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DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 23

[Docket No. CE199, Special Condition 23–139–SC]

Special Conditions; Garmin International, Inc. EFIS on the Diamond DA–40; Protection of Systems for High Intensity Radiated Fields (HIRF)

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final special conditions; request for comments.

SUMMARY: These special conditions are issued to Garmin International, Inc., 1200 E. 151st St., Olathe, KS 66062, for a Supplemental Type Certificate for the Diamond Aircraft Industries DA–40. This airplane will have novel and unusual design features when compared to the state of technology envisaged in the applicable airworthiness standards. These novel and unusual design features include the installation of an electronic flight instrument system (EFIS) display, Model G–1000, manufactured by Garmin International, Inc. for which the applicable regulations do not contain adequate or appropriate airworthiness standards for the protection of these systems from the effects of high intensity radiated fields (HIRF). These special conditions contain the additional safety standards that the Administrator considers necessary to establish a level of safety equivalent to the airworthiness standards applicable to these airplanes.

DATES: The effective date of these special conditions is October 22, 2003. Comments must be received on or before December 8, 2003.

ADDRESSES: Comments on these special conditions may be mailed in duplicate to: Federal Aviation Administration, Regional Counsel, ACE–7, Attention: Rules Docket Clerk, Docket No. CE199, Room 506, 901 Locust, Kansas City, Missouri 64106. All comments must be marked: Docket No. CE199. Comments may be inspected in the Rules Docket weekdays, except Federal holidays, between 7:30 a.m. and 4 p.m.

FOR FURTHER INFORMATION CONTACT: Wes Ryan, Aerospace Engineer, Standards Office (ACE–110), Small Airplane Directorate, Aircraft Certification Service, Federal Aviation Administration, 901 Locust, Room 301, Kansas City, Missouri 64106; telephone (816) 329–4127.

SUPPLEMENTARY INFORMATION:

The FAA has determined that notice and opportunity for prior public comment hereon are impracticable because these procedures would significantly delay issuance of the approval design and thus delivery of the affected aircraft. In addition, the substance of these special conditions has been subject to the public comment process in several prior instances with no substantive comments received. The FAA, therefore, finds that good cause exists for making these special conditions effective upon issuance.

Comments Invited

Interested persons are invited to submit such written data, views, or arguments, as they may desire. Communications should identify the regulatory docket or notice number and be submitted in duplicate to the address specified above. All communications received on or before the closing date for comments will be considered by the Administrator. The special conditions may be changed in light of the comments received. All comments received will be available in the Rules Docket for examination by interested persons, both before and after the closing date for comments. A report summarizing each substantive public contact with FAA personnel concerning this rulemaking will be filed in the docket. Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this notice must include a self-addressed, stamped postcard on which the following statement is made: "Comments to Docket No. CE199." The postcard will be date stamped and returned to the commenter.

Background

On March 6, 2003, Garmin International, Inc., 1200 E. 151st St., Olathe, KS 66062, made an application to the FAA for a new Supplemental Type Certificate for the Diamond Aircraft Industries DA–40 airplane. The DA–40 is currently approved under TC No. A47CE. The proposed modification incorporates a novel or unusual design feature, such as digital avionics consisting of an EFIS that is vulnerable to HIRF external to the airplane.

Type Certification Basis

Under the provisions of 14 CFR part 21, § 21.101, Garmin International, Inc. must show that the Diamond DA–40 aircraft meets the following original certification basis provisions or the applicable regulations in effect on the date of application for the change to the DA–40: Type Certification under 14 CFR part 21, § 21.29, including the following requirements: Joint Aviation Requirements (JAR) 23, Initial Issue, dated March 11, 1994. The DA–40 was certificated using the FAA/JAA validation certification procedures and significant regulatory differences were addressed. Therefore, the certification basis is equivalent to 14 CFR part 23, effective February 1, 1965, including Amendments 23–1 through Amendment 23–51. 14 CFR part 36, effective December 1, 1969, including Amendments 36–1 through Amendment 36–21. Special Condition 23–107–SC, applicable to the Model DA–40 for protection of systems for High Intensity Radiated Fields, published on June 7, 2001. Exemptions, if any; and the special conditions adopted by this rulemaking action.

Discussion

If the Administrator finds that the applicable airworthiness standards do not contain adequate or appropriate safety standards because of novel or unusual design features of an airplane, special conditions are prescribed under the provisions of § 21.16.

Special conditions, as appropriate, as defined in § 11.19, are issued in accordance with § 11.38 after public notice and become part of the type certification basis in accordance with § 21.101.

Special conditions are initially applicable to the model for which they are issued. Should the applicant apply

for a supplemental type certificate to modify any other model already included on the same type certificate to incorporate the same novel or unusual design feature, the special conditions would also apply to the other model under the provisions of § 21.101.

Novel or Unusual Design Features

Garmin International, Inc. plans to incorporate certain novel and unusual design features into the Diamond DA–40 airplane for which the airworthiness standards do not contain adequate or appropriate safety standards for protection from the effects of HIRF. These features include EFIS, which are susceptible to the HIRF environment, that were not envisaged by the existing regulations for this type of airplane.

Protection of Systems From High Intensity Radiated Fields (HIRF)

Recent advances in technology have given rise to the application in aircraft designs of advanced electrical and electronic systems that perform functions required for continued safe flight and landing. Due to the use of sensitive solid-state advanced components in analog and digital electronics circuits, these advanced systems are readily responsive to the transient effects of induced electrical current and voltage caused by the HIRF. The HIRF can degrade electronic systems performance by damaging components or upsetting system functions.

Furthermore, the HIRF environment has undergone a transformation that was not foreseen when the current requirements were developed. Higher energy levels are radiated from transmitters that are used for radar, radio, and television. Also, the number of transmitters has increased significantly. There is also uncertainty concerning the effectiveness of airframe shielding for HIRF. Furthermore, coupling to cockpit-installed equipment through the cockpit window apertures is undefined.

The combined effect of the technological advances in airplane design and the changing environment has resulted in an increased level of vulnerability of electrical and electronic systems required for the continued safe flight and landing of the airplane. Effective measures against the effects of exposure to HIRF must be provided by the design and installation of these systems. The accepted maximum energy levels in which civilian airplane system installations must be capable of operating safely are based on surveys and analysis of existing radio frequency emitters. These special conditions require that the airplane be evaluated under these energy levels for the protection of the electronic system and its associated wiring harness. These external threat levels, which are lower than previous required values, are believed to represent the worst case to which an airplane would be exposed in the operating environment.

These special conditions require qualification of systems that perform critical functions, as installed in aircraft, to the defined HIRF environment in paragraph 1 or, as an option to a fixed value using laboratory tests, in paragraph 2, as follows:

(1) The applicant may demonstrate that the operation and operational capability of the installed electrical and electronic systems that perform critical functions are not adversely affected when the aircraft is exposed to the HIRF environment defined below:

Frequency	Field Strength (volts per meter)	
	Peak	Average
10 kHz–100 kHz	50	50
100 kHz–500 kHz	50	50
500 kHz–2 MHz	50	50
2 MHz–30 MHz	100	100
30 MHz–70 MHz	50	50
70 MHz–100 MHz	50	50
100 MHz–200 MHz	100	100
200 MHz–400 MHz	100	100
400 MHz–700 MHz	700	50
700 MHz–1 GHz	700	100
1 GHz–2 GHz	2000	200
2 GHz–4 GHz	3000	200
4 GHz–6 GHz	3000	200
6 GHz–8 GHz	1000	200
8 GHz–12 GHz	3000	300
12 GHz–18 GHz	2000	200
18 GHz–40 GHz	600	200

The field strengths are expressed in terms of peak root-mean-square (rms) values.

or,

(2) The applicant may demonstrate by a system test and analysis that the electrical and electronic systems that perform critical functions can withstand a minimum threat of 100 volts per meter, electrical field strength, from 10 kHz to 18 GHz. When using this test to show compliance with the HIRF requirements, no credit is given for signal attenuation due to installation.

A preliminary hazard analysis must be performed by the applicant, for approval by the FAA, to identify either electrical or electronic systems that perform critical functions. The term "critical" means those functions whose failure would contribute to, or cause, a failure condition that would prevent the continued safe flight and landing of the airplane. The systems identified by the hazard analysis that perform critical functions are candidates for the application of HIRF requirements. A system may perform both critical and non-critical functions. Primary electronic flight display systems, and their associated components, perform critical functions such as attitude, altitude, and airspeed indication. The HIRF requirements apply only to critical functions.

Compliance with HIRF requirements may be demonstrated by tests, analysis, models, similarity with existing systems, or any combination of these. Service experience alone is not acceptable since normal flight operations may not include an exposure to the HIRF environment. Reliance on a system with similar design features for redundancy as a means of protection

against the effects of external HIRF is generally insufficient since all elements of a redundant system are likely to be exposed to the fields concurrently.

Applicability

As discussed above, these special conditions are applicable to the Diamond DA–40 airplane. Should Garmin International, Inc. apply at a later date for a supplemental type certificate to modify any other model on the same type certificate to incorporate the same novel or unusual design feature, the special conditions would apply to that model as well under the provisions of § 21.101.

Conclusion

This action affects only certain novel or unusual design features on one model of airplane. It is not a rule of general applicability and affects only the applicant who applied to the FAA for approval of these features on the airplane.

The substance of these special conditions has been subjected to the notice and comment period in several prior instances and has been derived without substantive change from those previously issued. It is unlikely that prior public comment would result in a significant change from the substance contained herein. For this reason, and because a delay would significantly affect the certification of the airplane, which is imminent, the FAA has determined that prior public notice and comment are unnecessary and impracticable, and good cause exists for adopting these special conditions upon issuance. The FAA is requesting comments to allow interested persons to submit views that may not have been submitted in response to the prior opportunities for comment described above.

List of Subjects in 14 CFR Part 23

Aircraft, Aviation safety, Signs and symbols.

Citation

The authority citation for these special conditions is as follows:

Authority: 49 U.S.C. 106(g), 40113 and 44701; 14 CFR 21.16 and 21.101; and 14 CFR 11.38 and 11.19.

The Special Conditions

■ Accordingly, pursuant to the authority delegated to me by the Administrator, the following special conditions are issued as part of the type certification basis for Diamond DA–40 airplane modified by Garmin International, Inc. to add a G–1000 EFIS system.

1. Protection of Electrical and Electronic Systems from High Intensity Radiated Fields (HIRF)

Each system that performs critical functions must be designed and installed to ensure that the operations, and operational capabilities of these systems to perform critical functions, are not adversely affected when the airplane is exposed to high intensity radiated electromagnetic fields external to the airplane.

2. For the purpose of these special conditions, the following definition applies:

Critical Functions: Functions whose failure would contribute to, or cause, a failure condition that would prevent the continued safe flight and landing of the airplane.

Issued in Kansas City, Missouri, on October 22, 2003.

Michael Gallagher,

Manager, Small Airplane Directorate, Aircraft Certification Service.

[FR Doc. 03–28013 Filed 11–6–03; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 2002–NM–157–AD; Amendment 39–13360; AD 2003–22–12]

RIN 2120–AA64

Airworthiness Directives; Bombardier Model CL–600–1A11 (CL–600), CL–600–2A12 (CL–601), and CL–600–2B16 (CL–601–3A, CL–601–3R, and CL–604) Series Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule.

SUMMARY: This amendment adopts a new airworthiness directive (AD), applicable to certain Bombardier Model CL–600–1A11 (CL–600), CL–600–2A12 (CL–601), and CL–600–2B16 (CL–601–3A, CL–601–3R, and CL–604) series airplanes. This amendment requires revising the airplane flight manual to provide the flightcrew with procedures and limitations for operating the airplane with out-of-tolerance angle of attack (AOA) transducers. This amendment also requires, among other actions, measuring the vane angles and voltage of the AOA transducers; reworking the AOA transducer assemblies; repetitive measurements of the resistance of both AOA transducers; and follow-on and corrective actions, as applicable. This action is necessary to prevent flat spots on the potentiometers of the AOA transducers due to wear, which may cause a delay in the commands for stall warning, stick shaker, and stick pusher operation. This action is intended to address the identified unsafe condition.

DATES: Effective December 12, 2003.

The incorporation by reference of certain publications listed in the regulations is approved by the Director of the Federal Register as of December 12, 2003.

ADDRESSES: The service information referenced in this AD may be obtained from Bombardier, Inc., Canadair, Aerospace Group, PO Box 6087, Station Centreville, Montreal, Quebec H3C 3G9, Canada. This information may be examined at the Federal Aviation Administration (FAA), Transport Airplane Directorate, Rules Docket, 1601 Lind Avenue, SW., Renton, Washington; or at the FAA, New York Aircraft Certification Office, 10 Fifth Street, Third Floor, Valley Stream, New York; or at the Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Luciano Castracane, Aerospace Engineer, Systems and Flight Test Branch, ANE–172, FAA, New York Aircraft Certification Office, 10 Fifth Street, Third Floor, Valley Stream, New York 11581; telephone (516) 256–7535; fax (516) 568–2716.

SUPPLEMENTARY INFORMATION: A proposal to amend part 39 of the Federal Aviation Regulations (14 CFR part 39) to include an airworthiness directive (AD) that is applicable to certain Bombardier Model CL–600–1A11 (CL–600), CL–600–2A12 (CL–601), and CL–600–2B16 (CL–601–3A, CL–601–3R, and CL–604) series airplanes was published in the **Federal Register** on February 28, 2003 (68 FR 9602). That action proposed to require revising the airplane flight manual to provide the flightcrew with procedures and limitations for operating the airplane with out-of-tolerance angle of attack (AOA) transducers. That action also proposed to require, among other actions, measuring the vane angles and voltage of the AOA transducers; reworking the AOA transducer assemblies; repetitive measurements of the resistance of both AOA transducers; and follow-on and corrective actions, as applicable.

Comments

Interested persons have been afforded an opportunity to participate in the making of this amendment. Due

consideration has been given to the single comment received.

The commenter concurs with the proposed rule.

Conclusion

After careful review of the available data, including the comment noted above, the FAA has determined that air safety and the public interest require the adoption of the rule as proposed.

Changes to 14 CFR Part 39/Effect on the AD

On July 10, 2002, the FAA issued a new version of 14 CFR part 39 (67 FR 47997, July 22, 2002), which governs the FAA's airworthiness directives system. The regulation now includes material that relates to altered products, special flight permits, and alternative methods of compliance. However, for clarity and consistency in this final rule, we have retained the language of the NPRM regarding that material.

Increase in Labor Rate

After the proposed AD was issued, we reviewed the figures we use to calculate the labor rate to do the required actions. To account for various inflationary costs in the airline industry, we find it appropriate to increase the labor rate used in these calculations from $60 per work hour to $65 per work hour. The economic impact information, below, has been revised to reflect this increase in the specified hourly labor rate.

Cost Impact

The FAA estimates that 424 airplanes of U.S. registry will be affected by this AD, and that the average labor rate is $65 per work hour. The estimated cost impact for airplanes affected by this AD are as follows:

TABLE—COST IMPACT

Actions	Work hour(s)	Parts cost	Total cost per airplane
AFM revision	1	None	$65
Measurement of the vane angles and voltage of AOA transducers (Part A)	5	None	325
Rework the AOA transducer assemblies and measurement of the baseline resistance of the applicable AOA transducers (Part B)	17	$161	1,266
Measurement of the resistance of both AOA transducers (Part C)	1	None	65
Inspection of the left- and right-side AOA vane decal	1	None	65

The cost impact figures discussed above are based on assumptions that no operator has yet accomplished any of the requirements of this AD action, and that no operator would accomplish those actions in the future if this AD were not adopted. The cost impact figures discussed in AD rulemaking actions represent only the time necessary to perform the specific actions actually required by the AD. These figures typically do not include incidental costs, such as the time required to gain access and close up, planning time, or time necessitated by other administrative actions. Manufacturer warranty remedies may be available for labor costs associated with this AD. As a result, the costs attributable to the AD may be less than stated above.

Regulatory Impact

The regulations adopted herein will not have a substantial direct effect on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, it is determined that this final rule does not have federalism implications under Executive Order 13132.

For the reasons discussed above, I certify that this action (1) is not a "significant regulatory action" under Executive Order 12866; (2) is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A final evaluation has been prepared for this action and it is contained in the Rules Docket. A copy of it may be obtained from the Rules Docket at the location provided under the caption **ADDRESSES.**

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

■ Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration amends part 39 of the Federal Aviation Regulations (14 CFR part 39) as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. Section 39.13 is amended by adding the following new airworthiness directive:

2003–22–12 **Bombardier, Inc.** (Formerly Canadair): Amendment 39–13360. Docket 2002–NM–157–AD.

Applicability: This AD applies to the airplanes listed in Table 1 of this AD, certificated in any category. Table 1 is as follows:

TABLE 1.—APPLICABILITY

Model	Serial Nos.
CL–600–1A11 (CL–600) series airplanes	1004 through 1085 inclusive.
CL–600–2A12 (CL–601) series airplanes	3001 through 3066 inclusive.
CL–600–2B16 (CL–601–3A and –3R) series airplanes	5001 through 5194 inclusive.
CL–600–2B16 (CL–604) series airplanes	5301 and subsequent.

Note 1: This AD applies to each airplane identified in the preceding applicability provision, regardless of whether it has been modified, altered, or repaired in the area subject to the requirements of this AD. For airplanes that have been modified, altered, or repaired so that the performance of the requirements of this AD is affected, the owner/operator must request approval for an alternative method of compliance in accordance with paragraph (n) of this AD. The request should include an assessment of the effect of the modification, alteration, or repair on the unsafe condition addressed by this AD; and, if the unsafe condition has not been eliminated, the request should include specific proposed actions to address it.

Compliance: Required as indicated, unless accomplished previously.

To prevent flat spots on the potentiometers of the AOA transducers due to wear, which may cause a delay in the commands for stall warning, stick shaker, and stick pusher operation, accomplish the following:

Revision of Airplane Flight Manual (AFM)

(a) Before the accumulation of 300 total flight hours, or within 7 days after the effective date of this AD, whichever occurs later: Revise the Limitations, Emergency Procedures, Normal Procedures, and Abnormal Procedures Sections of the applicable Canadair Challenger AFM by inserting a copy of the Temporary Revisions listed in Table 2 of this AD, as applicable. Table 2 is as follows (some Temporary Revisions listed in Table 2 of this AD contain Product Support Publication (PSP) identifiers):

TABLE 2.—TEMPORARY REVISIONS

Model	PSP	Temporary revision	Date
CL–600–1A11 (CL–600) series airplanes	None	600/20	Nov. 26, 2001.
	None	600/21	Nov. 26, 2001.
	PSP 600–1–18	600–1/13	Nov. 26, 2001.
	None	600–1/17	Nov. 26, 2001.
CL–600–2A12 (CL–601) series airplanes	None	601/25	Nov. 26, 2001.
	PSP 601–1A–1	601/13	Nov. 26, 2001.
	PSP 601–1A–17	601/24	Nov. 26, 2001.
	PSP 601–1A–18	601/25	Nov. 26, 2001.
	PSP 601–1B	601/17	Nov. 26, 2001.
	PSP 601–1B–1	601/12	Nov. 26, 2001.
CL–600–2B16 (CL–601–3A and –3R) series airplanes	PSP 601A–1	601/23	Nov. 26, 2001.
	PSP 601A–1–1	601/22	Nov. 26, 2001.
	PSP 601A–1–17	601/22	Nov. 26, 2001.
	PSP 601A–1–18	601/21	Nov. 26, 2001.
	PSP 601A–1–18A	601/24	Nov. 26, 2001.
	PSP 601A–1–20A	601/15	Nov 26, 2001.
CL–600–2B16 (CL–604) series airplanes	PSP 604–1	604/9	Nov. 26, 2001.

Measurement

(b) Before the accumulation of 300 total flight hours, or within 200 flight hours after the effective date of this AD, whichever occurs later: Measure the vane angles and voltage of the angle of attack (AOA) transducers by doing all actions specified in "PART A—Initial Special Check" of the Accomplishment Instructions of the applicable alert service bulletin listed in Table 3 of this AD, per the applicable Bombardier alert service bulletin. Table 3 is as follows:

TABLE 3.—ALERT SERVICE BULLETINS

For model	Alert service bulletin	Date	Including
CL–600–1A11 (CL–600) series airplanes	A600–0715	Jan. 7, 2002	Appendices A and B.
CL–600–2A12 (CL–601) series airplanes, and CL–600–2B16 (CL–601–3A and –3R) series airplanes.	A601–0550	Jan. 7, 2002	Appendices A and B.
CL–600–2B16 (CL–604) series airplanes	A604–27–011	Jan. 7, 2002	Appendices A and B.

Any Voltage Outside Tolerances: Replacement

(c) If, during the measurement required by paragraph (b) of this AD, any recorded voltage is found to be outside the tolerances specified in the applicable Bombardier alert service bulletin identified in Table 3 of this AD, before further flight: Replace the stall protection computer (SPC) with a new SPC and do the follow-on actions (*i.e.*, recording in Appendix A and repeat actions), per "PART A—Initial Special Check" of the Accomplishment Instructions of the applicable Bombardier alert service bulletin identified in Table 3 of this AD.

All AOA Vane Angles Within Tolerances: Disconnection and Measurement

(d) If, during the measurement required by paragraph (b) of this AD, all of the recorded AOA vane angles for both AOA transducers are found to be within the tolerances specified in the applicable Bombardier alert service bulletin listed in Table 3 of this AD, before further flight: Do the follow-on actions (*i.e.*, disconnect breakout box, and measure the baseline resistance of the AOA transducer between certain pins), per "PART B—AOA Transducer Assembly Rework/Baseline Resistance Check" of the Accomplishment Instructions of the applicable Bombardier alert service bulletin identified in Table 3 of this AD. After doing the follow-on actions, the applicable AFM revision required by paragraph (a) of this AD may be removed from the AFM.

One or More AOA Vane Angles Outside Tolerances, But All AOA Vane Angles Within Expanded Tolerances

(e) If, during the measurement required by paragraph (b) of this AD, one or more of the recorded AOA vane angles for either or both AOA transducers are found to be outside the tolerances specified in the applicable Bombardier alert service bulletin listed in Table 3 of this AD, but all recorded AOA vane angles are within the expanded tolerances specified in "Table A—Tolerances" of "PART A—Initial Special Check" of the Accomplishment Instructions of the applicable Bombardier alert service bulletin identified in Table 3 of this AD: Do

the action specified in paragraph (e)(1) of this AD, except as provided by paragraph (e)(2) of this AD.

(1) Before further flight, do the actions specified in paragraph (g) of this AD.

(2) In lieu of doing the actions required by paragraph (e)(1) of this AD, do the actions specified in paragraphs (e)(2)(i) and (e)(2)(ii) of this AD.

(i) Before further flight, measure the baseline resistance of the other AOA transducer (with recorded AOA vane angles within the tolerances specified in the applicable Bombardier alert service bulletin listed in Table 3 of this AD) per "Table A—Tolerances" of "PART A—Initial Special Check" of the Accomplishment Instructions of the applicable Bombardier alert service bulletin identified in Table 3 of this AD.

(ii) Within 150 flight hours after doing the measurement required by paragraph (b) of this AD, do the actions specified in paragraph (g) of this AD.

Any AOA Vane Angle Outside Tolerances

(f) If, during the measurement required by paragraph (b) of this AD, any recorded AOA vane angle of the AOA transducers is found to be outside the expanded tolerances specified in "Table A—Tolerances" of "PART A—Initial Special Check" of the applicable Bombardier alert service bulletin listed in Table 3 of this AD, before further flight: Do the actions specified in paragraph (g) of this AD.

Transducer Assembly Rework and Baseline Resistance Measurement

(g) Except as provided by paragraph (e)(2) of this AD, before further flight after doing the measurement required by paragraph (b) of this AD: Rework the AOA transducer assemblies and measure the baseline resistance of the applicable AOA transducers by doing all actions specified in "PART B—AOA Transducer Assembly Rework/Baseline Resistance Check" of the Accomplishment Instructions of the applicable Bombardier alert service bulletin identified in Table 3 of this AD, per the applicable Bombardier alert service bulletin. After doing the rework, the applicable AFM revision required by paragraph (a) of this AD may be removed from the AFM.

Repetitive Measurements and Corrective Actions

(h) Within 300 flight hours after doing the measurement required by paragraph (b) of this AD: Measure the resistance of both AOA transducers by doing all actions specified in "PART C—Repetitive Resistance Check/AOA Transducer Assembly Rework" of the Accomplishment Instructions of the applicable alert service bulletin listed in Table 3 of this AD, per the applicable Bombardier alert service bulletin. Repeat the measurement at least every 300 flight hours.

(i) If, during the measurement required by paragraph (h) of this AD, any recorded resistance is found to be outside the tolerances specified in the applicable Bombardier alert service bulletin listed in Table 3 of this AD (*i.e.*, more than 20 ohms from its baseline resistance value), before further flight: Do corrective actions (*e.g.*, replace AOA transducer with new AOA transducer; perform a visual inspection of the vane assembly; rework, if necessary; a test; and measure baseline resistance of applicable AOA transducer), as applicable, per PART C—Repetitive Resistance Check/AOA Transducer Assembly Rework" of the Accomplishment Instructions of the applicable alert service bulletin listed in Table 3 of this AD.

Concurrent Requirements: Inspection

(j) For airplanes identified in paragraphs (j)(1), (j)(2), and (j)(3) of this AD: Before or at the same time with accomplishment of the requirements of paragraph (b) of this AD, inspect the left- and right-side AOA vane decal to verify that the correct decal is installed per paragraph (j)(1), (j)(2), or (j)(3) of this AD, as applicable.

(1) For Model CL–600–2A12 (CL–601) and CL–600–2B16 (CL–601–3A and –3R) series airplanes having serial numbers 3001 through 3066 inclusive, and 5001 through 5194 inclusive, respectively, on which AOA calibration decals, part numbers (P/N) 600–52267–5 and 600–52267–6, have been installed: Inspect per Bombardier Alert Service Bulletin A601–0519, dated July 30, 1999.

(2) For Model CL–600–1A11 (CL–600) series airplanes having serial numbers 1004 through 1085 inclusive, on which AOA calibration decals, P/Ns 600–52267–5 and 600–52267–6, have been installed: Inspect per Bombardier Alert Service Bulletin A600–0693, dated July 30, 1999.

(3) For Model CL–600–2B16 (CL–604) series airplanes having serial numbers 5301 through 5990 inclusive, on which AOA calibration decals, P/Ns 600–52267–5 and 600–52267–6, have been installed: Inspect per Bombardier Alert Service Bulletin A604–11–009, dated July 30, 1999.

Concurrent Requirements: Corrective Actions

(k) If either of the AOA vane decals is found to be incorrect during the inspection required by paragraph (j) of this AD, before further flight: Replace the AOA vane decal(s) with new vane decal(s), and ensure that the new decal(s) is the correct type, per the applicable alert service bulletin identified in paragraph (j)(1), (j)(2), or (j)(3) of this AD; except as provided by paragraph (l) of this AD.

(l) If replacement decals are not available, before further flight: Remove existing decals and do the alignment check(s) of the AOA vane transducers per the applicable alert service bulletin identified in paragraph (j)(1), (j)(2), or (j)(3) of this AD.

Parts Installation

(m) As of the effective date of this AD, no person shall install an AOA transducer assembly on any airplane, unless the actions required by paragraphs (b) through (l) of this AD, as applicable, have been done.

Alternative Methods of Compliance

(n) An alternative method of compliance or adjustment of the compliance time that provides an acceptable level of safety may be used if approved by the Manager, New York Aircraft Certification Office (ACO), FAA. Operators shall submit their requests through an appropriate FAA Principal Maintenance Inspector, who may add comments and then send it to the Manager, New York ACO.

Note 2: Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the New York ACO.

Special Flight Permits

(o) Special flight permits may be issued in accordance with sections 21.197 and 21.199 of the Federal Aviation Regulations (14 CFR 21.197 and 21.199) to operate the airplane to a location where the requirements of this AD can be accomplished.

Incorporation by Reference

(p) The actions shall be done in accordance with the following Bombardier service bulletins and Temporary Revisions to the applicable Canadair Challenger Airplane Flight Manual, as applicable:

TABLE 4.—SERVICE DOCUMENTS

Document No.	PSP	Document date
Alert Service Bulletin A600–0693	None	July 30, 1999.
Alert Service Bulletin A600–0715, including Appendices A and B	None	Jan. 7, 2002.
Alert Service Bulletin A601–0519	None	July 30, 1999.
Alert Service Bulletin A601–0550, including Appendices A and B	None	Jan. 7, 2002.
Alert Service Bulletin A604–11–009	None	July 30, 1999.
Alert Service Bulletin A604–27–011, including Appendices A and B	None	Jan. 7, 2002.
Temporary Revision 600/20	None	Nov. 26, 2001.
Temporary Revision 600/21	None	Nov. 26, 2001.
Temporary Revision 600–1/13	PSP 600–1–18	Nov. 26, 2001.
Temporary Revision 600–1/17	None	Nov. 26, 2001.
Temporary Revision 601/12	PSP 601–1B–1	Nov. 26, 2001.
Temporary Revision 601/13	PSP 601–1A–1	Nov. 26, 2001.

TABLE 4.—SERVICE DOCUMENTS—Continued

Document No.	PSP	Document date
Temporary Revision 601/15	PSP 601A–1–20A	Nov. 26, 2001.
Temporary Revision 601/17	PSP 601–1B	Nov. 26, 2001.
Temporary Revision 601/21	PSP 601A–1–18	Nov. 26, 2001.
Temporary Revision 601/22	PSP 601A–1–1	Nov. 26, 2001.
Temporary Revision 601/22	PSP 601A–1–17	Nov. 26, 2001.
Temporary Revision 601/23	PSP 601A–1	Nov. 26, 2001.
Temporary Revision 601/24	PSP 601–1A–17	Nov. 26, 2001.
Temporary Revision 601/24	PSP 601A–1–18A	Nov. 26, 2001.
Temporary Revision 601/25	None	Nov. 26, 2001.
Temporary Revision 601/25	PSP 601–1A–18	Nov. 26, 2001.
Temporary Revision 604/9	PSP 604–1	Nov. 26, 2001.

This incorporation by reference was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. Copies may be obtained from Bombardier, Inc., Canadair, Aerospace Group, PO Box 6087, Station Centre-ville, Montreal, Quebec H3C 3G9, Canada. Copies may be inspected at the FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington; or at the FAA, New York Aircraft Certification Office, 10 Fifth Street, Third Floor, Valley Stream, New York; or at the Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

Note 3: The subject of this AD is addressed in Canadian airworthiness directive CF–2002–05, dated January 18, 2002.

Effective Date

(q) This amendment becomes effective on December 12, 2003.

Issued in Renton, Washington, on October 29, 2003.

Ali Bahrami,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 03–27668 Filed 11–6–03; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2003–16026; Airspace Docket No. 03–ACE–70]

Modification of Class D Airspace; and Modification of Class E Airspace; St. Joseph, MO

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Direct final rule; confirmation of effective date.

SUMMARY: This document confirms the effective date of the direct final rule which revises Class D and Class E airspace at St. Joseph, MO.

EFFECTIVE DATE: 0901 UTC, December 25, 2003.

FOR FURTHER INFORMATION CONTACT: Brenda Mumper, Air Traffic Division, Airspace Branch, ACE–520A, DOT Regional Headquarters Building, Federal Aviation Administration, 901 Locust, Kansas City, MO 64106; telephone: (816) 329–2524.

SUPPLEMENTARY INFORMATION:

The FAA published this direct final rule with a request for comments in the **Federal Register** on September 12, 2003 (68 FR 53674). The FAA uses the direct final rulemaking procedure for a non-controversial rule where the FAA believes that there will be no adverse public comment. This direct final rule advised the public that no adverse comments were anticipated, and that unless a written adverse comment, or a written notice of intent to submit such an adverse comment, were received within the comment period, the regulation would become effective on December 25, 2003. No adverse comments were received, and thus this notice confirms that this direct final rule will become effective on that date.

Issued in Kansas City, MO on October 23, 2003.

Paul J. Sheridan,

Acting Manager, Air Traffic Division, Central Region.

[FR Doc. 03–28014 Filed 11–6–03; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Parts 1 and 20

[Docket Nos. 2002N–0276 and 2002N–0278]

Interim Final Regulations Implementing Title III, Subtitle A, of Public Health Security and Bioterrorism Preparedness and Response Act of 2002—Section 305: Registration of Food Facilities and Section 307: Prior Notice of Imported Food Shipments; Notice of Public Meeting; Correction

AGENCY: Food and Drug Administration, HHS.

ACTION: Public meetings on interim final rules; correction.

SUMMARY: The Food and Drug Administration (FDA) is correcting a document that announced a series of domestic meetings to discuss the interim final regulations, issued on October 10, 2003, to implement two sections of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (Bioterrorism Act) regarding the registration of food facilities and prior notice of imported food shipments. The document that published in the **Federal Register** of October 28, 2003 (68 FR 61340), contained an error. This document corrects that error.

FOR FURTHER INFORMATION CONTACT: Joyce A. Strong, Office of Policy and Planning (HF–27), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–827–7010.

SUPPLEMENTARY INFORMATION: In FR Doc. 03–27182, appearing on page 61340 in the **Federal Register** of Tuesday, October 28, 2003, the following correction is made:

1. On page 61341, in the third column, the Internet address for online registration is corrected as follows:

http://www.cfsan.fda.gov/~dms/fsbtac15.html.

Dated: October 31, 2003.

Jeffrey Shuren,

Assistant Commissioner for Policy.

[FR Doc. 03–28046 Filed 11–6–03; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 100

[CGD07–03–099]

RIN 1625–AA08

Special Local Regulations; World Championship Super Boat Race, Deerfield Beach, FL

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: Temporary special local regulations are being established for the World Championship Super Boat Race held offshore of Deerfield Beach, Florida. These special local regulations restrict the movement of non-participating vessels in the regulated race area and provide for a viewing area for spectator craft. This rule is needed to provide for the safety of life on navigable waters during the event.

DATES: This rule is effective from 11 a.m. on November 4, 2003, until 4 p.m. on November 9, 2003.

ADDRESSES: Documents indicated in the preamble as being available in the docket are part of docket [CGD07–03–099] and are available for inspection or copying at Coast Guard Group Miami, 100 MacArthur Causeway, Miami Beach, FL 33139 between 8 a.m. and 4:30 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: Chief Daniel Vaughn, Coast Guard Group Miami, FL at (305) 535–4317.

SUPPLEMENTARY INFORMATION:

Regulatory Information

We did not publish a notice of proposed rulemaking (NPRM) for this regulation. Under 5 U.S.C. 553(b)(B), the Coast Guard finds that good cause exists for not publishing an NPRM. Publishing an NPRM, which would incorporate a comment period before a temporary rule could be issued, would be impracticable and contrary to public interest since immediate action is needed to minimize the potential danger to the public posed by the powerboat race and the number of expected spectator craft.

For the same reasons, under 5 U.S.C. 553(d)(3), the Coast Guard finds that good cause exists for making this rule effective less than 30 days after publication in the **Federal Register**.

Background and Purpose

Super Boat International Productions Inc. is sponsoring a high speed power boat race that will take place on November 4, 6, and 9, 2003, from 11 a.m. until 4 p.m. in the Atlantic Ocean off Deerfield Beach, Florida. The race organizers anticipate 80 participants and 200 spectator craft. The event will take place outside of the marked channel and will not interfere with commercial shipping. Recreational vessels and fishing vessels normally operate in the waters being used for the event. This rule is required to provide for the safety of life on navigable waters because of the inherent dangers associated with power boat races. The rule prohibits non-participating vessels from entering the regulated race area offshore of Deerfield Beach, Florida during the event. A Coast Guard Patrol Commander will be present during this event to monitor compliance with this regulation.

