimate that the cost to an individual EP associated with claims-based reporting of PQRI measures would range from approximately $4.35 (0.25 min per reporting instance × 6 reporting instances per measure × 3 measures × $58 per hour) to $208.80 (12 min per reporting instance × 6 reporting instances per measure × 3 measures × $58 per hour). If an EP satisfactorily reports, these costs will more than likely be negated by the incentive earned. For the 2007 PQRI, which had a 1.5 percent incentive for a 6-month reporting period, the mean incentive amount was close to $700 for an individual EP and the median incentive payment amount was over $300.

For registry-based reporting, individual EPs must generally incur a cost to submit data to registries. Estimated fees for using a qualified registry range from no charge, or a nominal charge, for an individual EP to use a registry to several thousand dollars, with a majority of registries charging fees ranging from $500–$1000. However, our impact analysis should be limited to the incremental costs associated with PQRI reporting, which we believe are minimal. Many EPs who select registry-based reporting were already utilizing the registry for other purposes and would not need to report additional data to the registry specifically for PQRI. The registries also often provide the EP services above and beyond what is required for PQRI.

For EHR-based reporting, an individual EP generally would incur a cost associated with purchasing an EHR product. Although we do not believe that the majority of EPs would purchase an EHR solely for the purpose of participating in PQRI, we estimate that an individual EP who chooses to do so would have to spend anywhere from $25,000–$54,000 to purchase and implement a certified EHR and $10,000 annually for ongoing maintenance.

Although we believe that the majority of EPs attempting to qualify for the additional 0.5 percent incentive payment authorized by section 1848(m)(7) of the Act would be those who are already required by their Boards to participate in an MOCP, individual EPs who wish to qualify for the additional 0.5 percent incentive payment and are not currently participating in an MOCP would also have to incur a cost for participating in an MOCP. The manner in which fees are charged for participating in an MOCP vary by specialty. Some Boards charge a single fee for participation in the full cycle of MOC. Such fees appear to range anywhere from over $1,100 to nearly $1,800 per cycle. Some Boards have annual fees that are paid by their diplomates. On average, ABMS diplomates pay approximately $200.00 per year for participating in MOC. Some Boards have an additional fee for the MOC Part III secure examination, but most Boards do not have additional charges for participation in the Part IV practice/quality improvement activities.

With respect to the proposed process for group practices to be treated as satisfactorily submitting quality measures data for the CY 2011 PQRI discussed in section VI.F.1 of this proposed rule, group practices interested in participating in the CY 2011 PQRI through the group practice reporting option (GPRO) I or GPRO II may also incur a cost. However, for groups that satisfactorily report for 2011 PQRI, we believe these costs would be completely offset by the incentive payment earned since the group practice would be eligible for an incentive payment equal to 1 percent of the entire group's total estimated Medicare Part B PFS allowed charges for covered professional services furnished during the reporting period.

One factor in the cost to group practices would be the costs associated with the self-nomination process. Similar to our estimates for staff involved with the claims-based reporting option for individual EPs, we also estimate that the group practice

staff involved in the group practice self-nomination process has an average labor cost of $58 per hour. Therefore, assuming 2 hours for a group practice to decide whether to participate individually or as a group and 4 hours for the self-nomination process, we estimate the total cost to a group practice associated with the group practice self-nomination process to be approximately $348 ($58 per hour × 6 hours per group practice).

For groups participating under the proposed GPRO I process, another factor in the cost to the group would be the time and effort associated with the group practice completing and submitting the proposed data collection tool. The information collection components of this data collection tool have been reviewed by OMB and are currently approved under OMB control number 0938–0941, with an expiration date of December 31, 2011. Based on the Physician Group Practice (PGP) demonstration's estimate that it takes approximately 79 hours for a group practice to complete the data collection tool, which uses the same data submission methods as those we have proposed, we estimate the cost associated with a physician group completing the data collection tool would be approximately $4,582 ($58 per hour × 79 hours per group practice).

For group practices participating under the proposed GPRO II process, the costs associated with submitting the PQRI quality measures data would be the time associated with the group practice submitting the required data to CMS via claims or a registry. The costs for a group practice reporting to a registry should be similar to the costs associated with registry reporting for an individual EP, as the process is the same with the exception that more patients and more measures must be reported in GPRO II compared to an individual EP. For similar reasons, the costs for a group practice reporting via claims should also be similar to the costs associated with claims-based reporting for an individual EP. Overall, there is significantly less burden associated with a group practice participating in PQRI via GPRO II than doing so as individual EPs. Participation in GPRO II requires the group practice as a whole to report a fewer number of measures on a fewer number of people since EPs within a group who share patients would not be required to separately report measures for those shared patients. Therefore, assuming that an average group practice would spend 20 hours for data submission, we estimate the cost of data submission under GPRO II would be approximately $1,160 (20 hours for data submission × $58 per hour). Smaller groups may need less time for data submission as they would be required to report fewer measures and presumably have a smaller patient population while larger groups may need more time for data submission since they would be required to report more measures and presumably have a larger patient population.

In addition to costs incurred by EPs and group practices, registries and EHR vendors may also incur some costs related to the PQRI. Registries interested in becoming "qualified" to submit on behalf of individual EPs would also have to incur a cost associated with the vetting process and with calculating quality measures results from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on quality measures to CMS on behalf of their participants. We estimate the registry self-nomination process would cost approximately $500 per registry ($50 per hour × 10 hours per registry). This cost estimate includes the cost of submitting the self-nomination letter to CMS and completing the CMS vetting process. Our estimate of $50 per hour average labor cost for registries is based on the assumption that registry staff include IT professionals whose average hourly rates range from $36 to $84 per hour depending on experience, with an average rate of nearly $50 per hour for a mid-level programmer. However, the 2010 qualified registries would not incur any costs associated with the self-nomination process unless they are unsuccessful at submitting 2010 PQRI results, they wish to be qualified to submit additional measures or for additional methods, or we finalize new requirements for 2011. We do not believe that there are any additional costs for registries associated with a registry calculating quality measures results from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on quality measures to CMS on behalf of their participants. We believe that the majority of registries already perform these functions for their participants.

An EHR vendor interested in having its product(s) be used by individual EPs to submit PQRI measures to CMS for 2012 would have to complete a vetting process during 2011 and program its EHR product(s) to extract the clinical data that the EP needs to submit to CMS for purposes of reporting 2012 quality measures as well. We propose that previously qualified vendors would need to only update their electronic measure specifications and data transmission schema to incorporate any new EHR measures to maintain their qualification for the 2012 PQRI. Therefore, for EHR vendors that were not previously qualified, the cost associated with completing the self-nomination process, including the vetting process with CMS officials, is estimated to be $500 ($50 per hour × 10 hours per EHR vendor). Our estimate of a $50 per hour average labor cost for EHR vendors is based on the assumption that vendor staff include IT professionals whose average hourly rates range from $36 to $84 per hour depending on experience, with an average rate of nearly $50 per hour for a mid-level programmer. We believe that the cost associated with the time and effort needed for an EHR vendor to review the quality measures and other information and program the EHR product to enable individual EPs to submit PQRI quality measures data to the CMS-designated clinical warehouse will be dependent on the EHR vendor's familiarity with PQRI, the vendor's system's capabilities, as well as the vendor's programming capabilities. Some vendors already have the necessary capabilities and for such vendors, we estimate the total cost to be approximately $2,000 ($50 per hour × 40 hours per vendor). However, given the variability in the capabilities of the vendors, we believe an estimate for those vendors with minimal experience would be approximately $10,000 per vendor ($50 per hour × 200 hours per EHR vendor).

6. Section 132 of the MIPPA: Incentives for Electronic Prescribing (eRx)—The eRx Incentive Program

Section VI.F.2. of this proposed rule describes the proposed 2011 Electronic Prescribing (eRx) Incentive Program. To be considered a successful electronic prescriber in CY 2011, an individual EP would need to meet the requirements proposed in section VI.F.2. of this proposed rule.

We anticipate that the cost impact of the eRx Incentive Program on the Medicare program would be the cost incurred for maintaining the electronic prescribing measure and its associated code set, and for maintaining the existing clinical data warehouse to accommodate registry-based reporting and EHR-based reporting for the electronic prescribing measure. However, we do not anticipate a significant cost impact on the Medicare program since much of this infrastructure has already been established for the PQRI program.

Individual EPs and group practices may have different processes for

integrating the eRx Incentive Program into their practices' work flows. Given this variability and the multiple reporting options that we propose to provide, it is difficult to accurately estimate the impact of the eRx Incentive Program on providers. Furthermore, we believe that costs for EPs who are participating in the eRx Incentive Program for the first time in 2011 will be considerably higher than the cost for EPs who participated in the eRx Incentive Program in prior years. In addition, for many EPs (especially those who participated in the eRx Incentive Program in prior years), the cost of participating in the eRx Incentive Program will be offset by the incentive payment received.

At this time, no eRx incentive payments have been made yet. We are currently analyzing 2009 eRx data, which was the first year of the program, and anticipate making the 2009 incentive payments later this year. We estimate that the incentive payments for the 2011 eRx Incentive Program (which will be paid in 2012) will be approximately $81 million. This estimate is based on preliminary participation numbers from the early part of 2010 and incentive payments that have been made for PQRI. We anticipate that despite a decrease in the incentive payment amount from 2 percent in 2010 to 1 percent of total estimated Medicare Part B allowed charges for covered professional services in 2011, more EPs (and groups) will choose to participate in the 2011 eRx Incentive Program to avoid a prospective 1 percent payment penalty in 2012 for not demonstrating that they are successful electronic prescribers. Even though the incentive payment amount for the 2011 eRx Incentive Program is equal to the incentive payment amount for the 2011 PQRI, we believe that the total incentive amount that will be paid for the 2011 eRx Incentive Program will be less than the total incentive payment amount that will be paid for the PQRI discussed above. The eRx Incentive Program does not apply to all EPs. For example, EPs who do not have prescribing privileges or EPs who do not practice in a particular care setting would not be able to participate in the eRx Incentive Program even though they can participate in PQRI.

Any EP who wishes to participate in the eRx Incentive Program must have a qualified electronic prescribing system in order to participate. Therefore, a one-time potential cost to some individual EPs would be the cost of purchasing and using an eRx system, which varies by the commercial software package selected, the level at which the professional currently employs information technology in his or her practice and the training needed. One study indicated that a midrange complete electronic medical record with electronic prescribing functionality costs $2,500 per license with an annual fee of $90 per license for quarterly updates of the drug database after setup costs while standalone prescribing, messaging, and problem list system may cost $1,200 per physician per year after setup costs. Hardware costs and setup fees substantially add to the final cost of any software package. (Corley, S.T. (2003). "Electronic prescribing: a review of costs and benefits." Topics in Health Information Management 24(1):29–38.). These are the estimates that we propose to use for our impact analysis.

Similar to PQRI, one factor in the cost to individual EPs is the time and effort associated with individual EPs reviewing the electronic prescribing measure to determine whether it is applicable to them, reviewing the available reporting options and selecting one, gathering the required information, and incorporating reporting of the measure into their office work flows. Since the eRx Incentive Program consists of only 1 quality measure, we propose to estimate 2 hours as the amount of time needed for individual EPs to prepare for participation in the eRx Incentive Program. Information obtained from the Physician Voluntary Reporting Program (PVRP), which was a predecessor to the PQRI and was the first step for the reporting of physician quality of care through certain quality metrics, indicated an average labor cost per practice of approximately $50 per hour. To account for salary increases over time, we will use an average practice labor cost of $58 per hour for our estimates, based on an assumption of an average annual increase of approximately 3 percent. At an average cost of approximately $58 per hour, we estimate the total preparation costs to individual EPs to be approximately $116 ($58 per hour × 2 hours).

Another factor that influences the cost to individual EPs is how they choose to report the electronic prescribing measure (that is, whether they select the claims-based, registry-based or EHR-based reporting mechanism). For claims-based reporting, there would be a cost associated with reporting the appropriate QDC on the claims an individual EP submits for payment. Based on the information from the PVRP described above for the amount of time it takes a median practice to report one measure one time (1.75 min) and the proposed requirement to report 25 electronic prescribing events during 2011, we estimate the annual estimated cost per individual EP to report the electronic prescribing measure via claims-submission to be $42.29 (1.75 min per case × 1 measure × 25 cases per measure × $58 per hour). Assuming that the mean and median incentive payment amounts per individual EP would be comparable to those for the PQRI since the incentive payments are calculated in the same manner, we believe that for most successful electronic prescribers who earn an incentive, these costs would be negated by the incentive payment received.

For EPs who select the registry-based reporting mechanism, we do not anticipate any additional cost for individual EPs to report data to a registry, as individual EPs opting for registry-based reporting are more than likely already reporting data to the registry. Little if any, additional data would need to be reported to the registry for purposes of participation in the CY 2011 eRx Incentive Program. Individual EPs using registries for PQRI will likely experience minimal, if any, increased costs charged by the registry to report this 1 additional measure.

For EHR-based reporting, the EP must extract the necessary clinical data from his or her EHR, and submit the necessary data to the CMS-designated clinical data warehouse. Once the EHR is programmed by the vendor to allow data submission to CMS, the cost to the individual EP associated with the time and effort to submit data on the electronic prescribing measure should be minimal.

With respect to the proposed process for group practices to be treated as successful electronic prescribers under the CY 2011 eRx Incentive Program discussed in section VI.F.2 of this proposed rule, group practices have the same option as individual eligible professionals in terms of the form and manner for reporting the eRx measure (that is, group practices have the option of reporting the measure through claims, a qualified registry, or a qualified EHR product). There are only 2 differences between the requirements for an individual EP and a group practice: (1) The fact that a group practice would have to self-nominate; and (2) the number of times a group practice would be required to report the eRx measure. Overall, there could be less cost associated with a practice participating in the eRx Incentive Program as a group rather than the individual members of the group separately participating. We do not anticipate any additional costs associated with the group practice self-nomination process since we propose to

limit the group practices to those selected to participate in the 2011 PQRI GPRO I or PQRI GPRO II. The practices only would need to indicate their desire to participate in the eRx GPRO at the time they self-nominate for either PQRI GPRO I or PQRI GPRO II.

The costs for a group practice reporting to an EHR or registry should be similar to the costs associated with registry and EHR reporting for an individual EP, as the process is the same with the exception that more electronic prescribing events must be reported by the group. For similar reasons, the costs for a group practice reporting via claims should also be similar to the costs associated with claims-based reporting for an individual EP. Therefore, we estimate that the costs for group practices who are selected to participate in the CY 2011 eRx Incentive Program as a group would range from $126.88 (1.75 min per case × 1 measure × 75 cases per measure × $58 per hour) for the smallest groups participating under GPRO II to $4,229.17 (1.75 min per case × 2500 cases per measure × $58 per hour) for the groups participating under GPRO I.

We believe that the costs to individual EPs and group practices associated with avoiding the eRx penalty that goes into effect in 2012 would be similar to the costs of an EP or group practice reporting the electronic prescribing measure for purposes of the 2011 eRx incentive. The proposed requirements for avoiding the 2012 eRx penalty, including the reporting period, essentially overlaps with the proposed requirements for the 2011 eRx incentive.

Based on our proposal to consider only registries qualified to submit quality measures results and numerator and denominator data on quality measures to CMS on their participant's behalf for the 2011 PQRI to be qualified to submit results and numerator and denominator data on the eRx measure for the CY 2011 eRx Incentive Program, we do not anticipate any cost to the registry associated with becoming a registry qualified to submit the eRx measure for CY 2011.

The cost for the registry would be the time and effort associated with the registry calculating results for the eRx measure from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on the eRx quality measure to CMS on behalf of their participants. We believe such costs would be minimal as registries would already be required to perform these activities for PQRI.

Likewise, based on our proposal to consider only EHR products qualified for the CY 2011 PQRI to be qualified to submit results and numerator and denominator data on the electronic prescribing measure for the CY 2011 eRx Incentive Program, there would be no need for EHR vendors to undergo a separate self-nomination process for the eRx Incentive Program. Therefore, there would be no additional cost associated with the self-nomination process.

The cost to the EHR vendor associated with the EHR-based reporting requirements of this reporting initiative is the time and effort associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the individual EP needs to submit to CMS for purposes of reporting the CY 2011 eRx measure. Since we propose that only EHR products qualified for the 2011 PQRI would be qualified for the CY 2011 eRx Incentive Program, and the eRx Incentive Program consists of only one measure, we believe that any burden associated with the EHR vendor to program its product(s) to enable individual EPs to submit data on the eRx measure to the CMS-designated clinical data warehouse would be minimal.

7. Durable Medical Equipment-Related Issues

a. Off-the-Shelf (OTS) Orthotics Exemption

In section VI.G. of this proposed rule, we are proposing to expand the exemptions from the Competitive Bidding Program (CBP) for certain OTS orthotics to physicians or other practitioners (as defined by the Secretary) if furnished to their own patients as part of their professional service.

The proposed exemption is a self-implementing mandate required by section 154(d) of MIPPA, which added section 1847(a)(7) of the Act. Section 1847(a)(7)(A) of the Act expanded the exemptions from the CBP for certain OTS orthotics to physicians or other practitioners (as defined by the Secretary) if furnished to their own patients as part of their professional service. Section 1847(a)(7)(B) of the Act, as added by section 154(d) of MIPPA, also expanded the exemption from CBP for certain OTS DME items (crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps) when furnished by hospitals to the hospital's own patients during an admission or on the date of discharge.

We believe this exemption would have a negligible impact on physicians and other providers. The exemption will allow physicians to continue to provide these items to their own patients without submitting a bid and becoming a contract supplier. This will also allow continued access to OTS items for beneficiaries while being seen in their physician's office.

b. Changes to Payment for Oxygen Equipment

The revisions pertaining to oxygen and oxygen equipment in section VI.G. of this proposed rule reflect changes made by section 144(b) of MIPPA and regulations implementing that provision. In § 414.226(g), exceptions are listed to the requirement that the supplier that furnishes oxygen equipment in the 1st month of the 36-month period must continue to furnish it until medical necessity ends or the 36-month of continuous use ends. Section VI.G. changes one exception (§ 414.226(g)(1)(ii)) to read that if a beneficiary relocates to an area that is outside the normal service area of the supplier before the 18th month, then the supplier does not have to continue to furnish the item or make arrangements.

We expect that revising § 414.226(g)(1)(ii) so that only suppliers that have received at least 18 months of rental payments must continue to furnish the oxygen equipment until medical necessity ends or the end of the reasonable useful lifetime should have a minor impact on the supplier, but should provide protection to beneficiaries. The reason that we expect the revised exception will have little impact has foremost to do with the fact that it applies in cases that are the exception to the normal circumstances. Only 38 percent of the beneficiaries are still renting by the 18th month of the rental period; only suppliers furnishing oxygen equipment to this subgroup of beneficiaries will be affected by this proposed change. Further, relocation between the 18th to the 36th month is not a common occurrence. Such relocation happens with less than 0.5 percent of the beneficiaries using oxygen equipment. In addition, between the 32nd and 35th month, relocation happens with the beneficiaries in about 0.06 percent of the time on average.

c. Diabetic Testing Supplies

We are establishing requirements for conducting a national competition for furnishing diabetic supplies on a mail order basis. Specifically this proposed rule will establish 3 requirements: A new definition for what constitutes mail order; a rule that requires contract suppliers to provide at a minimum 50 percent of all of the different types of diabetic testing products on the market by brand and model name; and a

prohibition against influencing and incentivizing beneficiaries to switch their brand of monitor and testing suppliers.

Currently based on claims data from fiscal year 2009 over 62 percent of beneficiaries receive their replacement diabetic testing supplies from mail order suppliers. This definition will not impact these beneficiaries because they can continue to obtain their items through mail order. The remaining 38 percent of beneficiaries may continue to obtain these items from a local storefront. We do not expect this rule to have any adverse affects on beneficiaries because the new definition of mail order is reflective of the way that beneficiaries currently get their testing supplies. However, we believe that by clarifying this definition we will protect beneficiaries from paying higher co-payment amounts and we anticipate program savings that would have been eroded by suppliers circumventing our definition to continue to provide items, even if not awarded a contract under competitive bidding and to obtain the higher fee schedule payment amount. This definition is also consistent with the way that suppliers currently do business by either providing items through mail order or at a local storefront. For these reasons we believe this new definition will have minimal impact.

Also, we considered the option to not bifurcate bidding based on delivery method and to bid for diabetic testing suppliers regardless of how the items were obtained. We rejected this approach because it would force companies with different business models to compete against each other, by requiring local pharmacies to compete with national mail order suppliers in order to win a contract to be able to furnish testing supplies.

In order to implement a national mail order competition for diabetic supplies, we are also proposing to implement the special "50 percent rule" mandated by MIPPA. This rule requires a bidder to demonstrate that its bid "covers types of diabetic testing strip products that, in the aggregate and taking into account volume for the different products, cover 50 percent (or such higher percentage as the Secretary may specify) of all such types of products." The 50 percent threshold would ensure that beneficiaries have access to mail order delivery of the top-selling diabetic test strip products from every contract supplier. We plan to use the information that bidding suppliers provide on their bidding Form B where suppliers list the products they plan to furnish. We believe this requirement will have a minimal impact on suppliers because most suppliers currently provide a wide range of the brands and models in order to gain market share. The statute states that suppliers are required to carry at least 50 percent of all brands on the market. However, the Secretary can establish suppliers to carry a higher percentage of brands. We have adopted 50 percent criteria because we believe this is reflective of what suppliers are currently doing and ensures appropriate access for beneficiaries.

In addition to the 50 percent rule, we are also proposing to establish an anti-switching requirement. This provision would prevent contract suppliers from switching beneficiaries from their current brand to a brand provided by the supplier. We believe this requirement will protect the beneficiary and physician choice of glucose monitoring systems. The decision concerning the type of monitor and testing supplies that a beneficiary chooses should not be made by the supplier but rather by the beneficiary and their physician. We believe that this provision will have a minimal impact on suppliers because suppliers currently offer a variety of products and generally do require beneficiaries to switch from the brands they are familiar with and customarily use.

d. Metropolitan Statistical Areas

We believe that the provisions pertaining to subdividing metropolitan statistical areas (MSAs) with populations of at least 8,000,000 for the purpose of establishing competitive bidding areas (CBAs) under Round 2 of the DMEPOS Competitive Bidding Program will have a positive impact on most suppliers, particularly small suppliers. The authority provided by section 1847(a)(1)(D)(ii)(II) of the Act would be used to create CBAs that are smaller than the highly and densely populated MSAs of: Chicago-Naperville-Joliet, IL–IN–WI; Los Angeles-Long Beach-Santa Ana, CA; and New York-Northern New Jersey-Long Island, NY–NJ–PA. This should result in more manageable service areas for suppliers to navigate when furnishing items. More importantly, it should ensure more timely delivery of items and services to beneficiaries located throughout each of the MSAs. It should also benefit small suppliers because they would have smaller geographic areas to cover as contract suppliers than the large MSAs, which in some cases, might prevent them from being considered for participation under the program. The larger suppliers would still have the opportunity to bid in all of the CBAs within each MSA. We expect that subdividing the large MSAs of Chicago, Los Angeles, and New York would not have a negative impact on program savings, as long as each CBA is large enough to be attractive to suppliers for bidding purposes.

Table 76 considers FY cash impact on the entire Medicare program, including Medicare Advantage for FYs 2011 thru 2015 of the provisions of this proposed rule related to the establishment of CBAs during Round 2 and prior to calendar year 2015. The FY–CY distinction is an important one when comparing savings. For example, the savings for the Medicare DMEPOS Competitive Bidding Program will be for 9 months of FY 2013, but for 12 months of CY 2013. Table 76 considers the impact on program expenditures, and does not include beneficiary coinsurance. Finally, the estimates in Table 76 incorporate spillover effects from the competitive acquisition program onto the Medicare Advantage program. The expectation is that the 21 additional MSAs added to the Medicare DMEPOS Competitive Bidding Program would lower prices for DME products in FFS would lead to lower prices in the Medicare Advantage market. The table below considers FY cash impact of the above provisions on the entire Medicare program, including Medicare Advantage for the FY.

TABLE 76—FISCAL YEAR COSTS TO THE MEDICARE PROGRAM

FY	Cost (in $millions)
2011	0
2012	0
2013	−40
2014	−70
2015	−110

Subdividing the large MSAs of Chicago, Los Angeles, and New York is considered to have little to no fiscal impact. The exceptions to the Medicare DMEPOS Competitive Bidding program involving rural areas, MSAs with populations less than 250,000, and low population density areas in selected MSAs before 2015 are considered to have little to no impact because the baseline never considered these areas as subject to competitive bidding prices.

8. Air Ambulance

In section VI.G. of this proposed rule, we present our proposals regarding air ambulance and provider and supplier enrollment. We note that this proposal is an administrative initiative that may result in Medicare program savings but at this time those savings are inestimable. We believe the probable

costs providers or suppliers will incur as a result of this rule to be negligible.

F. Alternatives Considered

This proposed rule contains a range of policies, including some provisions related to specific MIPPA and ACA provisions. The preceding preamble provides descriptions of the statutory provisions that are addressed, identifies those policies when discretion has been exercised, presents rationale for our proposals and, where relevant, alternatives that were considered.

G. Impact on Beneficiaries

There are a number of changes in this proposed rule that would have an effect on beneficiaries. In general, we believe that many of the proposed changes, including the refinements of the PQRI with its focus on measuring, submitting, and analyzing quality data, the expansion of the list of Medicare-approved telehealth services, the incentive payments for primary care services furnished by primary care practitioners in any location and major surgical procedures furnished by general surgeons in HPSAs, the waiver of beneficiary cost-sharing for most preventive services, and the annual wellness visit proposals, will have a positive impact and improve the quality and value of care provided to Medicare beneficiaries.

The regulatory provisions may affect beneficiary liability in some cases. For example, the waiver of the deductible and coinsurance for the annual wellness visit, the IPPE, and preventive services with a grade of A or B from the USPSTF would reduce beneficiary liability for these services. Most changes in aggregate beneficiary liability due to a particular provision would be a function of the coinsurance (20 percent if applicable for the particular provision after the beneficiary has met the deductible). To illustrate this point, as shown in Table 74, the CY 2010 national payment amount in the nonfacility setting for CPT code 99203 (Office/outpatient visit, new) under the conversion factor that was consistent with the statute as of October 30, 2009 and that would be in effect on December 31, 2010 under current law, is $76.93 which means that in CY 2010 a beneficiary would be responsible for 20 percent of this amount, or $15.39. Based on this proposed rule, the CY 2011 national payment amount in the nonfacility setting for CPT code 99203, as shown in Table 74, is $72.67, which means that, in CY 2011, the beneficiary coinsurance for this service would be $14.53.

Additionally, beneficiary liability would also be impacted by the effect of the aggregate cost (savings) of the provisions on the standard calculation of the Medicare Part B premium rate (generally 25 percent of the provision's cost or savings).

Most policies discussed in this rule that impact payment rates, such as the expansion of the MPPR to therapy services and the increased discount on the TC of multiple imaging procedures from 25 percent to 50 percent, would similarly impact beneficiaries' coinsurance.

H. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 77, we have prepared an accounting statement showing the estimated expenditures associated with this proposed rule. This estimate includes the estimated FY 2011 cash benefit impact associated with certain ACA and MIPPA provisions, and the CY 2011 incurred benefit impact associated with the estimated CY 2011 PFS conversion factor update based on the FY 2011 President's Budget baseline.

TABLE 77—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES

Category	Transfers
CY 2011 Annualized Monetized Transfers.	Estimated decrease in expenditures of $5.7 billion for PFS conversion factor update.
From Whom To Whom?	Federal Government to physicians, other practitioners and providers and suppliers who receive payment under Medicare.
FY 2011 Annualized Monetized Transfers.	Estimated increase in expenditures of $2 billion for Affordable Care Act provisions.
From Whom To Whom?	Federal Government to providers.

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medical devices, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 409

Health facilities, Medicare.

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 411

Kidney diseases, Medicare, Physician Referral, Reporting and record keeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare Reporting and recordkeeping requirements.

42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping.

42 CFR Part 415

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

1. The authority citation for part 405 continues to read as follows:

Authority: Secs. 1102, 1861, 1862(a), 1871, 1874, 1881, and 1886(k) of the Social Security Act (42 U.S.C. 1302, 1395x, 1395y(a), 1395hh, 1395kk, 1395rr and 1395ww(k)), and sec. 353 of the Public Health Service Act (42 U.S.C. 263a).

Subpart X—Rural Health Clinic and Federally Qualified Health Center Services

2. A new § 405.2449 is added to read as follows.

§ 405.2449 Preventive services.

For services furnished on or after January 1, 2011, preventive services covered under the Medicare Federally qualified health center benefit are those preventive services defined in section 1861(ddd)(3) of the Act, and § 410.2 of this chapter. Specifically, these include the following:

(a) The specific services currently listed in section 1861(ww)(2) of the Act, with the explicit exclusion of electrocardiograms;

(b) The Initial Preventive Physical Examination (IPPE) (as specified by section 1861(ww)(1) of the Act as added by section 611 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108–173) and § 410.16 of this chapter); and

(c) The Personalized Prevention Plan Services (PPPS), also known as the "Annual Wellness Visit" (as specified by section 1861(hhh) of the Act as added by section 4103 of the Affordable Care Act (Pub. L. 111–148) and part 410, subpart B, § 410.15 of this chapter).

3. Section 405.2470 is amended by adding a new paragraph (d) to read as follows:

§ 405.2470 Reports and maintenance of records.

* * * * *

(d) *Collection of additional claims data.* Beginning January 1, 2011, a Medicare FQHC must report on its Medicare claims such information as the Secretary determines is needed to develop and implement a prospective payment system for FQHCs including, but not limited to all pertinent HCPCS (Healthcare Common Procedure Coding System) code(s) corresponding to the service(s) provided for each Medicare FQHC visit (as defined in § 405.2463).

PART 409—HOSPITAL INSURANCE BENEFITS

4. The authority citation for part 409 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart B—Inpatient Hospital Services and Inpatient Critical Access Hospital Services

§ 409.17 [Amended]

5. Amend § 409.17(d) by removing the phrase "hospital policies and procedures" and adding in its place the phrase "the provider's policies and procedures."

Subpart C—Posthospital SNF Care

6. Section 409.20 is amended by revising paragraph (a)(3) to read as follows:

§ 409.20 Coverage of services.

(a) * * *

(3) Physical therapy, occupational therapy, and speech-language pathology services.

* * * * *

7. Section 409.23 is revised to read as follows:

§ 409.23 Physical therapy, occupational therapy, and speech-language pathology services.

Medicare pays for physical therapy, occupational therapy, or speech-language pathology services as posthospital SNF care if they are furnished—

(a) By (or under arrangements made by) the facility and billed by (or through) the facility;

(b) By qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, or speech-language pathologists as defined in part 484 of this chapter; and

(c) In accordance with a plan that meets the requirements of § 409.17(b) through (d) of this part.

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

8. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102, 1834, 1871, and 1893 of the Social Security Act (42 U.S.C. 1302, 1395m, 1395hh, and 1395ddd).

Subpart A—General Provisions

9. Section 410.2 is amended by adding the definition of "Preventive services" in alphabetical order to read as follows:

§ 410.2 Definitions.

* * * * *

Preventive services means all of the following:

(1) The specific services listed in section 1861(ww)(2) of the Act, with the explicit exclusion of electrocardiograms;

(2) The Initial Preventive Physical Examination (IPPE) (as specified by section 1861(ww)(1) of the Act); and

(3) The Personalized Prevention Plan Services (PPPS), also known as the "Annual Wellness Visit" (as specified by section 1861(hhh) of the Act)

§ 410.3 [Amended]

10. Amend § 410.3(b)(2) by removing the reference "subpart E" and adding in its place the reference "subpart I."

Subpart B—Medical and Other Health Services

11. Section 410.15 is added to read as follows:

§ 410.15 Annual wellness visits providing Personalized Prevention Plan Services: Conditions for and limitations on coverage.

(a) *Definitions.*

Detection of any cognitive impairment, for the purpose of this section, means assessment of an individual's cognitive function by direct observation, with due consideration of information obtained by way of patient report, concerns raised by family members, friends, caretakers or others.

Eligible beneficiary for purposes of this section means an individual who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage period and who has not received either an initial preventive physical examination or an annual wellness visit providing a personalized prevention plan within the past 12 months.

Establishment of, or an update to the individual's medical and family history for purposes of this section means, at a minimum, the collection and documentation of the following:

(i) Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries and treatments.

(ii) Use or exposure to medications and supplements, including calcium and vitamins.

(iii) Medical events in the beneficiary's parents and any siblings and children, including diseases that may be hereditary or place the individual at increased risk.

First annual wellness visit providing personalized prevention plan services for purposes of this section means the following services furnished an eligible beneficiary by a health professional as those terms are defined in this section:

(i) Establishment of an individual's medical and family history.

(ii) Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual.

(iii) Measurement of an individual's height, weight, body-mass index (or waist circumference, if appropriate), blood pressure, and other routine measurements as deemed appropriate, based on the beneficiary's medical and family history.

(iv) Detection of any cognitive impairment that the individual may have, as that term is defined in this section.

(v) Review of the individual's potential (risk factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national medical professional organizations.

(vi) Review of the individual's functional ability and level of safety, based on direct observation or the use of appropriate screening questions or a screening questionnaire, which the health professional as defined in this section may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations.

(vii) Establishment of the following:

(A) A written screening schedule for the individual such as a checklist for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force and the Advisory Committee on Immunization Practices, and the individual's health status, screening history, and age-appropriate preventive services covered by Medicare.

(B) A list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an initial preventive physical examination (as described under § 410.16 of this subpart), and a list of treatment options and their associated risks and benefits.

(viii) Furnishing of personalized health advice and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention and nutrition.

(ix) Any other element determined appropriate through the National Coverage Determination process.

Health professional for purposes of this section means:

(i) A physician who is a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Social Security Act); or

(ii) A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5) of the Act; or

(iii) A medical professional (including a health educator, registered dietitian or nutritionist) or a team of medical professionals, who are working under the supervision of a physician as defined in paragraph (i) of this definition.

Review of the individual's functional ability and level of safety for purposes of this section includes, at minimum, assessment of the following topics:

(i) Hearing impairment,

(ii) Ability to successfully perform activities of daily living,

(iii) Fall risk and

(iv) Home safety.

Subsequent annual wellness visit providing personalized prevention plan services means the following services furnished an eligible beneficiary by a health professional as those terms are defined in this section:

(i) An update of the individual's medical and family history.

(ii) An update of the list of current providers and suppliers that are regularly involved in providing medical care to the individual as that list was developed for the first annual wellness visit providing personalized prevention plan services.

(iii) Measurement of an individual's weight (or waist circumference), blood pressure and other routine measurements as deemed appropriate, based on the individual's medical and family history.

(iv) Detection of any cognitive impairment that the individual may have, as that term is defined in this section.

(v) An update to the following:

(A) The written screening schedule for the individual as that schedule is defined in paragraph (a) of this section for the first annual wellness visit providing personalized prevention plan services.

(B) The list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway for the individual as that list was developed at the first annual wellness visit providing personalized prevention plan services.

(vi) Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs as that advice and related services are defined in paragraph (a) of this section.

(vii) Any other element determined appropriate through the National Coverage Determination process.

(b) *Conditions for coverage of annual wellness visits providing personalized prevention plan services.* Medicare Part B pays for first and subsequent annual wellness visits providing personalized prevention plan services that are furnished to an eligible beneficiary, as described in this section, if they are furnished by a heath professional, as defined in this section.

(c) *Limitations on coverage of an annual wellness visit providing personalized prevention plan services.*

(1) Payment may not be made for either a first or a subsequent annual wellness visit providing personalized prevention plan services that is performed for an individual who is not an eligible beneficiary as described in this section.

(2) Payment may not be made for either a first or a subsequent annual wellness visit providing personalized prevention plan services that is performed for an individual who is an eligible beneficiary as described in this section and who has had either an initial preventive physical examination as specified in section 410.16 of this subpart or either a first or a subsequent annual wellness visit providing personalized prevention plan services performed within the past 12 months.

(d) *Effective date.* Coverage for an annual wellness visit providing personalized prevention plan services is effective for services furnished on or after January 1, 2011.

12. Section 410.32 is amended by adding paragraph (b)(2)(vii) to read as follows:

§ 410.32 Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions.

* * * * *

(b) * * *

(2) * * *

(vii) Diagnostic tests performed by a certified nurse-midwife authorized to perform the tests under applicable State laws.

* * * * *

13. Section 410.78 is amended by revising the introductory text of paragraph (b) to read as follows:

§ 410.78 Telehealth services.

* * * * *

(b) *General rule.* Medicare Part B pays for office or other outpatient visits, subsequent hospital care services (with the limitation of one telehealth visit every 3 days), subsequent nursing facility care services (not including the Federally-mandated periodic visits under § 483.40(c) of this chapter and with the limitation of one telehealth visit every 30 days), professional consultations, psychiatric diagnostic interview examination, neurobehavioral status exam, individual psychotherapy, pharmacologic management, end-stage renal disease-related services included in the monthly capitation payment (except for one "hands on" visit per month to examine the access site), individual and group medical nutrition therapy services, individual and group kidney disease education services, individual and group diabetes self-management (DSMT) training services (except for one hour of in-person services to be furnished in the year following the initial DSMT service to ensure effective injection training), and individual and group health and behavior assessment and intervention services furnished by an interactive telecommunications system if the following conditions are met:

* * * * *

Subpart I—Payment for SMI Benefits

14. Section 410.150 is amended by adding paragraph (a)(20) to read as follows:

§ 410.150 To whom payment is made.

(a) * * *

(20) To a certified nurse-midwife for professional services furnished by the certified nurse-midwife in all settings and for services and supplies furnished incident to those services. Payment is made only if no facility or other provider charges or is paid any amount for the furnishing of the professional services of the certified nurse-midwife.

15. Section 410.152 is amended by revising paragraph (l) to read as follows:

§ 410.152 Amounts of payment.

* * * * *

(l) *Amount of payment: Preventive services.* Medicare Part B pays 100 percent of the Medicare payment amount established under the applicable payment methodology for the service setting for providers and suppliers for the following preventive services:

(1) Pneumococcal (as specified in paragraph (h) of this section), influenza, and hepatitis B vaccine and administration.

(2) Screening mammography.

(3) Screening pap tests and screening pelvic exam.

(4) Prostate cancer screening tests (excluding digital rectal examinations).

(5) Colorectal cancer screening tests (excluding barium enemas).

(6) Bone mass measurement.

(7) Medical nutrition therapy (MNT) services.

(8) Cardiovascular screening blood tests.

(9) Diabetes screening tests.

(10) Ultrasound screening for abdominal aortic aneurysm (AAA).

(11) Additional preventive services identified for coverage through the national coverage determination (NCD) process.

(12) Initial Preventive Physical Examination (IPPE).

(13) Personalized Prevention Plan Services (PPPS).

16. Section 410.160 is amended by—

A. Revising paragraph (b)(2).

B. Adding paragraphs (b)(10), (11), (12), and (13).

The revisions and additions read as follows:

§ 410.160 Part B annual deductible.

* * * * *

(b) * * *

(2) Pneumococcal, influenza, and hepatitis b vaccines and their administration.

* * * * *

(10) Bone mass measurement.

(11) Medical nutrition therapy (MNT) services.

(12) Personalized prevention plan services (PPPS).

(13) Additional preventive services identified for coverage through the national coverage determination (NCD) process.

* * * * *

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

17. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102, 1860D–1 through 1860D–42, 1871, and 1877 of the Social Security Act (42 U.S.C. 1302, 1395w–101 through 1395w–152, 1395hh, and 1395nn).

Subpart A—General Exclusions and Exclusion of Particular Services

18. Section 411.15 is amended by—

A. Republishing the introductory text.

B. Revising paragraph (a)(1).

C. Adding new paragraph (k)(16).

The revision and addition read as follows:

§ 411.15 Particular services excluded from coverage.

The following services are excluded from coverage.

(a) * * *

(1) Examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury, except for screening mammography, colorectal cancer screening tests, screening pelvic exams, prostate cancer screening tests, glaucoma screening exams, ultrasound screening for abdominal aortic screening for abdominal aortic aneurysms (AAA), cardiovascular disease screening tests, diabetes screening tests, a screening electrocardiogram, initial preventive physical examinations that meet the criteria specified in paragraphs (k)(6) through (k)(15) of this section, additional preventive services that meet the criteria in § 410.64 of this chapter, or annual wellness visits providing personalized prevention plan services

* * * * *

(k) * * *

(16) In the case of an annual wellness visit providing a personalized prevention plan, subject to the conditions and limitations specified in § 410.15 of this chapter.

* * * * *

Subpart J—Financial Relationships Between Physicians and Entities Furnishing Designated Health Services

19. Section 411.355 is amended by adding paragraph (b)(7) to read as follows:

§ 411.355 General exceptions to the referral prohibition related to both ownership/investment and compensation.

* * * * *

(b) * * *

(7) *Disclosure requirement for certain imaging services.*

(i) With respect to magnetic resonance imaging, computed tomography, and positron emission tomography, the referring physician shall provide written notice to the patient at the time of the referral that the patient may receive the same services from a person other than one described in paragraph (b)(1) of this section. Except as set forth in paragraph (b)(7)(ii) of this section, the written notice shall include a list of at least 10 other suppliers (as defined in § 400.202 of this chapter) that provide the services for which the individual is being referred and which are located within a 25-mile radius of the referring physician's office location at the time of the referral. The notice should be written in a manner sufficient to be reasonably understood by all patients and should include for each supplier on the list, at a minimum, the supplier's name, address, telephone number, and distance from the referring physician's

office location. A record of the disclosure notification, signed by the patient, shall be maintained as a part of the patient's medical record.

(ii) If there are fewer than 10 other suppliers located within a 25-mile radius of the physician's office location at the time of the referral, the physician shall list all of the other suppliers of the imaging service that are present within a 25-mile radius of the referring physician's office location, including up to 10 suppliers. Provision of the written list of alternate suppliers will not be required if no other suppliers provide the services for which the individual is being referred within the 25-mile radius.

* * * * *

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

20. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); and sec. 124 of Public Law 106–133 (113 Stat. 1501A–332).

Subpart E—Payments to Providers

21. Section 413.70 is amended by adding a sentence at the end of paragraph (b)(3)(ii)(B) to read as follows:

§ 413.70 Payment for services of a CAH.

* * * * *

(b) * * *

(3) * * *

(ii) * * *

(B) * * * Effective for primary care services furnished by primary care practitioners (as defined in § 414.80(a)) and major surgical procedures furnished by general surgeons in health professional shortage areas (as defined in § 414.2) furnished on or after January 1, 2011 and before January 1, 2016, incentive payments specified under § 414.80 and § 414.67(b), respectively, of this chapter shall not be included in determining payment made under this paragraph.

* * * * *

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

22. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(l) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(l)).

Subpart A—General Provisions

23. Section 414.2 is amended by adding the definitions of "Health Professional Shortage Area" and "Major surgical procedure" in alphabetical order to read as follows:

§ 414.2 Definitions.

* * * * *

Health Professional Shortage Area (HPSA) means an area designated under section 332(a)(1)(A) of the Public Health Service Act as identified by the Secretary prior to the beginning of such year.

Major surgical procedure means a surgical procedure for which a 10-day or 90-day global period is used for payment under the PFS and section 1848(b) of the Act.

* * * * *

24. Section 414.26 is amended by—

A. Redesignating paragraph (c) as paragraph (d).

B. Adding a new paragraph (c).

The addition reads as follows:

§ 414.26 Determining the GAF.

* * * * *

(c) *Adjusting the practice expense index to account for the Frontier State floor.* (1) *General criteria.* Effective on or after January 1, 2011, CMS will adjust the practice expense index for physicians' services furnished in qualifying States to recognize the practice expense index floor established for Frontier States. A qualifying State must meet the following criteria:

(i) At least 50 percent of counties located within the State have a population density less than 6 persons per square mile.

(ii) The State does not receive a non-labor related share adjustment determined by the Secretary to take into account the unique circumstances of hospitals located in Alaska and Hawaii.

(2) *Amount of adjustment.* The practice expense value applied for physicians' services furnished in a qualifying State will be not less than 1.00.

(3) *Process for determining adjustment.* (i) CMS will use the most recent Population Estimate data published by the U.S. Census Bureau to determine county definitions and population density. This analysis will be periodically revised, such as for updates to the decennial census data.

(ii) CMS will publish annually a listing of qualifying Frontier States receiving a practice expense index floor attributable to this provision.

* * * * *

Subpart B—Physicians and Other Practitioners

25. Section 414.54 is revised to read as follows:

§ 414.54 Payment for certified nurse-midwives' services.

(a) For services furnished after December 31, 1991, allowed amounts under the fee schedule established under section 1833(a)(1)(K) of the Act for the payment of certified nurse-midwife services may not exceed 65 percent of the physician fee schedule amount for the service.

(b) For certified nurse midwife services furnished on or after January 1, 2011, allowed amounts may not exceed 100 percent of the physician fee schedule amount for the services.

26. Section 414.65 is amended by revising the introductory text of paragraph (a)(1) to read as follows:

§ 414.65 Payment for telehealth services.

(a) * * *

(1) The Medicare payment amount for office or other outpatient visits, subsequent hospital care services (with the limitation of one telehealth subsequent hospital care service every 3 days), subsequent nursing facility care services (not including the Federally-mandated periodic visits under § 483.40(c) and with the limitation of one telehealth nursing facility care service every 30 days), professional consultations, psychiatric diagnostic interview examination, neurobehavioral status exam, individual psychotherapy, pharmacologic management, end-stage renal disease-related services included in the monthly capitation payment (except for one "hands on" visit per month to examine the access site), individual and group medical nutrition therapy services, individual and group kidney disease education services, individual and group diabetes self-management training (DSMT) services (except for 1 hour of in-person DSMT services to be furnished in the year following the initial DSMT service to ensure effective injection training), and individual and group health and behavior assessment and intervention furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable for the service of the physician or practitioner.

* * * * *

27. Section 414.67 is revised to read as follows:

§ 414.67 Incentive payments for services furnished in Health Professional Shortage Areas.

(a) *Health Professional Shortage Area (HPSA) physician bonus program.* A HPSA physician incentive payment will be made subject to the following:

(1) HPSA bonuses are payable for services furnished by physicians as defined in section 1861(r) of the Act in areas designated as of December 31 of the prior year as geographic primary medical care HPSAs as defined in section 332(a)(1)(A) of the Public Health Service Act.

(2) HPSA bonuses are payable for services furnished by psychiatrists in areas designated as of December 31 of the prior year as geographic mental health HPSAs if the services are not already eligible for the bonus based on being in a geographic primary care HPSA.

(3) Physicians eligible for the HPSA physician bonus are entitled to a 10 percent incentive payment above the amount paid for their professional services under the physician fee schedule.

(4) Physicians furnishing services in areas that are designated as geographic HPSAs prior to the beginning of the year but not included on the published list of zip codes for which automated HPSA bonus payments are made should use the AQ modifier to receive the HPSA physician bonus payment.

(b) *HPSA surgical incentive payment program.* A HPSA surgical incentive payment will be made subject to the following:

(1) A major surgical procedure as defined in § 414.2 of this part is furnished by a general surgeon on or after January 1, 2011 and before January 1, 2016 in an area recognized for the HPSA physician bonus program under paragraph (a)(1) of this section.

(2) Payment will be made on a quarterly basis in an amount equal to 10 percent of the Part B payment amount for major surgical procedures furnished as described in paragraph (1), in addition to the amount the physician would otherwise be paid.

(3) Physicians furnishing services in areas that are designated as geographic HPSAs eligible for the HPSA physician bonus program under paragraph (a)(1) of this section prior to the beginning of the year but not included on the published list of zip codes for which automated HPSA surgical bonus payments are made should report a specified HCPCS code modifier to receive the HPSA surgical bonus payment.

(4) The payment described in paragraph (b)(2) of this section is made to the surgeon or, where the surgeon has reassigned his or her benefits to a critical access hospital (CAH) paid under the optional method, to the CAH based on an institutional claim.

28. Section 414.80 is added to subpart B to read as follows:

§ 414.80 Incentive payment for primary care services.

(a) *Definitions.* As defined in this section—

Eligible primary care practitioner means one of the following:

(i) A physician (as defined in section 1861(r)(1)) who meets all of the following criteria:

(A) Enrolled in Medicare with a primary specialty designation of 08-family practice, 11-internal medicine, 37-pediatrics, or 38-geriatrics.

(B) At least 60 percent of the physician's allowed charges during a reference period specified by the Secretary are for primary care services.

(ii) A nurse practitioner, clinical nurse specialist, or physician assistant (as defined in section 1861(aa)(5)) who meets all of the following criteria:

(A) Enrolled in Medicare with a primary specialty designation of 50-nurse practitioner, 89-certified clinical nurse, or 97-physician assistant.

(B) At least 60 percent of the practitioner's allowed charges during a reference period specified by the Secretary are for primary care services.

Primary care services means new and established patient office or other outpatient evaluation and management (E/M) visits; initial, subsequent, discharge, and other nursing facility E/M services; new and established patient domiciliary, rest home (e.g., boarding home), or custodial care E/M services; domiciliary, rest home (e.g., assisted living facility), or home care plan oversight services; and new and established patient home E/M visits.

(b) *Payment.*

(1) For primary care services furnished by an eligible primary care practitioner on or after January 1, 2011 and before January 1, 2016, payment is made on a quarterly basis in an amount equal to 10 percent of the payment amount for the primary care services under Part B, in addition to the amount the primary care practitioner would otherwise be paid for the primary care services under Part B.

(2) The payment described in paragraph (b)(1) of this section is made to the eligible primary care practitioner or, where the physician has reassigned his or her benefits to a critical access hospital (CAH) paid under the optional method, to the CAH based on an institutional claim.

29. A new § 414.90 is added to subpart B to read as follows:

§ 414.90 Physician quality reporting initiative (PQRI).

(a) *Basis and Scope.* This part implements the following provisions of the Act:

(1) 1848(a)—Payment Based on Fee Schedule.

(2) 1848(k)—Quality Reporting System.

(3) 1848(m)—Incentive Payments for Quality Reporting.

(b) *Definitions.* As used in this section, unless otherwise indicated—

Covered professional services means services for which payment is made under, or is based on, the Medicare physician fee schedule as provided under section 1848(k)(3) of the Act and which are furnished by an eligible professional.

Eligible professional (EP) means any of the following:

(i) A physician.

(ii) A practitioner described in section 1842(b)(18)(C) of the Act.

(iii) A physical or occupational therapist or a qualified speech-language pathologist.

(iv) A qualified audiologist (as defined in section 1861(ll)(3)(B) of the Act).

Group practice means a single Taxpayer Identification Number (TIN) with 2 or more eligible professionals, as identified by their individual National Provider Identifier (NPI), who have reassigned their Medicare billing rights to the TIN. This term also includes group practices participating in Medicare demonstration projects approved by the Secretary.

Maintenance of certification program means a continuous assessment program, such as qualified American Board of Medical Specialties Maintenance of Certification Program or an equivalent program (as determined by the Secretary), that advances quality and the lifelong learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills and professionalism. Such a program must include the following:

(i) The program requires the physician to maintain a valid unrestricted license in the United States.

(ii) The program requires a physician to participate in educational and self-assessment programs that require an assessment of what was learned.

(iii) The program requires a physician to demonstrate, through a formalized secure examination, that the physician

has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty.

(iv) The program requires successful completion of a qualified Maintenance of Certification Program practice assessment.

Maintenance of certification program practice assessment means an assessment of a physician's practice that—

(i) Includes an initial assessment of an eligible professional's practice that is designed to demonstrate the physician's use of evidence-based medicine;

(ii) Includes a survey of patient experience with care; and

(iii) Requires a physician to implement a quality improvement intervention to address a practice weakness identified in the initial assessment under paragraph (i) and then to remeasure to assess performance improvement after such intervention.

Measures group means a subset of four or more PQRI measures that have a particular clinical condition or focus in common. The denominator definition and coding of the measures group identifies the condition or focus that is shared across the measures within a particular measures group.

Performance rate means the percentage of a defined population who receives a particular process of care or achieve a particular outcome for a particular quality measure.

Physician quality reporting initiative (PQRI) means the physician reporting system under section 1848(k) of the Act for the reporting by eligible professionals of data on quality measures and the incentive payment associated with this physician reporting system.

Qualified electronic health record (EHR) means an EHR vendor's product and version that, with respect to a particular program year, has self-nominated and successfully completed a vetting process (as specified by CMS) to demonstrate the product's compliance with the PQRI qualification requirements specified by CMS for a program year.

Qualified registry means a medical registry or a Maintenance of Certification Program operated by a specialty body of the American Board of Medical Specialties that, with respect to a particular program year, has self-nominated and successfully completed a vetting process (as specified by CMS) to demonstrate its compliance with the PQRI qualification requirements specified by CMS for that program year. The registry may act as a data submission vendor, which has the requisite legal authority to provide PQRI data (as specified by CMS) on behalf of an eligible professional to CMS.

Quality reporting period means with respect to a year, a period specified by the Secretary.

Reporting rate means the percentage of patients that the eligible professional indicated a quality action was or was not performed divided by the total number of patients in the denominator of the measure.

(c) *Incentive payments.* With respect to covered professional services furnished during a reporting period by an eligible professional, if—

(1) There are any quality measures that have been established under the PQRI that are applicable to any such services furnished by such professional (or in the case of a group practice under paragraph (h) of this section, such group practice) for such reporting period; and

(2) The eligible professional (or in the case of a group practice under paragraph (h) of this section, the group practice) satisfactorily submits (as determined under paragraph (g) of this section for eligible professionals and paragraph (h) of this section for group practices) to the Secretary data on such quality measures in accordance with the PQRI for such reporting period, in addition to the amount otherwise paid under section 1848 of the Act, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in section 1842(b)(6)(A) of the Act or, in the case of a group practice) under paragraph (h) of this section, to the group practice, from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 an amount equal to the applicable quality percent (as specified in paragraph (c)(3) of this section) of the eligible professional's (or, in the case of a group practice under paragraph (h) of this section, the group practice's) total estimated allowed charges for all covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (h) of this section, by the group practice) during the applicable reporting period. For purposes of this paragraph,

(i) The eligible professional's (or, in the case of a group practice under paragraph (h) of this section, the group practice's) total estimated allowed charges for covered professional services furnished during a reporting period are determined based on claims processed in the National Claims History (NCH) no later than 2 months after the end of the applicable reporting period;

(ii) In the case of an eligible professional who furnishes covered professional services in more than one practice, incentive payments are separately determined for each practice based on claims submitted for the eligible professional for each practice;

(iii) Incentive payments earned by an eligible professional (or in the case of a group practice under paragraph (h) of this section, by a group practice) for a particular program year will be paid as a single consolidated payment to the TIN holder of record.

(3) *Applicable quality percent.* The applicable quality percent is as follows:

(i) For 2011, 1.0 percent; and

(ii) For 2012, 2013, and 2014, 0.5 percent;

(d) *Additional incentive payment.* (1) Through 2014, if an eligible professional meets the requirements described in paragraph (d)(2) of this section, the applicable percent for such year, as described in paragraphs (c)(3)(i) and (ii) of this section, must be increased by 0.5 percentage points.

(2) In order to qualify for the additional incentive payment described in paragraph (d)(1) of this section, an eligible professional shall meet the following requirements:

(i) The eligible professional must—

(A) Satisfactorily submit data on quality measures for purposes of this section for a year; and

(B) Have such data submitted on their behalf through a Maintenance of Certification program (as defined in paragraph (b) of this section) that meets:

(*1*) The criteria for a registry (as specified by CMS)); or

(*2*) An alternative form and manner determined appropriate by the Secretary.

(ii) The eligible professional, more frequently than is required to qualify for or maintain board certification status—

(A) Participates in such a Maintenance of Certification Program for a year; and

(B) Sucessfully completes a qualified Maintenance of Certification Program practice assessment (as defined in paragraph (b) of this section) for such year.

(iii) A Maintenance of Certification program submits to the Secretary, on behalf of the eligible professional, information —

(A) In a form and manner specified by the Secretary, that the eligible professional has successfully met the requirements of paragraph (d)(2)(ii) of this section which may be in the form of a structural measure);

(B) If requested by the Secretary, on the survey of patient experience with care (as described in paragraph (b) of this section); and

(C) As the Secretary may require, on the methods, measures, and data used

under the Maintenance of Certification Program and the qualified Maintenance of Certification Program practice assessment.

(e) *Incentive payment adjustment.* (1) With respect to covered professional services furnished by an eligible professional during 2015 or any subsequent year, if the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year (as determined under paragraph (g) for eligible professionals and paragraph (h) of this section for group practices), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) must be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under section 1848(m) of the Act.

(2) *Applicable percent.* For purposes of paragraph (1) of this section, the term 'applicable percent' means—

(i) For 2015, 98.5 percent; and

(ii) For 2016 and each subsequent year, 98 percent.

(f) *Use of consensus-based quality measures.* For each program year, CMS will publish the final list of measures and the final detailed measure specifications for all quality measures selected for inclusion in the PQRI quality measure set for a given program year on a CMS Web site by no later than December 31 of the prior year.

(1) Subject to paragraph (f)(2) of this section, for purposes of reporting data on quality measures for covered professional services furnished during a year, subject to paragraph (g) of this section, the quality measures specified under this paragraph must be such measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a) of the Act.

(2) *Exception.* In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) of the Act, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary, such as the AQA alliance.

(3) *Opportunity to provide input on measures.* For each quality measure adopted by the Secretary under this paragraph, the Secretary shall ensure that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of quality measures applicable to services they furnish.

(g) *Requirements for individual eligible professionals to qualify to receive an incentive payment.* In order to qualify to earn a PQRI incentive payment for a particular program year, an individual eligible professional, as identified by a unique TIN/NPI combination, must meet the criteria for satisfactory reporting specified by CMS for such year by reporting on either individual PQRI quality measures or PQRI measures groups identified by CMS during a reporting period specified in paragraph (g)(1) of this section and using one of the reporting mechanisms specified in paragraph (g)(2) of this section. Although an eligible professional may attempt to qualify for the PQRI incentive payment by reporting on both individual PQRI quality measures and measures groups, using more than one reporting mechanism (as specified in paragraph (g)(2) of this section), or reporting for more than one reporting period, he or she will receive only one PQRI incentive payment per TIN/NPI combination for a program year.

(1) *Reporting periods.* For purposes of this paragraph, the reporting period with respect to a program year are—

(i) The 12-month period from January 1 through December 31 of each program year; or

(ii) The 6-month period from July 1 through December 31 of each program year.

(iii) *Exceptions.* The 6-month reporting period is not available for EHR-based reporting of individual PQRI quality measures or for reporting by group practices under the process described in paragraph (h) of this section.

(2) *Reporting mechanisms.* For each program year, an eligible professional who wishes to participate in the PQRI must report information on the individual PQRI quality measures or PQRI measures groups identified by CMS in the following manner:

(i) Reporting the individual PQRI quality measures or PQRI measures groups to CMS, by no later than 2 months after the end of the applicable reporting period, on the eligible professional's Medicare Part B claims for covered professional services furnished during the applicable reporting period;

(ii) Reporting the individual PQRI quality measures or PQRI measures groups to a qualified registry (as specified in paragraph (b) of this section) in the form and manner and by the deadline specified by the qualified registry selected by the eligible professional. The selected registry will submit information, as required by CMS, for covered professional services furnished by the eligible professional during the applicable reporting period to CMS on the eligible professional's behalf; or

(iii) Reporting the individual PQRI quality measures to CMS by extracting clinical data using a secure data submission method, as required by CMS, from a qualified EHR product (as defined in paragraph (b) of this section) by the deadline specified by CMS for covered professional services furnished by the eligible professional during the applicable reporting period. Prior to actual data submission for a given program year and by a date specified by CMS, the eligible professional must submit a test file containing real or dummy clinical quality data extracted from the qualified EHR product selected by the eligible professional using a secure data submission method, as required by CMS.

(h) *Requirements for group practices to qualify to receive an incentive payment.* A group practice (as defined in paragraph (b) of this section) will be treated as satisfactorily submitting data on quality measures under PQRI for covered professional services for a reporting period (or for purposes of paragraph (e) of this section, for a quality reporting period for the year), if, in lieu of reporting PQRI measures, the group practice—

(1) Meets the participation requirements specified by CMS for the PQRI group practice reporting option (GPRO);

(2) Is selected by CMS to participate in the PQRI GPRO;

(3) Reports measures specified by CMS in the form and manner, and at a time specified by CMS; and

(4) Meets the criteria for satisfactory reporting specified by CMS.

(5) *No double payments.* Payments to a group practice under this paragraph must be in lieu of the payments that would otherwise be made under the PQRI to eligible professionals in the group practice for meeting the criteria for satisfactory reporting for individual eligible professionals.

(i) If an eligible professional, as identified by an individual NPI, has reassigned his or her Medicare billing rights to a TIN selected to participate in the PQRI GPRO for a program year, then for that program year the eligible professional must participate in the PQRI via the GPRO. For any program year in which the TIN is selected to

participate in the PQRI GPRO, the eligible professional cannot individually qualify for a PQRI incentive payment by meeting the requirements specified in paragraph (g) of this section.

(ii) If, for the program year, the eligible professional participates in the PQRI under another TIN that is not selected to participate in the PQRI GPRO for that program year, then the eligible professional may individually qualify for a PQRI incentive by meeting the requirements specified in paragraph (g) of this section under that TIN.

(i) *Limitations on review.* (1) Except as specified in paragraph (h)(2) of this section, there is no administrative or judicial review under section 1869, section 1879, or otherwise of—

(i) The determination of measures applicable to services furnished by eligible professionals under PQRI;

(ii) The determination of the payment limitation; and

(iii) The determination of any PQRI incentive payment and the PQRI payment adjustment.

(j) *Informal review.* Except as specified in paragraph (i) of this section eligible professionals (or in the case of reporting under paragraph (h) of this section, group practices) may seek a review of the determination that an eligible professional (or in the case of reporting under paragraph (h) of this section, group practices) did not satisfactorily submit data on quality measures under the PQRI.

(1) To request an informal review, an eligible professional (or in the case of reporting under paragraph (h) of this section, group practices) must submit a written request to CMS within 90 days of the release of the feedback reports. The request must summarize the concern(s) and reasons for requesting an informal review and may also include information to assist in the review.

(2) CMS will provide a written response within 60 days of the receipt of the original request. All decisions based on the informal review will be final. There will be no further review or appeal.

(k) *Public reporting of an eligible professional's or group practice's PQRI data.* For each program year, CMS will post on a public Web site, in an easily understandable format, a list of the names of eligible professionals (or in the case of reporting under paragraph (h), group practices) who satisfactorily submitted PQRI quality measures.

30. A new § 414.92 is added to subpart B to read as follows:

§ 414.92 Electronic prescribing incentive program.

(a) *Basis and scope.* This part implements the following provisions of the Act:

(1) Section 1848(a)—Payment Based on Fee Schedule.

(2) Section 1848(m)—Incentive Payments for Quality Reporting.

(b) *Definitions.* As used in the part, unless otherwise indicated—

Covered professional services means services for which payment is made under, or is based on, the Medicare physician fee schedule as provided under section 1848(k)(3) of the Act and which are furnished by an eligible professional.

Electronic prescribing (eRx) incentive program means the incentive payment program established under section 1848(m) of the Act for the adoption and use of electronic prescribing technology by eligible professionals.

Eligible professional means any of the following healthcare professionals who have prescribing authority:

(i) A physician.

(ii) A practitioner described in section 1842(b)(18)(C) of the Act.

(iii) A physical or occupational therapist or a qualified speech-language pathologist.

(iv) A qualified audiologist (as defined in section 1861(ll)(3)(B) of the Act).

Group practice means a group practice, as defined at § 414.90(b), that—

(i) Is or is deemed to be participating in the Physician Quality Reporting Initiative (PQRI) group practice reporting option (GPRO) under § 414.90; and

(ii) Has indicated its desire to participate in the eRx GPRO.

Qualified electronic health record (EHR) means an EHR product and version that, with respect to a particular program year, is designated by CMS as a qualified EHR for the purpose of the PQRI (as described in § 414.90) and the product's vendor has indicated a desire to have the product qualified for purposes of the product's users to submit information related to the eRx measure.

Qualified registry means a medical registry or a Maintenance of Certification Program operated by a specialty body of the American Board of Medical Specialties that, with respect to a particular program year, is designated by CMS as a qualified registry for the purpose of the PQRI (as described in § 414.90) and that has indicated its desire to be qualified to submit the eRx measure on behalf of eligible professionals for the purposes of the eRx Incentive Program.

(c) *Incentive payments.* (1) Subject to paragraph (c)(3) of this section, with respect to covered professional services furnished during a reporting period by an eligible professional, if the eligible professional is a successful electronic prescriber for such reporting period, in addition to the amount otherwise paid under section 1848 of the Act, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in paragraph (A) of section 1842(b)(6)) or, in the case of a group practice under paragraph (e) of this section, to the group practice, from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Act an amount equal to the applicable eRx percent (as specified in paragraph (c)(1)(ii) of this section) of the eligible professional's (or, in the case of a group practice under paragraph (e) of this section, the group practice's) total estimated allowed charges for all covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (e) of this section, by the group practice) during the applicable reporting period.

(i) For purposes of this paragraph,

(A) The eligible professional's (or, in the case of a group practice under paragraph (e) of this section, the group practice's) total estimated allowed charges for covered professional services furnished during a reporting period are determined based on claims processed in the National Claims History (NCH) no later than 2 months after the end of the applicable reporting period;

(B) In the case of an eligible professional who furnishes covered professional services in more than one practice, incentive payments are separately determined for each practice based on claims submitted for the eligible professional for each practice;

(C) Incentive payments earned by an eligible professional (or in the case of a group practice under paragraph (e) of this section, by a group practice) for a particular program year will be paid as a single consolidated payment to the TIN holder of record.

(ii) *Applicable eRx percent.* The applicable eRx percent is as follows:

(A) For the 2011 and 2012 program years, 1.0 percent; and

(B) For the 2013 program year, 0.5 percent.

(iii) *Limitation with respect to electronic health record (EHR) incentive payments.* The provisions of this paragraph do not apply to an eligible professional (or, in the case of a group practice under paragraph (e) of this section, a group practice) if, for the EHR

reporting period the eligible professional (or group practice) receives an incentive payment under section 1848(o)(1)(A) of the Act with respect to a certified EHR technology (as defined in section 1848(o)(4) of the Act) that has the capability of eRx.

(2) *Incentive payment adjustment.* Subject to paragraph (c)(1)(ii) and paragraph (c)(3) of this section, with respect to covered professional services furnished by an eligible professional during 2012, 2013, or 2014, if the eligible professional (or in the case of a group practice under paragraph (e) of this section, the group practice) is not a successful electronic prescriber (as specified by CMS for purposes of the payment adjustment) for an applicable reporting period (as specified by CMS) the fee schedule amount for such services furnished by such professional (or group practice) during the program year (including the fee schedule amount for purposes of determining a payment based on such amount) is equal to the applicable percent (as specified in paragraph (c)(2)(i) of this section) of the fee schedule amount that would otherwise apply to such services under section 1848 of the Act.

(i) *Applicable percent.* The applicable percent is as follows:

(A) For 2012, 99 percent;

(B) For 2013, 98.5 percent; and

(C) For 2014, 98 percent.

(ii) *Significant hardship exception.* An eligible professional (or in the case of a group practice under paragraph (e) of this section, a group practice) may be exempt from the application of the payment adjustment under this paragraph if, subject to annual renewal, CMS determines that compliance with the requirement for being a successful electronic prescriber (as specified by CMS for purposes of the payment adjustment) would result in a significant hardship. For purposes of this paragraph, any of the following circumstances constitute a "significant hardship:"

(A) An eligible professional (or group practice) who practices in a rural area with limited high speed Internet access.

(B) An eligible professional (or group practice) who practices in an area with limited available pharmacies for electronic prescribing.

(C) Other circumstances identified by CMS.

(3) *Limitation with respect to electronic prescribing quality measures.* The provisions of paragraphs (c)(1) and (c)(2) of this section do not apply to an eligible professional (or, in the case of a group practice under paragraph (e) of this section, a group practice) if for the reporting period the allowed charges under section 1848 of the Act for all covered professional services furnished by the eligible professional (or group, as applicable) for the codes to which the electronic prescribing measure (as identified by CMS) applies are less than 10 percent of the total of the allowed charges under section 1848 of the Act for all such covered professional services furnished by the eligible professional (or the group practice, as applicable).

(d) *Requirements for individual eligible professionals to qualify to receive an incentive payment.* In order to be considered a successful electronic prescriber and qualify to earn an eRx an incentive payment (subject to paragraph (c)(3) of this section), an individual eligible professional, as identified by a unique TIN/NPI combination, must meet the criteria for successful electronic prescriber specified by CMS during the reporting period specified in paragraph (d)(1) of this section and using one of the reporting mechanisms specified in paragraph (d)(2) of this section. Although an eligible professional may attempt to qualify for the eRx incentive payment using more than one reporting mechanism (as specified in paragraph (d)(2) of this section), he or she will receive only one eRx incentive payment per TIN/NPI combination for a program year.

(1) *Reporting period.* For purposes of this paragraph, the reporting period with respect to a program year is the entire calendar year.

(2) *Reporting mechanisms.* An eligible professional who wishes to participate in the eRx Incentive Program must report information on the eRx measure identified by CMS to—

(i) CMS, by no later than 2 months after the end of the applicable reporting period, on the eligible professional's Medicare Part B claims for covered professional services furnished by the eligible professional during the reporting period specified in paragraph (d)(1) of this section;

(ii) A qualified registry (as defined in paragraph (b)) in the form and manner and by the deadline specified by the qualified registry selected by the eligible professional. The selected registry will submit information, as required by CMS, for covered professional services furnished by the eligible professional during the reporting period specified in paragraph (d)(1) of this section to CMS on the eligible professional's behalf; or

(iii) CMS by extracting clinical data using a secure data submission method, as required by CMS, from a qualified EHR product (as defined in paragraph (b) of this section) by the deadline specified by CMS for covered professional services furnished by the eligible professional during the reporting period specified in paragraph (d)(1) of this section. Prior to actual data submission for a given program year and by a date specified by CMS, the eligible professional must submit a test file containing real or dummy clinical quality data extracted from the qualified EHR product selected by the eligible professional using a secure data submission method, as required by CMS.

(e) *Requirements for group practices to qualify to receive an incentive payment.*

(1) A group practice (as defined in paragraph (b) of this section) will be treated as a successful electronic prescriber for covered professional services for a reporting period if the group practice meets the criteria for successful electronic prescriber specified by CMS in the form and manner and at the time specified by CMS.

(2) *No double payments.* Payments to a group practice under this paragraph must be in lieu of the payments that would otherwise be made under the eRx Incentive Program to eligible professionals in the group practice for being a successful electronic prescriber.

(i) If an eligible professional, as identified by an individual NPI, has reassigned his or her Medicare billing rights to a TIN selected to participate in the eRx GPRO for a program year, then for that program year the eligible professional must participate in the eRx Incentive Program via the GPRO. For any program year in which the TIN is selected to participate in the eRx Incentive Program GPRO, the eligible professional cannot individually qualify for an eRx incentive payment by meeting the requirements specified in paragraph (d) of this section.

(ii) If, for the program year, the eligible professional participates in the eRx Incentive Program under another TIN that is not selected to participate in the eRx Incentive Program GPRO for that program year, then the eligible professional may individually qualify for an eRx incentive by meeting the requirements specified in paragraph (d) of this section under that TIN.

(f) *Public reporting of an eligible professional's or group practice's erx incentive program data.* For each program year, CMS will post on a public Web site, in an easily understandable format, a list of the names of eligible professionals (or in the case of reporting under paragraph (e) of this section, group practices) who are successful electronic prescribers.

Subpart D—Payment for Durable Medical Equipment and Prosthetic and Orthotic Devices

31. Section 414.202 is amended by adding a definition of "complex rehabilitative power-driven wheelchair" in alphabetical order to read as follows:

§ 414.202 Definitions.

* * * * *

Complex rehabilitative power-driven wheelchair means a power-driven wheelchair that is classified as—

(1) Group 2 power wheelchair with power options that can accommodate rehabilitative features (for example, tilt in space); or

(2) Group 3 power wheelchair.

* * * * *

32. Section 414.226 is amended by revising paragraph (g)(1) to read as follows:

§ 414.226 Oxygen and oxygen equipment.

* * * * *

(g) * * *

(1) The supplier that furnishes oxygen equipment for the first month during which payment is made under this section must continue to furnish the equipment until medical necessity ends, or the 36-month period of continuous use ends, whichever is earlier, unless—

(i) The item becomes subject to a competitive acquisition program implemented in accordance with section 1847(a) of the Act;

(ii) Before the 18th month of continuous use, the beneficiary relocates to an area that is outside the normal service area of the supplier that initially furnished the equipment;

(iii) The beneficiary elects to obtain oxygen equipment from a different supplier prior to the expiration of the 36-month rental period; or

(iv) CMS or the carrier determines that an exception should apply in an individual case based on the circumstances.

* * * * *

33. Section 414.229 is amended by—

A. Revising paragraphs (a)(3), (d)(1), and (h).

B. Adding paragraphs (a)(4), (a)(5), and (b)(3).

The revisions and additions read as follows:

§ 414.229 Other durable medical equipment-capped rental items.

(a) * * *

(3) For power-driven wheelchairs furnished on or after January 1, 2006 through December 31, 2010, payment is made in accordance with the rules set forth in paragraphs (f) or (h) of this section.

(4) For power-driven wheelchairs that are not classified as complex rehabilitative power-driven wheelchairs, furnished on or after January 1, 2011, payment is made in accordance with the rules set forth in paragraph (f) of this section.

(5) For power-driven wheelchairs classified as complex rehabilitative power-driven wheelchairs, furnished on or after January 1, 2011, payment is made in accordance with the rules set forth in paragraphs (f) or (h) of this section.

(b) * * *

(3) For power-driven wheelchairs furnished on or after January 1, 2011, the monthly fee schedule amount for rental equipment equals 15 percent of the purchase price recognized as determined under paragraph (c) of this section for each of the first 3 months and 6 percent of the purchase price for each of the remaining months.

* * * * *

(d) * * *

(1) Suppliers must offer beneficiaries the option of purchasing power-driven wheelchairs at the time the supplier first furnishes the item. On or after January 1, 2011, this option is available only for complex rehabilitative power-driven wheelchairs. Payment must be on a lump-sum fee schedule purchase basis if the beneficiary chooses the purchase option. The purchase fee is the amount established in paragraph (c) of this section.

* * * * *

(h) *Purchase of power-driven wheelchairs furnished on or after January 1, 2006.*

(1) Suppliers must offer beneficiaries the option to purchase power-driven wheelchairs at the time the equipment is initially furnished.

(2) Payment is made on a lump-sum purchase basis if the beneficiary chooses this option.

(3) On or after January 1, 2011, this option is available only for complex rehabilitative power-driven wheelchairs.

Subpart F—Competitive Bidding for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

34. Section 414.402 is amended by adding the definitions of "Affected party," "Breach of contract," "Corrective Action Plan," "Hearing Officer," "Mail order item," "National mail order competitive bidding program," "Nonmail order item" and "Parties to the hearing" in alphabetical order to read as follows:

§ 414.402 Definitions.

Affected party means a contract supplier that has been notified that their DMEPOS CBP contract will be terminated for a breach of contract.

* * * * *

Breach of contract means any deviation from contract requirements, including a failure to comply with a governmental agency or licensing organization requirements, constitutes a breach of contract.

* * * * *

Corrective action plan (CAP) means a contract supplier's written document with supporting information that describes the actions the contract supplier will take within a specified timeframe to remedy a breach of contract.

* * * * *

Hearing Officer (HO) means an individual, who was not involved with the CBIC recommendation to terminate a DMEPOS Competitive Bidding Program contract, who is designated by CMS to review and make an unbiased and independent determination following the Competitive Bidding Implementation Contractor's (CBIC's) recommendation to terminate a DMEPOS Competitive Bidding Program contract.

* * * * *

Mail order item means any item (for example, diabetic testing supplies) shipped or delivered to the beneficiary's home, regardless of the method of delivery.

* * * * *

National mail order competitive bidding program means a program and competition resulting in the award of contracts to suppliers for furnishing mail order items throughout the nation.

* * * * *

Nonmail order item means any item (for example, diabetic testing supplies) that a beneficiary or caregiver picks up in person at a local pharmacy or supplier storefront.

Parties to the hearing means the DMEPOS contract supplier and CMS.

* * * * *

35. Section 414.404 is amended by revising paragraph (b)(1)(i) to read as follows:

§ 414.404 Scope and applicability.

* * * * *

(b) * * *

(1) * * *

(i) The items furnished are limited to crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps that are DME, and,

in addition, off-the-shelf (OTS) orthotics.

* * * * *

36. Section 414.408 is amended by-–

A. Revising paragraph (f)(1).

B. Redesignating paragraphs (h)(2) through (h)(7) as paragraphs (h)(3) through (h)(8) respectively.

C. Adding new paragraph (h)(2).

D. In newly designated paragraphs (h)(3)(i) and (ii), remove the phrase "(h)(2)" and add in its place the phrase "(h)(3)."

The revision and addition reads as follows:

§ 414.408 Payment rules.

* * * * *

(f) * * *

(1) The single payment amounts for new purchased durable medical equipment, including power wheelchairs that are purchased when the equipment is initially furnished, and enteral nutrition equipment are calculated based on the bids submitted and accepted for these items. For contracts entered into beginning on or after January 1, 2011, payment on a lump sum purchase basis is only available for power wheelchairs classified as complex rehabilitative power wheelchairs.

* * * * *

(h) * * *

(2) For contracts entered into beginning on or after January 1, 2011, the monthly fee schedule amount for rental of power wheelchairs equals 15 percent of the single payment amounts calculated for new durable medical equipment under paragraph (f)(1) of this section for each of the first 3 months, and 6 percent of the single payment amounts calculated for these items for each of the remaining months 4 through 13.

* * * * *

37. Section 414.410 is amended as follows:

A. Revising paragraphs (a)(2) and (a)(3).

B. Adding a new paragraph (a)(4).

The revisions and addition read as follows:

§ 414.410 Phase-in implementation of competitive bidding programs.

(a) * * *

(2) In CY 2011, in an additional 91 MSAs (the additional 70 MSAs selected by CMS as of June 1, 2008, and the next 21 largest MSAs by total population based on 2009 population estimates, and not already phased in as of June 1, 2008). CMS may subdivide any of the 91 MSAs with a population of greater than 8,000,000 into separate CBAs, thereby resulting in more than 91 CBAs.

(3) After CY 2011, additional CBAs (or, in the case of national mail order for items and services, after CY 2010).

(4) For competitions (other than for national mail order items and services) after CY 2011 and prior to CY 2015, the following areas are excluded:

(i) Rural areas.

(ii) MSAs not selected under paragraphs (a)(1) or (a)(2) of this section with a population of less than 250,000.

(iii) An area with low population density within an MSA not selected under paragraphs (a)(1) or (a)(2) of this section.

* * * * *

38. Section 414.411 is added to read as follows:

§ 414.411 Special rule in case of competitions for diabetic testing strips conducted on or after January 1, 2011.

(a) *National mail order competitions.* A supplier must demonstrate that their bid submitted as part of a national mail order competition for diabetic testing strips covers the furnishing of a sufficient number of different types of diabetic testing strip products that, in the aggregate, and taking into account volume for the different products, includes at least 50 percent of all the different types of products on the market. A type of diabetic testing strip means a specific brand and model of testing strips.

(b) *Other competitions.* CMS may apply this special rule to non-mail order or local competitions for diabetic testing strips.

39. Section 414.422 is amended by adding paragraph (e)(3) to read as follows:

§ 414.422 Term of contracts.

* * * * *

(e) * * *

(3) Contract suppliers for diabetic testing supplies must furnish the brand of diabetic testing supplies that works with the home blood glucose monitor selected by the beneficiary. The contract supplier is prohibited from influencing or incentivizing the beneficiary by persuading, pressuring, or advising them to switch from their current brand or for new beneficiaries from their preferred brand of glucose monitor and testing supplies. The contract supplier may not furnish information about alternative brands to the beneficiary unless the beneficiary requests such information.

* * * * *

40. Section 414.423 is added to read as follows:

§ 414.423 Appeals process for termination of competitive bidding contract.

This section implements an appeals process for suppliers that CMS has determined are in breach of their Medicare DMEPOS Competitive Bidding Program contracts and where CMS has taken action to terminate the supplier's contract. Except as specified in this regulation termination decisions made under this section are final and binding.

(a) *Terminations for breach of contract.* CMS may terminate a supplier's DMEPOS Competitive Bidding Program contract when it determines that the supplier has violated any of the terms of its contract.

(b) *Notice of termination*—(1) *CMS notification.* If CMS determines a supplier to be in breach of its contract either in part or in whole, it will notify the Medicare DMEPOS supplier of the termination by certified mail.

(2) *Content of the notice.* The CMS notice sent by the CBIC will include the following:

(i) The reasons for the termination.

(ii) The right to request a hearing by a CBIC Hearing Officer, and depending on the nature of the breach, the supplier may also be allowed to submit a CAP in lieu of requesting a hearing by a CBIC Hearing Officer, as specified in paragraph (c)(1)(i) of this section.

(iii) The address to which the written request for a hearing must be mailed.

(iv) The address to which the CAP must be mailed, if applicable.

(v) Penalties that will accompany the termination, such as not being eligible to bid in future rounds of competitive bidding.

(vi) The effective date of termination is 45 days from the date of the notification letter unless a timely hearing request has been filed or a Corrective Action Plan (CAP) has been submitted within 30 days of the date on the notification letter.

(c) *Corrective Action Plan.*

(1) *Option for Corrective Action Plan (CAP).*

(i) CMS has the option to allow a DMEPOS supplier to provide a written Corrective Action Plan (CAP) to remedy the deficiencies identified in the notice, when CMS determines that the delay in the termination date caused by allowing a CAP will not cause harm to beneficiaries, for example, we would not allow a CAP if the supplier has been excluded, debarred, or convicted of a healthcare related crime.

(ii) If a supplier chooses not to submit a CAP or if CMS determines that a supplier's CAP is insufficient, the supplier may request a hearing on the termination.

(2) *Submission of a CAP.*

(i) A Corrective Action Plan must be submitted within 30 calendar days from the date on the notification letter. If the supplier decides not to submit a Corrective Action Plan the supplier may within 30 days of the date on the termination letter may request a hearing by a CBIC hearing officer.

(ii) Suppliers will only have the opportunity to submit a CAP when they are first notified that they have been determined to be in breach of contract. If the CAP is not acceptable or properly implemented, suppliers will receive a termination notice.

(d) *The purpose of the Corrective Action Plan.*

(1) For the supplier to eliminate all of the deficiencies that were identified in the CBIC notice to terminate its contract to avoid contract termination.

(2) To identify the timeframes by which the supplier will implement each of the components of the CAP.

(e) *Review of the CAP.*

(1) The CBIC will review the CAP and submit a recommendation to CMS concerning whether the CAP includes the steps necessary to remedy the contract deficiencies as identified in the notice.

(2) If CMS accepts the CAP, including supplier's designated timeframe for its completion; the supplier must provide a follow-up report within 5 days after the supplier has fully implemented the CAP that verifies that all of the deficiencies identified in the CAP have been corrected in accordance with the timeframes accepted by CMS.

(3) If the supplier does not implement an acceptable CAP the supplier will receive a new notice that their contract will be terminated within 45 calendar days of the date on the notice to terminate.

(f) *Right to request a hearing by the CBIC hearing officer (HO).*

(1) A supplier who has received a notice that CMS considers the supplier in breach of contract or that the supplier's CAP is not acceptable has the right to request a hearing before a HO who was not involved with the original determination.

(2) A supplier who wishes to appeal the termination notice must submit a written request to the CBIC. The request for a hearing must be received by the CBIC within 30 calendar days from the date of the notice to terminate.

(3) A request for hearing must be in writing and submitted by an authorized official of the supplier.

(4) The appeals process for the Medicare DMEPOS Competitive Bidding Program is not to be used in place of other existing appeals processes that apply to other parts of Medicare.

(5) In the absence of submitting a CAP when the supplier is offered the opportunity to submit a CAP within 30 days of the notice in accordance with paragraph (c)(1) of this section, a supplier's failure to timely request a hearing will result in a termination of the supplier's DMEPOS Competitive Bidding Program contract effective 45 days from the date on the notice to terminate.

(g) *The CBIC Hearing Officer schedules and conducts the hearing.*

(1) Within 30 calendar days from the receipt of the supplier's timely request for a hearing the hearing officer will contact the parties to schedule the hearing.

(2) The hearing may be held in person or by telephone at the supplier's request.

(3) The scheduling notice to the parties must indicate the time and place for the hearing and must be sent to the supplier 30 days before the date of the hearing.

(4) The HO may, on his or her own motion, or at the request of a party, change the time and place for the hearing, but must give the parties to the hearing 30 day notice of the change.

(5) The HO's scheduling notice must provide the parties to the hearing and the CBIC the following information:

(i) Description of the hearing procedure.

(ii) The general and specific issues to be resolved.

(iii) The supplier has the burden to prove it is not in violation of the contract.

(iv) The opportunity for parties to the hearing to submit evidence to support their positions.

(v) All evidence submitted, both from the supplier and CMS, in preparation for the hearing with all affected parties within 15 days prior to the scheduled dated of the hearing.

(h) *Burden of proof.*

(1) The burden of proof is on the Competitive Bidding Program contract supplier to demonstrate to the HO with convincing evidence that it has not breached its contract or that termination is not appropriate.

(2) The supplier's supporting evidence must be submitted with its request for a hearing.

(3) If the Medicare DMEPOS supplier fails to submit this evidence at the time of its submission, the Medicare DMEPOS supplier is precluded from introducing new evidence later during the hearing process, unless permitted by the hearing officer.

(4) The CBIC and CMS also have the opportunity to submit evidence to the HO within 10 days of receiving a notice announcing the hearing.

(5) The HO will share all evidence submitted, both from the supplier and/or CMS, in preparation for the hearing with all affected parties within 15 days prior to the scheduled date of the hearing.

(i) *Role of the Hearing Officer.* The HO will conduct a thorough and independent review of the evidence including the information and documentation submitted for the hearing and other information that the HO considers pertinent for the hearing. The role of the HO includes, at a minimum, the following:

(1) Conducts the hearing and decides the order in which the evidence and the arguments of the parties are presented;

(2) Determine the rules on admissibility of the evidence;

(3) Examines the witnesses, in addition to the examinations conducted by CMS, CBIC and the contract supplier;

(4) The CBIC may assist CMS in the appeals process including being present at the hearing, testifying as a witness, or performing other, related ministerial duties.

(5) Determines the rules for requesting documents and other evidence from other parties;

(6) Ensures a complete record of the hearing is made available to all parties to the hearing;

(7) Prepares a file of the record of the hearing which includes all evidence submitted as well as any relevant documents identified by the HO and considered as part of the hearing; and

(8) Complies with all applicable provisions of 42 U.S.C. Title 18 and related provisions of the Act, the applicable regulations issued by the Secretary, and manual instructions issued by CMS.

(j) *Hearing Officer recommendation.*

(1) The HO will issue a written recommendation to CMS within 30 days of the close of the hearing or as soon as practical after the hearing.

(2) The recommendation will explain the basis and the rationale for the HO's recommendation.

(3) The hearing officer must include the record of the hearing, along with evidence and documents produced during the hearing along with its recommendation.

(k) *CMS' consideration of a HO's recommendation.*

(1) CMS' review of the HO recommendation will not allow the supplier to submit new information.

(2) After reviewing the HO recommendation, CMS' decision will be made within 30 days from the date of receipt of the HO's recommendation.

(3) A CMS decision to terminate will indicate the effective date of the termination.

(4) This decision is final and binding.

(l) *Effect of contract termination.*

(1) A contract supplier whose contract has been terminated may no longer furnish competitive bid items to beneficiaries within a CBA and be reimbursed by Medicare for these items after the effective date of the termination.

(2) A contract supplier whose contract has been terminated must notify all beneficiaries who are receiving rented competitive bid items or competitive bid items received on a recurring basis, of the termination of their contract. The notice to the beneficiary from the supplier whose contract was terminated must be provided within 5 days of receipt of the final notice of termination. The notification to the beneficiaries must inform the beneficiaries that they are going to have to select a new contract supplier to furnish these items in order for Medicare to pay these items.

(m) *Effective date of the contract termination.*

(1) A supplier's DMEPOS CBP contract is terminated effective on the termination date specified in the CBIC notice to the supplier, unless the supplier timely requests a hearing with the HO or the supplier has submitted a CAP under paragraph (x) of this section.

(2) If a supplier requests an HO review of the CMS decision to terminate its contract, and CMS based upon on the HO recommendation terminates the supplier's contract, the effective date of the termination will be the date specified in the CBIC notice to the supplier.

(3) For violations of the terms of the supplier's DMEPOS CBP contract that may harm beneficiaries, such as a supplier providing an inferior product that causes harm to the beneficiary, no delays of the effective date of the termination will be allowed.

Subpart H–Fee Schedule for Ambulance Services

39. Section 414.610 is amended by revising paragraphs (c)(1)(i), (c)(5)(ii), (f), and (h) to read as follows:

§ 414.610 Basis of payments.

* * * * *

(c) * * *

(1) *Ground ambulance service levels.*

(i) The CF is multiplied by the applicable RVUs for each level of service to produce a service-level base rate. For services furnished during the period July 1, 2004 through December 31, 2006, ambulance services originating in urban areas (both base rate and mileage) are paid based on a rate that is one percent higher than otherwise is applicable under this section, and ambulance services originating in rural areas (both base rate and mileage) are paid based on a rate that is two percent higher than otherwise is applicable under this section. For services furnished during the period July 1, 2008 through December 21, 2010, ambulance services originating in urban areas (both base rate and mileage) are paid based on a rate that is two percent higher than otherwise is applicable under this section, and ambulance services originating in rural areas (both base rate and mileage) are paid based on a rate that is three percent higher than otherwise is applicable under this section.

* * * * *

(5) * * *

(ii) For services furnished during the period July 1, 2004 through December 31, 2010, the payment amount for the ground ambulance base rate is increased by 22.6 percent where the point of pickup is in a rural area determined to be in the lowest 25 percent of rural population arrayed by population density. The amount of this increase is based on CMS's estimate of the ratio of the average cost per trip for the rural areas in the lowest quartile of population compared to the average cost per trip for the rural areas in the highest quartile of population. In making this estimate, CMS may use data provided by the GAO.

* * * * *

(f) *Updates.* The CF, the air ambulance base rates, and the mileage rates are updated annually by an inflation factor established by law. The inflation factor is based on the consumer price index for all urban consumers (CPI–U) (U.S. city average) for the 12-month period ending with June of the previous year and, as of January 1, 2011, is reduced by the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (MFP) (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period.)

* * * * *

(h) *Treatment of certain areas for payment for air ambulance services.* Any area that was designated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished on December 31, 2006, must be treated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished during the period July 1, 2008 through December 31, 2010.

40. Section 414.620 is revised to read as follows:

§ 414.620 Publication of the ambulance fee schedule.

(a) Changes in payment rates resulting from incorporation of the annual inflation factor and the multi-factor productivity adjustment as described in § 414.610(f) will be announced by CMS by instruction and on the CMS Web site.

(b) CMS will follow applicable rulemaking procedures in publishing revisions to the fee schedule for ambulance services that result from any factors other than those described in § 414.610(f).

Subpart J—Submission of Manufacturer's Average Sales Price Data

41. Section 414.804 is amended by—

A. Redesignating paragraph (a)(6) as (a)(7).

B. Adding new paragraph (a)(6).

The addition reads as follows:

§ 414.804 Basis of payment.

(a) * * *

(6) The manufacturer's average sales price must be calculated based on the amount of product in a vial or other container as conspicuously reflected on the FDA approved label as defined by section 201(k) of the Food, Drug, and Cosmetic Act.

* * * * *

Subpart K—Payment for Drugs and Biologicals Under Part B

42. Section 414.902 is amended by adding the definitions of "Biosimilar biological product" and "Reference biological product" in alphabetical order to read as follows:

§ 414.902 Definitions.

* * * * *

Biosimilar biological product means a biological product approved under an abbreviated application for a license of a biological product that relies in part on data or information in an application for another biological product licensed under section 351 of the Public Health Service Act (PHSA) as defined at section 1847A(c)(6)(H) of the Act.

* * * * *

Reference biological product means the biological product licensed under such section 351 of the PHSA that is referred to in the application of the biosimilar biological product as defined at section 1847A(c)(6)(I) of the Act.

* * * * *

43. Section 414.904 is amended by—

A. Adding paragraphs (a)(3), (i), and (j).

B. Revising paragraph (d)(3).

The revisions and additions read as follows:

§ 414.904 Average sales price as the basis for payment.

(a) * * *

(3) For purposes of this section—

(i) CMS calculates an average sales price payment limit based on the amount of product included in a vial or other container as reflected on the FDA-approved label.

(ii) Additional product contained in the vial or other container does not represent a cost to providers and is not incorporated into the ASP payment limit.

(iii) No payment shall be made for amounts of product in excess of that reflected on the FDA-approved label.

* * * * *

(d) * * *

(3) *Widely available market price and average manufacturer price.* If the Inspector General finds that the average sales price exceeds the widely available market price or the average manufacturer price by the applicable threshold percentage specified in paragraph (d)(3)(iii) of this section, the Inspector General is responsible for informing the Secretary (at such times as specified by the Secretary) and the payment amount for the drug or biological will be substituted by the lesser of the widely available market price or 103 percent of the average manufacturer price as subject to the following adjustments:

(i) The payment amount substitution will be applied at the next ASP payment amount calculation period after the Inspector General informs the Secretary (at such times specified by the Secretary) about drugs or biologicals that have exceeded the applicable threshold percentage, and will remain in effect for one quarter after publication.

(ii) Payment at 103 percent of the average manufacturer price for a billing code will be applied at such times when:

(A) The threshold for making price substitutions, as defined in section (iii) is met; and,

(B) When 103 percent of the AMP is less than the 106 percent of the ASP during the quarter in which the average manufacturer price would be applied.

(iii) The applicable threshold for AMP comparisons for calendar years 2005, 2006, 2007, 2008, 2009, 2010, is 5 percent. For CY 2011, the threshold for ASP comparisons is reached when:

(A) The ASP for the billing code has exceeded the AMP for the billing code by 5 percent or more in two consecutive quarters, or three of the last four quarters; immediately preceding the quarter to which the price substitution recommendation would apply; and,

(B) The average manufacturer price for the billing code is calculated using the same set of NDCs used for the average sales price calculation as per this section for the billing code;

(iv) The applicable threshold for WAMP comparisons for calendar years 2005 through 2011 is 5 percent.

(v) No payment amount substitutions will occur before the preliminary injunction issued on December 19, 2007, by the United States District of Columbia in *National Association of Chain Drug Stores et al.* v. *Health and Human Services,* Civil Action No. 1:07–cv–02017 (RCL), is vacated.

* * * * *

(i) If manufacturer ASP data is not available prior to the publication deadline for quarterly payment limits, the payment limit is calculated by carrying over the most recent available manufacturer ASP price from a previous quarter for an NDC, adjusted by the weighted average of the change in the manufacturer ASPs for the NDCs that were reported during both the most recently available quarter and the current quarter.

(j) *Biosimilar biological products.* Effective July 1, 2010, the payment amount for a biosimilar biological drug product (as defined in § 414.902 of this subpart) is the sum of the average sales price of all NDCs assigned to the biosimilar biological product as determined under section 1847A(b)(6) of the Act and 6 percent of the amount determined under section 1847A(b)(4) of the Act for the reference drug product (as defined in § 414.902 of this subpart).

PART 415—SERVICES FURNISHED BY PHYSICIANS IN PROVIDERS, SUPERVISING PHYSICIANS IN TEACHING SETTINGS, AND RESIDENTS IN CERTAIN SETTINGS

44. The authority citation for part 415 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart C—Part B Carrier Payments for Physician Services to Beneficiaries in Providers

45. Section 415.130 is amended by revising paragraph (d) to read as follows:

§ 415.130 Conditions for payment: Physician pathology services.

* * * * *

(d) *Physician pathology services furnished by an independent laboratory.*

(1) The technical component of physician pathology services furnished by an independent laboratory to a hospital inpatient or outpatient on or before December 31, 2010, may be paid to the laboratory by the contractor under the physician fee schedule if the Medicare beneficiary is a patient of a covered hospital as defined in paragraph (a)(1) of this section.

(2) For services furnished after December 31, 2010, an independent laboratory may not bill the Medicare contractor for the technical component of physician pathology services furnished to a hospital inpatient or outpatient.

(3) For services furnished on or after January 1, 2008, the date of service policy in § 414.510 of this chapter applies to the TC of specimens for physician pathology services.

PART 424—CONDITIONS FOR MEDICARE PAYMENT

46. The authority citation for part 424 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart B—Certification and Plan of Treatment Requirements

47. Section 424.20 is amended by revising paragraph (e)(2) to read as follows:

§ 424.20 Requirements for posthospital SNF care.

* * * * *

(e) * * *

(2) A physician extender (that is, a nurse practitioner, a clinical nurse specialist, or a physician assistant as those terms are defined in section 1861(aa)(5) of the Act) who does not have a direct or indirect employment relationship with the facility but who is working in collaboration with a physician. For purposes of this section—

(i) *Collaboration.*

(A) Collaboration means a process whereby a physician extender works with a doctor of medicine or osteopathy to deliver health care services.

(B) The services are delivered within the scope of the physician extender's professional expertise, with medical direction and appropriate supervision as provided for in guidelines jointly developed by the physician extender and the physician or other mechanisms defined by Federal regulations and the law of the State in which the services are performed.

(ii) *Types of employment relationships.*

(A) *Direct employment relationship.* A direct employment relationship with the facility is one in which the physician extender meets the common law definition of the facility's "employee," as specified in 20 CFR 404.1005, 404.1007, and 404.1009. When a physician extender meets this definition with respect to an entity other than the facility itself, and that entity has an agreement with the facility for the provision of nursing services under § 409.21 of this subchapter, the facility is considered to have an indirect employment relationship with the physician extender.

(B) *Indirect employment relationship.* (*1*) When a physician extender meets the definition of a direct employment relationship in paragraph (e)(2)(ii)(A) of this section with respect to an entity other than the facility itself, and that entity has an agreement with the facility for the provision of nursing services under § 409.21 of this subchapter, the facility is considered to have an indirect employment relationship with the physician extender.

(*2*) An indirect employment relationship does not exist if the agreement between the entity and the facility involves only the performance of delegated physician tasks under § 483.40(e) of this chapter.

* * * * *

Subpart C—Claims for Payment

48. Section 424.44 is amended by revising paragraphs (a), (b), and (e) to read as follows:

§ 424.44 Time limits for filing claims.

(a) *Time limits.*

(1) For services furnished on or after January 1, 2010, except as provided in paragraphs (b) and (e) of this section, the claim must be filed no later than the close of the period ending 1 calendar year after the date of service.

(2) For services furnished before January 1, 2010, except as provided in paragraphs (b) and (e) of this section, the claim must be filed on or before December 31 of the following year for services that were furnished during the first 9 months of a calendar year, and on or before December 31st of the second following year for services that were furnished during the last 3 months of the calendar year, except that for services furnished during the last 3 months of 2009 all claims must be filed no later than December 31, 2010.

(b) *Exceptions to time limits.* Exceptions to the time limits for filing claims include the following:

(1) The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the deadline in paragraph (a) of this section was caused by error or misrepresentation of an employee, Medicare contractor (including Medicare Administrative Contractor, intermediary, or carrier), or agent of the Department that was performing Medicare functions and acting within the scope of its authority.

(2) The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the deadline in paragraph (a) of this section is caused by all of the following conditions:

(i) At the time the service was furnished the beneficiary was not entitled to Medicare.

(ii) The beneficiary subsequently received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.

(3) The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the deadline in paragraph (a) of this section is caused by all of the following conditions:

(i) At the time the service was furnished the beneficiary was not entitled to Medicare.

(ii) The beneficiary subsequently received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.

(iii) A State Medicaid agency recovered the Medicaid payment for the furnished service from a provider or supplier 11 months or more after the service was furnished.

(4) *Extension of time.* (i) The time to file a claim will be extended through the last day of the 6th calendar month following the month in which the error or misrepresentation referenced in paragraph (b)(1) of this section, is corrected. However, no extension of time will be granted for paragraph (b)(1) when the request for that exception is made to CMS or one of its contractors more than 4 years after the date of service.

(ii) If CMS or one of its contractors determines that both of the conditions are met in paragraph (b)(2) of this section but that all of the conditions in paragraph (b)(3) are not satisfied, the time to file a claim will be extended through the last day of the 6th calendar month following the month in which the beneficiary received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.

(iii) If CMS or one of its contractors determines that all of the conditions are met in paragraph (b)(3) of this section, the time to file a claim will be extended through the last day of the 6th calendar month following the month in which the State Medicaid agency recovered the Medicaid payment for the furnished service from the provider or supplier.

* * * * *

(e) As specified in §§ 424.520 and 424.521 of this subpart, there are restrictions on the ability of the following newly-enrolled suppliers to submit claims for items or services furnished prior to the effective date of their Medicare billing privileges:

(1) Physician or non-physician practitioner organizations.

(2) Physicians.

(3) Nonphysician practitioners.

(4) Independent diagnostic testing facilities.

* * * * *

Subpart P—Requirements for Establishing and Maintaining Medicare Billing Privileges

49. Section 424.502 is amended by adding a definition of "Voluntary termination" in alphabetical order to read as follows:

§ 424.502 Definitions.

* * * * *

Voluntary termination means that a provider or supplier, including an individual physician or non-physician practitioner, submits written confirmation to CMS of its decision to discontinue enrollment in the Medicare program.

50. Section 424.510 is amended by revising paragraph (d)(1)(iii) to read as follows:

§ 424.510 Requirements for enrolling in the Medicare program.

* * * * *

(d) * * *

(1) * * *

(iii) Submission of all documentation, including all applicable Federal and State licenses, certifications (including, but not limited to Federal Aviation Administration and Clinical Laboratory Improvement Act certifications), and regulatory requirements that apply to the specific provider or supplier type that relate to providing health care service, required by CMS under this or other statutory or regulatory authority, or under the Paperwork Reduction Act of 1995, to establish the provider or supplier's eligibility to furnish Medicare covered items or services to beneficiaries in the Medicare program.

* * * * *

51. Section 424.516 is amended by adding paragraph (e)(3) to read as follows:

§ 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare program.

* * * * *

(e) * * *

(3) Within 30 days any revocation or suspension of a Federal or State license or certification (including Federal Aviation Administration and Clinical Laboratory Improvement Act certifications), an air ambulance supplier must report a revocation or suspension of its license or certification to the applicable Medicare contractor.

* * * * *

Authority: (Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program).

Dated: June 18, 2010.

Marilyn Tavenner,

Acting Administrator and Chief Operating Officer, Centers for Medicare & Medicaid Services.

Approved: June 24, 2010.

Kathleen Sebelius,

Secretary.

ADDENDUM A: Explanation and Use of Addendum B

The Addenda on the following pages provide various data pertaining to the Medicare fee schedule for physicians' services furnished in CY 2011. Addendum B contains the RVUs for work, nonfacility PE, facility PE, and malpractice expense, and other information for all services included in the PFS.

In previous years, we have listed many services in Addendum B that are not paid under the PFS. To avoid publishing as many pages of codes for these services, we are not including clinical laboratory codes or the alpha-numeric codes (Healthcare Common Procedure Coding System (HCPCS) codes not included in CPT) not paid under the PFS in Addendum B.

Addendum B contains the following information for each CPT code and alpha-numeric HCPCS code, except for: Alpha-numeric codes beginning with B (enteral and parenteral therapy); "E" (durable medical equipment); "K" (temporary codes for nonphysicians' services or items); or "L" (orthotics); and codes for anesthesiology. Please also note the following:

- An "NA" in the "Nonfacility PE RVUs" column of Addendum B means that CMS has not developed PE RVUs in the nonfacility setting for the service because it is typically performed in the hospital (for example, an open heart surgery is generally performed in the hospital setting and not a physician's office). If there is an "NA" in the nonfacility PE RVU column, and the contractor determines that this service can be performed in the nonfacility setting, the service will be paid at the facility PE RVU rate.
- Services that have an "NA" in the "Facility PE RVUs" column of Addendum B are typically not paid under the PFS when provided in a facility setting. These services (which include "incident to" services and the technical portion of diagnostic tests) are generally paid under either the hospital outpatient prospective payment system or bundled into the hospital inpatient prospective payment system payment. In some cases, these services may be paid in a facility setting at the PFS rate (for example, therapy services), but there would be no payment made to the practitioner under the PFS in these situations.

1. CPT/HCPCS code. This is the CPT or alpha-numeric HCPCS number for the service. Alpha-numeric HCPCS codes are included at the end of this Addendum.

2. Modifier. A modifier is shown if there is a technical component (modifier TC) and a professional component (PC) (modifier-26) for the service. If there is a PC and a TC for the service, Addendum B contains three entries for the code, specifically a code for: The global values (both professional and technical); modifier—26 (PC); and modifier—TC. The global service is not designated by a modifier, and physicians must bill using the code without a modifier if the physician furnishes both the PC and the TC of the service. Modifier-53 is shown for a discontinued procedure, for example a colonoscopy that is not completed. There will be RVUs for a code with this modifier.

3. Status indicator. This indicator shows whether the CPT/HCPCS code is included in the PFS and whether it is separately payable if the service is covered.

A = Active code. These codes are separately payable under the PFS if covered. There will be RVUs for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service. Contractors remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payments for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident (an example is a telephone call from a hospital nurse regarding care of a patient).

C = Contractors price the code. Contractors establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation, such as an operative report.

E = Excluded from the PFS by regulation. These codes are for items and services that CMS chose to exclude from the PFS by regulation. No RVUs are shown, and no payment may be made under the PFS for these codes. Payment for them, when covered, continues under reasonable charge procedures.

I = Not valid for Medicare purposes. Medicare uses another code for the reporting of, and the payment for these services. (Codes not subject to a 90-day grace period.)

M = Measurement codes, used for reporting purposes only. There are no RVUs and no payment amounts for these codes. CMS uses them to aid with performance measurement. No separate payment is made. These codes should be billed with a zero (($0.00) charge and are denied) on the MPFSDB.

N = Noncovered service. These codes are noncovered services. Medicare payment may not be made for these codes. If RVUs are shown, they are not used for Medicare payment.

R = Restricted coverage. Special coverage instructions apply. If the service is covered and no RVUs are shown, it is contractor-priced.

T = There are RVUs for these services, but they are only paid if there are no other services payable under the PFS billed on the same date by the same provider. If any other services payable under the PFS are billed on the same date by the same provider, these services are bundled into the service(s) for which payment is made.

X = Statutory exclusion. These codes represent an item or service that is not within the statutory definition of "physicians' services" for PFS payment purposes. No RVUs are shown for these codes, and no payment may be made under the PFS. (Examples are ambulance services and clinical diagnostic laboratory services.)

4. Description of code. This is an abbreviated version of the narrative description of the code.

5. Physician work RVUs. These are the RVUs for the physician work in CY 2011.

6. Fully implemented nonfacility PE RVUs. These are the fully implemented resource-based PE RVUs for nonfacility settings.

7. CY 2011 transitional nonfacility PE RVUs. These are the CY 2011 resource-based PE RVUs for nonfacility settings.

8. Fully implemented facility PE RVUs. These are the fully implemented resource-based PE RVUs for facility settings.

9. CY 2011 Transitional facility PE RVUs. These are the CY 2011 resource-based PE RVUs for facility settings.

10. Malpractice expense RVUs. These are the RVUs for the malpractice expense for CY 2011.

Note: The BN reduction resulting from the chiropractic demonstration is *not* reflected in the RVUs for CPT codes 98940, 98941 and 98942. The required reduction will only be reflected in the files used for Medicare payment.

11. Global period. This indicator shows the number of days in the global period for the code (0, 10, or 90 days). An explanation of the alpha codes follows:

MMM = Code describes a service furnished in uncomplicated maternity cases, including antepartum care, delivery, and postpartum care. The usual global surgical concept does not apply. See the Physicians' Current Procedural Terminology for specific definitions.

XXX = The global concept does not apply.

YYY = The global period is to be set by the contractor (for example, unlisted surgery codes).

ZZZ = Code related to another service that is always included in the global period of the other service. (Note: Physician work and PE are associated with intra-service time and, in some instances, with the post-service time.)

ADDENDUM B: Proposed Relative Value Units and Related Information Used in Determining Medicare Payments for CY 2011

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
0016T		C	Thermotx choroid vasc lesion	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0017T		C	Photocoagulat macular drusen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0019T		C	Extracorp shock wv tx,ms nos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0030T		C	Antiprothrombin antibody	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0042T		C	Ct perfusion w/contrast, cbf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0048T		C	Implant ventricular device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0050T		C	Removal circulation assist	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0051T		C	Implant total heart system	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0052T		C	Replace component heart syst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0053T		C	Replace component heart syst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0054T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0055T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0071T		C	U/s leiomyomata ablate <200	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0072T		C	U/s leiomyomata ablate >200	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0073T		A	Delivery, comp imrt	0.00	13.68	15.38	NA	NA	0.01	XXX
0075T		C	Perq stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	XXX
0075T	TC	C	Perq stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	XXX
0075T	26	C	Perq stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0076T		C	S&i stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	XXX
0076T	TC	C	S&i stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	XXX
0076T	26	C	S&i stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0078T		C	Endovasc aort repr w/device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0079T		C	Endovasc visc extnsn repr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0080T		C	Endovasc aort repr rad s&i	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
0081T		C	Endovasc visc extnsn s&i	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0085T		N	Breath test heart reject	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0092T		C	Artific disc addl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0095T		C	Artific diskectomy addl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0098T		C	Rev artific disc addl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0099T		C	Implant corneal ring	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0100T		C	Prosth retina receive&gen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0101T		C	Extracorp shockwv tx,hi enrg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0102T		C	Extracorp shockwv tx,anesth	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0103T		C	Holotranscobalamin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0104T		C	At rest cardio gas rebreathe	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0105T		C	Exerc cardio gas rebreathe	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0106T		C	Touch quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0107T		C	Vibrate quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0108T		C	Cool quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0109T		C	Heat quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0110T		C	Nos quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0111T		C	Rbc membranes fatty acids	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0123T		C	Scleral fistulization	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0124T		C	Conjunctival drug placement	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0126T		C	Chd risk imt study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0130T		C	Chron care drug investigatn	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0140T		C	Exhaled breath condensate ph	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0141T		I	Perq islet transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0142T		I	Open islet transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0143T		I	Laparoscopic islet transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
0155T		C	Lap impl gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0156T		C	Lap remv gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0157T		C	Open impl gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0158T		C	Open remv gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0159T		C	Cad breast mri	0.00	0.00	0.00	NA	NA	0.00	ZZZ
0159T	TC	C	Cad breast mri	0.00	0.00	0.00	NA	NA	0.00	ZZZ
0159T	26	C	Cad breast mri	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
0160T		C	Tcranial magn stim tx plan	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0161T		C	Tcranial magn stim tx deliv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0163T		C	Lumb artif diskectomy addl	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0164T		C	Remove lumb artif disc addl	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0165T		C	Revise lumb artif disc addl	0.00	0.00	0.00	0.00	0.00	0.00	YYY
0166T		C	Tcath vsd close w/o bypass	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0167T		C	Tcath vsd close w bypass	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0168T		C	Rhinophototx light app bilat	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0169T		C	Place stereo cath brain	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0171T		C	Lumbar spine proces distract	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0172T		C	Lumbar spine process addl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0173T		C	Iop monit io pressure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0174T		C	Cad cxr with interp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0175T		C	Cad cxr remote	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0176T		C	Aqu canal dilat w/o retent	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0177T		C	Aqu canal dilat w retent	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0178T		C	64 lead ecg w i&r	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0179T		C	64 lead ecg w tracing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0180T		C	64 lead ecg w i&r only	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
0181T		C	Corneal hysteresis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0182T		C	Hdr elect brachytherapy	0.00	0.00	0.00	NA	NA	0.00	XXX
0182T	TC	C	Hdr elect brachytherapy	0.00	0.00	0.00	NA	NA	0.00	XXX
0182T	26	C	Hdr elect brachytherapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0183T		C	Wound ultrasound	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0184T		C	Exc rectal tumor endoscopic	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0185T		C	Comptr probability analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0186T		C	Suprachoroidal drug delivery	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0187T		C	Ophthalmic dx image anterior	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0188T		N	Videoconf crit care 74 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0189T		N	Videoconf crit care addl 30	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0190T		C	Place intraoc radiation src	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0191T		C	Insert ant segment drain int	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0192T		C	Insert ant segment drain ext	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0193T		C	Rf bladder neck microremodel	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0195T		C	Arthrod presac interbody	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0196T		C	Arthrod presac interbody eac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0197T		C	Intrafraction track motion	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0198T		C	Ocular blood flow measure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0199T		C	Physiologic tremor record	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0200T		C	Perq sacral augmt unilat inj	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0201T		C	Perq sacral augmt bilat inj	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0202T		C	Post vert arthrplst 1 lumbar	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0203T		C	Unattend sleep study w/time	0.00	0.00	0.00	NA	NA	0.00	XXX
0203T	TC	C	Unattend sleep study w/time	0.00	0.00	0.00	NA	NA	0.00	XXX
0203T	26	C	Unattend sleep study w/time	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
0204T		C	Unattended sleep study	0.00	0.00	0.00	NA	NA	0.00	XXX
0204T	TC	C	Unattended sleep study	0.00	0.00	0.00	NA	NA	0.00	XXX
0204T	26	C	Unattended sleep study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0205T		C	Inirs each vessel add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
0206T		C	Remote algorithm analys ecg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0207T		C	Clear eyelid gland w/heat	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0208T		C	Automated audiometry air	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0209T		C	Auto audiometry air/bone	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0210T		C	Auto audiometry sp thresh	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0211T		C	Auto audiometry sp thresh	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0212T		C	Comprehen auto audiometry	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0213T		C	Us facet jt inj cerv/t 1 lev	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0214T		C	Us facet jt inj cerv/t 2 lev	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
0215T		C	Us facet jt inj cerv/t 3 lev	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
0216T		C	Us facet jt inj ls 1 level	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0217T		C	Us facet jt inj ls 2 level	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
0218T		C	Us facet jt inj ls 3 level	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
0219T		C	Fuse spine facet jt cerv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0220T		C	Fuse spine facet jt thor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0221T		C	Fuse spine facet jt lumbar	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0222T		C	Fuse spine facet jt add seg	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
0528F		I	Rcmnd flw-up 10 yrs docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0535F		I	Dyspnea mngmnt plan docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0545F		I	Follow up care plan mdd docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10021		A	Fna w/o image	1.27	2.70	2.64	0.62	0.57	0.23	XXX
10022		A	Fna w/image	1.27	2.37	2.54	0.49	0.51	0.14	XXX

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10040		A	Acne surgery	1.21	1.60	1.56	1.25	1.20	0.18	010
10060		A	Drainage of skin abscess	1.22	1.96	1.83	1.43	1.34	0.13	010
10061		A	Drainage of skin abscess	2.45	2.69	2.55	1.99	1.90	0.31	010
10080		A	Drainage of pilonidal cyst	1.22	3.52	3.41	1.54	1.43	0.21	010
10081		A	Drainage of pilonidal cyst	2.50	4.66	4.52	2.09	1.94	0.47	010
10120		A	Remove foreign body	1.25	2.60	2.49	1.31	1.23	0.17	010
10121		A	Remove foreign body	2.74	4.71	4.44	2.32	2.18	0.42	010
10140		A	Drainage of hematoma/fluid	1.58	2.87	2.70	1.66	1.60	0.21	010
10160		A	Puncture drainage of lesion	1.25	2.31	2.21	1.37	1.33	0.17	010
10180		A	Complex drainage, wound	2.30	4.26	4.04	2.45	2.34	0.49	010
11000		A	Debride infected skin	0.60	0.91	0.86	0.21	0.21	0.06	000
11001		A	Debride infected skin add-on	0.30	0.29	0.28	0.10	0.11	0.03	ZZZ
11004		A	Debride genitalia & perineum	10.80	NA	NA	4.67	4.48	1.96	000
11005		A	Debride abdom wall	14.24	NA	NA	6.23	5.79	3.08	000
11006		A	Debride genit/per/abdom wall	13.10	NA	NA	5.77	5.50	2.43	000
11008		A	Remove mesh from abd wall	5.00	NA	NA	2.18	2.03	1.09	ZZZ
11010		A	Debride skin, fx	4.19	9.20	8.73	3.41	3.21	0.79	010
11011		A	Debride skin/muscle, fx	4.94	9.39	9.12	3.05	2.86	1.02	000
11012		A	Debride skin/muscle/bone, fx	6.87	12.17	12.00	4.57	4.36	1.36	000
11040		A	Debride skin, partial	0.50	0.84	0.79	0.20	0.20	0.04	000
11041		A	Debride skin, full	0.60	0.90	0.87	0.24	0.25	0.06	000
11042		A	Debride skin/tissue	0.80	1.25	1.20	0.35	0.35	0.10	000
11043		A	Debride tissue/muscle	3.14	4.72	4.44	3.57	3.35	0.52	010
11044		A	Debride tissue/muscle/bone	4.26	6.53	6.13	4.92	4.66	0.76	010
11055		R	Trim skin lesion	0.43	0.99	0.93	0.13	0.14	0.03	000
11056		R	Trim skin lesions, 2 to 4	0.61	1.07	1.02	0.18	0.20	0.04	000

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11057		R	Trim skin lesions, over 4	0.79	1.21	1.15	0.23	0.26	0.06	000
11100		A	Biopsy, skin lesion	0.81	2.04	2.05	0.57	0.53	0.11	000
11101		A	Biopsy, skin add-on	0.41	0.50	0.49	0.29	0.27	0.06	ZZZ
11200		A	Removal of skin tags	0.82	1.57	1.50	1.19	1.12	0.11	010
11201		A	Remove skin tags add-on	0.29	0.23	0.21	0.18	0.16	0.04	ZZZ
11300		A	Shave skin lesion	0.51	1.41	1.38	0.33	0.30	0.07	000
11301		A	Shave skin lesion	0.85	1.73	1.71	0.58	0.53	0.11	000
11302		A	Shave skin lesion	1.05	2.02	2.00	0.73	0.66	0.14	000
11303		A	Shave skin lesion	1.24	2.38	2.34	0.85	0.77	0.18	000
11305		A	Shave skin lesion	0.67	1.30	1.25	0.26	0.27	0.06	000
11306		A	Shave skin lesion	0.99	1.67	1.63	0.51	0.50	0.11	000
11307		A	Shave skin lesion	1.14	1.99	1.96	0.67	0.64	0.14	000
11308		A	Shave skin lesion	1.41	2.10	2.03	0.69	0.67	0.14	000
11310		A	Shave skin lesion	0.73	1.62	1.60	0.48	0.44	0.10	000
11311		A	Shave skin lesion	1.05	1.90	1.88	0.72	0.67	0.14	000
11312		A	Shave skin lesion	1.20	2.21	2.18	0.84	0.78	0.18	000
11313		A	Shave skin lesion	1.62	2.62	2.57	1.12	1.02	0.25	000
11400		A	Exc tr-ext b9+marg 0.5 < cm	0.90	2.44	2.37	1.29	1.20	0.13	010
11401		A	Exc tr-ext b9+marg 0.6-1 cm	1.28	2.76	2.68	1.57	1.47	0.21	010
11402		A	Exc tr-ext b9+marg 1.1-2 cm	1.45	3.03	2.94	1.66	1.56	0.25	010
11403		A	Exc tr-ext b9+marg 2.1-3 cm	1.84	3.32	3.18	2.15	1.99	0.32	010
11404		A	Exc tr-ext b9+marg 3.1-4 cm	2.11	3.73	3.58	2.27	2.11	0.38	010
11406		A	Exc tr-ext b9+marg > 4.0 cm	3.52	4.80	4.47	3.04	2.75	0.69	010
11420		A	Exc h-f-nk-sp b9+marg 0.5 <	1.03	2.33	2.24	1.23	1.18	0.13	010
11421		A	Exc h-f-nk-sp b9+marg 0.6-1	1.47	2.82	2.72	1.58	1.49	0.23	010
11422		A	Exc h-f-nk-sp b9+marg 1.1-2	1.68	3.09	2.97	2.04	1.92	0.27	010

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11423		A	Exc h-f-nk-sp b9+marg 2.1-3	2.06	3.43	3.31	2.25	2.10	0.34	010
11424		A	Exc h-f-nk-sp b9+marg 3.1-4	2.48	3.81	3.66	2.40	2.25	0.42	010
11426		A	Exc h-f-nk-sp b9+marg > 4 cm	4.09	4.85	4.59	3.31	3.05	0.73	010
11440		A	Exc face-mm b9+marg 0.5 < cm	1.05	2.61	2.54	1.78	1.69	0.17	010
11441		A	Exc face-mm b9+marg 0.6-1 cm	1.53	3.05	2.95	2.09	1.98	0.25	010
11442		A	Exc face-mm b9+marg 1.1-2 cm	1.77	3.36	3.26	2.24	2.12	0.30	010
11443		A	Exc face-mm b9+marg 2.1-3 cm	2.34	3.77	3.63	2.57	2.41	0.40	010
11444		A	Exc face-mm b9+marg 3.1-4 cm	3.19	4.47	4.27	3.05	2.84	0.54	010
11446		A	Exc face-mm b9+marg > 4 cm	4.80	5.82	5.40	4.12	3.74	0.83	010
11450		A	Removal, sweat gland lesion	3.22	6.91	6.52	3.46	3.15	0.68	090
11451		A	Removal, sweat gland lesion	4.43	8.27	7.96	4.10	3.76	0.93	090
11462		A	Removal, sweat gland lesion	3.00	6.90	6.60	3.42	3.13	0.62	090
11463		A	Removal, sweat gland lesion	4.43	8.47	8.25	4.24	3.92	0.92	090
11470		A	Removal, sweat gland lesion	3.74	7.38	6.91	3.84	3.47	0.73	090
11471		A	Removal, sweat gland lesion	4.89	8.73	8.26	4.42	4.01	0.95	090
1150F		I	Doc pt rsk death w/in 1yr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1151F		I	Doc no pt rsk death w/in 1yr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1152F		I	Doc advncd dis comfort 1st	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1153F		I	Doc advncd dis cmfrt not 1st	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1157F		I	Advnc care plan in rcrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1158F		I	Advnc care plan tlk docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1159F		I	Med list docd in rcrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
11600		A	Exc tr-ext mlg+marg 0.5 < cm	1.63	3.56	3.40	1.64	1.49	0.27	010
11601		A	Exc tr-ext mlg+marg 0.6-1 cm	2.07	4.18	4.05	2.07	1.92	0.32	010
11602		A	Exc tr-ext mlg+marg 1.1-2 cm	2.27	4.54	4.43	2.29	2.13	0.35	010
11603		A	Exc tr-ext mlg+marg 2.1-3 cm	2.82	4.94	4.77	2.62	2.39	0.44	010

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11604		A	Exc tr-ext mlg+marg 3.1-4 cm	3.17	5.40	5.19	2.76	2.51	0.54	010
11606		A	Exc tr-ext mlg+marg > 4 cm	5.02	7.15	6.69	3.69	3.28	0.92	010
1160F		I	Rvw meds by rx/dr in rcrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
11620		A	Exc h-f-nk-sp mlg+marg 0.5 <	1.64	3.62	3.49	1.69	1.54	0.27	010
11621		A	Exc h-f-nk-sp mlg+marg 0.6-1	2.08	4.22	4.10	2.10	1.95	0.32	010
11622		A	Exc h-f-nk-sp mlg+marg 1.1-2	2.41	4.63	4.53	2.38	2.22	0.38	010
11623		A	Exc h-f-nk-sp mlg+marg 2.1-3	3.11	5.14	4.95	2.79	2.56	0.51	010
11624		A	Exc h-f-nk-sp mlg+marg 3.1-4	3.62	5.63	5.40	3.02	2.76	0.62	010
11626		A	Exc h-f-nk-sp mlg+mar > 4 cm	4.61	6.51	6.22	3.48	3.20	0.83	010
11640		A	Exc face-mm malig+marg 0.5 <	1.67	3.80	3.67	1.80	1.66	0.27	010
11641		A	Exc face-mm malig+marg 0.6-1	2.17	4.37	4.27	2.20	2.08	0.34	010
11642		A	Exc face-mm malig+marg 1.1-2	2.62	4.85	4.76	2.53	2.38	0.41	010
11643		A	Exc face-mm malig+marg 2.1-3	3.42	5.38	5.20	3.01	2.79	0.57	010
11644		A	Exc face-mm malig+marg 3.1-4	4.34	6.49	6.25	3.59	3.32	0.73	010
11646		A	Exc face-mm mlg+marg > 4 cm	6.26	7.87	7.50	4.72	4.36	1.09	010
11719		R	Trim nail(s)	0.17	0.46	0.44	0.05	0.06	0.01	000
11720		A	Debride nail, 1-5	0.32	0.57	0.54	0.09	0.10	0.03	000
11721		A	Debride nail, 6 or more	0.54	0.66	0.64	0.16	0.18	0.04	000
11730		A	Removal of nail plate	1.10	1.63	1.56	0.33	0.36	0.08	000
11732		A	Remove nail plate, add-on	0.57	0.67	0.64	0.17	0.19	0.04	ZZZ
11740		A	Drain blood from under nail	0.37	0.99	0.92	0.53	0.51	0.03	000
11750		A	Removal of nail bed	2.50	3.68	3.47	2.34	2.27	0.23	010
11752		A	Remove nail bed/finger tip	3.63	5.27	4.90	3.63	3.52	0.41	010
11755		A	Biopsy, nail unit	1.31	2.44	2.35	0.92	0.92	0.11	000
11760		A	Repair of nail bed	1.63	4.60	4.22	1.99	1.91	0.27	010
11762		A	Reconstruction of nail bed	2.94	4.79	4.47	2.19	2.21	0.32	010

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11765		A	Excision of nail fold, toe	0.74	3.31	3.09	1.25	1.18	0.06	010
11770		A	Removal of pilonidal lesion	2.66	4.68	4.42	2.22	2.03	0.54	010
11771		A	Removal of pilonidal lesion	6.09	9.10	8.44	5.37	4.91	1.29	090
11772		A	Removal of pilonidal lesion	7.35	10.71	10.09	7.68	7.13	1.53	090
1180F		I	Thromboemb risk assessed	0.00	0.00	0.00	0.00	0.00	0.00	XXX
11900		A	Injection into skin lesions	0.52	1.03	1.03	0.37	0.34	0.07	000
11901		A	Added skin lesions injection	0.80	1.17	1.15	0.58	0.53	0.11	000
11920		R	Correct skin color defects	1.61	3.06	3.15	1.56	1.45	0.32	000
11921		R	Correct skin color defects	1.93	3.52	3.54	1.81	1.68	0.38	000
11922		R	Correct skin color defects	0.49	1.20	1.18	0.34	0.31	0.08	ZZZ
11950		R	Therapy for contour defects	0.84	1.02	1.10	0.47	0.48	0.10	000
11951		R	Therapy for contour defects	1.19	1.47	1.47	0.73	0.68	0.25	000
11952		R	Therapy for contour defects	1.69	1.58	1.81	0.79	0.86	0.25	000
11954		R	Therapy for contour defects	1.85	2.52	2.45	1.36	1.21	0.37	000
11960		A	Insert tissue expander(s)	11.49	NA	NA	12.79	12.82	1.91	090
11970		A	Replace tissue expander	8.01	NA	NA	8.88	8.20	1.62	090
11971		A	Remove tissue expander(s)	3.41	9.31	9.29	5.27	5.00	0.66	090
11975		N	Insert contraceptive cap	1.48	2.09	2.08	0.64	0.63	0.10	XXX
11976		R	Removal of contraceptive cap	1.78	2.07	2.11	0.80	0.73	0.31	000
11977		N	Removal/reinsert contra cap	3.30	2.91	2.91	1.43	1.41	0.25	XXX
11980		A	Implant hormone pellet(s)	1.48	1.34	1.31	0.72	0.67	0.24	000
11981		A	Insert drug implant device	1.48	2.13	2.18	0.70	0.73	0.25	XXX
11982		A	Remove drug implant device	1.78	2.20	2.32	0.83	0.89	0.25	XXX
11983		A	Remove/insert drug implant	3.30	2.53	2.83	1.36	1.54	0.37	XXX
12001		A	Repair superficial wound(s)	1.75	2.39	2.26	1.08	0.99	0.30	010
12002		A	Repair superficial wound(s)	1.91	2.48	2.35	1.22	1.12	0.32	010

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12004		A	Repair superficial wound(s)	2.29	2.85	2.70	1.33	1.23	0.40	010
12005		A	Repair superficial wound(s)	2.91	3.44	3.26	1.54	1.43	0.51	010
12006		A	Repair superficial wound(s)	3.71	4.11	3.90	1.87	1.74	0.66	010
12007		A	Repair superficial wound(s)	4.16	4.51	4.34	2.00	1.95	0.75	010
1200F		I	Seizure type(s)+ frq docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
12011		A	Repair superficial wound(s)	1.81	2.58	2.45	1.08	1.00	0.32	010
12013		A	Repair superficial wound(s)	2.04	2.79	2.65	1.25	1.16	0.35	010
12014		A	Repair superficial wound(s)	2.51	3.12	2.97	1.39	1.30	0.44	010
12015		A	Repair superficial wound(s)	3.24	3.76	3.59	1.57	1.48	0.57	010
12016		A	Repair superficial wound(s)	3.97	4.36	4.14	1.85	1.75	0.71	010
12017		A	Repair superficial wound(s)	4.75	NA	NA	1.78	1.84	0.86	010
12018		A	Repair superficial wound(s)	5.57	NA	NA	1.93	2.31	1.03	010
12020		A	Closure of split wound	2.67	4.82	4.63	2.42	2.30	0.44	010
12021		A	Closure of split wound	1.89	2.58	2.40	1.91	1.77	0.32	010
12031		A	Intmd wnd repair s/tr/ext	2.20	4.63	4.42	2.35	2.15	0.37	010
12032		A	Intmd wnd repair s/tr/ext	2.52	5.90	5.87	2.90	2.78	0.40	010
12034		A	Intmd wnd repair s/tr/ext	2.97	5.51	5.30	2.65	2.47	0.52	010
12035		A	Intmd wnd repair s/tr/ext	3.47	6.74	6.53	2.92	2.76	0.66	010
12036		A	Intmd wnd repair s/tr/ext	4.09	7.07	6.77	3.19	3.00	0.81	010
12037		A	Intmd wnd repair s/tr/ext	4.71	7.71	7.43	3.70	3.51	0.93	010
12041		A	Intmd wnd repair n-hf/genit	2.42	4.73	4.49	2.41	2.20	0.38	010
12042		A	Intmd wnd repair n-hg/genit	2.79	5.24	5.14	2.79	2.60	0.42	010
12044		A	Intmd wnd repair n-hg/genit	3.19	6.55	6.17	2.65	2.47	0.54	010
12045		A	Intmd wnd repair n-hg/genit	3.68	6.45	6.29	2.86	2.73	0.65	010
12046		A	Intmd wnd repair n-hg/genit	4.29	7.59	7.44	3.38	3.23	0.88	010
12047		A	Intmd wnd repair n-hg/genit	4.69	8.43	8.08	3.46	3.41	0.95	010

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12051		A	Intmd wnd repair face/mm	2.52	4.91	4.79	2.56	2.39	0.41	010
12052		A	Intmd wnd repair face/mm	2.87	5.64	5.50	3.27	3.03	0.44	010
12053		A	Intmd wnd repair face/mm	3.17	6.28	6.04	2.82	2.63	0.52	010
12054		A	Intmd wnd repair, face/mm	3.50	6.53	6.22	2.70	2.54	0.61	010
12055		A	Intmd wnd repair face/mm	4.47	7.63	7.18	2.92	2.74	0.76	010
12056		A	Intmd wnd repair face/mm	5.28	9.78	8.84	4.79	4.06	0.69	010
12057		A	Intmd wnd repair face/mm	6.00	11.35	10.07	4.67	4.31	0.79	010
1205F		I	EPI etiol synd rvwd and docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
13100		A	Repair of wound or lesion	3.17	5.38	5.34	3.29	3.17	0.52	010
13101		A	Repair of wound or lesion	3.96	6.95	6.87	3.94	3.77	0.64	010
13102		A	Repair wound/lesion add-on	1.24	1.73	1.65	0.82	0.75	0.24	ZZZ
13120		A	Repair of wound or lesion	3.35	5.56	5.50	3.45	3.29	0.54	010
13121		A	Repair of wound or lesion	4.42	7.79	7.67	4.71	4.47	0.69	010
13122		A	Repair wound/lesion add-on	1.44	1.80	1.75	0.92	0.83	0.27	ZZZ
13131		A	Repair of wound or lesion	3.83	6.01	5.94	3.82	3.66	0.61	010
13132		A	Repair of wound or lesion	6.58	9.45	9.22	6.54	6.22	1.02	010
13133		A	Repair wound/lesion add-on	2.19	2.44	2.34	1.50	1.38	0.35	ZZZ
13150		A	Repair of wound or lesion	3.85	5.95	5.84	3.77	3.57	0.64	010
13151		A	Repair of wound or lesion	4.49	6.68	6.57	4.33	4.15	0.69	010
13152		A	Repair of wound or lesion	6.37	9.10	8.90	5.44	5.19	0.99	010
13153		A	Repair wound/lesion add-on	2.38	2.73	2.60	1.60	1.46	0.40	ZZZ
13160		A	Late closure of wound	12.04	NA	NA	9.85	9.26	2.32	090
14000		A	Skin tissue rearrangement	6.37	10.75	10.46	7.58	7.25	1.17	090
14001		A	Skin tissue rearrangement	8.78	13.25	12.88	9.41	9.06	1.60	090
14020		A	Skin tissue rearrangement	7.22	12.04	11.72	8.66	8.34	1.26	090
14021		A	Skin tissue rearrangement	9.72	14.44	14.06	10.47	10.15	1.61	090

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14040		A	Skin tissue rearrangement	8.60	12.65	12.30	9.26	8.96	1.37	090
14041		A	Skin tissue rearrangement	10.83	15.45	15.10	11.15	10.81	1.68	090
14060		A	Skin tissue rearrangement	9.23	12.39	11.96	9.74	9.33	1.47	090
14061		A	Skin tissue rearrangement	11.48	16.75	16.37	12.00	11.64	1.78	090
14301		A	Skin tissue rearrangement	12.65	16.91	16.91	11.82	11.82	2.22	090
14302		A	Skin tissue rearrange add-on	3.73	2.49	2.49	2.49	2.49	0.65	ZZZ
14350		A	Skin tissue rearrangement	11.05	NA	NA	8.56	8.46	1.61	090
15002		A	Wound prep, trk/arm/leg	3.65	5.74	5.39	2.56	2.32	0.68	000
15003		A	Wound prep, addl 100 cm	0.80	1.21	1.15	0.42	0.38	0.17	ZZZ
15004		A	Wound prep, f/n/hf/g	4.58	6.39	6.15	2.95	2.76	0.69	000
15005		A	Wnd prep, f/n/hf/g, addl cm	1.60	1.70	1.59	0.84	0.75	0.32	ZZZ
15040		A	Harvest cultured skin graft	2.00	4.94	4.91	1.44	1.35	0.38	000
15050		A	Skin pinch graft	5.57	10.28	9.61	6.98	6.53	0.93	090
15100		A	Skin splt grft, trnk/arm/leg	9.90	13.40	13.03	9.63	9.08	2.02	090
15101		A	Skin splt grft t/a/l, add-on	1.72	3.27	3.31	1.26	1.20	0.35	ZZZ
15110		A	Epidrm autogrft trnk/arm/leg	10.97	11.93	11.43	8.93	8.33	2.23	090
15111		A	Epidrm autogrft t/a/l add-on	1.85	1.20	1.21	0.89	0.87	0.40	ZZZ
15115		A	Epidrm a-grft face/nck/hf/g	11.28	12.63	11.81	9.67	8.98	1.92	090
15116		A	Epidrm a-grft f/n/hf/g addl	2.50	2.20	1.95	1.78	1.52	0.51	ZZZ
15120		A	Skn splt a-grft fac/nck/hf/g	11.16	15.26	14.38	10.70	9.95	2.01	090
15121		A	Skn splt a-grft f/n/hf/g add	2.67	4.61	4.50	1.98	1.85	0.52	ZZZ
15130		A	Derm autograft, trnk/arm/leg	7.53	10.82	10.45	7.88	7.41	1.54	090
15131		A	Derm autograft t/a/l add-on	1.50	1.29	1.15	1.07	0.89	0.32	ZZZ
15135		A	Derm autograft face/nck/hf/g	11.03	13.03	12.19	10.10	9.42	1.95	090
15136		A	Derm autograft, f/n/hf/g add	1.50	1.16	0.97	0.98	0.78	0.10	ZZZ
15150		A	Cult epiderm grft t/arm/leg	9.39	8.81	8.68	7.19	7.04	2.06	090

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15151		A	Cult epiderm grft t/a/l addl	2.00	1.11	1.16	0.86	0.89	0.44	ZZZ
15152		A	Cult epiderm graft t/a/l +%	2.50	1.35	1.54	1.10	1.24	0.51	ZZZ
15155		A	Cult epiderm graft, f/n/hf/g	10.14	6.82	7.80	5.49	6.44	0.79	090
15156		A	Cult epidrm grft f/n/hfg add	2.75	1.44	1.59	1.18	1.33	0.61	ZZZ
15157		A	Cult epiderm grft f/n/hfg +%	3.00	1.19	1.58	0.89	1.23	0.23	ZZZ
15170		A	Acell graft trunk/arms/legs	5.99	6.00	5.48	4.22	3.75	1.13	090
15171		A	Acell graft t/arm/leg add-on	1.55	0.97	0.89	0.81	0.74	0.32	ZZZ
15175		A	Acellular graft, f/n/hf/g	7.99	6.12	5.94	4.46	4.31	1.09	090
15176		A	Acell graft, f/n/hf/g add-on	2.45	1.55	1.44	1.24	1.16	0.41	ZZZ
15200		A	Skin full graft, trunk	9.15	13.59	12.81	9.41	8.66	1.71	090
15201		A	Skin full graft trunk add-on	1.32	2.75	2.69	0.89	0.79	0.27	ZZZ
15220		A	Skin full graft sclp/arm/leg	8.09	13.20	12.72	9.08	8.64	1.44	090
15221		A	Skin full graft add-on	1.19	2.56	2.54	0.78	0.72	0.24	ZZZ
15240		A	Skin full grft face/genit/hf	10.41	15.45	14.74	12.02	11.32	1.77	090
15241		A	Skin full graft add-on	1.86	3.26	3.14	1.28	1.16	0.34	ZZZ
15260		A	Skin full graft een & lips	11.64	16.43	15.71	12.59	11.93	1.84	090
15261		A	Skin full graft add-on	2.23	3.76	3.62	1.74	1.63	0.38	ZZZ
15300		A	Apply skinallogrft, t/arm/lg	4.65	4.96	4.55	3.31	3.01	0.89	090
15301		A	Apply sknallogrft t/a/l addl	1.00	0.67	0.63	0.50	0.47	0.21	ZZZ
15320		A	Apply skin allogrft f/n/hf/g	5.36	4.89	4.69	3.13	3.02	0.76	090
15321		A	Aply sknallogrft f/n/hfg add	1.50	1.02	0.94	0.80	0.74	0.31	ZZZ
15330		A	Aply acell alogrft t/arm/leg	3.99	5.02	4.60	3.32	3.01	0.79	090
15331		A	Aply acell grft t/a/l add-on	1.00	0.74	0.66	0.58	0.52	0.21	ZZZ
15335		A	Apply acell graft, f/n/hf/g	4.50	4.38	4.19	2.76	2.66	0.52	090
15336		A	Aply acell grft f/n/hf/g add	1.43	1.31	1.04	1.02	0.79	0.10	ZZZ
15340		A	Apply cult skin substitute	3.82	4.83	4.68	3.51	3.36	0.54	010

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15341		A	Apply cult skin sub add-on	0.50	0.81	0.78	0.19	0.19	0.07	ZZZ
15360		A	Apply cult derm sub, t/a/l	4.02	5.76	5.66	4.27	4.15	0.62	090
15361		A	Aply cult derm sub t/a/l add	1.15	0.51	0.57	0.36	0.40	0.21	ZZZ
15365		A	Apply cult derm sub f/n/hf/g	4.30	5.23	5.12	3.85	3.74	0.42	090
15366		A	Apply cult derm f/hf/g add	1.45	0.74	0.74	0.51	0.53	0.17	ZZZ
15400		A	Apply skin xenograft, t/a/l	4.47	6.96	6.47	5.41	5.13	0.72	090
15401		A	Apply skn xenogrft t/a/l add	1.00	1.34	1.41	0.50	0.47	0.23	ZZZ
15420		A	Apply skin xgraft, f/n/hf/g	4.98	7.14	6.97	5.66	5.50	0.69	090
15421		A	Apply skn xgrft f/n/hf/g add	1.50	1.65	1.55	0.80	0.72	0.31	ZZZ
15430		A	Apply acellular xenograft	6.20	8.86	8.32	8.16	7.69	1.09	090
15431		C	Apply acellular xgraft add	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
15570		A	Form skin pedicle flap	10.21	14.16	13.50	9.49	8.83	2.15	090
15572		A	Form skin pedicle flap	10.12	14.10	13.18	10.43	9.52	1.89	090
15574		A	Form skin pedicle flap	10.70	14.55	13.75	10.68	9.91	1.89	090
15576		A	Form skin pedicle flap	9.37	13.05	12.42	9.49	8.83	1.60	090
15600		A	Skin graft	2.01	6.84	6.93	3.71	3.55	0.40	090
15610		A	Skin graft	2.52	7.22	6.81	4.16	3.98	0.47	090
15620		A	Skin graft	3.75	8.32	8.23	5.29	5.00	0.64	090
15630		A	Skin graft	4.08	8.68	8.57	5.64	5.41	0.68	090
15650		A	Transfer skin pedicle flap	4.77	9.17	9.15	5.93	5.75	0.81	090
15731		A	Forehead flap w/vasc pedicle	14.38	17.26	16.34	14.14	13.21	2.50	090
15732		A	Muscle-skin graft, head/neck	19.90	21.63	20.28	17.35	15.72	3.67	090
15734		A	Muscle-skin graft, trunk	19.86	21.30	20.53	16.59	15.64	4.14	090
15736		A	Muscle-skin graft, arm	17.04	19.32	18.64	14.65	13.60	3.49	090
15738		A	Muscle-skin graft, leg	19.04	19.43	18.76	15.01	14.05	3.96	090
15740		A	Island pedicle flap graft	11.80	16.68	16.09	12.49	11.89	1.84	090

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15750		A	Neurovascular pedicle graft	12.96	NA	NA	12.28	11.53	2.37	090
15756		A	Free myo/skin flap microvasc	36.94	NA	NA	28.48	26.11	6.60	090
15757		A	Free skin flap, microvasc	37.15	NA	NA	27.91	25.63	6.15	090
15758		A	Free fascial flap, microvasc	36.90	NA	NA	27.69	25.56	6.15	090
15760		A	Composite skin graft	9.86	13.91	13.21	10.09	9.41	1.64	090
15770		A	Derma-fat-fascia graft	8.96	NA	NA	9.62	8.89	1.70	090
15775		R	Hair transplant punch grafts	3.95	4.74	4.59	2.51	2.22	0.30	000
15776		R	Hair transplant punch grafts	5.53	6.48	6.28	3.30	3.10	0.40	000
15780		A	Abrasion treatment of skin	8.73	13.81	13.76	8.40	8.45	1.24	090
15781		A	Abrasion treatment of skin	5.02	10.19	9.86	7.02	6.77	0.79	090
15782		A	Abrasion treatment of skin	4.44	10.52	10.82	6.22	6.45	0.65	090
15783		A	Abrasion treatment of skin	4.41	9.07	8.97	6.14	5.86	0.65	090
15786		A	Abrasion, lesion, single	2.08	4.59	4.53	1.71	1.64	0.34	010
15787		A	Abrasion, lesions, add-on	0.33	0.98	1.00	0.16	0.15	0.04	ZZZ
15788		R	Chemical peel, face, epiderm	2.09	10.87	10.39	4.96	4.69	0.37	090
15789		R	Chemical peel, face, dermal	4.91	10.45	10.53	6.94	6.77	0.71	090
15792		R	Chemical peel, nonfacial	1.86	10.33	10.15	5.50	5.44	0.31	090
15793		A	Chemical peel, nonfacial	3.96	9.70	9.42	6.33	6.05	0.58	090
15819		A	Plastic surgery, neck	10.65	NA	NA	7.46	8.01	2.18	090
15820		A	Revision of lower eyelid	6.27	9.44	8.74	8.00	7.28	1.29	090
15821		A	Revision of lower eyelid	6.84	9.99	9.15	8.36	7.52	1.38	090
15822		A	Revision of upper eyelid	4.62	7.70	7.14	6.28	5.72	0.85	090
15823		A	Revision of upper eyelid	8.32	11.43	10.34	9.83	8.76	1.61	090
15824		R	Removal of forehead wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15825		R	Removal of neck wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15826		R	Removal of brow wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000

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15828		R	Removal of face wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15829		R	Removal of skin wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15830		R	Exc skin abd	17.11	NA	NA	14.87	13.55	3.52	090
15832		A	Excise excessive skin tissue	12.85	NA	NA	13.05	11.52	2.67	090
15833		A	Excise excessive skin tissue	11.90	NA	NA	11.37	10.57	2.42	090
15834		A	Excise excessive skin tissue	12.17	NA	NA	12.57	10.90	2.49	090
15835		A	Excise excessive skin tissue	12.99	NA	NA	13.12	11.40	2.66	090
15836		A	Excise excessive skin tissue	10.61	NA	NA	8.39	8.37	2.16	090
15837		A	Excise excessive skin tissue	9.55	14.13	12.35	9.79	8.73	2.09	090
15838		A	Excise excessive skin tissue	8.25	NA	NA	7.99	7.47	1.10	090
15839		A	Excise excessive skin tissue	10.50	13.21	12.50	9.34	8.73	2.01	090
15840		A	Graft for face nerve palsy	14.99	NA	NA	13.60	12.49	2.49	090
15841		A	Graft for face nerve palsy	25.99	NA	NA	22.37	19.96	3.49	090
15842		A	Flap for face nerve palsy	41.01	NA	NA	28.66	27.73	5.48	090
15845		A	Skin and muscle repair, face	14.32	NA	NA	14.18	12.48	1.91	090
15847		C	Exc skin abd add-on	0.00	0.00	0.00	0.00	0.00	0.00	YYY
15850		B	Removal of sutures	0.78	1.58	1.65	0.34	0.33	0.06	XXX
15851		A	Removal of sutures	0.86	1.80	1.74	0.41	0.36	0.13	000
15852		A	Dressing change not for burn	0.86	NA	NA	0.41	0.38	0.14	000
15860		A	Test for blood flow in graft	1.95	NA	NA	0.89	0.88	0.40	000
15876		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15877		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15878		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15879		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15920		A	Removal of tail bone ulcer	8.29	NA	NA	8.05	7.41	1.78	090
15922		A	Removal of tail bone ulcer	10.38	NA	NA	11.36	10.02	2.11	090

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15931		A	Remove sacrum pressure sore	10.07	NA	NA	7.92	7.37	2.15	090
15933		A	Remove sacrum pressure sore	11.77	NA	NA	10.75	9.99	2.50	090
15934		A	Remove sacrum pressure sore	13.68	NA	NA	11.35	10.41	2.88	090
15935		A	Remove sacrum pressure sore	15.78	NA	NA	13.78	12.86	3.31	090
15936		A	Remove sacrum pressure sore	13.16	NA	NA	10.95	10.10	2.77	090
15937		A	Remove sacrum pressure sore	15.14	NA	NA	13.17	12.15	3.18	090
15940		A	Remove hip pressure sore	10.20	NA	NA	8.51	7.83	2.15	090
15941		A	Remove hip pressure sore	12.41	NA	NA	11.91	11.17	2.57	090
15944		A	Remove hip pressure sore	12.44	NA	NA	11.96	10.98	2.60	090
15945		A	Remove hip pressure sore	13.75	NA	NA	13.44	12.31	2.84	090
15946		A	Remove hip pressure sore	24.12	NA	NA	20.59	18.92	5.00	090
15950		A	Remove thigh pressure sore	8.03	NA	NA	7.26	6.90	1.65	090
15951		A	Remove thigh pressure sore	11.58	NA	NA	12.86	11.02	2.36	090
15952		A	Remove thigh pressure sore	12.31	NA	NA	9.39	9.40	2.73	090
15953		A	Remove thigh pressure sore	13.57	NA	NA	10.31	10.47	2.77	090
15956		A	Remove thigh pressure sore	16.79	NA	NA	14.67	13.43	3.55	090
15958		A	Remove thigh pressure sore	16.75	NA	NA	15.43	14.17	3.52	090
15999		C	Removal of pressure sore	0.00	0.00	0.00	0.00	0.00	0.00	YYY
16000		A	Initial treatment of burn(s)	0.89	1.00	0.95	0.38	0.33	0.13	000
16020		A	Dress/debrid p-thick burn, s	0.80	1.53	1.45	0.80	0.74	0.11	000
16025		A	Dress/debrid p-thick burn, m	1.85	2.21	2.09	1.30	1.20	0.32	000
16030		A	Dress/debrid p-thick burn, l	2.08	2.81	2.66	1.50	1.38	0.38	000
16035		A	Incision of burn scab, initi	3.74	NA	NA	1.56	1.60	0.65	000
16036		A	Escharotomy; addl incision	1.50	NA	NA	0.66	0.64	0.28	ZZZ
17000		A	Destruct premalg lesion	0.65	1.59	1.57	0.92	0.88	0.08	010
17003		A	Destruct premalg les, 2-14	0.07	0.12	0.13	0.05	0.05	0.01	ZZZ

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17004		A	Destroy premlg lesions 15+	1.85	2.85	2.88	1.81	1.79	0.28	010
17106		A	Destruction of skin lesions	3.69	5.72	5.65	3.93	3.84	0.55	090
17107		A	Destruction of skin lesions	4.79	7.22	7.30	4.85	4.89	0.76	090
17108		A	Destruction of skin lesions	7.49	9.88	9.53	6.73	6.54	1.36	090
17110		A	Destruct b9 lesion, 1-14	0.70	2.35	2.37	1.25	1.21	0.08	010
17111		A	Destruct lesion, 15 or more	0.97	2.65	2.66	1.43	1.38	0.13	010
17250		A	Chemical cautery, tissue	0.50	1.65	1.60	0.50	0.48	0.07	000
17260		A	Destruction of skin lesions	0.96	1.65	1.65	0.95	0.90	0.13	010
17261		A	Destruction of skin lesions	1.22	2.73	2.72	1.35	1.30	0.18	010
17262		A	Destruction of skin lesions	1.63	3.15	3.13	1.65	1.57	0.24	010
17263		A	Destruction of skin lesions	1.84	3.42	3.40	1.79	1.70	0.27	010
17264		A	Destruction of skin lesions	1.99	3.64	3.61	1.87	1.77	0.30	010
17266		A	Destruction of skin lesions	2.39	4.00	3.96	2.12	1.99	0.35	010
17270		A	Destruction of skin lesions	1.37	2.76	2.72	1.43	1.35	0.21	010
17271		A	Destruction of skin lesions	1.54	2.97	2.95	1.58	1.51	0.24	010
17272		A	Destruction of skin lesions	1.82	3.33	3.30	1.78	1.70	0.27	010
17273		A	Destruction of skin lesions	2.10	3.63	3.60	1.97	1.87	0.31	010
17274		A	Destruction of skin lesions	2.64	4.11	4.07	2.31	2.19	0.38	010
17276		A	Destruction of skin lesions	3.25	4.56	4.47	2.66	2.51	0.49	010
17280		A	Destruction of skin lesions	1.22	2.64	2.62	1.33	1.26	0.18	010
17281		A	Destruction of skin lesions	1.77	3.10	3.08	1.74	1.66	0.27	010
17282		A	Destruction of skin lesions	2.09	3.57	3.52	1.97	1.87	0.31	010
17283		A	Destruction of skin lesions	2.69	4.11	4.05	2.38	2.25	0.40	010
17284		A	Destruction of skin lesions	3.26	4.62	4.55	2.74	2.59	0.47	010
17286		A	Destruction of skin lesions	4.48	5.47	5.32	3.49	3.30	0.69	010
17311		A	Mohs, 1 stage, h/n/hf/g	6.20	11.87	12.34	4.54	4.24	0.90	000

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17312		A	Mohs addl stage	3.30	7.46	7.83	2.41	2.25	0.47	ZZZ
17313		A	Mohs, 1 stage, t/a/l	5.56	10.92	11.37	4.08	3.81	0.81	000
17314		A	Mohs, addl stage, t/a/l	3.06	6.91	7.25	2.24	2.09	0.44	ZZZ
17315		A	Mohs surg, addl block	0.87	1.32	1.35	0.64	0.60	0.11	ZZZ
17340		A	Cryotherapy of skin	0.77	0.64	0.57	0.58	0.51	0.10	010
17360		A	Skin peel therapy	1.46	2.15	2.14	1.35	1.28	0.23	010
17380		R	Hair removal by electrolysis	0.00	0.00	0.00	0.00	0.00	0.00	000
17999		C	Skin tissue procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
19000		A	Drainage of breast lesion	0.84	2.06	2.19	0.32	0.34	0.11	000
19001		A	Drain breast lesion add-on	0.42	0.28	0.30	0.16	0.17	0.06	ZZZ
19020		A	Incision of breast lesion	3.83	8.70	8.27	4.23	3.90	0.81	090
19030		A	Injection for breast x-ray	1.53	2.68	2.99	0.53	0.61	0.14	000
19100		A	Bx breast percut w/o image	1.27	2.71	2.60	0.54	0.50	0.27	000
19101		A	Biopsy of breast, open	3.23	5.78	5.54	2.57	2.40	0.69	010
19102		A	Bx breast percut w/image	2.00	3.55	3.93	0.71	0.79	0.23	000
19103		A	Bx breast percut w/device	3.69	10.68	11.60	1.36	1.46	0.49	000
19105		A	Cryosurg ablate fa, each	3.69	48.12	54.84	1.58	1.57	0.41	000
19110		A	Nipple exploration	4.44	8.57	8.03	4.61	4.22	0.96	090
19112		A	Excise breast duct fistula	3.81	8.44	7.95	4.43	4.06	0.83	090
19120		A	Removal of breast lesion	5.92	7.03	6.51	4.89	4.47	1.30	090
19125		A	Excision, breast lesion	6.69	7.68	7.09	5.31	4.84	1.47	090
19126		A	Excision, addl breast lesion	2.93	NA	NA	1.26	1.14	0.65	ZZZ
19260		A	Removal of chest wall lesion	17.78	NA	NA	13.92	13.34	4.11	090
19271		A	Revision of chest wall	22.19	NA	NA	20.51	20.28	5.24	090
19272		A	Extensive chest wall surgery	25.17	NA	NA	21.62	21.51	6.19	090
19290		A	Place needle wire, breast	1.27	2.93	3.20	0.44	0.50	0.13	000

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19291		A	Place needle wire, breast	0.63	1.15	1.27	0.22	0.25	0.06	ZZZ
19295		A	Place breast clip, percut	0.00	2.34	2.59	NA	NA	0.01	ZZZ
19296		A	Place po breast cath for rad	3.63	106.59	110.18	1.87	1.73	0.76	000
19297		A	Place breast cath for rad	1.72	NA	NA	0.74	0.68	0.37	ZZZ
19298		A	Place breast rad tube/caths	6.00	25.46	29.02	3.07	2.90	0.79	000
19300		A	Removal of breast tissue	5.31	8.40	8.06	5.45	4.99	1.17	090
19301		A	Partical mastectomy	10.13	NA	NA	6.92	6.14	2.23	090
19302		A	P-mastectomy w/ln removal	13.99	NA	NA	9.20	8.43	3.09	090
19303		A	Mast, simple, complete	15.85	NA	NA	10.52	9.29	3.50	090
19304		A	Mast, subq	7.95	NA	NA	7.14	6.55	1.74	090
19305		A	Mast, radical	17.46	NA	NA	12.12	11.02	3.87	090
19306		A	Mast, rad, urban type	18.13	NA	NA	13.24	11.92	4.01	090
19307		A	Mast, mod rad	18.23	NA	NA	13.04	11.84	4.01	090
19316		A	Suspension of breast	11.09	NA	NA	10.03	9.32	2.27	090
19318		A	Reduction of large breast	16.03	NA	NA	14.65	13.61	3.28	090
19324		A	Enlarge breast	6.80	NA	NA	6.06	5.75	1.51	090
19325		A	Enlarge breast with implant	8.64	NA	NA	9.28	8.58	1.75	090
19328		A	Removal of breast implant	6.48	NA	NA	7.21	6.66	1.33	090
19330		A	Removal of implant material	8.54	NA	NA	8.94	8.22	1.72	090
19340		A	Immediate breast prosthesis	13.99	NA	NA	13.86	8.78	2.85	090
19342		A	Delayed breast prosthesis	12.63	NA	NA	13.05	12.01	2.53	090
19350		A	Breast reconstruction	9.11	13.59	13.34	9.55	8.88	1.85	090
19355		A	Correct inverted nipple(s)	8.52	9.94	9.94	6.40	6.12	1.89	090
19357		A	Breast reconstruction	21.07	NA	NA	22.41	20.64	4.28	090
19361		A	Breast reconstr w/lat flap	23.36	NA	NA	24.02	21.59	4.78	090
19364		A	Breast reconstruction	42.58	NA	NA	34.17	31.19	8.56	090

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19366		A	Breast reconstruction	21.84	NA	NA	15.49	14.15	4.63	090
19367		A	Breast reconstruction	26.80	NA	NA	22.89	21.08	5.47	090
19368		A	Breast reconstruction	33.90	NA	NA	27.67	25.16	6.92	090
19369		A	Breast reconstruction	31.31	NA	NA	25.83	23.22	6.39	090
19370		A	Surgery of breast capsule	9.17	NA	NA	9.86	9.09	1.87	090
19371		A	Removal of breast capsule	10.62	NA	NA	11.18	10.31	2.15	090
19380		A	Revise breast reconstruction	10.41	NA	NA	11.02	10.17	2.11	090
19396		A	Design custom breast implant	2.17	5.03	4.34	1.56	1.37	0.47	000
19499		C	Breast surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
20000		A	Incision of abscess	2.17	3.40	3.35	1.92	1.91	0.28	010
20005		A	Incision of deep abscess	3.58	4.89	4.63	2.80	2.67	0.61	010
20100		A	Explore wound, neck	10.38	NA	NA	5.64	5.04	2.03	010
20101		A	Explore wound, chest	3.23	7.72	7.56	2.00	1.94	0.72	010
20102		A	Explore wound, abdomen	3.98	9.11	8.79	2.75	2.53	0.83	010
20103		A	Explore wound, extremity	5.34	10.39	10.00	4.07	3.85	1.03	010
20150		A	Excise epiphyseal bar	14.75	NA	NA	12.26	11.04	3.04	090
20200		A	Muscle biopsy	1.46	4.02	3.87	1.01	0.95	0.34	000
20205		A	Deep muscle biopsy	2.35	5.16	4.89	1.64	1.52	0.58	000
20206		A	Needle biopsy, muscle	0.99	5.41	6.02	0.60	0.66	0.10	000
20220		A	Bone biopsy, trocar/needle	1.27	2.82	3.32	0.71	0.79	0.11	000
20225		A	Bone biopsy, trocar/needle	1.87	12.76	15.44	1.09	1.20	0.24	000
20240		A	Bone biopsy, excisional	3.28	NA	NA	2.79	2.72	0.54	010
20245		A	Bone biopsy, excisional	8.95	NA	NA	8.15	7.70	1.71	010
20250		A	Open bone biopsy	5.19	NA	NA	4.87	4.60	1.27	010
20251		A	Open bone biopsy	5.72	NA	NA	5.18	5.00	1.37	010
20500		A	Injection of sinus tract	1.28	1.62	1.76	1.07	1.17	0.13	010

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20501		A	Inject sinus tract for x-ray	0.76	2.41	2.71	0.26	0.31	0.07	000
2050F		I	Wound char size etc docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20520		A	Removal of foreign body	1.90	3.53	3.37	2.05	1.95	0.31	010
20525		A	Removal of foreign body	3.54	9.46	9.29	3.18	3.01	0.66	010
20526		A	Ther injection, carp tunnel	0.94	1.10	1.07	0.61	0.58	0.14	000
20550		A	Inj tendon sheath/ligament	0.75	0.83	0.81	0.39	0.36	0.08	000
20551		A	Inj tendon origin/insertion	0.75	0.89	0.83	0.44	0.40	0.08	000
20552		A	Inj trigger point, 1/2 muscl	0.66	0.84	0.79	0.39	0.34	0.07	000
20553		A	Inject trigger points, =/> 3	0.75	0.99	0.91	0.44	0.38	0.07	000
20555		A	Place ndl musc/tis for rt	6.00	NA	NA	2.91	2.86	0.89	000
20600		A	Drain/inject, joint/bursa	0.66	0.84	0.82	0.41	0.40	0.07	000
20605		A	Drain/inject, joint/bursa	0.68	0.96	0.92	0.45	0.43	0.08	000
2060F		I	Pt talk eval hlthwkr re mdd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20610		A	Drain/inject, joint/bursa	0.79	1.39	1.32	0.57	0.54	0.13	000
20612		A	Aspirate/inj ganglion cyst	0.70	0.94	0.89	0.45	0.43	0.08	000
20615		A	Treatment of bone cyst	2.33	3.67	3.60	2.02	1.95	0.30	010
20650		A	Insert and remove bone pin	2.28	3.24	3.08	1.92	1.85	0.30	010
20660		A	Apply, rem fixation device	4.00	NA	NA	2.18	2.06	1.14	000
20661		A	Application of head brace	5.26	NA	NA	7.58	7.20	1.71	090
20662		A	Application of pelvis brace	6.38	NA	NA	4.71	5.55	0.64	090
20663		A	Application of thigh brace	5.74	NA	NA	6.80	6.30	1.19	090
20664		A	Halo brace application	10.06	NA	NA	10.36	9.92	3.74	090
20665		A	Removal of fixation device	1.36	1.64	1.77	1.24	1.27	0.11	010
20670		A	Removal of support implant	1.79	8.59	8.96	2.24	2.19	0.31	010
20680		A	Removal of support implant	5.96	10.89	10.43	5.61	5.24	1.10	090
20690		A	Apply bone fixation device	8.78	NA	NA	7.09	6.26	1.68	090

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20692		A	Apply bone fixation device	16.27	NA	NA	14.05	12.25	2.91	090
20693		A	Adjust bone fixation device	6.06	NA	NA	6.23	6.03	1.12	090
20694		A	Remove bone fixation device	4.28	7.22	7.09	4.88	4.67	0.79	090
20696		A	Comp multiplane ext fixation	17.56	NA	NA	15.12	12.38	1.30	090
20697		A	Comp ext fixate strut change	0.00	56.39	48.20	NA	NA	0.01	000
20802		A	Replantation, arm, complete	42.62	NA	NA	22.68	21.70	3.17	090
20805		A	Replant forearm, complete	51.46	NA	NA	17.56	21.78	10.53	090
20808		A	Replantation hand, complete	63.09	NA	NA	49.13	46.17	12.90	090
20816		A	Replantation digit, complete	31.95	NA	NA	26.30	26.63	4.14	090
20822		A	Replantation digit, complete	26.66	NA	NA	23.70	23.46	5.47	090
20824		A	Replantation thumb, complete	31.95	NA	NA	23.54	25.07	6.53	090
20827		A	Replantation thumb, complete	27.48	NA	NA	24.28	24.62	5.62	090
20838		A	Replantation foot, complete	42.88	NA	NA	23.08	23.21	3.18	090
20900		A	Removal of bone for graft	3.00	8.40	8.30	2.71	3.18	0.58	000
20902		A	Removal of bone for graft	4.58	NA	NA	3.66	4.08	0.90	000
20910		A	Remove cartilage for graft	5.53	NA	NA	6.14	6.02	0.73	090
20912		A	Remove cartilage for graft	6.54	NA	NA	7.07	6.67	1.03	090
20920		A	Removal of fascia for graft	5.51	NA	NA	5.74	5.47	0.72	090
20922		A	Removal of fascia for graft	6.93	8.79	9.08	6.08	6.15	1.33	090
20924		A	Removal of tendon for graft	6.68	NA	NA	7.03	6.72	1.24	090
20926		A	Removal of tissue for graft	5.79	NA	NA	5.85	5.70	1.22	090
20930		B	Sp bone algrft morsel add-on	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20931		A	Sp bone algrft struct add-on	1.81	NA	NA	1.00	0.97	0.58	ZZZ
20936		B	Sp bone agrft local add-on	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20937		A	Sp bone agrft morsel add-on	2.79	NA	NA	1.58	1.53	0.71	ZZZ
20938		A	Sp bone agrft struct add-on	3.02	NA	NA	1.70	1.64	0.86	ZZZ

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20950		A	Fluid pressure, muscle	1.26	5.47	5.55	1.19	1.14	0.24	000
20955		A	Fibula bone graft, microvasc	40.26	NA	NA	30.36	28.00	6.92	090
20956		A	Iliac bone graft, microvasc	41.18	NA	NA	29.90	28.07	8.44	090
20957		A	Mt bone graft, microvasc	42.61	NA	NA	27.65	24.20	8.73	090
20962		A	Other bone graft, microvasc	39.21	NA	NA	32.35	29.73	8.03	090
20969		A	Bone/skin graft, microvasc	45.43	NA	NA	33.09	30.51	6.92	090
20970		A	Bone/skin graft, iliac crest	44.58	NA	NA	30.61	29.27	9.14	090
20972		A	Bone/skin graft, metatarsal	44.51	NA	NA	23.39	22.38	3.56	090
20973		A	Bone/skin graft, great toe	47.27	NA	NA	33.77	27.80	3.50	090
20974		A	Electrical bone stimulation	0.62	1.39	1.26	0.70	0.66	0.13	000
20975		A	Electrical bone stimulation	2.60	NA	NA	2.04	1.97	0.61	000
20979		A	Us bone stimulation	0.62	0.82	0.80	0.28	0.29	0.08	000
20982		A	Ablate, bone tumor(s) perq	7.27	85.61	94.84	2.92	3.21	0.83	000
20985		A	Cptr-asst dir ms px	2.50	NA	NA	1.46	1.37	0.51	ZZZ
20999		C	Musculoskeletal surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21010		A	Incision of jaw joint	11.04	NA	NA	9.31	8.59	1.47	090
21011		A	Exc face les sc < 2 cm	2.99	6.10	6.10	3.85	3.85	0.47	090
21012		A	Exc face les sc = 2 cm	4.45	NA	NA	4.91	4.91	0.75	090
21013		A	Exc face tum deep < 2 cm	5.42	8.52	8.52	5.52	5.52	0.85	090
21014		A	Exc face tum deep = 2 cm	7.13	NA	NA	7.30	7.30	1.20	090
21015		A	Resect face tum < 2 cm	9.89	NA	NA	9.32	7.43	1.94	090
21016		A	Resect face tum = 2 cm	15.26	NA	NA	12.82	12.82	3.02	090
21025		A	Excision of bone, lower jaw	10.03	14.85	14.13	11.07	10.29	1.50	090
21026		A	Excision of facial bone(s)	5.70	11.48	10.89	8.23	7.76	0.86	090
21029		A	Contour of face bone lesion	8.39	12.93	12.22	9.37	8.74	1.71	090
21030		A	Excise max/zygoma b9 tumor	4.91	9.50	8.94	6.73	6.26	0.79	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
21031		A	Remove exostosis, mandible	3.30	7.64	7.29	4.96	4.63	0.42	090
21032		A	Remove exostosis, maxilla	3.34	7.81	7.44	4.85	4.50	0.44	090
21034		A	Excise max/zygoma mlg tumor	17.38	20.12	18.87	15.69	14.48	2.53	090
21040		A	Excise mandible lesion	4.91	9.63	9.07	6.81	6.27	0.78	090
21044		A	Removal of jaw bone lesion	12.80	NA	NA	12.11	11.23	1.85	090
21045		A	Extensive jaw surgery	18.37	NA	NA	16.33	15.06	2.61	090
21046		A	Remove mandible cyst complex	14.21	NA	NA	17.08	15.71	1.89	090
21047		A	Excise lwr jaw cyst w/repair	20.07	NA	NA	16.88	15.33	2.68	090
21048		A	Remove maxilla cyst complex	14.71	NA	NA	17.45	15.84	1.96	090
21049		A	Excis uppr jaw cyst w/repair	19.32	NA	NA	15.42	14.62	2.56	090
21050		A	Removal of jaw joint	11.76	NA	NA	12.14	11.52	2.39	090
21060		A	Remove jaw joint cartilage	11.07	NA	NA	11.95	10.71	2.43	090
21070		A	Remove coronoid process	8.62	NA	NA	8.89	8.46	1.14	090
21073		A	Mnpj of tmj w/anesth	3.45	7.50	7.01	3.63	3.22	0.71	090
21076		A	Prepare face/oral prosthesis	13.40	13.89	12.60	10.30	8.97	1.77	010
21077		A	Prepare face/oral prosthesis	33.70	33.11	30.23	26.05	22.98	4.49	090
21079		A	Prepare face/oral prosthesis	22.31	23.73	21.66	17.40	15.24	2.98	090
21080		A	Prepare face/oral prosthesis	25.06	26.92	24.69	19.26	16.93	3.35	090
21081		A	Prepare face/oral prosthesis	22.85	24.80	22.75	17.55	15.48	3.07	090
21082		A	Prepare face/oral prosthesis	20.84	24.27	21.98	17.25	14.99	2.77	090
21083		A	Prepare face/oral prosthesis	19.27	23.63	21.52	16.10	13.96	1.43	090
21084		A	Prepare face/oral prosthesis	22.48	26.71	24.52	18.45	16.19	3.01	090
21085		A	Prepare face/oral prosthesis	8.99	10.82	9.84	7.11	6.26	3.48	010
21086		A	Prepare face/oral prosthesis	24.88	23.80	21.55	19.03	16.55	3.32	090
21087		A	Prepare face/oral prosthesis	24.88	23.51	21.41	18.67	16.40	3.32	090
21088		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
21089		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21100		A	Maxillofacial fixation	4.73	11.55	13.39	4.59	5.35	0.66	090
21110		A	Interdental fixation	5.99	16.37	15.46	12.81	12.04	0.79	090
21116		A	Injection, jaw joint x-ray	0.81	3.24	3.34	0.37	0.34	0.06	000
21120		A	Reconstruction of chin	5.10	12.68	12.28	9.22	8.75	1.05	090
21121		A	Reconstruction of chin	7.81	14.78	13.83	11.02	10.28	0.57	090
21122		A	Reconstruction of chin	8.71	NA	NA	11.47	10.90	0.64	090
21123		A	Reconstruction of chin	11.34	NA	NA	15.27	13.20	0.83	090
21125		A	Augmentation, lower jaw bone	10.80	72.64	74.63	11.26	10.12	2.22	090
21127		A	Augmentation, lower jaw bone	12.44	94.29	92.85	12.98	11.64	1.65	090
21137		A	Reduction of forehead	10.24	NA	NA	9.01	8.70	2.08	090
21138		A	Reduction of forehead	12.87	NA	NA	12.36	11.33	1.89	090
21139		A	Reduction of forehead	15.02	NA	NA	10.82	11.11	1.10	090
21141		A	Reconstruct midface, lefort	19.57	NA	NA	17.94	16.76	4.00	090
21142		A	Reconstruct midface, lefort	20.28	NA	NA	18.28	16.23	4.15	090
21143		A	Reconstruct midface, lefort	21.05	NA	NA	20.66	18.02	4.66	090
21145		A	Reconstruct midface, lefort	23.94	NA	NA	20.09	18.00	1.75	090
21146		A	Reconstruct midface, lefort	24.87	NA	NA	22.78	20.31	5.09	090
21147		A	Reconstruct midface, lefort	26.47	NA	NA	20.46	19.39	1.95	090
21150		A	Reconstruct midface, lefort	25.96	NA	NA	22.17	20.00	1.91	090
21151		A	Reconstruct midface, lefort	29.02	NA	NA	23.91	24.50	3.89	090
21154		A	Reconstruct midface, lefort	31.29	NA	NA	30.79	26.84	4.17	090
21155		A	Reconstruct midface, lefort	35.22	NA	NA	27.89	25.49	2.60	090
21159		A	Reconstruct midface, lefort	43.14	NA	NA	39.22	33.18	5.74	090
21160		A	Reconstruct midface, lefort	47.19	NA	NA	28.17	27.96	3.49	090
21172		A	Reconstruct orbit/forehead	28.20	NA	NA	24.01	20.66	3.76	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
21175		A	Reconstruct orbit/forehead	33.56	NA	NA	28.35	24.71	12.49	090
21179		A	Reconstruct entire forehead	22.65	NA	NA	19.85	17.58	4.63	090
21180		A	Reconstruct entire forehead	25.58	NA	NA	22.03	19.77	3.42	090
21181		A	Contour cranial bone lesion	10.28	NA	NA	10.40	9.21	1.36	090
21182		A	Reconstruct cranial bone	32.58	NA	NA	22.12	21.33	4.34	090
21183		A	Reconstruct cranial bone	35.70	NA	NA	23.92	23.36	7.29	090
21184		A	Reconstruct cranial bone	38.62	NA	NA	30.69	26.90	7.91	090
21188		A	Reconstruction of midface	23.15	NA	NA	21.65	20.91	3.09	090
21193		A	Reconst lwr jaw w/o graft	18.90	NA	NA	16.31	14.79	4.20	090
21194		A	Reconst lwr jaw w/graft	21.82	NA	NA	17.13	16.20	2.91	090
21195		A	Reconst lwr jaw w/o fixation	19.16	NA	NA	18.91	17.59	2.54	090
21196		A	Reconst lwr jaw w/fixation	20.83	NA	NA	21.42	19.48	2.77	090
21198		A	Reconstr lwr jaw segment	15.71	NA	NA	17.19	16.00	2.26	090
21199		A	Reconstr lwr jaw w/advance	16.73	NA	NA	12.01	11.03	2.23	090
21206		A	Reconstruct upper jaw bone	15.59	NA	NA	19.16	16.85	3.21	090
21208		A	Augmentation of facial bones	11.42	40.02	38.42	11.19	10.84	2.33	090
21209		A	Reduction of facial bones	7.82	15.39	14.86	10.48	9.87	1.60	090
21210		A	Face bone graft	11.69	51.85	49.16	12.63	11.31	1.57	090
21215		A	Lower jaw bone graft	12.23	99.07	93.97	12.88	11.55	2.49	090
21230		A	Rib cartilage graft	11.17	NA	NA	10.04	9.38	2.27	090
21235		A	Ear cartilage graft	7.50	13.01	12.58	8.58	8.12	1.14	090
21240		A	Reconstruction of jaw joint	16.07	NA	NA	15.34	13.97	2.12	090
21242		A	Reconstruction of jaw joint	14.59	NA	NA	14.01	12.96	1.95	090
21243		A	Reconstruction of jaw joint	24.53	NA	NA	22.87	20.76	3.28	090
21244		A	Reconstruction of lower jaw	13.62	NA	NA	16.43	15.34	2.01	090
21245		A	Reconstruction of jaw	13.12	18.58	17.97	12.21	11.65	1.74	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
21246		A	Reconstruction of jaw	12.92	NA	NA	10.52	9.87	1.71	090
21247		A	Reconstruct lower jaw bone	24.37	NA	NA	19.26	18.40	5.00	090
21248		A	Reconstruction of jaw	12.74	18.47	16.99	12.85	11.47	1.70	090
21249		A	Reconstruction of jaw	18.77	23.91	21.84	17.57	15.35	2.49	090
21255		A	Reconstruct lower jaw bone	18.46	NA	NA	19.29	19.42	2.44	090
21256		A	Reconstruction of orbit	17.66	NA	NA	16.58	14.83	2.35	090
21260		A	Revise eye sockets	17.90	NA	NA	21.40	19.56	1.31	090
21261		A	Revise eye sockets	34.07	NA	NA	23.21	23.84	6.98	090
21263		A	Revise eye sockets	31.01	NA	NA	21.88	21.94	2.29	090
21267		A	Revise eye sockets	20.69	NA	NA	24.09	22.30	4.24	090
21268		A	Revise eye sockets	27.07	NA	NA	20.18	21.31	5.54	090
21270		A	Augmentation, cheek bone	10.63	16.83	15.31	10.35	9.07	1.57	090
21275		A	Revision, orbitofacial bones	11.76	NA	NA	11.64	10.42	2.39	090
21280		A	Revision of eyelid	7.13	NA	NA	8.85	7.93	1.46	090
21282		A	Revision of eyelid	4.27	NA	NA	6.30	5.76	0.81	090
21295		A	Revision of jaw muscle/bone	1.90	NA	NA	2.84	2.86	0.38	090
21296		A	Revision of jaw muscle/bone	4.78	NA	NA	5.81	6.27	0.64	090
21299		C	Cranio/maxillofacial surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21310		A	Treatment of nose fracture	0.58	2.65	2.53	0.16	0.15	0.10	000
21315		A	Treatment of nose fracture	1.83	5.88	5.66	2.39	2.27	0.30	010
21320		A	Treatment of nose fracture	1.88	5.37	5.19	1.95	1.84	0.28	010
21325		A	Treatment of nose fracture	4.18	NA	NA	8.94	8.86	0.69	090
21330		A	Treatment of nose fracture	5.79	NA	NA	10.30	10.04	0.76	090
21335		A	Treatment of nose fracture	9.02	NA	NA	11.56	11.12	1.27	090
21336		A	Treat nasal septal fracture	6.77	NA	NA	11.63	11.17	0.95	090
21337		A	Treat nasal septal fracture	3.39	7.92	7.64	4.89	4.61	0.54	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
21338		A	Treat nasoethmoid fracture	6.87	NA	NA	13.99	13.52	1.41	090
21339		A	Treat nasoethmoid fracture	8.50	NA	NA	13.06	13.25	1.72	090
21340		A	Treatment of nose fracture	11.49	NA	NA	9.89	9.75	1.54	090
21343		A	Treatment of sinus fracture	14.32	NA	NA	16.68	16.45	2.94	090
21344		A	Treatment of sinus fracture	21.57	NA	NA	21.71	19.58	8.04	090
21345		A	Treat nose/jaw fracture	9.06	12.77	12.57	8.54	8.37	1.22	090
21346		A	Treat nose/jaw fracture	11.45	NA	NA	14.43	14.18	1.54	090
21347		A	Treat nose/jaw fracture	13.53	NA	NA	15.41	15.58	1.78	090
21348		A	Treat nose/jaw fracture	17.52	NA	NA	16.29	14.18	2.33	090
21355		A	Treat cheek bone fracture	4.45	8.32	7.88	5.07	4.64	0.58	010
21356		A	Treat cheek bone fracture	4.83	9.10	8.77	5.72	5.41	0.73	010
21360		A	Treat cheek bone fracture	7.19	NA	NA	7.97	7.37	0.95	090
21365		A	Treat cheek bone fracture	16.77	NA	NA	14.39	13.13	2.91	090
21366		A	Treat cheek bone fracture	18.60	NA	NA	17.07	14.84	3.82	090
21385		A	Treat eye socket fracture	9.57	NA	NA	9.92	9.56	1.27	090
21386		A	Treat eye socket fracture	9.57	NA	NA	8.26	8.00	1.95	090
21387		A	Treat eye socket fracture	10.11	NA	NA	10.22	9.80	2.05	090
21390		A	Treat eye socket fracture	11.23	NA	NA	11.16	10.08	1.96	090
21395		A	Treat eye socket fracture	14.70	NA	NA	13.51	11.90	1.95	090
21400		A	Treat eye socket fracture	1.50	3.71	3.53	2.73	2.58	0.28	090
21401		A	Treat eye socket fracture	3.68	9.31	9.29	4.49	4.33	0.75	090
21406		A	Treat eye socket fracture	7.42	NA	NA	8.57	7.67	0.99	090
21407		A	Treat eye socket fracture	9.02	NA	NA	9.10	8.36	1.65	090
21408		A	Treat eye socket fracture	12.78	NA	NA	12.39	11.13	2.61	090
21421		A	Treat mouth roof fracture	6.02	14.95	14.41	11.73	11.24	1.23	090
21422		A	Treat mouth roof fracture	8.73	NA	NA	10.07	9.46	1.17	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
21423		A	Treat mouth roof fracture	10.85	NA	NA	12.18	11.03	2.22	090
21431		A	Treat craniofacial fracture	7.90	NA	NA	12.20	12.12	1.61	090
21432		A	Treat craniofacial fracture	8.82	NA	NA	11.13	9.96	1.78	090
21433		A	Treat craniofacial fracture	26.29	NA	NA	18.47	17.97	5.38	090
21435		A	Treat craniofacial fracture	20.26	NA	NA	15.80	15.24	2.70	090
21436		A	Treat craniofacial fracture	30.30	NA	NA	26.90	23.86	6.20	090
21440		A	Treat dental ridge fracture	3.44	12.29	11.82	9.38	9.05	0.69	090
21445		A	Treat dental ridge fracture	6.26	15.23	14.74	11.29	10.84	0.83	090
21450		A	Treat lower jaw fracture	3.71	12.98	12.35	9.71	9.38	0.68	090
21451		A	Treat lower jaw fracture	5.65	16.18	15.28	12.39	11.79	0.75	090
21452		A	Treat lower jaw fracture	2.40	15.93	15.32	8.36	7.61	0.49	090
21453		A	Treat lower jaw fracture	6.64	18.78	17.66	15.19	14.47	1.09	090
21454		A	Treat lower jaw fracture	7.36	NA	NA	8.60	7.90	0.96	090
21461		A	Treat lower jaw fracture	9.31	50.62	47.65	17.16	16.34	1.46	090
21462		A	Treat lower jaw fracture	11.01	52.11	49.52	18.36	17.26	1.47	090
21465		A	Treat lower jaw fracture	13.12	NA	NA	13.50	12.06	2.68	090
21470		A	Treat lower jaw fracture	17.54	NA	NA	16.37	14.84	3.01	090
21480		A	Reset dislocated jaw	0.61	1.96	1.93	0.26	0.24	0.10	000
21485		A	Reset dislocated jaw	4.77	14.95	14.11	11.70	11.08	0.64	090
21490		A	Repair dislocated jaw	12.95	NA	NA	12.67	11.74	2.66	090
21495		A	Treat hyoid bone fracture	6.79	NA	NA	13.46	12.72	0.89	090
21497		A	Interdental wiring	4.64	14.40	14.01	11.46	11.14	0.93	090
21499		C	Head surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21501		A	Drain neck/chest lesion	3.98	8.43	8.13	4.77	4.57	0.78	090
21502		A	Drain chest lesion	7.55	NA	NA	5.60	5.75	1.67	090
21510		A	Drainage of bone lesion	6.20	NA	NA	6.23	6.06	1.51	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
21550		A	Biopsy of neck/chest	2.11	5.05	4.98	2.23	2.18	0.31	010
21552		A	Exc neck les sc = 3 cm	6.49	NA	NA	5.53	5.53	1.33	090
21554		A	Exc neck tum deep = 5 cm	11.13	NA	NA	8.61	8.61	2.16	090
21555		A	Exc neck les sc < 3 cm	3.96	7.29	7.10	4.29	4.20	0.81	090
21556		A	Exc neck tum deep < 5 cm	7.66	NA	NA	6.78	5.92	1.50	090
21557		A	Resect neck tum < 5 cm	14.75	NA	NA	11.17	8.53	2.90	090
21558		A	Resect neck tum = 5 cm	21.58	NA	NA	14.95	14.95	4.24	090
21600		A	Partial removal of rib	7.26	NA	NA	7.93	7.54	1.62	090
21610		A	Partial removal of rib	15.91	NA	NA	13.75	12.21	5.93	090
21615		A	Removal of rib	10.45	NA	NA	6.47	6.58	2.56	090
21616		A	Removal of rib and nerves	12.69	NA	NA	7.06	8.16	3.15	090
21620		A	Partial removal of sternum	7.28	NA	NA	6.60	6.44	1.68	090
21627		A	Sternal debridement	7.30	NA	NA	7.21	7.12	1.71	090
21630		A	Extensive sternum surgery	19.18	NA	NA	14.61	14.00	4.20	090
21632		A	Extensive sternum surgery	19.68	NA	NA	12.60	12.44	5.13	090
21685		A	Hyoid myotomy & suspension	15.26	NA	NA	13.20	12.19	2.03	090
21700		A	Revision of neck muscle	6.31	NA	NA	3.61	4.28	1.55	090
21705		A	Revision of neck muscle/rib	9.92	NA	NA	4.81	5.68	2.43	090
21720		A	Revision of neck muscle	5.80	NA	NA	5.72	5.20	2.15	090
21725		A	Revision of neck muscle	7.19	NA	NA	7.26	6.85	1.47	090
21740		A	Reconstruction of sternum	17.57	NA	NA	9.15	9.60	3.60	090
21742		C	Repair stern/nuss w/o scope	0.00	0.00	0.00	0.00	0.00	0.00	090
21743		C	Repair sternum/nuss w/scope	0.00	0.00	0.00	0.00	0.00	0.00	090
21750		A	Repair of sternum separation	11.40	NA	NA	6.54	6.73	2.81	090
21800		A	Treatment of rib fracture	1.01	1.86	1.74	1.95	1.81	0.18	090
21805		A	Treatment of rib fracture	2.88	NA	NA	4.12	4.06	0.69	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
21810		A	Treatment of rib fracture(s)	7.03	NA	NA	7.13	6.52	1.70	090
21820		A	Treat sternum fracture	1.36	2.43	2.27	2.51	2.34	0.27	090
21825		A	Treat sternum fracture	7.76	NA	NA	6.97	6.95	1.89	090
21899		C	Neck/chest surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21920		A	Biopsy soft tissue of back	2.11	5.01	4.96	2.35	2.25	0.35	010
21925		A	Biopsy soft tissue of back	4.63	7.19	6.81	4.73	4.40	0.96	090
21930		A	Exc back les sc < 3 cm	4.94	7.63	7.41	4.69	4.59	1.06	090
21931		A	Exc back les sc = 3 cm	6.88	NA	NA	5.60	5.60	1.47	090
21932		A	Exc back tum deep < 5 cm	9.82	NA	NA	7.89	7.89	2.16	090
21933		A	Exc back tum deep = 5 cm	11.13	NA	NA	8.35	8.35	2.44	090
21935		A	Resect back tum < 5 cm	15.72	NA	NA	11.50	11.19	3.33	090
21936		A	Resect back tum = 5 cm	22.55	NA	NA	15.22	15.22	4.78	090
22010		A	I&d, p-spine, c/t/cerv-thor	12.75	NA	NA	11.74	11.11	3.42	090
22015		A	I&d, p-spine, l/s/ls	12.64	NA	NA	11.51	10.99	3.19	090
22100		A	Remove part of neck vertebra	11.00	NA	NA	11.05	10.37	4.11	090
22101		A	Remove part, thorax vertebra	11.08	NA	NA	9.83	9.76	4.13	090
22102		A	Remove part, lumbar vertebra	11.08	NA	NA	10.55	10.09	2.77	090
22103		A	Remove extra spine segment	2.34	NA	NA	1.34	1.29	0.66	ZZZ
22110		A	Remove part of neck vertebra	14.00	NA	NA	12.78	12.13	5.23	090
22112		A	Remove part, thorax vertebra	14.07	NA	NA	12.60	11.61	5.24	090
22114		A	Remove part, lumbar vertebra	14.07	NA	NA	12.50	11.89	2.88	090
22116		A	Remove extra spine segment	2.32	NA	NA	1.30	1.24	0.62	ZZZ
22206		A	Cut spine 3 col, thor	37.18	NA	NA	25.80	24.14	7.60	090
22207		A	Cut spine 3 col, lumb	36.68	NA	NA	25.50	23.89	9.55	090
22208		A	Cut spine 3 col, addl seg	9.66	NA	NA	5.49	5.15	2.68	ZZZ
22210		A	Revision of neck spine	25.38	NA	NA	20.23	19.28	7.01	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
22212		A	Revision of thorax spine	20.99	NA	NA	17.57	16.64	5.16	090
22214		A	Revision of lumbar spine	21.02	NA	NA	17.53	16.74	5.31	090
22216		A	Revise, extra spine segment	6.03	NA	NA	3.43	3.32	1.57	ZZZ
22220		A	Revision of neck spine	22.94	NA	NA	18.58	17.44	6.67	090
22222		A	Revision of thorax spine	23.09	NA	NA	18.85	15.77	4.72	090
22224		A	Revision of lumbar spine	23.09	NA	NA	18.42	17.38	5.58	090
22226		A	Revise, extra spine segment	6.03	NA	NA	3.40	3.28	1.64	ZZZ
22305		A	Treat spine process fracture	2.13	2.99	2.82	2.53	2.38	0.42	090
22310		A	Treat spine fracture	3.89	4.26	3.93	3.62	3.33	0.81	090
22315		A	Treat spine fracture	10.11	13.22	12.52	10.21	9.61	2.64	090
22318		A	Treat odontoid fx w/o graft	22.72	NA	NA	17.85	17.05	7.97	090
22319		A	Treat odontoid fx w/graft	25.33	NA	NA	19.66	18.43	9.45	090
22325		A	Treat spine fracture	19.87	NA	NA	16.75	15.88	5.91	090
22326		A	Treat neck spine fracture	20.84	NA	NA	16.75	15.92	6.54	090
22327		A	Treat thorax spine fracture	20.77	NA	NA	17.49	16.37	5.84	090
22328		A	Treat each add spine fx	4.60	NA	NA	2.56	2.47	1.41	ZZZ
22505		A	Manipulation of spine	1.87	NA	NA	1.40	1.28	0.30	010
22520		A	Percut vertebroplasty thor	9.22	51.31	54.01	4.59	4.99	1.10	010
22521		A	Percut vertebroplasty lumb	8.65	51.12	53.41	4.41	4.78	1.05	010
22522		A	Percut vertebroplasty addl	4.30	NA	NA	1.81	1.91	0.57	ZZZ
22523		A	Percut kyphoplasty, thor	9.26	NA	NA	5.93	6.06	1.89	010
22524		A	Percut kyphoplasty, lumbar	8.86	NA	NA	5.78	5.88	1.81	010
22525		A	Percut kyphoplasty, add-on	4.47	NA	NA	2.26	2.29	0.99	ZZZ
22526		N	Idet, single level	6.10	57.67	53.91	3.43	2.87	0.57	010
22527		N	Idet, 1 or more levels	3.03	49.50	45.38	1.31	1.00	0.25	ZZZ
22532		A	Lat thorax spine fusion	25.99	NA	NA	19.41	18.40	7.86	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
22533		A	Lat lumbar spine fusion	24.79	NA	NA	18.77	17.78	6.63	090
22534		A	Lat thor/lumb, addl seg	5.99	NA	NA	3.35	3.24	1.65	ZZZ
22548		A	Neck spine fusion	27.06	NA	NA	21.32	19.89	10.09	090
22554		A	Neck spine fusion	17.69	NA	NA	14.35	13.96	5.68	090
22556		A	Thorax spine fusion	24.70	NA	NA	18.20	17.38	6.88	090
22558		A	Lumbar spine fusion	23.53	NA	NA	16.79	15.85	5.88	090
22585		A	Additional spinal fusion	5.52	NA	NA	3.03	2.93	1.65	ZZZ
22590		A	Spine & skull spinal fusion	21.76	NA	NA	17.81	16.99	7.32	090
22595		A	Neck spinal fusion	20.64	NA	NA	17.13	16.32	6.82	090
22600		A	Neck spine fusion	17.40	NA	NA	15.16	14.44	5.52	090
22610		A	Thorax spine fusion	17.28	NA	NA	14.97	14.26	5.04	090
22612		A	Lumbar spine fusion	23.53	NA	NA	17.61	16.84	6.47	090
22614		A	Spine fusion, extra segment	6.43	NA	NA	3.61	3.50	1.84	ZZZ
22630		A	Lumbar spine fusion	22.09	NA	NA	17.25	16.53	6.51	090
22632		A	Spine fusion, extra segment	5.22	NA	NA	2.92	2.82	1.55	ZZZ
22800		A	Fusion of spine	19.50	NA	NA	15.68	15.03	5.09	090
22802		A	Fusion of spine	32.11	NA	NA	23.08	22.14	7.80	090
22804		A	Fusion of spine	37.50	NA	NA	26.26	25.16	8.86	090
22808		A	Fusion of spine	27.51	NA	NA	19.76	18.93	7.55	090
22810		A	Fusion of spine	31.50	NA	NA	21.22	20.33	8.24	090
22812		A	Fusion of spine	34.25	NA	NA	25.20	23.54	7.01	090
22818		A	Kyphectomy, 1-2 segments	34.33	NA	NA	24.29	22.76	7.02	090
22819		A	Kyphectomy, 3 or more	39.38	NA	NA	28.06	26.29	14.70	090
22830		A	Exploration of spinal fusion	11.22	NA	NA	9.74	9.36	3.01	090
22840		A	Insert spine fixation device	12.52	NA	NA	7.00	6.79	3.62	ZZZ
22841		B	Insert spine fixation device	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
22842		A	Insert spine fixation device	12.56	NA	NA	7.04	6.83	3.57	ZZZ
22843		A	Insert spine fixation device	13.44	NA	NA	7.60	7.30	3.63	ZZZ
22844		A	Insert spine fixation device	16.42	NA	NA	9.40	9.15	3.83	ZZZ
22845		A	Insert spine fixation device	11.94	NA	NA	6.61	6.39	3.80	ZZZ
22846		A	Insert spine fixation device	12.40	NA	NA	6.87	6.64	3.91	ZZZ
22847		A	Insert spine fixation device	13.78	NA	NA	7.55	7.36	5.14	ZZZ
22848		A	Insert pelv fixation device	5.99	NA	NA	3.43	3.34	1.44	ZZZ
22849		A	Reinsert spinal fixation	19.17	NA	NA	14.30	13.73	5.34	090
22850		A	Remove spine fixation device	9.82	NA	NA	8.77	8.42	2.71	090
22851		A	Apply spine prosth device	6.70	NA	NA	3.74	3.60	1.96	ZZZ
22852		A	Remove spine fixation device	9.37	NA	NA	8.51	8.15	2.50	090
22855		A	Remove spine fixation device	15.86	NA	NA	12.49	11.97	4.93	090
22856		A	Cerv artific diskectomy	24.05	NA	NA	17.70	17.07	7.56	090
22857		R	Lumbar artif diskectomy	27.13	NA	NA	15.92	16.24	6.01	090
22861		A	Revise cerv artific disc	33.36	NA	NA	17.11	16.72	9.47	090
22862		R	Revise lumbar artif disc	32.63	NA	NA	17.28	16.91	6.67	090
22864		A	Remove cerv artif disc	29.40	NA	NA	21.23	18.01	8.35	090
22865		R	Remove lumb artif disc	31.75	NA	NA	20.60	21.27	6.49	090
22899		C	Spine surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
22900		A	Exc back tum deep < 5 cm	8.32	NA	NA	6.49	5.37	1.78	090
22901		A	Exc back tum deep = 5 cm	10.11	NA	NA	7.26	7.26	2.18	090
22902		A	Exc abd les sc < 3 cm	4.42	7.55	7.55	4.82	4.82	0.73	090
22903		A	Exc abd les sc > 3 cm	6.39	NA	NA	5.45	5.45	1.26	090
22904		A	Resect abd tum < 5 cm	16.69	NA	NA	10.14	10.14	3.69	090
22905		A	Resect abd tum > 5 cm	21.58	NA	NA	13.45	13.45	4.78	090
22999		C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
23000		A	Removal of calcium deposits	4.48	11.06	10.41	5.44	5.12	0.89	090
23020		A	Release shoulder joint	9.36	NA	NA	9.01	8.66	1.87	090
23030		A	Drain shoulder lesion	3.47	8.37	8.11	3.38	3.24	0.71	010
23031		A	Drain shoulder bursa	2.79	8.45	8.07	3.03	2.86	0.55	010
23035		A	Drain shoulder bone lesion	9.16	NA	NA	8.97	8.71	1.87	090
23040		A	Exploratory shoulder surgery	9.75	NA	NA	9.50	9.08	1.98	090
23044		A	Exploratory shoulder surgery	7.59	NA	NA	7.64	7.36	1.55	090
23065		A	Biopsy shoulder tissues	2.30	3.61	3.51	2.30	2.18	0.40	010
23066		A	Biopsy shoulder tissues	4.30	10.25	9.75	5.03	4.76	0.88	090
23071		A	Exc shoulder les sc > 3 cm	5.91	NA	NA	5.25	5.25	1.26	090
23073		A	Exc shoulder tum deep > 5 cm	10.13	NA	NA	8.33	8.33	2.12	090
23075		A	Exc shoulder les sc < 3 cm	4.21	8.30	6.38	4.44	3.29	0.89	090
23076		A	Exc shoulder tum deep < 5 cm	7.41	NA	NA	6.87	6.71	1.57	090
23077		A	Resect shoulder tum < 5 cm	17.66	NA	NA	12.90	12.46	3.73	090
23078		A	Resect shoulder tum > 5 cm	22.55	NA	NA	13.86	13.86	5.00	090
23100		A	Biopsy of shoulder joint	6.20	NA	NA	7.18	6.77	1.27	090
23101		A	Shoulder joint surgery	5.72	NA	NA	6.28	6.05	1.17	090
23105		A	Remove shoulder joint lining	8.48	NA	NA	8.55	8.20	1.72	090
23106		A	Incision of collarbone joint	6.13	NA	NA	7.14	6.64	1.26	090
23107		A	Explore treat shoulder joint	8.87	NA	NA	8.80	8.43	1.78	090
23120		A	Partial removal, collar bone	7.39	NA	NA	8.23	7.83	1.51	090
23125		A	Removal of collar bone	9.64	NA	NA	9.33	8.81	1.96	090
23130		A	Remove shoulder bone, part	7.77	NA	NA	8.53	8.15	1.58	090
23140		A	Removal of bone lesion	7.12	NA	NA	6.86	6.44	1.47	090
23145		A	Removal of bone lesion	9.40	NA	NA	9.19	8.74	1.92	090
23146		A	Removal of bone lesion	8.08	NA	NA	8.52	7.91	1.65	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
23150		A	Removal of humerus lesion	8.91	NA	NA	8.68	8.30	1.78	090
23155		A	Removal of humerus lesion	10.86	NA	NA	10.36	9.85	2.22	090
23156		A	Removal of humerus lesion	9.11	NA	NA	9.02	8.56	1.87	090
23170		A	Remove collar bone lesion	7.21	NA	NA	7.77	7.07	1.47	090
23172		A	Remove shoulder blade lesion	7.31	NA	NA	7.83	7.29	1.51	090
23174		A	Remove humerus lesion	10.05	NA	NA	10.24	9.76	2.05	090
23180		A	Remove collar bone lesion	8.99	NA	NA	8.90	8.77	1.88	090
23182		A	Remove shoulder blade lesion	8.61	NA	NA	9.15	8.82	1.75	090
23184		A	Remove humerus lesion	9.90	NA	NA	9.74	9.50	1.98	090
23190		A	Partial removal of scapula	7.47	NA	NA	7.81	7.32	1.54	090
23195		A	Removal of head of humerus	10.36	NA	NA	9.86	9.35	2.11	090
23200		A	Resect clavicle tumor	22.71	NA	NA	17.96	13.89	4.65	090
23210		A	Resect scapula tumor	27.21	NA	NA	20.59	15.51	5.57	090
23220		A	Resect prox humerus tumor	30.21	NA	NA	22.03	16.93	6.19	090
23330		A	Remove shoulder foreign body	1.90	4.42	4.27	2.13	2.05	0.37	010
23331		A	Remove shoulder foreign body	7.63	NA	NA	8.19	7.83	1.55	090
23332		A	Remove shoulder foreign body	12.37	NA	NA	11.23	10.75	2.49	090
23350		A	Injection for shoulder x-ray	1.00	2.85	3.17	0.38	0.41	0.10	000
23395		A	Muscle transfer,shoulder/arm	18.54	NA	NA	15.88	15.15	3.73	090
23397		A	Muscle transfers	16.76	NA	NA	13.81	13.17	3.43	090
23400		A	Fixation of shoulder blade	13.87	NA	NA	12.12	11.59	2.84	090
23405		A	Incision of tendon & muscle	8.54	NA	NA	8.20	7.91	1.72	090
23406		A	Incise tendon(s) & muscle(s)	11.01	NA	NA	9.77	9.40	2.25	090
23410		A	Repair rotator cuff, acute	11.39	NA	NA	10.59	10.22	2.30	090
23412		A	Repair rotator cuff, chronic	11.93	NA	NA	10.90	10.56	2.40	090
23415		A	Release of shoulder ligament	9.23	NA	NA	9.39	8.99	1.88	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
23420		A	Repair of shoulder	13.54	NA	NA	12.41	11.94	2.76	090
23430		A	Repair biceps tendon	10.17	NA	NA	9.48	9.12	2.05	090
23440		A	Remove/transplant tendon	10.64	NA	NA	9.54	9.18	2.15	090
23450		A	Repair shoulder capsule	13.70	NA	NA	11.62	11.10	2.81	090
23455		A	Repair shoulder capsule	14.67	NA	NA	12.20	11.70	2.97	090
23460		A	Repair shoulder capsule	15.82	NA	NA	13.37	12.80	3.25	090
23462		A	Repair shoulder capsule	15.72	NA	NA	12.99	12.37	3.24	090
23465		A	Repair shoulder capsule	16.30	NA	NA	13.57	12.96	3.33	090
23466		A	Repair shoulder capsule	15.80	NA	NA	14.16	13.51	3.24	090
23470		A	Reconstruct shoulder joint	17.89	NA	NA	14.44	13.85	3.65	090
23472		A	Reconstruct shoulder joint	22.65	NA	NA	17.39	16.62	4.59	090
23480		A	Revision of collar bone	11.54	NA	NA	10.44	9.94	2.35	090
23485		A	Revision of collar bone	13.91	NA	NA	11.76	11.26	2.83	090
23490		A	Reinforce clavicle	12.16	NA	NA	11.93	10.77	2.49	090
23491		A	Reinforce shoulder bones	14.54	NA	NA	12.56	12.02	2.98	090
23500		A	Treat clavicle fracture	2.21	3.57	3.41	3.67	3.44	0.42	090
23505		A	Treat clavicle fracture	3.83	5.53	5.26	5.02	4.74	0.75	090
23515		A	Treat clavicle fracture	9.69	NA	NA	9.84	9.18	1.96	090
23520		A	Treat clavicle dislocation	2.29	3.88	3.61	3.97	3.68	0.45	090
23525		A	Treat clavicle dislocation	3.79	6.72	5.85	5.68	5.02	0.76	090
23530		A	Treat clavicle dislocation	7.48	NA	NA	7.82	7.04	1.54	090
23532		A	Treat clavicle dislocation	8.20	NA	NA	8.49	8.09	1.67	090
23540		A	Treat clavicle dislocation	2.36	3.53	3.38	3.62	3.38	0.44	090
23545		A	Treat clavicle dislocation	3.43	5.25	4.97	4.45	4.22	0.62	090
23550		A	Treat clavicle dislocation	7.59	NA	NA	7.67	7.38	1.53	090
23552		A	Treat clavicle dislocation	8.82	NA	NA	8.81	8.42	1.77	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
23570		A	Treat shoulder blade fx	2.36	3.80	3.62	3.99	3.76	0.45	090
23575		A	Treat shoulder blade fx	4.23	6.47	6.05	5.79	5.39	0.86	090
23585		A	Treat scapula fracture	14.23	NA	NA	12.09	11.21	2.87	090
23600		A	Treat humerus fracture	3.11	5.53	5.29	4.98	4.68	0.62	090
23605		A	Treat humerus fracture	5.06	7.37	7.06	6.34	6.04	1.02	090
23615		A	Treat humerus fracture	12.30	NA	NA	11.42	10.82	2.49	090
23616		A	Treat humerus fracture	18.37	NA	NA	14.93	14.53	3.72	090
23620		A	Treat humerus fracture	2.55	4.63	4.40	4.28	4.02	0.51	090
23625		A	Treat humerus fracture	4.10	6.05	5.77	5.35	5.10	0.81	090
23630		A	Treat humerus fracture	10.57	NA	NA	10.41	9.65	2.15	090
23650		A	Treat shoulder dislocation	3.53	4.45	4.24	3.82	3.57	0.64	090
23655		A	Treat shoulder dislocation	4.76	NA	NA	5.85	5.46	0.92	090
23660		A	Treat shoulder dislocation	7.66	NA	NA	7.95	7.57	1.55	090
23665		A	Treat dislocation/fracture	4.66	6.65	6.34	5.88	5.61	0.92	090
23670		A	Treat dislocation/fracture	12.28	NA	NA	11.15	10.33	2.49	090
23675		A	Treat dislocation/fracture	6.27	8.45	8.01	7.15	6.79	1.24	090
23680		A	Treat dislocation/fracture	13.15	NA	NA	11.70	10.96	2.67	090
23700		A	Fixation of shoulder	2.57	NA	NA	2.63	2.52	0.51	010
23800		A	Fusion of shoulder joint	14.73	NA	NA	12.73	12.13	3.04	090
23802		A	Fusion of shoulder joint	18.42	NA	NA	15.99	14.79	3.76	090
23900		A	Amputation of arm & girdle	20.72	NA	NA	16.48	14.67	4.25	090
23920		A	Amputation at shoulder joint	16.23	NA	NA	13.97	12.62	3.32	090
23921		A	Amputation follow-up surgery	5.72	NA	NA	6.79	5.61	1.41	090
23929		C	Shoulder surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
23930		A	Drainage of arm lesion	2.99	6.54	6.48	2.77	2.66	0.64	010
23931		A	Drainage of arm bursa	1.84	5.87	5.77	2.46	2.36	0.35	010

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
23935		A	Drain arm/elbow bone lesion	6.38	NA	NA	7.24	6.81	1.29	090
24000		A	Exploratory elbow surgery	6.08	NA	NA	6.73	6.39	1.22	090
24006		A	Release elbow joint	9.74	NA	NA	9.40	8.94	1.89	090
24065		A	Biopsy arm/elbow soft tissue	2.13	4.92	4.82	2.50	2.40	0.35	010
24066		A	Biopsy arm/elbow soft tissue	5.35	11.17	10.66	5.61	5.23	1.12	090
24071		A	Exc arm/elbow les sc = 3 cm	5.70	NA	NA	5.20	5.20	1.20	090
24073		A	Ex arm/elbow tum deep > 5 cm	10.13	NA	NA	8.43	8.43	2.09	090
24075		A	Exc arm/elbow les sc < 3 cm	4.24	8.94	8.80	4.56	4.30	0.88	090
24076		A	Ex arm/elbow tum deep < 5 cm	7.41	NA	NA	7.02	6.36	1.54	090
24077		A	Resect arm/elbow tum < 5 cm	15.72	NA	NA	11.93	10.30	3.31	090
24079		A	Resect arm/elbow tum > 5 cm	20.61	NA	NA	13.03	13.03	4.55	090
24100		A	Biopsy elbow joint lining	5.07	NA	NA	6.09	5.70	1.05	090
24101		A	Explore/treat elbow joint	6.30	NA	NA	7.13	6.81	1.26	090
24102		A	Remove elbow joint lining	8.26	NA	NA	8.27	7.86	1.61	090
24105		A	Removal of elbow bursa	3.78	NA	NA	5.61	5.31	0.75	090
24110		A	Remove humerus lesion	7.58	NA	NA	8.12	7.73	1.55	090
24115		A	Remove/graft bone lesion	10.12	NA	NA	9.61	9.06	2.06	090
24116		A	Remove/graft bone lesion	12.23	NA	NA	10.84	10.31	2.50	090
24120		A	Remove elbow lesion	6.82	NA	NA	7.37	6.96	1.34	090
24125		A	Remove/graft bone lesion	8.14	NA	NA	8.45	7.94	1.65	090
24126		A	Remove/graft bone lesion	8.62	NA	NA	8.73	8.30	1.75	090
24130		A	Removal of head of radius	6.42	NA	NA	7.22	6.89	1.24	090
24134		A	Removal of arm bone lesion	10.22	NA	NA	9.77	9.42	2.08	090
24136		A	Remove radius bone lesion	8.40	NA	NA	8.46	7.60	1.71	090
24138		A	Remove elbow bone lesion	8.50	NA	NA	9.55	9.07	1.72	090
24140		A	Partial removal of arm bone	9.55	NA	NA	9.40	9.15	1.85	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
24145		A	Partial removal of radius	7.81	NA	NA	8.01	7.87	1.60	090
24147		A	Partial removal of elbow	7.84	NA	NA	8.89	8.65	1.57	090
24149		A	Radical resection of elbow	16.22	NA	NA	15.56	14.56	3.09	090
24150		A	Resect distal humerus tumor	23.46	NA	NA	18.29	14.66	4.80	090
24152		A	Resect radius tumor	19.99	NA	NA	16.26	12.43	4.08	090
24155		A	Removal of elbow joint	12.09	NA	NA	10.75	10.16	2.47	090
24160		A	Remove elbow joint implant	8.00	NA	NA	8.33	7.92	1.55	090
24164		A	Remove radius head implant	6.43	NA	NA	6.87	6.58	1.31	090
24200		A	Removal of arm foreign body	1.81	3.76	3.61	1.98	1.85	0.32	010
24201		A	Removal of arm foreign body	4.70	10.32	10.13	5.11	4.88	0.96	090
24220		A	Injection for elbow x-ray	1.31	2.88	3.23	0.55	0.57	0.13	000
24300		A	Manipulate elbow w/anesth	4.04	NA	NA	7.04	6.71	0.75	090
24301		A	Muscle/tendon transfer	10.38	NA	NA	9.70	9.30	2.11	090
24305		A	Arm tendon lengthening	7.62	NA	NA	8.07	7.67	1.41	090
24310		A	Revision of arm tendon	6.12	NA	NA	6.67	6.37	1.23	090
24320		A	Repair of arm tendon	10.86	NA	NA	10.03	9.49	2.22	090
24330		A	Revision of arm muscles	9.79	NA	NA	9.41	8.97	1.99	090
24331		A	Revision of arm muscles	10.95	NA	NA	10.98	10.13	2.25	090
24332		A	Tenolysis, triceps	7.91	NA	NA	8.47	8.06	1.61	090
24340		A	Repair of biceps tendon	8.08	NA	NA	8.35	7.98	1.64	090
24341		A	Repair arm tendon/muscle	9.49	NA	NA	10.55	9.94	1.92	090
24342		A	Repair of ruptured tendon	10.86	NA	NA	10.02	9.60	2.15	090
24343		A	Repr elbow lat ligmnt w/tiss	9.16	NA	NA	9.83	9.40	1.74	090
24344		A	Reconstruct elbow lat ligmnt	15.21	NA	NA	14.20	13.47	3.12	090
24345		A	Repr elbw med ligmnt w/tissu	9.16	NA	NA	9.74	9.28	1.74	090
24346		A	Reconstruct elbow med ligmnt	15.21	NA	NA	14.20	13.51	3.12	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
24357		A	Repair elbow, perc	5.44	NA	NA	6.53	6.27	1.07	090
24358		A	Repair elbow w/deb, open	6.66	NA	NA	7.45	7.10	1.30	090
24359		A	Repair elbow deb/attch open	8.98	NA	NA	8.82	8.25	1.74	090
24360		A	Reconstruct elbow joint	12.67	NA	NA	11.40	10.90	2.57	090
24361		A	Reconstruct elbow joint	14.41	NA	NA	12.52	12.01	2.95	090
24362		A	Reconstruct elbow joint	15.32	NA	NA	13.05	12.44	3.15	090
24363		A	Replace elbow joint	22.65	NA	NA	17.74	16.70	4.37	090
24365		A	Reconstruct head of radius	8.62	NA	NA	8.47	8.12	1.75	090
24366		A	Reconstruct head of radius	9.36	NA	NA	8.97	8.56	1.84	090
24400		A	Revision of humerus	11.33	NA	NA	10.60	10.17	2.27	090
24410		A	Revision of humerus	15.11	NA	NA	13.19	12.38	3.11	090
24420		A	Revision of humerus	13.73	NA	NA	12.80	12.21	2.81	090
24430		A	Repair of humerus	15.25	NA	NA	13.19	12.41	3.07	090
24435		A	Repair humerus with graft	14.99	NA	NA	13.96	13.21	3.04	090
24470		A	Revision of elbow joint	8.93	NA	NA	9.01	8.05	1.84	090
24495		A	Decompression of forearm	8.41	NA	NA	9.07	8.88	1.87	090
24498		A	Reinforce humerus	12.28	NA	NA	10.88	10.44	2.50	090
24500		A	Treat humerus fracture	3.41	6.06	5.78	5.22	4.90	0.66	090
24505		A	Treat humerus fracture	5.39	7.95	7.62	6.69	6.39	1.09	090
24515		A	Treat humerus fracture	12.12	NA	NA	11.37	10.85	2.43	090
24516		A	Treat humerus fracture	12.19	NA	NA	10.84	10.38	2.47	090
24530		A	Treat humerus fracture	3.69	6.45	6.15	5.50	5.18	0.72	090
24535		A	Treat humerus fracture	7.11	9.36	8.98	8.12	7.75	1.43	090
24538		A	Treat humerus fracture	9.77	NA	NA	10.13	9.73	1.99	090
24545		A	Treat humerus fracture	13.15	NA	NA	11.79	11.06	2.66	090
24546		A	Treat humerus fracture	14.91	NA	NA	13.00	12.48	3.01	090

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24560		A	Treat humerus fracture	2.98	5.53	5.29	4.65	4.35	0.58	090
24565		A	Treat humerus fracture	5.78	8.45	7.83	7.27	6.70	1.19	090
24566		A	Treat humerus fracture	9.06	NA	NA	10.12	9.62	1.87	090
24575		A	Treat humerus fracture	9.71	NA	NA	9.93	9.52	1.95	090
24576		A	Treat humerus fracture	3.06	6.01	5.71	5.09	4.78	0.61	090
24577		A	Treat humerus fracture	6.01	8.65	8.08	7.41	6.87	1.23	090
24579		A	Treat humerus fracture	11.44	NA	NA	10.97	10.43	2.29	090
24582		A	Treat humerus fracture	10.14	NA	NA	11.49	10.82	2.06	090
24586		A	Treat elbow fracture	15.78	NA	NA	13.35	12.78	3.17	090
24587		A	Treat elbow fracture	15.79	NA	NA	13.50	12.82	3.04	090
24600		A	Treat elbow dislocation	4.37	5.11	4.97	4.35	4.13	0.79	090
24605		A	Treat elbow dislocation	5.64	NA	NA	6.86	6.50	1.13	090
24615		A	Treat elbow dislocation	9.83	NA	NA	9.30	8.90	1.91	090
24620		A	Treat elbow fracture	7.22	NA	NA	7.58	7.24	1.41	090
24635		A	Treat elbow fracture	8.80	NA	NA	9.27	9.80	1.74	090
24640		A	Treat elbow dislocation	1.25	2.29	2.08	1.15	1.05	0.24	010
24650		A	Treat radius fracture	2.31	4.65	4.44	4.09	3.82	0.44	090
24655		A	Treat radius fracture	4.62	6.94	6.70	5.95	5.69	0.89	090
24665		A	Treat radius fracture	8.36	NA	NA	9.16	8.73	1.65	090
24666		A	Treat radius fracture	9.86	NA	NA	9.83	9.37	1.94	090
24670		A	Treat ulnar fracture	2.69	5.05	4.83	4.30	4.05	0.52	090
24675		A	Treat ulnar fracture	4.91	7.28	6.99	6.24	5.96	0.96	090
24685		A	Treat ulnar fracture	8.37	NA	NA	9.15	8.73	1.68	090
24800		A	Fusion of elbow joint	11.41	NA	NA	10.78	9.87	2.33	090
24802		A	Fusion/graft of elbow joint	14.32	NA	NA	12.48	11.85	2.94	090
24900		A	Amputation of upper arm	10.18	NA	NA	9.42	8.82	2.09	090

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24920		A	Amputation of upper arm	10.13	NA	NA	9.47	8.75	2.06	090
24925		A	Amputation follow-up surgery	7.30	NA	NA	7.81	7.42	1.50	090
24930		A	Amputation follow-up surgery	10.83	NA	NA	9.88	9.16	2.22	090
24931		A	Amputate upper arm & implant	13.44	NA	NA	8.26	8.02	0.99	090
24935		A	Revision of amputation	16.45	NA	NA	7.72	8.55	3.36	090
24940		C	Revision of upper arm	0.00	0.00	0.00	0.00	0.00	0.00	090
24999		C	Upper arm/elbow surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
25000		A	Incision of tendon sheath	3.55	NA	NA	5.53	5.62	0.66	090
25001		A	Incise flexor carpi radialis	3.79	NA	NA	5.55	5.21	0.69	090
25020		A	Decompress forearm 1 space	6.06	NA	NA	9.64	9.38	1.10	090
25023		A	Decompress forearm 1 space	13.83	NA	NA	15.83	15.26	2.84	090
25024		A	Decompress forearm 2 spaces	10.79	NA	NA	10.01	9.53	2.20	090
25025		A	Decompress forearm 2 spaces	17.94	NA	NA	14.90	13.70	3.67	090
25028		A	Drainage of forearm lesion	5.39	NA	NA	8.61	8.39	1.07	090
25031		A	Drainage of forearm bursa	4.26	NA	NA	5.02	5.32	0.86	090
25035		A	Treat forearm bone lesion	7.65	NA	NA	7.98	8.60	1.54	090
25040		A	Explore/treat wrist joint	7.50	NA	NA	7.65	7.44	1.41	090
25065		A	Biopsy forearm soft tissues	2.04	4.98	4.88	2.51	2.43	0.34	010
25066		A	Biopsy forearm soft tissues	4.27	NA	NA	5.36	5.50	0.83	090
25071		A	Exc forearm les sc > 3 cm	5.91	NA	NA	5.59	5.59	1.22	090
25073		A	Exc forearm tum deep = 3 cm	7.13	NA	NA	7.33	7.33	1.41	090
25075		A	Exc forearm les sc < 3 cm	3.96	8.99	6.91	4.55	4.67	0.79	090
25076		A	Exc forearm tum deep < 3 cm	6.74	NA	NA	7.11	6.88	1.33	090
25077		A	Resect forearm/wrist tum<3cm	12.93	NA	NA	10.70	10.03	2.71	090
25078		A	Resect forearm/wrist tum=3cm	17.69	NA	NA	11.77	11.77	3.93	090
25085		A	Incision of wrist capsule	5.64	NA	NA	6.45	6.43	1.14	090

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25100		A	Biopsy of wrist joint	4.02	NA	NA	5.22	5.11	0.81	090
25101		A	Explore/treat wrist joint	4.83	NA	NA	6.05	5.90	0.93	090
25105		A	Remove wrist joint lining	6.02	NA	NA	7.01	6.90	1.14	090
25107		A	Remove wrist joint cartilage	7.70	NA	NA	9.03	8.70	1.41	090
25109		A	Excise tendon forearm/wrist	6.94	NA	NA	7.65	7.11	1.29	090
25110		A	Remove wrist tendon lesion	4.04	NA	NA	5.09	5.27	0.78	090
25111		A	Remove wrist tendon lesion	3.53	NA	NA	5.07	4.90	0.69	090
25112		A	Reremove wrist tendon lesion	4.67	NA	NA	5.74	5.51	0.90	090
25115		A	Remove wrist/forearm lesion	10.09	NA	NA	10.57	10.80	1.87	090
25116		A	Remove wrist/forearm lesion	7.56	NA	NA	8.73	9.18	1.38	090
25118		A	Excise wrist tendon sheath	4.51	NA	NA	5.82	5.67	0.83	090
25119		A	Partial removal of ulna	6.21	NA	NA	7.10	7.03	1.27	090
25120		A	Removal of forearm lesion	6.27	NA	NA	7.14	7.74	1.22	090
25125		A	Remove/graft forearm lesion	7.67	NA	NA	8.18	8.75	1.57	090
25126		A	Remove/graft forearm lesion	7.74	NA	NA	8.22	8.74	1.58	090
25130		A	Removal of wrist lesion	5.43	NA	NA	6.71	6.51	1.03	090
25135		A	Remove & graft wrist lesion	7.08	NA	NA	7.82	7.65	1.44	090
25136		A	Remove & graft wrist lesion	6.14	NA	NA	7.03	6.85	1.26	090
25145		A	Remove forearm bone lesion	6.54	NA	NA	7.27	7.86	1.33	090
25150		A	Partial removal of ulna	7.38	NA	NA	7.84	7.73	1.41	090
25151		A	Partial removal of radius	7.68	NA	NA	7.98	8.52	1.57	090
25170		A	Resect radius/ulnar tumor	22.21	NA	NA	17.45	14.53	4.54	090
25210		A	Removal of wrist bone	6.12	NA	NA	7.14	6.92	1.12	090
25215		A	Removal of wrist bones	8.14	NA	NA	8.64	8.45	1.46	090
25230		A	Partial removal of radius	5.37	NA	NA	6.36	6.17	0.93	090
25240		A	Partial removal of ulna	5.31	NA	NA	6.29	6.25	0.95	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
25246		A	Injection for wrist x-ray	1.45	2.81	3.14	0.56	0.60	0.14	000
25248		A	Remove forearm foreign body	5.31	NA	NA	5.69	5.97	1.09	090
25250		A	Removal of wrist prosthesis	6.77	NA	NA	7.39	7.06	1.37	090
25251		A	Removal of wrist prosthesis	9.82	NA	NA	9.42	8.99	2.01	090
25259		A	Manipulate wrist w/anesthes	4.04	NA	NA	7.12	6.77	0.75	090
25260		A	Repair forearm tendon/muscle	8.04	NA	NA	9.03	9.44	1.54	090
25263		A	Repair forearm tendon/muscle	8.04	NA	NA	8.74	9.27	1.64	090
25265		A	Repair forearm tendon/muscle	10.10	NA	NA	9.92	10.40	2.05	090
25270		A	Repair forearm tendon/muscle	6.17	NA	NA	7.12	7.68	1.20	090
25272		A	Repair forearm tendon/muscle	7.21	NA	NA	7.74	8.32	1.37	090
25274		A	Repair forearm tendon/muscle	8.94	NA	NA	8.92	9.47	1.84	090
25275		A	Repair forearm tendon sheath	8.96	NA	NA	9.08	8.72	1.84	090
25280		A	Revise wrist/forearm tendon	7.39	NA	NA	7.89	8.42	1.33	090
25290		A	Incise wrist/forearm tendon	5.43	NA	NA	6.37	7.51	1.02	090
25295		A	Release wrist/forearm tendon	6.72	NA	NA	7.47	8.01	1.23	090
25300		A	Fusion of tendons at wrist	9.02	NA	NA	9.28	8.99	1.85	090
25301		A	Fusion of tendons at wrist	8.59	NA	NA	8.79	8.49	1.62	090
25310		A	Transplant forearm tendon	8.08	NA	NA	8.72	9.16	1.44	090
25312		A	Transplant forearm tendon	9.82	NA	NA	9.60	10.04	1.85	090
25315		A	Revise palsy hand tendon(s)	10.68	NA	NA	9.93	10.46	2.18	090
25316		A	Revise palsy hand tendon(s)	12.90	NA	NA	11.55	11.83	1.67	090
25320		A	Repair/revise wrist joint	12.75	NA	NA	14.11	13.33	2.35	090
25332		A	Revise wrist joint	11.74	NA	NA	11.08	10.50	2.26	090
25335		A	Realignment of hand	13.39	NA	NA	8.45	9.86	0.99	090
25337		A	Reconstruct ulna/radioulnar	11.73	NA	NA	12.49	11.94	2.09	090
25350		A	Revision of radius	9.09	NA	NA	9.11	9.65	1.67	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
25355		A	Revision of radius	10.53	NA	NA	9.96	10.47	2.15	090
25360		A	Revision of ulna	8.74	NA	NA	8.81	9.40	1.71	090
25365		A	Revise radius & ulna	12.91	NA	NA	11.56	11.85	2.64	090
25370		A	Revise radius or ulna	14.10	NA	NA	12.82	13.05	2.88	090
25375		A	Revise radius & ulna	13.55	NA	NA	11.93	12.37	0.99	090
25390		A	Shorten radius or ulna	10.70	NA	NA	10.16	10.57	1.95	090
25391		A	Lengthen radius or ulna	14.28	NA	NA	12.36	12.69	2.94	090
25392		A	Shorten radius & ulna	14.58	NA	NA	12.53	12.88	3.01	090
25393		A	Lengthen radius & ulna	16.56	NA	NA	15.11	14.72	3.41	090
25394		A	Repair carpal bone, shorten	10.85	NA	NA	10.10	9.62	2.22	090
25400		A	Repair radius or ulna	11.28	NA	NA	10.39	10.88	2.15	090
25405		A	Repair/graft radius or ulna	15.01	NA	NA	12.93	13.28	2.84	090
25415		A	Repair radius & ulna	13.80	NA	NA	12.57	12.88	2.83	090
25420		A	Repair/graft radius & ulna	17.04	NA	NA	14.22	14.57	3.50	090
25425		A	Repair/graft radius or ulna	13.72	NA	NA	12.03	13.15	2.81	090
25426		A	Repair/graft radius & ulna	16.45	NA	NA	13.63	12.88	3.36	090
25430		A	Vasc graft into carpal bone	9.71	NA	NA	9.84	9.28	1.26	090
25431		A	Repair nonunion carpal bone	10.89	NA	NA	10.21	9.63	2.23	090
25440		A	Repair/graft wrist bone	10.68	NA	NA	10.04	9.71	1.96	090
25441		A	Reconstruct wrist joint	13.29	NA	NA	12.86	11.86	1.71	090
25442		A	Reconstruct wrist joint	11.12	NA	NA	10.81	10.26	1.44	090
25443		A	Reconstruct wrist joint	10.66	NA	NA	10.22	9.81	2.18	090
25444		A	Reconstruct wrist joint	11.42	NA	NA	11.66	10.71	0.83	090
25445		A	Reconstruct wrist joint	9.88	NA	NA	9.58	9.11	1.87	090
25446		A	Wrist replacement	17.30	NA	NA	14.58	13.78	3.07	090
25447		A	Repair wrist joint(s)	11.14	NA	NA	11.30	10.63	2.03	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
25449		A	Remove wrist joint implant	14.94	NA	NA	13.18	12.40	3.07	090
25450		A	Revision of wrist joint	8.06	NA	NA	5.93	6.70	1.64	090
25455		A	Revision of wrist joint	9.71	NA	NA	6.86	7.60	0.71	090
25490		A	Reinforce radius	9.73	NA	NA	8.61	9.34	1.30	090
25491		A	Reinforce ulna	10.15	NA	NA	9.63	10.16	2.06	090
25492		A	Reinforce radius and ulna	12.66	NA	NA	11.52	11.86	2.57	090
25500		A	Treat fracture of radius	2.60	4.62	4.34	4.03	3.72	0.47	090
25505		A	Treat fracture of radius	5.45	7.93	7.61	6.84	6.52	1.07	090
25515		A	Treat fracture of radius	8.80	NA	NA	9.13	8.71	1.74	090
25520		A	Treat fracture of radius	6.50	8.65	8.01	7.87	7.25	1.33	090
25525		A	Treat fracture of radius	10.55	NA	NA	10.49	10.21	2.09	090
25526		A	Treat fracture of radius	13.15	NA	NA	12.39	12.32	2.70	090
25530		A	Treat fracture of ulna	2.24	4.73	4.51	4.08	3.82	0.42	090
25535		A	Treat fracture of ulna	5.36	7.73	7.34	6.78	6.43	1.06	090
25545		A	Treat fracture of ulna	7.94	NA	NA	8.77	8.43	1.57	090
25560		A	Treat fracture radius & ulna	2.59	4.70	4.44	4.02	3.70	0.49	090
25565		A	Treat fracture radius & ulna	5.85	8.08	7.76	6.79	6.49	1.14	090
25574		A	Treat fracture radius & ulna	8.80	NA	NA	9.20	8.73	1.77	090
25575		A	Treat fracture radius/ulna	12.29	NA	NA	11.82	11.25	2.43	090
25600		A	Treat fracture radius/ulna	2.78	5.00	4.78	4.34	4.06	0.54	090
25605		A	Treat fracture radius/ulna	7.25	9.41	8.92	8.45	7.98	1.44	090
25606		A	Treat fx distal radial	8.31	NA	NA	9.45	9.18	1.67	090
25607		A	Treat fx rad extra-articul	9.56	NA	NA	10.18	9.54	1.89	090
25608		A	Treat fx rad intra-articul	11.07	NA	NA	11.08	10.38	2.15	090
25609		A	Treat fx radial 3+ frag	14.38	NA	NA	13.84	12.93	2.80	090
25622		A	Treat wrist bone fracture	2.79	5.32	5.05	4.60	4.28	0.54	090

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25624		A	Treat wrist bone fracture	4.77	7.52	7.27	6.42	6.16	0.92	090
25628		A	Treat wrist bone fracture	9.67	NA	NA	9.77	9.28	1.81	090
25630		A	Treat wrist bone fracture	3.03	5.12	4.88	4.46	4.14	0.58	090
25635		A	Treat wrist bone fracture	4.61	7.54	7.03	6.48	5.84	0.93	090
25645		A	Treat wrist bone fracture	7.42	NA	NA	7.78	7.42	1.53	090
25650		A	Treat wrist bone fracture	3.23	5.32	5.05	4.79	4.44	0.62	090
25651		A	Pin ulnar styloid fracture	5.82	NA	NA	7.26	6.83	1.14	090
25652		A	Treat fracture ulnar styloid	8.06	NA	NA	8.74	8.29	1.53	090
25660		A	Treat wrist dislocation	4.98	NA	NA	5.78	5.56	0.93	090
25670		A	Treat wrist dislocation	8.09	NA	NA	8.12	7.82	1.55	090
25671		A	Pin radioulnar dislocation	6.46	NA	NA	7.80	7.36	1.31	090
25675		A	Treat wrist dislocation	4.89	6.64	6.36	5.67	5.40	0.90	090
25676		A	Treat wrist dislocation	8.29	NA	NA	8.72	8.31	1.60	090
25680		A	Treat wrist fracture	6.23	NA	NA	6.20	5.84	1.12	090
25685		A	Treat wrist fracture	10.09	NA	NA	9.58	9.09	2.05	090
25690		A	Treat wrist dislocation	5.72	NA	NA	7.11	6.64	1.19	090
25695		A	Treat wrist dislocation	8.51	NA	NA	8.41	8.05	1.72	090
25800		A	Fusion of wrist joint	10.07	NA	NA	9.70	9.39	1.88	090
25805		A	Fusion/graft of wrist joint	11.73	NA	NA	10.86	10.59	2.39	090
25810		A	Fusion/graft of wrist joint	11.95	NA	NA	11.57	11.03	2.20	090
25820		A	Fusion of hand bones	7.64	NA	NA	8.97	8.60	1.43	090
25825		A	Fuse hand bones with graft	9.69	NA	NA	10.85	10.36	1.75	090
25830		A	Fusion, radioulnar jnt/ulna	10.88	NA	NA	14.61	14.32	2.23	090
25900		A	Amputation of forearm	9.61	NA	NA	9.57	9.77	1.89	090
25905		A	Amputation of forearm	9.59	NA	NA	9.16	9.38	1.96	090
25907		A	Amputation follow-up surgery	8.09	NA	NA	8.28	8.57	1.65	090

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25909		A	Amputation follow-up surgery	9.31	NA	NA	9.00	9.27	1.91	090
25915		A	Amputation of forearm	17.52	NA	NA	9.98	12.37	3.22	090
25920		A	Amputate hand at wrist	9.03	NA	NA	9.59	9.13	1.85	090
25922		A	Amputate hand at wrist	7.65	NA	NA	6.10	6.71	0.55	090
25924		A	Amputation follow-up surgery	8.81	NA	NA	7.52	7.99	1.78	090
25927		A	Amputation of hand	9.09	NA	NA	12.58	12.01	1.87	090
25929		A	Amputation follow-up surgery	7.82	NA	NA	8.72	7.63	1.60	090
25931		A	Amputation follow-up surgery	8.04	NA	NA	11.86	11.30	1.77	090
25999		C	Forearm or wrist surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
26010		A	Drainage of finger abscess	1.59	5.37	5.34	2.11	1.99	0.28	010
26011		A	Drainage of finger abscess	2.24	8.29	8.27	2.77	2.64	0.41	010
26020		A	Drain hand tendon sheath	5.08	NA	NA	6.68	6.32	0.96	090
26025		A	Drainage of palm bursa	5.08	NA	NA	6.32	5.98	0.95	090
26030		A	Drainage of palm bursa(s)	6.25	NA	NA	7.08	6.70	1.20	090
26034		A	Treat hand bone lesion	6.63	NA	NA	7.87	7.47	1.27	090
26035		A	Decompress fingers/hand	11.37	NA	NA	11.57	10.71	2.32	090
26037		A	Decompress fingers/hand	7.57	NA	NA	7.84	7.41	1.50	090
26040		A	Release palm contracture	3.46	NA	NA	5.03	4.76	0.58	090
26045		A	Release palm contracture	5.73	NA	NA	6.83	6.51	1.13	090
26055		A	Incise finger tendon sheath	3.11	11.99	12.18	5.28	4.97	0.58	090
26060		A	Incision of finger tendon	2.91	NA	NA	4.34	4.12	0.57	090
26070		A	Explore/treat hand joint	3.81	NA	NA	4.55	4.22	0.68	090
26075		A	Explore/treat finger joint	3.91	NA	NA	4.83	4.54	0.69	090
26080		A	Explore/treat finger joint	4.47	NA	NA	6.09	5.76	0.81	090
26100		A	Biopsy hand joint lining	3.79	NA	NA	5.15	4.83	0.76	090
26105		A	Biopsy finger joint lining	3.83	NA	NA	5.17	4.91	0.78	090

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26110		A	Biopsy finger joint lining	3.65	NA	NA	5.08	4.80	0.66	090
26111		A	Exc hand les sc > 1.5 cm	5.42	NA	NA	5.95	5.95	1.03	090
26113		A	Exc hand tum deep > 1.5 cm	7.13	NA	NA	7.81	7.81	1.30	090
26115		A	Exc hand les sc < 1.5 cm	3.96	9.67	11.19	5.05	5.17	0.73	090
26116		A	Exc hand tum deep < 1.5 cm	6.74	NA	NA	7.56	7.12	1.24	090
26117		A	Exc hand tum ra < 3 cm	10.13	NA	NA	10.29	9.08	1.92	090
26118		A	Exc hand tum ra > 3 cm	14.81	NA	NA	13.92	13.92	3.05	090
26121		A	Release palm contracture	7.73	NA	NA	8.45	8.02	1.46	090
26123		A	Release palm contracture	10.88	NA	NA	11.78	11.03	1.99	090
26125		A	Release palm contracture	4.60	NA	NA	2.89	2.72	0.85	ZZZ
26130		A	Remove wrist joint lining	5.59	NA	NA	6.87	6.47	1.10	090
26135		A	Revise finger joint, each	7.13	NA	NA	7.80	7.40	1.31	090
26140		A	Revise finger joint, each	6.34	NA	NA	7.34	6.97	1.19	090
26145		A	Tendon excision, palm/finger	6.49	NA	NA	7.37	6.99	1.23	090
26160		A	Remove tendon sheath lesion	3.57	11.96	11.88	5.47	5.15	0.68	090
26170		A	Removal of palm tendon, each	4.91	NA	NA	6.12	5.81	0.89	090
26180		A	Removal of finger tendon	5.35	NA	NA	6.60	6.32	0.93	090
26185		A	Remove finger bone	6.52	NA	NA	8.19	7.71	1.33	090
26200		A	Remove hand bone lesion	5.65	NA	NA	6.52	6.21	1.07	090
26205		A	Remove/graft bone lesion	7.93	NA	NA	8.15	7.82	1.62	090
26210		A	Removal of finger lesion	5.32	NA	NA	6.66	6.33	0.99	090
26215		A	Remove/graft finger lesion	7.27	NA	NA	7.76	7.37	1.50	090
26230		A	Partial removal of hand bone	6.47	NA	NA	7.05	6.73	1.17	090
26235		A	Partial removal, finger bone	6.33	NA	NA	7.11	6.74	1.14	090
26236		A	Partial removal, finger bone	5.46	NA	NA	6.48	6.16	1.02	090
26250		A	Extensive hand surgery	15.21	NA	NA	13.47	10.39	3.12	090

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26260		A	Resect prox finger tumor	11.16	NA	NA	11.26	9.07	2.27	090
26262		A	Resect distal finger tumor	8.29	NA	NA	8.67	7.31	1.68	090
26320		A	Removal of implant from hand	4.10	NA	NA	5.34	5.06	0.73	090
26340		A	Manipulate finger w/anesth	2.80	NA	NA	6.26	5.94	0.54	090
26350		A	Repair finger/hand tendon	6.21	NA	NA	12.80	12.88	1.17	090
26352		A	Repair/graft hand tendon	7.87	NA	NA	13.70	13.68	1.61	090
26356		A	Repair finger/hand tendon	10.62	NA	NA	18.73	18.34	1.99	090
26357		A	Repair finger/hand tendon	8.77	NA	NA	14.23	14.20	1.78	090
26358		A	Repair/graft hand tendon	9.36	NA	NA	15.40	15.16	1.92	090
26370		A	Repair finger/hand tendon	7.28	NA	NA	13.07	13.14	1.41	090
26372		A	Repair/graft hand tendon	9.01	NA	NA	14.37	14.45	1.85	090
26373		A	Repair finger/hand tendon	8.41	NA	NA	14.02	14.06	1.71	090
26390		A	Revise hand/finger tendon	9.43	NA	NA	12.67	12.46	1.94	090
26392		A	Repair/graft hand tendon	10.50	NA	NA	15.24	15.12	2.15	090
26410		A	Repair hand tendon	4.77	NA	NA	10.33	10.41	0.90	090
26412		A	Repair/graft hand tendon	6.48	NA	NA	11.80	11.82	1.20	090
26415		A	Excision, hand/finger tendon	8.51	NA	NA	9.99	10.20	1.22	090
26416		A	Graft hand or finger tendon	9.56	NA	NA	14.10	12.48	1.95	090
26418		A	Repair finger tendon	4.47	NA	NA	10.95	10.99	0.85	090
26420		A	Repair/graft finger tendon	6.94	NA	NA	11.80	11.90	1.43	090
26426		A	Repair finger/hand tendon	6.32	NA	NA	7.25	7.98	1.19	090
26428		A	Repair/graft finger tendon	7.40	NA	NA	12.58	12.55	1.53	090
26432		A	Repair finger tendon	4.16	NA	NA	9.16	9.18	0.76	090
26433		A	Repair finger tendon	4.70	NA	NA	9.47	9.51	0.89	090
26434		A	Repair/graft finger tendon	6.26	NA	NA	10.82	10.74	1.29	090
26437		A	Realignment of tendons	5.99	NA	NA	10.68	10.61	1.07	090

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26440		A	Release palm/finger tendon	5.16	NA	NA	11.44	11.58	0.93	090
26442		A	Release palm & finger tendon	9.75	NA	NA	16.16	15.83	1.81	090
26445		A	Release hand/finger tendon	4.45	NA	NA	11.01	11.17	0.81	090
26449		A	Release forearm/hand tendon	8.59	NA	NA	10.43	10.96	1.57	090
26450		A	Incision of palm tendon	3.79	NA	NA	7.04	6.97	0.71	090
26455		A	Incision of finger tendon	3.76	NA	NA	7.04	6.95	0.72	090
26460		A	Incise hand/finger tendon	3.58	NA	NA	6.99	6.88	0.65	090
26471		A	Fusion of finger tendons	5.90	NA	NA	10.60	10.49	1.07	090
26474		A	Fusion of finger tendons	5.49	NA	NA	10.59	10.42	1.12	090
26476		A	Tendon lengthening	5.35	NA	NA	10.50	10.22	1.10	090
26477		A	Tendon shortening	5.32	NA	NA	10.24	10.17	1.06	090
26478		A	Lengthening of hand tendon	5.97	NA	NA	10.64	10.67	1.13	090
26479		A	Shortening of hand tendon	5.91	NA	NA	10.61	10.58	1.22	090
26480		A	Transplant hand tendon	6.90	NA	NA	13.23	13.25	1.26	090
26483		A	Transplant/graft hand tendon	8.48	NA	NA	13.97	13.99	1.62	090
26485		A	Transplant palm tendon	7.89	NA	NA	13.69	13.73	1.46	090
26489		A	Transplant/graft palm tendon	9.86	NA	NA	14.87	14.07	2.01	090
26490		A	Revise thumb tendon	8.60	NA	NA	12.59	12.32	1.75	090
26492		A	Tendon transfer with graft	9.84	NA	NA	13.48	13.28	2.01	090
26494		A	Hand tendon/muscle transfer	8.66	NA	NA	12.47	12.34	1.75	090
26496		A	Revise thumb tendon	9.78	NA	NA	13.23	12.97	1.71	090
26497		A	Finger tendon transfer	9.76	NA	NA	13.11	12.95	1.99	090
26498		A	Finger tendon transfer	14.21	NA	NA	16.03	15.75	2.91	090
26499		A	Revision of finger	9.17	NA	NA	12.76	12.59	1.88	090
26500		A	Hand tendon reconstruction	6.13	NA	NA	10.66	10.57	1.19	090
26502		A	Hand tendon reconstruction	7.31	NA	NA	11.83	11.54	1.51	090

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26508		A	Release thumb contracture	6.18	NA	NA	10.77	10.61	1.14	090
26510		A	Thumb tendon transfer	5.60	NA	NA	10.32	10.33	1.02	090
26516		A	Fusion of knuckle joint	7.32	NA	NA	11.40	11.30	1.34	090
26517		A	Fusion of knuckle joints	9.08	NA	NA	12.71	12.62	1.87	090
26518		A	Fusion of knuckle joints	9.27	NA	NA	13.14	12.86	1.89	090
26520		A	Release knuckle contracture	5.47	NA	NA	11.96	12.06	1.03	090
26525		A	Release finger contracture	5.50	NA	NA	11.97	12.08	0.99	090
26530		A	Revise knuckle joint	6.88	NA	NA	7.65	7.25	1.27	090
26531		A	Revise knuckle with implant	8.13	NA	NA	8.83	8.35	1.44	090
26535		A	Revise finger joint	5.41	NA	NA	5.96	5.44	0.86	090
26536		A	Revise/implant finger joint	6.56	NA	NA	12.62	11.95	1.17	090
26540		A	Repair hand joint	6.60	NA	NA	11.01	10.94	1.23	090
26541		A	Repair hand joint with graft	8.81	NA	NA	12.50	12.41	1.58	090
26542		A	Repair hand joint with graft	6.95	NA	NA	11.26	11.18	1.30	090
26545		A	Reconstruct finger joint	7.11	NA	NA	11.56	11.41	1.31	090
26546		A	Repair nonunion hand	10.83	NA	NA	15.76	15.37	1.92	090
26548		A	Reconstruct finger joint	8.22	NA	NA	12.23	12.05	1.55	090
26550		A	Construct thumb replacement	21.68	NA	NA	21.94	19.26	4.42	090
26551		A	Great toe-hand transfer	48.48	NA	NA	28.34	30.29	9.92	090
26553		A	Single transfer, toe-hand	48.17	NA	NA	44.03	34.58	3.56	090
26554		A	Double transfer, toe-hand	57.01	NA	NA	32.34	33.56	4.21	090
26555		A	Positional change of finger	17.08	NA	NA	19.26	18.86	3.50	090
26556		A	Toe joint transfer	49.75	NA	NA	31.98	28.92	4.11	090
26560		A	Repair of web finger	5.52	NA	NA	10.31	9.94	1.13	090
26561		A	Repair of web finger	11.10	NA	NA	14.64	13.59	2.44	090
26562		A	Repair of web finger	16.68	NA	NA	18.89	18.26	1.23	090

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26565		A	Correct metacarpal flaw	6.91	NA	NA	11.12	11.05	1.41	090
26567		A	Correct finger deformity	6.99	NA	NA	11.16	11.11	1.29	090
26568		A	Lengthen metacarpal/finger	9.27	NA	NA	14.52	14.43	1.89	090
26580		A	Repair hand deformity	19.75	NA	NA	15.35	15.80	4.04	090
26587		A	Reconstruct extra finger	14.50	NA	NA	14.57	12.28	3.22	090
26590		A	Repair finger deformity	18.67	NA	NA	14.91	14.12	3.84	090
26591		A	Repair muscles of hand	3.38	NA	NA	8.28	8.39	0.64	090
26593		A	Release muscles of hand	5.50	NA	NA	10.59	10.51	0.96	090
26596		A	Excision constricting tissue	9.14	NA	NA	11.05	10.39	1.88	090
26600		A	Treat metacarpal fracture	2.60	5.23	4.89	4.78	4.37	0.49	090
26605		A	Treat metacarpal fracture	3.03	5.58	5.32	4.82	4.55	0.58	090
26607		A	Treat metacarpal fracture	5.48	NA	NA	6.80	6.24	1.10	090
26608		A	Treat metacarpal fracture	5.55	NA	NA	7.32	7.01	1.07	090
26615		A	Treat metacarpal fracture	7.07	NA	NA	8.53	7.85	1.34	090
26641		A	Treat thumb dislocation	4.13	5.34	5.25	4.58	4.43	0.75	090
26645		A	Treat thumb fracture	4.58	6.82	6.34	5.89	5.42	0.92	090
26650		A	Treat thumb fracture	5.35	NA	NA	7.52	7.23	1.06	090
26665		A	Treat thumb fracture	7.94	NA	NA	8.97	8.41	1.53	090
26670		A	Treat hand dislocation	3.83	4.92	4.70	4.15	3.87	0.69	090
26675		A	Treat hand dislocation	4.83	7.29	6.78	6.31	5.82	0.99	090
26676		A	Pin hand dislocation	5.74	NA	NA	7.72	7.43	1.10	090
26685		A	Treat hand dislocation	7.07	NA	NA	8.43	7.91	1.44	090
26686		A	Treat hand dislocation	8.17	NA	NA	8.49	8.09	1.67	090
26700		A	Treat knuckle dislocation	3.83	4.56	4.32	4.07	3.78	0.68	090
26705		A	Treat knuckle dislocation	4.38	6.87	6.37	5.92	5.43	0.85	090
26706		A	Pin knuckle dislocation	5.31	NA	NA	6.62	6.19	0.99	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
26715		A	Treat knuckle dislocation	7.03	NA	NA	8.40	7.80	1.36	090
26720		A	Treat finger fracture, each	1.76	3.47	3.31	3.12	2.90	0.34	090
26725		A	Treat finger fracture, each	3.48	5.55	5.34	4.68	4.42	0.66	090
26727		A	Treat finger fracture, each	5.42	NA	NA	7.28	6.96	1.03	090
26735		A	Treat finger fracture, each	7.42	NA	NA	8.72	8.04	1.43	090
26740		A	Treat finger fracture, each	2.07	4.10	3.87	3.73	3.49	0.37	090
26742		A	Treat finger fracture, each	3.99	5.78	5.58	4.88	4.66	0.75	090
26746		A	Treat finger fracture, each	9.80	NA	NA	10.28	9.32	1.85	090
26750		A	Treat finger fracture, each	1.80	3.04	2.90	3.05	2.84	0.34	090
26755		A	Treat finger fracture, each	3.23	5.06	4.89	4.02	3.80	0.61	090
26756		A	Pin finger fracture, each	4.58	NA	NA	6.74	6.44	0.86	090
26765		A	Treat finger fracture, each	5.86	NA	NA	7.72	7.02	1.13	090
26770		A	Treat finger dislocation	3.15	3.99	3.80	3.49	3.24	0.57	090
26775		A	Treat finger dislocation	3.90	6.32	6.04	5.36	5.02	0.72	090
26776		A	Pin finger dislocation	4.99	NA	NA	6.95	6.66	0.95	090
26785		A	Treat finger dislocation	6.60	NA	NA	8.20	7.43	1.26	090
26820		A	Thumb fusion with graft	8.45	NA	NA	12.34	12.27	1.72	090
26841		A	Fusion of thumb	7.35	NA	NA	12.05	11.99	1.44	090
26842		A	Thumb fusion with graft	8.49	NA	NA	12.41	12.34	1.72	090
26843		A	Fusion of hand joint	7.78	NA	NA	11.71	11.61	1.60	090
26844		A	Fusion/graft of hand joint	8.98	NA	NA	12.65	12.55	1.85	090
26850		A	Fusion of knuckle	7.14	NA	NA	11.40	11.31	1.29	090
26852		A	Fusion of knuckle with graft	8.71	NA	NA	12.63	12.43	1.53	090
26860		A	Fusion of finger joint	4.88	NA	NA	10.22	10.19	0.88	090
26861		A	Fusion of finger jnt, add-on	1.74	NA	NA	1.08	1.02	0.32	ZZZ
26862		A	Fusion/graft of finger joint	7.56	NA	NA	11.89	11.74	1.36	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
26863		A	Fuse/graft added joint	3.89	NA	NA	2.27	2.21	0.78	ZZZ
26910		A	Amputate metacarpal bone	7.79	NA	NA	11.33	11.12	1.55	090
26951		A	Amputation of finger/thumb	6.04	NA	NA	11.39	11.01	1.19	090
26952		A	Amputation of finger/thumb	6.48	NA	NA	10.82	10.75	1.26	090
26989		C	Hand/finger surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
26990		A	Drainage of pelvis lesion	7.95	NA	NA	8.73	8.33	1.64	090
26991		A	Drainage of pelvis bursa	7.06	11.92	11.58	7.01	6.61	1.44	090
26992		A	Drainage of bone lesion	13.48	NA	NA	12.23	11.66	2.77	090
27000		A	Incision of hip tendon	5.74	NA	NA	5.91	5.82	1.12	090
27001		A	Incision of hip tendon	7.14	NA	NA	7.31	6.99	1.46	090
27003		A	Incision of hip tendon	7.81	NA	NA	8.12	7.65	1.60	090
27005		A	Incision of hip tendon	10.07	NA	NA	9.37	8.95	2.05	090
27006		A	Incision of hip tendons	10.11	NA	NA	9.65	9.20	2.03	090
27025		A	Incision of hip/thigh fascia	12.89	NA	NA	11.55	10.83	2.67	090
27027		A	Buttock fasciotomy	13.04	NA	NA	11.16	10.15	0.95	090
27030		A	Drainage of hip joint	13.65	NA	NA	11.28	10.89	2.77	090
27033		A	Exploration of hip joint	14.11	NA	NA	11.93	11.42	2.88	090
27035		A	Denervation of hip joint	17.37	NA	NA	14.16	12.42	3.56	090
27036		A	Excision of hip joint/muscle	14.38	NA	NA	12.58	11.99	2.90	090
27040		A	Biopsy of soft tissues	2.92	6.17	6.25	2.37	2.38	0.49	010
27041		A	Biopsy of soft tissues	10.18	NA	NA	7.77	7.63	1.88	090
27043		A	Exc hip pelvis les sc > 3 cm	6.88	NA	NA	5.59	5.59	1.47	090
27045		A	Exc hip/pelv tum deep > 5 cm	11.13	NA	NA	8.64	8.64	2.35	090
27047		A	Exc hip/pelvis les sc < 3 cm	4.94	7.57	8.03	4.69	5.12	1.06	090
27048		A	Exc hip/pelv tum deep < 5 cm	8.85	NA	NA	7.38	6.55	1.88	090
27049		A	Resect hip/pelv tum < 5 cm	21.55	NA	NA	14.66	12.41	4.49	090

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27050		A	Biopsy of sacroiliac joint	4.74	NA	NA	6.01	5.16	0.96	090
27052		A	Biopsy of hip joint	7.42	NA	NA	7.97	7.47	1.53	090
27054		A	Removal of hip joint lining	9.21	NA	NA	9.10	8.67	1.88	090
27057		A	Buttock fasciotomy w/dbrdmt	14.91	NA	NA	12.26	11.15	1.10	090
27059		A	Resect hip/pelv tum > 5 cm	29.35	NA	NA	18.88	18.88	6.01	090
27060		A	Removal of ischial bursa	5.87	NA	NA	6.56	5.89	1.22	090
27062		A	Remove femur lesion/bursa	5.75	NA	NA	6.47	6.15	1.17	090
27065		A	Removal of hip bone lesion	6.55	NA	NA	6.96	6.66	1.33	090
27066		A	Removal of hip bone lesion	11.20	NA	NA	10.53	10.02	2.29	090
27067		A	Remove/graft hip bone lesion	14.72	NA	NA	12.97	12.37	3.02	090
27070		A	Partial removal of hip bone	11.56	NA	NA	11.25	10.75	2.36	090
27071		A	Partial removal of hip bone	12.39	NA	NA	11.98	11.49	2.53	090
27075		A	Resect hip tumor	32.71	NA	NA	22.82	22.15	6.68	090
27076		A	Resect hip tum incl acetabul	40.21	NA	NA	27.55	21.99	8.24	090
27077		A	Resect hip tum w/innom bone	45.21	NA	NA	31.00	28.06	9.26	090
27078		A	Rsect hip tum incl femur	32.21	NA	NA	23.40	17.43	6.58	090
27080		A	Removal of tail bone	6.89	NA	NA	6.70	6.25	1.47	090
27086		A	Remove hip foreign body	1.92	4.36	4.53	1.92	1.93	0.32	010
27087		A	Remove hip foreign body	8.83	NA	NA	7.94	7.66	1.77	090
27090		A	Removal of hip prosthesis	11.69	NA	NA	10.52	10.06	2.37	090
27091		A	Removal of hip prosthesis	24.35	NA	NA	18.49	17.47	4.99	090
27093		A	Injection for hip x-ray	1.30	3.91	4.05	0.64	0.62	0.14	000
27095		A	Injection for hip x-ray	1.50	4.93	5.04	0.76	0.72	0.18	000
27096		A	Inject sacroiliac joint	1.40	4.09	3.85	0.68	0.55	0.13	000
27097		A	Revision of hip tendon	9.27	NA	NA	8.97	8.34	1.89	090
27098		A	Transfer tendon to pelvis	9.32	NA	NA	9.24	8.04	1.91	090

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27100		A	Transfer of abdominal muscle	11.35	NA	NA	10.75	10.22	2.32	090
27105		A	Transfer of spinal muscle	12.04	NA	NA	11.15	10.63	2.44	090
27110		A	Transfer of iliopsoas muscle	13.77	NA	NA	12.16	11.43	2.83	090
27111		A	Transfer of iliopsoas muscle	12.60	NA	NA	11.48	10.33	2.56	090
27120		A	Reconstruction of hip socket	19.25	NA	NA	15.59	14.63	3.94	090
27122		A	Reconstruction of hip socket	16.09	NA	NA	13.42	12.81	3.28	090
27125		A	Partial hip replacement	16.64	NA	NA	13.73	12.99	3.41	090
27130		A	Total hip arthroplasty	21.79	NA	NA	16.83	16.00	4.45	090
27132		A	Total hip arthroplasty	25.69	NA	NA	19.28	18.38	5.26	090
27134		A	Revise hip joint replacement	30.28	NA	NA	21.18	20.30	6.19	090
27137		A	Revise hip joint replacement	22.70	NA	NA	16.84	16.10	4.63	090
27138		A	Revise hip joint replacement	23.70	NA	NA	17.43	16.65	4.85	090
27140		A	Transplant femur ridge	12.78	NA	NA	11.11	10.68	2.61	090
27146		A	Incision of hip bone	18.92	NA	NA	15.53	14.49	3.89	090
27147		A	Revision of hip bone	22.07	NA	NA	17.37	16.44	4.51	090
27151		A	Incision of hip bones	24.12	NA	NA	18.57	16.61	4.95	090
27156		A	Revision of hip bones	26.23	NA	NA	19.80	18.62	5.36	090
27158		A	Revision of pelvis	21.04	NA	NA	16.55	15.39	4.31	090
27161		A	Incision of neck of femur	17.89	NA	NA	14.62	14.00	3.65	090
27165		A	Incision/fixation of femur	20.29	NA	NA	16.57	15.68	4.14	090
27170		A	Repair/graft femur head/neck	17.61	NA	NA	13.93	13.27	3.60	090
27175		A	Treat slipped epiphysis	9.38	NA	NA	8.47	8.03	1.92	090
27176		A	Treat slipped epiphysis	12.92	NA	NA	11.67	11.04	2.66	090
27177		A	Treat slipped epiphysis	16.09	NA	NA	13.76	13.06	3.29	090
27178		A	Treat slipped epiphysis	12.92	NA	NA	11.67	10.95	2.66	090
27179		A	Revise head/neck of femur	13.97	NA	NA	12.17	11.56	2.85	090

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27181		A	Treat slipped epiphysis	16.18	NA	NA	13.93	13.09	3.32	090
27185		A	Revision of femur epiphysis	9.79	NA	NA	6.68	6.94	0.72	090
27187		A	Reinforce hip bones	14.23	NA	NA	12.30	11.79	2.91	090
27193		A	Treat pelvic ring fracture	6.09	6.50	6.16	6.67	6.31	1.24	090
27194		A	Treat pelvic ring fracture	10.20	NA	NA	8.36	8.20	1.72	090
27200		A	Treat tail bone fracture	1.92	2.89	2.71	3.09	2.87	0.37	090
27202		A	Treat tail bone fracture	7.31	NA	NA	7.67	8.60	1.51	090
27215		I	Treat pelvic fracture(s)	10.45	NA	NA	6.46	7.26	0.76	090
27216		I	Treat pelvic ring fracture	15.73	NA	NA	9.35	10.40	1.17	090
27217		I	Treat pelvic ring fracture	14.65	NA	NA	8.88	10.04	1.09	090
27218		I	Treat pelvic ring fracture	20.93	NA	NA	11.59	12.82	1.55	090
27220		A	Treat hip socket fracture	6.83	7.36	6.98	7.23	6.86	1.38	090
27222		A	Treat hip socket fracture	14.11	NA	NA	11.95	11.46	2.87	090
27226		A	Treat hip wall fracture	15.57	NA	NA	12.85	11.85	3.19	090
27227		A	Treat hip fracture(s)	25.41	NA	NA	19.23	18.28	5.20	090
27228		A	Treat hip fracture(s)	29.33	NA	NA	21.47	20.50	6.01	090
27230		A	Treat thigh fracture	5.81	6.84	6.53	6.75	6.40	1.19	090
27232		A	Treat thigh fracture	11.72	NA	NA	8.65	8.29	2.33	090
27235		A	Treat thigh fracture	13.00	NA	NA	11.39	10.87	2.66	090
27236		A	Treat thigh fracture	17.61	NA	NA	14.47	13.69	3.60	090
27238		A	Treat thigh fracture	5.75	NA	NA	6.48	6.18	1.17	090
27240		A	Treat thigh fracture	13.81	NA	NA	11.76	11.21	2.80	090
27244		A	Treat thigh fracture	18.18	NA	NA	14.83	14.02	3.70	090
27245		A	Treat thigh fracture	18.18	NA	NA	14.86	14.41	3.70	090
27246		A	Treat thigh fracture	4.83	5.45	5.20	5.50	5.24	0.96	090
27248		A	Treat thigh fracture	10.78	NA	NA	9.11	8.80	2.20	090

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27250		A	Treat hip dislocation	3.82	NA	NA	0.95	1.51	0.69	000
27252		A	Treat hip dislocation	11.03	NA	NA	9.13	8.71	2.22	090
27253		A	Treat hip dislocation	13.58	NA	NA	11.62	11.13	2.77	090
27254		A	Treat hip dislocation	18.94	NA	NA	14.94	14.24	3.87	090
27256		A	Treat hip dislocation	4.28	3.43	3.34	1.73	1.82	0.78	010
27257		A	Treat hip dislocation	5.38	NA	NA	3.48	3.32	1.02	010
27258		A	Treat hip dislocation	16.18	NA	NA	13.57	12.86	3.32	090
27259		A	Treat hip dislocation	23.26	NA	NA	18.39	17.39	4.75	090
27265		A	Treat hip dislocation	5.24	NA	NA	5.15	5.04	0.96	090
27266		A	Treat hip dislocation	7.78	NA	NA	7.78	7.41	1.58	090
27267		A	Cltx thigh fx	5.50	NA	NA	6.09	5.63	1.13	090
27268		A	Cltx thigh fx w/mnpj	7.12	NA	NA	7.28	6.62	1.46	090
27269		A	Optx thigh fx	18.89	NA	NA	14.25	13.10	3.84	090
27275		A	Manipulation of hip joint	2.32	NA	NA	2.48	2.39	0.41	010
27280		A	Fusion of sacroiliac joint	14.64	NA	NA	12.79	12.20	3.15	090
27282		A	Fusion of pubic bones	11.85	NA	NA	11.04	9.90	2.40	090
27284		A	Fusion of hip joint	25.06	NA	NA	18.38	16.28	5.14	090
27286		A	Fusion of hip joint	25.17	NA	NA	19.18	18.29	5.16	090
27290		A	Amputation of leg at hip	24.55	NA	NA	19.03	17.33	5.03	090
27295		A	Amputation of leg at hip	19.66	NA	NA	14.16	13.40	4.17	090
27299		C	Pelvis/hip joint surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
27301		A	Drain thigh/knee lesion	6.78	11.18	10.84	6.60	6.24	1.43	090
27303		A	Drainage of bone lesion	8.63	NA	NA	8.48	8.09	1.75	090
27305		A	Incise thigh tendon & fascia	6.18	NA	NA	6.64	6.22	1.27	090
27306		A	Incision of thigh tendon	4.74	NA	NA	5.23	5.10	0.96	090
27307		A	Incision of thigh tendons	6.06	NA	NA	6.77	6.32	1.24	090

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27310		A	Exploration of knee joint	10.00	NA	NA	9.58	9.09	2.03	090
27323		A	Biopsy, thigh soft tissues	2.33	5.10	4.97	2.53	2.44	0.42	010
27324		A	Biopsy, thigh soft tissues	5.04	NA	NA	5.42	5.10	1.09	090
27325		A	Neurectomy, hamstring	7.20	NA	NA	7.69	7.01	1.47	090
27326		A	Neurectomy, popliteal	6.47	NA	NA	7.26	6.64	1.31	090
27327		A	Exc thigh/knee les sc < 3 cm	3.96	8.29	7.78	4.35	4.38	0.83	090
27328		A	Exc thigh/knee tum deep <5cm	8.85	NA	NA	7.62	6.36	1.88	090
27329		A	Resect thigh/knee tum < 5 cm	15.72	NA	NA	12.05	11.36	3.31	090
27330		A	Biopsy, knee joint lining	5.11	NA	NA	5.97	5.57	0.99	090
27331		A	Explore/treat knee joint	6.02	NA	NA	6.70	6.40	1.23	090
27332		A	Removal of knee cartilage	8.46	NA	NA	8.69	8.29	1.71	090
27333		A	Removal of knee cartilage	7.55	NA	NA	8.11	7.72	1.55	090
27334		A	Remove knee joint lining	9.19	NA	NA	9.11	8.65	1.88	090
27335		A	Remove knee joint lining	10.55	NA	NA	9.87	9.45	2.15	090
27337		A	Exc thigh/knee les sc > 3 cm	5.91	NA	NA	5.30	5.30	1.26	090
27339		A	Exc thigh/knee tum deep >5cm	11.13	NA	NA	8.94	8.94	2.35	090
27340		A	Removal of kneecap bursa	4.32	NA	NA	5.64	5.36	0.88	090
27345		A	Removal of knee cyst	6.09	NA	NA	6.76	6.50	1.24	090
27347		A	Remove knee cyst	6.73	NA	NA	7.41	6.98	1.37	090
27350		A	Removal of kneecap	8.66	NA	NA	8.78	8.40	1.75	090
27355		A	Remove femur lesion	8.00	NA	NA	8.10	7.77	1.64	090
27356		A	Remove femur lesion/graft	10.09	NA	NA	9.60	9.18	2.05	090
27357		A	Remove femur lesion/graft	11.16	NA	NA	10.62	10.14	2.29	090
27358		A	Remove femur lesion/fixation	4.73	NA	NA	2.76	2.67	0.95	ZZZ
27360		A	Partial removal, leg bone(s)	11.46	NA	NA	11.32	10.84	2.35	090
27364		A	Resect thigh/knee tum >5 cm	24.49	NA	NA	16.94	16.94	5.16	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
27365		A	Resect femur/knee tumor	32.21	NA	NA	23.28	18.34	6.60	090
27370		A	Injection for knee x-ray	0.96	3.75	3.77	0.50	0.46	0.13	000
27372		A	Removal of foreign body	5.21	11.12	10.85	5.65	5.40	1.07	090
27380		A	Repair of kneecap tendon	7.45	NA	NA	8.39	8.09	1.53	090
27381		A	Repair/graft kneecap tendon	10.76	NA	NA	10.56	10.18	2.20	090
27385		A	Repair of thigh muscle	8.11	NA	NA	8.81	8.48	1.65	090
27386		A	Repair/graft of thigh muscle	11.13	NA	NA	11.09	10.65	2.27	090
27390		A	Incision of thigh tendon	5.53	NA	NA	6.46	6.12	1.13	090
27391		A	Incision of thigh tendons	7.49	NA	NA	7.93	7.54	1.54	090
27392		A	Incision of thigh tendons	9.63	NA	NA	9.42	8.86	1.96	090
27393		A	Lengthening of thigh tendon	6.59	NA	NA	6.91	6.65	1.34	090
27394		A	Lengthening of thigh tendons	8.79	NA	NA	8.55	8.22	1.77	090
27395		A	Lengthening of thigh tendons	12.24	NA	NA	11.27	10.76	2.50	090
27396		A	Transplant of thigh tendon	8.15	NA	NA	8.31	7.95	1.67	090
27397		A	Transplants of thigh tendons	12.66	NA	NA	11.87	11.23	2.57	090
27400		A	Revise thigh muscles/tendons	9.33	NA	NA	9.25	8.78	1.91	090
27403		A	Repair of knee cartilage	8.62	NA	NA	8.51	8.16	1.74	090
27405		A	Repair of knee ligament	9.08	NA	NA	9.01	8.63	1.87	090
27407		A	Repair of knee ligament	10.85	NA	NA	10.35	9.58	2.22	090
27409		A	Repair of knee ligaments	13.71	NA	NA	12.13	11.54	2.81	090
27412		A	Autochondrocyte implant knee	24.74	NA	NA	19.52	18.46	5.07	090
27415		A	Osteochondral knee allograft	20.00	NA	NA	16.86	15.88	4.08	090
27416		A	Osteochondral knee autograft	14.16	NA	NA	12.10	11.28	2.90	090
27418		A	Repair degenerated kneecap	11.60	NA	NA	10.63	10.21	2.35	090
27420		A	Revision of unstable kneecap	10.26	NA	NA	9.70	9.29	2.08	090
27422		A	Revision of unstable kneecap	10.21	NA	NA	9.67	9.26	2.06	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
27424		A	Revision/removal of kneecap	10.24	NA	NA	9.61	9.25	2.08	090
27425		A	Lat retinacular release open	5.39	NA	NA	6.59	6.29	1.10	090
27427		A	Reconstruction, knee	9.79	NA	NA	9.39	8.99	1.99	090
27428		A	Reconstruction, knee	15.58	NA	NA	14.22	13.51	3.21	090
27429		A	Reconstruction, knee	17.54	NA	NA	15.72	14.99	3.60	090
27430		A	Revision of thigh muscles	10.16	NA	NA	9.63	9.21	2.06	090
27435		A	Incision of knee joint	10.88	NA	NA	10.69	10.16	2.23	090
27437		A	Revise kneecap	8.93	NA	NA	8.75	8.35	1.84	090
27438		A	Revise kneecap with implant	11.89	NA	NA	10.60	10.11	2.42	090
27440		A	Revision of knee joint	11.09	NA	NA	10.26	9.38	2.26	090
27441		A	Revision of knee joint	11.54	NA	NA	10.53	9.59	2.35	090
27442		A	Revision of knee joint	12.37	NA	NA	10.91	10.37	2.52	090
27443		A	Revision of knee joint	11.41	NA	NA	10.45	9.96	2.33	090
27445		A	Revision of knee joint	18.66	NA	NA	14.87	14.22	3.84	090
27446		A	Revision of knee joint	16.38	NA	NA	13.20	12.68	3.35	090
27447		A	Total knee arthroplasty	23.25	NA	NA	17.99	17.16	4.75	090
27448		A	Incision of thigh	11.60	NA	NA	10.29	9.84	2.37	090
27450		A	Incision of thigh	14.61	NA	NA	12.49	11.99	3.01	090
27454		A	Realignment of thigh bone	19.17	NA	NA	15.68	14.65	3.93	090
27455		A	Realignment of knee	13.36	NA	NA	11.87	11.33	2.73	090
27457		A	Realignment of knee	14.03	NA	NA	11.75	11.25	2.87	090
27465		A	Shortening of thigh bone	18.60	NA	NA	15.00	13.92	3.83	090
27466		A	Lengthening of thigh bone	17.28	NA	NA	14.20	13.63	3.55	090
27468		A	Shorten/lengthen thighs	19.97	NA	NA	16.03	15.10	4.08	090
27470		A	Repair of thigh	17.14	NA	NA	14.44	13.79	3.52	090
27472		A	Repair/graft of thigh	18.72	NA	NA	15.13	14.51	3.84	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
27475		A	Surgery to stop leg growth	8.93	NA	NA	6.22	7.08	1.84	090
27477		A	Surgery to stop leg growth	10.14	NA	NA	9.47	9.03	2.06	090
27479		A	Surgery to stop leg growth	13.16	NA	NA	11.48	10.98	0.96	090
27485		A	Surgery to stop leg growth	9.13	NA	NA	8.81	8.43	1.88	090
27486		A	Revise/replace knee joint	21.12	NA	NA	16.62	15.85	4.31	090
27487		A	Revise/replace knee joint	27.11	NA	NA	20.08	19.19	5.54	090
27488		A	Removal of knee prosthesis	17.60	NA	NA	14.59	13.89	3.60	090
27495		A	Reinforce thigh	16.54	NA	NA	13.67	13.09	3.38	090
27496		A	Decompression of thigh/knee	6.78	NA	NA	7.76	6.98	1.38	090
27497		A	Decompression of thigh/knee	7.79	NA	NA	7.78	6.95	1.60	090
27498		A	Decompression of thigh/knee	8.66	NA	NA	8.86	7.68	1.75	090
27499		A	Decompression of thigh/knee	9.43	NA	NA	9.31	8.32	1.94	090
27500		A	Treatment of thigh fracture	6.30	7.56	7.19	6.53	6.15	1.27	090
27501		A	Treatment of thigh fracture	6.45	7.02	6.71	6.91	6.55	1.31	090
27502		A	Treatment of thigh fracture	11.36	NA	NA	9.44	9.09	2.27	090
27503		A	Treatment of thigh fracture	11.27	NA	NA	10.26	9.76	2.29	090
27506		A	Treatment of thigh fracture	19.65	NA	NA	16.25	15.41	4.01	090
27507		A	Treatment of thigh fracture	14.48	NA	NA	11.60	11.13	2.97	090
27508		A	Treatment of thigh fracture	6.20	7.81	7.47	6.99	6.64	1.24	090
27509		A	Treatment of thigh fracture	8.14	NA	NA	9.17	8.82	1.65	090
27510		A	Treatment of thigh fracture	9.80	NA	NA	8.62	8.35	1.95	090
27511		A	Treatment of thigh fracture	15.11	NA	NA	11.65	11.36	3.09	090
27513		A	Treatment of thigh fracture	19.25	NA	NA	14.06	13.77	3.94	090
27514		A	Treatment of thigh fracture	14.60	NA	NA	11.34	11.42	2.98	090
27516		A	Treat thigh fx growth plate	5.59	8.00	7.52	7.16	6.71	1.14	090
27517		A	Treat thigh fx growth plate	9.12	NA	NA	9.23	8.77	1.87	090

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27519		A	Treat thigh fx growth plate	13.25	NA	NA	10.64	10.57	2.71	090
27520		A	Treat kneecap fracture	3.04	5.57	5.33	4.83	4.53	0.61	090
27524		A	Treat kneecap fracture	10.37	NA	NA	9.78	9.37	2.11	090
27530		A	Treat knee fracture	4.09	6.57	6.28	5.85	5.53	0.81	090
27532		A	Treat knee fracture	7.55	8.96	8.54	7.95	7.56	1.54	090
27535		A	Treat knee fracture	13.41	NA	NA	10.66	10.37	2.73	090
27536		A	Treat knee fracture	17.39	NA	NA	14.57	13.84	3.56	090
27538		A	Treat knee fracture(s)	5.09	7.56	7.22	6.76	6.40	1.03	090
27540		A	Treat knee fracture	11.30	NA	NA	10.49	10.16	2.30	090
27550		A	Treat knee dislocation	5.98	7.29	6.97	6.33	6.00	1.14	090
27552		A	Treat knee dislocation	8.18	NA	NA	8.61	8.18	1.67	090
27556		A	Treat knee dislocation	13.00	NA	NA	10.49	10.43	2.67	090
27557		A	Treat knee dislocation	15.90	NA	NA	12.19	12.08	3.26	090
27558		A	Treat knee dislocation	18.39	NA	NA	13.64	13.31	3.76	090
27560		A	Treat kneecap dislocation	3.99	6.19	5.83	5.49	5.00	0.79	090
27562		A	Treat kneecap dislocation	5.98	NA	NA	6.94	6.40	1.23	090
27566		A	Treat kneecap dislocation	12.71	NA	NA	11.11	10.65	2.60	090
27570		A	Fixation of knee joint	1.79	NA	NA	2.25	2.14	0.35	010
27580		A	Fusion of knee	21.10	NA	NA	17.45	16.72	4.31	090
27590		A	Amputate leg at thigh	13.47	NA	NA	8.36	7.99	3.07	090
27591		A	Amputate leg at thigh	13.94	NA	NA	9.99	9.76	3.02	090
27592		A	Amputate leg at thigh	10.98	NA	NA	7.71	7.38	2.43	090
27594		A	Amputation follow-up surgery	7.29	NA	NA	6.34	6.14	1.61	090
27596		A	Amputation follow-up surgery	11.29	NA	NA	8.26	7.94	2.49	090
27598		A	Amputate lower leg at knee	11.22	NA	NA	8.70	8.35	2.42	090
27599		C	Leg surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
27600		A	Decompression of lower leg	6.03	NA	NA	5.07	5.01	1.31	090
27601		A	Decompression of lower leg	6.05	NA	NA	5.91	5.68	1.31	090
27602		A	Decompression of lower leg	7.82	NA	NA	5.64	5.57	1.81	090
27603		A	Drain lower leg lesion	5.23	9.43	9.01	5.42	5.12	1.05	090
27604		A	Drain lower leg bursa	4.59	8.46	7.98	4.61	4.42	0.81	090
27605		A	Incision of achilles tendon	2.92	6.43	6.68	2.17	2.23	0.35	010
27606		A	Incision of achilles tendon	4.18	NA	NA	3.59	3.51	0.75	010
27607		A	Treat lower leg bone lesion	8.62	NA	NA	7.96	7.59	1.64	090
27610		A	Explore/treat ankle joint	9.13	NA	NA	8.54	8.16	1.70	090
27612		A	Exploration of ankle joint	8.15	NA	NA	7.21	6.95	1.20	090
27613		A	Biopsy lower leg soft tissue	2.22	4.80	4.66	2.33	2.26	0.32	010
27614		A	Biopsy lower leg soft tissue	5.80	9.92	9.46	5.20	5.03	1.07	090
27615		A	Resect leg/ankle tum < 5 cm	15.72	NA	NA	12.02	10.80	3.26	090
27616		A	Resect leg/ankle tum > 5 cm	19.63	NA	NA	14.38	14.38	4.06	090
27618		A	Exc leg/ankle tum < 3 cm	3.96	8.18	7.90	4.30	4.50	0.76	090
27619		A	Exc leg/ankle tum deep <5 cm	6.91	NA	NA	6.21	6.39	1.27	090
27620		A	Explore/treat ankle joint	6.15	NA	NA	6.29	6.07	1.09	090
27625		A	Remove ankle joint lining	8.49	NA	NA	7.16	7.02	1.31	090
27626		A	Remove ankle joint lining	9.10	NA	NA	7.96	7.69	1.58	090
27630		A	Removal of tendon lesion	4.94	10.38	9.86	5.06	4.90	0.81	090
27632		A	Exc leg/ankle les sc > 3 cm	5.91	NA	NA	5.25	5.25	1.17	090
27634		A	Exc leg/ankle tum deep >5 cm	10.13	NA	NA	8.00	8.00	1.87	090
27635		A	Remove lower leg bone lesion	8.03	NA	NA	7.97	7.64	1.55	090
27637		A	Remove/graft leg bone lesion	10.31	NA	NA	10.15	9.63	2.09	090
27638		A	Remove/graft leg bone lesion	10.99	NA	NA	9.69	9.38	2.25	090
27640		A	Partial removal of tibia	12.24	NA	NA	10.50	10.30	2.29	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
27641		A	Partial removal of fibula	9.84	NA	NA	8.32	8.21	1.74	090
27645		A	Resect tibia tumor	27.21	NA	NA	20.59	16.35	5.57	090
27646		A	Resect fibula tumor	23.21	NA	NA	18.25	14.43	4.75	090
27647		A	Resect talus/calcaneus tum	20.26	NA	NA	10.73	9.36	2.11	090
27648		A	Injection for ankle x-ray	0.96	3.54	3.57	0.48	0.45	0.13	000
27650		A	Repair achilles tendon	9.21	NA	NA	8.97	8.64	1.57	090
27652		A	Repair/graft achilles tendon	10.78	NA	NA	8.43	8.36	1.57	090
27654		A	Repair of achilles tendon	10.53	NA	NA	8.99	8.63	1.57	090
27656		A	Repair leg fascia defect	4.71	12.33	11.05	5.90	5.18	0.95	090
27658		A	Repair of leg tendon, each	5.12	NA	NA	5.18	5.04	0.81	090
27659		A	Repair of leg tendon, each	7.10	NA	NA	6.31	6.12	1.03	090
27664		A	Repair of leg tendon, each	4.73	NA	NA	5.27	5.06	0.78	090
27665		A	Repair of leg tendon, each	5.57	NA	NA	5.59	5.48	0.92	090
27675		A	Repair lower leg tendons	7.35	NA	NA	6.07	5.98	1.06	090
27676		A	Repair lower leg tendons	8.73	NA	NA	7.95	7.66	1.77	090
27680		A	Release of lower leg tendon	5.88	NA	NA	5.92	5.67	1.02	090
27681		A	Release of lower leg tendons	7.05	NA	NA	7.57	6.97	1.44	090
27685		A	Revision of lower leg tendon	6.69	11.58	10.80	6.11	5.95	0.95	090
27686		A	Revise lower leg tendons	7.75	NA	NA	7.30	7.09	1.34	090
27687		A	Revision of calf tendon	6.41	NA	NA	6.08	5.87	1.03	090
27690		A	Revise lower leg tendon	9.17	NA	NA	8.38	7.94	1.37	090
27691		A	Revise lower leg tendon	10.49	NA	NA	9.94	9.48	1.89	090
27692		A	Revise additional leg tendon	1.87	NA	NA	1.03	0.99	0.35	ZZZ
27695		A	Repair of ankle ligament	6.70	NA	NA	6.37	6.28	1.12	090
27696		A	Repair of ankle ligaments	8.58	NA	NA	6.89	6.77	1.20	090
27698		A	Repair of ankle ligament	9.61	NA	NA	7.94	7.70	1.57	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
27700		A	Revision of ankle joint	9.66	NA	NA	6.69	6.57	1.24	090
27702		A	Reconstruct ankle joint	14.42	NA	NA	11.88	11.55	2.76	090
27703		A	Reconstruction, ankle joint	16.94	NA	NA	13.44	13.05	3.31	090
27704		A	Removal of ankle implant	7.81	NA	NA	7.82	7.36	1.47	090
27705		A	Incision of tibia	10.86	NA	NA	9.73	9.31	2.09	090
27707		A	Incision of fibula	4.78	NA	NA	6.19	5.89	0.93	090
27709		A	Incision of tibia & fibula	17.48	NA	NA	14.29	13.01	3.50	090
27712		A	Realignment of lower leg	15.87	NA	NA	13.76	13.04	3.26	090
27715		A	Revision of lower leg	15.50	NA	NA	12.71	12.30	3.19	090
27720		A	Repair of tibia	12.36	NA	NA	11.14	10.71	2.49	090
27722		A	Repair/graft of tibia	12.45	NA	NA	11.40	10.75	2.53	090
27724		A	Repair/graft of tibia	19.31	NA	NA	14.74	14.12	3.94	090
27725		A	Repair of lower leg	17.41	NA	NA	15.30	14.44	3.57	090
27726		A	Repair fibula nonunion	14.34	NA	NA	11.83	10.67	2.88	090
27727		A	Repair of lower leg	14.84	NA	NA	12.93	11.43	3.05	090
27730		A	Repair of tibia epiphysis	7.70	NA	NA	7.98	7.59	1.58	090
27732		A	Repair of fibula epiphysis	5.46	NA	NA	6.51	5.74	1.12	090
27734		A	Repair lower leg epiphyses	8.83	NA	NA	8.72	7.60	0.65	090
27740		A	Repair of leg epiphyses	9.61	NA	NA	6.63	6.97	1.96	090
27742		A	Repair of leg epiphyses	10.63	NA	NA	8.77	7.91	2.16	090
27745		A	Reinforce tibia	10.49	NA	NA	9.68	9.31	2.12	090
27750		A	Treatment of tibia fracture	3.37	5.87	5.61	5.11	4.83	0.66	090
27752		A	Treatment of tibia fracture	6.27	8.16	7.80	7.06	6.73	1.26	090
27756		A	Treatment of tibia fracture	7.45	NA	NA	7.94	7.58	1.51	090
27758		A	Treatment of tibia fracture	12.54	NA	NA	11.37	10.82	2.54	090
27759		A	Treatment of tibia fracture	14.45	NA	NA	12.34	11.80	2.95	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
27760		A	Cltx medial ankle fx	3.21	5.74	5.49	4.96	4.68	0.61	090
27762		A	Cltx med ankle fx w/mnpj	5.47	7.40	7.15	6.30	6.08	1.05	090
27766		A	Optx medial ankle fx	7.89	NA	NA	8.55	8.19	1.57	090
27767		A	Cltx post ankle fx	2.64	4.94	4.56	4.98	4.60	0.52	090
27768		A	Cltx post ankle fx w/mnpj	5.14	NA	NA	6.63	5.98	1.06	090
27769		A	Optx post ankle fx	10.14	NA	NA	9.60	8.63	2.06	090
27780		A	Treatment of fibula fracture	2.83	5.33	5.05	4.60	4.29	0.55	090
27781		A	Treatment of fibula fracture	4.59	6.81	6.49	5.99	5.67	0.90	090
27784		A	Treatment of fibula fracture	9.67	NA	NA	9.63	8.97	1.95	090
27786		A	Treatment of ankle fracture	3.02	5.47	5.23	4.66	4.39	0.57	090
27788		A	Treatment of ankle fracture	4.64	6.70	6.45	5.74	5.50	0.88	090
27792		A	Treatment of ankle fracture	9.71	NA	NA	9.54	8.98	1.91	090
27808		A	Treatment of ankle fracture	3.03	5.90	5.65	5.00	4.73	0.58	090
27810		A	Treatment of ankle fracture	5.32	7.24	7.01	6.12	5.92	1.05	090
27814		A	Treatment of ankle fracture	10.62	NA	NA	10.17	9.75	2.12	090
27816		A	Treatment of ankle fracture	3.07	5.47	5.17	4.60	4.30	0.57	090
27818		A	Treatment of ankle fracture	5.69	7.14	6.95	5.86	5.70	1.09	090
27822		A	Treatment of ankle fracture	11.21	NA	NA	11.46	11.14	2.25	090
27823		A	Treatment of ankle fracture	13.16	NA	NA	12.59	12.18	2.64	090
27824		A	Treat lower leg fracture	3.31	5.06	4.83	4.82	4.55	0.64	090
27825		A	Treat lower leg fracture	6.69	7.95	7.64	6.59	6.32	1.33	090
27826		A	Treat lower leg fracture	11.10	NA	NA	11.46	10.87	2.22	090
27827		A	Treat lower leg fracture	14.79	NA	NA	14.37	13.84	3.01	090
27828		A	Treat lower leg fracture	18.43	NA	NA	16.45	15.76	3.73	090
27829		A	Treat lower leg joint	8.80	NA	NA	9.63	9.06	1.75	090
27830		A	Treat lower leg dislocation	3.96	6.23	5.71	5.53	5.04	0.79	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
27831		A	Treat lower leg dislocation	4.73	NA	NA	5.97	5.51	0.95	090
27832		A	Treat lower leg dislocation	10.17	NA	NA	10.09	9.18	2.06	090
27840		A	Treat ankle dislocation	4.77	NA	NA	4.82	4.59	0.86	090
27842		A	Treat ankle dislocation	6.46	NA	NA	6.90	6.46	1.26	090
27846		A	Treat ankle dislocation	10.28	NA	NA	9.47	9.11	2.02	090
27848		A	Treat ankle dislocation	11.68	NA	NA	10.30	10.06	2.33	090
27860		A	Fixation of ankle joint	2.39	NA	NA	2.32	2.28	0.41	010
27870		A	Fusion of ankle joint, open	15.41	NA	NA	12.66	12.17	2.91	090
27871		A	Fusion of tibiofibular joint	9.54	NA	NA	9.07	8.70	1.92	090
27880		A	Amputation of lower leg	15.37	NA	NA	9.43	8.92	3.45	090
27881		A	Amputation of lower leg	13.47	NA	NA	10.11	9.83	2.91	090
27882		A	Amputation of lower leg	9.79	NA	NA	6.66	6.56	2.23	090
27884		A	Amputation follow-up surgery	8.76	NA	NA	6.93	6.68	1.94	090
27886		A	Amputation follow-up surgery	10.02	NA	NA	7.82	7.56	2.22	090
27888		A	Amputation of foot at ankle	10.37	NA	NA	8.07	8.01	2.01	090
27889		A	Amputation of foot at ankle	10.86	NA	NA	7.07	6.98	2.50	090
27892		A	Decompression of leg	7.94	NA	NA	6.94	6.56	1.70	090
27893		A	Decompression of leg	7.90	NA	NA	8.41	7.43	1.74	090
27894		A	Decompression of leg	12.67	NA	NA	10.30	9.82	2.77	090
27899		C	Leg/ankle surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
28001		A	Drainage of bursa of foot	2.78	4.91	4.66	1.95	1.99	0.24	010
28002		A	Treatment of foot infection	5.93	8.40	7.92	4.52	4.44	0.69	010
28003		A	Treatment of foot infection	9.06	9.65	9.24	5.68	5.70	1.10	090
28005		A	Treat foot bone lesion	9.44	NA	NA	7.03	6.93	1.06	090
28008		A	Incision of foot fascia	4.59	7.52	7.13	3.63	3.61	0.42	090
28010		A	Incision of toe tendon	2.97	3.58	3.41	2.93	2.86	0.28	090