Discussion of Rule

This rule will create two regulated areas, a race area and a viewing area. These regulated areas assist in providing for the safety of life on navigable waters and minimizing the inherent dangers associated with power boat races. These dangers include race craft traveling at high speeds in close proximity to one other, and in relatively close proximity to spectator craft. Due to these concerns, public safety requires the creation of these two regulated areas.

Regulatory Evaluation

This rule is not a significant regulatory action under section 3(f) of Executive Order 12866, Regulatory Planning and Review, and does not require an assessment of potential costs and benefits under section 6(a)(3) of that Order. The Office of Management and Budget has not reviewed it under that Order. It is not "significant" under the regulatory policies and procedures of the Department of Homeland Security (DHS). The rule will be in place in a limited area offshore of Deerfield Beach, Florida. Although the rule will be effective from November 4 until November 9 the rule will only be enforced on November 4, 6 and 9, from 11 a.m. until 4 p.m. each day, corresponding with the scheduled races.

Small Entities

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

This rule may affect the following entities, some of which may be small entities: the owners or operators of vessels intending to transit or anchor in a portion of the Atlantic Ocean near Deerfield Beach, Florida from 11 a.m. until 4 p.m. on November 4, 6, and 9, 2003. The Coast Guard certifies under U.S.C. 605(b) that this rule will not have a significant economic impact on a substantial number of small entities because this rule will be in effect for a limited duration, the rule regulates a very small area, and commercial and recreational vessels may be allowed to transit through the zone during breaks in the racing. Moreover, all vessel traffic can pass safely around the zone. Before the effective period, we will issue maritime advisories over VHF-FM radio to allow the maritime community to plan accordingly.

Assistance for Small Entities

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Public Law 104–121), we offer to assist small entities in understanding the rule so that they can better evaluate its effects on them and participate in the rulemaking process. Small entities may contact the person listed under **FOR FURTHER INFORMATION CONTACT** for assistance in understanding and participating in this rulemaking.

Small businesses may send comments on the actions of Federal employees, who enforce, or otherwise determine compliance with, Federal regulations to the Small Business and Agriculture Regulatory Enforcement Ombudsman and the Regional Small Business Regulatory Fairness Boards. The Ombudsman evaluates these actions annually and rates each agency's responsiveness to small business. If you wish to comment on actions by employees of the Coast Guard, call 1–888-REG-FAIR (1–888–734–3247).

Collection of Information

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

Federalism

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

Unfunded Mandates Reform Act

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

Taking of Private Property

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

Civil Justice Reform

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

Protection of Children

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

Indian Tribal Governments

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

Energy Effects

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

Environment

We have analyzed this rule under Commandant Instruction M16475.1D, which guides the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA)(42 U.S.C. 4321–4370f), and have concluded that there are no factors in this case that would limit the use of a categorical exclusion under section 2.B.2 of the Instruction. Therefore, this rule is categorically excluded, under figure 2–1, paragraph (34)(h), of the Instruction, from further environmental documentation. A final "Environmental Analysis Check List" and a final "Categorical Exclusion Determination" are available in the docket where indicated under **ADDRESSES.**

List of Subjects in 33 CFR Part 100

Marine safety, Navigation (water), Reporting and record keeping requirements, Waterways.

■ For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 100, as follows:

PART 100—SAFETY OF LIFE ON NAVIGABLE WATERS

■ 1. The authority citation for part 100 continues to read as follows:

Authority: 33 U.S.C. 1233; Department of Homeland Security Delegation No. 0170.1.

■ 2. Add temporary § 100.35T–07–099 to read as follows:

§ 100.35T–07–099 World Championship Super Boat Race; Deerfield Beach, Florida.

(a) *Regulated areas.* (1) The regulated race area encompasses all waters located within a line connecting the following positions located offshore of Deerfield Beach, Florida—Point 1: 26°15.70 N, 080°04.90 W; Point 2: 26°15.70 N, 080°04.10 W, Point 3: 26°19.70 N, 080°03.70 W, and Point 4: 26°19.70 N, 080°04.40 W. All coordinates referenced use Datum: NAD 1983.

(2) The regulated viewing area encompasses all waters located within a line connecting the following positions located offshore of Deerfield Beach, Florida—Point 1: 26°15.50 N; 080°04.20 W; Point 2: 26°15.50 N; 080°04.00 W; Point 3: 26°19.39 N; 080°03.90 W; and Point 4: 26°19.39 N; 080°04.05 W. All coordinates referenced use Datum NAD: 1983.

(b) *Coast Guard Patrol Commander.* The Coast Guard Patrol Commander is a commissioned, warrant, or petty officer of the Coast Guard who has been designated by Commanding Officer, Coast Guard Group Miami, Florida.

(c) *Special Local Regulations.* From 11 a.m. until 4 p.m. on November 4, November 6, and November 9, 2003, non-participant vessels are prohibited from entering the race area unless authorized by the Coast Guard Patrol Commander. Spectator craft may remain in the designated viewing area, but must follow the directions of the Coast Guard Patrol Commander.

(d) *Dates:* This section is effective from 11 a.m. on November 4, 2003, until 4 p.m. on November 9, 2003.

Dated: October 31, 2003.

Harvey E. Johnson, Jr.,

Rear Admiral, U.S. Coast Guard, Commander, Seventh Coast Guard District.

[FR Doc. 03–28012 Filed 11–6–03; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF COMMERCE

Patent and Trademark Office

37 CFR Parts 2 and 7

[Docket No. 2003–T–030]

RIN 0651–AB0045

Modification to Temporary Postponement of Electronic Filing and Payment Rules for Certain Madrid Protocol-Related Rules

AGENCY: United States Patent and Trademark Office, Commerce.

ACTION: Final rule; modification to suspension of applicability dates.

SUMMARY: The United States Patent and Trademark Office (USPTO) is modifying a temporary postponement of those provisions of the Trademark Rules of Practice that require electronic transmission to the USPTO of applications for international registration, responses to irregularity notices, and subsequent designations submitted pursuant to the Madrid Protocol. That postponement was announced in a document published in the **Federal Register** on October 24, 2003.

The USPTO is also modifying a temporary suspension, announced in the same **Federal Register** document, of those provisions of the Rules of Practice

that allow payment of fees charged by the International Bureau of the World Intellectual Property Organization (IB) to be submitted through the USPTO, and those provisions of the Trademark Rules of Practice that require that all fees for international trademark applications and subsequent designations be paid at the time of filing.

The temporary postponements and the temporary suspensions of the Rules of Practice, as well as the modifications to these postponements and suspensions that are announced herein, are in effect from November 2, 2003, to January 2, 2004. If it becomes necessary to extend the suspensions and postponements, and/or the modifications thereto, the USPTO will issue a notice announcing these extensions at least 10 business days before the extensions commence.

The modifications announced herein are procedural in nature and do not affect any substantive rights.

DATES: The applicability date for regulations at 37 CFR 2.190(a), 2.198(a)(1), 7.7(a) and (b), 7.11(a) introductory text and (a)(9), 7.14(e), 7.21(b) introductory text and (b)(7) remains suspended from November 2. 2003, to January 2, 2004.

FOR FURTHER INFORMATION CONTACT: Ari Leifman, Office of the Commissioner for Trademarks, by telephone at (703) 308–8910, ext. 155, or by e-mail to *ari.leifman@uspto.gov*.

SUPPLEMENTARY INFORMATION:

Background

The Madrid Protocol provides a system for obtaining an international trademark registration. The Madrid Protocol Implementation Act of 2002, Pub. L. 107–273, 116 Stat. 1758, 1913–1921 (MPIA) amends the Trademark Act of 1946 to implement the provisions of the Madrid Protocol in the United States.

On September 26, 2003, the USPTO published new regulations to implement the MPIA. 68 FR 55748, posted on the USPTO Web site at *http://www.uspto.gov/web/offices/com/sol/notices/68fr55748.pdf*. These regulations take effect on November 2, 2003. The regulations require that certain submissions that are made to the USPTO in connection with the Madrid Protocol be transmitted using the Trademark Electronic Application System (TEAS). Specifically, 37 CFR 7.11(a) requires that an international application be submitted through TEAS; 37 CFR 7.21(b) requires that a subsequent designation (a request that protection be extended to countries not identified in the original international application) be submitted through TEAS; and 37 CFR 7.14(e) requires that where the International Bureau of the World Intellectual Property Organization (IB) has issued a notice of irregularity to an international applicant, and the international applicant submits a response to that notice through the USPTO, the response must be transmitted through TEAS.

Madrid Submissions Must Be Prepared Using Paper

On October 24, 2003, the USPTO published a notice in which it announced that it would permit international applications, responses to irregularity notices, and subsequent designations to be submitted on paper rather than through TEAS, for a temporary period of time. The notice accordingly postponed the applicability of 37 CFR 7.11(a), 7.21(b), and 7.14(e), to the extent that those provisions require transmission through TEAS. The notice further provided that this postponement would remain in effect until January 2, 2004, and that if the postponement was extended beyond January 2, 2004, a notice announcing such an extension would be published at least ten days before the extension commenced.

The postponement remains in effect, but is modified. The notice of the postponement provided that applicants could make their submission either on paper or through TEAS. However, certain technical difficulties will delay the deployment of those TEAS forms that will be used for Madrid submissions until some time after November 2, 2003. Therefore, the USPTO hereby announces that all Madrid submissions must be made on paper, until such time as the TEAS forms are posted on the USPTO web site.

The USPTO will issue a notice announcing the posting of the TEAS forms at least five days before such posting occurs.

If the TEAS forms are posted while the postponement of the applicability dates of 37 CFR 7.11(a), 7.21(b), and 7.14(e) is still in effect, then notwithstanding the modifications to the postponements that are announced herein, applicants will be able to file international applications, responses to irregularity notices, and subsequent designations either on paper or through TEAS. Under any circumstances, there will be a transition period during which the USPTO will accept both electronic and paper submissions.

International Fees Must Be Paid Directly to the IB

In addition to requiring that certain submissions that are made to the USPTO in connection with the Madrid Protocol be transmitted using TEAS, the Rules of Practice that take effect on November 2, 2003, also require that international application fees be paid at the time of submission. However, with respect to Madrid submissions that are to be made on paper, the notice of October 24, 2003, temporarily suspended the applicability of those requirements. Thus, the notice suspended 37 CFR 7.11(a)(9), to the extent that it requires that international application fees for all classes and the fees for all designated Contracting Parties identified in an international application be paid at the time of submission. Likewise, the notice suspended 37 CFR 7.21(b)(7), to the extent that it requires that all international fees for a subsequent designation be paid at the time of submission.

The notice of October 24, 2003, further provided that (1) applicants who file Madrid submissions on paper must pay the USPTO certification fee at the time of submission, but must pay the international fees directly to the IB, and that (2) applicants who submit a subsequent designation on paper must pay the USPTO transmittal fee at the time of submission, but must pay the international fees directly to the IB. Additionally, the notice provided that applicants may pay the international fees to the IB either before or after submission of the international application or subsequent designation.

All provisions of the notice of October 24, 2003, that pertain to payment of fees remain in effect. However, the following is noted: these provisions of the notice of October 24, 2003, apply in cases where Madrid submissions are made using paper. Pursuant to the present notice, all Madrid submissions must be made on paper. Hence, the provisions of the notice of October 24, 2003, regarding the payment of fees now apply in all cases where Madrid submissions are made.

If the TEAS forms are posted while the postponement of the effective dates of 37 CFR 7.11(a)(9) and 7.21(b)(7) remains in effect, then applicants who elect to use those forms will pay the international fees (1) at the time of submission, and (2) through the USPTO.

Applicants Should Utilize Madrid Forms Provided by the IB

Applicants making Madrid submissions should use forms provided

by the IB for that purpose. These forms may be downloaded from the IB Web site, *http://www.wipo.int/madrid/en/*. Please note that the IB will not process paper submissions that are not prepared using IB forms.

Applicants Should Mail Madrid Submissions to a Designated Address

Pursuant to 37 CFR 2.190(a), all trademark-related documents submitted on paper must be mailed to the USPTO address at 2900 Crystal Drive, Arlington, Virginia 22202–3514. However, the notice of October 24, 2003, waived that rule with respect to international applications, subsequent designations, and responses to notices of irregularities that are filed on paper The notice further provided that all Madrid submissions made on paper should be mailed to the following address: Commissioner for Trademarks, PO Box 16471, Arlington, Virginia 22215–1471, Attn: MPU.

The limited waiver of 37 CFR 2.190(a) remains in effect. However, the following is noted: pursuant to the notice of October 24, 2003, the waiver, and the instruction to utilize the above-identified address, applied to Madrid submissions made on paper. Pursuant to the present notice, all Madrid submissions must be made on paper. Hence, the provisions of the notice of October 24, 2003, regarding the USPTO mailing address apply to all Madrid submissions.

Please note that any trademark-related correspondence other than international applications, subsequent designations, and responses to irregularity notices that is sent to the above-identified address will not be accepted, and will be returned to the sender.

If a submission mailed to the above address pursuant to this notice and to the Notice of October 24, 2003, is delivered by the Express Mail service of the United States Postal Service, the USPTO will deem that the date of receipt of the submission in the USPTO is the date the submission was deposited as Express Mail, provided that the submitter complies with the requirements set forth in 37 CFR 2.198.

Dated: October 31, 2003.

James E. Rogan,

Under Secretary of Commerce for Intellectual Property and Director of the United States Patent and Trademark Office.

[FR Doc. 03–27917 Filed 11–6–03; 8:45 am]

BILLING CODE 3510–16–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Parts 51 and 52

[FRL–7583–7, E–Docket ID No. A–2001–0004 (Legacy Docket ID No. A–90–37)]

Prevention of Significant Deterioration (PSD) and Non-Attainment New Source Review (NSR): Reconsideration

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of final action on reconsideration; amendment to final rules.

SUMMARY: On December 31, 2002 and March 10, 2003, EPA revised regulations governing the major New Source Review (NSR) programs mandated by parts C and D of title I of the Clean Air Act (CAA or Act). Following these actions, the Administrator received a number of petitions for reconsideration. On July 30, 2003, EPA announced its reconsideration of certain issues arising from the final rules of December 31, 2002. We (the EPA) requested public comment on six issues for which we granted reconsideration. As a result of this reconsideration process, we have concluded that two clarifications to the underlying rules are warranted, which are: To include a definition of "replacement unit" and to clarify that the plantwide applicability limitation (PAL) baseline calculation procedures for newly constructed units do not apply to modified units. With respect to all other issues raised by the petitioners, we deny the requests for reconsideration.

EFFECTIVE DATE: This final action is effective on January 6, 2004.

ADDRESSES: *Docket.* Docket No. A–90–37 (E–Docket ID No. OAR–2001–0004), containing supporting information used to develop the proposed rule and the final rule, is available for public inspection and copying between 8 a.m. and 4:30 p.m., Monday through Friday (except government holidays) at the Air and Radiation Docket and Information Center (6102T), Room B108, EPA West Building, 1301 Constitution Avenue, NW., Washington, DC 20460; telephone (202) 566–1742, fax (202) 566–1741. A reasonable fee may be charged for copying docket materials.

Worldwide Web (WWW). In addition to being available in the docket, an electronic copy of this final action will also be available on the WWW. Following signature, a copy of the notice will be posted on the EPA's NSR page: *http://www.epa.gov/nsr.*

FOR FURTHER INFORMATION CONTACT: Ms. Lynn Hutchinson, Information Transfer and Program Integration Division (C339–03), U.S. Environmental Protection Agency, Research Triangle Park, NC 27711, telephone (919) 541–5795, or electronic mail at *hutchinson.lynn@epa.gov*, or Ms. Janet McDonald, at the same street address, telephone (919) 541–1450, or electronic mail at *mcdonald.janet@epa.gov*.

SUPPLEMENTARY INFORMATION:

I. General Information

A. What Are the Regulated Entities?

Entities potentially affected by the subject rule for today's action include sources in all industry groups. The majority of sources potentially affected are expected to be in the following groups.

Industry Group	SIC [a]	NAICS [b]
Electric Services	491	221111, 221112, 221113, 221119, 221121, 221122
Petroleum Refining	291	324110
Industrial Inorganic Chemicals	281	325181, 325120, 325131, 325182, 211112, 325998, 331311, 325188
Industrial Organic Chemicals	286	325110, 325132, 325192, 325188, 325193, 325120, 325199
Miscellaneous Chemical Products	289	325520, 325920, 325910, 325182, 325510
Natural Gas Liquids	132	211112
Natural Gas Transport	492	486210, 221210
Pulp and Paper Mills	261	322110, 322121, 322122, 322130
Paper Mills	262	322121, 322122
Automobile Manufacturing	371	336111, 336112, 336211, 336992, 336322, 336312, 336330, 336340, 336350, 336399, 336212, 336213
Pharmaceuticals	283	325411, 325412, 325413, 325414

[a] Standard Industrial Classification

[b] North American Industry Classification System. Entities potentially affected by the subject rule for today's action also include State, local, and tribal governments.

B. How Can I Get Copies of This Document and Other Related Information?

1. Docket. EPA has established an official public docket for this action under E–Docket ID No. OAR–2001–0004 (Legacy Docket ID No. A–90–37). The official public docket consists of the documents specifically referenced in this action, any public comments received, and other information related to this action. Although a part of the official docket, the public docket does not include Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. The official public docket is the collection of materials that is available for public viewing at the EPA Docket Center (Air Docket), U.S. Environmental Protection Agency, EPA West Building, 1301 Constitution Avenue, NW., Room B108, Mail Code: 6102T, Washington, DC 20460. The EPA Docket Center Public Reading Room is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The telephone number for the Reading Room is (202) 566–1742. A reasonable fee may be charged for copying.

2. Electronic Access. You may access this **Federal Register** document electronically through the EPA Internet under the **Federal Register** listings at *http://www.epa.gov/fedrgstr/.*

An electronic version of a portion of the public docket is available through EPA's electronic public docket and comment system, EPA Dockets. Interested persons may use EPA Dockets at *http://www.epa.gov/edocket/* to submit or view public comments, access the index listing of the contents of the official public docket, and access those documents in the public docket that are available electronically. Once in the system, select "search," then key in the appropriate docket identification number.

Certain types of information will not be placed in the EPA Dockets. Information claimed as CBI and other information whose disclosure is restricted by statute, which is not included in the official public docket, will not be available for public viewing in EPA's electronic public docket. EPA's policy is that copyrighted material will not be placed in EPA's electronic public docket but will be available only in printed, paper form in the official public docket. To the extent feasible, publicly available docket materials will be made available in EPA's electronic public docket. When a document is selected from the index list in EPA Dockets, the system will identify whether the document is available for viewing in EPA's electronic public docket. Although not all docket materials may be available electronically, you may still access any of the publicly available docket materials through the docket facility identified in section I.B.1. EPA intends to work towards providing electronic access to all of the publicly available docket materials through EPA's electronic public docket.

For additional information about EPA's electronic public docket visit EPA Dockets online or see 67 FR 38102, May 31, 2002.

C. Where Can I Obtain Additional Information?

In addition to being available in the docket, an electronic copy of this final action will also be available on the WWW. Following signature, a copy of the notice will be posted on the EPA's NSR page: http://www.epa.gov/nsr.

D. How Is This Preamble Organized?

The information presented in this preamble is organized as follows:

II. Background

For a brief history of the NSR rulemaking process that preceded today's final action, see our discussion at 68 FR 44623 (July 30, 2003). On December 31, 2002, we issued a final rule (67 FR 80186) that revised regulations governing the major NSR programs (final rules).[1] The revisions included five major changes to the major NSR program that will reduce burden, maximize operating flexibility, improve environmental quality, provide additional certainty, and promote administrative efficiency. These elements include baseline actual emissions, actual-to-projected-actual emissions methodology, plantwide applicability limitations (PALs), Clean Units, and pollution control projects (PCPs). The final rules also codified our longstanding policy regarding the calculation of baseline emissions for electric utility steam generating units (EUSGUs). In addition, the final action: (1) Responded to comments we received on a proposal to adopt a methodology, developed by the American Chemistry Council (formerly known as the Chemical Manufacturers Association (CMA)) and other industry petitioners, to determine whether a major stationary source has undertaken a major modification based on its potential emissions; and (2) included a new section that spells out in one place how a major modification is determined under the various major NSR applicability options. This topic had previously been addressed primarily in the definition section of the major NSR regulations. We also clarified where to find the provisions in the revised rules and codified a definition of "regulated NSR pollutant" that clarifies which pollutants are regulated under the Act for purposes of major NSR.

On February 28, 2003, we sent notice to affected States that, consistent with our proposal in 1996, we were revising the references to 40 CFR 52.21 in delegated States' plans to reflect the December 31, 2002 changes in the Prevention of Significant Deterioration (PSD) Federal Implementation Plan (FIP) (40 CFR 52.21(a)(2) and (b) through (bb)). This FIP applies in any area that does not have an approved PSD program in the State Implementation Plan (SIP), and in all Indian country. The notice was subsequently published in the **Federal Register** on March 10, 2003 (68 FR 11316).

Following publication of the December 31, 2002 and March 10, 2003 **Federal Register** notices, and prior to July 2003, the Administrator received numerous petitions, filed pursuant to section 307(d)(7)(B) of the CAA,

[1] The December 31, 2002 final rules did not act on several issues proposed in 1996. We intend to act on some or all issues from the 1996 proposal in subsequent **Federal Register** notices.

requesting reconsideration of many aspects of the final rules.[2]

On July 30, 2003 (68 FR 44624), we granted reconsideration on six issues raised by petitioners who had filed petitions prior to July 2003.[3] At that time, we did not act on any of the remaining issues in those petitions. Instead, we indicated that we planned to announce our final decision on whether to reconsider the remaining petition issues no later than 90 days after the publication of the **Federal Register** notice.

The first of the six issues on which we granted reconsideration involves a document we released in November 2002, entitled "Supplemental Analysis of the Environmental Impact of the 2002 Final NSR Improvement Rules."[4] Our purpose in granting reconsideration on this issue was to provide the public an opportunity to comment on our analysis and to submit any additional information that they believe to be relevant to the inquiry. The remaining issues for which we granted reconsideration involved five narrow aspects of the final rule as follows:

- Using potential-to-emit (PTE) to determine baseline actual emissions for an emissions unit on which actual construction began after the 24-month PAL baseline period when establishing a PAL;
- Eliminating synthetic minor limits [(r)(4) limits] under the PAL;
- Including a "reasonable possibility" requirement for triggering recordkeeping and reporting provisions;
- Using the actual-to-projected-actual test for replacement units; and,
- Effect of redesignation of an area from attainment to nonattainment on Clean Unit status.

We describe these issues at 68 FR 44624. For the reasons indicated at 68 FR 44624, we did not grant a stay of the final rules pending our reconsideration of these issues.

On August 14, 2003, we held a public hearing on the issues for which we granted reconsideration. Twenty-two individuals gave oral presentations at the hearing. The transcript of their comments is located in Docket OAR–2001–0004 (Legacy Number A–90–37), which can be accessed on the internet at *http://www.epa.gov/edocket.*

We provided a public comment period on the reconsideration issues that ended on August 29, 2003. For issues arising out of the August 14th public hearing, the comment period was extended until September 15, 2003. More than 400 written public comments on the reconsideration issues were received. The individual comment letters can be found in Docket OAR–2001–0004 (Legacy Number A–90–37).

III. Today's Action

At this time, we are announcing our final action after reconsideration of these six issues. We are also announcing our final decision on reconsideration of the remaining issues that were raised by the petitioners. Today, we are making available a document entitled, "Technical Support Document for Prevention of Significant Deterioration (PSD) and Non-attainment New Source Review (NSR): Reconsideration," EPA 456/R–03–005 (Technical Support Document). This document contains (1) a summary of comments received on the issues for which we granted reconsideration and our responses to these comments, and (2) a summary of petition issues for which we are not granting reconsideration, and our rationale for denying reconsideration. This document is available on our Web site at *http://www.epa.gov/nsr/;* and, through the National Technical Information Services, 5285 Port Royal Road, Springfield, VA 22161; telephone (800) 553–6846, e-mail *http://www.ntis.gov;* and, from the US EPA, Library Services, MD C267–01, Research Triangle Park, NC 27711, telephone (919) 541–2777, e-mail *library.rtp@epa.gov.*

A. Six Issues for Which Reconsideration Was Granted

We received numerous responses to our request for comment on the "Supplemental Analysis of the Environmental Impact of the 2002 Final NSR Improvement Rule." After carefully considering the information that was submitted, we have determined that none of the new information presented leads us to conclude that the analysis was incorrect or substantially flawed. Therefore, we are re-affirming the validity of the original conclusions. A summary of the comments received and our responses to these comments can be found in our Technical Support Document.

With respect to the five remaining issues on which we granted reconsideration, we have concluded that two clarifications to the underlying rules are warranted. These changes relate to issues raised as a result of our request for comment on: (1) Whether replacement units should be allowed to use the actual-to-projected-actual applicability test to determine whether installing a replacement unit results in a significant emissions increase; and, (2) using potential-to-emit (PTE) to determine the baseline actual emissions for an emissions unit on which construction began after the 24-month baseline period when establishing a PAL. As explained below, while we are not making any changes to the general approach in the final rules with respect to these issues, we are making two clarifying changes to the regulations. First, we are adding a definition of replacement unit to the final rules. Second. we are clarifying that the potential-to-emit approach for determining baseline actual emissions when establishing a PAL is only available to emissions units that are added to the major stationary source after the 24-month baseline period, and is not available to emissions units that existed during the baseline period whether or not they have been modified since that time.

We are not making any changes to the final rules with respect to eliminating synthetic minor limits [(r)(4) limits] under the PAL, the "reasonable possibility" requirement for triggering recordkeeping and reporting provisions, or the effect of redesignation of an area from attainment to nonattainment on Clean Unit status. Our reasons for this conclusion, and our response to significant comments received, are summarized in our Technical Support Document.

1. Replacement Units

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[2] Petitions for reconsideration of the December 31, 2002 final rule that EPA received before July 2003 were filed by: Northeastern States (CT, ME, MD, MA, NH, NJ, NY, PA, RI, VT); South Coast Air Quality Management District (CA); and Environmental Groups (led by NRDC, Earthjustice, Clean Air Task Force, and Environmental Defense). Additional petitioners joined existing petitions: The People of California and California Air Resources Board (joined South Coast and Northeastern States petitions); Yolo-Solano Air Quality Management District (CA) (joined South Coast petition); Santa Barbara, Ventura, and Monterey Air Pollution Control Districts (CA); and Sacramento Air Quality Management District (CA) (joined South Coast petition). Petitions for reconsideration of the FIP rule were filed by: Delegated States (CA, CT, IL, MA, NJ, NY, DC, South Coast Air Quality Management District (CA), and Santa Barbara Air Pollution Control District (CA)); and Environmental Groups (essentially the same groups that filed petitions to reconsider the December 31, 2002 rule).

On July 11, 2003, we received another petition for reconsideration filed by Newmont USA Limited, dba Newmont Mining Corporation. This petition was subsequently joined by the National Cattlemen's Beef Association and the National Mining Association. We are not responding to that petition at this time, but will do so in the near future.

[3] In this notice, the term "petitioner" refers only to those entities that filed petitions for reconsideration with EPA prior to July 2003.

[4] Available through our NSR Web site at *http://www.epa.gov/nsr* and in Docket ID No. A–90–37, Document IV–A–7.

We have decided to continue to allow the owner or operator of a major stationary source (you) to use the actual-to-projected-actual applicability test to determine whether installing a replacement unit results in a significant emissions increase. However, as we reconsidered this issue and reviewed comments, we found one commenter that recommended that EPA include a definition of "replacement unit" in the regulations. The commenter asked that this definition describe how the replacement unit may differ from the replaced unit. The commenter also recommended that we indicate that the replaced unit must be removed from the site or rendered permanently inoperable.

We believe that the current rules, as supplemented by the discussion in the December 2002 preamble, are self-implementing for replacement units. Nevertheless, we agree with the commenter that a definition of "replacement unit" would render implementation easier. Thus, today we are adding regulatory language to further clarify our intentions regarding replacement units. Today's action revises the definition of "emissions unit" to clarify that a replacement unit is considered an existing emissions unit (*e.g.*, § 51.166(b)(7)(ii)) and therefore is eligible for the actual-to-projected-actual test for major NSR applicability determinations.

In addition, today's rule revisions add a definition of "replacement unit" that codifies longstanding policy and practice. In the preamble to the 1992 WEPCO rule, we first stated that we would "consider a unit to be replaced if it would constitute a reconstructed unit within the meaning of 40 CFR 60.15," which is the section of the New Source Performance Standards (NSPS) General Provisions that governs reconstruction. *See* 57 FR 32323, column 1. We have adopted this threshold in today's rule, by defining "replacement unit" to include reconstructed units, as well as emissions units that completely take the place of an existing emissions unit. *See, e.g.*, § 51.166(b)(32)(i).

We note that we have never considered "replacement units" to include replacements that significantly change the nature of the replaced unit; it is this inherent limitation that makes the application of the actual-to-projected-actual applicability test appropriate. It is reasonable to compare the baseline actual emissions from the replaced unit to the projected actual emissions of the replacement unit because the units are effectively the same existing emissions unit. Thus, consistent with the recently finalized equipment replacement exclusion provisions, the limiting principle here is that the replacement unit must be identical or functionally equivalent and must not change the basic design parameters of the affected process unit (*e.g.*, for EUSGUs this might mean heat input and fuel consumption specifications). *See, e.g.*, §§ 51.166(b)(32)(ii) and (iii). We also believe, however, that we need not and should not treat efficiency as a basic design parameter, as we do not believe major NSR was intended to impede industry in making energy and process efficiency improvements. We believe such improvements, on balance, will be beneficial both economically and environmentally.

We also believe that it has always been implicit in the concept of a replacement unit that the replaced unit must cease operation. Today's rule makes this principle explicit by requiring you to remove or permanently disable the replaced unit, or take a permit condition to permanently prohibit its operation. In general, if you bring the replaced unit back into operation, it must be treated as a new emissions unit, to which the actual-to-potential emissions test applies. *See, e.g.*, § 51.166(b)(32)(iv).

Finally, today's rule spells out that you cannot generate an emissions reduction credit from emissions reductions that are attributable to the shutdown of the replaced emissions unit. *See, e.g.*, § 51.166(b)(32). This provision addresses concerns about the possible double-counting of emissions reductions that could otherwise occur. Thus, if you use the baseline actual emissions of the replaced unit when applying the actual-to-projected-actual emissions test to measure the emissions increase resulting from the replacement unit, you cannot subsequently take credit for the emissions reductions that occur when you shut down the replaced unit. However, this provision is not intended to prevent you from generating creditable emissions reductions through other activities at the replacement unit. For example, you may be able to generate an emissions reduction credit if you reduce emissions by installing an inherently less-polluting replacement unit and accept an enforceable emission limitation that is lower than the baseline actual emissions of the replaced unit. Such an emissions reduction would be creditable if all other criteria for generating such credit are met.

2. Emission Units for Which You Began Actual Construction After the PAL Baseline Period

We have decided to retain the calculation method that uses potential-to-emit (PTE) to determine the baseline actual emissions for an emissions unit for which you began actual construction after the 24-month PAL baseline period when establishing a PAL. As we reconsidered this issue and reviewed comments, however, we decided it was appropriate to clarify that this method of calculation applies only to emissions units initially constructed after the PAL baseline period.

As reflected in the July 30, 2003 **Federal Register** notice, our intent was to limit the use of PTE to emissions units that were not in existence during the baseline period. We explained in the July notice that we included this provision, and the provision requiring the emissions of shut down units to be subtracted from the PAL level, "in recognition that the set of emissions units at your source at the time of PAL permit issuance may be different from the set of emissions units that existed during the baseline period. You may have constructed additional emissions units, permanently shut down previously existing emissions units, or both." *See* 68 FR 44625, column 3.

However, in providing for the inclusion of PTE for some units, the language of the rule referred only to "units on which actual construction began" after the PAL baseline period. *See, e.g.*, 40 CFR 52.21(aa)(6). "Construction" is defined as "any physical change or change in the method of operation (including fabrication, erection, installation, demolition, or modification of an emissions unit) which would result in a change in actual emissions." *See, e.g.*, 40 CFR 52.21(b)(8). Because the definition of "construction" encompasses modifications, we are concerned that, in the future, there might be confusion regarding the intended scope of this provision. It was not our intention to extend this provision to units that merely undergo a modification following the baseline period. Therefore, we are changing the rule language to explicitly exclude such units.

B. Remaining Issues in Petitions for Reconsideration

We deny the petitioners' requests for reconsideration on the remaining issues raised in the petitions, because they have failed to meet the standard for reconsideration under section 307(d)(7)(B) of the CAA. Specifically,

the petitioners have failed to show: That it was impracticable to raise their objections during the comment period, or that the grounds for their objections arose after the close of the comment period; and/or that their concern is of central relevance to the outcome of the rule. We discuss our reasons for denying reconsideration in the Technical Support Document, which is available on our Web site at *http://www.epa.gov/nsr*.

IV. Statutory and Executive Order Reviews

On December 31, 2002, we finalized rule changes to the regulations governing the NSR programs mandated by parts C and D of title I of the Act. With today's action we are promulgating two minor clarifications to the final rules. Accordingly, we believe that the rationale provided with the final rules is still applicable and sufficient.

A. Executive Order 12866—Regulatory Planning and Review

Under Executive Order 12866 (58 FR 51735, October 4, 1993), the Agency must determine whether the regulatory action is "significant" and therefore subject to Office of Management and Budget (OMB) review and the requirements of the Executive Order. The Order defines "significant regulatory action" as one that is likely to result in a rule that may:

(1) Have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities;

(2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency;

(3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs, or the rights and obligations of recipients thereof; or

(4) Raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

Pursuant to the terms of Executive Order 12866, OMB has notified EPA that it considers this a "significant regulatory action" within the meaning of the Executive Order. EPA has submitted this action to OMB for review. Changes made in response to OMB suggestions or recommendations will be documented in the public record.

B. Paperwork Reduction Act

This action does not impose any new information collection burden. We are not promulgating any new paperwork (*e.g.*, monitoring, reporting, recordkeeping) as part of today's final action. The OMB has previously approved the information collection requirements contained in the existing regulations (40 CFR parts 51 and 52) under the provisions of the Paperwork Reduction Act, 44 U.S.C. 3501 *et seq.*, and has assigned OMB control number 2060–0003, EPA ICR number 1230.11. A copy of the OMB approved Information Collection Request (ICR) may be obtained from Susan Auby, Collection Strategies Division; U.S. Environmental Protection Agency (2822T); 1200 Pennsylvania Avenue, NW., Washington, DC 20460 or by calling (202) 566–1672.

Burden means the total time, effort, or financial resources expended by persons to generate, maintain, retain, or disclose or provide information to or for a Federal agency. This includes the time needed to review instructions; develop, acquire, install, and utilize technology and systems for the purposes of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information; adjust the existing ways to comply with any previously applicable instructions and requirements; train personnel to be able to respond to a collection of information; search data sources; complete and review the collection of information; and transmit or otherwise disclose the information.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for EPA's regulations in 40 CFR are listed in 40 CFR part 9.

C. Regulatory Flexibility Analysis

The EPA has determined that it is not necessary to prepare a regulatory flexibility analysis in connection with this final rule.

For purposes of assessing the impacts of today's action on small entities, a small entity is defined as: (1) A small business that is a small industrial entity as defined in the U.S. Small Business Administration (SBA) size standards (*see* 13 CFR 121.201); (2) a small governmental jurisdiction that is a government of a city, county, town, school district, or special district with a population of less than 50,000; or (3) a small organization that is any not-for-profit enterprise that is independently owned and operated and is not dominant in its field.