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28011		A	Incision of toe tendons	4.28	4.97	4.69	3.97	3.85	0.51	090
28020		A	Exploration of foot joint	5.15	9.70	9.01	4.77	4.62	0.69	090
28022		A	Exploration of foot joint	4.81	8.58	8.11	4.11	4.11	0.51	090
28024		A	Exploration of toe joint	4.52	8.13	7.74	3.86	3.91	0.44	090
28035		A	Decompression of tibia nerve	5.23	9.30	8.81	4.56	4.52	0.68	090
28039		A	Exc foot/toe tum sc > 1.5 cm	5.42	8.21	8.21	3.98	3.98	0.57	090
28041		A	Exc foot/toe tum deep >1.5cm	7.13	NA	NA	5.20	5.20	0.76	090
28043		A	Exc foot/toe tum sc < 1.5 cm	3.96	7.38	6.38	3.47	3.43	0.41	090
28045		A	Exc foot/toe tum deep <1.5cm	5.45	8.72	8.28	4.47	4.24	0.58	090
28046		A	Resect foot/toe tumor < 3 cm	12.38	NA	NA	8.42	7.79	1.72	090
28047		A	Resect foot/toe tumor > 3 cm	17.45	NA	NA	8.45	8.45	1.38	090
28050		A	Biopsy of foot joint lining	4.39	7.59	7.58	3.51	3.76	0.41	090
28052		A	Biopsy of foot joint lining	4.06	7.91	7.46	3.61	3.60	0.51	090
28054		A	Biopsy of toe joint lining	3.57	7.01	6.95	3.07	3.26	0.28	090
28055		A	Neurectomy, foot	6.29	NA	NA	4.35	4.30	0.55	090
28060		A	Partial removal, foot fascia	5.40	9.03	8.48	4.52	4.43	0.57	090
28062		A	Removal of foot fascia	6.69	9.78	9.34	4.75	4.69	0.62	090
28070		A	Removal of foot joint lining	5.24	9.70	8.83	4.69	4.47	0.58	090
28072		A	Removal of foot joint lining	4.72	9.60	9.00	4.59	4.58	0.66	090
28080		A	Removal of foot lesion	4.86	9.68	8.98	5.30	5.06	0.49	090
28086		A	Excise foot tendon sheath	4.92	10.04	9.60	4.92	4.83	0.75	090
28088		A	Excise foot tendon sheath	3.98	9.60	8.82	4.47	4.29	0.57	090
28090		A	Removal of foot lesion	4.55	8.56	8.04	4.02	3.95	0.49	090
28092		A	Removal of toe lesions	3.78	8.18	7.70	3.79	3.75	0.41	090
28100		A	Removal of ankle/heel lesion	5.83	10.59	10.14	5.31	5.20	0.79	090
28102		A	Remove/graft foot lesion	7.92	NA	NA	8.32	7.63	0.64	090

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28103		A	Remove/graft foot lesion	6.67	NA	NA	4.39	4.84	0.52	090
28104		A	Removal of foot lesion	5.26	9.04	8.52	4.33	4.30	0.57	090
28106		A	Remove/graft foot lesion	7.35	NA	NA	4.76	4.99	0.58	090
28107		A	Remove/graft foot lesion	5.73	8.85	8.94	4.11	4.40	0.44	090
28108		A	Removal of toe lesions	4.30	7.97	7.46	3.73	3.68	0.40	090
28110		A	Part removal of metatarsal	4.22	8.69	8.17	3.83	3.76	0.42	090
28111		A	Part removal of metatarsal	5.15	9.06	8.65	4.13	4.07	0.62	090
28112		A	Part removal of metatarsal	4.63	9.12	8.62	4.13	4.06	0.54	090
28113		A	Part removal of metatarsal	6.11	10.59	9.92	5.85	5.64	0.65	090
28114		A	Removal of metatarsal heads	12.00	17.65	16.56	11.06	10.55	1.71	090
28116		A	Revision of foot	9.14	11.97	11.12	6.76	6.51	0.99	090
28118		A	Removal of heel bone	6.13	10.26	9.64	5.26	5.13	0.78	090
28119		A	Removal of heel spur	5.56	9.11	8.54	4.50	4.40	0.55	090
28120		A	Part removal of ankle/heel	8.27	11.86	10.61	6.83	5.87	1.19	090
28122		A	Partial removal of foot bone	7.72	10.51	10.05	6.05	5.97	0.85	090
28124		A	Partial removal of toe	5.00	8.41	7.94	4.27	4.23	0.44	090
28126		A	Partial removal of toe	3.64	7.43	6.98	3.30	3.29	0.35	090
28130		A	Removal of ankle bone	9.50	NA	NA	10.03	8.73	1.94	090
28140		A	Removal of metatarsal	7.14	9.71	9.42	5.16	5.16	0.93	090
28150		A	Removal of toe	4.23	7.98	7.51	3.74	3.69	0.44	090
28153		A	Partial removal of toe	3.80	7.83	7.30	3.64	3.51	0.38	090
28160		A	Partial removal of toe	3.88	7.98	7.47	3.69	3.66	0.40	090
28171		A	Resect tarsal tumor	16.41	NA	NA	7.61	6.96	1.30	090
28173		A	Resect metatarsal tumor	14.16	NA	NA	7.36	6.55	1.62	090
28175		A	Resect phalanx of toe tumor	8.29	NA	NA	5.49	4.93	0.83	090
28190		A	Removal of foot foreign body	2.01	5.11	4.84	1.72	1.68	0.21	010

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28192		A	Removal of foot foreign body	4.78	8.45	7.99	4.02	3.98	0.51	090
28193		A	Removal of foot foreign body	5.90	9.05	8.59	4.47	4.44	0.58	090
28200		A	Repair of foot tendon	4.74	8.62	8.11	4.03	3.99	0.47	090
28202		A	Repair/graft of foot tendon	7.07	9.36	9.21	4.68	4.79	0.66	090
28208		A	Repair of foot tendon	4.51	8.58	7.98	4.09	3.97	0.51	090
28210		A	Repair/graft of foot tendon	6.52	9.44	9.01	4.84	4.78	0.66	090
28220		A	Release of foot tendon	4.67	7.93	7.48	3.77	3.77	0.42	090
28222		A	Release of foot tendons	5.76	8.61	8.13	4.12	4.16	0.52	090
28225		A	Release of foot tendon	3.78	7.42	6.95	3.33	3.28	0.37	090
28226		A	Release of foot tendons	4.67	7.78	7.68	3.59	3.84	0.37	090
28230		A	Incision of foot tendon(s)	4.36	7.74	7.32	3.52	3.59	0.41	090
28232		A	Incision of toe tendon	3.51	7.48	7.04	3.36	3.37	0.35	090
28234		A	Incision of foot tendon	3.54	8.03	7.52	3.90	3.83	0.37	090
28238		A	Revision of foot tendon	7.96	10.91	10.27	5.70	5.57	0.89	090
28240		A	Release of big toe	4.48	7.83	7.46	3.60	3.67	0.45	090
28250		A	Revision of foot fascia	6.06	9.88	9.20	5.04	4.90	0.79	090
28260		A	Release of midfoot joint	8.19	11.31	10.33	6.24	5.94	1.07	090
28261		A	Revision of foot tendon	13.11	13.88	13.02	8.26	8.11	1.33	090
28262		A	Revision of foot and ankle	17.21	20.54	19.24	13.19	12.68	3.12	090
28264		A	Release of midfoot joint	10.65	16.54	14.29	9.95	8.94	0.85	090
28270		A	Release of foot contracture	4.93	8.90	8.25	4.43	4.32	0.52	090
28272		A	Release of toe joint, each	3.92	7.17	6.77	3.23	3.22	0.32	090
28280		A	Fusion of toes	5.33	9.16	8.76	4.44	4.49	0.62	090
28285		A	Repair of hammertoe	4.76	8.51	7.95	4.24	4.13	0.47	090
28286		A	Repair of hammertoe	4.70	8.17	7.66	3.80	3.75	0.41	090
28288		A	Partial removal of foot bone	6.02	11.10	10.23	6.09	5.87	0.69	090

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28289		A	Repair hallux rigidus	8.31	12.20	11.47	6.95	6.73	1.05	090
28290		A	Correction of bunion	5.83	10.57	9.83	5.14	5.05	0.72	090
28292		A	Correction of bunion	9.05	13.15	12.29	7.83	7.51	0.90	090
28293		A	Correction of bunion	11.48	17.93	16.94	8.52	8.26	0.99	090
28294		A	Correction of bunion	8.75	11.46	11.04	5.72	5.72	0.96	090
28296		A	Correction of bunion	8.35	11.70	11.20	6.27	6.20	0.79	090
28297		A	Correction of bunion	9.43	13.36	12.67	6.83	6.77	1.23	090
28298		A	Correction of bunion	8.13	12.02	11.24	5.95	5.81	0.90	090
28299		A	Correction of bunion	11.57	13.50	12.79	7.32	7.19	1.19	090
28300		A	Incision of heel bone	9.73	NA	NA	8.25	7.97	1.67	090
28302		A	Incision of ankle bone	9.74	NA	NA	9.42	8.51	1.99	090
28304		A	Incision of midfoot bones	9.41	12.98	12.03	7.01	6.73	1.26	090
28305		A	Incise/graft midfoot bones	10.77	NA	NA	7.50	7.56	0.85	090
28306		A	Incision of metatarsal	6.00	11.15	10.40	5.22	5.03	0.86	090
28307		A	Incision of metatarsal	6.50	12.25	12.19	5.81	5.82	1.33	090
28308		A	Incision of metatarsal	5.48	10.22	9.50	4.95	4.76	0.64	090
28309		A	Incision of metatarsals	14.16	NA	NA	10.42	9.81	2.18	090
28310		A	Revision of big toe	5.57	9.63	9.01	4.36	4.25	0.57	090
28312		A	Revision of toe	4.69	9.41	8.81	4.13	4.08	0.52	090
28313		A	Repair deformity of toe	5.15	9.60	8.95	4.81	4.83	0.72	090
28315		A	Removal of sesamoid bone	5.00	8.35	7.84	4.01	3.94	0.51	090
28320		A	Repair of foot bones	9.37	NA	NA	7.35	7.23	1.44	090
28322		A	Repair of metatarsals	8.53	13.11	12.29	7.28	7.01	1.36	090
28340		A	Resect enlarged toe tissue	7.15	9.22	9.04	4.53	4.66	0.57	090
28341		A	Resect enlarged toe	8.72	10.28	9.93	5.19	5.26	0.69	090
28344		A	Repair extra toe(s)	4.40	7.71	7.96	3.58	3.88	0.35	090

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28345		A	Repair webbed toe(s)	6.09	8.68	8.76	4.22	4.58	0.47	090
28360		A	Reconstruct cleft foot	14.92	NA	NA	14.15	12.26	3.31	090
28400		A	Treatment of heel fracture	2.31	4.44	4.26	3.86	3.69	0.38	090
28405		A	Treatment of heel fracture	4.74	6.10	5.72	5.10	4.86	0.68	090
28406		A	Treatment of heel fracture	6.56	NA	NA	7.65	7.40	1.22	090
28415		A	Treat heel fracture	16.19	NA	NA	14.09	13.73	2.94	090
28420		A	Treat/graft heel fracture	17.52	NA	NA	16.11	14.81	3.59	090
28430		A	Treatment of ankle fracture	2.22	4.16	3.96	3.45	3.25	0.37	090
28435		A	Treatment of ankle fracture	3.54	6.13	5.42	5.09	4.57	0.72	090
28436		A	Treatment of ankle fracture	4.90	NA	NA	7.14	6.70	1.02	090
28445		A	Treat ankle fracture	15.76	NA	NA	12.81	12.39	2.88	090
28446		A	Osteochondral talus autogrft	17.71	NA	NA	15.13	13.99	3.63	090
28450		A	Treat midfoot fracture, each	2.03	3.85	3.68	3.20	3.05	0.31	090
28455		A	Treat midfoot fracture, each	3.24	4.82	4.57	4.01	3.89	0.45	090
28456		A	Treat midfoot fracture	2.86	NA	NA	5.94	5.21	0.58	090
28465		A	Treat midfoot fracture, each	8.80	NA	NA	7.93	7.64	1.31	090
28470		A	Treat metatarsal fracture	2.03	3.72	3.59	3.15	3.01	0.34	090
28475		A	Treat metatarsal fracture	3.01	4.04	3.92	3.25	3.23	0.40	090
28476		A	Treat metatarsal fracture	3.60	NA	NA	5.92	5.69	0.55	090
28485		A	Treat metatarsal fracture	7.44	NA	NA	7.27	6.96	0.99	090
28490		A	Treat big toe fracture	1.17	2.76	2.61	2.22	2.10	0.17	090
28495		A	Treat big toe fracture	1.68	3.25	3.05	2.47	2.38	0.21	090
28496		A	Treat big toe fracture	2.48	9.63	9.25	3.93	3.76	0.37	090
28505		A	Treat big toe fracture	7.44	11.18	10.58	6.43	5.99	0.96	090
28510		A	Treatment of toe fracture	1.17	2.20	2.07	2.11	2.00	0.14	090
28515		A	Treatment of toe fracture	1.56	2.87	2.70	2.35	2.27	0.18	090

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28525		A	Treat toe fracture	5.62	10.26	9.73	5.48	5.13	0.73	090
28530		A	Treat sesamoid bone fracture	1.11	2.13	2.00	1.76	1.69	0.11	090
28531		A	Treat sesamoid bone fracture	2.57	7.10	7.22	2.57	2.55	0.52	090
28540		A	Treat foot dislocation	2.19	3.47	3.28	2.91	2.81	0.23	090
28545		A	Treat foot dislocation	2.60	5.35	4.61	4.43	3.87	0.52	090
28546		A	Treat foot dislocation	3.40	12.24	10.71	5.72	5.14	0.69	090
28555		A	Repair foot dislocation	9.65	14.27	13.56	8.46	8.02	1.67	090
28570		A	Treat foot dislocation	1.76	2.81	2.80	2.16	2.23	0.13	090
28575		A	Treat foot dislocation	3.49	6.31	5.72	5.36	4.93	0.71	090
28576		A	Treat foot dislocation	4.60	NA	NA	6.01	5.32	0.93	090
28585		A	Repair foot dislocation	11.13	14.17	13.40	8.56	8.36	1.71	090
28600		A	Treat foot dislocation	2.02	4.02	3.77	3.17	3.04	0.30	090
28605		A	Treat foot dislocation	2.89	5.90	5.05	5.01	4.35	0.58	090
28606		A	Treat foot dislocation	5.09	NA	NA	5.63	5.35	0.88	090
28615		A	Repair foot dislocation	10.70	NA	NA	10.81	10.31	1.84	090
28630		A	Treat toe dislocation	1.75	2.48	2.29	1.23	1.18	0.24	010
28635		A	Treat toe dislocation	1.96	3.04	2.84	1.79	1.73	0.23	010
28636		A	Treat toe dislocation	2.77	4.36	4.60	1.96	2.25	0.41	010
28645		A	Repair toe dislocation	7.44	10.63	9.79	5.89	5.54	0.83	090
28660		A	Treat toe dislocation	1.28	1.79	1.67	1.08	1.02	0.21	010
28665		A	Treat toe dislocation	1.97	2.35	2.20	1.71	1.67	0.25	010
28666		A	Treat toe dislocation	2.66	NA	NA	3.02	2.72	0.54	010
28675		A	Repair of toe dislocation	5.62	10.45	10.03	5.67	5.38	0.78	090
28705		A	Fusion of foot bones	20.33	NA	NA	14.60	14.13	3.59	090
28715		A	Fusion of foot bones	14.60	NA	NA	11.73	11.27	2.57	090
28725		A	Fusion of foot bones	12.18	NA	NA	9.40	9.04	1.95	090

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28730		A	Fusion of foot bones	12.42	NA	NA	10.66	10.17	1.99	090
28735		A	Fusion of foot bones	12.23	NA	NA	9.52	9.15	1.85	090
28737		A	Revision of foot bones	11.03	NA	NA	7.63	7.62	1.33	090
28740		A	Fusion of foot bones	9.29	14.33	13.64	8.01	7.70	1.41	090
28750		A	Fusion of big toe joint	8.57	14.23	13.73	7.89	7.64	1.36	090
28755		A	Fusion of big toe joint	4.88	9.21	8.76	4.25	4.20	0.54	090
28760		A	Fusion of big toe joint	9.14	13.12	12.21	7.06	6.78	1.09	090
28800		A	Amputation of midfoot	8.79	NA	NA	6.49	6.39	1.36	090
28805		A	Amputation thru metatarsal	12.71	NA	NA	7.75	7.44	2.22	090
28810		A	Amputation toe & metatarsal	6.64	NA	NA	5.32	5.18	1.23	090
28820		A	Amputation of toe	5.00	9.51	9.28	4.51	4.42	0.76	090
28825		A	Partial amputation of toe	6.01	10.16	9.72	5.27	5.02	0.88	090
28890		A	High energy eswt, plantar f	3.45	6.12	5.95	2.98	2.79	0.37	090
28899		C	Foot/toes surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
29000		A	Application of body cast	2.25	6.82	5.82	2.70	2.41	0.18	000
29010		A	Application of body cast	2.06	6.72	5.52	2.60	2.26	0.41	000
29015		A	Application of body cast	2.41	4.02	3.91	1.87	1.81	0.42	000
29020		A	Application of body cast	2.11	3.81	3.84	1.49	1.55	0.08	000
29025		A	Application of body cast	2.40	4.15	4.22	1.93	2.01	0.49	000
29035		A	Application of body cast	1.77	5.10	4.86	2.10	1.99	0.35	000
29040		A	Application of body cast	2.22	4.34	4.06	1.95	1.85	0.44	000
29044		A	Application of body cast	2.12	5.59	5.16	2.40	2.24	0.42	000
29046		A	Application of body cast	2.41	4.43	4.72	2.00	2.20	0.49	000
29049		A	Application of figure eight	0.89	1.76	1.55	0.99	0.83	0.18	000
29055		A	Application of shoulder cast	1.78	4.19	3.90	1.94	1.81	0.37	000
29058		A	Application of shoulder cast	1.31	1.20	1.36	0.77	0.78	0.24	000

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
29065		A	Application of long arm cast	0.87	1.70	1.63	0.97	0.92	0.17	000
29075		A	Application of forearm cast	0.77	1.65	1.57	0.91	0.86	0.14	000
29085		A	Apply hand/wrist cast	0.87	1.70	1.61	0.96	0.89	0.14	000
29086		A	Apply finger cast	0.62	1.51	1.38	0.79	0.72	0.08	000
29105		A	Apply long arm splint	0.87	1.45	1.40	0.73	0.69	0.14	000
29125		A	Apply forearm splint	0.59	1.29	1.23	0.59	0.55	0.10	000
29126		A	Apply forearm splint	0.77	1.38	1.31	0.68	0.63	0.11	000
29130		A	Application of finger splint	0.50	0.60	0.56	0.28	0.25	0.07	000
29131		A	Application of finger splint	0.55	0.86	0.82	0.36	0.33	0.08	000
29200		A	Strapping of chest	0.65	0.85	0.80	0.49	0.45	0.06	000
29240		A	Strapping of shoulder	0.71	0.86	0.85	0.51	0.48	0.06	000
29260		A	Strapping of elbow or wrist	0.55	0.88	0.84	0.50	0.46	0.06	000
29280		A	Strapping of hand or finger	0.51	0.89	0.86	0.51	0.46	0.04	000
29305		A	Application of hip cast	2.03	4.61	4.32	2.25	2.13	0.41	000
29325		A	Application of hip casts	2.32	5.02	4.72	2.48	2.36	0.47	000
29345		A	Application of long leg cast	1.40	2.24	2.14	1.31	1.25	0.28	000
29355		A	Application of long leg cast	1.53	2.28	2.14	1.36	1.29	0.30	000
29358		A	Apply long leg cast brace	1.43	2.87	2.68	1.36	1.28	0.30	000
29365		A	Application of long leg cast	1.18	2.12	2.02	1.18	1.14	0.24	000
29405		A	Apply short leg cast	0.86	1.57	1.50	0.88	0.84	0.13	000
29425		A	Apply short leg cast	1.01	1.59	1.52	0.86	0.84	0.13	000
29435		A	Apply short leg cast	1.18	1.99	1.92	1.09	1.06	0.24	000
29440		A	Addition of walker to cast	0.57	0.65	0.72	0.24	0.28	0.08	000
29445		A	Apply rigid leg cast	1.78	2.03	1.99	1.17	1.13	0.25	000
29450		A	Application of leg cast	2.08	1.88	1.85	1.05	1.08	0.23	000
29505		A	Application, long leg splint	0.69	1.42	1.36	0.62	0.58	0.11	000

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29515		A	Application lower leg splint	0.73	1.26	1.19	0.62	0.59	0.10	000
29520		A	Strapping of hip	0.54	0.84	0.82	0.47	0.46	0.04	000
29530		A	Strapping of knee	0.57	0.88	0.84	0.49	0.46	0.06	000
29540		A	Strapping of ankle and/or ft	0.51	0.67	0.64	0.37	0.37	0.04	000
29550		A	Strapping of toes	0.47	0.69	0.65	0.36	0.36	0.04	000
29580		A	Application of paste boot	0.55	0.90	0.87	0.44	0.42	0.07	000
29581		A	Apply multlay comprs lwr leg	0.60	2.00	2.00	0.27	0.27	0.07	000
29590		A	Application of foot splint	0.76	0.73	0.70	0.31	0.32	0.06	000
29700		A	Removal/revision of cast	0.57	1.22	1.17	0.35	0.34	0.10	000
29705		A	Removal/revision of cast	0.76	1.05	1.00	0.52	0.49	0.13	000
29710		A	Removal/revision of cast	1.34	1.97	1.82	0.91	0.83	0.28	000
29715		A	Removal/revision of cast	0.94	1.28	1.35	0.52	0.52	0.13	000
29720		A	Repair of body cast	0.68	1.57	1.48	0.50	0.47	0.13	000
29730		A	Windowing of cast	0.75	1.01	0.96	0.48	0.45	0.11	000
29740		A	Wedging of cast	1.12	1.27	1.26	0.58	0.58	0.18	000
29750		A	Wedging of clubfoot cast	1.26	1.43	1.37	0.76	0.73	0.27	000
29799		C	Casting/strapping procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
29800		A	Jaw arthroscopy/surgery	6.84	NA	NA	7.33	6.98	1.38	090
29804		A	Jaw arthroscopy/surgery	8.87	NA	NA	9.01	8.34	1.81	090
29805		A	Shoulder arthroscopy, dx	6.03	NA	NA	6.62	6.35	1.23	090
29806		A	Shoulder arthroscopy/surgery	15.14	NA	NA	13.30	12.73	3.09	090
29807		A	Shoulder arthroscopy/surgery	14.67	NA	NA	13.13	12.55	2.98	090
29819		A	Shoulder arthroscopy/surgery	7.79	NA	NA	7.96	7.63	1.58	090
29820		A	Shoulder arthroscopy/surgery	7.21	NA	NA	7.26	6.98	1.46	090
29821		A	Shoulder arthroscopy/surgery	7.89	NA	NA	7.94	7.63	1.61	090
29822		A	Shoulder arthroscopy/surgery	7.60	NA	NA	7.79	7.49	1.55	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
29823		A	Shoulder arthroscopy/surgery	8.36	NA	NA	8.44	8.12	1.70	090
29824		A	Shoulder arthroscopy/surgery	8.98	NA	NA	9.11	8.73	1.84	090
29825		A	Shoulder arthroscopy/surgery	7.79	NA	NA	7.90	7.59	1.58	090
29826		A	Shoulder arthroscopy/surgery	9.16	NA	NA	8.68	8.36	1.87	090
29827		A	Arthroscop rotator cuff repr	15.59	NA	NA	13.22	12.73	3.19	090
29828		A	Arthroscopy biceps tenodesis	13.16	NA	NA	11.56	10.88	2.68	090
29830		A	Elbow arthroscopy	5.88	NA	NA	6.31	6.04	1.22	090
29834		A	Elbow arthroscopy/surgery	6.42	NA	NA	6.85	6.57	1.27	090
29835		A	Elbow arthroscopy/surgery	6.62	NA	NA	6.98	6.69	1.34	090
29836		A	Elbow arthroscopy/surgery	7.72	NA	NA	7.92	7.60	1.58	090
29837		A	Elbow arthroscopy/surgery	7.01	NA	NA	7.20	6.91	1.41	090
29838		A	Elbow arthroscopy/surgery	7.88	NA	NA	8.05	7.71	1.55	090
29840		A	Wrist arthroscopy	5.68	NA	NA	6.43	6.16	1.17	090
29843		A	Wrist arthroscopy/surgery	6.15	NA	NA	6.82	6.53	1.26	090
29844		A	Wrist arthroscopy/surgery	6.51	NA	NA	7.02	6.65	1.23	090
29845		A	Wrist arthroscopy/surgery	7.69	NA	NA	7.97	7.50	1.43	090
29846		A	Wrist arthroscopy/surgery	6.89	NA	NA	7.29	6.92	1.27	090
29847		A	Wrist arthroscopy/surgery	7.22	NA	NA	7.33	7.04	1.47	090
29848		A	Wrist endoscopy/surgery	6.39	NA	NA	7.49	7.02	1.22	090
29850		A	Knee arthroscopy/surgery	8.27	NA	NA	8.45	7.39	1.68	090
29851		A	Knee arthroscopy/surgery	13.26	NA	NA	11.74	11.20	2.71	090
29855		A	Tibial arthroscopy/surgery	10.76	NA	NA	10.32	9.89	2.20	090
29856		A	Tibial arthroscopy/surgery	14.28	NA	NA	12.44	11.92	2.94	090
29860		A	Hip arthroscopy, dx	9.00	NA	NA	8.88	8.33	1.85	090
29861		A	Hip arthroscopy/surgery	10.10	NA	NA	9.52	8.96	2.05	090
29862		A	Hip arthroscopy/surgery	11.17	NA	NA	10.80	10.24	2.27	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
29863		A	Hip arthroscopy/surgery	11.17	NA	NA	10.76	10.17	2.29	090
29866		A	Autgrft implnt, knee w/scope	14.67	NA	NA	13.47	12.82	3.02	090
29867		A	Allgrft implnt, knee w/scope	18.39	NA	NA	15.92	15.01	3.76	090
29868		A	Meniscal trnspl, knee w/scpe	25.10	NA	NA	19.84	18.76	5.14	090
29870		A	Knee arthroscopy, dx	5.19	10.54	10.54	5.89	5.62	1.06	090
29871		A	Knee arthroscopy/drainage	6.69	NA	NA	7.11	6.79	1.36	090
29873		A	Knee arthroscopy/surgery	6.24	NA	NA	7.84	7.49	1.27	090
29874		A	Knee arthroscopy/surgery	7.19	NA	NA	7.29	6.96	1.46	090
29875		A	Knee arthroscopy/surgery	6.45	NA	NA	6.86	6.58	1.31	090
29876		A	Knee arthroscopy/surgery	8.87	NA	NA	8.78	8.33	1.81	090
29877		A	Knee arthroscopy/surgery	8.30	NA	NA	8.44	8.02	1.68	090
29879		A	Knee arthroscopy/surgery	8.99	NA	NA	8.83	8.40	1.84	090
29880		A	Knee arthroscopy/surgery	9.45	NA	NA	9.11	8.67	1.92	090
29881		A	Knee arthroscopy/surgery	8.71	NA	NA	8.68	8.25	1.77	090
29882		A	Knee arthroscopy/surgery	9.60	NA	NA	9.17	8.69	1.96	090
29883		A	Knee arthroscopy/surgery	11.77	NA	NA	10.74	10.30	2.39	090
29884		A	Knee arthroscopy/surgery	8.28	NA	NA	8.41	7.99	1.68	090
29885		A	Knee arthroscopy/surgery	10.21	NA	NA	9.98	9.47	2.08	090
29886		A	Knee arthroscopy/surgery	8.49	NA	NA	8.58	8.15	1.72	090
29887		A	Knee arthroscopy/surgery	10.16	NA	NA	9.90	9.40	2.06	090
29888		A	Knee arthroscopy/surgery	14.30	NA	NA	12.21	11.67	2.91	090
29889		A	Knee arthroscopy/surgery	17.41	NA	NA	15.41	14.64	3.55	090
29891		A	Ankle arthroscopy/surgery	9.67	NA	NA	9.06	8.72	1.71	090
29892		A	Ankle arthroscopy/surgery	10.27	NA	NA	6.09	7.09	2.09	090
29893		A	Scope, plantar fasciotomy	6.32	10.85	10.24	5.70	5.51	0.52	090
29894		A	Ankle arthroscopy/surgery	7.35	NA	NA	6.68	6.36	1.27	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
29895		A	Ankle arthroscopy/surgery	7.13	NA	NA	6.26	6.03	1.17	090
29897		A	Ankle arthroscopy/surgery	7.32	NA	NA	6.59	6.42	1.29	090
29898		A	Ankle arthroscopy/surgery	8.49	NA	NA	7.11	6.88	1.34	090
29899		A	Ankle arthroscopy/surgery	15.41	NA	NA	12.66	12.19	2.98	090
29900		A	Mcp joint arthroscopy, dx	5.88	NA	NA	7.39	6.70	0.42	090
29901		A	Mcp joint arthroscopy, surg	6.59	NA	NA	7.70	7.03	1.34	090
29902		A	Mcp joint arthroscopy, surg	7.16	NA	NA	8.50	7.58	2.67	090
29904		A	Subtalar arthro w/fb rmvl	8.65	NA	NA	8.46	7.90	1.75	090
29905		A	Subtalar arthro w/exc	9.18	NA	NA	9.33	8.72	1.88	090
29906		A	Subtalar arthro w/deb	9.65	NA	NA	9.85	9.19	1.96	090
29907		A	Subtalar arthro w/fusion	12.18	NA	NA	11.33	10.58	2.49	090
29999		C	Arthroscopy of joint	0.00	0.00	0.00	0.00	0.00	0.00	YYY
30000		A	Drainage of nose lesion	1.48	5.02	4.94	1.86	1.76	0.23	010
30020		A	Drainage of nose lesion	1.48	5.12	4.89	1.90	1.79	0.21	010
3008F		I	Body mass index docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30100		A	Intranasal biopsy	0.94	3.10	2.99	1.00	0.97	0.11	000
30110		A	Removal of nose polyp(s)	1.68	4.86	4.67	2.02	1.91	0.24	010
30115		A	Removal of nose polyp(s)	4.44	NA	NA	7.79	7.47	0.58	090
30117		A	Removal of intranasal lesion	3.26	21.57	20.83	6.32	6.07	0.42	090
30118		A	Removal of intranasal lesion	9.92	NA	NA	11.74	11.16	1.36	090
30120		A	Revision of nose	5.39	9.09	8.81	6.85	6.72	0.88	090
30124		A	Removal of nose lesion	3.20	NA	NA	4.57	4.33	0.42	090
30125		A	Removal of nose lesion	7.30	NA	NA	9.95	9.56	0.96	090
30130		A	Excise inferior turbinate	3.47	NA	NA	7.31	7.04	0.45	090
30140		A	Resect inferior turbinate	3.57	NA	NA	8.92	8.58	0.47	090
30150		A	Partial removal of nose	9.55	NA	NA	12.06	11.76	1.47	090

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3015F		I	Cerv cancer screen docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30160		A	Removal of nose	9.99	NA	NA	11.96	11.52	1.33	090
3018F		I	Pre-prxd rsk et al docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30200		A	Injection treatment of nose	0.78	2.46	2.37	0.92	0.88	0.10	000
30210		A	Nasal sinus therapy	1.13	3.14	3.02	1.70	1.63	0.14	010
30220		A	Insert nasal septal button	1.59	7.04	6.76	1.97	1.87	0.23	010
30300		A	Remove nasal foreign body	1.09	5.42	5.32	2.47	2.36	0.14	010
30310		A	Remove nasal foreign body	2.01	NA	NA	3.81	3.68	0.27	010
30320		A	Remove nasal foreign body	4.64	NA	NA	8.17	7.88	0.62	090
3038F		I	Pulm fx w/in 12 mon b/4 surg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30400		R	Reconstruction of nose	10.86	NA	NA	17.73	17.49	1.44	090
30410		R	Reconstruction of nose	14.00	NA	NA	19.54	19.21	1.87	090
30420		R	Reconstruction of nose	16.90	NA	NA	21.71	20.80	2.49	090
30430		R	Revision of nose	8.24	NA	NA	16.23	16.49	1.68	090
30435		R	Revision of nose	12.73	NA	NA	21.85	20.74	1.70	090
30450		R	Revision of nose	19.66	NA	NA	22.79	22.57	2.61	090
30460		A	Revision of nose	10.32	NA	NA	10.36	10.04	2.09	090
30462		A	Revision of nose	20.28	NA	NA	23.08	21.43	4.15	090
30465		A	Repair nasal stenosis	12.36	NA	NA	15.35	14.55	1.81	090
30520		A	Repair of nasal septum	7.01	NA	NA	10.70	10.01	0.93	090
30540		A	Repair nasal defect	7.92	NA	NA	11.58	10.83	1.06	090
30545		A	Repair nasal defect	11.62	NA	NA	12.04	12.86	0.85	090
30560		A	Release of nasal adhesions	1.31	6.39	6.27	2.61	2.54	0.18	010
30580		A	Repair upper jaw fistula	6.88	11.21	10.52	7.43	6.79	0.90	090
30600		A	Repair mouth/nose fistula	6.16	10.08	9.69	6.02	5.73	0.81	090
30620		A	Intranasal reconstruction	6.16	NA	NA	11.35	10.95	0.92	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
30630		A	Repair nasal septum defect	7.29	NA	NA	10.39	9.92	1.03	090
30801		A	Ablate inf turbinate, superf	1.14	5.31	5.22	2.73	2.62	0.14	010
30802		A	Ablate inf turbinate submuc	2.08	6.15	6.00	3.31	3.15	0.28	010
30901		A	Control of nosebleed	1.21	1.69	1.62	0.50	0.44	0.18	000
30903		A	Control of nosebleed	1.54	4.11	3.92	0.68	0.62	0.24	000
30905		A	Control of nosebleed	1.97	5.01	4.79	0.82	0.77	0.31	000
30906		A	Repeat control of nosebleed	2.45	5.42	5.23	1.27	1.19	0.34	000
30915		A	Ligation, nasal sinus artery	7.44	NA	NA	8.88	8.40	1.03	090
30920		A	Ligation, upper jaw artery	11.14	NA	NA	12.48	11.70	1.51	090
30930		A	Ther fx, nasal inf turbinate	1.31	NA	NA	2.19	2.09	0.18	010
30999		C	Nasal surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31000		A	Irrigation, maxillary sinus	1.20	3.94	3.83	1.78	1.71	0.14	010
31002		A	Irrigation, sphenoid sinus	1.96	NA	NA	3.67	3.60	0.27	010
31020		A	Exploration, maxillary sinus	3.07	10.53	10.40	7.01	6.79	0.41	090
31030		A	Exploration, maxillary sinus	6.01	13.39	13.14	8.78	8.35	0.78	090
31032		A	Explore sinus, remove polyps	6.69	NA	NA	9.49	9.03	0.90	090
31040		A	Exploration behind upper jaw	9.77	NA	NA	11.31	10.69	1.44	090
31050		A	Exploration, sphenoid sinus	5.37	NA	NA	8.37	8.13	0.71	090
31051		A	Sphenoid sinus surgery	7.25	NA	NA	11.04	10.55	0.95	090
31070		A	Exploration of frontal sinus	4.40	NA	NA	8.03	7.71	0.61	090
31075		A	Exploration of frontal sinus	9.51	NA	NA	12.63	12.07	1.27	090
31080		A	Removal of frontal sinus	12.74	NA	NA	16.46	15.32	1.70	090
31081		A	Removal of frontal sinus	14.19	NA	NA	23.58	20.88	5.28	090
31084		A	Removal of frontal sinus	14.95	NA	NA	17.73	17.17	1.99	090
31085		A	Removal of frontal sinus	15.64	NA	NA	18.13	17.75	5.84	090
31086		A	Removal of frontal sinus	14.36	NA	NA	17.39	16.46	1.92	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
31087		A	Removal of frontal sinus	14.57	NA	NA	16.07	15.36	1.94	090
31090		A	Exploration of sinuses	11.17	NA	NA	17.81	16.87	1.53	090
31200		A	Removal of ethmoid sinus	5.14	NA	NA	10.54	10.06	0.76	090
31201		A	Removal of ethmoid sinus	8.60	NA	NA	12.28	11.62	1.19	090
31205		A	Removal of ethmoid sinus	10.58	NA	NA	14.49	13.48	1.65	090
31225		A	Removal of upper jaw	26.70	NA	NA	26.13	24.09	3.69	090
31230		A	Removal of upper jaw	30.82	NA	NA	28.11	25.86	4.11	090
31231		A	Nasal endoscopy, dx	1.10	4.36	4.29	1.10	1.04	0.13	000
31233		A	Nasal/sinus endoscopy, dx	2.18	5.35	5.23	1.72	1.61	0.30	000
31235		A	Nasal/sinus endoscopy, dx	2.64	5.83	5.77	1.95	1.84	0.34	000
31237		A	Nasal/sinus endoscopy, surg	2.98	6.23	6.10	2.18	2.03	0.40	000
31238		A	Nasal/sinus endoscopy, surg	3.26	6.20	6.07	2.34	2.19	0.42	000
31239		A	Nasal/sinus endoscopy, surg	9.33	NA	NA	9.99	9.22	1.29	010
31240		A	Nasal/sinus endoscopy, surg	2.61	NA	NA	1.97	1.85	0.35	000
31254		A	Revision of ethmoid sinus	4.64	NA	NA	3.15	2.93	0.62	000
31255		A	Removal of ethmoid sinus	6.95	NA	NA	4.47	4.15	0.92	000
31256		A	Exploration maxillary sinus	3.29	NA	NA	2.36	2.20	0.42	000
31267		A	Endoscopy, maxillary sinus	5.45	NA	NA	3.60	3.35	0.72	000
31276		A	Sinus endoscopy, surgical	8.84	NA	NA	5.55	5.14	1.19	000
31287		A	Nasal/sinus endoscopy, surg	3.91	NA	NA	2.71	2.53	0.52	000
31288		A	Nasal/sinus endoscopy, surg	4.57	NA	NA	3.10	2.89	0.62	000
31290		A	Nasal/sinus endoscopy, surg	18.61	NA	NA	14.09	13.15	2.74	010
31291		A	Nasal/sinus endoscopy, surg	19.56	NA	NA	14.79	13.77	3.26	010
31292		A	Nasal/sinus endoscopy, surg	15.90	NA	NA	12.48	11.66	2.12	010
31293		A	Nasal/sinus endoscopy, surg	17.47	NA	NA	13.44	12.54	2.32	010
31294		A	Nasal/sinus endoscopy, surg	20.31	NA	NA	15.08	14.04	2.71	010

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31299		C	Sinus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31300		A	Removal of larynx lesion	15.91	NA	NA	20.03	18.99	2.11	090
31320		A	Diagnostic incision, larynx	5.73	NA	NA	12.91	12.52	0.75	090
31360		A	Removal of larynx	29.91	NA	NA	29.10	26.38	4.07	090
31365		A	Removal of larynx	38.81	NA	NA	34.18	30.92	5.27	090
31367		A	Partial removal of larynx	30.57	NA	NA	32.02	29.72	4.13	090
31368		A	Partial removal of larynx	34.19	NA	NA	35.23	32.80	4.55	090
31370		A	Partial removal of larynx	27.57	NA	NA	31.26	29.23	3.67	090
31375		A	Partial removal of larynx	26.07	NA	NA	29.77	27.77	3.49	090
31380		A	Partial removal of larynx	25.57	NA	NA	29.49	27.48	3.42	090
31382		A	Partial removal of larynx	28.57	NA	NA	31.84	29.58	3.83	090
31390		A	Removal of larynx & pharynx	42.51	NA	NA	37.97	34.79	6.06	090
31395		A	Reconstruct larynx & pharynx	43.80	NA	NA	41.62	38.31	5.85	090
31400		A	Revision of larynx	11.60	NA	NA	16.72	16.15	1.55	090
31420		A	Removal of epiglottis	11.43	NA	NA	12.30	11.61	1.53	090
31500		A	Insert emergency airway	2.33	NA	NA	0.62	0.59	0.32	000
31502		A	Change of windpipe airway	0.65	NA	NA	0.33	0.31	0.07	000
31505		A	Diagnostic laryngoscopy	0.61	1.75	1.73	0.79	0.76	0.07	000
31510		A	Laryngoscopy with biopsy	1.92	4.04	3.97	1.50	1.42	0.27	000
31511		A	Remove foreign body, larynx	2.16	3.74	3.67	1.38	1.33	0.32	000
31512		A	Removal of larynx lesion	2.07	3.85	3.74	1.66	1.54	0.28	000
31513		A	Injection into vocal cord	2.10	NA	NA	1.67	1.57	0.28	000
31515		A	Laryngoscopy for aspiration	1.80	4.06	4.02	1.29	1.22	0.25	000
31520		A	Dx laryngoscopy, newborn	2.56	NA	NA	1.94	1.76	0.34	000
31525		A	Dx laryngoscopy excl nb	2.63	4.50	4.36	1.91	1.79	0.35	000
31526		A	Dx laryngoscopy w/oper scope	2.57	NA	NA	1.94	1.82	0.34	000

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31527		A	Laryngoscopy for treatment	3.27	NA	NA	2.35	2.13	0.42	000
31528		A	Laryngoscopy and dilation	2.37	NA	NA	1.77	1.65	0.32	000
31529		A	Laryngoscopy and dilation	2.68	NA	NA	1.95	1.83	0.35	000
31530		A	Laryngoscopy w/fb removal	3.38	NA	NA	2.27	2.11	0.45	000
31531		A	Laryngoscopy w/fb & op scope	3.58	NA	NA	2.50	2.34	0.47	000
31535		A	Laryngoscopy w/biopsy	3.16	NA	NA	2.27	2.12	0.42	000
31536		A	Laryngoscopy w/bx & op scope	3.55	NA	NA	2.51	2.34	0.47	000
31540		A	Laryngoscopy w/exc of tumor	4.12	NA	NA	2.83	2.64	0.55	000
31541		A	Larynscop w/tumr exc + scope	4.52	NA	NA	3.06	2.86	0.61	000
31545		A	Remove vc lesion w/scope	6.30	NA	NA	4.12	3.80	0.83	000
31546		A	Remove vc lesion scope/graft	9.73	NA	NA	6.11	5.53	1.30	000
31560		A	Laryngoscop w/arytenoidectom	5.45	NA	NA	3.56	3.29	0.72	000
31561		A	Larynscop, remve cart + scop	5.99	NA	NA	3.87	3.57	0.79	000
31570		A	Laryngoscope w/vc inj	3.86	5.74	5.67	2.65	2.47	0.55	000
31571		A	Laryngoscop w/vc inj + scope	4.26	NA	NA	2.90	2.71	0.57	000
31575		A	Diagnostic laryngoscopy	1.10	2.16	2.13	1.09	1.03	0.13	000
31576		A	Laryngoscopy with biopsy	1.97	4.39	4.35	1.56	1.47	0.25	000
31577		A	Remove foreign body, larynx	2.47	4.40	4.29	1.73	1.64	0.34	000
31578		A	Removal of larynx lesion	2.84	5.16	5.03	2.10	1.91	0.37	000
31579		A	Diagnostic laryngoscopy	2.26	3.74	3.74	1.76	1.65	0.31	000
31580		A	Revision of larynx	14.66	NA	NA	20.07	18.98	1.95	090
31582		A	Revision of larynx	23.22	NA	NA	30.63	29.54	3.11	090
31584		A	Treat larynx fracture	20.47	NA	NA	22.41	21.22	2.73	090
31587		A	Revision of larynx	15.27	NA	NA	13.26	12.13	2.02	090
31588		A	Revision of larynx	14.99	NA	NA	17.48	16.54	2.01	090
31590		A	Reinnervate larynx	7.85	NA	NA	17.45	17.12	1.06	090

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31595		A	Larynx nerve surgery	8.84	NA	NA	12.87	12.41	1.19	090
31599		C	Larynx surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31600		A	Incision of windpipe	7.17	NA	NA	3.58	3.37	1.31	000
31601		A	Incision of windpipe	4.44	NA	NA	2.98	2.77	0.58	000
31603		A	Incision of windpipe	4.14	NA	NA	1.97	1.83	0.72	000
31605		A	Incision of windpipe	3.57	NA	NA	1.31	1.23	0.65	000
31610		A	Incision of windpipe	9.38	NA	NA	10.71	10.14	1.37	090
31611		A	Surgery/speech prosthesis	6.00	NA	NA	9.34	8.94	0.79	090
31612		A	Puncture/clear windpipe	0.91	1.40	1.35	0.43	0.39	0.11	000
31613		A	Repair windpipe opening	4.71	NA	NA	7.95	7.66	0.75	090
31614		A	Repair windpipe opening	8.63	NA	NA	12.77	12.06	1.23	090
31615		A	Visualization of windpipe	2.09	3.03	2.98	1.54	1.44	0.27	000
31620		A	Endobronchial us add-on	1.40	6.07	6.52	0.48	0.48	0.13	ZZZ
31622		A	Dx bronchoscope/wash	2.78	5.65	5.99	1.23	1.19	0.35	000
31623		A	Dx bronchoscope/brush	2.88	6.07	6.62	1.20	1.17	0.27	000
31624		A	Dx bronchoscope/lavage	2.88	5.56	5.99	1.22	1.18	0.27	000
31625		A	Bronchoscopy w/biopsy(s)	3.36	5.71	6.14	1.38	1.34	0.32	000
31626		A	Bronchoscopy w/markers	4.16	8.30	8.30	1.66	1.66	0.32	000
31627		A	Navigational bronchoscopy	2.00	34.63	34.63	0.86	0.86	0.14	ZZZ
31628		A	Bronchoscopy/lung bx, each	3.80	6.57	7.38	1.51	1.46	0.31	000
31629		A	Bronchoscopy/needle bx, each	4.09	12.03	13.39	1.62	1.56	0.35	000
31630		A	Bronchoscopy dilate/fx repr	3.81	NA	NA	1.71	1.71	0.51	000
31631		A	Bronchoscopy, dilate w/stent	4.36	NA	NA	1.92	1.89	0.62	000
31632		A	Bronchoscopy/lung bx, addl	1.03	0.95	0.98	0.36	0.34	0.07	ZZZ
31633		A	Bronchoscopy/needle bx addl	1.32	1.10	1.13	0.45	0.43	0.10	ZZZ
31635		A	Bronchoscopy w/fb removal	3.67	5.60	6.02	1.54	1.51	0.41	000

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31636		A	Bronchoscopy, bronch stents	4.30	NA	NA	1.77	1.78	0.58	000
31637		A	Bronchoscopy, stent add-on	1.58	NA	NA	0.59	0.57	0.11	ZZZ
31638		A	Bronchoscopy, revise stent	4.88	NA	NA	2.09	2.07	0.68	000
31640		A	Bronchoscopy w/tumor excise	4.93	NA	NA	2.10	2.09	0.66	000
31641		A	Bronchoscopy, treat blockage	5.02	NA	NA	2.10	2.03	0.61	000
31643		A	Diag bronchoscope/catheter	3.49	NA	NA	1.39	1.36	0.30	000
31645		A	Bronchoscopy, clear airways	3.16	4.99	5.35	1.31	1.27	0.30	000
31646		A	Bronchoscopy, reclear airway	2.72	4.70	5.04	1.15	1.12	0.27	000
31656		A	Bronchoscopy, inj for x-ray	2.17	5.86	6.56	0.89	0.89	0.17	000
31715		A	Injection for bronchus x-ray	1.11	NA	NA	0.35	0.37	0.08	000
31717		A	Bronchial brush biopsy	2.12	5.26	6.00	1.00	0.94	0.17	000
31720		A	Clearance of airways	1.06	NA	NA	0.39	0.37	0.08	000
31725		A	Clearance of airways	1.96	NA	NA	0.71	0.63	0.21	000
31730		A	Intro, windpipe wire/tube	2.85	28.92	26.09	1.16	1.10	0.47	000
31750		A	Repair of windpipe	15.39	NA	NA	23.15	22.16	2.36	090
31755		A	Repair of windpipe	17.54	NA	NA	31.53	30.45	2.33	090
31760		A	Repair of windpipe	23.48	NA	NA	12.10	12.53	5.69	090
31766		A	Reconstruction of windpipe	31.67	NA	NA	14.36	14.70	7.69	090
31770		A	Repair/graft of bronchus	23.54	NA	NA	10.96	11.21	5.71	090
31775		A	Reconstruct bronchus	24.59	NA	NA	10.05	10.77	5.98	090
31780		A	Reconstruct windpipe	19.84	NA	NA	13.20	12.46	3.35	090
31781		A	Reconstruct windpipe	24.85	NA	NA	10.97	11.93	6.03	090
31785		A	Remove windpipe lesion	18.35	NA	NA	11.86	11.11	2.71	090
31786		A	Remove windpipe lesion	25.42	NA	NA	11.93	12.78	6.19	090
31800		A	Repair of windpipe injury	8.18	NA	NA	11.79	11.26	1.09	090
31805		A	Repair of windpipe injury	13.42	NA	NA	7.77	8.02	3.28	090

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31820		A	Closure of windpipe lesion	4.64	7.68	7.35	4.64	4.38	0.69	090
31825		A	Repair of windpipe defect	7.07	10.00	9.57	6.55	6.18	1.03	090
31830		A	Revise windpipe scar	4.62	7.79	7.45	5.00	4.74	0.73	090
31899		C	Airways surgical procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
32035		A	Exploration of chest	11.29	NA	NA	7.84	7.65	2.67	090
32036		A	Exploration of chest	12.30	NA	NA	8.10	8.04	3.01	090
32095		A	Biopsy through chest wall	10.14	NA	NA	6.47	6.46	2.43	090
32100		A	Exploration/biopsy of chest	16.16	NA	NA	8.78	8.91	3.94	090
32110		A	Explore/repair chest	25.28	NA	NA	13.03	12.84	5.96	090
32120		A	Re-exploration of chest	14.39	NA	NA	8.47	8.53	3.53	090
32124		A	Explore chest free adhesions	15.45	NA	NA	8.84	8.82	3.82	090
32140		A	Removal of lung lesion(s)	16.66	NA	NA	9.22	9.26	4.04	090
32141		A	Remove/treat lung lesions	27.18	NA	NA	12.77	12.51	6.64	090
32150		A	Removal of lung lesion(s)	16.82	NA	NA	9.40	9.35	4.08	090
32151		A	Remove lung foreign body	16.94	NA	NA	9.23	9.54	4.13	090
32160		A	Open chest heart massage	13.10	NA	NA	7.38	7.24	3.11	090
32200		A	Drain, open, lung lesion	18.68	NA	NA	11.20	11.04	4.45	090
32201		A	Drain, percut, lung lesion	3.99	20.33	22.22	1.39	1.60	0.40	000
32215		A	Treat chest lining	13.05	NA	NA	7.90	7.99	3.17	090
32220		A	Release of lung	26.65	NA	NA	14.91	15.10	6.54	090
32225		A	Partial release of lung	16.75	NA	NA	9.33	9.35	4.07	090
32310		A	Removal of chest lining	15.28	NA	NA	8.65	8.73	3.76	090
32320		A	Free/remove chest lining	27.25	NA	NA	14.66	14.66	6.57	090
32400		A	Needle biopsy chest lining	1.76	2.20	2.40	0.61	0.67	0.18	000
32402		A	Open biopsy chest lining	8.97	NA	NA	5.93	5.99	2.11	090
32405		A	Biopsy, lung or mediastinum	1.93	0.66	0.78	0.66	0.77	0.18	000

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
32420		A	Puncture/clear lung	2.18	NA	NA	0.78	0.85	0.25	000
32421		A	Thoracentesis for aspiration	1.54	2.54	2.82	0.56	0.58	0.14	000
32422		A	Thoracentesis w/tube insert	2.19	3.00	3.29	1.14	1.23	0.23	000
32440		A	Removal of lung	27.28	NA	NA	13.62	13.99	6.60	090
32442		A	Sleeve pneumonectomy	56.47	NA	NA	22.74	22.33	4.41	090
32445		A	Removal of lung	63.84	NA	NA	27.64	26.82	15.51	090
32480		A	Partial removal of lung	25.82	NA	NA	12.91	13.18	6.29	090
32482		A	Bilobectomy	27.44	NA	NA	14.04	14.31	6.67	090
32484		A	Segmentectomy	25.38	NA	NA	12.15	12.39	6.13	090
32486		A	Sleeve lobectomy	42.88	NA	NA	18.31	18.28	10.53	090
32488		A	Completion pneumonectomy	42.99	NA	NA	19.47	19.21	10.50	090
32491		R	Lung volume reduction	25.24	NA	NA	13.28	13.78	6.10	090
32500		A	Partial removal of lung	24.64	NA	NA	12.91	13.23	6.02	090
32501		A	Repair bronchus add-on	4.68	NA	NA	1.67	1.74	1.13	ZZZ
32503		A	Resect apical lung tumor	31.74	NA	NA	15.37	15.71	7.79	090
32504		A	Resect apical lung tum/chest	36.54	NA	NA	16.52	17.39	8.85	090
32540		A	Removal of lung lesion	30.35	NA	NA	14.59	14.45	7.38	090
32550		A	Insert pleural cath	4.17	16.95	18.19	1.80	1.89	0.72	000
32551		A	Insertion of chest tube	3.29	NA	NA	1.25	1.31	0.54	000
32552		A	Remove lung catheter	2.53	2.34	2.34	1.69	1.69	0.62	010
32553		A	Ins mark thor for rt perq	3.80	13.17	13.17	1.48	1.48	0.92	000
32560		A	Treat pleurodesis w/agent	1.54	5.06	5.75	0.55	0.67	0.28	000
32561		A	Lyse chest fibrin init day	1.39	1.18	1.18	0.50	0.50	0.25	000
32562		A	Lyse chest fibrin subq day	1.24	1.05	1.05	0.45	0.45	0.24	000
32601		A	Thoracoscopy, diagnostic	5.45	NA	NA	2.59	2.65	1.31	000
32602		A	Thoracoscopy, diagnostic	5.95	NA	NA	2.78	2.83	1.41	000

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
32603		A	Thoracoscopy, diagnostic	7.80	NA	NA	3.36	3.49	2.02	000
32604		A	Thoracoscopy, diagnostic	8.77	NA	NA	3.70	3.89	2.12	000
32605		A	Thoracoscopy, diagnostic	6.92	NA	NA	3.05	3.13	1.68	000
32606		A	Thoracoscopy, diagnostic	8.39	NA	NA	3.65	3.76	2.01	000
32650		A	Thoracoscopy, surgical	10.83	NA	NA	6.67	6.83	2.57	090
32651		A	Thoracoscopy, surgical	18.78	NA	NA	9.92	9.70	4.48	090
32652		A	Thoracoscopy, surgical	29.13	NA	NA	14.15	13.95	6.98	090
32653		A	Thoracoscopy, surgical	18.17	NA	NA	9.43	9.30	4.28	090
32654		A	Thoracoscopy, surgical	20.52	NA	NA	10.26	10.11	4.83	090
32655		A	Thoracoscopy, surgical	16.17	NA	NA	8.86	8.80	3.91	090
32656		A	Thoracoscopy, surgical	13.26	NA	NA	7.67	7.85	3.12	090
32657		A	Thoracoscopy, surgical	12.93	NA	NA	7.65	7.82	3.15	090
32658		A	Thoracoscopy, surgical	11.71	NA	NA	6.87	7.19	2.85	090
32659		A	Thoracoscopy, surgical	11.94	NA	NA	7.22	7.46	2.91	090
32660		A	Thoracoscopy, surgical	17.77	NA	NA	9.15	9.51	4.62	090
32661		A	Thoracoscopy, surgical	13.33	NA	NA	7.43	7.75	3.25	090
32662		A	Thoracoscopy, surgical	14.99	NA	NA	8.35	8.65	3.63	090
32663		A	Thoracoscopy, surgical	24.64	NA	NA	11.79	12.05	5.96	090
32664		A	Thoracoscopy, surgical	14.28	NA	NA	7.76	7.99	3.49	090
32665		A	Thoracoscopy, surgical	21.53	NA	NA	10.45	10.53	4.78	090
32800		A	Repair lung hernia	15.71	NA	NA	8.82	8.86	3.83	090
32810		A	Close chest after drainage	14.95	NA	NA	8.50	8.70	3.65	090
32815		A	Close bronchial fistula	50.03	NA	NA	22.77	21.95	12.35	090
32820		A	Reconstruct injured chest	22.51	NA	NA	12.06	12.66	5.48	090
32850		X	Donor pneumonectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32851		A	Lung transplant, single	41.61	NA	NA	25.75	26.79	10.17	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
32852		A	Lung transplant with bypass	45.48	NA	NA	28.96	30.35	11.06	090
32853		A	Lung transplant, double	50.78	NA	NA	28.96	30.22	12.48	090
32854		A	Lung transplant with bypass	54.74	NA	NA	32.74	34.13	13.40	090
32855		C	Prepare donor lung, single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32856		C	Prepare donor lung, double	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32900		A	Removal of rib(s)	23.81	NA	NA	12.93	12.53	5.69	090
32905		A	Revise & repair chest wall	23.29	NA	NA	11.39	11.69	5.65	090
32906		A	Revise & repair chest wall	29.30	NA	NA	13.47	13.91	7.14	090
3293F		I	Abo rh blood typing docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32940		A	Revision of lung	21.34	NA	NA	10.80	10.91	5.20	090
3294F		I	Grp b strep screening docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32960		A	Therapeutic pneumothorax	1.84	1.66	1.85	0.77	0.82	0.44	000
32997		A	Total lung lavage	7.31	NA	NA	2.32	2.28	0.95	000
32998		A	Perq rf ablate tx, pul tumor	5.68	71.17	76.62	2.09	2.45	0.62	000
32999		C	Chest surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
33010		A	Drainage of heart sac	2.24	NA	NA	0.84	1.02	0.47	000
33011		A	Repeat drainage of heart sac	2.24	NA	NA	0.87	0.99	0.51	000
33015		A	Incision of heart sac	8.52	NA	NA	4.72	5.54	1.74	090
33020		A	Incision of heart sac	14.95	NA	NA	8.06	8.12	3.65	090
33025		A	Incision of heart sac	13.70	NA	NA	7.21	7.37	3.38	090
33030		A	Partial removal of heart sac	22.39	NA	NA	11.38	11.48	5.52	090
33031		A	Partial removal of heart sac	25.38	NA	NA	11.85	12.13	6.34	090
33050		A	Removal of heart sac lesion	16.97	NA	NA	9.46	9.45	4.13	090
33120		A	Removal of heart lesion	27.45	NA	NA	13.05	13.41	6.82	090
33130		A	Removal of heart lesion	24.17	NA	NA	11.69	12.02	6.27	090
33140		A	Heart revascularize (tmr)	28.34	NA	NA	12.77	13.17	7.35	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
33141		A	Heart tmr w/other procedure	2.54	NA	NA	0.91	1.07	0.64	ZZZ
33202		A	Insert epicard eltrd, open	13.20	NA	NA	6.97	7.28	3.28	090
33203		A	Insert epicard eltrd, endo	13.97	NA	NA	6.90	7.58	3.41	090
33206		A	Insertion of heart pacemaker	7.39	NA	NA	4.33	5.15	1.68	090
33207		A	Insertion of heart pacemaker	8.05	NA	NA	4.39	5.27	1.84	090
33208		A	Insertion of heart pacemaker	8.77	NA	NA	4.66	5.61	1.99	090
33210		A	Insertion of heart electrode	3.30	NA	NA	1.28	1.59	0.73	000
33211		A	Insertion of heart electrode	3.39	NA	NA	1.29	1.54	0.78	000
33212		A	Insertion of pulse generator	5.52	NA	NA	3.15	3.76	1.26	090
33213		A	Insertion of pulse generator	6.37	NA	NA	3.47	4.20	1.46	090
33214		A	Upgrade of pacemaker system	7.84	NA	NA	4.57	5.40	1.77	090
33215		A	Reposition pacing-defib lead	4.92	NA	NA	2.87	3.48	1.12	090
33216		A	Insert 1 electrode pm-defib	5.87	NA	NA	3.73	4.55	1.33	090
33217		A	Insert 2 electrode pm-defib	5.84	NA	NA	3.74	4.51	1.33	090
33218		A	Repair lead pace-defib, one	6.07	NA	NA	4.01	4.81	1.37	090
3321F		I	AJCC cncr 0/IA melan docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33220		A	Repair lead pace-defib, dual	6.15	NA	NA	4.01	4.82	1.38	090
33222		A	Revise pocket, pacemaker	5.10	NA	NA	3.81	4.48	1.19	090
33223		A	Revise pocket for defib	6.55	NA	NA	3.99	4.88	1.51	090
33224		A	Insert pacing lead & connect	9.04	NA	NA	3.87	4.78	2.06	000
33225		A	L ventric pacing lead add-on	8.33	NA	NA	3.27	4.10	1.89	ZZZ
33226		A	Reposition l ventric lead	8.68	NA	NA	3.75	4.63	1.98	000
3322F		I	Melan >AJCC stage 0 or IA	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33233		A	Removal of pacemaker system	3.39	NA	NA	2.70	3.29	0.76	090
33234		A	Removal of pacemaker system	7.91	NA	NA	4.52	5.47	1.81	090
33235		A	Removal pacemaker electrode	10.15	NA	NA	6.10	7.33	2.33	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
33236		A	Remove electrode/thoracotomy	12.73	NA	NA	7.72	8.02	3.31	090
33237		A	Remove electrode/thoracotomy	13.84	NA	NA	7.60	8.63	3.36	090
33238		A	Remove electrode/thoracotomy	15.40	NA	NA	9.16	9.40	3.83	090
33240		A	Insert pulse generator	7.64	NA	NA	4.11	5.11	1.72	090
33241		A	Remove pulse generator	3.29	NA	NA	2.41	2.98	0.73	090
33243		A	Remove eltrd/thoracotomy	23.57	NA	NA	11.94	12.84	5.78	090
33244		A	Remove eltrd, transven	13.99	NA	NA	7.75	9.48	3.22	090
33249		A	Eltrd/insert pace-defib	15.17	NA	NA	7.91	9.77	3.45	090
3324F		I	Mri ct scan ord rvwd rqstd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33250		A	Ablate heart dysrhythm focus	25.90	NA	NA	12.29	12.70	6.71	090
33251		A	Ablate heart dysrhythm focus	28.92	NA	NA	13.82	14.01	7.28	090
33254		A	Ablate atria, lmtd	23.71	NA	NA	12.00	12.25	6.15	090
33255		A	Ablate atria w/o bypass, ext	29.04	NA	NA	13.81	14.57	7.53	090
33256		A	Ablate atria w/bypass, exten	34.90	NA	NA	15.83	16.78	9.09	090
33257		A	Ablate atria, lmtd, add-on	9.63	NA	NA	5.72	5.90	2.40	ZZZ
33258		A	Ablate atria, x10sv, add-on	11.00	NA	NA	6.23	6.44	2.73	ZZZ
33259		A	Ablate atria w/bypass add-on	14.14	NA	NA	8.07	8.36	3.56	ZZZ
33261		A	Ablate heart dysrhythm focus	28.92	NA	NA	13.20	13.62	7.50	090
33265		A	Ablate atria, lmtd, endo	23.71	NA	NA	11.68	12.04	5.86	090
33266		A	Ablate atria, x10sv, endo	33.04	NA	NA	15.01	15.60	8.28	090
33282		A	Implant pat-active ht record	4.80	NA	NA	3.42	4.20	1.09	090
33284		A	Remove pat-active ht record	3.14	NA	NA	2.78	3.41	0.71	090
3328F		I	Prfrmnc docd 2 wks b/4 surg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33300		A	Repair of heart wound	44.97	NA	NA	18.86	18.22	11.15	090
33305		A	Repair of heart wound	76.93	NA	NA	30.02	29.02	19.13	090
33310		A	Exploratory heart surgery	20.34	NA	NA	10.26	10.55	4.66	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
33315		A	Exploratory heart surgery	26.17	NA	NA	12.48	12.93	6.53	090
33320		A	Repair major blood vessel(s)	18.54	NA	NA	9.41	9.65	4.47	090
33321		A	Repair major vessel	20.81	NA	NA	10.37	10.60	5.06	090
33322		A	Repair major blood vessel(s)	24.42	NA	NA	12.07	12.37	6.09	090
33330		A	Insert major vessel graft	25.29	NA	NA	11.96	12.01	6.57	090
33332		A	Insert major vessel graft	24.56	NA	NA	11.55	12.13	6.36	090
33335		A	Insert major vessel graft	33.91	NA	NA	15.30	15.70	8.49	090
33400		A	Repair of aortic valve	41.50	NA	NA	18.22	18.82	10.27	090
33401		A	Valvuloplasty, open	24.63	NA	NA	12.37	14.05	5.58	090
33403		A	Valvuloplasty, w/cp bypass	25.61	NA	NA	13.00	13.90	6.64	090
33404		A	Prepare heart-aorta conduit	31.37	NA	NA	14.46	15.24	7.62	090
33405		A	Replacement of aortic valve	41.32	NA	NA	18.53	19.35	10.30	090
33406		A	Replacement of aortic valve	52.68	NA	NA	22.29	22.99	13.25	090
33410		A	Replacement of aortic valve	46.41	NA	NA	20.30	20.71	11.57	090
33411		A	Replacement of aortic valve	62.07	NA	NA	25.83	26.05	15.50	090
33412		A	Replacement of aortic valve	43.94	NA	NA	19.78	20.93	11.42	090
33413		A	Replacement of aortic valve	59.87	NA	NA	24.56	25.57	14.55	090
33414		A	Repair of aortic valve	39.37	NA	NA	16.73	17.56	10.22	090
33415		A	Revision, subvalvular tissue	37.27	NA	NA	16.02	16.10	8.85	090
33416		A	Revise ventricle muscle	36.56	NA	NA	16.80	16.93	9.14	090
33417		A	Repair of aortic valve	29.33	NA	NA	14.33	14.89	7.31	090
33420		A	Revision of mitral valve	25.79	NA	NA	15.33	13.35	3.67	090
33422		A	Revision of mitral valve	29.73	NA	NA	13.93	14.60	7.70	090
33425		A	Repair of mitral valve	49.96	NA	NA	21.58	21.29	12.45	090
33426		A	Repair of mitral valve	43.28	NA	NA	19.29	19.88	10.81	090
33427		A	Repair of mitral valve	44.83	NA	NA	19.19	20.14	11.19	090

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33430		A	Replacement of mitral valve	50.93	NA	NA	22.69	22.97	12.73	090
33460		A	Revision of tricuspid valve	44.70	NA	NA	18.02	18.24	11.60	090
33463		A	Valvuloplasty, tricuspid	57.08	NA	NA	23.79	23.42	14.31	090
33464		A	Valvuloplasty, tricuspid	44.62	NA	NA	19.65	19.54	11.15	090
33465		A	Replace tricuspid valve	50.72	NA	NA	21.44	21.21	12.76	090
33468		A	Revision of tricuspid valve	32.94	NA	NA	14.77	16.12	8.56	090
33470		A	Revision of pulmonary valve	21.54	NA	NA	12.29	11.93	5.24	090
33471		A	Valvotomy, pulmonary valve	22.96	NA	NA	12.85	12.55	1.68	090
33472		A	Revision of pulmonary valve	23.06	NA	NA	10.85	11.65	1.70	090
33474		A	Revision of pulmonary valve	39.40	NA	NA	16.96	16.42	9.58	090
33475		A	Replacement, pulmonary valve	42.40	NA	NA	18.49	18.85	11.01	090
33476		A	Revision of heart chamber	26.57	NA	NA	13.04	13.10	6.90	090
33478		A	Revision of heart chamber	27.54	NA	NA	13.24	13.79	7.15	090
33496		A	Repair, prosth valve clot	29.84	NA	NA	13.95	14.40	7.25	090
33500		A	Repair heart vessel fistula	27.94	NA	NA	12.99	13.50	7.25	090
33501		A	Repair heart vessel fistula	19.51	NA	NA	9.70	9.95	5.07	090
33502		A	Coronary artery correction	21.85	NA	NA	11.29	11.68	5.67	090
33503		A	Coronary artery graft	22.51	NA	NA	11.56	13.40	5.12	090
33504		A	Coronary artery graft	25.46	NA	NA	12.57	12.88	6.60	090
33505		A	Repair artery w/tunnel	38.40	NA	NA	15.07	15.40	9.96	090
33506		A	Repair artery, translocation	37.85	NA	NA	22.35	19.60	9.21	090
33507		A	Repair art, intramural	31.40	NA	NA	13.20	14.03	7.63	090
33508		A	Endoscopic vein harvest	0.31	NA	NA	0.11	0.12	0.07	ZZZ
33510		A	CABG, vein, single	34.98	NA	NA	15.97	16.71	8.73	090
33511		A	CABG, vein, two	38.45	NA	NA	17.40	18.15	9.61	090
33512		A	CABG, vein, three	43.98	NA	NA	19.42	20.12	11.01	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
33513		A	CABG, vein, four	45.37	NA	NA	19.79	20.21	11.39	090
33514		A	CABG, vein, five	48.08	NA	NA	20.68	21.43	11.98	090
33516		A	Cabg, vein, six or more	49.76	NA	NA	21.35	22.27	12.90	090
33517		A	CABG, artery-vein, single	3.61	NA	NA	1.29	1.31	0.89	ZZZ
33518		A	CABG, artery-vein, two	7.93	NA	NA	2.84	2.83	1.98	ZZZ
33519		A	CABG, artery-vein, three	10.49	NA	NA	3.76	3.79	2.61	ZZZ
3351F		I	Neg scrn dep symp by deptool	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33521		A	CABG, artery-vein, four	12.59	NA	NA	4.53	4.60	3.17	ZZZ
33522		A	CABG, artery-vein, five	14.14	NA	NA	5.09	5.22	3.56	ZZZ
33523		A	Cabg, art-vein, six or more	16.08	NA	NA	5.75	5.92	4.01	ZZZ
3352F		I	No sig dep symp by dep tool	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33530		A	Coronary artery, bypass/reop	10.13	NA	NA	3.62	3.59	2.52	ZZZ
33533		A	CABG, arterial, single	33.75	NA	NA	15.36	16.26	8.44	090
33534		A	CABG, arterial, two	39.88	NA	NA	17.88	18.76	9.95	090
33535		A	CABG, arterial, three	44.75	NA	NA	19.62	20.48	11.16	090
33536		A	Cabg, arterial, four or more	48.43	NA	NA	20.99	21.61	12.15	090
3353F		I	Mild-mod dep symp by deptool	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33542		A	Removal of heart lesion	48.21	NA	NA	20.71	20.49	12.08	090
33545		A	Repair of heart damage	57.06	NA	NA	23.76	23.69	14.20	090
33548		A	Restore/remodel, ventricle	54.14	NA	NA	23.60	24.39	13.61	090
3354F		I	Clin sig dep sym by dep tool	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33572		A	Open coronary endarterectomy	4.44	NA	NA	1.59	1.66	1.12	ZZZ
33600		A	Closure of valve	30.31	NA	NA	14.38	14.72	7.35	090
33602		A	Closure of valve	29.34	NA	NA	14.05	14.07	6.49	090
33606		A	Anastomosis/artery-aorta	31.53	NA	NA	16.73	16.21	6.98	090
33608		A	Repair anomaly w/conduit	31.88	NA	NA	14.93	15.72	7.74	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
33610		A	Repair by enlargement	31.40	NA	NA	14.60	15.21	7.63	090
33611		A	Repair double ventricle	35.57	NA	NA	15.10	15.78	9.24	090
33612		A	Repair double ventricle	36.57	NA	NA	15.28	15.92	8.28	090
33615		A	Repair, modified fontan	35.89	NA	NA	16.28	17.16	8.73	090
33617		A	Repair single ventricle	39.09	NA	NA	17.09	17.44	9.51	090
33619		A	Repair single ventricle	48.76	NA	NA	25.36	23.27	11.86	090
33641		A	Repair heart septum defect	29.58	NA	NA	13.53	13.48	7.39	090
33645		A	Revision of heart veins	28.10	NA	NA	12.96	13.51	7.29	090
33647		A	Repair heart septum defects	29.53	NA	NA	14.11	15.06	7.66	090
33660		A	Repair of heart defects	31.83	NA	NA	19.60	17.20	8.27	090
33665		A	Repair of heart defects	34.85	NA	NA	14.85	15.50	9.07	090
33670		A	Repair of heart chambers	36.63	NA	NA	14.54	15.20	9.52	090
33675		A	Close mult vsd	35.95	NA	NA	15.11	15.74	9.33	090
33676		A	Close mult vsd w/resection	36.95	NA	NA	18.30	17.85	2.73	090
33677		A	Cl mult vsd w/rem pul band	38.45	NA	NA	13.77	15.86	2.84	090
33681		A	Repair heart septum defect	32.34	NA	NA	15.88	16.19	8.10	090
33684		A	Repair heart septum defect	34.37	NA	NA	14.68	15.32	8.93	090
33688		A	Repair heart septum defect	34.75	NA	NA	13.98	14.32	9.03	090
33690		A	Reinforce pulmonary artery	20.36	NA	NA	13.04	12.11	4.95	090
33692		A	Repair of heart defects	31.54	NA	NA	16.04	15.66	2.32	090
33694		A	Repair of heart defects	35.57	NA	NA	14.94	15.92	9.24	090
33697		A	Repair of heart defects	37.57	NA	NA	16.44	18.42	8.51	090
33702		A	Repair of heart defects	27.24	NA	NA	12.98	13.30	7.07	090
33710		A	Repair of heart defects	30.41	NA	NA	13.93	16.77	7.39	090
33720		A	Repair of heart defect	27.26	NA	NA	12.85	13.49	6.63	090
33722		A	Repair of heart defect	29.21	NA	NA	15.03	14.31	7.57	090

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33724		A	Repair venous anomaly	27.63	NA	NA	12.59	13.41	6.70	090
33726		A	Repair pul venous stenosis	37.12	NA	NA	19.08	18.28	9.64	090
33730		A	Repair heart-vein defect(s)	36.14	NA	NA	15.77	15.67	9.40	090
33732		A	Repair heart-vein defect	28.96	NA	NA	13.92	14.45	7.52	090
33735		A	Revision of heart chamber	22.20	NA	NA	11.45	11.72	5.78	090
33736		A	Revision of heart chamber	24.32	NA	NA	12.18	12.65	6.30	090
33737		A	Revision of heart chamber	22.47	NA	NA	11.21	11.70	5.47	090
33750		A	Major vessel shunt	22.22	NA	NA	9.14	11.81	8.28	090
33755		A	Major vessel shunt	22.60	NA	NA	11.71	11.76	5.13	090
33762		A	Major vessel shunt	22.60	NA	NA	12.17	12.00	1.67	090
33764		A	Major vessel shunt & graft	22.60	NA	NA	12.97	12.15	5.02	090
33766		A	Major vessel shunt	23.57	NA	NA	10.96	12.35	5.33	090
33767		A	Major vessel shunt	25.30	NA	NA	11.68	11.85	6.57	090
33768		A	Cavopulmonary shunting	8.00	NA	NA	3.46	3.35	0.58	ZZZ
33770		A	Repair great vessels defect	39.07	NA	NA	15.68	16.51	9.51	090
33771		A	Repair great vessels defect	40.63	NA	NA	19.02	18.13	3.01	090
33774		A	Repair great vessels defect	31.73	NA	NA	14.92	15.63	8.24	090
33775		A	Repair great vessels defect	32.99	NA	NA	17.37	17.19	2.42	090
33776		A	Repair great vessels defect	34.75	NA	NA	18.46	18.25	2.54	090
33777		A	Repair great vessels defect	34.17	NA	NA	17.34	17.23	2.52	090
33778		A	Repair great vessels defect	42.75	NA	NA	21.31	20.82	3.17	090
33779		A	Repair great vessels defect	43.23	NA	NA	20.42	19.78	3.21	090
33780		A	Repair great vessels defect	43.90	NA	NA	20.89	20.76	3.25	090
33781		A	Repair great vessels defect	43.21	NA	NA	20.14	19.23	3.21	090
33782		A	Nikaidoh proc	60.08	NA	NA	23.63	23.63	14.61	090
33783		A	Nikaidoh proc w/ostia implt	65.08	NA	NA	25.37	25.37	15.83	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
33786		A	Repair arterial trunk	41.87	NA	NA	16.98	17.98	3.09	090
33788		A	Revision of pulmonary artery	27.42	NA	NA	12.28	13.05	2.01	090
33800		A	Aortic suspension	17.28	NA	NA	8.33	8.45	4.48	090
33802		A	Repair vessel defect	18.37	NA	NA	11.81	10.85	4.78	090
33803		A	Repair vessel defect	20.31	NA	NA	9.51	9.62	5.27	090
33813		A	Repair septal defect	21.36	NA	NA	12.15	12.83	5.20	090
33814		A	Repair septal defect	26.57	NA	NA	12.95	13.50	6.90	090
33820		A	Revise major vessel	16.69	NA	NA	8.56	9.01	4.34	090
33822		A	Revise major vessel	17.71	NA	NA	9.95	9.93	1.30	090
33824		A	Revise major vessel	20.23	NA	NA	11.63	11.38	4.92	090
33840		A	Remove aorta constriction	21.34	NA	NA	10.93	10.84	5.54	090
33845		A	Remove aorta constriction	22.93	NA	NA	11.70	12.81	5.95	090
33851		A	Remove aorta constriction	21.98	NA	NA	18.08	14.82	5.69	090
33852		A	Repair septal defect	24.41	NA	NA	11.81	12.33	6.33	090
33853		A	Repair septal defect	32.51	NA	NA	14.98	16.45	8.45	090
33860		A	Ascending aortic graft	59.46	NA	NA	24.60	24.67	14.79	090
33861		A	Ascending aortic graft	44.07	NA	NA	19.10	19.83	11.05	090
33863		A	Ascending aortic graft	58.79	NA	NA	23.56	24.15	14.61	090
33864		A	Ascending aortic graft	60.08	NA	NA	24.06	24.97	14.86	090
33870		A	Transverse aortic arch graft	46.06	NA	NA	19.72	20.56	11.42	090
33875		A	Thoracic aortic graft	35.78	NA	NA	16.84	16.81	8.87	090
33877		A	Thoracoabdominal graft	69.03	NA	NA	26.65	26.03	16.97	090
33880		A	Endovasc taa repr incl subcl	34.58	NA	NA	13.61	14.22	8.01	090
33881		A	Endovasc taa repr w/o subcl	29.58	NA	NA	11.98	12.44	6.85	090
33883		A	Insert endovasc prosth, taa	21.09	NA	NA	9.12	9.44	4.87	090
33884		A	Endovasc prosth, taa, add-on	8.20	NA	NA	2.78	2.82	1.91	ZZZ

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
33886		A	Endovasc prosth, delayed	18.09	NA	NA	7.98	8.21	4.47	090
33889		A	Artery transpose/endovas taa	15.92	NA	NA	5.52	5.48	3.93	000
33891		A	Car-car bp grft/endovas taa	20.00	NA	NA	6.15	6.41	4.93	000
33910		A	Remove lung artery emboli	29.71	NA	NA	14.03	14.36	7.70	090
33915		A	Remove lung artery emboli	24.95	NA	NA	10.36	10.94	5.65	090
33916		A	Surgery of great vessel	28.42	NA	NA	13.03	14.69	7.38	090
33917		A	Repair pulmonary artery	25.30	NA	NA	12.65	13.87	6.15	090
33920		A	Repair pulmonary atresia	32.74	NA	NA	14.25	14.91	8.49	090
33922		A	Transect pulmonary artery	24.22	NA	NA	11.81	12.22	6.29	090
33924		A	Remove pulmonary shunt	5.49	NA	NA	1.88	1.96	1.33	ZZZ
33925		A	Rpr pul art unifocal w/o cpb	31.30	NA	NA	13.31	14.37	7.60	090
33926		A	Repr pul art, unifocal w/cpb	44.73	NA	NA	26.15	21.44	11.60	090
33930		X	Removal of donor heart/lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33933		C	Prepare donor heart/lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33935		R	Transplantation, heart/lung	62.01	NA	NA	27.41	28.77	16.09	090
33940		X	Removal of donor heart	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33944		C	Prepare donor heart	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33945		R	Transplantation of heart	89.50	NA	NA	36.75	36.43	22.16	090
33960		A	External circulation assist	19.33	NA	NA	6.99	6.97	3.97	000
33961		A	External circulation assist	10.91	NA	NA	3.93	4.06	1.72	ZZZ
33967		A	Insert ia percut device	4.84	NA	NA	1.87	2.32	1.12	000
33968		A	Remove aortic assist device	0.64	NA	NA	0.25	0.28	0.14	000
33970		A	Aortic circulation assist	6.74	NA	NA	2.47	2.81	1.62	000
33971		A	Aortic circulation assist	11.99	NA	NA	6.62	7.11	2.91	090
33973		A	Insert balloon device	9.75	NA	NA	3.64	4.13	2.35	000
33974		A	Remove intra-aortic balloon	15.03	NA	NA	7.91	8.88	3.91	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
33975		A	Implant ventricular device	20.97	NA	NA	7.51	7.87	5.19	XXX
33976		A	Implant ventricular device	22.97	NA	NA	8.00	8.84	5.96	XXX
33977		A	Remove ventricular device	20.28	NA	NA	11.27	11.78	5.00	090
33978		A	Remove ventricular device	22.72	NA	NA	12.21	12.54	5.91	090
33979		A	Insert intracorporeal device	45.93	NA	NA	16.15	17.04	11.42	XXX
33980		A	Remove intracorporeal device	65.20	NA	NA	29.25	30.10	16.33	090
33981		C	Replace vad pump ext	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33982		C	Replace vad intra w/o bp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33983		C	Replace vad intra w/bp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33999		C	Cardiac surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
34001		A	Removal of artery clot	17.88	NA	NA	8.76	8.50	4.22	090
34051		A	Removal of artery clot	16.99	NA	NA	8.91	9.01	4.41	090
34101		A	Removal of artery clot	10.93	NA	NA	5.67	5.66	2.56	090
34111		A	Removal of arm artery clot	10.93	NA	NA	5.69	5.66	2.53	090
34151		A	Removal of artery clot	26.52	NA	NA	11.81	11.52	6.20	090
34201		A	Removal of artery clot	19.48	NA	NA	8.81	8.32	4.65	090
34203		A	Removal of leg artery clot	17.86	NA	NA	8.48	8.48	4.27	090
34401		A	Removal of vein clot	26.52	NA	NA	14.36	13.71	5.88	090
34421		A	Removal of vein clot	13.37	NA	NA	6.81	6.80	3.08	090
34451		A	Removal of vein clot	28.52	NA	NA	10.62	11.43	7.04	090
34471		A	Removal of vein clot	21.11	NA	NA	12.03	10.26	4.68	090
34490		A	Removal of vein clot	10.91	NA	NA	6.00	5.89	2.52	090
34501		A	Repair valve, femoral vein	16.85	NA	NA	7.66	8.26	4.15	090
34502		A	Reconstruct vena cava	28.07	NA	NA	13.07	13.32	6.12	090
3450F		I	Dyspnea scrnd, no-mild dysp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
34510		A	Transposition of vein valve	19.91	NA	NA	11.53	10.47	4.39	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
3451F		I	Dyspnea scrnd mod-high dysp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
34520		A	Cross-over vein graft	19.18	NA	NA	7.86	8.39	4.72	090
3452F		I	Dyspnea not screened	0.00	0.00	0.00	0.00	0.00	0.00	XXX
34530		A	Leg vein fusion	17.93	NA	NA	7.78	8.33	3.97	090
34800		A	Endovas aaa repr w/sm tube	21.54	NA	NA	9.06	9.47	4.75	090
34802		A	Endovas aaa repr w/2-p part	23.79	NA	NA	10.10	10.42	5.28	090
34803		A	Endovas aaa repr w/3-p part	24.82	NA	NA	10.25	10.48	5.54	090
34804		A	Endovas aaa repr w/1-p part	23.79	NA	NA	10.08	10.41	5.34	090
34805		A	Endovas aaa repr w/long tube	22.67	NA	NA	9.63	9.72	5.23	090
34806		A	Aneurysm press sensor add-on	2.06	NA	NA	0.70	0.74	0.47	ZZZ
34808		A	Endovas iliac a device addon	4.12	NA	NA	1.43	1.43	0.93	ZZZ
34812		A	Xpose for endoprosth, femorl	6.74	NA	NA	2.35	2.33	1.61	000
34813		A	Femoral endovas graft add-on	4.79	NA	NA	1.63	1.61	1.14	ZZZ
34820		A	Xpose for endoprosth, iliac	9.74	NA	NA	3.34	3.36	2.26	000
34825		A	Endovasc extend prosth, init	12.80	NA	NA	6.24	6.48	2.85	090
34826		A	Endovasc exten prosth, addl	4.12	NA	NA	1.44	1.47	0.92	ZZZ
34830		A	Open aortic tube prosth repr	35.23	NA	NA	12.77	13.53	8.68	090
34831		A	Open aortoiliac prosth repr	37.98	NA	NA	13.62	13.95	9.37	090
34832		A	Open aortofemor prosth repr	37.98	NA	NA	13.62	14.41	9.37	090
34833		A	Xpose for endoprosth, iliac	11.98	NA	NA	4.41	4.46	2.90	000
34834		A	Xpose, endoprosth, brachial	5.34	NA	NA	2.08	2.12	1.29	000
34900		A	Endovasc iliac repr w/graft	16.85	NA	NA	7.60	7.87	3.72	090
3491F		I	HIV unsure baby of HIV+moms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3497F		I	CD4+ cell percentage <15%	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3498F		I	CD4+ cell percentage >=15%	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35001		A	Repair defect of artery	20.81	NA	NA	9.73	9.95	5.00	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
35002		A	Repair artery rupture, neck	22.23	NA	NA	8.77	9.57	4.93	090
35005		A	Repair defect of artery	19.29	NA	NA	11.38	10.59	4.75	090
35011		A	Repair defect of artery	18.58	NA	NA	8.67	8.56	4.38	090
35013		A	Repair artery rupture, arm	23.23	NA	NA	11.05	10.70	5.48	090
35021		A	Repair defect of artery	22.17	NA	NA	8.97	9.97	5.40	090
35022		A	Repair artery rupture, chest	25.70	NA	NA	11.90	11.79	6.25	090
35045		A	Repair defect of arm artery	18.01	NA	NA	9.13	8.72	4.15	090
35081		A	Repair defect of artery	33.53	NA	NA	14.42	14.06	8.07	090
35082		A	Repair artery rupture, aorta	42.09	NA	NA	17.71	17.28	10.03	090
35091		A	Repair defect of artery	35.35	NA	NA	13.49	13.59	8.51	090
35092		A	Repair artery rupture, aorta	50.97	NA	NA	19.80	19.55	12.24	090
35102		A	Repair defect of artery	36.53	NA	NA	15.13	14.84	8.77	090
35103		A	Repair artery rupture, groin	43.62	NA	NA	17.45	17.27	10.37	090
3510F		I	Doc tb scrng-rslts interpd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35111		A	Repair defect of artery	26.28	NA	NA	14.26	12.83	5.82	090
35112		A	Repair artery rupture,spleen	32.57	NA	NA	17.11	15.37	7.21	090
35121		A	Repair defect of artery	31.52	NA	NA	13.64	13.29	7.53	090
35122		A	Repair artery rupture, belly	37.89	NA	NA	13.59	14.59	8.39	090
35131		A	Repair defect of artery	26.40	NA	NA	11.56	11.54	6.33	090
35132		A	Repair artery rupture, groin	32.57	NA	NA	11.96	12.65	7.73	090
3513F		I	Hep B scrng docd as done	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35141		A	Repair defect of artery	20.91	NA	NA	9.31	9.29	5.02	090
35142		A	Repair artery rupture, thigh	25.16	NA	NA	11.02	11.03	6.01	090
3514F		I	Hep C scrng docd as done	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35151		A	Repair defect of artery	23.72	NA	NA	10.42	10.37	5.68	090
35152		A	Repair artery rupture, knee	27.66	NA	NA	10.44	11.20	6.82	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
3515F		I	Pt has docd immun to hep C	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35180		A	Repair blood vessel lesion	15.10	NA	NA	11.10	9.88	3.72	090
35182		A	Repair blood vessel lesion	31.71	NA	NA	14.79	14.87	7.02	090
35184		A	Repair blood vessel lesion	18.82	NA	NA	9.25	8.98	4.17	090
35188		A	Repair blood vessel lesion	15.16	NA	NA	6.59	7.32	3.36	090
35189		A	Repair blood vessel lesion	29.98	NA	NA	16.00	14.48	7.79	090
35190		A	Repair blood vessel lesion	13.42	NA	NA	7.11	6.99	3.18	090
35201		A	Repair blood vessel lesion	16.93	NA	NA	8.72	8.57	3.90	090
35206		A	Repair blood vessel lesion	13.84	NA	NA	7.36	7.14	3.18	090
35207		A	Repair blood vessel lesion	10.94	NA	NA	9.66	9.03	2.01	090
35211		A	Repair blood vessel lesion	24.58	NA	NA	11.80	12.06	6.13	090
35216		A	Repair blood vessel lesion	36.61	NA	NA	17.67	16.69	8.97	090
35221		A	Repair blood vessel lesion	26.62	NA	NA	12.20	11.62	6.05	090
35226		A	Repair blood vessel lesion	15.30	NA	NA	7.36	7.50	3.66	090
35231		A	Repair blood vessel lesion	21.16	NA	NA	11.45	11.05	4.32	090
35236		A	Repair blood vessel lesion	18.02	NA	NA	8.71	8.56	4.14	090
35241		A	Repair blood vessel lesion	25.58	NA	NA	13.01	12.92	6.54	090
35246		A	Repair blood vessel lesion	28.23	NA	NA	10.74	12.06	6.95	090
35251		A	Repair blood vessel lesion	31.91	NA	NA	13.95	13.32	7.26	090
35256		A	Repair blood vessel lesion	19.06	NA	NA	8.66	8.65	4.52	090
35261		A	Repair blood vessel lesion	18.96	NA	NA	9.52	9.33	4.82	090
35266		A	Repair blood vessel lesion	15.83	NA	NA	7.71	7.61	3.76	090
35271		A	Repair blood vessel lesion	24.58	NA	NA	11.82	12.05	6.37	090
35276		A	Repair blood vessel lesion	25.83	NA	NA	12.33	12.54	6.27	090
35281		A	Repair blood vessel lesion	30.06	NA	NA	13.64	13.17	7.05	090
35286		A	Repair blood vessel lesion	17.19	NA	NA	8.41	8.41	4.11	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
35301		A	Rechanneling of artery	19.61	NA	NA	9.03	8.97	4.73	090
35302		A	Rechanneling of artery	21.35	NA	NA	9.42	9.10	5.12	090
35303		A	Rechanneling of artery	23.60	NA	NA	10.40	9.97	5.64	090
35304		A	Rechanneling of artery	24.60	NA	NA	10.55	10.19	5.86	090
35305		A	Rechanneling of artery	23.60	NA	NA	10.30	9.89	5.64	090
35306		A	Rechanneling of artery	9.25	NA	NA	3.98	3.45	2.27	ZZZ
35311		A	Rechanneling of artery	28.60	NA	NA	12.01	12.24	6.95	090
35321		A	Rechanneling of artery	16.59	NA	NA	7.84	7.78	3.91	090
35331		A	Rechanneling of artery	27.72	NA	NA	12.12	12.17	6.68	090
35341		A	Rechanneling of artery	26.21	NA	NA	11.02	11.12	6.29	090
35351		A	Rechanneling of artery	24.61	NA	NA	10.53	10.39	5.86	090
35355		A	Rechanneling of artery	19.86	NA	NA	8.62	8.57	4.73	090
35361		A	Rechanneling of artery	30.24	NA	NA	11.24	11.96	7.46	090
35363		A	Rechanneling of artery	32.35	NA	NA	14.02	14.34	7.86	090
35371		A	Rechanneling of artery	15.31	NA	NA	7.26	7.20	3.66	090
35372		A	Rechanneling of artery	18.58	NA	NA	8.31	8.28	4.42	090
35390		A	Reoperation, carotid add-on	3.19	NA	NA	1.12	1.12	0.76	ZZZ
35400		A	Angioscopy	3.00	NA	NA	1.02	1.05	0.71	ZZZ
35450		A	Repair arterial blockage	10.05	NA	NA	3.82	3.89	2.33	000
35452		A	Repair arterial blockage	6.90	NA	NA	2.78	2.78	1.64	000
35454		A	Repair arterial blockage	6.03	NA	NA	2.38	2.41	1.41	000
35456		A	Repair arterial blockage	7.34	NA	NA	2.89	2.90	1.72	000
35458		A	Repair arterial blockage	9.48	NA	NA	3.76	3.73	2.22	000
35459		A	Repair arterial blockage	8.62	NA	NA	3.31	3.39	2.02	000
35460		A	Repair venous blockage	6.03	NA	NA	2.53	2.45	1.37	000
35470		A	Repair arterial blockage	8.62	59.94	70.16	3.35	3.80	1.84	000

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
35471		A	Repair arterial blockage	10.05	60.21	73.93	3.96	4.73	2.06	000
35472		A	Repair arterial blockage	6.90	46.98	53.91	2.78	3.07	1.50	000
35473		A	Repair arterial blockage	6.03	45.52	52.16	2.44	2.75	1.29	000
35474		A	Repair arterial blockage	7.35	59.13	69.24	2.91	3.29	1.54	000
35475		R	Repair arterial blockage	9.48	52.40	56.10	3.63	3.98	1.58	000
35476		A	Repair venous blockage	6.03	40.84	43.75	2.41	2.62	0.86	000
35480		A	Atherectomy, open	11.06	NA	NA	5.13	4.65	2.73	000
35481		A	Atherectomy, open	7.60	NA	NA	3.09	3.19	1.85	000
35482		A	Atherectomy, open	6.64	NA	NA	2.27	2.61	1.64	000
35483		A	Atherectomy, open	8.09	NA	NA	3.34	3.38	1.89	000
35484		A	Atherectomy, open	10.42	NA	NA	3.43	3.70	2.56	000
35485		A	Atherectomy, open	9.48	NA	NA	3.86	3.85	2.22	000
35490		A	Atherectomy, percutaneous	11.06	NA	NA	4.89	5.62	2.47	000
35491		A	Atherectomy, percutaneous	7.60	NA	NA	3.54	3.69	1.88	000
35492		A	Atherectomy, percutaneous	6.64	NA	NA	3.12	3.55	1.51	000
35493		A	Atherectomy, percutaneous	8.09	NA	NA	3.64	4.23	1.77	000
35494		A	Atherectomy, percutaneous	10.42	NA	NA	4.48	5.24	2.26	000
35495		A	Atherectomy, percutaneous	9.48	NA	NA	4.15	4.79	2.09	000
35500		A	Harvest vein for bypass	6.44	NA	NA	2.23	2.20	1.55	ZZZ
35501		A	Artery bypass graft	29.09	NA	NA	14.25	13.79	6.95	090
35506		A	Artery bypass graft	25.33	NA	NA	10.66	10.90	6.25	090
35508		A	Artery bypass graft	26.09	NA	NA	12.06	11.91	6.77	090
35509		A	Artery bypass graft	28.09	NA	NA	12.28	12.47	6.92	090
3550F		I	Low rsk thromboembolism	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35510		A	Artery bypass graft	24.39	NA	NA	9.18	9.88	6.01	090
35511		A	Artery bypass graft	22.20	NA	NA	12.61	11.38	5.48	090

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35512		A	Artery bypass graft	23.89	NA	NA	9.02	9.58	5.89	090
35515		A	Artery bypass graft	26.09	NA	NA	10.20	10.19	6.43	090
35516		A	Artery bypass graft	24.21	NA	NA	9.08	9.09	5.96	090
35518		A	Artery bypass graft	22.65	NA	NA	8.51	9.34	5.58	090
3551F		I	Intrmed rsk thromboembolism	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35521		A	Artery bypass graft	24.13	NA	NA	13.48	11.98	5.95	090
35522		A	Artery bypass graft	23.15	NA	NA	10.18	10.14	5.69	090
35523		A	Artery bypass graft	24.13	NA	NA	10.91	11.10	5.69	090
35525		A	Artery bypass graft	21.69	NA	NA	9.81	9.63	5.02	090
35526		A	Artery bypass graft	31.55	NA	NA	11.67	12.82	8.20	090
3552F		I	Hgh risk for thromboembolism	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35531		A	Artery bypass graft	39.11	NA	NA	16.25	15.99	9.26	090
35533		A	Artery bypass graft	29.92	NA	NA	15.97	14.39	7.38	090
35535		A	Artery bypass graft	38.13	NA	NA	13.71	15.02	2.81	090
35536		A	Artery bypass graft	33.73	NA	NA	12.31	12.87	8.32	090
35537		A	Artery bypass graft	41.88	NA	NA	21.25	18.94	10.31	090
35538		A	Artery bypass graft	47.03	NA	NA	23.51	21.13	11.59	090
35539		A	Artery bypass graft	44.11	NA	NA	15.58	16.07	10.88	090
35540		A	Artery bypass graft	49.33	NA	NA	20.81	19.73	11.78	090
35548		A	Artery bypass graft	22.68	NA	NA	8.91	9.51	5.60	090
35549		A	Artery bypass graft	24.45	NA	NA	15.70	13.47	5.41	090
35551		A	Artery bypass graft	27.83	NA	NA	15.06	13.93	6.17	090
35556		A	Artery bypass graft	26.75	NA	NA	11.68	11.40	6.37	090
35558		A	Artery bypass graft	23.13	NA	NA	10.81	10.58	5.54	090
3555F		I	Pt inr measurement performed	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35560		A	Artery bypass graft	34.03	NA	NA	12.40	13.30	8.39	090

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35563		A	Artery bypass graft	26.12	NA	NA	9.97	10.47	6.43	090
35565		A	Artery bypass graft	25.13	NA	NA	11.07	11.00	5.96	090
35566		A	Artery bypass graft	32.35	NA	NA	13.56	13.24	7.79	090
35570		A	Artery bypass graft	29.15	NA	NA	11.05	12.11	2.15	090
35571		A	Artery bypass graft	25.52	NA	NA	11.02	11.01	6.12	090
35572		A	Harvest femoropopliteal vein	6.81	NA	NA	2.45	2.51	1.65	ZZZ
35583		A	Vein bypass graft	27.75	NA	NA	12.07	11.71	6.60	090
35585		A	Vein bypass graft	32.35	NA	NA	13.87	13.53	7.69	090
35587		A	Vein bypass graft	26.21	NA	NA	11.73	11.61	6.27	090
35600		A	Harvest art for cabg add-on	4.94	NA	NA	1.81	1.89	1.24	ZZZ
35601		A	Artery bypass graft	27.09	NA	NA	13.32	12.73	6.58	090
35606		A	Artery bypass graft	22.46	NA	NA	9.63	9.65	5.45	090
35612		A	Artery bypass graft	16.82	NA	NA	7.10	7.82	4.15	090
35616		A	Artery bypass graft	21.82	NA	NA	11.85	10.51	4.83	090
35621		A	Artery bypass graft	21.03	NA	NA	9.12	9.08	5.06	090
35623		A	Bypass graft, not vein	25.92	NA	NA	14.25	12.69	6.37	090
35626		A	Artery bypass graft	29.14	NA	NA	12.75	13.04	7.25	090
35631		A	Artery bypass graft	36.03	NA	NA	14.29	14.28	8.75	090
35632		A	Artery bypass graft	36.13	NA	NA	13.10	14.35	2.67	090
35633		A	Artery bypass graft	39.11	NA	NA	15.24	15.97	2.88	090
35634		A	Artery bypass graft	35.33	NA	NA	13.72	14.52	2.60	090
35636		A	Artery bypass graft	31.75	NA	NA	16.76	15.01	7.83	090
35637		A	Artery bypass graft	33.05	NA	NA	14.02	13.64	7.94	090
35638		A	Artery bypass graft	33.60	NA	NA	14.41	14.09	8.12	090
35642		A	Artery bypass graft	18.94	NA	NA	11.74	10.72	4.66	090
35645		A	Artery bypass graft	18.43	NA	NA	10.73	9.54	4.79	090

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35646		A	Artery bypass graft	32.98	NA	NA	13.93	13.90	7.88	090
35647		A	Artery bypass graft	29.73	NA	NA	12.92	12.82	7.16	090
35650		A	Artery bypass graft	20.16	NA	NA	9.28	9.10	4.78	090
35651		A	Artery bypass graft	26.08	NA	NA	9.95	10.82	5.79	090
35654		A	Artery bypass graft	26.28	NA	NA	11.38	11.28	6.30	090
35656		A	Artery bypass graft	20.47	NA	NA	9.24	9.16	4.89	090
35661		A	Artery bypass graft	20.35	NA	NA	9.51	9.45	4.87	090
35663		A	Artery bypass graft	23.93	NA	NA	10.34	10.41	5.68	090
35665		A	Artery bypass graft	22.35	NA	NA	9.89	9.87	5.31	090
35666		A	Artery bypass graft	23.66	NA	NA	11.30	11.26	5.65	090
35671		A	Artery bypass graft	20.77	NA	NA	10.02	10.01	4.96	090
35681		A	Composite bypass graft	1.60	NA	NA	0.57	0.56	0.38	ZZZ
35682		A	Composite bypass graft	7.19	NA	NA	2.41	2.41	1.72	ZZZ
35683		A	Composite bypass graft	8.49	NA	NA	2.61	2.72	2.08	ZZZ
35685		A	Bypass graft patency/patch	4.04	NA	NA	1.39	1.37	0.96	ZZZ
35686		A	Bypass graft/av fist patency	3.34	NA	NA	1.14	1.17	0.78	ZZZ
35691		A	Arterial transposition	18.41	NA	NA	7.42	7.97	4.54	090
35693		A	Arterial transposition	15.73	NA	NA	7.17	7.77	3.89	090
35694		A	Arterial transposition	19.28	NA	NA	8.62	8.56	4.75	090
35695		A	Arterial transposition	20.06	NA	NA	7.93	8.43	4.95	090
35697		A	Reimplant artery each	3.00	NA	NA	1.03	1.03	0.72	ZZZ
35700		A	Reoperation, bypass graft	3.08	NA	NA	1.07	1.07	0.73	ZZZ
35701		A	Exploration, carotid artery	9.19	NA	NA	6.46	6.07	1.87	090
35721		A	Exploration, femoral artery	7.72	NA	NA	4.71	4.77	1.81	090
3572F		I	Pt consid poss risk fx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3573F		I	Pt not consid poss risk fx	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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35741		A	Exploration popliteal artery	8.69	NA	NA	5.29	5.16	2.01	090
35761		A	Exploration of artery/vein	5.93	NA	NA	4.77	4.60	1.34	090
35800		A	Explore neck vessels	8.07	NA	NA	5.51	5.31	1.77	090
35820		A	Explore chest vessels	36.89	NA	NA	15.72	15.21	9.17	090
35840		A	Explore abdominal vessels	10.96	NA	NA	6.70	6.39	2.44	090
35860		A	Explore limb vessels	6.80	NA	NA	4.42	4.40	1.61	090
35870		A	Repair vessel graft defect	24.50	NA	NA	9.47	9.99	6.03	090
35875		A	Removal of clot in graft	10.72	NA	NA	5.71	5.64	2.53	090
35876		A	Removal of clot in graft	17.82	NA	NA	8.15	8.04	4.24	090
35879		A	Revise graft w/vein	17.41	NA	NA	8.10	8.01	4.17	090
35881		A	Revise graft w/vein	19.35	NA	NA	8.74	8.76	4.66	090
35883		A	Revise graft w/nonauto graft	23.15	NA	NA	10.04	9.66	5.54	090
35884		A	Revise graft w/vein	24.65	NA	NA	9.19	9.32	6.06	090
35901		A	Excision, graft, neck	8.38	NA	NA	5.58	5.55	1.98	090
35903		A	Excision, graft, extremity	9.53	NA	NA	6.13	6.13	2.23	090
35905		A	Excision, graft, thorax	33.52	NA	NA	12.25	13.00	8.27	090
35907		A	Excision, graft, abdomen	37.27	NA	NA	15.31	15.01	8.92	090
36000		A	Place needle in vein	0.18	0.47	0.53	0.08	0.08	0.03	XXX
36002		A	Pseudoaneurysm injection trt	1.96	2.37	2.65	0.92	1.02	0.31	000
36005		A	Injection ext venography	0.95	8.31	9.00	0.34	0.39	0.14	000
36010		A	Place catheter in vein	2.43	11.63	13.65	0.85	0.93	0.37	XXX
36011		A	Place catheter in vein	3.14	20.91	23.32	1.13	1.22	0.45	XXX
36012		A	Place catheter in vein	3.51	20.65	22.10	1.26	1.41	0.54	XXX
36013		A	Place catheter in artery	2.52	19.04	20.82	0.92	0.99	0.47	XXX
36014		A	Place catheter in artery	3.02	19.80	21.48	1.07	1.24	0.34	XXX
36015		A	Place catheter in artery	3.51	21.05	23.10	1.25	1.43	0.38	XXX

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36100		A	Establish access to artery	3.02	10.70	11.99	1.13	1.28	0.69	XXX
36120		A	Establish access to artery	2.01	10.13	10.89	0.70	0.74	0.34	XXX
36140		A	Establish access to artery	2.01	10.48	11.79	0.73	0.80	0.41	XXX
36147		A	Access av dial grft for eval	3.72	19.47	19.47	1.37	1.37	0.52	XXX
36148		A	Access av dial grft for proc	1.00	6.33	6.33	0.35	0.35	0.13	ZZZ
36160		A	Establish access to aorta	2.52	10.84	12.41	0.88	1.04	0.40	XXX
36200		A	Place catheter in aorta	3.02	14.04	15.57	1.06	1.17	0.62	XXX
36215		A	Place catheter in artery	4.67	25.88	28.46	1.76	2.01	0.85	XXX
36216		A	Place catheter in artery	5.27	28.59	31.15	2.04	2.29	0.96	XXX
36217		A	Place catheter in artery	6.29	49.15	53.44	2.45	2.73	1.10	XXX
36218		A	Place catheter in artery	1.01	4.04	4.47	0.39	0.43	0.17	ZZZ
36245		A	Place catheter in artery	4.67	26.00	30.38	1.76	2.12	0.90	XXX
36246		A	Place catheter in artery	5.27	26.81	30.05	1.91	2.18	1.02	XXX
36247		A	Place catheter in artery	6.29	44.40	49.59	2.27	2.58	1.23	XXX
36248		A	Place catheter in artery	1.01	3.13	3.58	0.35	0.41	0.17	ZZZ
36260		A	Insertion of infusion pump	9.91	NA	NA	7.08	6.43	2.20	090
36261		A	Revision of infusion pump	5.63	NA	NA	4.92	4.52	1.38	090
36262		A	Removal of infusion pump	4.11	NA	NA	3.99	3.67	0.90	090
36299		C	Vessel injection procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
36400		A	Bl draw < 3 yrs fem/jugular	0.38	0.50	0.42	0.07	0.08	0.06	XXX
36405		A	Bl draw < 3 yrs scalp vein	0.31	0.32	0.34	0.12	0.11	0.06	XXX
36406		A	Bl draw < 3 yrs other vein	0.18	0.27	0.29	0.07	0.07	0.03	XXX
36410		A	Non-routine bl draw > 3 yrs	0.18	0.40	0.39	0.08	0.07	0.03	XXX
36415		X	Routine venipuncture	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36416		B	Capillary blood draw	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36420		A	Vein access cutdown < 1 yr	1.01	NA	NA	0.22	0.26	0.13	XXX

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36425		A	Vein access cutdown > 1 yr	0.76	NA	NA	0.33	0.31	0.11	XXX
36430		A	Blood transfusion service	0.00	0.87	1.00	NA	NA	0.01	XXX
36440		A	Bl push transfuse, 2 yr or <	1.03	NA	NA	0.49	0.41	0.25	XXX
36450		A	Bl exchange/transfuse, nb	2.23	NA	NA	1.06	1.01	0.11	XXX
36455		A	Bl exchange/transfuse non-nb	2.43	NA	NA	0.83	0.97	0.14	XXX
36460		A	Transfusion service, fetal	6.58	NA	NA	2.96	2.64	1.46	XXX
36468		R	Injection(s), spider veins	0.00	0.00	0.00	0.00	0.00	0.00	000
36469		R	Injection(s), spider veins	0.00	0.00	0.00	0.00	0.00	0.00	000
36470		A	Injection therapy of vein	1.10	2.86	2.89	0.83	0.82	0.23	010
36471		A	Injection therapy of veins	1.65	3.17	3.22	1.09	1.06	0.34	010
36475		A	Endovenous rf, 1st vein	6.72	43.24	45.70	2.77	2.71	1.47	000
36476		A	Endovenous rf, vein add-on	3.38	7.50	7.70	1.23	1.21	0.75	ZZZ
36478		A	Endovenous laser, 1st vein	6.72	30.82	34.49	2.70	2.73	1.37	000
36479		A	Endovenous laser vein addon	3.38	7.63	8.08	1.27	1.24	0.68	ZZZ
36481		A	Insertion of catheter, vein	6.98	51.68	28.38	2.88	2.88	0.92	000
36500		A	Insertion of catheter, vein	3.51	NA	NA	1.31	1.45	0.55	000
3650F		I	Eeg ordered rvwd reqstd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36510		A	Insertion of catheter, vein	1.09	1.48	1.78	0.52	0.49	0.25	000
36511		A	Apheresis wbc	1.74	NA	NA	0.85	0.80	0.28	000
36512		A	Apheresis rbc	1.74	NA	NA	0.84	0.82	0.17	000
36513		A	Apheresis platelets	1.74	NA	NA	0.95	0.89	0.35	000
36514		A	Apheresis plasma	1.74	11.68	13.00	0.76	0.74	0.28	000
36515		A	Apheresis, adsorp/reinfuse	1.74	48.65	54.00	0.85	0.76	0.25	000
36516		A	Apheresis, selective	1.22	52.68	60.37	0.54	0.52	0.37	000
36522		A	Photopheresis	1.67	33.80	37.55	1.16	1.16	0.17	000
36555		A	Insert non-tunnel cv cath	2.68	4.50	4.95	0.63	0.72	0.23	000

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36556		A	Insert non-tunnel cv cath	2.50	3.80	4.04	0.82	0.78	0.32	000
36557		A	Insert tunneled cv cath	5.14	22.24	21.23	3.54	3.31	1.13	010
36558		A	Insert tunneled cv cath	4.84	16.33	18.00	2.71	2.87	0.75	010
36560		A	Insert tunneled cv cath	6.29	31.33	30.09	4.05	3.76	0.61	010
36561		A	Insert tunneled cv cath	6.04	26.10	27.41	3.51	3.45	1.14	010
36563		A	Insert tunneled cv cath	6.24	29.87	29.29	3.82	3.59	1.36	010
36565		A	Insert tunneled cv cath	6.04	21.21	22.16	3.30	3.27	1.34	010
36566		A	Insert tunneled cv cath	6.54	137.55	122.33	3.63	3.52	1.31	010
36568		A	Insert picc cath	1.92	5.58	6.54	0.69	0.73	0.18	000
36569		A	Insert picc cath	1.82	4.75	5.51	0.69	0.76	0.18	000
36570		A	Insert picvad cath	5.36	23.21	26.86	2.83	3.10	0.51	010
36571		A	Insert picvad cath	5.34	29.61	30.79	3.27	3.19	1.06	010
36575		A	Repair tunneled cv cath	0.67	3.72	3.94	0.28	0.29	0.10	000
36576		A	Repair tunneled cv cath	3.24	6.95	7.18	2.01	2.02	0.58	010
36578		A	Replace tunneled cv cath	3.54	10.17	10.88	2.29	2.41	0.55	010
36580		A	Replace cvad cath	1.31	4.42	5.04	0.52	0.54	0.17	000
36581		A	Replace tunneled cv cath	3.48	16.91	18.37	1.88	2.06	0.45	010
36582		A	Replace tunneled cv cath	5.24	24.83	26.04	3.03	3.10	0.92	010
36583		A	Replace tunneled cv cath	5.29	31.74	29.50	3.61	3.38	1.19	010
36584		A	Replace picc cath	1.20	4.17	4.93	0.62	0.69	0.11	000
36585		A	Replace picvad cath	4.84	24.90	26.77	2.76	2.92	0.69	010
36589		A	Removal tunneled cv cath	2.28	2.21	2.30	1.50	1.54	0.38	010
36590		A	Removal tunneled cv cath	3.35	4.55	4.43	2.17	2.10	0.65	010
36591		T	Draw blood off venous device	0.00	0.59	0.66	NA	NA	0.01	XXX
36592		T	Collect blood from picc	0.00	0.67	0.73	NA	NA	0.01	XXX
36593		A	Declot vascular device	0.00	0.79	0.82	NA	NA	0.01	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
36595		A	Mech remov tunneled cv cath	3.59	11.42	13.19	1.45	1.63	0.41	000
36596		A	Mech remov tunneled cv cath	0.75	2.80	3.11	0.47	0.51	0.10	000
36597		A	Reposition venous catheter	1.21	2.11	2.35	0.46	0.52	0.11	000
36598		T	Inj w/fluor, eval cv device	0.74	2.21	2.48	0.26	0.65	0.07	000
36600		A	Withdrawal of arterial blood	0.32	0.51	0.55	0.11	0.10	0.03	XXX
36620		A	Insertion catheter, artery	1.15	NA	NA	0.28	0.24	0.10	000
36625		A	Insertion catheter, artery	2.11	NA	NA	0.70	0.69	0.44	000
36640		A	Insertion catheter, artery	2.10	NA	NA	1.38	1.27	0.44	000
36660		A	Insertion catheter, artery	1.40	NA	NA	0.67	0.52	0.35	000
36680		A	Insert needle, bone cavity	1.20	NA	NA	0.34	0.36	0.23	000
36800		A	Insertion of cannula	2.43	NA	NA	1.97	1.96	0.44	000
36810		A	Insertion of cannula	3.96	NA	NA	1.76	1.71	0.76	000
36815		A	Insertion of cannula	2.62	NA	NA	1.44	1.40	0.58	000
36818		A	Av fuse, uppr arm, cephalic	11.89	NA	NA	6.33	6.20	2.76	090
36819		A	Av fuse, uppr arm, basilic	14.47	NA	NA	7.21	7.00	3.38	090
36820		A	Av fusion/forearm vein	14.47	NA	NA	7.46	7.17	3.36	090
36821		A	Av fusion direct any site	12.11	NA	NA	6.76	6.37	2.81	090
36822		A	Insertion of cannula(s)	5.57	NA	NA	4.63	4.72	1.34	090
36823		A	Insertion of cannula(s)	22.98	NA	NA	12.27	11.75	5.20	090
36825		A	Artery-vein autograft	15.13	NA	NA	7.77	6.64	3.50	090
36830		A	Artery-vein nonautograft	12.03	NA	NA	5.79	5.64	2.81	090
36831		A	Open thrombect av fistula	8.04	NA	NA	4.42	4.30	1.87	090
36832		A	Av fistula revision, open	10.53	NA	NA	5.26	5.11	2.43	090
36833		A	Av fistula revision	11.98	NA	NA	5.82	5.65	2.80	090
36835		A	Artery to vein shunt	7.51	NA	NA	5.84	5.42	1.85	090
36838		A	Dist revas ligation, hemo	21.69	NA	NA	9.51	9.48	5.13	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
36860		A	External cannula declotting	2.01	3.69	3.64	1.02	0.92	0.27	000
36861		A	Cannula declotting	2.52	NA	NA	1.57	1.59	0.49	000
36870		A	Percut thrombect av fistula	5.20	44.72	48.60	2.98	3.26	0.71	090
37140		A	Revision of circulation	25.23	NA	NA	13.94	12.69	5.58	090
37145		A	Revision of circulation	26.24	NA	NA	14.28	13.48	5.93	090
37160		A	Revision of circulation	23.24	NA	NA	13.08	11.81	5.16	090
37180		A	Revision of circulation	26.24	NA	NA	14.37	12.88	5.82	090
37181		A	Splice spleen/kidney veins	28.37	NA	NA	15.29	13.88	6.27	090
37182		A	Insert hepatic shunt (tips)	16.97	NA	NA	5.96	7.07	1.68	000
37183		A	Remove hepatic shunt (tips)	7.99	145.78	145.78	2.83	3.41	0.76	000
37184		A	Prim art mech thrombectomy	8.66	53.20	59.90	3.47	3.83	1.57	000
37185		A	Prim art m-thrombect add-on	3.28	17.07	19.28	1.18	1.30	0.64	ZZZ
37186		A	Sec art m-thrombect add-on	4.92	33.73	39.87	1.80	2.07	0.99	ZZZ
37187		A	Venous mech thrombectomy	8.03	50.66	57.41	3.08	3.49	1.17	000
37188		A	Venous m-thrombectomy add-on	5.71	43.51	49.71	2.31	2.63	0.72	000
37195		C	Thrombolytic therapy, stroke	0.00	0.00	0.00	0.00	0.00	0.00	XXX
37200		A	Transcatheter biopsy	4.55	NA	NA	1.54	1.83	0.44	000
37201		A	Transcatheter therapy infuse	4.99	NA	NA	2.41	2.70	0.79	000
37202		A	Transcatheter therapy infuse	5.67	NA	NA	2.94	3.45	1.23	000
37203		A	Transcatheter retrieval	5.02	30.61	33.65	2.01	2.31	0.71	000
37204		A	Transcatheter occlusion	18.11	NA	NA	6.22	7.13	2.30	000
37205		A	Transcath iv stent, percut	8.27	106.19	116.33	3.01	3.58	1.62	000
37206		A	Transcath iv stent/perc addl	4.12	64.76	71.03	1.48	1.69	0.85	ZZZ
37207		A	Transcath iv stent, open	8.27	NA	NA	3.24	3.25	1.94	000
37208		A	Transcath iv stent/open addl	4.12	NA	NA	1.42	1.41	0.96	ZZZ
37209		A	Change iv cath at thromb tx	2.27	NA	NA	0.77	0.87	0.34	000

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37210		A	Embolization uterine fibroid	10.60	84.76	92.32	3.65	4.45	1.06	000
37215		R	Transcath stent, cca w/eps	19.68	NA	NA	8.88	10.37	4.35	090
37216		N	Transcath stent, cca w/o eps	18.95	NA	NA	9.92	9.85	1.38	090
37250		A	Iv us first vessel add-on	2.10	NA	NA	0.74	0.84	0.47	ZZZ
37251		A	Iv us each add vessel add-on	1.60	NA	NA	0.54	0.58	0.37	ZZZ
37500		A	Endoscopy ligate perf veins	11.67	NA	NA	7.08	7.07	2.73	090
37501		C	Vascular endoscopy procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
37565		A	Ligation of neck vein	12.05	NA	NA	7.65	7.11	2.67	090
37600		A	Ligation of neck artery	12.42	NA	NA	7.08	6.81	2.64	090
37605		A	Ligation of neck artery	14.28	NA	NA	7.47	7.28	3.52	090
37606		A	Ligation of neck artery	8.81	NA	NA	4.41	4.87	1.95	090
37607		A	Ligation of a-v fistula	6.25	NA	NA	4.08	3.98	1.43	090
37609		A	Temporal artery procedure	3.05	5.54	5.34	2.64	2.46	0.66	010
37615		A	Ligation of neck artery	7.80	NA	NA	6.81	5.94	1.71	090
37616		A	Ligation of chest artery	18.97	NA	NA	10.21	10.10	4.21	090
37617		A	Ligation of abdomen artery	23.79	NA	NA	11.64	10.93	5.21	090
37618		A	Ligation of extremity artery	6.03	NA	NA	4.48	4.34	1.37	090
37620		A	Revision of major vein	11.57	NA	NA	5.81	6.38	1.77	090
37650		A	Revision of major vein	8.49	NA	NA	4.16	4.73	1.95	090
37660		A	Revision of major vein	22.28	NA	NA	12.06	10.94	4.93	090
37700		A	Revise leg vein	3.82	NA	NA	3.13	3.08	0.88	090
37718		A	Ligate/strip short leg vein	7.13	NA	NA	4.82	4.68	1.62	090
37722		A	Ligate/strip long leg vein	8.16	NA	NA	5.09	4.93	1.88	090
37735		A	Removal of leg veins/lesion	10.90	NA	NA	6.12	6.06	2.49	090
37760		A	Ligate leg veins radical	10.78	NA	NA	7.35	6.61	2.37	090
37761		A	Ligate leg veins open	9.13	NA	NA	6.14	6.14	2.03	090

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37765		A	Phleb veins - extrem - to 20	7.71	10.42	7.61	NA	NA	1.62	090
37766		A	Phleb veins - extrem 20+	9.66	11.80	8.66	NA	NA	2.09	090
37780		A	Revision of leg vein	3.93	NA	NA	3.23	3.19	0.89	090
37785		A	Ligate/divide/excise vein	3.93	5.90	5.94	3.24	3.20	0.89	090
37788		A	Revascularization, penis	23.33	NA	NA	12.62	13.48	5.17	090
37790		A	Penile venous occlusion	8.43	NA	NA	5.00	5.22	0.85	090
37799		C	Vascular surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38100		A	Removal of spleen, total	19.55	NA	NA	10.62	9.49	4.24	090
38101		A	Removal of spleen, partial	19.55	NA	NA	10.89	9.67	4.32	090
38102		A	Removal of spleen, total	4.79	NA	NA	2.05	1.88	1.03	ZZZ
38115		A	Repair of ruptured spleen	21.88	NA	NA	11.65	10.41	4.45	090
38120		A	Laparoscopy, splenectomy	17.07	NA	NA	10.56	9.63	3.74	090
38129		C	Laparoscope proc, spleen	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38200		A	Injection for spleen x-ray	2.64	NA	NA	1.14	1.16	0.65	000
38204		B	Bl donor search management	2.00	NA	NA	0.86	0.84	0.14	XXX
38205		R	Harvest allogenic stem cells	1.50	NA	NA	0.78	0.75	0.08	000
38206		R	Harvest auto stem cells	1.50	NA	NA	0.78	0.75	0.11	000
38207		I	Cryopreserve stem cells	0.89	NA	NA	0.38	0.46	0.06	XXX
38208		I	Thaw preserved stem cells	0.56	NA	NA	0.24	0.29	0.04	XXX
38209		I	Wash harvest stem cells	0.24	NA	NA	0.10	0.12	0.01	XXX
38210		I	T-cell depletion of harvest	1.57	NA	NA	0.68	0.81	0.10	XXX
38211		I	Tumor cell deplete of harvst	1.42	NA	NA	0.61	0.73	0.10	XXX
38212		I	Rbc depletion of harvest	0.94	NA	NA	0.41	0.49	0.06	XXX
38213		I	Platelet deplete of harvest	0.24	NA	NA	0.10	0.12	0.01	XXX
38214		I	Volume deplete of harvest	0.81	NA	NA	0.35	0.42	0.06	XXX
38215		I	Harvest stem cell concentrte	0.94	NA	NA	0.41	0.49	0.06	XXX

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38220		A	Bone marrow aspiration	1.08	2.85	3.20	0.61	0.61	0.11	XXX
38221		A	Bone marrow biopsy	1.37	2.87	3.29	0.77	0.76	0.08	XXX
38230		R	Bone marrow collection	4.85	NA	NA	4.34	4.07	1.14	010
38240		R	Bone marrow/stem transplant	2.24	NA	NA	1.31	1.27	0.17	XXX
38241		R	Bone marrow/stem transplant	2.24	NA	NA	1.30	1.27	0.14	XXX
38242		A	Lymphocyte infuse transplant	1.71	NA	NA	1.03	0.98	0.10	000
38300		A	Drainage, lymph node lesion	2.36	5.20	5.16	2.66	2.57	0.42	010
38305		A	Drainage, lymph node lesion	6.68	NA	NA	5.61	5.38	1.38	090
38308		A	Incision of lymph channels	6.81	NA	NA	5.09	4.75	1.51	090
38380		A	Thoracic duct procedure	8.46	NA	NA	7.87	7.13	1.13	090
38381		A	Thoracic duct procedure	13.38	NA	NA	7.51	7.64	3.26	090
38382		A	Thoracic duct procedure	10.65	NA	NA	6.92	6.81	2.35	090
38500		A	Biopsy/removal, lymph nodes	3.79	5.05	4.78	2.92	2.72	0.81	010
38505		A	Needle biopsy, lymph nodes	1.14	2.23	2.38	0.80	0.86	0.13	000
38510		A	Biopsy/removal, lymph nodes	6.74	7.45	7.03	4.70	4.33	1.26	010
38520		A	Biopsy/removal, lymph nodes	7.03	NA	NA	5.42	5.08	1.47	090
38525		A	Biopsy/removal, lymph nodes	6.43	NA	NA	5.03	4.62	1.41	090
38530		A	Biopsy/removal, lymph nodes	8.34	NA	NA	6.17	5.69	1.89	090
38542		A	Explore deep node(s), neck	7.95	NA	NA	6.37	5.89	1.38	090
38550		A	Removal, neck/armpit lesion	7.11	NA	NA	6.27	5.69	1.58	090
38555		A	Removal, neck/armpit lesion	15.59	NA	NA	10.89	10.24	3.48	090
38562		A	Removal, pelvic lymph nodes	11.06	NA	NA	7.51	7.32	2.03	090
38564		A	Removal, abdomen lymph nodes	11.38	NA	NA	7.23	6.82	2.33	090
38570		A	Laparoscopy, lymph node biop	9.34	NA	NA	5.08	5.09	1.43	010
38571		A	Laparoscopy, lymphadenectomy	14.76	NA	NA	7.03	7.71	1.54	010
38572		A	Laparoscopy, lymphadenectomy	16.94	NA	NA	8.70	8.26	2.49	010

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38589		C	Laparoscope proc, lymphatic	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38700		A	Removal of lymph nodes, neck	12.81	NA	NA	9.92	8.97	1.84	090
38720		A	Removal of lymph nodes, neck	21.95	NA	NA	15.57	14.02	3.52	090
38724		A	Removal of lymph nodes, neck	23.95	NA	NA	17.22	15.28	3.48	090
38740		A	Remove armpit lymph nodes	10.70	NA	NA	7.42	6.80	2.35	090
38745		A	Remove armpit lymph nodes	13.87	NA	NA	9.09	8.29	3.07	090
38746		A	Remove thoracic lymph nodes	4.88	NA	NA	1.77	1.83	1.19	ZZZ
38747		A	Remove abdominal lymph nodes	4.88	NA	NA	2.07	1.90	1.07	ZZZ
38760		A	Remove groin lymph nodes	13.62	NA	NA	8.58	8.01	2.90	090
38765		A	Remove groin lymph nodes	21.91	NA	NA	12.14	11.42	4.39	090
38770		A	Remove pelvis lymph nodes	14.06	NA	NA	7.77	7.97	1.84	090
38780		A	Remove abdomen lymph nodes	17.70	NA	NA	10.09	10.17	2.66	090
38790		A	Inject for lymphatic x-ray	1.29	NA	NA	0.94	0.93	0.25	000
38792		A	Identify sentinel node	0.52	NA	NA	0.57	0.58	0.08	000
38794		A	Access thoracic lymph duct	4.62	NA	NA	3.22	3.65	0.44	090
38999		C	Blood/lymph system procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
39000		A	Exploration of chest	7.57	NA	NA	5.67	5.58	1.74	090
39010		A	Exploration of chest	13.19	NA	NA	7.47	7.73	3.25	090
39200		A	Removal chest lesion	15.09	NA	NA	7.80	7.98	3.67	090
39220		A	Removal chest lesion	19.55	NA	NA	10.27	10.39	4.61	090
39400		A	Visualization of chest	8.05	NA	NA	5.23	5.30	1.95	010
39499		C	Chest procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
39501		A	Repair diaphragm laceration	13.98	NA	NA	8.32	7.88	3.07	090
39502		A	Repair paraesophageal hernia	17.18	NA	NA	9.98	9.17	3.82	090
39503		A	Repair of diaphragm hernia	108.91	NA	NA	51.39	45.17	24.12	090
39520		A	Repair of diaphragm hernia	16.74	NA	NA	9.50	9.17	3.84	090

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39530		A	Repair of diaphragm hernia	16.30	NA	NA	9.03	8.58	3.74	090
39531		A	Repair of diaphragm hernia	17.31	NA	NA	10.09	9.11	3.84	090
39540		A	Repair of diaphragm hernia	14.57	NA	NA	8.64	7.93	3.24	090
39541		A	Repair of diaphragm hernia	15.75	NA	NA	9.08	8.43	3.53	090
39545		A	Revision of diaphragm	14.67	NA	NA	8.61	8.68	3.55	090
39560		A	Resect diaphragm, simple	13.06	NA	NA	7.72	7.41	2.90	090
39561		A	Resect diaphragm, complex	19.99	NA	NA	12.81	12.20	4.55	090
39599		C	Diaphragm surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
4004F		I	Pt tobacco use done rcvd tlk	0.00	0.00	0.00	0.00	0.00	0.00	XXX
40490		A	Biopsy of lip	1.22	2.34	2.35	0.87	0.81	0.18	000
40500		A	Partial excision of lip	4.47	9.80	9.47	5.85	5.55	0.69	090
40510		A	Partial excision of lip	4.82	8.81	8.46	5.28	4.93	0.73	090
40520		A	Partial excision of lip	4.79	9.01	8.77	5.37	5.04	0.78	090
40525		A	Reconstruct lip with flap	7.72	NA	NA	7.81	7.38	1.31	090
40527		A	Reconstruct lip with flap	9.32	NA	NA	8.43	8.19	1.24	090
40530		A	Partial removal of lip	5.54	9.66	9.39	5.89	5.57	0.89	090
4063F		I	Antidepres rxthxpy not rxd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
40650		A	Repair lip	3.78	7.80	7.60	4.20	4.03	0.68	090
40652		A	Repair lip	4.43	9.07	8.87	5.40	5.14	0.79	090
40654		A	Repair lip	5.48	10.39	10.14	6.41	6.10	0.96	090
40700		A	Repair cleft lip/nasal	14.17	NA	NA	14.13	12.32	1.89	090
40701		A	Repair cleft lip/nasal	17.23	NA	NA	13.54	13.27	2.29	090
40702		A	Repair cleft lip/nasal	14.27	NA	NA	8.96	9.01	1.06	090
40720		A	Repair cleft lip/nasal	14.72	NA	NA	11.81	11.33	3.02	090
40761		A	Repair cleft lip/nasal	15.84	NA	NA	14.67	13.27	3.25	090
40799		C	Lip surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY

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40800		A	Drainage of mouth lesion	1.23	4.68	4.51	2.48	2.36	0.18	010
40801		A	Drainage of mouth lesion	2.63	6.25	5.96	3.68	3.45	0.38	010
40804		A	Removal, foreign body, mouth	1.30	4.89	4.64	2.53	2.37	0.17	010
40805		A	Removal, foreign body, mouth	2.79	6.38	6.14	3.63	3.44	0.37	010
40806		A	Incision of lip fold	0.31	2.66	2.68	0.51	0.56	0.04	000
40808		A	Biopsy of mouth lesion	1.01	4.30	4.16	2.09	2.01	0.13	010
40810		A	Excision of mouth lesion	1.36	4.52	4.34	2.30	2.18	0.18	010
40812		A	Excise/repair mouth lesion	2.37	5.78	5.51	3.27	3.05	0.32	010
40814		A	Excise/repair mouth lesion	3.52	7.42	7.02	5.20	4.88	0.49	090
40816		A	Excision of mouth lesion	3.77	7.69	7.31	5.30	4.99	0.54	090
40818		A	Excise oral mucosa for graft	2.83	7.15	7.00	4.81	4.73	0.38	090
40819		A	Excise lip or cheek fold	2.51	6.18	5.92	4.19	3.97	0.34	090
40820		A	Treatment of mouth lesion	1.34	6.16	6.09	3.56	3.50	0.18	010
40830		A	Repair mouth laceration	1.82	5.16	4.96	2.65	2.54	0.32	010
40831		A	Repair mouth laceration	2.57	6.78	6.45	3.69	3.55	0.44	010
40840		R	Reconstruction of mouth	9.15	15.44	13.84	9.74	8.57	1.23	090
40842		R	Reconstruction of mouth	9.15	13.83	12.84	9.27	8.14	1.23	090
40843		R	Reconstruction of mouth	12.79	16.79	15.62	9.80	8.90	2.61	090
40844		R	Reconstruction of mouth	16.80	21.94	20.60	15.76	14.12	3.45	090
40845		R	Reconstruction of mouth	19.36	22.03	20.88	15.51	14.48	2.57	090
40899		C	Mouth surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
41000		A	Drainage of mouth lesion	1.35	3.24	3.11	1.84	1.74	0.18	010
41005		A	Drainage of mouth lesion	1.31	4.99	4.96	2.36	2.26	0.17	010
41006		A	Drainage of mouth lesion	3.34	6.94	6.62	4.25	3.89	0.44	090
41007		A	Drainage of mouth lesion	3.20	6.94	6.74	3.87	3.69	0.42	090
41008		A	Drainage of mouth lesion	3.46	7.23	6.83	4.23	3.93	0.45	090

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41009		A	Drainage of mouth lesion	3.71	7.67	7.24	4.64	4.32	0.49	090
41010		A	Incision of tongue fold	1.11	4.77	4.66	2.04	1.97	0.14	010
41015		A	Drainage of mouth lesion	4.08	8.63	7.94	5.82	5.34	0.54	090
41016		A	Drainage of mouth lesion	4.19	8.25	7.81	5.82	5.43	0.55	090
41017		A	Drainage of mouth lesion	4.19	8.38	7.93	5.86	5.48	0.55	090
41018		A	Drainage of mouth lesion	5.22	8.79	8.39	6.18	5.84	0.69	090
41019		A	Place needles h&n for rt	8.84	NA	NA	4.78	4.52	0.75	000
41100		A	Biopsy of tongue	1.42	3.37	3.26	1.67	1.59	0.21	010
41105		A	Biopsy of tongue	1.47	3.40	3.25	1.73	1.62	0.21	010
41108		A	Biopsy of floor of mouth	1.10	3.13	3.01	1.50	1.41	0.14	010
41110		A	Excision of tongue lesion	1.56	4.53	4.35	2.23	2.11	0.23	010
41112		A	Excision of tongue lesion	2.83	6.70	6.40	4.43	4.18	0.38	090
41113		A	Excision of tongue lesion	3.29	7.10	6.76	4.74	4.44	0.44	090
41114		A	Excision of tongue lesion	8.82	NA	NA	9.43	8.74	1.22	090
41115		A	Excision of tongue fold	1.79	5.17	5.01	2.56	2.37	0.24	010
41116		A	Excision of mouth lesion	2.52	6.93	6.61	3.80	3.59	0.35	090
41120		A	Partial removal of tongue	11.14	NA	NA	18.83	18.25	1.54	090
41130		A	Partial removal of tongue	15.74	NA	NA	21.48	20.42	2.16	090
41135		A	Tongue and neck surgery	30.14	NA	NA	31.21	29.21	4.20	090
41140		A	Removal of tongue	29.15	NA	NA	33.27	31.63	3.90	090
41145		A	Tongue removal, neck surgery	37.93	NA	NA	41.01	38.48	5.06	090
41150		A	Tongue, mouth, jaw surgery	29.86	NA	NA	32.33	30.53	4.11	090
41153		A	Tongue, mouth, neck surgery	33.59	NA	NA	34.21	31.96	4.58	090
41155		A	Tongue, jaw, & neck surgery	44.30	NA	NA	40.59	37.26	6.15	090
41250		A	Repair tongue laceration	1.96	5.08	4.63	2.20	1.99	0.34	010
41251		A	Repair tongue laceration	2.32	5.28	4.62	2.45	2.23	0.31	010

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41252		A	Repair tongue laceration	3.02	5.84	5.51	2.93	2.75	0.49	010
41500		A	Fixation of tongue	3.80	NA	NA	9.19	8.89	0.51	090
41510		A	Tongue to lip surgery	3.51	NA	NA	6.44	7.17	0.45	090
41512		A	Tongue suspension	6.86	NA	NA	11.44	10.82	0.51	090
41520		A	Reconstruction, tongue fold	2.83	7.12	6.83	4.50	4.26	0.37	090
41530		A	Tongue base vol reduction	4.51	88.45	88.27	7.42	7.07	0.32	010
41599		C	Tongue and mouth surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
41800		A	Drainage of gum lesion	1.27	6.03	5.55	2.73	2.51	0.23	010
41805		A	Removal foreign body, gum	1.34	5.60	5.39	3.50	3.36	0.18	010
41806		A	Removal foreign body,jawbone	2.79	7.54	6.97	4.71	4.36	0.57	010
41820		R	Excision, gum, each quadrant	0.00	0.00	0.00	0.00	0.00	0.00	000
41821		R	Excision of gum flap	0.00	0.00	0.00	0.00	0.00	0.00	000
41822		R	Excision of gum lesion	2.41	5.80	5.55	2.83	2.51	0.32	010
41823		R	Excision of gum lesion	3.77	8.33	8.02	5.48	5.12	0.49	090
41825		A	Excision of gum lesion	1.41	4.54	4.39	2.07	2.05	0.21	010
41826		A	Excision of gum lesion	2.41	6.44	5.90	3.65	3.33	0.32	010
41827		A	Excision of gum lesion	3.83	8.59	8.15	4.97	4.61	0.51	090
41828		R	Excision of gum lesion	3.14	5.54	5.18	2.98	2.71	0.41	010
41830		R	Removal of gum tissue	3.45	7.65	7.25	4.66	4.29	0.45	010
41850		R	Treatment of gum lesion	0.00	0.00	0.00	0.00	0.00	0.00	000
41870		R	Gum graft	0.00	0.00	0.00	0.00	0.00	0.00	000
41872		R	Repair gum	3.01	7.24	7.04	4.43	4.23	0.62	090
41874		R	Repair tooth socket	3.19	7.35	6.98	4.11	3.80	0.41	090
41899		C	Dental surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
42000		A	Drainage mouth roof lesion	1.28	3.17	3.09	1.71	1.60	0.17	010
42100		A	Biopsy roof of mouth	1.36	2.92	2.80	1.78	1.67	0.18	010

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42104		A	Excision lesion, mouth roof	1.69	4.48	4.23	2.32	2.15	0.24	010
42106		A	Excision lesion, mouth roof	2.15	5.60	5.30	2.95	2.80	0.30	010
42107		A	Excision lesion, mouth roof	4.56	8.56	8.13	5.35	4.99	0.61	090
42120		A	Remove palate/lesion	11.86	NA	NA	16.62	15.67	1.62	090
42140		A	Excision of uvula	1.70	5.62	5.42	2.79	2.67	0.24	090
42145		A	Repair palate, pharynx/uvula	9.78	NA	NA	10.51	9.81	1.30	090
42160		A	Treatment mouth roof lesion	1.85	4.81	4.77	2.38	2.32	0.25	010
42180		A	Repair palate	2.55	3.90	3.93	2.33	2.35	0.34	010
42182		A	Repair palate	3.87	5.36	5.11	3.52	3.34	0.51	010
42200		A	Reconstruct cleft palate	12.53	NA	NA	11.95	11.44	1.67	090
42205		A	Reconstruct cleft palate	13.66	NA	NA	14.21	12.64	1.84	090
42210		A	Reconstruct cleft palate	15.03	NA	NA	13.41	13.03	3.08	090
42215		A	Reconstruct cleft palate	8.99	NA	NA	11.31	10.41	1.85	090
42220		A	Reconstruct cleft palate	7.16	NA	NA	8.15	7.78	0.52	090
42225		A	Reconstruct cleft palate	9.77	NA	NA	15.53	15.80	1.30	090
42226		A	Lengthening of palate	10.35	NA	NA	15.38	15.22	1.37	090
42227		A	Lengthening of palate	9.90	NA	NA	14.23	14.52	1.31	090
42235		A	Repair palate	8.01	NA	NA	13.14	12.71	1.07	090
42260		A	Repair nose to lip fistula	10.22	13.14	12.46	8.77	8.18	1.36	090
42280		A	Preparation, palate mold	1.59	3.02	2.81	1.55	1.34	0.35	010
42281		A	Insertion, palate prosthesis	1.98	3.92	3.71	2.37	2.24	0.27	010
42299		C	Palate/uvula surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
42300		A	Drainage of salivary gland	1.98	4.03	3.84	2.41	2.27	0.28	010
42305		A	Drainage of salivary gland	6.31	NA	NA	5.94	5.57	0.89	090
42310		A	Drainage of salivary gland	1.61	3.05	2.91	1.98	1.87	0.23	010
42320		A	Drainage of salivary gland	2.40	4.81	4.58	2.67	2.52	0.32	010

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42330		A	Removal of salivary stone	2.26	4.40	4.21	2.48	2.32	0.31	010
42335		A	Removal of salivary stone	3.41	7.36	7.02	4.02	3.80	0.44	090
42340		A	Removal of salivary stone	4.72	8.58	8.20	4.95	4.67	0.64	090
42400		A	Biopsy of salivary gland	0.78	2.26	2.26	0.80	0.80	0.08	000
42405		A	Biopsy of salivary gland	3.34	5.13	4.98	3.09	2.92	0.44	010
42408		A	Excision of salivary cyst	4.66	8.46	8.02	4.81	4.46	0.62	090
42409		A	Drainage of salivary cyst	2.91	6.72	6.41	3.51	3.32	0.38	090
42410		A	Excise parotid gland/lesion	9.57	NA	NA	8.01	7.45	1.50	090
42415		A	Excise parotid gland/lesion	18.12	NA	NA	13.51	12.49	2.52	090
42420		A	Excise parotid gland/lesion	21.00	NA	NA	15.19	14.01	2.94	090
42425		A	Excise parotid gland/lesion	13.42	NA	NA	10.40	9.70	1.91	090
42426		A	Excise parotid gland/lesion	22.66	NA	NA	15.78	14.61	3.24	090
42440		A	Excise submaxillary gland	7.13	NA	NA	6.21	5.77	0.99	090
42450		A	Excise sublingual gland	4.74	8.22	7.86	5.56	5.25	0.66	090
42500		A	Repair salivary duct	4.42	7.99	7.63	5.40	5.11	0.62	090
42505		A	Repair salivary duct	6.32	9.59	9.14	6.70	6.31	0.83	090
42507		A	Parotid duct diversion	6.25	NA	NA	8.55	8.17	0.83	090
42508		A	Parotid duct diversion	9.33	NA	NA	10.54	10.39	1.24	090
42509		A	Parotid duct diversion	11.76	NA	NA	9.97	10.28	2.39	090
42510		A	Parotid duct diversion	8.35	NA	NA	9.76	9.24	1.12	090
42550		A	Injection for salivary x-ray	1.25	2.30	2.67	0.44	0.50	0.11	000
42600		A	Closure of salivary fistula	4.94	8.88	8.55	5.10	4.85	0.66	090
4260F		I	Wound srfc culturetech used	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4261F		I	Tech other than surfc cultr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42650		A	Dilation of salivary duct	0.77	1.64	1.56	0.92	0.87	0.10	000
4265F		I	Wet-dry dressings Rx-recmd	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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42660		A	Dilation of salivary duct	1.13	1.92	1.83	1.11	1.04	0.14	000
42665		A	Ligation of salivary duct	2.63	6.44	6.14	3.35	3.18	0.35	090
4266F		I	No wet-dry drssings Rx-recmd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4268F		I	Pt ed re comp thxpy rcvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42699		C	Salivary surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
4269F		I	Appropos mthd offloading Rxd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42700		A	Drainage of tonsil abscess	1.67	3.75	3.61	2.22	2.12	0.24	010
42720		A	Drainage of throat abscess	6.31	6.70	6.28	4.94	4.56	0.86	010
42725		A	Drainage of throat abscess	12.41	NA	NA	10.80	10.03	1.65	090
4275F		I	Hep b vac inj admin/ rcvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4279F		I	PCP prophylaxis Rxd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42800		A	Biopsy of throat	1.44	3.13	3.00	1.79	1.70	0.21	010
42802		A	Biopsy of throat	1.59	5.08	5.11	2.24	2.19	0.23	010
42804		A	Biopsy of upper nose/throat	1.29	4.40	4.37	1.99	1.94	0.17	010
42806		A	Biopsy of upper nose/throat	1.63	4.74	4.70	2.18	2.12	0.23	010
42808		A	Excise pharynx lesion	2.35	4.20	4.02	2.32	2.20	0.31	010
42809		A	Remove pharynx foreign body	1.86	2.97	2.85	1.86	1.73	0.28	010
42810		A	Excision of neck cyst	3.38	7.84	7.54	4.99	4.70	0.44	090
42815		A	Excision of neck cyst	7.31	NA	NA	8.64	8.16	1.05	090
42820		A	Remove tonsils and adenoids	4.22	NA	NA	4.14	3.88	0.55	090
42821		A	Remove tonsils and adenoids	4.36	NA	NA	4.33	4.08	0.58	090
42825		A	Removal of tonsils	3.51	NA	NA	4.04	3.83	0.45	090
42826		A	Removal of tonsils	3.45	NA	NA	3.79	3.59	0.45	090
42830		A	Removal of adenoids	2.65	NA	NA	3.33	3.16	0.35	090
42831		A	Removal of adenoids	2.81	NA	NA	3.64	3.47	0.37	090
42835		A	Removal of adenoids	2.38	NA	NA	2.54	2.61	0.31	090

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42836		A	Removal of adenoids	3.26	NA	NA	3.68	3.50	0.42	090
42842		A	Extensive surgery of throat	12.23	NA	NA	16.39	15.35	1.64	090
42844		A	Extensive surgery of throat	17.78	NA	NA	21.50	20.33	2.36	090
42845		A	Extensive surgery of throat	32.56	NA	NA	31.09	28.97	4.34	090
42860		A	Excision of tonsil tags	2.30	NA	NA	3.13	2.98	0.31	090
42870		A	Excision of lingual tonsil	5.52	NA	NA	11.16	10.80	0.73	090
42890		A	Partial removal of pharynx	19.13	NA	NA	21.40	19.86	2.61	090
42892		A	Revision of pharyngeal walls	26.03	NA	NA	27.69	25.32	3.55	090
42894		A	Revision of pharyngeal walls	33.92	NA	NA	33.77	31.13	4.59	090
42900		A	Repair throat wound	5.29	NA	NA	4.46	4.16	0.71	010
42950		A	Reconstruction of throat	8.27	NA	NA	14.41	14.01	1.19	090
42953		A	Repair throat, esophagus	9.45	NA	NA	17.80	17.69	1.36	090
42955		A	Surgical opening of throat	8.01	NA	NA	13.64	13.03	1.07	090
42960		A	Control throat bleeding	2.38	NA	NA	2.48	2.33	0.32	010
42961		A	Control throat bleeding	5.77	NA	NA	6.33	5.97	0.76	090
42962		A	Control throat bleeding	7.40	NA	NA	7.48	7.05	0.99	090
42970		A	Control nose/throat bleeding	5.82	NA	NA	5.43	5.02	0.88	090
42971		A	Control nose/throat bleeding	6.60	NA	NA	6.58	6.14	0.88	090
42972		A	Control nose/throat bleeding	7.59	NA	NA	7.15	6.65	1.02	090
42999		C	Throat surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
4300F		I	Pt rcvng warf thxpy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4301F		I	Pt not rcvng warf thxpy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43020		A	Incision of esophagus	8.23	NA	NA	7.29	6.47	1.10	090
43030		A	Throat muscle surgery	7.99	NA	NA	6.73	6.32	1.22	090
43045		A	Incision of esophagus	21.88	NA	NA	11.98	12.15	5.31	090
4305F		I	Pt ed re ft care inspct rcvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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4306F		I	Pt tlk psych & Rx opd addic	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43100		A	Excision of esophagus lesion	9.66	NA	NA	8.37	7.63	1.29	090
43101		A	Excision of esophagus lesion	17.07	NA	NA	9.09	9.22	4.15	090
43107		A	Removal of esophagus	44.18	NA	NA	22.36	21.75	10.24	090
43108		A	Removal of esophagus	82.87	NA	NA	39.73	34.35	18.34	090
43112		A	Removal of esophagus	47.48	NA	NA	22.24	22.16	11.18	090
43113		A	Removal of esophagus	80.06	NA	NA	39.87	35.93	17.73	090
43116		A	Partial removal of esophagus	92.99	NA	NA	57.11	46.42	12.39	090
43117		A	Partial removal of esophagus	43.65	NA	NA	20.54	20.25	10.24	090
43118		A	Partial removal of esophagus	67.07	NA	NA	32.93	28.81	14.85	090
43121		A	Partial removal of esophagus	51.43	NA	NA	22.70	22.03	12.49	090
43122		A	Partial removal of esophagus	44.18	NA	NA	22.33	21.22	10.00	090
43123		A	Partial removal of esophagus	83.12	NA	NA	41.19	35.25	18.38	090
43124		A	Removal of esophagus	69.09	NA	NA	36.00	31.69	16.80	090
43130		A	Removal of esophagus pouch	12.53	NA	NA	9.43	8.89	2.06	090
43135		A	Removal of esophagus pouch	26.17	NA	NA	12.98	12.44	6.20	090
43200		A	Esophagus endoscopy	1.59	4.43	4.49	1.35	1.29	0.24	000
43201		A	Esoph scope w/submucous inj	2.09	6.06	6.22	1.46	1.45	0.31	000
43202		A	Esophagus endoscopy, biopsy	1.89	5.91	6.07	1.30	1.25	0.30	000
43204		A	Esoph scope w/sclerosis inj	3.76	NA	NA	2.23	2.28	0.61	000
43205		A	Esophagus endoscopy/ligation	3.78	NA	NA	2.35	2.35	0.58	000
4320F		I	Pt talk psychsoc+rx oh dpnd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43215		A	Esophagus endoscopy	2.60	NA	NA	1.64	1.60	0.42	000
43216		A	Esophagus endoscopy/lesion	2.40	3.57	3.31	1.56	1.52	0.37	000
43217		A	Esophagus endoscopy	2.90	7.48	7.66	1.77	1.71	0.51	000
43219		A	Esophagus endoscopy	2.80	NA	NA	1.83	1.84	0.49	000

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
43220		A	Esoph endoscopy, dilation	2.10	NA	NA	1.42	1.38	0.32	000
43226		A	Esoph endoscopy, dilation	2.34	NA	NA	1.52	1.51	0.38	000
43227		A	Esoph endoscopy, repair	3.59	NA	NA	2.18	2.14	0.57	000
43228		A	Esoph endoscopy, ablation	3.76	NA	NA	2.33	2.31	0.61	000
43231		A	Esoph endoscopy w/us exam	3.19	NA	NA	2.02	2.02	0.49	000
43232		A	Esoph endoscopy w/us fn bx	4.47	NA	NA	2.68	2.67	0.72	000
43234		A	Upper GI endoscopy, exam	2.01	5.65	5.83	1.30	1.25	0.35	000
43235		A	Uppr gi endoscopy, diagnosis	2.39	5.59	5.90	1.58	1.57	0.38	000
43236		A	Uppr gi scope w/submuc inj	2.92	6.96	7.39	1.88	1.89	0.44	000
43237		A	Endoscopic us exam, esoph	3.98	NA	NA	2.44	2.46	0.62	000
43238		A	Uppr gi endoscopy w/us fn bx	5.02	NA	NA	2.98	3.01	0.78	000
43239		A	Upper GI endoscopy, biopsy	2.87	6.43	6.75	1.84	1.82	0.44	000
43240		A	Esoph endoscope w/drain cyst	6.85	NA	NA	3.99	3.97	1.07	000
43241		A	Upper GI endoscopy with tube	2.59	NA	NA	1.68	1.66	0.41	000
43242		A	Uppr gi endoscopy w/us fn bx	7.30	NA	NA	4.28	4.28	1.12	000
43243		A	Upper gi endoscopy & inject	4.56	NA	NA	2.75	2.75	0.71	000
43244		A	Upper GI endoscopy/ligation	5.04	NA	NA	3.05	3.05	0.76	000
43245		A	Uppr gi scope dilate strictr	3.18	NA	NA	1.96	1.93	0.52	000
43246		A	Place gastrostomy tube	4.32	NA	NA	2.53	2.51	0.72	000
43247		A	Operative upper GI endoscopy	3.38	NA	NA	2.10	2.09	0.54	000
43248		A	Uppr gi endoscopy/guide wire	3.15	NA	NA	2.02	2.03	0.47	000
43249		A	Esoph endoscopy, dilation	2.90	NA	NA	1.87	1.87	0.44	000
43250		A	Upper GI endoscopy/tumor	3.20	NA	NA	1.96	1.92	0.54	000
43251		A	Operative upper GI endoscopy	3.69	NA	NA	2.28	2.26	0.58	000
43255		A	Operative upper GI endoscopy	4.81	NA	NA	2.92	2.92	0.73	000
43256		A	Uppr gi endoscopy w/stent	4.34	NA	NA	2.59	2.59	0.71	000

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
43257		A	Uppr gi scope w/thrml txmnt	5.50	NA	NA	3.39	3.20	0.83	000
43258		A	Operative upper GI endoscopy	4.54	NA	NA	2.75	2.75	0.71	000
43259		A	Endoscopic ultrasound exam	5.19	NA	NA	3.13	3.13	0.78	000
43260		A	Endo cholangiopancreatograph	5.95	NA	NA	3.53	3.54	0.90	000
43261		A	Endo cholangiopancreatograph	6.26	NA	NA	3.71	3.72	0.95	000
43262		A	Endo cholangiopancreatograph	7.38	NA	NA	4.32	4.33	1.13	000
43263		A	Endo cholangiopancreatograph	7.28	NA	NA	4.19	4.25	1.12	000
43264		A	Endo cholangiopancreatograph	8.89	NA	NA	5.14	5.15	1.36	000
43265		A	Endo cholangiopancreatograph	10.00	NA	NA	5.74	5.75	1.54	000
43267		A	Endo cholangiopancreatograph	7.38	NA	NA	4.27	4.27	1.13	000
43268		A	Endo cholangiopancreatograph	7.38	NA	NA	4.48	4.49	1.13	000
43269		A	Endo cholangiopancreatograph	8.20	NA	NA	4.76	4.77	1.26	000
43271		A	Endo cholangiopancreatograph	7.38	NA	NA	4.31	4.32	1.13	000
43272		A	Endo cholangiopancreatograph	7.38	NA	NA	4.35	4.33	1.13	000
43273		A	Endoscopic pancreatoscopy	2.24	NA	NA	1.22	1.26	0.34	ZZZ
43279		A	Lap myotomy, heller	22.10	NA	NA	11.86	10.80	4.89	090
43280		A	Laparoscopy, fundoplasty	18.10	NA	NA	10.27	9.38	4.00	090
43281		A	Lap paraesophag hern repair	26.60	NA	NA	13.93	13.93	5.88	090
43282		A	Lap paraesoph her rpr w/mesh	30.10	NA	NA	15.42	15.42	6.63	090
43289		C	Laparoscope proc, esoph	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43300		A	Repair of esophagus	9.33	NA	NA	8.37	7.69	1.24	090
43305		A	Repair esophagus and fistula	18.10	NA	NA	13.27	12.19	2.40	090
4330F		I	Cnslng epi spec sfty issues	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43310		A	Repair of esophagus	26.26	NA	NA	12.22	12.57	6.37	090
43312		A	Repair esophagus and fistula	29.25	NA	NA	12.09	12.96	7.12	090
43313		A	Esophagoplasty congenital	48.45	NA	NA	25.63	23.21	11.78	090

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43314		A	Tracheo-esophagoplasty cong	53.43	NA	NA	22.75	24.38	7.14	090
43320		A	Fuse esophagus & stomach	23.31	NA	NA	13.19	12.35	5.17	090
43324		A	Revise esophagus & stomach	22.99	NA	NA	12.40	11.50	5.19	090
43325		A	Revise esophagus & stomach	22.60	NA	NA	12.19	11.37	5.02	090
43326		A	Revise esophagus & stomach	22.28	NA	NA	12.32	11.92	5.24	090
43330		A	Repair of esophagus	22.19	NA	NA	12.25	11.26	4.96	090
43331		A	Repair of esophagus	23.06	NA	NA	12.06	12.16	5.61	090
43340		A	Fuse esophagus & intestine	22.99	NA	NA	13.06	12.00	5.09	090
43341		A	Fuse esophagus & intestine	24.23	NA	NA	14.62	13.91	5.89	090
43350		A	Surgical opening, esophagus	19.49	NA	NA	14.14	12.15	4.31	090
43351		A	Surgical opening, esophagus	22.05	NA	NA	11.70	11.96	5.36	090
43352		A	Surgical opening, esophagus	17.81	NA	NA	9.97	10.09	4.32	090
43360		A	Gastrointestinal repair	40.11	NA	NA	18.39	18.64	9.76	090
43361		A	Gastrointestinal repair	45.68	NA	NA	20.18	20.49	10.12	090
43400		A	Ligate esophagus veins	25.60	NA	NA	14.18	15.40	3.91	090
43401		A	Esophagus surgery for veins	26.49	NA	NA	14.56	13.27	5.86	090
43405		A	Ligate/staple esophagus	24.73	NA	NA	15.68	14.31	5.48	090
4340F		I	Cnslng chldbrng+ women epi	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43410		A	Repair esophagus wound	16.41	NA	NA	11.16	10.42	3.98	090
43415		A	Repair esophagus wound	28.91	NA	NA	16.04	15.41	6.85	090
43420		A	Repair esophagus opening	16.78	NA	NA	12.48	10.98	2.23	090
43425		A	Repair esophagus opening	25.04	NA	NA	14.97	14.20	5.55	090
43450		A	Dilate esophagus	1.38	2.82	2.99	1.05	1.06	0.23	000
43453		A	Dilate esophagus	1.51	6.41	6.86	1.12	1.13	0.24	000
43456		A	Dilate esophagus	2.57	13.49	14.45	1.69	1.67	0.40	000
43458		A	Dilate esophagus	3.06	7.49	7.80	1.94	1.90	0.47	000

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43460		A	Pressure treatment esophagus	3.79	NA	NA	2.38	2.27	0.57	000
43496		C	Free jejunum flap, microvasc	0.00	0.00	0.00	0.00	0.00	0.00	090
43499		C	Esophagus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43500		A	Surgical opening of stomach	12.79	NA	NA	7.80	7.11	2.81	090
43501		A	Surgical repair of stomach	22.60	NA	NA	12.61	11.39	4.96	090
43502		A	Surgical repair of stomach	25.69	NA	NA	14.17	12.73	5.68	090
43510		A	Surgical opening of stomach	15.14	NA	NA	11.13	10.10	2.30	090
43520		A	Incision of pyloric muscle	11.29	NA	NA	6.72	6.42	2.60	090
43600		A	Biopsy of stomach	1.91	NA	NA	0.97	0.97	0.30	000
43605		A	Biopsy of stomach	13.72	NA	NA	8.18	7.39	2.98	090
43610		A	Excision of stomach lesion	16.34	NA	NA	9.36	8.46	3.59	090
43611		A	Excision of stomach lesion	20.38	NA	NA	11.60	10.51	4.47	090
43620		A	Removal of stomach	34.04	NA	NA	17.33	15.74	7.53	090
43621		A	Removal of stomach	39.53	NA	NA	19.65	17.58	8.73	090
43622		A	Removal of stomach	40.03	NA	NA	20.04	17.86	8.87	090
43631		A	Removal of stomach, partial	24.51	NA	NA	13.45	12.18	5.40	090
43632		A	Removal of stomach, partial	35.14	NA	NA	17.94	15.73	7.70	090
43633		A	Removal of stomach, partial	33.14	NA	NA	17.11	15.09	7.26	090
43634		A	Removal of stomach, partial	36.64	NA	NA	18.88	16.65	8.11	090
43635		A	Removal of stomach, partial	2.06	NA	NA	0.88	0.79	0.44	ZZZ
43640		A	Vagotomy & pylorus repair	19.56	NA	NA	11.38	10.24	4.28	090
43641		A	Vagotomy & pylorus repair	19.81	NA	NA	11.64	10.37	4.38	090
43644		A	Lap gastric bypass/roux-en-y	29.40	NA	NA	15.93	14.48	6.46	090
43645		A	Lap gastr bypass incl smll i	31.53	NA	NA	16.82	15.26	6.99	090
43647		C	Lap impl electrode, antrum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43648		C	Lap revise/remv eltrd antrum	0.00	0.00	0.00	0.00	0.00	0.00	YYY

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43651		A	Laparoscopy, vagus nerve	10.13	NA	NA	7.05	6.43	2.25	090
43652		A	Laparoscopy, vagus nerve	12.13	NA	NA	7.91	7.20	2.68	090
43653		A	Laparoscopy, gastrostomy	8.48	NA	NA	6.54	5.97	1.88	090
43659		C	Laparoscope proc, stom	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43752		A	Nasal/orogastric w/stent	0.81	NA	NA	0.30	0.32	0.08	000
43760		A	Change gastrostomy tube	0.90	11.99	10.63	0.41	0.43	0.14	000
43761		A	Reposition gastrostomy tube	2.01	1.16	1.26	0.79	0.85	0.25	000
43770		A	Lap place gastr adj device	18.00	NA	NA	11.35	10.34	3.96	090
43771		A	Lap revise gastr adj device	20.79	NA	NA	12.58	11.41	4.61	090
43772		A	Lap rmvl gastr adj device	15.70	NA	NA	9.35	8.54	3.49	090
43773		A	Lap replace gastr adj device	20.79	NA	NA	12.56	11.41	4.61	090
43774		A	Lap rmvl gastr adj all parts	15.76	NA	NA	9.35	8.56	3.49	090
43775		A	Lap sleeve gastrectomy	21.56	NA	NA	12.74	12.74	4.78	090
43800		A	Reconstruction of pylorus	15.43	NA	NA	8.87	8.08	3.43	090
43810		A	Fusion of stomach and bowel	16.88	NA	NA	9.71	8.72	3.73	090
43820		A	Fusion of stomach and bowel	22.53	NA	NA	12.59	11.10	4.95	090
43825		A	Fusion of stomach and bowel	21.76	NA	NA	12.51	11.20	4.82	090
43830		A	Place gastrostomy tube	10.85	NA	NA	7.58	6.93	2.32	090
43831		A	Place gastrostomy tube	8.49	NA	NA	7.19	6.60	1.88	090
43832		A	Place gastrostomy tube	17.34	NA	NA	10.23	9.49	3.72	090
43840		A	Repair of stomach lesion	22.83	NA	NA	12.74	11.26	5.00	090
43842		N	V-band gastroplasty	21.03	NA	NA	11.46	11.04	1.55	090
43843		A	Gastroplasty w/o v-band	21.21	NA	NA	12.29	10.98	4.69	090
43845		A	Gastroplasty duodenal switch	33.30	NA	NA	18.07	16.12	7.33	090
43846		A	Gastric bypass for obesity	27.41	NA	NA	15.34	13.86	6.02	090
43847		A	Gastric bypass incl small i	30.28	NA	NA	16.84	14.95	6.70	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
43848		A	Revision gastroplasty	32.75	NA	NA	17.82	16.04	7.21	090
43850		A	Revise stomach-bowel fusion	27.58	NA	NA	14.98	13.34	6.10	090
43855		A	Revise stomach-bowel fusion	28.69	NA	NA	15.46	13.91	6.34	090
43860		A	Revise stomach-bowel fusion	27.89	NA	NA	14.84	13.44	6.10	090
43865		A	Revise stomach-bowel fusion	29.05	NA	NA	15.61	14.01	6.43	090
43870		A	Repair stomach opening	11.44	NA	NA	7.31	6.62	2.44	090
43880		A	Repair stomach-bowel fistula	27.18	NA	NA	14.61	13.22	5.92	090
43881		C	Impl/redo electrd, antrum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43882		C	Revise/remove electrd antrum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43886		A	Revise gastric port, open	4.64	NA	NA	4.96	4.53	1.03	090
43887		A	Remove gastric port, open	4.32	NA	NA	4.33	3.99	0.95	090
43888		A	Change gastric port, open	6.44	NA	NA	5.70	5.22	1.43	090
43999		C	Stomach surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44005		A	Freeing of bowel adhesion	18.46	NA	NA	10.24	9.25	3.98	090
44010		A	Incision of small bowel	14.26	NA	NA	8.48	7.68	3.12	090
44015		A	Insert needle cath bowel	2.62	NA	NA	1.09	1.01	0.58	ZZZ
44020		A	Explore small intestine	16.22	NA	NA	9.32	8.40	3.53	090
44021		A	Decompress small bowel	16.31	NA	NA	9.42	8.56	3.57	090
44025		A	Incision of large bowel	16.51	NA	NA	9.44	8.52	3.56	090
44050		A	Reduce bowel obstruction	15.52	NA	NA	9.02	8.16	3.36	090
44055		A	Correct malrotation of bowel	25.63	NA	NA	13.49	12.12	5.62	090
44100		A	Biopsy of bowel	2.01	NA	NA	1.06	1.07	0.32	000
44110		A	Excise intestine lesion(s)	14.04	NA	NA	8.27	7.50	3.01	090
44111		A	Excision of bowel lesion(s)	16.52	NA	NA	9.31	8.43	3.57	090
44120		A	Removal of small intestine	20.82	NA	NA	11.26	10.10	4.49	090
44121		A	Removal of small intestine	4.44	NA	NA	1.90	1.72	0.93	ZZZ

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44125		A	Removal of small intestine	20.03	NA	NA	11.07	9.97	4.22	090
44126		A	Enterectomy w/o taper, cong	42.23	NA	NA	22.20	19.72	9.34	090
44127		A	Enterectomy w/taper, cong	49.30	NA	NA	25.15	22.38	10.91	090
44128		A	Enterectomy cong, add-on	4.44	NA	NA	1.91	1.73	0.96	ZZZ
44130		A	Bowel to bowel fusion	22.11	NA	NA	12.41	10.92	4.73	090
44132		R	Enterectomy, cadaver donor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44133		R	Enterectomy, live donor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44135		R	Intestine transplnt, cadaver	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44136		R	Intestine transplant, live	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44137		C	Remove intestinal allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44139		A	Mobilization of colon	2.23	NA	NA	0.96	0.86	0.45	ZZZ
44140		A	Partial removal of colon	22.59	NA	NA	12.68	11.47	4.82	090
44141		A	Partial removal of colon	29.91	NA	NA	18.17	16.16	6.42	090
44143		A	Partial removal of colon	27.79	NA	NA	16.03	14.49	5.96	090
44144		A	Partial removal of colon	29.91	NA	NA	16.66	14.82	6.42	090
44145		A	Partial removal of colon	28.58	NA	NA	15.25	13.77	5.88	090
44146		A	Partial removal of colon	35.30	NA	NA	20.87	18.68	7.14	090
44147		A	Partial removal of colon	33.69	NA	NA	17.49	15.22	7.04	090
44150		A	Removal of colon	30.18	NA	NA	19.31	17.37	6.36	090
44151		A	Removal of colon/ileostomy	34.92	NA	NA	21.34	19.21	7.73	090
44155		A	Removal of colon/ileostomy	34.42	NA	NA	21.07	18.84	6.71	090
44156		A	Removal of colon/ileostomy	37.42	NA	NA	23.24	20.85	8.29	090
44157		A	Colectomy w/ileoanal anast	35.70	NA	NA	21.40	19.31	7.91	090
44158		A	Colectomy w/neo-rectum pouch	36.70	NA	NA	21.69	19.59	8.12	090
44160		A	Removal of colon	20.89	NA	NA	11.84	10.65	4.42	090
44180		A	Lap, enterolysis	15.27	NA	NA	8.90	8.12	3.29	090

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44186		A	Lap, jejunostomy	10.38	NA	NA	6.73	6.23	2.30	090
44187		A	Lap, ileo/jejuno-stomy	17.40	NA	NA	12.06	10.99	3.43	090
44188		A	Lap, colostomy	19.35	NA	NA	13.18	11.99	3.98	090
44202		A	Lap, enterectomy	23.39	NA	NA	13.07	11.82	5.03	090
44203		A	Lap resect s/intestine, addl	4.44	NA	NA	1.89	1.71	0.96	ZZZ
44204		A	Laparo partial colectomy	26.42	NA	NA	14.31	12.88	5.43	090
44205		A	Lap colectomy part w/ileum	22.95	NA	NA	12.56	11.33	4.68	090
44206		A	Lap part colectomy w/stoma	29.79	NA	NA	16.58	14.95	6.29	090
44207		A	L colectomy/coloproctostomy	31.92	NA	NA	16.58	14.86	6.42	090
44208		A	L colectomy/coloproctostomy	33.99	NA	NA	19.02	17.13	6.64	090
44210		A	Laparo total proctocolectomy	30.09	NA	NA	17.64	15.89	6.03	090
44211		A	Lap colectomy w/proctectomy	37.08	NA	NA	22.09	19.62	8.22	090
44212		A	Laparo total proctocolectomy	34.58	NA	NA	20.41	18.43	6.61	090
44213		A	Lap, mobil splenic fl add-on	3.50	NA	NA	1.50	1.35	0.69	ZZZ
44227		A	Lap, close enterostomy	28.62	NA	NA	15.39	13.88	6.06	090
44238		C	Laparoscope proc, intestine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44300		A	Open bowel to skin	13.75	NA	NA	8.37	7.63	3.02	090
44310		A	Ileostomy/jejunostomy	17.59	NA	NA	10.03	9.06	3.59	090
44312		A	Revision of ileostomy	9.43	NA	NA	6.37	5.95	1.78	090
44314		A	Revision of ileostomy	16.74	NA	NA	10.06	9.22	3.28	090
44316		A	Devise bowel pouch	23.59	NA	NA	13.39	11.99	5.23	090
44320		A	Colostomy	19.91	NA	NA	11.76	10.62	4.22	090
44322		A	Colostomy with biopsies	13.32	NA	NA	13.18	12.04	2.95	090
44340		A	Revision of colostomy	9.28	NA	NA	7.25	6.55	1.95	090
44345		A	Revision of colostomy	17.22	NA	NA	10.66	9.62	3.57	090
44346		A	Revision of colostomy	19.63	NA	NA	11.71	10.51	4.03	090

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44360		A	Small bowel endoscopy	2.59	NA	NA	1.72	1.73	0.40	000
44361		A	Small bowel endoscopy/biopsy	2.87	NA	NA	1.87	1.88	0.42	000
44363		A	Small bowel endoscopy	3.49	NA	NA	2.19	2.15	0.54	000
44364		A	Small bowel endoscopy	3.73	NA	NA	2.33	2.33	0.57	000
44365		A	Small bowel endoscopy	3.31	NA	NA	2.10	2.09	0.51	000
44366		A	Small bowel endoscopy	4.40	NA	NA	2.71	2.72	0.66	000
44369		A	Small bowel endoscopy	4.51	NA	NA	2.77	2.77	0.68	000
44370		A	Small bowel endoscopy/stent	4.79	NA	NA	3.11	3.09	0.72	000
44372		A	Small bowel endoscopy	4.40	NA	NA	2.58	2.53	0.72	000
44373		A	Small bowel endoscopy	3.49	NA	NA	2.11	2.11	0.55	000
44376		A	Small bowel endoscopy	5.25	NA	NA	3.04	3.01	0.85	000
44377		A	Small bowel endoscopy/biopsy	5.52	NA	NA	3.26	3.26	0.85	000
44378		A	Small bowel endoscopy	7.12	NA	NA	4.18	4.16	1.09	000
44379		A	S bowel endoscope w/stent	7.46	NA	NA	4.58	4.51	1.13	000
44380		A	Small bowel endoscopy	1.05	NA	NA	0.82	0.84	0.14	000
44382		A	Small bowel endoscopy	1.27	NA	NA	0.99	0.99	0.21	000
44383		A	Ileoscopy w/stent	2.94	NA	NA	1.61	1.76	0.34	000
44385		A	Endoscopy of bowel pouch	1.82	5.27	5.28	1.09	1.06	0.27	000
44386		A	Endoscopy, bowel pouch/biop	2.12	7.48	7.68	1.36	1.29	0.34	000
44388		A	Colonoscopy	2.82	6.81	6.87	1.72	1.67	0.47	000
44389		A	Colonoscopy with biopsy	3.13	7.73	8.00	1.93	1.89	0.51	000
44390		A	Colonoscopy for foreign body	3.82	8.96	9.12	2.40	2.27	0.58	000
44391		A	Colonoscopy for bleeding	4.31	9.30	9.84	2.56	2.53	0.68	000
44392		A	Colonoscopy & polypectomy	3.81	8.20	8.31	2.17	2.09	0.65	000
44393		A	Colonoscopy, lesion removal	4.83	9.10	9.18	2.79	2.70	0.79	000
44394		A	Colonoscopy w/snare	4.42	9.30	9.60	2.58	2.53	0.72	000

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44397		A	Colonoscopy w/stent	4.70	NA	NA	2.88	2.83	0.71	000
44500		A	Intro, gastrointestinal tube	0.49	NA	NA	0.18	0.20	0.04	000
44602		A	Suture, small intestine	24.72	NA	NA	12.25	10.70	5.30	090
44603		A	Suture, small intestine	28.16	NA	NA	14.35	12.55	5.98	090
44604		A	Suture, large intestine	18.16	NA	NA	9.60	8.66	3.86	090
44605		A	Repair of bowel lesion	22.08	NA	NA	12.33	11.13	4.73	090
44615		A	Intestinal stricturoplasty	18.16	NA	NA	10.19	9.21	3.87	090
44620		A	Repair bowel opening	14.43	NA	NA	8.57	7.68	2.94	090
44625		A	Repair bowel opening	17.28	NA	NA	9.78	8.76	3.49	090
44626		A	Repair bowel opening	27.90	NA	NA	14.34	12.91	5.92	090
44640		A	Repair bowel-skin fistula	24.20	NA	NA	12.76	11.51	5.07	090
44650		A	Repair bowel fistula	25.12	NA	NA	13.02	11.85	5.26	090
44660		A	Repair bowel-bladder fistula	23.91	NA	NA	12.02	11.75	4.00	090
44661		A	Repair bowel-bladder fistula	27.35	NA	NA	13.80	12.83	5.30	090
44680		A	Surgical revision, intestine	17.96	NA	NA	10.10	9.12	3.98	090
44700		A	Suspend bowel w/prosthesis	17.48	NA	NA	9.80	8.82	3.15	090
44701		A	Intraop colon lavage add-on	3.10	NA	NA	1.32	1.19	0.61	ZZZ
44715		C	Prepare donor intestine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44720		A	Prep donor intestine/venous	5.00	NA	NA	2.15	2.09	0.37	XXX
44721		A	Prep donor intestine/artery	7.00	NA	NA	3.03	2.77	1.55	XXX
44799		C	Unlisted procedure intestine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44800		A	Excision of bowel pouch	12.05	NA	NA	8.10	7.42	2.53	090
44820		A	Excision of mesentery lesion	13.73	NA	NA	8.32	7.62	2.94	090
44850		A	Repair of mesentery	12.11	NA	NA	7.63	6.87	2.61	090
44899		C	Bowel surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44900		A	Drain app abscess, open	12.57	NA	NA	7.76	6.98	2.74	090

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44901		A	Drain app abscess, percut	3.37	20.57	23.42	1.18	1.34	0.37	000
44950		A	Appendectomy	10.60	NA	NA	6.24	5.68	2.32	090
44955		A	Appendectomy add-on	1.53	NA	NA	0.66	0.61	0.32	ZZZ
44960		A	Appendectomy	14.50	NA	NA	8.41	7.57	3.19	090
44970		A	Laparoscopy, appendectomy	9.45	NA	NA	6.33	5.74	2.05	090
44979		C	Laparoscope proc, app	0.00	0.00	0.00	0.00	0.00	0.00	YYY
45000		A	Drainage of pelvic abscess	6.30	NA	NA	5.03	4.63	1.13	090
45005		A	Drainage of rectal abscess	2.02	5.20	4.97	2.21	2.06	0.40	010
45020		A	Drainage of rectal abscess	8.56	NA	NA	6.56	5.89	1.68	090
45100		A	Biopsy of rectum	4.04	NA	NA	4.00	3.65	0.75	090
45108		A	Removal of anorectal lesion	5.12	NA	NA	4.62	4.16	1.13	090
45110		A	Removal of rectum	30.76	NA	NA	18.57	16.74	6.05	090
45111		A	Partial removal of rectum	18.01	NA	NA	10.91	9.83	3.69	090
45112		A	Removal of rectum	33.18	NA	NA	17.13	15.31	6.32	090
45113		A	Partial proctectomy	33.22	NA	NA	18.65	16.75	7.35	090
45114		A	Partial removal of rectum	30.79	NA	NA	16.71	14.81	6.82	090
45116		A	Partial removal of rectum	27.72	NA	NA	15.37	13.52	4.11	090
45119		A	Remove rectum w/reservoir	33.48	NA	NA	18.97	16.85	6.09	090
45120		A	Removal of rectum	26.40	NA	NA	15.22	13.65	5.85	090
45121		A	Removal of rectum and colon	29.08	NA	NA	16.37	14.64	6.43	090
45123		A	Partial proctectomy	18.86	NA	NA	11.29	9.96	3.29	090
45126		A	Pelvic exenteration	49.10	NA	NA	26.25	24.48	10.87	090
45130		A	Excision of rectal prolapse	18.50	NA	NA	10.88	9.61	3.25	090
45135		A	Excision of rectal prolapse	22.36	NA	NA	13.71	12.12	4.95	090
45136		A	Excise ileoanal reservior	30.82	NA	NA	18.70	16.84	4.58	090
45150		A	Excision of rectal stricture	5.85	NA	NA	5.06	4.64	0.86	090

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45160		A	Excision of rectal lesion	16.33	NA	NA	10.12	9.18	3.62	090
45171		A	Exc rect tum transanal part	8.13	NA	NA	7.91	7.91	1.57	090
45172		A	Exc rect tum transanal full	12.13	NA	NA	9.62	9.62	2.32	090
45190		A	Destruction, rectal tumor	10.42	NA	NA	8.11	7.30	1.94	090
45300		A	Proctosigmoidoscopy dx	0.80	2.53	2.38	0.67	0.59	0.13	000
45303		A	Proctosigmoidoscopy dilate	1.50	24.29	23.73	0.98	0.85	0.27	000
45305		A	Proctosigmoidoscopy w/bx	1.25	3.99	3.81	0.88	0.80	0.24	000
45307		A	Proctosigmoidoscopy fb	1.70	4.15	3.92	1.05	0.91	0.34	000
45308		A	Proctosigmoidoscopy removal	1.40	4.27	3.93	0.96	0.83	0.27	000
45309		A	Proctosigmoidoscopy removal	1.50	4.35	4.19	1.01	0.95	0.28	000
45315		A	Proctosigmoidoscopy removal	1.80	4.76	4.47	1.12	1.05	0.34	000
45317		A	Proctosigmoidoscopy bleed	2.00	4.35	4.04	1.21	1.06	0.34	000
45320		A	Proctosigmoidoscopy ablate	1.78	4.38	4.20	1.12	1.06	0.32	000
45321		A	Proctosigmoidoscopy volvul	1.75	NA	NA	1.14	1.05	0.34	000
45327		A	Proctosigmoidoscopy w/stent	2.00	NA	NA	1.42	1.29	0.44	000
45330		A	Diagnostic sigmoidoscopy	0.96	2.86	2.89	0.78	0.75	0.14	000
45331		A	Sigmoidoscopy and biopsy	1.15	3.48	3.65	0.92	0.91	0.18	000
45332		A	Sigmoidoscopy w/fb removal	1.79	6.09	6.24	1.24	1.20	0.30	000
45333		A	Sigmoidoscopy & polypectomy	1.79	6.21	6.33	1.22	1.19	0.30	000
45334		A	Sigmoidoscopy for bleeding	2.73	NA	NA	1.76	1.76	0.41	000
45335		A	Sigmoidoscopy w/submuc inj	1.46	5.67	5.64	1.06	1.04	0.24	000
45337		A	Sigmoidoscopy & decompress	2.36	NA	NA	1.53	1.49	0.40	000
45338		A	Sigmoidoscopy w/tumr remove	2.34	6.31	6.53	1.53	1.51	0.37	000
45339		A	Sigmoidoscopy w/ablate tumr	3.14	6.13	6.11	1.95	1.93	0.49	000
45340		A	Sig w/balloon dilation	1.89	11.05	10.98	1.28	1.25	0.31	000
45341		A	Sigmoidoscopy w/ultrasound	2.60	NA	NA	1.70	1.70	0.40	000

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45342		A	Sigmoidoscopy w/us guide bx	4.05	NA	NA	2.51	2.50	0.62	000
45345		A	Sigmoidoscopy w/stent	2.92	NA	NA	1.86	1.84	0.45	000
45355		A	Surgical colonoscopy	3.51	NA	NA	2.05	1.94	0.61	000
45378		A	Diagnostic colonoscopy	3.69	6.98	7.24	2.23	2.19	0.61	000
45378	53	A	Diagnostic colonoscopy	0.96	2.86	2.89	0.78	0.75	0.14	000
45379		A	Colonoscopy w/fb removal	4.68	9.04	9.29	2.77	2.68	0.75	000
45380		A	Colonoscopy and biopsy	4.43	8.30	8.67	2.67	2.64	0.69	000
45381		A	Colonoscopy, submucous inj	4.19	8.18	8.57	2.54	2.52	0.65	000
45382		A	Colonoscopy/control bleeding	5.68	10.88	11.50	3.37	3.36	0.88	000
45383		A	Lesion removal colonoscopy	5.86	9.55	9.77	3.31	3.22	0.95	000
45384		A	Lesion remove colonoscopy	4.69	7.99	8.21	2.71	2.65	0.76	000
45385		A	Lesion removal colonoscopy	5.30	9.04	9.42	3.12	3.08	0.83	000
45386		A	Colonoscopy dilate stricture	4.57	13.27	13.92	2.69	2.63	0.75	000
45387		A	Colonoscopy w/stent	5.90	NA	NA	3.56	3.51	0.92	000
45391		A	Colonoscopy w/endoscope us	5.09	NA	NA	3.03	3.01	0.76	000
45392		A	Colonoscopy w/endoscopic fnb	6.54	NA	NA	3.81	3.78	1.06	000
45395		A	Lap, removal of rectum	33.00	NA	NA	20.31	18.37	6.22	090
45397		A	Lap, remove rectum w/pouch	36.50	NA	NA	21.65	19.36	6.25	090
45400		A	Laparoscopic proc	19.44	NA	NA	11.34	10.20	3.70	090
45402		A	Lap proctopexy w/sig resect	26.51	NA	NA	14.38	12.87	5.00	090
45499		C	Laparoscope proc, rectum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
45500		A	Repair of rectum	7.73	NA	NA	6.50	5.83	1.26	090
45505		A	Repair of rectum	8.36	NA	NA	7.49	6.67	1.57	090
45520		A	Treatment of rectal prolapse	0.55	3.67	3.36	0.56	0.51	0.07	000
45540		A	Correct rectal prolapse	18.12	NA	NA	10.24	9.19	3.24	090
45541		A	Correct rectal prolapse	14.85	NA	NA	10.12	9.04	2.68	090

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45550		A	Repair rectum/remove sigmoid	24.80	NA	NA	14.42	12.84	4.65	090
45560		A	Repair of rectocele	11.50	NA	NA	7.36	7.01	1.87	090
45562		A	Exploration/repair of rectum	17.98	NA	NA	11.69	10.71	3.50	090
45563		A	Exploration/repair of rectum	26.38	NA	NA	16.77	15.01	5.85	090
45800		A	Repair rect/bladder fistula	20.31	NA	NA	11.81	11.35	3.52	090
45805		A	Repair fistula w/colostomy	23.32	NA	NA	14.96	13.43	5.17	090
45820		A	Repair rectourethral fistula	20.37	NA	NA	12.25	11.52	2.03	090
45825		A	Repair fistula w/colostomy	24.17	NA	NA	15.26	14.17	3.59	090
45900		A	Reduction of rectal prolapse	2.99	NA	NA	2.39	2.19	0.58	010
45905		A	Dilation of anal sphincter	2.35	NA	NA	2.19	2.05	0.42	010
45910		A	Dilation of rectal narrowing	2.85	NA	NA	2.40	2.29	0.49	010
45915		A	Remove rectal obstruction	3.19	5.60	5.33	2.87	2.67	0.54	010
45990		A	Surg dx exam, anorectal	1.80	NA	NA	1.08	1.00	0.32	000
45999		C	Rectum surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
46020		A	Placement of seton	3.00	4.43	4.00	3.31	2.98	0.57	010
46030		A	Removal of rectal marker	1.26	2.50	2.30	1.17	1.06	0.24	010
46040		A	Incision of rectal abscess	5.37	8.82	8.18	5.62	5.17	1.09	090
46045		A	Incision of rectal abscess	5.87	NA	NA	5.62	5.05	1.22	090
46050		A	Incision of anal abscess	1.24	4.15	3.87	1.37	1.25	0.25	010
46060		A	Incision of rectal abscess	6.37	NA	NA	6.34	5.69	1.23	090
46070		A	Incision of anal septum	2.79	NA	NA	3.75	3.43	0.21	090
46080		A	Incision of anal sphincter	2.52	4.14	3.81	1.71	1.55	0.51	010
46083		A	Incise external hemorrhoid	1.45	3.24	3.25	1.41	1.35	0.25	010
46200		A	Removal of anal fissure	3.59	8.32	7.56	5.14	4.69	0.65	090
46220		A	Excise anal ext tag/papilla	1.61	3.96	3.68	1.58	1.44	0.31	010
46221		A	Ligation of hemorrhoid(s)	2.36	4.89	4.52	2.78	2.56	0.42	010

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46230		A	Removal of anal tags	2.62	4.73	4.41	2.00	1.82	0.49	010
46250		A	Remove ext hem groups = 2	4.25	8.08	7.54	4.11	3.76	0.85	090
46255		A	Remove int/ext hem 1 group	4.96	8.46	7.98	4.41	4.05	0.99	090
46257		A	Remove in/ex hem grp & fiss	5.76	NA	NA	5.51	4.94	1.12	090
46258		A	Remove in/ex hem grp w/fistu	6.41	NA	NA	5.98	5.35	1.43	090
46260		A	Remove in/ex hem groups = 2	6.73	NA	NA	5.91	5.30	1.31	090
46261		A	Remove in/ex hem grps & fiss	7.76	NA	NA	6.39	5.72	1.44	090
46262		A	Remove in/ex hem grps w/fist	7.91	NA	NA	6.87	6.18	1.50	090
46270		A	Remove anal fist subq	4.92	8.60	7.92	5.50	4.96	1.02	090
46275		A	Remove anal fist inter	5.42	8.95	8.16	5.66	5.09	1.02	090
46280		A	Remove anal fist complex	6.39	NA	NA	6.17	5.53	1.17	090
46285		A	Remove anal fist 2 stage	5.42	8.90	7.97	5.69	5.07	0.95	090
46288		A	Repair anal fistula	7.81	NA	NA	6.90	6.18	1.38	090
46320		A	Removal of hemorrhoid clot	1.64	3.28	3.04	1.33	1.20	0.31	010
46500		A	Injection into hemorrhoid(s)	1.69	4.71	4.29	1.80	1.65	0.30	010
46505		A	Chemodenervation anal musc	3.18	4.51	4.20	3.26	2.98	0.61	010
46600		A	Diagnostic anoscopy	0.55	1.82	1.76	0.56	0.50	0.08	000
46604		A	Anoscopy and dilation	1.03	15.57	14.62	0.76	0.71	0.17	000
46606		A	Anoscopy and biopsy	1.20	4.83	4.73	0.85	0.76	0.24	000
46608		A	Anoscopy, remove for body	1.30	4.99	4.82	0.84	0.78	0.25	000
46610		A	Anoscopy, remove lesion	1.28	4.86	4.74	0.89	0.81	0.25	000
46611		A	Anoscopy	1.30	3.48	3.36	0.91	0.84	0.24	000
46612		A	Anoscopy, remove lesions	1.50	5.65	5.57	0.99	0.95	0.32	000
46614		A	Anoscopy, control bleeding	1.00	2.44	2.44	0.76	0.75	0.14	000
46615		A	Anoscopy	1.50	2.34	2.32	0.99	0.95	0.30	000
46700		A	Repair of anal stricture	9.81	NA	NA	7.82	6.94	1.70	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
46705		A	Repair of anal stricture	7.43	NA	NA	6.10	5.90	0.54	090
46706		A	Repr of anal fistula w/glue	2.44	NA	NA	2.04	1.90	0.44	010
46707		A	Repair anorectal fist w/plug	6.39	NA	NA	6.40	6.40	0.93	090
46710		A	Repr per/vag pouch sngl proc	17.14	NA	NA	11.37	10.60	3.82	090
46712		A	Repr per/vag pouch dbl proc	36.45	NA	NA	21.84	19.62	2.68	090
46715		A	Rep perf anoper fistu	7.62	NA	NA	6.25	5.75	0.55	090
46716		A	Rep perf anoper/vestib fistu	17.54	NA	NA	13.54	14.23	1.29	090
46730		A	Construction of absent anus	30.65	NA	NA	18.88	18.14	2.26	090
46735		A	Construction of absent anus	36.14	NA	NA	21.26	20.39	2.67	090
46740		A	Construction of absent anus	33.90	NA	NA	22.21	19.90	7.50	090
46742		A	Repair of imperforated anus	40.14	NA	NA	24.80	22.55	8.89	090
46744		A	Repair of cloacal anomaly	58.94	NA	NA	34.40	29.80	8.75	090
46746		A	Repair of cloacal anomaly	65.44	NA	NA	34.06	33.03	4.82	090
46748		A	Repair of cloacal anomaly	71.42	NA	NA	33.50	33.42	5.27	090
46750		A	Repair of anal sphincter	12.15	NA	NA	8.44	7.70	2.05	090
46751		A	Repair of anal sphincter	9.30	NA	NA	6.84	6.78	1.62	090
46753		A	Reconstruction of anus	8.89	NA	NA	6.88	6.19	1.57	090
46754		A	Removal of suture from anus	3.01	5.07	4.76	3.31	2.95	0.44	010
46760		A	Repair of anal sphincter	17.45	NA	NA	12.31	10.94	2.57	090
46761		A	Repair of anal sphincter	15.29	NA	NA	9.99	8.94	2.52	090
46762		A	Implant artificial sphincter	14.82	NA	NA	10.29	9.27	2.20	090
46900		A	Destruction, anal lesion(s)	1.91	4.65	4.37	1.86	1.73	0.31	010
46910		A	Destruction, anal lesion(s)	1.91	4.79	4.60	1.67	1.56	0.35	010
46916		A	Cryosurgery, anal lesion(s)	1.91	4.44	4.42	2.10	2.00	0.28	010
46917		A	Laser surgery, anal lesions	1.91	10.67	10.63	1.70	1.58	0.34	010
46922		A	Excision of anal lesion(s)	1.91	5.28	4.97	1.72	1.57	0.37	010

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
46924		A	Destruction, anal lesion(s)	2.81	11.75	11.47	2.20	2.02	0.47	010
46930		A	Destroy internal hemorrhoids	1.61	3.84	4.05	2.35	2.43	0.27	090
46940		A	Treatment of anal fissure	2.35	3.86	3.51	1.62	1.46	0.38	010
46942		A	Treatment of anal fissure	2.07	3.76	3.42	1.50	1.35	0.34	010
46945		A	Remove by ligat int hem grp	2.21	6.03	5.63	3.85	3.62	0.40	090
46946		A	Remove by ligat int hem grps	2.63	5.74	5.50	3.41	3.26	0.45	090
46947		A	Hemorrhoidopexy by stapling	5.57	NA	NA	4.60	4.15	1.13	090
46999		C	Anus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47000		A	Needle biopsy of liver	1.90	7.84	7.82	0.69	0.79	0.21	000
47001		A	Needle biopsy, liver add-on	1.90	NA	NA	0.81	0.74	0.40	ZZZ
47010		A	Open drainage, liver lesion	19.40	NA	NA	11.95	11.13	4.11	090
47011		A	Percut drain, liver lesion	3.69	NA	NA	1.27	1.48	0.37	000
47015		A	Inject/aspirate liver cyst	18.50	NA	NA	11.97	10.77	4.08	090
47100		A	Wedge biopsy of liver	12.91	NA	NA	9.31	8.51	2.80	090
47120		A	Partial removal of liver	39.01	NA	NA	21.81	19.85	8.58	090
47122		A	Extensive removal of liver	59.48	NA	NA	29.82	27.14	13.13	090
47125		A	Partial removal of liver	53.04	NA	NA	27.07	24.64	11.63	090
47130		A	Partial removal of liver	57.19	NA	NA	28.70	26.18	12.51	090
47133		X	Removal of donor liver	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47135		R	Transplantation of liver	83.64	NA	NA	44.17	40.04	18.38	090
47136		R	Transplantation of liver	70.74	NA	NA	36.91	34.18	15.67	090
47140		A	Partial removal, donor liver	59.40	NA	NA	33.89	30.54	13.16	090
47141		A	Partial removal, donor liver	71.50	NA	NA	37.78	34.96	5.27	090
47142		A	Partial removal, donor liver	79.44	NA	NA	43.36	39.13	17.58	090
47143		C	Prep donor liver, whole	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47144		C	Prep donor liver, 3-segment	0.00	0.00	0.00	0.00	0.00	0.00	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
47145		C	Prep donor liver, lobe split	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47146		A	Prep donor liver/venous	6.00	NA	NA	2.58	2.34	1.33	XXX
47147		A	Prep donor liver/arterial	7.00	NA	NA	3.01	2.73	1.54	XXX
47300		A	Surgery for liver lesion	18.14	NA	NA	11.67	10.51	3.98	090
47350		A	Repair liver wound	22.49	NA	NA	13.48	12.27	4.87	090
47360		A	Repair liver wound	31.31	NA	NA	17.76	15.99	6.92	090
47361		A	Repair liver wound	52.60	NA	NA	26.27	23.95	11.11	090
47362		A	Repair liver wound	23.54	NA	NA	14.42	12.89	5.13	090
47370		A	Laparo ablate liver tumor rf	20.80	NA	NA	11.72	10.70	4.38	090
47371		A	Laparo ablate liver cryosurg	20.80	NA	NA	12.05	11.18	4.61	090
47379		C	Laparoscope procedure, liver	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47380		A	Open ablate liver tumor rf	24.56	NA	NA	13.12	12.10	5.14	090
47381		A	Open ablate liver tumor cryo	24.88	NA	NA	10.56	11.06	5.51	090
47382		A	Percut ablate liver rf	15.22	114.73	114.73	5.83	6.90	1.54	010
47399		C	Liver surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47400		A	Incision of liver duct	36.36	NA	NA	19.93	17.99	8.04	090
47420		A	Incision of bile duct	22.03	NA	NA	13.12	11.91	4.85	090
47425		A	Incision of bile duct	22.31	NA	NA	13.46	12.12	4.95	090
47460		A	Incise bile duct sphincter	20.52	NA	NA	12.69	11.87	4.54	090
47480		A	Incision of gallbladder	13.25	NA	NA	9.72	8.85	2.85	090
47490		A	Incision of gallbladder	8.13	NA	NA	5.24	5.98	0.79	090
47500		A	Injection for liver x-rays	1.96	NA	NA	0.67	0.79	0.21	000
47505		A	Injection for liver x-rays	0.76	NA	NA	0.26	0.30	0.07	000
47510		A	Insert catheter, bile duct	8.03	NA	NA	4.61	5.27	0.83	090
47511		A	Insert bile duct drain	10.77	NA	NA	4.86	5.68	1.06	090
47525		A	Change bile duct catheter	1.54	11.84	13.12	0.77	1.19	0.14	000

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47530		A	Revise/reinsert bile tube	6.05	32.33	35.08	3.48	3.96	0.64	090
47550		A	Bile duct endoscopy add-on	3.02	NA	NA	1.30	1.19	0.65	ZZZ
47552		A	Biliary endoscopy thru skin	6.03	NA	NA	2.46	2.84	0.65	000
47553		A	Biliary endoscopy thru skin	6.34	NA	NA	2.19	2.53	0.65	000
47554		A	Biliary endoscopy thru skin	9.05	NA	NA	3.93	4.05	1.57	000
47555		A	Biliary endoscopy thru skin	7.55	NA	NA	2.55	3.03	0.73	000
47556		A	Biliary endoscopy thru skin	8.55	NA	NA	2.91	3.44	0.83	000
47560		A	Laparoscopy w/cholangio	4.88	NA	NA	2.10	1.93	1.09	000
47561		A	Laparo w/cholangio/biopsy	5.17	NA	NA	2.51	2.30	1.14	000
47562		A	Laparoscopic cholecystectomy	11.76	NA	NA	7.94	7.18	2.57	090
47563		A	Laparo cholecystectomy/graph	12.11	NA	NA	7.73	7.04	2.67	090
47564		A	Laparo cholecystectomy/explr	14.24	NA	NA	8.35	7.63	3.15	090
47570		A	Laparo cholecystoenterostomy	12.56	NA	NA	7.73	7.04	2.77	090
47579		C	Laparoscope proc, biliary	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47600		A	Removal of gallbladder	17.48	NA	NA	10.97	9.80	3.84	090
47605		A	Removal of gallbladder	15.98	NA	NA	9.76	8.85	3.53	090
47610		A	Removal of gallbladder	20.92	NA	NA	11.89	10.76	4.62	090
47612		A	Removal of gallbladder	21.21	NA	NA	11.96	10.81	4.68	090
47620		A	Removal of gallbladder	23.07	NA	NA	12.96	11.68	5.13	090
47630		A	Remove bile duct stone	9.65	NA	NA	5.03	5.53	1.26	090
47700		A	Exploration of bile ducts	16.50	NA	NA	11.09	10.15	3.66	090
47701		A	Bile duct revision	28.73	NA	NA	16.64	15.91	6.34	090
47711		A	Excision of bile duct tumor	25.90	NA	NA	14.92	13.52	5.69	090
47712		A	Excision of bile duct tumor	33.72	NA	NA	18.52	16.65	7.47	090
47715		A	Excision of bile duct cyst	21.55	NA	NA	13.28	11.91	4.78	090
47720		A	Fuse gallbladder & bowel	18.34	NA	NA	11.71	10.61	4.03	090

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47721		A	Fuse upper gi structures	21.99	NA	NA	13.47	12.10	4.87	090
47740		A	Fuse gallbladder & bowel	21.23	NA	NA	13.14	11.78	4.69	090
47741		A	Fuse gallbladder & bowel	24.21	NA	NA	14.42	12.97	5.36	090
47760		A	Fuse bile ducts and bowel	38.32	NA	NA	20.66	18.18	8.42	090
47765		A	Fuse liver ducts & bowel	52.19	NA	NA	27.17	23.41	11.56	090
47780		A	Fuse bile ducts and bowel	42.32	NA	NA	22.27	19.55	9.33	090
47785		A	Fuse bile ducts and bowel	56.19	NA	NA	28.46	24.73	12.45	090
47800		A	Reconstruction of bile ducts	26.17	NA	NA	15.21	13.71	5.81	090
47801		A	Placement, bile duct support	17.60	NA	NA	9.59	10.09	2.53	090
47802		A	Fuse liver duct & intestine	24.93	NA	NA	15.02	13.53	5.52	090
47900		A	Suture bile duct injury	22.44	NA	NA	13.28	12.07	4.90	090
47999		C	Bile tract surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
48000		A	Drainage of abdomen	31.95	NA	NA	16.64	15.37	6.42	090
48001		A	Placement of drain, pancreas	39.69	NA	NA	20.60	18.53	8.80	090
48020		A	Removal of pancreatic stone	19.09	NA	NA	11.73	10.63	4.24	090
48100		A	Biopsy of pancreas, open	14.46	NA	NA	8.84	8.04	3.11	090
48102		A	Needle biopsy, pancreas	4.70	9.76	10.47	1.85	2.16	0.45	010
48105		A	Resect/debride pancreas	49.26	NA	NA	25.44	22.78	10.70	090
48120		A	Removal of pancreas lesion	18.41	NA	NA	10.56	9.55	4.06	090
48140		A	Partial removal of pancreas	26.32	NA	NA	14.53	13.14	5.79	090
48145		A	Partial removal of pancreas	27.39	NA	NA	15.31	13.70	6.05	090
48146		A	Pancreatectomy	30.60	NA	NA	18.60	16.68	6.77	090
48148		A	Removal of pancreatic duct	20.39	NA	NA	12.29	11.02	4.51	090
48150		A	Partial removal of pancreas	52.84	NA	NA	28.07	25.54	11.66	090
48152		A	Pancreatectomy	48.65	NA	NA	26.79	24.17	10.78	090
48153		A	Pancreatectomy	52.79	NA	NA	28.05	25.49	11.64	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
48154		A	Pancreatectomy	48.88	NA	NA	26.89	24.18	10.82	090
48155		A	Removal of pancreas	29.45	NA	NA	18.02	16.36	6.51	090
48160		N	Pancreas removal/transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48400		A	Injection, intraop add-on	1.95	NA	NA	0.84	0.85	0.30	ZZZ
48500		A	Surgery of pancreatic cyst	18.16	NA	NA	12.02	10.82	4.01	090
48510		A	Drain pancreatic pseudocyst	17.19	NA	NA	11.36	10.32	3.73	090
48511		A	Drain pancreatic pseudocyst	3.99	20.88	22.73	1.39	1.61	0.40	000
48520		A	Fuse pancreas cyst and bowel	18.15	NA	NA	10.47	9.49	3.98	090
48540		A	Fuse pancreas cyst and bowel	21.94	NA	NA	12.33	11.03	4.85	090
48545		A	Pancreatorrhaphy	22.23	NA	NA	12.96	11.54	4.93	090
48547		A	Duodenal exclusion	30.38	NA	NA	16.47	14.70	6.71	090
48548		A	Fuse pancreas and bowel	28.09	NA	NA	15.40	13.95	6.20	090
48550		X	Donor pancreatectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48551		C	Prep donor pancreas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48552		A	Prep donor pancreas/venous	4.30	NA	NA	1.85	1.70	0.93	XXX
48554		R	Transpl allograft pancreas	37.80	NA	NA	29.62	27.12	8.20	090
48556		A	Removal, allograft pancreas	19.47	NA	NA	14.00	12.66	4.31	090
48999		C	Pancreas surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49000		A	Exploration of abdomen	12.54	NA	NA	7.71	7.12	2.67	090
49002		A	Reopening of abdomen	17.63	NA	NA	9.80	8.68	3.80	090
49010		A	Exploration behind abdomen	16.06	NA	NA	8.77	8.23	3.32	090
49020		A	Drain abdominal abscess	26.67	NA	NA	15.14	13.79	5.62	090
49021		A	Drain abdominal abscess	3.37	20.15	22.09	1.16	1.35	0.32	000
49040		A	Drain, open, abdom abscess	16.52	NA	NA	9.80	8.94	3.52	090
49041		A	Drain, percut, abdom abscess	3.99	20.58	22.22	1.37	1.60	0.40	000
49060		A	Drain, open, retrop abscess	18.53	NA	NA	10.41	9.75	3.83	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
49061		A	Drain, percut, retroper absc	3.69	20.21	21.97	1.27	1.48	0.35	000
49062		A	Drain to peritoneal cavity	12.22	NA	NA	7.41	6.96	2.56	090
49080		A	Puncture, peritoneal cavity	1.35	2.84	3.25	0.50	0.56	0.13	000
49081		A	Removal of abdominal fluid	1.26	3.21	3.31	0.55	0.56	0.17	000
49180		A	Biopsy, abdominal mass	1.73	2.51	2.86	0.60	0.70	0.17	000
49203		A	Exc abd tum 5 cm or less	20.13	NA	NA	11.36	10.52	4.08	090
49204		A	Exc abd tum over 5 cm	26.13	NA	NA	13.92	12.85	5.27	090
49205		A	Exc abd tum over 10 cm	30.13	NA	NA	15.66	14.42	6.26	090
49215		A	Excise sacral spine tumor	37.81	NA	NA	20.39	18.39	7.83	090
49220		A	Multiple surgery, abdomen	15.79	NA	NA	9.61	8.80	3.52	090
49250		A	Excision of umbilicus	9.01	NA	NA	6.41	5.88	1.91	090
49255		A	Removal of omentum	12.56	NA	NA	8.23	7.59	2.64	090
49320		A	Diag laparo separate proc	5.14	NA	NA	3.49	3.28	1.07	010
49321		A	Laparoscopy, biopsy	5.44	NA	NA	3.70	3.44	1.17	010
49322		A	Laparoscopy, aspiration	6.01	NA	NA	3.79	3.59	1.20	010
49323		A	Laparo drain lymphocele	10.23	NA	NA	6.79	6.26	2.22	090
49324		A	Lap insertion perm ip cath	6.32	NA	NA	4.07	3.75	1.38	010
49325		A	Lap revision perm ip cath	6.82	NA	NA	4.26	3.92	1.53	010
49326		A	Lap w/omentopexy add-on	3.50	NA	NA	1.45	1.30	0.76	ZZZ
49329		C	Laparo proc, abdm/per/oment	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49400		A	Air injection into abdomen	1.88	2.65	2.93	0.67	0.74	0.25	000
49402		A	Remove foreign body, adbomen	14.09	NA	NA	8.42	7.66	3.01	090
49411		A	Ins mark abd/pel for rt perq	3.82	10.89	10.89	1.62	1.62	0.37	000
49419		A	Insrt abdom cath for chemotx	7.08	NA	NA	4.68	4.50	1.27	090
49420		A	Insert abdom drain, temp	2.22	NA	NA	1.34	1.38	0.35	000
49421		A	Insert abdom drain, perm	5.90	NA	NA	4.13	3.99	1.22	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
49422		A	Remove perm cannula/catheter	6.29	NA	NA	3.78	3.56	1.34	010
49423		A	Exchange drainage catheter	1.46	13.58	14.82	0.53	0.63	0.13	000
49424		A	Assess cyst, contrast inject	0.76	3.19	3.55	0.29	0.34	0.07	000
49425		A	Insert abdomen-venous drain	12.22	NA	NA	7.43	7.07	2.77	090
49426		A	Revise abdomen-venous shunt	10.41	NA	NA	6.36	6.05	2.15	090
49427		A	Injection, abdominal shunt	0.89	NA	NA	0.33	0.37	0.10	000
49428		A	Ligation of shunt	6.87	NA	NA	4.45	4.28	1.53	010
49429		A	Removal of shunt	7.44	NA	NA	4.58	4.24	1.65	010
49435		A	Insert subq exten to ip cath	2.25	NA	NA	0.88	0.80	0.47	ZZZ
49436		A	Embedded ip cath exit-site	2.72	NA	NA	2.19	2.07	0.61	010
49440		A	Place gastrostomy tube perc	4.18	24.11	26.74	1.91	2.10	0.49	010
49441		A	Place duod/jej tube perc	4.77	27.19	29.50	2.19	2.37	0.57	010
49442		A	Place cecostomy tube perc	4.00	20.70	24.76	1.88	1.96	0.38	010
49446		A	Change g-tube to g-j perc	3.31	23.20	25.35	1.15	1.34	0.32	000
49450		A	Replace g/c tube perc	1.36	16.44	19.20	0.49	0.53	0.13	000
49451		A	Replace duod/jej tube perc	1.84	17.53	18.88	0.65	0.75	0.21	000
49452		A	Replace g-j tube perc	2.86	20.99	22.89	1.00	1.17	0.28	000
49460		A	Fix g/colon tube w/device	0.96	18.77	21.76	0.36	0.39	0.10	000
49465		A	Fluoro exam of g/colon tube	0.62	3.94	4.30	0.21	0.25	0.06	000
49491		A	Rpr hern preemie reduc	12.53	NA	NA	8.25	7.42	2.77	090
49492		A	Rpr ing hern premie, blocked	15.43	NA	NA	9.59	8.69	3.42	090
49495		A	Rpr ing hernia baby, reduc	6.20	NA	NA	4.56	4.05	1.37	090
49496		A	Rpr ing hernia baby, blocked	9.42	NA	NA	6.68	6.05	2.29	090
49500		A	Rpr ing hernia, init, reduce	5.84	NA	NA	3.82	3.90	1.29	090
49501		A	Rpr ing hernia, init blocked	9.36	NA	NA	6.50	5.90	2.06	090
49505		A	Prp i/hern init reduc >5 yr	7.96	NA	NA	5.72	5.23	1.72	090

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49507		A	Prp i/hern init block >5 yr	10.05	NA	NA	6.68	6.09	2.20	090
49520		A	Rerepair ing hernia, reduce	9.99	NA	NA	6.59	6.01	2.18	090
49521		A	Rerepair ing hernia, blocked	12.44	NA	NA	7.61	6.94	2.71	090
49525		A	Repair ing hernia, sliding	8.93	NA	NA	6.12	5.60	1.94	090
49540		A	Repair lumbar hernia	10.74	NA	NA	7.05	6.39	2.35	090
49550		A	Rpr rem hernia, init, reduce	8.99	NA	NA	6.14	5.61	1.96	090
49553		A	Rpr fem hernia, init blocked	9.92	NA	NA	6.65	6.05	2.18	090
49555		A	Rerepair fem hernia, reduce	9.39	NA	NA	6.30	5.76	2.05	090
49557		A	Rerepair fem hernia, blocked	11.62	NA	NA	7.37	6.71	2.54	090
49560		A	Rpr ventral hern init, reduc	11.92	NA	NA	7.43	6.78	2.57	090
49561		A	Rpr ventral hern init, block	15.38	NA	NA	8.98	8.14	3.36	090
49565		A	Rerepair ventrl hern, reduce	12.37	NA	NA	7.80	7.09	2.70	090
49566		A	Rerepair ventrl hern, block	15.53	NA	NA	9.09	8.23	3.42	090
49568		A	Hernia repair w/mesh	4.88	NA	NA	2.10	1.91	1.07	ZZZ
49570		A	Rpr epigastric hern, reduce	6.05	NA	NA	4.89	4.48	1.33	090
49572		A	Rpr epigastric hern, blocked	7.87	NA	NA	5.68	5.14	1.71	090
49580		A	Rpr umbil hern, reduc < 5 yr	4.47	NA	NA	4.30	3.92	0.99	090
49582		A	Rpr umbil hern, block < 5 yr	7.13	NA	NA	5.54	5.03	1.58	090
49585		A	Rpr umbil hern, reduc > 5 yr	6.59	NA	NA	5.11	4.68	1.43	090
49587		A	Rpr umbil hern, block > 5 yr	8.04	NA	NA	5.73	5.23	1.75	090
49590		A	Repair spigelian hernia	8.90	NA	NA	6.13	5.59	1.95	090
49600		A	Repair umbilical lesion	11.55	NA	NA	7.58	7.05	2.54	090
49605		A	Repair umbilical lesion	87.09	NA	NA	41.56	38.48	19.29	090
49606		A	Repair umbilical lesion	19.00	NA	NA	10.57	9.62	4.21	090
49610		A	Repair umbilical lesion	10.91	NA	NA	7.09	6.54	2.40	090
49611		A	Repair umbilical lesion	9.34	NA	NA	5.92	6.03	0.68	090

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49650		A	Lap ing hernia repair init	6.36	NA	NA	4.91	4.49	1.38	090
49651		A	Lap ing hernia repair recur	8.38	NA	NA	6.27	5.70	1.85	090
49652		A	Lap vent/abd hernia repair	12.88	NA	NA	8.01	7.28	0.93	090
49653		A	Lap vent/abd hern proc comp	16.21	NA	NA	9.96	9.03	1.20	090
49654		A	Lap inc hernia repair	15.03	NA	NA	8.96	8.12	1.10	090
49655		A	Lap inc hern repair comp	18.11	NA	NA	10.75	9.74	1.33	090
49656		A	Lap inc hernia repair recur	15.08	NA	NA	9.00	8.14	1.12	090
49657		A	Lap inc hern recur comp	22.11	NA	NA	12.50	11.27	1.62	090
49659		C	Laparo proc, hernia repair	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49900		A	Repair of abdominal wall	12.41	NA	NA	9.14	8.44	2.64	090
49904		A	Omental flap, extra-abdom	22.35	NA	NA	15.50	15.50	4.93	090
49905		A	Omental flap, intra-abdom	6.54	NA	NA	2.77	2.56	1.29	ZZZ
49906		C	Free omental flap, microvasc	0.00	0.00	0.00	0.00	0.00	0.00	090
49999		C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50010		A	Exploration of kidney	12.28	NA	NA	7.71	7.82	1.87	090
50020		A	Renal abscess, open drain	18.08	NA	NA	10.66	10.63	2.50	090
50021		A	Renal abscess, percut drain	3.37	21.56	23.54	1.15	1.35	0.32	000
50040		A	Drainage of kidney	16.68	NA	NA	8.67	9.65	1.75	090
50045		A	Exploration of kidney	16.82	NA	NA	8.90	9.71	1.68	090
50060		A	Removal of kidney stone	20.95	NA	NA	10.52	11.64	2.09	090
50065		A	Incision of kidney	22.32	NA	NA	11.06	11.98	2.25	090
50070		A	Incision of kidney	21.85	NA	NA	10.88	12.12	2.20	090
50075		A	Removal of kidney stone	27.09	NA	NA	13.16	14.63	2.73	090
50080		A	Removal of kidney stone	15.74	NA	NA	8.23	9.16	1.61	090
50081		A	Removal of kidney stone	23.50	NA	NA	11.75	13.03	2.40	090
50100		A	Revise kidney blood vessels	17.45	NA	NA	7.41	8.35	3.87	090

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50120		A	Exploration of kidney	17.21	NA	NA	8.98	9.84	1.72	090
50125		A	Explore and drain kidney	17.82	NA	NA	10.93	10.91	1.78	090
50130		A	Removal of kidney stone	18.82	NA	NA	9.73	10.76	1.89	090
50135		A	Exploration of kidney	20.59	NA	NA	10.38	11.43	2.06	090
50200		A	Renal biopsy perq	2.63	13.53	13.53	1.22	1.37	0.32	000
50205		A	Renal biopsy open	12.29	NA	NA	7.53	7.11	2.49	090
5020F		I	Txmnts 2 main Dr by 1 mon	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50220		A	Remove kidney, open	18.68	NA	NA	9.83	10.56	2.33	090
50225		A	Removal kidney open, complex	21.88	NA	NA	11.02	11.91	2.47	090
50230		A	Removal kidney open, radical	23.81	NA	NA	11.48	12.65	2.54	090
50234		A	Removal of kidney & ureter	24.05	NA	NA	11.84	13.01	2.53	090
50236		A	Removal of kidney & ureter	26.94	NA	NA	13.50	14.98	2.74	090
50240		A	Partial removal of kidney	24.21	NA	NA	12.31	13.56	2.52	090
50250		A	Cryoablate renal mass open	22.22	NA	NA	11.33	12.69	2.26	090
50280		A	Removal of kidney lesion	17.09	NA	NA	9.19	9.96	1.94	090
50290		A	Removal of kidney lesion	16.15	NA	NA	10.21	9.70	1.62	090
50300		X	Remove cadaver donor kidney	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50320		A	Remove kidney, living donor	22.43	NA	NA	15.25	15.13	4.03	090
50323		C	Prep cadaver renal allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50325		C	Prep donor renal graft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50327		A	Prep renal graft/venous	4.00	NA	NA	1.68	1.58	0.81	XXX
50328		A	Prep renal graft/arterial	3.50	NA	NA	1.47	1.39	0.69	XXX
50329		A	Prep renal graft/ureteral	3.34	NA	NA	1.36	1.40	0.49	XXX
50340		A	Removal of kidney	14.04	NA	NA	10.86	9.91	3.12	090
50360		A	Transplantation of kidney	40.90	NA	NA	26.81	24.47	8.62	090
50365		A	Transplantation of kidney	46.13	NA	NA	29.30	27.00	10.22	090

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50370		A	Remove transplanted kidney	18.88	NA	NA	12.81	11.77	3.90	090
50380		A	Reimplantation of kidney	30.11	NA	NA	22.45	21.61	6.66	090
50382		A	Change ureter stent, percut	5.50	26.99	30.96	1.97	2.30	0.54	000
50384		A	Remove ureter stent, percut	5.00	21.18	25.44	1.77	2.08	0.49	000
50385		A	Change stent via transureth	4.44	27.38	31.38	1.92	2.25	0.44	000
50386		A	Remove stent via transureth	3.30	17.77	20.09	1.54	1.78	0.32	000
50387		A	Change ext/int ureter stent	2.00	12.94	14.90	0.68	0.82	0.21	000
50389		A	Remove renal tube w/fluoro	1.10	6.79	8.32	0.38	0.45	0.10	000
50390		A	Drainage of kidney lesion	1.96	NA	NA	0.67	0.79	0.18	000
50391		A	Instll rx agnt into rnal tub	1.96	1.42	1.63	0.79	0.87	0.21	000
50392		A	Insert kidney drain	3.37	NA	NA	1.46	1.71	0.32	000
50393		A	Insert ureteral tube	4.15	NA	NA	1.73	2.03	0.40	000
50394		A	Injection for kidney x-ray	0.76	1.90	2.21	0.58	0.66	0.07	000
50395		A	Create passage to kidney	3.37	NA	NA	1.53	1.75	0.34	000
50396		A	Measure kidney pressure	2.09	NA	NA	1.02	1.21	0.21	000
50398		A	Change kidney tube	1.46	12.21	13.88	0.54	0.63	0.13	000
50400		A	Revision of kidney/ureter	21.27	NA	NA	10.69	11.72	2.18	090
50405		A	Revision of kidney/ureter	25.86	NA	NA	12.68	13.98	2.60	090
50500		A	Repair of kidney wound	21.22	NA	NA	11.88	11.46	4.69	090
50520		A	Close kidney-skin fistula	18.88	NA	NA	9.71	10.59	1.91	090
50525		A	Repair renal-abdomen fistula	24.39	NA	NA	13.97	13.69	5.40	090
50526		A	Repair renal-abdomen fistula	26.31	NA	NA	13.98	13.51	1.94	090
50540		A	Revision of horseshoe kidney	21.10	NA	NA	10.58	11.37	2.11	090
50541		A	Laparo ablate renal cyst	16.86	NA	NA	8.52	9.40	1.77	090
50542		A	Laparo ablate renal mass	21.36	NA	NA	10.88	12.02	2.18	090
50543		A	Laparo partial nephrectomy	27.41	NA	NA	13.69	15.14	2.83	090

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50544		A	Laparoscopy, pyeloplasty	23.37	NA	NA	11.07	12.28	2.40	090
50545		A	Laparo radical nephrectomy	25.06	NA	NA	11.97	13.25	2.64	090
50546		A	Laparoscopic nephrectomy	21.87	NA	NA	11.19	12.27	2.39	090
50547		A	Laparo removal donor kidney	26.34	NA	NA	16.19	15.65	5.02	090
50548		A	Laparo remove w/ureter	25.36	NA	NA	11.88	13.18	2.60	090
50549		C	Laparoscope proc, renal	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50551		A	Kidney endoscopy	5.59	4.25	4.88	2.57	2.86	0.57	000
50553		A	Kidney endoscopy	5.98	4.46	5.03	2.63	2.94	0.68	000
50555		A	Kidney endoscopy & biopsy	6.52	4.75	5.42	2.94	3.26	0.65	000
50557		A	Kidney endoscopy & treatment	6.61	4.85	5.56	2.97	3.31	0.66	000
50561		A	Kidney endoscopy & treatment	7.58	5.43	6.21	3.35	3.74	0.78	000
50562		A	Renal scope w/tumor resect	10.90	NA	NA	5.17	5.81	1.10	090
50570		A	Kidney endoscopy	9.53	NA	NA	4.09	4.57	0.95	000
50572		A	Kidney endoscopy	10.33	NA	NA	4.40	4.94	1.05	000
50574		A	Kidney endoscopy & biopsy	11.00	NA	NA	4.67	5.22	1.12	000
50575		A	Kidney endoscopy	13.96	NA	NA	5.83	6.53	1.41	000
50576		A	Kidney endoscopy & treatment	10.97	NA	NA	4.65	5.21	1.10	000
50580		A	Kidney endoscopy & treatment	11.84	NA	NA	5.00	5.53	1.20	000
50590		A	Fragmenting of kidney stone	9.77	15.23	17.22	5.81	6.42	0.99	090
50592		A	Perc rf ablate renal tumor	6.80	73.39	91.82	2.99	3.44	0.66	010
50593		A	Perc cryo ablate renal tum	9.13	111.59	126.81	4.04	4.18	0.89	010
50600		A	Exploration of ureter	17.17	NA	NA	8.75	9.57	1.72	090
50605		A	Insert ureteral support	16.79	NA	NA	9.31	9.38	2.76	090
50610		A	Removal of ureter stone	17.25	NA	NA	8.84	9.79	1.72	090
50620		A	Removal of ureter stone	16.43	NA	NA	8.52	9.43	1.65	090
50630		A	Removal of ureter stone	16.21	NA	NA	8.43	9.12	1.62	090

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50650		A	Removal of ureter	18.82	NA	NA	9.74	10.70	1.96	090
50660		A	Removal of ureter	21.02	NA	NA	10.55	11.58	2.11	090
50684		A	Injection for ureter x-ray	0.76	3.81	4.42	0.60	0.67	0.07	000
50686		A	Measure ureter pressure	1.51	2.57	1.88	1.01	1.09	0.23	000
50688		A	Change of ureter tube/stent	1.20	NA	NA	0.94	1.08	0.11	010
50690		A	Injection for ureter x-ray	1.16	1.42	1.66	0.73	0.83	0.10	000
50700		A	Revision of ureter	16.69	NA	NA	8.84	9.69	1.68	090
50715		A	Release of ureter	20.64	NA	NA	11.39	11.08	3.12	090
50722		A	Release of ureter	17.95	NA	NA	10.17	9.77	3.17	090
50725		A	Release/revise ureter	20.20	NA	NA	11.95	11.80	2.02	090
50727		A	Revise ureter	8.28	NA	NA	5.64	6.16	0.88	090
50728		A	Revise ureter	12.18	NA	NA	7.07	7.61	1.23	090
50740		A	Fusion of ureter & kidney	20.07	NA	NA	11.89	11.37	4.45	090
50750		A	Fusion of ureter & kidney	21.22	NA	NA	10.63	11.84	2.12	090
50760		A	Fusion of ureters	20.07	NA	NA	10.54	11.09	2.77	090
50770		A	Splicing of ureters	21.22	NA	NA	10.63	11.18	2.12	090
50780		A	Reimplant ureter in bladder	19.95	NA	NA	10.31	11.12	2.40	090
50782		A	Reimplant ureter in bladder	19.66	NA	NA	10.01	10.76	4.35	090
50783		A	Reimplant ureter in bladder	20.70	NA	NA	12.16	11.76	2.08	090
50785		A	Reimplant ureter in bladder	22.23	NA	NA	11.15	12.21	2.33	090
50800		A	Implant ureter in bowel	16.41	NA	NA	9.04	9.86	1.81	090
50810		A	Fusion of ureter & bowel	22.61	NA	NA	11.84	12.01	5.02	090
50815		A	Urine shunt to intestine	22.26	NA	NA	11.48	12.63	2.25	090
50820		A	Construct bowel bladder	24.07	NA	NA	12.18	13.08	2.76	090
50825		A	Construct bowel bladder	30.68	NA	NA	14.99	16.39	3.29	090
50830		A	Revise urine flow	33.77	NA	NA	16.01	17.32	3.42	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
50840		A	Replace ureter by bowel	22.39	NA	NA	11.53	12.73	2.26	090
50845		A	Appendico-vesicostomy	22.46	NA	NA	12.00	13.22	2.26	090
50860		A	Transplant ureter to skin	17.08	NA	NA	9.00	9.86	1.71	090
50900		A	Repair of ureter	15.04	NA	NA	8.45	8.95	1.53	090
50920		A	Closure ureter/skin fistula	15.81	NA	NA	8.50	9.37	1.60	090
50930		A	Closure ureter/bowel fistula	20.19	NA	NA	10.22	10.62	4.47	090
50940		A	Release of ureter	15.93	NA	NA	8.54	9.31	1.61	090
50945		A	Laparoscopy ureterolithotomy	17.97	NA	NA	8.91	9.84	1.81	090
50947		A	Laparo new ureter/bladder	25.78	NA	NA	12.42	13.57	2.60	090
50948		A	Laparo new ureter/bladder	23.82	NA	NA	11.40	12.72	2.39	090
50949		C	Laparoscope proc, ureter	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50951		A	Endoscopy of ureter	5.83	4.45	5.11	2.67	2.98	0.58	000
50953		A	Endoscopy of ureter	6.23	4.66	5.33	3.15	3.51	0.64	000
50955		A	Ureter endoscopy & biopsy	6.74	4.90	5.86	3.36	3.76	0.68	000
50957		A	Ureter endoscopy & treatment	6.78	4.96	5.66	3.04	3.38	0.68	000
50961		A	Ureter endoscopy & treatment	6.04	4.53	5.19	2.74	3.07	0.61	000
50970		A	Ureter endoscopy	7.13	NA	NA	3.14	3.51	0.71	000
50972		A	Ureter endoscopy & catheter	6.88	NA	NA	3.04	3.38	0.69	000
50974		A	Ureter endoscopy & biopsy	9.16	NA	NA	3.94	4.41	0.92	000
50976		A	Ureter endoscopy & treatment	9.03	NA	NA	3.89	4.33	0.90	000
50980		A	Ureter endoscopy & treatment	6.84	NA	NA	3.03	3.39	0.68	000
5100F		I	Rsk fx ref w/n 24 hrs x-ray	0.00	0.00	0.00	0.00	0.00	0.00	XXX
51020		A	Incise & treat bladder	7.69	NA	NA	5.18	5.73	0.81	090
51030		A	Incise & treat bladder	7.81	NA	NA	5.14	5.52	0.78	090
51040		A	Incise & drain bladder	4.49	NA	NA	3.46	3.86	0.45	090
51045		A	Incise bladder/drain ureter	7.81	NA	NA	5.53	5.79	1.10	090

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51050		A	Removal of bladder stone	7.97	NA	NA	5.04	5.58	0.81	090
51060		A	Removal of ureter stone	9.95	NA	NA	6.05	6.71	1.02	090
51065		A	Remove ureter calculus	9.95	NA	NA	5.97	6.60	1.02	090
51080		A	Drainage of bladder abscess	6.71	NA	NA	4.53	4.97	0.68	090
51100		A	Drain bladder by needle	0.78	0.93	1.00	0.31	0.32	0.08	000
51101		A	Drain bladder by trocar/cath	1.02	2.40	2.65	0.44	0.45	0.13	000
51102		A	Drain bl w/cath insertion	2.70	3.45	3.96	1.29	1.48	0.30	000
51500		A	Removal of bladder cyst	11.05	NA	NA	7.81	7.45	1.12	090
51520		A	Removal of bladder lesion	10.21	NA	NA	6.16	6.65	1.03	090
51525		A	Removal of bladder lesion	15.42	NA	NA	8.24	9.10	1.62	090
51530		A	Removal of bladder lesion	13.71	NA	NA	7.91	8.35	1.71	090
51535		A	Repair of ureter lesion	13.90	NA	NA	7.59	8.21	1.38	090
51550		A	Partial removal of bladder	17.23	NA	NA	9.16	9.79	2.22	090
51555		A	Partial removal of bladder	23.18	NA	NA	11.68	12.61	2.70	090
51565		A	Revise bladder & ureter(s)	23.68	NA	NA	12.05	13.02	2.52	090
51570		A	Removal of bladder	27.46	NA	NA	13.47	14.48	2.91	090
51575		A	Removal of bladder & nodes	34.18	NA	NA	16.13	17.83	3.48	090
51580		A	Remove bladder/revise tract	35.37	NA	NA	16.99	18.85	3.57	090
51585		A	Removal of bladder & nodes	39.64	NA	NA	18.67	20.72	4.00	090
51590		A	Remove bladder/revise tract	36.33	NA	NA	16.99	18.70	3.82	090
51595		A	Remove bladder/revise tract	41.32	NA	NA	19.16	21.16	4.27	090
51596		A	Remove bladder/create pouch	44.26	NA	NA	20.74	22.94	4.51	090
51597		A	Removal of pelvic structures	42.86	NA	NA	20.35	22.15	4.71	090
51600		A	Injection for bladder x-ray	0.88	4.09	4.71	0.32	0.37	0.08	000
51605		A	Preparation for bladder xray	0.64	NA	NA	0.42	0.46	0.06	000
51610		A	Injection for bladder x-ray	1.05	1.83	2.12	0.69	0.77	0.10	000

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51700		A	Irrigation of bladder	0.88	1.38	1.60	0.36	0.38	0.08	000
51701		A	Insert bladder catheter	0.50	0.98	1.19	0.26	0.27	0.06	000
51702		A	Insert temp bladder cath	0.50	1.41	1.70	0.33	0.36	0.06	000
51703		A	Insert bladder cath, complex	1.47	2.06	2.47	0.78	0.86	0.14	000
51705		A	Change of bladder tube	1.05	1.83	2.17	0.80	0.89	0.10	010
51710		A	Change of bladder tube	1.52	2.45	2.96	1.10	1.22	0.14	010
51715		A	Endoscopic injection/implant	3.73	4.12	4.66	1.78	1.92	0.41	000
51720		A	Treatment of bladder lesion	1.50	1.48	1.75	0.72	0.82	0.14	000
51725		A	Simple cystometrogram	1.51	3.56	4.50	NA	NA	0.14	000
51725	TC	A	Simple cystometrogram	0.00	2.94	3.85	NA	NA	0.01	000
51725	26	A	Simple cystometrogram	1.51	0.62	0.65	0.62	0.65	0.13	000
51726		A	Complex cystometrogram	1.71	5.61	7.09	NA	NA	0.17	000
51726	TC	A	Complex cystometrogram	0.00	4.91	6.34	NA	NA	0.03	000
51726	26	A	Complex cystometrogram	1.71	0.70	0.75	0.70	0.75	0.14	000
51727		A	Cystometrogram w/up	2.11	6.57	6.57	NA	NA	0.24	000
51727	TC	A	Cystometrogram w/up	0.00	5.68	5.68	NA	NA	0.01	000
51727	26	A	Cystometrogram w/up	2.11	0.89	0.89	0.89	0.89	0.23	000
51728		A	Cystometrogram w/vp	2.11	6.54	6.54	NA	NA	0.19	000
51728	TC	A	Cystometrogram w/vp	0.00	5.68	5.68	NA	NA	0.01	000
51728	26	A	Cystometrogram w/vp	2.11	0.86	0.86	0.86	0.86	0.18	000
51729		A	Cystometrogram w/vp&up	2.51	6.91	6.91	NA	NA	0.26	000
51729	TC	A	Cystometrogram w/vp&up	0.00	5.86	5.86	NA	NA	0.01	000
51729	26	A	Cystometrogram w/vp&up	2.51	1.05	1.05	1.05	1.05	0.25	000
51736		A	Urine flow measurement	0.61	0.85	0.94	NA	NA	0.05	000
51736	TC	A	Urine flow measurement	0.00	0.60	0.67	NA	NA	0.01	000
51736	26	A	Urine flow measurement	0.61	0.25	0.27	0.25	0.27	0.04	000

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51741		A	Electro-uroflowmetry, first	1.14	1.16	1.28	NA	NA	0.08	000
51741	TC	A	Electro-uroflowmetry, first	0.00	0.70	0.78	NA	NA	0.01	000
51741	26	A	Electro-uroflowmetry, first	1.14	0.46	0.50	0.46	0.50	0.07	000
51784		A	Anal/urinary muscle study	1.53	3.85	4.34	NA	NA	0.14	000
51784	TC	A	Anal/urinary muscle study	0.00	3.22	3.68	NA	NA	0.01	000
51784	26	A	Anal/urinary muscle study	1.53	0.63	0.66	0.63	0.66	0.13	000
51785		A	Anal/urinary muscle study	1.53	4.43	4.92	NA	NA	0.14	000
51785	TC	A	Anal/urinary muscle study	0.00	3.79	4.25	NA	NA	0.01	000
51785	26	A	Anal/urinary muscle study	1.53	0.64	0.67	0.64	0.67	0.13	000
51792		A	Urinary reflex study	1.10	4.89	5.57	NA	NA	0.11	000
51792	TC	A	Urinary reflex study	0.00	4.42	5.08	NA	NA	0.01	000
51792	26	A	Urinary reflex study	1.10	0.47	0.49	0.47	0.49	0.10	000
51797		A	Intraabdominal pressure test	0.80	2.25	3.08	NA	NA	0.07	ZZZ
51797	TC	A	Intraabdominal pressure test	0.00	1.92	2.69	NA	NA	0.01	ZZZ
51797	26	A	Intraabdominal pressure test	0.80	0.33	0.39	0.33	0.39	0.06	ZZZ
51798		A	Us urine capacity measure	0.00	0.50	0.56	NA	NA	0.01	XXX
51800		A	Revision of bladder/urethra	18.89	NA	NA	9.89	10.85	2.02	090
51820		A	Revision of urinary tract	19.59	NA	NA	10.30	10.81	1.96	090
51840		A	Attach bladder/urethra	11.36	NA	NA	6.69	6.92	1.55	090
51841		A	Attach bladder/urethra	13.68	NA	NA	7.78	8.00	1.91	090
51845		A	Repair bladder neck	10.15	NA	NA	6.00	6.46	1.24	090
51860		A	Repair of bladder wound	12.60	NA	NA	7.62	7.84	1.92	090
51865		A	Repair of bladder wound	15.80	NA	NA	8.69	9.29	1.99	090
51880		A	Repair of bladder opening	7.87	NA	NA	4.94	5.28	1.03	090
51900		A	Repair bladder/vagina lesion	14.63	NA	NA	8.29	8.75	1.47	090
51920		A	Close bladder-uterus fistula	13.41	NA	NA	7.63	8.12	1.34	090

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51925		A	Hysterectomy/bladder repair	17.53	NA	NA	11.50	11.13	3.08	090
51940		A	Correction of bladder defect	30.66	NA	NA	14.68	15.38	3.09	090
51960		A	Revision of bladder & bowel	25.40	NA	NA	12.86	14.15	2.76	090
51980		A	Construct bladder opening	12.57	NA	NA	7.09	7.78	1.27	090
51990		A	Laparo urethral suspension	13.36	NA	NA	7.37	7.54	1.84	090
51992		A	Laparo sling operation	14.87	NA	NA	8.29	8.21	2.32	090
51999		C	Laparoscope proc, bla	0.00	0.00	0.00	0.00	0.00	0.00	YYY
52000		A	Cystoscopy	2.23	3.27	3.79	1.25	1.36	0.24	000
52001		A	Cystoscopy, removal of clots	5.44	4.67	5.44	2.52	2.79	0.55	000
52005		A	Cystoscopy & ureter catheter	2.37	5.05	5.94	1.30	1.44	0.25	000
52007		A	Cystoscopy and biopsy	3.02	9.44	12.00	1.55	1.73	0.31	000
5200F		I	Eval appros surg thxpy epi	0.00	0.00	0.00	0.00	0.00	0.00	XXX
52010		A	Cystoscopy & duct catheter	3.02	7.14	8.51	1.56	1.64	0.31	000
52204		A	Cystoscopy w/biopsy(s)	2.59	7.29	9.54	1.32	1.45	0.27	000
52214		A	Cystoscopy and treatment	3.70	13.73	14.44	1.76	2.29	0.37	000
52224		A	Cystoscopy and treatment	3.14	13.03	18.64	1.54	1.71	0.32	000
52234		A	Cystoscopy and treatment	4.62	NA	NA	2.19	2.44	0.45	000
52235		A	Cystoscopy and treatment	5.44	NA	NA	2.54	2.83	0.55	000
52240		A	Cystoscopy and treatment	9.71	NA	NA	4.22	4.72	0.99	000
52250		A	Cystoscopy and radiotracer	4.49	NA	NA	2.24	2.47	0.47	000
52260		A	Cystoscopy and treatment	3.91	NA	NA	1.90	2.09	0.41	000
52265		A	Cystoscopy and treatment	2.94	6.88	8.78	1.55	1.64	0.37	000
52270		A	Cystoscopy & revise urethra	3.36	6.20	7.92	1.67	1.86	0.34	000
52275		A	Cystoscopy & revise urethra	4.69	8.23	10.65	2.19	2.44	0.47	000
52276		A	Cystoscopy and treatment	4.99	NA	NA	2.35	2.63	0.51	000
52277		A	Cystoscopy and treatment	6.16	NA	NA	2.87	3.16	0.62	000

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52281		A	Cystoscopy and treatment	2.80	4.69	5.80	1.47	1.63	0.30	000
52282		A	Cystoscopy, implant stent	6.39	NA	NA	2.92	3.22	0.68	000
52283		A	Cystoscopy and treatment	3.73	3.81	4.37	1.86	2.04	0.38	000
52285		A	Cystoscopy and treatment	3.60	3.96	4.56	1.81	1.98	0.38	000
52290		A	Cystoscopy and treatment	4.58	NA	NA	2.18	2.43	0.45	000
52300		A	Cystoscopy and treatment	5.30	NA	NA	2.54	2.78	0.58	000
52301		A	Cystoscopy and treatment	5.50	NA	NA	2.60	2.90	0.55	000
52305		A	Cystoscopy and treatment	5.30	NA	NA	2.42	2.69	0.54	000
52310		A	Cystoscopy and treatment	2.81	3.60	4.33	1.38	1.53	0.30	000
52315		A	Cystoscopy and treatment	5.20	5.96	7.31	2.39	2.67	0.52	000
52317		A	Remove bladder stone	6.71	15.00	19.51	2.91	3.25	0.68	000
52318		A	Remove bladder stone	9.18	NA	NA	3.94	4.40	0.92	000
52320		A	Cystoscopy and treatment	4.69	NA	NA	2.14	2.38	0.47	000
52325		A	Cystoscopy, stone removal	6.15	NA	NA	2.72	3.03	0.62	000
52327		A	Cystoscopy, inject material	5.18	NA	NA	2.06	2.30	0.54	000
52330		A	Cystoscopy and treatment	5.03	8.28	14.16	2.27	2.53	0.51	000
52332		A	Cystoscopy and treatment	2.83	10.83	11.82	1.48	1.64	0.30	000
52334		A	Create passage to kidney	4.82	NA	NA	2.26	2.53	0.49	000
52341		A	Cysto w/ureter stricture tx	5.35	NA	NA	2.63	2.97	0.54	000
52342		A	Cysto w/up stricture tx	5.85	NA	NA	2.83	3.19	0.58	000
52343		A	Cysto w/renal stricture tx	6.55	NA	NA	3.11	3.51	0.66	000
52344		A	Cysto/uretero, stricture tx	7.05	NA	NA	3.45	3.88	0.71	000
52345		A	Cysto/uretero w/up stricture	7.55	NA	NA	3.65	4.11	0.75	000
52346		A	Cystouretero w/renal strict	8.58	NA	NA	4.04	4.56	0.86	000
52351		A	Cystouretero & or pyeloscope	5.85	NA	NA	2.84	3.16	0.58	000
52352		A	Cystouretero w/stone remove	6.87	NA	NA	3.33	3.71	0.69	000

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52353		A	Cystouretero w/lithotripsy	7.96	NA	NA	3.76	4.19	0.79	000
52354		A	Cystouretero w/biopsy	7.33	NA	NA	3.51	3.91	0.73	000
52355		A	Cystouretero w/excise tumor	8.81	NA	NA	4.09	4.57	0.89	000
52400		A	Cystouretero w/congen repr	8.69	NA	NA	4.51	5.07	0.88	090
52402		A	Cystourethro cut ejacul duct	5.27	NA	NA	2.12	2.38	0.52	000
52450		A	Incision of prostate	7.78	NA	NA	5.16	5.70	0.78	090
52500		A	Revision of bladder neck	8.14	NA	NA	5.30	5.88	0.81	090
52601		A	Prostatectomy (TURP)	15.26	NA	NA	8.06	8.62	1.55	090
52630		A	Remove prostate regrowth	7.73	NA	NA	4.54	4.99	0.78	090
52640		A	Relieve bladder contracture	4.79	NA	NA	3.31	3.77	0.47	090
52647		A	Laser surgery of prostate	11.30	36.62	48.14	6.54	7.22	1.14	090
52648		A	Laser surgery of prostate	12.15	37.19	48.67	6.88	7.59	1.24	090
52649		A	Prostate laser enucleation	17.29	NA	NA	8.93	10.40	1.74	090
52700		A	Drainage of prostate abscess	7.49	NA	NA	4.65	5.04	0.75	090
53000		A	Incision of urethra	2.33	NA	NA	1.74	1.94	0.25	010
53010		A	Incision of urethra	4.45	NA	NA	3.64	4.04	0.44	090
53020		A	Incision of urethra	1.77	NA	NA	0.91	1.01	0.18	000
53025		A	Incision of urethra	1.13	NA	NA	0.82	0.80	0.07	000
53040		A	Drainage of urethra abscess	6.55	NA	NA	4.26	4.69	0.66	090
53060		A	Drainage of urethra abscess	2.68	2.32	2.38	1.83	1.80	0.45	010
53080		A	Drainage of urinary leakage	6.92	NA	NA	4.64	5.38	0.69	090
53085		A	Drainage of urinary leakage	11.18	NA	NA	6.70	6.76	1.51	090
53200		A	Biopsy of urethra	2.59	1.67	1.83	1.31	1.42	0.28	000
53210		A	Removal of urethra	13.72	NA	NA	7.64	8.35	1.37	090
53215		A	Removal of urethra	16.85	NA	NA	8.76	9.75	1.70	090
53220		A	Treatment of urethra lesion	7.63	NA	NA	4.91	5.36	0.76	090

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53230		A	Removal of urethra lesion	10.44	NA	NA	6.25	6.80	1.22	090
53235		A	Removal of urethra lesion	10.99	NA	NA	6.44	7.22	1.10	090
53240		A	Surgery for urethra pouch	7.08	NA	NA	4.61	5.17	0.71	090
53250		A	Removal of urethra gland	6.52	NA	NA	4.75	5.06	1.47	090
53260		A	Treatment of urethra lesion	3.03	2.47	2.69	1.92	2.03	0.37	010
53265		A	Treatment of urethra lesion	3.17	2.78	3.14	1.95	2.11	0.35	010
53270		A	Removal of urethra gland	3.14	2.57	2.72	2.04	2.09	0.55	010
53275		A	Repair of urethra defect	4.57	NA	NA	2.65	2.97	0.47	010
53400		A	Revise urethra, stage 1	14.13	NA	NA	7.98	8.77	1.47	090
53405		A	Revise urethra, stage 2	15.66	NA	NA	8.43	9.40	1.58	090
53410		A	Reconstruction of urethra	17.68	NA	NA	9.36	10.36	1.78	090
53415		A	Reconstruction of urethra	20.70	NA	NA	10.47	11.57	2.12	090
53420		A	Reconstruct urethra, stage 1	15.17	NA	NA	8.03	8.26	1.54	090
53425		A	Reconstruct urethra, stage 2	17.07	NA	NA	8.78	9.82	1.71	090
53430		A	Reconstruction of urethra	17.43	NA	NA	9.14	9.74	2.05	090
53431		A	Reconstruct urethra/bladder	21.18	NA	NA	10.68	11.80	2.12	090
53440		A	Male sling procedure	15.54	NA	NA	8.83	9.70	1.58	090
53442		A	Remove/revise male sling	13.49	NA	NA	8.09	8.84	1.36	090
53444		A	Insert tandem cuff	14.19	NA	NA	7.69	8.56	1.43	090
53445		A	Insert uro/ves nck sphincter	15.39	NA	NA	8.78	9.81	1.57	090
53446		A	Remove uro sphincter	11.02	NA	NA	6.68	7.44	1.13	090
53447		A	Remove/replace ur sphincter	14.28	NA	NA	8.01	8.95	1.46	090
53448		A	Remov/replc ur sphinctr comp	23.44	NA	NA	11.90	13.21	2.35	090
53449		A	Repair uro sphincter	10.56	NA	NA	6.29	7.00	1.09	090
53450		A	Revision of urethra	6.77	NA	NA	4.47	4.97	0.68	090
53460		A	Revision of urethra	7.75	NA	NA	4.86	5.40	0.76	090

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53500		A	Urethrlys, transvag w/ scope	13.00	NA	NA	7.54	8.16	1.55	090
53502		A	Repair of urethra injury	8.26	NA	NA	5.14	5.63	0.83	090
53505		A	Repair of urethra injury	8.26	NA	NA	5.13	5.70	0.83	090
53510		A	Repair of urethra injury	10.96	NA	NA	6.43	7.15	1.10	090
53515		A	Repair of urethra injury	14.22	NA	NA	7.72	8.51	1.43	090
53520		A	Repair of urethra defect	9.48	NA	NA	5.85	6.48	0.95	090
53600		A	Dilate urethra stricture	1.21	1.06	1.23	0.56	0.62	0.11	000
53601		A	Dilate urethra stricture	0.98	1.23	1.42	0.50	0.56	0.08	000
53605		A	Dilate urethra stricture	1.28	NA	NA	0.51	0.56	0.13	000
53620		A	Dilate urethra stricture	1.62	1.54	1.85	0.79	0.88	0.17	000
53621		A	Dilate urethra stricture	1.35	1.62	1.95	0.64	0.72	0.13	000
53660		A	Dilation of urethra	0.71	1.20	1.39	0.44	0.48	0.07	000
53661		A	Dilation of urethra	0.72	1.16	1.36	0.40	0.44	0.07	000
53665		A	Dilation of urethra	0.76	NA	NA	0.31	0.32	0.08	000
53850		A	Prostatic microwave thermotx	10.08	42.86	57.47	5.59	6.18	1.03	090
53852		A	Prostatic rf thermotx	10.83	40.42	54.21	6.32	6.97	1.10	090
53855		A	Insert prost urethral stent	1.64	18.83	18.83	0.65	0.65	0.17	000
53899		C	Urology surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
54000		A	Slitting of prepuce	1.59	2.42	2.88	1.38	1.52	0.14	010
54001		A	Slitting of prepuce	2.24	2.79	3.26	1.58	1.73	0.24	010
54015		A	Drain penis lesion	5.36	NA	NA	3.08	3.45	0.58	010
54050		A	Destruction, penis lesion(s)	1.29	2.34	2.38	1.63	1.62	0.17	010
54055		A	Destruction, penis lesion(s)	1.25	1.98	2.13	1.29	1.34	0.14	010
54056		A	Cryosurgery, penis lesion(s)	1.29	2.65	2.63	1.82	1.77	0.18	010
54057		A	Laser surg, penis lesion(s)	1.29	2.43	2.72	1.31	1.40	0.13	010
54060		A	Excision of penis lesion(s)	1.98	2.90	3.33	1.61	1.72	0.23	010

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54065		A	Destruction, penis lesion(s)	2.47	3.57	3.66	2.33	2.27	0.32	010
54100		A	Biopsy of penis	1.90	3.54	3.71	1.65	1.59	0.25	000
54105		A	Biopsy of penis	3.54	3.66	4.31	2.33	2.61	0.37	010
54110		A	Treatment of penis lesion	10.92	NA	NA	6.28	6.95	1.10	090
54111		A	Treat penis lesion, graft	14.42	NA	NA	7.66	8.53	1.46	090
54112		A	Treat penis lesion, graft	16.98	NA	NA	8.89	9.93	1.70	090
54115		A	Treatment of penis lesion	6.95	5.43	6.07	4.72	5.21	0.69	090
54120		A	Partial removal of penis	11.01	NA	NA	6.40	7.09	1.13	090
54125		A	Removal of penis	14.56	NA	NA	7.84	8.66	1.54	090
54130		A	Remove penis & nodes	21.84	NA	NA	11.09	12.33	2.20	090
54135		A	Remove penis & nodes	28.17	NA	NA	13.59	15.12	2.84	090
54150		A	Circumcision w/regionl block	1.90	2.31	2.80	0.80	0.85	0.24	000
54160		A	Circumcision, neonate	2.53	3.43	4.08	1.44	1.60	0.25	010
54161		A	Circum 28 days or older	3.32	NA	NA	2.09	2.32	0.35	010
54162		A	Lysis penil circumic lesion	3.32	3.70	4.37	2.17	2.36	0.34	010
54163		A	Repair of circumcision	3.32	NA	NA	2.70	2.99	0.34	010
54164		A	Frenulotomy of penis	2.82	NA	NA	2.48	2.75	0.30	010
54200		A	Treatment of penis lesion	1.11	1.81	2.09	1.19	1.34	0.10	010
54205		A	Treatment of penis lesion	8.97	NA	NA	5.69	6.40	0.89	090
54220		A	Treatment of penis lesion	2.42	3.03	3.60	1.29	1.42	0.27	000
54230		A	Prepare penis study	1.34	1.29	1.46	0.85	0.95	0.13	000
54231		A	Dynamic cavernosometry	2.04	1.79	2.01	1.17	1.31	0.21	000
54235		A	Penile injection	1.19	1.28	1.43	0.84	0.93	0.11	000
54240		A	Penis study	1.31	1.42	1.58	NA	NA	0.09	000
54240	TC	A	Penis study	0.00	0.91	1.01	NA	NA	0.01	000
54240	26	A	Penis study	1.31	0.51	0.57	0.51	0.57	0.08	000

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54250		A	Penis study	2.22	1.20	1.34	NA	NA	0.15	000
54250	TC	A	Penis study	0.00	0.32	0.36	NA	NA	0.01	000
54250	26	A	Penis study	2.22	0.88	0.98	0.88	0.98	0.14	000
54300		A	Revision of penis	11.20	NA	NA	6.50	7.32	1.13	090
54304		A	Revision of penis	13.28	NA	NA	7.40	8.36	1.33	090
54308		A	Reconstruction of urethra	12.62	NA	NA	7.74	8.33	1.27	090
54312		A	Reconstruction of urethra	14.51	NA	NA	8.79	9.48	1.46	090
54316		A	Reconstruction of urethra	18.05	NA	NA	10.36	11.13	1.81	090
54318		A	Reconstruction of urethra	12.43	NA	NA	7.81	8.37	0.90	090
54322		A	Reconstruction of urethra	13.98	NA	NA	7.56	8.53	1.41	090
54324		A	Reconstruction of urethra	17.55	NA	NA	9.19	10.39	1.75	090
54326		A	Reconstruction of urethra	17.02	NA	NA	9.08	9.65	1.71	090
54328		A	Revise penis/urethra	16.89	NA	NA	9.03	9.99	1.70	090
54332		A	Revise penis/urethra	18.37	NA	NA	9.62	10.78	1.85	090
54336		A	Revise penis/urethra	21.62	NA	NA	12.24	12.10	2.18	090
54340		A	Secondary urethral surgery	9.71	NA	NA	5.99	6.56	0.96	090
54344		A	Secondary urethral surgery	17.06	NA	NA	9.92	10.68	1.71	090
54348		A	Secondary urethral surgery	18.32	NA	NA	16.54	14.40	1.34	090
54352		A	Reconstruct urethra/penis	26.13	NA	NA	22.46	19.46	2.64	090
54360		A	Penis plastic surgery	12.78	NA	NA	7.09	8.00	1.29	090
54380		A	Repair penis	14.18	NA	NA	7.86	8.86	1.43	090
54385		A	Repair penis	16.56	NA	NA	9.04	10.93	2.52	090
54390		A	Repair penis and bladder	22.77	NA	NA	12.55	12.22	2.29	090
54400		A	Insert semi-rigid prosthesis	9.17	NA	NA	5.43	6.07	0.92	090
54401		A	Insert self-contd prosthesis	10.44	NA	NA	7.58	8.45	1.07	090
54405		A	Insert multi-comp penis pros	14.52	NA	NA	7.80	8.67	1.47	090

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54406		A	Remove muti-comp penis pros	12.89	NA	NA	7.25	8.05	1.30	090
54408		A	Repair multi-comp penis pros	13.91	NA	NA	7.89	8.73	1.43	090
54410		A	Remove/replace penis prosth	15.18	NA	NA	8.53	9.51	1.54	090
54411		A	Remov/replc penis pros, comp	18.35	NA	NA	9.98	11.02	1.85	090
54415		A	Remove self-contd penis pros	8.88	NA	NA	5.66	6.28	0.89	090
54416		A	Remv/repl penis contain pros	12.08	NA	NA	7.50	8.29	1.23	090
54417		A	Remv/replc penis pros, compl	16.10	NA	NA	8.69	9.62	1.62	090
54420		A	Revision of penis	12.39	NA	NA	7.04	7.88	1.26	090
54430		A	Revision of penis	11.06	NA	NA	6.58	7.36	1.12	090
54435		A	Revision of penis	6.81	NA	NA	4.66	5.20	0.68	090
54440		C	Repair of penis	0.00	0.00	0.00	0.00	0.00	0.00	090
54450		A	Preputial stretching	1.12	0.80	0.94	0.47	0.54	0.10	000
54500		A	Biopsy of testis	1.31	NA	NA	0.75	0.84	0.13	000
54505		A	Biopsy of testis	3.50	NA	NA	2.28	2.57	0.35	010
54512		A	Excise lesion testis	9.33	NA	NA	5.49	6.02	0.96	090
54520		A	Removal of testis	5.30	NA	NA	3.65	3.98	0.64	090
54522		A	Orchiectomy, partial	10.25	NA	NA	6.01	6.42	1.05	090
54530		A	Removal of testis	8.46	NA	NA	5.43	6.04	0.90	090
54535		A	Extensive testis surgery	13.19	NA	NA	7.33	7.91	1.33	090
54550		A	Exploration for testis	8.41	NA	NA	5.15	5.63	0.85	090
54560		A	Exploration for testis	12.10	NA	NA	6.83	7.16	1.23	090
54600		A	Reduce testis torsion	7.64	NA	NA	4.84	5.35	0.76	090
54620		A	Suspension of testis	5.21	NA	NA	3.06	3.43	0.52	010
54640		A	Suspension of testis	7.73	NA	NA	5.44	5.80	0.90	090
54650		A	Orchiopexy (Fowler-Stephens)	12.39	NA	NA	7.22	7.85	1.26	090
54660		A	Revision of testis	5.74	NA	NA	4.09	4.50	0.57	090

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54670		A	Repair testis injury	6.65	NA	NA	4.50	4.97	0.66	090
54680		A	Relocation of testis(es)	14.04	NA	NA	7.67	8.32	1.41	090
54690		A	Laparoscopy, orchiectomy	11.70	NA	NA	6.43	6.58	2.57	090
54692		A	Laparoscopy, orchiopexy	13.74	NA	NA	7.21	8.04	1.37	090
54699		C	Laparoscope proc, testis	0.00	0.00	0.00	0.00	0.00	0.00	YYY
54700		A	Drainage of scrotum	3.47	NA	NA	2.38	2.58	0.41	010
54800		A	Biopsy of epididymis	2.33	NA	NA	2.02	1.78	0.34	000
54830		A	Remove epididymis lesion	6.01	NA	NA	4.24	4.64	0.65	090
54840		A	Remove epididymis lesion	5.27	NA	NA	3.57	3.98	0.54	090
54860		A	Removal of epididymis	6.95	NA	NA	4.58	5.07	0.71	090
54861		A	Removal of epididymis	9.70	NA	NA	5.89	6.51	0.96	090
54865		A	Explore epididymis	5.77	NA	NA	4.10	4.51	0.58	090
54900		A	Fusion of spermatic ducts	14.20	NA	NA	7.87	7.93	1.06	090
54901		A	Fusion of spermatic ducts	19.10	NA	NA	10.96	11.64	1.41	090
55000		A	Drainage of hydrocele	1.43	1.76	2.04	0.91	0.99	0.14	000
55040		A	Removal of hydrocele	5.45	NA	NA	3.83	4.20	0.64	090
55041		A	Removal of hydroceles	8.54	NA	NA	5.49	6.02	0.93	090
55060		A	Repair of hydrocele	6.15	NA	NA	4.30	4.70	0.69	090
55100		A	Drainage of scrotum abscess	2.45	3.38	3.82	2.09	2.24	0.31	010
55110		A	Explore scrotum	6.33	NA	NA	4.36	4.74	0.71	090
55120		A	Removal of scrotum lesion	5.72	NA	NA	4.07	4.44	0.64	090
55150		A	Removal of scrotum	8.14	NA	NA	5.37	5.86	0.89	090
55175		A	Revision of scrotum	5.87	NA	NA	4.14	4.56	0.62	090
55180		A	Revision of scrotum	11.78	NA	NA	7.28	7.88	1.34	090
55200		A	Incision of sperm duct	4.55	7.27	9.08	3.11	3.39	0.45	090
55250		A	Removal of sperm duct(s)	3.37	7.23	8.84	2.93	3.20	0.34	090

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55300		A	Prepare, sperm duct x-ray	3.50	NA	NA	1.68	1.71	0.35	000
55400		A	Repair of sperm duct	8.61	NA	NA	5.13	5.74	0.86	090
55450		A	Ligation of sperm duct	4.43	5.33	6.38	2.66	2.90	0.44	010
55500		A	Removal of hydrocele	6.22	NA	NA	4.62	4.73	0.92	090
55520		A	Removal of sperm cord lesion	6.66	NA	NA	5.29	4.90	1.41	090
55530		A	Revise spermatic cord veins	5.75	NA	NA	3.95	4.35	0.65	090
55535		A	Revise spermatic cord veins	7.19	NA	NA	4.66	5.10	0.72	090
55540		A	Revise hernia & sperm veins	8.30	NA	NA	6.01	5.58	1.71	090
55550		A	Laparo ligate spermatic vein	7.20	NA	NA	4.60	4.95	0.72	090
55559		C	Laparo proc, spermatic cord	0.00	0.00	0.00	0.00	0.00	0.00	YYY
55600		A	Incise sperm duct pouch	7.01	NA	NA	4.60	5.11	0.71	090
55605		A	Incise sperm duct pouch	8.76	NA	NA	6.08	6.11	0.88	090
55650		A	Remove sperm duct pouch	12.65	NA	NA	7.13	7.78	1.27	090
55680		A	Remove sperm pouch lesion	5.67	NA	NA	3.86	4.12	0.57	090
55700		A	Biopsy of prostate	2.58	3.33	3.98	1.27	1.37	0.27	000
55705		A	Biopsy of prostate	4.61	NA	NA	2.74	3.07	0.47	010
55706		A	Prostate saturation sampling	6.28	NA	NA	4.00	4.64	0.45	010
55720		A	Drainage of prostate abscess	7.73	NA	NA	4.73	5.22	0.76	090
55725		A	Drainage of prostate abscess	10.05	NA	NA	6.29	6.88	1.02	090
55801		A	Removal of prostate	19.80	NA	NA	10.38	11.35	1.99	090
55810		A	Extensive prostate surgery	24.29	NA	NA	12.03	13.23	2.57	090
55812		A	Extensive prostate surgery	29.89	NA	NA	14.55	16.10	3.02	090
55815		A	Extensive prostate surgery	32.95	NA	NA	15.76	17.48	3.32	090
55821		A	Removal of prostate	15.76	NA	NA	8.36	9.26	1.61	090
55831		A	Removal of prostate	17.19	NA	NA	8.92	9.89	1.72	090
55840		A	Extensive prostate surgery	24.63	NA	NA	12.31	13.64	2.50	090

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55842		A	Extensive prostate surgery	26.49	NA	NA	13.04	14.48	2.70	090
55845		A	Extensive prostate surgery	30.67	NA	NA	14.50	16.07	3.15	090
55860		A	Surgical exposure, prostate	15.84	NA	NA	8.29	9.22	1.58	090
55862		A	Extensive prostate surgery	20.04	NA	NA	10.24	11.43	2.01	090
55865		A	Extensive prostate surgery	24.57	NA	NA	12.27	13.67	2.47	090
55866		A	Laparo radical prostatectomy	32.46	NA	NA	15.60	17.28	3.31	090
55870		A	Electroejaculation	2.58	2.22	2.48	1.35	1.52	0.27	000
55873		A	Cryoablate prostate	13.60	169.57	169.57	7.47	10.45	1.41	090
55875		A	Transperi needle place, pros	13.46	NA	NA	7.66	8.43	1.34	090
55876		A	Place rt device/marker, pros	1.73	1.99	2.25	1.06	1.19	0.17	000
55899		C	Genital surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
55920		A	Place needles pelvic for rt	8.31	NA	NA	4.40	4.26	0.83	000
55970		N	Sex transformation, M to F	0.00	0.00	0.00	0.00	0.00	0.00	XXX
55980		N	Sex transformation, F to M	0.00	0.00	0.00	0.00	0.00	0.00	XXX
56405		A	I & D of vulva/perineum	1.49	1.45	1.46	1.43	1.41	0.27	010
56420		A	Drainage of gland abscess	1.44	1.82	1.94	1.02	1.02	0.25	010
56440		A	Surgery for vulva lesion	2.89	NA	NA	2.05	2.01	0.51	010
56441		A	Lysis of labial lesion(s)	2.02	1.88	1.99	1.74	1.80	0.30	010
56442		A	Hymenotomy	0.68	NA	NA	0.61	0.63	0.11	000
56501		A	Destroy, vulva lesions, sim	1.58	1.94	1.98	1.52	1.51	0.28	010
56515		A	Destroy vulva lesion/s compl	3.08	3.00	2.98	2.35	2.26	0.52	010
56605		A	Biopsy of vulva/perineum	1.10	1.11	1.14	0.54	0.50	0.18	000
56606		A	Biopsy of vulva/perineum	0.55	0.46	0.47	0.25	0.23	0.08	ZZZ
56620		A	Partial removal of vulva	7.53	NA	NA	6.10	5.91	1.31	090
56625		A	Complete removal of vulva	9.68	NA	NA	6.66	6.36	1.68	090
56630		A	Extensive vulva surgery	14.80	NA	NA	9.20	8.61	2.66	090

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56631		A	Extensive vulva surgery	18.99	NA	NA	11.45	10.71	3.33	090
56632		A	Extensive vulva surgery	21.86	NA	NA	13.70	12.68	3.84	090
56633		A	Extensive vulva surgery	19.62	NA	NA	11.62	10.82	3.45	090
56634		A	Extensive vulva surgery	20.66	NA	NA	12.46	11.55	3.63	090
56637		A	Extensive vulva surgery	24.75	NA	NA	14.09	13.08	4.34	090
56640		A	Extensive vulva surgery	24.78	NA	NA	13.21	12.42	4.34	090
56700		A	Partial removal of hymen	2.84	NA	NA	2.21	2.19	0.49	010
56740		A	Remove vagina gland lesion	4.88	NA	NA	3.17	3.05	0.86	010
56800		A	Repair of vagina	3.93	NA	NA	2.60	2.56	0.66	010
56805		A	Repair clitoris	19.88	NA	NA	11.13	10.62	3.50	090
56810		A	Repair of perineum	4.29	NA	NA	2.75	2.68	0.72	010
56820		A	Exam of vulva w/scope	1.50	1.47	1.48	0.80	0.75	0.27	000
56821		A	Exam/biopsy of vulva w/scope	2.05	1.89	1.91	1.05	0.99	0.35	000
57000		A	Exploration of vagina	3.02	NA	NA	2.09	2.08	0.52	010
57010		A	Drainage of pelvic abscess	6.84	NA	NA	4.90	4.76	1.20	090
57020		A	Drainage of pelvic fluid	1.50	1.02	1.00	0.70	0.65	0.27	000
57022		A	I & d vaginal hematoma, pp	2.73	NA	NA	1.82	1.76	0.47	010
57023		A	I & d vag hematoma, non-ob	5.18	NA	NA	3.23	3.13	0.90	010
57061		A	Destroy vag lesions, simple	1.30	1.75	1.81	1.34	1.35	0.23	010
57065		A	Destroy vag lesions, complex	2.66	2.50	2.52	1.97	1.92	0.45	010
57100		A	Biopsy of vagina	1.20	1.17	1.18	0.58	0.54	0.21	000
57105		A	Biopsy of vagina	1.74	1.87	1.93	1.62	1.63	0.30	010
57106		A	Remove vagina wall, partial	7.50	NA	NA	5.58	5.41	1.26	090
57107		A	Remove vagina tissue, part	24.56	NA	NA	13.55	12.69	4.31	090
57109		A	Vaginectomy partial w/nodes	28.40	NA	NA	15.90	14.47	4.99	090
57110		A	Remove vagina wall, complete	15.48	NA	NA	8.80	8.42	2.68	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
57111		A	Remove vagina tissue, compl	28.40	NA	NA	15.05	14.32	4.99	090
57112		A	Vaginectomy w/nodes, compl	30.52	NA	NA	9.16	11.65	2.52	090
57120		A	Closure of vagina	8.28	NA	NA	5.53	5.42	1.41	090
57130		A	Remove vagina lesion	2.46	2.31	2.38	1.84	1.84	0.42	010
57135		A	Remove vagina lesion	2.70	2.45	2.50	1.96	1.94	0.45	010
57150		A	Treat vagina infection	0.55	0.67	0.77	0.25	0.23	0.08	000
57155		A	Insert uteri tandems/ovoids	6.87	NA	NA	4.77	4.70	0.62	090
57160		A	Insert pessary/other device	0.89	1.17	1.21	0.40	0.37	0.14	000
57170		A	Fitting of diaphragm/cap	0.91	0.72	0.85	0.40	0.37	0.14	000
57180		A	Treat vaginal bleeding	1.63	2.13	2.23	1.21	1.23	0.28	010
57200		A	Repair of vagina	4.42	NA	NA	3.66	3.63	0.73	090
57210		A	Repair vagina/perineum	5.71	NA	NA	4.19	4.15	0.95	090
57220		A	Revision of urethra	4.85	NA	NA	3.80	3.77	0.83	090
57230		A	Repair of urethral lesion	6.30	NA	NA	4.39	4.42	1.10	090
57240		A	Repair bladder & vagina	11.50	NA	NA	6.73	6.53	1.70	090
57250		A	Repair rectum & vagina	11.50	NA	NA	6.85	6.35	1.94	090
57260		A	Repair of vagina	14.44	NA	NA	8.15	7.58	2.43	090
57265		A	Extensive repair of vagina	15.94	NA	NA	8.81	8.33	2.67	090
57267		A	Insert mesh/pelvic flr addon	4.88	NA	NA	2.12	2.09	0.75	ZZZ
57268		A	Repair of bowel bulge	7.57	NA	NA	5.49	5.39	1.27	090
57270		A	Repair of bowel pouch	13.67	NA	NA	7.96	7.62	2.33	090
57280		A	Suspension of vagina	16.72	NA	NA	9.18	8.96	2.70	090
57282		A	Colpopexy, extraperitoneal	7.97	NA	NA	5.63	5.60	1.29	090
57283		A	Colpopexy, intraperitoneal	11.66	NA	NA	7.01	6.80	1.99	090
57284		A	Repair paravag defect, open	14.33	NA	NA	7.85	7.83	2.25	090
57285		A	Repair paravag defect, vag	11.60	NA	NA	6.75	6.61	1.87	090

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57287		A	Revise/remove sling repair	11.15	NA	NA	7.38	7.70	1.53	090
57288		A	Repair bladder defect	12.13	NA	NA	7.05	7.38	1.65	090
57289		A	Repair bladder & vagina	12.80	NA	NA	7.29	7.63	1.29	090
57291		A	Construction of vagina	8.64	NA	NA	8.95	7.39	1.53	090
57292		A	Construct vagina with graft	14.01	NA	NA	8.11	7.93	2.43	090
57295		A	Revise vag graft via vagina	7.82	NA	NA	5.17	5.22	1.24	090
57296		A	Revise vag graft, open abd	16.56	NA	NA	9.14	8.72	2.90	090
57300		A	Repair rectum-vagina fistula	8.71	NA	NA	6.36	5.90	1.58	090
57305		A	Repair rectum-vagina fistula	15.35	NA	NA	9.45	8.61	3.08	090
57307		A	Fistula repair & colostomy	17.17	NA	NA	10.85	9.76	3.82	090
57308		A	Fistula repair, transperine	10.59	NA	NA	7.29	6.70	1.87	090
57310		A	Repair urethrovaginal lesion	7.65	NA	NA	5.02	5.43	0.76	090
57311		A	Repair urethrovaginal lesion	8.91	NA	NA	5.52	5.97	0.89	090
57320		A	Repair bladder-vagina lesion	8.88	NA	NA	5.67	6.01	1.09	090
57330		A	Repair bladder-vagina lesion	13.21	NA	NA	7.17	7.67	1.33	090
57335		A	Repair vagina	20.02	NA	NA	11.29	11.00	3.52	090
57400		A	Dilation of vagina	2.27	NA	NA	1.33	1.31	0.40	000
57410		A	Pelvic examination	1.75	NA	NA	1.15	1.11	0.30	000
57415		A	Remove vaginal foreign body	2.49	NA	NA	1.85	1.84	0.38	010
57420		A	Exam of vagina w/scope	1.60	1.52	1.53	0.84	0.79	0.27	000
57421		A	Exam/biopsy of vag w/scope	2.20	1.98	2.00	1.12	1.05	0.38	000
57423		A	Repair paravag defect, lap	16.08	NA	NA	8.66	8.44	2.83	090
57425		A	Laparoscopy, surg, colpopexy	17.03	NA	NA	9.38	8.98	2.77	090
57426		A	Revise prosth vag graft lap	14.30	NA	NA	8.93	8.93	2.50	090
57452		A	Exam of cervix w/scope	1.50	1.42	1.44	0.99	0.95	0.25	000
57454		A	Bx/curett of cervix w/scope	2.33	1.80	1.79	1.36	1.30	0.40	000

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
57455		A	Biopsy of cervix w/scope	1.99	1.85	1.87	1.01	0.95	0.34	000
57456		A	Endocerv curettage w/scope	1.85	1.77	1.80	0.95	0.90	0.32	000
57460		A	Bx of cervix w/scope, leep	2.83	4.75	5.18	1.58	1.52	0.49	000
57461		A	Conz of cervix w/scope, leep	3.43	5.13	5.55	1.65	1.56	0.61	000
57500		A	Biopsy of cervix	1.20	2.22	2.40	0.85	0.82	0.21	000
57505		A	Endocervical curettage	1.19	1.54	1.59	1.28	1.29	0.21	010
57510		A	Cauterization of cervix	1.90	1.64	1.65	1.23	1.19	0.32	010
57511		A	Cryocautery of cervix	1.95	1.96	1.99	1.62	1.60	0.34	010
57513		A	Laser surgery of cervix	1.95	1.91	1.93	1.62	1.61	0.34	010
57520		A	Conization of cervix	4.11	4.09	4.18	3.24	3.21	0.71	090
57522		A	Conization of cervix	3.67	3.40	3.44	2.89	2.85	0.65	090
57530		A	Removal of cervix	5.27	NA	NA	4.04	3.98	0.90	090
57531		A	Removal of cervix, radical	29.95	NA	NA	16.83	15.51	5.26	090
57540		A	Removal of residual cervix	13.29	NA	NA	7.79	7.43	2.32	090
57545		A	Remove cervix/repair pelvis	14.10	NA	NA	8.16	7.78	2.44	090
57550		A	Removal of residual cervix	6.34	NA	NA	4.67	4.60	1.12	090
57555		A	Remove cervix/repair vagina	9.94	NA	NA	6.32	6.08	1.72	090
57556		A	Remove cervix, repair bowel	9.36	NA	NA	5.98	5.91	1.51	090
57558		A	D&c of cervical stump	1.72	1.64	1.66	1.35	1.33	0.30	010
57700		A	Revision of cervix	4.35	NA	NA	4.04	4.05	0.75	090
57720		A	Revision of cervix	4.61	NA	NA	3.70	3.66	0.79	090
57800		A	Dilation of cervical canal	0.77	0.85	0.87	0.55	0.53	0.13	000
58100		A	Biopsy of uterus lining	1.53	1.41	1.43	0.84	0.80	0.27	000
58110		A	Bx done w/colposcopy add-on	0.77	0.53	0.53	0.35	0.32	0.13	ZZZ
58120		A	Dilation and curettage	3.59	3.33	3.25	2.29	2.20	0.64	010
58140		A	Myomectomy abdom method	15.79	NA	NA	8.98	8.47	2.91	090

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58145		A	Myomectomy vag method	8.91	NA	NA	5.79	5.60	1.55	090
58146		A	Myomectomy abdom complex	20.34	NA	NA	10.89	10.35	3.57	090
58150		A	Total hysterectomy	17.31	NA	NA	9.64	9.05	3.05	090
58152		A	Total hysterectomy	21.86	NA	NA	11.83	11.19	3.89	090
58180		A	Partial hysterectomy	16.60	NA	NA	9.27	8.77	2.91	090
58200		A	Extensive hysterectomy	23.10	NA	NA	12.53	11.66	4.04	090
58210		A	Extensive hysterectomy	30.91	NA	NA	16.73	15.49	5.47	090
58240		A	Removal of pelvis contents	49.33	NA	NA	26.31	24.38	8.65	090
58260		A	Vaginal hysterectomy	14.15	NA	NA	8.23	7.85	2.47	090
58262		A	Vag hyst including t/o	15.94	NA	NA	9.01	8.58	2.80	090
58263		A	Vag hyst w/t/o & vag repair	17.23	NA	NA	9.59	9.14	3.02	090
58267		A	Vag hyst w/urinary repair	18.36	NA	NA	10.17	9.66	3.24	090
58270		A	Vag hyst w/enterocele repair	15.30	NA	NA	8.55	8.15	2.67	090
58275		A	Hysterectomy/revise vagina	17.03	NA	NA	9.54	9.09	3.01	090
58280		A	Hysterectomy/revise vagina	18.33	NA	NA	10.18	9.63	3.19	090
58285		A	Extensive hysterectomy	23.38	NA	NA	12.12	11.43	4.08	090
58290		A	Vag hyst complex	20.27	NA	NA	10.87	10.31	3.56	090
58291		A	Vag hyst incl t/o, complex	22.06	NA	NA	11.68	11.10	3.87	090
58292		A	Vag hyst t/o & repair, compl	23.35	NA	NA	12.24	11.59	4.08	090
58293		A	Vag hyst w/uro repair, compl	24.33	NA	NA	12.68	11.96	4.27	090
58294		A	Vag hyst w/enterocele, compl	21.55	NA	NA	11.43	10.79	3.80	090
58300		N	Insert intrauterine device	1.01	0.92	1.03	0.44	0.43	0.07	XXX
58301		A	Remove intrauterine device	1.27	1.28	1.32	0.57	0.53	0.23	000
58321		A	Artificial insemination	0.92	1.15	1.21	0.41	0.39	0.06	000
58322		A	Artificial insemination	1.10	1.21	1.25	0.49	0.46	0.18	000
58323		A	Sperm washing	0.23	0.19	0.24	0.10	0.10	0.04	000

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58340		A	Catheter for hysterography	0.88	2.26	2.57	0.69	0.71	0.13	000
58345		A	Reopen fallopian tube	4.70	NA	NA	2.85	2.77	0.81	010
58346		A	Insert heyman uteri capsule	7.56	NA	NA	5.23	4.96	0.65	090
58350		A	Reopen fallopian tube	1.06	1.52	1.59	1.06	1.07	0.18	010
58353		A	Endometr ablate, thermal	3.60	23.15	27.05	2.32	2.27	0.64	010
58356		A	Endometrial cryoablation	6.41	43.89	50.40	2.96	2.78	1.12	010
58400		A	Suspension of uterus	7.14	NA	NA	4.81	4.80	1.12	090
58410		A	Suspension of uterus	13.80	NA	NA	7.96	7.57	2.40	090
58520		A	Repair of ruptured uterus	13.48	NA	NA	7.82	7.39	3.01	090
58540		A	Revision of uterus	15.71	NA	NA	8.88	8.41	2.76	090
58541		A	Lsh, uterus 250 g or less	14.70	NA	NA	8.69	8.19	2.56	090
58542		A	Lsh w/t/o ut 250 g or less	16.56	NA	NA	9.54	8.95	2.91	090
58543		A	Lsh uterus above 250 g	16.87	NA	NA	9.69	9.07	2.97	090
58544		A	Lsh w/t/o uterus above 250 g	18.37	NA	NA	10.35	9.65	3.24	090
58545		A	Laparoscopic myomectomy	15.55	NA	NA	8.64	8.17	2.77	090
58546		A	Laparo-myomectomy, complex	19.94	NA	NA	10.53	9.97	3.52	090
58548		A	Lap radical hyst	31.63	NA	NA	17.37	15.75	5.52	090
58550		A	Laparo-asst vag hysterectomy	15.10	NA	NA	8.77	8.38	2.66	090
58552		A	Laparo-vag hyst incl t/o	16.91	NA	NA	9.58	9.11	2.98	090
58553		A	Laparo-vag hyst, complex	20.06	NA	NA	10.66	10.05	3.53	090
58554		A	Laparo-vag hyst w/t/o, compl	23.11	NA	NA	12.47	11.73	4.08	090
58555		A	Hysteroscopy, dx, sep proc	3.33	4.81	4.00	1.81	1.72	0.58	000
58558		A	Hysteroscopy, biopsy	4.74	5.89	4.93	2.47	2.35	0.83	000
58559		A	Hysteroscopy, lysis	6.16	NA	NA	3.11	2.95	1.09	000
58560		A	Hysteroscopy, resect septum	6.99	NA	NA	3.48	3.30	1.23	000
58561		A	Hysteroscopy, remove myoma	9.99	NA	NA	4.83	4.55	1.74	000

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58562		A	Hysteroscopy, remove fb	5.20	5.82	4.89	2.64	2.52	0.90	000
58563		A	Hysteroscopy, ablation	6.16	37.97	43.95	3.11	2.95	1.09	000
58565		A	Hysteroscopy, sterilization	7.12	42.54	47.36	4.60	4.47	1.24	090
58570		A	Tlh, uterus 250 g or less	15.88	NA	NA	9.27	8.69	2.80	090
58571		A	Tlh w/t/o 250 g or less	17.69	NA	NA	10.28	9.52	3.12	090
58572		A	Tlh, uterus over 250 g	20.09	NA	NA	11.20	10.39	3.53	090
58573		A	Tlh w/t/o uterus over 250 g	23.11	NA	NA	12.74	11.69	4.04	090
58578		C	Laparo proc, uterus	0.00	0.00	0.00	0.00	0.00	0.00	YYY
58579		C	Hysteroscope procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
58600		A	Division of fallopian tube	5.91	NA	NA	3.94	3.80	1.05	090
58605		A	Division of fallopian tube	5.28	NA	NA	3.62	3.53	0.92	090
58611		A	Ligate oviduct(s) add-on	1.45	NA	NA	0.65	0.60	0.25	ZZZ
58615		A	Occlude fallopian tube(s)	3.94	NA	NA	2.65	2.65	0.69	010
58660		A	Laparoscopy, lysis	11.59	NA	NA	6.54	6.19	2.12	090
58661		A	Laparoscopy, remove adnexa	11.35	NA	NA	6.03	5.69	2.01	010
58662		A	Laparoscopy, excise lesions	12.15	NA	NA	6.89	6.56	2.15	090
58670		A	Laparoscopy, tubal cautery	5.91	NA	NA	3.96	3.85	1.05	090
58671		A	Laparoscopy, tubal block	5.91	NA	NA	3.96	3.84	1.05	090
58672		A	Laparoscopy, fimbrioplasty	12.91	NA	NA	7.00	6.64	2.26	090
58673		A	Laparoscopy, salpingostomy	14.04	NA	NA	7.60	7.24	2.44	090
58679		C	Laparo proc, oviduct-ovary	0.00	0.00	0.00	0.00	0.00	0.00	YYY
58700		A	Removal of fallopian tube	12.95	NA	NA	7.90	7.42	2.50	090
58720		A	Removal of ovary/tube(s)	12.16	NA	NA	7.31	6.92	2.23	090
58740		A	Adhesiolysis tube, ovary	14.90	NA	NA	8.66	8.27	2.74	090
58750		A	Repair oviduct	15.64	NA	NA	8.75	8.35	2.74	090
58752		A	Revise ovarian tube(s)	15.64	NA	NA	8.69	8.44	1.14	090

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58760		A	Fimbrioplasty	13.93	NA	NA	7.98	7.68	2.43	090
58770		A	Create new tubal opening	14.77	NA	NA	8.30	7.68	2.57	090
58800		A	Drainage of ovarian cyst(s)	4.62	3.95	4.02	3.44	3.43	0.79	090
58805		A	Drainage of ovarian cyst(s)	6.42	NA	NA	4.36	4.35	1.13	090
58820		A	Drain ovary abscess, open	4.70	NA	NA	4.54	4.12	0.81	090
58822		A	Drain ovary abscess, percut	11.81	NA	NA	7.13	6.96	2.61	090
58823		A	Drain pelvic abscess, percut	3.37	20.70	22.52	1.19	1.35	0.40	000
58825		A	Transposition, ovary(s)	11.78	NA	NA	7.39	6.91	2.05	090
58900		A	Biopsy of ovary(s)	6.59	NA	NA	5.35	4.87	1.46	090
58920		A	Partial removal of ovary(s)	11.95	NA	NA	6.99	6.64	2.08	090
58925		A	Removal of ovarian cyst(s)	12.43	NA	NA	7.51	7.09	2.32	090
58940		A	Removal of ovary(s)	8.22	NA	NA	5.72	5.36	1.60	090
58943		A	Removal of ovary(s)	19.52	NA	NA	10.92	10.18	3.66	090
58950		A	Resect ovarian malignancy	18.37	NA	NA	10.82	10.11	3.38	090
58951		A	Resect ovarian malignancy	24.26	NA	NA	13.30	12.34	4.34	090
58952		A	Resect ovarian malignancy	27.29	NA	NA	15.09	13.99	4.92	090
58953		A	Tah, rad dissect for debulk	34.13	NA	NA	18.30	16.94	6.10	090
58954		A	Tah rad debulk/lymph remove	37.13	NA	NA	19.69	18.23	6.60	090
58956		A	Bso, omentectomy w/tah	22.80	NA	NA	12.96	12.12	4.14	090
58957		A	Resect recurrent gyn mal	26.22	NA	NA	14.65	13.38	4.99	090
58958		A	Resect recur gyn mal w/lym	29.22	NA	NA	15.98	14.65	5.13	090
58960		A	Exploration of abdomen	15.79	NA	NA	9.28	8.74	2.87	090
58970		A	Retrieval of oocyte	3.52	2.49	2.45	1.92	1.79	0.27	000
58974		C	Transfer of embryo	0.00	0.00	0.00	0.00	0.00	0.00	000
58976		A	Transfer of embryo	3.82	2.99	3.01	2.06	2.04	0.28	000
58999		C	Genital surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
59000		A	Amniocentesis, diagnostic	1.30	1.95	2.08	0.77	0.74	0.38	000
59001		A	Amniocentesis, therapeutic	3.00	NA	NA	1.58	1.59	0.89	000
59012		A	Fetal cord puncture,prenatal	3.44	NA	NA	1.73	1.64	1.03	000
59015		A	Chorion biopsy	2.20	1.79	1.79	1.17	1.12	0.65	000
59020		A	Fetal contract stress test	0.66	1.19	1.18	NA	NA	0.18	000
59020	TC	A	Fetal contract stress test	0.00	0.89	0.91	NA	NA	0.01	000
59020	26	A	Fetal contract stress test	0.66	0.30	0.27	0.30	0.27	0.17	000
59025		A	Fetal non-stress test	0.53	0.72	0.71	NA	NA	0.14	000
59025	TC	A	Fetal non-stress test	0.00	0.48	0.49	NA	NA	0.01	000
59025	26	A	Fetal non-stress test	0.53	0.24	0.22	0.24	0.22	0.13	000
59030		A	Fetal scalp blood sample	1.99	NA	NA	0.86	0.81	0.13	000
59050		A	Fetal monitor w/report	0.89	NA	NA	0.40	0.37	0.27	XXX
59051		A	Fetal monitor/interpret only	0.74	NA	NA	0.33	0.31	0.23	XXX
59070		A	Transabdom amnioinfus w/us	5.24	5.63	5.70	2.66	2.60	1.57	000
59072		A	Umbilical cord occlud w/us	8.99	NA	NA	4.28	4.14	2.68	000
59074		A	Fetal fluid drainage w/us	5.24	5.75	5.44	2.93	2.70	1.57	000
59076		A	Fetal shunt placement, w/us	8.99	NA	NA	4.28	3.97	2.68	000
59100		A	Remove uterus lesion	13.37	NA	NA	7.92	7.51	3.98	090
59120		A	Treat ectopic pregnancy	12.67	NA	NA	7.60	7.29	3.80	090
59121		A	Treat ectopic pregnancy	12.74	NA	NA	7.55	7.25	3.82	090
59130		A	Treat ectopic pregnancy	15.08	NA	NA	8.60	8.16	1.12	090
59135		A	Treat ectopic pregnancy	14.92	NA	NA	8.49	8.41	1.10	090
59136		A	Treat ectopic pregnancy	14.25	NA	NA	8.16	7.77	4.25	090
59140		A	Treat ectopic pregnancy	5.94	NA	NA	4.32	4.16	0.42	090
59150		A	Treat ectopic pregnancy	12.29	NA	NA	7.35	7.03	3.67	090
59151		A	Treat ectopic pregnancy	12.11	NA	NA	6.99	6.70	3.62	090

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59160		A	D & c after delivery	2.76	2.48	2.65	1.67	1.72	0.81	010
59200		A	Insert cervical dilator	0.79	1.07	1.14	0.36	0.33	0.24	000
59300		A	Episiotomy or vaginal repair	2.41	2.56	2.58	1.39	1.29	0.71	000
59320		A	Revision of cervix	2.48	NA	NA	1.42	1.37	0.72	000
59325		A	Revision of cervix	4.06	NA	NA	2.13	2.03	0.30	000
59350		A	Repair of uterus	4.94	NA	NA	2.22	1.99	1.47	000
59400		A	Obstetrical care	27.48	NA	NA	19.18	18.46	7.94	MMM
59409		A	Obstetrical care	13.48	NA	NA	6.10	5.64	3.87	MMM
59410		A	Obstetrical care	15.37	NA	NA	7.66	7.14	4.42	MMM
59412		A	Antepartum manipulation	1.71	NA	NA	0.93	0.89	0.51	MMM
59414		A	Deliver placenta	1.61	NA	NA	0.72	0.67	0.47	MMM
59425		A	Antepartum care only	6.50	5.56	5.36	2.92	2.56	1.87	MMM
59426		A	Antepartum care only	11.57	10.13	9.77	5.19	4.54	3.25	MMM
59430		A	Care after delivery	2.13	1.47	1.42	1.09	1.02	0.61	MMM
59510		A	Cesarean delivery	31.07	NA	NA	21.51	20.79	9.20	MMM
59514		A	Cesarean delivery only	15.95	NA	NA	7.23	6.69	4.71	MMM
59515		A	Cesarean delivery	18.39	NA	NA	9.40	8.83	5.41	MMM
59525		A	Remove uterus after cesarean	8.53	NA	NA	3.83	3.56	2.53	ZZZ
59610		A	Vbac delivery	28.86	NA	NA	19.78	19.20	8.62	MMM
59612		A	Vbac delivery only	15.04	NA	NA	6.82	6.35	4.49	MMM
59614		A	Vbac care after delivery	16.64	NA	NA	8.00	7.51	4.96	MMM
59618		A	Attempted vbac delivery	32.51	NA	NA	22.22	21.56	9.71	MMM
59620		A	Attempted vbac delivery only	17.50	NA	NA	7.92	7.35	5.23	MMM
59622		A	Attempted vbac after care	19.83	NA	NA	10.19	9.62	5.92	MMM
59812		A	Treatment of miscarriage	4.44	3.73	3.67	3.14	3.05	1.30	090
59820		A	Care of miscarriage	4.84	4.91	4.98	4.31	4.28	1.44	090