After considering the economic impacts of today's action on small entities, EPA has concluded that this action will not have a significant economic impact on a substantial number of small entities. In determining whether a rule has a significant economic impact on a substantial number of small entities, the impact of concern is any significant adverse economic impact on small entities, since the primary purpose of the regulatory flexibility analyses is to identify and address regulatory alternatives "which minimize any significant economic impact of the proposed rule on small entities." 5 U.S.C. 603 and 604. Thus, an agency may conclude that a rule will not have a significant economic impact on a substantial number of small entities if the rule relieves regulatory burden, or otherwise has a positive economic effect, on all of the small entities subject to the rule. A Regulatory Flexibility Act Screening Analysis (RFASA), developed as part of a 1994 draft Regulatory Impact Analysis (RIA) and incorporated into the September 1995 ICR renewal analysis, showed that the changes to the NSR program due to the 1990 Clean Air Act amendments would not have an adverse impact on small entities. This analysis encompassed the entire universe of applicable major sources that were likely to also be small businesses (approximately 50 "small business" major sources). Because the administrative burden of the NSR program is the primary source of the NSR program's regulatory costs, the analysis estimated a negligible "cost to sales" (regulatory cost divided by the business category mean revenue) ratio for this source group. Currently, and as reported in the current ICR, there is no economic basis for a different conclusion.

We believe the rule changes in the December 31, 2002 final rule will reduce the regulatory burden associated with the major NSR program for all sources, including all small businesses, by improving the operational flexibility of owners and operators, improving the clarity of requirements, and providing alternatives that sources may take advantage of to further improve their operational flexibility. Today's action consists of two minor clarifications to the December 31, 2002 final rule and does not change our overall assessment of regulatory burden. We have therefore concluded that the rule changes in December 31, 2002 final rule, as clarified by today's action, will relieve regulatory burden for all small entities.

D. Unfunded Mandates Reform Act

Title II of the Unfunded Mandates Reform Act of 1995 (UMRA), Public Law 104–4, establishes requirements for Federal agencies to assess the effects of their regulatory actions on State, local, and tribal governments and the private sector. Under section 202 of the UMRA, EPA generally must prepare a written statement, including a cost-benefit analysis, for proposed and final rules with "Federal mandates" that may result in expenditures to State, local, and tribal governments, in the aggregate, or to the private sector, of $100 million or more in any 1 year. Before promulgating an EPA rule for which a written statement is needed, section 205 of the UMRA generally requires EPA to identify and consider a reasonable number of regulatory alternatives and adopt the least costly, most cost-effective or least burdensome alternative that achieves the objectives of the rule. The provisions of section 205 do not apply when they are inconsistent with applicable law. Moreover, section 205 allows EPA to adopt an alternative other than the least costly, most cost-effective or least burdensome alternative if the Administrator publishes with the final rule an explanation as to why that alternative was not adopted. Before EPA establishes any regulatory requirements that may significantly or uniquely affect small governments, including tribal governments, it must have developed under section 203 of the UMRA a small government agency plan.

The plan must provide for notifying potentially affected small governments, enabling officials of affected small governments to have meaningful and timely input in the development of EPA regulatory proposals with significant Federal intergovernmental mandates, and informing, educating, and advising small governments on compliance with the regulatory requirements.

We have determined that today's action does not contain a Federal mandate that may result in expenditures of $100 million or more for State, local, and tribal governments, in the aggregate, or the private sector in any 1 year. Although initially the changes in the December 31, 2002 final rule are expected to result in a small increase in the burden imposed upon reviewing authorities in order for them to be included in the State's SIP, as well as other small increases in burden discussed under "Paperwork Reduction Act" in the preamble to the December 31, 2002 final rule, those revisions will ultimately provide greater operational flexibility to sources permitted by the States, which will in turn reduce the overall burden of the program on State and local authorities by reducing the number of required permit modifications. In addition, we believe the 2002 rule changes will actually reduce the regulatory burden associated with the major NSR program by improving the operational flexibility of owners and operators, improving the clarity of requirements, and providing alternatives that sources may take advantage of to further improve their operational flexibility. Today's action does not increase regulatory burden but merely clarifies two aspects of the 2002 rule changes. Thus, today's action is not subject to the requirements of sections 202 and 205 of the UMRA. For the same reasons stated above, we have determined that today's action contains no regulatory requirements that might significantly or uniquely affect small governments. Thus, today's action is not subject to the requirements of section 203 of the UMRA.

E. Executive Order 13132—Federalism

Executive Order 13132, entitled "Federalism" (64 FR 43255, August 10, 1999), requires EPA to develop an accountable process to ensure "meaningful and timely input by State and local officials in the development of regulatory policies that have federalism implications." "Policies that have federalism implications" is defined in the Executive Order to include regulations that have "substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government."

Today's action does not have federalism implications. It will not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government, as specified in Executive Order 13132. While the final rule published on December 31, 2002 will result in some expenditures by the States, we expect those expenditures to be limited to $331,250 per year. This figure includes the small increase in the burden imposed upon reviewing authorities in order for them to revise the State's SIP. However, the revisions contained in the December 31, 2002 final rule provide greater operational flexibility to sources permitted by the States, which will in turn reduce the overall burden of the program on State and local authorities by reducing the number of required permit modifications. Today's action does not increase regulatory burden but merely clarifies two aspects of the December 31, 2002 final rule. Thus, Executive Order 13132 does not apply to today's action.

F. Executive Order 13175—Consultation and Coordination With Indian Tribal Governments

Executive Order 13175, entitled "Consultation and Coordination with Indian Tribal Governments" (65 FR 67249, November 9, 2000), requires EPA to develop an accountable process to ensure "meaningful and timely input by tribal officials in the development of regulatory policies that have tribal implications." Today's action does not have tribal implications as specified in Executive Order 13175. Thus, Executive Order 13175 does not apply to this action.

The purpose of the December 31, 2002 final rule is to add greater flexibility to the existing major NSR regulations. Those changes will benefit permitting authorities and the regulated community, including any major source owned by a tribal government or located in or near tribal land, by providing increased certainty as to when the requirements of the NSR program apply. Taken as a whole, the December 31, 2002 final rule should result in no added burden or compliance costs and should not substantially change the level of environmental performance achieved under the previous rules.

EPA anticipates that initially the changes in the December 31, 2002 final rule will result in a small increase in the burden imposed upon Reviewing Authorities in order for them to be included in the State's SIP. Nevertheless, those revisions will ultimately provide greater operational flexibility to sources permitted by the States, which will in turn reduce the overall burden of the program on State and local authorities by reducing the number of required permit modifications. In comparison, no tribal government currently has an approved tribal implementation plan (TIP) under the Clean Air Act to implement the NSR program. The Federal government is currently the NSR permitting authority in Indian country. Thus, tribal governments should not experience added burden from the December 31, 2002 final rule, nor should their laws be affected with respect to implementation of that rule. Additionally, although major stationary sources affected by the December 31, 2002 final rule could be located in or near Indian country and/or be owned or operated by tribal governments, such sources would not incur additional costs or compliance burdens as a result of that rule. Instead, the only effect on such sources should

be the benefit of the added certainty and flexibility provided by that rule. For the reasons stated above, we do not believe that today's action, which clarifies two aspects of the December 31, 2002 final rule, would increase burden for tribal governments. In addition, we do not anticipate that today's action would have substantial direct effects on sources located in or near Indian country or sources owned or operated by tribal governments.

In our July 30, 2003 notice, EPA specifically solicited additional comment on today's final action from tribal officials.

G. Executive Order 13045—Protection of Children From Environmental Health Risks and Safety Risks

Executive Order 13045, entitled "Protection of Children from Environmental Health Risks and Safety Risks" (62 FR 19885, April 23, 1997), applies to any rule that: (1) Is determined to be "economically significant" as defined under Executive Order 12866; and (2) concerns an environmental health or safety risk that EPA has reason to believe may have a disproportionate effect on children. If the regulatory action meets both criteria, the Agency must evaluate the environmental health or safety effects of the planned rule on children, and explain why the planned regulation is preferable to other potentially effective and reasonably feasible alternatives considered by the Agency.

Today's action is not subject to the Executive Order because it is not economically significant as defined in Executive Order 12866, and because the Agency does not have reason to believe the environmental health or safety risks addressed by this action present a disproportionate risk to children. We believe that the December 31, 2002 final rule as a whole will result in equal or better environmental protection than provided by earlier regulations, and do so in a more streamlined and effective manner. Similarly, today's action merely clarifies two aspects of the December 31, 2002 final rule and does not change substantially the level of environmental protection provided by that rule. As a result, today's action is not expected to present a disproportionate environmental health or safety risk for children.

H. Executive Order 13211—Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use

Today's action is not a "significant energy action" as defined in Executive Order 13211, "Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use" (66 FR 28355, May 22, 2001) because it is not likely to have a significant adverse effect on the supply, distribution, or use of energy. The December 31, 2002 final rule improves the ability of sources to undertake pollution prevention or energy efficiency projects, switch to less polluting fuels or raw materials, maintain the reliability of production facilities, and effectively utilize and improve existing capacity. That rule also includes a number of provisions to streamline administrative and permitting processes so that facilities can quickly accommodate changes in supply and demand. It provides several alternatives that are specifically designed to reduce administrative burden for sources that use pollution prevention or energy efficient projects. Today's action merely clarifies two aspects of the December 31, 2002 final rule and thus is not likely to have a significant adverse effect on the supply, distribution, or use of energy.

I. National Technology Transfer and Advancement Act

Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (NTTAA), Public Law 104–113, 12(d) (15 U.S.C. 272 note) directs EPA to use voluntary consensus standards in its regulatory activities unless to do so would be inconsistent with applicable law or otherwise impractical.

Voluntary consensus standards are technical standards (for example, materials specifications, test methods, sampling procedures, and business practices) that are developed or adopted by voluntary consensus standards bodies. The NTTAA directs EPA to provide Congress, through OMB, explanations when the Agency decides not to use available and applicable voluntary consensus standards.

Today's action does not involve technical standards. Therefore, EPA did not consider the use of any voluntary consensus standards.

J. Congressional Review Act

The Congressional Review Act, § 5 U.S.C. 801, *et seq.*, as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. The EPA will submit a report containing the final rule and other required information to the United States Senate, the United States House of Representatives, and the Comptroller General of the United States prior to publication of the final rule in the **Federal Register**. A major rule cannot take effect until 60 days after it is published in the **Federal Register**. This action is not a "major rule" as defined by 5 U.S.C. § 804(2). The rule will be effective November 7, 2003.

V. Statutory Authority

The statutory authority for this action is provided by sections 101, 111, 114, 116, 301, and 307 of the CAA as amended (42 U.S.C. 7401, 7407, 7411, 7414, 7416, and 7601).

VI. Judicial Review

Under section 307(b)(1) of the Act, judicial review of the December 31, 2002 final rule is available only by the filing of a petition for review in the U.S. Court of Appeals for the District of Columbia Circuit by March 3, 2003. Any such judicial review is limited to only those objections that are raised with reasonable specificity in timely comments. Under section 307(b)(2) of the Act, the requirements that are the subject of the December 31, 2002 final rule may not be challenged later in civil or criminal proceedings brought by us to enforce these requirements.

List of Subjects in 40 CFR Parts 51 and 52

Environmental protection, Administrative practice and procedure, Air pollution control, Carbon monoxide, Hydrocarbons, Intergovernmental relations, Lead, Nitrogen oxides, Ozone, Particulate matter, Reporting and recordkeeping requirements, Sulfur oxides.

Dated: October 30, 2003.

Marianne Horinko,

Acting Administrator.

■ For the reasons set out in the preamble, title 40, chapter I of the Code of Federal Regulations is amended as follows:

PART 51—[AMENDED]

■ 1. The authority citation for part 51 continues to read as follows:

Authority: 23 U.S.C. 101; 42 U.S.C. 7401–7671q.

Subpart I—[Amended]

■ 2. Section 51.165 is amended:
■ a. By revising paragraph (a)(1)(vii)(B).
■ b. By adding paragraph (a)(1)(xxi).
■ c. By revising paragraph (f)(6).

The revisions read as follows:

§ 51.165 Permit requirements.

(a) * * *

(1) * * *

(vii) * * *

(B) An existing emissions unit is any emissions unit that does not meet the requirements in paragraph (a)(1)(vii)(A) of this section. A replacement unit, as defined in paragraph (a)(1)(xxi) of this section, is an existing emissions unit.

* * * * *

(xxi) *Replacement unit* means an emissions unit for which all the criteria listed in paragraphs (a)(1)(xxi)(A) through (D) of this section are met. No creditable emission reductions shall be generated from shutting down the existing emissions unit that is replaced.

(A) The emissions unit is a reconstructed unit within the meaning of § 60.15(b)(1) of this chapter, or the emissions unit completely takes the place of an existing emissions unit.

(B) The emissions unit is identical to or functionally equivalent to the replaced emissions unit.

(C) The replacement does not alter the basic design parameters (as discussed in paragraph (h)(2) of this section) of the process unit.

(D) The replaced emissions unit is permanently removed from the major stationary source, otherwise permanently disabled, or permanently barred from operation by a permit that is enforceable as a practical matter. If the replaced emissions unit is brought back into operation, it shall constitute a new emissions unit.

* * * * *

(f) * * *

(6) *Setting the 10-year actuals PAL level.* (i) Except as provided in paragraph (f)(6)(ii) of this section, the plan shall provide that the actuals PAL level for a major stationary source shall be established as the sum of the baseline actual emissions (as defined in paragraph (a)(1)(xxxv) of this section) of the PAL pollutant for each emissions unit at the source; plus an amount equal to the applicable significant level for the PAL pollutant under paragraph (a)(1)(x) of this section or under the Act, whichever is lower. When establishing the actuals PAL level, for a PAL pollutant, only one consecutive 24-month period must be used to determine the baseline actual emissions for all existing emissions units. However, a different consecutive 24-month period may be used for each different PAL pollutant. Emissions associated with units that were permanently shut down after this 24-month period must be subtracted from the PAL level. The reviewing authority shall specify a reduced PAL level(s) (in tons/yr) in the PAL permit to become effective on the future compliance date(s) of any applicable Federal or State regulatory requirement(s) that the reviewing authority is aware of prior to issuance of the PAL permit. For instance, if the source owner or operator will be required to reduce emissions from industrial boilers in half from baseline emissions of 60 ppm NO_X to a new rule limit of 30 ppm, then the permit shall contain a future effective PAL level that is equal to the current PAL level reduced by half of the original baseline emissions of such unit(s).

(ii) For newly constructed units (which do not include modifications to existing units) on which actual construction began after the 24-month period, in lieu of adding the baseline actual emissions as specified in paragraph (f)(6)(i) of this section, the emissions must be added to the PAL level in an amount equal to the potential to emit of the units.

* * * * *

■ 3. Section 51.166 is amended:

■ a. By revising paragraph (b)(7)(ii).

■ b. By adding paragraph (b)(32).

■ c. By revising paragraph (w)(6).

The revisions read as follows:

§ 51.166 Prevention of significant deterioration of air quality.

(b) * * *

(7) * * *

(ii) An existing emissions unit is any emissions unit that does not meet the requirements in paragraph (b)(7)(i) of this section. A replacement unit, as defined in paragraph (b)(32) of this section, is an existing emissions unit.

* * * * *

(32) *Replacement unit* means an emissions unit for which all the criteria listed in paragraphs (b)(32)(i) through (iv) of this section are met. No creditable emission reductions shall be generated from shutting down the existing emissions unit that is replaced.

(i) The emissions unit is a reconstructed unit within the meaning of § 60.15(b)(1) of this chapter, or the emissions unit completely takes the place of an existing emissions unit.

(ii) The emissions unit is identical to or functionally equivalent to the replaced emissions unit.

(iii) The replacement does not change the basic design parameter(s) (as discussed in paragraph (y)(2) of this section) of the process unit.

(iv) The replaced emissions unit is permanently removed from the major stationary source, otherwise permanently disabled, or permanently barred from operation by a permit that is enforceable as a practical matter. If the replaced emissions unit is brought back into operation, it shall constitute a new emissions unit.

* * * * *

(w) * * *

(6) *Setting the 10-year actuals PAL level.* (i) Except as provided in paragraph (w)(6)(ii) of this section, the plan shall provide that the actuals PAL level for a major stationary source shall be established as the sum of the baseline actual emissions (as defined in paragraph (b)(47) of this section) of the PAL pollutant for each emissions unit at the source; plus an amount equal to the applicable significant level for the PAL pollutant under paragraph (b)(23) of this section or under the Act, whichever is lower. When establishing the actuals PAL level, for a PAL pollutant, only one consecutive 24-month period must be used to determine the baseline actual emissions for all existing emissions units. However, a different consecutive 24-month period may be used for each different PAL pollutant. Emissions associated with units that were permanently shut down after this 24-month period must be subtracted from the PAL level. The reviewing authority shall specify a reduced PAL level(s) (in tons/yr) in the PAL permit to become effective on the future compliance date(s) of any applicable Federal or State regulatory requirement(s) that the reviewing authority is aware of prior to issuance of the PAL permit. For instance, if the source owner or operator will be required to reduce emissions from industrial boilers in half from baseline emissions of 60 ppm NO_X to a new rule limit of 30 ppm, then the permit shall contain a future effective PAL level that is equal to the current PAL level reduced by half of the original baseline emissions of such unit(s).

(ii) For newly constructed units (which do not include modifications to existing units) on which actual construction began after the 24-month period, in lieu of adding the baseline actual emissions as specified in paragraph (w)(6)(i) of this section, the emissions must be added to the PAL level in an amount equal to the potential to emit of the units.

* * * * *

PART 52—[AMENDED]

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

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

Subpart A—[Amended]

■ 2. Section 52.21 is amended:

■ a. By revising paragraph (b)(7)(ii).

■ b. By adding paragraph (b)(33).

■ c. By revising paragraph (aa)(6).

The revisions read as follows:

§ 52.21 Prevention of significant deterioration of air quality.

(b) * * *

(7) * * *

(ii) An existing emissions unit is any emissions unit that does not meet the requirements in paragraph (b)(7)(i) of this section. A replacement unit, as defined in paragraph (b)(33) of this section, is an existing emissions unit.

* * * * *

(33) *Replacement unit* means an emissions unit for which all the criteria listed in paragraphs (b)(33)(i) through (iv) of this section are met. No creditable emission reductions shall be generated from shutting down the existing emissions unit that is replaced.

(i) The emissions unit is a reconstructed unit within the meaning of § 60.15(b)(1) of this chapter, or the emissions unit completely takes the place of an existing emissions unit.

(ii) The emissions unit is identical to or functionally equivalent to the replaced emissions unit.

(iii) The replacement does not alter the basic design parameters (as discussed in paragraph (cc)(2) of this section) of the process unit.

(iv) The replaced emissions unit is permanently removed from the major stationary source, otherwise permanently disabled, or permanently barred from operation by a permit that is enforceable as a practical matter. If the replaced emissions unit is brought back into operation, it shall constitute a new emissions unit.

* * * * *

(aa) * * *

(6) *Setting the 10-year actuals PAL level.* (i) Except as provided in paragraph (aa)(6)(ii) of this section, the plan shall provide that the actuals PAL level for a major stationary source shall be established as the sum of the baseline actual emissions (as defined in paragraph (b)(48) of this section) of the PAL pollutant for each emissions unit at the source; plus an amount equal to the applicable significant level for the PAL pollutant under paragraph (b)(23) of this section or under the Act, whichever is lower. When establishing the actuals PAL level, for a PAL pollutant, only one consecutive 24-month period must be used to determine the baseline actual emissions for all existing emissions units. However, a different consecutive 24-month period may be used for each different PAL pollutant. Emissions associated with units that were permanently shut down after this 24-month period must be subtracted from the PAL level. The reviewing authority shall specify a reduced PAL level(s) (in tons/yr) in the PAL permit to become effective on the future compliance date(s) of any applicable Federal or State regulatory requirement(s) that the reviewing authority is aware of prior to issuance of the PAL permit. For instance, if the source owner or operator will be required to reduce emissions from industrial boilers in half from baseline emissions of 60 ppm NO_X to a new rule limit of 30 ppm, then the permit shall contain a future effective PAL level that is equal to the current PAL level reduced by half of the original baseline emissions of such unit(s).

(ii) For newly constructed units (which do not include modifications to existing units) on which actual construction began after the 24-month period, in lieu of adding the baseline actual emissions as specified in paragraph (aa)(6)(i) of this section, the emissions must be added to the PAL level in an amount equal to the potential to emit of the units.

[FR Doc. 03–28104 Filed 11–6–03; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 64

[CC Docket No. 98–67, DA 03–3109]

Telecommunication Relay Services and Speech-to-Speech Services for Individuals With Hearing and Speech Disabilities

AGENCY: Federal Communications Commission.

ACTION: Final rule; petition for reconsideration, comments requested.

SUMMARY: This document seeks public comment on petitions filed for reconsideration of certain rules adopted by the Commission in the *Second Improved TRS Order,* published at 68 FR 50973 (August 25, 2003). The petitions request that the Commission waive and reconsider its rules regarding the emergency call handling of TRS calls, and that the Commission waive its rules regarding three-way call processing at telecommunications relay centers.

DATES: Interested parties may file comments in this proceeding on or before October 20, 2003. Reply comments may be filed on or before October 30, 2003. Parties that may have already submitted comments in this proceeding need not resubmit those comments unless they choose to update them.

ADDRESSES: Federal Communications Commission, 445 12th Street, SW., Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Dana Jackson, Consumer & Governmental Affairs Bureau, Disability Rights Office at (202) 418–2247 (voice), (202) 418–7898 (TTY), or e-mail at *Dana.Jackson@fcc.gov.*

SUPPLEMENTARY INFORMATION: When filing comments, please reference CC Docket No. 98–67. Comments may be filed using the Commission's Electronic Comment Filing System (ECFS) or by filing paper copies. *See* Electronic Filing of Documents in Rulemaking Proceedings, 63 FR 24121 (May 1, 1998). Comments filed through the ECFS can be sent as an electronic file via the Internet to *http://www.fcc.gov/e-file/ecfs.html.* Generally, only one copy of an electronic submission must be filed. If multiple docket or rulemaking numbers appear in the caption of this proceeding, however, commenters must transmit one electronic copy of the comments to each docket or rulemaking number referenced in the caption. In completing the transmittal screen, commenters should include their full name, Postal Service mailing address, and the applicable docket or rulemaking number. Parties may also submit an electronic comment by Internet e-mail. To get filing instructions for e-mail comments, commenters should send an e-mail to *ecfs@fcc.gov,* and should include the following words in the body of the message, "get form <your e-mail address>." A sample form and directions will be sent in reply.

Parties who choose to file by paper must file an original and four copies of each filing. If more than one docket or rulemaking number appears in the caption of this proceeding, commenters must submit two additional copies for each additional docket or rulemaking number. Filings can be sent by hand or messenger delivery, by commercial overnight courier, or by first-class or overnight U.S. Postal Services mail (although we continue to experience delays in receiving U.S. Postal Service mail). The Commission's contractor, Natek, Inc., will receive hand-delivered or messenger-delivered paper filings for the Commission's Secretary at 236 Massachusetts Avenue, NE., Suite 110, Washington, DC 20002. The filing hours at this location are 8 a.m. to 7 p.m. All hand deliveries must be held together with rubber bands or fasteners. Any envelopes must be disposed of before entering the building. Commercial overnight mail (other than U.S. Postal Service Express Mail and Priority Mail) must be sent to 9300 East Hampton

Drive, Capitol Heights, MD 20743. U.S. Postal Service first-class mail, Express Mail, and Priority Mail should be addressed to 445 12th Street, SW., Washington, DC 20554. All filings must be addressed to the Commission's Secretary, Marlene H. Dortch, Office of the Secretary, Federal Communications Commission, 445 12th Street, SW., Room TW–B204, Washington, DC 20554.

Parties who choose to file by paper should also submit their comments on diskette. These diskettes should be submitted, along with three paper copies, to: Dana Jackson, Consumer & Governmental Affairs Bureau, Disability Rights Office, 445 12th Street, SW., Room 6–C410, Washington DC 20554. Such a submission should be on a 3.5 inch diskette formatted in an IBM compatible format using Word 97 or compatible software. The diskette should be accompanied by a cover letter and should be submitted in "read only" mode. The diskette should be clearly labeled with the commenter's name, proceeding (including the lead docket number in this case, CC Docket No. 98–67), type of pleading (comment or reply comment), date of submission, and the name of the electronic file on the diskette. The label should also include the following phrase "Disk Copy—Not an Original." Each diskette should contain only one party's pleadings, preferably in a single electronic file. In addition, commenters must send diskette copies to the Commission's copy contractor, Qualex International, Portals II, 445 12th Street, SW., Room CY–B402, Washington, DC 20554.

Pursuant to § 1.1206 of the Commission's rules, 47 CFR 1.1206, this proceeding will be conducted as a permit-but-disclose proceeding in which *ex parte* communications are subject to disclosure.

Copies of any subsequently filed documents in this matter will be available for public inspection and copying during regular business hours at the FCC Reference Information Center, Portals II, 445 12th Street, SW, Room CY–A257, Washington, DC 20554. The complete text of this *Public Notice* may be purchased from the Commission's duplicating contractor, Qualex International, Portals II, 445 12th Street, SW., Room CY–B402, Washington, DC 20554, telephone (202) 863–2893, facsimile (202) 863–2898, or via e-mail *qualexint@aol.com*.

To request materials in accessible formats for people with disabilities (Braille, large print, electronic files, audio format), send an e-mail to *fcc504@fcc.gov* or call the Consumer & Governmental Affairs Bureau at (202) 418–0531 (voice), (202) 418–7365 (TTY). This Public Notice can also be downloaded in Text and ASCII formats at: *http://www.fcc.gov/cgb/dro*.

Synopsis

On September 23, 2003, AT&T Corp. ("AT&T") filed a petition for limited reconsideration to the *Second Improved TRS Order* published at 68 FR 50973 (August 25, 2003). AT&T requests that the Commission grant waivers to certain requirements adopted by the Commission in the *Second Improved TRS Order* concerning emergency call handling and three-way calling. *See* AT&T, *AT&T Petition for Limited Reconsideration and for Waiver*, CC Docket No. 98–67, CG Docket 03–123.

On September 29, 2003, Verizon filed a petition for reconsideration to the *Second Improved TRS Order*. Verizon also requests that the Commission reconsider the requirements regarding the handling of emergency calls at telecommunications relay centers. *See* Verizon, *Petition for Reconsideration of Verizon*, CC Docket No. 98–67, CG Docket No. 03–123.

Federal Communications Commission.

Margaret M. Egler,

Deputy Chief, Consumer & Governmental Affairs Bureau.

[FR Doc. 03–28016 Filed 11–6–03; 8:45 am]

BILLING CODE 6712–01–P

DEPARTMENT OF TRANSPORTATION

Federal Motor Carrier Safety Administration

49 CFR Part 383

[Docket No. FMCSA–2001–11117]

RIN 2126–AA70

Limitations on the Issuance of Commercial Driver's Licenses With a Hazardous Materials Endorsement

AGENCY: Federal Motor Carrier Safety Administration (FMCSA), DOT.

ACTION: Interim final rule; delay of compliance date; request for comments.

SUMMARY: The FMCSA amends the Federal Motor Carrier Safety Regulations (FMCSRs) prohibiting States from issuing, renewing, transferring or upgrading a commercial driver's license (CDL) with a hazardous materials (hazmat) endorsement unless the Transportation Security Administration (TSA) has first conducted a background records check of the applicant and determined the applicant does not pose a security risk warranting denial of the hazardous materials endorsement. The compliance date provisions being revised require States to collect fingerprints from individuals applying for, renewing, upgrading or transferring a hazmat endorsement for a CDL beginning November 3, 2003. FMCSA and TSA are changing that date to April 1, 2004, and TSA may postpone that date, in individual cases, to not later than December 1, 2004.

DATES: *Effective:* This rule is effective on November 3, 2003. *Compliance:* State compliance with this rule is required beginning April 1, 2004.

Comments: Comments must be received on or before January 6, 2004.

ADDRESSES: You may submit comments identified by DOT DMS Docket Number FMCSA—2001–11117 by any of the following methods:

- *Web site: http://dms.dot.gov.* Follow the instructions for submitting comments on the DOT electronic docket site.
- *Fax:* 1–202–493–2251.
- *Mail:* Docket Management Facility; U.S. Department of Transportation, 400 Seventh Street, SW., Nassif Building, Room PL–401, Washington, DC 20590–0001.
- *Hand delivery:* Room PL–401 on the plaza level of the Nassif Building, 400 Seventh Street, SW., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal Holidays.
- *Federal eRulemaking Portal:* Go to *http://www.regulations.gov*. Follow the online instructions for submitting comments.

Instructions: All submissions must include the agency name and docket number or Regulatory Identification Number (RIN) for this rulemaking. Note that all comments received will be posted without change to *http://dms.dot.gov*, including any personal information provided. Please see the Privacy Act heading for further information.

Docket: For access to the docket to read background documents or comments received, go to *http://dms.dot.gov* at any time or to Room PL–401 on the plaza level of the Nassif Building, 400 Seventh Street, SW., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal Holidays.

Privacy Act: Anyone is able to search the electronic form of all comments received into any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review DOT's complete Privacy Act

Statement in the **Federal Register** published on April 11, 2000 (Volume 65, Number 70; Pages 19477) or you may visit *http://dms.dot.gov.*

Comments received after the comment closing date will be included in the docket and we will consider late comments to the extent practicable. The FMCSA may, however, issue a final rule at any time after the close of the comment period.

FOR FURTHER INFORMATION CONTACT: Mr. Robert Redmond, Office of Safety Programs, (202) 366–9579, FMCSA, 400 7th Street, SW., Washington, DC 20590. Office hours are from 8:30 a.m. to 5 p.m., e.t., Monday through Friday, except Federal holidays.

SUPPLEMENTARY INFORMATION:

Comments Invited

This IFR is being adopted without prior notice and public comment. However, interested parties are invited to participate in this rulemaking by submitting written data, views, or arguments. All comments received, as well as a report summarizing each substantive public contact with FMCSA personnel on this rulemaking, will be filed in the public docket. The docket is available for public inspection before and after the comment closing date.

See **ADDRESSES** above for information on how to submit comments.

Small Entity Inquiries

The Small Business Regulatory Enforcement Fairness Act (SBREFA) of 1996 requires FMCSA to comply with small entity requests for information or advice about compliance with statutes and regulations within FMCSA's jurisdiction. Any small entity that has a question regarding this document may contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section for information or advice. You can get further information regarding SBREFA on the Small Business Administration's web page at *http://www.sba.gov/advo/laws/law_lib.html.*

Background

On September 11, 2001, several terrorist attacks were made against the United States. Those attacks resulted in catastrophic human casualties and property damage. In response to those attacks, the Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism (USA PATRIOT) Act was enacted on October 26, 2001.[1] Section 1012 of the USA PATRIOT Act amended 49 U.S.C. Chapter 51 by adding a new section 5103a titled "Limitation on issuance of hazmat licenses." Section 5103a(a)(1) provides:

> A State may not issue to any individual a license to operate a motor vehicle transporting in commerce a hazardous material unless the Secretary of Transportation has first determined, upon receipt of a notification under subsection (c)(1)(B), that the individual does not pose a security risk warranting denial of the license.[2]

Section 5103a(a)(2) subjects license renewals to the same requirements.

Section 5103a(c) requires the Attorney General, upon the request of a State in connection with issuance of a hazardous materials endorsement, to carry out a background records check of the individual applying for the endorsement and, upon completing the check, to notify the Secretary of the results. The Secretary then determines whether the individual poses a security risk warranting denial of the endorsement. The term "Secretary" originally referred to the Department of Transportation, but these functions have been transferred to the Secretary of the Department of Homeland Security (DHS), and subsequently delegated by the Secretary to the TSA Administrator. The background records check must consist of: (1) A check of the relevant criminal history databases; (2) in the case of an alien, a check of the relevant databases to determine the status of the alien under U.S. immigration laws; and (3) as appropriate, a check of the relevant international databases through Interpol-U.S. National Central Bureau or other appropriate means.

Safe Explosives Act

Congress enacted the Safe Explosives Act (SEA) on November 25, 2002.[3] Sections 1121–1123 of the SEA amended section 842(i) of Title 18 of the U.S. Code by adding several categories to the list of persons who may not lawfully "ship or transport any explosive in or affecting interstate or foreign commerce" or "receive or possess any explosive which has been shipped or transported in or affecting interstate or foreign commerce." Prior to the amendment, 18 U.S.C. 842(i) prohibited the transportation of explosives by any person under indictment for or convicted of a felony, a fugitive from justice, an unlawful user or addict of any controlled substance, and any person who had been adjudicated as a mental defective or committed to a mental institution. The amendment added three new categories to the list of prohibited persons: aliens (with certain limited exceptions), persons dishonorably discharged from the armed forces, and former U.S. citizens who have renounced their citizenship. Individuals who violate 18 U.S.C. 842(i) are subject to criminal prosecution.[4] These incidents are investigated by the Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF) of the Department of Justice and referred, as appropriate, to the United States Attorneys.

However, 18 U.S.C. 845(a)(1) provides an exception to section 842(i) for "any aspect of the transportation of explosive materials via railroad, water, highway, or air which are regulated by the United States Department of Transportation and agencies thereof, and which pertains to safety." Under this exception, if DOT regulations address the transportation security issues of persons engaged in a particular aspect of the safe transportation of explosive materials, then those persons are not subject to prosecution under 18 U.S.C. 842(i) while they are engaged in the transportation of explosives in commerce.

The PATRIOT Act Rule

To comply with the mandates of the USA PATRIOT Act, and to trigger the exception in 18 U.S.C. 845(a)(1) for the transportation of explosives, TSA and FMCSA issued interim final rules on May 5, 2003.[5] The TSA rule established security threat assessment standards for determining whether an individual poses a security threat warranting denial of a hazmat endorsement for a CDL. Under the rules, TSA determines that an individual poses a security threat if he or she: (1) Is an alien (unless he or she is a lawful permanent resident) or a U.S. citizen who has renounced his or her U.S. citizenship; (2) is wanted or under indictment for certain felonies; (3) has a conviction in military or civilian court for certain felonies; (4) has been adjudicated as a mental defective or involuntarily committed to a mental institution; or (5) is considered to pose a security threat based on a review of pertinent databases.

The rules also established conditions under which an individual who has been determined to be a security threat could appeal the determination, and procedures TSA follows when

[1] Pub. L. 107–56, October 25, 2001, 115 Stat. 272.

[2] The Secretary of Transportation delegated the authority to carry out the provisions of this section to the Under Secretary of Transportation for Security/Administrator. 68 FR 10988, March 7, 2003.

[3] Pub. L. 107–296, November 25, 2002, 116 Stat. 2280.

[4] The penalty for violation of 18 U.S.C. 842(i) is up to ten years imprisonment and a fine of up to $250,000.

[5] 68 FR 23844 and 68 FR 23851.

considering an appeal. In addition, the rules provide a waiver process for those individuals who otherwise could not obtain a hazmat endorsement because they had a disqualifying felony, or were adjudicated as a mental defective or involuntarily committed to a mental institution. Finally, the rules prohibit an individual from holding, and a State from issuing, renewing, or transferring, a hazmat endorsement for a CDL unless the individual met the TSA security threat assessment standards.

The FMCSA rule places States on notice that failure to comply with those portions of the TSA rule applicable to States by November 3, 2003, will result in the withholding by DOT of certain Federal-aid highway funds.

The TSA rule requires States to begin collecting fingerprints from individuals applying for, renewing, or transferring a hazmat endorsement for a CDL on November 3, 2003, and to submit those fingerprints to TSA so that TSA can conduct fingerprint-based criminal history records checks (CHRCs).

Summary of Today's IFR

Elsewhere in today's issue of the **Federal Register**, TSA is postponing the date on which States are required to collect fingerprints from individuals who are applying for, renewing, upgrading, or transferring a hazmat endorsement for a CDL from November 3, 2003, to April 1, 2004. However, if a State requests a postponement of that date and provides a written justification, TSA may grant an extension, but in no case beyond December 1, 2004. FMCSA is therefore amending its rule to incorporate the same standard: States must comply with the TSA rule requiring the collection of fingerprints by April 1, 2004, unless TSA authorizes a later date under 49 CFR 1572.5(c)(4). After this date, whatever it may be, States that fail to comply with the TSA rule risk the loss of Federal-aid highway funds. FMCSA and TSA are making this change for several reasons.