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59821		A	Treatment of miscarriage	5.09	4.71	4.76	4.06	4.01	1.53	090
59830		A	Treat uterus infection	6.59	NA	NA	4.57	4.48	1.96	090
59840		R	Abortion	3.01	2.58	2.54	2.34	2.32	0.83	010
59841		R	Abortion	5.65	4.13	4.03	3.56	3.42	1.68	010
59850		R	Abortion	5.90	NA	NA	3.89	3.87	0.42	090
59851		R	Abortion	5.92	NA	NA	4.28	4.22	1.75	090
59852		R	Abortion	8.23	NA	NA	5.90	5.91	0.61	090
59855		R	Abortion	6.43	NA	NA	4.18	4.06	1.92	090
59856		R	Abortion	7.79	NA	NA	4.65	4.50	2.32	090
59857		R	Abortion	9.33	NA	NA	5.25	5.25	0.68	090
59866		R	Abortion (mpr)	3.99	NA	NA	2.12	2.04	0.30	000
59870		A	Evacuate mole of uterus	6.57	NA	NA	5.54	5.56	1.96	090
59871		A	Remove cerclage suture	2.13	NA	NA	1.30	1.25	0.64	000
59897		C	Fetal invas px w/us	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59898		C	Laparo proc, ob care/deliver	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59899		C	Maternity care procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
60000		A	Drain thyroid/tongue cyst	1.81	2.78	2.67	2.30	2.23	0.25	010
60100		A	Biopsy of thyroid	1.56	1.41	1.53	0.58	0.62	0.17	000
60200		A	Remove thyroid lesion	10.02	NA	NA	8.06	7.50	1.77	090
60210		A	Partial thyroid excision	11.23	NA	NA	7.97	7.30	2.15	090
60212		A	Partial thyroid excision	16.43	NA	NA	11.17	10.08	3.18	090
60220		A	Partial removal of thyroid	12.37	NA	NA	8.71	7.96	2.23	090
60225		A	Partial removal of thyroid	14.79	NA	NA	10.50	9.62	2.74	090
60240		A	Removal of thyroid	16.22	NA	NA	10.11	9.24	3.07	090
60252		A	Removal of thyroid	22.01	NA	NA	13.85	12.64	4.03	090
60254		A	Extensive thyroid surgery	28.42	NA	NA	18.00	16.45	4.71	090

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60260		A	Repeat thyroid surgery	18.26	NA	NA	11.67	10.66	3.25	090
60270		A	Removal of thyroid	23.20	NA	NA	13.73	12.88	4.55	090
60271		A	Removal of thyroid	17.62	NA	NA	11.18	10.32	3.12	090
60280		A	Remove thyroid duct lesion	6.16	NA	NA	6.36	5.95	0.88	090
60281		A	Remove thyroid duct lesion	8.82	NA	NA	8.00	7.31	1.19	090
60300		A	Aspir/inj thyroid cyst	0.97	2.09	2.13	0.36	0.38	0.11	000
60500		A	Explore parathyroid glands	16.78	NA	NA	10.62	9.67	3.36	090
60502		A	Re-explore parathyroids	21.15	NA	NA	13.16	12.01	4.31	090
60505		A	Explore parathyroid glands	23.06	NA	NA	14.42	13.33	4.49	090
60512		A	Autotransplant parathyroid	4.44	NA	NA	2.06	1.86	0.86	ZZZ
60520		A	Removal of thymus gland	17.16	NA	NA	10.34	9.68	3.60	090
60521		A	Removal of thymus gland	19.18	NA	NA	10.21	10.46	4.71	090
60522		A	Removal of thymus gland	23.48	NA	NA	12.27	12.45	5.67	090
60540		A	Explore adrenal gland	18.02	NA	NA	10.09	10.09	3.15	090
60545		A	Explore adrenal gland	20.93	NA	NA	11.46	11.16	3.83	090
60600		A	Remove carotid body lesion	25.09	NA	NA	12.79	12.31	5.51	090
60605		A	Remove carotid body lesion	31.96	NA	NA	18.48	16.53	4.27	090
60650		A	Laparoscopy adrenalectomy	20.73	NA	NA	11.00	10.56	3.89	090
60659		C	Laparo proc, endocrine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
60699		C	Endocrine surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
6070F		I	Pt asked/cnsld aed effects	0.00	0.00	0.00	0.00	0.00	0.00	XXX
61000		A	Remove cranial cavity fluid	1.58	NA	NA	1.29	1.32	0.14	000
61001		A	Remove cranial cavity fluid	1.49	NA	NA	1.30	1.34	0.55	000
61020		A	Remove brain cavity fluid	1.51	NA	NA	2.03	1.94	0.52	000
61026		A	Injection into brain canal	1.69	NA	NA	1.63	1.63	0.40	000
61050		A	Remove brain canal fluid	1.51	NA	NA	1.32	1.38	0.13	000

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61055		A	Injection into brain canal	2.10	NA	NA	1.49	1.57	0.30	000
61070		A	Brain canal shunt procedure	0.89	NA	NA	1.36	1.33	0.21	000
61105		A	Twist drill hole	5.45	NA	NA	6.17	5.77	1.99	090
61107		A	Drill skull for implantation	4.99	NA	NA	2.71	2.62	1.85	000
61108		A	Drill skull for drainage	11.64	NA	NA	10.96	10.32	4.30	090
61120		A	Burr hole for puncture	9.60	NA	NA	8.99	8.44	3.59	090
61140		A	Pierce skull for biopsy	17.23	NA	NA	13.89	13.24	6.34	090
61150		A	Pierce skull for drainage	18.90	NA	NA	14.54	13.73	7.04	090
61151		A	Pierce skull for drainage	13.49	NA	NA	11.12	10.41	5.03	090
61154		A	Pierce skull & remove clot	17.07	NA	NA	14.31	13.55	6.33	090
61156		A	Pierce skull for drainage	17.45	NA	NA	13.18	12.65	6.50	090
61210		A	Pierce skull, implant device	5.83	NA	NA	3.16	3.05	2.16	000
61215		A	Insert brain-fluid device	5.85	NA	NA	6.85	6.48	2.15	090
61250		A	Pierce skull & explore	11.49	NA	NA	10.02	9.34	4.28	090
61253		A	Pierce skull & explore	13.49	NA	NA	9.91	9.38	1.78	090
61304		A	Open skull for exploration	23.41	NA	NA	17.19	16.33	8.46	090
61305		A	Open skull for exploration	28.64	NA	NA	20.86	19.80	10.67	090
61312		A	Open skull for drainage	30.17	NA	NA	20.88	19.84	11.21	090
61313		A	Open skull for drainage	28.09	NA	NA	20.74	19.69	10.41	090
61314		A	Open skull for drainage	25.90	NA	NA	19.09	18.10	9.62	090
61315		A	Open skull for drainage	29.65	NA	NA	21.17	20.21	11.06	090
61316		A	Implt cran bone flap to abdo	1.39	NA	NA	0.76	0.72	0.51	ZZZ
61320		A	Open skull for drainage	27.42	NA	NA	19.34	18.56	10.06	090
61321		A	Open skull for drainage	30.53	NA	NA	21.90	20.46	11.39	090
61322		A	Decompressive craniotomy	34.26	NA	NA	24.09	22.53	12.70	090
61323		A	Decompressive lobectomy	35.06	NA	NA	23.79	22.29	12.93	090

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61330		A	Decompress eye socket	25.30	NA	NA	18.97	17.17	9.44	090
61332		A	Explore/biopsy eye socket	28.60	NA	NA	20.23	18.55	10.65	090
61333		A	Explore orbit/remove lesion	29.27	NA	NA	23.34	20.36	10.91	090
61334		A	Explore orbit/remove object	19.60	NA	NA	15.31	13.27	7.29	090
61340		A	Subtemporal decompression	20.11	NA	NA	15.59	14.66	7.50	090
61343		A	Incise skull (press relief)	31.86	NA	NA	22.10	21.09	11.78	090
61345		A	Relieve cranial pressure	29.23	NA	NA	20.99	19.96	10.89	090
61440		A	Incise skull for surgery	28.66	NA	NA	20.67	19.58	10.67	090
61450		A	Incise skull for surgery	27.69	NA	NA	19.62	18.52	10.31	090
61458		A	Incise skull for brain wound	28.84	NA	NA	20.55	19.65	10.64	090
61460		A	Incise skull for surgery	30.24	NA	NA	21.54	20.10	11.26	090
61470		A	Incise skull for surgery	27.62	NA	NA	19.58	18.58	10.29	090
61480		A	Incise skull for surgery	28.05	NA	NA	14.21	14.49	2.05	090
61490		A	Incise skull for surgery	27.22	NA	NA	19.36	18.47	10.16	090
61500		A	Removal of skull lesion	19.18	NA	NA	14.99	14.11	6.01	090
61501		A	Remove infected skull bone	16.35	NA	NA	13.41	12.56	4.85	090
61510		A	Removal of brain lesion	30.83	NA	NA	22.92	21.87	11.43	090
61512		A	Remove brain lining lesion	37.14	NA	NA	25.43	24.33	13.79	090
61514		A	Removal of brain abscess	27.23	NA	NA	19.45	18.64	10.09	090
61516		A	Removal of brain lesion	26.58	NA	NA	19.18	18.30	9.58	090
61517		A	Implt brain chemotx add-on	1.38	NA	NA	0.75	0.72	0.51	ZZZ
61518		A	Removal of brain lesion	39.89	NA	NA	27.81	26.52	14.85	090
61519		A	Remove brain lining lesion	43.43	NA	NA	28.94	27.63	16.08	090
61520		A	Removal of brain lesion	57.09	NA	NA	37.02	35.34	18.65	090
61521		A	Removal of brain lesion	46.99	NA	NA	31.16	29.53	17.51	090
61522		A	Removal of brain abscess	31.54	NA	NA	22.25	21.21	11.76	090

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61524		A	Removal of brain lesion	29.89	NA	NA	21.35	20.15	11.15	090
61526		A	Removal of brain lesion	54.08	NA	NA	35.46	32.91	20.15	090
61530		A	Removal of brain lesion	45.56	NA	NA	29.93	28.01	17.00	090
61531		A	Implant brain electrodes	16.41	NA	NA	13.86	13.16	6.12	090
61533		A	Implant brain electrodes	21.46	NA	NA	16.12	15.30	7.98	090
61534		A	Removal of brain lesion	23.01	NA	NA	17.58	16.70	8.58	090
61535		A	Remove brain electrodes	13.15	NA	NA	11.66	11.05	4.90	090
61536		A	Removal of brain lesion	37.72	NA	NA	25.63	24.52	14.06	090
61537		A	Removal of brain tissue	36.45	NA	NA	24.07	22.39	13.51	090
61538		A	Removal of brain tissue	39.45	NA	NA	26.06	24.10	14.72	090
61539		A	Removal of brain tissue	34.28	NA	NA	23.75	22.41	12.77	090
61540		A	Removal of brain tissue	31.43	NA	NA	22.28	21.26	11.71	090
61541		A	Incision of brain tissue	30.94	NA	NA	21.92	20.77	11.53	090
61542		A	Removal of brain tissue	33.16	NA	NA	19.78	20.41	12.35	090
61543		A	Removal of brain tissue	31.31	NA	NA	22.12	20.68	11.66	090
61544		A	Remove & treat brain lesion	27.36	NA	NA	19.44	16.85	10.20	090
61545		A	Excision of brain tumor	46.43	NA	NA	31.82	30.11	17.30	090
61546		A	Removal of pituitary gland	33.44	NA	NA	23.29	22.07	12.45	090
61548		A	Removal of pituitary gland	23.37	NA	NA	16.50	15.63	6.92	090
61550		A	Release of skull seams	15.59	NA	NA	10.26	10.36	1.14	090
61552		A	Release of skull seams	20.40	NA	NA	11.23	12.57	1.51	090
61556		A	Incise skull/sutures	24.09	NA	NA	15.47	15.35	8.99	090
61557		A	Incise skull/sutures	23.31	NA	NA	18.19	17.46	8.69	090
61558		A	Excision of skull/sutures	26.50	NA	NA	14.01	15.94	9.88	090
61559		A	Excision of skull/sutures	34.02	NA	NA	24.88	23.90	2.50	090
61563		A	Excision of skull tumor	28.44	NA	NA	20.28	19.32	10.60	090

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61564		A	Excision of skull tumor	34.74	NA	NA	24.45	23.34	12.93	090
61566		A	Removal of brain tissue	32.45	NA	NA	22.84	21.91	12.08	090
61567		A	Incision of brain tissue	37.00	NA	NA	26.04	25.04	13.81	090
61570		A	Remove foreign body, brain	26.51	NA	NA	19.50	18.29	9.88	090
61571		A	Incise skull for brain wound	28.42	NA	NA	20.54	19.60	10.58	090
61575		A	Skull base/brainstem surgery	36.56	NA	NA	25.00	23.08	13.62	090
61576		A	Skull base/brainstem surgery	55.31	NA	NA	42.57	41.30	7.38	090
61580		A	Craniofacial approach, skull	34.51	NA	NA	33.30	31.09	6.12	090
61581		A	Craniofacial approach, skull	39.13	NA	NA	37.56	34.73	5.23	090
61582		A	Craniofacial approach, skull	35.14	NA	NA	41.57	38.86	13.10	090
61583		A	Craniofacial approach, skull	38.50	NA	NA	34.13	32.69	13.44	090
61584		A	Orbitocranial approach/skull	37.70	NA	NA	33.83	32.33	13.18	090
61585		A	Orbitocranial approach/skull	42.57	NA	NA	37.91	34.39	15.87	090
61586		A	Resect nasopharynx, skull	27.48	NA	NA	34.26	30.56	10.24	090
61590		A	Infratemporal approach/skull	47.04	NA	NA	37.61	34.85	8.77	090
61591		A	Infratemporal approach/skull	47.02	NA	NA	37.26	34.86	9.96	090
61592		A	Orbitocranial approach/skull	43.08	NA	NA	36.12	34.66	15.06	090
61595		A	Transtemporal approach/skull	33.74	NA	NA	29.98	28.29	7.42	090
61596		A	Transcochlear approach/skull	39.43	NA	NA	30.77	28.94	5.26	090
61597		A	Transcondylar approach/skull	40.82	NA	NA	30.65	29.43	15.22	090
61598		A	Transpetrosal approach/skull	36.53	NA	NA	34.01	30.24	13.61	090
61600		A	Resect/excise cranial lesion	30.01	NA	NA	28.14	26.20	6.46	090
61601		A	Resect/excise cranial lesion	31.14	NA	NA	29.07	27.71	10.56	090
61605		A	Resect/excise cranial lesion	32.57	NA	NA	28.98	26.94	5.14	090
61606		A	Resect/excise cranial lesion	42.05	NA	NA	33.00	31.91	14.20	090
61607		A	Resect/excise cranial lesion	40.93	NA	NA	31.20	29.31	15.25	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
61608		A	Resect/excise cranial lesion	45.54	NA	NA	35.17	33.65	15.97	090
61609		A	Transect artery, sinus	9.88	0.00	2.21	0.00	2.21	3.69	ZZZ
61610		A	Transect artery, sinus	29.63	NA	NA	13.96	14.27	11.05	ZZZ
61611		A	Transect artery, sinus	7.41	NA	NA	3.20	3.50	0.54	ZZZ
61612		A	Transect artery, sinus	27.84	NA	NA	12.04	12.60	2.03	ZZZ
61613		A	Remove aneurysm, sinus	45.03	NA	NA	36.15	34.05	16.79	090
61615		A	Resect/excise lesion, skull	35.77	NA	NA	28.81	27.78	4.78	090
61616		A	Resect/excise lesion, skull	46.74	NA	NA	37.41	35.54	14.96	090
61618		A	Repair dura	18.69	NA	NA	14.40	13.56	5.98	090
61619		A	Repair dura	22.10	NA	NA	16.25	15.24	6.57	090
61623		A	Endovasc tempory vessel occl	9.95	NA	NA	4.32	4.56	1.92	000
61624		A	Transcath occlusion, cns	20.12	NA	NA	8.43	8.87	3.91	000
61626		A	Transcath occlusion, non-cns	16.60	NA	NA	6.13	6.87	2.22	000
61630		R	Intracranial angioplasty	22.07	NA	NA	10.81	11.31	4.34	XXX
61635		R	Intracran angioplsty w/stent	24.28	NA	NA	11.73	12.26	4.22	XXX
61640		N	Dilate ic vasospasm, init	12.32	NA	NA	5.33	5.15	0.90	000
61641		N	Dilate ic vasospasm add-on	4.33	NA	NA	1.87	1.81	0.32	ZZZ
61642		N	Dilate ic vasospasm add-on	8.66	NA	NA	3.74	3.62	0.64	ZZZ
61680		A	Intracranial vessel surgery	32.55	NA	NA	22.98	22.00	12.12	090
61682		A	Intracranial vessel surgery	63.41	NA	NA	38.93	37.35	23.63	090
61684		A	Intracranial vessel surgery	41.64	NA	NA	28.23	26.53	15.51	090
61686		A	Intracranial vessel surgery	67.50	NA	NA	42.81	40.96	25.17	090
61690		A	Intracranial vessel surgery	31.34	NA	NA	22.46	21.27	11.69	090
61692		A	Intracranial vessel surgery	54.59	NA	NA	35.19	33.38	20.35	090
61697		A	Brain aneurysm repr, complx	63.40	NA	NA	40.27	37.93	23.39	090
61698		A	Brain aneurysm repr, complx	69.63	NA	NA	43.98	40.81	25.94	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
61700		A	Brain aneurysm repr, simple	50.62	NA	NA	33.28	32.04	18.75	090
61702		A	Inner skull vessel surgery	60.04	NA	NA	38.72	36.14	22.37	090
61703		A	Clamp neck artery	18.80	NA	NA	14.75	14.07	7.01	090
61705		A	Revise circulation to head	38.10	NA	NA	25.84	24.06	14.20	090
61708		A	Revise circulation to head	37.20	NA	NA	21.81	20.09	3.19	090
61710		A	Revise circulation to head	31.29	NA	NA	15.61	16.75	6.77	090
61711		A	Fusion of skull arteries	38.23	NA	NA	25.84	24.47	14.24	090
61720		A	Incise skull/brain surgery	17.62	NA	NA	13.74	12.30	6.57	090
61735		A	Incise skull/brain surgery	22.35	NA	NA	14.50	13.76	8.32	090
61750		A	Incise skull/brain biopsy	19.83	NA	NA	14.86	14.14	7.33	090
61751		A	Brain biopsy w/ct/mr guide	18.79	NA	NA	15.21	14.52	6.95	090
61760		A	Implant brain electrodes	22.39	NA	NA	16.55	15.24	8.34	090
61770		A	Incise skull for treatment	23.19	NA	NA	16.79	15.32	8.51	090
61790		A	Treat trigeminal nerve	11.60	NA	NA	10.20	9.45	4.22	090
61791		A	Treat trigeminal tract	15.41	NA	NA	12.38	11.67	5.40	090
61795		A	Brain surgery using computer	4.03	NA	NA	2.24	2.12	1.10	ZZZ
61796		A	Srs, cranial lesion simple	13.93	NA	NA	11.15	9.71	4.80	090
61797		A	Srs, cran les simple, addl	3.48	NA	NA	1.90	1.76	1.20	ZZZ
61798		A	Srs, cranial lesion complex	19.85	NA	NA	14.36	11.34	6.85	090
61799		A	Srs, cran les complex, addl	4.81	NA	NA	2.62	2.43	1.65	ZZZ
61800		A	Apply srs headframe add-on	2.25	NA	NA	1.55	1.44	0.76	ZZZ
61850		A	Implant neuroelectrodes	13.34	NA	NA	8.09	9.01	4.99	090
61860		A	Implant neuroelectrodes	22.26	NA	NA	16.28	15.52	8.29	090
61863		A	Implant neuroelectrode	20.71	NA	NA	16.30	15.63	7.69	090
61864		A	Implant neuroelectrde, addl	4.49	NA	NA	2.46	2.37	1.67	ZZZ
61867		A	Implant neuroelectrode	33.03	NA	NA	23.09	22.06	12.28	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
61868		A	Implant neuroelectrde, addl	7.91	NA	NA	4.32	4.17	2.95	ZZZ
61870		A	Implant neuroelectrodes	16.34	NA	NA	12.89	12.38	6.09	090
61875		A	Implant neuroelectrodes	16.46	NA	NA	12.95	12.27	1.22	090
61880		A	Revise/remove neuroelectrode	6.95	NA	NA	7.26	6.79	2.56	090
61885		A	Insrt/redo neurostim 1 array	7.57	NA	NA	9.59	8.94	2.68	090
61886		A	Implant neurostim arrays	9.93	NA	NA	11.31	10.63	3.66	090
61888		A	Revise/remove neuroreceiver	5.23	NA	NA	4.57	4.44	1.78	010
62000		A	Treat skull fracture	13.93	NA	NA	11.57	9.87	5.20	090
62005		A	Treat skull fracture	17.63	NA	NA	13.74	12.85	6.57	090
62010		A	Treatment of head injury	21.43	NA	NA	16.35	15.37	7.98	090
62100		A	Repair brain fluid leakage	23.53	NA	NA	16.82	15.89	7.80	090
62115		A	Reduction of skull defect	22.91	NA	NA	12.75	11.39	1.68	090
62116		A	Reduction of skull defect	25.02	NA	NA	18.69	17.80	9.33	090
62117		A	Reduction of skull defect	28.35	NA	NA	19.91	19.08	3.80	090
62120		A	Repair skull cavity lesion	24.59	NA	NA	23.11	22.29	3.29	090
62121		A	Incise skull repair	23.03	NA	NA	19.09	18.36	8.59	090
62140		A	Repair of skull defect	14.55	NA	NA	11.66	11.03	4.93	090
62141		A	Repair of skull defect	16.07	NA	NA	12.57	11.95	5.51	090
62142		A	Remove skull plate/flap	11.83	NA	NA	10.33	9.81	4.24	090
62143		A	Replace skull plate/flap	14.15	NA	NA	11.57	10.96	5.20	090
62145		A	Repair of skull & brain	20.09	NA	NA	14.67	14.03	7.49	090
62146		A	Repair of skull with graft	17.28	NA	NA	13.55	12.61	6.44	090
62147		A	Repair of skull with graft	20.67	NA	NA	15.41	14.52	7.69	090
62148		A	Retr bone flap to fix skull	2.00	NA	NA	1.10	1.03	0.73	ZZZ
62160		A	Neuroendoscopy add-on	3.00	NA	NA	1.63	1.58	1.12	ZZZ
62161		A	Dissect brain w/scope	21.23	NA	NA	16.17	15.39	7.91	090

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62162		A	Remove colloid cyst w/scope	26.80	NA	NA	19.77	18.93	9.98	090
62163		A	Neuroendoscopy w/fb removal	16.53	NA	NA	13.78	13.20	6.15	090
62164		A	Remove brain tumor w/scope	29.43	NA	NA	22.08	20.55	10.98	090
62165		A	Remove pituit tumor w/scope	23.23	NA	NA	16.94	16.08	6.61	090
62180		A	Establish brain cavity shunt	22.58	NA	NA	16.87	16.07	8.42	090
62190		A	Establish brain cavity shunt	12.17	NA	NA	10.75	10.16	4.54	090
62192		A	Establish brain cavity shunt	13.35	NA	NA	10.97	10.34	4.80	090
62194		A	Replace/irrigate catheter	5.78	NA	NA	6.40	5.15	0.47	010
62200		A	Establish brain cavity shunt	19.29	NA	NA	14.65	13.93	7.19	090
62201		A	Brain cavity shunt w/scope	16.04	NA	NA	13.80	13.05	5.95	090
62220		A	Establish brain cavity shunt	14.10	NA	NA	11.23	10.60	5.02	090
62223		A	Establish brain cavity shunt	14.05	NA	NA	12.22	11.63	5.03	090
62225		A	Replace/irrigate catheter	6.19	NA	NA	6.86	6.43	2.29	090
62230		A	Replace/revise brain shunt	11.43	NA	NA	9.48	9.02	4.13	090
62252		A	Csf shunt reprogram	0.74	2.03	2.01	NA	NA	0.26	XXX
62252	TC	A	Csf shunt reprogram	0.00	1.63	1.62	NA	NA	0.01	XXX
62252	26	A	Csf shunt reprogram	0.74	0.40	0.39	0.40	0.39	0.25	XXX
62256		A	Remove brain cavity shunt	7.38	NA	NA	7.59	7.19	2.73	090
62258		A	Replace brain cavity shunt	15.64	NA	NA	12.15	11.62	5.64	090
62263		A	Epidural lysis mult sessions	6.54	15.52	13.65	5.73	4.66	0.54	010
62264		A	Epidural lysis on single day	4.42	7.97	7.27	2.52	2.04	0.37	010
62267		A	Interdiscal perq aspir, dx	3.00	3.61	3.84	1.29	1.34	0.31	000
62268		A	Drain spinal cord cyst	4.73	6.91	7.60	2.45	2.40	0.47	000
62269		A	Needle biopsy, spinal cord	5.01	6.54	7.87	2.20	2.20	0.58	000
62270		A	Spinal fluid tap, diagnostic	1.37	2.74	2.89	0.68	0.69	0.24	000
62272		A	Drain cerebro spinal fluid	1.35	3.94	3.89	0.81	0.80	0.34	000

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62273		A	Inject epidural patch	2.15	2.69	2.52	1.05	0.91	0.21	000
62280		A	Treat spinal cord lesion	2.63	6.65	6.30	1.91	1.62	0.52	010
62281		A	Treat spinal cord lesion	2.66	6.16	5.74	1.72	1.47	0.28	010
62282		A	Treat spinal canal lesion	2.33	5.77	5.91	1.67	1.47	0.30	010
62284		A	Injection for myelogram	1.54	4.00	4.45	0.76	0.83	0.18	000
62287		A	Percutaneous diskectomy	9.03	NA	NA	6.78	6.22	0.85	090
62290		A	Inject for spine disk x-ray	3.00	6.54	6.37	1.90	1.70	0.31	000
62291		A	Inject for spine disk x-ray	2.91	6.22	5.94	1.86	1.63	0.28	000
62292		A	Injection into disk lesion	9.24	NA	NA	8.59	6.05	0.78	090
62294		A	Injection into spinal artery	12.87	NA	NA	4.41	6.16	1.06	090
62310		A	Inject spine c/t	1.91	5.07	4.64	1.19	0.96	0.17	000
62311		A	Inject spine l/s (cd)	1.54	4.28	4.09	0.97	0.82	0.13	000
62318		A	Inject spine w/cath, c/t	2.04	4.82	4.66	0.81	0.70	0.17	000
62319		A	Inject spine w/cath l/s (cd)	1.87	4.48	4.27	0.84	0.72	0.17	000
62350		A	Implant spinal canal cath	6.05	NA	NA	4.89	4.31	1.09	010
62351		A	Implant spinal canal cath	11.66	NA	NA	10.63	9.88	3.52	090
62355		A	Remove spinal canal catheter	4.35	NA	NA	3.97	3.53	0.76	010
62360		A	Insert spine infusion device	4.33	NA	NA	4.10	3.59	0.90	010
62361		A	Implant spine infusion pump	5.65	NA	NA	4.86	4.60	1.14	010
62362		A	Implant spine infusion pump	6.10	NA	NA	5.03	4.59	1.27	010
62365		A	Remove spine infusion device	4.65	NA	NA	4.37	3.96	0.92	010
62367		A	Analyze spine infusion pump	0.48	0.71	0.65	0.23	0.19	0.06	XXX
62368		A	Analyze spine infusion pump	0.75	1.00	0.87	0.37	0.30	0.07	XXX
63001		A	Removal of spinal lamina	17.61	NA	NA	13.39	12.68	5.91	090
63003		A	Removal of spinal lamina	17.74	NA	NA	13.46	12.76	5.85	090
63005		A	Removal of spinal lamina	16.43	NA	NA	13.39	12.78	5.27	090

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63011		A	Removal of spinal lamina	15.91	NA	NA	12.46	11.66	4.17	090
63012		A	Removal of spinal lamina	16.85	NA	NA	13.20	12.67	5.30	090
63015		A	Removal of spinal lamina	20.85	NA	NA	16.09	15.34	7.28	090
63016		A	Removal of spinal lamina	22.03	NA	NA	16.26	15.39	7.04	090
63017		A	Removal of spinal lamina	17.33	NA	NA	14.06	13.40	5.78	090
63020		A	Neck spine disk surgery	16.20	NA	NA	13.29	12.69	5.26	090
63030		A	Low back disk surgery	13.18	NA	NA	11.60	11.04	4.01	090
63035		A	Spinal disk surgery add-on	3.15	NA	NA	1.76	1.70	0.92	ZZZ
63040		A	Laminotomy, single cervical	20.31	NA	NA	15.13	14.42	6.51	090
63042		A	Laminotomy, single lumbar	18.76	NA	NA	14.61	13.95	5.40	090
63043		C	Laminotomy, addl cervical	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
63044		C	Laminotomy, addl lumbar	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
63045		A	Removal of spinal lamina	17.95	NA	NA	14.01	13.35	5.95	090
63046		A	Removal of spinal lamina	17.25	NA	NA	13.50	12.87	5.34	090
63047		A	Removal of spinal lamina	15.37	NA	NA	12.78	12.22	4.58	090
63048		A	Remove spinal lamina add-on	3.47	NA	NA	1.94	1.85	1.05	ZZZ
63050		A	Cervical laminoplasty	22.01	NA	NA	17.01	15.91	8.21	090
63051		A	C-laminoplasty w/graft/plate	25.51	NA	NA	18.33	17.36	7.52	090
63055		A	Decompress spinal cord	23.55	NA	NA	17.14	16.38	7.96	090
63056		A	Decompress spinal cord	21.86	NA	NA	15.96	15.18	6.43	090
63057		A	Decompress spine cord add-on	5.25	NA	NA	2.93	2.82	1.57	ZZZ
63064		A	Decompress spinal cord	26.22	NA	NA	18.48	17.52	8.25	090
63066		A	Decompress spine cord add-on	3.26	NA	NA	1.79	1.74	1.22	ZZZ
63075		A	Neck spine disk surgery	19.60	NA	NA	15.04	14.46	6.34	090
63076		A	Neck spine disk surgery	4.04	NA	NA	2.24	2.16	1.30	ZZZ
63077		A	Spine disk surgery, thorax	22.88	NA	NA	15.93	15.17	6.09	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
63078		A	Spine disk surgery, thorax	3.28	NA	NA	1.82	1.74	0.78	ZZZ
63081		A	Removal of vertebral body	26.10	NA	NA	18.73	17.85	8.20	090
63082		A	Remove vertebral body add-on	4.36	NA	NA	2.42	2.34	1.36	ZZZ
63085		A	Removal of vertebral body	29.47	NA	NA	19.12	18.26	8.24	090
63086		A	Remove vertebral body add-on	3.19	NA	NA	1.68	1.64	0.90	ZZZ
63087		A	Removal of vertebral body	37.53	NA	NA	24.00	22.96	10.10	090
63088		A	Remove vertebral body add-on	4.32	NA	NA	2.42	2.33	1.10	ZZZ
63090		A	Removal of vertebral body	30.93	NA	NA	20.65	19.54	7.47	090
63091		A	Remove vertebral body add-on	3.03	NA	NA	1.66	1.60	0.71	ZZZ
63101		A	Removal of vertebral body	34.10	NA	NA	24.43	23.22	11.04	090
63102		A	Removal of vertebral body	34.10	NA	NA	24.11	22.92	8.93	090
63103		A	Remove vertebral body add-on	4.82	NA	NA	2.69	2.61	1.34	ZZZ
63170		A	Incise spinal cord tract(s)	22.21	NA	NA	17.09	15.89	8.28	090
63172		A	Drainage of spinal cyst	19.76	NA	NA	14.97	14.19	7.35	090
63173		A	Drainage of spinal cyst	24.31	NA	NA	18.24	17.35	9.09	090
63180		A	Revise spinal cord ligaments	20.53	NA	NA	16.17	14.66	7.64	090
63182		A	Revise spinal cord ligaments	22.82	NA	NA	17.43	14.81	8.51	090
63185		A	Incise spinal column/nerves	16.49	NA	NA	13.02	12.18	6.15	090
63190		A	Incise spinal column/nerves	18.89	NA	NA	14.54	13.80	4.45	090
63191		A	Incise spinal column/nerves	18.92	NA	NA	15.14	11.94	3.89	090
63194		A	Incise spinal column & cord	22.10	NA	NA	15.75	15.07	2.95	090
63195		A	Incise spinal column & cord	21.64	NA	NA	16.26	15.20	8.07	090
63196		A	Incise spinal column & cord	25.27	NA	NA	13.24	15.02	1.87	090
63197		A	Incise spinal column & cord	24.08	NA	NA	18.12	17.15	8.99	090
63198		A	Incise spinal column & cord	29.90	NA	NA	15.46	14.55	2.20	090
63199		A	Incise spinal column & cord	31.47	NA	NA	16.14	17.62	2.32	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
63200		A	Release of spinal cord	21.44	NA	NA	16.21	15.35	7.87	090
63250		A	Revise spinal cord vessels	43.86	NA	NA	29.00	27.33	16.35	090
63251		A	Revise spinal cord vessels	44.64	NA	NA	29.87	28.36	16.65	090
63252		A	Revise spinal cord vessels	44.63	NA	NA	29.86	28.31	16.65	090
63265		A	Excise intraspinal lesion	23.82	NA	NA	17.63	16.80	8.39	090
63266		A	Excise intraspinal lesion	24.68	NA	NA	17.98	17.09	8.72	090
63267		A	Excise intraspinal lesion	19.45	NA	NA	15.06	14.38	6.50	090
63268		A	Excise intraspinal lesion	20.02	NA	NA	15.94	14.83	7.46	090
63270		A	Excise intraspinal lesion	29.80	NA	NA	21.30	20.11	11.12	090
63271		A	Excise intraspinal lesion	29.92	NA	NA	21.09	20.08	10.98	090
63272		A	Excise intraspinal lesion	27.50	NA	NA	19.57	18.68	9.83	090
63273		A	Excise intraspinal lesion	26.47	NA	NA	19.47	17.88	9.86	090
63275		A	Biopsy/excise spinal tumor	25.86	NA	NA	18.68	17.75	9.16	090
63276		A	Biopsy/excise spinal tumor	25.69	NA	NA	18.65	17.73	9.04	090
63277		A	Biopsy/excise spinal tumor	22.39	NA	NA	16.73	15.90	7.26	090
63278		A	Biopsy/excise spinal tumor	22.12	NA	NA	17.09	15.95	8.25	090
63280		A	Biopsy/excise spinal tumor	30.29	NA	NA	21.64	20.77	11.25	090
63281		A	Biopsy/excise spinal tumor	29.99	NA	NA	21.59	20.62	11.08	090
63282		A	Biopsy/excise spinal tumor	28.15	NA	NA	20.48	19.61	10.33	090
63283		A	Biopsy/excise spinal tumor	26.76	NA	NA	20.08	18.93	9.96	090
63285		A	Biopsy/excise spinal tumor	38.05	NA	NA	25.98	24.55	14.19	090
63286		A	Biopsy/excise spinal tumor	37.62	NA	NA	25.68	24.51	13.71	090
63287		A	Biopsy/excise spinal tumor	40.08	NA	NA	27.37	25.89	14.95	090
63290		A	Biopsy/excise spinal tumor	40.82	NA	NA	27.36	26.06	15.22	090
63295		A	Repair of laminectomy defect	5.25	NA	NA	2.87	2.68	1.95	ZZZ
63300		A	Removal of vertebral body	26.80	NA	NA	19.01	18.10	9.01	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
63301		A	Removal of vertebral body	31.57	NA	NA	22.71	20.61	11.77	090
63302		A	Removal of vertebral body	31.15	NA	NA	22.48	20.50	11.60	090
63303		A	Removal of vertebral body	33.55	NA	NA	23.35	21.18	12.49	090
63304		A	Removal of vertebral body	33.85	NA	NA	23.96	22.57	12.60	090
63305		A	Removal of vertebral body	36.24	NA	NA	25.12	22.68	13.51	090
63306		A	Removal of vertebral body	35.55	NA	NA	15.92	19.10	13.25	090
63307		A	Removal of vertebral body	34.96	NA	NA	24.11	22.52	13.04	090
63308		A	Remove vertebral body add-on	5.24	NA	NA	2.84	2.76	1.62	ZZZ
63600		A	Remove spinal cord lesion	15.12	NA	NA	10.55	8.17	1.64	090
63610		A	Stimulation of spinal cord	8.72	17.25	23.43	2.29	2.25	0.71	000
63615		A	Remove lesion of spinal cord	17.32	NA	NA	13.20	11.98	6.44	090
63620		A	Srs, spinal lesion	15.60	NA	NA	11.93	10.11	5.38	090
63621		A	Srs, spinal lesion, addl	4.00	NA	NA	2.19	2.02	1.37	ZZZ
63650		A	Implant neuroelectrodes	7.20	NA	NA	5.25	4.34	0.66	010
63655		A	Implant neuroelectrodes	11.56	NA	NA	10.49	9.82	3.76	090
63661		A	Remove spine eltrd perq aray	5.08	11.66	11.66	3.90	3.90	0.73	010
63662		A	Remove spine eltrd plate	11.00	NA	NA	8.48	8.48	1.61	090
63663		A	Revise spine eltrd perq aray	7.75	16.11	16.11	5.24	5.24	1.13	010
63664		A	Revise spine eltrd plate	11.52	NA	NA	8.75	8.75	1.67	090
63685		A	Insrt/redo spine n generator	6.05	NA	NA	5.04	4.47	1.14	010
63688		A	Revise/remove neuroreceiver	5.30	NA	NA	4.68	4.18	1.05	010
63700		A	Repair of spinal herniation	17.47	NA	NA	14.67	13.55	6.50	090
63702		A	Repair of spinal herniation	19.41	NA	NA	15.73	14.92	7.23	090
63704		A	Repair of spinal herniation	22.43	NA	NA	18.36	16.58	8.35	090
63706		A	Repair of spinal herniation	25.35	NA	NA	19.96	18.68	9.47	090
63707		A	Repair spinal fluid leakage	12.65	NA	NA	10.80	10.19	3.63	090

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63709		A	Repair spinal fluid leakage	15.65	NA	NA	12.43	11.83	4.68	090
63710		A	Graft repair of spine defect	15.40	NA	NA	12.48	11.86	5.04	090
63740		A	Install spinal shunt	12.63	NA	NA	10.80	10.43	4.42	090
63741		A	Install spinal shunt	9.12	NA	NA	7.40	6.53	2.27	090
63744		A	Revision of spinal shunt	8.94	NA	NA	7.92	7.24	3.18	090
63746		A	Removal of spinal shunt	7.33	NA	NA	7.65	7.04	2.73	090
64400		A	N block inj, trigeminal	1.11	2.14	2.00	0.77	0.66	0.18	000
64402		A	N block inj, facial	1.25	1.96	1.85	0.78	0.70	0.18	000
64405		A	N block inj, occipital	1.32	1.91	1.70	0.88	0.74	0.27	000
64408		A	N block inj, vagus	1.41	2.15	2.00	1.21	1.08	0.17	000
64410		A	N block inj, phrenic	1.43	2.68	2.55	0.74	0.68	0.34	000
64412		A	N block inj, spinal accessor	1.18	3.20	2.96	0.91	0.79	0.21	000
64413		A	N block inj, cervical plexus	1.40	1.97	1.85	0.82	0.71	0.21	000
64415		A	N block inj, brachial plexus	1.48	2.15	2.13	0.53	0.48	0.11	000
64416		A	N block cont infuse, b plex	1.81	NA	NA	0.41	0.42	0.14	000
64417		A	N block inj, axillary	1.44	2.17	2.17	0.54	0.49	0.11	000
64418		A	N block inj, suprascapular	1.32	2.64	2.54	0.82	0.71	0.13	000
64420		A	N block inj, intercost, sng	1.18	1.97	2.67	0.75	0.65	0.13	000
64421		A	N block inj, intercost, mlt	1.68	2.60	3.82	0.95	0.81	0.21	000
64425		A	N block inj, ilio-ing/hypogi	1.75	2.04	1.87	0.95	0.81	0.21	000
64430		A	N block inj, pudendal	1.46	2.22	2.57	0.78	0.84	0.14	000
64435		A	N block inj, paracervical	1.45	2.28	2.41	0.77	0.75	0.25	000
64445		A	N block inj, sciatic, sng	1.48	2.23	2.24	0.74	0.68	0.17	000
64446		A	N blk inj, sciatic, cont inf	1.81	NA	NA	0.42	0.47	0.14	000
64447		A	N block inj fem, single	1.50	NA	NA	0.34	0.32	0.11	000
64448		A	N block inj fem, cont inf	1.63	NA	NA	0.37	0.40	0.13	000

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64449		A	N block inj, lumbar plexus	1.81	NA	NA	0.49	0.51	0.14	000
64450		A	N block, other peripheral	1.27	1.69	1.60	0.67	0.63	0.11	000
64455		A	N block inj, plantar digit	0.75	0.58	0.60	0.23	0.26	0.08	000
64479		A	Inj foramen epidural c/t	2.20	5.94	5.81	1.48	1.26	0.27	000
64480		A	Inj foramen epidural add-on	1.54	2.66	2.48	0.81	0.67	0.24	ZZZ
64483		A	Inj foramen epidural l/s	1.90	5.97	5.89	1.34	1.15	0.17	000
64484		A	Inj foramen epidural add-on	1.33	2.71	2.60	0.69	0.56	0.11	ZZZ
64490		A	Inj paravert f jnt c/t 1 lev	1.82	3.72	3.72	1.25	1.25	0.21	000
64491		A	Inj paravert f jnt c/t 2 lev	1.16	1.57	1.57	0.58	0.58	0.11	ZZZ
64492		A	Inj paravert f jnt c/t 3 lev	1.16	1.61	1.61	0.61	0.61	0.11	ZZZ
64493		A	Inj paravert f jnt l/s 1 lev	1.52	3.45	3.45	1.09	1.09	0.14	000
64494		A	Inj paravert f jnt l/s 2 lev	1.00	1.49	1.49	0.48	0.48	0.08	ZZZ
64495		A	Inj paravert f jnt l/s 3 lev	1.00	1.53	1.53	0.51	0.51	0.08	ZZZ
64505		A	N block, spenopalatine gangl	1.36	1.42	1.40	1.00	0.93	0.10	000
64508		A	N block, carotid sinus s/p	1.12	3.54	3.23	0.98	0.86	0.25	000
64510		A	N block, stellate ganglion	1.22	2.46	2.61	0.89	0.73	0.10	000
64517		A	N block inj, hypogas plxs	2.20	2.95	2.69	1.34	1.13	0.18	000
64520		A	N block, lumbar/thoracic	1.35	4.26	4.10	1.00	0.83	0.11	000
64530		A	N block inj, celiac pelus	1.58	3.99	3.91	1.05	0.92	0.14	000
64550		A	Apply neurostimulator	0.18	0.29	0.27	0.08	0.07	0.01	000
64553		A	Implant neuroelectrodes	2.36	3.34	3.27	1.98	1.93	0.40	010
64555		A	Implant neuroelectrodes	2.32	2.97	3.29	1.70	1.77	0.27	010
64560		A	Implant neuroelectrodes	2.41	4.68	4.06	2.41	2.14	0.17	010
64561		A	Implant neuroelectrodes	7.15	17.71	22.09	3.84	4.11	0.81	010
64565		A	Implant neuroelectrodes	1.81	3.23	3.07	1.76	1.58	0.25	010
64573		A	Implant neuroelectrodes	8.25	NA	NA	7.48	6.94	2.53	090

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64575		A	Implant neuroelectrodes	4.42	NA	NA	4.17	3.53	0.45	090
64577		A	Implant neuroelectrodes	4.69	NA	NA	2.79	3.52	1.74	090
64580		A	Implant neuroelectrodes	4.19	NA	NA	3.85	3.75	0.92	090
64581		A	Implant neuroelectrodes	14.23	NA	NA	6.86	7.39	1.64	090
64585		A	Revise/remove neuroelectrode	2.11	4.67	6.12	1.86	2.06	0.28	010
64590		A	Insrt/redo pn/gastr stimul	2.45	4.68	5.61	1.94	2.19	0.30	010
64595		A	Revise/rmv pn/gastr stimul	1.78	4.89	6.27	1.68	1.89	0.23	010
64600		A	Injection treatment of nerve	3.49	8.04	7.90	2.75	2.41	0.55	010
64605		A	Injection treatment of nerve	5.65	15.54	12.68	4.73	3.84	0.45	010
64610		A	Injection treatment of nerve	7.20	12.76	11.87	5.16	4.90	2.23	010
64612		A	Destroy nerve, face muscle	2.01	2.49	2.35	2.16	1.90	0.68	010
64613		A	Destroy nerve, neck muscle	2.01	2.23	2.18	1.87	1.64	0.61	010
64614		A	Destroy nerve, extrem musc	2.20	2.53	2.48	2.04	1.82	0.44	010
64620		A	Injection treatment of nerve	2.89	3.02	3.80	2.10	1.79	0.30	010
64622		A	Destr paravertebrl nerve l/s	3.05	6.90	6.48	2.50	2.05	0.27	010
64623		A	Destr paravertebral n add-on	0.99	2.74	2.58	0.51	0.39	0.08	ZZZ
64626		A	Destr paravertebrl nerve c/t	3.92	8.08	7.38	3.64	3.00	0.35	010
64627		A	Destr paravertebral n add-on	1.16	3.92	3.73	0.60	0.47	0.10	ZZZ
64630		A	Injection treatment of nerve	3.05	3.11	3.20	2.13	2.11	0.35	010
64632		A	N block inj, common digit	1.23	1.16	1.15	0.71	0.73	0.10	010
64640		A	Injection treatment of nerve	2.81	3.23	3.32	1.92	1.88	0.25	010
64650		A	Chemodenerv eccrine glands	0.70	1.32	1.23	0.41	0.37	0.11	000
64653		A	Chemodenerv eccrine glands	0.88	1.49	1.37	0.46	0.43	0.25	000
64680		A	Injection treatment of nerve	2.67	6.33	6.16	1.99	1.80	0.31	010
64681		A	Injection treatment of nerve	3.78	6.26	6.74	1.63	1.74	0.31	010
64702		A	Revise finger/toe nerve	6.26	NA	NA	7.35	6.64	1.10	090

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64704		A	Revise hand/foot nerve	4.69	NA	NA	4.25	4.16	0.57	090
64708		A	Revise arm/leg nerve	6.36	NA	NA	6.95	6.49	1.20	090
64712		A	Revision of sciatic nerve	8.07	NA	NA	7.08	6.56	1.38	090
64713		A	Revision of arm nerve(s)	11.40	NA	NA	8.88	8.39	2.43	090
64714		A	Revise low back nerve(s)	10.55	NA	NA	8.57	7.33	1.78	090
64716		A	Revision of cranial nerve	6.99	NA	NA	7.80	7.33	1.17	090
64718		A	Revise ulnar nerve at elbow	7.26	NA	NA	8.68	8.10	1.54	090
64719		A	Revise ulnar nerve at wrist	4.97	NA	NA	5.84	5.51	0.96	090
64721		A	Carpal tunnel surgery	4.97	6.57	6.25	6.50	6.19	1.02	090
64722		A	Relieve pressure on nerve(s)	4.82	NA	NA	4.72	4.31	0.88	090
64726		A	Release foot/toe nerve	4.27	NA	NA	3.50	3.40	0.41	090
64727		A	Internal nerve revision	3.10	NA	NA	1.85	1.74	0.62	ZZZ
64732		A	Incision of brow nerve	4.89	NA	NA	6.17	5.52	1.84	090
64734		A	Incision of cheek nerve	5.55	NA	NA	6.98	6.03	0.73	090
64736		A	Incision of chin nerve	5.23	NA	NA	5.85	5.47	1.95	090
64738		A	Incision of jaw nerve	6.36	NA	NA	7.42	6.41	2.36	090
64740		A	Incision of tongue nerve	6.22	NA	NA	6.83	6.33	0.83	090
64742		A	Incision of facial nerve	6.85	NA	NA	7.10	6.23	0.90	090
64744		A	Incise nerve, back of head	5.72	NA	NA	6.62	5.64	2.12	090
64746		A	Incise diaphragm nerve	6.56	NA	NA	4.67	4.77	1.60	090
64752		A	Incision of vagus nerve	7.69	NA	NA	5.95	5.57	1.88	090
64755		A	Incision of stomach nerves	15.05	NA	NA	8.97	8.13	3.33	090
64760		A	Incision of vagus nerve	7.59	NA	NA	5.91	5.24	1.67	090
64761		A	Incision of pelvis nerve	7.04	NA	NA	5.33	5.01	1.05	090
64763		A	Incise hip/thigh nerve	7.56	NA	NA	5.80	6.19	1.67	090
64766		A	Incise hip/thigh nerve	9.47	NA	NA	6.96	6.83	0.95	090

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64771		A	Sever cranial nerve	8.15	NA	NA	7.35	7.18	1.09	090
64772		A	Incision of spinal nerve	7.84	NA	NA	7.49	7.02	1.88	090
64774		A	Remove skin nerve lesion	5.80	NA	NA	5.51	5.16	1.09	090
64776		A	Remove digit nerve lesion	5.60	NA	NA	5.19	4.86	0.88	090
64778		A	Digit nerve surgery add-on	3.11	NA	NA	2.21	1.90	0.64	ZZZ
64782		A	Remove limb nerve lesion	6.86	NA	NA	5.64	5.34	0.95	090
64783		A	Limb nerve surgery add-on	3.71	NA	NA	2.52	2.23	0.47	ZZZ
64784		A	Remove nerve lesion	10.62	NA	NA	9.29	8.57	2.08	090
64786		A	Remove sciatic nerve lesion	16.25	NA	NA	12.74	11.82	3.33	090
64787		A	Implant nerve end	4.29	NA	NA	2.24	2.21	0.71	ZZZ
64788		A	Remove skin nerve lesion	5.24	NA	NA	5.57	5.16	1.12	090
64790		A	Removal of nerve lesion	12.10	NA	NA	10.10	9.35	2.85	090
64792		A	Removal of nerve lesion	15.86	NA	NA	11.96	11.53	5.91	090
64795		A	Biopsy of nerve	3.01	NA	NA	2.10	1.96	0.85	000
64802		A	Remove sympathetic nerves	10.37	NA	NA	8.63	6.72	0.85	090
64804		A	Remove sympathetic nerves	15.91	NA	NA	6.76	6.83	1.31	090
64809		A	Remove sympathetic nerves	14.71	NA	NA	10.45	8.82	1.22	090
64818		A	Remove sympathetic nerves	11.34	NA	NA	6.73	6.14	2.15	090
64820		A	Remove sympathetic nerves	10.74	NA	NA	10.27	9.44	1.98	090
64821		A	Remove sympathetic nerves	9.33	NA	NA	9.21	8.79	1.91	090
64822		A	Remove sympathetic nerves	9.33	NA	NA	9.21	8.64	1.91	090
64823		A	Remove sympathetic nerves	10.94	NA	NA	10.16	9.40	2.23	090
64831		A	Repair of digit nerve	9.16	NA	NA	9.57	8.92	1.70	090
64832		A	Repair nerve add-on	5.65	NA	NA	3.63	3.37	1.05	ZZZ
64834		A	Repair of hand or foot nerve	10.81	NA	NA	9.60	8.92	1.92	090
64835		A	Repair of hand or foot nerve	11.73	NA	NA	10.10	9.50	2.39	090

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64836		A	Repair of hand or foot nerve	11.73	NA	NA	10.10	9.51	2.39	090
64837		A	Repair nerve add-on	6.25	NA	NA	3.65	3.55	0.79	ZZZ
64840		A	Repair of leg nerve	14.02	NA	NA	10.83	10.30	1.12	090
64856		A	Repair/transpose nerve	15.07	NA	NA	12.51	11.66	2.95	090
64857		A	Repair arm/leg nerve	15.82	NA	NA	12.87	12.04	3.02	090
64858		A	Repair sciatic nerve	17.82	NA	NA	15.65	14.23	3.65	090
64859		A	Nerve surgery	4.25	NA	NA	3.03	2.67	0.86	ZZZ
64861		A	Repair of arm nerves	20.89	NA	NA	12.26	12.71	4.28	090
64862		A	Repair of low back nerves	21.09	NA	NA	16.46	14.20	7.86	090
64864		A	Repair of facial nerve	13.41	NA	NA	10.87	10.13	1.77	090
64865		A	Repair of facial nerve	16.09	NA	NA	15.69	15.13	2.12	090
64866		A	Fusion of facial/other nerve	16.83	NA	NA	14.44	14.52	2.25	090
64868		A	Fusion of facial/other nerve	14.90	NA	NA	14.20	13.52	1.98	090
64870		A	Fusion of facial/other nerve	17.08	NA	NA	12.11	10.84	4.15	090
64872		A	Subsequent repair of nerve	1.99	NA	NA	1.16	1.14	0.27	ZZZ
64874		A	Repair & revise nerve add-on	2.98	NA	NA	2.03	1.80	0.38	ZZZ
64876		A	Repair nerve/shorten bone	3.37	NA	NA	1.85	1.70	0.68	ZZZ
64885		A	Nerve graft, head or neck	17.60	NA	NA	13.54	12.78	2.33	090
64886		A	Nerve graft, head or neck	20.82	NA	NA	15.44	14.82	2.77	090
64890		A	Nerve graft, hand or foot	16.24	NA	NA	12.74	12.17	3.32	090
64891		A	Nerve graft, hand or foot	17.35	NA	NA	15.32	13.59	3.56	090
64892		A	Nerve graft, arm or leg	15.74	NA	NA	12.44	11.81	3.24	090
64893		A	Nerve graft, arm or leg	16.87	NA	NA	13.85	12.62	3.48	090
64895		A	Nerve graft, hand or foot	20.39	NA	NA	17.48	15.24	4.17	090
64896		A	Nerve graft, hand or foot	21.96	NA	NA	15.55	15.13	8.20	090
64897		A	Nerve graft, arm or leg	19.38	NA	NA	15.22	14.09	3.97	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
64898		A	Nerve graft, arm or leg	20.97	NA	NA	15.93	15.14	4.30	090
64901		A	Nerve graft add-on	10.20	NA	NA	7.26	6.29	2.08	ZZZ
64902		A	Nerve graft add-on	11.81	NA	NA	8.41	7.22	2.40	ZZZ
64905		A	Nerve pedicle transfer	15.11	NA	NA	12.74	11.82	3.09	090
64907		A	Nerve pedicle transfer	20.03	NA	NA	10.82	12.21	1.47	090
64910		A	Nerve repair w/allograft	11.39	NA	NA	11.23	10.47	2.05	090
64911		A	Neurorraphy w/vein autograft	14.39	NA	NA	14.06	12.54	2.95	090
64999		C	Nervous system surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
65091		A	Revise eye	7.26	NA	NA	10.40	9.58	1.50	090
65093		A	Revise eye with implant	7.04	NA	NA	10.39	9.67	1.44	090
65101		A	Removal of eye	8.30	NA	NA	12.22	11.24	1.70	090
65103		A	Remove eye/insert implant	8.84	NA	NA	12.59	11.54	1.81	090
65105		A	Remove eye/attach implant	9.93	NA	NA	13.72	12.54	2.02	090
65110		A	Removal of eye	15.70	NA	NA	18.28	16.56	2.08	090
65112		A	Remove eye/revise socket	18.51	NA	NA	21.22	19.20	2.44	090
65114		A	Remove eye/revise socket	19.65	NA	NA	22.03	19.82	2.61	090
65125		A	Revise ocular implant	3.27	9.11	8.89	4.82	4.41	0.66	090
65130		A	Insert ocular implant	8.42	NA	NA	11.95	10.93	1.71	090
65135		A	Insert ocular implant	8.60	NA	NA	12.08	11.06	1.74	090
65140		A	Attach ocular implant	9.46	NA	NA	13.04	11.94	1.27	090
65150		A	Revise ocular implant	6.43	NA	NA	9.61	8.95	0.47	090
65155		A	Reinsert ocular implant	10.10	NA	NA	13.50	12.36	2.05	090
65175		A	Removal of ocular implant	7.40	NA	NA	10.90	10.02	0.99	090
65205		A	Remove foreign body from eye	0.71	0.82	0.76	0.51	0.45	0.10	000
65210		A	Remove foreign body from eye	0.84	1.08	0.99	0.67	0.58	0.13	000
65220		A	Remove foreign body from eye	0.71	0.86	0.80	0.45	0.40	0.11	000

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65222		A	Remove foreign body from eye	0.93	1.18	1.08	0.71	0.62	0.14	000
65235		A	Remove foreign body from eye	9.01	NA	NA	10.93	9.67	1.29	090
65260		A	Remove foreign body from eye	12.54	NA	NA	14.36	12.77	0.92	090
65265		A	Remove foreign body from eye	14.34	NA	NA	15.96	14.14	3.19	090
65270		A	Repair of eye wound	1.95	5.28	5.16	1.99	1.77	0.28	010
65272		A	Repair of eye wound	4.62	9.22	8.68	5.25	4.63	0.34	090
65273		A	Repair of eye wound	5.16	NA	NA	5.57	4.92	0.38	090
65275		A	Repair of eye wound	6.29	9.78	8.76	6.74	5.81	0.89	090
65280		A	Repair of eye wound	9.10	NA	NA	9.64	8.54	1.87	090
65285		A	Repair of eye wound	14.71	NA	NA	14.50	12.67	2.70	090
65286		A	Repair of eye wound	6.63	12.79	12.09	7.31	6.44	0.93	090
65290		A	Repair of eye socket wound	6.53	NA	NA	7.27	6.45	1.33	090
65400		A	Removal of eye lesion	7.50	11.41	10.42	9.40	8.37	1.07	090
65410		A	Biopsy of cornea	1.47	2.48	2.33	1.47	1.29	0.32	000
65420		A	Removal of eye lesion	4.36	9.81	9.38	6.16	5.60	0.58	090
65426		A	Removal of eye lesion	6.05	11.94	11.26	7.37	6.58	0.86	090
65430		A	Corneal smear	1.47	1.73	1.57	1.44	1.28	0.23	000
65435		A	Curette/treat cornea	0.92	1.31	1.20	1.04	0.93	0.17	000
65436		A	Curette/treat cornea	4.82	6.03	5.40	5.61	4.98	0.88	090
65450		A	Treatment of corneal lesion	3.47	5.57	5.10	5.48	5.00	0.49	090
65600		A	Revision of cornea	4.20	6.77	6.20	5.45	4.83	0.62	090
65710		A	Corneal transplant	14.45	NA	NA	16.67	14.82	2.05	090
65730		A	Corneal transplant	16.35	NA	NA	18.20	16.11	2.32	090
65750		A	Corneal transplant	16.90	NA	NA	17.87	15.80	2.25	090
65755		A	Corneal transplant	16.79	NA	NA	17.80	15.73	2.37	090
65756		A	Corneal trnspl, endothelial	16.84	NA	NA	16.58	14.42	1.24	090

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65757		C	Prep corneal endo allograft	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
65760		N	Revision of cornea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65765		N	Revision of cornea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65767		N	Corneal tissue transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65770		A	Revise cornea with implant	19.74	NA	NA	19.87	17.50	7.35	090
65771		N	Radial keratotomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65772		A	Correction of astigmatism	5.09	7.48	6.83	6.31	5.62	0.68	090
65775		A	Correction of astigmatism	6.91	NA	NA	8.57	7.68	0.51	090
65780		A	Ocular reconst, transplant	10.73	NA	NA	14.14	12.80	1.44	090
65781		A	Ocular reconst, transplant	18.14	NA	NA	19.42	17.29	1.33	090
65782		A	Ocular reconst, transplant	15.43	NA	NA	16.97	15.14	3.18	090
65800		A	Drainage of eye	1.91	2.24	2.05	1.77	1.56	0.28	000
65805		A	Drainage of eye	1.91	2.63	2.44	1.78	1.56	0.35	000
65810		A	Drainage of eye	5.82	NA	NA	7.44	6.63	0.88	090
65815		A	Drainage of eye	6.00	11.59	10.95	7.39	6.57	1.10	090
65820		A	Relieve inner eye pressure	8.91	NA	NA	11.99	10.92	0.65	090
65850		A	Incision of eye	11.39	NA	NA	12.23	10.88	2.06	090
65855		A	Laser surgery of eye	3.99	5.47	5.02	4.38	3.91	0.65	010
65860		A	Incise inner eye adhesions	3.59	5.04	4.65	3.55	3.15	1.37	090
65865		A	Incise inner eye adhesions	5.77	NA	NA	7.45	6.78	0.41	090
65870		A	Incise inner eye adhesions	7.39	NA	NA	9.17	8.23	1.34	090
65875		A	Incise inner eye adhesions	7.81	NA	NA	9.84	8.83	1.12	090
65880		A	Incise inner eye adhesions	8.36	NA	NA	10.22	9.14	0.62	090
65900		A	Remove eye lesion	12.51	NA	NA	14.56	13.01	0.92	090
65920		A	Remove implant of eye	9.99	NA	NA	12.12	10.81	1.34	090
65930		A	Remove blood clot from eye	8.39	NA	NA	9.50	8.51	1.54	090

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66020		A	Injection treatment of eye	1.64	3.49	3.32	2.04	1.84	0.11	010
66030		A	Injection treatment of eye	1.30	3.25	3.12	1.80	1.63	0.18	010
66130		A	Remove eye lesion	7.83	11.54	10.72	8.20	7.27	1.72	090
66150		A	Glaucoma surgery	10.53	NA	NA	13.99	12.55	0.76	090
66155		A	Glaucoma surgery	10.52	NA	NA	13.99	12.53	0.76	090
66160		A	Glaucoma surgery	12.39	NA	NA	15.31	13.66	0.90	090
66165		A	Glaucoma surgery	10.24	NA	NA	13.79	12.37	0.75	090
66170		A	Glaucoma surgery	15.02	NA	NA	18.64	16.60	1.99	090
66172		A	Incision of eye	18.86	NA	NA	23.61	20.99	2.50	090
66180		A	Implant eye shunt	16.30	NA	NA	16.54	14.53	2.20	090
66185		A	Revise eye shunt	9.58	NA	NA	11.46	10.17	1.74	090
66220		A	Repair eye lesion	9.21	NA	NA	11.63	10.25	1.31	090
66225		A	Repair/graft eye lesion	12.63	NA	NA	13.58	11.97	2.57	090
66250		A	Follow-up surgery of eye	7.10	13.56	12.80	8.53	7.57	1.46	090
66500		A	Incision of iris	3.83	NA	NA	6.01	5.53	0.28	090
66505		A	Incision of iris	4.22	NA	NA	6.56	6.03	0.31	090
66600		A	Remove iris and lesion	10.12	NA	NA	13.16	11.71	0.79	090
66605		A	Removal of iris	14.22	NA	NA	15.52	13.65	1.06	090
66625		A	Removal of iris	5.30	NA	NA	6.72	6.05	0.75	090
66630		A	Removal of iris	7.28	NA	NA	8.70	7.73	1.27	090
66635		A	Removal of iris	7.37	NA	NA	8.77	7.79	0.54	090
66680		A	Repair iris & ciliary body	6.39	NA	NA	8.08	7.21	1.41	090
66682		A	Repair iris & ciliary body	7.33	NA	NA	10.44	9.35	1.51	090
66700		A	Destruction, ciliary body	5.14	7.42	6.74	5.91	5.25	0.51	090
66710		A	Ciliary transsleral therapy	5.14	7.17	6.51	5.90	5.24	1.06	090
66711		A	Ciliary endoscopic ablation	7.93	NA	NA	10.10	8.99	0.58	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
66720		A	Destruction, ciliary body	5.00	8.11	7.39	6.77	6.10	0.71	090
66740		A	Destruction, ciliary body	5.14	7.07	6.42	5.91	5.26	0.37	090
66761		A	Revision of iris	5.02	7.69	7.02	6.65	5.94	0.78	090
66762		A	Revision of iris	5.38	7.88	7.17	6.58	5.85	0.71	090
66770		A	Removal of inner eye lesion	6.13	8.60	7.80	7.42	6.60	0.44	090
66820		A	Incision, secondary cataract	4.01	NA	NA	6.88	6.46	0.69	090
66821		A	After cataract laser surgery	3.42	5.75	5.26	5.24	4.76	0.55	090
66825		A	Reposition intraocular lens	9.01	NA	NA	12.20	11.10	1.22	090
66830		A	Removal of lens lesion	9.47	NA	NA	10.60	9.37	0.69	090
66840		A	Removal of lens material	9.18	NA	NA	10.40	9.19	1.88	090
66850		A	Removal of lens material	10.55	NA	NA	11.74	10.38	1.51	090
66852		A	Removal of lens material	11.41	NA	NA	12.36	10.92	2.08	090
66920		A	Extraction of lens	10.13	NA	NA	11.09	9.80	0.73	090
66930		A	Extraction of lens	11.61	NA	NA	12.51	11.04	0.85	090
66940		A	Extraction of lens	10.37	NA	NA	11.61	10.27	1.81	090
66982		A	Cataract surgery, complex	15.02	NA	NA	14.70	12.95	2.42	090
66983		A	Cataract surg w/iol, 1 stage	10.43	NA	NA	10.42	9.20	0.86	090
66984		A	Cataract surg w/iol, 1 stage	10.52	NA	NA	10.86	9.63	1.71	090
66985		A	Insert lens prosthesis	9.98	NA	NA	11.66	10.32	1.34	090
66986		A	Exchange lens prosthesis	12.26	NA	NA	13.31	11.87	1.62	090
66990		A	Ophthalmic endoscope add-on	1.51	NA	NA	1.07	0.91	0.10	ZZZ
66999		C	Eye surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67005		A	Partial removal of eye fluid	5.89	NA	NA	7.34	6.56	1.30	090
67010		A	Partial removal of eye fluid	7.06	NA	NA	8.16	7.26	1.02	090
67015		A	Release of eye fluid	7.14	NA	NA	9.09	8.19	1.03	090
67025		A	Replace eye fluid	8.11	12.10	11.10	9.65	8.55	1.50	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
67027		A	Implant eye drug system	11.62	NA	NA	12.30	10.86	2.11	090
67028		A	Injection eye drug	2.52	3.36	3.10	2.21	1.93	0.38	000
67030		A	Incise inner eye strands	6.11	NA	NA	8.74	7.87	0.44	090
67031		A	Laser surgery, eye strands	4.47	6.37	5.79	5.53	4.93	0.61	090
67036		A	Removal of inner eye fluid	13.32	NA	NA	13.71	12.08	1.89	090
67039		A	Laser treatment of retina	16.74	NA	NA	17.97	15.92	3.08	090
67040		A	Laser treatment of retina	19.61	NA	NA	20.39	17.99	2.80	090
67041		A	Vit for macular pucker	19.25	NA	NA	18.17	15.73	2.74	090
67042		A	Vit for macular hole	22.38	NA	NA	20.38	17.58	3.21	090
67043		A	Vit for membrane dissect	23.24	NA	NA	21.70	18.77	4.25	090
67101		A	Repair detached retina	8.80	13.07	11.86	10.15	8.98	1.61	090
67105		A	Repair detached retina	8.53	11.63	10.50	9.58	8.46	1.22	090
67107		A	Repair detached retina	16.71	NA	NA	17.53	15.41	3.07	090
67108		A	Repair detached retina	22.89	NA	NA	22.41	19.59	3.26	090
67110		A	Repair detached retina	10.25	14.01	12.73	11.54	10.19	1.36	090
67112		A	Rerepair detached retina	18.75	NA	NA	18.65	16.31	2.67	090
67113		A	Repair retinal detach, cplx	25.35	NA	NA	23.93	20.72	3.62	090
67115		A	Release encircling material	6.11	NA	NA	7.87	7.02	0.81	090
67120		A	Remove eye implant material	7.10	11.18	10.30	8.57	7.61	1.46	090
67121		A	Remove eye implant material	12.25	NA	NA	13.32	11.73	2.25	090
67141		A	Treatment of retina	6.15	8.48	7.65	7.53	6.69	1.13	090
67145		A	Treatment of retina	6.32	8.44	7.58	7.65	6.79	0.89	090
67208		A	Treatment of retinal lesion	7.65	9.16	8.17	8.60	7.60	0.55	090
67210		A	Treatment of retinal lesion	9.45	9.95	8.79	9.35	8.17	1.46	090
67218		A	Treatment of retinal lesion	20.36	NA	NA	18.74	16.33	1.51	090
67220		A	Treatment of choroid lesion	14.39	15.43	13.68	14.10	12.33	2.64	090

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67221		R	Ocular photodynamic ther	3.45	4.57	4.31	2.63	2.27	0.49	000
67225		A	Eye photodynamic ther add-on	0.47	0.38	0.33	0.33	0.28	0.03	ZZZ
67227		A	Treatment of retinal lesion	7.53	9.57	8.60	8.51	7.53	0.55	090
67228		A	Treatment of retinal lesion	13.82	18.48	17.29	15.99	14.10	2.18	090
67229		A	Tr retinal les preterm inf	16.30	NA	NA	15.57	13.82	1.22	090
67250		A	Reinforce eye wall	9.61	NA	NA	12.22	11.10	1.68	090
67255		A	Reinforce/graft eye wall	10.17	NA	NA	13.33	12.11	2.06	090
67299		C	Eye surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67311		A	Revise eye muscle	7.77	NA	NA	9.02	8.03	1.36	090
67312		A	Revise two eye muscles	9.66	NA	NA	10.35	9.14	1.98	090
67314		A	Revise eye muscle	8.79	NA	NA	10.10	8.95	1.54	090
67316		A	Revise two eye muscles	10.93	NA	NA	11.58	10.18	2.23	090
67318		A	Revise eye muscle(s)	9.12	NA	NA	10.69	9.47	0.66	090
67320		A	Revise eye muscle(s) add-on	5.40	NA	NA	3.79	3.16	0.40	ZZZ
67331		A	Eye surgery follow-up add-on	5.13	NA	NA	3.57	2.97	0.89	ZZZ
67332		A	Rerevise eye muscles add-on	5.56	NA	NA	3.92	3.26	0.96	ZZZ
67334		A	Revise eye muscle w/suture	5.05	NA	NA	3.58	2.96	0.37	ZZZ
67335		A	Eye suture during surgery	2.49	NA	NA	1.75	1.49	0.42	ZZZ
67340		A	Revise eye muscle add-on	6.00	NA	NA	4.25	3.53	0.44	ZZZ
67343		A	Release eye tissue	8.47	NA	NA	9.85	8.76	1.72	090
67345		A	Destroy nerve of eye muscle	3.01	3.54	3.18	2.92	2.57	0.83	010
67346		A	Biopsy, eye muscle	2.87	NA	NA	2.79	2.46	0.64	000
67399		C	Eye muscle surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67400		A	Explore/biopsy eye socket	11.20	NA	NA	14.76	13.48	2.15	090
67405		A	Explore/drain eye socket	9.20	NA	NA	12.85	11.84	1.23	090
67412		A	Explore/treat eye socket	10.30	NA	NA	13.45	12.38	1.94	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
67413		A	Explore/treat eye socket	10.24	NA	NA	13.60	12.50	2.08	090
67414		A	Explr/decompress eye socket	17.94	NA	NA	19.30	17.01	2.37	090
67415		A	Aspiration, orbital contents	1.76	NA	NA	1.25	1.04	0.25	000
67420		A	Explore/treat eye socket	21.87	NA	NA	23.51	21.13	4.48	090
67430		A	Explore/treat eye socket	15.29	NA	NA	19.56	17.79	1.13	090
67440		A	Explore/drain eye socket	14.84	NA	NA	18.87	17.15	1.98	090
67445		A	Explr/decompress eye socket	19.12	NA	NA	20.26	18.03	3.91	090
67450		A	Explore/biopsy eye socket	15.41	NA	NA	19.65	17.84	2.05	090
67500		A	Inject/treat eye socket	1.44	0.87	0.82	0.69	0.61	0.11	000
67505		A	Inject/treat eye socket	1.27	1.24	1.08	1.04	0.85	0.27	000
67515		A	Inject/treat eye socket	1.40	1.34	1.13	1.13	0.92	0.27	000
67550		A	Insert eye socket implant	11.77	NA	NA	15.17	13.84	2.39	090
67560		A	Revise eye socket implant	12.18	NA	NA	15.49	14.04	1.62	090
67570		A	Decompress optic nerve	14.40	NA	NA	17.43	16.01	5.36	090
67599		C	Orbit surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67700		A	Drainage of eyelid abscess	1.40	5.81	5.76	1.84	1.66	0.24	010
67710		A	Incision of eyelid	1.07	4.95	4.96	1.64	1.50	0.23	010
67715		A	Incision of eyelid fold	1.27	5.11	5.08	1.77	1.61	0.27	010
67800		A	Remove eyelid lesion	1.41	2.13	1.96	1.50	1.34	0.25	010
67801		A	Remove eyelid lesions	1.91	2.61	2.39	1.86	1.64	0.38	010
67805		A	Remove eyelid lesions	2.27	3.35	3.08	2.38	2.11	0.45	010
67808		A	Remove eyelid lesion(s)	4.60	NA	NA	5.72	5.11	0.93	090
67810		A	Biopsy of eyelid	1.48	4.42	4.48	1.06	0.96	0.23	000
67820		A	Revise eyelashes	0.71	0.70	0.65	0.79	0.71	0.11	000
67825		A	Revise eyelashes	1.43	2.14	1.98	1.96	1.79	0.28	010
67830		A	Revise eyelashes	1.75	5.49	5.39	2.12	1.91	0.35	010

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
67835		A	Revise eyelashes	5.70	NA	NA	6.62	5.93	1.17	090
67840		A	Remove eyelid lesion	2.09	5.43	5.32	2.36	2.12	0.35	010
67850		A	Treat eyelid lesion	1.74	4.18	4.16	2.07	1.97	0.25	010
67875		A	Closure of eyelid by suture	1.35	3.33	3.25	1.39	1.23	0.25	000
67880		A	Revision of eyelid	4.60	8.08	7.54	5.72	5.12	0.85	090
67882		A	Revision of eyelid	6.02	9.62	8.92	7.24	6.45	1.23	090
67900		A	Repair brow defect	6.82	10.93	10.23	7.48	6.71	1.27	090
67901		A	Repair eyelid defect	7.59	13.26	11.59	8.58	7.59	1.55	090
67902		A	Repair eyelid defect	9.82	NA	NA	10.55	9.13	2.01	090
67903		A	Repair eyelid defect	6.51	9.98	9.49	7.10	6.43	1.31	090
67904		A	Repair eyelid defect	7.97	12.35	11.41	8.83	7.75	1.58	090
67906		A	Repair eyelid defect	6.93	NA	NA	7.38	6.57	0.51	090
67908		A	Repair eyelid defect	5.30	8.41	7.78	6.60	6.05	1.09	090
67909		A	Revise eyelid defect	5.57	9.24	8.69	6.70	6.06	1.14	090
67911		A	Revise eyelid defect	7.50	NA	NA	8.30	7.26	1.46	090
67912		A	Correction eyelid w/implant	6.36	17.83	17.71	7.41	6.76	0.96	090
67914		A	Repair eyelid defect	3.75	6.94	6.61	4.34	3.90	0.71	090
67915		A	Repair eyelid defect	3.26	6.24	6.00	3.84	3.48	0.47	090
67916		A	Repair eyelid defect	5.48	9.42	8.86	6.63	5.98	0.99	090
67917		A	Repair eyelid defect	6.19	10.05	9.41	7.14	6.42	1.20	090
67921		A	Repair eyelid defect	3.47	6.73	6.42	4.13	3.71	0.71	090
67922		A	Repair eyelid defect	3.14	6.04	5.82	3.69	3.35	0.44	090
67923		A	Repair eyelid defect	6.05	9.70	9.05	7.04	6.31	1.17	090
67924		A	Repair eyelid defect	5.93	10.27	9.68	6.67	5.97	1.17	090
67930		A	Repair eyelid wound	3.65	6.43	6.10	3.15	2.77	0.73	010
67935		A	Repair eyelid wound	6.36	10.11	9.47	6.12	5.44	1.30	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
67938		A	Remove eyelid foreign body	1.38	5.21	5.15	1.86	1.69	0.23	010
67950		A	Revision of eyelid	5.99	9.88	9.31	7.01	6.35	1.14	090
67961		A	Revision of eyelid	5.86	10.06	9.48	6.91	6.24	1.14	090
67966		A	Revision of eyelid	8.97	12.45	11.35	9.54	8.34	1.77	090
67971		A	Reconstruction of eyelid	10.01	NA	NA	10.38	9.23	2.03	090
67973		A	Reconstruction of eyelid	13.13	NA	NA	13.14	11.68	2.68	090
67974		A	Reconstruction of eyelid	13.10	NA	NA	13.12	11.63	2.68	090
67975		A	Reconstruction of eyelid	9.35	NA	NA	9.93	8.85	1.91	090
67999		C	Revision of eyelid	0.00	0.00	0.00	0.00	0.00	0.00	YYY
68020		A	Incise/drain eyelid lining	1.42	1.92	1.75	1.68	1.52	0.21	010
68040		A	Treatment of eyelid lesions	0.85	0.97	0.88	0.65	0.56	0.17	000
68100		A	Biopsy of eyelid lining	1.35	3.27	3.20	1.41	1.25	0.21	000
68110		A	Remove eyelid lining lesion	1.82	4.35	4.20	2.34	2.11	0.37	010
68115		A	Remove eyelid lining lesion	2.41	6.09	5.91	2.76	2.46	0.32	010
68130		A	Remove eyelid lining lesion	5.10	9.76	9.26	6.45	5.82	0.37	090
68135		A	Remove eyelid lining lesion	1.89	2.48	2.25	2.34	2.11	0.27	010
68200		A	Treat eyelid by injection	0.49	0.69	0.64	0.49	0.43	0.08	000
68320		A	Revise/graft eyelid lining	6.64	13.34	12.59	8.47	7.57	1.34	090
68325		A	Revise/graft eyelid lining	8.63	NA	NA	9.89	8.79	1.75	090
68326		A	Revise/graft eyelid lining	8.42	NA	NA	9.73	8.63	1.71	090
68328		A	Revise/graft eyelid lining	9.45	NA	NA	10.52	9.36	1.94	090
68330		A	Revise eyelid lining	5.78	10.89	10.28	7.15	6.38	1.19	090
68335		A	Revise/graft eyelid lining	8.46	NA	NA	9.72	8.63	1.72	090
68340		A	Separate eyelid adhesions	4.97	10.02	9.50	6.22	5.54	1.03	090
68360		A	Revise eyelid lining	5.17	9.44	8.90	6.33	5.66	1.06	090
68362		A	Revise eyelid lining	8.61	NA	NA	9.85	8.72	1.75	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
68371		A	Harvest eye tissue, alograft	5.09	NA	NA	6.49	5.86	0.37	010
68399		C	Eyelid lining surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
68400		A	Incise/drain tear gland	1.74	5.91	5.81	1.95	1.81	0.35	010
68420		A	Incise/drain tear sac	2.35	6.38	6.21	2.39	2.19	0.31	010
68440		A	Incise tear duct opening	0.99	1.84	1.81	1.76	1.62	0.21	010
68500		A	Removal of tear gland	12.77	NA	NA	14.64	12.99	3.11	090
68505		A	Partial removal, tear gland	12.69	NA	NA	14.58	13.09	2.57	090
68510		A	Biopsy of tear gland	4.60	7.72	7.37	3.71	3.16	0.93	000
68520		A	Removal of tear sac	8.78	NA	NA	10.45	9.41	1.19	090
68525		A	Biopsy of tear sac	4.42	NA	NA	3.12	2.65	0.89	000
68530		A	Clearance of tear duct	3.70	8.00	7.80	3.56	3.17	0.75	010
68540		A	Remove tear gland lesion	12.18	NA	NA	13.93	12.40	1.62	090
68550		A	Remove tear gland lesion	15.16	NA	NA	16.87	14.94	2.01	090
68700		A	Repair tear ducts	7.87	NA	NA	9.10	8.08	1.60	090
68705		A	Revise tear duct opening	2.11	4.38	4.21	2.55	2.29	0.42	010
68720		A	Create tear sac drain	9.96	NA	NA	11.29	10.09	1.72	090
68745		A	Create tear duct drain	9.90	NA	NA	11.45	10.23	2.02	090
68750		A	Create tear duct drain	10.10	NA	NA	11.98	10.73	2.05	090
68760		A	Close tear duct opening	1.78	3.73	3.58	2.30	2.08	0.35	010
68761		A	Close tear duct opening	1.41	2.66	2.52	1.92	1.74	0.23	010
68770		A	Close tear system fistula	8.29	NA	NA	9.40	7.88	1.68	090
68801		A	Dilate tear duct opening	1.00	2.44	2.32	1.99	1.86	0.17	010
68810		A	Probe nasolacrimal duct	2.15	4.52	4.24	3.08	2.87	0.41	010
68811		A	Probe nasolacrimal duct	2.45	NA	NA	3.33	3.02	0.49	010
68815		A	Probe nasolacrimal duct	3.30	8.94	8.64	3.92	3.53	0.61	010
68816		A	Probe nl duct w/balloon	3.06	16.92	16.10	3.98	3.56	0.62	010

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68840		A	Explore/irrigate tear ducts	1.30	2.25	2.06	1.95	1.74	0.25	010
68850		A	Injection for tear sac x-ray	0.80	0.80	0.87	0.68	0.72	0.07	000
68899		C	Tear duct system surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69000		A	Drain external ear lesion	1.50	3.70	3.58	1.84	1.74	0.23	010
69005		A	Drain external ear lesion	2.16	3.90	3.75	2.29	2.17	0.30	010
69020		A	Drain outer ear canal lesion	1.53	5.10	5.00	2.54	2.45	0.21	010
69090		N	Pierce earlobes	0.00	0.00	0.00	0.00	0.00	0.00	XXX
69100		A	Biopsy of external ear	0.81	1.98	2.07	0.58	0.54	0.11	000
69105		A	Biopsy of external ear canal	0.85	3.17	3.12	0.97	0.93	0.10	000
69110		A	Remove external ear, partial	3.53	9.35	9.23	5.64	5.53	0.55	090
69120		A	Removal of external ear	4.14	NA	NA	7.33	7.04	0.62	090
69140		A	Remove ear canal lesion(s)	8.14	NA	NA	16.86	16.41	1.09	090
69145		A	Remove ear canal lesion(s)	2.70	8.65	8.33	4.44	4.25	0.37	090
69150		A	Extensive ear canal surgery	13.61	NA	NA	15.83	15.24	2.02	090
69155		A	Extensive ear/neck surgery	23.35	NA	NA	24.32	23.08	3.12	090
69200		A	Clear outer ear canal	0.77	2.72	2.68	0.86	0.79	0.10	000
69205		A	Clear outer ear canal	1.21	NA	NA	1.68	1.61	0.17	010
69210		A	Remove impacted ear wax	0.61	0.83	0.77	0.31	0.27	0.07	000
69220		A	Clean out mastoid cavity	0.83	3.12	3.06	0.94	0.89	0.10	000
69222		A	Clean out mastoid cavity	1.45	4.85	4.78	2.48	2.41	0.18	010
69300		R	Revise external ear	6.69	13.06	11.92	6.91	6.44	0.89	YYY
69310		A	Rebuild outer ear canal	10.97	NA	NA	20.03	19.45	1.50	090
69320		A	Rebuild outer ear canal	17.18	NA	NA	26.50	25.69	2.29	090
69399		C	Outer ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69400		A	Inflate middle ear canal	0.83	3.40	3.28	0.94	0.89	0.10	000
69401		A	Inflate middle ear canal	0.63	1.85	1.76	0.78	0.74	0.07	000

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69405		A	Catheterize middle ear canal	2.68	4.79	4.58	2.82	2.67	0.35	010
69420		A	Incision of eardrum	1.38	4.10	4.01	2.07	1.98	0.18	010
69421		A	Incision of eardrum	1.78	NA	NA	2.50	2.42	0.24	010
69424		A	Remove ventilating tube	0.85	2.82	2.78	0.93	0.87	0.10	000
69433		A	Create eardrum opening	1.57	4.14	4.02	2.15	2.05	0.23	010
69436		A	Create eardrum opening	2.01	NA	NA	2.59	2.51	0.27	010
69440		A	Exploration of middle ear	7.71	NA	NA	12.05	11.48	1.03	090
69450		A	Eardrum revision	5.69	NA	NA	9.93	9.48	0.75	090
69501		A	Mastoidectomy	9.21	NA	NA	11.76	11.13	1.23	090
69502		A	Mastoidectomy	12.56	NA	NA	15.18	14.38	1.75	090
69505		A	Remove mastoid structures	13.17	NA	NA	21.24	20.50	1.77	090
69511		A	Extensive mastoid surgery	13.70	NA	NA	21.54	20.83	1.84	090
69530		A	Extensive mastoid surgery	20.38	NA	NA	26.87	25.77	2.71	090
69535		A	Remove part of temporal bone	37.42	NA	NA	38.53	36.48	5.43	090
69540		A	Remove ear lesion	1.25	4.75	4.67	2.40	2.33	0.17	010
69550		A	Remove ear lesion	11.15	NA	NA	18.61	18.00	1.50	090
69552		A	Remove ear lesion	19.81	NA	NA	25.06	23.97	2.64	090
69554		A	Remove ear lesion	35.97	NA	NA	36.15	33.35	4.79	090
69601		A	Mastoid surgery revision	13.45	NA	NA	16.54	15.66	1.78	090
69602		A	Mastoid surgery revision	13.76	NA	NA	17.43	16.53	1.84	090
69603		A	Mastoid surgery revision	14.20	NA	NA	21.83	21.18	1.89	090
69604		A	Mastoid surgery revision	14.20	NA	NA	17.68	16.90	1.89	090
69605		A	Mastoid surgery revision	18.69	NA	NA	25.90	24.90	2.49	090
69610		A	Repair of eardrum	4.47	6.53	6.34	3.86	3.63	0.61	010
69620		A	Repair of eardrum	6.03	13.75	13.45	7.92	7.57	0.79	090
69631		A	Repair eardrum structures	10.05	NA	NA	15.30	14.58	1.34	090

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69632		A	Rebuild eardrum structures	12.96	NA	NA	17.94	17.08	1.72	090
69633		A	Rebuild eardrum structures	12.31	NA	NA	17.52	16.69	1.65	090
69635		A	Repair eardrum structures	13.51	NA	NA	21.44	20.65	1.81	090
69636		A	Rebuild eardrum structures	15.43	NA	NA	24.03	23.18	2.05	090
69637		A	Rebuild eardrum structures	15.32	NA	NA	24.02	23.16	2.08	090
69641		A	Revise middle ear & mastoid	12.89	NA	NA	16.89	16.07	1.74	090
69642		A	Revise middle ear & mastoid	17.06	NA	NA	21.24	20.18	2.27	090
69643		A	Revise middle ear & mastoid	15.59	NA	NA	19.43	18.44	2.08	090
69644		A	Revise middle ear & mastoid	17.23	NA	NA	24.99	24.11	2.30	090
69645		A	Revise middle ear & mastoid	16.71	NA	NA	24.77	23.88	2.26	090
69646		A	Revise middle ear & mastoid	18.37	NA	NA	25.67	24.66	2.44	090
69650		A	Release middle ear bone	9.80	NA	NA	13.24	12.44	1.30	090
69660		A	Revise middle ear bone	12.03	NA	NA	14.52	13.77	1.61	090
69661		A	Revise middle ear bone	15.92	NA	NA	18.67	17.74	2.08	090
69662		A	Revise middle ear bone	15.60	NA	NA	17.48	16.57	2.08	090
69666		A	Repair middle ear structures	9.89	NA	NA	13.28	12.58	1.33	090
69667		A	Repair middle ear structures	9.90	NA	NA	13.26	12.61	1.33	090
69670		A	Remove mastoid air cells	11.73	NA	NA	15.32	14.51	1.57	090
69676		A	Remove middle ear nerve	9.69	NA	NA	14.14	13.52	1.29	090
69700		A	Close mastoid fistula	8.37	NA	NA	11.27	10.84	1.12	090
69710		N	Implant/replace hearing aid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
69711		A	Remove/repair hearing aid	10.62	NA	NA	14.10	13.48	1.41	090
69714		A	Implant temple bone w/stimul	14.45	NA	NA	16.32	15.45	1.94	090
69715		A	Temple bne implnt w/stimulat	18.96	NA	NA	19.11	17.99	2.52	090
69717		A	Temple bone implant revision	15.43	NA	NA	16.93	16.19	2.05	090
69718		A	Revise temple bone implant	19.21	NA	NA	19.25	18.15	2.54	090

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
69720		A	Release facial nerve	14.71	NA	NA	18.94	17.99	1.96	090
69725		A	Release facial nerve	27.64	NA	NA	26.23	24.54	3.69	090
69740		A	Repair facial nerve	16.27	NA	NA	17.17	16.21	2.16	090
69745		A	Repair facial nerve	17.02	NA	NA	18.57	17.63	2.26	090
69799		C	Middle ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69801		A	Incise inner ear	8.70	NA	NA	12.82	12.21	1.17	090
69802		A	Incise inner ear	13.50	NA	NA	16.33	15.47	1.78	090
69805		A	Explore inner ear	14.71	NA	NA	15.50	14.55	1.96	090
69806		A	Explore inner ear	12.63	NA	NA	14.41	13.65	1.70	090
69820		A	Establish inner ear window	10.52	NA	NA	14.04	13.45	1.41	090
69840		A	Revise inner ear window	10.44	NA	NA	12.47	13.41	0.76	090
69905		A	Remove inner ear	11.26	NA	NA	15.05	14.35	1.51	090
69910		A	Remove inner ear & mastoid	13.91	NA	NA	15.23	14.43	1.87	090
69915		A	Incise inner ear nerve	22.77	NA	NA	21.30	19.87	3.08	090
69930		A	Implant cochlear device	17.73	NA	NA	17.27	16.41	2.36	090
69949		C	Inner ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69950		A	Incise inner ear nerve	27.63	NA	NA	28.17	24.54	3.69	090
69955		A	Release facial nerve	29.42	NA	NA	27.27	25.54	3.93	090
69960		A	Release inner ear canal	29.42	NA	NA	25.72	23.95	3.93	090
69970		A	Remove inner ear lesion	32.41	NA	NA	28.97	27.13	4.32	090
69979		C	Temporal bone surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69990		R	Microsurgery add-on	3.46	NA	NA	1.89	1.83	1.20	ZZZ
70010		A	Contrast x-ray of brain	1.19	2.75	3.34	NA	NA	0.22	XXX
70010	TC	A	Contrast x-ray of brain	0.00	2.34	2.88	NA	NA	0.01	XXX
70010	26	A	Contrast x-ray of brain	1.19	0.41	0.46	0.41	0.46	0.21	XXX
70015		A	Contrast x-ray of brain	1.19	2.87	2.99	NA	NA	0.08	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
70015	TC	A	Contrast x-ray of brain	0.00	2.45	2.51	NA	NA	0.01	XXX
70015	26	A	Contrast x-ray of brain	1.19	0.42	0.48	0.42	0.48	0.07	XXX
70030		A	X-ray eye for foreign body	0.17	0.60	0.65	NA	NA	0.02	XXX
70030	TC	A	X-ray eye for foreign body	0.00	0.54	0.58	NA	NA	0.01	XXX
70030	26	A	X-ray eye for foreign body	0.17	0.06	0.07	0.06	0.07	0.01	XXX
70100		A	X-ray exam of jaw	0.18	0.78	0.77	NA	NA	0.02	XXX
70100	TC	A	X-ray exam of jaw	0.00	0.70	0.69	NA	NA	0.01	XXX
70100	26	A	X-ray exam of jaw	0.18	0.08	0.08	0.08	0.08	0.01	XXX
70110		A	X-ray exam of jaw	0.25	0.82	0.88	NA	NA	0.02	XXX
70110	TC	A	X-ray exam of jaw	0.00	0.73	0.78	NA	NA	0.01	XXX
70110	26	A	X-ray exam of jaw	0.25	0.09	0.10	0.09	0.10	0.01	XXX
70120		A	X-ray exam of mastoids	0.18	0.82	0.82	NA	NA	0.02	XXX
70120	TC	A	X-ray exam of mastoids	0.00	0.74	0.74	NA	NA	0.01	XXX
70120	26	A	X-ray exam of mastoids	0.18	0.08	0.08	0.08	0.08	0.01	XXX
70130		A	X-ray exam of mastoids	0.34	1.23	1.27	NA	NA	0.02	XXX
70130	TC	A	X-ray exam of mastoids	0.00	1.10	1.13	NA	NA	0.01	XXX
70130	26	A	X-ray exam of mastoids	0.34	0.13	0.14	0.13	0.14	0.01	XXX
70134		A	X-ray exam of middle ear	0.34	0.90	0.98	NA	NA	0.02	XXX
70134	TC	A	X-ray exam of middle ear	0.00	0.78	0.85	NA	NA	0.01	XXX
70134	26	A	X-ray exam of middle ear	0.34	0.12	0.13	0.12	0.13	0.01	XXX
70140		A	X-ray exam of facial bones	0.19	0.66	0.68	NA	NA	0.02	XXX
70140	TC	A	X-ray exam of facial bones	0.00	0.56	0.59	NA	NA	0.01	XXX
70140	26	A	X-ray exam of facial bones	0.19	0.10	0.09	0.10	0.09	0.01	XXX
70150		A	X-ray exam of facial bones	0.26	0.92	0.97	NA	NA	0.02	XXX
70150	TC	A	X-ray exam of facial bones	0.00	0.81	0.86	NA	NA	0.01	XXX
70150	26	A	X-ray exam of facial bones	0.26	0.11	0.11	0.11	0.11	0.01	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
70160		A	X-ray exam of nasal bones	0.17	0.74	0.77	NA	NA	0.02	XXX
70160	TC	A	X-ray exam of nasal bones	0.00	0.67	0.70	NA	NA	0.01	XXX
70160	26	A	X-ray exam of nasal bones	0.17	0.07	0.07	0.07	0.07	0.01	XXX
70170		C	X-ray exam of tear duct	0.00	0.00	0.00	NA	NA	0.00	XXX
70170	TC	C	X-ray exam of tear duct	0.00	0.00	0.00	NA	NA	0.00	XXX
70170	26	A	X-ray exam of tear duct	0.30	0.10	0.12	0.10	0.12	0.03	XXX
70190		A	X-ray exam of eye sockets	0.21	0.78	0.82	NA	NA	0.02	XXX
70190	TC	A	X-ray exam of eye sockets	0.00	0.69	0.73	NA	NA	0.01	XXX
70190	26	A	X-ray exam of eye sockets	0.21	0.09	0.09	0.09	0.09	0.01	XXX
70200		A	X-ray exam of eye sockets	0.28	0.92	0.99	NA	NA	0.02	XXX
70200	TC	A	X-ray exam of eye sockets	0.00	0.81	0.87	NA	NA	0.01	XXX
70200	26	A	X-ray exam of eye sockets	0.28	0.11	0.12	0.11	0.12	0.01	XXX
70210		A	X-ray exam of sinuses	0.17	0.69	0.70	NA	NA	0.02	XXX
70210	TC	A	X-ray exam of sinuses	0.00	0.61	0.63	NA	NA	0.01	XXX
70210	26	A	X-ray exam of sinuses	0.17	0.08	0.07	0.08	0.07	0.01	XXX
70220		A	X-ray exam of sinuses	0.25	0.82	0.87	NA	NA	0.02	XXX
70220	TC	A	X-ray exam of sinuses	0.00	0.72	0.77	NA	NA	0.01	XXX
70220	26	A	X-ray exam of sinuses	0.25	0.10	0.10	0.10	0.10	0.01	XXX
70240		A	X-ray exam, pituitary saddle	0.19	0.62	0.66	NA	NA	0.02	XXX
70240	TC	A	X-ray exam, pituitary saddle	0.00	0.54	0.58	NA	NA	0.01	XXX
70240	26	A	X-ray exam, pituitary saddle	0.19	0.08	0.08	0.08	0.08	0.01	XXX
70250		A	X-ray exam of skull	0.24	0.81	0.83	NA	NA	0.02	XXX
70250	TC	A	X-ray exam of skull	0.00	0.70	0.72	NA	NA	0.01	XXX
70250	26	A	X-ray exam of skull	0.24	0.11	0.11	0.11	0.11	0.01	XXX
70260		A	X-ray exam of skull	0.34	0.98	1.03	NA	NA	0.02	XXX
70260	TC	A	X-ray exam of skull	0.00	0.83	0.89	NA	NA	0.01	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
70260	26	A	X-ray exam of skull	0.34	0.15	0.14	0.15	0.14	0.01	XXX
70300		A	X-ray exam of teeth	0.10	0.30	0.31	NA	NA	0.02	XXX
70300	TC	A	X-ray exam of teeth	0.00	0.23	0.25	NA	NA	0.01	XXX
70300	26	A	X-ray exam of teeth	0.10	0.07	0.06	0.07	0.06	0.01	XXX
70310		A	X-ray exam of teeth	0.16	0.94	0.91	NA	NA	0.02	XXX
70310	TC	A	X-ray exam of teeth	0.00	0.84	0.82	NA	NA	0.01	XXX
70310	26	A	X-ray exam of teeth	0.16	0.10	0.09	0.10	0.09	0.01	XXX
70320		A	Full mouth x-ray of teeth	0.22	1.22	1.22	NA	NA	0.02	XXX
70320	TC	A	Full mouth x-ray of teeth	0.00	1.09	1.11	NA	NA	0.01	XXX
70320	26	A	Full mouth x-ray of teeth	0.22	0.13	0.11	0.13	0.11	0.01	XXX
70328		A	X-ray exam of jaw joint	0.18	0.67	0.69	NA	NA	0.02	XXX
70328	TC	A	X-ray exam of jaw joint	0.00	0.60	0.62	NA	NA	0.01	XXX
70328	26	A	X-ray exam of jaw joint	0.18	0.07	0.07	0.07	0.07	0.01	XXX
70330		A	X-ray exam of jaw joints	0.24	1.09	1.14	NA	NA	0.02	XXX
70330	TC	A	X-ray exam of jaw joints	0.00	0.98	1.03	NA	NA	0.01	XXX
70330	26	A	X-ray exam of jaw joints	0.24	0.11	0.11	0.11	0.11	0.01	XXX
70332		A	X-ray exam of jaw joint	0.54	1.82	1.90	NA	NA	0.04	XXX
70332	TC	A	X-ray exam of jaw joint	0.00	1.52	1.64	NA	NA	0.01	XXX
70332	26	A	X-ray exam of jaw joint	0.54	0.30	0.26	0.30	0.26	0.03	XXX
70336		A	Magnetic image, jaw joint	1.48	8.61	11.50	NA	NA	0.09	XXX
70336	TC	A	Magnetic image, jaw joint	0.00	8.10	10.92	NA	NA	0.01	XXX
70336	26	A	Magnetic image, jaw joint	1.48	0.51	0.58	0.51	0.58	0.08	XXX
70350		A	X-ray head for orthodontia	0.17	0.43	0.43	NA	NA	0.02	XXX
70350	TC	A	X-ray head for orthodontia	0.00	0.31	0.34	NA	NA	0.01	XXX
70350	26	A	X-ray head for orthodontia	0.17	0.12	0.09	0.12	0.09	0.01	XXX
70355		A	Panoramic x-ray of jaws	0.20	0.38	0.42	NA	NA	0.02	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
70355	TC	A	Panoramic x-ray of jaws	0.00	0.26	0.32	NA	NA	0.01	XXX
70355	26	A	Panoramic x-ray of jaws	0.20	0.12	0.10	0.12	0.10	0.01	XXX
70360		A	X-ray exam of neck	0.17	0.57	0.61	NA	NA	0.02	XXX
70360	TC	A	X-ray exam of neck	0.00	0.51	0.54	NA	NA	0.01	XXX
70360	26	A	X-ray exam of neck	0.17	0.06	0.07	0.06	0.07	0.01	XXX
70370		A	Throat x-ray & fluoroscopy	0.32	2.07	2.01	NA	NA	0.02	XXX
70370	TC	A	Throat x-ray & fluoroscopy	0.00	1.94	1.88	NA	NA	0.01	XXX
70370	26	A	Throat x-ray & fluoroscopy	0.32	0.13	0.13	0.13	0.13	0.01	XXX
70371		A	Speech evaluation, complex	0.84	1.70	1.86	NA	NA	0.04	XXX
70371	TC	A	Speech evaluation, complex	0.00	1.36	1.53	NA	NA	0.01	XXX
70371	26	A	Speech evaluation, complex	0.84	0.34	0.33	0.34	0.33	0.03	XXX
70373		A	Contrast x-ray of larynx	0.44	1.88	1.92	NA	NA	0.02	XXX
70373	TC	A	Contrast x-ray of larynx	0.00	1.70	1.76	NA	NA	0.01	XXX
70373	26	A	Contrast x-ray of larynx	0.44	0.18	0.16	0.18	0.16	0.01	XXX
70380		A	X-ray exam of salivary gland	0.17	0.98	0.96	NA	NA	0.02	XXX
70380	TC	A	X-ray exam of salivary gland	0.00	0.87	0.87	NA	NA	0.01	XXX
70380	26	A	X-ray exam of salivary gland	0.17	0.11	0.09	0.11	0.09	0.01	XXX
70390		A	X-ray exam of salivary duct	0.38	2.37	2.51	NA	NA	0.04	XXX
70390	TC	A	X-ray exam of salivary duct	0.00	2.23	2.36	NA	NA	0.01	XXX
70390	26	A	X-ray exam of salivary duct	0.38	0.14	0.15	0.14	0.15	0.03	XXX
70450		A	Ct head/brain w/o dye	0.85	3.67	4.79	NA	NA	0.05	XXX
70450	TC	A	Ct head/brain w/o dye	0.00	3.38	4.45	NA	NA	0.01	XXX
70450	26	A	Ct head/brain w/o dye	0.85	0.29	0.34	0.29	0.34	0.04	XXX
70460		A	Ct head/brain w/dye	1.13	4.85	6.23	NA	NA	0.07	XXX
70460	TC	A	Ct head/brain w/dye	0.00	4.45	5.78	NA	NA	0.01	XXX
70460	26	A	Ct head/brain w/dye	1.13	0.40	0.45	0.40	0.45	0.06	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
70470		A	Ct head/brain w/o & w/dye	1.27	5.92	7.63	NA	NA	0.08	XXX
70470	TC	A	Ct head/brain w/o & w/dye	0.00	5.47	7.12	NA	NA	0.01	XXX
70470	26	A	Ct head/brain w/o & w/dye	1.27	0.45	0.51	0.45	0.51	0.07	XXX
70480		A	Ct orbit/ear/fossa w/o dye	1.28	6.39	7.75	NA	NA	0.08	XXX
70480	TC	A	Ct orbit/ear/fossa w/o dye	0.00	5.93	7.24	NA	NA	0.01	XXX
70480	26	A	Ct orbit/ear/fossa w/o dye	1.28	0.46	0.51	0.46	0.51	0.07	XXX
70481		A	Ct orbit/ear/fossa w/dye	1.38	7.45	9.10	NA	NA	0.09	XXX
70481	TC	A	Ct orbit/ear/fossa w/dye	0.00	6.97	8.55	NA	NA	0.01	XXX
70481	26	A	Ct orbit/ear/fossa w/dye	1.38	0.48	0.55	0.48	0.55	0.08	XXX
70482		A	Ct orbit/ear/fossa w/o&w/dye	1.45	8.38	10.41	NA	NA	0.09	XXX
70482	TC	A	Ct orbit/ear/fossa w/o&w/dye	0.00	7.87	9.84	NA	NA	0.01	XXX
70482	26	A	Ct orbit/ear/fossa w/o&w/dye	1.45	0.51	0.57	0.51	0.57	0.08	XXX
70486		A	Ct maxillofacial w/o dye	1.14	5.18	6.39	NA	NA	0.07	XXX
70486	TC	A	Ct maxillofacial w/o dye	0.00	4.76	5.93	NA	NA	0.01	XXX
70486	26	A	Ct maxillofacial w/o dye	1.14	0.42	0.46	0.42	0.46	0.06	XXX
70487		A	Ct maxillofacial w/dye	1.30	6.23	7.77	NA	NA	0.08	XXX
70487	TC	A	Ct maxillofacial w/dye	0.00	5.78	7.25	NA	NA	0.01	XXX
70487	26	A	Ct maxillofacial w/dye	1.30	0.45	0.52	0.45	0.52	0.07	XXX
70488		A	Ct maxillofacial w/o & w/dye	1.42	7.71	9.62	NA	NA	0.09	XXX
70488	TC	A	Ct maxillofacial w/o & w/dye	0.00	7.21	9.06	NA	NA	0.01	XXX
70488	26	A	Ct maxillofacial w/o & w/dye	1.42	0.50	0.56	0.50	0.56	0.08	XXX
70490		A	Ct soft tissue neck w/o dye	1.28	4.84	6.09	NA	NA	0.08	XXX
70490	TC	A	Ct soft tissue neck w/o dye	0.00	4.39	5.58	NA	NA	0.01	XXX
70490	26	A	Ct soft tissue neck w/o dye	1.28	0.45	0.51	0.45	0.51	0.07	XXX
70491		A	Ct soft tissue neck w/dye	1.38	6.01	7.51	NA	NA	0.08	XXX
70491	TC	A	Ct soft tissue neck w/dye	0.00	5.52	6.96	NA	NA	0.01	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
70491	26	A	Ct soft tissue neck w/dye	1.38	0.49	0.55	0.49	0.55	0.07	XXX
70492		A	Ct sft tsue nck w/o & w/dye	1.45	7.38	9.30	NA	NA	0.09	XXX
70492	TC	A	Ct sft tsue nck w/o & w/dye	0.00	6.87	8.73	NA	NA	0.01	XXX
70492	26	A	Ct sft tsue nck w/o & w/dye	1.45	0.51	0.57	0.51	0.57	0.08	XXX
70496		A	Ct angiography, head	1.75	12.06	15.32	NA	NA	0.11	XXX
70496	TC	A	Ct angiography, head	0.00	11.45	14.62	NA	NA	0.01	XXX
70496	26	A	Ct angiography, head	1.75	0.61	0.70	0.61	0.70	0.10	XXX
70498		A	Ct angiography, neck	1.75	12.56	15.63	NA	NA	0.11	XXX
70498	TC	A	Ct angiography, neck	0.00	11.95	14.92	NA	NA	0.01	XXX
70498	26	A	Ct angiography, neck	1.75	0.61	0.71	0.61	0.71	0.10	XXX
70540		A	Mri orbit/face/neck w/o dye	1.35	9.96	13.05	NA	NA	0.09	XXX
70540	TC	A	Mri orbit/face/neck w/o dye	0.00	9.49	12.52	NA	NA	0.01	XXX
70540	26	A	Mri orbit/face/neck w/o dye	1.35	0.47	0.53	0.47	0.53	0.08	XXX
70542		A	Mri orbit/face/neck w/dye	1.62	11.17	14.46	NA	NA	0.11	XXX
70542	TC	A	Mri orbit/face/neck w/dye	0.00	10.60	13.82	NA	NA	0.01	XXX
70542	26	A	Mri orbit/face/neck w/dye	1.62	0.57	0.64	0.57	0.64	0.10	XXX
70543		A	Mri orbt/fac/nck w/o & w/dye	2.15	13.42	18.89	NA	NA	0.14	XXX
70543	TC	A	Mri orbt/fac/nck w/o & w/dye	0.00	12.67	18.05	NA	NA	0.01	XXX
70543	26	A	Mri orbt/fac/nck w/o & w/dye	2.15	0.75	0.84	0.75	0.84	0.13	XXX
70544		A	Mr angiography head w/o dye	1.20	11.48	14.53	NA	NA	0.08	XXX
70544	TC	A	Mr angiography head w/o dye	0.00	11.06	14.06	NA	NA	0.01	XXX
70544	26	A	Mr angiography head w/o dye	1.20	0.42	0.47	0.42	0.47	0.07	XXX
70545		A	Mr angiography head w/dye	1.20	11.38	14.44	NA	NA	0.08	XXX
70545	TC	A	Mr angiography head w/dye	0.00	10.96	13.97	NA	NA	0.01	XXX
70545	26	A	Mr angiography head w/dye	1.20	0.42	0.47	0.42	0.47	0.07	XXX
70546		A	Mr angiograph head w/o&w/dye	1.80	17.39	22.84	NA	NA	0.12	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
70546	TC	A	Mr angiograph head w/o&w/dye	0.00	16.76	22.13	NA	NA	0.01	XXX
70546	26	A	Mr angiograph head w/o&w/dye	1.80	0.63	0.71	0.63	0.71	0.11	XXX
70547		A	Mr angiography neck w/o dye	1.20	11.48	14.51	NA	NA	0.08	XXX
70547	TC	A	Mr angiography neck w/o dye	0.00	11.06	14.03	NA	NA	0.01	XXX
70547	26	A	Mr angiography neck w/o dye	1.20	0.42	0.48	0.42	0.48	0.07	XXX
70548		A	Mr angiography neck w/dye	1.20	12.24	15.28	NA	NA	0.08	XXX
70548	TC	A	Mr angiography neck w/dye	0.00	11.82	14.80	NA	NA	0.01	XXX
70548	26	A	Mr angiography neck w/dye	1.20	0.42	0.48	0.42	0.48	0.07	XXX
70549		A	Mr angiograph neck w/o&w/dye	1.80	17.40	22.85	NA	NA	0.11	XXX
70549	TC	A	Mr angiograph neck w/o&w/dye	0.00	16.77	22.14	NA	NA	0.01	XXX
70549	26	A	Mr angiograph neck w/o&w/dye	1.80	0.63	0.71	0.63	0.71	0.10	XXX
70551		A	Mri brain w/o dye	1.48	10.40	13.39	NA	NA	0.09	XXX
70551	TC	A	Mri brain w/o dye	0.00	9.88	12.81	NA	NA	0.01	XXX
70551	26	A	Mri brain w/o dye	1.48	0.52	0.58	0.52	0.58	0.08	XXX
70552		A	Mri brain w/dye	1.78	11.48	14.80	NA	NA	0.12	XXX
70552	TC	A	Mri brain w/dye	0.00	10.85	14.09	NA	NA	0.01	XXX
70552	26	A	Mri brain w/dye	1.78	0.63	0.71	0.63	0.71	0.11	XXX
70553		A	Mri brain w/o & w/dye	2.36	13.18	18.51	NA	NA	0.15	XXX
70553	TC	A	Mri brain w/o & w/dye	0.00	12.35	17.57	NA	NA	0.01	XXX
70553	26	A	Mri brain w/o & w/dye	2.36	0.83	0.94	0.83	0.94	0.14	XXX
70554		A	Fmri brain by tech	2.11	11.55	14.26	NA	NA	0.14	XXX
70554	TC	A	Fmri brain by tech	0.00	10.79	13.40	NA	NA	0.01	XXX
70554	26	A	Fmri brain by tech	2.11	0.76	0.86	0.76	0.86	0.13	XXX
70555		C	Fmri brain by phys/psych	0.00	0.00	0.00	NA	NA	0.00	XXX
70555	TC	C	Fmri brain by phys/psych	0.00	0.00	0.00	NA	NA	0.00	XXX
70555	26	A	Fmri brain by phys/psych	2.54	0.86	1.02	0.86	1.02	0.25	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
70557		C	Mri brain w/o dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70557	TC	C	Mri brain w/o dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70557	26	A	Mri brain w/o dye	2.90	1.59	1.48	1.59	1.48	1.09	XXX
70558		C	Mri brain w/dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70558	TC	C	Mri brain w/dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70558	26	A	Mri brain w/dye	3.20	1.12	1.28	1.12	1.28	0.31	XXX
70559		C	Mri brain w/o & w/dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70559	TC	C	Mri brain w/o & w/dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70559	26	A	Mri brain w/o & w/dye	3.20	1.16	1.33	1.16	1.33	0.31	XXX
71010		A	Chest x-ray	0.18	0.45	0.49	NA	NA	0.02	XXX
71010	TC	A	Chest x-ray	0.00	0.38	0.42	NA	NA	0.01	XXX
71010	26	A	Chest x-ray	0.18	0.07	0.07	0.07	0.07	0.01	XXX
71015		A	Chest x-ray	0.21	0.60	0.64	NA	NA	0.02	XXX
71015	TC	A	Chest x-ray	0.00	0.52	0.56	NA	NA	0.01	XXX
71015	26	A	Chest x-ray	0.21	0.08	0.08	0.08	0.08	0.01	XXX
71020		A	Chest x-ray	0.22	0.59	0.66	NA	NA	0.02	XXX
71020	TC	A	Chest x-ray	0.00	0.51	0.57	NA	NA	0.01	XXX
71020	26	A	Chest x-ray	0.22	0.08	0.09	0.08	0.09	0.01	XXX
71021		A	Chest x-ray	0.27	0.78	0.83	NA	NA	0.02	XXX
71021	TC	A	Chest x-ray	0.00	0.66	0.72	NA	NA	0.01	XXX
71021	26	A	Chest x-ray	0.27	0.12	0.11	0.12	0.11	0.01	XXX
71022		A	Chest x-ray	0.31	0.96	1.03	NA	NA	0.02	XXX
71022	TC	A	Chest x-ray	0.00	0.84	0.90	NA	NA	0.01	XXX
71022	26	A	Chest x-ray	0.31	0.12	0.13	0.12	0.13	0.01	XXX
71023		A	Chest x-ray and fluoroscopy	0.38	1.56	1.61	NA	NA	0.02	XXX
71023	TC	A	Chest x-ray and fluoroscopy	0.00	1.41	1.45	NA	NA	0.01	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
71023	26	A	Chest x-ray and fluoroscopy	0.38	0.15	0.16	0.15	0.16	0.01	XXX
71030		A	Chest x-ray	0.31	0.92	1.00	NA	NA	0.02	XXX
71030	TC	A	Chest x-ray	0.00	0.81	0.88	NA	NA	0.01	XXX
71030	26	A	Chest x-ray	0.31	0.11	0.12	0.11	0.12	0.01	XXX
71034		A	Chest x-ray and fluoroscopy	0.46	1.85	2.10	NA	NA	0.02	XXX
71034	TC	A	Chest x-ray and fluoroscopy	0.00	1.68	1.89	NA	NA	0.01	XXX
71034	26	A	Chest x-ray and fluoroscopy	0.46	0.17	0.21	0.17	0.21	0.01	XXX
71035		A	Chest x-ray	0.18	0.77	0.82	NA	NA	0.02	XXX
71035	TC	A	Chest x-ray	0.00	0.71	0.75	NA	NA	0.01	XXX
71035	26	A	Chest x-ray	0.18	0.06	0.07	0.06	0.07	0.01	XXX
71040		A	Contrast x-ray of bronchi	0.58	2.06	2.20	NA	NA	0.02	XXX
71040	TC	A	Contrast x-ray of bronchi	0.00	1.86	1.97	NA	NA	0.01	XXX
71040	26	A	Contrast x-ray of bronchi	0.58	0.20	0.23	0.20	0.23	0.01	XXX
71060		A	Contrast x-ray of bronchi	0.74	3.06	3.29	NA	NA	0.05	XXX
71060	TC	A	Contrast x-ray of bronchi	0.00	2.80	3.00	NA	NA	0.01	XXX
71060	26	A	Contrast x-ray of bronchi	0.74	0.26	0.29	0.26	0.29	0.04	XXX
71090		C	X-ray & pacemaker insertion	0.00	0.00	0.00	NA	NA	0.00	XXX
71090	TC	C	X-ray & pacemaker insertion	0.00	0.00	0.00	NA	NA	0.00	XXX
71090	26	A	X-ray & pacemaker insertion	0.54	0.21	0.26	0.21	0.26	0.04	XXX
71100		A	X-ray exam of ribs	0.22	0.67	0.71	NA	NA	0.02	XXX
71100	TC	A	X-ray exam of ribs	0.00	0.58	0.62	NA	NA	0.01	XXX
71100	26	A	X-ray exam of ribs	0.22	0.09	0.09	0.09	0.09	0.01	XXX
71101		A	X-ray exam of ribs/chest	0.27	0.80	0.86	NA	NA	0.02	XXX
71101	TC	A	X-ray exam of ribs/chest	0.00	0.70	0.75	NA	NA	0.01	XXX
71101	26	A	X-ray exam of ribs/chest	0.27	0.10	0.11	0.10	0.11	0.01	XXX
71110		A	X-ray exam of ribs	0.27	0.85	0.90	NA	NA	0.02	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
71110	TC	A	X-ray exam of ribs	0.00	0.74	0.79	NA	NA	0.01	XXX
71110	26	A	X-ray exam of ribs	0.27	0.11	0.11	0.11	0.11	0.01	XXX
71111		A	X-ray exam of ribs/chest	0.32	1.15	1.20	NA	NA	0.02	XXX
71111	TC	A	X-ray exam of ribs/chest	0.00	1.02	1.07	NA	NA	0.01	XXX
71111	26	A	X-ray exam of ribs/chest	0.32	0.13	0.13	0.13	0.13	0.01	XXX
71120		A	X-ray exam of breastbone	0.20	0.64	0.71	NA	NA	0.02	XXX
71120	TC	A	X-ray exam of breastbone	0.00	0.57	0.63	NA	NA	0.01	XXX
71120	26	A	X-ray exam of breastbone	0.20	0.07	0.08	0.07	0.08	0.01	XXX
71130		A	X-ray exam of breastbone	0.22	0.79	0.85	NA	NA	0.02	XXX
71130	TC	A	X-ray exam of breastbone	0.00	0.70	0.76	NA	NA	0.01	XXX
71130	26	A	X-ray exam of breastbone	0.22	0.09	0.09	0.09	0.09	0.01	XXX
71250		A	Ct thorax w/o dye	1.16	4.81	6.23	NA	NA	0.08	XXX
71250	TC	A	Ct thorax w/o dye	0.00	4.40	5.77	NA	NA	0.01	XXX
71250	26	A	Ct thorax w/o dye	1.16	0.41	0.46	0.41	0.46	0.07	XXX
71260		A	Ct thorax w/dye	1.24	5.98	7.68	NA	NA	0.08	XXX
71260	TC	A	Ct thorax w/dye	0.00	5.54	7.18	NA	NA	0.01	XXX
71260	26	A	Ct thorax w/dye	1.24	0.44	0.50	0.44	0.50	0.07	XXX
71270		A	Ct thorax w/o & w/dye	1.38	7.41	9.60	NA	NA	0.08	XXX
71270	TC	A	Ct thorax w/o & w/dye	0.00	6.93	9.05	NA	NA	0.01	XXX
71270	26	A	Ct thorax w/o & w/dye	1.38	0.48	0.55	0.48	0.55	0.07	XXX
71275		A	Ct angiography, chest	1.92	9.04	11.72	NA	NA	0.12	XXX
71275	TC	A	Ct angiography, chest	0.00	8.37	10.95	NA	NA	0.01	XXX
71275	26	A	Ct angiography, chest	1.92	0.67	0.77	0.67	0.77	0.11	XXX
71550		A	Mri chest w/o dye	1.46	11.56	14.81	NA	NA	0.09	XXX
71550	TC	A	Mri chest w/o dye	0.00	11.05	14.24	NA	NA	0.01	XXX
71550	26	A	Mri chest w/o dye	1.46	0.51	0.57	0.51	0.57	0.08	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
71551		A	Mri chest w/dye	1.73	13.10	16.62	NA	NA	0.11	XXX
71551	TC	A	Mri chest w/dye	0.00	12.49	15.94	NA	NA	0.01	XXX
71551	26	A	Mri chest w/dye	1.73	0.61	0.68	0.61	0.68	0.10	XXX
71552		A	Mri chest w/o & w/dye	2.26	16.05	21.90	NA	NA	0.14	XXX
71552	TC	A	Mri chest w/o & w/dye	0.00	15.26	21.00	NA	NA	0.01	XXX
71552	26	A	Mri chest w/o & w/dye	2.26	0.79	0.90	0.79	0.90	0.13	XXX
71555		R	Mri angio chest w or w/o dye	1.81	11.18	14.18	NA	NA	0.11	XXX
71555	TC	R	Mri angio chest w or w/o dye	0.00	10.54	13.44	NA	NA	0.01	XXX
71555	26	R	Mri angio chest w or w/o dye	1.81	0.64	0.74	0.64	0.74	0.10	XXX
72010		A	X-ray exam of spine	0.45	1.71	1.67	NA	NA	0.04	XXX
72010	TC	A	X-ray exam of spine	0.00	1.51	1.49	NA	NA	0.01	XXX
72010	26	A	X-ray exam of spine	0.45	0.20	0.18	0.20	0.18	0.03	XXX
72020		A	X-ray exam of spine	0.15	0.48	0.52	NA	NA	0.02	XXX
72020	TC	A	X-ray exam of spine	0.00	0.42	0.46	NA	NA	0.01	XXX
72020	26	A	X-ray exam of spine	0.15	0.06	0.06	0.06	0.06	0.01	XXX
72040		A	X-ray exam of neck spine	0.22	0.86	0.88	NA	NA	0.04	XXX
72040	TC	A	X-ray exam of neck spine	0.00	0.76	0.78	NA	NA	0.01	XXX
72040	26	A	X-ray exam of neck spine	0.22	0.10	0.10	0.10	0.10	0.03	XXX
72050		A	X-ray exam of neck spine	0.31	1.12	1.19	NA	NA	0.04	XXX
72050	TC	A	X-ray exam of neck spine	0.00	1.00	1.06	NA	NA	0.01	XXX
72050	26	A	X-ray exam of neck spine	0.31	0.12	0.13	0.12	0.13	0.03	XXX
72052		A	X-ray exam of neck spine	0.36	1.48	1.55	NA	NA	0.04	XXX
72052	TC	A	X-ray exam of neck spine	0.00	1.34	1.40	NA	NA	0.01	XXX
72052	26	A	X-ray exam of neck spine	0.36	0.14	0.15	0.14	0.15	0.03	XXX
72069		A	X-ray exam of trunk spine	0.22	0.81	0.82	NA	NA	0.04	XXX
72069	TC	A	X-ray exam of trunk spine	0.00	0.72	0.73	NA	NA	0.01	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
72069	26	A	X-ray exam of trunk spine	0.22	0.09	0.09	0.09	0.09	0.03	XXX
72070		A	X-ray exam of thoracic spine	0.22	0.70	0.74	NA	NA	0.02	XXX
72070	TC	A	X-ray exam of thoracic spine	0.00	0.61	0.65	NA	NA	0.01	XXX
72070	26	A	X-ray exam of thoracic spine	0.22	0.09	0.09	0.09	0.09	0.01	XXX
72072		A	X-ray exam of thoracic spine	0.22	0.78	0.86	NA	NA	0.02	XXX
72072	TC	A	X-ray exam of thoracic spine	0.00	0.70	0.77	NA	NA	0.01	XXX
72072	26	A	X-ray exam of thoracic spine	0.22	0.08	0.09	0.08	0.09	0.01	XXX
72074		A	X-ray exam of thoracic spine	0.22	0.96	1.05	NA	NA	0.02	XXX
72074	TC	A	X-ray exam of thoracic spine	0.00	0.88	0.96	NA	NA	0.01	XXX
72074	26	A	X-ray exam of thoracic spine	0.22	0.08	0.09	0.08	0.09	0.01	XXX
72080		A	X-ray exam of trunk spine	0.22	0.78	0.81	NA	NA	0.04	XXX
72080	TC	A	X-ray exam of trunk spine	0.00	0.68	0.71	NA	NA	0.01	XXX
72080	26	A	X-ray exam of trunk spine	0.22	0.10	0.10	0.10	0.10	0.03	XXX
72090		A	X-ray exam of trunk spine	0.28	1.10	1.12	NA	NA	0.05	XXX
72090	TC	A	X-ray exam of trunk spine	0.00	0.98	0.99	NA	NA	0.01	XXX
72090	26	A	X-ray exam of trunk spine	0.28	0.12	0.13	0.12	0.13	0.04	XXX
72100		A	X-ray exam of lower spine	0.22	0.91	0.93	NA	NA	0.04	XXX
72100	TC	A	X-ray exam of lower spine	0.00	0.81	0.83	NA	NA	0.01	XXX
72100	26	A	X-ray exam of lower spine	0.22	0.10	0.10	0.10	0.10	0.03	XXX
72110		A	X-ray exam of lower spine	0.31	1.20	1.27	NA	NA	0.04	XXX
72110	TC	A	X-ray exam of lower spine	0.00	1.08	1.14	NA	NA	0.01	XXX
72110	26	A	X-ray exam of lower spine	0.31	0.12	0.13	0.12	0.13	0.03	XXX
72114		A	X-ray exam of lower spine	0.36	1.71	1.76	NA	NA	0.05	XXX
72114	TC	A	X-ray exam of lower spine	0.00	1.56	1.60	NA	NA	0.01	XXX
72114	26	A	X-ray exam of lower spine	0.36	0.15	0.16	0.15	0.16	0.04	XXX
72120		A	X-ray exam of lower spine	0.22	1.24	1.25	NA	NA	0.04	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
72120	TC	A	X-ray exam of lower spine	0.00	1.14	1.15	NA	NA	0.01	XXX
72120	26	A	X-ray exam of lower spine	0.22	0.10	0.10	0.10	0.10	0.03	XXX
72125		A	Ct neck spine w/o dye	1.16	4.85	6.27	NA	NA	0.08	XXX
72125	TC	A	Ct neck spine w/o dye	0.00	4.45	5.81	NA	NA	0.01	XXX
72125	26	A	Ct neck spine w/o dye	1.16	0.40	0.46	0.40	0.46	0.07	XXX
72126		A	Ct neck spine w/dye	1.22	5.99	7.68	NA	NA	0.08	XXX
72126	TC	A	Ct neck spine w/dye	0.00	5.56	7.20	NA	NA	0.01	XXX
72126	26	A	Ct neck spine w/dye	1.22	0.43	0.48	0.43	0.48	0.07	XXX
72127		A	Ct neck spine w/o & w/dye	1.27	7.38	9.54	NA	NA	0.08	XXX
72127	TC	A	Ct neck spine w/o & w/dye	0.00	6.94	9.04	NA	NA	0.01	XXX
72127	26	A	Ct neck spine w/o & w/dye	1.27	0.44	0.50	0.44	0.50	0.07	XXX
72128		A	Ct chest spine w/o dye	1.16	4.85	6.25	NA	NA	0.08	XXX
72128	TC	A	Ct chest spine w/o dye	0.00	4.44	5.79	NA	NA	0.01	XXX
72128	26	A	Ct chest spine w/o dye	1.16	0.41	0.46	0.41	0.46	0.07	XXX
72129		A	Ct chest spine w/dye	1.22	6.01	7.70	NA	NA	0.08	XXX
72129	TC	A	Ct chest spine w/dye	0.00	5.58	7.21	NA	NA	0.01	XXX
72129	26	A	Ct chest spine w/dye	1.22	0.43	0.49	0.43	0.49	0.07	XXX
72130		A	Ct chest spine w/o & w/dye	1.27	7.39	9.55	NA	NA	0.08	XXX
72130	TC	A	Ct chest spine w/o & w/dye	0.00	6.95	9.05	NA	NA	0.01	XXX
72130	26	A	Ct chest spine w/o & w/dye	1.27	0.44	0.50	0.44	0.50	0.07	XXX
72131		A	Ct lumbar spine w/o dye	1.16	4.83	6.24	NA	NA	0.08	XXX
72131	TC	A	Ct lumbar spine w/o dye	0.00	4.42	5.78	NA	NA	0.01	XXX
72131	26	A	Ct lumbar spine w/o dye	1.16	0.41	0.46	0.41	0.46	0.07	XXX
72132		A	Ct lumbar spine w/dye	1.22	5.97	7.68	NA	NA	0.08	XXX
72132	TC	A	Ct lumbar spine w/dye	0.00	5.55	7.19	NA	NA	0.01	XXX
72132	26	A	Ct lumbar spine w/dye	1.22	0.42	0.49	0.42	0.49	0.07	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
72133		A	Ct lumbar spine w/o & w/dye	1.27	7.38	9.54	NA	NA	0.08	XXX
72133	TC	A	Ct lumbar spine w/o & w/dye	0.00	6.94	9.04	NA	NA	0.01	XXX
72133	26	A	Ct lumbar spine w/o & w/dye	1.27	0.44	0.50	0.44	0.50	0.07	XXX
72141		A	Mri neck spine w/o dye	1.60	9.00	11.82	NA	NA	0.11	XXX
72141	TC	A	Mri neck spine w/o dye	0.00	8.43	11.19	NA	NA	0.01	XXX
72141	26	A	Mri neck spine w/o dye	1.60	0.57	0.63	0.57	0.63	0.10	XXX
72142		A	Mri neck spine w/dye	1.92	11.59	14.88	NA	NA	0.12	XXX
72142	TC	A	Mri neck spine w/dye	0.00	10.90	14.11	NA	NA	0.01	XXX
72142	26	A	Mri neck spine w/dye	1.92	0.69	0.77	0.69	0.77	0.11	XXX
72146		A	Mri chest spine w/o dye	1.60	9.01	12.02	NA	NA	0.11	XXX
72146	TC	A	Mri chest spine w/o dye	0.00	8.44	11.38	NA	NA	0.01	XXX
72146	26	A	Mri chest spine w/o dye	1.60	0.57	0.64	0.57	0.64	0.10	XXX
72147		A	Mri chest spine w/dye	1.92	10.08	13.22	NA	NA	0.12	XXX
72147	TC	A	Mri chest spine w/dye	0.00	9.40	12.45	NA	NA	0.01	XXX
72147	26	A	Mri chest spine w/dye	1.92	0.68	0.77	0.68	0.77	0.11	XXX
72148		A	Mri lumbar spine w/o dye	1.48	8.96	11.96	NA	NA	0.11	XXX
72148	TC	A	Mri lumbar spine w/o dye	0.00	8.43	11.37	NA	NA	0.01	XXX
72148	26	A	Mri lumbar spine w/o dye	1.48	0.53	0.59	0.53	0.59	0.10	XXX
72149		A	Mri lumbar spine w/dye	1.78	11.38	14.74	NA	NA	0.12	XXX
72149	TC	A	Mri lumbar spine w/dye	0.00	10.74	14.02	NA	NA	0.01	XXX
72149	26	A	Mri lumbar spine w/dye	1.78	0.64	0.72	0.64	0.72	0.11	XXX
72156		A	Mri neck spine w/o & w/dye	2.57	13.00	18.29	NA	NA	0.18	XXX
72156	TC	A	Mri neck spine w/o & w/dye	0.00	12.09	17.27	NA	NA	0.01	XXX
72156	26	A	Mri neck spine w/o & w/dye	2.57	0.91	1.02	0.91	1.02	0.17	XXX
72157		A	Mri chest spine w/o & w/dye	2.57	11.91	17.04	NA	NA	0.18	XXX
72157	TC	A	Mri chest spine w/o & w/dye	0.00	11.01	16.02	NA	NA	0.01	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
72157	26	A	Mri chest spine w/o & w/dye	2.57	0.90	1.02	0.90	1.02	0.17	XXX
72158		A	Mri lumbar spine w/o & w/dye	2.36	12.89	18.18	NA	NA	0.18	XXX
72158	TC	A	Mri lumbar spine w/o & w/dye	0.00	12.05	17.24	NA	NA	0.01	XXX
72158	26	A	Mri lumbar spine w/o & w/dye	2.36	0.84	0.94	0.84	0.94	0.17	XXX
72159		N	Mr angio spine w/o&w/dye	1.80	13.41	15.99	NA	NA	0.08	XXX
72159	TC	N	Mr angio spine w/o&w/dye	0.00	12.63	15.22	NA	NA	0.01	XXX
72159	26	N	Mr angio spine w/o&w/dye	1.80	0.78	0.77	0.78	0.77	0.07	XXX
72170		A	X-ray exam of pelvis	0.17	0.55	0.58	NA	NA	0.04	XXX
72170	TC	A	X-ray exam of pelvis	0.00	0.48	0.51	NA	NA	0.01	XXX
72170	26	A	X-ray exam of pelvis	0.17	0.07	0.07	0.07	0.07	0.03	XXX
72190		A	X-ray exam of pelvis	0.21	0.95	0.97	NA	NA	0.04	XXX
72190	TC	A	X-ray exam of pelvis	0.00	0.86	0.88	NA	NA	0.01	XXX
72190	26	A	X-ray exam of pelvis	0.21	0.09	0.09	0.09	0.09	0.03	XXX
72191		A	Ct angiograph pelv w/o&w/dye	1.81	8.61	11.26	NA	NA	0.14	XXX
72191	TC	A	Ct angiograph pelv w/o&w/dye	0.00	7.98	10.54	NA	NA	0.01	XXX
72191	26	A	Ct angiograph pelv w/o&w/dye	1.81	0.63	0.72	0.63	0.72	0.13	XXX
72192		A	Ct pelvis w/o dye	1.09	4.49	5.89	NA	NA	0.07	XXX
72192	TC	A	Ct pelvis w/o dye	0.00	4.11	5.45	NA	NA	0.01	XXX
72192	26	A	Ct pelvis w/o dye	1.09	0.38	0.44	0.38	0.44	0.06	XXX
72193		A	Ct pelvis w/dye	1.16	5.63	7.27	NA	NA	0.08	XXX
72193	TC	A	Ct pelvis w/dye	0.00	5.22	6.81	NA	NA	0.01	XXX
72193	26	A	Ct pelvis w/dye	1.16	0.41	0.46	0.41	0.46	0.07	XXX
72194		A	Ct pelvis w/o & w/dye	1.22	7.47	9.60	NA	NA	0.08	XXX
72194	TC	A	Ct pelvis w/o & w/dye	0.00	7.04	9.11	NA	NA	0.01	XXX
72194	26	A	Ct pelvis w/o & w/dye	1.22	0.43	0.49	0.43	0.49	0.07	XXX
72195		A	Mri pelvis w/o dye	1.46	10.31	13.34	NA	NA	0.11	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
72195	TC	A	Mri pelvis w/o dye	0.00	9.79	12.76	NA	NA	0.01	XXX
72195	26	A	Mri pelvis w/o dye	1.46	0.52	0.58	0.52	0.58	0.10	XXX
72196		A	Mri pelvis w/dye	1.73	11.32	14.64	NA	NA	0.11	XXX
72196	TC	A	Mri pelvis w/dye	0.00	10.71	13.95	NA	NA	0.01	XXX
72196	26	A	Mri pelvis w/dye	1.73	0.61	0.69	0.61	0.69	0.10	XXX
72197		A	Mri pelvis w/o & w/dye	2.26	13.64	19.11	NA	NA	0.14	XXX
72197	TC	A	Mri pelvis w/o & w/dye	0.00	12.86	18.22	NA	NA	0.01	XXX
72197	26	A	Mri pelvis w/o & w/dye	2.26	0.78	0.89	0.78	0.89	0.13	XXX
72198		A	Mr angio pelvis w/o & w/dye	1.80	11.12	14.08	NA	NA	0.11	XXX
72198	TC	A	Mr angio pelvis w/o & w/dye	0.00	10.50	13.37	NA	NA	0.01	XXX
72198	26	A	Mr angio pelvis w/o & w/dye	1.80	0.62	0.71	0.62	0.71	0.10	XXX
72200		A	X-ray exam sacroiliac joints	0.17	0.63	0.67	NA	NA	0.02	XXX
72200	TC	A	X-ray exam sacroiliac joints	0.00	0.56	0.60	NA	NA	0.01	XXX
72200	26	A	X-ray exam sacroiliac joints	0.17	0.07	0.07	0.07	0.07	0.01	XXX
72202		A	X-ray exam sacroiliac joints	0.19	0.74	0.80	NA	NA	0.02	XXX
72202	TC	A	X-ray exam sacroiliac joints	0.00	0.67	0.72	NA	NA	0.01	XXX
72202	26	A	X-ray exam sacroiliac joints	0.19	0.07	0.08	0.07	0.08	0.01	XXX
72220		A	X-ray exam of tailbone	0.17	0.62	0.66	NA	NA	0.02	XXX
72220	TC	A	X-ray exam of tailbone	0.00	0.55	0.59	NA	NA	0.01	XXX
72220	26	A	X-ray exam of tailbone	0.17	0.07	0.07	0.07	0.07	0.01	XXX
72240		A	Contrast x-ray of neck spine	0.91	2.62	3.22	NA	NA	0.07	XXX
72240	TC	A	Contrast x-ray of neck spine	0.00	2.29	2.86	NA	NA	0.01	XXX
72240	26	A	Contrast x-ray of neck spine	0.91	0.33	0.36	0.33	0.36	0.06	XXX
72255		A	Contrast x-ray, thorax spine	0.91	2.55	2.99	NA	NA	0.05	XXX
72255	TC	A	Contrast x-ray, thorax spine	0.00	2.20	2.63	NA	NA	0.01	XXX
72255	26	A	Contrast x-ray, thorax spine	0.91	0.35	0.36	0.35	0.36	0.04	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
72265		A	Contrast x-ray, lower spine	0.83	2.63	3.11	NA	NA	0.05	XXX
72265	TC	A	Contrast x-ray, lower spine	0.00	2.32	2.78	NA	NA	0.01	XXX
72265	26	A	Contrast x-ray, lower spine	0.83	0.31	0.33	0.31	0.33	0.04	XXX
72270		A	Contrast x-ray, spine	1.33	4.06	4.81	NA	NA	0.08	XXX
72270	TC	A	Contrast x-ray, spine	0.00	3.58	4.28	NA	NA	0.01	XXX
72270	26	A	Contrast x-ray, spine	1.33	0.48	0.53	0.48	0.53	0.07	XXX
72275		A	Epidurography	0.76	2.65	2.46	NA	NA	0.05	XXX
72275	TC	A	Epidurography	0.00	2.27	2.14	NA	NA	0.01	XXX
72275	26	A	Epidurography	0.76	0.38	0.32	0.38	0.32	0.04	XXX
72285		A	X-ray c/t spine disk	1.16	2.23	3.09	NA	NA	0.07	XXX
72285	TC	A	X-ray c/t spine disk	0.00	1.63	2.59	NA	NA	0.01	XXX
72285	26	A	X-ray c/t spine disk	1.16	0.60	0.50	0.60	0.50	0.06	XXX
72291		C	Perq verte/sacroplsty, fluor	0.00	0.00	0.00	NA	NA	0.00	XXX
72291	TC	C	Perq verte/sacroplsty, fluor	0.00	0.00	0.00	NA	NA	0.00	XXX
72291	26	A	Perq verte/sacroplsty, fluor	1.31	0.57	0.59	0.57	0.59	0.23	XXX
72292		C	Perq verte/sacroplsty, ct	0.00	0.00	0.00	NA	NA	0.00	XXX
72292	TC	C	Perq verte/sacroplsty, ct	0.00	0.00	0.00	NA	NA	0.00	XXX
72292	26	A	Perq verte/sacroplsty, ct	1.38	0.56	0.60	0.56	0.60	0.21	XXX
72295		A	X-ray of lower spine disk	0.83	2.09	2.92	NA	NA	0.05	XXX
72295	TC	A	X-ray of lower spine disk	0.00	1.67	2.55	NA	NA	0.01	XXX
72295	26	A	X-ray of lower spine disk	0.83	0.42	0.37	0.42	0.37	0.04	XXX
73000		A	X-ray exam of collar bone	0.16	0.63	0.65	NA	NA	0.02	XXX
73000	TC	A	X-ray exam of collar bone	0.00	0.56	0.58	NA	NA	0.01	XXX
73000	26	A	X-ray exam of collar bone	0.16	0.07	0.07	0.07	0.07	0.01	XXX
73010		A	X-ray exam of shoulder blade	0.17	0.69	0.69	NA	NA	0.04	XXX
73010	TC	A	X-ray exam of shoulder blade	0.00	0.61	0.61	NA	NA	0.01	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
73010	26	A	X-ray exam of shoulder blade	0.17	0.08	0.08	0.08	0.08	0.03	XXX
73020		A	X-ray exam of shoulder	0.15	0.50	0.52	NA	NA	0.02	XXX
73020	TC	A	X-ray exam of shoulder	0.00	0.43	0.46	NA	NA	0.01	XXX
73020	26	A	X-ray exam of shoulder	0.15	0.07	0.06	0.07	0.06	0.01	XXX
73030		A	X-ray exam of shoulder	0.18	0.65	0.68	NA	NA	0.04	XXX
73030	TC	A	X-ray exam of shoulder	0.00	0.57	0.60	NA	NA	0.01	XXX
73030	26	A	X-ray exam of shoulder	0.18	0.08	0.08	0.08	0.08	0.03	XXX
73040		A	Contrast x-ray of shoulder	0.54	2.37	2.55	NA	NA	0.05	XXX
73040	TC	A	Contrast x-ray of shoulder	0.00	2.16	2.32	NA	NA	0.01	XXX
73040	26	A	Contrast x-ray of shoulder	0.54	0.21	0.23	0.21	0.23	0.04	XXX
73050		A	X-ray exam of shoulders	0.20	0.89	0.89	NA	NA	0.04	XXX
73050	TC	A	X-ray exam of shoulders	0.00	0.79	0.79	NA	NA	0.01	XXX
73050	26	A	X-ray exam of shoulders	0.20	0.10	0.10	0.10	0.10	0.03	XXX
73060		A	X-ray exam of humerus	0.17	0.64	0.66	NA	NA	0.02	XXX
73060	TC	A	X-ray exam of humerus	0.00	0.56	0.59	NA	NA	0.01	XXX
73060	26	A	X-ray exam of humerus	0.17	0.08	0.07	0.08	0.07	0.01	XXX
73070		A	X-ray exam of elbow	0.15	0.64	0.66	NA	NA	0.02	XXX
73070	TC	A	X-ray exam of elbow	0.00	0.57	0.59	NA	NA	0.01	XXX
73070	26	A	X-ray exam of elbow	0.15	0.07	0.07	0.07	0.07	0.01	XXX
73080		A	X-ray exam of elbow	0.17	0.82	0.84	NA	NA	0.02	XXX
73080	TC	A	X-ray exam of elbow	0.00	0.75	0.77	NA	NA	0.01	XXX
73080	26	A	X-ray exam of elbow	0.17	0.07	0.07	0.07	0.07	0.01	XXX
73085		A	Contrast x-ray of elbow	0.54	2.14	2.26	NA	NA	0.04	XXX
73085	TC	A	Contrast x-ray of elbow	0.00	1.90	2.02	NA	NA	0.01	XXX
73085	26	A	Contrast x-ray of elbow	0.54	0.24	0.24	0.24	0.24	0.03	XXX
73090		A	X-ray exam of forearm	0.16	0.61	0.63	NA	NA	0.02	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
73090	TC	A	X-ray exam of forearm	0.00	0.54	0.57	NA	NA	0.01	XXX
73090	26	A	X-ray exam of forearm	0.16	0.07	0.06	0.07	0.06	0.01	XXX
73092		A	X-ray exam of arm, infant	0.16	0.74	0.72	NA	NA	0.02	XXX
73092	TC	A	X-ray exam of arm, infant	0.00	0.67	0.65	NA	NA	0.01	XXX
73092	26	A	X-ray exam of arm, infant	0.16	0.07	0.07	0.07	0.07	0.01	XXX
73100		A	X-ray exam of wrist	0.16	0.71	0.71	NA	NA	0.04	XXX
73100	TC	A	X-ray exam of wrist	0.00	0.63	0.63	NA	NA	0.01	XXX
73100	26	A	X-ray exam of wrist	0.16	0.08	0.08	0.08	0.08	0.03	XXX
73110		A	X-ray exam of wrist	0.17	0.87	0.86	NA	NA	0.02	XXX
73110	TC	A	X-ray exam of wrist	0.00	0.79	0.79	NA	NA	0.01	XXX
73110	26	A	X-ray exam of wrist	0.17	0.08	0.07	0.08	0.07	0.01	XXX
73115		A	Contrast x-ray of wrist	0.54	2.57	2.57	NA	NA	0.05	XXX
73115	TC	A	Contrast x-ray of wrist	0.00	2.33	2.33	NA	NA	0.01	XXX
73115	26	A	Contrast x-ray of wrist	0.54	0.24	0.24	0.24	0.24	0.04	XXX
73120		A	X-ray exam of hand	0.16	0.61	0.63	NA	NA	0.02	XXX
73120	TC	A	X-ray exam of hand	0.00	0.54	0.56	NA	NA	0.01	XXX
73120	26	A	X-ray exam of hand	0.16	0.07	0.07	0.07	0.07	0.01	XXX
73130		A	X-ray exam of hand	0.17	0.72	0.74	NA	NA	0.02	XXX
73130	TC	A	X-ray exam of hand	0.00	0.65	0.67	NA	NA	0.01	XXX
73130	26	A	X-ray exam of hand	0.17	0.07	0.07	0.07	0.07	0.01	XXX
73140		A	X-ray exam of finger(s)	0.13	0.79	0.77	NA	NA	0.02	XXX
73140	TC	A	X-ray exam of finger(s)	0.00	0.73	0.71	NA	NA	0.01	XXX
73140	26	A	X-ray exam of finger(s)	0.13	0.06	0.06	0.06	0.06	0.01	XXX
73200		A	Ct upper extremity w/o dye	1.09	4.77	6.04	NA	NA	0.08	XXX
73200	TC	A	Ct upper extremity w/o dye	0.00	4.39	5.61	NA	NA	0.01	XXX
73200	26	A	Ct upper extremity w/o dye	1.09	0.38	0.43	0.38	0.43	0.07	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
73201		A	Ct upper extremity w/dye	1.16	5.92	7.43	NA	NA	0.08	XXX
73201	TC	A	Ct upper extremity w/dye	0.00	5.51	6.97	NA	NA	0.01	XXX
73201	26	A	Ct upper extremity w/dye	1.16	0.41	0.46	0.41	0.46	0.07	XXX
73202		A	Ct uppr extremity w/o&w/dye	1.22	7.80	9.80	NA	NA	0.08	XXX
73202	TC	A	Ct uppr extremity w/o&w/dye	0.00	7.37	9.32	NA	NA	0.01	XXX
73202	26	A	Ct uppr extremity w/o&w/dye	1.22	0.43	0.48	0.43	0.48	0.07	XXX
73206		A	Ct angio upr extrm w/o&w/dye	1.81	8.19	10.70	NA	NA	0.09	XXX
73206	TC	A	Ct angio upr extrm w/o&w/dye	0.00	7.55	9.96	NA	NA	0.01	XXX
73206	26	A	Ct angio upr extrm w/o&w/dye	1.81	0.64	0.74	0.64	0.74	0.08	XXX
73218		A	Mri upper extremity w/o dye	1.35	10.66	13.60	NA	NA	0.08	XXX
73218	TC	A	Mri upper extremity w/o dye	0.00	10.15	13.06	NA	NA	0.01	XXX
73218	26	A	Mri upper extremity w/o dye	1.35	0.51	0.54	0.51	0.54	0.07	XXX
73219		A	Mri upper extremity w/dye	1.62	11.04	14.50	NA	NA	0.11	XXX
73219	TC	A	Mri upper extremity w/dye	0.00	10.46	13.86	NA	NA	0.01	XXX
73219	26	A	Mri upper extremity w/dye	1.62	0.58	0.64	0.58	0.64	0.10	XXX
73220		A	Mri uppr extremity w/o&w/dye	2.15	13.70	19.16	NA	NA	0.14	XXX
73220	TC	A	Mri uppr extremity w/o&w/dye	0.00	12.94	18.31	NA	NA	0.01	XXX
73220	26	A	Mri uppr extremity w/o&w/dye	2.15	0.76	0.85	0.76	0.85	0.13	XXX
73221		A	Mri joint upr extrem w/o dye	1.35	9.81	12.68	NA	NA	0.11	XXX
73221	TC	A	Mri joint upr extrem w/o dye	0.00	9.30	12.13	NA	NA	0.01	XXX
73221	26	A	Mri joint upr extrem w/o dye	1.35	0.51	0.55	0.51	0.55	0.10	XXX
73222		A	Mri joint upr extrem w/dye	1.62	10.39	13.67	NA	NA	0.11	XXX
73222	TC	A	Mri joint upr extrem w/dye	0.00	9.81	13.03	NA	NA	0.01	XXX
73222	26	A	Mri joint upr extrem w/dye	1.62	0.58	0.64	0.58	0.64	0.10	XXX
73223		A	Mri joint upr extr w/o&w/dye	2.15	12.79	18.09	NA	NA	0.14	XXX
73223	TC	A	Mri joint upr extr w/o&w/dye	0.00	12.02	17.24	NA	NA	0.01	XXX