TSA received comments from departments of motor vehicles and other agencies in over 23 States stating they have neither the infrastructure nor the funding to comply with the requirements of the rule. The main costs identified by States included the costs of purchasing fingerprinting equipment, and hiring and training personnel to operate the fingerprinting equipment. Most of the States requested Federal funding for these costs. The TSA rule discusses the cost issue in more detail.

Many States also commented that compliance with the Patriot Act rule, specifically the fingerprinting requirements, would require legislative changes. In many States, the State legislatures meet only once a year with a few State legislatures meeting biennially. These States requested additional time to make necessary legislative changes.

For these reasons, FMCSA and TSA are moving the date that States must begin collecting fingerprints to April 1, 2004, with the possibility of postponement to a later date.

FMCSA is amending 49 CFR 383.141 paragraphs (a) and (c) to move the date on which States are required to collect fingerprints from individuals who are applying for, renewing, or transferring a hazmat endorsement for a CDL from November 3, 2003, to April 1, 2004, though TSA may extend the compliance date to not later than December 1, 2004. Section 383.141(c) requires States to notify drivers at least 180 days before the expiration date of a hazardous materials endorsement. Because FMCSA's May 5 IFR allowed only slightly more than 180 days before States were required to begin collecting fingerprints, part of which the States would need to establish notification procedures, § 383.141(c) provides that "Before November 3, 2003, a State must give the holder of a hazardous materials endorsement as much advance notice as practicable" [68 FR at 23850]. In view of today's postponement of the States' compliance date, which will allow them to give drivers a full 180 days of advance notice, the sentence quoted above has been deleted.

Rulemaking Analyses and Notices

Justification for Immediate Adoption

FMCSA is issuing this IFR without prior notice and opportunity to comment pursuant to its authority under section 4(a) of the Administrative Procedure Act (5 U.S.C. 553(b)). This provision allows the agency to issue a final rule without notice and opportunity to comment when the agency for good cause finds that notice and comment procedures are "impracticable, unnecessary or contrary to the public interest." If the agency fails to immediately adopt this interim final rule, States could lose certain Federal-aid funding due to the short implementation deadline for TSA requirements announced in the May 2003 interim final rule (68 FR 23852) and an inability to meet those requirements due to lack of infrastructure and funding through no fault of their own and circumstances beyond their control.

This IFR changes the date on which States are required to collect fingerprints from individuals who are applying for, renewing, or transferring a hazmat endorsement for a CDL. Because this IFR does not impose any new burdens on stakeholders, FMCSA believes that notice and comment procedures are "unnecessary." Due to the short deadline, the agency finds good cause under 5 U.S.C. 553(d)(3) to make this rule effective upon publication.

Regulatory Evaluation

Executive Order 12866, "Regulatory Planning and Review" (58 FR 51735, October 4, 1993), provides for making determinations whether a regulatory action is "significant" and therefore subject to Office of Management and Budget (OMB) review and to the requirements of the Executive Order. FMCSA has determined that this is a significant regulatory action within the meaning of Executive Order 12866 and under the Department's regulatory policies and procedures because of substantial public interest. This rule does not impose any costs on any public, private, or government sector, therefore further economic analysis is unnecessary.

Regulatory Flexibility Determination

The Regulatory Flexibility Act of 1980 (RFA), as amended, was enacted by Congress to ensure that small entities (small businesses, small not-for-profit organizations, and small governmental jurisdictions) are not unnecessarily or disproportionately burdened by Federal regulations. The RFA requires agencies to review rules to determine if they have "a significant economic impact on a substantial number of small entities." I certify that the IFR will not have a significant economic impact on a substantial number of small entities. As noted above, this IFR will not impose any costs on any public, private, or government sector.

Paperwork Reduction Act

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501–3520), a Federal agency must obtain approval from the Office of Management and Budget (OMB) for each collection of information it conducts, sponsors, or requires through regulations. This IFR does not contain any information collection requirements.

Executive Order 13132 (Federalism)

Executive Order 13132 requires FMCSA to develop an accountable process to ensure "meaningful and timely input by State and local officials in the development of regulatory policies that have federalism implications." "Policies that have

federalism implications" is defined in the Executive Order to include regulations that have "substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government." Under the Executive Order, FMCSA may construe a Federal statute to preempt State law only where, among other things, the exercise of State authority conflicts with the exercise of Federal authority under the federal statute.

Although this IFR has direct effects on the States, they are not substantial because the IFR will continue the status quo while allowing States more time to comply with the May 5, 2003, interim final rules. Thus, FMCSA has determined that this IFR does not have sufficient Federalism implications to warrant the preparation of a Federal Assessment.

As discussed in detail in the May 5 IFR [see 68 FR at 23847–23848], the provisions of 49 U.S.C. 31314, which require DOT to withhold certain Federal-aid highway funds from States that fail to comply substantially with the requirements for State participation in the CDL program, apply also to State compliance with those portions of the Transportation Security Administration (TSA) rule implementing Sec. 1012 that apply to States. In addition, 49 U.S.C. 31312 authorizes DOT to prohibit States from issuing CDLs if the Secretary determines "that a State is in substantial noncompliance" with 49 U.S.C. chapter 313. These penalties are available for DOT to use when and if appropriate to encourage State compliance with TSA's Sec. 1012 rule.

Trade Impact Assessment

The Trade Agreement Act of 1979 prohibits Federal agencies from engaging in any standards-related activities that create unnecessary obstacles to the foreign commerce of the United States. Legitimate domestic objectives, such as safety and security, are not considered unnecessary obstacles. The statute also requires consideration of international standards and, where appropriate, that they be the basis for U.S. standards. FMCSA has assessed the potential effect of this IFR and has determined that it will not impose any costs on domestic or international entities and thus would have a neutral trade impact.

Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires Federal agencies to prepare a written assessment of the costs, benefits, and other effects of proposed or final rules that include a Federal mandate likely to result in the expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of more than $100 million in any one year (adjusted for inflation with base year of 1995). Before promulgating a rule for which a written statement is needed, section 205 of the UMRA generally requires FMCSA to identify and consider a reasonable number of regulatory alternatives and adopt the least costly, most cost-effective, or least burdensome alternative that achieves the objective of the rule. The provisions of section 205 do not apply when they are inconsistent with applicable law. Moreover, section 205 allows FMCSA to adopt an alternative other than the least costly, most cost-effective, or least burdensome alternative if the agency publishes with the final rule an explanation why that alternative was not adopted.

This IFR will not result in the expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of more than $100 million annually. Thus, FMCSA has not prepared a written assessment under the UMRA.

National Environmental Policy Act

FMCSA has analyzed this rulemaking action for the purposes of the National Environmental Policy Act. The agency has determined that implementation of this IFR will not have any significant impact on the quality of the human environment.

Energy Impact

FMCSA has assessed the energy impact of this rule in accordance with the Energy Policy and Conservation Act (EPCA), Public Law 94–163, as amended (42 U.S.C. 6362). FMCSA has determined that this IFR is not a major regulatory action under the provisions of the EPCA.

List of Subjects in 49 CFR Part 383

Administrative practice and procedure, Commercial driver's license, Commercial motor vehicles, Highway safety, Motor carriers.

■ For the reasons set forth in the preamble, the FMCSA amends title 49, Code of Federal Regulations, Chapter III, as follows:

PART 383—COMMERCIAL DRIVER'S LICENSE STANDARDS; REQUIREMENTS AND PENALTIES [AMENDED]

■ 1. The authority citation for part 383 continues to read as follows:

Authority: 49 U.S.C. 521, 31136, 31301 *et seq.*, 31502; Sec. 214 of Pub. L. 106–159, 113 Stat. 1766; Sec. 1012(b) of Pub. L. 107–56, 115 Stat. 397; and 49 CFR 1.73.

■ 2. Revise § 383.141 paragraphs (a) and (c) to read as follows:

§ 383.141 General.

(a) *Applicability date.* Beginning on April 1, 2004, this section applies to State agencies responsible for issuing hazardous materials endorsements for a CDL, and applicants for such endorsements. Individual State licensing agencies, pursuant to 49 CFR 1572.5(c)(4), may request an extension of the compliance date.

* * * * *

(c) *Individual notification.* At least 180 days before the expiration date of the CDL or hazardous materials endorsement, a State must notify the holder of a hazardous materials endorsement that the individual must pass a Transportation Security Administration security screening process as part of any application for renewal of the hazardous materials endorsement. The notice must advise a driver that, in order to expedite the security screening process, he or she should file a renewal application as soon as possible, but not later than 90 days before the date of expiration of the endorsement. An individual who does not successfully complete the Transportation Security Administration security screening process referenced in paragraph (b) of this section may not be issued a hazardous materials endorsement.

* * * * *

Issued on: November 5, 2003.

Annette M. Sandberg,

Administrator.

[FR Doc. 03–28175 Filed 11–5–03; 2:44 pm]

BILLING CODE 4910–EX–P

DEPARTMENT OF HOMELAND SECURITY

Transportation Security Administration

49 CFR Part 1572

[Docket No. TSA–2003–14610; Amendment No. 1572–2]

RIN 1652–AA17

Security Threat Assessment for Individuals Applying for a Hazardous Materials Endorsement for a Commercial Drivers License; Amended Interim Final Rule

AGENCY: Transportation Security Administration (TSA), Department of Homeland Security (DHS).

ACTION: Interim final rule; amendment.

SUMMARY: The Transportation Security Administration (TSA) is amending its Interim Final Rule (IFR) that establishes standards for security threat assessments of individuals applying for, renewing, or transferring a hazardous materials endorsement (HME) for a commercial drivers license (CDL). TSA is adding a definition and moving the date on which fingerprint-based criminal history record checks must begin. TSA will not authorize a State to issue HME unless the State is collecting the biographical and criminal history information required with fingerprints and submitting fingerprints by April 1, 2004. If a State is unable to collect this information by April 1, 2004, the State must submit a request for extension to TSA on or before April 1, 2004. TSA may approve the extension request, but will not extend the due date beyond December 1, 2004. If the State cannot begin submitting fingerprints of HME applicants as of April 1, 2004, the State must submit a plan to TSA outlining the fingerprint process that it will deploy and a timeline to ensure that the State will be submitting fingerprints by December 1, 2004. The plan must be submitted by April 1, 2004, and be consistent with Federal Bureau of Investigation (FBI) fingerprint collection and submission procedures. TSA is not changing the provision in the IFR that requires individuals with a HME to surrender their endorsement if they do not meet the threat assessment standards in the rule.

DATES: *Effective Date:* This interim final rule is effective on November 3, 2003.

FOR FURTHER INFORMATION CONTACT: For technical questions: John Berry, Credentialing Program Office, Transportation Security Administration Headquarters, East Building, Floor 8, 601 12th Street, telephone: 571–227–1757, e-mail: *John.Berry1@dhs.gov*. Steve Sprague, Maritime and Land, Transportation Security Administration, West Building, Floor 9, 701 12th Street, telephone: (571) 227–1468, *Steve.Sprague@dhs.gov*.

For legal questions: Dion Casey, Office of Chief Counsel, Transportation Security Administration Headquarters, West Building, Floor 8, TSA–2, 601 South 12th Street; Arlington, VA 22202–4220 telephone: 571–227–2663; e-mail: *Dion.Casey@dhs.gov*; or Christine Beyer, same office address as above; telephone: 571–227–2657; e-mail: *Christine.Beyer@dhs.gov*.

SUPPLEMENTARY INFORMATION:

Comments

TSA is not requesting comments to this amended interim final rule. Instead, TSA will publish a notice of proposed rulemaking shortly to address the criminal history background check process for HME applicants, and will solicit comments at that time. With publication of the NPRM, TSA will open a new docket and request comments on the security threat assessment process for HME applicants in its entirety.

Availability of Rulemaking Document

You can get an electronic copy of this interim final rule (IFR) using the Internet by:

(1) Searching the Department of Transportation's electronic Docket Management System (DMS) Web page (*http://dms.dot.gov/search*);

(2) Accessing the Government Printing Office's Web page at *http://www.access.gpo.gov/su_docs/aces/aces140.html*; or

(3) Visiting the TSA's Laws and Regulations Web page at *http://www.tsa.gov/laws_regs/gov_index.shtm*.

In addition, copies are available by writing or calling the individuals in the **FOR FURTHER INFORMATION CONTACT** section. Please be sure to identify the docket number when making requests.

Small Entity Inquiries

The Small Business Regulatory Enforcement Fairness Act (SBREFA) of 1996 requires TSA to comply with small entity requests for information or advice about compliance with statutes and regulations within TSA's jurisdiction. Any small entity that has a question regarding this document may contact the persons listed in the **FOR FURTHER INFORMATION CONTACT** section for information or advice. You can get further information regarding SBREFA on the Small Business Administration's Web page at *http://www.sba.gov/advo/laws/law_lib.html*.

Background

On May 5, 2003, TSA published an IFR that requires a security threat assessment of commercial drivers who are authorized to transport hazardous materials.[1] The IFR implements several statutory mandates, discussed below, including criminal history record checks, checks against international databases, and appeal and waiver procedures. (Although the statute does not clearly state that the criminal history background check must be based on fingerprinting, the criminal history databases cannot be accessed without submitting fingerprints, when the check is done for a non-criminal justice purpose as is the case here.) In the IFR, TSA also stated that it would provide guidance on the form and manner fingerprints would be collected and adjudicated.

TSA requested and received comments from the States, labor organizations, and trucking industry associations. In addition, TSA held working group sessions with the States to discuss potential fingerprinting systems that would achieve the statutory requirements, but would not adversely impact the States.

Based on the comments received and our working sessions with the States, it appears that the States are in the best position to develop a plan to ensure that HME holders will be fingerprinted. TSA, however, is best situated to examine whether an individual poses a security threat under the other provisions of the rule, such as alien status, and terrorist connections. Under this scheme, TSA would continue to make the final determination as to whether an individual poses a security threat, combining the criminal history information the State develops with the terrorist-related background information, including alien status and terrorist-related databases, that TSA develops. In addition, TSA would continue to administer appeals of the terrorist-related background information for individuals who believe the records on which TSA's determination is made are incorrect or involve mistaken identity. Finally, TSA would administer the waiver program set forth in the IFR for all HME applicants. Shortly after publication of this amended IFR, TSA is issuing a separate notice of proposed rulemaking (NPRM) to explain and solicit comments on the revised process.

USA PATRIOT Act

The Uniting and Strengthening America by Providing Appropriate Tools Required To Intercept and Obstruct Terrorism (USA PATRIOT) Act was enacted on October 25, 2001.[2] Section 1012 of the USA PATRIOT Act amended 49 U.S.C. Chapter 51 by adding a new section 5103a titled "Limitation on issuance of hazmat licenses." Section 5103a(a)(1) provides:

> A State may not issue to any individual a license to operate a motor vehicle transporting in commerce a hazardous material unless the Secretary of Transportation has first determined, upon receipt of a notification under subsection (c)(1)(B), that the individual does not pose a

[1] 68 FR 23852 (May 5, 2003).

[2] Pub. L. 107–56, October 25, 2001, 115 Stat. 272.

security risk warranting denial of the license.[3]

Section 5103a(a)(2) subjects license renewals to the same requirements.

Section 5103a(c) requires the Attorney General, upon the request of a State in connection with issuance of a HME, to carry out a background records check of the individual applying for the endorsement and, upon completing the check, to notify the Secretary (as delegated to the Administrator of TSA) of the results. The Secretary then determines whether the individual poses a security risk warranting denial of the endorsement. The background records check must consist of: (1) A check of the relevant criminal history databases; (2) in the case of an alien, a check of the relevant databases to determine the status of the alien under U.S. immigration laws; and (3) as appropriate, a check of the relevant international databases through Interpol-U.S. National Central Bureau or other appropriate means.

Safe Explosives Act

Congress enacted the Safe Explosives Act (SEA) on November 25, 2002.[4] Sections 1121–1123 of the SEA amended section 842(i) of Title 18 of the U.S. Code by adding several categories to the list of persons who may not lawfully "ship or transport any explosive in or affecting interstate or foreign commerce" or "receive or possess any explosive which has been shipped or transported in or affecting interstate or foreign commerce." Prior to the amendment, 18 U.S.C. 842(i) prohibited the transportation of explosives by any person under indictment for or convicted of a felony, a fugitive from justice, an unlawful user or addict of any controlled substance, and any person who had been adjudicated as a mental defective or committed to a mental institution. The amendment added three new categories to the list of prohibited persons: aliens (with certain limited exceptions), persons dishonorably discharged from the armed forces, and former U.S. citizens who have renounced their citizenship. Individuals who violate 18 U.S.C. 842(i) are subject to criminal prosecution.[5] These incidents are investigated by the Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF) of the Department of Justice and referred, as appropriate, to United States Attorneys.

However, 18 U.S.C. 845(a)(1) provides an exception to section 842(i) for "any aspect of the transportation of explosive materials via railroad, water, highway, or air which are regulated by the United States Department of Transportation (DOT) and agencies thereof, and which pertain to safety." Under this exception, if DOT regulations address the transportation security issues of persons engaged in a particular aspect of the safe transportation of explosive materials, then those persons are not subject to prosecution under 18 U.S.C. 842(i) while they are engaged in the transportation of explosives in commerce. TSA issued the interim final rule in coordination with agencies within DOT, the Federal Motor Carrier Safety Administration and Research and Special Programs Administration, and triggered this exception. For the reasons set forth below, the action TSA takes now does not affect the application of the exception.

The Interim Final Rule

To comply with the mandates of the USA PATRIOT Act, and to trigger the exception in 18 U.S.C. 845(a)(1) for the transportation of explosives, TSA issued the IFR (68 FR 23852). Under the IFR, TSA determines that an individual poses a security threat if he or she: (1) Is an alien (unless he or she is a lawful permanent resident) or a U.S. citizen who has renounced his or her U.S. citizenship; (2) is wanted or under indictment for certain felonies; (3) has a conviction in military or civilian court for certain felonies; (4) has been adjudicated as a mental defective or involuntarily committed to a mental institution; or (5) is considered to pose a security threat based on a review of pertinent databases.

The IFR also establishes conditions under which an individual who has been determined to be a security threat can appeal the determination, and a waiver process for those individuals who otherwise could not obtain an HME because they had a disqualifying felony, or were adjudicated as a mental defective or involuntarily committed to a mental institution. Finally, the IFR prohibits an individual from holding, and a State from issuing, renewing, or transferring, an HME for a driver unless the individual has met the TSA security threat assessment standards.

Summary of the Amended IFR

This amended IFR adds a definition and changes language in the original IFR (68 FR 23852) regarding the date on which the States cannot issue, transfer, or renew HME unless a fingerprint-based background check has been completed. TSA provides a definition for the term "revoke" in response to comments received from the States. In some States, legislative language does not permit "revocation" of a hazardous material endorsement, but does permit removing authority to transport hazardous materials through disqualification, suspension, cancellation or other similar term. However, the IFR uses "revoke" when referring to individuals who are disqualified from holding a HME. Therefore, as requested by the States, we provide a definition to make clear that revocation is equivalent to cancellation, suspension, annulment, disqualification, or similar term.

TSA is delaying the date on which fingerprint-based criminal history record checks must be underway from November 3 for several reasons. First, TSA received comments from 23 States requesting an extension of time so that they can garner needed State legislative changes, funds, and infrastructure to implement the new background check portion of the HME program. The primary concerns identified by States include the cost of purchasing fingerprinting equipment; time needed to hire and train personnel to operate the fingerprinting equipment; and State legislative changes necessary to collect fees and implement the program. Most of the States requested Federal funding to assist with development of the program.

Second, TSA has worked closely with the States and pertinent nongovernmental organizations since the IFR was published and has determined that a "one size fits all" approach for fingerprint collection and adjudication is impractical. Each State currently has a system in place to license commercial drivers and award hazardous material endorsements. Also, each State currently has a system in place to collect fingerprints for criminal justice purposes and transmit them to the Attorney General. The States' systems vary widely in terms of size, complexity, automation, and funding. The States have consistently stated that TSA should not prescribe one detailed fingerprinting program, but should set minimum standards so that the States can make use of their current resources and programs. This should minimize costs, take into account unique State legislative requirements, and accommodate the level of automation each State currently possesses. Based on the foregoing, TSA is delaying the date

[3] The Secretary of Transportation delegated the authority to carry out the provisions of this section to the Under Secretary of Transportation for Security/Administrator of TSA. 68 FR 10988, March 7, 2003.

[4] Pub. L. 107–296, November 25, 2002, 116 Stat. 2280.

[5] The penalty for violation of 18 U.S.C. 842(i) is up to ten years imprisonment and a fine of up to $250,000.

on which: (1) The information required in section 1572.5(e) of the IFR is collected; and (2) fingerprints are submitted.

Information Collection

With respect to the first requirement, as of April 1, 2004, the States must be collecting the biographical and criminal history information currently required in section 1572.5(e), with the applicant's certification under penalty of criminal prosecution that the information is correct. This requirement applies only to individuals who are applying for, renewing or transferring a HME. The State is not required to gather this information for all current HME holders as of April 1, 2004; however, it must be collecting the information as drivers become due for renewal or seek to transfer or obtain a HME.

This requirement enhances the State's ability to determine whether individuals with disqualifying offenses continue to transport hazardous materials in violation of the law. The individual's signature on the application required in section 1572.5(e) is a certification under penalty of 18 U.S.C. 1001 that the individual meets the security threat assessment standards set forth in the IFR. If the individual intentionally provides inaccurate information, an enforcement action can be initiated that may include imprisonment of not more than five years or a fine of up to $250,000, or both. The government believes this adds a deterrent for HME holders who have committed disqualifying offenses but have not surrendered their HME as required by section 1572.5(b). However, it is important to note that nothing in this requirement alters an individual's ability to apply for a waiver under section 1572.143, if they have committed a disqualifying offense.

If the State is unable to collect the information required in section 1572.5(e) by April 2004, the State may submit a written request to TSA to delay the collection requirement. TSA understands that some States may need to seek legislative changes and fee authority, or raise funds in order to accomplish the collection requirement, and it may be impossible to do so by April 2004. However, TSA will not grant any delays beyond December 1, 2004.

Fingerprint Submission

With respect to the second requirement concerning fingerprint collection, the amended IFR provides that the State must be collecting fingerprints from individuals applying for, renewing, or transferring a HME and submitting them to the FBI as of April 1, 2004. The fingerprint collection must be accomplished in a manner consistent with FBI procedures. If the State is unable to collect fingerprints on or before April 2004, the State must submit a plan to TSA by April 1, 2004 outlining the system it will put in place to capture fingerprints and pertinent information. The States must be collecting fingerprints and the required information for HME applicants no later than December 1, 2004.

As indicated in State comments to the IFR, most if not all States have devoted considerable attention to determining how the fingerprinting of HME applicants can be accomplished and coordinated within the existing hazardous material endorsement and commercial driver licensing programs. In meeting with the States, it has been evident that many States have a clear plan in mind to collect fingerprints and the other information required in section 1572.5(e), including the number of staff needed to administer the program, appropriate training for personnel involved in capturing fingerprints, and electronic upgrades necessary to handle increased data. Therefore, TSA does not anticipate that the States will have to expend significant time on developing the fingerprint collection plans. Many States will submit the plans they have been working with since publication of the IFR.

Also, each State currently has fingerprint collection procedures in place that meet the FBI's collection standards, in order to process fingerprints through the FBI for criminal enforcement. These procedures may include electronic capture, or paper capture that can be digitally transmitted to the FBI. In addition, the procedures require an applicant to present proof of identity when the fingerprints are captured and sign a document certifying that all information provided with the fingerprints is true, under penalty of 18 U.S.C. 1001. The State plan must include these procedures or others that the FBI approves in the collection portion of the program in order to be acceptable to TSA.

Terrorist Checks

Prior to December 2004, pursuant to § 1572.107, TSA will conduct name-based background checks of Federal and international databases relating to terrorist activity. TSA will then conduct (1) checks for wants and warrants for the crimes listed in § 1572.103; (2) checks of an individual's citizenship status under § 1572.105; and (3) checks utilizing the Interstate Identification Index.

If TSA discovers during the course of these name-based checks that an individual poses a security threat, has committed a disqualifying offense, or is evading law enforcement, consistent with § 1572.5(c)(1), TSA will contact the appropriate law enforcement agency and/or direct the State to revoke the individual's HME. If the individual challenges TSA's assertion, TSA or the State will provide the individual with an opportunity to correct underlying records or cases of mistaken identity by submitting fingerprints or corrected court records.

With an estimated population exceeding 3.5 million drivers, the government must prioritize the background check process. TSA believes that these name-based checks enable the agency to focus on individuals who may pose a more immediate threat of terrorist or criminal activity, such as those who are wanted or under a warrant for one of the disqualifying crimes listed in § 1572.103, those who are not citizens or lawful permanent residents of the U.S., and those who may present a potential terrorist threat.

TSA has assessed the risks associated with the transportation of hazardous materials via commercial vehicle and has determined that in conducting name-based checks prior to December 2004 and initiating fingerprint-based criminal history checks as early as April 1, 2004, the risks are effectively addressed. The terrorist-related information that TSA will search prior to December 2004 is the best indication of an individual's predisposition to commit or conspire to commit terrorist acts. Evidence that an individual has been convicted recently of a felony such as theft or assault is important, and may indicate a security threat; but TSA has determined that the more imminent threat is an individual whose background includes terrorism-related information. This approach is consistent with the Patriot Act and the Safe Explosives Act, and meets the needs of the States.

Also, it is important to note that TSA is not delaying the September 2, 2003 compliance date set forth in § 1572.5(b) for surrendering a HME. This section requires any HME holder who does not meet the security threat assessment standards in part 1572 to surrender the endorsement beginning on September 2, 2003. For instance, an individual who knows that he or she has committed a disqualifying offense within the prescribed time periods, is required to relinquish their HME beginning September 2, 2003. Nothing in this

amended IFR alters this surrender requirement.

The surrender requirement buttresses TSA's determination that we should attempt to identify potential terrorist threats from terrorism-related information databases before analyzing criminal history records. As of today, all HME drivers are required to self-report any disqualifying offenses that would appear on a fingerprint-based criminal history records check. TSA will work closely with the State Departments of Motor Vehicles, labor organizations, and the trucking industry to communicate this surrender provision widely and to inform affected drivers of the existing waiver process.

Based on the foregoing, the exception found in 18 U.S.C. 845(a)(1) continues to apply, and persons otherwise prohibited from lawfully possessing explosives who are transporting explosives in commerce would not be subject to criminal prosecution under section 842(i).

Section-by-Section Analysis

TSA is adding a definition to § 1572.3 to make certain that the current IFR, which requires revocation of a HME under certain conditions, will not impose a condition in the HME process that the States cannot complete. As discussed earlier, in some States legislative language prohibits the 'revocation' of a HME legal, but permits the State to cancel, suspend, withdraw, or disqualify a hazardous material endorsement. TSA's new definition resolves this conflict with certain State legislation.

TSA makes several changes to § 1572.5 concerning the date on which TSA's threat assessment based on fingerprint-based criminal history record checks will begin. In paragraphs 1572.5(b) and (c), the new dates reflect TSA's decision to delay the date on which the States must be collecting information and submitting fingerprints to the FBI from November 3, 2003 to April 1, 2004, or under certain conditions to December 1, 2004 at the very latest.

Paragraph 1572.5(c)(4) establishes the requirement that TSA will not authorize a State to issue, renew, or transfer a HME unless it is collecting the information required in § 1572.5(e) and submitting fingerprints as of April 1, 2004. If the State cannot collect the required information by that date, the State may submit and TSA may approve a request to delay the collection requirement to December 1, 2004. Also, if the State cannot submit fingerprints from HME applicants by April 1, 2004, the State must submit a plan to TSA explaining how fingerprint collection and submission will be accomplished before December 1, 2004.

Compliance

As discussed in detail in the IFR published by FMCSA on May 5, 2003, the provisions of 49 U.S.C. 31314, which require DOT to withhold certain Federal-aid highway funds from States that fail to comply substantially with the requirements for State participation in the CDL program, apply also to State compliance with those portions of the TSA rule implementing the Patriot Act that apply to States. In addition, 49 U.S.C. 31312 authorizes DOT to prohibit States from issuing CDLs if the Secretary determines "that a State is in substantial noncompliance" with 49 U.S.C. chapter 313. These penalties are available for DOT to use when and if appropriate to encourage State compliance with TSA's rule.

Future Rulemaking

It is important to note that TSA will publish a NPRM shortly after publication of this amended IFR, to propose minimum federal standards for the fingerprint collection, criminal history adjudication, and appeal process for HME applicants. In the NPRM, TSA will provide greater detail about what each State program should include, minimum standards for adjudication of the criminal history record check results, minimum standards for establishing an appeal process for the adjudication of the criminal history checks, and the potential costs for each portion of the background check.

TSA will rely heavily on the comments the States provide to ensure that no State is forced to adhere to a rigid form beyond its financial or technological capacity. The NPRM will propose minimum components that each State program should include, but would permit the States to determine how it meets the minimum standards.

The NPRM process will also provide TSA with the empirical data and information necessary to complete a comprehensive regulatory evaluation. TSA understands that the IFR and the amended IFR impose financial burdens on the States, some of which may be minimized through State and Federal fee authority. However, there may be States in which this is not possible, and TSA must seek a regulatory regime to prevent unnecessary financial burdens. TSA can achieve this through active participation of the States, the trucking industry, and private entities that may be able to provide low cost operational assistance.

In addition, on October 3, 2003, legislation was enacted[6] authorizing DHS to collect fees to cover the costs of implementing section 1012 of the Patriot Act. This new authority will aid TSA in completing the security threat assessment check for an estimated 3.5 million commercial drivers. Therefore, TSA is also issuing a separate proposed rule to determine reasonable costs of background checks, on which drivers, the States and other interested parties may comment.

Rulemaking Analyses and Notices

Justification for Immediate Adoption

TSA is issuing this final rule without prior notice and opportunity to comment pursuant to its authority under section 4(a) of the Administrative Procedure Act (5 U.S.C. 553(b)). This provision allows the agency to issue a final rule without notice and opportunity to comment when the agency for good cause finds that notice and comment procedures are "impracticable, unnecessary or contrary to the public interest."

The catastrophic effect of the attacks on the World Trade Center and Pentagon on September 11, 2001, revealed the vulnerability of the nation's transportation system to terrorism. National security and intelligence officials have warned that future terrorist attacks are likely. The number of commercial vehicles that carry hazardous materials is far greater than the number of aircraft that might be hijacked by terrorists. A vehicle carrying hazardous materials, if used as a weapon in a terrorist attack, could cause significant loss of life and property damage.

Section 1012 of the USA PATRIOT Act is a measure to increase the security of highway transportation of hazardous materials. Because of the likelihood of future terrorist attacks, and the potential for significant casualties and property damage in the event of a terrorist attack involving a vehicle carrying hazardous materials, TSA believes that immediate action is warranted, and TSA finds that notice and public comment procedures under 5 U.S.C. 553(b) are impracticable and contrary to the public interest.

It is important to note that TSA is not making fingerprint collection or submission of the State plan due upon publication of this document. The intervening months between the date this amended IFR is published and April 1, 2004 will provide additional time for the States to develop a plan for

[6] Department of Homeland Security Appropriations Act, 2004, Public Law 108–90, 117 Stat. 1137, October 1, 2003.

fingerprint collection or begin it. As indicated in comments to the IFR, most States have already devoted considerable time to determining how drivers could best be fingerprinted in light of each State's current hazardous material endorsement and licensing program. Submitting a fingerprint collection plan to TSA that reflects this thinking by April 1 should be possible. On the other hand, some States will be prepared to begin fingerprint collection within three months and so need not prepare or submit a new plan to TSA. Therefore, TSA believes that this amended IFR will not impose significant time constraints on the States.

By making the rule effective as of the date of publication, however, TSA can begin name checks of individuals against international and terrorist-related databases as soon as TSA has accurate driver data and is able to adjudicate the results of the checks.

Regulatory Evaluation

Executive Order 12866, "Regulatory Planning and Review" (58 FR 51735, October 4, 1993), provides for making determinations whether a regulatory action is "significant" and therefore subject to Office of Management and Budget (OMB) review and to the requirements of the Executive Order.

TSA has determined that this action is a significant regulatory action within the meaning of Executive Order 12866 because there is significant public interest in security issues since the events of September 11, 2001. This amended interim final rule responds to the background check requirements of section 1012 of the USA PATRIOT Act by establishing the criteria that will be used in determining whether an individual applying for, transferring, or renewing a HME poses a security risk warranting denial of the endorsement.

TSA has performed a preliminary analysis of the expected costs of this interim final rule, but the figures may change when a full Regulatory Evaluation is completed in the proposed rulemaking that will follow publication of this document. TSA will prepare a full regulatory evaluation based on comments received from the States, the trucking industry, and pertinent nongovernmental organizations, which will improve the reliability of the cost and benefit estimates.

Initial Regulatory Flexibility Determination

The Regulatory Flexibility Act of 1980, as amended, (RFA) was enacted by Congress to ensure that small entities (small businesses, small not-for-profit organizations, and small governmental jurisdictions) are not unnecessarily or disproportionately burdened by Federal regulations. The RFA requires agencies to review rules to determine if they have "a significant economic impact on a substantial number of small entities." TSA has determined that the amended interim final rule will not have a significant economic impact on a substantial number of small entities.

Current industry practice is for drivers to obtain their CDL certification as a condition of employment. Individuals are required to have a current CDL with appropriate endorsements to be eligible for employment. This is an employment cost typically borne by the individual employee. This amended IFR will affect the States, but they are not considered "small governmental jurisdictions", such as small towns or boroughs. Therefore, the burden on small business entities from this rule is expected to be *de minimis*.

TSA conducted the required review of this rule accordingly, pursuant to the Regulatory Flexibility Act, 5 U.S.C. 605(b) TSA certifies that this rule will not have a significant impact on a substantial number of small entities.

Paperwork Reduction Act

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501, *et seq.*), a Federal agency must obtain approval from the Office of Management and Budget (OMB) for each collection of information it conducts, sponsors, or requires through regulations. This amended interim final rule contains information collection activities subject to the PRA. Accordingly, the following information requirements are being submitted to OMB for its review.

Title: Security Threat Assessment for Individuals Applying for a Hazardous Materials Endorsement for a Commercial Driver's License.

Summary: TSA is establishing standards for security threat assessments of individuals applying for, renewing, or transferring a hazardous materials endorsement (HME) for a commercial driver's license (CDL), which in addition to the information already collected by the States for the purpose of HME applications will now include fingerprints as well as the disclosure of the applicant's citizenship, mental health defects, and criminal history. States must also submit a plan to TSA outlining the fingerprint process they intend to implement.

Use of: Truck drivers must complete an application and provide fingerprints for the purpose of conducting a background check. The States and local agencies will most likely collect this information when individuals apply for, renew or transfer an HME. This information will be used to conduct background checks to ensure that these individuals do not have a disqualifying criminal offense on their record. In addition, the States' fingerprint collection plans will be used by TSA to ensure regulatory compliance, uniformity of standards, and adequacy of process.

Respondents (including number of): The likely respondents to this proposed information requirement are individuals applying for, renewing or transferring an HME and each of the 50 States, for a pool of approximately 3.5 million respondents.

Frequency: Estimates indicate that approximately 3.5 million people have an HME and this number is expected to grow by approximately 2.8% people per year for a ten-year total of approximately 4.5 million people (450,000 annualized). The number of fingerprint applications to be collected over a ten-year period is approximately 8.7 million (870,000 annualized). This number includes new applicants and renewals, which occur at least once every five years. States are required to submit their fingerprinting plans upon their completion or amendment.

Annual Burden Estimate: Fingerprint costs consist of a processing fee, processing time, and material. The average cost for the fingerprint process was estimated at approximately $50 per set when the original IFR was published. However, empirical data and further research indicate that this estimate is low for the population covered by this rule. We also estimate that it would take an average of thirty minutes to complete an FBI fingerprint card and forward it to the FBI for further processing. Based on this information, TSA originally estimated that the background check process would involve 4.4 million hours over the ten-year (436,000 annualized) and would cost $452 million over the ten-year period ($45.2 million annualized). However, TSA now believes that these estimates may be low and requests comment from all affected parties concerning cost assumptions that can be made in preparing this analysis.

The agency is soliciting comments to—

(1) Evaluate whether the proposed information requirement is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(2) Evaluate the accuracy of the agency's estimate of the burden;

(3) Enhance the quality, utility, and clarity of the information to be collected; and

(4) Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

Individuals and organizations may submit comments on the information collection requirement by January 6, 2004, and should direct them via fax to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: DHS–TSA Desk Officer, at (202) 395–5806. Comments to OMB are most useful if received within 30 days of publication.

As protection provided by the Paperwork Reduction Act, as amended, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection will be published in the **Federal Register** after OMB approves it.

Executive Order 13132 (Federalism)

Executive Order 13132 requires TSA to develop an accountable process to ensure "meaningful and timely input by State and local officials in the development of regulatory policies that have federalism implications." "Policies that have federalism implications" are defined in the Executive Order to include regulations that have "substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government." Under the Executive Order, TSA may construe a Federal statute to preempt State law only where, among other things, the exercise of State authority conflicts with the exercise of Federal authority under the Federal statute.

This action has been analyzed in accordance with the principles and criteria in the Executive Order, and it has been determined that this interim final rule does have Federalism implications or a substantial direct effect on the States. The amended interim final rule requires States to collect fingerprints or to submit a plan to TSA outlining how the fingerprint collection process would work. TSA will publish a NPRM shortly that will solicit comments from the States on the fingerprint collection process and other aspects of implementing the HME background check program. TSA will continue to consult extensively with the States to ensure that any burdens are minimized to the extent possible.

TSA notes that FMCSA has communicated with the States on the requirements of the USA PATRIOT Act. The Assistant Administrator of FMCSA wrote to licensing officials in each State on October 31, 2001, briefly summarizing section 1012 of the USA PATRIOT Act, and asking them to continue issuing and renewing hazardous materials endorsements until the regulations implementing section 1012 were completed. Some States have already enacted legislation they consider necessary to carry out the mandates of section 1012.

Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires Federal agencies to prepare a written assessment of the costs, benefits, and other effects of proposed or final rules that include a Federal mandate likely to result in the expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of more than $100 million in any one year (adjusted for inflation with base year of 1995). Before promulgating a rule for which a written statement is needed, section 205 of the UMRA generally requires TSA to identify and consider a reasonable number of regulatory alternatives and adopt the least costly, most cost-effective, or least burdensome alternative that achieves the objective of the rule. The provisions of section 205 do not apply when they are inconsistent with applicable law. In addition, section 205 allows TSA to adopt an alternative other than the least costly, most cost-effective, or least burdensome alternative if the agency publishes with the final rule an explanation why that alternative was not adopted.

This interim final rule will not result in the expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of more than $100 million annually. Thus, TSA has not prepared a written assessment under the UMRA.

Environmental Analysis

TSA has analyzed this rulemaking action for the purposes of the National Environmental Policy Act. The agency has determined that implementation of this final rule will not have any significant impact on the quality of the human environment.

Energy Impact

TSA has assessed the energy impact of this rule in accordance with the Energy Policy and Conservation Act (EPCA), Public Law 94–163, as amended (42 U.S.C. 6362). TSA has determined that this rule is not a major regulatory action under the provisions of the EPCA.

Trade Impact Assessment

The Trade Agreement Act of 1979 prohibits Federal agencies from engaging in any standards or related activities that create unnecessary obstacles to the foreign commerce of the United States. Legitimate domestic objectives, such as safety, are not considered unnecessary obstacles. The statute also requires consideration of international standards and, where appropriate, that they be the basis for U.S. standards. TSA will continue to consult with Mexico and Canada under the North American Free Trade Agreement to ensure that any adverse impacts on trade are minimized. This rule applies only to individuals applying for a State-issued hazardous materials endorsement for a commercial drivers license. Thus, TSA has determined that this rule will have no impact on trade.

List of Subjects in 49 CFR Part 1572

Commercial drivers license, Criminal history background checks, Explosives, Hazardous materials, Motor carriers, Motor vehicle carriers, Security measures, Security threat assessment.

The Amendments

■ For the reasons set forth in the preamble, the Transportation Security Administration amends 49 CFR Chapter XII, Subchapter D as follows:

PART 1572—CREDENTIALING AND BACKGROUND CHECKS FOR LAND TRANSPORTATION SECURITY

■ 1. The authority citation for part 1572 continues to read as follows:

Authority: 49 U.S.C. 114, 5103a, 40113, 46105.

■ 2. Amend § 1572.3 by adding the following definition in alphabetical order to read as follows:

§ 1572.3 Terms used in this part.

* * * * *

Revoke means the process by which a State cancels, suspends, withdraws, annuls, or disqualifies a hazardous material endorsement.

* * * * *

■ 3. In § 1572.5, revise paragraphs (b)(2)(i), (b)(2)(ii), (c)(1), (c)(2) introductory text and (c)(3) and add paragraph (c)(4) to read as follows.

§ 1572.5 Security threat assessment for commercial drivers' licenses with a hazardous materials endorsement.

* * * * *

(b) * * *

(2) * * *

(i) From November 3, 2003 to December 1, 2004, an individual may submit fingerprints, in a form and manner specified by the State and TSA, when a State revokes the individual's hazardous materials endorsement under paragraph (c)(1) of this section.

(ii) When so notified by the State, an individual must submit fingerprints, in a form and manner specified by the State and TSA, when he or she applies to obtain, renew, or transfer a hazardous materials endorsement for a CDL, or when requested by TSA.

* * * * *

(c)(1) Each State must revoke an individual's hazardous materials endorsement if TSA informs the State that the individual does not meet the standards for security threat assessment in paragraph (d) of this section.

(2) No later than December 1, 2004:

* * * * *

(3) From November 3, 2003 to June 1, 2005, while TSA is conducting a security threat assessment on an individual, if the individual holds a CDL with a hazardous materials endorsement, and is applying for renewal or transfer of the endorsement, the State that issued the endorsement may extend the expiration date of the individual's endorsement until the State receives a Final Notification of Threat Assessment or Notification of No Security Threat from TSA.

(4) TSA will not authorize a State to issue, renew, or transfer hazardous material endorsements unless the State issuing the endorsement is —

(i) Collecting the information required in § 1572.5(e) as of April 1, 2004; or the State provides written justification for an extension of time not to exceed December 1, 2004 and TSA grants the extension; and

(ii) Submitting fingerprints in accordance with fingerprint collection standards of the Federal Bureau of Investigation and in accordance with procedures approved by TSA as of April 1, 2004; or the State submits a plan to TSA that describes how the State will collect fingerprints of individuals applying for, renewing, or transferring a hazardous materials endorsement no later than December 1, 2004.

* * * * *

Issued in Arlington, VA on November 4, 2003.

Stephen McHale,

Deputy Administrator.

[FR Doc. 03–28136 Filed 11–4–03; 4:22 pm]

BILLING CODE 4910–62–P

Proposed Rules

Federal Register
Vol. 68, No. 216
Friday, November 7, 2003

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

RAILROAD RETIREMENT BOARD

20 CFR Part 321

RIN 3220–AB57

Electronic Filing of Applications and Claims for Benefits Under the Railroad Unemployment Insurance Act

AGENCY: Railroad Retirement Board.

ACTION: Proposed rule.

SUMMARY: The Railroad Retirement Board (Board) proposes to amend its regulations to permit the filing of applications and claims for benefits under the Railroad Unemployment Insurance Act via the Internet. The Government Paperwork Elimination Act provides that Federal agencies are required to provide "for the option of the electronic maintenance, submission, or disclosure of information, when practicable as a substitute for paper". This proposed new part will permit the filing of applications and claims for benefits under the Railroad Unemployment Insurance Act electronically.

DATES: Submit comments on or before January 6, 2004.

ADDRESSES: Address any comments concerning this proposed rule to Beatrice Ezerski, Secretary to the Board, Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois 60611–2092.

FOR FURTHER INFORMATION CONTACT: Marguerite P. Dadabo, Assistant General Counsel, (312) 751–4945, TTD (312) 751–4701.

SUPPLEMENTARY INFORMATION: The amendments would add a new part 321 to the Board's regulations (20 CFR 321) to permit the filing of applications and claims for benefits under the Railroad Unemployment Insurance Act via the Internet. The Government Paperwork Elimination Act, Public Law 105–277, sections 1701–1710 (codified as 44 U.S.C. 3504n) provides that Federal agencies are required to provide "for the option of the electronic maintenance, submission, or disclosure of information, when practicable as a substitute for paper". The proposed part 321 will permit the filing of applications and claims for benefits under the Railroad Unemployment Insurance Act electronically.

The new part 321 provides that both an application and claims for benefits under the Railroad Unemployment Insurance Act may be filed electronically through the Board's Web site utilizing a User ID/PIN/Password system. The new part further provides that determinations regarding those applications and claims will be adjudicated in accord with established procedures.

In establishing the authenticity of the person who is filing an application or claim for benefits, the Board intends to use a User ID/PIN/Password system for identification as a substitute for a signature.

The Board currently uses a User ID/PIN/password system to allow employers access to RRBLINK to make electronic tax deposits and submit Form DC–1, "Employer's Quarterly Report of Contributions Under the RUIA" (Railroad Unemployment Insurance Act) electronically. A PIN/password system is used to access the Pay.gov website. The U.S. Department of the Treasury operates the Pay.gov website. Such a system also is consistent with the guidance provided by the Department of Justice regarding the use of electronic processes. The Board has also proposed amending its regulations to permit the filing of an application for benefits under the Railroad Retirement Act using the same User ID/PIN/password system.

The Board, with the concurrence of the Office of Management and Budget, has determined that this is not a significant regulatory action under Executive Order 12866. Therefore, no regulatory analysis is required. The Office of Management and Budget has approved information collections associated with this rule under control numbers 3220–0022, 3220–0039, and 3220–0198.

List of Subjects in 20 CFR Part 321

Claims, Railroad unemployment insurance, Reporting and recordkeeping requirements.

For the reasons set out in the preamble, the Railroad Retirement Board proposes to amend title 20, chapter II, of the Code of Federal Regulations by adding a new part 321 to read as follows:

PART 321—ELECTRONIC FILING OF APPLICATIONS AND CLAIMS FOR BENEFITS UNDER THE RAILROAD UNEMPLOYMENT INSURANCE ACT

Sec.
321.1 Filing applications electronically.
321.2 Filing claims for benefits electronically.

Authority: 45 U.S.C. 355 and 362(l).

§ 321.1 Filing applications electronically.

(a) *Electronic filing.* An application for benefits under the Railroad Unemployment Insurance Act may be filed electronically through the Board's Web site, *http://www.rrb.gov*, utilizing a User ID/PIN/Password.

(b) *Adjudication of applications filed electronically.* An application filed electronically shall be adjudicated in accordance with the procedures set forth in this part.

(c) *Date of filing.* The date of filing for an application filed electronically shall be the date that the electronic filing of the application is accepted by the Board's electronic system. If an attempt to file an application through the Board's electronic system is unsuccessful and is rejected by that system, the claimant must submit another application. If the subsequent application, filed either electronically or on paper, is received by the Board within 30 days from the date of the notification that the initial filing attempt was rejected, the Board will establish the filing date of the subsequent application as the date the rejected application was attempted to be filed.

§ 321.2 Filing claims for benefits electronically.

(a) *Electronic Filing.* A claim for benefits under the Railroad Unemployment Insurance Act may be filed electronically through the Board's website, http://www.rrb.gov, utilizing a User ID/PIN/Password.

(b) *Adjudication of claims filed electronically.* A claim for benefits under the Railroad Unemployment Insurance Act filed electronically shall be adjudicated in accordance with the procedures set forth in this part.

(c) *Date of filing.* The date of filing for a claim for benefits under the Railroad Unemployment Insurance Act filed electronically shall be the date that the

electronic filing of the claim is accepted by the Board's electronic system. If an attempt to file a claim for benefits under the Railroad Unemployment Insurance Act is unsuccessful and is rejected by the Board's electronic system, the claimant must submit another claim for benefits. If the subsequent claim for benefits, either filed electronically or on paper, is received by the Board within 30 days from the date of the notification that the initial filing was rejected, the Board will establish the filing date of the subsequent claim as the date the rejected claim was attempted to be filed.

Dated: November 3, 2003.

By Authority of the Board.

Beatrice Ezerski,

Secretary to the Board.

[FR Doc. 03–28031 Filed 11–6–03; 8:45 am]

BILLING CODE 7905–01–P

DEPARTMENT OF THE TREASURY

Alcohol and Tobacco Tax and Trade Bureau

27 CFR Part 9

[TTB Notice No. 22; Re: TTB Notice No. 15]

RIN 1513–AA41

Proposed Eola Hills Viticultural Area (2002R–216P)

AGENCY: Alcohol and Tobacco Tax and Trade Bureau (TTB), Treasury.

ACTION: Notice of proposed rulemaking; extension of comment period.

SUMMARY: We are extending the comment period for TTB Notice No. 15, a notice of proposed rulemaking published in the **Federal Register** on September 8, 2003, for an additional 60 days. The proposed rule would amend our regulations to add Eola Hills as an approved American viticultural area in Oregon. We are acting on a request to extend the comment period submitted on behalf of the Eola Hills Wine Cellars of Salem, Oregon.

DATES: We must receive written comments on or before January 6, 2004.

ADDRESSES: You may send comments to any of the following addresses—

- Chief, Regulations and Procedures Division, Alcohol and Tobacco Tax and Trade Bureau, P.O. Box 50221, Washington, DC 20091–0221 (Attn: Notice No. 15);
- 202–927–8525 (facsimile);
- *nprm@ttb.gov* (e-mail); or
- *http://www.ttb.gov* (An online comment form is posted with Notice No. 15 on our Web site).

You may view copies of the petition, the notice of proposed rulemaking, the appropriate maps, and any comments we receive by appointment at our library, 1310 G Street, NW., Washington, DC 20005; phone 202–927–8210. You may also access copies of the notice and comments on our Web site at *http://www.ttb.gov*.

FOR FURTHER INFORMATION CONTACT: Jennifer Berry, Regulations and Procedures Division, Alcohol and Tobacco Tax and Trade Bureau, P.O. Box 18152, Roanoke, Virginia 24014; telephone 540–344–9333; e-mail *Jennifer.Berry@ttb.treas.gov*.

SUPPLEMENTARY INFORMATION:

Background

On September 8, 2003, the Alcohol and Tobacco Tax and Trade Bureau (TTB) published a notice of proposed rulemaking (Notice No. 15, 68 FR 52875) to establish "Eola Hills" as an American viticultural area in Oregon. The comment period was to end November 7, 2003.

We have, however, received a request for a 60-day extension of the comment period from Kevin Crawford, an attorney representing a winery with a similar name to that of the proposed viticultural area, Eola Hills Wine Cellars Inc. of Salem, Oregon. Mr. Crawford requested the extension to allow his client more time to gather evidence to support its comment. In consideration of this request, and in light of the impact that the approval of the proposed Eola Hills viticultural area may have on the Eola Hills Wine Cellars' wine labels, we are extending the comment period for an additional 60 days.

Public Participation

See the "Public Participation" section of TTB Notice No. 15 for detailed instructions on submitting and reviewing comments. We will carefully consider comments received on or before the new closing date.

We will not recognize any submitted material as confidential. All comments are part of the public record and subject to disclosure. Do not enclose in your comments any material you consider confidential or inappropriate for disclosure. The name of the person submitting a comment is not exempt from disclosure.

Drafting Information

Jennifer Berry of the Regulations and Procedures Division, Alcohol and Tobacco Tax and Trade Bureau, drafted this notice.

List of Subjects in 27 CFR Part 9

Wine.

Authority and Issuance

TTB Notice No. 15 was issued under the authority of 27 U.S.C. 205.

Signed: November 4, 2003.

Arthur J. Libertucci,

Administrator.

[FR Doc. 03–28062 Filed 11–6–03; 8:45 am]

BILLING CODE 4810–31–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Parts 122 and 133

[FRL–7584–5]

National Pollutant Discharge Elimination System (NPDES) Permit Requirements for Municipal Wastewater Treatment Discharges During Wet Weather Conditions

AGENCY: Environmental Protection Agency (EPA).

ACTION: Request for comment on proposed policy.

SUMMARY: Today, EPA is inviting comment on a proposed policy regarding NPDES permit requirements for treatment plants in publicly owned treatment works (POTWs) under peak wet weather flow conditions. Regulatory agencies, municipal operators of POTWs, and representatives of environmental advocacy groups have expressed uncertainty about the appropriate regulatory interpretation for such situations. Today's document describes both a proposed interpretation of regulations, as well as draft guidance to implement such an interpretation. EPA's intention is to ensure that NPDES requirements be applied in a nationally-consistent manner that improves the capacity, management, operation and maintenance of POTW treatment plants and collection systems and protects human health and the environment.

DATES: Written comments on this proposed policy must be received by EPA or postmarked by January 9, 2004.

ADDRESSES: Comments may be submitted electronically, by mail, or through hand delivery/courier. Follow the detailed instructions as provided in section I.B. of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: For questions about the substance of this proposed policy, contact Kevin Weiss (e-mail at *weiss.kevin@epa.gov* or phone at (202) 564–0742) at Office of Wastewater Management, U.S.

Environmental Protection Agency (Mailcode 4203M), 1200 Pennsylvania Ave., NW., Washington, D.C. 20460.

SUPPLEMENTARY INFORMATION:

I. General Information

A. How Can I Get Copies of This Document and Other Related Information ?

1. *Docket.* EPA has established an official public docket for this action under Docket ID No. OW–2003–0025. The official public docket consists of the documents specifically referenced in this action, any public comments received, and other information related to this action. Although a part of the official docket, the public docket does not include Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. The official public docket is the collection of materials that is available for public viewing at the Water Docket in the EPA Docket Center, (EPA/DC) EPA West, Room B102, 1301 Constitution Ave., NW., Washington, DC. The EPA Docket Center Public Reading Room is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The telephone number for the Public Reading Room is (202) 566–1744, and the telephone number for the Water Docket is (202) 566–2426. You may copy 266 pages per day free of charge. Beginning with page 267, you will be changed $0.15 per page plus an administrative fee of $25.00.

2. *Electronic Access.* You may access this **Federal Register** document electronically through the EPA Internet under the "**Federal Register**" listings at *http://www.epa.gov/fedrgstr/.*

An electronic version of the public docket is available through EPA's electronic public docket and comment system, EPA Dockets. You may use EPA Dockets at *http://www.epa.gov/edocket/* to submit or view public comments, access the index listing of the contents of the official public docket, and to access those documents in the public docket that are available electronically. Once in the system, select "search," then key in the appropriate docket identification number.

Certain types of information will not be placed in the EPA Dockets. Information claimed as CBI and other information whose disclosure is restricted by statute, which is not included in the official public docket, will not be available for public viewing in EPA's electronic public docket. EPA's policy is that copyrighted material will not be placed in EPA's electronic public docket but will be available only in printed, paper form in the official public docket. To the extent feasible, publicly available docket materials will be made available in EPA's electronic public docket. When a document is selected from the index list in EPA Dockets, the system will identify whether the document is available for viewing in EPA's electronic public docket. Although not all docket materials may be available electronically, you may still access any of the publicly available docket materials through the docket facility identified in section I.A.1. EPA intends to work toward providing electronic access to all of the publicly available docket materials through EPA's electronic public docket.

For public commenters, it is important to note that EPA's policy is that public comments, whether submitted electronically or in paper, will be made available for public viewing in EPA's electronic public docket as EPA receives them and without change, unless the comment contains copyrighted material, CBI, or other information whose disclosure is restricted by statute. When EPA identifies a comment containing copyrighted material, EPA will provide a reference to that material in the version of the comment that is placed in EPA's electronic public docket. The entire printed comment, including the copyrighted material, will be available in the public docket.

Public comments submitted on computer disks that are mailed or delivered to the docket will be transferred to EPA's electronic public docket. Public comments that are mailed or delivered to the docket will be scanned and placed in EPA's electronic public docket. Where practical, physical objects will be photographed, and the photograph will be placed in EPA's electronic public docket along with a brief description written by the docket staff.

For additional information about EPA's electronic public docket visit EPA Dockets online or see 67 FR 38102 (May 31, 2002).

B. How and To Whom Do I Submit Comments?

You may submit comments electronically, by mail, or through hand delivery/courier. To ensure proper receipt by EPA, identify the appropriate docket identification number in the subject line on the first page of your comment. Please ensure that your comments are submitted within the specified comment period. Comments received after the close of the comment period will be marked "late." EPA is not required to consider these late comments. Late comments may be considered if time permits.

1. *Electronically.* If you submit an electronic comment as prescribed below, EPA recommends that you include your name, mailing address, and an e-mail address or other contact information in the body of your comment. Also include this contact information on the outside of any disk or CD ROM you submit, and in any cover letter accompanying the disk or CD ROM. This ensures that you can be identified as the submitter of the comment and allows EPA to contact you in case EPA cannot read your comment due to technical difficulties or needs further information on the substance of your comment. EPA's policy is that EPA will not edit your comment, and any identifying or contact information provided in the body of a comment will be included as part of the comment that is placed in the official public docket, and made available in EPA's electronic public docket. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment.

i. *EPA Dockets.* Your use of EPA's electronic public docket to submit comments to EPA electronically is EPA's preferred method for receiving comments. Go directly to EPA Dockets at *http://www.epa.gov/edocket,* and follow the online instructions for submitting comments. To access EPA's electronic public docket from the EPA Internet Home Page, select "Information Sources," "Dockets," and "EPA Dockets." Once in the system, select "search," and then key in Docket ID No. OW–2003–0025. The system is an "anonymous access" system, which means EPA will not know your identity, e-mail address, or other contact information unless you provide it in the body of your comment.

ii. *E-mail.* Comments may be sent by electronic mail (e-mail) to *OW-Docket@epa.gov,* Attention Docket ID No. OW–2003–0025. In contrast to EPA's electronic public docket, EPA's e-mail system is not an "anonymous access" system. If you send an e-mail comment directly to the Docket without going through EPA's electronic public docket, EPA's e-mail system automatically captures your e-mail address. E-mail addresses that are automatically captured by EPA's e-mail system are included as part of the comment that is placed in the official public docket, and made available in EPA's electronic public docket.

iii. *Disk or CD ROM.* You may submit comments on a disk or CD ROM that you mail to the mailing address

identified in section I.B.2. These electronic submissions will be accepted in WordPerfect or ASCII file format. Avoid the use of special characters and any form of encryption.

2. *By Mail.* Send an original and three copies of your comments to: Water Docket, Environmental Protection Agency, Mailcode 4101T, 1200 Pennsylvania Ave., NW., Washington, DC 20460, Attention Docket ID No. OW–2003–0025.

3. *By Hand Delivery or Courier.* Deliver your comments to: EPA Docket Center, EPA West, Room B102, 1301 Constitution Ave., NW., Washington, DC, Attention Docket ID No. OW–2003–0025. Such deliveries are only accepted during the Docket's normal hours of operation as identified in section I.A.1.

C. How Should I Submit CBI To the Agency?

Do not submit information that you consider to be CBI electronically through EPA's electronic public docket or by e-mail. You should send information that you consider to be CBI in one of two ways: (1) By U.S. Mail to: Kevin Weiss, Office of Wastewater Management, U.S. Environmental Protection Agency (Mailcode 4203M), 1200 Pennsylvania Ave., NW., Washington, DC 20460—Attention Docket ID No. OW–2003–0025; or (2) By courier or delivery to: Kevin Weiss, Office of Wastewater Management, U.S. Environmental Protection Agency, EPA East Building (Room 7334), 1301 Constitution Ave., NW., Washington, DC 20004—Attention Docket ID No. OW–2003–0025. You may claim information that you submit to EPA as CBI by marking any part or all of that information as CBI (if you submit CBI on disk or CD ROM, mark the outside of the disk or CD ROM as CBI and then identify electronically within the disk or CD ROM the specific information that is CBI). Information so marked will not be disclosed except in accordance with procedures set forth in 40 CFR part 2.

In addition to one complete version of the comment that includes any information claimed as CBI, a copy of the comment that does not contain the information claimed as CBI must be submitted for inclusion in the public docket and EPA's electronic public docket. If you submit the copy that does not contain CBI on disk or CD ROM, mark the outside of the disk or CD ROM clearly that it does not contain CBI. Information not marked as CBI will be included in the public docket and EPA's electronic public docket without prior notice. If you have any questions about CBI or the procedures for claiming CBI, please consult the person identified in the **FOR FURTHER INFORMATION CONTACT** section.

D. What Should I Consider as I Prepare My Comments for EPA?

You may find the following suggestions helpful for preparing your comments:

1. Explain your views as clearly as possible.

2. Describe any assumptions that you used.

3. Provide any technical information and/or data you used that support your views.

4. If you estimate potential burden or costs, explain how you arrived at your estimate.

5. Provide specific examples to illustrate your concerns.

6. Offer alternatives.

7. Make sure to submit your comments by the comment period deadline identified.

8. To ensure proper receipt by EPA, identify the appropriate docket identification number in the subject line on the first page of your response. It would also be helpful if you provided the name, date, and **Federal Register** citation related to your comments.

Acronyms Used

BOD_5 five-day biochemical oxygen demand
CSO combined sewer overflow
EPA Environmental Protection Agency
I/I infiltration and inflow
NPDES National Pollutant Discharge Elimination System
POTW publicly owned treatment works
SS total suspended solids
SSO sanitary sewer overflow

II. Background

A. Why Is EPA Taking This Action?

Wastewater collection systems collect domestic sewage and other wastewater from homes and other buildings and convey it to wastewater sewage treatment plants for proper treatment and disposal. The collection and treatment of municipal sewage and wastewater is vital to public health in our cities and towns, and to the viability of our receiving waters. The proper functioning of wastewater systems is among the most important factors responsible for the general level of good health enjoyed in the United States. The United States Centers for Disease Control and Prevention named clean water and sanitation technology one of the twentieth century's great public health achievements (see Morbidity and Mortality Weekly Report, April 2, 1999, v. 48, no. 12, pp. 241–243), while the National Academy of Engineering included such technology on its list of the 20 engineering achievements that had the greatest impact on quality of life in the twentieth century. (National Academy of Engineering, press release, February 22, 2000).

Municipal collection systems and treatment facilities are an extensive, valuable, and complex part of the nation's infrastructure. In the last twenty years, communities have spent $1 trillion in 2001 dollars on drinking water treatment and supply and wastewater treatment and disposal (see The Clean Water and Drinking Water Infrastructure Gap Analysis, EPA, September 2002). Another source estimates that wastewater treatment and collection systems represent about 10–15 percent of the total infrastructure value in the United States. (Fragile Foundations: A Report on America's Public Works. Final Report to the President and Congress. National Council on Public Works Improvement. February 1988.) The collection system and treatment facilities of a single large municipality can represent an investment worth billions of dollars.

The efficiency of wastewater treatment at a wastewater treatment plant depends strongly on the design and performance of the collection system. Many collection systems in the United States are subject to high volumes of infiltration (including rainfall-induced infiltration) and inflow during wet weather conditions. High levels of infiltration and inflow (I/I) increase the hydraulic load on treatment plants, which can reduce treatment efficiency, can exceed the capacity of components within the treatment process, and in extreme situations make biological treatment facilities inoperable (*e.g.*, wash out the biological organisms that treat the waste).

In 1972, the Federal Water Pollution Control Act, also referred to as the Clean Water Act (CWA), dramatically increased the role of the Federal government in protecting water resources by establishing a framework for upgrading the nation's wastewater infrastructure. With respect to the municipal wastewater infrastructure, the 1972 Act: established a minimum pollution control standard based on the application of secondary treatment; mandated the development of more stringent standards where necessary to protect water quality; established the National Pollutant Discharge Elimination System (NPDES) permit program to ensure implementation of standards; and dramatically increased Federal funding for municipal treatment works.

During the 1970's and 1980's the nation's municipal wastewater infrastructure dramatically expanded and improved, particularly with respect to treatment plants. In 1968, 72 percent of the Nation's municipal wastewater plants were providing secondary treatment and less than one percent were providing greater than secondary treatment (out of 14,051 facilities). By 1996, 59 percent of the Nation's municipal wastewater plants were providing secondary treatment and 27 percent were providing greater than secondary treatment (out of 16,024 facilities). During this time, the overall number of people served by municipal wastewater treatment facilities increased from 140.1 million in 1968 to 189.7 million in 1996 (a 35 percent increase).

In the mid-1980's and 1990's EPA increased its emphasis on addressing wet weather conditions and discharges from municipal collection systems and at treatment facilities. In 1989, EPA published the National Combined Sewer Overflow (CSO) Control Strategy which provided recommendations for NPDES permits for CSOs. See 54 FR 37370 (September 8, 1989). In 1994, EPA issued the CSO Control Policy to provide greater national clarity and consistency in the way NPDES requirements apply to flows in combined sewers and to CSO discharges. See 59 FR 18688 (April 19, 1994). In addition, the Agency increased compliance assistance and enforcement activities associated with sanitary sewer overflows (SSOs) during the 1990s. In 2000, EPA issued the Compliance and Enforcement Strategy Addressing Combined Sewer Overflows and Sanitary Sewer Overflows. This strategy called for each EPA Region to develop an enforcement response plan, including an inventory of SSO violations and a description of how 20% of the priority systems with SSO violations would be addressed each year.

Reducing the frequency and volume of collection system overflows and backups of sewage into buildings, and improving the structural integrity of collection systems have been some of the major objectives of EPA's emphasis on wet weather discharges. Typically, an important component of strategies to reduce collection system overflows and backups into buildings is to increase the conveyance of wet weather flows to the treatment plant. The volume of wet weather flows delivered to treatment facilities can also be increased by measures that reduce exfiltration of wastewater out of a collection system. Increased wet weather flow volumes at treatment plants, along with increased attention to water quality problems caused by wet weather flows have lead to increased attention to the manner by which POTWs manage wet weather flows.

As these issues received greater attention, regulatory agencies, municipal operators of POTWs, and representatives of environmental advocacy groups have expressed confusion over and requested clarification regarding the proper interpretation of certain regulatory provisions in the context of wet weather flow management at POTW treatment plants. Of particular concern are National Pollutant Discharge Elimination System (NPDES) permit requirements for peak wet weather discharges from a publicly owned treatment works (POTW) treatment plant when the portion of the flow that exceeds the capacity of the biological treatment units is routed around biological treatment units and blended with the flows from the biological units (or other advanced treatment units) prior to discharge. Such re-routing where the capacity of biological (or other advanced) treatment units is exceeded might be necessary to avoid damaging the treatment units. Questions have focused primarily on the situation where the final discharge of these blended waste streams would meet effluent limitations based upon the secondary treatment regulations and any more stringent limitations necessary to meet water quality standards.

Today's proposed policy may affect certain actions under consideration by NPDES permit authorities to address comprehensive sewer collection system and treatment activities by POTWs. The Agency seeks comment on what, if any, impact today's proposed policy may have on Federal or State enforcement actions under the CWA or citizen suit actions under section 505 of the Act, including assurance of implementation of the various criteria identified in the proposed interpretation and draft guidance.

After review of public comments, and following any appropriate revisions, EPA intends that ultimately such policy would provide a framework that (1) ensures appropriate management of wet weather flows at a POTW consistent with generally accepted good engineering practices and criteria for long-term design, (2) clarifies technology-based requirements (3) uses water quality-based effluent limitations to address residual site-specific health and environmental risks, and (4) provides appropriate safeguards, including comprehensive monitoring and protection for sensitive waters.

B. Sewage Treatment Issues Associated With Wet Weather Flows

Although a number of sewage treatment processes are used to comply with Clean Water Act requirements, most municipalities typically use a series of unit operations and processes to treat wastewater prior to discharge. The typical series of unit processes includes: preliminary treatment or screening to remove large solids; primary clarification (or preliminary sedimentation) to remove floating and settleable solids; and biological treatment units (also referred to as secondary treatment units) to remove biodegradable organic pollutants and suspended solids. The most common type of conventional biological treatment unit, an activated sludge process, typically consists of aerator tanks (also called reactors) followed by separate settling basins or clarifiers. Many treatment facilities also provide disinfection to deactivate pathogens and achieve microbial water quality standards. Some facilities also provide advanced treatment which are designed to reduce constituents, such as nitrogen and phosphorus, that are not significantly removed by biological treatment processes, or are designed to provide greater solids and pathogen reductions than traditional biological treatment processes.

During periods of wet weather, flows received by a POTW's collection system and treatment facility typically increase. Significant increases in influent flow caused by wet weather conditions (*e.g.*, due to infiltration and/or inflow of water into the collection system) can create operational challenges for treatment facilities and potentially adversely affect treatment efficiency, reliability, and control of unit process operations with a treatment plant. Activated sludge systems are particularly vulnerable to high volume peak flows. Peak flows that approach or exceed design capacity of an activated sludge unit can shift the solids inventory from the aeration basin to the clarifier(s), and can result in excessive solids losses from the clarifier(s) (*i.e.*, wash out the biological mass necessary for treatment). The shifting of solids from an aeration basin to a clarifier diminishes treatment rates until after flows have decreased and the solids are returned to the aeration basin. If a clarifier experiences excessive loss of solids, treatment efficiencies can be lowered for weeks or months until the biological mass in the aeration basins is reestablished. In addition to these

hydraulic concerns, wastewater associated with peak flows may have low concentrations of oxygen demanding pollutants, which can also decrease treatment efficiencies.

Generally, biological treatment units are designed and operated to maintain a relatively stable population of microorganisms. See 48 FR 52258, 52275 (November 16, 1983). This means that biological treatment units generally cannot be designed to accommodate wide variations in flow volumes and influent strength. Primary clarification units are less sensitive to variations in flow volumes and influent strength. In addition, primary clarification units can be brought into operation and taken out of operation to respond to changes in flow volume.

Many POTW treatment plants have been designed with primary treatment capacity that is significantly greater than the biological treatment capacity. These treatment plants often have multiple primary clarification units that are operated in parallel, with one or more primary clarification units not operating during low flow conditions, and brought into service during high flow conditions. These POTWs typically provide screening and primary clarification of all flows entering the plant, and, in order to protect their biological treatment units, route flows in excess of full capacity of the biological treatment unit around the biological treatment units. In some cases, chemicals are added to the portion of the flow that is routed around the biological treatment units to enhance solids and/or pathogen removal. Another option is to provide other forms of enhanced physical/chemical treatment for the portion of the flow that is routed around the biological units. Some POTWs discharge flows routed around biological treatment units directly to a surface water, while others blend the flows routed around the biological treatment units with flows that have gone through the biological treatment unit (*e.g.*, for disinfection or other advanced treatment) prior to discharge.

Other design and operational options routinely employed to enhance treatment of wet weather flows without damaging biological treatment capabilities include:

- Increasing the size of secondary clarifiers to accommodate a pre-determined amount of peak wet weather flow;
- Providing alternative feed patterns in the aeration basin(s);
- Increasing the returned activated sludge capacities relative to those needed for steady flow;
- Providing flow equalization (*i.e.* short term storage) prior to the biological unit either at the plant or before flows get to the plant; and
- Decreasing peak flow volumes through I/I removal, sewer separation or rerouting flows to a different treatment plant.

See Design of Municipal Wastewater Treatment Plants Fourth Edition, 1998, Water Environment Federal Manual of Practice 8, ASCE Manual and Report of Engineering Practice No. 76, Volume 2, page 11–5; Prevention and Control of Sewer System Overflows Second Edition, 1999, Water Environment Federation Manual of Practice FD–17.