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73223	26	A	Mri joint upr extr w/o&w/dye	2.15	0.77	0.85	0.77	0.85	0.13	XXX
73225		N	Mr angio upr extr w/o&w/dye	1.73	13.38	15.78	NA	NA	0.08	XXX
73225	TC	N	Mr angio upr extr w/o&w/dye	0.00	12.63	15.04	NA	NA	0.01	XXX
73225	26	N	Mr angio upr extr w/o&w/dye	1.73	0.75	0.74	0.75	0.74	0.07	XXX
73500		A	X-ray exam of hip	0.17	0.56	0.58	NA	NA	0.04	XXX
73500	TC	A	X-ray exam of hip	0.00	0.48	0.50	NA	NA	0.01	XXX
73500	26	A	X-ray exam of hip	0.17	0.08	0.08	0.08	0.08	0.03	XXX
73510		A	X-ray exam of hip	0.21	0.86	0.88	NA	NA	0.04	XXX
73510	TC	A	X-ray exam of hip	0.00	0.77	0.78	NA	NA	0.01	XXX
73510	26	A	X-ray exam of hip	0.21	0.09	0.10	0.09	0.10	0.03	XXX
73520		A	X-ray exam of hips	0.26	0.87	0.90	NA	NA	0.04	XXX
73520	TC	A	X-ray exam of hips	0.00	0.75	0.79	NA	NA	0.01	XXX
73520	26	A	X-ray exam of hips	0.26	0.12	0.11	0.12	0.11	0.03	XXX
73525		A	Contrast x-ray of hip	0.54	2.31	2.34	NA	NA	0.05	XXX
73525	TC	A	Contrast x-ray of hip	0.00	2.05	2.09	NA	NA	0.01	XXX
73525	26	A	Contrast x-ray of hip	0.54	0.26	0.25	0.26	0.25	0.04	XXX
73530		C	X-ray exam of hip	0.00	0.00	0.00	NA	NA	0.00	XXX
73530	TC	C	X-ray exam of hip	0.00	0.00	0.00	NA	NA	0.00	XXX
73530	26	A	X-ray exam of hip	0.29	0.10	0.12	0.10	0.12	0.03	XXX
73540		A	X-ray exam of pelvis & hips	0.20	1.01	0.95	NA	NA	0.04	XXX
73540	TC	A	X-ray exam of pelvis & hips	0.00	0.91	0.86	NA	NA	0.01	XXX
73540	26	A	X-ray exam of pelvis & hips	0.20	0.10	0.09	0.10	0.09	0.03	XXX
73542		A	X-ray exam, sacroiliac joint	0.59	1.83	1.78	NA	NA	0.04	XXX
73542	TC	A	X-ray exam, sacroiliac joint	0.00	1.54	1.54	NA	NA	0.01	XXX
73542	26	A	X-ray exam, sacroiliac joint	0.59	0.29	0.24	0.29	0.24	0.03	XXX
73550		A	X-ray exam of thigh	0.17	0.59	0.63	NA	NA	0.04	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
73550	TC	A	X-ray exam of thigh	0.00	0.52	0.56	NA	NA	0.01	XXX
73550	26	A	X-ray exam of thigh	0.17	0.07	0.07	0.07	0.07	0.03	XXX
73560		A	X-ray exam of knee, 1 or 2	0.17	0.67	0.68	NA	NA	0.04	XXX
73560	TC	A	X-ray exam of knee, 1 or 2	0.00	0.59	0.60	NA	NA	0.01	XXX
73560	26	A	X-ray exam of knee, 1 or 2	0.17	0.08	0.08	0.08	0.08	0.03	XXX
73562		A	X-ray exam of knee, 3	0.18	0.85	0.85	NA	NA	0.04	XXX
73562	TC	A	X-ray exam of knee, 3	0.00	0.76	0.76	NA	NA	0.01	XXX
73562	26	A	X-ray exam of knee, 3	0.18	0.09	0.09	0.09	0.09	0.03	XXX
73564		A	X-ray exam, knee, 4 or more	0.22	0.97	0.97	NA	NA	0.04	XXX
73564	TC	A	X-ray exam, knee, 4 or more	0.00	0.87	0.87	NA	NA	0.01	XXX
73564	26	A	X-ray exam, knee, 4 or more	0.22	0.10	0.10	0.10	0.10	0.03	XXX
73565		A	X-ray exam of knees	0.17	0.81	0.78	NA	NA	0.04	XXX
73565	TC	A	X-ray exam of knees	0.00	0.72	0.69	NA	NA	0.01	XXX
73565	26	A	X-ray exam of knees	0.17	0.09	0.09	0.09	0.09	0.03	XXX
73580		A	Contrast x-ray of knee joint	0.54	3.36	3.25	NA	NA	0.07	XXX
73580	TC	A	Contrast x-ray of knee joint	0.00	3.07	2.98	NA	NA	0.01	XXX
73580	26	A	Contrast x-ray of knee joint	0.54	0.29	0.27	0.29	0.27	0.06	XXX
73590		A	X-ray exam of lower leg	0.17	0.59	0.62	NA	NA	0.02	XXX
73590	TC	A	X-ray exam of lower leg	0.00	0.52	0.55	NA	NA	0.01	XXX
73590	26	A	X-ray exam of lower leg	0.17	0.07	0.07	0.07	0.07	0.01	XXX
73592		A	X-ray exam of leg, infant	0.16	0.77	0.73	NA	NA	0.02	XXX
73592	TC	A	X-ray exam of leg, infant	0.00	0.69	0.66	NA	NA	0.01	XXX
73592	26	A	X-ray exam of leg, infant	0.16	0.08	0.07	0.08	0.07	0.01	XXX
73600		A	X-ray exam of ankle	0.16	0.64	0.65	NA	NA	0.02	XXX
73600	TC	A	X-ray exam of ankle	0.00	0.57	0.58	NA	NA	0.01	XXX
73600	26	A	X-ray exam of ankle	0.16	0.07	0.07	0.07	0.07	0.01	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
73610		A	X-ray exam of ankle	0.17	0.75	0.76	NA	NA	0.02	XXX
73610	TC	A	X-ray exam of ankle	0.00	0.68	0.69	NA	NA	0.01	XXX
73610	26	A	X-ray exam of ankle	0.17	0.07	0.07	0.07	0.07	0.01	XXX
73615		A	Contrast x-ray of ankle	0.54	2.45	2.45	NA	NA	0.05	XXX
73615	TC	A	Contrast x-ray of ankle	0.00	2.19	2.20	NA	NA	0.01	XXX
73615	26	A	Contrast x-ray of ankle	0.54	0.26	0.25	0.26	0.25	0.04	XXX
73620		A	X-ray exam of foot	0.16	0.62	0.62	NA	NA	0.02	XXX
73620	TC	A	X-ray exam of foot	0.00	0.56	0.56	NA	NA	0.01	XXX
73620	26	A	X-ray exam of foot	0.16	0.06	0.06	0.06	0.06	0.01	XXX
73630		A	X-ray exam of foot	0.17	0.73	0.75	NA	NA	0.02	XXX
73630	TC	A	X-ray exam of foot	0.00	0.67	0.68	NA	NA	0.01	XXX
73630	26	A	X-ray exam of foot	0.17	0.06	0.07	0.06	0.07	0.01	XXX
73650		A	X-ray exam of heel	0.16	0.64	0.63	NA	NA	0.02	XXX
73650	TC	A	X-ray exam of heel	0.00	0.57	0.57	NA	NA	0.01	XXX
73650	26	A	X-ray exam of heel	0.16	0.07	0.06	0.07	0.06	0.01	XXX
73660		A	X-ray exam of toe(s)	0.13	0.71	0.70	NA	NA	0.02	XXX
73660	TC	A	X-ray exam of toe(s)	0.00	0.66	0.65	NA	NA	0.01	XXX
73660	26	A	X-ray exam of toe(s)	0.13	0.05	0.05	0.05	0.05	0.01	XXX
73700		A	Ct lower extremity w/o dye	1.09	4.78	6.05	NA	NA	0.08	XXX
73700	TC	A	Ct lower extremity w/o dye	0.00	4.40	5.62	NA	NA	0.01	XXX
73700	26	A	Ct lower extremity w/o dye	1.09	0.38	0.43	0.38	0.43	0.07	XXX
73701		A	Ct lower extremity w/dye	1.16	5.98	7.51	NA	NA	0.08	XXX
73701	TC	A	Ct lower extremity w/dye	0.00	5.58	7.04	NA	NA	0.01	XXX
73701	26	A	Ct lower extremity w/dye	1.16	0.40	0.47	0.40	0.47	0.07	XXX
73702		A	Ct lwr extremity w/o&w/dye	1.22	7.87	9.85	NA	NA	0.08	XXX
73702	TC	A	Ct lwr extremity w/o&w/dye	0.00	7.44	9.36	NA	NA	0.01	XXX

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73702	26	A	Ct lwr extremity w/o&w/dye	1.22	0.43	0.49	0.43	0.49	0.07	XXX
73706		A	Ct angio lwr extr w/o&w/dye	1.90	9.22	11.85	NA	NA	0.12	XXX
73706	TC	A	Ct angio lwr extr w/o&w/dye	0.00	8.55	11.07	NA	NA	0.01	XXX
73706	26	A	Ct angio lwr extr w/o&w/dye	1.90	0.67	0.78	0.67	0.78	0.11	XXX
73718		A	Mri lower extremity w/o dye	1.35	10.31	13.27	NA	NA	0.09	XXX
73718	TC	A	Mri lower extremity w/o dye	0.00	9.83	12.73	NA	NA	0.01	XXX
73718	26	A	Mri lower extremity w/o dye	1.35	0.48	0.54	0.48	0.54	0.08	XXX
73719		A	Mri lower extremity w/dye	1.62	11.13	14.44	NA	NA	0.11	XXX
73719	TC	A	Mri lower extremity w/dye	0.00	10.56	13.80	NA	NA	0.01	XXX
73719	26	A	Mri lower extremity w/dye	1.62	0.57	0.64	0.57	0.64	0.10	XXX
73720		A	Mri lwr extremity w/o&w/dye	2.15	13.74	19.17	NA	NA	0.14	XXX
73720	TC	A	Mri lwr extremity w/o&w/dye	0.00	12.99	18.32	NA	NA	0.01	XXX
73720	26	A	Mri lwr extremity w/o&w/dye	2.15	0.75	0.85	0.75	0.85	0.13	XXX
73721		A	Mri jnt of lwr extre w/o dye	1.35	10.05	12.96	NA	NA	0.11	XXX
73721	TC	A	Mri jnt of lwr extre w/o dye	0.00	9.55	12.41	NA	NA	0.01	XXX
73721	26	A	Mri jnt of lwr extre w/o dye	1.35	0.50	0.55	0.50	0.55	0.10	XXX
73722		A	Mri joint of lwr extr w/dye	1.62	10.70	13.90	NA	NA	0.12	XXX
73722	TC	A	Mri joint of lwr extr w/dye	0.00	10.11	13.25	NA	NA	0.01	XXX
73722	26	A	Mri joint of lwr extr w/dye	1.62	0.59	0.65	0.59	0.65	0.11	XXX
73723		A	Mri joint lwr extr w/o&w/dye	2.15	12.77	18.05	NA	NA	0.14	XXX
73723	TC	A	Mri joint lwr extr w/o&w/dye	0.00	12.01	17.20	NA	NA	0.01	XXX
73723	26	A	Mri joint lwr extr w/o&w/dye	2.15	0.76	0.85	0.76	0.85	0.13	XXX
73725		R	Mr ang lwr ext w or w/o dye	1.82	11.15	14.10	NA	NA	0.11	XXX
73725	TC	R	Mr ang lwr ext w or w/o dye	0.00	10.52	13.38	NA	NA	0.01	XXX
73725	26	R	Mr ang lwr ext w or w/o dye	1.82	0.63	0.72	0.63	0.72	0.10	XXX
74000		A	X-ray exam of abdomen	0.18	0.48	0.53	NA	NA	0.02	XXX

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74000	TC	A	X-ray exam of abdomen	0.00	0.41	0.46	NA	NA	0.01	XXX
74000	26	A	X-ray exam of abdomen	0.18	0.07	0.07	0.07	0.07	0.01	XXX
74010		A	X-ray exam of abdomen	0.23	0.82	0.86	NA	NA	0.02	XXX
74010	TC	A	X-ray exam of abdomen	0.00	0.73	0.77	NA	NA	0.01	XXX
74010	26	A	X-ray exam of abdomen	0.23	0.09	0.09	0.09	0.09	0.01	XXX
74020		A	X-ray exam of abdomen	0.27	0.81	0.88	NA	NA	0.02	XXX
74020	TC	A	X-ray exam of abdomen	0.00	0.71	0.77	NA	NA	0.01	XXX
74020	26	A	X-ray exam of abdomen	0.27	0.10	0.11	0.10	0.11	0.01	XXX
74022		A	X-ray exam series, abdomen	0.32	0.98	1.06	NA	NA	0.02	XXX
74022	TC	A	X-ray exam series, abdomen	0.00	0.87	0.93	NA	NA	0.01	XXX
74022	26	A	X-ray exam series, abdomen	0.32	0.11	0.13	0.11	0.13	0.01	XXX
74150		A	Ct abdomen w/o dye	1.19	4.53	5.89	NA	NA	0.08	XXX
74150	TC	A	Ct abdomen w/o dye	0.00	4.11	5.42	NA	NA	0.01	XXX
74150	26	A	Ct abdomen w/o dye	1.19	0.42	0.47	0.42	0.47	0.07	XXX
74160		A	Ct abdomen w/dye	1.27	6.57	8.32	NA	NA	0.08	XXX
74160	TC	A	Ct abdomen w/dye	0.00	6.12	7.81	NA	NA	0.01	XXX
74160	26	A	Ct abdomen w/dye	1.27	0.45	0.51	0.45	0.51	0.07	XXX
74170		A	Ct abdomen w/o & w/dye	1.40	9.02	11.29	NA	NA	0.09	XXX
74170	TC	A	Ct abdomen w/o & w/dye	0.00	8.52	10.73	NA	NA	0.01	XXX
74170	26	A	Ct abdomen w/o & w/dye	1.40	0.50	0.56	0.50	0.56	0.08	XXX
74175		A	Ct angio abdom w/o & w/dye	1.90	9.22	11.99	NA	NA	0.14	XXX
74175	TC	A	Ct angio abdom w/o & w/dye	0.00	8.56	11.23	NA	NA	0.01	XXX
74175	26	A	Ct angio abdom w/o & w/dye	1.90	0.66	0.76	0.66	0.76	0.13	XXX
74181		A	Mri abdomen w/o dye	1.46	8.95	11.78	NA	NA	0.09	XXX
74181	TC	A	Mri abdomen w/o dye	0.00	8.44	11.20	NA	NA	0.01	XXX
74181	26	A	Mri abdomen w/o dye	1.46	0.51	0.58	0.51	0.58	0.08	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
74182		A	Mri abdomen w/dye	1.73	12.63	16.17	NA	NA	0.11	XXX
74182	TC	A	Mri abdomen w/dye	0.00	12.03	15.49	NA	NA	0.01	XXX
74182	26	A	Mri abdomen w/dye	1.73	0.60	0.68	0.60	0.68	0.10	XXX
74183		A	Mri abdomen w/o & w/dye	2.26	13.69	19.15	NA	NA	0.14	XXX
74183	TC	A	Mri abdomen w/o & w/dye	0.00	12.91	18.26	NA	NA	0.01	XXX
74183	26	A	Mri abdomen w/o & w/dye	2.26	0.78	0.89	0.78	0.89	0.13	XXX
74185		R	Mri angio, abdom w orw/o dye	1.80	11.10	14.05	NA	NA	0.11	XXX
74185	TC	R	Mri angio, abdom w orw/o dye	0.00	10.48	13.34	NA	NA	0.01	XXX
74185	26	R	Mri angio, abdom w orw/o dye	1.80	0.62	0.71	0.62	0.71	0.10	XXX
74190		C	X-ray exam of peritoneum	0.00	0.00	0.00	NA	NA	0.00	XXX
74190	TC	C	X-ray exam of peritoneum	0.00	0.00	0.00	NA	NA	0.00	XXX
74190	26	A	X-ray exam of peritoneum	0.48	0.17	0.19	0.17	0.19	0.04	XXX
74210		A	Contrst x-ray exam of throat	0.36	1.77	1.88	NA	NA	0.02	XXX
74210	TC	A	Contrst x-ray exam of throat	0.00	1.64	1.73	NA	NA	0.01	XXX
74210	26	A	Contrst x-ray exam of throat	0.36	0.13	0.15	0.13	0.15	0.01	XXX
74220		A	Contrast x-ray, esophagus	0.46	2.00	2.11	NA	NA	0.04	XXX
74220	TC	A	Contrast x-ray, esophagus	0.00	1.84	1.93	NA	NA	0.01	XXX
74220	26	A	Contrast x-ray, esophagus	0.46	0.16	0.18	0.16	0.18	0.03	XXX
74230		A	Cine/vid x-ray, throat/esoph	0.53	1.96	2.07	NA	NA	0.04	XXX
74230	TC	A	Cine/vid x-ray, throat/esoph	0.00	1.77	1.86	NA	NA	0.01	XXX
74230	26	A	Cine/vid x-ray, throat/esoph	0.53	0.19	0.21	0.19	0.21	0.03	XXX
74235		C	Remove esophagus obstruction	0.00	0.00	0.00	NA	NA	0.00	XXX
74235	TC	C	Remove esophagus obstruction	0.00	0.00	0.00	NA	NA	0.00	XXX
74235	26	A	Remove esophagus obstruction	1.19	0.65	0.62	0.65	0.62	0.10	XXX
74240		A	X-ray exam, upper gi tract	0.69	2.42	2.50	NA	NA	0.05	XXX
74240	TC	A	X-ray exam, upper gi tract	0.00	2.17	2.22	NA	NA	0.01	XXX

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74240	26	A	X-ray exam, upper gi tract	0.69	0.25	0.28	0.25	0.28	0.04	XXX
74241		A	X-ray exam, upper gi tract	0.69	2.58	2.70	NA	NA	0.04	XXX
74241	TC	A	X-ray exam, upper gi tract	0.00	2.34	2.43	NA	NA	0.01	XXX
74241	26	A	X-ray exam, upper gi tract	0.69	0.24	0.27	0.24	0.27	0.03	XXX
74245		A	X-ray exam, upper gi tract	0.91	3.92	4.14	NA	NA	0.07	XXX
74245	TC	A	X-ray exam, upper gi tract	0.00	3.60	3.78	NA	NA	0.01	XXX
74245	26	A	X-ray exam, upper gi tract	0.91	0.32	0.36	0.32	0.36	0.06	XXX
74246		A	Contrst x-ray uppr gi tract	0.69	2.78	2.93	NA	NA	0.05	XXX
74246	TC	A	Contrst x-ray uppr gi tract	0.00	2.54	2.65	NA	NA	0.01	XXX
74246	26	A	Contrst x-ray uppr gi tract	0.69	0.24	0.28	0.24	0.28	0.04	XXX
74247		A	Contrst x-ray uppr gi tract	0.69	3.20	3.34	NA	NA	0.05	XXX
74247	TC	A	Contrst x-ray uppr gi tract	0.00	2.96	3.06	NA	NA	0.01	XXX
74247	26	A	Contrst x-ray uppr gi tract	0.69	0.24	0.28	0.24	0.28	0.04	XXX
74249		A	Contrst x-ray uppr gi tract	0.91	4.32	4.54	NA	NA	0.07	XXX
74249	TC	A	Contrst x-ray uppr gi tract	0.00	4.00	4.18	NA	NA	0.01	XXX
74249	26	A	Contrst x-ray uppr gi tract	0.91	0.32	0.36	0.32	0.36	0.06	XXX
74250		A	X-ray exam of small bowel	0.47	2.46	2.56	NA	NA	0.04	XXX
74250	TC	A	X-ray exam of small bowel	0.00	2.30	2.38	NA	NA	0.01	XXX
74250	26	A	X-ray exam of small bowel	0.47	0.16	0.18	0.16	0.18	0.03	XXX
74251		A	X-ray exam of small bowel	0.69	10.09	9.76	NA	NA	0.05	XXX
74251	TC	A	X-ray exam of small bowel	0.00	9.85	9.48	NA	NA	0.01	XXX
74251	26	A	X-ray exam of small bowel	0.69	0.24	0.28	0.24	0.28	0.04	XXX
74260		A	X-ray exam of small bowel	0.50	8.33	8.14	NA	NA	0.04	XXX
74260	TC	A	X-ray exam of small bowel	0.00	8.16	7.94	NA	NA	0.01	XXX
74260	26	A	X-ray exam of small bowel	0.50	0.17	0.20	0.17	0.20	0.03	XXX
74261		A	Ct colonography, w/o dye	2.28	12.18	12.18	NA	NA	0.14	XXX

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74261	TC	A	Ct colonography, w/o dye	0.00	11.38	11.38	NA	NA	0.01	XXX
74261	26	A	Ct colonography, w/o dye	2.28	0.80	0.80	0.80	0.80	0.13	XXX
74262		A	Ct colonography, w/dye	2.50	13.73	13.73	NA	NA	0.15	XXX
74262	TC	A	Ct colonography, w/dye	0.00	12.85	12.85	NA	NA	0.01	XXX
74262	26	A	Ct colonography, w/dye	2.50	0.88	0.88	0.88	0.88	0.14	XXX
74263		N	Ct colonography, screen	2.28	19.72	19.72	NA	NA	0.14	XXX
74263	TC	N	Ct colonography, screen	0.00	18.73	18.73	NA	NA	0.01	XXX
74263	26	N	Ct colonography, screen	2.28	0.99	0.99	0.99	0.99	0.13	XXX
74270		A	Contrast x-ray exam of colon	0.69	3.56	3.68	NA	NA	0.05	XXX
74270	TC	A	Contrast x-ray exam of colon	0.00	3.32	3.40	NA	NA	0.01	XXX
74270	26	A	Contrast x-ray exam of colon	0.69	0.24	0.28	0.24	0.28	0.04	XXX
74280		A	Contrast x-ray exam of colon	0.99	4.92	5.07	NA	NA	0.07	XXX
74280	TC	A	Contrast x-ray exam of colon	0.00	4.58	4.68	NA	NA	0.01	XXX
74280	26	A	Contrast x-ray exam of colon	0.99	0.34	0.39	0.34	0.39	0.06	XXX
74283		A	Contrast x-ray exam of colon	2.02	3.59	3.87	NA	NA	0.07	XXX
74283	TC	A	Contrast x-ray exam of colon	0.00	2.86	3.06	NA	NA	0.01	XXX
74283	26	A	Contrast x-ray exam of colon	2.02	0.73	0.81	0.73	0.81	0.06	XXX
74290		A	Contrast x-ray, gallbladder	0.32	1.58	1.63	NA	NA	0.02	XXX
74290	TC	A	Contrast x-ray, gallbladder	0.00	1.47	1.50	NA	NA	0.01	XXX
74290	26	A	Contrast x-ray, gallbladder	0.32	0.11	0.13	0.11	0.13	0.01	XXX
74291		A	Contrast x-rays, gallbladder	0.20	1.71	1.63	NA	NA	0.02	XXX
74291	TC	A	Contrast x-rays, gallbladder	0.00	1.63	1.55	NA	NA	0.01	XXX
74291	26	A	Contrast x-rays, gallbladder	0.20	0.08	0.08	0.08	0.08	0.01	XXX
74300		C	X-ray bile ducts/pancreas	0.00	0.00	0.00	NA	NA	0.00	XXX
74300	TC	C	X-ray bile ducts/pancreas	0.00	0.00	0.00	NA	NA	0.00	XXX
74300	26	A	X-ray bile ducts/pancreas	0.36	0.13	0.14	0.13	0.14	0.03	XXX

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74301		C	X-rays at surgery add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
74301	TC	C	X-rays at surgery add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
74301	26	A	X-rays at surgery add-on	0.21	0.08	0.09	0.08	0.09	0.03	ZZZ
74305		C	X-ray bile ducts/pancreas	0.00	0.00	0.00	NA	NA	0.00	XXX
74305	TC	C	X-ray bile ducts/pancreas	0.00	0.00	0.00	NA	NA	0.00	XXX
74305	26	A	X-ray bile ducts/pancreas	0.42	0.14	0.17	0.14	0.17	0.04	XXX
74320		A	Contrast x-ray of bile ducts	0.54	2.15	2.55	NA	NA	0.04	XXX
74320	TC	A	Contrast x-ray of bile ducts	0.00	1.97	2.33	NA	NA	0.01	XXX
74320	26	A	Contrast x-ray of bile ducts	0.54	0.18	0.22	0.18	0.22	0.03	XXX
74327		A	X-ray bile stone removal	0.70	3.03	3.16	NA	NA	0.14	XXX
74327	TC	A	X-ray bile stone removal	0.00	2.79	2.88	NA	NA	0.01	XXX
74327	26	A	X-ray bile stone removal	0.70	0.24	0.28	0.24	0.28	0.13	XXX
74328		C	X-ray bile duct endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74328	TC	C	X-ray bile duct endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74328	26	A	X-ray bile duct endoscopy	0.70	0.27	0.30	0.27	0.30	0.06	XXX
74329		C	X-ray for pancreas endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74329	TC	C	X-ray for pancreas endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74329	26	A	X-ray for pancreas endoscopy	0.70	0.28	0.30	0.28	0.30	0.06	XXX
74330		C	X-ray bile/panc endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74330	TC	C	X-ray bile/panc endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74330	26	A	X-ray bile/panc endoscopy	0.90	0.34	0.37	0.34	0.37	0.07	XXX
74340		C	X-ray guide for GI tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74340	TC	C	X-ray guide for GI tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74340	26	A	X-ray guide for GI tube	0.54	0.19	0.22	0.19	0.22	0.04	XXX
74355		C	X-ray guide, intestinal tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74355	TC	C	X-ray guide, intestinal tube	0.00	0.00	0.00	NA	NA	0.00	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
74355	26	A	X-ray guide, intestinal tube	0.76	0.30	0.32	0.30	0.32	0.07	XXX
74360		C	X-ray guide, GI dilation	0.00	0.00	0.00	NA	NA	0.00	XXX
74360	TC	C	X-ray guide, GI dilation	0.00	0.00	0.00	NA	NA	0.00	XXX
74360	26	A	X-ray guide, GI dilation	0.54	0.27	0.27	0.27	0.27	0.04	XXX
74363		C	X-ray, bile duct dilation	0.00	0.00	0.00	NA	NA	0.00	XXX
74363	TC	C	X-ray, bile duct dilation	0.00	0.00	0.00	NA	NA	0.00	XXX
74363	26	A	X-ray, bile duct dilation	0.88	0.30	0.35	0.30	0.35	0.08	XXX
74400		A	Contrst x-ray, urinary tract	0.49	2.53	2.70	NA	NA	0.04	XXX
74400	TC	A	Contrst x-ray, urinary tract	0.00	2.36	2.51	NA	NA	0.01	XXX
74400	26	A	Contrst x-ray, urinary tract	0.49	0.17	0.19	0.17	0.19	0.03	XXX
74410		A	Contrst x-ray, urinary tract	0.49	2.57	2.81	NA	NA	0.04	XXX
74410	TC	A	Contrst x-ray, urinary tract	0.00	2.39	2.61	NA	NA	0.01	XXX
74410	26	A	Contrst x-ray, urinary tract	0.49	0.18	0.20	0.18	0.20	0.03	XXX
74415		A	Contrst x-ray, urinary tract	0.49	3.21	3.41	NA	NA	0.04	XXX
74415	TC	A	Contrst x-ray, urinary tract	0.00	3.04	3.22	NA	NA	0.01	XXX
74415	26	A	Contrst x-ray, urinary tract	0.49	0.17	0.19	0.17	0.19	0.03	XXX
74420		C	Contrst x-ray, urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74420	TC	C	Contrst x-ray, urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74420	26	A	Contrst x-ray, urinary tract	0.36	0.13	0.15	0.13	0.15	0.03	XXX
74425		C	Contrst x-ray, urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74425	TC	C	Contrst x-ray, urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74425	26	A	Contrst x-ray, urinary tract	0.36	0.12	0.15	0.12	0.15	0.03	XXX
74430		A	Contrast x-ray, bladder	0.32	1.91	2.01	NA	NA	0.02	XXX
74430	TC	A	Contrast x-ray, bladder	0.00	1.79	1.88	NA	NA	0.01	XXX
74430	26	A	Contrast x-ray, bladder	0.32	0.12	0.13	0.12	0.13	0.01	XXX
74440		A	X-ray, male genital tract	0.38	2.00	2.11	NA	NA	0.04	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
74440	TC	A	X-ray, male genital tract	0.00	1.85	1.95	NA	NA	0.01	XXX
74440	26	A	X-ray, male genital tract	0.38	0.15	0.16	0.15	0.16	0.03	XXX
74445		C	X-ray exam of penis	0.00	0.00	0.00	NA	NA	0.00	XXX
74445	TC	C	X-ray exam of penis	0.00	0.00	0.00	NA	NA	0.00	XXX
74445	26	A	X-ray exam of penis	1.14	0.45	0.50	0.45	0.50	0.10	XXX
74450		C	X-ray, urethra/bladder	0.00	0.00	0.00	NA	NA	0.00	XXX
74450	TC	C	X-ray, urethra/bladder	0.00	0.00	0.00	NA	NA	0.00	XXX
74450	26	A	X-ray, urethra/bladder	0.33	0.12	0.14	0.12	0.14	0.03	XXX
74455		A	X-ray, urethra/bladder	0.33	2.05	2.26	NA	NA	0.02	XXX
74455	TC	A	X-ray, urethra/bladder	0.00	1.93	2.12	NA	NA	0.01	XXX
74455	26	A	X-ray, urethra/bladder	0.33	0.12	0.14	0.12	0.14	0.01	XXX
74470		C	X-ray exam of kidney lesion	0.00	0.00	0.00	NA	NA	0.00	XXX
74470	TC	C	X-ray exam of kidney lesion	0.00	0.00	0.00	NA	NA	0.00	XXX
74470	26	A	X-ray exam of kidney lesion	0.54	0.19	0.22	0.19	0.22	0.04	XXX
74475		A	X-ray control, cath insert	0.54	2.13	2.66	NA	NA	0.04	XXX
74475	TC	A	X-ray control, cath insert	0.00	1.95	2.44	NA	NA	0.01	XXX
74475	26	A	X-ray control, cath insert	0.54	0.18	0.22	0.18	0.22	0.03	XXX
74480		A	X-ray control, cath insert	0.54	2.14	2.67	NA	NA	0.04	XXX
74480	TC	A	X-ray control, cath insert	0.00	1.95	2.45	NA	NA	0.01	XXX
74480	26	A	X-ray control, cath insert	0.54	0.19	0.22	0.19	0.22	0.03	XXX
74485		A	X-ray guide, GU dilation	0.54	2.21	2.63	NA	NA	0.04	XXX
74485	TC	A	X-ray guide, GU dilation	0.00	2.02	2.41	NA	NA	0.01	XXX
74485	26	A	X-ray guide, GU dilation	0.54	0.19	0.22	0.19	0.22	0.03	XXX
74710		A	X-ray measurement of pelvis	0.34	0.64	0.80	NA	NA	0.02	XXX
74710	TC	A	X-ray measurement of pelvis	0.00	0.52	0.66	NA	NA	0.01	XXX
74710	26	A	X-ray measurement of pelvis	0.34	0.12	0.14	0.12	0.14	0.01	XXX

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74740		A	X-ray, female genital tract	0.38	1.77	1.89	NA	NA	0.02	XXX
74740	TC	A	X-ray, female genital tract	0.00	1.63	1.74	NA	NA	0.01	XXX
74740	26	A	X-ray, female genital tract	0.38	0.14	0.15	0.14	0.15	0.01	XXX
74742		C	X-ray, fallopian tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74742	TC	C	X-ray, fallopian tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74742	26	A	X-ray, fallopian tube	0.61	0.27	0.27	0.27	0.27	0.06	XXX
74775		C	X-ray exam of perineum	0.00	0.00	0.00	NA	NA	0.00	XXX
74775	TC	C	X-ray exam of perineum	0.00	0.00	0.00	NA	NA	0.00	XXX
74775	26	A	X-ray exam of perineum	0.62	0.22	0.25	0.22	0.25	0.06	XXX
75557		A	Cardiac mri for morph	2.35	7.92	10.58	NA	NA	0.11	XXX
75557	TC	A	Cardiac mri for morph	0.00	7.06	9.55	NA	NA	0.01	XXX
75557	26	A	Cardiac mri for morph	2.35	0.86	1.03	0.86	1.03	0.10	XXX
75559		A	Cardiac mri w/stress img	2.95	11.55	15.86	NA	NA	0.14	XXX
75559	TC	A	Cardiac mri w/stress img	0.00	10.42	14.49	NA	NA	0.01	XXX
75559	26	A	Cardiac mri w/stress img	2.95	1.13	1.37	1.13	1.37	0.13	XXX
75561		A	Cardiac mri for morph w/dye	2.60	11.11	14.93	NA	NA	0.12	XXX
75561	TC	A	Cardiac mri for morph w/dye	0.00	10.15	13.79	NA	NA	0.01	XXX
75561	26	A	Cardiac mri for morph w/dye	2.60	0.96	1.14	0.96	1.14	0.11	XXX
75563		A	Card mri w/stress img & dye	3.00	13.37	18.43	NA	NA	0.12	XXX
75563	TC	A	Card mri w/stress img & dye	0.00	12.21	16.99	NA	NA	0.01	XXX
75563	26	A	Card mri w/stress img & dye	3.00	1.16	1.44	1.16	1.44	0.11	XXX
75565		A	Card mri vel flw map add-on	0.25	1.89	1.89	NA	NA	0.02	ZZZ
75565	TC	A	Card mri vel flw map add-on	0.00	1.78	1.78	NA	NA	0.01	ZZZ
75565	26	A	Card mri vel flw map add-on	0.25	0.11	0.11	0.11	0.11	0.01	ZZZ
75571		A	Ct hrt w/o dye w/ca test	0.58	2.50	2.50	NA	NA	0.02	XXX
75571	TC	A	Ct hrt w/o dye w/ca test	0.00	2.29	2.29	NA	NA	0.01	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
75571	26	A	Ct hrt w/o dye w/ca test	0.58	0.21	0.21	0.21	0.21	0.01	XXX
75572		A	Ct hrt w/3d image	1.75	6.71	6.71	NA	NA	0.07	XXX
75572	TC	A	Ct hrt w/3d image	0.00	6.05	6.05	NA	NA	0.01	XXX
75572	26	A	Ct hrt w/3d image	1.75	0.66	0.66	0.66	0.66	0.06	XXX
75573		A	Ct hrt w/3d image, congen	2.55	9.05	9.05	NA	NA	0.09	XXX
75573	TC	A	Ct hrt w/3d image, congen	0.00	8.05	8.05	NA	NA	0.01	XXX
75573	26	A	Ct hrt w/3d image, congen	2.55	1.00	1.00	1.00	1.00	0.08	XXX
75574		A	Ct angio hrt w/3d image	2.40	10.45	10.45	NA	NA	0.09	XXX
75574	TC	A	Ct angio hrt w/3d image	0.00	9.55	9.55	NA	NA	0.01	XXX
75574	26	A	Ct angio hrt w/3d image	2.40	0.90	0.90	0.90	0.90	0.08	XXX
75600		A	Contrast x-ray exam of aorta	0.49	5.38	7.36	NA	NA	0.04	XXX
75600	TC	A	Contrast x-ray exam of aorta	0.00	5.19	7.13	NA	NA	0.01	XXX
75600	26	A	Contrast x-ray exam of aorta	0.49	0.19	0.23	0.19	0.23	0.03	XXX
75605		A	Contrast x-ray exam of aorta	1.14	3.14	5.07	NA	NA	0.08	XXX
75605	TC	A	Contrast x-ray exam of aorta	0.00	2.72	4.57	NA	NA	0.01	XXX
75605	26	A	Contrast x-ray exam of aorta	1.14	0.42	0.50	0.42	0.50	0.07	XXX
75625		A	Contrast x-ray exam of aorta	1.14	3.22	5.04	NA	NA	0.11	XXX
75625	TC	A	Contrast x-ray exam of aorta	0.00	2.81	4.58	NA	NA	0.01	XXX
75625	26	A	Contrast x-ray exam of aorta	1.14	0.41	0.46	0.41	0.46	0.10	XXX
75630		A	X-ray aorta, leg arteries	1.79	3.47	5.46	NA	NA	0.11	XXX
75630	TC	A	X-ray aorta, leg arteries	0.00	2.81	4.70	NA	NA	0.01	XXX
75630	26	A	X-ray aorta, leg arteries	1.79	0.66	0.76	0.66	0.76	0.10	XXX
75635		A	Ct angio abdominal arteries	2.40	9.83	13.19	NA	NA	0.16	XXX
75635	TC	A	Ct angio abdominal arteries	0.00	8.98	12.19	NA	NA	0.03	XXX
75635	26	A	Ct angio abdominal arteries	2.40	0.85	1.00	0.85	1.00	0.13	XXX
75650		A	Artery x-rays, head & neck	1.49	3.37	5.23	NA	NA	0.11	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
75650	TC	A	Artery x-rays, head & neck	0.00	2.83	4.61	NA	NA	0.01	XXX
75650	26	A	Artery x-rays, head & neck	1.49	0.54	0.62	0.54	0.62	0.10	XXX
75658		A	Artery x-rays, arm	1.31	3.96	5.58	NA	NA	0.09	XXX
75658	TC	A	Artery x-rays, arm	0.00	3.51	5.08	NA	NA	0.01	XXX
75658	26	A	Artery x-rays, arm	1.31	0.45	0.50	0.45	0.50	0.08	XXX
75660		A	Artery x-rays, head & neck	1.31	4.03	5.70	NA	NA	0.05	XXX
75660	TC	A	Artery x-rays, head & neck	0.00	3.52	5.14	NA	NA	0.01	XXX
75660	26	A	Artery x-rays, head & neck	1.31	0.51	0.56	0.51	0.56	0.04	XXX
75662		A	Artery x-rays, head & neck	1.66	4.94	6.65	NA	NA	0.10	XXX
75662	TC	A	Artery x-rays, head & neck	0.00	4.28	5.91	NA	NA	0.03	XXX
75662	26	A	Artery x-rays, head & neck	1.66	0.66	0.74	0.66	0.74	0.07	XXX
75665		A	Artery x-rays, head & neck	1.31	4.27	5.94	NA	NA	0.12	XXX
75665	TC	A	Artery x-rays, head & neck	0.00	3.76	5.38	NA	NA	0.01	XXX
75665	26	A	Artery x-rays, head & neck	1.31	0.51	0.56	0.51	0.56	0.11	XXX
75671		A	Artery x-rays, head & neck	1.66	5.10	6.81	NA	NA	0.13	XXX
75671	TC	A	Artery x-rays, head & neck	0.00	4.47	6.10	NA	NA	0.03	XXX
75671	26	A	Artery x-rays, head & neck	1.66	0.63	0.71	0.63	0.71	0.10	XXX
75676		A	Artery x-rays, neck	1.31	3.93	5.65	NA	NA	0.12	XXX
75676	TC	A	Artery x-rays, neck	0.00	3.43	5.10	NA	NA	0.01	XXX
75676	26	A	Artery x-rays, neck	1.31	0.50	0.55	0.50	0.55	0.11	XXX
75680		A	Artery x-rays, neck	1.66	4.46	6.26	NA	NA	0.11	XXX
75680	TC	A	Artery x-rays, neck	0.00	3.83	5.55	NA	NA	0.01	XXX
75680	26	A	Artery x-rays, neck	1.66	0.63	0.71	0.63	0.71	0.10	XXX
75685		A	Artery x-rays, spine	1.31	4.02	5.71	NA	NA	0.09	XXX
75685	TC	A	Artery x-rays, spine	0.00	3.51	5.15	NA	NA	0.01	XXX
75685	26	A	Artery x-rays, spine	1.31	0.51	0.56	0.51	0.56	0.08	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
75705		A	Artery x-rays, spine	2.18	4.22	5.99	NA	NA	0.08	XXX
75705	TC	A	Artery x-rays, spine	0.00	3.42	5.08	NA	NA	0.01	XXX
75705	26	A	Artery x-rays, spine	2.18	0.80	0.91	0.80	0.91	0.07	XXX
75710		A	Artery x-rays, arm/leg	1.14	3.84	5.60	NA	NA	0.07	XXX
75710	TC	A	Artery x-rays, arm/leg	0.00	3.43	5.14	NA	NA	0.01	XXX
75710	26	A	Artery x-rays, arm/leg	1.14	0.41	0.46	0.41	0.46	0.06	XXX
75716		A	Artery x-rays, arms/legs	1.31	4.63	6.44	NA	NA	0.13	XXX
75716	TC	A	Artery x-rays, arms/legs	0.00	4.16	5.90	NA	NA	0.03	XXX
75716	26	A	Artery x-rays, arms/legs	1.31	0.47	0.54	0.47	0.54	0.10	XXX
75722		A	Artery x-rays, kidney	1.14	3.47	5.38	NA	NA	0.08	XXX
75722	TC	A	Artery x-rays, kidney	0.00	3.06	4.89	NA	NA	0.01	XXX
75722	26	A	Artery x-rays, kidney	1.14	0.41	0.49	0.41	0.49	0.07	XXX
75724		A	Artery x-rays, kidneys	1.49	4.17	6.27	NA	NA	0.09	XXX
75724	TC	A	Artery x-rays, kidneys	0.00	3.60	5.56	NA	NA	0.03	XXX
75724	26	A	Artery x-rays, kidneys	1.49	0.57	0.71	0.57	0.71	0.06	XXX
75726		A	Artery x-rays, abdomen	1.14	3.70	5.49	NA	NA	0.09	XXX
75726	TC	A	Artery x-rays, abdomen	0.00	3.31	5.03	NA	NA	0.01	XXX
75726	26	A	Artery x-rays, abdomen	1.14	0.39	0.46	0.39	0.46	0.08	XXX
75731		A	Artery x-rays, adrenal gland	1.14	3.63	5.61	NA	NA	0.05	XXX
75731	TC	A	Artery x-rays, adrenal gland	0.00	3.23	5.10	NA	NA	0.01	XXX
75731	26	A	Artery x-rays, adrenal gland	1.14	0.40	0.51	0.40	0.51	0.04	XXX
75733		A	Artery x-rays, adrenals	1.31	4.41	6.54	NA	NA	0.07	XXX
75733	TC	A	Artery x-rays, adrenals	0.00	3.90	5.91	NA	NA	0.03	XXX
75733	26	A	Artery x-rays, adrenals	1.31	0.51	0.63	0.51	0.63	0.04	XXX
75736		A	Artery x-rays, pelvis	1.14	3.69	5.52	NA	NA	0.07	XXX
75736	TC	A	Artery x-rays, pelvis	0.00	3.28	5.05	NA	NA	0.01	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
75736	26	A	Artery x-rays, pelvis	1.14	0.41	0.47	0.41	0.47	0.06	XXX
75741		A	Artery x-rays, lung	1.31	3.14	4.96	NA	NA	0.09	XXX
75741	TC	A	Artery x-rays, lung	0.00	2.69	4.43	NA	NA	0.01	XXX
75741	26	A	Artery x-rays, lung	1.31	0.45	0.53	0.45	0.53	0.08	XXX
75743		A	Artery x-rays, lungs	1.66	3.52	5.36	NA	NA	0.11	XXX
75743	TC	A	Artery x-rays, lungs	0.00	2.95	4.68	NA	NA	0.01	XXX
75743	26	A	Artery x-rays, lungs	1.66	0.57	0.68	0.57	0.68	0.10	XXX
75746		A	Artery x-rays, lung	1.14	3.46	5.27	NA	NA	0.08	XXX
75746	TC	A	Artery x-rays, lung	0.00	3.06	4.81	NA	NA	0.01	XXX
75746	26	A	Artery x-rays, lung	1.14	0.40	0.46	0.40	0.46	0.07	XXX
75756		A	Artery x-rays, chest	1.14	3.75	5.69	NA	NA	0.24	XXX
75756	TC	A	Artery x-rays, chest	0.00	3.34	5.16	NA	NA	0.01	XXX
75756	26	A	Artery x-rays, chest	1.14	0.41	0.53	0.41	0.53	0.23	XXX
75774		A	Artery x-ray, each vessel	0.36	2.45	4.24	NA	NA	0.04	ZZZ
75774	TC	A	Artery x-ray, each vessel	0.00	2.32	4.09	NA	NA	0.01	ZZZ
75774	26	A	Artery x-ray, each vessel	0.36	0.13	0.15	0.13	0.15	0.03	ZZZ
75791		A	Av dialysis shunt imaging	1.71	7.59	7.59	NA	NA	0.11	XXX
75791	TC	A	Av dialysis shunt imaging	0.00	6.99	6.99	NA	NA	0.01	XXX
75791	26	A	Av dialysis shunt imaging	1.71	0.60	0.60	0.60	0.60	0.10	XXX
75801		C	Lymph vessel x-ray, arm/leg	0.00	0.00	0.00	NA	NA	0.00	XXX
75801	TC	C	Lymph vessel x-ray, arm/leg	0.00	0.00	0.00	NA	NA	0.00	XXX
75801	26	A	Lymph vessel x-ray, arm/leg	0.81	0.35	0.33	0.35	0.33	0.18	XXX
75803		C	Lymph vessel x-ray,arms/legs	0.00	0.00	0.00	NA	NA	0.00	XXX
75803	TC	C	Lymph vessel x-ray,arms/legs	0.00	0.00	0.00	NA	NA	0.00	XXX
75803	26	A	Lymph vessel x-ray,arms/legs	1.17	0.41	0.47	0.41	0.47	0.10	XXX
75805		C	Lymph vessel x-ray, trunk	0.00	0.00	0.00	NA	NA	0.00	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
75805	TC	C	Lymph vessel x-ray, trunk	0.00	0.00	0.00	NA	NA	0.00	XXX
75805	26	A	Lymph vessel x-ray, trunk	0.81	0.28	0.33	0.28	0.33	0.07	XXX
75807		C	Lymph vessel x-ray, trunk	0.00	0.00	0.00	NA	NA	0.00	XXX
75807	TC	C	Lymph vessel x-ray, trunk	0.00	0.00	0.00	NA	NA	0.00	XXX
75807	26	A	Lymph vessel x-ray, trunk	1.17	0.42	0.48	0.42	0.48	0.10	XXX
75809		A	Nonvascular shunt, x-ray	0.47	2.41	2.33	NA	NA	0.04	XXX
75809	TC	A	Nonvascular shunt, x-ray	0.00	2.22	2.13	NA	NA	0.01	XXX
75809	26	A	Nonvascular shunt, x-ray	0.47	0.19	0.20	0.19	0.20	0.03	XXX
75810		C	Vein x-ray, spleen/liver	0.00	0.00	0.00	NA	NA	0.00	XXX
75810	TC	C	Vein x-ray, spleen/liver	0.00	0.00	0.00	NA	NA	0.00	XXX
75810	26	A	Vein x-ray, spleen/liver	1.14	0.40	0.47	0.40	0.47	0.10	XXX
75820		A	Vein x-ray, arm/leg	0.70	2.83	2.91	NA	NA	0.05	XXX
75820	TC	A	Vein x-ray, arm/leg	0.00	2.57	2.61	NA	NA	0.01	XXX
75820	26	A	Vein x-ray, arm/leg	0.70	0.26	0.30	0.26	0.30	0.04	XXX
75822		A	Vein x-ray, arms/legs	1.06	3.24	3.32	NA	NA	0.08	XXX
75822	TC	A	Vein x-ray, arms/legs	0.00	2.87	2.90	NA	NA	0.01	XXX
75822	26	A	Vein x-ray, arms/legs	1.06	0.37	0.42	0.37	0.42	0.07	XXX
75825		A	Vein x-ray, trunk	1.14	3.00	4.77	NA	NA	0.09	XXX
75825	TC	A	Vein x-ray, trunk	0.00	2.61	4.33	NA	NA	0.01	XXX
75825	26	A	Vein x-ray, trunk	1.14	0.39	0.44	0.39	0.44	0.08	XXX
75827		A	Vein x-ray, chest	1.14	3.17	4.86	NA	NA	0.08	XXX
75827	TC	A	Vein x-ray, chest	0.00	2.78	4.43	NA	NA	0.01	XXX
75827	26	A	Vein x-ray, chest	1.14	0.39	0.43	0.39	0.43	0.07	XXX
75831		A	Vein x-ray, kidney	1.14	3.10	4.88	NA	NA	0.26	XXX
75831	TC	A	Vein x-ray, kidney	0.00	2.71	4.43	NA	NA	0.01	XXX
75831	26	A	Vein x-ray, kidney	1.14	0.39	0.45	0.39	0.45	0.25	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
75833		A	Vein x-ray, kidneys	1.49	3.75	5.47	NA	NA	0.09	XXX
75833	TC	A	Vein x-ray, kidneys	0.00	3.25	4.91	NA	NA	0.01	XXX
75833	26	A	Vein x-ray, kidneys	1.49	0.50	0.56	0.50	0.56	0.08	XXX
75840		A	Vein x-ray, adrenal gland	1.14	3.01	4.79	NA	NA	0.26	XXX
75840	TC	A	Vein x-ray, adrenal gland	0.00	2.63	4.37	NA	NA	0.01	XXX
75840	26	A	Vein x-ray, adrenal gland	1.14	0.38	0.42	0.38	0.42	0.25	XXX
75842		A	Vein x-ray, adrenal glands	1.49	3.61	5.45	NA	NA	0.09	XXX
75842	TC	A	Vein x-ray, adrenal glands	0.00	3.09	4.85	NA	NA	0.01	XXX
75842	26	A	Vein x-ray, adrenal glands	1.49	0.52	0.60	0.52	0.60	0.08	XXX
75860		A	Vein x-ray, neck	1.14	3.12	4.98	NA	NA	0.09	XXX
75860	TC	A	Vein x-ray, neck	0.00	2.70	4.49	NA	NA	0.01	XXX
75860	26	A	Vein x-ray, neck	1.14	0.42	0.49	0.42	0.49	0.08	XXX
75870		A	Vein x-ray, skull	1.14	3.00	4.87	NA	NA	0.08	XXX
75870	TC	A	Vein x-ray, skull	0.00	2.60	4.42	NA	NA	0.01	XXX
75870	26	A	Vein x-ray, skull	1.14	0.40	0.45	0.40	0.45	0.07	XXX
75872		A	Vein x-ray, skull	1.14	6.55	7.03	NA	NA	0.08	XXX
75872	TC	A	Vein x-ray, skull	0.00	5.93	6.45	NA	NA	0.01	XXX
75872	26	A	Vein x-ray, skull	1.14	0.62	0.58	0.62	0.58	0.07	XXX
75880		A	Vein x-ray, eye socket	0.70	5.35	4.21	NA	NA	0.05	XXX
75880	TC	A	Vein x-ray, eye socket	0.00	5.02	3.90	NA	NA	0.01	XXX
75880	26	A	Vein x-ray, eye socket	0.70	0.33	0.31	0.33	0.31	0.04	XXX
75885		A	Vein x-ray, liver	1.44	3.15	5.00	NA	NA	0.09	XXX
75885	TC	A	Vein x-ray, liver	0.00	2.66	4.42	NA	NA	0.01	XXX
75885	26	A	Vein x-ray, liver	1.44	0.49	0.58	0.49	0.58	0.08	XXX
75887		A	Vein x-ray, liver	1.44	3.24	5.08	NA	NA	0.07	XXX
75887	TC	A	Vein x-ray, liver	0.00	2.74	4.49	NA	NA	0.01	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
75887	26	A	Vein x-ray, liver	1.44	0.50	0.59	0.50	0.59	0.06	XXX
75889		A	Vein x-ray, liver	1.14	3.08	4.88	NA	NA	0.08	XXX
75889	TC	A	Vein x-ray, liver	0.00	2.69	4.42	NA	NA	0.01	XXX
75889	26	A	Vein x-ray, liver	1.14	0.39	0.46	0.39	0.46	0.07	XXX
75891		A	Vein x-ray, liver	1.14	3.08	4.88	NA	NA	0.08	XXX
75891	TC	A	Vein x-ray, liver	0.00	2.69	4.42	NA	NA	0.01	XXX
75891	26	A	Vein x-ray, liver	1.14	0.39	0.46	0.39	0.46	0.07	XXX
75893		A	Venous sampling by catheter	0.54	2.82	4.59	NA	NA	0.02	XXX
75893	TC	A	Venous sampling by catheter	0.00	2.63	4.38	NA	NA	0.01	XXX
75893	26	A	Venous sampling by catheter	0.54	0.19	0.21	0.19	0.21	0.01	XXX
75894		C	X-rays, transcath therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
75894	TC	C	X-rays, transcath therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
75894	26	A	X-rays, transcath therapy	1.31	0.46	0.52	0.46	0.52	0.17	XXX
75896		C	X-rays, transcath therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
75896	TC	C	X-rays, transcath therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
75896	26	A	X-rays, transcath therapy	1.31	0.47	0.55	0.47	0.55	0.17	XXX
75898		C	Follow-up angiography	0.00	0.00	0.00	NA	NA	0.00	XXX
75898	TC	C	Follow-up angiography	0.00	0.00	0.00	NA	NA	0.00	XXX
75898	26	A	Follow-up angiography	1.65	0.60	0.69	0.60	0.69	0.21	XXX
75900		C	Intravascular cath exchange	0.00	0.00	0.00	NA	NA	0.00	XXX
75900	TC	C	Intravascular cath exchange	0.00	0.00	0.00	NA	NA	0.00	XXX
75900	26	A	Intravascular cath exchange	0.49	0.17	0.19	0.17	0.19	0.06	XXX
75901		A	Remove cva device obstruct	0.49	4.39	4.29	NA	NA	0.04	XXX
75901	TC	A	Remove cva device obstruct	0.00	4.22	4.10	NA	NA	0.01	XXX
75901	26	A	Remove cva device obstruct	0.49	0.17	0.19	0.17	0.19	0.03	XXX
75902		A	Remove cva lumen obstruct	0.39	1.70	1.80	NA	NA	0.05	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
75902	TC	A	Remove cva lumen obstruct	0.00	1.57	1.65	NA	NA	0.01	XXX
75902	26	A	Remove cva lumen obstruct	0.39	0.13	0.15	0.13	0.15	0.04	XXX
75940		C	X-ray placement, vein filter	0.00	0.00	0.00	NA	NA	0.00	XXX
75940	TC	C	X-ray placement, vein filter	0.00	0.00	0.00	NA	NA	0.00	XXX
75940	26	A	X-ray placement, vein filter	0.54	0.19	0.21	0.19	0.21	0.07	XXX
75945		C	Intravascular us	0.00	0.00	0.00	NA	NA	0.00	XXX
75945	TC	C	Intravascular us	0.00	0.00	0.00	NA	NA	0.00	XXX
75945	26	A	Intravascular us	0.40	0.14	0.16	0.14	0.16	0.06	XXX
75946		C	Intravascular us add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75946	TC	C	Intravascular us add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75946	26	A	Intravascular us add-on	0.40	0.13	0.15	0.13	0.15	0.07	ZZZ
75952		C	Endovasc repair abdom aorta	0.00	0.00	0.00	NA	NA	0.00	XXX
75952	TC	C	Endovasc repair abdom aorta	0.00	0.00	0.00	NA	NA	0.00	XXX
75952	26	A	Endovasc repair abdom aorta	4.49	1.54	1.62	1.54	1.62	0.89	XXX
75953		C	Abdom aneurysm endovas rpr	0.00	0.00	0.00	NA	NA	0.00	XXX
75953	TC	C	Abdom aneurysm endovas rpr	0.00	0.00	0.00	NA	NA	0.00	XXX
75953	26	A	Abdom aneurysm endovas rpr	1.36	0.47	0.49	0.47	0.49	0.28	XXX
75954		C	Iliac aneurysm endovas rpr	0.00	0.00	0.00	NA	NA	0.00	XXX
75954	TC	C	Iliac aneurysm endovas rpr	0.00	0.00	0.00	NA	NA	0.00	XXX
75954	26	A	Iliac aneurysm endovas rpr	2.25	0.79	0.82	0.79	0.82	0.42	XXX
75956		C	Xray, endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75956	TC	C	Xray, endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75956	26	A	Xray, endovasc thor ao repr	7.00	2.33	2.52	2.33	2.52	1.50	XXX
75957		C	Xray, endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75957	TC	C	Xray, endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75957	26	A	Xray, endovasc thor ao repr	6.00	2.02	2.17	2.02	2.17	1.26	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
75958		C	Xray, place prox ext thor ao	0.00	0.00	0.00	NA	NA	0.00	XXX
75958	TC	C	Xray, place prox ext thor ao	0.00	0.00	0.00	NA	NA	0.00	XXX
75958	26	A	Xray, place prox ext thor ao	4.00	1.34	1.41	1.34	1.41	0.85	XXX
75959		C	Xray, place dist ext thor ao	0.00	0.00	0.00	NA	NA	0.00	XXX
75959	TC	C	Xray, place dist ext thor ao	0.00	0.00	0.00	NA	NA	0.00	XXX
75959	26	A	Xray, place dist ext thor ao	3.50	1.08	1.20	1.08	1.20	0.86	XXX
75960		A	Transcath iv stent rs&i	0.82	2.64	4.79	NA	NA	0.07	XXX
75960	TC	A	Transcath iv stent rs&i	0.00	2.35	4.45	NA	NA	0.01	XXX
75960	26	A	Transcath iv stent rs&i	0.82	0.29	0.34	0.29	0.34	0.06	XXX
75961		A	Retrieval, broken catheter	4.24	4.62	6.26	NA	NA	0.29	XXX
75961	TC	A	Retrieval, broken catheter	0.00	3.16	4.57	NA	NA	0.01	XXX
75961	26	A	Retrieval, broken catheter	4.24	1.46	1.69	1.46	1.69	0.28	XXX
75962		A	Repair arterial blockage	0.54	3.39	5.62	NA	NA	0.04	XXX
75962	TC	A	Repair arterial blockage	0.00	3.20	5.40	NA	NA	0.01	XXX
75962	26	A	Repair arterial blockage	0.54	0.19	0.22	0.19	0.22	0.03	XXX
75964		A	Repair artery blockage, each	0.36	2.31	3.46	NA	NA	0.05	ZZZ
75964	TC	A	Repair artery blockage, each	0.00	2.18	3.32	NA	NA	0.01	ZZZ
75964	26	A	Repair artery blockage, each	0.36	0.13	0.14	0.13	0.14	0.04	ZZZ
75966		A	Repair arterial blockage	1.31	3.66	6.07	NA	NA	0.08	XXX
75966	TC	A	Repair arterial blockage	0.00	3.18	5.50	NA	NA	0.01	XXX
75966	26	A	Repair arterial blockage	1.31	0.48	0.57	0.48	0.57	0.07	XXX
75968		A	Repair artery blockage, each	0.36	2.17	3.41	NA	NA	0.02	ZZZ
75968	TC	A	Repair artery blockage, each	0.00	2.04	3.25	NA	NA	0.01	ZZZ
75968	26	A	Repair artery blockage, each	0.36	0.13	0.16	0.13	0.16	0.01	ZZZ
75970		C	Vascular biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX
75970	TC	C	Vascular biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
75970	26	A	Vascular biopsy	0.83	0.29	0.33	0.29	0.33	0.07	XXX
75978		A	Repair venous blockage	0.54	3.50	5.60	NA	NA	0.04	XXX
75978	TC	A	Repair venous blockage	0.00	3.31	5.39	NA	NA	0.01	XXX
75978	26	A	Repair venous blockage	0.54	0.19	0.21	0.19	0.21	0.03	XXX
75980		C	Contrast xray exam bile duct	0.00	0.00	0.00	NA	NA	0.00	XXX
75980	TC	C	Contrast xray exam bile duct	0.00	0.00	0.00	NA	NA	0.00	XXX
75980	26	A	Contrast xray exam bile duct	1.44	0.49	0.58	0.49	0.58	0.13	XXX
75982		C	Contrast xray exam bile duct	0.00	0.00	0.00	NA	NA	0.00	XXX
75982	TC	C	Contrast xray exam bile duct	0.00	0.00	0.00	NA	NA	0.00	XXX
75982	26	A	Contrast xray exam bile duct	1.44	0.49	0.58	0.49	0.58	0.13	XXX
75984		A	Xray control catheter change	0.72	2.35	2.56	NA	NA	0.05	XXX
75984	TC	A	Xray control catheter change	0.00	2.10	2.27	NA	NA	0.01	XXX
75984	26	A	Xray control catheter change	0.72	0.25	0.29	0.25	0.29	0.04	XXX
75989		A	Abscess drainage under x-ray	1.19	2.26	2.69	NA	NA	0.07	XXX
75989	TC	A	Abscess drainage under x-ray	0.00	1.85	2.21	NA	NA	0.01	XXX
75989	26	A	Abscess drainage under x-ray	1.19	0.41	0.48	0.41	0.48	0.06	XXX
75992		C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX
75992	TC	C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX
75992	26	A	Atherectomy, x-ray exam	0.54	0.20	0.23	0.20	0.23	0.07	XXX
75993		C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75993	TC	C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75993	26	A	Atherectomy, x-ray exam	0.36	0.13	0.15	0.13	0.15	0.04	ZZZ
75994		C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX
75994	TC	C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX
75994	26	A	Atherectomy, x-ray exam	1.31	0.40	0.42	0.40	0.42	0.11	XXX
75995		C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
75995	TC	C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX
75995	26	A	Atherectomy, x-ray exam	1.31	0.51	0.54	0.51	0.54	0.08	XXX
75996		C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75996	TC	C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75996	26	A	Atherectomy, x-ray exam	0.36	0.14	0.15	0.14	0.15	0.08	ZZZ
76000		A	Fluoroscope examination	0.17	2.93	2.90	NA	NA	0.02	XXX
76000	TC	A	Fluoroscope examination	0.00	2.86	2.83	NA	NA	0.01	XXX
76000	26	A	Fluoroscope examination	0.17	0.07	0.07	0.07	0.07	0.01	XXX
76001		C	Fluoroscope exam, extensive	0.00	0.00	0.00	NA	NA	0.00	XXX
76001	TC	C	Fluoroscope exam, extensive	0.00	0.00	0.00	NA	NA	0.00	XXX
76001	26	A	Fluoroscope exam, extensive	0.67	0.29	0.30	0.29	0.30	0.08	XXX
76010		A	X-ray, nose to rectum	0.18	0.53	0.60	NA	NA	0.02	XXX
76010	TC	A	X-ray, nose to rectum	0.00	0.47	0.53	NA	NA	0.01	XXX
76010	26	A	X-ray, nose to rectum	0.18	0.06	0.07	0.06	0.07	0.01	XXX
76080		A	X-ray exam of fistula	0.54	1.10	1.23	NA	NA	0.04	XXX
76080	TC	A	X-ray exam of fistula	0.00	0.91	1.01	NA	NA	0.01	XXX
76080	26	A	X-ray exam of fistula	0.54	0.19	0.22	0.19	0.22	0.03	XXX
76098		A	X-ray exam, breast specimen	0.16	0.32	0.37	NA	NA	0.02	XXX
76098	TC	A	X-ray exam, breast specimen	0.00	0.26	0.31	NA	NA	0.01	XXX
76098	26	A	X-ray exam, breast specimen	0.16	0.06	0.06	0.06	0.06	0.01	XXX
76100		A	X-ray exam of body section	0.58	2.27	2.94	NA	NA	0.07	XXX
76100	TC	A	X-ray exam of body section	0.00	1.97	2.66	NA	NA	0.01	XXX
76100	26	A	X-ray exam of body section	0.58	0.30	0.28	0.30	0.28	0.06	XXX
76101		A	Complex body section x-ray	0.58	3.65	4.47	NA	NA	0.09	XXX
76101	TC	A	Complex body section x-ray	0.00	3.24	4.15	NA	NA	0.01	XXX
76101	26	A	Complex body section x-ray	0.58	0.41	0.32	0.41	0.32	0.08	XXX

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76102		A	Complex body section x-rays	0.58	5.09	6.22	NA	NA	0.11	XXX
76102	TC	A	Complex body section x-rays	0.00	4.68	5.90	NA	NA	0.01	XXX
76102	26	A	Complex body section x-rays	0.58	0.41	0.32	0.41	0.32	0.10	XXX
76120		A	Cine/video x-rays	0.38	1.69	1.82	NA	NA	0.04	XXX
76120	TC	A	Cine/video x-rays	0.00	1.55	1.67	NA	NA	0.01	XXX
76120	26	A	Cine/video x-rays	0.38	0.14	0.15	0.14	0.15	0.03	XXX
76125		C	Cine/video x-rays add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
76125	TC	C	Cine/video x-rays add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
76125	26	A	Cine/video x-rays add-on	0.27	0.11	0.13	0.11	0.13	0.03	ZZZ
76140		I	X-ray consultation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76150		A	X-ray exam, dry process	0.00	0.64	0.61	NA	NA	0.01	XXX
76350		C	Special x-ray contrast study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76376		A	3d render w/o postprocess	0.20	1.39	1.84	NA	NA	0.02	XXX
76376	TC	A	3d render w/o postprocess	0.00	1.32	1.76	NA	NA	0.01	XXX
76376	26	A	3d render w/o postprocess	0.20	0.07	0.08	0.07	0.08	0.01	XXX
76377		A	3d rendering w/postprocess	0.79	1.36	1.87	NA	NA	0.05	XXX
76377	TC	A	3d rendering w/postprocess	0.00	1.08	1.55	NA	NA	0.01	XXX
76377	26	A	3d rendering w/postprocess	0.79	0.28	0.32	0.28	0.32	0.04	XXX
76380		A	CAT scan follow-up study	0.98	3.58	4.48	NA	NA	0.05	XXX
76380	TC	A	CAT scan follow-up study	0.00	3.22	4.08	NA	NA	0.01	XXX
76380	26	A	CAT scan follow-up study	0.98	0.36	0.40	0.36	0.40	0.04	XXX
76390		N	Mr spectroscopy	1.40	11.68	12.30	NA	NA	0.07	XXX
76390	TC	N	Mr spectroscopy	0.00	11.07	11.71	NA	NA	0.01	XXX
76390	26	N	Mr spectroscopy	1.40	0.61	0.59	0.61	0.59	0.06	XXX
76496		C	Fluoroscopic procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76496	TC	C	Fluoroscopic procedure	0.00	0.00	0.00	NA	NA	0.00	XXX

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76496	26	C	Fluoroscopic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76497		C	Ct procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76497	TC	C	Ct procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76497	26	C	Ct procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76498		C	Mri procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76498	TC	C	Mri procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76498	26	C	Mri procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76499		C	Radiographic procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76499	TC	C	Radiographic procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76499	26	C	Radiographic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76506		A	Echo exam of head	0.63	2.73	2.82	NA	NA	0.05	XXX
76506	TC	A	Echo exam of head	0.00	2.50	2.57	NA	NA	0.01	XXX
76506	26	A	Echo exam of head	0.63	0.23	0.25	0.23	0.25	0.04	XXX
76510		A	Ophth us, b & quant a	1.55	3.24	3.08	NA	NA	0.28	XXX
76510	TC	A	Ophth us, b & quant a	0.00	2.15	2.16	NA	NA	0.01	XXX
76510	26	A	Ophth us, b & quant a	1.55	1.09	0.92	1.09	0.92	0.27	XXX
76511		A	Ophth us, quant a only	0.94	1.94	1.95	NA	NA	0.02	XXX
76511	TC	A	Ophth us, quant a only	0.00	1.30	1.41	NA	NA	0.01	XXX
76511	26	A	Ophth us, quant a only	0.94	0.64	0.54	0.64	0.54	0.01	XXX
76512		A	Ophth us, b w/non-quant a	0.94	1.69	1.72	NA	NA	0.05	XXX
76512	TC	A	Ophth us, b w/non-quant a	0.00	1.05	1.17	NA	NA	0.01	XXX
76512	26	A	Ophth us, b w/non-quant a	0.94	0.64	0.55	0.64	0.55	0.04	XXX
76513		A	Echo exam of eye, water bath	0.66	1.95	1.90	NA	NA	0.02	XXX
76513	TC	A	Echo exam of eye, water bath	0.00	1.57	1.57	NA	NA	0.01	XXX
76513	26	A	Echo exam of eye, water bath	0.66	0.38	0.33	0.38	0.33	0.01	XXX
76514		A	Echo exam of eye, thickness	0.17	0.24	0.22	NA	NA	0.02	XXX

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76514	TC	A	Echo exam of eye, thickness	0.00	0.13	0.12	NA	NA	0.01	XXX
76514	26	A	Echo exam of eye, thickness	0.17	0.11	0.10	0.11	0.10	0.01	XXX
76516		A	Echo exam of eye	0.54	1.62	1.55	NA	NA	0.02	XXX
76516	TC	A	Echo exam of eye	0.00	1.25	1.24	NA	NA	0.01	XXX
76516	26	A	Echo exam of eye	0.54	0.37	0.31	0.37	0.31	0.01	XXX
76519		A	Echo exam of eye	0.54	1.77	1.70	NA	NA	0.04	XXX
76519	TC	A	Echo exam of eye	0.00	1.39	1.38	NA	NA	0.01	XXX
76519	26	A	Echo exam of eye	0.54	0.38	0.32	0.38	0.32	0.03	XXX
76529		A	Echo exam of eye	0.57	1.62	1.54	NA	NA	0.04	XXX
76529	TC	A	Echo exam of eye	0.00	1.22	1.21	NA	NA	0.01	XXX
76529	26	A	Echo exam of eye	0.57	0.40	0.33	0.40	0.33	0.03	XXX
76536		A	Us exam of head and neck	0.56	2.78	2.82	NA	NA	0.04	XXX
76536	TC	A	Us exam of head and neck	0.00	2.57	2.60	NA	NA	0.01	XXX
76536	26	A	Us exam of head and neck	0.56	0.21	0.22	0.21	0.22	0.03	XXX
76604		A	Us exam, chest	0.55	1.82	1.96	NA	NA	0.04	XXX
76604	TC	A	Us exam, chest	0.00	1.63	1.74	NA	NA	0.01	XXX
76604	26	A	Us exam, chest	0.55	0.19	0.22	0.19	0.22	0.03	XXX
76645		A	Us exam, breast(s)	0.54	2.11	2.20	NA	NA	0.05	XXX
76645	TC	A	Us exam, breast(s)	0.00	1.92	1.98	NA	NA	0.01	XXX
76645	26	A	Us exam, breast(s)	0.54	0.19	0.22	0.19	0.22	0.04	XXX
76700		A	Us exam, abdom, complete	0.81	3.04	3.21	NA	NA	0.05	XXX
76700	TC	A	Us exam, abdom, complete	0.00	2.75	2.89	NA	NA	0.01	XXX
76700	26	A	Us exam, abdom, complete	0.81	0.29	0.32	0.29	0.32	0.04	XXX
76705		A	Echo exam of abdomen	0.59	2.33	2.47	NA	NA	0.04	XXX
76705	TC	A	Echo exam of abdomen	0.00	2.12	2.23	NA	NA	0.01	XXX
76705	26	A	Echo exam of abdomen	0.59	0.21	0.24	0.21	0.24	0.03	XXX

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76770		A	Us exam abdo back wall, comp	0.74	2.88	3.09	NA	NA	0.05	XXX
76770	TC	A	Us exam abdo back wall, comp	0.00	2.61	2.79	NA	NA	0.01	XXX
76770	26	A	Us exam abdo back wall, comp	0.74	0.27	0.30	0.27	0.30	0.04	XXX
76775		A	Us exam abdo back wall, lim	0.58	2.36	2.61	NA	NA	0.04	XXX
76775	TC	A	Us exam abdo back wall, lim	0.00	2.15	2.37	NA	NA	0.01	XXX
76775	26	A	Us exam abdo back wall, lim	0.58	0.21	0.24	0.21	0.24	0.03	XXX
76776		A	Us exam k transpl w/doppler	0.76	3.38	3.56	NA	NA	0.05	XXX
76776	TC	A	Us exam k transpl w/doppler	0.00	3.12	3.26	NA	NA	0.01	XXX
76776	26	A	Us exam k transpl w/doppler	0.76	0.26	0.30	0.26	0.30	0.04	XXX
76800		A	Us exam, spinal canal	1.13	2.84	2.71	NA	NA	0.05	XXX
76800	TC	A	Us exam, spinal canal	0.00	2.35	2.27	NA	NA	0.01	XXX
76800	26	A	Us exam, spinal canal	1.13	0.49	0.44	0.49	0.44	0.04	XXX
76801		A	Ob us < 14 wks, single fetus	0.99	2.52	2.74	NA	NA	0.04	XXX
76801	TC	A	Ob us < 14 wks, single fetus	0.00	2.13	2.34	NA	NA	0.01	XXX
76801	26	A	Ob us < 14 wks, single fetus	0.99	0.39	0.40	0.39	0.40	0.03	XXX
76802		A	Ob us < 14 wks, addl fetus	0.83	1.05	1.17	NA	NA	0.04	ZZZ
76802	TC	A	Ob us < 14 wks, addl fetus	0.00	0.71	0.83	NA	NA	0.01	ZZZ
76802	26	A	Ob us < 14 wks, addl fetus	0.83	0.34	0.34	0.34	0.34	0.03	ZZZ
76805		A	Ob us >/= 14 wks, sngl fetus	0.99	3.12	3.29	NA	NA	0.04	XXX
76805	TC	A	Ob us >/= 14 wks, sngl fetus	0.00	2.72	2.89	NA	NA	0.01	XXX
76805	26	A	Ob us >/= 14 wks, sngl fetus	0.99	0.40	0.40	0.40	0.40	0.03	XXX
76810		A	Ob us >/= 14 wks, addl fetus	0.98	1.74	1.82	NA	NA	0.04	ZZZ
76810	TC	A	Ob us >/= 14 wks, addl fetus	0.00	1.34	1.42	NA	NA	0.01	ZZZ
76810	26	A	Ob us >/= 14 wks, addl fetus	0.98	0.40	0.40	0.40	0.40	0.03	ZZZ
76811		A	Ob us, detailed, sngl fetus	1.90	3.32	3.66	NA	NA	0.07	XXX
76811	TC	A	Ob us, detailed, sngl fetus	0.00	2.49	2.88	NA	NA	0.01	XXX

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76811	26	A	Ob us, detailed, sngl fetus	1.90	0.83	0.78	0.83	0.78	0.06	XXX
76812		A	Ob us, detailed, addl fetus	1.78	4.19	4.12	NA	NA	0.07	ZZZ
76812	TC	A	Ob us, detailed, addl fetus	0.00	3.41	3.39	NA	NA	0.01	ZZZ
76812	26	A	Ob us, detailed, addl fetus	1.78	0.78	0.73	0.78	0.73	0.06	ZZZ
76813		A	Ob us nuchal meas, 1 gest	1.18	2.33	2.47	NA	NA	0.05	XXX
76813	TC	A	Ob us nuchal meas, 1 gest	0.00	1.81	1.99	NA	NA	0.01	XXX
76813	26	A	Ob us nuchal meas, 1 gest	1.18	0.52	0.48	0.52	0.48	0.04	XXX
76814		A	Ob us nuchal meas, add-on	0.99	1.30	1.33	NA	NA	0.04	XXX
76814	TC	A	Ob us nuchal meas, add-on	0.00	0.86	0.93	NA	NA	0.01	XXX
76814	26	A	Ob us nuchal meas, add-on	0.99	0.44	0.40	0.44	0.40	0.03	XXX
76815		A	Ob us, limited, fetus(s)	0.65	1.85	1.98	NA	NA	0.02	XXX
76815	TC	A	Ob us, limited, fetus(s)	0.00	1.59	1.72	NA	NA	0.01	XXX
76815	26	A	Ob us, limited, fetus(s)	0.65	0.26	0.26	0.26	0.26	0.01	XXX
76816		A	Ob us, follow-up, per fetus	0.85	2.48	2.51	NA	NA	0.04	XXX
76816	TC	A	Ob us, follow-up, per fetus	0.00	2.11	2.16	NA	NA	0.01	XXX
76816	26	A	Ob us, follow-up, per fetus	0.85	0.37	0.35	0.37	0.35	0.03	XXX
76817		A	Transvaginal us, obstetric	0.75	2.07	2.21	NA	NA	0.04	XXX
76817	TC	A	Transvaginal us, obstetric	0.00	1.77	1.91	NA	NA	0.01	XXX
76817	26	A	Transvaginal us, obstetric	0.75	0.30	0.30	0.30	0.30	0.03	XXX
76818		A	Fetal biophys profile w/nst	1.05	2.37	2.48	NA	NA	0.04	XXX
76818	TC	A	Fetal biophys profile w/nst	0.00	1.91	2.04	NA	NA	0.01	XXX
76818	26	A	Fetal biophys profile w/nst	1.05	0.46	0.44	0.46	0.44	0.03	XXX
76819		A	Fetal biophys profil w/o nst	0.77	1.70	1.87	NA	NA	0.04	XXX
76819	TC	A	Fetal biophys profil w/o nst	0.00	1.38	1.55	NA	NA	0.01	XXX
76819	26	A	Fetal biophys profil w/o nst	0.77	0.32	0.32	0.32	0.32	0.03	XXX
76820		A	Umbilical artery echo	0.50	0.64	0.85	NA	NA	0.02	XXX

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76820	TC	A	Umbilical artery echo	0.00	0.42	0.64	NA	NA	0.01	XXX
76820	26	A	Umbilical artery echo	0.50	0.22	0.21	0.22	0.21	0.01	XXX
76821		A	Middle cerebral artery echo	0.70	1.96	2.09	NA	NA	0.04	XXX
76821	TC	A	Middle cerebral artery echo	0.00	1.65	1.80	NA	NA	0.01	XXX
76821	26	A	Middle cerebral artery echo	0.70	0.31	0.29	0.31	0.29	0.03	XXX
76825		A	Echo exam of fetal heart	1.67	4.52	4.61	NA	NA	0.05	XXX
76825	TC	A	Echo exam of fetal heart	0.00	3.81	3.92	NA	NA	0.01	XXX
76825	26	A	Echo exam of fetal heart	1.67	0.71	0.69	0.71	0.69	0.04	XXX
76826		A	Echo exam of fetal heart	0.83	2.83	2.77	NA	NA	0.04	XXX
76826	TC	A	Echo exam of fetal heart	0.00	2.48	2.44	NA	NA	0.01	XXX
76826	26	A	Echo exam of fetal heart	0.83	0.35	0.33	0.35	0.33	0.03	XXX
76827		A	Echo exam of fetal heart	0.58	1.14	1.34	NA	NA	0.02	XXX
76827	TC	A	Echo exam of fetal heart	0.00	0.89	1.10	NA	NA	0.01	XXX
76827	26	A	Echo exam of fetal heart	0.58	0.25	0.24	0.25	0.24	0.01	XXX
76828		A	Echo exam of fetal heart	0.56	0.72	0.84	NA	NA	0.02	XXX
76828	TC	A	Echo exam of fetal heart	0.00	0.47	0.61	NA	NA	0.01	XXX
76828	26	A	Echo exam of fetal heart	0.56	0.25	0.23	0.25	0.23	0.01	XXX
76830		A	Transvaginal us, non-ob	0.69	2.78	2.89	NA	NA	0.04	XXX
76830	TC	A	Transvaginal us, non-ob	0.00	2.51	2.61	NA	NA	0.01	XXX
76830	26	A	Transvaginal us, non-ob	0.69	0.27	0.28	0.27	0.28	0.03	XXX
76831		A	Echo exam, uterus	0.72	2.81	2.88	NA	NA	0.04	XXX
76831	TC	A	Echo exam, uterus	0.00	2.50	2.59	NA	NA	0.01	XXX
76831	26	A	Echo exam, uterus	0.72	0.31	0.29	0.31	0.29	0.03	XXX
76856		A	Us exam, pelvic, complete	0.69	2.75	2.89	NA	NA	0.04	XXX
76856	TC	A	Us exam, pelvic, complete	0.00	2.49	2.61	NA	NA	0.01	XXX
76856	26	A	Us exam, pelvic, complete	0.69	0.26	0.28	0.26	0.28	0.03	XXX

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76857		A	Us exam, pelvic, limited	0.38	2.29	2.53	NA	NA	0.04	XXX
76857	TC	A	Us exam, pelvic, limited	0.00	2.14	2.37	NA	NA	0.01	XXX
76857	26	A	Us exam, pelvic, limited	0.38	0.15	0.16	0.15	0.16	0.03	XXX
76870		A	Us exam, scrotum	0.64	2.75	2.90	NA	NA	0.05	XXX
76870	TC	A	Us exam, scrotum	0.00	2.52	2.64	NA	NA	0.01	XXX
76870	26	A	Us exam, scrotum	0.64	0.23	0.26	0.23	0.26	0.04	XXX
76872		A	Us, transrectal	0.69	3.01	3.37	NA	NA	0.05	XXX
76872	TC	A	Us, transrectal	0.00	2.74	3.07	NA	NA	0.01	XXX
76872	26	A	Us, transrectal	0.69	0.27	0.30	0.27	0.30	0.04	XXX
76873		A	Echograp trans r, pros study	1.55	3.49	3.65	NA	NA	0.09	XXX
76873	TC	A	Echograp trans r, pros study	0.00	2.79	2.96	NA	NA	0.01	XXX
76873	26	A	Echograp trans r, pros study	1.55	0.70	0.69	0.70	0.69	0.08	XXX
76880		A	Us exam, extremity	0.59	3.44	3.38	NA	NA	0.04	XXX
76880	TC	A	Us exam, extremity	0.00	3.23	3.16	NA	NA	0.01	XXX
76880	26	A	Us exam, extremity	0.59	0.21	0.22	0.21	0.22	0.03	XXX
76885		A	Us exam infant hips, dynamic	0.74	3.36	3.42	NA	NA	0.05	XXX
76885	TC	A	Us exam infant hips, dynamic	0.00	3.09	3.12	NA	NA	0.01	XXX
76885	26	A	Us exam infant hips, dynamic	0.74	0.27	0.30	0.27	0.30	0.04	XXX
76886		A	Us exam infant hips, static	0.62	2.95	2.71	NA	NA	0.02	XXX
76886	TC	A	Us exam infant hips, static	0.00	2.66	2.44	NA	NA	0.01	XXX
76886	26	A	Us exam infant hips, static	0.62	0.29	0.27	0.29	0.27	0.01	XXX
76930		A	Echo guide, cardiocentesis	0.67	1.61	1.96	NA	NA	0.02	XXX
76930	TC	A	Echo guide, cardiocentesis	0.00	1.35	1.64	NA	NA	0.01	XXX
76930	26	A	Echo guide, cardiocentesis	0.67	0.26	0.32	0.26	0.32	0.01	XXX
76932		C	Echo guide for heart biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX
76932	TC	C	Echo guide for heart biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
76932	26	A	Echo guide for heart biopsy	0.67	0.26	0.32	0.26	0.32	0.04	XXX
76936		A	Echo guide for artery repair	1.99	6.13	6.83	NA	NA	0.25	XXX
76936	TC	A	Echo guide for artery repair	0.00	5.43	6.04	NA	NA	0.01	XXX
76936	26	A	Echo guide for artery repair	1.99	0.70	0.79	0.70	0.79	0.24	XXX
76937		A	Us guide, vascular access	0.30	0.65	0.68	NA	NA	0.04	ZZZ
76937	TC	A	Us guide, vascular access	0.00	0.54	0.56	NA	NA	0.01	ZZZ
76937	26	A	Us guide, vascular access	0.30	0.11	0.12	0.11	0.12	0.03	ZZZ
76940		C	Us guide, tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
76940	TC	C	Us guide, tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
76940	26	A	Us guide, tissue ablation	2.00	0.77	0.80	0.77	0.80	0.30	XXX
76941		C	Echo guide for transfusion	0.00	0.00	0.00	NA	NA	0.00	XXX
76941	TC	C	Echo guide for transfusion	0.00	0.00	0.00	NA	NA	0.00	XXX
76941	26	A	Echo guide for transfusion	1.34	0.60	0.57	0.60	0.57	0.11	XXX
76942		A	Echo guide for biopsy	0.67	4.81	5.00	NA	NA	0.05	XXX
76942	TC	A	Echo guide for biopsy	0.00	4.56	4.72	NA	NA	0.01	XXX
76942	26	A	Echo guide for biopsy	0.67	0.25	0.28	0.25	0.28	0.04	XXX
76945		C	Echo guide, villus sampling	0.00	0.00	0.00	NA	NA	0.00	XXX
76945	TC	C	Echo guide, villus sampling	0.00	0.00	0.00	NA	NA	0.00	XXX
76945	26	A	Echo guide, villus sampling	0.67	0.30	0.28	0.30	0.28	0.04	XXX
76946		A	Echo guide for amniocentesis	0.38	0.51	0.71	NA	NA	0.02	XXX
76946	TC	A	Echo guide for amniocentesis	0.00	0.34	0.55	NA	NA	0.01	XXX
76946	26	A	Echo guide for amniocentesis	0.38	0.17	0.16	0.17	0.16	0.01	XXX
76948		A	Echo guide, ova aspiration	0.38	0.52	0.71	NA	NA	0.04	XXX
76948	TC	A	Echo guide, ova aspiration	0.00	0.35	0.55	NA	NA	0.01	XXX
76948	26	A	Echo guide, ova aspiration	0.38	0.17	0.16	0.17	0.16	0.03	XXX
76950		A	Echo guidance radiotherapy	0.58	1.34	1.44	NA	NA	0.04	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
76950	TC	A	Echo guidance radiotherapy	0.00	1.06	1.18	NA	NA	0.01	XXX
76950	26	A	Echo guidance radiotherapy	0.58	0.28	0.26	0.28	0.26	0.03	XXX
76965		A	Echo guidance radiotherapy	1.34	1.23	2.06	NA	NA	0.09	XXX
76965	TC	A	Echo guidance radiotherapy	0.00	0.65	1.46	NA	NA	0.01	XXX
76965	26	A	Echo guidance radiotherapy	1.34	0.58	0.60	0.58	0.60	0.08	XXX
76970		A	Ultrasound exam follow-up	0.40	2.52	2.35	NA	NA	0.05	XXX
76970	TC	A	Ultrasound exam follow-up	0.00	2.35	2.19	NA	NA	0.01	XXX
76970	26	A	Ultrasound exam follow-up	0.40	0.17	0.16	0.17	0.16	0.04	XXX
76975		C	GI endoscopic ultrasound	0.00	0.00	0.00	NA	NA	0.00	XXX
76975	TC	C	GI endoscopic ultrasound	0.00	0.00	0.00	NA	NA	0.00	XXX
76975	26	A	GI endoscopic ultrasound	0.81	0.39	0.38	0.39	0.38	0.08	XXX
76977		A	Us bone density measure	0.05	0.13	0.24	NA	NA	0.02	XXX
76977	TC	A	Us bone density measure	0.00	0.11	0.22	NA	NA	0.01	XXX
76977	26	A	Us bone density measure	0.05	0.02	0.02	0.02	0.02	0.01	XXX
76998		C	Us guide, intraop	0.00	0.00	0.00	NA	NA	0.00	XXX
76998	TC	C	Us guide, intraop	0.00	0.00	0.00	NA	NA	0.00	XXX
76998	26	A	Us guide, intraop	1.20	0.46	0.47	0.46	0.47	0.27	XXX
76999		C	Echo examination procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76999	TC	C	Echo examination procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76999	26	C	Echo examination procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77001		A	Fluoroguide for vein device	0.38	2.89	2.88	NA	NA	0.04	ZZZ
77001	TC	A	Fluoroguide for vein device	0.00	2.75	2.73	NA	NA	0.01	ZZZ
77001	26	A	Fluoroguide for vein device	0.38	0.14	0.15	0.14	0.15	0.03	ZZZ
77002		A	Needle localization by xray	0.54	1.62	1.61	NA	NA	0.04	XXX
77002	TC	A	Needle localization by xray	0.00	1.37	1.38	NA	NA	0.01	XXX
77002	26	A	Needle localization by xray	0.54	0.25	0.23	0.25	0.23	0.03	XXX

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77003		A	Fluoroguide for spine inject	0.60	1.23	1.19	NA	NA	0.04	XXX
77003	TC	A	Fluoroguide for spine inject	0.00	0.94	0.95	NA	NA	0.01	XXX
77003	26	A	Fluoroguide for spine inject	0.60	0.29	0.24	0.29	0.24	0.03	XXX
77011		A	Ct scan for localization	1.21	21.33	20.94	NA	NA	0.05	XXX
77011	TC	A	Ct scan for localization	0.00	20.78	20.40	NA	NA	0.01	XXX
77011	26	A	Ct scan for localization	1.21	0.55	0.54	0.55	0.54	0.04	XXX
77012		A	Ct scan for needle biopsy	1.16	2.34	3.53	NA	NA	0.05	XXX
77012	TC	A	Ct scan for needle biopsy	0.00	1.94	3.06	NA	NA	0.01	XXX
77012	26	A	Ct scan for needle biopsy	1.16	0.40	0.47	0.40	0.47	0.04	XXX
77013		C	Ct guide for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77013	TC	C	Ct guide for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77013	26	A	Ct guide for tissue ablation	3.99	1.37	1.60	1.37	1.60	0.38	XXX
77014		A	Ct scan for therapy guide	0.85	4.69	4.79	NA	NA	0.05	XXX
77014	TC	A	Ct scan for therapy guide	0.00	4.27	4.41	NA	NA	0.01	XXX
77014	26	A	Ct scan for therapy guide	0.85	0.42	0.38	0.42	0.38	0.04	XXX
77021		A	Mr guidance for needle place	1.50	9.40	10.88	NA	NA	0.14	XXX
77021	TC	A	Mr guidance for needle place	0.00	8.87	10.28	NA	NA	0.01	XXX
77021	26	A	Mr guidance for needle place	1.50	0.53	0.60	0.53	0.60	0.13	XXX
77022		C	Mri for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77022	TC	C	Mri for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77022	26	A	Mri for tissue ablation	4.24	1.53	1.66	1.53	1.66	0.40	XXX
77031		A	Stereotact guide for brst bx	1.59	1.92	2.97	NA	NA	0.14	XXX
77031	TC	A	Stereotact guide for brst bx	0.00	1.35	2.34	NA	NA	0.01	XXX
77031	26	A	Stereotact guide for brst bx	1.59	0.57	0.63	0.57	0.63	0.13	XXX
77032		A	Guidance for needle, breast	0.56	0.82	1.02	NA	NA	0.04	XXX
77032	TC	A	Guidance for needle, breast	0.00	0.63	0.80	NA	NA	0.01	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
77032	26	A	Guidance for needle, breast	0.56	0.19	0.22	0.19	0.22	0.03	XXX
77051		A	Computer dx mammogram add-on	0.06	0.19	0.25	NA	NA	0.02	ZZZ
77051	TC	A	Computer dx mammogram add-on	0.00	0.17	0.23	NA	NA	0.01	ZZZ
77051	26	A	Computer dx mammogram add-on	0.06	0.02	0.02	0.02	0.02	0.01	ZZZ
77052		A	Comp screen mammogram add-on	0.06	0.19	0.25	NA	NA	0.02	ZZZ
77052	TC	A	Comp screen mammogram add-on	0.00	0.17	0.23	NA	NA	0.01	ZZZ
77052	26	A	Comp screen mammogram add-on	0.06	0.02	0.02	0.02	0.02	0.01	ZZZ
77053		A	X-ray of mammary duct	0.36	1.20	1.57	NA	NA	0.02	XXX
77053	TC	A	X-ray of mammary duct	0.00	1.08	1.43	NA	NA	0.01	XXX
77053	26	A	X-ray of mammary duct	0.36	0.12	0.14	0.12	0.14	0.01	XXX
77054		A	X-ray of mammary ducts	0.45	1.67	2.16	NA	NA	0.04	XXX
77054	TC	A	X-ray of mammary ducts	0.00	1.51	1.98	NA	NA	0.01	XXX
77054	26	A	X-ray of mammary ducts	0.45	0.16	0.18	0.16	0.18	0.03	XXX
77055		A	Mammogram, one breast	0.70	1.63	1.75	NA	NA	0.05	XXX
77055	TC	A	Mammogram, one breast	0.00	1.38	1.47	NA	NA	0.01	XXX
77055	26	A	Mammogram, one breast	0.70	0.25	0.28	0.25	0.28	0.04	XXX
77056		A	Mammogram, both breasts	0.87	2.11	2.26	NA	NA	0.07	XXX
77056	TC	A	Mammogram, both breasts	0.00	1.81	1.92	NA	NA	0.01	XXX
77056	26	A	Mammogram, both breasts	0.87	0.30	0.34	0.30	0.34	0.06	XXX
77057		A	Mammogram, screening	0.70	1.44	1.60	NA	NA	0.05	XXX
77057	TC	A	Mammogram, screening	0.00	1.19	1.32	NA	NA	0.01	XXX
77057	26	A	Mammogram, screening	0.70	0.25	0.28	0.25	0.28	0.04	XXX
77058		A	Mri, one breast	1.63	15.45	20.13	NA	NA	0.11	XXX
77058	TC	A	Mri, one breast	0.00	14.89	19.49	NA	NA	0.01	XXX
77058	26	A	Mri, one breast	1.63	0.56	0.64	0.56	0.64	0.10	XXX
77059		A	Mri, both breasts	1.63	15.36	20.97	NA	NA	0.11	XXX

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77059	TC	A	Mri, both breasts	0.00	14.80	20.33	NA	NA	0.01	XXX
77059	26	A	Mri, both breasts	1.63	0.56	0.64	0.56	0.64	0.10	XXX
77071		A	X-ray stress view	0.41	1.00	0.88	1.00	0.88	0.07	XXX
77072		A	X-rays for bone age	0.19	0.44	0.48	NA	NA	0.02	XXX
77072	TC	A	X-rays for bone age	0.00	0.37	0.40	NA	NA	0.01	XXX
77072	26	A	X-rays for bone age	0.19	0.07	0.08	0.07	0.08	0.01	XXX
77073		A	X-rays, bone length studies	0.27	0.78	0.82	NA	NA	0.05	XXX
77073	TC	A	X-rays, bone length studies	0.00	0.65	0.69	NA	NA	0.01	XXX
77073	26	A	X-rays, bone length studies	0.27	0.13	0.13	0.13	0.13	0.04	XXX
77074		A	X-rays, bone survey, limited	0.45	1.42	1.53	NA	NA	0.04	XXX
77074	TC	A	X-rays, bone survey, limited	0.00	1.26	1.35	NA	NA	0.01	XXX
77074	26	A	X-rays, bone survey, limited	0.45	0.16	0.18	0.16	0.18	0.03	XXX
77075		A	X-rays, bone survey complete	0.54	2.25	2.40	NA	NA	0.04	XXX
77075	TC	A	X-rays, bone survey complete	0.00	2.06	2.18	NA	NA	0.01	XXX
77075	26	A	X-rays, bone survey complete	0.54	0.19	0.22	0.19	0.22	0.03	XXX
77076		A	X-rays, bone survey, infant	0.70	2.15	2.15	NA	NA	0.05	XXX
77076	TC	A	X-rays, bone survey, infant	0.00	1.90	1.89	NA	NA	0.01	XXX
77076	26	A	X-rays, bone survey, infant	0.70	0.25	0.26	0.25	0.26	0.04	XXX
77077		A	Joint survey, single view	0.31	0.80	0.88	NA	NA	0.05	XXX
77077	TC	A	Joint survey, single view	0.00	0.65	0.74	NA	NA	0.01	XXX
77077	26	A	Joint survey, single view	0.31	0.15	0.14	0.15	0.14	0.04	XXX
77078		A	Ct bone density, axial	0.25	3.42	4.29	NA	NA	0.02	XXX
77078	TC	A	Ct bone density, axial	0.00	3.33	4.19	NA	NA	0.01	XXX
77078	26	A	Ct bone density, axial	0.25	0.09	0.10	0.09	0.10	0.01	XXX
77079		A	Ct bone density, peripheral	0.22	0.91	1.24	NA	NA	0.02	XXX
77079	TC	A	Ct bone density, peripheral	0.00	0.81	1.15	NA	NA	0.01	XXX

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77079	26	A	Ct bone density, peripheral	0.22	0.10	0.09	0.10	0.09	0.01	XXX
77080		A	Dxa bone density, axial	0.32	3.46	3.46	NA	NA	0.19	XXX
77080	TC	A	Dxa bone density, axial	0.00	3.35	3.35	NA	NA	0.18	XXX
77080	26	A	Dxa bone density, axial	0.32	0.11	0.11	0.11	0.11	0.01	XXX
77081		A	Dxa bone density/peripheral	0.22	0.61	0.61	NA	NA	0.02	XXX
77081	TC	A	Dxa bone density/peripheral	0.00	0.55	0.55	NA	NA	0.01	XXX
77081	26	A	Dxa bone density/peripheral	0.22	0.06	0.06	0.06	0.06	0.01	XXX
77082		A	Dxa bone density, vert fx	0.18	0.87	0.87	NA	NA	0.06	XXX
77082	TC	A	Dxa bone density, vert fx	0.00	0.81	0.81	NA	NA	0.05	XXX
77082	26	A	Dxa bone density, vert fx	0.18	0.06	0.06	0.06	0.06	0.01	XXX
77083		A	Radiographic absorptiometry	0.20	0.46	0.52	NA	NA	0.02	XXX
77083	TC	A	Radiographic absorptiometry	0.00	0.37	0.44	NA	NA	0.01	XXX
77083	26	A	Radiographic absorptiometry	0.20	0.09	0.08	0.09	0.08	0.01	XXX
77084		A	Magnetic image, bone marrow	1.60	10.57	13.56	NA	NA	0.11	XXX
77084	TC	A	Magnetic image, bone marrow	0.00	10.00	12.92	NA	NA	0.01	XXX
77084	26	A	Magnetic image, bone marrow	1.60	0.57	0.64	0.57	0.64	0.10	XXX
77261		A	Radiation therapy planning	1.39	0.72	0.67	0.72	0.67	0.10	XXX
77262		A	Radiation therapy planning	2.11	1.05	0.97	1.05	0.97	0.18	XXX
77263		A	Radiation therapy planning	3.14	1.56	1.44	1.56	1.44	0.27	XXX
77280		A	Set radiation therapy field	0.70	4.71	4.88	NA	NA	0.04	XXX
77280	TC	A	Set radiation therapy field	0.00	4.36	4.56	NA	NA	0.01	XXX
77280	26	A	Set radiation therapy field	0.70	0.35	0.32	0.35	0.32	0.03	XXX
77285		A	Set radiation therapy field	1.05	8.52	8.71	NA	NA	0.07	XXX
77285	TC	A	Set radiation therapy field	0.00	8.00	8.24	NA	NA	0.01	XXX
77285	26	A	Set radiation therapy field	1.05	0.52	0.47	0.52	0.47	0.06	XXX
77290		A	Set radiation therapy field	1.56	14.18	14.10	NA	NA	0.08	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
77290	TC	A	Set radiation therapy field	0.00	13.40	13.39	NA	NA	0.01	XXX
77290	26	A	Set radiation therapy field	1.56	0.78	0.71	0.78	0.71	0.07	XXX
77295		A	Set radiation therapy field	4.56	8.42	11.95	NA	NA	0.29	XXX
77295	TC	A	Set radiation therapy field	0.00	6.15	9.88	NA	NA	0.04	XXX
77295	26	A	Set radiation therapy field	4.56	2.27	2.07	2.27	2.07	0.25	XXX
77299		C	Radiation therapy planning	0.00	0.00	0.00	NA	NA	0.00	XXX
77299	TC	C	Radiation therapy planning	0.00	0.00	0.00	NA	NA	0.00	XXX
77299	26	C	Radiation therapy planning	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77300		A	Radiation therapy dose plan	0.62	1.33	1.42	NA	NA	0.04	XXX
77300	TC	A	Radiation therapy dose plan	0.00	1.02	1.14	NA	NA	0.01	XXX
77300	26	A	Radiation therapy dose plan	0.62	0.31	0.28	0.31	0.28	0.03	XXX
77301		A	Radiotherapy dose plan, imrt	7.99	60.71	60.43	NA	NA	0.65	XXX
77301	TC	A	Radiotherapy dose plan, imrt	0.00	56.74	56.80	NA	NA	0.23	XXX
77301	26	A	Radiotherapy dose plan, imrt	7.99	3.97	3.63	3.97	3.63	0.42	XXX
77305		A	Teletx isodose plan simple	0.70	1.04	1.24	NA	NA	0.04	XXX
77305	TC	A	Teletx isodose plan simple	0.00	0.69	0.92	NA	NA	0.01	XXX
77305	26	A	Teletx isodose plan simple	0.70	0.35	0.32	0.35	0.32	0.03	XXX
77310		A	Teletx isodose plan intermed	1.05	1.46	1.70	NA	NA	0.07	XXX
77310	TC	A	Teletx isodose plan intermed	0.00	0.94	1.22	NA	NA	0.01	XXX
77310	26	A	Teletx isodose plan intermed	1.05	0.52	0.48	0.52	0.48	0.06	XXX
77315		A	Teletx isodose plan complex	1.56	2.41	2.62	NA	NA	0.08	XXX
77315	TC	A	Teletx isodose plan complex	0.00	1.63	1.91	NA	NA	0.01	XXX
77315	26	A	Teletx isodose plan complex	1.56	0.78	0.71	0.78	0.71	0.07	XXX
77321		A	Special teletx port plan	0.95	1.71	2.19	NA	NA	0.05	XXX
77321	TC	A	Special teletx port plan	0.00	1.24	1.76	NA	NA	0.01	XXX
77321	26	A	Special teletx port plan	0.95	0.47	0.43	0.47	0.43	0.04	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
77326		A	Brachytx isodose calc simp	0.93	3.25	3.34	NA	NA	0.07	XXX
77326	TC	A	Brachytx isodose calc simp	0.00	2.78	2.92	NA	NA	0.03	XXX
77326	26	A	Brachytx isodose calc simp	0.93	0.47	0.42	0.47	0.42	0.04	XXX
77327		A	Brachytx isodose calc interm	1.39	4.47	4.64	NA	NA	0.10	XXX
77327	TC	A	Brachytx isodose calc interm	0.00	3.78	4.01	NA	NA	0.03	XXX
77327	26	A	Brachytx isodose calc interm	1.39	0.69	0.63	0.69	0.63	0.07	XXX
77328		A	Brachytx isodose plan compl	2.09	5.75	6.05	NA	NA	0.14	XXX
77328	TC	A	Brachytx isodose plan compl	0.00	4.71	5.10	NA	NA	0.04	XXX
77328	26	A	Brachytx isodose plan compl	2.09	1.04	0.95	1.04	0.95	0.10	XXX
77331		A	Special radiation dosimetry	0.87	0.97	0.97	NA	NA	0.05	XXX
77331	TC	A	Special radiation dosimetry	0.00	0.54	0.57	NA	NA	0.01	XXX
77331	26	A	Special radiation dosimetry	0.87	0.43	0.40	0.43	0.40	0.04	XXX
77332		A	Radiation treatment aid(s)	0.54	1.69	1.76	NA	NA	0.04	XXX
77332	TC	A	Radiation treatment aid(s)	0.00	1.42	1.52	NA	NA	0.01	XXX
77332	26	A	Radiation treatment aid(s)	0.54	0.27	0.24	0.27	0.24	0.03	XXX
77333		A	Radiation treatment aid(s)	0.84	0.67	0.89	NA	NA	0.05	XXX
77333	TC	A	Radiation treatment aid(s)	0.00	0.25	0.51	NA	NA	0.01	XXX
77333	26	A	Radiation treatment aid(s)	0.84	0.42	0.38	0.42	0.38	0.04	XXX
77334		A	Radiation treatment aid(s)	1.24	3.02	3.27	NA	NA	0.07	XXX
77334	TC	A	Radiation treatment aid(s)	0.00	2.40	2.71	NA	NA	0.01	XXX
77334	26	A	Radiation treatment aid(s)	1.24	0.62	0.56	0.62	0.56	0.06	XXX
77336		A	Radiation physics consult	0.00	1.18	1.54	NA	NA	0.01	XXX
77338		A	Design mlc device for imrt	4.29	10.10	10.10	NA	NA	0.28	XXX
77338	TC	A	Design mlc device for imrt	0.00	7.96	7.96	NA	NA	0.04	XXX
77338	26	A	Design mlc device for imrt	4.29	2.14	2.14	2.14	2.14	0.24	XXX
77370		A	Radiation physics consult	0.00	3.16	3.44	NA	NA	0.04	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
77371		C	Srs, multisource	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77372		A	Srs, linear based	0.00	23.63	25.23	NA	NA	0.06	XXX
77373		A	Sbrt delivery	0.00	44.40	47.10	NA	NA	0.07	XXX
77399		C	External radiation dosimetry	0.00	0.00	0.00	NA	NA	0.00	XXX
77399	TC	C	External radiation dosimetry	0.00	0.00	0.00	NA	NA	0.00	XXX
77399	26	C	External radiation dosimetry	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77401		A	Radiation treatment delivery	0.00	0.54	0.74	NA	NA	0.01	XXX
77402		A	Radiation treatment delivery	0.00	5.74	5.08	NA	NA	0.01	XXX
77403		A	Radiation treatment delivery	0.00	3.89	3.88	NA	NA	0.01	XXX
77404		A	Radiation treatment delivery	0.00	4.37	4.31	NA	NA	0.01	XXX
77406		A	Radiation treatment delivery	0.00	4.39	4.34	NA	NA	0.01	XXX
77407		A	Radiation treatment delivery	0.00	7.82	7.38	NA	NA	0.01	XXX
77408		A	Radiation treatment delivery	0.00	5.37	5.28	NA	NA	0.01	XXX
77409		A	Radiation treatment delivery	0.00	6.01	5.87	NA	NA	0.01	XXX
77411		A	Radiation treatment delivery	0.00	5.99	5.85	NA	NA	0.01	XXX
77412		A	Radiation treatment delivery	0.00	7.09	6.90	NA	NA	0.01	XXX
77413		A	Radiation treatment delivery	0.00	7.11	6.94	NA	NA	0.01	XXX
77414		A	Radiation treatment delivery	0.00	8.01	7.77	NA	NA	0.01	XXX
77416		A	Radiation treatment delivery	0.00	8.05	7.80	NA	NA	0.01	XXX
77417		A	Radiology port film(s)	0.00	0.38	0.44	NA	NA	0.01	XXX
77418		A	Radiation tx delivery, imrt	0.00	13.68	15.38	NA	NA	0.01	XXX
77421		A	Stereoscopic x-ray guidance	0.39	2.54	2.86	NA	NA	0.02	XXX
77421	TC	A	Stereoscopic x-ray guidance	0.00	2.35	2.68	NA	NA	0.01	XXX
77421	26	A	Stereoscopic x-ray guidance	0.39	0.19	0.18	0.19	0.18	0.01	XXX
77422		A	Neutron beam tx, simple	0.00	5.50	5.90	NA	NA	0.01	XXX
77423		A	Neutron beam tx, complex	0.00	7.77	7.52	NA	NA	0.01	XXX

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77427		A	Radiation tx management, x5	3.70	2.02	1.83	2.02	1.83	0.31	XXX
77431		A	Radiation therapy management	1.81	1.08	1.01	1.08	1.01	0.14	XXX
77432		A	Stereotactic radiation trmt	7.92	3.97	3.66	3.97	3.66	0.68	XXX
77435		A	Sbrt management	13.00	6.67	6.21	6.67	6.21	1.12	XXX
77470		A	Special radiation treatment	2.09	2.33	3.81	NA	NA	0.11	XXX
77470	TC	A	Special radiation treatment	0.00	1.29	2.86	NA	NA	0.01	XXX
77470	26	A	Special radiation treatment	2.09	1.04	0.95	1.04	0.95	0.10	XXX
77499		C	Radiation therapy management	0.00	0.00	0.00	NA	NA	0.00	XXX
77499	TC	C	Radiation therapy management	0.00	0.00	0.00	NA	NA	0.00	XXX
77499	26	C	Radiation therapy management	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77520		C	Proton trmt, simple w/o comp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77522		C	Proton trmt, simple w/comp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77523		C	Proton trmt, intermediate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77525		C	Proton treatment, complex	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77600		R	Hyperthermia treatment	1.56	10.84	10.50	NA	NA	0.10	XXX
77600	TC	R	Hyperthermia treatment	0.00	10.05	9.78	NA	NA	0.03	XXX
77600	26	R	Hyperthermia treatment	1.56	0.79	0.72	0.79	0.72	0.07	XXX
77605		R	Hyperthermia treatment	2.09	29.52	24.33	NA	NA	0.43	XXX
77605	TC	R	Hyperthermia treatment	0.00	28.62	23.52	NA	NA	0.03	XXX
77605	26	R	Hyperthermia treatment	2.09	0.90	0.81	0.90	0.81	0.40	XXX
77610		R	Hyperthermia treatment	1.56	18.12	18.24	NA	NA	0.10	XXX
77610	TC	R	Hyperthermia treatment	0.00	17.35	17.57	NA	NA	0.03	XXX
77610	26	R	Hyperthermia treatment	1.56	0.77	0.67	0.77	0.67	0.07	XXX
77615		R	Hyperthermia treatment	2.09	27.27	26.70	NA	NA	0.17	XXX
77615	TC	R	Hyperthermia treatment	0.00	26.22	25.75	NA	NA	0.07	XXX
77615	26	R	Hyperthermia treatment	2.09	1.05	0.95	1.05	0.95	0.10	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
77620		R	Hyperthermia treatment	1.56	13.94	12.29	NA	NA	0.08	XXX
77620	TC	R	Hyperthermia treatment	0.00	13.27	11.68	NA	NA	0.04	XXX
77620	26	R	Hyperthermia treatment	1.56	0.67	0.61	0.67	0.61	0.04	XXX
77750		A	Infuse radioactive materials	5.00	5.51	5.25	NA	NA	0.30	090
77750	TC	A	Infuse radioactive materials	0.00	3.04	3.00	NA	NA	0.03	090
77750	26	A	Infuse radioactive materials	5.00	2.47	2.25	2.47	2.25	0.27	090
77761		A	Apply intrcav radiat simple	3.85	7.05	6.90	NA	NA	0.25	090
77761	TC	A	Apply intrcav radiat simple	0.00	5.17	5.20	NA	NA	0.04	090
77761	26	A	Apply intrcav radiat simple	3.85	1.88	1.70	1.88	1.70	0.21	090
77762		A	Apply intrcav radiat interm	5.76	8.78	8.65	NA	NA	0.37	090
77762	TC	A	Apply intrcav radiat interm	0.00	5.97	6.07	NA	NA	0.06	090
77762	26	A	Apply intrcav radiat interm	5.76	2.81	2.58	2.81	2.58	0.31	090
77763		A	Apply intrcav radiat compl	8.66	11.99	11.74	NA	NA	0.52	090
77763	TC	A	Apply intrcav radiat compl	0.00	7.76	7.86	NA	NA	0.07	090
77763	26	A	Apply intrcav radiat compl	8.66	4.23	3.88	4.23	3.88	0.45	090
77776		A	Apply interstit radiat simpl	4.70	7.61	7.57	NA	NA	0.38	090
77776	TC	A	Apply interstit radiat simpl	0.00	5.24	5.44	NA	NA	0.06	090
77776	26	A	Apply interstit radiat simpl	4.70	2.37	2.13	2.37	2.13	0.32	090
77777		A	Apply interstit radiat inter	7.52	9.25	9.33	NA	NA	0.57	090
77777	TC	A	Apply interstit radiat inter	0.00	5.62	5.91	NA	NA	0.06	090
77777	26	A	Apply interstit radiat inter	7.52	3.63	3.42	3.63	3.42	0.51	090
77778		A	Apply interstit radiat compl	11.32	13.39	13.14	NA	NA	0.70	090
77778	TC	A	Apply interstit radiat compl	0.00	7.87	8.06	NA	NA	0.08	090
77778	26	A	Apply interstit radiat compl	11.32	5.52	5.08	5.52	5.08	0.62	090
77785		A	Hdr brachytx, 1 channel	1.42	5.81	5.05	NA	NA	0.10	XXX
77785	TC	A	Hdr brachytx, 1 channel	0.00	5.11	4.40	NA	NA	0.03	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
77785	26	A	Hdr brachytx, 1 channel	1.42	0.70	0.65	0.70	0.65	0.07	XXX
77786		A	Hdr brachytx, 2-12 channel	3.25	12.94	13.55	NA	NA	0.23	XXX
77786	TC	A	Hdr brachytx, 2-12 channel	0.00	11.32	12.11	NA	NA	0.06	XXX
77786	26	A	Hdr brachytx, 2-12 channel	3.25	1.62	1.44	1.62	1.44	0.17	XXX
77787		A	Hdr brachytx over 12 chan	4.89	22.87	21.94	NA	NA	0.35	XXX
77787	TC	A	Hdr brachytx over 12 chan	0.00	20.42	19.68	NA	NA	0.08	XXX
77787	26	A	Hdr brachytx over 12 chan	4.89	2.45	2.26	2.45	2.26	0.27	XXX
77789		A	Apply surface radiation	1.14	2.23	2.12	NA	NA	0.07	000
77789	TC	A	Apply surface radiation	0.00	1.64	1.59	NA	NA	0.01	000
77789	26	A	Apply surface radiation	1.14	0.59	0.53	0.59	0.53	0.06	000
77790		A	Radiation handling	1.05	1.68	1.62	NA	NA	0.05	XXX
77790	TC	A	Radiation handling	0.00	1.17	1.15	NA	NA	0.01	XXX
77790	26	A	Radiation handling	1.05	0.51	0.47	0.51	0.47	0.04	XXX
77799		C	Radium/radioisotope therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
77799	TC	C	Radium/radioisotope therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
77799	26	C	Radium/radioisotope therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78000		A	Thyroid, single uptake	0.19	1.73	1.85	NA	NA	0.02	XXX
78000	TC	A	Thyroid, single uptake	0.00	1.67	1.78	NA	NA	0.01	XXX
78000	26	A	Thyroid, single uptake	0.19	0.06	0.07	0.06	0.07	0.01	XXX
78001		A	Thyroid, multiple uptakes	0.26	2.22	2.35	NA	NA	0.04	XXX
78001	TC	A	Thyroid, multiple uptakes	0.00	2.13	2.25	NA	NA	0.03	XXX
78001	26	A	Thyroid, multiple uptakes	0.26	0.09	0.10	0.09	0.10	0.01	XXX
78003		A	Thyroid suppress/stimul	0.33	1.85	1.95	NA	NA	0.02	XXX
78003	TC	A	Thyroid suppress/stimul	0.00	1.73	1.82	NA	NA	0.01	XXX
78003	26	A	Thyroid suppress/stimul	0.33	0.12	0.13	0.12	0.13	0.01	XXX
78006		A	Thyroid imaging with uptake	0.49	6.04	6.20	NA	NA	0.06	XXX

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78006	TC	A	Thyroid imaging with uptake	0.00	5.88	6.01	NA	NA	0.03	XXX
78006	26	A	Thyroid imaging with uptake	0.49	0.16	0.19	0.16	0.19	0.03	XXX
78007		A	Thyroid image, mult uptakes	0.50	6.41	5.01	NA	NA	0.06	XXX
78007	TC	A	Thyroid image, mult uptakes	0.00	6.24	4.81	NA	NA	0.03	XXX
78007	26	A	Thyroid image, mult uptakes	0.50	0.17	0.20	0.17	0.20	0.03	XXX
78010		A	Thyroid imaging	0.39	4.15	4.25	NA	NA	0.04	XXX
78010	TC	A	Thyroid imaging	0.00	4.02	4.10	NA	NA	0.03	XXX
78010	26	A	Thyroid imaging	0.39	0.13	0.15	0.13	0.15	0.01	XXX
78011		A	Thyroid imaging with flow	0.45	4.40	4.66	NA	NA	0.06	XXX
78011	TC	A	Thyroid imaging with flow	0.00	4.24	4.48	NA	NA	0.03	XXX
78011	26	A	Thyroid imaging with flow	0.45	0.16	0.18	0.16	0.18	0.03	XXX
78015		A	Thyroid met imaging	0.67	5.20	5.45	NA	NA	0.07	XXX
78015	TC	A	Thyroid met imaging	0.00	4.99	5.20	NA	NA	0.03	XXX
78015	26	A	Thyroid met imaging	0.67	0.21	0.25	0.21	0.25	0.04	XXX
78016		A	Thyroid met imaging/studies	0.82	6.95	7.94	NA	NA	0.06	XXX
78016	TC	A	Thyroid met imaging/studies	0.00	6.81	7.69	NA	NA	0.03	XXX
78016	26	A	Thyroid met imaging/studies	0.82	0.14	0.25	0.14	0.25	0.03	XXX
78018		A	Thyroid met imaging, body	0.86	7.57	8.22	NA	NA	0.07	XXX
78018	TC	A	Thyroid met imaging, body	0.00	7.31	7.90	NA	NA	0.03	XXX
78018	26	A	Thyroid met imaging, body	0.86	0.26	0.32	0.26	0.32	0.04	XXX
78020		A	Thyroid met uptake	0.60	1.60	1.86	NA	NA	0.04	ZZZ
78020	TC	A	Thyroid met uptake	0.00	1.44	1.64	NA	NA	0.01	ZZZ
78020	26	A	Thyroid met uptake	0.60	0.16	0.22	0.16	0.22	0.03	ZZZ
78070		A	Parathyroid nuclear imaging	0.82	3.24	3.88	NA	NA	0.07	XXX
78070	TC	A	Parathyroid nuclear imaging	0.00	2.98	3.56	NA	NA	0.03	XXX
78070	26	A	Parathyroid nuclear imaging	0.82	0.26	0.32	0.26	0.32	0.04	XXX

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78075		A	Adrenal nuclear imaging	0.74	10.74	11.42	NA	NA	0.08	XXX
78075	TC	A	Adrenal nuclear imaging	0.00	10.53	11.14	NA	NA	0.04	XXX
78075	26	A	Adrenal nuclear imaging	0.74	0.21	0.28	0.21	0.28	0.04	XXX
78099		C	Endocrine nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
78099	TC	C	Endocrine nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
78099	26	C	Endocrine nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78102		A	Bone marrow imaging, ltd	0.55	3.90	4.18	NA	NA	0.06	XXX
78102	TC	A	Bone marrow imaging, ltd	0.00	3.74	3.97	NA	NA	0.03	XXX
78102	26	A	Bone marrow imaging, ltd	0.55	0.16	0.21	0.16	0.21	0.03	XXX
78103		A	Bone marrow imaging, mult	0.75	5.03	5.49	NA	NA	0.07	XXX
78103	TC	A	Bone marrow imaging, mult	0.00	4.82	5.22	NA	NA	0.03	XXX
78103	26	A	Bone marrow imaging, mult	0.75	0.21	0.27	0.21	0.27	0.04	XXX
78104		A	Bone marrow imaging, body	0.80	5.73	6.30	NA	NA	0.07	XXX
78104	TC	A	Bone marrow imaging, body	0.00	5.49	6.00	NA	NA	0.03	XXX
78104	26	A	Bone marrow imaging, body	0.80	0.24	0.30	0.24	0.30	0.04	XXX
78110		A	Plasma volume, single	0.19	2.09	2.15	NA	NA	0.04	XXX
78110	TC	A	Plasma volume, single	0.00	2.02	2.07	NA	NA	0.03	XXX
78110	26	A	Plasma volume, single	0.19	0.07	0.08	0.07	0.08	0.01	XXX
78111		A	Plasma volume, multiple	0.22	1.77	2.29	NA	NA	0.04	XXX
78111	TC	A	Plasma volume, multiple	0.00	1.73	2.21	NA	NA	0.03	XXX
78111	26	A	Plasma volume, multiple	0.22	0.04	0.08	0.04	0.08	0.01	XXX
78120		A	Red cell mass, single	0.23	2.02	2.24	NA	NA	0.04	XXX
78120	TC	A	Red cell mass, single	0.00	1.94	2.15	NA	NA	0.03	XXX
78120	26	A	Red cell mass, single	0.23	0.08	0.09	0.08	0.09	0.01	XXX
78121		A	Red cell mass, multiple	0.32	2.13	2.53	NA	NA	0.04	XXX
78121	TC	A	Red cell mass, multiple	0.00	2.02	2.40	NA	NA	0.03	XXX

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78121	26	A	Red cell mass, multiple	0.32	0.11	0.13	0.11	0.13	0.01	XXX
78122		A	Blood volume	0.45	2.01	2.75	NA	NA	0.04	XXX
78122	TC	A	Blood volume	0.00	1.88	2.59	NA	NA	0.03	XXX
78122	26	A	Blood volume	0.45	0.13	0.16	0.13	0.16	0.01	XXX
78130		A	Red cell survival study	0.61	3.41	3.76	NA	NA	0.08	XXX
78130	TC	A	Red cell survival study	0.00	3.19	3.51	NA	NA	0.04	XXX
78130	26	A	Red cell survival study	0.61	0.22	0.25	0.22	0.25	0.04	XXX
78135		A	Red cell survival kinetics	0.64	8.87	9.15	NA	NA	0.07	XXX
78135	TC	A	Red cell survival kinetics	0.00	8.64	8.89	NA	NA	0.03	XXX
78135	26	A	Red cell survival kinetics	0.64	0.23	0.26	0.23	0.26	0.04	XXX
78140		A	Red cell sequestration	0.61	2.76	3.32	NA	NA	0.07	XXX
78140	TC	A	Red cell sequestration	0.00	2.55	3.08	NA	NA	0.03	XXX
78140	26	A	Red cell sequestration	0.61	0.21	0.24	0.21	0.24	0.04	XXX
78185		A	Spleen imaging	0.40	5.16	5.31	NA	NA	0.04	XXX
78185	TC	A	Spleen imaging	0.00	5.02	5.15	NA	NA	0.03	XXX
78185	26	A	Spleen imaging	0.40	0.14	0.16	0.14	0.16	0.01	XXX
78190		A	Platelet survival, kinetics	1.09	9.16	9.73	NA	NA	0.07	XXX
78190	TC	A	Platelet survival, kinetics	0.00	8.75	9.30	NA	NA	0.03	XXX
78190	26	A	Platelet survival, kinetics	1.09	0.41	0.43	0.41	0.43	0.04	XXX
78191		A	Platelet survival	0.61	3.43	4.41	NA	NA	0.08	XXX
78191	TC	A	Platelet survival	0.00	3.21	4.17	NA	NA	0.04	XXX
78191	26	A	Platelet survival	0.61	0.22	0.24	0.22	0.24	0.04	XXX
78195		A	Lymph system imaging	1.20	8.47	8.82	NA	NA	0.10	XXX
78195	TC	A	Lymph system imaging	0.00	8.08	8.36	NA	NA	0.03	XXX
78195	26	A	Lymph system imaging	1.20	0.39	0.46	0.39	0.46	0.07	XXX
78199		C	Blood/lymph nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
78199	TC	C	Blood/lymph nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78199	26	C	Blood/lymph nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78201		A	Liver imaging	0.44	4.72	4.83	NA	NA	0.07	XXX
78201	TC	A	Liver imaging	0.00	4.58	4.67	NA	NA	0.03	XXX
78201	26	A	Liver imaging	0.44	0.14	0.16	0.14	0.16	0.04	XXX
78202		A	Liver imaging with flow	0.51	4.84	5.28	NA	NA	0.04	XXX
78202	TC	A	Liver imaging with flow	0.00	4.71	5.10	NA	NA	0.03	XXX
78202	26	A	Liver imaging with flow	0.51	0.13	0.18	0.13	0.18	0.01	XXX
78205		A	Liver imaging (3D)	0.71	4.94	5.77	NA	NA	0.07	XXX
78205	TC	A	Liver imaging (3D)	0.00	4.73	5.50	NA	NA	0.03	XXX
78205	26	A	Liver imaging (3D)	0.71	0.21	0.27	0.21	0.27	0.04	XXX
78206		A	Liver image (3d) with flow	0.96	8.34	8.97	NA	NA	0.07	XXX
78206	TC	A	Liver image (3d) with flow	0.00	8.04	8.60	NA	NA	0.03	XXX
78206	26	A	Liver image (3d) with flow	0.96	0.30	0.37	0.30	0.37	0.04	XXX
78215		A	Liver and spleen imaging	0.49	4.65	4.96	NA	NA	0.06	XXX
78215	TC	A	Liver and spleen imaging	0.00	4.49	4.77	NA	NA	0.03	XXX
78215	26	A	Liver and spleen imaging	0.49	0.16	0.19	0.16	0.19	0.03	XXX
78216		A	Liver & spleen image/flow	0.57	2.61	3.13	NA	NA	0.06	XXX
78216	TC	A	Liver & spleen image/flow	0.00	2.43	2.92	NA	NA	0.03	XXX
78216	26	A	Liver & spleen image/flow	0.57	0.18	0.21	0.18	0.21	0.03	XXX
78220		A	Liver function study	0.49	2.86	3.41	NA	NA	0.04	XXX
78220	TC	A	Liver function study	0.00	2.71	3.22	NA	NA	0.03	XXX
78220	26	A	Liver function study	0.49	0.15	0.19	0.15	0.19	0.01	XXX
78223		A	Hepatobiliary imaging	0.84	8.32	8.57	NA	NA	0.07	XXX
78223	TC	A	Hepatobiliary imaging	0.00	8.04	8.24	NA	NA	0.03	XXX
78223	26	A	Hepatobiliary imaging	0.84	0.28	0.33	0.28	0.33	0.04	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
78230		A	Salivary gland imaging	0.45	4.07	4.24	NA	NA	0.06	XXX
78230	TC	A	Salivary gland imaging	0.00	3.91	4.07	NA	NA	0.03	XXX
78230	26	A	Salivary gland imaging	0.45	0.16	0.17	0.16	0.17	0.03	XXX
78231		A	Serial salivary imaging	0.52	2.71	3.13	NA	NA	0.04	XXX
78231	TC	A	Serial salivary imaging	0.00	2.53	2.93	NA	NA	0.03	XXX
78231	26	A	Serial salivary imaging	0.52	0.18	0.20	0.18	0.20	0.01	XXX
78232		A	Salivary gland function exam	0.47	2.08	2.88	NA	NA	0.06	XXX
78232	TC	A	Salivary gland function exam	0.00	2.00	2.73	NA	NA	0.03	XXX
78232	26	A	Salivary gland function exam	0.47	0.08	0.15	0.08	0.15	0.03	XXX
78258		A	Esophageal motility study	0.74	5.45	5.76	NA	NA	0.06	XXX
78258	TC	A	Esophageal motility study	0.00	5.20	5.46	NA	NA	0.03	XXX
78258	26	A	Esophageal motility study	0.74	0.25	0.30	0.25	0.30	0.03	XXX
78261		A	Gastric mucosa imaging	0.69	5.99	6.40	NA	NA	0.07	XXX
78261	TC	A	Gastric mucosa imaging	0.00	5.75	6.12	NA	NA	0.03	XXX
78261	26	A	Gastric mucosa imaging	0.69	0.24	0.28	0.24	0.28	0.04	XXX
78262		A	Gastroesophageal reflux exam	0.68	5.92	6.32	NA	NA	0.04	XXX
78262	TC	A	Gastroesophageal reflux exam	0.00	5.70	6.06	NA	NA	0.03	XXX
78262	26	A	Gastroesophageal reflux exam	0.68	0.22	0.26	0.22	0.26	0.01	XXX
78264		A	Gastric emptying study	0.78	6.95	7.34	NA	NA	0.07	XXX
78264	TC	A	Gastric emptying study	0.00	6.69	7.04	NA	NA	0.03	XXX
78264	26	A	Gastric emptying study	0.78	0.26	0.30	0.26	0.30	0.04	XXX
78267		X	Breath tst attain/anal c-14	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78268		X	Breath test analysis, c-14	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78270		A	Vit B-12 absorption exam	0.20	1.98	2.12	NA	NA	0.02	XXX
78270	TC	A	Vit B-12 absorption exam	0.00	1.91	2.04	NA	NA	0.01	XXX
78270	26	A	Vit B-12 absorption exam	0.20	0.07	0.08	0.07	0.08	0.01	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
78271		A	Vit b-12 absrp exam, int fac	0.20	2.25	2.26	NA	NA	0.02	XXX
78271	TC	A	Vit b-12 absrp exam, int fac	0.00	2.16	2.18	NA	NA	0.01	XXX
78271	26	A	Vit b-12 absrp exam, int fac	0.20	0.09	0.08	0.09	0.08	0.01	XXX
78272		A	Vit B-12 absorp, combined	0.27	2.10	2.31	NA	NA	0.04	XXX
78272	TC	A	Vit B-12 absorp, combined	0.00	2.00	2.21	NA	NA	0.03	XXX
78272	26	A	Vit B-12 absorp, combined	0.27	0.10	0.10	0.10	0.10	0.01	XXX
78278		A	Acute GI blood loss imaging	0.99	8.37	8.83	NA	NA	0.09	XXX
78278	TC	A	Acute GI blood loss imaging	0.00	8.05	8.45	NA	NA	0.03	XXX
78278	26	A	Acute GI blood loss imaging	0.99	0.32	0.38	0.32	0.38	0.06	XXX
78282		C	GI protein loss exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78282	TC	C	GI protein loss exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78282	26	A	GI protein loss exam	0.38	0.13	0.15	0.13	0.15	0.03	XXX
78290		A	Meckels divert exam	0.68	8.28	8.45	NA	NA	0.07	XXX
78290	TC	A	Meckels divert exam	0.00	8.06	8.18	NA	NA	0.03	XXX
78290	26	A	Meckels divert exam	0.68	0.22	0.27	0.22	0.27	0.04	XXX
78291		A	Leveen/shunt patency exam	0.88	6.01	6.30	NA	NA	0.09	XXX
78291	TC	A	Leveen/shunt patency exam	0.00	5.73	5.96	NA	NA	0.03	XXX
78291	26	A	Leveen/shunt patency exam	0.88	0.28	0.34	0.28	0.34	0.06	XXX
78299		C	GI nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
78299	TC	C	GI nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
78299	26	C	GI nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78300		A	Bone imaging, limited area	0.62	4.16	4.38	NA	NA	0.06	XXX
78300	TC	A	Bone imaging, limited area	0.00	3.94	4.13	NA	NA	0.03	XXX
78300	26	A	Bone imaging, limited area	0.62	0.22	0.25	0.22	0.25	0.03	XXX
78305		A	Bone imaging, multiple areas	0.83	5.47	5.78	NA	NA	0.07	XXX
78305	TC	A	Bone imaging, multiple areas	0.00	5.19	5.46	NA	NA	0.03	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
78305	26	A	Bone imaging, multiple areas	0.83	0.28	0.32	0.28	0.32	0.04	XXX
78306		A	Bone imaging, whole body	0.86	5.86	6.34	NA	NA	0.07	XXX
78306	TC	A	Bone imaging, whole body	0.00	5.58	6.01	NA	NA	0.03	XXX
78306	26	A	Bone imaging, whole body	0.86	0.28	0.33	0.28	0.33	0.04	XXX
78315		A	Bone imaging, 3 phase	1.02	8.33	8.80	NA	NA	0.09	XXX
78315	TC	A	Bone imaging, 3 phase	0.00	8.00	8.41	NA	NA	0.03	XXX
78315	26	A	Bone imaging, 3 phase	1.02	0.33	0.39	0.33	0.39	0.06	XXX
78320		A	Bone imaging (3D)	1.04	5.09	5.91	NA	NA	0.09	XXX
78320	TC	A	Bone imaging (3D)	0.00	4.77	5.52	NA	NA	0.03	XXX
78320	26	A	Bone imaging (3D)	1.04	0.32	0.39	0.32	0.39	0.06	XXX
78350		N	Bone mineral, single photon	0.22	0.67	0.72	NA	NA	0.02	XXX
78350	TC	N	Bone mineral, single photon	0.00	0.57	0.63	NA	NA	0.01	XXX
78350	26	N	Bone mineral, single photon	0.22	0.10	0.09	0.10	0.09	0.01	XXX
78351		N	Bone mineral, dual photon	0.30	0.13	0.13	0.13	0.13	0.01	XXX
78399		C	Musculoskeletal nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78399	TC	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78399	26	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78414		C	Non-imaging heart function	0.00	0.00	0.00	NA	NA	0.00	XXX
78414	TC	C	Non-imaging heart function	0.00	0.00	0.00	NA	NA	0.00	XXX
78414	26	A	Non-imaging heart function	0.45	0.20	0.18	0.20	0.18	0.03	XXX
78428		A	Cardiac shunt imaging	0.78	4.28	4.79	NA	NA	0.06	XXX
78428	TC	A	Cardiac shunt imaging	0.00	4.01	4.45	NA	NA	0.03	XXX
78428	26	A	Cardiac shunt imaging	0.78	0.27	0.34	0.27	0.34	0.03	XXX
78445		A	Vascular flow imaging	0.49	4.14	4.39	NA	NA	0.04	XXX
78445	TC	A	Vascular flow imaging	0.00	3.99	4.21	NA	NA	0.03	XXX
78445	26	A	Vascular flow imaging	0.49	0.15	0.18	0.15	0.18	0.01	XXX

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78451		A	Ht muscle image spect, sing	1.38	8.42	8.42	NA	NA	0.09	XXX
78451	TC	A	Ht muscle image spect, sing	0.00	7.91	7.91	NA	NA	0.03	XXX
78451	26	A	Ht muscle image spect, sing	1.38	0.51	0.51	0.51	0.51	0.06	XXX
78452		A	Ht muscle image spect, mult	1.62	12.17	12.17	NA	NA	0.10	XXX
78452	TC	A	Ht muscle image spect, mult	0.00	11.55	11.55	NA	NA	0.04	XXX
78452	26	A	Ht muscle image spect, mult	1.62	0.62	0.62	0.62	0.62	0.06	XXX
78453		A	Ht muscle image,planar,sing	1.00	7.28	7.28	NA	NA	0.09	XXX
78453	TC	A	Ht muscle image,planar,sing	0.00	6.93	6.93	NA	NA	0.03	XXX
78453	26	A	Ht muscle image,planar,sing	1.00	0.35	0.35	0.35	0.35	0.06	XXX
78454		A	Ht musc image, planar, mult	1.34	10.57	10.57	NA	NA	0.10	XXX
78454	TC	A	Ht musc image, planar, mult	0.00	10.10	10.10	NA	NA	0.04	XXX
78454	26	A	Ht musc image, planar, mult	1.34	0.47	0.47	0.47	0.47	0.06	XXX
78456		A	Acute venous thrombus image	1.00	8.42	9.12	NA	NA	0.06	XXX
78456	TC	A	Acute venous thrombus image	0.00	8.07	8.67	NA	NA	0.03	XXX
78456	26	A	Acute venous thrombus image	1.00	0.35	0.45	0.35	0.45	0.03	XXX
78457		A	Venous thrombosis imaging	0.77	4.59	4.83	NA	NA	0.07	XXX
78457	TC	A	Venous thrombosis imaging	0.00	4.32	4.53	NA	NA	0.03	XXX
78457	26	A	Venous thrombosis imaging	0.77	0.27	0.30	0.27	0.30	0.04	XXX
78458		A	Ven thrombosis images, bilat	0.90	3.93	4.69	NA	NA	0.09	XXX
78458	TC	A	Ven thrombosis images, bilat	0.00	3.73	4.39	NA	NA	0.03	XXX
78458	26	A	Ven thrombosis images, bilat	0.90	0.20	0.30	0.20	0.30	0.06	XXX
78459		C	Heart muscle imaging (PET)	0.00	0.00	0.00	NA	NA	0.00	XXX
78459	TC	C	Heart muscle imaging (PET)	0.00	0.00	0.00	NA	NA	0.00	XXX
78459	26	A	Heart muscle imaging (PET)	1.50	0.43	0.61	0.43	0.61	0.10	XXX
78466		A	Heart infarct image	0.69	4.07	4.48	NA	NA	0.06	XXX
78466	TC	A	Heart infarct image	0.00	3.82	4.18	NA	NA	0.03	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
78466	26	A	Heart infarct image	0.69	0.25	0.30	0.25	0.30	0.03	XXX
78468		A	Heart infarct image (ef)	0.80	4.80	5.52	NA	NA	0.06	XXX
78468	TC	A	Heart infarct image (ef)	0.00	4.49	5.14	NA	NA	0.03	XXX
78468	26	A	Heart infarct image (ef)	0.80	0.31	0.38	0.31	0.38	0.03	XXX
78469		A	Heart infarct image (3D)	0.92	5.92	6.48	NA	NA	0.06	XXX
78469	TC	A	Heart infarct image (3D)	0.00	5.53	6.04	NA	NA	0.03	XXX
78469	26	A	Heart infarct image (3D)	0.92	0.39	0.44	0.39	0.44	0.03	XXX
78472		A	Gated heart, planar, single	0.98	5.38	6.24	NA	NA	0.07	XXX
78472	TC	A	Gated heart, planar, single	0.00	5.04	5.82	NA	NA	0.03	XXX
78472	26	A	Gated heart, planar, single	0.98	0.34	0.42	0.34	0.42	0.04	XXX
78473		A	Gated heart, multiple	1.47	6.72	8.11	NA	NA	0.09	XXX
78473	TC	A	Gated heart, multiple	0.00	6.18	7.45	NA	NA	0.03	XXX
78473	26	A	Gated heart, multiple	1.47	0.54	0.66	0.54	0.66	0.06	XXX
78481		A	Heart first pass, single	0.98	4.15	5.10	NA	NA	0.04	XXX
78481	TC	A	Heart first pass, single	0.00	3.77	4.63	NA	NA	0.01	XXX
78481	26	A	Heart first pass, single	0.98	0.38	0.47	0.38	0.47	0.03	XXX
78483		A	Heart first pass, multiple	1.47	5.48	6.95	NA	NA	0.09	XXX
78483	TC	A	Heart first pass, multiple	0.00	4.91	6.23	NA	NA	0.03	XXX
78483	26	A	Heart first pass, multiple	1.47	0.57	0.72	0.57	0.72	0.06	XXX
78491		C	Heart image (pet), single	0.00	0.00	0.00	NA	NA	0.00	XXX
78491	TC	C	Heart image (pet), single	0.00	0.00	0.00	NA	NA	0.00	XXX
78491	26	A	Heart image (pet), single	1.50	0.48	0.64	0.48	0.64	0.10	XXX
78492		C	Heart image (pet), multiple	0.00	0.00	0.00	NA	NA	0.00	XXX
78492	TC	C	Heart image (pet), multiple	0.00	0.00	0.00	NA	NA	0.00	XXX
78492	26	A	Heart image (pet), multiple	1.87	0.64	0.84	0.64	0.84	0.13	XXX
78494		A	Heart image, spect	1.19	5.48	6.53	NA	NA	0.07	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
78494	TC	A	Heart image, spect	0.00	5.01	5.99	NA	NA	0.03	XXX
78494	26	A	Heart image, spect	1.19	0.47	0.54	0.47	0.54	0.04	XXX
78496		A	Heart first pass add-on	0.50	0.73	1.84	NA	NA	0.02	ZZZ
78496	TC	A	Heart first pass add-on	0.00	0.54	1.61	NA	NA	0.01	ZZZ
78496	26	A	Heart first pass add-on	0.50	0.19	0.23	0.19	0.23	0.01	ZZZ
78499		C	Cardiovascular nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78499	TC	C	Cardiovascular nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78499	26	C	Cardiovascular nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78580		A	Lung perfusion imaging	0.74	4.91	5.31	NA	NA	0.06	XXX
78580	TC	A	Lung perfusion imaging	0.00	4.67	5.02	NA	NA	0.03	XXX
78580	26	A	Lung perfusion imaging	0.74	0.24	0.29	0.24	0.29	0.03	XXX
78584		A	Lung V/Q image single breath	0.99	2.87	3.32	NA	NA	0.09	XXX
78584	TC	A	Lung V/Q image single breath	0.00	2.53	2.93	NA	NA	0.03	XXX
78584	26	A	Lung V/Q image single breath	0.99	0.34	0.39	0.34	0.39	0.06	XXX
78585		A	Lung V/Q imaging	1.09	8.36	8.96	NA	NA	0.09	XXX
78585	TC	A	Lung V/Q imaging	0.00	8.01	8.54	NA	NA	0.03	XXX
78585	26	A	Lung V/Q imaging	1.09	0.35	0.42	0.35	0.42	0.06	XXX
78586		A	Aerosol lung image, single	0.40	4.12	4.33	NA	NA	0.04	XXX
78586	TC	A	Aerosol lung image, single	0.00	3.98	4.17	NA	NA	0.03	XXX
78586	26	A	Aerosol lung image, single	0.40	0.14	0.16	0.14	0.16	0.01	XXX
78587		A	Aerosol lung image, multiple	0.49	5.12	5.45	NA	NA	0.06	XXX
78587	TC	A	Aerosol lung image, multiple	0.00	4.97	5.26	NA	NA	0.03	XXX
78587	26	A	Aerosol lung image, multiple	0.49	0.15	0.19	0.15	0.19	0.03	XXX
78588		A	Perfusion lung image	1.09	8.44	8.66	NA	NA	0.09	XXX
78588	TC	A	Perfusion lung image	0.00	8.08	8.23	NA	NA	0.03	XXX
78588	26	A	Perfusion lung image	1.09	0.36	0.43	0.36	0.43	0.06	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
78591		A	Vent image, 1 breath, 1 proj	0.40	4.15	4.39	NA	NA	0.04	XXX
78591	TC	A	Vent image, 1 breath, 1 proj	0.00	4.01	4.23	NA	NA	0.03	XXX
78591	26	A	Vent image, 1 breath, 1 proj	0.40	0.14	0.16	0.14	0.16	0.01	XXX
78593		A	Vent image, 1 proj, gas	0.49	4.73	5.07	NA	NA	0.06	XXX
78593	TC	A	Vent image, 1 proj, gas	0.00	4.57	4.88	NA	NA	0.03	XXX
78593	26	A	Vent image, 1 proj, gas	0.49	0.16	0.19	0.16	0.19	0.03	XXX
78594		A	Vent image, mult proj, gas	0.53	4.93	5.63	NA	NA	0.06	XXX
78594	TC	A	Vent image, mult proj, gas	0.00	4.78	5.44	NA	NA	0.03	XXX
78594	26	A	Vent image, mult proj, gas	0.53	0.15	0.19	0.15	0.19	0.03	XXX
78596		A	Lung differential function	1.27	8.66	9.39	NA	NA	0.07	XXX
78596	TC	A	Lung differential function	0.00	8.25	8.92	NA	NA	0.03	XXX
78596	26	A	Lung differential function	1.27	0.41	0.47	0.41	0.47	0.04	XXX
78599		C	Respiratory nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78599	TC	C	Respiratory nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78599	26	C	Respiratory nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78600		A	Brain image < 4 views	0.44	4.35	4.66	NA	NA	0.04	XXX
78600	TC	A	Brain image < 4 views	0.00	4.20	4.48	NA	NA	0.03	XXX
78600	26	A	Brain image < 4 views	0.44	0.15	0.18	0.15	0.18	0.01	XXX
78601		A	Brain image w/flow < 4 views	0.51	5.18	5.55	NA	NA	0.06	XXX
78601	TC	A	Brain image w/flow < 4 views	0.00	5.02	5.35	NA	NA	0.03	XXX
78601	26	A	Brain image w/flow < 4 views	0.51	0.16	0.20	0.16	0.20	0.03	XXX
78605		A	Brain image 4+ views	0.53	4.66	5.06	NA	NA	0.06	XXX
78605	TC	A	Brain image 4+ views	0.00	4.48	4.84	NA	NA	0.03	XXX
78605	26	A	Brain image 4+ views	0.53	0.18	0.22	0.18	0.22	0.03	XXX
78606		A	Brain image w/flow 4 + views	0.64	8.35	8.59	NA	NA	0.04	XXX
78606	TC	A	Brain image w/flow 4 + views	0.00	8.14	8.34	NA	NA	0.03	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
78606	26	A	Brain image w/flow 4 + views	0.64	0.21	0.25	0.21	0.25	0.01	XXX
78607		A	Brain imaging (3D)	1.23	8.34	9.14	NA	NA	0.09	XXX
78607	TC	A	Brain imaging (3D)	0.00	7.97	8.68	NA	NA	0.03	XXX
78607	26	A	Brain imaging (3D)	1.23	0.37	0.46	0.37	0.46	0.06	XXX
78608		C	Brain imaging (PET)	0.00	0.00	0.00	NA	NA	0.00	XXX
78608	TC	C	Brain imaging (PET)	0.00	0.00	0.00	NA	NA	0.00	XXX
78608	26	A	Brain imaging (PET)	1.50	0.45	0.56	0.45	0.56	0.11	XXX
78609		N	Brain imaging (PET)	1.50	0.65	0.62	NA	NA	0.10	XXX
78609	TC	N	Brain imaging (PET)	0.00	0.00	0.00	NA	NA	0.00	XXX
78609	26	N	Brain imaging (PET)	1.50	0.65	0.62	0.65	0.62	0.10	XXX
78610		A	Brain flow imaging only	0.30	4.28	4.75	NA	NA	0.04	XXX
78610	TC	A	Brain flow imaging only	0.00	4.18	4.62	NA	NA	0.03	XXX
78610	26	A	Brain flow imaging only	0.30	0.10	0.13	0.10	0.13	0.01	XXX
78630		A	Cerebrospinal fluid scan	0.68	8.45	8.90	NA	NA	0.06	XXX
78630	TC	A	Cerebrospinal fluid scan	0.00	8.22	8.63	NA	NA	0.03	XXX
78630	26	A	Cerebrospinal fluid scan	0.68	0.23	0.27	0.23	0.27	0.03	XXX
78635		A	CSF ventriculography	0.61	8.43	8.52	NA	NA	0.04	XXX
78635	TC	A	CSF ventriculography	0.00	8.22	8.27	NA	NA	0.03	XXX
78635	26	A	CSF ventriculography	0.61	0.21	0.25	0.21	0.25	0.01	XXX
78645		A	CSF shunt evaluation	0.57	8.15	8.44	NA	NA	0.06	XXX
78645	TC	A	CSF shunt evaluation	0.00	7.97	8.22	NA	NA	0.03	XXX
78645	26	A	CSF shunt evaluation	0.57	0.18	0.22	0.18	0.22	0.03	XXX
78647		A	Cerebrospinal fluid scan	0.90	8.43	9.01	NA	NA	0.09	XXX
78647	TC	A	Cerebrospinal fluid scan	0.00	8.16	8.68	NA	NA	0.03	XXX
78647	26	A	Cerebrospinal fluid scan	0.90	0.27	0.33	0.27	0.33	0.06	XXX
78650		A	CSF leakage imaging	0.61	8.34	8.77	NA	NA	0.07	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
78650	TC	A	CSF leakage imaging	0.00	8.15	8.54	NA	NA	0.03	XXX
78650	26	A	CSF leakage imaging	0.61	0.19	0.23	0.19	0.23	0.04	XXX
78660		A	Nuclear exam of tear flow	0.53	4.49	4.52	NA	NA	0.06	XXX
78660	TC	A	Nuclear exam of tear flow	0.00	4.28	4.29	NA	NA	0.03	XXX
78660	26	A	Nuclear exam of tear flow	0.53	0.21	0.23	0.21	0.23	0.03	XXX
78699		C	Nervous system nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78699	TC	C	Nervous system nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78699	26	C	Nervous system nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78700		A	Kidney imaging, morphol	0.45	4.24	4.56	NA	NA	0.06	XXX
78700	TC	A	Kidney imaging, morphol	0.00	4.08	4.38	NA	NA	0.03	XXX
78700	26	A	Kidney imaging, morphol	0.45	0.16	0.18	0.16	0.18	0.03	XXX
78701		A	Kidney imaging with flow	0.49	5.19	5.56	NA	NA	0.06	XXX
78701	TC	A	Kidney imaging with flow	0.00	5.03	5.37	NA	NA	0.03	XXX
78701	26	A	Kidney imaging with flow	0.49	0.16	0.19	0.16	0.19	0.03	XXX
78707		A	K flow/funct image w/o drug	0.96	5.22	5.81	NA	NA	0.07	XXX
78707	TC	A	K flow/funct image w/o drug	0.00	4.92	5.44	NA	NA	0.03	XXX
78707	26	A	K flow/funct image w/o drug	0.96	0.30	0.37	0.30	0.37	0.04	XXX
78708		A	K flow/funct image w/drug	1.21	3.20	3.91	NA	NA	0.09	XXX
78708	TC	A	K flow/funct image w/drug	0.00	2.82	3.44	NA	NA	0.03	XXX
78708	26	A	K flow/funct image w/drug	1.21	0.38	0.47	0.38	0.47	0.06	XXX
78709		A	K flow/funct image, multiple	1.41	8.55	9.03	NA	NA	0.10	XXX
78709	TC	A	K flow/funct image, multiple	0.00	8.10	8.49	NA	NA	0.03	XXX
78709	26	A	K flow/funct image, multiple	1.41	0.45	0.54	0.45	0.54	0.07	XXX
78710		A	Kidney imaging (3D)	0.66	4.84	5.71	NA	NA	0.04	XXX
78710	TC	A	Kidney imaging (3D)	0.00	4.65	5.47	NA	NA	0.03	XXX
78710	26	A	Kidney imaging (3D)	0.66	0.19	0.24	0.19	0.24	0.01	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
78725		A	Kidney function study	0.38	2.38	2.52	NA	NA	0.04	XXX
78725	TC	A	Kidney function study	0.00	2.25	2.38	NA	NA	0.03	XXX
78725	26	A	Kidney function study	0.38	0.13	0.14	0.13	0.14	0.01	XXX
78730		A	Urinary bladder retention	0.15	1.77	2.00	NA	NA	0.02	ZZZ
78730	TC	A	Urinary bladder retention	0.00	1.71	1.92	NA	NA	0.01	ZZZ
78730	26	A	Urinary bladder retention	0.15	0.06	0.08	0.06	0.08	0.01	ZZZ
78740		A	Ureteral reflux study	0.57	5.72	5.77	NA	NA	0.06	XXX
78740	TC	A	Ureteral reflux study	0.00	5.50	5.53	NA	NA	0.03	XXX
78740	26	A	Ureteral reflux study	0.57	0.22	0.24	0.22	0.24	0.03	XXX
78761		A	Testicular imaging w/flow	0.71	5.09	5.36	NA	NA	0.07	XXX
78761	TC	A	Testicular imaging w/flow	0.00	4.83	5.07	NA	NA	0.03	XXX
78761	26	A	Testicular imaging w/flow	0.71	0.26	0.29	0.26	0.29	0.04	XXX
78799		C	Genitourinary nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78799	TC	C	Genitourinary nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78799	26	C	Genitourinary nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78800		A	Tumor imaging, limited area	0.66	4.34	4.65	NA	NA	0.07	XXX
78800	TC	A	Tumor imaging, limited area	0.00	4.11	4.40	NA	NA	0.03	XXX
78800	26	A	Tumor imaging, limited area	0.66	0.23	0.25	0.23	0.25	0.04	XXX
78801		A	Tumor imaging, mult areas	0.79	6.03	6.41	NA	NA	0.07	XXX
78801	TC	A	Tumor imaging, mult areas	0.00	5.75	6.10	NA	NA	0.03	XXX
78801	26	A	Tumor imaging, mult areas	0.79	0.28	0.31	0.28	0.31	0.04	XXX
78802		A	Tumor imaging, whole body	0.86	7.81	8.46	NA	NA	0.07	XXX
78802	TC	A	Tumor imaging, whole body	0.00	7.54	8.13	NA	NA	0.03	XXX
78802	26	A	Tumor imaging, whole body	0.86	0.27	0.33	0.27	0.33	0.04	XXX
78803		A	Tumor imaging (3D)	1.09	8.03	8.93	NA	NA	0.09	XXX
78803	TC	A	Tumor imaging (3D)	0.00	7.72	8.53	NA	NA	0.03	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
78803	26	A	Tumor imaging (3D)	1.09	0.31	0.40	0.31	0.40	0.06	XXX
78804		A	Tumor imaging, whole body	1.07	14.18	15.50	NA	NA	0.12	XXX
78804	TC	A	Tumor imaging, whole body	0.00	13.86	15.09	NA	NA	0.06	XXX
78804	26	A	Tumor imaging, whole body	1.07	0.32	0.41	0.32	0.41	0.06	XXX
78805		A	Abscess imaging, ltd area	0.73	4.11	4.51	NA	NA	0.07	XXX
78805	TC	A	Abscess imaging, ltd area	0.00	3.87	4.23	NA	NA	0.03	XXX
78805	26	A	Abscess imaging, ltd area	0.73	0.24	0.28	0.24	0.28	0.04	XXX
78806		A	Abscess imaging, whole body	0.86	8.01	8.77	NA	NA	0.07	XXX
78806	TC	A	Abscess imaging, whole body	0.00	7.74	8.45	NA	NA	0.03	XXX
78806	26	A	Abscess imaging, whole body	0.86	0.27	0.32	0.27	0.32	0.04	XXX
78807		A	Nuclear localization/abscess	1.09	8.01	8.94	NA	NA	0.07	XXX
78807	TC	A	Nuclear localization/abscess	0.00	7.71	8.54	NA	NA	0.03	XXX
78807	26	A	Nuclear localization/abscess	1.09	0.30	0.40	0.30	0.40	0.04	XXX
78808		A	Iv inj ra drug dx study	0.18	0.85	1.03	NA	NA	0.03	XXX
78811		C	Pet image, ltd area	0.00	0.00	0.00	NA	NA	0.00	XXX
78811	TC	C	Pet image, ltd area	0.00	0.00	0.00	NA	NA	0.00	XXX
78811	26	A	Pet image, ltd area	1.54	0.51	0.60	0.51	0.60	0.18	XXX
78812		C	Pet image, skull-thigh	0.00	0.00	0.00	NA	NA	0.00	XXX
78812	TC	C	Pet image, skull-thigh	0.00	0.00	0.00	NA	NA	0.00	XXX
78812	26	A	Pet image, skull-thigh	1.93	0.62	0.75	0.62	0.75	0.17	XXX
78813		C	Pet image, full body	0.00	0.00	0.00	NA	NA	0.00	XXX
78813	TC	C	Pet image, full body	0.00	0.00	0.00	NA	NA	0.00	XXX
78813	26	A	Pet image, full body	2.00	0.67	0.79	0.67	0.79	0.18	XXX
78814		C	Pet image w/ct, lmtd	0.00	0.00	0.00	NA	NA	0.00	XXX
78814	TC	C	Pet image w/ct, lmtd	0.00	0.00	0.00	NA	NA	0.00	XXX
78814	26	A	Pet image w/ct, lmtd	2.20	0.68	0.84	0.68	0.84	0.21	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
78815		C	Pet image w/ct, skull-thigh	0.00	0.00	0.00	NA	NA	0.00	XXX
78815	TC	C	Pet image w/ct, skull-thigh	0.00	0.00	0.00	NA	NA	0.00	XXX
78815	26	A	Pet image w/ct, skull-thigh	2.44	0.78	0.94	0.78	0.94	0.23	XXX
78816		C	Pet image w/ct, full body	0.00	0.00	0.00	NA	NA	0.00	XXX
78816	TC	C	Pet image w/ct, full body	0.00	0.00	0.00	NA	NA	0.00	XXX
78816	26	A	Pet image w/ct, full body	2.50	0.75	0.94	0.75	0.94	0.23	XXX
78999		C	Nuclear diagnostic exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78999	TC	C	Nuclear diagnostic exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78999	26	C	Nuclear diagnostic exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79005		A	Nuclear rx, oral admin	1.80	1.85	2.27	NA	NA	0.08	XXX
79005	TC	A	Nuclear rx, oral admin	0.00	1.22	1.57	NA	NA	0.01	XXX
79005	26	A	Nuclear rx, oral admin	1.80	0.63	0.70	0.63	0.70	0.07	XXX
79101		A	Nuclear rx, iv admin	1.96	2.21	2.67	NA	NA	0.08	XXX
79101	TC	A	Nuclear rx, iv admin	0.00	1.32	1.71	NA	NA	0.01	XXX
79101	26	A	Nuclear rx, iv admin	1.96	0.89	0.96	0.89	0.96	0.07	XXX
79200		A	Nuclear rx, intracav admin	1.99	2.30	2.73	NA	NA	0.12	XXX
79200	TC	A	Nuclear rx, intracav admin	0.00	1.59	1.93	NA	NA	0.01	XXX
79200	26	A	Nuclear rx, intracav admin	1.99	0.71	0.80	0.71	0.80	0.11	XXX
79300		C	Nuclr rx, interstit colloid	0.00	0.00	0.00	NA	NA	0.00	XXX
79300	TC	C	Nuclr rx, interstit colloid	0.00	0.00	0.00	NA	NA	0.00	XXX
79300	26	A	Nuclr rx, interstit colloid	1.60	0.57	0.63	0.57	0.63	0.14	XXX
79403		A	Hematopoietic nuclear tx	2.25	2.91	3.61	NA	NA	0.14	XXX
79403	TC	A	Hematopoietic nuclear tx	0.00	2.08	2.67	NA	NA	0.03	XXX
79403	26	A	Hematopoietic nuclear tx	2.25	0.83	0.94	0.83	0.94	0.11	XXX
79440		A	Nuclear rx, intra-articular	1.99	2.32	2.53	NA	NA	0.07	XXX
79440	TC	A	Nuclear rx, intra-articular	0.00	1.42	1.63	NA	NA	0.01	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
79440	26	A	Nuclear rx, intra-articular	1.99	0.90	0.90	0.90	0.90	0.06	XXX
79445		C	Nuclear rx, intra-arterial	0.00	0.00	0.00	NA	NA	0.00	XXX
79445	TC	C	Nuclear rx, intra-arterial	0.00	0.00	0.00	NA	NA	0.00	XXX
79445	26	A	Nuclear rx, intra-arterial	2.40	0.75	0.92	0.75	0.92	0.21	XXX
79999		C	Nuclear medicine therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
79999	TC	C	Nuclear medicine therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
79999	26	C	Nuclear medicine therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
80500		A	Lab pathology consultation	0.37	0.18	0.20	0.12	0.13	0.03	XXX
80502		A	Lab pathology consultation	1.33	0.44	0.47	0.39	0.42	0.07	XXX
83020	26	A	Hemoglobin electrophoresis	0.37	0.17	0.17	0.17	0.17	0.03	XXX
83912	26	A	Genetic examination	0.37	0.15	0.14	0.15	0.14	0.03	XXX
84165	26	A	Protein e-phoresis, serum	0.37	0.17	0.16	0.17	0.16	0.03	XXX
84166	26	A	Protein e-phoresis/urine/csf	0.37	0.17	0.16	0.17	0.16	0.03	XXX
84181	26	A	Western blot test	0.37	0.17	0.16	0.17	0.16	0.03	XXX
84182	26	A	Protein, western blot test	0.37	0.16	0.16	0.16	0.16	0.03	XXX
85060		A	Blood smear interpretation	0.45	0.21	0.20	0.21	0.20	0.03	XXX
85097		A	Bone marrow interpretation	0.94	1.31	1.50	0.38	0.37	0.06	XXX
85390	26	A	Fibrinolysins screen	0.37	0.18	0.17	0.18	0.17	0.03	XXX
85396		A	Clotting assay, whole blood	0.37	NA	NA	0.16	0.15	0.03	XXX
85576	26	A	Blood platelet aggregation	0.37	0.17	0.17	0.17	0.17	0.03	XXX
86077		A	Physician blood bank service	0.94	0.52	0.49	0.43	0.41	0.06	XXX
86078		A	Physician blood bank service	0.94	0.53	0.50	0.44	0.41	0.06	XXX
86079		A	Physician blood bank service	0.94	0.52	0.51	0.43	0.41	0.06	XXX
86255	26	A	Fluorescent antibody, screen	0.37	0.17	0.16	0.17	0.16	0.03	XXX
86256	26	A	Fluorescent antibody, titer	0.37	0.17	0.16	0.17	0.16	0.01	XXX
86320	26	A	Serum immunoelectrophoresis	0.37	0.17	0.16	0.17	0.16	0.01	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
86325	26	A	Other immunoelectrophoresis	0.37	0.17	0.16	0.17	0.16	0.01	XXX
86327	26	A	Immunoelectrophoresis assay	0.42	0.20	0.19	0.20	0.19	0.03	XXX
86334	26	A	Immunofix e-phoresis, serum	0.37	0.17	0.16	0.17	0.16	0.03	XXX
86335	26	A	Immunfix e-phorsis/urine/csf	0.37	0.17	0.16	0.17	0.16	0.03	XXX
86485		C	Skin test, candida	0.00	0.00	0.00	0.00	0.00	0.00	XXX
86486		A	Skin test, nos antigen	0.00	0.12	0.13	NA	NA	0.01	XXX
86490		A	Coccidioidomycosis skin test	0.00	0.16	0.18	NA	NA	0.01	XXX
86510		A	Histoplasmosis skin test	0.00	0.16	0.18	NA	NA	0.01	XXX
86580		A	TB intradermal test	0.00	0.20	0.21	NA	NA	0.01	XXX
87164	26	A	Dark field examination	0.37	0.17	0.16	0.17	0.16	0.03	XXX
87207	26	A	Smear, special stain	0.37	0.18	0.17	0.18	0.17	0.03	XXX
88104		A	Cytopath fl nongyn, smears	0.56	1.31	1.31	NA	NA	0.02	XXX
88104	TC	A	Cytopath fl nongyn, smears	0.00	1.07	1.08	NA	NA	0.01	XXX
88104	26	A	Cytopath fl nongyn, smears	0.56	0.24	0.23	0.24	0.23	0.01	XXX
88106		A	Cytopath fl nongyn, filter	0.56	1.66	1.73	NA	NA	0.02	XXX
88106	TC	A	Cytopath fl nongyn, filter	0.00	1.43	1.50	NA	NA	0.01	XXX
88106	26	A	Cytopath fl nongyn, filter	0.56	0.23	0.23	0.23	0.23	0.01	XXX
88107		A	Cytopath fl nongyn, sm/fltr	0.76	1.98	2.09	NA	NA	0.04	XXX
88107	TC	A	Cytopath fl nongyn, sm/fltr	0.00	1.66	1.77	NA	NA	0.01	XXX
88107	26	A	Cytopath fl nongyn, sm/fltr	0.76	0.32	0.32	0.32	0.32	0.03	XXX
88108		A	Cytopath, concentrate tech	0.56	1.52	1.59	NA	NA	0.02	XXX
88108	TC	A	Cytopath, concentrate tech	0.00	1.30	1.37	NA	NA	0.01	XXX
88108	26	A	Cytopath, concentrate tech	0.56	0.22	0.22	0.22	0.22	0.01	XXX
88112		A	Cytopath, cell enhance tech	1.18	1.61	1.75	NA	NA	0.05	XXX
88112	TC	A	Cytopath, cell enhance tech	0.00	1.17	1.32	NA	NA	0.01	XXX
88112	26	A	Cytopath, cell enhance tech	1.18	0.44	0.43	0.44	0.43	0.04	XXX

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88125		A	Forensic cytopathology	0.26	0.35	0.36	NA	NA	0.02	XXX
88125	TC	A	Forensic cytopathology	0.00	0.23	0.25	NA	NA	0.01	XXX
88125	26	A	Forensic cytopathology	0.26	0.12	0.11	0.12	0.11	0.01	XXX
88141		A	Cytopath, c/v, interpret	0.42	0.40	0.39	0.40	0.39	0.03	XXX
88160		A	Cytopath smear, other source	0.50	1.04	1.05	NA	NA	0.02	XXX
88160	TC	A	Cytopath smear, other source	0.00	0.83	0.85	NA	NA	0.01	XXX
88160	26	A	Cytopath smear, other source	0.50	0.21	0.20	0.21	0.20	0.01	XXX
88161		A	Cytopath smear, other source	0.50	0.97	1.05	NA	NA	0.02	XXX
88161	TC	A	Cytopath smear, other source	0.00	0.79	0.87	NA	NA	0.01	XXX
88161	26	A	Cytopath smear, other source	0.50	0.18	0.18	0.18	0.18	0.01	XXX
88162		A	Cytopath smear, other source	0.76	1.33	1.47	NA	NA	0.04	XXX
88162	TC	A	Cytopath smear, other source	0.00	1.05	1.18	NA	NA	0.01	XXX
88162	26	A	Cytopath smear, other source	0.76	0.28	0.29	0.28	0.29	0.03	XXX
88172		A	Cytopathology eval of fna	0.60	0.98	0.98	NA	NA	0.02	XXX
88172	TC	A	Cytopathology eval of fna	0.00	0.71	0.72	NA	NA	0.01	XXX
88172	26	A	Cytopathology eval of fna	0.60	0.27	0.26	0.27	0.26	0.01	XXX
88173		A	Cytopath eval, fna, report	1.39	2.44	2.54	NA	NA	0.05	XXX
88173	TC	A	Cytopath eval, fna, report	0.00	1.87	1.98	NA	NA	0.01	XXX
88173	26	A	Cytopath eval, fna, report	1.39	0.57	0.56	0.57	0.56	0.04	XXX
88182		A	Cell marker study	0.77	2.00	2.18	NA	NA	0.06	XXX
88182	TC	A	Cell marker study	0.00	1.80	1.97	NA	NA	0.03	XXX
88182	26	A	Cell marker study	0.77	0.20	0.21	0.20	0.21	0.03	XXX
88184		A	Flowcytometry/ tc, 1 marker	0.00	2.24	2.41	NA	NA	0.01	XXX
88185		A	Flowcytometry/tc, add-on	0.00	1.36	1.45	NA	NA	0.01	ZZZ
88187		A	Flowcytometry/read, 2-8	1.36	0.56	0.53	0.56	0.53	0.08	XXX
88188		A	Flowcytometry/read, 9-15	1.69	0.72	0.66	0.72	0.66	0.10	XXX

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88189		A	Flowcytometry/read, 16 & >	2.23	0.67	0.67	0.67	0.67	0.13	XXX
88199		C	Cytopathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
88199	TC	C	Cytopathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
88199	26	C	Cytopathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88291		A	Cyto/molecular report	0.52	0.29	0.30	0.29	0.30	0.03	XXX
88299		C	Cytogenetic study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88300		A	Surgical path, gross	0.08	0.62	0.64	NA	NA	0.02	XXX
88300	TC	A	Surgical path, gross	0.00	0.58	0.60	NA	NA	0.01	XXX
88300	26	A	Surgical path, gross	0.08	0.04	0.04	0.04	0.04	0.01	XXX
88302		A	Tissue exam by pathologist	0.13	1.34	1.38	NA	NA	0.02	XXX
88302	TC	A	Tissue exam by pathologist	0.00	1.28	1.33	NA	NA	0.01	XXX
88302	26	A	Tissue exam by pathologist	0.13	0.06	0.05	0.06	0.05	0.01	XXX
88304		A	Tissue exam by pathologist	0.22	1.56	1.66	NA	NA	0.02	XXX
88304	TC	A	Tissue exam by pathologist	0.00	1.47	1.57	NA	NA	0.01	XXX
88304	26	A	Tissue exam by pathologist	0.22	0.09	0.09	0.09	0.09	0.01	XXX
88305		A	Tissue exam by pathologist	0.75	2.16	2.32	NA	NA	0.02	XXX
88305	TC	A	Tissue exam by pathologist	0.00	1.86	2.02	NA	NA	0.01	XXX
88305	26	A	Tissue exam by pathologist	0.75	0.30	0.30	0.30	0.30	0.01	XXX
88307		A	Tissue exam by pathologist	1.59	4.87	4.87	NA	NA	0.05	XXX
88307	TC	A	Tissue exam by pathologist	0.00	4.16	4.19	NA	NA	0.01	XXX
88307	26	A	Tissue exam by pathologist	1.59	0.71	0.68	0.71	0.68	0.04	XXX
88309		A	Tissue exam by pathologist	2.80	7.05	6.98	NA	NA	0.11	XXX
88309	TC	A	Tissue exam by pathologist	0.00	5.79	5.81	NA	NA	0.03	XXX
88309	26	A	Tissue exam by pathologist	2.80	1.26	1.17	1.26	1.17	0.08	XXX
88311		A	Decalcify tissue	0.24	0.28	0.29	NA	NA	0.02	XXX
88311	TC	A	Decalcify tissue	0.00	0.18	0.19	NA	NA	0.01	XXX

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88311	26	A	Decalcify tissue	0.24	0.10	0.10	0.10	0.10	0.01	XXX
88312		A	Special stains group 1	0.54	2.44	2.51	NA	NA	0.02	XXX
88312	TC	A	Special stains group 1	0.00	2.23	2.30	NA	NA	0.01	XXX
88312	26	A	Special stains group 1	0.54	0.21	0.21	0.21	0.21	0.01	XXX
88313		A	Special stains group 2	0.24	1.89	1.98	NA	NA	0.02	XXX
88313	TC	A	Special stains group 2	0.00	1.80	1.89	NA	NA	0.01	XXX
88313	26	A	Special stains group 2	0.24	0.09	0.09	0.09	0.09	0.01	XXX
88314		A	Histochemical stain add-on	0.45	1.93	2.12	NA	NA	0.02	XXX
88314	TC	A	Histochemical stain add-on	0.00	1.73	1.93	NA	NA	0.01	XXX
88314	26	A	Histochemical stain add-on	0.45	0.20	0.19	0.20	0.19	0.01	XXX
88318		A	Chemical histochemistry	0.42	3.06	2.90	NA	NA	0.02	XXX
88318	TC	A	Chemical histochemistry	0.00	2.88	2.73	NA	NA	0.01	XXX
88318	26	A	Chemical histochemistry	0.42	0.18	0.17	0.18	0.17	0.01	XXX
88319		A	Enzyme histochemistry	0.53	3.41	3.63	NA	NA	0.04	XXX
88319	TC	A	Enzyme histochemistry	0.00	3.19	3.42	NA	NA	0.01	XXX
88319	26	A	Enzyme histochemistry	0.53	0.22	0.21	0.22	0.21	0.03	XXX
88321		A	Microslide consultation	1.63	0.92	0.91	0.68	0.64	0.10	XXX
88323		A	Microslide consultation	1.83	2.09	2.27	NA	NA	0.05	XXX
88323	TC	A	Microslide consultation	0.00	1.52	1.69	NA	NA	0.01	XXX
88323	26	A	Microslide consultation	1.83	0.57	0.58	0.57	0.58	0.04	XXX
88325		A	Comprehensive review of data	2.50	3.18	3.18	1.23	1.11	0.13	XXX
88329		A	Path consult introp	0.67	0.80	0.80	0.30	0.29	0.04	XXX
88331		A	Path consult intraop, 1 bloc	1.19	1.45	1.44	NA	NA	0.02	XXX
88331	TC	A	Path consult intraop, 1 bloc	0.00	0.89	0.91	NA	NA	0.01	XXX
88331	26	A	Path consult intraop, 1 bloc	1.19	0.56	0.53	0.56	0.53	0.01	XXX
88332		A	Path consult intraop, addl	0.59	0.57	0.56	NA	NA	0.02	XXX

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88332	TC	A	Path consult intraop, addl	0.00	0.30	0.31	NA	NA	0.01	XXX
88332	26	A	Path consult intraop, addl	0.59	0.27	0.25	0.27	0.25	0.01	XXX
88333		A	Intraop cyto path consult, 1	1.20	1.53	1.52	NA	NA	0.05	XXX
88333	TC	A	Intraop cyto path consult, 1	0.00	0.99	1.00	NA	NA	0.01	XXX
88333	26	A	Intraop cyto path consult, 1	1.20	0.54	0.52	0.54	0.52	0.04	XXX
88334		A	Intraop cyto path consult, 2	0.73	0.96	0.93	NA	NA	0.04	XXX
88334	TC	A	Intraop cyto path consult, 2	0.00	0.62	0.62	NA	NA	0.01	XXX
88334	26	A	Intraop cyto path consult, 2	0.73	0.34	0.31	0.34	0.31	0.03	XXX
88342		A	Immunohistochemistry	0.85	2.04	2.12	NA	NA	0.04	XXX
88342	TC	A	Immunohistochemistry	0.00	1.71	1.80	NA	NA	0.01	XXX
88342	26	A	Immunohistochemistry	0.85	0.33	0.32	0.33	0.32	0.03	XXX
88346		A	Immunofluorescent study	0.86	1.96	2.07	NA	NA	0.02	XXX
88346	TC	A	Immunofluorescent study	0.00	1.62	1.74	NA	NA	0.01	XXX
88346	26	A	Immunofluorescent study	0.86	0.34	0.33	0.34	0.33	0.01	XXX
88347		A	Immunofluorescent study	0.86	1.23	1.37	NA	NA	0.02	XXX
88347	TC	A	Immunofluorescent study	0.00	1.00	1.12	NA	NA	0.01	XXX
88347	26	A	Immunofluorescent study	0.86	0.23	0.25	0.23	0.25	0.01	XXX
88348		A	Electron microscopy	1.51	17.26	17.95	NA	NA	0.12	XXX
88348	TC	A	Electron microscopy	0.00	16.68	17.37	NA	NA	0.08	XXX
88348	26	A	Electron microscopy	1.51	0.58	0.58	0.58	0.58	0.04	XXX
88349		A	Scanning electron microscopy	0.76	10.10	9.46	NA	NA	0.07	XXX
88349	TC	A	Scanning electron microscopy	0.00	9.74	9.12	NA	NA	0.04	XXX
88349	26	A	Scanning electron microscopy	0.76	0.36	0.34	0.36	0.34	0.03	XXX
88355		A	Analysis, skeletal muscle	1.85	3.13	4.30	NA	NA	0.07	XXX
88355	TC	A	Analysis, skeletal muscle	0.00	2.61	3.75	NA	NA	0.01	XXX
88355	26	A	Analysis, skeletal muscle	1.85	0.52	0.55	0.52	0.55	0.06	XXX

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88356		A	Analysis, nerve	3.02	4.37	5.03	NA	NA	0.18	XXX
88356	TC	A	Analysis, nerve	0.00	3.83	4.35	NA	NA	0.04	XXX
88356	26	A	Analysis, nerve	3.02	0.54	0.68	0.54	0.68	0.14	XXX
88358		A	Analysis, tumor	0.95	1.12	1.18	NA	NA	0.04	XXX
88358	TC	A	Analysis, tumor	0.00	0.89	0.93	NA	NA	0.01	XXX
88358	26	A	Analysis, tumor	0.95	0.23	0.25	0.23	0.25	0.03	XXX
88360		A	Tumor immunohistochem/manual	1.10	2.32	2.43	NA	NA	0.04	XXX
88360	TC	A	Tumor immunohistochem/manual	0.00	1.92	2.03	NA	NA	0.01	XXX
88360	26	A	Tumor immunohistochem/manual	1.10	0.40	0.40	0.40	0.40	0.03	XXX
88361		A	Tumor immunohistochem/comput	1.18	2.92	3.16	NA	NA	0.05	XXX
88361	TC	A	Tumor immunohistochem/comput	0.00	2.50	2.75	NA	NA	0.01	XXX
88361	26	A	Tumor immunohistochem/comput	1.18	0.42	0.41	0.42	0.41	0.04	XXX
88362		A	Nerve teasing preparations	2.17	5.84	5.85	NA	NA	0.14	XXX
88362	TC	A	Nerve teasing preparations	0.00	4.94	4.99	NA	NA	0.04	XXX
88362	26	A	Nerve teasing preparations	2.17	0.90	0.86	0.90	0.86	0.10	XXX
88365		A	Insitu hybridization (fish)	1.20	3.44	3.55	NA	NA	0.04	XXX
88365	TC	A	Insitu hybridization (fish)	0.00	3.00	3.11	NA	NA	0.01	XXX
88365	26	A	Insitu hybridization (fish)	1.20	0.44	0.44	0.44	0.44	0.03	XXX
88367		A	Insitu hybridization, auto	1.30	5.90	6.06	NA	NA	0.07	XXX
88367	TC	A	Insitu hybridization, auto	0.00	5.47	5.63	NA	NA	0.01	XXX
88367	26	A	Insitu hybridization, auto	1.30	0.43	0.43	0.43	0.43	0.06	XXX
88368		A	Insitu hybridization, manual	1.40	4.69	4.92	NA	NA	0.05	XXX
88368	TC	A	Insitu hybridization, manual	0.00	4.35	4.54	NA	NA	0.01	XXX
88368	26	A	Insitu hybridization, manual	1.40	0.34	0.38	0.34	0.38	0.04	XXX
88371	26	A	Protein, western blot tissue	0.37	0.17	0.16	0.17	0.16	0.03	XXX
88372	26	A	Protein analysis w/probe	0.37	0.17	0.16	0.17	0.16	0.03	XXX

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88380		A	Microdissection, laser	1.56	2.52	3.47	NA	NA	0.05	XXX
88380	TC	A	Microdissection, laser	0.00	2.09	2.96	NA	NA	0.01	XXX
88380	26	A	Microdissection, laser	1.56	0.43	0.51	0.43	0.51	0.04	XXX
88381		A	Microdissection, manual	1.18	2.73	4.13	NA	NA	0.04	XXX
88381	TC	A	Microdissection, manual	0.00	2.49	3.78	NA	NA	0.01	XXX
88381	26	A	Microdissection, manual	1.18	0.24	0.35	0.24	0.35	0.03	XXX
88384		C	Eval molecular probes, 11-50	0.00	0.00	0.00	NA	NA	0.00	XXX
88384	TC	C	Eval molecular probes, 11-50	0.00	0.00	0.00	NA	NA	0.00	XXX
88384	26	C	Eval molecular probes, 11-50	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88385		A	Eval molecul probes, 51-250	1.50	14.78	15.06	NA	NA	0.07	XXX
88385	TC	A	Eval molecul probes, 51-250	0.00	14.42	14.68	NA	NA	0.03	XXX
88385	26	A	Eval molecul probes, 51-250	1.50	0.36	0.38	0.36	0.38	0.04	XXX
88386		A	Eval molecul probes, 251-500	1.88	13.57	16.61	NA	NA	0.09	XXX
88386	TC	A	Eval molecul probes, 251-500	0.00	13.24	16.01	NA	NA	0.03	XXX
88386	26	A	Eval molecul probes, 251-500	1.88	0.33	0.60	0.33	0.60	0.06	XXX
88387		A	Tiss exam molecular study	0.62	0.52	0.52	NA	NA	0.02	XXX
88387	TC	A	Tiss exam molecular study	0.00	0.24	0.24	NA	NA	0.01	XXX
88387	26	A	Tiss exam molecular study	0.62	0.28	0.28	0.28	0.28	0.01	XXX
88388		A	Tiss ex molecul study add-on	0.45	0.20	0.20	NA	NA	0.02	XXX
88388	TC	A	Tiss ex molecul study add-on	0.00	0.11	0.11	NA	NA	0.01	XXX
88388	26	A	Tiss ex molecul study add-on	0.45	0.09	0.09	0.09	0.09	0.01	XXX
88399		C	Surgical pathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
88399	TC	C	Surgical pathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
88399	26	C	Surgical pathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
89049		A	Chct for mal hyperthermia	1.40	5.63	5.87	0.38	0.44	0.10	XXX
89060	26	A	Exam,synovial fluid crystals	0.37	0.17	0.16	0.17	0.16	0.03	XXX

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89100		A	Sample intestinal contents	0.60	8.90	8.07	0.64	0.59	0.04	XXX
89105		A	Sample intestinal contents	0.50	7.79	7.68	0.51	0.49	0.03	XXX
89130		A	Sample stomach contents	0.45	7.19	6.79	0.46	0.42	0.03	XXX
89132		A	Sample stomach contents	0.19	7.26	7.46	0.34	0.35	0.01	XXX
89135		A	Sample stomach contents	0.79	8.70	8.57	0.71	0.71	0.06	XXX
89136		A	Sample stomach contents	0.21	7.23	6.84	0.35	0.33	0.01	XXX
89140		A	Sample stomach contents	0.94	7.70	7.19	0.67	0.61	0.06	XXX
89141		A	Sample stomach contents	0.85	8.21	7.64	0.67	0.62	0.06	XXX
89220		A	Sputum specimen collection	0.00	0.42	0.45	NA	NA	0.01	XXX
89230		A	Collect sweat for test	0.00	0.05	0.08	NA	NA	0.01	XXX
89240		C	Pathology lab procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90281		I	Human ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90283		I	Human ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90284		X	Human ig, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90287		I	Botulinum antitoxin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90288		I	Botulism ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90291		I	Cmv ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90296		E	Diphtheria antitoxin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90371		E	Hep b ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90375		E	Rabies ig, im/sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90376		E	Rabies ig, heat treated	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90378		X	Rsv, mab, im, 50mg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90384		I	Rh ig, full-dose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90385		E	Rh ig, minidose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90386		I	Rh ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90389		I	Tetanus ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
90393		E	Vaccina ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90396		E	Varicella-zoster ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90399		I	Immune globulin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90465		A	Immune admin 1 inj, < 8 yrs	0.17	0.49	0.49	NA	NA	0.01	XXX
90466		A	Immune admin addl inj, < 8 y	0.15	0.24	0.20	0.07	0.07	0.01	ZZZ
90467		R	Immune admin o or n, < 8 yrs	0.17	0.49	0.49	NA	NA	0.01	XXX
90468		R	Immune admin o/n, addl < 8 y	0.15	0.19	0.18	0.07	0.07	0.01	ZZZ
90470		I	Immune admin H1N1 im/nasal	0.20	0.39	0.39	NA	NA	0.01	XXX
90471		A	Immunization admin	0.17	0.49	0.49	NA	NA	0.01	XXX
90472		A	Immunization admin, each add	0.15	0.19	0.18	0.07	0.07	0.01	ZZZ
90473		R	Immune admin oral/nasal	0.17	0.49	0.49	NA	NA	0.01	XXX
90474		R	Immune admin oral/nasal addl	0.15	0.19	0.18	0.07	0.07	0.01	ZZZ
90476		E	Adenovirus vaccine, type 4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90477		E	Adenovirus vaccine, type 7	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90581		E	Anthrax vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90585		E	Bcg vaccine, percut	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90586		E	Bcg vaccine, intravesical	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90632		E	Hep a vaccine, adult im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90633		E	Hep a vacc, ped/adol, 2 dose	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90634		E	Hep a vacc, ped/adol, 3 dose	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90636		E	Hep a/hep b vacc, adult im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90644		X	HIB/men/tt vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90645		E	Hib vaccine, hboc, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90646		E	Hib vaccine, prp-d, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90647		E	Hib vaccine, prp-omp, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90648		E	Hib vaccine, prp-t, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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90649		E	Hpv vaccine 4 valent, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90650		E	Hpv vaccine 2 valent, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90655		X	Flu vaccine no preserv 6-35m	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90656		X	Flu vaccine no preserv 3 & >	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90657		X	Flu vaccine, 3 yrs, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90658		X	Flu vaccine, 3 yrs & >, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90660		X	Flu vaccine, nasal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90661		X	Flu vacc cell cult prsv free	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90662		X	Flu vacc prsv free inc antig	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90663		X	Flu vacc pandemic H1N1	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90665		E	Lyme disease vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90669		X	Pneumococcal vacc, 7 val im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90670		X	Pneumococcal vacc, 13 val im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90675		E	Rabies vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90676		E	Rabies vaccine, id	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90680		E	Rotovirus vacc 3 dose, oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90681		E	Rotavirus vacc 2 dose oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90690		E	Typhoid vaccine, oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90691		E	Typhoid vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90692		E	Typhoid vaccine, h-p, sc/id	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90693		E	Typhoid vaccine, akd, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90696		E	Dtap-ipv vacc 4-6 yr im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90698		E	Dtap-hib-ip vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90700		E	Dtap vaccine, < 7 yrs, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90701		E	Dtp vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90702		E	Dt vaccine < 7, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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90703		E	Tetanus vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90704		E	Mumps vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90705		E	Measles vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90706		E	Rubella vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90707		E	Mmr vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90708		E	Measles-rubella vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90710		E	Mmrv vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90712		E	Oral poliovirus vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90713		E	Poliovirus, ipv, sc/im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90714		E	Td vaccine no prsrv >/= 7 im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90715		E	Tdap vaccine >7 im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90716		E	Chicken pox vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90717		E	Yellow fever vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90718		E	Td vaccine > 7, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90719		E	Diphtheria vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90720		E	Dtp/hib vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90721		E	Dtap/hib vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90723		I	Dtap-hep b-ipv vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90725		E	Cholera vaccine, injectable	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90727		E	Plague vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90732		X	Pneumococcal vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90733		E	Meningococcal vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90734		E	Meningococcal vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90735		E	Encephalitis vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90736		E	Zoster vacc, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90738		I	Inactivated je vacc im	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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90740		X	Hepb vacc, ill pat 3 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90743		X	Hep b vacc, adol, 2 dose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90744		X	Hepb vacc ped/adol 3 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90746		X	Hep b vaccine, adult, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90747		X	Hepb vacc, ill pat 4 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90748		I	Hep b/hib vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90749		E	Vaccine toxoid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90801		A	Psy dx interview	2.80	1.51	1.59	0.59	0.71	0.11	XXX
90802		A	Intac psy dx interview	3.01	1.78	1.76	0.76	0.83	0.13	XXX
90804		A	Psytx, office, 20-30 min	1.21	0.55	0.59	0.17	0.24	0.04	XXX
90805		A	Psytx, off, 20-30 min w/e&m	1.37	0.68	0.68	0.28	0.31	0.06	XXX
90806		A	Psytx, off, 45-50 min	1.86	0.45	0.57	0.24	0.36	0.07	XXX
90807		A	Psytx, off, 45-50 min w/e&m	2.02	0.81	0.83	0.41	0.46	0.08	XXX
90808		A	Psytx, office, 75-80 min	2.79	0.62	0.78	0.42	0.58	0.10	XXX
90809		A	Psytx, off, 75-80, w/e&m	2.95	1.00	1.04	0.63	0.70	0.13	XXX
90810		A	Intac psytx, off, 20-30 min	1.32	0.47	0.55	0.20	0.27	0.06	XXX
90811		A	Intac psytx, 20-30, w/e&m	1.48	0.84	0.82	0.31	0.35	0.07	XXX
90812		A	Intac psytx, off, 45-50 min	1.97	0.56	0.69	0.26	0.39	0.07	XXX
90813		A	Intac psytx, 45-50 min w/e&m	2.13	0.95	0.96	0.42	0.49	0.08	XXX
90814		A	Intac psytx, off, 75-80 min	2.90	0.73	0.93	0.36	0.60	0.11	XXX
90815		A	Intac psytx, 75-80 w/e&m	3.06	1.32	1.27	0.79	0.79	0.14	XXX
90816		A	Psytx, hosp, 20-30 min	1.25	0.26	0.34	0.26	0.34	0.04	XXX
90817		A	Psytx, hosp, 20-30 min w/e&m	1.41	0.40	0.43	0.40	0.43	0.06	XXX
90818		A	Psytx, hosp, 45-50 min	1.89	0.33	0.47	0.33	0.47	0.07	XXX
90819		A	Psytx, hosp, 45-50 min w/e&m	2.05	0.54	0.58	0.54	0.58	0.08	XXX
90821		A	Psytx, hosp, 75-80 min	2.83	0.47	0.66	0.47	0.66	0.10	XXX

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90822		A	Psytx, hosp, 75-80 min w/e&m	2.99	0.72	0.79	0.72	0.79	0.13	XXX
90823		A	Intac psytx, hosp, 20-30 min	1.36	0.28	0.37	0.28	0.37	0.04	XXX
90824		A	Intac psytx, hsp 20-30 w/e&m	1.52	0.42	0.46	0.42	0.46	0.07	XXX
90826		A	Intac psytx, hosp, 45-50 min	2.01	0.37	0.50	0.37	0.50	0.07	XXX
90827		A	Intac psytx, hsp 45-50 w/e&m	2.16	0.55	0.60	0.55	0.60	0.08	XXX
90828		A	Intac psytx, hosp, 75-80 min	2.94	0.50	0.69	0.50	0.69	0.10	XXX
90829		A	Intac psytx, hsp 75-80 w/e&m	3.10	0.73	0.81	0.73	0.81	0.13	XXX
90845		A	Psychoanalysis	1.79	0.42	0.47	0.34	0.41	0.07	XXX
90846		R	Family psytx w/o patient	1.83	0.48	0.57	0.39	0.49	0.07	XXX
90847		R	Family psytx w/patient	2.21	0.68	0.79	0.43	0.55	0.08	XXX
90849		R	Multiple family group psytx	0.59	0.38	0.37	0.22	0.24	0.03	XXX
90853		A	Group psychotherapy	0.59	0.32	0.32	0.24	0.25	0.03	XXX
90857		A	Intac group psytx	0.63	0.43	0.42	0.29	0.28	0.03	XXX
90862		A	Medication management	0.95	0.71	0.69	0.31	0.33	0.04	XXX
90865		A	Narcosynthesis	2.84	1.72	1.66	0.68	0.78	0.11	XXX
90870		A	Electroconvulsive therapy	1.88	2.20	2.22	0.44	0.48	0.08	000
90875		N	Psychophysiological therapy	1.20	0.82	0.85	0.52	0.51	0.08	XXX
90876		N	Psychophysiological therapy	1.90	1.11	1.13	0.82	0.81	0.13	XXX
90880		A	Hypnotherapy	2.19	0.51	0.68	0.36	0.47	0.08	XXX
90882		N	Environmental manipulation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90885		B	Psy evaluation of records	0.97	0.42	0.41	0.42	0.41	0.07	XXX
90887		B	Consultation with family	1.48	0.97	0.97	0.64	0.63	0.10	XXX
90889		B	Preparation of report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90899		C	Psychiatric service/therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90901		A	Biofeedback train, any meth	0.41	0.68	0.64	0.19	0.17	0.01	000
90911		A	Biofeedback peri/uro/rectal	0.89	1.45	1.58	0.37	0.38	0.07	000

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90935		A	Hemodialysis, one evaluation	1.22	NA	NA	0.69	0.70	0.07	000
90937		A	Hemodialysis, repeated eval	2.11	NA	NA	1.02	1.02	0.11	000
90940		X	Hemodialysis access study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90945		A	Dialysis, one evaluation	1.28	NA	NA	0.71	0.71	0.07	000
90947		A	Dialysis, repeated eval	2.16	NA	NA	1.03	1.03	0.13	000
90951		A	Esrd serv, 4 visits p mo, <2	18.46	7.75	8.45	7.75	8.45	1.06	XXX
90952		C	Esrd serv, 2-3 vsts p mo, <2	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90953		C	Esrd serv, 1 visit p mo, <2	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90954		A	Esrd serv, 4 vsts p mo, 2-11	15.98	6.63	6.52	6.63	6.52	0.93	XXX
90955		A	Esrd srv 2-3 vsts p mo, 2-11	8.79	3.90	3.93	3.90	3.93	0.51	XXX
90956		A	Esrd srv, 1 visit p mo, 2-11	5.95	2.85	2.78	2.85	2.78	0.35	XXX
90957		A	Esrd srv, 4 vsts p mo, 12-19	12.52	5.34	5.45	5.34	5.45	0.75	XXX
90958		A	Esrd srv 2-3 vsts p mo 12-19	8.34	3.79	3.84	3.79	3.84	0.49	XXX
90959		A	Esrd serv, 1 vst p mo, 12-19	5.50	2.71	2.62	2.71	2.62	0.32	XXX
90960		A	Esrd srv, 4 visits p mo, 20+	5.18	2.65	2.81	2.65	2.81	0.32	XXX
90961		A	Esrd srv, 2-3 vsts p mo, 20+	4.26	2.32	2.30	2.32	2.30	0.27	XXX
90962		A	Esrd serv, 1 visit p mo, 20+	3.15	1.92	1.74	1.92	1.74	0.21	XXX
90963		A	Esrd home pt, serv p mo, <2	10.56	4.55	4.77	4.55	4.77	0.62	XXX
90964		A	Esrd home pt serv p mo, 2-11	9.14	4.03	3.87	4.03	3.87	0.54	XXX
90965		A	Esrd home pt serv p mo 12-19	8.69	3.87	3.71	3.87	3.71	0.51	XXX
90966		A	Esrd home pt, serv p mo, 20+	4.26	2.31	2.26	2.31	2.26	0.27	XXX
90967		A	Esrd home pt serv p day, <2	0.35	0.15	0.18	0.15	0.18	0.01	XXX
90968		A	Esrd home pt srv p day, 2-11	0.30	0.13	0.13	0.13	0.13	0.01	XXX
90969		A	Esrd home pt srv p day 12-19	0.29	0.13	0.13	0.13	0.13	0.01	XXX
90970		A	Esrd home pt serv p day, 20+	0.14	0.08	0.08	0.08	0.08	0.01	XXX
90989		X	Dialysis training, complete	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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90993		X	Dialysis training, incompl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90997		A	Hemoperfusion	1.84	NA	NA	0.64	0.66	0.10	000
90999		C	Dialysis procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91000		A	Esophageal intubation	0.73	2.25	2.12	NA	NA	0.04	000
91000	TC	A	Esophageal intubation	0.00	1.96	1.83	NA	NA	0.01	000
91000	26	A	Esophageal intubation	0.73	0.29	0.29	0.29	0.29	0.03	000
91010		A	Esophagus motility study	1.25	3.80	4.16	NA	NA	0.08	000
91010	TC	A	Esophagus motility study	0.00	3.14	3.50	NA	NA	0.01	000
91010	26	A	Esophagus motility study	1.25	0.66	0.66	0.66	0.66	0.07	000
91011		A	Esophagus motility study	1.50	5.35	5.82	NA	NA	0.07	000
91011	TC	A	Esophagus motility study	0.00	4.53	4.99	NA	NA	0.01	000
91011	26	A	Esophagus motility study	1.50	0.82	0.83	0.82	0.83	0.06	000
91012		A	Esophagus motility study	1.46	5.42	5.94	NA	NA	0.07	000
91012	TC	A	Esophagus motility study	0.00	4.63	5.15	NA	NA	0.01	000
91012	26	A	Esophagus motility study	1.46	0.79	0.79	0.79	0.79	0.06	000
91020		A	Gastric motility studies	1.44	5.11	5.36	NA	NA	0.08	000
91020	TC	A	Gastric motility studies	0.00	4.34	4.61	NA	NA	0.01	000
91020	26	A	Gastric motility studies	1.44	0.77	0.75	0.77	0.75	0.07	000
91022		A	Duodenal motility study	1.44	3.38	3.83	NA	NA	0.07	000
91022	TC	A	Duodenal motility study	0.00	2.59	3.03	NA	NA	0.01	000
91022	26	A	Duodenal motility study	1.44	0.79	0.80	0.79	0.80	0.06	000
91030		A	Acid perfusion of esophagus	0.91	2.94	3.13	NA	NA	0.05	000
91030	TC	A	Acid perfusion of esophagus	0.00	2.44	2.63	NA	NA	0.01	000
91030	26	A	Acid perfusion of esophagus	0.91	0.50	0.50	0.50	0.50	0.04	000
91034		A	Gastroesophageal reflux test	0.97	4.27	4.71	NA	NA	0.05	000
91034	TC	A	Gastroesophageal reflux test	0.00	3.76	4.21	NA	NA	0.01	000

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
91034	26	A	Gastroesophageal reflux test	0.97	0.51	0.50	0.51	0.50	0.04	000
91035		A	G-esoph reflx tst w/electrod	1.59	11.71	12.43	NA	NA	0.08	000
91035	TC	A	G-esoph reflx tst w/electrod	0.00	10.87	11.59	NA	NA	0.01	000
91035	26	A	G-esoph reflx tst w/electrod	1.59	0.84	0.84	0.84	0.84	0.07	000
91037		A	Esoph imped function test	0.97	3.50	3.70	NA	NA	0.08	000
91037	TC	A	Esoph imped function test	0.00	2.99	3.18	NA	NA	0.01	000
91037	26	A	Esoph imped function test	0.97	0.51	0.52	0.51	0.52	0.07	000
91038		A	Esoph imped funct test > 1h	1.10	11.69	7.45	NA	NA	0.07	000
91038	TC	A	Esoph imped funct test > 1h	0.00	11.10	6.86	NA	NA	0.01	000
91038	26	A	Esoph imped funct test > 1h	1.10	0.59	0.59	0.59	0.59	0.06	000
91040		A	Esoph balloon distension tst	0.97	6.99	8.98	NA	NA	0.04	000
91040	TC	A	Esoph balloon distension tst	0.00	6.61	8.51	NA	NA	0.01	000
91040	26	A	Esoph balloon distension tst	0.97	0.38	0.47	0.38	0.47	0.03	000
91052		A	Gastric analysis test	0.79	2.96	2.98	NA	NA	0.02	000
91052	TC	A	Gastric analysis test	0.00	2.53	2.58	NA	NA	0.01	000
91052	26	A	Gastric analysis test	0.79	0.43	0.40	0.43	0.40	0.01	000
91055		A	Gastric intubation for smear	0.94	2.80	2.96	NA	NA	0.04	000
91055	TC	A	Gastric intubation for smear	0.00	2.38	2.57	NA	NA	0.01	000
91055	26	A	Gastric intubation for smear	0.94	0.42	0.39	0.42	0.39	0.03	000
91065		A	Breath hydrogen test	0.20	2.30	2.08	NA	NA	0.02	000
91065	TC	A	Breath hydrogen test	0.00	2.19	1.98	NA	NA	0.01	000
91065	26	A	Breath hydrogen test	0.20	0.11	0.10	0.11	0.10	0.01	000
91105		A	Gastric intubation treatment	0.37	2.25	2.17	0.10	0.09	0.03	000
91110		A	Gi tract capsule endoscopy	3.64	21.05	22.86	NA	NA	0.18	XXX
91110	TC	A	Gi tract capsule endoscopy	0.00	19.08	20.89	NA	NA	0.01	XXX
91110	26	A	Gi tract capsule endoscopy	3.64	1.97	1.97	1.97	1.97	0.17	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
91111		A	Esophageal capsule endoscopy	1.00	18.94	20.25	NA	NA	0.05	XXX
91111	TC	A	Esophageal capsule endoscopy	0.00	18.40	19.70	NA	NA	0.01	XXX
91111	26	A	Esophageal capsule endoscopy	1.00	0.54	0.55	0.54	0.55	0.04	XXX
91120		A	Rectal sensation test	0.97	8.85	10.08	NA	NA	0.09	XXX
91120	TC	A	Rectal sensation test	0.00	8.42	9.67	NA	NA	0.01	XXX
91120	26	A	Rectal sensation test	0.97	0.43	0.41	0.43	0.41	0.08	XXX
91122		A	Anal pressure record	1.77	4.35	4.77	NA	NA	0.11	000
91122	TC	A	Anal pressure record	0.00	3.58	4.01	NA	NA	0.01	000
91122	26	A	Anal pressure record	1.77	0.77	0.76	0.77	0.76	0.10	000
91123		B	Irrigate fecal impaction	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91132		C	Electrogastrography	0.00	0.00	0.00	NA	NA	0.00	XXX
91132	TC	C	Electrogastrography	0.00	0.00	0.00	NA	NA	0.00	XXX
91132	26	A	Electrogastrography	0.52	0.28	0.28	0.28	0.28	0.03	XXX
91133		C	Electrogastrography w/test	0.00	0.00	0.00	NA	NA	0.00	XXX
91133	TC	C	Electrogastrography w/test	0.00	0.00	0.00	NA	NA	0.00	XXX
91133	26	A	Electrogastrography w/test	0.66	0.36	0.37	0.36	0.37	0.04	XXX
91299		C	Gastroenterology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
91299	TC	C	Gastroenterology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
91299	26	C	Gastroenterology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92002		A	Eye exam, new patient	0.88	1.36	1.26	0.49	0.43	0.07	XXX
92004		A	Eye exam, new patient	1.82	2.36	2.17	1.06	0.91	0.13	XXX
92012		A	Eye exam established pat	0.92	1.47	1.35	0.61	0.50	0.07	XXX
92014		A	Eye exam & treatment	1.42	2.06	1.88	0.90	0.75	0.10	XXX
92015		N	Refraction	0.38	0.18	0.38	0.16	0.16	0.03	XXX
92018		A	New eye exam & treatment	2.50	NA	NA	1.66	1.42	0.17	XXX
92019		A	Eye exam & treatment	1.31	NA	NA	0.67	0.59	0.07	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
92020		A	Special eye evaluation	0.37	0.40	0.37	0.24	0.21	0.03	XXX
92025		A	Corneal topography	0.35	0.70	0.64	NA	NA	0.02	XXX
92025	TC	A	Corneal topography	0.00	0.47	0.45	NA	NA	0.01	XXX
92025	26	A	Corneal topography	0.35	0.23	0.19	0.23	0.19	0.01	XXX
92060		A	Special eye evaluation	0.69	1.13	1.03	NA	NA	0.04	XXX
92060	TC	A	Special eye evaluation	0.00	0.70	0.66	NA	NA	0.01	XXX
92060	26	A	Special eye evaluation	0.69	0.43	0.37	0.43	0.37	0.03	XXX
92065		A	Orthoptic/pleoptic training	0.37	1.13	1.03	NA	NA	0.02	XXX
92065	TC	A	Orthoptic/pleoptic training	0.00	0.97	0.89	NA	NA	0.01	XXX
92065	26	A	Orthoptic/pleoptic training	0.37	0.16	0.14	0.16	0.14	0.01	XXX
92070		A	Fitting of contact lens	0.70	1.29	1.22	0.43	0.37	0.04	XXX
92081		A	Visual field examination(s)	0.36	1.29	1.22	NA	NA	0.04	XXX
92081	TC	A	Visual field examination(s)	0.00	1.08	1.04	NA	NA	0.01	XXX
92081	26	A	Visual field examination(s)	0.36	0.21	0.18	0.21	0.18	0.03	XXX
92082		A	Visual field examination(s)	0.44	1.75	1.66	NA	NA	0.05	XXX
92082	TC	A	Visual field examination(s)	0.00	1.50	1.44	NA	NA	0.01	XXX
92082	26	A	Visual field examination(s)	0.44	0.25	0.22	0.25	0.22	0.04	XXX
92083		A	Visual field examination(s)	0.50	2.04	1.93	NA	NA	0.04	XXX
92083	TC	A	Visual field examination(s)	0.00	1.72	1.65	NA	NA	0.01	XXX
92083	26	A	Visual field examination(s)	0.50	0.32	0.28	0.32	0.28	0.03	XXX
92100		A	Serial tonometry exam(s)	0.92	1.81	1.68	0.55	0.47	0.06	XXX
92120		A	Tonography & eye evaluation	0.81	1.40	1.31	0.47	0.41	0.06	XXX
92130		A	Water provocation tonography	0.81	1.65	1.55	0.51	0.44	0.04	XXX
92135		A	Ophth dx imaging post seg	0.35	1.09	1.03	NA	NA	0.02	XXX
92135	TC	A	Ophth dx imaging post seg	0.00	0.86	0.83	NA	NA	0.01	XXX
92135	26	A	Ophth dx imaging post seg	0.35	0.23	0.20	0.23	0.20	0.01	XXX

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92136		A	Ophthalmic biometry	0.54	1.94	1.86	NA	NA	0.02	XXX
92136	TC	A	Ophthalmic biometry	0.00	1.56	1.54	NA	NA	0.01	XXX
92136	26	A	Ophthalmic biometry	0.54	0.38	0.32	0.38	0.32	0.01	XXX
92140		A	Glaucoma provocative tests	0.50	1.24	1.18	0.28	0.24	0.03	XXX
92225		A	Special eye exam, initial	0.38	0.39	0.34	0.24	0.21	0.03	XXX
92226		A	Special eye exam, subsequent	0.33	0.38	0.33	0.23	0.19	0.01	XXX
92230		A	Eye exam with photos	0.60	1.00	1.04	0.36	0.31	0.04	XXX
92235		A	Eye exam with photos	0.81	3.07	2.96	NA	NA	0.04	XXX
92235	TC	A	Eye exam with photos	0.00	2.50	2.47	NA	NA	0.01	XXX
92235	26	A	Eye exam with photos	0.81	0.57	0.49	0.57	0.49	0.03	XXX
92240		A	Icg angiography	1.10	5.83	5.81	NA	NA	0.04	XXX
92240	TC	A	Icg angiography	0.00	5.05	5.15	NA	NA	0.01	XXX
92240	26	A	Icg angiography	1.10	0.78	0.66	0.78	0.66	0.03	XXX
92250		A	Eye exam with photos	0.44	1.73	1.68	NA	NA	0.02	XXX
92250	TC	A	Eye exam with photos	0.00	1.47	1.45	NA	NA	0.01	XXX
92250	26	A	Eye exam with photos	0.44	0.26	0.23	0.26	0.23	0.01	XXX
92260		A	Ophthalmoscopy/dynamometry	0.20	0.33	0.31	0.13	0.11	0.01	XXX
92265		A	Eye muscle evaluation	0.81	1.59	1.46	NA	NA	0.02	XXX
92265	TC	A	Eye muscle evaluation	0.00	1.02	1.02	NA	NA	0.01	XXX
92265	26	A	Eye muscle evaluation	0.81	0.57	0.44	0.57	0.44	0.01	XXX
92270		A	Electro-oculography	0.81	1.68	1.68	NA	NA	0.04	XXX
92270	TC	A	Electro-oculography	0.00	1.30	1.33	NA	NA	0.01	XXX
92270	26	A	Electro-oculography	0.81	0.38	0.35	0.38	0.35	0.03	XXX
92275		A	Electroretinography	1.01	3.37	3.08	NA	NA	0.05	XXX
92275	TC	A	Electroretinography	0.00	2.67	2.49	NA	NA	0.01	XXX
92275	26	A	Electroretinography	1.01	0.70	0.59	0.70	0.59	0.04	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
92283		A	Color vision examination	0.17	1.31	1.23	NA	NA	0.02	XXX
92283	TC	A	Color vision examination	0.00	1.22	1.15	NA	NA	0.01	XXX
92283	26	A	Color vision examination	0.17	0.09	0.08	0.09	0.08	0.01	XXX
92284		A	Dark adaptation eye exam	0.24	1.39	1.47	NA	NA	0.02	XXX
92284	TC	A	Dark adaptation eye exam	0.00	1.28	1.37	NA	NA	0.01	XXX
92284	26	A	Dark adaptation eye exam	0.24	0.11	0.10	0.11	0.10	0.01	XXX
92285		A	Eye photography	0.20	1.04	1.03	NA	NA	0.04	XXX
92285	TC	A	Eye photography	0.00	0.92	0.92	NA	NA	0.01	XXX
92285	26	A	Eye photography	0.20	0.12	0.11	0.12	0.11	0.03	XXX
92286		A	Internal eye photography	0.66	2.78	2.79	NA	NA	0.02	XXX
92286	TC	A	Internal eye photography	0.00	2.36	2.43	NA	NA	0.01	XXX
92286	26	A	Internal eye photography	0.66	0.42	0.36	0.42	0.36	0.01	XXX
92287		A	Internal eye photography	0.81	2.65	2.55	0.57	0.47	0.04	XXX
92310		N	Contact lens fitting	1.17	1.47	1.47	0.51	0.50	0.08	XXX
92311		A	Contact lens fitting	1.08	1.81	1.66	0.56	0.49	0.08	XXX
92312		A	Contact lens fitting	1.26	2.10	1.89	0.65	0.57	0.06	XXX
92313		A	Contact lens fitting	0.92	1.98	1.79	0.58	0.48	0.06	XXX
92314		N	Prescription of contact lens	0.69	1.49	1.47	0.30	0.29	0.04	XXX
92315		A	Prescription of contact lens	0.45	1.69	1.56	0.22	0.19	0.04	XXX
92316		A	Prescription of contact lens	0.68	2.30	2.02	0.48	0.39	0.04	XXX
92317		A	Prescription of contact lens	0.45	1.66	1.57	0.18	0.17	0.01	XXX
92325		A	Modification of contact lens	0.00	1.06	0.97	NA	NA	0.01	XXX
92326		A	Replacement of contact lens	0.00	0.92	1.03	NA	NA	0.01	XXX
92340		N	Fitting of spectacles	0.37	0.59	0.63	0.16	0.16	0.03	XXX
92341		N	Fitting of spectacles	0.47	0.64	0.68	0.20	0.20	0.03	XXX
92342		N	Fitting of spectacles	0.53	0.66	0.70	0.23	0.23	0.04	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
92352		B	Special spectacles fitting	0.37	0.74	0.77	0.16	0.16	0.03	XXX
92353		B	Special spectacles fitting	0.50	0.80	0.82	0.22	0.21	0.03	XXX
92354		B	Special spectacles fitting	0.00	0.35	1.64	NA	NA	0.01	XXX
92355		B	Special spectacles fitting	0.00	0.54	1.14	NA	NA	0.01	XXX
92358		B	Eye prosthesis service	0.00	0.29	0.41	NA	NA	0.01	XXX
92370		N	Repair & adjust spectacles	0.32	0.52	0.55	0.14	0.14	0.03	XXX
92371		B	Repair & adjust spectacles	0.00	0.30	0.36	NA	NA	0.01	XXX
92499		C	Eye service or procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
92499	TC	C	Eye service or procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
92499	26	C	Eye service or procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92502		A	Ear and throat examination	1.51	NA	NA	1.33	1.25	0.07	000
92504		A	Ear microscopy examination	0.18	0.72	0.71	0.10	0.09	0.01	XXX
92506		A	Speech/hearing evaluation	0.86	3.96	3.90	NA	NA	0.06	XXX
92507		A	Speech/hearing therapy	0.52	1.37	1.38	NA	NA	0.03	XXX
92508		A	Speech/hearing therapy	0.26	0.67	0.66	NA	NA	0.01	XXX
92511		A	Nasopharyngoscopy	0.84	3.74	3.76	0.92	0.88	0.04	000
92512		A	Nasal function studies	0.55	1.19	1.21	0.30	0.26	0.03	XXX
92516		A	Facial nerve function test	0.43	1.57	1.51	0.24	0.22	0.03	XXX
92520		A	Laryngeal function studies	0.75	1.35	1.18	0.48	0.41	0.04	XXX
92526		A	Oral function therapy	1.34	0.72	1.32	NA	NA	0.07	XXX
92531		B	Spontaneous nystagmus study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92532		B	Positional nystagmus test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92533		B	Caloric vestibular test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92534		B	Optokinetic nystagmus test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92540		A	Basic vestibular evaluation	1.50	1.28	1.28	NA	NA	0.05	XXX
92540	TC	A	Basic vestibular evaluation	0.00	0.53	0.53	NA	NA	0.01	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
92540	26	A	Basic vestibular evaluation	1.50	0.75	0.75	0.75	0.75	0.04	XXX
92541		A	Spontaneous nystagmus test	0.40	0.45	0.90	NA	NA	0.02	XXX
92541	TC	A	Spontaneous nystagmus test	0.00	0.25	0.72	NA	NA	0.01	XXX
92541	26	A	Spontaneous nystagmus test	0.40	0.20	0.18	0.20	0.18	0.01	XXX
92542		A	Positional nystagmus test	0.33	0.41	0.97	NA	NA	0.02	XXX
92542	TC	A	Positional nystagmus test	0.00	0.24	0.81	NA	NA	0.01	XXX
92542	26	A	Positional nystagmus test	0.33	0.17	0.16	0.17	0.16	0.01	XXX
92543		A	Caloric vestibular test	0.10	0.30	0.53	NA	NA	0.02	XXX
92543	TC	A	Caloric vestibular test	0.00	0.25	0.48	NA	NA	0.01	XXX
92543	26	A	Caloric vestibular test	0.10	0.05	0.05	0.05	0.05	0.01	XXX
92544		A	Optokinetic nystagmus test	0.26	0.36	0.80	NA	NA	0.02	XXX
92544	TC	A	Optokinetic nystagmus test	0.00	0.23	0.68	NA	NA	0.01	XXX
92544	26	A	Optokinetic nystagmus test	0.26	0.13	0.12	0.13	0.12	0.01	XXX
92545		A	Oscillating tracking test	0.23	0.34	0.76	NA	NA	0.02	XXX
92545	TC	A	Oscillating tracking test	0.00	0.23	0.65	NA	NA	0.01	XXX
92545	26	A	Oscillating tracking test	0.23	0.11	0.11	0.11	0.11	0.01	XXX
92546		A	Sinusoidal rotational test	0.29	2.53	2.41	NA	NA	0.02	XXX
92546	TC	A	Sinusoidal rotational test	0.00	2.39	2.28	NA	NA	0.01	XXX
92546	26	A	Sinusoidal rotational test	0.29	0.14	0.13	0.14	0.13	0.01	XXX
92547		A	Supplemental electrical test	0.00	0.15	0.13	0.15	0.13	0.01	ZZZ
92548		A	Posturography	0.50	2.58	2.43	NA	NA	0.02	XXX
92548	TC	A	Posturography	0.00	2.33	2.20	NA	NA	0.01	XXX
92548	26	A	Posturography	0.50	0.25	0.23	0.25	0.23	0.01	XXX
92550		A	Tympanometry & reflex thresh	0.35	0.24	0.24	NA	NA	0.01	XXX
92551		N	Pure tone hearing test, air	0.00	0.31	0.32	NA	NA	0.01	XXX
92552		A	Pure tone audiometry, air	0.00	0.79	0.73	NA	NA	0.01	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
92553		A	Audiometry, air & bone	0.00	0.96	0.92	NA	NA	0.01	XXX
92555		A	Speech threshold audiometry	0.00	0.57	0.53	NA	NA	0.01	XXX
92556		A	Speech audiometry, complete	0.00	0.90	0.82	NA	NA	0.01	XXX
92557		A	Comprehensive hearing test	0.60	0.46	0.55	0.32	0.44	0.03	XXX
92559		N	Group audiometric testing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92560		N	Bekesy audiometry, screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92561		A	Bekesy audiometry, diagnosis	0.00	1.01	0.93	NA	NA	0.01	XXX
92562		A	Loudness balance test	0.00	1.10	0.90	NA	NA	0.01	XXX
92563		A	Tone decay hearing test	0.00	0.78	0.71	NA	NA	0.01	XXX
92564		A	Sisi hearing test	0.00	0.68	0.63	NA	NA	0.01	XXX
92565		A	Stenger test, pure tone	0.00	0.36	0.37	NA	NA	0.01	XXX
92567		A	Tympanometry	0.20	0.20	0.24	0.11	0.16	0.01	XXX
92568		A	Acoustic refl threshold tst	0.29	0.16	0.18	0.16	0.18	0.01	XXX
92570		A	Acoustic immittance testing	0.55	0.35	0.35	0.29	0.29	0.03	XXX
92571		A	Filtered speech hearing test	0.00	0.63	0.56	NA	NA	0.01	XXX
92572		A	Staggered spondaic word test	0.00	1.24	0.90	NA	NA	0.01	XXX
92575		A	Sensorineural acuity test	0.00	1.69	1.41	NA	NA	0.01	XXX
92576		A	Synthetic sentence test	0.00	0.91	0.77	NA	NA	0.01	XXX
92577		A	Stenger test, speech	0.00	0.42	0.46	NA	NA	0.01	XXX
92579		A	Visual audiometry (vra)	0.70	0.54	0.54	0.40	0.42	0.03	XXX
92582		A	Conditioning play audiometry	0.00	1.65	1.46	NA	NA	0.01	XXX
92583		A	Select picture audiometry	0.00	1.03	1.02	NA	NA	0.01	XXX
92584		A	Electrocochleography	0.00	1.84	1.91	NA	NA	0.01	XXX
92585		A	Auditor evoke potent, compre	0.50	2.98	2.75	NA	NA	0.02	XXX
92585	TC	A	Auditor evoke potent, compre	0.00	2.72	2.51	NA	NA	0.01	XXX
92585	26	A	Auditor evoke potent, compre	0.50	0.26	0.24	0.26	0.24	0.01	XXX

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92586		A	Auditor evoke potent, limit	0.00	2.14	2.02	NA	NA	0.01	XXX
92587		A	Evoked auditory test	0.13	0.85	0.91	NA	NA	0.02	XXX
92587	TC	A	Evoked auditory test	0.00	0.78	0.85	NA	NA	0.01	XXX
92587	26	A	Evoked auditory test	0.13	0.07	0.06	0.07	0.06	0.01	XXX
92588		A	Evoked auditory test	0.36	1.57	1.53	NA	NA	0.02	XXX
92588	TC	A	Evoked auditory test	0.00	1.38	1.36	NA	NA	0.01	XXX
92588	26	A	Evoked auditory test	0.36	0.19	0.17	0.19	0.17	0.01	XXX
92590		N	Hearing aid exam, one ear	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92591		N	Hearing aid exam, both ears	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92592		N	Hearing aid check, one ear	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92593		N	Hearing aid check, both ears	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92594		N	Electro hearng aid test, one	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92595		N	Electro hearng aid tst, both	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92596		A	Ear protector evaluation	0.00	1.20	1.14	NA	NA	0.01	XXX
92597		A	Oral speech device eval	1.26	0.78	1.52	NA	NA	0.07	XXX
92601		A	Cochlear implt f/up exam < 7	2.30	1.49	1.85	0.99	1.38	0.11	XXX
92602		A	Reprogram cochlear implt < 7	1.30	1.00	1.26	0.56	0.84	0.07	XXX
92603		A	Cochlear implt f/up exam 7 >	2.25	1.83	1.80	1.19	1.28	0.11	XXX
92604		A	Reprogram cochlear implt 7 >	1.25	1.19	1.16	0.66	0.73	0.06	XXX
92605		B	Eval for nonspeech device rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92606		B	Non-speech device service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92607		A	Ex for speech device rx, 1hr	0.00	5.22	5.09	NA	NA	0.07	XXX
92608		A	Ex for speech device rx addl	0.00	1.36	1.14	NA	NA	0.01	XXX
92609		A	Use of speech device service	0.00	2.13	2.38	NA	NA	0.04	XXX
92610		A	Evaluate swallowing function	1.30	0.89	1.69	0.64	0.64	0.07	XXX
92611		A	Motion fluoroscopy/swallow	1.34	1.05	1.88	NA	NA	0.08	XXX

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92612		A	Endoscopy swallow tst (fees)	1.27	3.52	3.50	0.70	0.65	0.07	XXX
92613		A	Endoscopy swallow tst (fees)	0.71	0.39	0.37	0.39	0.37	0.04	XXX
92614		A	Laryngoscopic sensory test	1.27	3.02	2.97	0.72	0.66	0.07	XXX
92615		A	Eval laryngoscopy sense tst	0.63	0.36	0.34	0.36	0.34	0.03	XXX
92616		A	Fees w/laryngeal sense test	1.88	3.86	3.86	1.02	0.95	0.10	XXX
92617		A	Interprt fees/laryngeal test	0.79	0.43	0.40	0.43	0.40	0.04	XXX
92620		A	Auditory function, 60 min	1.50	1.15	0.84	0.87	0.70	0.07	XXX
92621		A	Auditory function, + 15 min	0.35	0.27	0.20	0.18	0.15	0.01	ZZZ
92625		A	Tinnitus assessment	1.15	0.81	0.64	0.61	0.54	0.06	XXX
92626		A	Eval aud rehab status	1.40	1.09	0.99	0.73	0.80	0.07	XXX
92627		A	Eval aud status rehab add-on	0.33	0.29	0.26	0.17	0.20	0.01	ZZZ
92630		I	Aud rehab pre-ling hear loss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92633		I	Aud rehab postling hear loss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92640		A	Aud brainstem implt programg	1.76	1.20	0.76	0.89	0.60	0.38	XXX
92700		C	Ent procedure/service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92950		A	Heart/lung resuscitation cpr	3.79	4.07	4.10	1.04	1.03	0.31	000
92953		A	Temporary external pacing	0.23	NA	NA	0.07	0.08	0.01	000
92960		A	Cardioversion electric, ext	2.25	3.60	4.65	1.13	1.39	0.14	000
92961		A	Cardioversion, electric, int	4.59	NA	NA	2.03	2.45	0.45	000
92970		A	Cardioassist, internal	3.51	NA	NA	1.37	1.51	0.25	000
92971		A	Cardioassist, external	1.77	NA	NA	0.82	1.04	0.11	000
92973		A	Percut coronary thrombectomy	3.28	NA	NA	1.29	1.63	0.73	ZZZ
92974		A	Cath place, cardio brachytx	3.00	NA	NA	1.17	1.50	0.68	ZZZ
92975		A	Dissolve clot, heart vessel	7.24	NA	NA	2.88	3.60	1.64	000
92977		A	Dissolve clot, heart vessel	0.00	1.42	2.66	NA	NA	0.03	XXX
92978		C	Intravasc us, heart add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ

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92978	TC	C	Intravasc us, heart add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
92978	26	A	Intravasc us, heart add-on	1.80	0.71	0.89	0.71	0.89	0.13	ZZZ
92979		C	Intravasc us, heart add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
92979	TC	C	Intravasc us, heart add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
92979	26	A	Intravasc us, heart add-on	1.44	0.56	0.72	0.56	0.72	0.10	ZZZ
92980		A	Insert intracoronary stent	14.82	NA	NA	5.99	7.59	3.36	000
92981		A	Insert intracoronary stent	4.16	NA	NA	1.63	2.07	0.93	ZZZ
92982		A	Coronary artery dilation	10.96	NA	NA	4.48	5.67	2.47	000
92984		A	Coronary artery dilation	2.97	NA	NA	1.16	1.48	0.66	ZZZ
92986		A	Revision of aortic valve	22.85	NA	NA	11.68	14.46	5.17	090
92987		A	Revision of mitral valve	23.63	NA	NA	11.91	14.88	5.34	090
92990		A	Revision of pulmonary valve	18.27	NA	NA	9.74	11.72	4.14	090
92992		C	Revision of heart chamber	0.00	0.00	0.00	0.00	0.00	0.00	090
92993		C	Revision of heart chamber	0.00	0.00	0.00	0.00	0.00	0.00	090
92995		A	Coronary atherectomy	12.07	NA	NA	4.91	6.24	2.73	000
92996		A	Coronary atherectomy add-on	3.26	NA	NA	1.28	1.63	0.73	ZZZ
92997		A	Pul art balloon repr, percut	11.98	NA	NA	4.84	5.58	2.71	000
92998		A	Pul art balloon repr, percut	5.99	NA	NA	2.33	2.84	1.36	ZZZ
93000		A	Electrocardiogram, complete	0.17	0.32	0.39	NA	NA	0.02	XXX
93005		A	Electrocardiogram, tracing	0.00	0.25	0.31	NA	NA	0.01	XXX
93010		A	Electrocardiogram report	0.17	0.07	0.08	0.07	0.08	0.01	XXX
93012		A	Transmission of ecg	0.00	3.87	4.86	NA	NA	0.01	XXX
93014		A	Report on transmitted ecg	0.52	0.21	0.24	0.21	0.24	0.03	XXX
93015		A	Cardiovascular stress test	0.75	1.56	1.92	NA	NA	0.03	XXX
93016		A	Cardiovascular stress test	0.45	0.18	0.22	0.18	0.22	0.01	XXX
93017		A	Cardiovascular stress test	0.00	1.26	1.56	NA	NA	0.01	XXX

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93018		A	Cardiovascular stress test	0.30	0.12	0.14	0.12	0.14	0.01	XXX
93024		A	Cardiac drug stress test	1.17	1.88	2.19	NA	NA	0.05	XXX
93024	TC	A	Cardiac drug stress test	0.00	1.42	1.64	NA	NA	0.01	XXX
93024	26	A	Cardiac drug stress test	1.17	0.46	0.55	0.46	0.55	0.04	XXX
93025		A	Microvolt t-wave assess	0.75	3.63	4.83	NA	NA	0.04	XXX
93025	TC	A	Microvolt t-wave assess	0.00	3.33	4.46	NA	NA	0.01	XXX
93025	26	A	Microvolt t-wave assess	0.75	0.30	0.37	0.30	0.37	0.03	XXX
93040		A	Rhythm ECG with report	0.16	0.19	0.21	NA	NA	0.02	XXX
93041		A	Rhythm ECG, tracing	0.00	0.14	0.15	NA	NA	0.01	XXX
93042		A	Rhythm ECG, report	0.16	0.05	0.06	0.05	0.06	0.01	XXX
93224		A	ECG monitor/report, 24 hrs	0.52	1.95	2.50	NA	NA	0.03	XXX
93225		A	ECG monitor/record, 24 hrs	0.00	0.89	0.99	NA	NA	0.01	XXX
93226		A	ECG monitor/report, 24 hrs	0.00	0.82	1.24	NA	NA	0.01	XXX
93227		A	ECG monitor/review, 24 hrs	0.52	0.24	0.27	0.24	0.27	0.01	XXX
93228		A	Remote 30 day ecg rev/report	0.52	0.21	0.21	0.21	0.21	0.03	XXX
93229		C	Remote 30 day ecg tech supp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93230		A	ECG monitor/report, 24 hrs	0.52	1.95	2.55	NA	NA	0.03	XXX
93231		A	Ecg monitor/record, 24 hrs	0.00	0.78	0.93	NA	NA	0.01	XXX
93232		A	ECG monitor/report, 24 hrs	0.00	0.96	1.38	NA	NA	0.01	XXX
93233		A	ECG monitor/review, 24 hrs	0.52	0.21	0.24	0.21	0.24	0.01	XXX
93235		C	ECG monitor/report, 24 hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93236		C	ECG monitor/report, 24 hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93237		A	ECG monitor/review, 24 hrs	0.45	0.18	0.22	0.18	0.22	0.03	XXX
93268		A	ECG record/review	0.52	5.52	6.70	NA	NA	0.03	XXX
93270		A	ECG recording	0.00	0.23	0.43	NA	NA	0.01	XXX
93271		A	Ecg/monitoring and analysis	0.00	5.09	6.04	NA	NA	0.01	XXX

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93272		A	Ecg/review, interpret only	0.52	0.20	0.23	0.20	0.23	0.01	XXX
93278		A	ECG/signal-averaged	0.25	0.60	0.75	NA	NA	0.02	XXX
93278	TC	A	ECG/signal-averaged	0.00	0.49	0.64	NA	NA	0.01	XXX
93278	26	A	ECG/signal-averaged	0.25	0.11	0.11	0.11	0.11	0.01	XXX
93279		A	Pm device progr eval, sngl	0.65	0.70	0.86	NA	NA	0.04	XXX
93279	TC	A	Pm device progr eval, sngl	0.00	0.44	0.53	NA	NA	0.01	XXX
93279	26	A	Pm device progr eval, sngl	0.65	0.26	0.33	0.26	0.33	0.03	XXX
93280		A	Pm device progr eval, dual	0.77	0.80	1.01	NA	NA	0.04	XXX
93280	TC	A	Pm device progr eval, dual	0.00	0.50	0.61	NA	NA	0.01	XXX
93280	26	A	Pm device progr eval, dual	0.77	0.30	0.40	0.30	0.40	0.03	XXX
93281		A	Pm device progr eval, multi	0.90	0.93	1.17	NA	NA	0.04	XXX
93281	TC	A	Pm device progr eval, multi	0.00	0.58	0.71	NA	NA	0.01	XXX
93281	26	A	Pm device progr eval, multi	0.90	0.35	0.46	0.35	0.46	0.03	XXX
93282		A	Icd device prog eval, 1 sngl	0.85	0.84	1.06	NA	NA	0.04	XXX
93282	TC	A	Icd device prog eval, 1 sngl	0.00	0.51	0.63	NA	NA	0.01	XXX
93282	26	A	Icd device prog eval, 1 sngl	0.85	0.33	0.43	0.33	0.43	0.03	XXX
93283		A	Icd device progr eval, dual	1.15	1.05	1.29	NA	NA	0.05	XXX
93283	TC	A	Icd device progr eval, dual	0.00	0.60	0.73	NA	NA	0.01	XXX
93283	26	A	Icd device progr eval, dual	1.15	0.45	0.56	0.45	0.56	0.04	XXX
93284		A	Icd device progr eval, mult	1.25	1.17	1.48	NA	NA	0.05	XXX
93284	TC	A	Icd device progr eval, mult	0.00	0.68	0.83	NA	NA	0.01	XXX
93284	26	A	Icd device progr eval, mult	1.25	0.49	0.65	0.49	0.65	0.04	XXX
93285		A	Ilr device eval progr	0.52	0.61	0.76	NA	NA	0.02	XXX
93285	TC	A	Ilr device eval progr	0.00	0.40	0.49	NA	NA	0.01	XXX
93285	26	A	Ilr device eval progr	0.52	0.21	0.27	0.21	0.27	0.01	XXX
93286		A	Pre-op pm device eval	0.30	0.41	0.46	NA	NA	0.02	XXX

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93286	TC	A	Pre-op pm device eval	0.00	0.29	0.34	NA	NA	0.01	XXX
93286	26	A	Pre-op pm device eval	0.30	0.12	0.12	0.12	0.12	0.01	XXX
93287		A	Pre-op icd device eval	0.45	0.50	0.55	NA	NA	0.02	XXX
93287	TC	A	Pre-op icd device eval	0.00	0.32	0.37	NA	NA	0.01	XXX
93287	26	A	Pre-op icd device eval	0.45	0.18	0.18	0.18	0.18	0.01	XXX
93288		A	Pm device eval in person	0.43	0.57	0.72	NA	NA	0.02	XXX
93288	TC	A	Pm device eval in person	0.00	0.40	0.50	NA	NA	0.01	XXX
93288	26	A	Pm device eval in person	0.43	0.17	0.22	0.17	0.22	0.01	XXX
93289		A	Icd device interrogate	0.92	0.86	1.04	NA	NA	0.04	XXX
93289	TC	A	Icd device interrogate	0.00	0.50	0.61	NA	NA	0.01	XXX
93289	26	A	Icd device interrogate	0.92	0.36	0.43	0.36	0.43	0.03	XXX
93290		A	Icm device eval	0.43	0.40	0.44	NA	NA	0.02	XXX
93290	TC	A	Icm device eval	0.00	0.23	0.27	NA	NA	0.01	XXX
93290	26	A	Icm device eval	0.43	0.17	0.17	0.17	0.17	0.01	XXX
93291		A	Ilr device interrogate	0.43	0.54	0.67	NA	NA	0.02	XXX
93291	TC	A	Ilr device interrogate	0.00	0.37	0.45	NA	NA	0.01	XXX
93291	26	A	Ilr device interrogate	0.43	0.17	0.22	0.17	0.22	0.01	XXX
93292		A	Wcd device interrogate	0.43	0.45	0.56	NA	NA	0.02	XXX
93292	TC	A	Wcd device interrogate	0.00	0.28	0.34	NA	NA	0.01	XXX
93292	26	A	Wcd device interrogate	0.43	0.17	0.22	0.17	0.22	0.01	XXX
93293		A	Pm phone r-strip device eval	0.32	1.13	1.30	NA	NA	0.02	XXX
93293	TC	A	Pm phone r-strip device eval	0.00	1.01	1.16	NA	NA	0.01	XXX
93293	26	A	Pm phone r-strip device eval	0.32	0.12	0.14	0.12	0.14	0.01	XXX
93294		A	Pm device interrogate remote	0.65	0.26	0.33	0.26	0.33	0.04	XXX
93295		A	Icd device interrogat remote	1.29	0.51	0.63	0.51	0.63	0.08	XXX
93296		A	Pm/icd remote tech serv	0.00	0.69	0.94	NA	NA	0.01	XXX

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93297		A	Icm device interrogat remote	0.52	0.20	0.20	0.20	0.20	0.03	XXX
93298		A	Ilr device interrogat remote	0.52	0.20	0.27	0.20	0.27	0.03	XXX
93299		C	Icm/ilr remote tech serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93303		A	Echo transthoracic	1.30	4.16	4.77	NA	NA	0.05	XXX
93303	TC	A	Echo transthoracic	0.00	3.64	4.17	NA	NA	0.01	XXX
93303	26	A	Echo transthoracic	1.30	0.52	0.60	0.52	0.60	0.04	XXX
93304		A	Echo transthoracic	0.75	2.82	3.11	NA	NA	0.04	XXX
93304	TC	A	Echo transthoracic	0.00	2.52	2.78	NA	NA	0.01	XXX
93304	26	A	Echo transthoracic	0.75	0.30	0.33	0.30	0.33	0.03	XXX
93306		A	Tte w/doppler, complete	1.30	3.97	5.43	NA	NA	0.05	XXX
93306	TC	A	Tte w/doppler, complete	0.00	3.45	4.78	NA	NA	0.01	XXX
93306	26	A	Tte w/doppler, complete	1.30	0.52	0.65	0.52	0.65	0.04	XXX
93307		A	Tte w/o doppler, complete	0.92	2.25	3.36	NA	NA	0.04	XXX
93307	TC	A	Tte w/o doppler, complete	0.00	1.87	2.91	NA	NA	0.01	XXX
93307	26	A	Tte w/o doppler, complete	0.92	0.38	0.45	0.38	0.45	0.03	XXX
93308		A	Tte, f-up or lmtd	0.53	2.14	2.52	NA	NA	0.02	XXX
93308	TC	A	Tte, f-up or lmtd	0.00	1.93	2.26	NA	NA	0.01	XXX
93308	26	A	Tte, f-up or lmtd	0.53	0.21	0.26	0.21	0.26	0.01	XXX
93312		A	Echo transesophageal	2.20	6.49	7.13	NA	NA	0.10	XXX
93312	TC	A	Echo transesophageal	0.00	5.70	6.17	NA	NA	0.03	XXX
93312	26	A	Echo transesophageal	2.20	0.79	0.96	0.79	0.96	0.07	XXX
93313		A	Echo transesophageal	0.95	NA	NA	0.22	0.19	0.07	XXX
93314		A	Echo transesophageal	1.25	6.49	6.97	NA	NA	0.07	XXX
93314	TC	A	Echo transesophageal	0.00	6.03	6.42	NA	NA	0.03	XXX
93314	26	A	Echo transesophageal	1.25	0.46	0.55	0.46	0.55	0.04	XXX
93315		C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
93315	TC	C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93315	26	A	Echo transesophageal	2.78	1.04	1.27	1.04	1.27	0.24	XXX
93316		A	Echo transesophageal	0.95	NA	NA	0.27	0.29	0.07	XXX
93317		C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93317	TC	C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93317	26	A	Echo transesophageal	1.83	0.66	0.72	0.66	0.72	0.24	XXX
93318		C	Echo transesophageal intraop	0.00	0.00	0.00	NA	NA	0.00	XXX
93318	TC	C	Echo transesophageal intraop	0.00	0.00	0.00	NA	NA	0.00	XXX
93318	26	A	Echo transesophageal intraop	2.20	0.76	0.86	0.76	0.86	0.32	XXX
93320		A	Doppler echo exam, heart	0.38	0.87	1.43	NA	NA	0.02	ZZZ
93320	TC	A	Doppler echo exam, heart	0.00	0.72	1.25	NA	NA	0.01	ZZZ
93320	26	A	Doppler echo exam, heart	0.38	0.15	0.18	0.15	0.18	0.01	ZZZ
93321		A	Doppler echo exam, heart	0.15	0.50	0.69	NA	NA	0.02	ZZZ
93321	TC	A	Doppler echo exam, heart	0.00	0.44	0.62	NA	NA	0.01	ZZZ
93321	26	A	Doppler echo exam, heart	0.15	0.06	0.07	0.06	0.07	0.01	ZZZ
93325		A	Doppler color flow add-on	0.07	0.47	0.95	NA	NA	0.02	ZZZ
93325	TC	A	Doppler color flow add-on	0.00	0.44	0.92	NA	NA	0.01	ZZZ
93325	26	A	Doppler color flow add-on	0.07	0.03	0.03	0.03	0.03	0.01	ZZZ
93350		A	Stress tte only	1.46	4.14	4.61	NA	NA	0.07	XXX
93350	TC	A	Stress tte only	0.00	3.56	3.89	NA	NA	0.01	XXX
93350	26	A	Stress tte only	1.46	0.58	0.72	0.58	0.72	0.06	XXX
93351		A	Stress tte complete	1.75	4.70	5.40	NA	NA	0.09	XXX
93351	TC	A	Stress tte complete	0.00	4.01	4.50	NA	NA	0.03	XXX
93351	26	A	Stress tte complete	1.75	0.69	0.90	0.69	0.90	0.06	XXX
93352		A	Admin ecg contrast agent	0.19	0.71	0.86	NA	NA	0.01	ZZZ
93501		A	Right heart catheterization	3.02	15.50	18.56	NA	NA	0.59	000

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
93501	TC	A	Right heart catheterization	0.00	14.32	17.08	NA	NA	0.01	000
93501	26	A	Right heart catheterization	3.02	1.18	1.48	1.18	1.48	0.58	000
93503		A	Insert/place heart catheter	2.91	NA	NA	0.77	0.77	0.28	000
93505		A	Biopsy of heart lining	4.37	17.19	18.14	NA	NA	0.89	000
93505	TC	A	Biopsy of heart lining	0.00	15.47	16.00	NA	NA	0.03	000
93505	26	A	Biopsy of heart lining	4.37	1.72	2.14	1.72	2.14	0.86	000
93508		A	Cath placement, angiography	4.09	23.65	26.49	NA	NA	0.81	000
93508	TC	A	Cath placement, angiography	0.00	22.05	24.39	NA	NA	0.03	000
93508	26	A	Cath placement, angiography	4.09	1.60	2.10	1.60	2.10	0.78	000
93510		A	Left heart catheterization	4.32	23.12	29.59	NA	NA	0.86	000
93510	TC	A	Left heart catheterization	0.00	21.43	27.38	NA	NA	0.03	000
93510	26	A	Left heart catheterization	4.32	1.69	2.21	1.69	2.21	0.83	000
93511		C	Left heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93511	TC	C	Left heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93511	26	A	Left heart catheterization	5.02	1.96	2.56	1.96	2.56	1.14	000
93514		C	Left heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93514	TC	C	Left heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93514	26	A	Left heart catheterization	7.04	2.75	3.46	2.75	3.46	1.60	000
93524		C	Left heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93524	TC	C	Left heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93524	26	A	Left heart catheterization	6.94	2.72	3.53	2.72	3.53	1.57	000
93526		A	Rt & Lt heart catheters	5.98	28.80	37.22	NA	NA	1.20	000
93526	TC	A	Rt & Lt heart catheters	0.00	26.46	34.18	NA	NA	0.03	000
93526	26	A	Rt & Lt heart catheters	5.98	2.34	3.04	2.34	3.04	1.17	000
93527		C	Rt & Lt heart catheters	0.00	NA	NA	NA	NA	0.00	000
93527	TC	C	Rt & Lt heart catheters	0.00	NA	NA	NA	NA	0.00	000

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
93527	26	A	Rt & Lt heart catheters	7.27	2.84	3.66	2.84	3.66	1.64	000
93528		C	Rt & Lt heart catheters	0.00	NA	NA	NA	NA	0.00	000
93528	TC	C	Rt & Lt heart catheters	0.00	NA	NA	NA	NA	0.00	000
93528	26	A	Rt & Lt heart catheters	8.99	3.51	4.20	3.51	4.20	2.02	000
93529		C	Rt, lt heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93529	TC	C	Rt, lt heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93529	26	A	Rt, lt heart catheterization	4.79	1.87	2.44	1.87	2.44	1.09	000
93530		C	Rt heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93530	TC	C	Rt heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93530	26	A	Rt heart cath, congenital	4.22	1.67	2.03	1.67	2.03	0.95	000
93531		C	R & l heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93531	TC	C	R & l heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93531	26	A	R & l heart cath, congenital	8.34	3.26	3.92	3.26	3.92	1.89	000
93532		C	R & l heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93532	TC	C	R & l heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93532	26	A	R & l heart cath, congenital	9.99	3.90	4.60	3.90	4.60	2.26	000
93533		C	R & l heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93533	TC	C	R & l heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93533	26	A	R & l heart cath, congenital	6.69	2.60	3.10	2.60	3.10	1.53	000
93539		A	Injection, cardiac cath	0.40	2.03	2.10	0.16	0.20	0.03	000
93540		A	Injection, cardiac cath	0.43	3.86	5.64	0.17	0.22	0.03	000
93541		A	Injection for lung angiogram	0.29	0.11	0.14	0.11	0.14	0.01	000
93542		A	Injection for heart x-rays	0.29	2.37	3.41	0.11	0.14	0.01	000
93543		A	Injection for heart x-rays	0.29	2.16	2.23	0.11	0.14	0.01	000
93544		A	Injection for aortography	0.25	1.52	1.57	0.10	0.13	0.01	000
93545		A	Inject for coronary x-rays	0.40	4.86	4.97	0.16	0.20	0.03	000

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
93555		A	Imaging, cardiac cath	0.81	0.45	1.47	NA	NA	0.04	XXX
93555	TC	A	Imaging, cardiac cath	0.00	0.13	1.07	NA	NA	0.01	XXX
93555	26	A	Imaging, cardiac cath	0.81	0.32	0.40	0.32	0.40	0.03	XXX
93556		A	Imaging, cardiac cath	0.83	0.65	2.24	NA	NA	0.04	XXX
93556	TC	A	Imaging, cardiac cath	0.00	0.33	1.83	NA	NA	0.01	XXX
93556	26	A	Imaging, cardiac cath	0.83	0.32	0.41	0.32	0.41	0.03	XXX
93561		C	Cardiac output measurement	0.00	NA	NA	NA	NA	0.00	000
93561	TC	C	Cardiac output measurement	0.00	NA	NA	NA	NA	0.00	000
93561	26	A	Cardiac output measurement	0.50	0.20	0.18	0.20	0.18	0.04	000
93562		C	Cardiac output measurement	0.00	NA	NA	NA	NA	0.00	000
93562	TC	C	Cardiac output measurement	0.00	NA	NA	NA	NA	0.00	000
93562	26	A	Cardiac output measurement	0.16	0.06	0.05	0.06	0.05	0.01	000
93571		C	Heart flow reserve measure	0.00	NA	NA	NA	NA	0.00	ZZZ
93571	TC	C	Heart flow reserve measure	0.00	NA	NA	NA	NA	0.00	ZZZ
93571	26	A	Heart flow reserve measure	1.80	0.71	0.89	0.71	0.89	0.11	ZZZ
93572		C	Heart flow reserve measure	0.00	NA	NA	NA	NA	0.00	ZZZ
93572	TC	C	Heart flow reserve measure	0.00	NA	NA	NA	NA	0.00	ZZZ
93572	26	A	Heart flow reserve measure	1.44	0.56	0.69	0.56	0.69	0.11	ZZZ
93580		A	Transcath closure of asd	17.97	NA	NA	7.39	9.12	4.07	000
93581		A	Transcath closure of vsd	24.39	NA	NA	9.85	11.47	5.52	000
93600		C	Bundle of His recording	0.00	0.00	0.00	NA	NA	0.00	000
93600	TC	C	Bundle of His recording	0.00	0.00	0.00	NA	NA	0.00	000
93600	26	A	Bundle of His recording	2.12	0.84	1.04	0.84	1.04	0.47	000
93602		C	Intra-atrial recording	0.00	0.00	0.00	NA	NA	0.00	000
93602	TC	C	Intra-atrial recording	0.00	0.00	0.00	NA	NA	0.00	000
93602	26	A	Intra-atrial recording	2.12	0.83	1.02	0.83	1.02	0.47	000

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
93603		C	Right ventricular recording	0.00	0.00	0.00	NA	NA	0.00	000
93603	TC	C	Right ventricular recording	0.00	0.00	0.00	NA	NA	0.00	000
93603	26	A	Right ventricular recording	2.12	0.82	1.02	0.82	1.02	0.47	000
93609		C	Map tachycardia, add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93609	TC	C	Map tachycardia, add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93609	26	A	Map tachycardia, add-on	4.99	1.96	2.46	1.96	2.46	1.13	ZZZ
93610		C	Intra-atrial pacing	0.00	0.00	0.00	NA	NA	0.00	000
93610	TC	C	Intra-atrial pacing	0.00	0.00	0.00	NA	NA	0.00	000
93610	26	A	Intra-atrial pacing	3.02	1.17	1.44	1.17	1.44	0.68	000
93612		C	Intraventricular pacing	0.00	0.00	0.00	NA	NA	0.00	000
93612	TC	C	Intraventricular pacing	0.00	0.00	0.00	NA	NA	0.00	000
93612	26	A	Intraventricular pacing	3.02	1.16	1.42	1.16	1.42	0.68	000
93613		A	Electrophys map 3d, add-on	6.99	NA	NA	2.74	3.46	1.58	ZZZ
93615		C	Esophageal recording	0.00	0.00	0.00	NA	NA	0.00	000
93615	TC	C	Esophageal recording	0.00	0.00	0.00	NA	NA	0.00	000
93615	26	A	Esophageal recording	0.99	0.39	0.48	0.39	0.48	0.06	000
93616		C	Esophageal recording	0.00	0.00	0.00	NA	NA	0.00	000
93616	TC	C	Esophageal recording	0.00	0.00	0.00	NA	NA	0.00	000
93616	26	A	Esophageal recording	1.49	0.33	0.38	0.33	0.38	0.11	000
93618		C	Heart rhythm pacing	0.00	0.00	0.00	NA	NA	0.00	000
93618	TC	C	Heart rhythm pacing	0.00	0.00	0.00	NA	NA	0.00	000
93618	26	A	Heart rhythm pacing	4.25	1.66	2.12	1.66	2.12	0.95	000
93619		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93619	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93619	26	A	Electrophysiology evaluation	7.31	2.86	3.68	2.86	3.68	1.65	000
93620		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
93620	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93620	26	A	Electrophysiology evaluation	11.57	4.54	5.76	4.54	5.76	2.61	000
93621		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93621	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93621	26	A	Electrophysiology evaluation	2.10	0.82	1.04	0.82	1.04	0.47	ZZZ
93622		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93622	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93622	26	A	Electrophysiology evaluation	3.10	1.22	1.50	1.22	1.50	0.69	ZZZ
93623		C	Stimulation, pacing heart	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93623	TC	C	Stimulation, pacing heart	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93623	26	A	Stimulation, pacing heart	2.85	1.12	1.40	1.12	1.40	0.65	ZZZ
93624		C	Electrophysiologic study	0.00	0.00	0.00	NA	NA	0.00	000
93624	TC	C	Electrophysiologic study	0.00	0.00	0.00	NA	NA	0.00	000
93624	26	A	Electrophysiologic study	4.80	1.87	2.42	NA	NA	1.09	000
93631		C	Heart pacing, mapping	0.00	0.00	0.00	NA	NA	0.00	000
93631	TC	C	Heart pacing, mapping	0.00	0.00	0.00	NA	NA	0.00	000
93631	26	A	Heart pacing, mapping	7.59	2.74	3.03	2.74	3.03	1.88	000
93640		C	Evaluation heart device	0.00	0.00	0.00	NA	NA	0.00	000
93640	TC	C	Evaluation heart device	0.00	0.00	0.00	NA	NA	0.00	000
93640	26	A	Evaluation heart device	3.51	1.38	1.72	1.38	1.72	0.79	000
93641		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93641	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93641	26	A	Electrophysiology evaluation	5.92	2.32	2.92	2.32	2.92	1.34	000
93642		A	Electrophysiology evaluation	4.88	5.66	7.43	NA	NA	0.21	000
93642	TC	A	Electrophysiology evaluation	0.00	3.74	4.96	NA	NA	0.03	000
93642	26	A	Electrophysiology evaluation	4.88	1.92	2.47	1.92	2.47	0.18	000

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
93650		A	Ablate heart dysrhythm focus	10.49	NA	NA	4.39	5.48	2.36	000
93651		A	Ablate heart dysrhythm focus	16.23	NA	NA	6.37	8.00	3.67	000
93652		A	Ablate heart dysrhythm focus	17.65	NA	NA	6.95	8.73	4.00	000
93660		A	Tilt table evaluation	1.89	2.34	2.84	NA	NA	0.08	000
93660	TC	A	Tilt table evaluation	0.00	1.59	1.91	NA	NA	0.01	000
93660	26	A	Tilt table evaluation	1.89	0.75	0.93	0.75	0.93	0.07	000
93662		C	Intracardiac ecg (ice)	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93662	TC	C	Intracardiac ecg (ice)	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93662	26	A	Intracardiac ecg (ice)	2.80	1.09	1.38	1.09	1.38	0.21	ZZZ
93668		N	Peripheral vascular rehab	0.00	0.50	0.53	NA	NA	0.01	XXX
93701		A	Bioimpedance, cv analysis	0.00	0.64	0.77	NA	NA	0.01	XXX
93720		A	Total body plethysmography	0.17	1.19	1.22	NA	NA	0.02	XXX
93721		A	Plethysmography tracing	0.00	1.13	1.16	NA	NA	0.01	XXX
93722		A	Plethysmography report	0.17	0.06	0.06	0.06	0.06	0.01	XXX
93724		A	Analyze pacemaker system	4.88	2.66	3.73	NA	NA	0.19	000
93724	TC	A	Analyze pacemaker system	0.00	0.71	1.33	NA	NA	0.01	000
93724	26	A	Analyze pacemaker system	4.88	1.95	2.40	1.95	2.40	0.18	000
93740		B	Temperature gradient studies	0.16	0.07	0.08	NA	NA	0.02	XXX
93740	TC	B	Temperature gradient studies	0.00	0.00	0.02	NA	NA	0.01	XXX
93740	26	B	Temperature gradient studies	0.16	0.07	0.06	0.07	0.06	0.01	XXX
93745		C	Set-up cardiovert-defibrill	0.00	0.00	0.00	NA	NA	0.00	XXX
93745	TC	C	Set-up cardiovert-defibrill	0.00	0.00	0.00	NA	NA	0.00	XXX
93745	26	C	Set-up cardiovert-defibrill	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93750		A	Interrogation vad, in person	0.92	0.54	0.54	0.34	0.34	0.06	XXX
93770		B	Measure venous pressure	0.16	0.07	0.07	NA	NA	0.02	XXX
93770	TC	B	Measure venous pressure	0.00	0.00	0.01	NA	NA	0.01	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
93770	26	B	Measure venous pressure	0.16	0.07	0.06	0.07	0.06	0.01	XXX
93784		A	Ambulatory BP monitoring	0.38	1.10	1.39	NA	NA	0.03	XXX
93786		A	Ambulatory BP recording	0.00	0.81	0.89	NA	NA	0.01	XXX
93788		A	Ambulatory BP analysis	0.00	0.13	0.34	NA	NA	0.01	XXX
93790		A	Review/report BP recording	0.38	0.16	0.16	0.16	0.16	0.01	XXX
93797		A	Cardiac rehab	0.18	0.30	0.34	0.08	0.09	0.01	000
93798		A	Cardiac rehab/monitor	0.28	0.40	0.46	0.11	0.14	0.01	000
93799		C	Cardiovascular procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
93799	TC	C	Cardiovascular procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
93799	26	C	Cardiovascular procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93875		A	Extracranial study	0.22	2.68	2.82	NA	NA	0.02	XXX
93875	TC	A	Extracranial study	0.00	2.59	2.73	NA	NA	0.01	XXX
93875	26	A	Extracranial study	0.22	0.09	0.09	0.09	0.09	0.01	XXX
93880		A	Extracranial study	0.60	6.10	6.60	NA	NA	0.05	XXX
93880	TC	A	Extracranial study	0.00	5.87	6.35	NA	NA	0.01	XXX
93880	26	A	Extracranial study	0.60	0.23	0.25	0.23	0.25	0.04	XXX
93882		A	Extracranial study	0.40	4.49	4.58	NA	NA	0.07	XXX
93882	TC	A	Extracranial study	0.00	4.34	4.43	NA	NA	0.01	XXX
93882	26	A	Extracranial study	0.40	0.15	0.15	0.15	0.15	0.06	XXX
93886		A	Intracranial study	0.94	8.84	8.56	NA	NA	0.05	XXX
93886	TC	A	Intracranial study	0.00	8.44	8.17	NA	NA	0.01	XXX
93886	26	A	Intracranial study	0.94	0.40	0.39	0.40	0.39	0.04	XXX
93888		A	Intracranial study	0.62	5.24	5.45	NA	NA	0.05	XXX
93888	TC	A	Intracranial study	0.00	4.99	5.19	NA	NA	0.01	XXX
93888	26	A	Intracranial study	0.62	0.25	0.26	0.25	0.26	0.04	XXX
93890		A	Tcd, vasoreactivity study	1.00	6.54	6.77	NA	NA	0.05	XXX

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93890	TC	A	Tcd, vasoreactivity study	0.00	6.13	6.37	NA	NA	0.01	XXX
93890	26	A	Tcd, vasoreactivity study	1.00	0.41	0.40	0.41	0.40	0.04	XXX
93892		A	Tcd, emboli detect w/o inj	1.15	8.37	8.01	NA	NA	0.07	XXX
93892	TC	A	Tcd, emboli detect w/o inj	0.00	7.87	7.54	NA	NA	0.01	XXX
93892	26	A	Tcd, emboli detect w/o inj	1.15	0.50	0.47	0.50	0.47	0.06	XXX
93893		A	Tcd, emboli detect w/inj	1.15	9.18	8.41	NA	NA	0.07	XXX
93893	TC	A	Tcd, emboli detect w/inj	0.00	8.67	7.93	NA	NA	0.01	XXX
93893	26	A	Tcd, emboli detect w/inj	1.15	0.51	0.48	0.51	0.48	0.06	XXX
93922		A	Extremity study	0.25	3.26	3.41	NA	NA	0.02	XXX
93922	TC	A	Extremity study	0.00	3.17	3.31	NA	NA	0.01	XXX
93922	26	A	Extremity study	0.25	0.09	0.10	0.09	0.10	0.01	XXX
93923		A	Extremity study	0.45	4.84	5.09	NA	NA	0.05	XXX
93923	TC	A	Extremity study	0.00	4.67	4.92	NA	NA	0.01	XXX
93923	26	A	Extremity study	0.45	0.17	0.17	0.17	0.17	0.04	XXX
93924		A	Extremity study	0.50	5.96	6.32	NA	NA	0.05	XXX
93924	TC	A	Extremity study	0.00	5.77	6.12	NA	NA	0.01	XXX
93924	26	A	Extremity study	0.50	0.19	0.20	0.19	0.20	0.04	XXX
93925		A	Lower extremity study	0.58	7.95	8.53	NA	NA	0.07	XXX
93925	TC	A	Lower extremity study	0.00	7.73	8.30	NA	NA	0.03	XXX
93925	26	A	Lower extremity study	0.58	0.22	0.23	0.22	0.23	0.04	XXX
93926		A	Lower extremity study	0.39	5.26	5.52	NA	NA	0.07	XXX
93926	TC	A	Lower extremity study	0.00	5.12	5.37	NA	NA	0.01	XXX
93926	26	A	Lower extremity study	0.39	0.14	0.15	0.14	0.15	0.06	XXX
93930		A	Upper extremity study	0.46	6.33	6.72	NA	NA	0.05	XXX
93930	TC	A	Upper extremity study	0.00	6.16	6.54	NA	NA	0.01	XXX
93930	26	A	Upper extremity study	0.46	0.17	0.18	0.17	0.18	0.04	XXX

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93931		A	Upper extremity study	0.31	4.21	4.49	NA	NA	0.04	XXX
93931	TC	A	Upper extremity study	0.00	4.10	4.37	NA	NA	0.01	XXX
93931	26	A	Upper extremity study	0.31	0.11	0.12	0.11	0.12	0.03	XXX
93965		A	Extremity study	0.35	3.05	3.28	NA	NA	0.04	XXX
93965	TC	A	Extremity study	0.00	2.92	3.14	NA	NA	0.01	XXX
93965	26	A	Extremity study	0.35	0.13	0.14	0.13	0.14	0.03	XXX
93970		A	Extremity study	0.68	6.29	6.69	NA	NA	0.08	XXX
93970	TC	A	Extremity study	0.00	6.05	6.43	NA	NA	0.01	XXX
93970	26	A	Extremity study	0.68	0.24	0.26	0.24	0.26	0.07	XXX
93971		A	Extremity study	0.45	4.08	4.40	NA	NA	0.05	XXX
93971	TC	A	Extremity study	0.00	3.92	4.22	NA	NA	0.01	XXX
93971	26	A	Extremity study	0.45	0.16	0.18	0.16	0.18	0.04	XXX
93975		A	Vascular study	1.80	8.33	9.05	NA	NA	0.17	XXX
93975	TC	A	Vascular study	0.00	7.67	8.33	NA	NA	0.03	XXX
93975	26	A	Vascular study	1.80	0.66	0.72	0.66	0.72	0.14	XXX
93976		A	Vascular study	1.21	4.54	4.97	NA	NA	0.09	XXX
93976	TC	A	Vascular study	0.00	4.11	4.49	NA	NA	0.01	XXX
93976	26	A	Vascular study	1.21	0.43	0.48	0.43	0.48	0.08	XXX
93978		A	Vascular study	0.65	5.98	6.32	NA	NA	0.08	XXX
93978	TC	A	Vascular study	0.00	5.74	6.07	NA	NA	0.01	XXX
93978	26	A	Vascular study	0.65	0.24	0.25	0.24	0.25	0.07	XXX
93979		A	Vascular study	0.44	4.15	4.40	NA	NA	0.05	XXX
93979	TC	A	Vascular study	0.00	3.99	4.23	NA	NA	0.01	XXX
93979	26	A	Vascular study	0.44	0.16	0.17	0.16	0.17	0.04	XXX
93980		A	Penile vascular study	1.25	3.48	3.82	NA	NA	0.08	XXX
93980	TC	A	Penile vascular study	0.00	2.99	3.28	NA	NA	0.01	XXX

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93980	26	A	Penile vascular study	1.25	0.49	0.54	0.49	0.54	0.07	XXX
93981		A	Penile vascular study	0.44	2.64	3.03	NA	NA	0.04	XXX
93981	TC	A	Penile vascular study	0.00	2.48	2.85	NA	NA	0.01	XXX
93981	26	A	Penile vascular study	0.44	0.16	0.18	0.16	0.18	0.03	XXX
93982		R	Aneurysm pressure sens study	0.30	0.85	0.90	NA	NA	0.06	XXX
93990		A	Doppler flow testing	0.25	5.80	5.82	NA	NA	0.05	XXX
93990	TC	A	Doppler flow testing	0.00	5.71	5.73	NA	NA	0.01	XXX
93990	26	A	Doppler flow testing	0.25	0.09	0.09	0.09	0.09	0.04	XXX
94002		A	Vent mgmt inpat, init day	1.99	NA	NA	0.58	0.50	0.17	XXX
94003		A	Vent mgmt inpat, subq day	1.37	NA	NA	0.48	0.44	0.10	XXX
94004		A	Vent mgmt nf per day	1.00	NA	NA	0.34	0.32	0.07	XXX
94005		B	Home vent mgmt supervision	1.50	1.08	1.07	NA	NA	0.10	XXX
94010		A	Breathing capacity test	0.17	0.81	0.83	NA	NA	0.02	XXX
94010	TC	A	Breathing capacity test	0.00	0.74	0.77	NA	NA	0.01	XXX
94010	26	A	Breathing capacity test	0.17	0.07	0.06	0.07	0.06	0.01	XXX
94011		A	Up to 2 yrs old, spirometry	2.00	NA	NA	0.74	0.74	0.14	XXX
94012		A	= 2 yrs, spiromtry w/dilator	3.10	NA	NA	1.12	1.12	0.24	XXX
94013		A	= 2 yrs, lung volumes	0.66	NA	NA	0.21	0.21	0.04	XXX
94014		A	Patient recorded spirometry	0.52	0.81	0.88	NA	NA	0.02	XXX
94015		A	Patient recorded spirometry	0.00	0.63	0.70	NA	NA	0.01	XXX
94016		A	Review patient spirometry	0.52	0.18	0.18	0.18	0.18	0.01	XXX
94060		A	Evaluation of wheezing	0.31	1.39	1.43	NA	NA	0.02	XXX
94060	TC	A	Evaluation of wheezing	0.00	1.27	1.32	NA	NA	0.01	XXX
94060	26	A	Evaluation of wheezing	0.31	0.12	0.11	0.12	0.11	0.01	XXX
94070		A	Evaluation of wheezing	0.60	1.07	1.10	NA	NA	0.04	XXX
94070	TC	A	Evaluation of wheezing	0.00	0.85	0.89	NA	NA	0.01	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
94070	26	A	Evaluation of wheezing	0.60	0.22	0.21	0.22	0.21	0.03	XXX
94150		B	Vital capacity test	0.07	0.60	0.61	NA	NA	0.02	XXX
94150	TC	B	Vital capacity test	0.00	0.57	0.58	NA	NA	0.01	XXX
94150	26	B	Vital capacity test	0.07	0.03	0.03	0.03	0.03	0.01	XXX
94200		A	Lung function test (MBC/MVV)	0.11	0.55	0.57	NA	NA	0.02	XXX
94200	TC	A	Lung function test (MBC/MVV)	0.00	0.51	0.53	NA	NA	0.01	XXX
94200	26	A	Lung function test (MBC/MVV)	0.11	0.04	0.04	0.04	0.04	0.01	XXX
94240		A	Residual lung capacity	0.26	0.83	0.88	NA	NA	0.02	XXX
94240	TC	A	Residual lung capacity	0.00	0.74	0.79	NA	NA	0.01	XXX
94240	26	A	Residual lung capacity	0.26	0.09	0.09	0.09	0.09	0.01	XXX
94250		A	Expired gas collection	0.11	0.56	0.61	NA	NA	0.02	XXX
94250	TC	A	Expired gas collection	0.00	0.52	0.57	NA	NA	0.01	XXX
94250	26	A	Expired gas collection	0.11	0.04	0.04	0.04	0.04	0.01	XXX
94260		A	Thoracic gas volume	0.13	0.75	0.79	NA	NA	0.02	XXX
94260	TC	A	Thoracic gas volume	0.00	0.71	0.75	NA	NA	0.01	XXX
94260	26	A	Thoracic gas volume	0.13	0.04	0.04	0.04	0.04	0.01	XXX
94350		A	Lung nitrogen washout curve	0.26	0.66	0.73	NA	NA	0.02	XXX
94350	TC	A	Lung nitrogen washout curve	0.00	0.57	0.64	NA	NA	0.01	XXX
94350	26	A	Lung nitrogen washout curve	0.26	0.09	0.09	0.09	0.09	0.01	XXX
94360		A	Measure airflow resistance	0.26	0.96	1.01	NA	NA	0.02	XXX
94360	TC	A	Measure airflow resistance	0.00	0.87	0.92	NA	NA	0.01	XXX
94360	26	A	Measure airflow resistance	0.26	0.09	0.09	0.09	0.09	0.01	XXX
94370		A	Breath airway closing volume	0.26	0.68	0.71	NA	NA	0.02	XXX
94370	TC	A	Breath airway closing volume	0.00	0.58	0.62	NA	NA	0.01	XXX
94370	26	A	Breath airway closing volume	0.26	0.10	0.09	0.10	0.09	0.01	XXX
94375		A	Respiratory flow volume loop	0.31	0.75	0.78	NA	NA	0.02	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
94375	TC	A	Respiratory flow volume loop	0.00	0.64	0.68	NA	NA	0.01	XXX
94375	26	A	Respiratory flow volume loop	0.31	0.11	0.10	0.11	0.10	0.01	XXX
94400		A	CO2 breathing response curve	0.40	1.10	1.14	NA	NA	0.02	XXX
94400	TC	A	CO2 breathing response curve	0.00	0.96	1.00	NA	NA	0.01	XXX
94400	26	A	CO2 breathing response curve	0.40	0.14	0.14	0.14	0.14	0.01	XXX
94450		A	Hypoxia response curve	0.40	1.44	1.29	NA	NA	0.02	XXX
94450	TC	A	Hypoxia response curve	0.00	1.27	1.15	NA	NA	0.01	XXX
94450	26	A	Hypoxia response curve	0.40	0.17	0.14	0.17	0.14	0.01	XXX
94452		A	Hast w/report	0.31	1.25	1.33	NA	NA	0.02	XXX
94452	TC	A	Hast w/report	0.00	1.14	1.23	NA	NA	0.01	XXX
94452	26	A	Hast w/report	0.31	0.11	0.10	0.11	0.10	0.01	XXX
94453		A	Hast w/oxygen titrate	0.40	1.71	1.82	NA	NA	0.02	XXX
94453	TC	A	Hast w/oxygen titrate	0.00	1.58	1.69	NA	NA	0.01	XXX
94453	26	A	Hast w/oxygen titrate	0.40	0.13	0.13	0.13	0.13	0.01	XXX
94610		A	Surfactant admin thru tube	1.16	0.55	0.50	0.55	0.50	0.07	XXX
94620		A	Pulmonary stress test/simple	0.64	0.87	1.16	NA	NA	0.04	XXX
94620	TC	A	Pulmonary stress test/simple	0.00	0.64	0.94	NA	NA	0.01	XXX
94620	26	A	Pulmonary stress test/simple	0.64	0.23	0.22	0.23	0.22	0.03	XXX
94621		A	Pulm stress test/complex	1.42	3.03	3.25	NA	NA	0.07	XXX
94621	TC	A	Pulm stress test/complex	0.00	2.51	2.71	NA	NA	0.01	XXX
94621	26	A	Pulm stress test/complex	1.42	0.52	0.54	0.52	0.54	0.06	XXX
94640		A	Airway inhalation treatment	0.00	0.47	0.45	NA	NA	0.01	XXX
94642		C	Aerosol inhalation treatment	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94644		A	Cbt, 1st hour	0.00	1.18	1.15	NA	NA	0.01	XXX
94645		A	Cbt, each addl hour	0.00	0.39	0.41	NA	NA	0.01	XXX
94660		A	Pos airway pressure, CPAP	0.76	0.93	0.92	0.29	0.27	0.06	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
94662		A	Neg press ventilation, cnp	0.76	NA	NA	0.25	0.25	0.06	XXX
94664		A	Evaluate pt use of inhaler	0.00	0.46	0.45	NA	NA	0.01	XXX
94667		A	Chest wall manipulation	0.00	0.65	0.64	NA	NA	0.01	XXX
94668		A	Chest wall manipulation	0.00	0.62	0.62	NA	NA	0.01	XXX
94680		A	Exhaled air analysis, o2	0.26	1.32	1.42	NA	NA	0.02	XXX
94680	TC	A	Exhaled air analysis, o2	0.00	1.21	1.32	NA	NA	0.01	XXX
94680	26	A	Exhaled air analysis, o2	0.26	0.11	0.10	0.11	0.10	0.01	XXX
94681		A	Exhaled air analysis, o2/co2	0.20	1.17	1.43	NA	NA	0.02	XXX
94681	TC	A	Exhaled air analysis, o2/co2	0.00	1.09	1.36	NA	NA	0.01	XXX
94681	26	A	Exhaled air analysis, o2/co2	0.20	0.08	0.07	0.08	0.07	0.01	XXX
94690		A	Exhaled air analysis	0.07	1.28	1.41	NA	NA	0.02	XXX
94690	TC	A	Exhaled air analysis	0.00	1.25	1.38	NA	NA	0.01	XXX
94690	26	A	Exhaled air analysis	0.07	0.03	0.03	0.03	0.03	0.01	XXX
94720		A	Monoxide diffusing capacity	0.26	1.15	1.23	NA	NA	0.02	XXX
94720	TC	A	Monoxide diffusing capacity	0.00	1.06	1.14	NA	NA	0.01	XXX
94720	26	A	Monoxide diffusing capacity	0.26	0.09	0.09	0.09	0.09	0.01	XXX
94725		A	Membrane diffusion capacity	0.26	1.14	1.44	NA	NA	0.02	XXX
94725	TC	A	Membrane diffusion capacity	0.00	1.04	1.35	NA	NA	0.01	XXX
94725	26	A	Membrane diffusion capacity	0.26	0.10	0.09	0.10	0.09	0.01	XXX
94750		A	Pulmonary compliance study	0.23	1.99	2.00	NA	NA	0.02	XXX
94750	TC	A	Pulmonary compliance study	0.00	1.90	1.92	NA	NA	0.01	XXX
94750	26	A	Pulmonary compliance study	0.23	0.09	0.08	0.09	0.08	0.01	XXX
94760		T	Measure blood oxygen level	0.00	0.07	0.07	NA	NA	0.01	XXX
94761		T	Measure blood oxygen level	0.00	0.12	0.12	NA	NA	0.01	XXX
94762		A	Measure blood oxygen level	0.00	0.28	0.57	NA	NA	0.01	XXX
94770		A	Exhaled carbon dioxide test	0.15	0.06	0.50	NA	NA	0.02	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
94770	TC	A	Exhaled carbon dioxide test	0.00	0.00	0.44	NA	NA	0.01	XXX
94770	26	A	Exhaled carbon dioxide test	0.15	0.06	0.06	0.06	0.06	0.01	XXX
94772		C	Breath recording, infant	0.00	0.00	0.00	NA	NA	0.00	XXX
94772	TC	C	Breath recording, infant	0.00	0.00	0.00	NA	NA	0.00	XXX
94772	26	C	Breath recording, infant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94774		C	Ped home apnea rec, compl	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94775		C	Ped home apnea rec, hk-up	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94776		C	Ped home apnea rec, downld	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94777		C	Ped home apnea rec, report	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94799		C	Pulmonary service/procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
94799	TC	C	Pulmonary service/procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
94799	26	C	Pulmonary service/procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95004		A	Percut allergy skin tests	0.01	0.16	0.17	NA	NA	0.01	XXX
95010		A	Percut allergy titrate test	0.15	0.37	0.37	NA	NA	0.01	XXX
95012		A	Exhaled nitric oxide meas	0.00	0.54	0.59	NA	NA	0.01	XXX
95015		A	Id allergy titrate-drug/bug	0.15	0.29	0.26	NA	NA	0.01	XXX
95024		A	Id allergy test, drug/bug	0.01	0.19	0.19	NA	NA	0.01	XXX
95027		A	Id allergy titrate-airborne	0.01	0.11	0.12	NA	NA	0.01	XXX
95028		A	Id allergy test-delayed type	0.00	0.37	0.36	NA	NA	0.01	XXX
95044		A	Allergy patch tests	0.00	0.15	0.17	NA	NA	0.01	XXX
95052		A	Photo patch test	0.00	0.17	0.19	NA	NA	0.01	XXX
95056		A	Photosensitivity tests	0.00	1.20	1.17	NA	NA	0.01	XXX
95060		A	Eye allergy tests	0.00	0.90	0.82	0.90	0.82	0.01	XXX
95065		A	Nose allergy test	0.00	0.70	0.70	0.70	0.70	0.01	XXX
95070		A	Bronchial allergy tests	0.00	0.78	1.09	NA	NA	0.01	XXX
95071		A	Bronchial allergy tests	0.00	1.20	1.47	NA	NA	0.01	XXX

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95075		A	Ingestion challenge test	0.95	0.89	0.89	0.43	0.41	0.04	XXX
95115		A	Immunotherapy, one injection	0.00	0.25	0.29	NA	NA	0.01	XXX
95117		A	Immunotherapy injections	0.00	0.30	0.35	NA	NA	0.01	XXX
95120		I	Immunotherapy, one injection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95125		I	Immunotherapy, many antigens	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95130		I	Immunotherapy, insect venom	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95131		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95132		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95133		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95134		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95144		A	Antigen therapy services	0.06	0.29	0.30	0.03	0.03	0.01	XXX
95145		A	Antigen therapy services	0.06	0.54	0.48	0.03	0.03	0.01	XXX
95146		A	Antigen therapy services	0.06	1.03	0.89	0.03	0.03	0.01	XXX
95147		A	Antigen therapy services	0.06	0.93	0.83	0.03	0.03	0.01	XXX
95148		A	Antigen therapy services	0.06	1.42	1.24	0.03	0.03	0.01	XXX
95149		A	Antigen therapy services	0.06	1.93	1.67	0.03	0.03	0.01	XXX
95165		A	Antigen therapy services	0.06	0.29	0.30	0.03	0.03	0.01	XXX
95170		A	Antigen therapy services	0.06	0.21	0.21	0.03	0.03	0.01	XXX
95180		A	Rapid desensitization	2.01	1.90	2.03	0.97	1.00	0.07	XXX
95199		C	Allergy immunology services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95250		A	Glucose monitoring, cont	0.00	4.25	4.26	NA	NA	0.01	XXX
95251		A	Gluc monitor, cont, phys i&r	0.85	0.38	0.33	0.38	0.33	0.04	XXX
95803		A	Actigraphy testing	1.00	3.05	3.05	NA	NA	0.05	XXX
95803	TC	A	Actigraphy testing	0.00	2.58	2.58	NA	NA	0.01	XXX
95803	26	A	Actigraphy testing	1.00	0.47	0.47	0.47	0.47	0.04	XXX
95805		A	Multiple sleep latency test	1.88	7.45	9.36	NA	NA	0.11	XXX

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95805	TC	A	Multiple sleep latency test	0.00	6.72	8.66	NA	NA	0.04	XXX
95805	26	A	Multiple sleep latency test	1.88	0.73	0.70	0.73	0.70	0.07	XXX
95806		A	Sleep study unatt&resp efft	1.66	4.22	4.36	NA	NA	0.10	XXX
95806	TC	A	Sleep study unatt&resp efft	0.00	3.58	3.74	NA	NA	0.03	XXX
95806	26	A	Sleep study unatt&resp efft	1.66	0.64	0.62	0.64	0.62	0.07	XXX
95807		A	Sleep study, attended	1.66	11.94	12.90	NA	NA	0.17	XXX
95807	TC	A	Sleep study, attended	0.00	11.35	12.31	NA	NA	0.10	XXX
95807	26	A	Sleep study, attended	1.66	0.59	0.59	0.59	0.59	0.07	XXX
95808		A	Polysomnography, 1-3	2.65	18.28	18.00	NA	NA	0.21	XXX
95808	TC	A	Polysomnography, 1-3	0.00	17.21	16.99	NA	NA	0.10	XXX
95808	26	A	Polysomnography, 1-3	2.65	1.07	1.01	1.07	1.01	0.11	XXX
95810		A	Polysomnography, 4 or more	3.52	18.17	19.41	NA	NA	0.25	XXX
95810	TC	A	Polysomnography, 4 or more	0.00	16.85	18.15	NA	NA	0.11	XXX
95810	26	A	Polysomnography, 4 or more	3.52	1.32	1.26	1.32	1.26	0.14	XXX
95811		A	Polysomnography w/cpap	3.79	20.09	21.50	NA	NA	0.30	XXX
95811	TC	A	Polysomnography w/cpap	0.00	18.68	20.15	NA	NA	0.13	XXX
95811	26	A	Polysomnography w/cpap	3.79	1.41	1.35	1.41	1.35	0.17	XXX
95812		A	Eeg, 41-60 minutes	1.08	9.44	7.91	NA	NA	0.07	XXX
95812	TC	A	Eeg, 41-60 minutes	0.00	8.94	7.45	NA	NA	0.03	XXX
95812	26	A	Eeg, 41-60 minutes	1.08	0.50	0.46	0.50	0.46	0.04	XXX
95813		A	Eeg, over 1 hour	1.73	9.39	8.36	NA	NA	0.11	XXX
95813	TC	A	Eeg, over 1 hour	0.00	8.61	7.64	NA	NA	0.04	XXX
95813	26	A	Eeg, over 1 hour	1.73	0.78	0.72	0.78	0.72	0.07	XXX
95816		A	Eeg, awake and drowsy	1.08	8.71	7.22	NA	NA	0.09	XXX
95816	TC	A	Eeg, awake and drowsy	0.00	8.20	6.76	NA	NA	0.03	XXX
95816	26	A	Eeg, awake and drowsy	1.08	0.51	0.46	0.51	0.46	0.06	XXX

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95819		A	Eeg, awake and asleep	1.08	10.12	8.20	NA	NA	0.07	XXX
95819	TC	A	Eeg, awake and asleep	0.00	9.61	7.74	NA	NA	0.03	XXX
95819	26	A	Eeg, awake and asleep	1.08	0.51	0.46	0.51	0.46	0.04	XXX
95822		A	Eeg, coma or sleep only	1.08	8.99	7.59	NA	NA	0.07	XXX
95822	TC	A	Eeg, coma or sleep only	0.00	8.48	7.13	NA	NA	0.03	XXX
95822	26	A	Eeg, coma or sleep only	1.08	0.51	0.46	0.51	0.46	0.04	XXX
95824		C	Eeg, cerebral death only	0.00	0.00	0.00	NA	NA	0.00	XXX
95824	TC	C	Eeg, cerebral death only	0.00	0.00	0.00	NA	NA	0.00	XXX
95824	26	A	Eeg, cerebral death only	0.74	0.34	0.32	0.34	0.32	0.06	XXX
95827		A	Eeg, all night recording	1.08	18.67	14.83	NA	NA	0.14	XXX
95827	TC	A	Eeg, all night recording	0.00	18.16	14.37	NA	NA	0.08	XXX
95827	26	A	Eeg, all night recording	1.08	0.51	0.46	0.51	0.46	0.06	XXX
95829		A	Surgery electrocorticogram	6.20	41.25	36.63	NA	NA	0.23	XXX
95829	TC	A	Surgery electrocorticogram	0.00	38.33	33.96	NA	NA	0.06	XXX
95829	26	A	Surgery electrocorticogram	6.20	2.92	2.67	2.92	2.67	0.17	XXX
95830		A	Insert electrodes for EEG	1.70	3.74	3.69	0.72	0.69	0.14	XXX
95831		A	Limb muscle testing, manual	0.28	0.56	0.53	0.14	0.13	0.03	XXX
95832		A	Hand muscle testing, manual	0.29	0.55	0.49	0.16	0.14	0.03	XXX
95833		A	Body muscle testing, manual	0.47	0.60	0.59	0.16	0.18	0.01	XXX
95834		A	Body muscle testing, manual	0.60	0.80	0.71	0.25	0.24	0.03	XXX
95851		A	Range of motion measurements	0.16	0.34	0.34	0.06	0.06	0.01	XXX
95852		A	Range of motion measurements	0.11	0.34	0.31	0.05	0.05	0.01	XXX
95857		A	Tensilon test	0.53	0.90	0.80	0.30	0.26	0.04	XXX
95860		A	Muscle test, one limb	0.96	1.79	1.63	NA	NA	0.04	XXX
95860	TC	A	Muscle test, one limb	0.00	1.30	1.17	NA	NA	0.01	XXX
95860	26	A	Muscle test, one limb	0.96	0.49	0.46	0.49	0.46	0.03	XXX

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95861		A	Muscle test, 2 limbs	1.54	2.52	2.21	NA	NA	0.07	XXX
95861	TC	A	Muscle test, 2 limbs	0.00	1.74	1.48	NA	NA	0.01	XXX
95861	26	A	Muscle test, 2 limbs	1.54	0.78	0.73	0.78	0.73	0.06	XXX
95863		A	Muscle test, 3 limbs	1.87	3.07	2.64	NA	NA	0.08	XXX
95863	TC	A	Muscle test, 3 limbs	0.00	2.16	1.80	NA	NA	0.01	XXX
95863	26	A	Muscle test, 3 limbs	1.87	0.91	0.84	0.91	0.84	0.07	XXX
95864		A	Muscle test, 4 limbs	1.99	3.25	2.98	NA	NA	0.08	XXX
95864	TC	A	Muscle test, 4 limbs	0.00	2.28	2.07	NA	NA	0.01	XXX
95864	26	A	Muscle test, 4 limbs	1.99	0.97	0.91	0.97	0.91	0.07	XXX
95865		A	Muscle test, larynx	1.57	2.01	1.86	NA	NA	0.05	XXX
95865	TC	A	Muscle test, larynx	0.00	1.19	1.09	NA	NA	0.01	XXX
95865	26	A	Muscle test, larynx	1.57	0.82	0.77	0.82	0.77	0.04	XXX
95866		A	Muscle test, hemidiaphragm	1.25	1.96	1.70	NA	NA	0.07	XXX
95866	TC	A	Muscle test, hemidiaphragm	0.00	1.37	1.13	NA	NA	0.01	XXX
95866	26	A	Muscle test, hemidiaphragm	1.25	0.59	0.57	0.59	0.57	0.06	XXX
95867		A	Muscle test cran nerv unilat	0.79	1.68	1.50	NA	NA	0.04	XXX
95867	TC	A	Muscle test cran nerv unilat	0.00	1.28	1.13	NA	NA	0.01	XXX
95867	26	A	Muscle test cran nerv unilat	0.79	0.40	0.37	0.40	0.37	0.03	XXX
95868		A	Muscle test cran nerve bilat	1.18	2.19	1.93	NA	NA	0.05	XXX
95868	TC	A	Muscle test cran nerve bilat	0.00	1.61	1.39	NA	NA	0.01	XXX
95868	26	A	Muscle test cran nerve bilat	1.18	0.58	0.54	0.58	0.54	0.04	XXX
95869		A	Muscle test, thor paraspinal	0.37	1.59	1.29	NA	NA	0.02	XXX
95869	TC	A	Muscle test, thor paraspinal	0.00	1.40	1.12	NA	NA	0.01	XXX
95869	26	A	Muscle test, thor paraspinal	0.37	0.19	0.17	0.19	0.17	0.01	XXX
95870		A	Muscle test, nonparaspinal	0.37	1.55	1.26	NA	NA	0.02	XXX
95870	TC	A	Muscle test, nonparaspinal	0.00	1.37	1.09	NA	NA	0.01	XXX