Other facilities may employ other modifications to manage peak wet weather flows. For example, some facilities divert dilute wet weather flows around primary clarifiers to the biological treatment units in order to ensure adequate organic loadings in the biological units. Given the complexity and site-specific nature of collection systems and treatment facilities, site-specific planning processes are necessary to identify the optimal mix of peak wet weather management measures.

Many States have developed detailed design criteria and/or operating practices for municipal wastewater treatment facilities. EPA has also developed guidance on design considerations and operation of POTWs, including guidance on the composite correction program approach to identify and address performance limitations and to obtain improved performance at POTWs. EPA Technology Transfer Handbook: Retrofitting POTWs, 1989, Hegg, B.A., L.D. DeMers, and J.B. Barber. This guidance identifies specific low cost modifications that can be used to optimize an existing facility's performance which can result in significant improvements of performance at many wastewater treatment facilities without major capital improvements. Hegg, B.A., K.L. Rakness, and J.R. Schultz, 1979, *A Demonstration Approach for Improving Performance and Reliability of Biological Wastewater Treatment Plants* EPA 600/2–79–035, NTIS No. PB–300476, USEPA, Cincinnati, OH.

C. NPDES Requirements for POTWs

The CWA requires that most POTWs achieve effluent limitations based upon secondary treatment as defined by EPA and any more stringent limitations necessary to meet water quality standards prior to discharging to waters of the United States. NPDES permits are issued by EPA or States, U.S. Territories, or Tribes authorized by EPA to do so. Currently, 45 States and one U.S. Territory administer the NPDES permit program. EPA issues NPDES permits in the remaining States and Territories, and in Indian country.

1. Secondary Treatment Regulations

Section 301(b)(1)(B) of the Clean Water Act, 33 U.S.C. 1311(b)(1)(B), requires that publicly owned treatment works (POTWs) achieve effluent limitations based upon secondary treatment as defined by the Administrator of EPA pursuant to section 304(d)(1) of the Act. Section 304(d)(1) of the Act directed EPA to publish information, in terms of amounts of constituents and chemical, physical, and biological characteristics of pollutants, on the degree of effluent reduction attainable through the application of secondary treatment. Section 304(d)(4) of the Act, 33 U.S.C. 1314(d)(4), deems treatment facilities such as oxidation ponds, lagoons, ditches and trickling filters to be the "equivalent" of secondary treatment. That section directed the Administrator to provide guidance on design criteria for such facilities, taking into account pollutant removal efficiencies. Section 304(d)(4) further requires that water quality not be adversely affected by deeming such facilities to be the equivalent of secondary treatment.

EPA promulgated the secondary treatment information regulations at 40 CFR part 133 to define minimum levels of effluent quality for publicly owned treatment works (POTWs) prior to discharge. The secondary treatment regulations were based on performance data for a sample of well-designed and well-operated secondary treatment plants. The 30-day average effluent limitations in the secondary treatment regulations were based on the 95th-percentile value of data representing well-operated POTWs, excluding values attributable to upsets, bypasses, operational errors, or other unusual conditions. With the exception of section 304(d)(4) facilities eligible for treatment equivalent to secondary treatment, the secondary treatment regulations do not otherwise specify the type of treatment process to be used to meet secondary treatment requirements nor do they preclude the use of non-biological facilities. Rather, the basic decisions on the choice of a technology or alternative waste management technique were left to a case-by-case cost-effectiveness analysis. See 48 FR 52258, 52260 (November 16, 1983).

The requirements of the secondary treatment regulations are expressed as concentration limitations (seven-day and 30-day average effluent

concentration limitations for total suspended solids and five-day biochemical oxygen demand (BOD_5)), percent removal requirements (for total suspended solids and BOD_5), as well as a limitation on pH. The regulations require that percent removal requirements for total suspended solids (SS) and the five-day measure of biochemical oxygen demand (BOD_5) be determined according to a 30-day average. The percent removal requirements were originally established to achieve two basic objectives: (1) to encourage municipalities to correct excessive I/I problems in their sanitary sewer systems, and (2) to help prevent intentional dilution of influent wastewater as a means of meeting permit limits. See 50 FR 23382 (June 3, 1985).

For most types of POTWs, the secondary treatment regulations establish a 30-day average percent removal requirement of 85 percent for SS and BOD_5. Facilities eligible for equivalent treatment considerations under section 304(d)(4) are subject to less stringent percent removal requirements. The secondary treatment regulations provide for case-by-case adjustments to the percent removal requirements to address several special considerations. Under § 133.103(a), for treatment works that receive flows from combined sewers, the decision must be made on a case-by-case basis as to whether any attainable percentage removal level can be defined when the plant receives highly dilute influent, *e.g.*, during wet weather flows, and, if so, what the level should be. For treatment works that receive flows from separate sewers, § 133.103(d) authorizes the permit issuing authority to substitute a less restrictive 30-day average percent removal requirement or a mass loading limit for the percent removal requirement if the permittee demonstrates that:

(i) The treatment facility will consistently meet its permit effluent concentration limitations but its percent removal requirements cannot be met due to less concentrated influent,

(ii) to meet the percent removal requirements, the facility would have to achieve significantly more stringent limitations than would otherwise be required by concentration-based standards, and

(iii) the less concentrated influent is not the result of excessive I/I. Excessive I/I is the quantities of I/I that can be economically eliminated from a sewer system as determined by a cost-effectiveness analysis that compares the costs for correcting the I/I conditions to the total costs for transportation and treatment of the I/I to a treatment facility.

For these separate sanitary sewer systems, the determination of whether the less concentrated wastewater is the result of excessive I/I uses the definition of excessive I/I in 40 CFR 35.2005(b)(16) plus the additional criterion that inflow is deemed nonexcessive if the total flow to the POTW (*i.e.*, wastewater plus inflow plus infiltration) is less than 275 gallons per capita per day. See 40 CFR 133.103(d). The 275 gallons per capita per day figure is only a threshold value, and permittees may determine that even higher values of I/I are nonexcessive through a cost-effective evaluation on a case-by-case sewer system basis. See 50 FR 23384 (June 3, 1985) and 54 FR 4225 (January 27, 1989). Guidance for the cost-effectiveness analysis associated with demonstrating that I/I is not excessive is provided in *Sewer System Infrastructure Analysis and Rehabilitation,* (EPA, 1991, EPA/625/6–91/030).

EPA adopted this approach to provide flexibility to address facilities experiencing various degrees of less concentrated influent that cannot meet the 85 percent removal requirement without significant additional construction, and, at the same time, encourage cost effective I/I reduction. See 40 CFR 133.101(m) and 133.103(d)(3). The approach was based on the following considerations: (1) In general, I/I programs had not been as successful in reducing excessive I/I as expected; (2) many treatment systems without excessive I/I had relatively low concentrations of BOD_5 and SS in the influent; (3) certain treatment technologies could not achieve 85 percent removal under all conditions; and (4) a mandatory requirement of 85 percent removal for all POTWs could have caused overly stringent levels of treatment and use of expensive advanced treatment processes in some cases. See 50 FR 23382 (June 3, 1985).

2. Bypass Provision

The NPDES regulations define standard permit conditions which are to be included in all NPDES permits, except that authorized NPDES States are not precluded from omitting or modifying a standard permit condition to impose a more stringent requirement. 40 CFR 122.41 and 123.25 (note). One of those standard permit condition is the "bypass" provision at 40 CFR 122.41(m).

The bypass provision defines bypass to mean the "intentional diversion of waste streams from any portion of a treatment facility." The regulation prohibits bypasses except for where necessary for essential maintenance to assure efficient operation. 40 CFR 122.41(m)(2). In such cases, the bypass cannot cause effluent limitations to be exceeded. For all other bypasses, the Director of the NPDES program may take enforcement action against a permittee for a bypass, unless:

(A) Bypass was unavoidable to prevent loss of life, personal injury, or severe property damage;

(B) There were no feasible alternatives to the bypass, such as the use of auxiliary treatment facilities, retention of untreated wastes, or maintenance during normal periods of equipment downtime. This condition is not satisfied if adequate back-up equipment should have been installed in the exercise of reasonable engineering judgment to prevent a bypass which occurred during normal periods of equipment downtime or preventative maintenance; and

(C) The permittee submitted the required notices. 40 CFR 122.41(m)(4)(i).

In order to satisfy the "no feasible alternatives" criterion, adequate back-up equipment should be installed in the exercise of reasonable engineering judgment to prevent a bypass. 40 CFR 122.41(m)(4)(i)(B). The "no feasible alternatives" provision of 40 CFR 122.41(m) requires, among other things, that consideration be given to the feasibility of additional construction to prevent any bypasses that occur because of inadequate capacity. See *United States* v. *City of Toledo, Ohio* 63 F.Supp.2d 834 (N.D. Ohio 1999).

The regulation at 40 CFR 122.41(m) also provides that the Director of the NPDES program may approve an anticipated bypass, after considering its adverse effects, if the Director determines that it will meet the three conditions listed in the bypass provision at 40 CFR 122.41(m)(4)(i). As discussed below, EPA provided guidance on approval of anticipated bypasses at POTWs served by combined sewers in the 1994 Combined Sewer Overflow (CSO) Control Policy. An approved anticipated bypass would be a recognition that the permitting authority had considered the adverse impacts of the bypass and has found that the bypass would or does meet the criteria of 40 CFR 122.41(m)(4)(i)(A), (B) and (C), and would not take enforcement action against a permittee for the bypass. Compliance with 40 CFR 122.41(m)(4)(i), in and of itself, would not shield a permittee from citizen suits for conducting a prohibited bypass. *Southern Ohio Coal Company* v. *Office of Surface Mining, Reclamation and*

Enforcement, 20 F.3d 1418, 1427 (6th Cir. 1994).

The bypass regulation does not dictate that any specific treatment technology be employed. Instead, the regulation requires that a system be operated as designed and according to the conditions of the NPDES permit. See *NRDC* v. *EPA*, 822 F.2d 104, 123 (D.C. Cir. 1987). For example, seasonal effluent limitations which allow the facility to shut down a specific pollution control process during certain periods of the year are not considered to be a bypass provided the variation in effluent limits is accounted for and recognized in the permit which allows a facility to dispense with some unit processes under certain conditions. See 49 FR 37998, 38037 (September 26, 1984).

As noted earlier, all NPDES permits are required to contain a prohibition on bypasses consistent with or more stringent than 40 CFR 122.41(m). See 40 CFR 123.25 (note). The bypass provision at 40 CFR 122.41(m) defines bypass to mean the intentional diversion of waste streams from any portion of a treatment facility. However, the term "treatment facility" is not defined in the bypass regulation. Today's action requests public comment on: (1) A proposed interpretation of the bypass regulations regarding the term "treatment facility" as it relates to the treatment plant at a POTW; and (2) draft guidance on how NPDES authorities can characterize the "treatment facility" in a specific permit for a POTW treatment plant to account for the flow routing scenario. The Agency's proposed policy would be restricted to POTW treatment plant discharges under peak wet weather conditions where flows in excess of the biological or advanced treatment units are routed around the biological or advanced treatment units and blended with the wastewaters from the biological units (or other advanced treatment units) prior to discharge, and where the final discharge would meet effluent limitations based upon the secondary treatment regulations and any more stringent limitations necessary to meet water quality standards.

3. Combined Sewer Overflow Control Policy

EPA has provided guidance on the planning, selection and implementation of controls to meet technology- and water quality-based requirements for CSOs under the NPDES program in the National CSO Control Strategy, 54 FR 37370 (September 8, 1989), and the CSO Control Policy, 59 FR 18688 (April 19, 1994). The 1994 CSO Control Policy provides comprehensive guidance for developing site-specific NPDES permit requirements for combined sewer systems to address wet weather CSO discharges from designed overflow points. The Wet Weather Water Quality Act of 2000 amended the CWA to provide that each permit, order or decree issued after December 15, 2000, for a discharge from a municipal combined sewer shall conform to the CSO Control Policy. 33 U.S.C. 1342(q)(1).

Under the CSO Control Policy, permittees with combined sewer systems were to immediately undertake a process to accurately characterize their sewer systems, to demonstrate implementation of nine minimum controls identified in the Policy, and to develop and implement a long-term CSO control plan that would ultimately provide for compliance with the requirements of the CWA. See 59 FR 18688 (April 19, 1994). The CSO Control Policy identifies EPA's major objectives for long-term control plans.

When developing the CSO Control Policy, EPA recognized that some POTW treatment plants may have primary treatment capacity in excess of their biological treatment capacity. See 59 FR 18693, column 2. The Policy indicates that one effective strategy to abate pollution resulting from CSOs is to maximize the delivery of flows during wet weather to the POTW treatment plant for treatment. This strategy can maximize the use of available POTW facilities for wet weather flows and ensure that combined sewer flows receive at least primary treatment prior to discharge. In addition, this strategy may enable the permittee to eliminate or minimize overflows to sensitive areas. In recognition of the significant water quality benefits of maximizing flow to the POTW treatment plant, the CSO Control Policy includes it as a minimum element of a long-term control plan.

To further the objective of maximizing treatment at the POTW treatment plant, the CSO Control Policy provides guidance on the use of an NPDES permit to recognize approval of anticipated bypasses where the criteria of the bypass provision for such approvals are met. The CSO Control Policy clarifies that normally it is the responsibility of the permittee to document, on a case-by-case basis, compliance with 40 CFR 122.41(m) in order to have an anticipated bypass approved in a permit. The Policy indicates that for some CSO-related permits, the study of feasible alternatives in the long-term control plan, along with other information in the permit record, may provide sufficient support for approval of a CSO-related bypass in the permit, and to define the specific parameters under which a bypass can be approved. The Policy provides that where a permit includes an approval of a CSO-related bypass, the permit would define the specific wet weather conditions under which a CSO-related bypass would be allowed and would also specify what treatment, monitoring, and effluent limitations would apply to the bypass flow.

The Policy provides that permits with approved bypasses should also make it clear that all wet weather flows passing the headworks of the POTW treatment plant will receive at least primary clarification, solids and floatables removal and disposal, and disinfection where necessary, and any other treatment that can reasonably be provided.

The CSO Policy further indicates that the "no feasible alternatives" requirement of the bypass regulation can be met if the record shows that the secondary treatment system is properly operated and maintained, that the system has been designed to meet secondary limits for flows greater than the peak dry weather flow, plus an appropriate quantity of wet weather flow, and that it is either technically or financially infeasible to provide secondary treatment at the existing facilities for greater amounts of wet weather flow. See 59 FR 18694, column 3. The feasible alternative analysis should include, for example, consideration of enhanced primary treatment—*e.g.*, chemical addition and non-biological secondary treatment. *Id.* Other bases supporting a finding of "no feasible alternatives" may also be available on a case-by-case basis. As part of its consideration of possible adverse effects resulting from the bypass, the permitting authority should also ensure that the bypass will not cause exceedances of water quality standards. *Id.*

D. Water Quality Criteria for Bacteria

In 1986, EPA published Ambient Water Quality Criteria for Bacteria—1986, which contained EPA's recommended water quality criteria for bacteria for protection of bathers from gastrointestinal illness in recreational waters. The water quality criteria established levels of indicator bacteria, namely Escherichia coli (E. coli) and enterococci, that demonstrate the presence of fecal pollution and which should not be exceeded in order to protect bathers in fresh and marine recreational waters. Prior to its 1986 recommendations, EPA recommended specific levels of fecal coliforms to be

used as the indicator organism to protect bathers from gastrointestinal illness in recreational waters.

The data supporting the 1986 bacteria water quality criteria were obtained from a series of epidemiological studies that examined the relationship between swimming-associated illness (namely, acute gastrointestinal illness) and the microbiological quality of the waters used by recreational bathers. The epidemiological studies demonstrated that fecal coliforms, the indicator originally recommended in 1968 by the Federal Water Pollution Control Administration of the Department of Interior, are correlated less strongly with swimming-associated gastroenteritis than other possible indicator organisms. Two indicator organisms, E. coli and enterococci, exhibited a strong correlation to swimming-associated gastroenteritis, the former in fresh water only and the latter in both fresh and marine waters. The strong correlation is due to the indicator organisms being more similar to many of the pathogens of concern in their ability to survive treatment and in the environment. Enterococci are also resistant to saline environments, enhancing their utility as an indicator in marine waters. In addition, E.coli and enterococci are less frequently found than fecal coliforms in environmental settings where fecal contamination is known to be absent.

The Beaches Environmental Assessment and Coastal Health (BEACH) Act was enacted on October 10, 2000. Public Law 106–284, 114 Stat. 870 (2000). The BEACH Act addresses pathogens and pathogen indicators in coastal recreation waters. Among other things, the BEACH Act added section 303(i) to the Clean Water Act to require States and Tribes with coastal (and Great Lake) recreation waters to adopt new or revised water quality standards by April 10, 2004, for pathogens and pathogen indicators for which EPA has published criteria under section 304(a). The BEACH Act also directs EPA to promulgate standards for States and Tribes that fail to adopt standards for pathogens and pathogen indicators for coastal recreation waters that are as protective of human health as those published by EPA.

III. Proposed Policy

EPA has received requests from many stakeholders to clarify the NPDES requirements for discharges from POTWs where peak wet weather flow is routed around biological treatment units and then blended with the effluent from the biological units prior to discharge where the final discharge meets permit effluent limitations based on the secondary treatment regulation (40 CFR part 133) or any more stringent limitations necessary to attain water quality standards. Today's proposed policy has two components, (1) a proposed interpretation of the bypass provision (40 CFR 122.41(m)) as it applies to alternative wet weather treatment scenarios at POTW treatment plants that involve blending; and (2) draft guidance on how such an interpretation should be implemented. EPA requests comments on both the proposed interpretation and the draft guidance.

Peak wet weather discharges from POTWs that consist of effluent routed around biological or other advanced treatment units blended together with the effluent from the biological units (or from other advanced treatment units) prior to discharge would not be a prohibited bypass and could be authorized in an NPDES permit if all of the following principles were followed:

1. The final discharge meets effluent limitations based on the secondary treatment regulation (40 CFR part 133), including applicable 30-day average percent removal requirements, or any more stringent limitations necessary to attain water quality standards. For treatment works served by sanitary sewers, the Director of the NPDES permit program may substitute lower 30-day average percent removal requirements or a mass loading limit for the percent removal requirement only if the permittee demonstrates the criteria in § 133.103(d) are met, including that the less concentrated influent is not the result of excessive I/I. For treatment works served by combined sewers, § 133.103(a) provides that the decision must be made on a case-by-case basis as to whether any attainable percentage removal level can be defined during wet weather flows, and, if so, what the level should be.

2. The NPDES permit application for the POTW provides notice of, and specifically recognizes, the treatment scenario that would be used for peak flow management. The treatment scenario, including designed capacity of various units, should be consistent with generally accepted practices and long-term design criteria, and designed to ensure that discharges meet effluent limitations based on the secondary treatment regulation and any more stringent limitations necessary to meet water quality standards (including limitations necessary to meet applicable total maximum daily loadings). The application of the generally accepted practices and long-term design criterion typically would include an evaluation of changes to the base and peak design flows at the treatment plant from the time the peak flow treatment scenario was last recognized by the NPDES authority, and, if circumstances have materially and substantially changed, an evaluation of the cost-effectiveness of a reasonable range of alternatives, which may entail construction of facilities to provide additional wet weather capabilities, such as equalization and/or storage facilities, or high-efficiency physical/chemical treatment for diverted flows. The application of the generally accepted practices and long-term design criterion should be reevaluated as circumstances change materially and substantially, and at permit reissuance. Any permit issued after EPA evaluates public comments received and takes further action on today's proposed policy should specifically recognize or incorporate by reference the treatment scenario that would be used for peak flow management. EPA notes that requiring documentation of the treatment scenario in the permit would ensure that EPA would have an opportunity to review the documentation during its review of permits issued by an authorized NPDES State. In addition, the public would have an opportunity to review and comment on the specific conditions under which blending would be authorized prior to final approval and issuance of the permit.

3. The treatment scenario that would be used for peak flow management should provide, prior to blending, at least the equivalent of primary clarification for the portion of flow routed around biological or other advanced treatment units.

4. The peak flow treatment scenario chosen by the permittee for use when flows exceed the capacity of storage/equalization units, biological treatment units or advanced treatment units should be operated as it is designed to be operated and in accordance with the treatment scenario reflected in the permit record and conditions set forth in the permit. A portion of the flow should only be routed around a biological or advanced treatment unit when the capacity of the treatment unit is being fully utilized. Additionally, for permits issued after EPA evaluates public comments received and takes further action on today's proposed policy, such a peak flow treatment scenario should only be used when flows exceed the capacity of storage/equalization units based on generally accepted good engineering practices and long-term design criteria aimed at protecting the structural integrity and function of the treatment units and

under the specific circumstances recognized in the permit.

5. The permit must require monitoring, including type, interval and frequency sufficient to yield data which are representative of the final blended discharge to ensure compliance with applicable water quality-based effluent limitations. See 40 CFR 122.48(b). The permit should require reporting of the date and volume of blended discharges along with appropriate pollutant parameter concentrations. In addition, the permit should ensure that permittees develop additional information to support the development of water quality-based effluent limitations in subsequent permits, including information to: (a) Assess potential water quality impacts associated with blended effluent; (b) evaluate the effectiveness of the treatment of key parameters, such as pathogens, resulting from alternative flow routing scenarios; and (c) characterize ambient levels of such pollutant parameters.

6. The permit must require, at a minimum, that the permittee properly operate and maintain all parts of the collection system over which the permittee has operational control in a manner consistent with 40 CFR 122.41(e). For POTWs served by combined sewers, any permit issued after December 15, 2000, shall conform to the provisions of the 1994 CSO Control Policy, including the development and implementation of a long-term control plan (LTCP), and appropriate requirements for the collection system. As applied to POTWs serving separate sanitary sewers, EPA would interpret "proper operation and maintenance" to include appropriate removal of infiltration and inflow from parts of the collection system over which the permittee has operational control as well as measures to evaluate the structural integrity of the system. Such a demonstration may be made with a program self-evaluation report, appropriate to the size of the system, which includes an identification of program deficiencies and steps to respond to them.

In situations where one or more of the above principles would not be met, EPA would continue to interpret the "intentional diversion of waste streams from any portion of a treatment facility" at a POTW treatment plant to be a bypass subject to the restrictions of the bypass provision as reflected in the permit. The proposed policy upon which EPA invites comment today is not intended to modify the provision for approval of anticipated bypasses at 40 CFR 122.41(m)(4)(ii). See 59 FR 18693, column 3.

The principles described above for characterizing the "treatment facility" at a POTW plant (as it relates to the bypass provision) are not intended to address or apply to NPDES permit requirements for treatment of flows at a POTW during dry weather conditions or to discharges from facilities other than POTW plants, including industrial facilities where storm water is treated with non-storm water wastewater. The matters addressed in today's action focus on situations with elevated I/I levels in municipal collection system resulting from wet weather conditions. EPA has not evaluated and does not propose to interpret its regulations to apply to other circumstances.

EPA requests comment on the use of the six principles listed above to define the conditions under which the blending of effluent routed around the biological treatment unit with effluent from the biological treatment unit, prior to discharge would not be a prohibited bypass and could be authorized in an NPDES permit. EPA specifically requests comment on the following issues:

(1) Is the current interpretation of "excessive I/I" under 40 CFR 133.103(d) adequate? What challenges, if any, would facilities face in meeting the percent removal requirements or obtaining an adjustment to percent removal requirements under § 133.103(d), including the excessive I/I provisions, as a pre-condition for authorization of blending in an NPDES permit?

(2) In principle 4, which would require that flow only be routed around the biological or advanced treatment unit when the capacity of treatment and storage units is being fully utilized, should EPA define the term "fully utilized"? Are there situations where system operators might need to keep some treatment or storage capacity in reserve, for example, to help prevent overflows or address other peak flow concerns where exceedences of treatment capacity is likely but has not yet occurred? If so, the commenter should describe the situations.

(3) Principle 5 of this draft policy is designed to ensure compliance with applicable water quality-based effluent limitations, including those based on water quality criteria for bacteria. Would this principle be sufficient to protect against discharges of pathogenic organisms or should principle 5 of this draft policy include an explicit requirement for disinfection of blended effluent prior to discharge, where appropriate?

(4) In developing principle 6, what factors should be considered when evaluating if a permittee is properly operating and maintaining their collection system in a manner consistent with 40 CFR 122.41(e)?

Additional considerations for permit writers addressing POTW plants that use peak flow treatment scenarios that consist of effluent routed around biological or other advanced treatment units blended together with the effluent from the biological units prior to discharge should include:

A. To the extent practicable, NPDES permit requirements for discharges of peak wet weather flows at the POTW should be developed in a manner that encourages the permittee to consider the relationship between the performance of the collection system and the performance of treatment plants serving the system.

B. Any POTW receiving wastes from an industrial user to which a categorical pretreatment standard applies may, at its discretion and subject to the conditions of 40 CFR 403.7, grant removal credits to reflect removal by the POTW of pollutants specified in the categorical pretreatment standard. The POTW may grant a removal credit equal to or, at its discretion, less than its consistent removal rate. The permit writer should ensure that the POTW's determination of the consistent removal rate adequately reflects the frequency of use of and treatment effectiveness of the peak flow treatment scenarios in a manner that is consistent with 40 CFR 403.7(b). In a similar manner, the permit writer should ensure that the POTW adequately reflects the frequency of use of and treatment effectiveness of the peak flow treatment scenarios in developing local limits for industrial users.

C. NPDES Permit Conditions That Are Clear and Enforceable.

Under the interpretation proposed today, NPDES authorities would be able to characterize the term "treatment facility" in a specific permit for a POTW treatment plant to account for peak flow treatment scenarios that are consistent with generally accepted good engineering practices and criteria for long-term design in a manner consistent with the principles previously identified. Where all of the identified principles are followed, flows through a treatment system that is operated as designed and according to the permit would not be considered a bypass, and the permittee would not be required to make each of the demonstrations otherwise required under the bypass provision at 40 CFR 122.41(m)(4)(i),

including a demonstration that there were no feasible alternatives to the bypass.

Where a POTW treatment facility has multiple primary clarification units operating in parallel to provide excess primary treatment capacity for high flow conditions, removing one or more primary clarification units from operation during low flo conditions would not be considered a bypass provided the capacity of the primary clarification units remaining in operation is not exceeded. Similarly, where chemical addition is used to enhance wet weather treatment performance (*i.e.*, to enhance solids removal or disinfection), discontinuing chemical addition during low flow conditions would not be considered a bypass if the permit does not call for such chemical addition during low flow conditions.

The NPDES regulations require that NPDES permits must include water quality-based effluent limitations to control all pollutants or pollutant parameters which the Director of the NPDES program determines are or may be discharged at a level which will cause, have the reasonable potential to cause, or contribute to non-attainment of any water quality standard (see 40 CFR 122.44(d)). The potential impact of either blended peak wet weather flows discharged from POTWs or peak wet weather flows that receive biological treatment may raise a number of site-specific water quality issues depending on the performance of treatment technologies under peak flow conditions, the volume of discharges, receiving water conditions, the uses of receiving waters and other factors. Ensuring appropriate characterization of potential human health and environmental risks associated with peak flows with enhanced effluent and ambient monitoring data describing peak flow conditions is important for discharges to receiving waters with designated uses for primary contact recreation and/or drinking water. Additional information may be needed to determine if POTW discharges that occur under peak wet weather flow conditions would cause, have a reasonable potential to cause, or contribute to non-attainment of a water quality standard. Modeling of the collection system, treatment facility and receiving water may be necessary to characterize the impact of peak wet weather flows on receiving water quality and to predict the improvements that would result from different treatment scenarios.

The NPDES regulations authorize permitting authorities to modify permits for cause. See 40 CFR 122.62 and 124.5. In addition, permits often contain a reopener clause. Examples include general reopener clauses that mirror the causes for modification in the NPDES regulations. Permits also often contain specific reopener clauses for the purpose of modifying conditions based on results of specific pollutant monitoring required in the permit, such as for toxic pollutants. EPA requests comment on whether permits that authorize blending should contain a specific reopener clause. Such a reopener clause could address situations where additional controls are necessary to assure attainment of water quality standards or where new monitoring information justifies the application of different permit conditions.

One of EPA's highest priorities in developing control strategies for wet weather discharges is ensuring adequate control of such discharges to sensitive receiving waters. Sensitive receiving waters, as determined by the NPDES authority in coordination with State and Federal agencies, as appropriate, include: Designated Outstanding National Resource Waters; National Marine Sanctuaries; waters with threatened or endangered species (and associated habitat;) waters with primary contact recreation (*e.g.*, beaches and other points of public access); public drinking water intakes or their designated protection areas; and shellfish beds. See the 1994 CSO Control Policy (59 FR 18688, April 19, 1994). Wherever physically possible and economically achievable, discharges of blended effluent to a sensitive area should not be authorized, except where prohibiting the discharge of blended effluent would provide less environmental protection than additional treatment. Where elimination of the discharge of blended effluent to a sensitive receiving water is not physically possible and economically achievable, the permitting authorities must ensure an adequate demonstration that the discharge will not cause or have reasonable potential to cause or contribute to non-attainment of applicable water quality standards. For such discharges, each subsequent permit term should require a reassessment based on new or improved techniques, or on changing circumstances that influence economic achievability.

EPA strongly encourages States that have not already done so to adopt the recommendations set forth in Ambient Water Quality Criteria for Bacteria—1986 or other protective water quality criteria for bacteria based on scientifically defensible methods as their water quality standards to replace water quality standards based on total or fecal coliforms.

Today's proposed policy would provide guidance to EPA Regional and State permitting authorities as well as to municipal permittees and the general public on how EPA intends to exercise its discretion in implementing the statutory and regulatory provisions related to discharges from POTWs where peak wet weather flow is routed around biological treatment units and then blended with the effluent from the biological units prior to discharge and where the final discharge meets permit effluent limitations based on the secondary treatment regulation (40 CFR part 133) or any more stringent limitations necessary to attain water quality standards. The guidance is designed to implement national policy on these issues.

The statutory provisions and EPA regulations described in this document contain legally binding requirements. Today's document would not substitute for those provisions or regulations, nor is it intended to be a regulation itself. In fact, today's action invites public comment on a proposed interpretation of EPA regulations in a specific context and invites comment on guidance to implement such a proposed interpretation. Thus, this document would not impose legally binding requirements on EPA, States, or the regulated community, and may not apply to a particular situation based upon the circumstances. EPA and State decisionmakers would retain the discretion to adopt approaches on a case-by-case basis that differ from this proposed policy where appropriate. Any decisions regarding a particular facility should be made based on the statute and regulations. Therefore, interested parties are free to raise questions and objections about the substance of this proposed policy and the appropriateness of the application of this proposed policy to a particular situation. EPA intends to and States should, consider whether or not the recommendations or interpretations in the proposed policy are appropriate in that situation. EPA may revise today's proposed policy after consideration of public comment, or at some other time in the future. EPA welcomes public comments on this document and will consider those comments in any future revision of today's proposed policy.

EPA's intention is to reduce confusion regarding appropriate consideration of blending at POTWs. Because of significant interest from various stakeholders, the Agency is inviting public comment on the proposed policy, including the proposed interpretation of

EPA regulations. To date, EPA has not established a national policy (either through rulemaking or through non-binding guidance to assist in the interpretation of the bypass regulation) regarding whether and under what circumstances wet weather blending at a POTW plant would not constitute a bypass. Prior to today's action, permitting agencies have interpreted and applied the bypass regulation on a case-by-case basis according to the facts and circumstances presented by a particular POTW. Therefore, by today's action, EPA also invites comment on whether or not it should conduct rulemaking to implement the proposed policy, specifically, whether the Agency should revise the text of the regulations specifically to address the matters discussed in today's proposal.

Dated: November 3, 2003.

G. Tracy Mehan, III,

Assistant Administrator, Office of Water.

[FR Doc. 03–28103 Filed 11–6–03; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 300

[Docket No. 0310222265–3265–01; I.D. 092203E]

RIN 0648–AQ93

International Fisheries; Pacific Tuna Fisheries

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

ACTION: Proposed rule; 2003 management measures for tuna purse seine fisheries in the Eastern Pacific Ocean

SUMMARY: NMFS proposes this rule to implement the 2003 management measures to prevent overfishing of eastern tropical Pacific Ocean (ETP) tuna stocks, consistent with recommendations by the Inter-American Tropical Tuna Commission (IATTC) that have been approved by the Department of State (DOS) under the Tuna Conventions Act. The purse seine fishery for tuna in a portion of the Convention Area would be closed for the month of December, 2003. This action is taken to limit fishing mortality caused by purse seine fishing in that portion of the Convention Area and contribute to long-term conservation of the tuna stocks at levels that support healthy fisheries.

DATES: Comments must be submitted in writing by November 19, 2003.

ADDRESSES: Copies of the regulatory impact review/regulatory analysis may be obtained from the Southwest Regional Administrator, Southwest Region, NMFS, 501 W. Ocean Blvd., Long Beach, CA 90802–4213.

FOR FURTHER INFORMATION CONTACT: Svein Fougner, Sustainable Fisheries Division, Southwest Region, NMFS, 562–980–4040.

This **Federal Register** document is also accessible via the Internet at the Office of the **Federal Register**'s website at *http://www.access.gpo.gov/su-docs/aces/aces140.html.*

SUPPLEMENTARY INFORMATION: The United States is a member of the IATTC, which was established under the Convention for the Establishment of an Inter-American Tropical Tuna Commission signed in 1949. The IATTC was established to provide an international arrangement to ensure the effective international conservation and management of highly migratory species of fish in the Convention Area. The IATTC has maintained a scientific research and fishery monitoring program for many years and annually assesses the status of stocks of tuna and the fisheries to determine appropriate harvest limits or other measures to prevent overexploitation of the stocks and promote viable fisheries. The Convention Area is defined to include waters of the eastern tropical Pacific Ocean bounded by the coast of the Americas, the 40° N. and 40° S. parallels, and the 150° W. meridian. Under the Tuna Conventions Act, NMFS must publish proposed rules to carry out IATTC recommendations that have been approved by DOS. The Southwest Regional Administrator, also is required by rules at 50 CFR 300.29(b)(3) to issue a direct notice to the owners or agents of all U.S. purse seine vessels that operate in the ETP of actions recommended by the IATTC and approved by the DOS.

At its annual meeting held on June 25–27, 2003, the IATTC provisionally adopted a resolution dealing with conservation of ETP tuna stocks. However, one Party to the IATTC indicated that it would have to obtain higher level concurrence before it could officially agree to those measures and ultimately indicated it could not agree. The IATTC then held another meeting October 6–7, 2003, and agreed to measures for 2003. The IATTC agreed to recommend that purse seine fishing for tuna be prohibited in December 2003 in waters bounded by a line from the point where the 95° W. long. meridian intersects the west coast of the Americas, south to 10° S. lat, then west to 120° W. long., then south to 5° S. lat., then east to 100° W. long., then north to 5° N. lat., then east to 85° W. long., and then north to the point of intersection with the west coast of the Americas. This is a smaller closure than originally agreed to but will target fishing which has higher catches of juvenile tuna. Thus, there should be improved yields from the stocks later in the year. The IATTC action came after considering a variety of measures, including the use of quotas and partial fishery closures as in 1999, 2000, and 2001 and the full month purse seine closure used in 2002. In addition, the IATTC agreed to broader measures for 2004, which NMFS will consider in a future rulemaking, including a 6–week closure of all purse seine fisheries in the eastern Pacific Ocean beginning August 1, 2004, and limitation of longline fisheries to the bigeye tuna catch levels achieved in 2001. This approach should provide protection against overfishing of the stocks in a manner that is fair, equitable and readily enforceable. The DOS has approved this recommendation.

The proposed 2003 time/area closure is based on 2003 assessments of the condition of the tuna stocks in the ETP and historic catch and effort data for different portions of the eastern Pacific Ocean, as well as records relating to implementation of quotas and closures in prior years. To ensure the continued health of the stocks, the IATTC recommended and the DOS approved a closure in a portion of the Convention Area for the month of December 2003. The closure is targeted to areas with high catches of bigeye tuna in the purse seine fishery and, together with agreed upon restriction for 2004, is believed by the IATTC scientific staff to be sufficient to reduce the risk of overfishing of that stock, especially when considered in combination with the measures recommended for 2004. The IATTC will meet in June 2004 and review new tuna stock assessments and fishery information and will consider that new information in evaluating the need for management measures for 2005 and future years.

The Acting Regional Administrator, Southwest Region, sent a notice October 10, 2003, to owners and agents of U.S. tuna purse seine fishing vessels of the actions that were recommended by the IATTC and have been approved by the DOS.

Classification

This action is authorized by the Tuna Conventions Act, 16 U.S.C. 951–961 and 971 *et seq.*

On December 8, 1999, NMFS prepared a biological opinion (BO) assessing the impacts of the fisheries as they would operate under the regulations (65 FR 47, January 3, 2000) implementing the International Dolphin Conservation Program Act (IDCPA). NMFS concluded that the fishing activities conducted under those regulations are not likely to jeopardize the continued existence of any endangered or threatened species under the jurisdiction of NMFS or result in the destruction or adverse modification of critical habitat. This rule will not result in any changes in the fisheries such that there would be impacts beyond those considered in that BO. The IATTC has also taken action to reduce sea turtle injury and mortality from interactions in the purse seine fishery so impacts of the fisheries should be lower than in the past. Because this closure does not alter the scope of the fishery management regime analyzed in the IDCPA rule, or the scope of the impacts considered in that consultation, NMFS is relying on that analysis to conclude that this rule will not likely jeopardize the continued existence of any endangered or threatened species under the jurisdiction of NMFS or result in the destruction or adverse modification of critical habitat. Therefore, NMFS has determined that additional consultation is not required for this action.

The eastern Pacific Ocean tuna purse seine fisheries occasionally interact with a variety of species of dolphin, and dolphin takes are authorized and managed under the IDCPA. These quotas do not affect the administration of that program, which is consistent with section 303(a)(2) of the Marine Mammal Protection Act (MMPA). Therefore, this rule is consistent with the MMPA.

This proposed rule has been determined to be not significant for the purposes of Executive Order 12866.

The Chief Counsel for Regulation of the Department of Commerce certified to the Chief Counsel for Advocacy of the Small Business Administration that this proposed rule, if adopted, would not have a significant economic impact on a substantial number of small entities as follows:

The purpose of this action is to prohibit the use of purse seine gear to harvest tuna in a portion of the Convention Area in December 2003, consistent with the October 2003 IATTC recommendation. The closure is intended to promote conservation of tuna stocks by eliminating purse seine fishing mortality by vessels from all parties to the IATTC. The proposed closure would apply to the U.S. tuna purse seine fleet, which consists of 10–20 small vessels (carrying capacity below 400 short tons (363 metric tons)) and 4–6 large vessels (carrying capacity 400 short tons (363 metric tons) or greater). The large vessels generally fish outside U.S. waters and deliver their catch to foreign ports or transship to processors outside the mainland United States. The large vessels are categorized as large business entities (revenues in excess of $3.5 million per year). The closure should not significantly affect their operations as they are capable of fishing in other areas that would remain open. The small vessels are categorizes as small business entities (revenues below $3.5 million per year). They fish in the U.S. exclusive economic zone most of the year for small pelagic fish (Pacific sardine, Pacific mackerel) and for market squid in the winter. However, some small vessels harvest tuna seasonally when they are available, usually late in the summer and early fall. The proposed time/area closure should have little effect on small vessels because there is little tuna fishing by small vessels in that time/area stratum. The small vessel fleet should not be affected by the time/area closure as the closed waters are out of the range of almost all the small vessels. In addition, the small vessels will be able to target market squid or sardine in December as is their normal pattern. As a result, an Initial Regulatory Flexibility Analysis was not prepared.

Authority: 16 U.S.C. 951–961 and 971 *et seq.*

Dated: November 4, 2003.

William T. Hogarth,

Assistant Administrator for Fisheries, National Marine Fisheries Service.

[FR Doc. 03–28128 Filed 11–4–03; 2:39 pm]

BILLING CODE 3510–22–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 660

[I.D. 110303A]

RIN 0648–AR35

Fisheries off West Coast States and in the Western Pacific; Notice of Availability of FMP Amendment

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

ACTION: Notice of availability of an amendment to a fishery management plan; request for comments.

SUMMARY: NMFS announces that the Pacific Fishery Management Council (Pacific Council) has submitted Amendment 16–2 to the Pacific Coast Groundfish Fishery Management Plan (FMP) for Secretarial review. Amendment 16–2 would amend the FMP to include overfished species rebuilding plans for lingcod, canary rockfish, darkblotched rockfish, and Pacific ocean perch (POP). Amendment 16–2 is intended to address the requirements of the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act) to protect and rebuild overfished species managed under a Federal FMP. Amendment 16–2 is also intended to partially respond to a Court order in which NMFS was ordered to provide Pacific Coast groundfish rebuilding plans as FMPs, FMP amendments, or regulations, per the Magnuson-Stevens Act.

DATES: Comments on Amendment 16–2 must be received on or before January 6, 2004.

ADDRESSES: Comments on Amendment 16–2 or supporting documents should be sent to D. Robert Lohn, Administrator, Northwest Region, National Marine Fisheries Service, Sand Point Way NE., BIN C15700, Seattle, WA 98115–0070, attn: Becky Renko

Copies of Amendment 16–2 and the Environmental Impact Statement/Regulatory Impact Review/Initial Regulatory Flexibility Analysis for the amendment are available from Donald McIsaac, Executive Director, Pacific Fishery Management Council, 7700 NE Ambassador Place, Portland, OR 97220.

FOR FURTHER INFORMATION CONTACT: Becky Renko (Northwest Region, NMFS), phone: 206–526–6150; fax; 206–526–6736 and e-mail: *becky.renko@noaa.gov.*

SUPPLEMENTARY INFORMATION:

Electronic Access

This **Federal Register** document is also accessible via the internet at the website of the Office of the Federal Register: *http://www.gpoaccess.gov/fr/index.html.*

Background

The Magnuson-Stevens Act requires each regional fishery management council to submit fishery management plans or plan amendments to NMFS for review and approval, disapproval, or partial approval. The Magnuson-Stevens Act also requires NMFS, immediately upon receiving a fishery management plan or plan amendment, to publish notification in the **Federal Register** that the fishery management plan or plan amendment is available for public review and comment. At the end of the comment period, NMFS considers the public comments received during the

comment period described above in determining whether to approve, partially approve, or disapprove the fishery management plan or plan amendment.

NMFS declared the POP and lingcod stocks overfished on March 3, 1999. This was followed by canary rockfish, which was declared overfished on January 4, 2000 (65 FR 221) and darkblotched rockfish, which was declared overfished on January 11, 2001 (66 FR 2338). Because the spawning stock biomass levels for these stocks were determined to be below the minimum stock size threshold defined by the FMP, rebuilding plans had to be implemented to return the stocks to their maximum sustainable yield biomass levels (target biomass). Amendment 16–2, would revise the FMP to include overfished species rebuilding plans for lingcod, canary rockfish, darkblotched rockfish, and POP.

The rebuilding plans being adopted under Amendment 16–2 were approved by the Pacific Council at its June 2003 meeting. These rebuilding plans specify rebuilding parameters for individual stocks and are intended to address the Magnuson-Stevens Act requirement to protect and rebuild overfished species, in particular National Standard 1 on overfishing and section 304(e). When making the recommendation to implement these rebuilding plans, the Pacific Council sought to balance the rebuilding risks to each stock with the short and long-term socio-economic costs borne by groundfish buyers, commercial harvesters, and recreational operators as a result of constraining the fisheries to reduce total mortality of these overfished species.

On August 18, 2003 (68 FR 49415), NMFS published a notice of availability for Amendment 16–1 to the FMP. Amendment 16–1 will amend the FMP to require that Pacific Coast groundfish overfished species rebuilding plans be added into the FMP via FMP amendment, and then implemented through Federal regulations. For each approved overfished species rebuilding plan, the following parameters are to be specified in the FMP: estimates of unfished biomass and target biomass, the year the stock would be rebuilt in the absence of fishing, the year the stock would be rebuilt if the maximum time period permissible under the National Standard Guidelines were applied, and the target year in which the stock would be rebuilt under the adopted rebuilding plan.

As required by the standards proposed in Amendment 16–1, the rebuilding plans under Amendment 16–2 for lingcod, canary rockfish, darkblotched rockfish, and POP include estimates of unfished biomass and target biomass, the year the stock would be rebuilt in the absence of fishing, the year the stock would be rebuilt if the maximum time period permissible under the National Standard Guidelines were applied, and the target year in which the stock would be rebuilt under the adopted rebuilding plan for each species. Amendment 16–2 would add these parameters to section 4.5.4. of the FMP. Other relevant information on each of these overfished stocks, such as stock distribution, fishery interaction, and the rebuilding strategy would also be added to section 4.5.4 of the FMP. The information described above would be included in the FMP to serve as management benchmarks.

NMFS plans to publish a proposed rule that would codify in Federal regulations the two rebuilding parameters needed to establish annual or biannual optimum yields (OYs). These parameters are the target year for rebuilding and the harvest control rule that is to be used during the rebuilding period. The target rebuilding year is the year the stock will have been rebuilt under the adopted rebuilding plan. The harvest control rule expresses a given fishing mortality rate that is to be used over the course of rebuilding, unless modified in a subsequent rulemaking.

An approved rebuilding plan will be implemented through setting OYs and establishing management measures necessary to maintain the fishing mortality within the OYs to achieve objectives related to rebuilding requirements.

Public comments on Amendment 16–2 must be received by January 6, 2004, to be considered by NMFS in the decision whether to approve, disapprove, or partially approve amendment 16–2. A proposed rule to implement Amendment 16–2 has been submitted for Secretarial review and approval. NMFS expects to publish and request public comments on proposed regulations to implement Amendment 16–2 in the near future.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: November 4, 2003.

Bruce C. Morehead,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 03–28131 Filed 11–6–03; 8:45 am]

BILLING CODE 3510–22–S

Notices

Federal Register
Vol. 68, No. 216
Friday, November 7, 2003

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

AFRICAN DEVELOPMENT FOUNDATION

Sunshine Act Meeting

TIME: 11 a.m. to 5 p.m.
PLACE: ADF Headquarters.
DATE: Monday, November 17, 2003.
STATUS: Open.

Agenda

11 a.m.—Chairman's Report
11:30 a.m.—President's Report
1 p.m.—New Business
5 p.m.—Adjournment

If you have any questions or comments, please direct them to Doris Martin, General Counsel, who may be reached at (202) 673–3916.

Nathaniel Fields,
President.
[FR Doc. 03–28152 Filed 11–4–03; 4:24 pm]
BILLING CODE 6116–01–P

AGENCY FOR INTERNATIONAL DEVELOPMENT

Bureau for Democracy, Conflict and Humanitarian Assistance, Office of Food for Peace; Announcement of Draft Public Law 480 Title II, FY 2005 Development Program Policies and Guidelines

Pursuant to the Agricultural Trade Development and Assistance Act of 1954 (Pub. L. 480, as amended), notice is hereby given that the Public Law 480 Title II FY 2005 Development Program Policies and Guidelines are being made available to interested parties for the required thirty (30) day comment period. Individuals who wish to receive a copy of these draft guidelines should contact: Office of Food for Peace, Agency for International Development, RRB 7.06–153, 1300 Pennsylvania Avenue, Washington, DC 20523. Individuals who have questions or comments on the draft guidelines should contact Kathy Hunt at the above address or at (202) 712–1446.

The thirty-day comment period will begin on the date that this announcement is published in the **Federal Register**.

Dated: November 3, 2003.
P.E. Balakrishnan,
Acting Director, Office of Food for Peace, Bureau for Democracy, Conflict and Humanitarian Assistance.
[FR Doc. 03–28043 Filed 11–6–03; 8:45 am]
BILLING CODE 6116–01–P

DEPARTMENT OF AGRICULTURE

Forest Service

Siskiyou County Resource Advisory Committee

AGENCY: Forest Service, USDA.
ACTION: Notice of meeting.

SUMMARY: The Siskiyou County Resource Advisory Committee will meet in Yreka, California, November 17, 2003. The meeting will include routine business and a discussion of larger scale projects.

DATES: The meeting will be held November 17, 2003, from 4 p.m. until 6 p.m.

ADDRESSES: Don Hall, RAC Coordinator, Klamath National Forest, (530) 841–4468 or electronically at *donaldhall@fs.fed.us.*

FOR FURTHER INFORMATION CONTACT: The meeting is open to the public. Public comment opportunity will be provided and individuals will have the opportunity to address the Committee at that time.

Dated: October 31, 2003.
Margaret J. Boland,
Designated Federal Official.
[FR Doc. 03–28093 Filed 11–6–03; 8:45 am]
BILLING CODE 3410–11–M

DEPARTMENT OF AGRICULTURE

Grain Inspection, Packers and Stockyards Administration

Proposed Posting of Stockyards

AGENCY: Grain Inspection, Packers and Stockyards Administration, USDA.
ACTION: Notice and request for comments.

SUMMARY: We propose to post five stockyards. We have received information that the stockyards meet the definition of a stockyard under the Packers and Stockyards Act and, therefore, need to be posted. Posted stockyards are subject to the provisions of the Packers and Stockyards Act.

DATES: We will consider comments that we receive by November 24, 2003.

ADDRESSES: Send comments via electronic mail to *comments.gipsa@usda.gov*. Send hardcopy written comments to Tess Butler, GIPSA, USDA, 1400 Independence Avenue, SW., Room 1647–S, Washington, DC 20250–3604, or fax to (202) 690-2755. All comments should make reference to the date and page number of this issue of the **Federal Register**, and will be available for public inspection in the above office during regular business hours (7 CFR 1.27(b)).

SUPPLEMENTARY INFORMATION: The Grain Inspection, Packers and Stockyards Administration (GIPSA) administers and enforces the Packers and Stockyards Act of 1921, as amended and supplemented (7 U.S.C. 181–229) (P&S Act). The P&S Act prohibits unfair, deceptive, and fraudulent practices by livestock market agencies, dealers, stockyard owners, meat packers, swine contractors, and live poultry dealers in the livestock, poultry, and meatpacking industries.

Section 302 of the P&S Act (7 U.S.C. 202) defines the term "stockyard" as follows:

* * * any place, establishment, or facility commonly known as stockyards, conducted, operated, or managed for profit or nonprofit as a public market for livestock producers, feeders, market agencies, and buyers, consisting of pens, or other inclosures, and their appurtenances, in which live cattle, sheep, swine, horses, mules, or goats are received, held, or kept for sale or shipment in commerce.

Section 302(b) of the P&S Act requires the Secretary to determine which stockyards meet this definition, and to notify the owner of the stockyard and the public of that determination by posting a notice in each designated stockyard. After giving notice to the stockyard owner and to the public, the stockyard will be subject to the provisions of Title III of the Packers and Stockyards Act (7 U.S.C. 201–203 and 205–217a) until the Secretary deposts the stockyard by public notice.

This document notifies the stockyard owners and the public that the following five stockyards meet the definition of stockyard and that we propose to designate the stockyards as posted stockyards.

Facility No.	Stockyard name and location
AR–176	101 Livestock Auction, Blackwell, Arkansas.
GA–225	Bradley-Wayside Auction Co., Inc., Gray, Georgia.
MO–285	Gainesville Livestock Auction, Inc., Gainesville, Missouri.
TN–193	Lewisburg Livestock, Columbia, Tennessee.
WI–147	WFA Cattle Sales, Brooklyn, Wisconsin.

Authority: 7 U.S.C. 202.

Dated: November 4, 2003.

Donna Reifschneider,

Administrator, Grain Inspection, Packers and Stockyards Administration.

[FR Doc. 03–28064 Filed 11–6–03; 8:45 am]

BILLING CODE 3410–EN–P

DEPARTMENT OF AGRICULTURE

Grain Inspection, Packers and Stockyards Administration

Posting of Stockyards

AGENCY: Grain Inspection, Packers and Stockyards Administration, USDA.

ACTION: Notice.

SUMMARY: We posted two stockyards. We determined that the stockyards meet the definition of a stockyard under the Packers and Stockyards Act and, therefore, needed to be posted. Posted stockyards are subject to the provisions of the Packers and Stockyards Act.

SUPPLEMENTARY INFORMATION: The Grain Inspection, Packers and Stockyards Administration (GIPSA) administers and enforces the Packers and Stockyards Act of 1921, as amended and supplemented (7 U.S.C. 181–229) (P&S Act). The P&S Act prohibits unfair, deceptive, and fraudulent practices by livestock market agencies, dealers, stockyard owners, meat packers, swine contractors, and live poultry dealers in the livestock, poultry, and meatpacking industries.

Section 302 of the P&S Act (7 U.S.C. 202) defines the term "stockyard" as follows:

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Section 302(b) of the P&S Act requires the Secretary to determine which stockyards meet this definition, and to notify the owner of the stockyard and the public of that determination by posting a notice in each designated stockyard. After giving notice to the stockyard owner and to the public, the stockyard remains subject to the provisions of Title III of the Packers and Stockyards Act (7 U.S.C. 201–203 and 205–217a) until the Secretary deposts the stockyard by public notice.

This document notifies the public that the following two stockyards meet the definition of stockyard and that we posted the stockyards. To post stockyards, we assign the stockyard a facility number, notify the owner of the stockyard facility, and send notices to the owner of the stockyard to post on display in public areas of the stockyard. The date of posting is the date on which the posting notices are physically displayed.

Facility No.	Stockyard name and location	Date of posting
SC–159	Hendrix Horse Auction, Hartsville, South Carolina	April 8, 2002.
TX–346	Texas Cattle Exchange, Inc., Eastland, Texas	December 11, 2000.

Authority: 7 U.S.C. 202.

Dated: November 4, 2003.

Donna Reifschneider,

Administrator, Grain Inspection, Packers and Stockyards Administration.

[FR Doc. 03–28063 Filed 11–6–03; 8:45 am]

BILLING CODE 3410–EN–P

DEPARTMENT OF AGRICULTURE

Rural Housing Service

Notice of Request for Extension of a Currently Approved Information Collection

AGENCY: Rural Housing Service (RHS), USDA.

ACTION: Proposed collection; comments requested.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, this notice announces the intention of the above-named Agency to request an extension for a currently approved information collection in support of the Community Facilities Grant Program.

DATES: Comments on this notice must be received by January 6, 2004 to be assured of consideration.

FOR FURTHER INFORMATION CONTACT: Derek L. Jones, Loan Specialist, Community Programs, RHS, USDA, 1400 Independence Ave. SW, Mail Stop 0787, Washington, DC 20250–0787. Telephone: (202)720–1504. E-mail: *derek.jones@usda.gov.*

SUPPLEMENTARY INFORMATION:

Title: Community Facilities Grant Program.

OMB Number: 0575–0173.

Expiration Date of Approval: June 30, 2004.

Type of Request: Extension of a currently approved information collection.

Abstract: Community Programs, a division of the Rural Housing Service (RHS), is part of the United States Department of Agriculture's Rural Development mission area. The Agency is authorized by Section 306(a) of the Consolidated Farm and Rural Development Act (7 U.S.C. 1926), as amended, to make grants to public agencies, nonprofit corporations, and Indian tribes to develop essential community facilities and services for public use in rural areas. These facilities include schools, libraries, child care, hospitals, clinics, assisted-living facilities, fire and rescue stations, police stations, community centers, public buildings, and transportation. Through its Community Programs, the Department of Agriculture is striving to ensure that such facilities are readily available to all rural communities.

Information will be collected by the field offices from applicants, consultants, lenders, and public entities. The collection of information is considered the minimum necessary to effectively evaluate the overall scope of the project.

Failure to collect information could have an adverse impact on effectively carrying out the mission,

administration, processing, and program requirements.

Estimate of Burden: Public reporting burden for this collection of information is estimated to average .63 hours per response.

Respondents: Public bodies, nonprofit corporations and associations, and federally recognized Indian tribes.

Estimated Number of Respondents: 863.

Estimated Number of Responses per Respondent: 1.96.

Estimated Total Annual Burden on Respondents: 1,070 hours.

Copies of this information collection can be obtained from Tracy Givelekian, Regulations and Paperwork Management Branch, at (202) 692–0039.

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the Agency, including whether the information will have practical utility; (b) the accuracy of the Agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology. Comments may be sent to Tracy Givelekian, Regulations and Paperwork Management Branch, U.S. Department of Agriculture, Rural Development, STOP 0742, 1400 Independence Ave. SW., Washington, DC 20250–0742. All responses to this notice will be summarized and included in the request for OMB approval. All comments will also become a matter of public record.

Dated: October 28, 2003.

Arthur A. Garcia,

Administrator, Rural Housing Service.

[FR Doc. 03–28061 Filed 11–6–03; 8:45 am]

BILLING CODE 3410–XV–P

COMMITTEE FOR PURCHASE FROM PEOPLE WHO ARE BLIND OR SEVERELY DISABLED

Procurement List; Proposed Additions and Deletion

AGENCY: Committee for Purchase from People Who Are Blind or Severely Disabled.

ACTION: Proposed Additions to and Deletion from Procurement List.

SUMMARY: The Committee is proposing to add to the Procurement List products and services to be furnished by nonprofit agencies employing persons who are blind or have other severe disabilities, and to delete a product previously furnished by such agencies.

COMMENTS MUST BE RECEIVED ON OR BEFORE: December 7, 2003.

ADDRESSES: Committee for Purchase From People Who Are Blind or Severely Disabled, Jefferson Plaza 2, Suite 10800, 1421 Jefferson Davis Highway, Arlington, Virginia, 22202–3259.

FOR FURTHER INFORMATION CONTACT: Sheryl D. Kennerly, (703) 603–7740.

SUPPLEMENTARY INFORMATION: This notice is published pursuant to 41 U.S.C. 47(a)(2) and 41 CFR 51–2.3. Its purpose is to provide interested persons an opportunity to submit comments on the proposed actions.

Additions

If the Committee approves the proposed additions, the entities of the Federal Government identified in this notice for each product or service will be required to procure the products and services listed below from nonprofit agencies employing persons who are blind or have other severe disabilities.

Regulatory Flexibility Act Certification

I certify that the following action will not have a significant impact on a substantial number of small entities. The major factors considered for this certification were:

1. If approved, the action will not result in any additional reporting, recordkeeping or other compliance requirements for small entities other than the small organizations that will furnish the products and services to the Government.

2. If approved, the action will result in authorizing small entities to furnish the products and services to the Government.

3. There are no known regulatory alternatives which would accomplish the objectives of the Javits-Wagner-O'Day Act (41 U.S.C. 46–48c) in connection with the products and services proposed for addition to the Procurement List. Comments on this certification are invited. Commenters should identify the statement(s) underlying the certification on which they are providing additional information.

End of Certification

The following products and services are proposed for addition to the Procurement List for production by the nonprofit agencies listed:

Products

Product/NSN: Jersey, Flight Deck, Crewman's (The remaining 50% of the Defense Supply Center Philadelphia's Requirement)
8415–00–914–0312
8415–00–914–0313
8415–00–914–0314
8415–00–914–0315
8415–00–914–0316
8415–00–914–0317
8415–00–914–0318
8415–00–914–0319
8415–00–914–0321
8415–00–914–0322
8415–00–914–0323
8415–00–914–0324
8415–00–914–0325
8415–00–914–0326
8415–00–914–0327
8415–00–914–0328
8415–00–914–0329
8415–00–914–0331
8415–00–914–0333
8415–00–914–0334
8415–00–914–0335
8415–00–914–0336
8415–00–914–0337
8415–00–914–0338
8415–00–914–0339
8415–00–914–0340
8415–00–914–4143
8415–00–914–9481
NPA: Bestwork Industries for the Blind, Inc., Runnemede, New Jersey.
NPA: El Paso Lighthouse for the Blind, El Paso, Texas.
NPA: Elizabeth Pierce Olmsted, M.D. Center for the Visually Impaired. Buffalo, New York.
NPA: Westmoreland County Blind Association, Greensburg, Pennsylvania.
Contract Activity: Defense Supply Center Philadelphia, Philadelphia, Pennsylvania.

Product/NSN: Type C Pallet, 3990–00–NSH–0002.
NPA: Goodwill Industries of South Texas, Inc., Corpus Christi, Texas.
Contract Activity: Corpus Christi Army Depot, Texas.

Services

Service Type/Location: Administrative Support Services, USDA, Rural Development Agency, Abrams Federal Building, 1520 Market Street, St. Louis, Missouri.
NPA: MGI Services Corporation, St. Louis, Missouri.
Contract Activity: USDA, Rural Development Agency, St. Louis, Missouri.

Service Type/Location: Base Supply Center, NASA Ames Research Center, Moffett Field, California.
NPA: Associated Industries for the Blind, Milwaukee, Wisconsin.
Contract Activity: NASA Ames Research Center, Moffett Field, California.

Service Type/Location: Custodial Services, VA Community Based Outpatient Clinic North Shore, Lynn, Massachusetts, VA Community Based Outpatient Clinic, Haverill, Massachusetts.
NPA: Morgan Memorial Goodwill Industries, Boston, Massachusetts.

Contract Activity: VA Medical Center—Edith Nourse Rogers Memorial, Bedford, Massachusetts.

Service Type/Location: Mailing Services, U.S. Mint, Washington, DC.

NPA: ServiceSource, Inc., Alexandria, Virginia.

Contract Activity: Department of the Treasury, U.S. Mint, Washington, DC.

Deletion

Regulatory Flexibility Act Certification

I certify that the following action will not have a significant impact on a substantial number of small entities. The major factors considered for this certification were:

1. If approved, the action will not result in any additional reporting, recordkeeping or other compliance requirements for small entities.

2. If approved, the action will result in authorizing small entities to furnish the product to the Government.

3. There are no known regulatory alternatives which would accomplish the objectives of the Javits-Wagner-O'Day Act (41 U.S.C. 46–48c) in connection with the product proposed for deletion from the Procurement List.

End of Certification

The following product is proposed for deletion from the Procurement List:

Product

Product/NSN: Scraper, Ice, 7920–01–323–0793.

NPA: L.C. Industries For The Blind, Inc., Durham, North Carolina.

Contract Activity: GSA, Southwest Supply Center, Fort Worth, Texas.

Sheryl D. Kennerly,

Director, Information Management.

[FR Doc. 03–28111 Filed 11–6–03; 8:45 am]

BILLING CODE 6353–01–P

COMMITTEE FOR PURCHASE FROM PEOPLE WHO ARE BLIND OR SEVERELY DISABLED

Procurement List; Additions

AGENCY: Committee for Purchase from People Who Are Blind or Severely Disabled.

ACTION: Additions to Procurement List.

SUMMARY: This action adds to the Procurement List services to be furnished by nonprofit agencies employing persons who are blind or have other severe disabilities.

EFFECTIVE DATE: December 7, 2003.

ADDRESSES: Committee for Purchase From People Who Are Blind or Severely Disabled, Jefferson Plaza 2, Suite 10800, 1421 Jefferson Davis Highway, Arlington, Virginia, 22202–3259.

FOR FURTHER INFORMATION CONTACT: Sheryl D. Kennerly, (703) 603–7740.

SUPPLEMENTARY INFORMATION: On September 12, 2003, the Committee for Purchase From People Who Are Blind or Severely Disabled published notice (68 F.R. 53710) of proposed additions to the Procurement List. After consideration of the material presented to it concerning capability of qualified nonprofit agencies to provide the services and impact of the additions on the current or most recent contractors, the Committee has determined that the services listed below are suitable for procurement by the Federal Government under 41 U.S.C. 46–48c and 41 CFR 51–2.4.

Regulatory Flexibility Act Certification

I certify that the following action will not have a significant impact on a substantial number of small entities. The major factors considered for this certification were:

1. The action will not result in any additional reporting, recordkeeping or other compliance requirements for small entities other than the small organizations that will furnish the services to the Government.

2. The action will result in authorizing small entities to furnish the services to the Government.

3. There are no known regulatory alternatives which would accomplish the objectives of the Javits-Wagner-O'Day Act (41 U.S.C. 46–48c) in connection with the services proposed for addition to the Procurement List.

End of Certification

Accordingly, the following services are added to the Procurement List:

Services

Service Type/Location: Commissary Warehousing and Warehouse Custodial, Fort Sill Commissary, Lawton, Oklahoma.

NPA: Trace, Inc., Eagle, Idaho.

Contract Activity: Defense Commissary Agency (DeCA), Ft. Lee, Virginia.

Service Type/Location: Custodial Services, Denver Federal Center, Building 56, Denver, Colorado.

NPA: Aspen Diversified Industries, Inc., Colorado Springs, Colorado.

Contract Activity: GSA/PBS Rocky Mountain Region, Denver, Colorado.

This action does not affect current contracts awarded prior to the effective date of this addition or options that may be exercised under those contracts.

Sheryl D. Kennerly,

Director, Information Management.

[FR Doc. 03–28112 Filed 11–6–03; 8:45 am]

BILLING CODE 6353–01–P

BROADCASTING BOARD OF GOVERNORS

Sunshine Act; Meetings

DATE AND TIME: November 12, 2003; 1 p.m.–4:30 p.m.

PLACE: Broadcasting Board of Governors, 330 Independence Avenue, SW., Washington, DC 20237.

CLOSED MEETING: The members of the Broadcasting Board of Governors (BBG) will meet in closed session to review and discuss a number of issues relating to U.S. Government-funded non-military international broadcasting. They will address internal procedural, budgetary, and personnel issues, as well as sensitive foreign policy issues relating to potential options in the U.S. international broadcasting field. This meeting is closed because if open it likely would either disclose matters that would be properly classified to be kept secret in the interest of foreign policy under the appropriate executive order (5 U.S.C. 552b.(c)(1)) or would disclose information the premature disclosure of which would be likely to significantly frustrate implementation of a proposed agency action. (5 U.S.C. 552b.(c)(9)(B)) In addition, part of the discussion will relate solely to the internal personnel and organizational issues of the BBG or the International Broadcasting Bureau. (5 U.S.C. 552b.(c)(2) and (6))

FOR FURTHER INFORMATION CONTACT: Persons interested in obtaining more information should contact either Brenda Hardnett or Carol Booker at (202) 401–3736.

Dated: November 4, 2003.

Carol Booker,

Legal Counsel.

[FR Doc. 03–28162 Filed 11–5–03; 9:59 am]

BILLING CODE 8230–01–M

COMMISSION ON CIVIL RIGHTS

Sunshine Act Meeting

AGENCY: U.S. Commission on Civil Rights.

DATE AND TIME: Friday, November 14, 2003, 9:30 a.m.

PLACE: U.S. Commission on Civil Rights, 624 9th Street, NW., Room 540, Washington, DC 20425.

STATUS:

Agenda

I. Approval of Agenda
II. Approval of Minutes of October 17, 2003 Meeting
III. Announcements
IV. Staff Director's Report
V. Future Agenda Items

10 a.m. Briefing on Lewis Mumford Center Study "How Race Counts for Hispanic Americans".

FOR FURTHER INFORMATION CONTACT: Les Jin, Press and Communications (202) 376–7700.

Debra A. Carr,

Deputy General Counsel.

[FR Doc. 03–28206 Filed 11–5–03; 12:30 pm]

BILLING CODE 6335–01–M

DEPARTMENT OF COMMERCE

Submission For OMB Review; Comment Request

DOC has submitted to the Office of Management and Budget (OMB) for clearance the following proposal for collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C. chapter 35).

AGENCY: U.S. Census Bureau.

Title: 2003 Service Annual Survey (SAS).

Form Number(s): SA–484, SA–492, SA–493, SA–511, SA–512, SA–513, SA–514, SA–523, SA–532, SA–541, SA–560, SA–621, SA–622, SA–623, SA–624, SA–711, SA–712, SA–713, SA–811, SA–812, SA–813.

Agency Approval Number: 0607–0422.

Type of Request: Revision of a currently approved collection.

Burden: 89,930 hours.

Number of Respondents: 44,996.

Avg Hours Per Response: 2 hours.

Needs and Uses: Today, about 50 percent of all economic activity is accounted for by services that are narrowly defined to exclude retail and wholesale trade. The Census Bureau currently measures the total output of most of these service industries annually in its Service Annual Survey (SAS). This survey now covers all or some of the following nine sectors: Transportation and Warehousing; Information; Finance and Insurance; Real Estate and Rental and Leasing; Professional, Scientific, and Technical Services; Administration and Support and Waste Management and Remediation Services; Health Care and Social Assistance; Arts, Entertainment, and Recreation; and Other Services.

The Census Bureau will expand the SAS to provide data on product composition of service industry output and to provide data that will improve the quality of value-added measures for these service industries.

We will begin to implement, incrementally, the collection of detailed service products defined in the provisional North American Product Classification System (NAPCS) into the 2003 SAS. Provisional NAPCS products were added to the 2001 SAS for most of the Information Sector (NAICS 51, except 512) and Computer Systems Design and Related Services (NAICS 5415). For 2003, we plan to add provisional NAPCS products to the Motion Picture and Sound Recording Industries (NAICS 512). In the 2004 Service Annual Survey, we will begin collecting NAPCS product detail for Professional, Scientific, and Technical Services (NAICS 54); Administrative Support and Waste Management and Remediation Services (NAICS 56); and Hospitals and Nursing and Residential Care Facilities (NAICS 622 and 623). We will complete NAPCS product coverage of all remaining industries in the 2005 Service Annual Survey.

We will also collect annual data on the cost of materials and supplies other than for resale, contract labor, and purchased services in the 2003 SAS for the following: Information (NAICS 51); selected Financial Services (NAICS 5231 and 5239); Professional, Scientific, and Technical Services (NAICS 54); Administrative and Support and Waste Management and Remediation Services (NAICS 56); and Hospitals and Nursing and Residential Care Facilities (NAICS 622 and 623). For the 2004 survey, we will begin collecting these data for all remaining industries covered in the SAS.

Key data items include:

- expensed materials and supplies;
- contract labor;
- computer services with detail breakouts between custom coded software and data processing services;
- purchased communication services;
- purchased electricity;
- purchased fuels (except motor fuels);
- management consulting, administrative services, and other professional services;
- lease and rental costs,
- and all other purchased services.

The availability of these data will greatly improve the quality of the intermediate-inputs and value-added estimates in BEA's annual input-output and GDP by industry accounts. Annual data on purchased services and materials also will be used as indicators to update census year data collected on the Business Expenses Survey.

Affected Public: Businesses or other for-profit; not-for-profit institutions.

Frequency: Annually.

Respondent's Obligation: Mandatory.

Legal Authority: Title 13 U.S.C., Sections 182, 224 & 225.

OMB Desk Officer: Susan Schechter, (202) 395–5103.

Copies of the above information collection proposal can be obtained by calling or writing Diana Hynek, Departmental Paperwork Clearance Officer, (202) 482–0266, Department of Commerce, room 6625, 14th and Constitution Avenue NW., Washington, DC 20230 (or via the Internet at *dhynek@doc.gov).*

Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to Susan Schechter, OMB Desk Officer either by fax; (202) 395–7245, or email; *susan_schechter@omb.eop.gov.*

Dated: November 4, 2003.

Madeleine Clayton,

Management Analyst, Office of the Chief Information Officer.

[FR Doc. 03–28117 Filed 11–6–03; 8:45 am]

BILLING CODE 3510–07–P

DEPARTMENT OF COMMERCE

Bureau of Industry and Security

International Import Certificate

ACTION: Proposed collection; comment request.

SUMMARY: The Department of Commerce, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A)).

DATES: Written comments must be submitted on or before January 6, 2004.