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95870	26	A	Muscle test, nonparaspinal	0.37	0.18	0.17	0.18	0.17	0.01	XXX
95872		A	Muscle test, one fiber	2.88	2.50	2.18	NA	NA	0.12	XXX
95872	TC	A	Muscle test, one fiber	0.00	1.16	1.00	NA	NA	0.01	XXX
95872	26	A	Muscle test, one fiber	2.88	1.34	1.18	1.34	1.18	0.11	XXX
95873		A	Guide nerv destr, elec stim	0.37	1.57	1.30	NA	NA	0.02	ZZZ
95873	TC	A	Guide nerv destr, elec stim	0.00	1.36	1.10	NA	NA	0.01	ZZZ
95873	26	A	Guide nerv destr, elec stim	0.37	0.21	0.20	0.21	0.20	0.01	ZZZ
95874		A	Guide nerv destr, needle emg	0.37	1.49	1.22	NA	NA	0.02	ZZZ
95874	TC	A	Guide nerv destr, needle emg	0.00	1.30	1.04	NA	NA	0.01	ZZZ
95874	26	A	Guide nerv destr, needle emg	0.37	0.19	0.18	0.19	0.18	0.01	ZZZ
95875		A	Limb exercise test	1.10	2.14	1.88	NA	NA	0.07	XXX
95875	TC	A	Limb exercise test	0.00	1.62	1.40	NA	NA	0.01	XXX
95875	26	A	Limb exercise test	1.10	0.52	0.48	0.52	0.48	0.06	XXX
95900		A	Motor nerve conduction test	0.42	1.40	1.30	NA	NA	0.02	XXX
95900	TC	A	Motor nerve conduction test	0.00	1.19	1.10	NA	NA	0.01	XXX
95900	26	A	Motor nerve conduction test	0.42	0.21	0.20	0.21	0.20	0.01	XXX
95903		A	Motor nerve conduction test	0.60	1.50	1.38	NA	NA	0.04	XXX
95903	TC	A	Motor nerve conduction test	0.00	1.21	1.12	NA	NA	0.01	XXX
95903	26	A	Motor nerve conduction test	0.60	0.29	0.26	0.29	0.26	0.03	XXX
95904		A	Sense nerve conduction test	0.34	1.25	1.17	NA	NA	0.02	XXX
95904	TC	A	Sense nerve conduction test	0.00	1.08	1.01	NA	NA	0.01	XXX
95904	26	A	Sense nerve conduction test	0.34	0.17	0.16	0.17	0.16	0.01	XXX
95905		A	Motor/sens nrve conduct test	0.05	2.34	2.34	NA	NA	0.02	XXX
95905	TC	A	Motor/sens nrve conduct test	0.00	2.32	2.32	NA	NA	0.01	XXX
95905	26	A	Motor/sens nrve conduct test	0.05	0.02	0.02	0.02	0.02	0.01	XXX
95920		A	Intraop nerve test add-on	2.11	2.62	2.41	NA	NA	0.09	ZZZ

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95920	TC	A	Intraop nerve test add-on	0.00	1.62	1.48	NA	NA	0.01	ZZZ
95920	26	A	Intraop nerve test add-on	2.11	1.00	0.93	1.00	0.93	0.08	ZZZ
95921		A	Autonomic nerv function test	0.90	1.49	1.38	NA	NA	0.04	XXX
95921	TC	A	Autonomic nerv function test	0.00	1.09	1.01	NA	NA	0.01	XXX
95921	26	A	Autonomic nerv function test	0.90	0.40	0.37	0.40	0.37	0.03	XXX
95922		A	Autonomic nerv function test	0.96	2.05	1.86	NA	NA	0.04	XXX
95922	TC	A	Autonomic nerv function test	0.00	1.62	1.46	NA	NA	0.01	XXX
95922	26	A	Autonomic nerv function test	0.96	0.43	0.40	0.43	0.40	0.03	XXX
95923		A	Autonomic nerv function test	0.90	3.80	3.22	NA	NA	0.05	XXX
95923	TC	A	Autonomic nerv function test	0.00	3.37	2.83	NA	NA	0.01	XXX
95923	26	A	Autonomic nerv function test	0.90	0.43	0.39	0.43	0.39	0.04	XXX
95925		A	Somatosensory testing	0.54	4.79	3.96	NA	NA	0.02	XXX
95925	TC	A	Somatosensory testing	0.00	4.54	3.72	NA	NA	0.01	XXX
95925	26	A	Somatosensory testing	0.54	0.25	0.24	0.25	0.24	0.01	XXX
95926		A	Somatosensory testing	0.54	4.50	3.78	NA	NA	0.04	XXX
95926	TC	A	Somatosensory testing	0.00	4.25	3.55	NA	NA	0.01	XXX
95926	26	A	Somatosensory testing	0.54	0.25	0.23	0.25	0.23	0.03	XXX
95927		A	Somatosensory testing	0.54	3.94	3.54	NA	NA	0.02	XXX
95927	TC	A	Somatosensory testing	0.00	3.69	3.30	NA	NA	0.01	XXX
95927	26	A	Somatosensory testing	0.54	0.25	0.24	0.25	0.24	0.01	XXX
95928		A	C motor evoked, uppr limbs	1.50	6.06	5.17	NA	NA	0.10	XXX
95928	TC	A	C motor evoked, uppr limbs	0.00	5.35	4.52	NA	NA	0.03	XXX
95928	26	A	C motor evoked, uppr limbs	1.50	0.71	0.65	0.71	0.65	0.07	XXX
95929		A	C motor evoked, lwr limbs	1.50	6.51	5.57	NA	NA	0.10	XXX
95929	TC	A	C motor evoked, lwr limbs	0.00	5.80	4.91	NA	NA	0.03	XXX
95929	26	A	C motor evoked, lwr limbs	1.50	0.71	0.66	0.71	0.66	0.07	XXX

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95930		A	Visual evoked potential test	0.35	3.98	3.48	NA	NA	0.02	XXX
95930	TC	A	Visual evoked potential test	0.00	3.80	3.32	NA	NA	0.01	XXX
95930	26	A	Visual evoked potential test	0.35	0.18	0.16	0.18	0.16	0.01	XXX
95933		A	Blink reflex test	0.59	1.73	1.51	NA	NA	0.04	XXX
95933	TC	A	Blink reflex test	0.00	1.44	1.25	NA	NA	0.01	XXX
95933	26	A	Blink reflex test	0.59	0.29	0.26	0.29	0.26	0.03	XXX
95934		A	H-reflex test	0.51	1.27	1.09	NA	NA	0.02	XXX
95934	TC	A	H-reflex test	0.00	1.02	0.86	NA	NA	0.01	XXX
95934	26	A	H-reflex test	0.51	0.25	0.23	0.25	0.23	0.01	XXX
95936		A	H-reflex test	0.55	0.87	0.78	NA	NA	0.02	XXX
95936	TC	A	H-reflex test	0.00	0.61	0.53	NA	NA	0.01	XXX
95936	26	A	H-reflex test	0.55	0.26	0.25	0.26	0.25	0.01	XXX
95937		A	Neuromuscular junction test	0.65	1.36	1.18	NA	NA	0.05	XXX
95937	TC	A	Neuromuscular junction test	0.00	1.05	0.89	NA	NA	0.01	XXX
95937	26	A	Neuromuscular junction test	0.65	0.31	0.29	0.31	0.29	0.04	XXX
95950		A	Ambulatory eeg monitoring	1.51	7.96	6.74	NA	NA	0.10	XXX
95950	TC	A	Ambulatory eeg monitoring	0.00	7.25	6.09	NA	NA	0.03	XXX
95950	26	A	Ambulatory eeg monitoring	1.51	0.71	0.65	0.71	0.65	0.07	XXX
95951		C	EEG monitoring/videorecord	0.00	0.00	0.00	NA	NA	0.00	XXX
95951	TC	C	EEG monitoring/videorecord	0.00	0.00	0.00	NA	NA	0.00	XXX
95951	26	A	EEG monitoring/videorecord	5.99	2.82	2.59	2.82	2.59	0.49	XXX
95953		A	EEG monitoring/computer	3.30	12.06	10.36	NA	NA	0.20	XXX
95953	TC	A	EEG monitoring/computer	0.00	10.51	8.95	NA	NA	0.03	XXX
95953	26	A	EEG monitoring/computer	3.30	1.55	1.41	1.55	1.41	0.17	XXX
95954		A	EEG monitoring/giving drugs	2.45	7.85	6.41	NA	NA	0.15	XXX
95954	TC	A	EEG monitoring/giving drugs	0.00	6.98	5.64	NA	NA	0.04	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
95954	26	A	EEG monitoring/giving drugs	2.45	0.87	0.77	0.87	0.77	0.11	XXX
95955		A	EEG during surgery	1.01	4.48	3.78	NA	NA	0.05	XXX
95955	TC	A	EEG during surgery	0.00	4.01	3.36	NA	NA	0.01	XXX
95955	26	A	EEG during surgery	1.01	0.47	0.42	0.47	0.42	0.04	XXX
95956		A	Eeg monitoring, cable/radio	3.08	22.11	20.56	NA	NA	0.31	XXX
95956	TC	A	Eeg monitoring, cable/radio	0.00	20.74	19.27	NA	NA	0.17	XXX
95956	26	A	Eeg monitoring, cable/radio	3.08	1.37	1.29	1.37	1.29	0.14	XXX
95957		A	EEG digital analysis	1.98	9.42	7.67	NA	NA	0.11	XXX
95957	TC	A	EEG digital analysis	0.00	8.50	6.82	NA	NA	0.01	XXX
95957	26	A	EEG digital analysis	1.98	0.92	0.85	0.92	0.85	0.10	XXX
95958		A	EEG monitoring/function test	4.24	10.07	8.61	NA	NA	0.27	XXX
95958	TC	A	EEG monitoring/function test	0.00	8.17	6.81	NA	NA	0.04	XXX
95958	26	A	EEG monitoring/function test	4.24	1.90	1.80	1.90	1.80	0.23	XXX
95961		A	Electrode stimulation, brain	2.97	4.83	4.17	NA	NA	0.15	XXX
95961	TC	A	Electrode stimulation, brain	0.00	3.40	2.84	NA	NA	0.01	XXX
95961	26	A	Electrode stimulation, brain	2.97	1.43	1.33	1.43	1.33	0.14	XXX
95962		A	Electrode stim, brain add-on	3.21	3.65	3.21	NA	NA	0.15	ZZZ
95962	TC	A	Electrode stim, brain add-on	0.00	2.12	1.81	NA	NA	0.01	ZZZ
95962	26	A	Electrode stim, brain add-on	3.21	1.53	1.40	1.53	1.40	0.14	ZZZ
95965		C	Meg, spontaneous	0.00	0.00	0.00	NA	NA	0.00	XXX
95965	TC	C	Meg, spontaneous	0.00	0.00	0.00	NA	NA	0.00	XXX
95965	26	A	Meg, spontaneous	7.99	3.76	3.61	3.76	3.61	0.66	XXX
95966		C	Meg, evoked, single	0.00	0.00	0.00	NA	NA	0.00	XXX
95966	TC	C	Meg, evoked, single	0.00	0.00	0.00	NA	NA	0.00	XXX
95966	26	A	Meg, evoked, single	3.99	1.88	1.81	1.88	1.81	0.32	XXX
95967		C	Meg, evoked, each addl	0.00	0.00	0.00	NA	NA	0.00	ZZZ

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
95967	TC	C	Meg, evoked, each addl	0.00	0.00	0.00	NA	NA	0.00	ZZZ
95967	26	A	Meg, evoked, each addl	3.49	1.64	1.52	1.64	1.52	0.30	ZZZ
95970		A	Analyze neurostim, no prog	0.45	1.36	1.21	0.21	0.18	0.04	XXX
95971		A	Analyze neurostim, simple	0.78	0.81	0.84	0.34	0.32	0.07	XXX
95972		A	Analyze neurostim, complex	1.50	1.54	1.47	0.70	0.63	0.14	XXX
95973		A	Analyze neurostim, complex	0.92	0.85	0.75	0.46	0.39	0.08	ZZZ
95974		A	Cranial neurostim, complex	3.00	2.42	2.13	1.37	1.25	0.27	XXX
95975		A	Cranial neurostim, complex	1.70	1.24	1.09	0.80	0.73	0.13	ZZZ
95978		A	Analyze neurostim brain/1h	3.50	3.01	2.64	1.68	1.52	0.40	XXX
95979		A	Analyz neurostim brain addon	1.64	1.21	1.07	0.78	0.72	0.14	ZZZ
95980		A	Io anal gast n-stim init	0.80	NA	NA	0.43	0.37	0.17	XXX
95981		A	Io anal gast n-stim subsq	0.30	0.59	0.56	0.20	0.17	0.03	XXX
95982		A	Io ga n-stim subsq w/reprog	0.65	0.79	0.69	0.36	0.30	0.06	XXX
95990		A	Spin/brain pump refil & main	0.00	2.45	2.17	NA	NA	0.03	XXX
95991		A	Spin/brain pump refil & main	0.77	2.60	2.25	0.36	0.29	0.06	XXX
95992		A	Canalith repositioning proc	0.75	0.45	0.44	0.32	0.31	0.06	XXX
95999		C	Neurological procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96000		A	Motion analysis, video/3d	1.80	NA	NA	0.91	0.75	0.11	XXX
96001		A	Motion test w/ft press meas	2.15	NA	NA	0.65	0.67	0.13	XXX
96002		A	Dynamic surface emg	0.41	NA	NA	0.20	0.18	0.03	XXX
96003		A	Dynamic fine wire emg	0.37	NA	NA	0.17	0.15	0.03	XXX
96004		A	Phys review of motion tests	2.14	1.00	0.98	1.00	0.98	0.14	XXX
96020		C	Functional brain mapping	0.00	0.00	0.00	NA	NA	0.00	XXX
96020	TC	C	Functional brain mapping	0.00	0.00	0.00	NA	NA	0.00	XXX
96020	26	A	Functional brain mapping	3.43	1.19	1.39	1.19	1.39	0.32	XXX
96040		B	Genetic counseling, 30 min	0.00	1.20	1.26	NA	NA	0.03	XXX

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96101		A	Psycho testing by psych/phys	1.86	0.30	0.41	0.28	0.39	0.07	XXX
96102		A	Psycho testing by technician	0.50	1.13	1.12	0.17	0.16	0.03	XXX
96103		A	Psycho testing admin by comp	0.51	1.29	1.10	0.19	0.18	0.03	XXX
96105		A	Assessment of aphasia	0.00	2.42	2.33	NA	NA	0.04	XXX
96110		A	Developmental test, lim	0.00	0.23	0.22	NA	NA	0.01	XXX
96111		A	Developmental test, extend	2.60	0.82	0.91	0.65	0.78	0.17	XXX
96116		A	Neurobehavioral status exam	1.86	0.69	0.71	0.54	0.55	0.10	XXX
96118		A	Neuropsych tst by psych/phys	1.86	0.68	0.91	0.25	0.37	0.07	XXX
96119		A	Neuropsych testing by tec	0.55	1.36	1.48	0.09	0.12	0.01	XXX
96120		A	Neuropsych tst admin w/comp	0.51	2.03	1.84	0.18	0.17	0.03	XXX
96125		A	Cognitive test by hc pro	1.70	1.02	0.97	NA	NA	0.07	XXX
96150		A	Assess hlth/behave, init	0.50	0.07	0.11	0.06	0.10	0.01	XXX
96151		A	Assess hlth/behave, subseq	0.48	0.07	0.11	0.07	0.10	0.01	XXX
96152		A	Intervene hlth/behave, indiv	0.46	0.07	0.10	0.06	0.09	0.01	XXX
96153		A	Intervene hlth/behave, group	0.10	0.02	0.03	0.02	0.02	0.01	XXX
96154		A	Interv hlth/behav, fam w/pt	0.45	0.06	0.10	0.06	0.09	0.01	XXX
96155		N	Interv hlth/behav fam no pt	0.44	0.19	0.19	0.19	0.19	0.03	XXX
96360		A	Hydration iv infusion, init	0.17	1.30	1.45	NA	NA	0.03	XXX
96361		A	Hydrate iv infusion, add-on	0.09	0.30	0.35	NA	NA	0.01	ZZZ
96365		A	Ther/proph/diag iv inf, init	0.21	1.66	1.81	NA	NA	0.03	XXX
96366		A	Ther/proph/diag iv inf addon	0.18	0.41	0.44	NA	NA	0.01	ZZZ
96367		A	Tx/proph/dg addl seq iv inf	0.19	0.64	0.76	NA	NA	0.01	ZZZ
96368		A	Ther/diag concurrent inf	0.17	0.34	0.39	NA	NA	0.01	ZZZ
96369		A	Sc ther infusion, up to 1 hr	0.21	4.71	4.69	NA	NA	0.03	XXX
96370		A	Sc ther infusion, addl hr	0.18	0.25	0.26	NA	NA	0.01	ZZZ
96371		A	Sc ther infusion, reset pump	0.00	2.18	2.30	NA	NA	0.01	ZZZ

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96372		A	Ther/proph/diag inj, sc/im	0.17	0.49	0.49	NA	NA	0.01	XXX
96373		A	Ther/proph/diag inj, ia	0.17	0.37	0.37	NA	NA	0.01	XXX
96374		A	Ther/proph/diag inj, iv push	0.18	1.26	1.40	NA	NA	0.03	XXX
96375		A	Tx/pro/dx inj new drug addon	0.10	0.47	0.55	NA	NA	0.01	ZZZ
96376		X	Tx/pro/dx inj new drug adon	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
96379		C	Ther/prop/diag inj/inf proc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96401		A	Chemo, anti-neopl, sq/im	0.21	1.71	1.85	NA	NA	0.04	XXX
96402		A	Chemo hormon antineopl sq/im	0.19	0.66	0.82	NA	NA	0.01	XXX
96405		A	Chemo intralesional, up to 7	0.52	1.74	1.95	0.36	0.33	0.03	000
96406		A	Chemo intralesional over 7	0.80	2.30	2.59	0.49	0.44	0.04	000
96409		A	Chemo, iv push, sngl drug	0.24	2.57	2.97	NA	NA	0.06	XXX
96411		A	Chemo, iv push, addl drug	0.20	1.38	1.60	NA	NA	0.03	ZZZ
96413		A	Chemo, iv infusion, 1 hr	0.28	3.33	3.91	NA	NA	0.06	XXX
96415		A	Chemo, iv infusion, addl hr	0.19	0.60	0.70	NA	NA	0.01	ZZZ
96416		A	Chemo prolong infuse w/pump	0.21	3.75	4.38	NA	NA	0.07	XXX
96417		A	Chemo iv infus each addl seq	0.21	1.59	1.85	NA	NA	0.03	ZZZ
96420		A	Chemo, ia, push tecnique	0.17	2.52	2.90	NA	NA	0.08	XXX
96422		A	Chemo ia infusion up to 1 hr	0.17	4.14	4.82	NA	NA	0.08	XXX
96423		A	Chemo ia infuse each addl hr	0.17	1.84	2.10	NA	NA	0.04	ZZZ
96425		A	Chemotherapy,infusion method	0.17	4.43	4.92	NA	NA	0.10	XXX
96440		A	Chemotherapy, intracavitary	2.37	19.36	18.15	1.47	1.42	0.57	000
96445		A	Chemotherapy, intracavitary	2.20	5.10	5.90	1.11	1.10	0.21	000
96450		A	Chemotherapy, into CNS	1.53	3.26	4.12	0.72	0.85	0.11	000
96521		A	Refill/maint, portable pump	0.21	3.26	3.59	NA	NA	0.06	XXX
96522		A	Refill/maint pump/resvr syst	0.21	2.63	2.95	NA	NA	0.06	XXX
96523		T	Irrig drug delivery device	0.04	0.59	0.69	NA	NA	0.01	XXX

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96542		A	Chemotherapy injection	0.75	2.31	2.90	0.44	0.49	0.04	XXX
96549		C	Chemotherapy, unspecified	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96567		A	Photodynamic tx, skin	0.00	3.67	3.76	NA	NA	0.01	XXX
96570		A	Photodynmc tx, 30 min add-on	1.10	0.43	0.46	0.43	0.46	0.18	ZZZ
96571		A	Photodynamic tx, addl 15 min	0.55	0.18	0.20	0.18	0.20	0.04	ZZZ
96900		A	Ultraviolet light therapy	0.00	0.55	0.59	NA	NA	0.01	XXX
96902		B	Trichogram	0.41	0.20	0.20	0.18	0.17	0.03	XXX
96904		R	Whole body photography	0.00	1.75	1.94	NA	NA	0.01	XXX
96910		A	Photochemotherapy with UV-B	0.00	1.93	1.99	NA	NA	0.01	XXX
96912		A	Photochemotherapy with UV-A	0.00	2.49	2.56	NA	NA	0.01	XXX
96913		A	Photochemotherapy, UV-A or B	0.00	3.50	3.56	NA	NA	0.01	XXX
96920		A	Laser tx, skin < 250 sq cm	1.15	3.72	3.83	0.83	0.77	0.04	000
96921		A	Laser tx, skin 250-500 sq cm	1.17	3.84	3.82	0.83	0.75	0.04	000
96922		A	Laser tx, skin > 500 sq cm	2.10	4.95	5.07	1.52	1.35	0.08	000
96999		C	Dermatological procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97001		A	Pt evaluation	1.20	0.91	0.87	NA	NA	0.06	XXX
97002		A	Pt re-evaluation	0.60	0.57	0.54	NA	NA	0.03	XXX
97003		A	Ot evaluation	1.20	1.20	1.08	NA	NA	0.06	XXX
97004		A	Ot re-evaluation	0.60	0.87	0.78	NA	NA	0.03	XXX
97005		I	Athletic train eval	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97006		I	Athletic train reeval	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97010		B	Hot or cold packs therapy	0.06	0.10	0.09	NA	NA	0.01	XXX
97012		A	Mechanical traction therapy	0.25	0.20	0.18	NA	NA	0.01	XXX
97014		I	Electric stimulation therapy	0.18	0.26	0.24	NA	NA	0.01	XXX
97016		A	Vasopneumatic device therapy	0.18	0.35	0.31	NA	NA	0.01	XXX
97018		A	Paraffin bath therapy	0.06	0.23	0.20	NA	NA	0.01	XXX

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97022		A	Whirlpool therapy	0.17	0.47	0.41	NA	NA	0.01	XXX
97024		A	Diathermy eg, microwave	0.06	0.11	0.11	NA	NA	0.01	XXX
97026		A	Infrared therapy	0.06	0.10	0.09	NA	NA	0.01	XXX
97028		A	Ultraviolet therapy	0.08	0.12	0.11	NA	NA	0.01	XXX
97032		A	Electrical stimulation	0.25	0.28	0.25	NA	NA	0.01	XXX
97033		A	Electric current therapy	0.26	0.63	0.56	NA	NA	0.01	XXX
97034		A	Contrast bath therapy	0.21	0.29	0.26	NA	NA	0.01	XXX
97035		A	Ultrasound therapy	0.21	0.14	0.13	NA	NA	0.01	XXX
97036		A	Hydrotherapy	0.28	0.62	0.56	NA	NA	0.01	XXX
97039		C	Physical therapy treatment	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97110		A	Therapeutic exercises	0.45	0.45	0.41	NA	NA	0.01	XXX
97112		A	Neuromuscular reeducation	0.45	0.48	0.45	NA	NA	0.01	XXX
97113		A	Aquatic therapy/exercises	0.44	0.75	0.68	NA	NA	0.01	XXX
97116		A	Gait training therapy	0.40	0.39	0.36	NA	NA	0.01	XXX
97124		A	Massage therapy	0.35	0.38	0.35	NA	NA	0.01	XXX
97139		C	Physical medicine procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97140		A	Manual therapy	0.43	0.41	0.37	NA	NA	0.01	XXX
97150		A	Group therapeutic procedures	0.27	0.30	0.28	NA	NA	0.01	XXX
97530		A	Therapeutic activities	0.44	0.53	0.49	NA	NA	0.01	XXX
97532		A	Cognitive skills development	0.44	0.31	0.29	NA	NA	0.01	XXX
97533		A	Sensory integration	0.44	0.38	0.35	NA	NA	0.01	XXX
97535		A	Self care mngment training	0.45	0.53	0.48	NA	NA	0.01	XXX
97537		A	Community/work reintegration	0.45	0.39	0.37	NA	NA	0.01	XXX
97542		A	Wheelchair mngment training	0.45	0.41	0.38	NA	NA	0.01	XXX
97545		R	Work hardening	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97546		R	Work hardening add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ

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97597		A	Active wound care/20 cm or <	0.58	1.56	1.38	0.17	0.24	0.06	XXX
97598		A	Active wound care > 20 cm	0.80	1.80	1.60	0.23	0.31	0.07	XXX
97602		B	Wound(s) care non-selective	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97605		A	Neg press wound tx, < 50 cm	0.55	0.57	0.52	0.16	0.17	0.08	XXX
97606		A	Neg press wound tx, > 50 cm	0.60	0.58	0.53	0.17	0.18	0.10	XXX
97750		A	Physical performance test	0.45	0.47	0.43	NA	NA	0.03	XXX
97755		A	Assistive technology assess	0.62	0.38	0.36	NA	NA	0.03	XXX
97760		A	Orthotic mgmt and training	0.45	0.60	0.55	NA	NA	0.03	XXX
97761		A	Prosthetic training	0.45	0.46	0.42	NA	NA	0.03	XXX
97762		A	C/o for orthotic/prosth use	0.25	1.04	0.91	NA	NA	0.01	XXX
97799		C	Physical medicine procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97802		A	Medical nutrition, indiv, in	0.53	0.40	0.36	0.35	0.31	0.03	XXX
97803		A	Med nutrition, indiv, subseq	0.45	0.35	0.33	0.30	0.27	0.03	XXX
97804		A	Medical nutrition, group	0.25	0.17	0.15	0.16	0.14	0.01	XXX
97810		N	Acupunct w/o stimul 15 min	0.60	0.41	0.41	0.26	0.26	0.04	XXX
97811		N	Acupunct w/o stimul addl 15m	0.50	0.26	0.26	0.22	0.21	0.03	ZZZ
97813		N	Acupunct w/stimul 15 min	0.65	0.43	0.43	0.28	0.28	0.04	XXX
97814		N	Acupunct w/stimul addl 15m	0.55	0.31	0.31	0.24	0.23	0.04	ZZZ
98925		A	Osteopathic manipulation	0.45	0.43	0.40	0.20	0.18	0.03	000
98926		A	Osteopathic manipulation	0.65	0.55	0.50	0.27	0.26	0.03	000
98927		A	Osteopathic manipulation	0.87	0.69	0.63	0.34	0.32	0.04	000
98928		A	Osteopathic manipulation	1.03	0.77	0.71	0.40	0.38	0.06	000
98929		A	Osteopathic manipulation	1.19	0.90	0.82	0.47	0.44	0.07	000
98940		A	Chiropractic manipulation	0.45	0.29	0.28	0.16	0.15	0.01	000
98941		A	Chiropractic manipulation	0.65	0.38	0.36	0.23	0.22	0.03	000
98942		A	Chiropractic manipulation	0.87	0.46	0.43	0.30	0.30	0.03	000

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
98943		N	Chiropractic manipulation	0.40	0.27	0.27	0.17	0.17	0.03	XXX
98960		B	Self-mgmt educ & train, 1 pt	0.00	0.71	0.75	NA	NA	0.01	XXX
98961		B	Self-mgmt educ/train, 2-4 pt	0.00	0.34	0.36	NA	NA	0.01	XXX
98962		B	Self-mgmt educ/train, 5-8 pt	0.00	0.25	0.26	NA	NA	0.01	XXX
98966		N	Hc pro phone call 5-10 min	0.25	0.14	0.14	0.11	0.10	0.01	XXX
98967		N	Hc pro phone call 11-20 min	0.50	0.25	0.25	0.22	0.21	0.03	XXX
98968		N	Hc pro phone call 21-30 min	0.75	0.36	0.35	0.32	0.31	0.06	XXX
98969		N	Online service by hc pro	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99000		B	Specimen handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99001		B	Specimen handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99002		B	Device handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99024		B	Postop follow-up visit	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99026		N	In-hospital on call service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99027		N	Out-of-hosp on call service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99050		B	Medical services after hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99051		B	Med serv, eve/wkend/holiday	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99053		B	Med serv 10pm-8am, 24 hr fac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99056		B	Med service out of office	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99058		B	Office emergency care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99060		B	Out of office emerg med serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99070		B	Special supplies	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99071		B	Patient education materials	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99075		N	Medical testimony	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99078		B	Group health education	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99080		B	Special reports or forms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99082		C	Unusual physician travel	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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99090		B	Computer data analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99091		B	Collect/review data from pt	1.10	0.48	0.46	NA	NA	0.07	XXX
99100		B	Special anesthesia service	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99116		B	Anesthesia with hypothermia	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99135		B	Special anesthesia procedure	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99140		B	Emergency anesthesia	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99143		C	Mod cs by same phys, < 5 yrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99144		C	Mod cs by same phys, 5 yrs +	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99145		C	Mod cs by same phys add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99148		C	Mod cs diff phys < 5 yrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99149		C	Mod cs diff phys 5 yrs +	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99150		C	Mod cs diff phys add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99170		A	Anogenital exam, child	1.75	2.13	2.33	0.84	0.89	0.13	000
99172		N	Ocular function screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99173		N	Visual acuity screen	0.00	0.07	0.07	NA	NA	0.01	XXX
99174		N	Ocular photoscreening	0.00	0.76	0.80	NA	NA	0.01	XXX
99175		A	Induction of vomiting	0.00	0.64	0.69	NA	NA	0.01	XXX
99183		A	Hyperbaric oxygen therapy	2.34	3.60	3.46	0.97	0.87	0.27	XXX
99190		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99191		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99192		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99195		A	Phlebotomy	0.00	2.54	2.43	NA	NA	0.06	XXX
99199		C	Special service/proc/report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99201		A	Office/outpatient visit, new	0.48	0.71	0.68	0.26	0.23	0.04	XXX
99202		A	Office/outpatient visit, new	0.93	1.13	1.07	0.48	0.43	0.07	XXX
99203		A	Office/outpatient visit, new	1.42	1.54	1.44	0.71	0.63	0.14	XXX

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99204		A	Office/outpatient visit, new	2.43	2.11	1.97	1.19	1.04	0.24	XXX
99205		A	Office/outpatient visit, new	3.17	2.46	2.32	1.47	1.32	0.28	XXX
99211		A	Office/outpatient visit, est	0.18	0.36	0.38	0.08	0.08	0.01	XXX
99212		A	Office/outpatient visit, est	0.48	0.71	0.69	0.24	0.22	0.04	XXX
99213		A	Office/outpatient visit, est	0.97	1.03	0.97	0.46	0.41	0.07	XXX
99214		A	Office/outpatient visit, est	1.50	1.45	1.38	0.70	0.62	0.10	XXX
99215		A	Office/outpatient visit, est	2.11	1.86	1.76	0.98	0.88	0.14	XXX
99217		A	Observation care discharge	1.28	NA	NA	0.72	0.67	0.08	XXX
99218		A	Observation care	1.28	NA	NA	0.56	0.52	0.08	XXX
99219		A	Observation care	2.14	NA	NA	0.96	0.87	0.14	XXX
99220		A	Observation care	2.99	NA	NA	1.31	1.21	0.21	XXX
99221		A	Initial hospital care	1.92	NA	NA	0.84	0.75	0.18	XXX
99222		A	Initial hospital care	2.61	NA	NA	1.18	1.04	0.23	XXX
99223		A	Initial hospital care	3.86	NA	NA	1.73	1.52	0.30	XXX
99231		A	Subsequent hospital care	0.76	NA	NA	0.34	0.31	0.06	XXX
99232		A	Subsequent hospital care	1.39	NA	NA	0.62	0.56	0.08	XXX
99233		A	Subsequent hospital care	2.00	NA	NA	0.88	0.80	0.13	XXX
99234		A	Observ/hosp same date	2.56	NA	NA	1.14	1.07	0.23	XXX
99235		A	Observ/hosp same date	3.41	NA	NA	1.52	1.40	0.24	XXX
99236		A	Observ/hosp same date	4.26	NA	NA	1.86	1.71	0.30	XXX
99238		A	Hospital discharge day	1.28	NA	NA	0.72	0.67	0.07	XXX
99239		A	Hospital discharge day	1.90	NA	NA	1.06	0.95	0.11	XXX
99241		I	Office consultation	0.64	0.66	0.66	0.24	0.24	0.07	XXX
99242		I	Office consultation	1.34	1.10	1.10	0.51	0.51	0.14	XXX
99243		I	Office consultation	1.88	1.46	1.46	0.71	0.71	0.18	XXX
99244		I	Office consultation	3.02	1.96	1.96	1.14	1.14	0.23	XXX

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99245		I	Office consultation	3.77	2.30	2.30	1.38	1.38	0.30	XXX
99251		I	Inpatient consultation	1.00	NA	NA	0.32	0.32	0.07	XXX
99252		I	Inpatient consultation	1.50	NA	NA	0.52	0.52	0.13	XXX
99253		I	Inpatient consultation	2.27	NA	NA	0.84	0.84	0.16	XXX
99254		I	Inpatient consultation	3.29	NA	NA	1.23	1.23	0.18	XXX
99255		I	Inpatient consultation	4.00	NA	NA	1.44	1.44	0.25	XXX
99281		A	Emergency dept visit	0.45	NA	NA	0.14	0.13	0.03	XXX
99282		A	Emergency dept visit	0.88	NA	NA	0.26	0.23	0.07	XXX
99283		A	Emergency dept visit	1.34	NA	NA	0.38	0.35	0.10	XXX
99284		A	Emergency dept visit	2.56	NA	NA	0.65	0.61	0.23	XXX
99285		A	Emergency dept visit	3.80	NA	NA	0.88	0.86	0.31	XXX
99288		B	Direct advanced life support	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99291		A	Critical care, first hour	4.50	2.94	2.88	1.62	1.52	0.35	XXX
99292		A	Critical care, addl 30 min	2.25	1.10	1.04	0.82	0.76	0.18	ZZZ
99304		A	Nursing facility care, init	1.64	0.92	0.80	0.92	0.80	0.14	XXX
99305		A	Nursing facility care, init	2.35	1.25	1.07	1.25	1.07	0.21	XXX
99306		A	Nursing facility care, init	3.06	1.55	1.31	1.55	1.31	0.24	XXX
99307		A	Nursing fac care, subseq	0.76	0.48	0.43	0.48	0.43	0.04	XXX
99308		A	Nursing fac care, subseq	1.16	0.75	0.66	0.75	0.66	0.07	XXX
99309		A	Nursing fac care, subseq	1.55	0.97	0.86	0.97	0.86	0.08	XXX
99310		A	Nursing fac care, subseq	2.35	1.38	1.21	1.38	1.21	0.14	XXX
99315		A	Nursing fac discharge day	1.13	0.68	0.60	0.68	0.60	0.07	XXX
99316		A	Nursing fac discharge day	1.50	0.85	0.75	0.85	0.75	0.08	XXX
99318		A	Annual nursing fac assessmnt	1.71	0.96	0.82	0.96	0.82	0.10	XXX
99324		A	Domicil/r-home visit new pat	1.01	0.54	0.53	NA	NA	0.07	XXX
99325		A	Domicil/r-home visit new pat	1.52	0.72	0.71	NA	NA	0.10	XXX

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99326		A	Domicil/r-home visit new pat	2.63	1.28	1.16	NA	NA	0.17	XXX
99327		A	Domicil/r-home visit new pat	3.46	1.70	1.51	NA	NA	0.23	XXX
99328		A	Domicil/r-home visit new pat	4.09	1.95	1.73	NA	NA	0.25	XXX
99334		A	Domicil/r-home visit est pat	1.07	0.61	0.57	NA	NA	0.07	XXX
99335		A	Domicil/r-home visit est pat	1.72	0.92	0.82	NA	NA	0.10	XXX
99336		A	Domicil/r-home visit est pat	2.46	1.28	1.12	NA	NA	0.14	XXX
99337		A	Domicil/r-home visit est pat	3.58	1.79	1.56	NA	NA	0.24	XXX
99339		B	Domicil/r-home care supervis	1.25	0.90	0.89	NA	NA	0.08	XXX
99340		B	Domicil/r-home care supervis	1.80	1.21	1.20	NA	NA	0.13	XXX
99341		A	Home visit, new patient	1.01	0.52	0.52	NA	NA	0.07	XXX
99342		A	Home visit, new patient	1.52	0.69	0.70	NA	NA	0.11	XXX
99343		A	Home visit, new patient	2.53	1.13	1.09	NA	NA	0.18	XXX
99344		A	Home visit, new patient	3.38	1.71	1.51	NA	NA	0.23	XXX
99345		A	Home visit, new patient	4.09	2.00	1.77	NA	NA	0.27	XXX
99347		A	Home visit, est patient	1.00	0.54	0.52	NA	NA	0.07	XXX
99348		A	Home visit, est patient	1.56	0.79	0.74	NA	NA	0.10	XXX
99349		A	Home visit, est patient	2.33	1.23	1.09	NA	NA	0.14	XXX
99350		A	Home visit, est patient	3.28	1.66	1.46	NA	NA	0.23	XXX
99354		A	Prolonged service, office	1.77	0.98	0.91	0.80	0.74	0.11	ZZZ
99355		A	Prolonged service, office	1.77	0.94	0.88	0.76	0.71	0.11	ZZZ
99356		A	Prolonged service, inpatient	1.71	NA	NA	0.83	0.74	0.11	ZZZ
99357		A	Prolonged service, inpatient	1.71	NA	NA	0.83	0.75	0.11	ZZZ
99358		B	Prolong service w/o contact	2.10	0.94	0.92	0.94	0.92	0.14	XXX
99359		B	Prolong serv w/o contact add	1.00	0.47	0.46	0.47	0.46	0.07	ZZZ
99360		X	Physician standby services	1.20	NA	NA	0.52	0.50	0.08	XXX
99363		B	Anticoag mgmt, init	1.65	1.83	1.86	0.71	0.69	0.11	XXX

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99364		B	Anticoag mgmt, subseq	0.63	0.56	0.56	0.27	0.26	0.04	XXX
99366		B	Team conf w/pat by hc pro	0.82	0.37	0.36	0.35	0.34	0.06	XXX
99367		B	Team conf w/o pat by phys	1.10	NA	NA	0.48	0.46	0.07	XXX
99368		B	Team conf w/o pat by hc pro	0.72	NA	NA	0.31	0.30	0.04	XXX
99374		B	Home health care supervision	1.10	0.83	0.83	0.48	0.47	0.07	XXX
99375		I	Home health care supervision	1.73	1.18	1.26	0.75	0.87	0.11	XXX
99377		B	Hospice care supervision	1.10	0.83	0.83	0.48	0.47	0.07	XXX
99378		I	Hospice care supervision	1.73	1.18	1.32	0.75	0.93	0.11	XXX
99379		B	Nursing fac care supervision	1.10	0.83	0.83	0.48	0.47	0.07	XXX
99380		B	Nursing fac care supervision	1.73	1.18	1.17	0.75	0.74	0.11	XXX
99381		N	Init pm e/m, new pat, inf	1.19	1.40	1.46	0.51	0.50	0.08	XXX
99382		N	Init pm e/m, new pat 1-4 yrs	1.36	1.47	1.53	0.59	0.58	0.08	XXX
99383		N	Prev visit, new, age 5-11	1.36	1.46	1.51	0.59	0.58	0.08	XXX
99384		N	Prev visit, new, age 12-17	1.53	1.53	1.58	0.66	0.65	0.10	XXX
99385		N	Prev visit, new, age 18-39	1.53	1.53	1.58	0.66	0.65	0.10	XXX
99386		N	Prev visit, new, age 40-64	1.88	1.68	1.74	0.81	0.80	0.13	XXX
99387		N	Init pm e/m, new pat 65+ yrs	2.06	1.87	1.93	0.89	0.88	0.14	XXX
99391		N	Per pm reeval, est pat, inf	1.02	1.20	1.22	0.44	0.43	0.07	XXX
99392		N	Prev visit, est, age 1-4	1.19	1.28	1.29	0.51	0.50	0.08	XXX
99393		N	Prev visit, est, age 5-11	1.19	1.27	1.28	0.51	0.50	0.08	XXX
99394		N	Prev visit, est, age 12-17	1.36	1.34	1.36	0.59	0.58	0.08	XXX
99395		N	Prev visit, est, age 18-39	1.36	1.35	1.37	0.59	0.58	0.08	XXX
99396		N	Prev visit, est, age 40-64	1.53	1.42	1.44	0.66	0.65	0.10	XXX
99397		N	Per pm reeval est pat 65+ yr	1.71	1.62	1.63	0.74	0.73	0.11	XXX
99401		N	Preventive counseling, indiv	0.48	0.51	0.54	0.21	0.21	0.03	XXX
99402		N	Preventive counseling, indiv	0.98	0.73	0.77	0.42	0.42	0.07	XXX

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99403		N	Preventive counseling, indiv	1.46	0.94	0.98	0.63	0.62	0.10	XXX
99404		N	Preventive counseling, indiv	1.95	1.15	1.19	0.84	0.83	0.13	XXX
99406		A	Behav chng smoking 3-10 min	0.24	0.15	0.14	0.10	0.09	0.01	XXX
99407		A	Behav chng smoking > 10 min	0.50	0.27	0.24	0.22	0.20	0.03	XXX
99408		N	Audit/dast, 15-30 min	0.65	0.33	0.32	0.28	0.27	0.04	XXX
99409		N	Audit/dast, over 30 min	1.30	0.61	0.60	0.56	0.55	0.08	XXX
99411		N	Preventive counseling, group	0.15	0.29	0.29	0.06	0.06	0.01	XXX
99412		N	Preventive counseling, group	0.25	0.33	0.34	0.11	0.11	0.01	XXX
99420		N	Health risk assessment test	0.00	0.27	0.29	NA	NA	0.01	XXX
99429		N	Unlisted preventive service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99441		N	Phone e/m by phys 5-10 min	0.25	0.14	0.14	0.11	0.10	0.01	XXX
99442		N	Phone e/m by phys 11-20 min	0.50	0.25	0.25	0.22	0.21	0.03	XXX
99443		N	Phone e/m by phys 21-30 min	0.75	0.36	0.35	0.32	0.31	0.06	XXX
99444		N	Online e/m by phys	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99450		N	Basic life disability exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99455		R	Work related disability exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99456		R	Disability examination	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99460		A	Init nb em per day, hosp	1.17	NA	NA	0.53	0.47	0.06	XXX
99461		A	Init nb em per day, non-fac	1.26	1.42	1.32	0.54	0.53	0.08	XXX
99462		A	Sbsq nb em per day, hosp	0.62	NA	NA	0.28	0.26	0.04	XXX
99463		A	Same day nb discharge	1.50	NA	NA	0.84	0.74	0.08	XXX
99464		A	Attendance at delivery	1.50	NA	NA	0.58	0.53	0.07	XXX
99465		A	Nb resuscitation	2.93	NA	NA	0.65	0.91	0.23	XXX
99466		A	Ped crit care transport	4.79	NA	NA	2.19	1.94	1.06	XXX
99467		A	Ped crit care transport addl	2.40	NA	NA	1.04	0.94	0.14	ZZZ
99468		A	Neonate crit care, initial	18.46	NA	NA	7.15	6.31	1.58	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
99469		A	Neonate crit care, subsq	7.99	NA	NA	3.46	3.06	0.44	XXX
99471		A	Ped critical care, initial	15.98	NA	NA	6.19	5.79	0.90	XXX
99472		A	Ped critical care, subsq	7.99	NA	NA	3.16	2.92	0.49	XXX
99475		A	Ped crit care age 2-5, init	11.25	4.37	3.90	4.37	3.90	0.89	XXX
99476		A	Ped crit care age 2-5, subsq	6.75	2.81	2.43	2.81	2.43	0.54	XXX
99477		A	Init day hosp neonate care	7.00	NA	NA	3.03	2.75	0.40	XXX
99478		A	Ic, lbw inf < 1500 gm subsq	2.75	NA	NA	1.07	1.08	0.18	XXX
99479		A	Ic lbw inf 1500-2500 g subsq	2.50	NA	NA	1.19	1.02	0.17	XXX
99480		A	Ic inf pbw 2501-5000 g subsq	2.40	NA	NA	0.93	0.88	0.17	XXX
99499		C	Unlisted e&m service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99500		I	Home visit, prenatal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99501		I	Home visit, postnatal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99502		I	Home visit, nb care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99503		I	Home visit, resp therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99504		I	Home visit mech ventilator	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99505		I	Home visit, stoma care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99506		I	Home visit, im injection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99507		I	Home visit, cath maintain	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99509		I	Home visit day life activity	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99510		I	Home visit, sing/m/fam couns	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99511		I	Home visit, fecal/enema mgmt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99512		I	Home visit for hemodialysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99600		I	Home visit nos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99601		I	Home infusion/visit, 2 hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99602		I	Home infusion, each addtl hr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99605		X	Mtms by pharm, np, 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
99606		X	Mtms by pharm, est, 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99607		X	Mtms by pharm, addl 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A4641		C	Radiopharm dx agent noc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A4642		C	In111 satumomab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A4890		R	Repair/maint cont hemo equip	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9500		C	Tc99m sestamibi	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9501		C	Technetium TC-99m teboroxime	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9502		C	Tc99m tetrofosmin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9503		C	Tc99m medronate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9504		C	Tc99m apcitide	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9505		C	TL201 thallium	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9507		C	In111 capromab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9508		C	I131 iodobenguate, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9509		C	Iodine I-123 sod iodide mil	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9510		C	Tc99m disofenin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9512		C	Tc99m pertechnetate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9516		C	Iodine I-123 sod iodide mic	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9517		C	I131 iodide cap, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9521		C	Tc99m exametazime	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9524		C	I131 serum albumin, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9526		C	Nitrogen N-13 ammonia	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9527		C	Iodine I-125 sodium iodide	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9528		C	Iodine I-131 iodide cap, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9529		C	I131 iodide sol, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9530		C	I131 iodide sol, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9531		C	I131 max 100uCi	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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A9532		C	I125 serum albumin, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9536		C	Tc99m depreotide	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9537		C	Tc99m mebrofenin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9538		C	Tc99m pyrophosphate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9539		C	Tc99m pentetate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9540		C	Tc99m MAA	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9541		C	Tc99m sulfur colloid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9542		C	In111 ibritumomab, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9543		C	Y90 ibritumomab, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9544		C	I131 tositumomab, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9545		C	I131 tositumomab, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9546		C	Co57/58	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9547		C	In111 oxyquinoline	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9548		C	In111 pentetate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9550		C	Tc99m gluceptate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9551		C	Tc99m succimer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9552		C	F18 fdg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9553		C	Cr51 chromate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9554		C	I125 iothalamate, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9555		C	Rb82 rubidium	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9556		C	Ga67 gallium	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9557		C	Tc99m bicisate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9558		C	Xe133 xenon 10mci	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9559		C	Co57 cyano	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9560		C	Tc99m labeled rbc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9561		C	Tc99m oxidronate	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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A9562		C	Tc99m mertiatide	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9563		C	P32 Na phosphate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9564		C	P32 chromic phosphate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9566		C	Tc99m fanolesomab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9567		C	Technetium TC-99m aerosol	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9568		C	Technetium tc99m arcitumomab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9569		C	Technetium TC-99m auto WBC	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9570		C	Indium In-111 auto WBC	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9571		C	Indium IN-111 auto platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9572		C	Indium In-111 pentetreotide	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9580		C	Sodium fluoride F-18	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9600		C	Sr89 strontium	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9699		C	Radiopharm rx agent noc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0008		X	Admin influenza virus vac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0009		X	Admin pneumococcal vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0010		X	Admin hepatitis b vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0027		X	Semen analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0101		A	CA screen;pelvic/breast exam	0.45	0.59	0.59	0.31	0.45	0.03	XXX
G0102		A	Prostate ca screening; dre	0.17	0.36	0.38	0.08	0.08	0.01	XXX
G0103		X	PSA screening	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0104		A	CA screen;flexi sigmoidscope	0.96	2.86	2.89	0.78	0.75	0.14	000
G0105		A	Colorectal scrn; hi risk ind	3.69	6.98	7.24	2.23	2.19	0.61	000
G0105	53	A	Colorectal scrn; hi risk ind	0.96	2.86	2.89	0.78	0.75	0.14	000
G0106		A	Colon CA screen;barium enema	0.99	4.92	5.07	NA	NA	0.04	XXX
G0106	TC	A	Colon CA screen;barium enema	0.00	4.58	4.68	NA	NA	0.01	XXX
G0106	26	A	Colon CA screen;barium enema	0.99	0.34	0.39	0.34	0.39	0.03	XXX

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G0108		A	Diab manage trn per indiv	0.90	0.56	0.66	NA	NA	0.06	XXX
G0109		A	Diab manage trn ind/group	0.25	0.15	0.28	NA	NA	0.01	XXX
G0117		T	Glaucoma scrn hgh risk direc	0.45	1.02	0.96	NA	NA	0.03	XXX
G0118		T	Glaucoma scrn hgh risk direc	0.17	0.86	0.82	NA	NA	0.01	XXX
G0120		A	Colon ca scrn; barium enema	0.99	4.92	5.07	NA	NA	0.04	XXX
G0120	TC	A	Colon ca scrn; barium enema	0.00	4.58	4.68	NA	NA	0.01	XXX
G0120	26	A	Colon ca scrn; barium enema	0.99	0.34	0.39	0.34	0.39	0.03	XXX
G0121		A	Colon ca scrn not hi rsk ind	3.69	6.98	7.24	2.23	2.19	0.61	000
G0121	53	A	Colon ca scrn not hi rsk ind	0.96	2.86	2.89	0.78	0.75	0.14	000
G0122		N	Colon ca scrn; barium enema	0.99	7.02	6.75	NA	NA	0.05	XXX
G0122	TC	N	Colon ca scrn; barium enema	0.00	6.59	6.33	NA	NA	0.01	XXX
G0122	26	N	Colon ca scrn; barium enema	0.99	0.43	0.42	0.43	0.42	0.04	XXX
G0123		X	Screen cerv/vag thin layer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0124		A	Screen c/v thin layer by MD	0.42	0.40	0.39	0.40	0.39	0.03	XXX
G0127		R	Trim nail(s)	0.17	0.47	0.44	0.05	0.06	0.01	000
G0128		R	CORF skilled nursing service	0.08	0.20	0.18	NA	NA	0.01	XXX
G0130		A	Single energy x-ray study	0.22	0.70	0.73	NA	NA	0.02	XXX
G0130	TC	A	Single energy x-ray study	0.00	0.60	0.64	NA	NA	0.01	XXX
G0130	26	A	Single energy x-ray study	0.22	0.10	0.09	0.10	0.09	0.01	XXX
G0141		A	Scr c/v cyto,autosys and md	0.42	0.40	0.39	0.40	0.39	0.03	XXX
G0143		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0144		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0145		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0147		X	Scr c/v cyto, automated sys	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0148		X	Scr c/v cyto, autosys, rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0166		A	Extrnl counterpulse, per tx	0.07	3.80	4.35	NA	NA	0.03	XXX

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G0168		A	Wound closure by adhesive	0.45	2.07	2.01	0.30	0.27	0.03	000
G0173		X	Linear acc stereo radsur com	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0175		X	OPPS Service,sched team conf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0176		X	OPPS/PHP;activity therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0177		X	OPPS/PHP; train & educ serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0179		A	MD recertification HHA PT	0.45	0.66	0.70	0.43	0.58	0.03	XXX
G0180		A	MD certification HHA patient	0.67	0.78	0.83	0.55	0.71	0.04	XXX
G0181		A	Home health care supervision	1.73	1.25	1.21	NA	NA	0.10	XXX
G0182		A	Hospice care supervision	1.73	1.25	1.25	NA	NA	0.10	XXX
G0186		C	Dstry eye lesn,fdr vssl tech	0.00	0.00	0.00	0.00	0.00	0.00	YYY
G0202		A	Screeningmammographydigital	0.70	3.31	3.34	NA	NA	0.05	XXX
G0202	TC	A	Screeningmammographydigital	0.00	3.03	3.05	NA	NA	0.01	XXX
G0202	26	A	Screeningmammographydigital	0.70	0.28	0.29	0.28	0.29	0.04	XXX
G0204		A	Diagnosticmammographydigital	0.87	4.01	3.96	NA	NA	0.07	XXX
G0204	TC	A	Diagnosticmammographydigital	0.00	3.66	3.61	NA	NA	0.01	XXX
G0204	26	A	Diagnosticmammographydigital	0.87	0.35	0.35	0.35	0.35	0.06	XXX
G0206		A	Diagnosticmammographydigital	0.70	3.14	3.12	NA	NA	0.05	XXX
G0206	TC	A	Diagnosticmammographydigital	0.00	2.86	2.83	NA	NA	0.01	XXX
G0206	26	A	Diagnosticmammographydigital	0.70	0.28	0.29	0.28	0.29	0.04	XXX
G0219		N	PET img wholbod melano nonco	0.00	0.00	0.00	NA	NA	0.00	XXX
G0219	TC	N	PET img wholbod melano nonco	0.00	0.00	0.00	NA	NA	0.00	XXX
G0219	26	N	PET img wholbod melano nonco	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0235		N	PET not otherwise specified	0.00	0.00	0.00	NA	NA	0.00	XXX
G0235	TC	N	PET not otherwise specified	0.00	0.00	0.00	NA	NA	0.00	XXX
G0235	26	N	PET not otherwise specified	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0237		A	Therapeutic procd strg endur	0.00	0.24	0.28	NA	NA	0.01	XXX

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G0238		A	Oth resp proc, indiv	0.00	0.25	0.30	NA	NA	0.01	XXX
G0239		A	Oth resp proc, group	0.00	0.30	0.33	NA	NA	0.01	XXX
G0245		R	Initial foot exam pt lops	0.88	1.13	1.07	0.48	0.43	0.06	XXX
G0246		R	Followup eval of foot pt lop	0.45	0.71	0.69	0.24	0.22	0.03	XXX
G0247		R	Routine footcare pt w lops	0.50	0.84	0.79	0.20	0.20	0.04	ZZZ
G0248		R	Demonstrate use home inr mon	0.00	3.17	4.05	NA	NA	0.01	XXX
G0249		R	Provide INR test mater/equip	0.00	2.96	3.58	NA	NA	0.01	XXX
G0250		R	MD INR test revie inter mgmt	0.18	0.07	0.08	NA	NA	0.01	XXX
G0251		E	Linear acc based stero radio	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0252		N	PET imaging initial dx	0.00	0.00	0.00	NA	NA	0.00	XXX
G0252	TC	N	PET imaging initial dx	0.00	0.00	0.00	NA	NA	0.00	XXX
G0252	26	N	PET imaging initial dx	1.50	0.65	0.69	0.65	0.69	0.10	XXX
G0255		N	Current percep threshold tst	0.00	0.00	0.00	NA	NA	0.00	XXX
G0255	TC	N	Current percep threshold tst	0.00	0.00	0.00	NA	NA	0.00	XXX
G0255	26	N	Current percep threshold tst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0257		E	Unsched dialysis ESRD pt hos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0259		E	Inject for sacroiliac joint	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0260		E	Inj for sacroiliac jt anesth	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0268		A	Removal of impacted wax md	0.61	0.89	0.84	0.35	0.31	0.03	000
G0269		B	Occlusive device in vein art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0270		A	MNT subs tx for change dx	0.45	0.35	0.33	0.30	0.27	0.03	XXX
G0271		A	Group MNT 2 or more 30 mins	0.25	0.17	0.15	0.16	0.14	0.01	XXX
G0275		A	Renal angio, cardiac cath	0.25	NA	NA	0.10	0.13	0.01	ZZZ
G0278		A	Iliac art angio,cardiac cath	0.25	NA	NA	0.10	0.13	0.01	ZZZ
G0281		A	Elec stim unattend for press	0.18	0.20	0.18	NA	NA	0.01	XXX
G0282		N	Elect stim wound care not pd	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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G0283		A	Elec stim other than wound	0.18	0.20	0.18	NA	NA	0.01	XXX
G0288		A	Recon, CTA for surg plan	0.00	0.98	2.52	NA	NA	0.01	XXX
G0289		A	Arthro, loose body + chondro	1.48	NA	NA	0.86	0.83	0.30	ZZZ
G0290		E	Drug-eluting stents, single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0291		E	Drug-eluting stents,each add	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0293		E	Non-cov surg proc,clin trial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0294		E	Non-cov proc, clinical trial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0295		N	Electromagnetic therapy onc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0302		X	Pre-op service LVRS complete	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0303		X	Pre-op service LVRS 10-15dos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0304		X	Pre-op service LVRS 1-9 dos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0305		X	Post op service LVRS min 6	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0306		X	CBC/diffwbc w/o platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0307		X	CBC without platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0328		X	Fecal blood scrn immunoassay	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0329		A	Electromagntic tx for ulcers	0.06	0.21	0.19	NA	NA	0.01	XXX
G0333		X	Dispense fee initial 30 day	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0337		X	Hospice evaluation preelecti	1.42	0.61	0.61	0.61	0.61	0.10	XXX
G0339		C	Robot lin-radsurg com, first	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0340		C	Robt lin-radsurg fractx 2-5	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0341		A	Percutaneous islet celltrans	6.98	51.68	28.38	NA	NA	0.51	000
G0342		A	Laparoscopy islet cell trans	11.92	NA	NA	7.73	7.04	0.88	090
G0343		A	Laparotomy islet cell transp	19.85	NA	NA	13.12	11.91	1.46	090
G0364		A	Bone marrow aspirate &biopsy	0.16	0.18	0.19	0.09	0.09	0.01	ZZZ
G0365		A	Vessel mapping hemo access	0.25	5.80	5.82	NA	NA	0.04	XXX
G0365	TC	A	Vessel mapping hemo access	0.00	5.71	5.73	NA	NA	0.01	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
G0365	26	A	Vessel mapping hemo access	0.25	0.09	0.09	0.09	0.09	0.03	XXX
G0372		A	MD service required for PMD	0.17	0.08	0.12	0.08	0.07	0.01	XXX
G0378		X	Hospital observation per hr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0379		X	Direct refer hospital observ	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0389		A	Ultrasound exam AAA screen	0.58	2.36	2.61	NA	NA	0.04	XXX
G0389	TC	A	Ultrasound exam AAA screen	0.00	2.15	2.37	NA	NA	0.01	XXX
G0389	26	A	Ultrasound exam AAA screen	0.58	0.21	0.24	0.21	0.24	0.03	XXX
G0396		A	Alcohol/subs interv 15-30mn	0.65	0.32	0.28	0.26	0.23	0.04	XXX
G0397		A	Alcohol/subs interv >30 min	1.30	0.80	0.61	0.75	0.56	0.08	XXX
G0398		C	Home sleep test/type 2 Porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0398	TC	C	Home sleep test/type 2 Porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0398	26	C	Home sleep test/type 2 Porta	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0399		C	Home sleep test/type 3 Porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0399	TC	C	Home sleep test/type 3 Porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0399	26	C	Home sleep test/type 3 Porta	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0400		C	Home sleep test/type 4 Porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0400	TC	C	Home sleep test/type 4 Porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0400	26	C	Home sleep test/type 4 Porta	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0402		A	Initial preventive exam	2.43	2.14	1.76	NA	NA	0.13	XXX
G0403		A	EKG for initial prevent exam	0.17	0.32	0.39	0.32	0.40	0.02	XXX
G0404		A	EKG tracing for initial prev	0.00	0.25	0.31	0.25	0.34	0.01	XXX
G0405		A	EKG interpret & report preve	0.17	0.07	0.08	0.07	0.06	0.01	XXX
G0406		A	Telhealth inpt consult 15min	0.76	NA	NA	0.34	0.31	0.06	XXX
G0407		A	Telheath inpt consult 25min	1.39	NA	NA	0.62	0.56	0.08	XXX
G0408		A	Telhealth inpt consult 35min	2.00	NA	NA	0.88	0.80	0.13	XXX
G0409		A	CORF related serv 15 mins ea	0.00	0.29	0.28	NA	NA	0.01	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
G0410		X	Grp psych partial hosp 45-50	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0411		X	Inter active grp psych parti	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0412		A	Open tx iliac spine uni/bil	10.45	NA	NA	9.03	8.56	2.12	090
G0413		A	Pelvic ring fracture uni/bil	15.73	NA	NA	12.41	11.95	3.18	090
G0414		A	Pelvic ring fx treat int fix	14.65	NA	NA	12.31	11.77	2.97	090
G0415		A	Open tx post pelvic fxcture	20.93	NA	NA	16.01	15.05	4.37	090
G0416		A	Sat biopsy prostate 1-20 spc	3.09	13.96	13.96	NA	NA	0.12	XXX
G0416	TC	A	Sat biopsy prostate 1-20 spc	0.00	12.14	12.14	NA	NA	0.01	XXX
G0416	26	A	Sat biopsy prostate 1-20 spc	3.09	1.82	1.82	1.82	1.82	0.11	XXX
G0417		A	Sat biopsy prostate 21-40	5.86	27.26	27.26	NA	NA	0.26	XXX
G0417	TC	A	Sat biopsy prostate 21-40	0.00	23.71	23.71	NA	NA	0.01	XXX
G0417	26	A	Sat biopsy prostate 21-40	5.86	3.55	3.55	3.55	3.55	0.25	XXX
G0418		A	Sat biopsy prostate 41-60	10.30	46.56	46.56	NA	NA	0.43	XXX
G0418	TC	A	Sat biopsy prostate 41-60	0.00	40.50	40.50	NA	NA	0.01	XXX
G0418	26	A	Sat biopsy prostate 41-60	10.30	6.06	6.06	6.06	6.06	0.42	XXX
G0419		A	Sat biopsy prostate: >60	11.61	55.86	55.86	NA	NA	0.48	XXX
G0419	TC	A	Sat biopsy prostate: >60	0.00	48.60	48.60	NA	NA	0.01	XXX
G0419	26	A	Sat biopsy prostate: >60	11.61	7.26	7.26	7.26	7.26	0.47	XXX
G0420		A	Ed svc CKD ind per session	2.12	1.01	1.01	NA	NA	0.11	XXX
G0421		A	Ed svc CKD grp per session	0.50	0.23	0.23	NA	NA	0.03	XXX
G0422		A	Intens cardiac rehab w/exerc	0.60	0.87	0.88	0.87	0.88	0.04	XXX
G0423		A	Intens cardiac rehab no exer	0.60	0.87	0.88	0.87	0.88	0.04	XXX
G0424		A	Pulmonary rehab w exer	0.28	0.58	0.58	0.12	0.12	0.03	XXX
G0425		A	Inpt telehealth consult 30m	1.92	NA	NA	0.84	0.84	0.18	XXX
G0426		A	Inpt telehealth consult 50m	2.61	NA	NA	1.18	1.18	0.23	XXX
G0427		A	Inpt telehealth con 70/>m	3.86	NA	NA	1.73	1.73	0.30	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
G0430		X	Drug screen multi class	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0431		X	Drug screen single class	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0432		X	EIA HIV-1/HIV-2 screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0433		X	ELISA HIV-1/HIV-2 screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0435		X	Oral HIV-1/HIV-2 screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G3001		X	Admin + supply, tositumomab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9001		X	MCCD, initial rate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9002		X	MCCD,maintenance rate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9003		X	MCCD, risk adj hi, initial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9004		X	MCCD, risk adj lo, initial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9005		X	MCCD, risk adj, maintenance	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9006		X	MCCD, Home monitoring	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9007		X	MCCD, sch team conf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9008		X	Mccd,phys coor-care ovrsght	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9009		X	MCCD, risk adj, level 3	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9010		X	MCCD, risk adj, level 4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9011		X	MCCD, risk adj, level 5	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9012		X	Other Specified Case Mgmt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9013		N	ESRD demo bundle level I	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9014		N	ESRD demo bundle-level II	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9016		N	Demo-smoking cessation coun	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9017		X	Amantadine HCL 100mg oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9018		X	Zanamivir,inhalation pwd 10m	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9019		X	Oseltamivir phosphate 75mg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9020		X	Rimantadine HCL 100mg oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9033		X	Amantadine HCL oral brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX

CPT[1]/ HCPCS Code	Mod	Status	Short Descriptor	Physician Work RVUs[2,3]	Fully Implemented Non-facility PE RVUs[2,3]	CY 2011 Transitional Non-facility PE RVUs[2,3]	Fully Implemented Facility PE RVUs[2,3]	CY 2011 Transitional Facility PE RVUs[2,3]	Malpractice RVUs[2,3]	Global
G9034		X	Zanamivir, inh pwdr, brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9035		X	Oseltamivir phosp, brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9036		X	Rimantadine HCL, brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9041		A	Low vision rehab occupationa	0.69	0.28	0.28	0.28	0.28	0.04	XXX
G9042		A	Low vision rehab orient/mobi	0.25	0.25	0.25	0.25	0.25	0.01	XXX
G9043		A	Low vision lowvision therapi	0.25	0.25	0.25	0.25	0.25	0.01	XXX
G9044		A	Low vision rehabilate teache	0.24	0.19	0.19	0.19	0.19	0.01	XXX
G9140		X	Frontier extended stay demo	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9141		X	Influenza A H1N1,admin w cou	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9142		X	Influenza A H1N1, vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9143		X	Warfarin respon genetic test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9147		N	Outpt IV insulin tx any mea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
GXXX1		A	Skin/dermal subs init 25or<	2.22	3.10	3.10	1.43	1.43	0.28	000
GXXX2		A	Skin/dermal subs each addition	0.50	0.81	0.81	0.19	0.19	0.07	ZZZ
GXXXA		A	PPPS, initial visit	2.43	2.14	2.14	NA	NA	0.13	XXX
GXXXB		A	PPPS, subseq visit	1.50	1.59	1.59	NA	NA	0.03	XXX
M0064		A	Visit for drug monitoring	0.37	1.04	0.97	0.07	0.09	0.01	XXX
P3001		A	Screening pap smear by phys	0.42	0.40	0.39	0.40	0.39	0.03	XXX
Q0035		A	Cardiokymography	0.17	0.30	0.35	NA	NA	0.02	XXX
Q0035	TC	A	Cardiokymography	0.00	0.24	0.29	NA	NA	0.01	XXX
Q0035	26	A	Cardiokymography	0.17	0.06	0.06	0.06	0.06	0.01	XXX
Q0091		A	Obtaining screen pap smear	0.37	0.85	0.86	0.17	0.15	0.03	XXX
Q0092		A	Set up port xray equipment	0.00	0.69	0.61	0.69	0.61	0.01	XXX
Q3001		C	Brachytherapy Radioelements	0.00	0.00	0.00	0.00	0.00	0.00	XXX
Q3014		X	Telehealth facility fee	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0070		C	Transport portable x-ray	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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R0075		C	Transport port x-ray multipl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0076		B	Transport portable EKG	0.00	0.00	0.00	0.00	0.00	0.00	XXX
V5299		R	Hearing service	0.00	0.00	0.00	0.00	0.00	0.00	XXX

1 CPT codes and descriptors only are copyright 2010 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
3 The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

ADDENDUM C: [Reserved]

ADDENDUM D: Proposed CY 2011 Geographic Adjustment Factors (GAFs)

Contractor	Locality	Locality Name	2010 GAF[1]	2011 GAF[2]	Percent Change (2010 to 2011)
00831	01	Alaska **	1.288	1.267	-1.63%
01102	06	San Mateo, CA	1.203	1.187	-1.33%
01102	05	San Francisco, CA	1.201	1.186	-1.25%
13202	02	NYC Suburbs/Long I., NY	1.162	1.153	-0.77%
13202	01	Manhattan, NY	1.164	1.148	-1.37%
01102	09	Santa Clara, CA	1.148	1.147	-0.09%
13292	04	Queens, NY	1.130	1.135	0.44%
01102	07	Oakland/Berkley, CA	1.130	1.126	-0.35%
01192	26	Anaheim/Santa Ana, CA	1.128	1.118	-0.89%
12202	01	DC + MD/VA Suburbs	1.121	1.117	-0.36%
12402	01	Northern NJ	1.134	1.116	-1.59%
09102	04	Miami, FL	1.114	1.111	-0.27%
01102	03	Marin/Napa/Solano, CA	1.112	1.110	-0.18%
01192	17	Ventura, CA	1.121	1.103	-1.61%
14202	01	Metropolitan Boston	1.133	1.101	-2.82%
01192	18	Los Angeles, CA	1.112	1.097	-1.35%
13102	00	Connecticut	1.100	1.091	-0.82%
00952	16	Chicago, IL	1.084	1.084	0.00%
12502	01	Metropolitan Philadelphia, PA	1.075	1.070	-0.47%
12402	99	Rest of New Jersey	1.082	1.070	-1.11%
00953	01	Detroit, MI	1.071	1.065	-0.56%
01202	01	Hawaii/Guam	1.057	1.063	0.57%
00952	15	Suburban Chicago, IL	1.063	1.063	0.00%
09102	03	Fort Lauderdale, FL	1.056	1.057	0.09%
12302	01	Baltimore/Surr. Cntys, MD	1.035	1.050	1.45%
00836	02	Seattle (King Cnty), WA	1.033	1.044	1.06%
14402	01	Rhode Island	1.045	1.043	-0.19%
14202	99	Rest of Massachusetts	1.041	1.038	-0.29%
13202	03	Poughkpsie/N NYC Suburbs, NY	1.034	1.034	0.00%
01302	00	Nevada***	1.016	1.023	0.69%
01102	99	Rest of California*	1.012	1.020	0.79%
01192	99	Rest of California*	1.012	1.020	0.79%
00952	12	East St. Louis, IL	1.013	1.016	0.30%
12102	01	Delaware	1.013	1.010	-0.30%
04402	18	Houston, TX	1.019	1.009	-0.98%
09102	99	Rest of Florida	1.015	1.006	-0.89%
04402	11	Dallas, TX	1.009	1.004	-0.50%
12302	99	Rest of Maryland	0.991	1.002	1.11%
10202	01	Atlanta, GA	1.004	1.002	-0.20%
04402	15	Galveston, TX	1.000	0.999	-0.10%
00528	01	New Orleans, LA	1.018	0.998	-1.96%
14302	40	New Hampshire	0.996	0.997	0.10%
09202	50	Virgin Islands	0.996	0.997	0.10%
04402	09	Brazoria, TX	1.002	0.997	-0.50%

Contractor	Locality	Locality Name	2010 GAF[1]	2011 GAF[2]	Percent Change (2010 to 2011)
00883	00	Ohio	0.993	0.993	0.00%
00835	01	Portland, OR	0.987	0.992	0.51%
05302	02	Metropolitan Kansas City, MO	0.995	0.992	-0.30%
04402	28	Fort Worth, TX	0.994	0.990	-0.40%
05302	01	Metropolitan St Louis, MO	0.988	0.986	-0.20%
04402	31	Austin, TX	0.995	0.986	-0.90%
03602	21	Wyoming***	0.961	0.985	2.50%
04102	01	Colorado	0.984	0.985	0.10%
00953	99	Rest of Michigan	0.987	0.985	-0.20%
14102	03	Southern Maine	0.991	0.985	-0.61%
00836	99	Rest of Washington	0.983	0.983	0.00%
12502	99	Rest of Pennsylvania	0.987	0.982	-0.51%
03102	00	Arizona	0.984	0.981	-0.30%
00952	99	Rest of Illinois	0.982	0.976	-0.61%
04202	05	New Mexico	0.980	0.972	-0.82%
00904	00	Virginia	0.975	0.971	-0.41%
03502	09	Utah	0.981	0.971	-1.02%
03202	01	Montana***	0.954	0.970	1.68%
04402	20	Beaumont, TX	0.986	0.968	-1.83%
14502	50	Vermont	0.977	0.966	-1.13%
00954	00	Minnesota	0.967	0.965	-0.21%
04402	99	Rest of Texas	0.976	0.961	-1.54%
13282	99	Rest of New York	0.961	0.960	-0.10%
10202	99	Rest of Georgia	0.968	0.960	-0.83%
00884	16	West Virginia	0.976	0.960	-1.64%
00951	00	Wisconsin	0.960	0.958	-0.21%
03302	01	North Dakota***	0.942	0.956	1.49%
05535	00	North Carolina	0.970	0.956	-1.44%
00835	99	Rest of Oregon	0.964	0.955	-0.93%
00630	00	Indiana	0.967	0.955	-1.24%
00528	99	Rest of Louisiana	0.969	0.950	-1.96%
03402	02	South Dakota***	0.948	0.949	0.11%
05202	00	Kansas	0.957	0.948	-0.94%
00880	01	South Carolina	0.959	0.947	-1.25%
10302	35	Tennessee	0.961	0.947	-1.46%
05130	00	Idaho	0.957	0.946	-1.15%
00660	00	Kentucky	0.956	0.945	-1.15%
14102	99	Rest of Maine	0.957	0.943	-1.46%
00512	00	Mississippi	0.961	0.942	-1.98%
05302	99	Rest of Missouri	0.961	0.941	-2.08%
10102	00	Alabama	0.949	0.938	-1.16%
04302	00	Oklahoma	0.953	0.936	-1.78%
05102	00	Iowa	0.950	0.931	-2.00%
05402	00	Nebraska	0.947	0.928	-2.01%
00520	13	Arkansas	0.945	0.926	-2.01%
09202	20	Puerto Rico	0.904	0.856	-5.31%

* Indicates multiple contractors.

** GAF reflects a 1.5 work GPCI floor in Alaska established by the MIPPA.
*** 2011 GAF reflects a 1.0 PE GPCI floor for frontier states as required by the Affordable Care Act.
[1] 2010 GAF equation: (0.52466*work GPCI)+(0.43669*PE GPCI)+(0.03865*MP GPCI).
2010 GAF contains a 1.0 work GPCI floor and reflects a limited recognition of cost differences for the rent and employee compensation components of the PE GPCI as required by the Affordable Care Act.
[2] 2011 GAF equation: (0.48266*work GPCI) + (0.47439*PE GPCI) + (0.04295*MP GPCI).
2011 GAF does not contain a 1.0 work GPCI floor which expires December 31, 2010 as required by the Affordable Care Act. 2011 GAF reflects a limited recognition of cost differences for the rent and employee compensation components of the PE GPCI as required by the Affordable Care Act.

ADDENDUM E: Proposed CY 2011 Geographic Practice Cost Indices (GPCIs) by State and Medicare Locality****

Contractor	Locality	Locality Name	2010 Work GPCI [1]	2010 PE GPCI [2]	2010 MP GPCI	2011 Work GPCI [3]	2011 PE GPCI	2011 MP GPCI	2012 Work GPCI [3]	2012 PE GPCI [4]	2012 MP GPCI
10102	00	Alabama	1.000	0.927	0.496	0.979	0.937	0.484	0.976	0.892	0.472
00831	01	Alaska**	1.500	1.090	0.646	1.500	1.086	0.647	1.500	1.081	0.648
03102	00	Arizona	1.000	0.979	0.822	0.983	0.985	0.913	0.977	0.982	1.003
00520	13	Arkansas	1.000	0.923	0.446	0.964	0.932	0.444	0.967	0.880	0.441
01192	26	Anaheim/Santa Ana, CA	1.034	1.269	0.811	1.039	1.232	0.742	1.043	1.195	0.672
01192	18	Los Angeles, CA	1.041	1.225	0.804	1.039	1.190	0.721	1.036	1.154	0.638
01102	03	Marin/Napa/Solano, CA	1.034	1.265	0.432	1.042	1.239	0.443	1.050	1.213	0.454
01102	07	Oakland/Berkley, CA	1.053	1.286	0.425	1.055	1.258	0.469	1.057	1.229	0.513
01102	05	San Francisco, CA	1.059	1.441	0.414	1.065	1.375	0.464	1.071	1.309	0.513
01102	06	San Mateo, CA	1.072	1.433	0.394	1.072	1.371	0.454	1.071	1.309	0.513
01102	09	Santa Clara, CA	1.083	1.294	0.377	1.080	1.279	0.445	1.077	1.264	0.513
01192	17	Ventura, CA	1.027	1.265	0.766	1.030	1.216	0.683	1.033	1.166	0.600
01102	99	Rest of California*	1.007	1.058	0.549	1.016	1.067	0.546	1.024	1.076	0.543
01192	99	Rest of California*	1.007	1.058	0.549	1.016	1.067	0.546	1.024	1.076	0.543
04102	01	Colorado	1.000	0.996	0.641	0.991	0.999	0.754	0.996	1.002	0.867
13102	00	Connecticut	1.038	1.185	0.980	1.031	1.151	1.102	1.023	1.117	1.224
12202	01	DC + MD/VA Suburbs	1.047	1.218	1.032	1.048	1.191	1.081	1.048	1.163	1.129
12102	01	Delaware	1.011	1.046	0.678	1.012	1.039	0.678	1.012	1.031	0.678
09102	03	Fort Lauderdale, FL	1.000	1.018	2.250	0.992	1.028	2.112	0.994	1.038	1.973
09102	04	Miami, FL	1.000	1.069	3.167	0.998	1.057	2.984	0.996	1.045	2.800
09102	99	Rest of Florida	1.000	0.970	1.724	0.978	0.977	1.634	0.983	0.966	1.544
10202	01	Atlanta, GA	1.009	1.014	0.836	1.006	1.007	0.891	1.002	0.999	0.945
10202	99	Rest of Georgia	1.000	0.942	0.829	0.978	0.950	0.876	0.977	0.915	0.923
01202	01	Hawaii/Guam	1.000	1.161	0.665	0.999	1.162	0.685	1.000	1.162	0.704
05130	00	Idaho	1.000	0.942	0.546	0.974	0.951	0.572	0.981	0.917	0.597
00952	16	Chicago, IL	1.025	1.080	1.940	1.028	1.058	2.005	1.030	1.036	2.069
00952	12	East St. Louis, IL	1.000	0.960	1.793	0.988	0.968	1.851	0.987	0.950	1.908

Contractor	Locality	Locality Name	2010 Work GPCI [1]	2010 PE GPCI [2]	2010 MP GPCI	2011 Work GPCI [3]	2011 PE GPCI	2011 MP GPCI	2012 Work GPCI [3]	2012 PE GPCI [4]	2012 MP GPCI
00952	15	Suburban Chicago, IL	1.017	1.068	1.629	1.021	1.052	1.664	1.024	1.036	1.699
00952	99	Rest of Illinois	1.000	0.940	1.219	0.976	0.949	1.275	0.976	0.915	1.330
00630	00	Indiana	1.000	0.960	0.599	0.978	0.963	0.603	0.969	0.932	0.606
05102	00	Iowa	1.000	0.935	0.434	0.962	0.943	0.443	0.958	0.899	0.451
05202	00	Kansas	1.000	0.941	0.557	0.966	0.948	0.746	0.962	0.907	0.935
00660	00	Kentucky	1.000	0.930	0.652	0.971	0.941	0.701	0.972	0.901	0.749
00528	01	New Orleans, LA	1.000	1.044	0.956	0.985	1.017	0.933	0.983	0.978	0.910
00528	99	Rest of Louisiana	1.000	0.939	0.892	0.969	0.943	0.816	0.967	0.894	0.739
14102	03	Southern Maine	1.000	1.025	0.492	0.982	1.024	0.583	0.984	1.023	0.674
14102	99	Rest of Maine	1.000	0.947	0.492	0.964	0.954	0.583	0.965	0.921	0.674
12302	01	Baltimore/Surr. Cntys, MD	1.012	1.057	1.086	1.019	1.073	1.146	1.026	1.089	1.206
12302	99	Rest of Maryland	1.000	0.991	0.874	1.002	1.008	0.930	1.010	1.034	0.986
14202	01	Metropolitan Boston	1.029	1.291	0.764	1.021	1.212	0.776	1.013	1.132	0.788
14202	99	Rest of Massachusetts	1.007	1.106	0.764	1.010	1.090	0.776	1.013	1.073	0.788
00953	01	Detroit, MI	1.036	1.040	1.906	1.029	1.030	1.855	1.021	1.019	1.803
00953	99	Rest of Michigan	1.000	0.962	1.083	0.995	0.967	1.075	0.991	0.944	1.066
00954	00	Minnesota	1.000	0.992	0.245	0.995	0.998	0.262	0.997	1.005	0.279
00512	00	Mississippi	1.000	0.927	0.808	0.961	0.937	0.782	0.962	0.891	0.756
05302	02	Metropolitan Kansas City, MO	1.000	0.973	1.188	0.986	0.978	1.204	0.982	0.964	1.219
05302	01	Metropolitan St Louis, MO	1.000	0.966	1.075	0.992	0.973	1.063	0.990	0.958	1.051
05302	99	Rest of Missouri	1.000	0.911	0.997	0.953	0.924	1.004	0.956	0.871	1.010
03202	01	Montana ***	1.000	0.924	0.673	0.948	1.000	0.887	0.946	1.000	1.100
05402	00	Nebraska	1.000	0.946	0.245	0.964	0.951	0.280	0.968	0.910	0.314
01302	00	Nevada ***	1.002	1.026	1.083	0.999	1.036	1.149	0.996	1.045	1.215
14302	40	New Hampshire	1.000	1.039	0.462	0.987	1.038	0.658	0.991	1.037	0.853
12402	01	Northern NJ	1.057	1.228	1.116	1.051	1.185	1.077	1.044	1.142	1.037
12402	99	Rest of New Jersey	1.042	1.126	1.116	1.031	1.110	1.077	1.020	1.093	1.037
04202	05	New Mexico	1.000	0.946	1.096	0.981	0.955	1.053	0.989	0.925	1.010
13202	01	Manhattan, NY	1.064	1.298	1.010	1.063	1.235	1.137	1.062	1.172	1.264

Contractor	Locality	Locality Name	2010 Work GPCI [1]	2010 PE GPCI [2]	2010 MP GPCI	2011 Work GPCI [3]	2011 PE GPCI	2011 MP GPCI	2012 Work GPCI [3]	2012 PE GPCI [4]	2012 MP GPCI
13202	02	NYC Suburbs/Long I., NY	1.051	1.289	1.235	1.050	1.242	1.334	1.048	1.195	1.433
13202	03	Poughkpsie/N NYC Suburbs, NY	1.014	1.077	0.822	1.013	1.064	0.945	1.011	1.050	1.067
13292	04	Queens, NY	1.032	1.239	1.220	1.047	1.206	1.351	1.062	1.172	1.482
13282	99	Rest of New York	1.000	0.961	0.425	0.993	0.969	0.493	0.988	0.952	0.560
05535	00	North Carolina	1.000	0.963	0.634	0.972	0.966	0.664	0.971	0.937	0.693
03302	01	North Dakota ***	1.000	0.922	0.387	0.957	1.000	0.453	0.966	1.000	0.519
00883	00	Ohio	1.000	0.964	1.232	0.996	0.968	1.229	0.998	0.940	1.226
04302	00	Oklahoma	1.000	0.925	0.627	0.960	0.936	0.671	0.955	0.890	0.715
00835	01	Portland, OR	1.002	1.015	0.472	1.003	1.021	0.542	1.004	1.027	0.612
00835	99	Rest of Oregon	1.000	0.964	0.472	0.974	0.974	0.542	0.980	0.965	0.612
12502	01	Metropolitan Philadelphia, PA	1.016	1.097	1.617	1.015	1.077	1.619	1.014	1.056	1.621
12502	99	Rest of Pennsylvania	1.000	0.963	1.081	0.990	0.964	1.100	0.987	0.930	1.119
09202	20	Puerto Rico	1.000	0.847	0.250	0.907	0.860	0.249	0.909	0.744	0.248
14402	01	Rhode Island	1.013	1.088	0.996	1.015	1.067	1.089	1.016	1.045	1.181
00880	01	South Carolina	1.000	0.954	0.446	0.976	0.959	0.483	0.976	0.926	0.519
03402	02	South Dakota***	1.000	0.932	0.420	0.946	1.000	0.424	0.950	1.000	0.428
10302	35	Tennessee	1.000	0.945	0.608	0.976	0.952	0.566	0.973	0.916	0.523
04402	31	Austin, TX	1.000	0.992	0.969	0.988	0.995	0.859	0.984	0.993	0.748
04402	20	Beaumont, TX	1.000	0.938	1.346	0.978	0.944	1.131	0.971	0.899	0.916
04402	09	Brazoria, TX	1.019	0.961	1.223	1.014	0.973	1.070	1.008	0.968	0.916
04402	11	Dallas, TX	1.009	1.001	1.110	1.009	1.003	0.970	1.008	1.005	0.829
04402	28	Fort Worth, TX	1.000	0.977	1.110	0.999	0.984	0.966	0.999	0.981	0.821
04402	15	Galveston, TX	1.000	0.980	1.223	1.000	0.988	1.100	1.008	0.989	0.977
04402	18	Houston, TX	1.016	0.994	1.345	1.012	0.995	1.131	1.008	0.989	0.916
04402	99	Rest of Texas	1.000	0.940	1.065	0.974	0.949	0.936	0.979	0.916	0.807
03502	09	Utah	1.000	0.954	1.026	0.975	0.959	1.058	0.972	0.925	1.090
14502	50	Vermont	1.000	0.992	0.489	0.973	1.000	0.523	0.977	1.013	0.557
00904	00	Virginia	1.000	0.972	0.657	0.988	0.980	0.692	0.993	0.974	0.726
09202	50	Virgin Islands	1.000	0.990	1.009	0.998	0.995	1.006	0.998	0.997	1.003

Contractor	Locality	Locality Name	2010 Work GPCI [1]	2010 PE GPCI [2]	2010 MP GPCI	2011 Work GPCI [3]	2011 PE GPCI	2011 MP GPCI	2012 Work GPCI [3]	2012 PE GPCI [4]	2012 MP GPCI
00836	02	Seattle (King Cnty), WA	1.014	1.085	0.706	1.020	1.091	0.786	1.025	1.096	0.865
00836	99	Rest of Washington	1.000	0.988	0.693	0.991	0.994	0.770	0.994	0.999	0.846
00884	16	West Virginia	1.000	0.914	1.353	0.968	0.923	1.279	0.963	0.861	1.205
00951	00	Wisconsin	1.000	0.961	0.409	0.988	0.971	0.477	0.987	0.962	0.544
03602	21	Wyoming ***	1.000	0.921	0.889	0.964	1.000	1.052	0.972	1.000	1.214

[1] 2010 work GPCI reflects a 1.0 floor required by the Affordable Care Act.
[2] 2010 PE GPCI reflects a limited recognition of cost differences for the rent and employee compensation components and application of the hold harmless provision as required by Affordable Care Act.
[3] 2011 and 2012 work GPCI does not reflect a 1.0 floor which expires December 31, 2010 as required by the Affordable Care Act.
[4] 2012 PE GPCI does not reflect a limited recognition of cost differences for the rent and employee compensation components which expires December 31, 2011 as required by the Affordable Care Act.
* Indicates multiple contractors.
** Work GPCI reflects a 1.5 floor in Alaska established by the MIPPA.
*** 2011 and 2012 PE GPCIs reflect a 1.0 floor for frontier states as required by the Affordable Care Act.
****2011 GPCIs are the first year of the update transition; 2012 GPCIs are the fully implemented updated GPCIs.
2011 work GPCI transition: ½ the difference between 2010 (without 1.0 work GPCI floor) and 2012 work GPCI.
2011 PE GPCI transition (and hold harmless as required by the ACA): Greater of ½ the difference between 2010 PE GPCI and 2012 PE GPCI with limited recognition of cost differences for the rent and employee compensation components (as required by the Affordable Care Act) or ½ the difference between 2010 PE GPCI and 2012 PE GPCI without the limited recognition of cost differences for the rent and employee compensation components. 2011 MP GPCI transition: ½ the difference between 2010 MP GPCI and 2012 MP GPCI.

ADDENDUM F--Proposed CY 2011 Diagnostic Imaging Services Subject to the Multiple Procedure Payment Reduction

CPT/HCPCS Code	Short Descriptor
70336	Magnetic image, jaw joint
70450	Ct head/brain w/o dye
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye
70480	Ct orbit/ear/fossa w/o dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o&w/dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/dye
70488	Ct maxillofacial w/o & w/dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70544	Mr angiography head w/o dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o&w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiograph neck w/o&w/dye
70551	Mri brain w/o dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
70554	Fmri brain by tech
71250	Ct thorax w/o dye
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye
71275	Ct angiography, chest
71550	Mri chest w/o dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
71555	Mri angio chest w or w/o dye
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

CPT/HCPCS Code	Short Descriptor
72131	Ct lumbar spine w/o dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72141	Mri neck spine w/o dye
72142	Mri neck spine w/dye
72146	Mri chest spine w/o dye
72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72191	Ct angiograph pelv w/o&w/dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
72198	Mr angio pelvis w/o & w/dye
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o&w/dye
73206	Ct angio upr extrm w/o&w/dye
73218	Mri upper extremity w/o dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o&w/dye
73221	Mri joint upr extrem w/o dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o&w/dye
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o&w/dye
73706	Ct angio lwr extr w/o&w/dye
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o&w/dye
73721	Mri jnt of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o&w/dye
73725	Mr ang lwr ext w or w/o dye
74150	Ct abdomen w/o dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye
74175	Ct angio abdom w/o & w/dye

CPT/HCPCS Code	Short Descriptor
74181	Mri abdomen w/o dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
74185	Mri angio, abdom w orw/o dye
74261	Ct colonography, w/o dye
74262	Ct colonography, w/dye
75557	Cardiac mri for morph
75559	Cardiac mri w/stress img
75561	Cardiac mri for morph w/dye
75563	Card mri w/stress img & dye
75571	Ct hrt w/o dye w/ca test
75572	Ct hrt w/3d image
75573	Ct hrt w/3d image, congen
75574	Ct angio hrt w/3d image
75574	Ct angio hrt w/3d image
75635	Ct angio abdominal arteries
76604	Us exam, chest
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76776	Us exam k transpl w/doppler
76831	Echo exam, uterus
76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited
76870	Us exam, scrotum
77058	Mri, one breast
77059	Mri, both breasts

ADDENDUM G: CPT/HCPCS Imaging Codes Defined By Section 5102(b) of the DRA

CPT/HCPCS Code	Short Descriptor
31620	Endobronchial us add-on
37250	Iv us first vessel add-on
37251	Iv us each add vessel add-on
51798	Us urine capacity measure
70010	Contrast x-ray of brain
70015	Contrast x-ray of brain
70030	X-ray eye for foreign body
70100	X-ray exam of jaw
70110	X-ray exam of jaw
70120	X-ray exam of mastoids
70130	X-ray exam of mastoids
70134	X-ray exam of middle ear
70140	X-ray exam of facial bones
70150	X-ray exam of facial bones
70160	X-ray exam of nasal bones
70170	X-ray exam of tear duct
70190	X-ray exam of eye sockets
70200	X-ray exam of eye sockets
70210	X-ray exam of sinuses
70220	X-ray exam of sinuses
70240	X-ray exam, pituitary saddle
70250	X-ray exam of skull
70260	X-ray exam of skull
70300	X-ray exam of teeth
70310	X-ray exam of teeth
70320	Full mouth x-ray of teeth
70328	X-ray exam of jaw joint
70330	X-ray exam of jaw joints
70332	X-ray exam of jaw joint
70336	Magnetic image, jaw joint
70350	X-ray head for orthodontia
70355	Panoramic x-ray of jaws
70360	X-ray exam of neck
70370	Throat x-ray & fluoroscopy
70371	Speech evaluation, complex
70373	Contrast x-ray of larynx
70380	X-ray exam of salivary gland
70390	X-ray exam of salivary duct
70450	Ct head/brain w/o dye
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye
70480	Ct orbit/ear/fossa w/o dye

CPT/HCPCS Code	Short Descriptor
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o&w/dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/dye
70488	Ct maxillofacial w/o & w/dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70544	Mr angiography head w/o dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o&w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiograph neck w/o&w/dye
70551	Mri brain w/o dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
70557	Mri brain w/o dye
70558	Mri brain w/dye
70559	Mri brain w/o & w/dye
71010	Chest x-ray
71015	Chest x-ray
71020	Chest x-ray
71021	Chest x-ray
71022	Chest x-ray
71023	Chest x-ray and fluoroscopy
71030	Chest x-ray
71034	Chest x-ray and fluoroscopy
71035	Chest x-ray
71040	Contrast x-ray of bronchi
71060	Contrast x-ray of bronchi
71090	X-ray & pacemaker insertion
71100	X-ray exam of ribs
71101	X-ray exam of ribs/chest
71110	X-ray exam of ribs
71111	X-ray exam of ribs/chest
71120	X-ray exam of breastbone
71130	X-ray exam of breastbone
71250	Ct thorax w/o dye

CPT/HCPCS Code	Short Descriptor
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye
71275	Ct angiography, chest
71550	Mri chest w/o dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
71555	Mri angio chest w or w/o dye
72010	X-ray exam of spine
72020	X-ray exam of spine
72040	X-ray exam of neck spine
72050	X-ray exam of neck spine
72052	X-ray exam of neck spine
72069	X-ray exam of trunk spine
72070	X-ray exam of thoracic spine
72072	X-ray exam of thoracic spine
72074	X-ray exam of thoracic spine
72080	X-ray exam of trunk spine
72090	X-ray exam of trunk spine
72100	X-ray exam of lower spine
72110	X-ray exam of lower spine
72114	X-ray exam of lower spine
72120	X-ray exam of lower spine
72125	Ct neck spine w/o dye
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72131	Ct lumbar spine w/o dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72141	Mri neck spine w/o dye
72142	Mri neck spine w/dye
72146	Mri chest spine w/o dye
72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72159	Mr angio spine w/o&w/dye
72170	X-ray exam of pelvis
72190	X-ray exam of pelvis
72191	Ct angiograph pelv w/o&w/dye

CPT/HCPCS Code	Short Descriptor
72192	Ct pelvis w/o dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
72198	Mr angio pelvis w/o & w/dye
72200	X-ray exam sacroiliac joints
72202	X-ray exam sacroiliac joints
72220	X-ray exam of tailbone
72240	Contrast x-ray of neck spine
72255	Contrast x-ray, thorax spine
72265	Contrast x-ray, lower spine
72270	Contrast x-ray, spine
72275	Epidurography
72285	X-ray c/t spine disk
72291	Percut vertebroplasty fluor
72293	Percut vertebroplasty, ct
72295	X-ray of lower spine disk
73000	X-ray exam of collar bone
73010	X-ray exam of shoulder blade
73020	X-ray exam of shoulder
73030	X-ray exam of shoulder
73040	Contrast x-ray of shoulder
73050	X-ray exam of shoulders
73060	X-ray exam of humerus
73070	X-ray exam of elbow
73080	X-ray exam of elbow
73085	Contrast x-ray of elbow
73090	X-ray exam of forearm
73092	X-ray exam of arm, infant
73100	X-ray exam of wrist
73110	X-ray exam of wrist
73115	Contrast x-ray of wrist
73120	X-ray exam of hand
73130	X-ray exam of hand
73140	X-ray exam of finger(s)
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o&w/dye
73206	Ct angio upr extrm w/o&w/dye
73218	Mri upper extremity w/o dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o&w/dye

CPT/HCPCS Code	Short Descriptor
73221	Mri joint upr extrem w/o dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o&w/dye
73225	Mr angio upr extr w/o&w/dye
73500	X-ray exam of hip
73510	X-ray exam of hip
73520	X-ray exam of hips
73525	Contrast x-ray of hip
73530	X-ray exam of hip
73540	X-ray exam of pelvis & hips
73542	X-ray exam, sacroiliac joint
73550	X-ray exam of thigh
73560	X-ray exam of knee, 1 or 2
73562	X-ray exam of knee, 3
73564	X-ray exam, knee, 4 or more
73565	X-ray exam of knees
73580	Contrast x-ray of knee joint
73590	X-ray exam of lower leg
73592	X-ray exam of leg, infant
73600	X-ray exam of ankle
73610	X-ray exam of ankle
73615	Contrast x-ray of ankle
73620	X-ray exam of foot
73630	X-ray exam of foot
73650	X-ray exam of heel
73660	X-ray exam of toe(s)
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o&w/dye
73706	Ct angio lwr extr w/o&w/dye
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o&w/dye
73721	Mri jnt of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o&w/dye
73725	Mr ang lwr ext w or w/o dye
74000	X-ray exam of abdomen
74010	X-ray exam of abdomen
74020	X-ray exam of abdomen
74022	X-ray exam series, abdomen
74150	Ct abdomen w/o dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye

CPT/HCPCS Code	Short Descriptor
74175	Ct angio abdom w/o & w/dye
74181	Mri abdomen w/o dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
74185	Mri angio, abdom w orw/o dye
74190	X-ray exam of peritoneum
74210	Contrst x-ray exam of throat
74220	Contrast x-ray, esophagus
74230	Cine/vid x-ray, throat/esoph
74235	Remove esophagus obstruction
74240	X-ray exam, upper gi tract
74241	X-ray exam, upper gi tract
74245	X-ray exam, upper gi tract
74246	Contrst x-ray uppr gi tract
74247	Contrst x-ray uppr gi tract
74249	Contrst x-ray uppr gi tract
74250	X-ray exam of small bowel
74251	X-ray exam of small bowel
74260	X-ray exam of small bowel
74261	Ct colonography, w/o dye
74262	Ct colonography, w/dye
74263	Ct colonography, screen
74270	Contrast x-ray exam of colon
74280	Contrast x-ray exam of colon
74283	Contrast x-ray exam of colon
74290	Contrast x-ray, gallbladder
74291	Contrast x-rays, gallbladder
74300	X-ray bile ducts/pancreas
74301	X-rays at surgery add-on
74305	X-ray bile ducts/pancreas
74320	Contrast x-ray of bile ducts
74327	X-ray bile stone removal
74328	X-ray bile duct endoscopy
74329	X-ray for pancreas endoscopy
74330	X-ray bile/panc endoscopy
74340	X-ray guide for GI tube
74355	X-ray guide, intestinal tube
74360	X-ray guide, GI dilation
74363	X-ray, bile duct dilation
74400	Contrst x-ray, urinary tract
74410	Contrst x-ray, urinary tract
74415	Contrst x-ray, urinary tract
74420	Contrst x-ray, urinary tract
74425	Contrst x-ray, urinary tract

CPT/HCPCS Code	Short Descriptor
74430	Contrast x-ray, bladder
74440	X-ray, male genital tract
74445	X-ray exam of penis
74450	X-ray, urethra/bladder
74455	X-ray, urethra/bladder
74470	X-ray exam of kidney lesion
74475	X-ray control, cath insert
74480	X-ray control, cath insert
74485	X-ray guide, GU dilation
74710	X-ray measurement of pelvis
74740	X-ray, female genital tract
74742	X-ray, fallopian tube
74775	X-ray exam of perineum
75557	Cardiac MRI w/o contrast
75559	Cardiac MRI w/ stress imaging
75561	Cardiac MRI w/ & w/o contrast
75563	Cardiac MRI w/ stress imaging
75565	Card mri vel flw map add-on
75571	Ct hrt w/o dye w/ca test
75572	Ct hrt w/3d image
75573	Ct hrt w/3d image, congen
75574	Ct angio hrt w/3d image
75600	Contrast x-ray exam of aorta
75605	Contrast x-ray exam of aorta
75625	Contrast x-ray exam of aorta
75630	X-ray aorta, leg arteries
75635	Ct angio abdominal arteries
75650	Artery x-rays, head & neck
75658	Artery x-rays, arm
75660	Artery x-rays, head & neck
75662	Artery x-rays, head & neck
75665	Artery x-rays, head & neck
75671	Artery x-rays, head & neck
75676	Artery x-rays, neck
75680	Artery x-rays, neck
75685	Artery x-rays, spine
75705	Artery x-rays, spine
75710	Artery x-rays, arm/leg
75716	Artery x-rays, arms/legs
75722	Artery x-rays, kidney
75724	Artery x-rays, kidneys
75726	Artery x-rays, abdomen
75731	Artery x-rays, adrenal gland
75733	Artery x-rays, adrenals

CPT/HCPCS Code	Short Descriptor
75736	Artery x-rays, pelvis
75741	Artery x-rays, lung
75743	Artery x-rays, lungs
75746	Artery x-rays, lung
75756	Artery x-rays, chest
75774	Artery x-ray, each vessel
75790	Visualize A-V shunt
75791	Av dialysis shunt imaging
75801	Lymph vessel x-ray, arm/leg
75803	Lymph vessel x-ray,arms/legs
75805	Lymph vessel x-ray, trunk
75807	Lymph vessel x-ray, trunk
75809	Nonvascular shunt, x-ray
75810	Vein x-ray, spleen/liver
75820	Vein x-ray, arm/leg
75822	Vein x-ray, arms/legs
75825	Vein x-ray, trunk
75827	Vein x-ray, chest
75831	Vein x-ray, kidney
75833	Vein x-ray, kidneys
75840	Vein x-ray, adrenal gland
75842	Vein x-ray, adrenal glands
75860	Vein x-ray, neck
75870	Vein x-ray, skull
75872	Vein x-ray, skull
75880	Vein x-ray, eye socket
75885	Vein x-ray, liver
75887	Vein x-ray, liver
75889	Vein x-ray, liver
75891	Vein x-ray, liver
75893	Venous sampling by catheter
75894	X-rays, transcath therapy
75896	X-rays, transcath therapy
75898	Follow-up angiography
75900	Intravascular cath exchange
75901	Remove cva device obstruct
75902	Remove cva lumen obstruct
75940	X-ray placement, vein filter
75945	Intravascular us
75946	Intravascular us add-on
75953	Abdom aneurysm endovas rpr
75956	Xray, endovasc thor ao repr
75957	Xray, endovasc thor ao repr
75958	Xray, place prox ext thor ao

CPT/HCPCS Code	Short Descriptor
75959	Xray, place dist ext thor ao
75960	Transcath iv stent rs&i
75961	Retrieval, broken catheter
75962	Repair arterial blockage
75964	Repair artery blockage, each
75966	Repair arterial blockage
75968	Repair artery blockage, each
75970	Vascular biopsy
75978	Repair venous blockage
75980	Contrast xray exam bile duct
75982	Contrast xray exam bile duct
75984	Xray control catheter change
75989	Abscess drainage under x-ray
75992	Atherectomy, x-ray exam
76000	Fluoroscope examination
76001	Fluoroscope exam, extensive
76010	X-ray, nose to rectum
76080	X-ray exam of fistula
76098	X-ray exam, breast specimen
76100	X-ray exam of body section
76101	Complex body section x-ray
76102	Complex body section x-rays
76120	Cine/video x-rays
76125	Cine/video x-rays add-on
76140	X-ray consultation
76150	X-ray exam, dry process
76350	Special x-ray contrast study
76376	3d render w/o postprocess
76377	3d rendering w/postprocess
76380	CAT scan follow-up study
76390	Mr spectroscopy
76496	Fluoroscopic procedure
76497	Ct procedure
76498	Mri procedure
76506	Echo exam of head
76510	Ophth us, b & quant a
76511	Ophth us, quant a only
76512	Ophth us, b w/non-quant a
76513	Echo exam of eye, water bath
76514	Echo exam of eye, thickness
76516	Echo exam of eye
76519	Echo exam of eye
76529	Echo exam of eye
76536	Us exam of head and neck

CPT/HCPCS Code	Short Descriptor
76604	Us exam, chest, b-scan
76645	Us exam, breast(s)
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76778	Us exam kidney transplant
76800	Us exam, spinal canal
76801	Ob us < 14 wks, single fetus
76802	Ob us < 14 wks, add'l fetus
76805	Ob us >/= 14 wks, sngl fetus
76810	Ob us >/= 14 wks, addl fetus
76811	Ob us, detailed, sngl fetus
76812	Ob us, detailed, addl fetus
76815	Ob us, limited, fetus(s)
76816	Ob us, follow-up, per fetus
76817	Transvaginal us, obstetric
76818	Fetal biophys profile w/nst
76819	Fetal biophys profil w/o nst
76820	Umbilical artery echo
76821	Middle cerebral artery echo
76825	Echo exam of fetal heart
76826	Echo exam of fetal heart
76827	Echo exam of fetal heart
76828	Echo exam of fetal heart
76830	Transvaginal us, non-ob
76831	Echo exam, uterus
76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited
76870	Us exam, scrotum
76872	Us, transrectal
76873	Echograp trans r, pros study
76880	Us exam, extremity
76885	Us exam infant hips, dynamic
76886	Us exam infant hips, static
76930	Echo guide, cardiocentesis
76932	Echo guide for heart biopsy
76936	Echo guide for artery repair
76937	Us guide, vascular access
76940	Us guide, tissue ablation
76941	Echo guide for transfusion
76942	Echo guide for biopsy
76945	Echo guide, villus sampling
76946	Echo guide for amniocentesis

CPT/HCPCS Code	Short Descriptor
76948	Echo guide, ova aspiration
76950	Echo guidance radiotherapy
76965	Echo guidance radiotherapy
76970	Ultrasound exam follow-up
76975	GI endoscopic ultrasound
76977	Us bone density measure
76998	Ultrasound guide intraoper
77001	Fluoroguide for vein device
77002	Needle localization by x-ray
77003	Fluoroguide for spine inject
77011	Ct scan for localization
77012	Ct scan for needle biopsy
77013	Ct guide for tissue ablation
77014	Ct scan for therapy guide
77021	Mr guidance for needle place
77022	Mri for tissue ablation
77031	Stereotactic breast biopsy
77032	X-ray of needle wire, breast
77053	X-ray of mammary duct
77054	X-ray of mammary ducts
77058	Magnetic image, breast
77059	Magnetic image, both breasts
77071	X-ray stress view
77072	X-rays for bone age
77073	X-rays, bone evaluation
77074	X-rays, bone survey
77075	X-rays, bone survey
77076	X-rays, bone evaluation
77077	Joint survey, single view
77078	Ct bone density, axial
77079	Ct bone density, peripheral
77081	Dxa bone density/peripheral
77083	Radiographic absorptiometry
77084	Magnetic image, bone marrow
77417	Radiology port film(s)
77421	Stereoscopic x-ray guidance
78006	Thyroid imaging with uptake
78007	Thyroid image, mult uptakes
78010	Thyroid imaging
78011	Thyroid imaging with flow
78015	Thyroid met imaging
78016	Thyroid met imaging/studies
78018	Thyroid met imaging, body
78020	Thyroid met uptake

CPT/HCPCS Code	Short Descriptor
78070	Parathyroid nuclear imaging
78075	Adrenal nuclear imaging
78102	Bone marrow imaging, ltd
78103	Bone marrow imaging, mult
78104	Bone marrow imaging, body
78135	Red cell survival kinetics
78140	Red cell sequestration
78185	Spleen imaging
78190	Platelet survival, kinetics
78195	Lymph system imaging
78201	Liver imaging
78202	Liver imaging with flow
78205	Liver imaging (3D)
78206	Liver image (3d) with flow
78215	Liver and spleen imaging
78216	Liver & spleen image/flow
78220	Liver function study
78223	Hepatobiliary imaging
78230	Salivary gland imaging
78231	Serial salivary imaging
78232	Salivary gland function exam
78258	Esophageal motility study
78261	Gastric mucosa imaging
78262	Gastroesophageal reflux exam
78264	Gastric emptying study
78278	Acute GI blood loss imaging
78282	GI protein loss exam
78290	Meckel's divert exam
78291	Leveen/shunt patency exam
78300	Bone imaging, limited area
78305	Bone imaging, multiple areas
78306	Bone imaging, whole body
78315	Bone imaging, 3 phase
78320	Bone imaging (3D)
78350	Bone mineral, single photon
78351	Bone mineral, dual photon
78428	Cardiac shunt imaging
78445	Vascular flow imaging
78451	Ht muscle image spect, sing
78452	Ht muscle image spect, mult
78453	Ht muscle image,planar,sing
78454	Ht musc image, planar, mult
78456	Acute venous thrombus image
78457	Venous thrombosis imaging

CPT/HCPCS Code	Short Descriptor
78458	Ven thrombosis images, bilat
78459	Heart muscle imaging (PET)
78466	Heart infarct image
78468	Heart infarct image (ef)
78469	Heart infarct image (3D)
78472	Gated heart, planar, single
78473	Gated heart, multiple
78481	Heart first pass, single
78483	Heart first pass, multiple
78491	Heart image (pet), single
78492	Heart image (pet), multiple
78494	Heart image, spect
78496	Heart first pass add-on
78580	Lung perfusion imaging
78584	Lung V/Q image single breath
78585	Lung V/Q imaging
78586	Aerosol lung image, single
78587	Aerosol lung image, multiple
78588	Perfusion lung image
78591	Vent image, 1 breath, 1 proj
78593	Vent image, 1 proj, gas
78594	Vent image, mult proj, gas
78596	Lung differential function
78600	Brain imaging, ltd static
78601	Brain imaging, ltd w/flow
78605	Brain imaging, complete
78606	Brain imaging, compl w/flow
78607	Brain imaging (3D)
78608	Brain imaging (PET)
78609	Brain imaging (PET)
78610	Brain flow imaging only
78630	Cerebrospinal fluid scan
78635	CSF ventriculography
78645	CSF shunt evaluation
78647	Cerebrospinal fluid scan
78650	CSF leakage imaging
78660	Nuclear exam of tear flow
78700	Kidney imaging, static
78701	Kidney imaging with flow
78704	Imaging renogram
78707	Kidney flow/function image
78708	Kidney flow/function image
78709	Kidney flow/function image
78710	Kidney imaging (3D)

CPT/HCPCS Code	Short Descriptor
78715	Renal vascular flow exam
78730	Urinary bladder retention
78740	Ureteral reflux study
78760	Testicular imaging
78761	Testicular imaging/flow
78800	Tumor imaging, limited area
78801	Tumor imaging, mult areas
78802	Tumor imaging, whole body
78803	Tumor imaging (3D)
78804	Tumor imaging, whole body
78805	Abscess imaging, ltd area
78806	Abscess imaging, whole body
78807	Nuclear localization/abscess
78808	Iv inj ra drug dx study
78811	Tumor imaging (pet), limited
78812	Tumor image (pet)/skul-thigh
78813	Tumor image (pet) full body
78814	Tumor image pet/ct, limited
78815	Tumorimage pet/ct skul-thigh
78816	Tumor image pet/ct full body
92135	Scanning computer ophthalmic
92235	Fluorscein angioscopy
92240	IDC green angiography
92250	Fundus photography
92285	External ocular photography
92286	Anterior segment photography
93303	Echo transthoracic
93304	Echo transthoracic
93306	Tte w/doppler, complete
93307	Echo exam of heart
93308	Echo exam of heart
93312	Echo transesophageal
93313	Echo transesophageal
93314	Echo transesophageal
93315	Echo transesophageal
93316	Echo transesophageal
93317	Echo transesophageal
93318	Echo transesophageal intraop
93320	Doppler echo exam, heart
93321	Doppler echo exam, heart
93325	Doppler color flow add-on
93350	Echo transthoracic
93351	Stress tte complete
93352	Admin ecg contrast agent

CPT/HCPCS Code	Short Descriptor
93555	Imaging, cardiac cath
93556	Imaging, cardiac cath
93571	Heart flow reserve measure
93572	Heart flow reserve measure
93880	Extracranial study
93882	Extracranial study
93886	Intracranial study
93888	Intracranial study
93890	Tcd, vasoreactivity study
93892	Tcd, emboli detect w/o inj
93893	Tcd, emboli detect w/inj
93925	Lower extremity study
93926	Lower extremity study
93930	Upper extremity study
93931	Upper extremity study
93970	Extremity study
93971	Extremity study
93975	Vascular study
93976	Vascular study
93978	Vascular study
93979	Vascular study
93980	Penile vascular study
93981	Penile vascular study
93990	Doppler flow testing
0028T	Dexa body composition study
0042T	Ct perfusion w/contrast, cbf
0066T	Ct colonography;screen
0080T	Endovasc aort repr rad s&i
0081T	Endovasc visc extnsn s&i
0144T	CT heart wo dye; qual calc
0145T	CT heart w/wo dye funct
0146T	CCTA w/wo dye
0147T	CCTA w/wo, quan calcium
0148T	CCTA w/wo, strxr
0149T	CCTA w/wo, strxr quan calc
0150T	CCTA w/wo, disease strxr
0151T	CT heart funct add-on
0152T	Computer chest add-on
G0120	Colon ca scrn; barium enema
G0122	Colon ca scrn; barium enema
G0130	Single energy x-ray study
G0219	PET img wholbod melano nonco
G0235	PET not otherwise specified
G0275	Renal angio, cardiac cath

CPT/HCPCS Code	Short Descriptor
G0278	Iliac art angio,cardiac cath
G0288	Recon, CTA for surg plan
G0365	Vessel mapping hemo access

Addendum H--Proposed CY 2011 "Always Therapy" Services* Subject to the Multiple Procedure Payment Reduction

HCPCS/CPT Code	Short Descriptor
92506	Speech/hearing evaluation
92507	Speech/hearing therapy
92508	Speech/hearing therapy
92526	Oral function therapy
92597	Oral speech device eval
92607	Ex for speech device rx, 1hr
92608	Ex for speech device rx addl
92609	Use of speech device service
96125	Cognitive test by hc pro
97001	Pt evaluation
97002	Pt re-evaluation
97003	Ot evaluation
97004	Ot re-evaluation
97012	Mechanical traction therapy
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97022	Whirlpool therapy
97024	Diathermy eg, microwave
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation
97033	Electric current therapy
97034	Contrast bath therapy
97035	Ultrasound therapy
97036	Hydrotherapy
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97113	Aquatic therapy/exercises
97116	Gait training therapy
97124	Massage therapy
97140	Manual therapy
97150	Group therapeutic procedures
97530	Therapeutic activities
97533	Sensory integration
97535	Self care mngment training
97537	Community/work reintegration
97542	Wheelchair mngment training

HCPCS/CPT Code	Short Descriptor
97750	Physical performance test
97755	Assistive technology assess
97760	Orthotic mgmt and training
97761	Prosthetic training
97762	C/o for orthotic/prosth use
G0281	Elec stim unattend for press
G0283	Elec stim other than wound
G0329	Electromagntic tx for ulcers

*Excludes contractor-priced codes and bundled codes.

ADDENDUM I: [Reserved]

ADDENDUM J: [Reserved]

ADDENDUM K: Proposed CY 2011 ESRD PPS and Composite Rate Wage Indices for Urban Areas Based on CBSA Labor Market Areas

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
10180	Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX	0.8473	0.8016
10380	Aguadilla-Isabela-San Sebastián, PR Aguada Municipio, PR Aguadilla Municipio, PR Añasco Municipio, PR Isabela Municipio, PR Lares Municipio, PR Moca Municipio, PR Rincón Municipio, PR San Sebastián Municipio, PR	0.6342	0.6000
10420	Akron, OH Portage County, OH Summit County, OH	0.9362	0.8857
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.9566	0.9050
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.9162	0.8667
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9993	0.9454
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8465	0.8008
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	0.9702	0.9178
11020	Altoona, PA Blair County, PA	0.9127	0.8634

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.9152	0.8658
11180	Ames, IA Story County, IA	1.0556	0.9986
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.2668	1.1984
11300	Anderson, IN Madison County, IN	0.9732	0.9207
11340	Anderson, SC Anderson County, SC	0.9460	0.8949
11460	Ann Arbor, MI Washtenaw County, MI	1.0719	1.0140
11500	Anniston-Oxford, AL Calhoun County, AL	0.8384	0.7931
11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9911	0.9376
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.9530	0.9016
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA	1.0091	0.9546

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
12060	Atlanta-Sandy Springs-Marietta, GA Barrow County, GA Bartow County, GA Butts County, GA Carroll County, GA Cherokee County, GA Clayton County, GA Cobb County, GA Coweta County, GA Dawson County, GA DeKalb County, GA Douglas County, GA Fayette County, GA Forsyth County, GA Fulton County, GA Gwinnett County, GA Haralson County, GA Heard County, GA Henry County, GA Jasper County, GA Lamar County, GA Meriwether County, GA Newton County, GA Paulding County, GA Pickens County, GA Pike County, GA Rockdale County, GA Spalding County, GA Walton County, GA	1.0112	0.9566
12100	Atlantic City-Hammonton, NJ Atlantic County, NJ	1.1783	1.1147
12220	Auburn-Opelika, AL Lee County, AL	0.7669	0.7255
12260	Augusta-Richmond County, GA-SC Burke County, GA Columbia County, GA McDuffie County, GA Richmond County, GA Aiken County, SC Edgefield County, SC	1.0065	0.9522
12420	Austin-Round Rock-San Marcos, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX	1.0073	0.9529
12540	Bakersfield-Delano, CA Kern County, CA	1.2320	1.1655

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
12580	Baltimore-Towson, MD Anne Arundel County, MD Baltimore County, MD Carroll County, MD Harford County, MD Howard County, MD Queen Anne's County, MD Baltimore City, MD	1.0853	1.0267
12620	Bangor, ME Penobscot County, ME	1.0352	0.9793
12700	Barnstable Town, MA Barnstable County, MA	1.3577	1.2844
12940	Baton Rouge, LA Ascension Parish, LA East Baton Rouge Parish, LA East Feliciana Parish, LA Iberville Parish, LA Livingston Parish, LA Pointe Coupee Parish, LA St. Helena Parish, LA West Baton Rouge Parish, LA West Feliciana Parish, LA	0.9088	0.8597
12980	Battle Creek, MI Calhoun County, MI	1.0223	0.9671
13020	Bay City, MI Bay County, MI	0.9762	0.9235
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8987	0.8502
13380	Bellingham, WA Whatcom County, WA	1.2059	1.1408
13460	Bend, OR Deschutes County, OR	1.2038	1.1388
13644	Bethesda-Rockville-Frederick, MD Frederick County, MD Montgomery County, MD	1.1143	1.0542
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.9184	0.8688
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.9231	0.8733

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
13820	Birmingham-Hoover, AL Bibb County, AL Blount County, AL Chilton County, AL Jefferson County, AL St. Clair County, AL Shelby County, AL Walker County, AL	0.9108	0.8616
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.7780	0.7360
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8803	0.8328
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.9518	0.9004
14060	Bloomington-Normal, IL McLean County, IL	0.9994	0.9455
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9818	0.9288
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.2912	1.2215
14500	Boulder, CO Boulder County, CO	1.0656	1.0081
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.9175	0.8680
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.1294	1.0684
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.3284	1.2567
15180	Brownsville-Harlingen, TX Cameron County, TX	0.9712	0.9188
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9750	0.9224

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15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	1.0090	0.9545
15500	Burlington, NC Alamance County, NC	0.9385	0.8878
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	1.0531	0.9963
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1911	1.1268
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0997	1.0403
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.9261	0.8761
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9715	0.9191
16020	Cape Girardeau-Jackson, MO-IL Alexander County, IL Bollinger County, MO Cape Girardeau County, MO	0.9413	0.8905
16180	Carson City, NV Carson City, NV	1.1080	1.0482
16220	Casper, WY Natrona County, WY	1.0222	0.9670
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.9363	0.8858
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	1.0836	1.0251
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8359	0.7908
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9878	0.9345

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16740	Charlotte-Gastonia-Rock Hill, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	0.9973	0.9435
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	0.9892	0.9358
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.9255	0.8755
16940	Cheyenne, WY Laramie County, WY	0.9945	0.9408
16974	Chicago-Joliet-Naperville, IL Cook County, IL DeKalb County, IL DuPage County, IL Grundy County, IL Kane County, IL Kendall County, IL McHenry County, IL Will County, IL	1.1176	1.0573
17020	Chico, CA Butte County, CA	1.2232	1.1572
17140	Cincinnati-Middletown, OH-KY-IN Dearborn County, IN Franklin County, IN Ohio County, IN Boone County, KY Bracken County, KY Campbell County, KY Gallatin County, KY Grant County, KY Kenton County, KY Pendleton County, KY Brown County, OH Butler County, OH Clermont County, OH Hamilton County, OH Warren County, OH	1.0268	0.9714

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17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN	0.8349	0.7898
17420	Cleveland, TN Bradley County, TN Polk County, TN	0.8186	0.7744
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.9568	0.9052
17660	Coeur d'Alene, ID Kootenai County, ID	0.9914	0.9379
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	1.0152	0.9604
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	1.0039	0.9497
17860	Columbia, MO Boone County, MO Howard County, MO	0.8768	0.8295
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.9219	0.8721
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.9558	0.9042
18020	Columbus, IN Bartholomew County, IN	0.9988	0.9449

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18140	Columbus, OH Delaware County, OH Fairfield County, OH Franklin County, OH Licking County, OH Madison County, OH Morrow County, OH Pickaway County, OH Union County, OH	1.0737	1.0157
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.9090	0.8599
18700	Corvallis, OR Benton County, OR	1.1070	1.0472
18880	Crestview-Fort Walton Beach-Destin, FL Okaloosa, FL	0.9361	0.8856
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.8667	0.8199
19124	Dallas-Plano-Irving, TX Collin County, TX Dallas County, TX Delta County, TX Denton County, TX Ellis County, TX Hunt County, TX Kaufman County, TX Rockwall County, TX	1.0410	0.9848
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.9101	0.8610
19180	Danville, IL Vermilion County, IL	1.0262	0.9708
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.8649	0.8182
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.8894	0.8414
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9677	0.9155

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19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.8053	0.7618
19500	Decatur, IL Macon County, IL	0.8381	0.7929
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.9249	0.8750
19740	Denver-Aurora-Broomfield, CO Adams County, CO Arapahoe County, CO Broomfield County, CO Clear Creek County, CO Denver County, CO Douglas County, CO Elbert County, CO Gilpin County, CO Jefferson County, CO Park County, CO	1.1348	1.0735
19780	Des Moines-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	1.0187	0.9637
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	1.0256	0.9702
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.8071	0.7635
20100	Dover, DE Kent County, DE	1.0504	0.9937
20220	Dubuque, IA Dubuque County, IA	0.9289	0.8788
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.1066	1.0469
20500	Durham-Chapel Hill, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	1.0232	0.9680
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	1.0206	0.9655

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20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1651	1.1022
20940	El Centro, CA Imperial County, CA	0.9802	0.9273
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8946	0.8463
21140	Elkhart-Goshen, IN Elkhart County, IN	1.0021	0.9480
21300	Elmira, NY Chemung County, NY	0.8942	0.8459
21340	El Paso, TX El Paso County, TX	0.8973	0.8489
21500	Erie, PA Erie County, PA	0.8849	0.8371
21660	Eugene-Springfield, OR Lane County, OR	1.2053	1.1402
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.8928	0.8446
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1731	1.1098
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.6342	0.6000
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8508	0.8049
22140	Farmington, NM San Juan County, NM	0.8456	0.8000
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9872	0.9339
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.9122	0.8630
22380	Flagstaff, AZ Coconino County, AZ	1.3174	1.2463

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22420	Flint, MI Genesee County, MI	1.2172	1.1515
22500	Florence, SC Darlington County, SC Florence County, SC	0.8736	0.8264
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.8518	0.8058
22540	Fond du Lac, WI Fond du Lac County, WI	0.9765	0.9238
22660	Fort Collins-Loveland, CO Larimer County, CO	1.0473	0.9908
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0750	1.0170
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.8035	0.7601
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9854	0.9322
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	1.0031	0.9490
23420	Fresno, CA Fresno County, CA	1.2092	1.1439
23460	Gadsden, AL Etowah County, AL	0.7429	0.7028
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9698	0.9175
23580	Gainesville, GA Hall County, GA	0.9922	0.9386
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9618	0.9099
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.9007	0.8521

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24140	Goldsboro, NC Wayne County, NC	0.9599	0.9081
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.8170	0.7729
24300	Grand Junction, CO Mesa County, CO	1.0429	0.9866
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9707	0.9183
24500	Great Falls, MT Cascade County, MT	0.8777	0.8303
24540	Greeley, CO Weld County, CO	1.0054	0.9511
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	1.0149	0.9601
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.9405	0.8897
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9920	0.9385
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	1.0109	0.9563
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.6342	0.6000
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.9503	0.8990
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.9798	0.9269
25260	Hanford-Corcoran, CA Kings County, CA	1.1863	1.1223

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25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9842	0.9311
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.9696	0.9173
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.1560	1.0936
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	0.8168	0.7727
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.9204	0.8707
25980	Hinesville-Fort Stewart, GA Liberty County, GA Long County, GA	0.9466	0.8955
26100	Holland-Grand Haven, MI Ottawa County, MI	0.9139	0.8646
26180	Honolulu, HI Honolulu County, HI	1.2474	1.1801
26300	Hot Springs, AR Garland County, AR	0.9689	0.9166
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.8314	0.7865
726420	Houston-Sugar Land-Baytown, TX Austin County, TX Brazoria County, TX Chambers County, TX Fort Bend County, TX Galveston County, TX Harris County, TX Liberty County, TX Montgomery County, TX San Jacinto County, TX Waller County, TX	1.0399	0.9838

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26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	0.9479	0.8967
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.9651	0.9130
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	1.0230	0.9678
26900	Indianapolis-Carmel, IN Boone County, IN Brown County, IN Hamilton County, IN Hancock County, IN Hendricks County, IN Johnson County, IN Marion County, IN Morgan County, IN Putnam County, IN Shelby County, IN	1.0240	0.9687
26980	Iowa City, IA Johnson County, IA Washington County, IA	1.0224	0.9672
27060	Ithaca, NY Tompkins County, NY	1.0420	0.9858
27100	Jackson, MI Jackson County, MI	0.9693	0.9170
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8567	0.8105
27180	Jackson, TN Chester County, TN Madison County, TN	0.8898	0.8418
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.9407	0.8899
27340	Jacksonville, NC Onslow County, NC	0.8265	0.7819

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
27500	Janesville, WI Rock County, WI	0.9968	0.9430
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.8930	0.8448
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.7684	0.7269
27780	Johnstown, PA Cambria County, PA	0.8565	0.8103
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.8213	0.7770
27900	Joplin, MO Jasper County, MO Newton County, MO	0.8696	0.8227
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	1.0897	1.0309
28100	Kankakee-Bradley, IL Kankakee County, IL	1.1243	1.0636
28140	Kansas City, MO-KS Franklin County, KS Johnson County, KS Leavenworth County, KS Linn County, KS Miami County, KS Wyandotte County, KS Bates County, MO Caldwell County, MO Cass County, MO Clay County, MO Clinton County, MO Jackson County, MO Lafayette County, MO Platte County, MO Ray County, MO	1.0219	0.9667
28420	Kennewick-Pasco-Richland, WA Benton County, WA Franklin County, WA	1.0562	0.9992
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.9208	0.8711

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28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA	0.8029	0.7596
28740	Kingston, NY Ulster County, NY	0.9608	0.9089
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.8304	0.7856
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.9655	0.9134
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	1.0379	0.9819
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9835	0.9304
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8984	0.8499
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.8677	0.8209
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.1415	1.0799
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ	1.0837	1.0252
29460	Lakeland-Winter Haven, FL Polk County, FL	0.8944	0.8461
29540	Lancaster, PA Lancaster County, PA	0.9893	0.9359
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	1.0904	1.0315
29700	Laredo, TX Webb County, TX	0.8379	0.7927
29740	Las Cruces, NM Dona Ana County, NM	0.9842	0.9311

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29820	Las Vegas-Paradise, NV Clark County, NV	1.2810	1.2119
29940	Lawrence, KS Douglas County, KS	0.9035	0.8547
30020	Lawton, OK Comanche County, OK	0.8771	0.8298
30140	Lebanon, PA Lebanon County, PA	0.8266	0.7820
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.9908	0.9373
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.9426	0.8917
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.9336	0.8832
30620	Lima, OH Allen County, OH	0.9815	0.9285
30700	Lincoln, NE Lancaster County, NE Seward County, NE	1.0183	0.9633
30780	Little Rock-North Little Rock-Conway, AR Faulkner County, AR Grant County, AR Lonoke County, AR Perry County, AR Pulaski County, AR Saline County, AR	0.9029	0.8542
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.9311	0.8808
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.9072	0.8582
31020	Longview, WA Cowlitz County, WA	1.0901	1.0313
31084	Los Angeles-Long Beach-Santa Ana, CA Los Angeles County, CA	1.2742	1.2054

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
31140	Louisville-Jefferson County, KY-IN Clark County, IN Floyd County, IN Harrison County, IN Washington County, IN Bullitt County, KY Henry County, KY Meade County, KY Nelson County, KY Oldham County, KY Shelby County, KY Spencer County, KY Trimble County, KY	0.9406	0.8898
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.9368	0.8862
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.9174	0.8679
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	0.9560	0.9044
31460	Madera-Chowchilla, CA Madera County, CA	0.8455	0.7999
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.1952	1.1307
31700	Manchester-Nashua, NH Hillsborough County, NH	1.0449	0.9885
31740	Manhattan, KS Geary County, KS Pottawatomie County, KS Riley County, KS	0.8308	0.7860
31860	Mankato-North Mankato, MN Blue Earth County, MN Nicollet County, MN	0.9617	0.9098
31900	Mansfield, OH Richland County, OH	0.9442	0.8932

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.6342	0.6000
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.9357	0.8852
32780	Medford, OR Jackson County, OR	1.0652	1.0077
32820	Memphis, TN-MS-AR Crittenden County, AR DeSoto County, MS Marshall County, MS Tate County, MS Tunica County, MS Fayette County, TN Shelby County, TN Tipton County, TN	0.9730	0.9205
32900	Merced, CA Merced County, CA	1.2939	1.2241
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	1.0723	1.0144
33140	Michigan City-La Porte, IN LaPorte County, IN	1.0026	0.9485
33260	Midland, TX Midland County, TX	1.0282	0.9727
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	1.0782	1.0200
33460	Minneapolis-St. Paul-Bloomington, MN-WI Anoka County, MN Carver County, MN Chisago County, MN Dakota County, MN Hennepin County, MN Isanti County, MN Ramsey County, MN Scott County, MN Sherburne County, MN Washington County, MN Wright County, MN Pierce County, WI St. Croix County, WI	1.1798	1.1161
33540	Missoula, MT Missoula County, MT	0.9445	0.8935
33660	Mobile, AL Mobile County, AL	0.8403	0.7949

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
33700	Modesto, CA Stanislaus County, CA	1.2815	1.2123
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.8465	0.8008
33780	Monroe, MI Monroe County, MI	0.9194	0.8698
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8822	0.8346
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8615	0.8150
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.7448	0.7046
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.0971	1.0379
34620	Muncie, IN Delaware County, IN	0.8688	0.8219
34740	Muskegon-Norton Shores, MI Muskegon County, MI	1.0364	0.9805
34820	Myrtle Beach-North Myrtle Beach-Conway, SC Horry County, SC	0.9224	0.8726
34900	Napa, CA Napa County, CA	1.5463	1.4628
34940	Naples-Marco Island, FL Collier County, FL	1.0268	0.9714
34980	Nashville-Davidson-—Murfreesboro--Franklin, TN Cannon County, TN Cheatham County, TN Davidson County, TN Dickson County, TN Hickman County, TN Macon County, TN Robertson County, TN Rutherford County, TN Smith County, TN Sumner County, TN Trousdale County, TN Williamson County, TN Wilson County, TN	0.9926	0.9390
35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY	1.3037	1.2333

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
35084	Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	1.2115	1.1461
35300	New Haven-Milford, CT New Haven County, CT	1.2192	1.1534
35380	New Orleans-Metairie-Kenner, LA Jefferson Parish, LA Orleans Parish, LA Plaquemines Parish, LA St. Bernard Parish, LA St. Charles Parish, LA St. John the Baptist Parish, LA St. Tammany Parish, LA	0.9603	0.9085
35644	New York-White Plains-Wayne, NY-NJ Bergen County, NJ Hudson County, NJ Passaic County, NJ Bronx County, NY Kings County, NY New York County, NY Putnam County, NY Queens County, NY Richmond County, NY Rockland County, NY Westchester County, NY	1.3688	1.2949
35660	Niles-Benton Harbor, MI Berrien County, MI	0.9394	0.8887
35840	North Port-Bradenton-Sarasota, FL New London County, CT	1.0037	0.9495
35980	Norwich-New London, CT New London County, CT	1.1875	1.1234
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.7308	1.6374
36100	Ocala, FL Marion County, FL	0.8966	0.8482
36140	Ocean City, NJ Cape May County, NJ	1.1518	1.0896
36220	Odessa, TX Ector County, TX	0.9990	0.9451
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9812	0.9282

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
36420	Oklahoma City, OK Canadian County, OK Cleveland County, OK Grady County, OK Lincoln County, OK Logan County, OK McClain County, OK Oklahoma County, OK	0.9399	0.8892
36500	Olympia, WA Thurston County, WA	1.1931	1.1287
36540	Omaha-Council Bluffs, NE-IA Harrison County, IA Mills County, IA Pottawattamie County, IA Cass County, NE Douglas County, NE Sarpy County, NE Saunders County, NE Washington County, NE	1.0147	0.9599
36740	Orlando-Kissimmee-Sanford, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9682	0.9159
36780	Oshkosh-Neenah, WI Winnebago County, WI	1.0129	0.9582
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.8862	0.8384
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.3104	1.2397
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9752	0.9226
37380	Palm Coast, FL Flagler County, FL	0.8899	0.8419
37460	Panama City-Lynn Haven-Panama City Beach, FL Bay County, FL	0.8422	0.7967
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.7893	0.7467
37700	Pascagoula, MS George County, MS Jackson County, MS	0.8786	0.8312
37764	Peabody, MA Essex County, MA	1.1623	1.0996

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8739	0.8267
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.9686	0.9163
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.1435	1.0818
38060	Phoenix-Mesa-Glendale, AZ Maricopa County, AZ Pinal County, AZ	1.1270	1.0662
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.8483	0.8025
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.9111	0.8619
38340	Pittsfield, MA Berkshire County, MA	1.0981	1.0388
38540	Pocatello, ID Bannock County, ID Power County, ID	1.0066	0.9523
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.6342	0.6000
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	1.0470	0.9905

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
38900	Portland-Vancouver-Hillsboro, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA	1.2151	1.1495
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL	1.1353	1.0740
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.1998	1.1350
39140	Prescott, AZ Yavapai County, AZ	1.2952	1.2253
39300	Providence-New Bedford-Fall River, RI-MA Bristol County, MA Bristol County, RI Kent County, RI Newport County, RI Providence County, RI Washington County, RI	1.1343	1.0731
39340	Provo-Orem, UT Juab County, UT Utah County, UT	0.9869	0.9336
39380	Pueblo, CO Pueblo County, CO	0.9233	0.8735
39460	Punta Gorda, FL Charlotte County, FL	0.9274	0.8773
39540	Racine, WI Racine County, WI	1.1202	1.0597
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	1.0388	0.9827
39660	Rapid City, SD Meade County, SD Pennington County, SD	1.1056	1.0459
39740	Reading, PA Berks County, PA	0.9427	0.8918
39820	Redding, CA Shasta County, CA	1.4953	1.4146
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.1031	1.0436

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
40060	Richmond, VA Amelia County, VA Caroline County, VA Charles City County, VA Chesterfield County, VA Cumberland County, VA Dinwiddie County, VA Goochland County, VA Hanover County, VA Henrico County, VA King and Queen County, VA King William County, VA Louisa County, VA New Kent County, VA Powhatan County, VA Prince George County, VA Sussex County, VA Colonial Heights City, VA Hopewell City, VA Petersburg City, VA Richmond City, VA	1.0229	0.9677
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.2212	1.1553
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.9345	0.8841
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.1585	1.0960
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.9100	0.8609
40420	Rockford, IL Boone County, IL Winnebago County, IL	1.0622	1.0049
40484	Rockingham, NH Rockingham County, NH Strafford County, NH	1.0615	1.0042

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.9565	0.9049
40660	Rome, GA Floyd County, GA	0.9320	0.8817
40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.4745	1.3949
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.9241	0.8742
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.1691	1.1060
41100	St. George, UT Washington County, UT	0.9670	0.9148
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0907	1.0318
41180	St. Louis, MO-IL Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL St. Clair County, IL Crawford County, MO Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Louis County, MO Warren County, MO Washington County, MO St. Louis City, MO	0.9625	0.9105
41420	Salem, OR Marion County, OR Polk County, OR	1.1787	1.1151
41500	Salinas, CA Monterey County, CA	1.6607	1.5711
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9535	0.9020

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9811	0.9281
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8792	0.8317
41700	San Antonio- New Braunfels, TX Atascosa County, TX Bandera County, TX Bexar County, TX Comal County, TX Guadalupe County, TX Kendall County, TX Medina County, TX Wilson County, TX	0.9527	0.9013
41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.2535	1.1858
41780	Sandusky, OH Erie County, OH	0.9196	0.8700
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.6638	1.5740
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR	0.6342	0.6000
41940	San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA	1.7685	1.6730

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
41980	San Juan-Caguas-Guaynabo, PR Aguas Buenas Municipio, PR Aibonito Municipio, PR Arecibo Municipio, PR Barceloneta Municipio, PR Barranquitas Municipio, PR Bayamón Municipio, PR Caguas Municipio, PR Camuy Municipio, PR Canóvanas Municipio, PR Carolina Municipio, PR Cataño Municipio, PR Cayey Municipio, PR Ciales Municipio, PR Cidra Municipio, PR Comerío Municipio, PR Corozal Municipio, PR Dorado Municipio, PR Florida Municipio, PR Guaynabo Municipio, PR Gurabo Municipio, PR Hatillo Municipio, PR Humacao Municipio, PR Juncos Municipio, PR Las Piedras Municipio, PR Loíza Municipio, PR Manatí Municipio, PR Maunabo Municipio, PR Morovis Municipio, PR Naguabo Municipio, PR Naranjito Municipio, PR Orocovis Municipio, PR Quebradillas Municipio, PR Río Grande Municipio, PR San Juan Municipio, PR San Lorenzo Municipio, PR Toa Alta Municipio, PR Toa Baja Municipio, PR Trujillo Alto Municipio, PR Vega Alta Municipio, PR Vega Baja Municipio, PR Yabucoa Municipio, PR	0.6342	0.6000
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.3665	1.2927
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.2876	1.2181
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.2670	1.1986

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.7725	1.6768
42140	Santa Fe, NM Santa Fe County, NM	1.1484	1.0864
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.7089	1.6167
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.9427	0.8918
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8723	0.8252
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.2234	1.1574
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.9631	0.9111
43100	Sheboygan, WI Sheboygan County, WI	0.9776	0.9248
43300	Sherman-Denison, TX Grayson County, TX	0.8765	0.8292
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.9038	0.8550
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.9626	0.9106
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.9845	0.9314
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	1.0533	0.9964
43900	Spartanburg, SC Spartanburg County, SC	0.9797	0.9268
44060	Spokane, WA Spokane County, WA	1.1192	1.0588
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.9667	0.9145

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0820	1.0236
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8743	0.8271
44220	Springfield, OH Clark County, OH	0.9777	0.9249
44300	State College, PA Centre County, PA	0.9295	0.8793
44600	Steubenville-Weirton, OH-WV Centre County, PA	0.7744	0.7326
44700	Stockton, CA San Joaquin County, CA	1.3294	1.2576
44940	Sumter, SC Sumter County, SC	0.8322	0.7873
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	1.0181	0.9631
45104	Tacoma, WA Pierce County, WA	1.2010	1.1362
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.9323	0.8820
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.9585	0.9068
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.9746	0.9220
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.8091	0.7654

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9986	0.9447
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.9479	0.8967
45940	Trenton-Ewing, NJ Mercer County, NJ	1.0747	1.0167
46060	Tucson, AZ Pima County, AZ	1.0037	0.9495
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.9304	0.8802
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.8460	0.8003
46340	Tyler, TX Smith County, TX	0.8539	0.8078
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8969	0.8485
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.8390	0.7937
46700	Vallejo-Fairfield, CA Solano County, CA	1.5791	1.4939
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8702	0.8232
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.1027	1.0432

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
47260	Virginia Beach-Norfolk-Newport News, VA-NC Currituck County, NC Gloucester County, VA Isle of Wight County, VA James City County, VA Mathews County, VA Surry County, VA York County, VA Chesapeake City, VA Hampton City, VA Newport News City, VA Norfolk City, VA Poquoson City, VA Portsmouth City, VA Suffolk City, VA Virginia Beach City, VA Williamsburg City, VA	0.9487	0.8975
47300	Visalia-Porterville, CA Tulare County, CA	1.1370	1.0756
47380	Waco, TX McLennan County, TX	0.8897	0.8417
47580	Warner Robins, GA Houston County, GA	0.8405	0.7951
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	1.0213	0.9662

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV District of Columbia, DC Calvert County, MD Charles County, MD Prince George's County, MD Arlington County, VA Clarke County, VA Fairfax County, VA Fauquier County, VA Loudoun County, VA Prince William County, VA Spotsylvania County, VA Stafford County, VA Warren County, VA Alexandria City, VA Fairfax City, VA Falls Church City, VA Fredericksburg City, VA Manassas City, VA Manassas Park City, VA Jefferson County, WV	1.1334	1.0722
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8960	0.8476
48140	Wausau, WI Marathon County, WI	0.9892	0.9358
48300	Wenatchee-East Wenatchee, WA Chelan County, WA Douglas County, WA	1.0181	0.9631
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	1.0517	0.9949
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.7067	0.6686
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.9422	0.8913
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	1.0128	0.9581
48700	Williamsport, PA Lycoming County, PA	0.7682	0.7267

CBSA Code	Urban Area (Constituent Counties)	Composite Rate Wage Index	ESRD PPS Wage Index
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.1202	1.0597
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9672	0.9150
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	1.0590	1.0018
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.9464	0.8953
49340	Worcester, MA Worcester County, MA	1.1659	1.1030
49420	Yakima, WA Yakima County, WA	1.0658	1.0083
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.6342	0.6000
49620	York-Hanover, PA York County, PA	1.0086	0.9542
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.9132	0.8639
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.1692	1.1061
49740	Yuma, AZ Yuma County, AZ	0.9829	0.9298

ADDENDUM L: Proposed CY 2011 ESRD Composite Rate and PPS Wage Indices for Rural Areas Based on CBSA Labor Market Areas

State Code	Nonurban Area	Composite Rate Wage Index	ESRD PPS Wage Index
1	Alabama	0.7797	0.7376
2	Alaska	1.3368	1.2646
3	Arizona	0.9613	0.9094
4	Arkansas	0.7647	0.7234
5	California	1.3167	1.2456
6	Colorado	1.0517	0.9949
7	Connecticut	1.1775	1.1139
8	Delaware	1.0329	0.9771
10	Florida	0.8903	0.8422
11	Georgia	0.7999	0.7567
12	Hawaii	1.1733	1.1100
13	Idaho	0.8000	0.7568
14	Illinois	0.8834	0.8357
15	Indiana	0.8884	0.8404
16	Iowa	0.9074	0.8584
17	Kansas	0.8450	0.7994
18	Kentucky	0.8274	0.7827
19	Louisiana	0.8165	0.7724
20	Maine	0.9093	0.8602
21	Maryland	0.9713	0.9189
22	Massachusetts[1]	1.2460	1.1788
23	Michigan	0.9058	0.8569
24	Minnesota	0.9570	0.9053
25	Mississippi	0.8083	0.7647
26	Missouri	0.8084	0.7648
27	Montana	0.9018	0.8531
28	Nebraska	0.9429	0.8920
29	Nevada	0.9899	0.9365
30	New Hampshire	1.0459	0.9894
31	New Jersey[1]	-----	------
32	New Mexico	0.9459	0.8948
33	New York	0.8666	0.8198
34	North Carolina	0.8857	0.8379
35	North Dakota	0.7232	0.6842
36	Ohio	0.9029	0.8542
37	Oklahoma	0.8316	0.7867
38	Oregon	1.0618	1.0045
39	Pennsylvania	0.8966	0.8482
40	Puerto Rico	0.6342	0.6000

State Code	Nonurban Area	Composite Rate Wage Index	ESRD PPS Wage Index
41	Rhode Island[1]	-----	-----
42	South Carolina	0.8912	0.8431
43	South Dakota	0.9037	0.8549
44	Tennessee	0.8329	0.7879
45	Texas	0.8264	0.7818
46	Utah	0.9157	0.8663
47	Vermont	1.0154	0.9606
48	Virgin Islands	0.8463	0.8006
49	Virginia	0.8301	0.7853
50	Washington	1.0782	1.0200
51	West Virginia	0.7911	0.7484
52	Wisconsin	0.9488	0.8976
53	Wyoming	1.0089	0.9544

[1] All counties within the State are classified as urban.

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