ADDRESSES: Direct all written comments to Diana Hynek, DOC Paperwork Clearance Officer, (202) 482–0266, Department of Commerce, Room 6625, 14th and Constitution Avenue, NW., Washington, DC 20230.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the information collection instrument(s) and instructions should be directed to Ms. Marna Dove, BIS ICB Liaison, (202) 482–5211, Department of Commerce, Room 6622, 14th & Constitution Avenue, NW., Washington, DC, 20230.

SUPPLEMENTARY INFORMATION:

I. Abstract

The United States and several other countries have undertaken to increase the effectiveness of their respective controls over international trade in strategic commodities by means of an Import Certificate procedure. For the U.S. importer, this procedure provides that, where required by the exporting country with respect to a specific transaction, the importer certifies to the U.S. Government that he/she will import specific commodities into the United States and will not reexport such commodities except in accordance with the export control regulations of the United States. The U.S. Government, in turn, certifies that such representations have been made.

II. Data

OMB Number: 0694–0017.

Form Number: Form BIS–645P, International Import Certificate.

Type of Review: Regular submission for renewal of a currently approved collection.

Affected Public: Individuals, businesses or other for-profit and not-for-profit institutions.

Estimated Number of Respondents: 1,008.

Estimated Time Per Response: 16 minutes per response.

Estimated Total Annual Burden Hours: 270.

Estimated Total Annual Cost: No start-up capital expenditures.

III. Request for Comments

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden (including hours and cost) of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval of this information collection; they will also become a matter of public record.

Dated: November 4, 2003.

Madeleine Clayton,

Management Analyst, Office of the Chief Information Officer.

[FR Doc. 03–28048 Filed 11–6–03; 8:45 am]

BILLING CODE 3510–33–P

DEPARTMENT OF COMMERCE

Bureau of Industry and Security

License Exception, Humanitarian License

ACTION: Proposed collection; comment request.

SUMMARY: The Department of Commerce, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A)).

DATES: Written comments must be submitted on or before January 6, 2004.

ADDRESSES: Direct all written comments to Diana Hynek, Departmental Paperwork Clearance Officer, Department of Commerce, Office of the Chief Information Officer, 202–482–0266, Room 6625, 14th and Constitution Avenue, NW., Washington, DC 20230.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the information collection instrument(s) and instructions should be directed to Marna Dove, BIS ICB Liaison, Department of Commerce, BIS Office of the Chief Information Officer, Room 6622, 14th and Constitution Avenue, NW., Washington, DC 20230.

SUPPLEMENTARY INFORMATION:

I. Abstract

Section 7(g) of the EAA, as amended by the Export Administration Amendments Act of 1985 (Pub. L. 99–64), exempts from foreign policy controls exports of donations to meet basic human needs. Since the enactment of Public Law 99–74, an exporter had to apply for a bulk Humanitarian license, permitting the export of goods identified in a supplement to the regulation without restriction as to quantity or number of shipments to any of the embargoed destinations. New License Exception procedures contained in this regulation reduce the regulatory burden on these exporters by enabling them to make humanitarian donations with only minimal recordkeeping.

II. Data

OMB Number: 0694–0033.

Form Number: None.

Type of Review: Regular submission for extension of a currently approved collection.

Affected Public: Individuals, businesses or other for-profit and not-for-profit institutions.

Estimated Number of Respondents: 2.

Estimated Time Per Response: 5 hours per response.

Estimated Total Annual Burden Hours: 10.

Estimated Total Annual Cost: No start-up or capital expenditures.

III. Request for Comments

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden (including hours and cost) of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.

Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval of this information collection; they will also become a matter of public record.

Dated: November 4, 2003.

Madeleine Clayton,

Management Analyst, Office of the Chief Information Officer.

[FR Doc. 03–28050 Filed 11–6–03; 8:45 am]

BILLING CODE 3510–33–P

DEPARTMENT OF COMMERCE

International Trade Administration

[A–570–822]

Certain Helical Spring Lock Washers From the People's Republic of China; Preliminary Results of Antidumping Duty Administrative Review

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

ACTION: Notice of preliminary results of antidumping duty administrative review, request for revocation of the antidumping duty order, and determination not to revoke, in part.

SUMMARY: We preliminarily find that helical spring lock washers from the People's Republic of China were being sold in the United States below normal value by the Hangzhou Spring Washer Co., Ltd. (also known as Zhejiang Wanxin Group, Ltd. (ZWG)) (collectively, Hangzhou) during the period October 1, 2001 through September 30, 2002. We have also preliminarily determined not to revoke the antidumping duty order on the subject merchandise with respect to this company. Interested parties are invited to comment on these preliminary results.

EFFECTIVE DATE: November 7, 2003.

FOR FURTHER INFORMATION CONTACT: Ryan Langan and Audrey Twyman, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW., Washington, DC 20230; telephone (202) 482–2613 or (202) 482–3534.

Background

On October 19, 1993, the Department published the antidumping duty order on certain helical spring lock washers (HSLWs) from the People's Republic of China (PRC) (58 FR 53914), as amended on November 23, 1993 (58 FR 61859). The Department notified interested parties of the opportunity to request an administrative review of this order on October 2, 2002 (67 FR 61849). The petitioner, Shakeproof Assembly Components Division of Illinois Tool Works, Inc. (Shakeproof), requested that the Department conduct an administrative review of Hangzhou on October 22, 2002. Hangzhou requested an administrative review and revocation of the antidumping duty order with respect to itself on October 31, 2002. The notice of initiation of this administrative review was published on November 22, 2002 (67 FR 70402).

On January 21 and 22, 2003, Hangzhou responded to the Department's December 5, 2002 questionnaire. Next, on February 4, 2003, the Department provided parties with an opportunity to submit information regarding appropriate surrogate values. On February 28, 2003, Hangzhou submitted surrogate value comments. The petitioner submitted factual information, including surrogate value comments, on March 20, 2003. The Department received petitioner's comments on Hangzhou's questionnaire responses on March 14, 2003, and its additional deficiency comments and verification comments on March 26, 2003.

The Department issued its first supplemental questionnaire to Hangzhou on March 31, 2003, and received Hangzhou's responses on April 11 and 15, 2003. On April 22, 2003, Hangzhou submitted additional information about its platers. Shakeproof submitted its second and third sets of deficiency comments on April 29 and May 15, 2003, respectively.

On June 4, 2003, the Department published *Certain Helical Spring Lock Washers from the People's Republic of China: Notice of Extension of Time Limit for the Preliminary Results of the Ninth Antidumping Administrative Review,* 68 FR 33472. The petitioner filed pre-preliminary determination comments on June 20, 2003. On August 12, 2003, the Department issued its second supplemental questionnaire. Hangzhou submitted its response to that questionnaire on August 27, 2003.

The Department verified Hangzhou's questionnaire response on September 1 through 4, 2003, in Xiaoshan City, Xinjie Town, People's Republic of China (PRC). Hangzhou submitted its pre-verification corrections on September 9, 2003, and new databases on October 17, 2003. The Department issued its verification report on October 23, 2003.

Scope of the Order

The products covered by the order are HSLWs of carbon steel, of carbon alloy steel, or of stainless steel, heat-treated or non-heat-treated, plated or non-plated, with ends that are off-line. HSLWs are designed to: (1) Function as a spring to compensate for developed looseness between the component parts of a fastened assembly; (2) distribute the load over a larger area for screws or bolts; and, (3) provide a hardened bearing surface. The scope does not include internal or external tooth washers, nor does it include spring lock washers made of other metals, such as copper.

HSLWs subject to the order are currently classifiable under subheading 7318.21.0030 of the *Harmonized Tariff Schedule of the United States (HTSUS).* Although the *HTSUS* subheading is provided for convenience and customs purposes, the written description of the scope of this proceeding is dispositive.

Period of Review

This review covers the period October 1, 2001, through September 30, 2002.

Separate Rates Determination

To establish whether a company operating in a state-controlled economy is sufficiently independent to be entitled to a separate rate, the Department analyzes each exporting entity under the test established in the *Final Determination of Sales at Less Than Fair Value: Sparklers from the People's Republic of China,* 56 FR 20588 (May 6, 1991) (*Sparklers*), as amplified by the *Final Determination of Sales at Less Than Fair Value: Silicon Carbide from the People's Republic of China,* 59 FR 22585 (May 2, 1994) (*Silicon Carbide*). Under this policy, exporters in non-market economy countries (NMEs) are entitled to separate, company-specific margins when they can demonstrate an absence of government control, both in law and in fact, with respect to export activities. Evidence supporting, though not requiring, a finding of *de jure* absence of government control over export activities includes: (1) An absence of restrictive stipulations associated with the individual exporter's business and export licenses; (2) any legislative enactments decentralizing control of companies; and, (3) any other formal measures by the government decentralizing control of companies. *De facto* absence of government control over exports is based on four factors: (1) Whether each exporter sets its own export prices independently of the government and without the approval of a government authority; (2) whether each exporter retains the proceeds from its sales and makes independent decisions regarding the disposition of profits or the financing of losses; (3) whether each exporter has the authority to negotiate and sign contracts and other agreements; and, (4) whether each exporter has autonomy from the government regarding the selection of management. (*See Silicon Carbide,* 59 FR at 22587 and *Sparklers,* 56 FR at 20589.)

In each of the previous administrative reviews of the antidumping duty order on HSLWs from the PRC, covering successive review periods from October 1, 1993, through September 30, 2001, we determined that Hangzhou and its predecessor, ZWG, merited separate rates. We found, in each review, an absence of government control, both in law and in fact, with respect to Hangzhou's export activities according to the criteria identified in *Sparklers,* and an absence of government control with respect to the additional criteria identified in *Silicon Carbide.* During this period of review (POR), we have no evidence of any change in either the *Sparklers* or *Silicon Carbide* criteria. Therefore, we have assigned Hangzhou a separate rate.

Verification

Pursuant to section 782(i) of the Tariff Act of 1930, as amended ("the Act"), we

verified sales and factors of production information provided by Hangzhou in Xiaoshan City, Xinjie Town, PRC, on September 1 through 4, 2003. We used standard verification procedures, including the examination of relevant sales, accounting and production records, as well as original source documents provided by the respondents. Our verification results are outlined in the public version of the verification report, dated October 22, 2003, and located in the public file in the Central Records Unit, Room B–099 of the Department's main building (CRU).

Export Price

Because Hangzhou sold the subject merchandise to unaffiliated purchasers in the United States prior to importation into the United States and constructed export price methodology is not otherwise indicated, we have used export price in accordance with section 772(a) of the Act.

We calculated export price based on the FOB price to unaffiliated purchasers. From this price, we deducted amounts for foreign inland freight, and brokerage and handling pursuant to section 772(c)(2)(A) of the Act. We valued these deductions using surrogate values. We selected India as the primary surrogate country for the reasons explained in the "Normal Value" section of this notice.

Normal Value

The Department has determined the PRC to be an NME country in all previous antidumping cases. In accordance with section 771(18)(C)(i) of the Act, any determination that a foreign country is an NME shall remain in effect until revoked by the administering authority. None of the parties to this proceeding has contested such treatment in this review. Moreover, parties to this proceeding have not argued that the PRC HSLW industry is a market-oriented industry and, consequently, we have no basis to determine that the information in this review would permit the calculation of normal value (NV) using PRC prices or costs.

Section 773(c)(1) of the Act provides that, in the case of an NME, the Department shall determine NV using a factors-of-production methodology if: (1) The merchandise is exported from an NME, and (2) the information does not permit the calculation of NV using home-market prices, third-country prices, or constructed value under section 773(a) of the Act. Because information on the record does not permit the calculation of NV using home-market prices, third-country prices, or constructed value, and no party has argued otherwise, we calculated NV based on factors of production in accordance with sections 773(c)(3) and (4) of the Act and 19 CFR 351.408(c).

Because we are using surrogate country factors-of-production prices to determine NV, section 773(c)(4) of the Act requires that the Department use values from a market economy (surrogate) country that (1) is at a level of economic development comparable to that of the PRC, and (2) is a significant producer of comparable merchandise. We have determined that India, Pakistan, Indonesia, Sri Lanka and the Philippines are market economy countries at a comparable level of economic development to that of the PRC. (*See* "Memorandum to Susan Kuhbach from Jeffrey May), dated January 27, 2003, "Ninth Administrative Review for Certain Helical Spring Lock Washers from the People's Republic of China," which is available in the CRU.) In addition, we have found that India is a significant producer of comparable merchandise, *i.e.*, fasteners. (*See* Memorandum to File from Sally Hastings, dated October 31, 2003, and available in the public file in the CRU.) As in the investigation and eight previous reviews, we have chosen India as the primary surrogate country. Thus, we have used Indian prices to value the factors of production.

We selected, where possible, publicly available values from India which were: (1) Average non-export values; (2) representative of a range of prices within the POR or most contemporaneous with the POR; (3) product-specific; and, (4) tax-exclusive. Also, where we have relied upon import values, we have excluded imports from South Korea, Thailand, and Indonesia. The Department has found that these countries maintain broadly available, non-industry specific export subsidies, and that the existence of these subsidies provides sufficient reason to believe or suspect that export prices from these countries are distorted. *See Final Determination of Sales at Less Than Fair Value: Certain Automotive Replacement Glass Windshields From the People's Republic of China*, 67 FR 6482 (February 12, 2002) and accompanying *Issues and Decision Memorandum (Replacement Glass Windshields)*. Our practice of excluding subsidized prices has been upheld in *China National Machinery Import and Export Corporation* v. *United States and the Timken Company*, Court No. 01–01114, slip op. 03–133 (CIT Oct. 15, 2003) (Confidential version; public version not yet issued).

In its submission of June 20, 2003, the petitioner argues that the Department should exclude any import values into India where the exporting country maintains subsidies, *i.e.*, any subsidizing country in addition to Indonesia, South Korea, and Thailand. The petitioner provides a list of countries that are subject to U.S. countervailing duty orders, and countries that have been found to provide "generally available subsidies" or "N.T.E. export subsidies."

In past proceedings, we disregarded input prices where particular and objective record evidence provided the Department with a reason to believe or suspect that these prices may be distorted by subsidies. *See, e.g., Tapered Roller Bearings and Parts Thereof, Finished and Unfinished, from the People's Republic of China; Final Results of 1999–2000 Administrative Review, Partial Rescission of Review, and Determination Not to Revoke Order in Part*, 66 FR 57420 (November 15, 2001), and accompanying Decision Memorandum at Comment 1; *Final Determination of Sales at Less Than Fair Value: Certain Automotive Replacement Glass Windshields from the Peoples Republic of China*, 67 FR 6482 (February 12, 2002) and accompanying Issues and Decision Memorandum at Comment 1. In those and a number of other prior proceedings, parties demonstrated, on the basis of record evidence, that certain countries maintained broadly available, non-industry specific export subsidies, or that certain countries provided industry-specific subsidies which may have benefitted certain input products covered by the proceeding.

The information provided by the petitioner in this proceeding (with the exception of certain steel products) does not identify the particular products or the particular subsidies which allegedly distort the prices of these products. Without such evidence, we cannot preliminarily conclude that these input prices should be disregarded. We acknowledge that there may be other information, outside the record of this proceeding, which may be material to the question of whether other input prices are distorted by subsidies. However, it would be impractical for the Department to attempt to identify and consider such information without the parties first having demonstrated, on the basis of record evidence, that certain countries maintained broadly available, non-industry specific export subsidies, or that certain countries provided industry-specific subsidies which may

have benefitted certain input products covered by the proceeding. Therefore, except for valuing steel and steel scrap (discussed further below), we have preliminarily determined not to exclude imports from countries beyond Indonesia, South Korea and Thailand.

Steel Value

During the POR, Hangzhou imported a portion of its steel input (carbon steel wire rod (CSWR)) from the United Kingdom (UK) and it paid for this input in a market economy currency. The petitioner, in its submission dated June 20, 2003, argues that the Department should disregard the steel import prices reported by Hangzhou because there is "reason to believe or suspect" the steel benefitted from subsidies. In support of its claim, the petitioner points to the Department's finding in the sunset review of cut-to-length carbon steel plate from the UK, in which the Department found a subsidy rate of 12 percent for all UK producers and exporters (*see Calculation of Net Countervailable Subsidy: Cut-to-Length Carbon Steel Plate from the United Kingdom*, March 29, 2000). Consistent with the above-described practice of disregarding subsidized prices to value NME inputs, we have preliminarily determined not to use the market economy prices paid by Hangzhou for CSWR.

Instead, we have used the value of imports of CSWR into India, based on information from the *Monthly Foreign Trade Statistics of India—Imports (MSFTI)*. In computing this value, we have taken into account that the Department has made final affirmative countervailing duty determinations on steel products from numerous countries. Therefore, we have not included values for imports of CSWR into India from Belgium, Canada, France, Germany, and the UK (as well as South Korea and Thailand). Similarly, in valuing steel scrap, we have excluded values for imports into India from Belgium, France, Germany, South Africa and the UK (as well as Indonesia, South Korea and Thailand).

The remaining inputs are addressed below:

- To value the hydrochloric acid used in the production process, we used per kilogram values obtained from the Indian publication *Chemical Weekly*.
- To value other chemicals used in the production of HSLWs, we used per kilogram import values obtained from *MSFTI*. We also adjusted these values to account for freight costs incurred between the supplier and Hangzhou.
- To value plating, we used a March 14, 2003, price quote supplied by the petitioner in its submission dated March 20, 2003, subsequently resubmitted as a public document.
- To value coal, we used a per kilogram value obtained from the *MFSTI*. We also made adjustments to account for freight costs incurred between the supplier and Hangzhou.
- To value electricity, we used the electricity price data from the Energy Data Directory and Yearbook (1999/2000) published by the Tata Energy Research Institute. We adjusted the value to reflect inflation using the electricity sector-specific inflation index published in the *Reserve Bank of India (RBI) Bulletin*.
- To value water, we used the *Second Water Utilities Data Book for the Asian and Pacific Region* published by the Asian Development Bank in 1997. We adjusted the value to reflect inflation using the wholesale price index (WPI) published by the International Monetary Fund (IMF).
- For labor, we used the regression-based wage rate for the PRC in "Expected Wages of Selected NME Countries," located on the Internet at *http://ia.ita.doc.gov.wages/corrected00wages/htm*.
- For factory overhead, selling, general, and administrative expenses (SG&A), and profit values, we used information from the September 12, 2002, *RBI Bulletin* report entitled "Combined Income, Value of Production, Expenditure and Appropriations Accounts of the Selected 1,927 Public Limited Companies (2000–2001)." From this information, we were able to determine factory overhead as a percentage of the total raw materials, labor and energy (ML&E) costs, SG&A as a percentage of ML&E plus overhead (*i.e.*, cost of manufacture), and the profit rate as a percentage of the cost of manufacture plus SG&A.
- For packing materials, we used the per kilogram values obtained from the *MFSTI*. Where necessary, we adjusted these values to reflect inflation using the WPI published by the IMF. We also made adjustments to account for freight costs incurred between the PRC supplier and Hangzhou.
- To value foreign brokerage and handling, we used information reported in the *New Shipper Review for Stainless Steel Wire Rod from India*, 66 FR 27629 (May 18, 2001). *See* Meltroll Engineering Pvt. Ltd.'s submission dated September 12, 1999. We adjusted this value to reflect inflation using the WPI published by the IMF.
- To value truck freight, we used the freight rates published in the Indian publication *Chemical Weekly*. We obtained distances between cities from the following Web sites: *http://www.infreight.com; http://www.sitaindia.com/Packages/CityDistance.php; http://indiatravelinfo.com/distance.html; and, http://www/abcindia.com*.
- To value shipping freight, we used a rate reported in a July 14, 1997, letter from the Inland Waterways of India which was used in *Certain Helical Spring Lock Washers from the People's Republic of China; Final Results of the Antidumping Duty Administrative Review*, 67 FR 8520 (February 25, 2002) (*HSLWs–7*) and *Certain Helical Spring Lock Washers from the People's Republic of China; Final Results of the Antidumping Duty Administrative Review*, 67 FR 69717 (November 19, 2002) (*HSLWs–8*). We adjusted the rate to reflect inflation using the WPI published by the IMF.

For a complete description of the factor values used, *see* "Memorandum to File: Factor Values Used for the Preliminary Results of the Ninth Administrative Review," dated October 31, 2003 (Factors Memorandum), a public version of which is available in the Public File of the CRU.

Revocation

The Department "may revoke, in whole or in part" an antidumping duty order upon completion of a review under section 751 of the Act. While Congress has not specified the procedures that the Department must follow in revoking an order, the Department has developed a procedure for revocation that is described in 19 CFR 351.222. This regulation requires, *inter alia*, that a company requesting revocation must submit the following: (1) A certification that the company has sold the subject merchandise at not less than NV in the current review period and that the company will not sell at less than NV in the future; (2) a certification that the company sold the subject merchandise in each of the three years forming the basis of the request in commercial quantities; and, (3) an agreement to reinstatement of the order if the Department concludes that the company, subsequent to the revocation, sold subject merchandise at less than NV. *See* 19 CFR 351.222(e)(1).

Pursuant to 19 CFR 351.222(e)(1), Hangzhou requested revocation of the antidumping duty order as it pertains to that company. According to 19 CFR 351.222(b)(2), upon receipt of such a request, the Department may revoke an order, in part, if it concludes that (1) the company in question has sold subject merchandise at not less than NV for a period of at least three consecutive

years; (2) the continued application of the antidumping duty order is not otherwise necessary to offset dumping; and, (3) the company has agreed to its immediate reinstatement in the order if the Department concludes that the company, subsequent to the revocation, sold subject merchandise at less than NV.

Based on our analysis of the sales and factors of production information submitted by Hangzhou, we preliminarily determine that Hangzhou sold the subject merchandise in the United States below normal value during the POR. Thus, we find that Hangzhou has not sold the subject merchandise below NV for a period of at least three consecutive years. Therefore, pursuant to 19 CFR 351.222(b)(2), we preliminarily determine that Hangzhou does not qualify for revocation of the order on HSLWs from the PRC and that the order, with respect to Hangzhou, should not be revoked.

Preliminary Results of Review

We preliminarily determine that the following dumping margin exists:

Manufacturer/exporter	Time period	Margin (percent)
Hang Zhou Spring Washer Co. Ltd./Zhejiang Wanxin Group, Ltd	10/1/01–9/30/02	29.03

The Department shall determine, and the U.S. Customs and Border Protection (CBP) shall assess, antidumping duties on all appropriate entries. Upon completion of this administrative review, the Department will determine, and the CBP shall assess, antidumping duties on all appropriate entries. In accordance with 19 CFR 351.212(b)(1), we have calculated an exporter/importer (or customer)-specific assessment rate for merchandise subject to this review. We calculated importer (or customer)-specific *ad valorem* rates by aggregating the dumping duties due for all U.S. sales to each importer (or customer) and dividing this amount by the total entered value of the sales to that importer (or customer). In accordance with the requirement set forth in 19 CFR 351.106(c)(2), where an importer (or customer)-specific *ad valorem* rate is less than *de minimis*, we will direct the CBP to liquidate without regard to antidumping duties. Where an importer (or customer)-specific ad valorem rate is greater than *de minimis*, we will direct the CBP to apply the *ad valorem* assessment rates against the entered value of each of the importer's/customer's entries during the review period. All other entries of the subject merchandise during the POR will be liquidated at the antidumping duty rate in place at the time of entry.

Furthermore, the following cash deposit rates will be effective upon publication of the final results for all shipments of HSLWs from the PRC entered, or withdrawn from warehouse, for consumption on or after the publication date, as provided for by section 751(a)(1) of the Act: (1) For Hangzhou, which has a separate rate, the cash deposit rate will be the company-specific rate established in the final results of review; (2) for all other PRC exporters, the cash deposit rate will be the PRC rate, 128.63 percent, which is the "All Other PRC Manufacturers, Producers and Exporters" rate from the *Final Determination of Sales at Less Than Fair Value: Certain Helical Spring Lock Washers from the People's Republic of China*, 58 FR 48833 (September 20, 1993); and, (3) for non-PRC exporters of subject merchandise from the PRC, the cash deposit rate will be the rate applicable to the PRC supplier of that exporter. These deposit rates, when imposed, shall remain in effect until publication of the final results of the next administrative review.

This notice also serves as a preliminary reminder to importers of their responsibility under 19 CFR 351.402(f) to file a certificate regarding the reimbursement of antidumping duties prior to liquidation of the relevant entries during this review period. Failure to comply with this requirement could result in the Secretary's presumption that reimbursement of antidumping duties occurred and the subsequent assessment of double antidumping duties.

Public Comment

Pursuant to 19 CFR 351.224, the Department will disclose to parties the calculations performed in connection with these preliminary results within five days of the date of any public announcement, or, if there is no public announcement, within five days of the date of publication of this notice. Interested parties may request a hearing within 30 days of the date of publication of this notice (*See* 19 CFR 351.310). Any hearing, if requested, will be held two days after the scheduled date for submission of rebuttal briefs (*see* below). According to 19 CFR 351.309, interested parties may submit written arguments in case briefs within 30 days of the date of publication of this notice. Rebuttal briefs, limited to issues raised in case briefs, may be filed no later than five days after the date of filing the case briefs. Parties who submit briefs in these proceedings should provide a summary of the arguments not to exceed five pages and a table of statutes, regulations, and cases cited. Copies of case briefs and rebuttal briefs must be served on interested parties in accordance with 19 CFR 351.303(f)(3).

The Department will publish the final results of this administrative review, including the results of its analysis of issues raised in any such briefs or hearing, within 120 days of publication of these preliminary result.

This administrative review and notice are in accordance with sections 751(a)(1) and 777(i)(1) of the Act.

Dated: October 31, 2003.

James J. Jochum,

Assistant Secretary for Import Administration.

[FR Doc. 03–28123 Filed 11–6–03; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

International Trade Administration

[A-570–502]

Iron Construction Castings from the People's Republic of China: Rescission of Antidumping Duty Administrative Review

AGENCY: Import Administration, International Trade Administration, U.S. Department of Commerce

SUMMARY: : In response to a timely request from an interested party, the Department of Commerce (the Department) initiated an administrative review of the antidumping duty order on iron construction castings (castings) from the People's Republic of China (PRC). *See Initiation of Antidumping and Countervailing Duty Administrative Reviews and Request for Revocation in Part*, 68 FR 39055 (July 1, 2003)(*Initiation Notice*). This review covers the period May 1, 2002 through April 30, 2003. Powin Corporation (Powin), the U.S. importer which

requested the administrative review, has now withdrawn its request for an administrative review. Accordingly, the Department is rescinding this review in accordance with section 351.213(d)(1) of the Department's regulations.

EFFECTIVE DATE: November 7, 2003.

FOR FURTHER INFORMATION CONTACT: Sean Carey, AD/CVD Enforcement Group III, Office 7, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, N.W., Washington D.C. 20230; telephone (202) 482–3964.

SUPPLEMENTARY INFORMATION:

Background

The Department published in the **Federal Register** an antidumping duty order on castings from the PRC on May 9, 1986. *See Antidumping Duty Order: Iron Construction Castings from the People's Republic of China*, 51 FR 17222 (May 9, 1986). On May 29, 2003, the Department received a timely request from Powin, a U.S. importer, for an administrative review of the PRC exporter of subject merchandise, Shandong Himight Machinery Co., Ltd. (Shandong Himight). The Department published its initiation of administrative review on July 1, 2003. *See Initiation Notice.*

On July 24, 2003, counsel for Powin entered an appearance on behalf of Weifang Fangzi Tongbao Foundry and Weifang Fangzi Mucun Foundry, producers of subject merchandise, and Shandong Machinery I/E Corp., a company which facilitated Shandong Himight's exports to the United States. On July 25, 2003, the Department issued its antidumping duty questionnaire. The Department extended the deadline for the questionnaire response on September 3 and again on September 16, 2003 pursuant to Powin's request for an extension of the deadline. In a letter to the Department filed September 30, 2003, Powin withdrew its request for an administrative review.

Rescission of Antidumping Duty Administrative Review of Castings

The Department is rescinding the antidumping duty administrative review of Powin, covering the period May 1, 2002 through April 30, 2003, in accordance with section 351.213(d)(1) of the Department's regulations. Although Powin's withdrawal request for this review was not within the normal time limit as prescribed in section 351.213(d)(1) of the Department's regulations, we find that, under the circumstances of this review, it is appropriate to accept the withdrawal request and rescind the review with respect to Shandong Himight.

According to section 351.213(d)(1) of the Department's regulations, the Department will rescind an administrative review "if a party that requested the review withdraws the request within 90 days of the date of publication of notice of initiation of the requested review." The regulations further provide that the Secretary "may extend this time limit if the Secretary decides that it is reasonable to do so." In the instant case, Powin's withdrawal request was not filed within the 90-day time limit. However, the Department has determined that rescinding the review is appropriate since continuing the review would only require Powin, the domestic industry and the Department to expend time and resources on a review in which the only party that requested the review is no longer interested. Powin has not filed a questionnaire response with respect to Shandong Himight, and the Department has neither released supplemental questionnaires nor conducted verification at this point in the proceeding. Accordingly, the Department does not believe the administrative review has proceeded to a point at which it would be "unreasonable" to rescind the review.

The Department, therefore, determines that it is reasonable to extend the 90-day time limit and to rescind the administrative review for the period May 1, 2002 through April 30, 2003. The Department will issue appropriate assessment instructions directly to the U.S. Customs and Border Protection (Customs) within 15 days of publication of this notice. The Department will direct Customs to assess antidumping duties for this company at the cash deposit rate in effect on the date of entry for entries during the period May 1, 2002 through April 30, 2003.

Notification to Importers

This notice serves as a final reminder to importers of their responsibility under section 351.402(f) of the Department's regulations to file a certificate regarding the reimbursement of antidumping duties prior to liquidation of the relevant entries during this review period. Failure to comply with this requirement could result in the Secretary's presumption that reimbursement of antidumping duties occurred and subsequent assessment of double antidumping duties. The Department will issue appropriate assessment instructions to the U.S. Bureau of Customs and Border Protection.

This determination and notice are issued and published in accordance with 19 CFR 351.213(d)(4) and sections 751(a)(1) and 777(i)(1) of the Act.

Dated: October 28, 2003.

James J. Jochum,

Assistant Secretary for Import Administration.

[FR Doc. 03–28122 Filed 11–6–03; 8:45 am]

BILLING CODE 3510–DS–S

DEPARTMENT OF COMMERCE

International Trade Administration

[A-570–851]

Certain Preserved Mushrooms from the People's Republic of China: Notice of Partial Rescission of Fourth Antidumping Duty Administrative Review

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

ACTION: Notice of Partial Rescission of Fourth Antidumping Duty Administrative Review.

EFFECTIVE DATE: November 7, 2003.

FOR FURTHER INFORMATION CONTACT: Brian Smith or Jim Mathews, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, N.W., Washington, D.C. 20230; telephone: (202) 482–1766 or (202) 482–2778, respectively.

SUPPLEMENTARY INFORMATION:

Background

On February 3, 2003, the Department published in the **Federal Register** (68 FR 5272) a notice of "Antidumping or Countervailing Duty Order, Finding, or Suspended Investigation; Opportunity To Request Administrative Review" of the antidumping duty order on certain preserved mushrooms from the People's Republic of China ("PRC") for the period February 1, 2002, through January 31, 2003. On February 25, 2003, Green Fresh Foods (Zhangzhou) Co., Ltd. ("Green Fresh") requested an administrative review of its sales. On February 28, 2003, Guangxi Yulin Oriental Co., Ltd. ("Guangxi Yulin") requested an administrative review of its sales. Also, on February 28, 2003, the petitioner[1] requested an administrative

[1] The petitioner is the Coalition for Fair Preserved Mushroom Trade which includes the American Mushroom Institute and the following domestic companies: L.K. Bowman, Inc., Modern Mushroom Farms, Inc., Monterey Mushrooms, Inc., Mount Laurel Canning Corp., Mushroom Canning

Continued

review of the antidumping duty order for the following companies: China Processed Food Import & Export Company ("China Processed), Gerber Food (Yunnan) Co., Ltd. ("Gerber"), Green Fresh, Guangxi Yulin, Raoping Xingyu Foods Co., Ltd. ("Raoping"), Shantou Hongda Industrial General Corporation ("Shantou Hongda"), Shenxian Dongxing Foods Co., Ltd. ("Shenxian Dongxing"), Shenzhen Qunxingyuan Trading Co., Ltd. ("Shenzhen Qunxingyuan"), Xiamen Zhongjia Imp. & Exp. Co., Ltd. ("Zhongjia"), Zhangzhou Jingxiang Foods Co., Ltd. ("Jingxiang"), and Zhangzhou Longhai Minhui Industry and Trade Co., Ltd ("Minhui"). On March 6, 2003, Shantou Hongda and Shenxian Dongxing requested an administrative review of their sales.[2] On March 25, 2003, the Department published a notice of initiation of an administrative review of the antidumping duty order on certain preserved mushrooms from the PRC with respect to these companies. *See Initiation of Antidumping and Countervailing Duty Administrative Reviews and Requests for Revocations in Part*, 68 FR 14394.

On May 7, 2003, Raoping and Shenzhen Qunxingyuan requested that the Department rescind their respective reviews because they did not export to the United States during the period of review ("POR"). We confirmed the claims of Raoping and Shenzhen Qunxingyuan by reviewing data from U.S. Customs and Border Protection. *See* Memorandum to the File dated September 29, 2003, on file in Room B-099 of the Commerce Department. We received no comments on this memorandum from any party.

On June 12, 2003, the petitioner requested an extension of the deadline to withdraw its requests for review. On June 16, 2003, the Department granted the petitioner's request and extended the deadline until July 10, 2003. On August 7, 2003, the petitioner withdrew its request for an administrative review of Zhongjia and Minhui, following the Department's preliminary decision to rescind the new shipper review with respect to these companies due to the filing of improper certifications. *See Certain Preserved Mushrooms from the People's Republic of China: Intent to Rescind Antidumping Duty New Shipper Review*, 68 FR 45792 (August 4, 2003). On August 20, 2003, Zhongjia and Minhui requested that the data submitted on the record of the above-mentioned new shipper review be transferred to the record of the fourth administrative review.[3] The petitioner objected to this request on September 2, 2003. On September 15, 2003, respondents Zhongjia and Minhui submitted a letter in opposition to the petitioner's August 7 review request withdrawal. On September 23, 2003, the petitioner submitted a letter in opposition to Zhongjia's and Minhui's September 15 letter.

Partial Rescission of Review

Pursuant to section 351.213 (d)(1) of the Department's regulations, the Secretary will rescind an administrative review in whole or in part if a party that requested the review withdraws its request within ninety days of publication of the **Federal Register** notice that initiated the review. Section 351.213(d)(1) further provides that the Secretary may extend this time limit if the Secretary decides that it is reasonable to do so. The administrative review is still at the early stages of the proceeding, and the Department has not conducted verification or issued a preliminary determination. The Department has determined that it is reasonable to extend the time in which the petitioner can request a withdrawal of its request for the administrative review of Zhongjia and Minhui.

Zhongjia and Minhui contest the petitioners request and argue that the Department should continue with the administrative review covering their sales of subject merchandise. For purposes of our analysis, it is important to distinguish that Zhongjia and Minhui each requested a new shipper review but did not request an administrative review. This is in contrast to the situation in which a respondent requests both a new shipper review and an administrative review. Section 351.214(j) of the Department's regulations provides that if a party requests multiple reviews, the Department may choose to initiate one and not the other after consulting with the party. For example, *in Certain In-Shell Roasted Pistachios From Iran: Notice of Initiation of New Shipper Countervailing Duty Review*, 66 FR 59235, 59235–6 (November 27, 2001) (*Pistachios from Iran*), the respondent requested both a new shipper and an administrative review in a timely manner. Pursuant to 19 CFR 351.214(j), the Department only initiated the new shipper review. Had the new shipper review been rescinded in *Pistachios from Iran* under facts similar to those in this case, the Department would have considered continuing the administrative review. However, in this case, because neither Zhongjia nor Minhui submitted a request for an administrative review of their sales in a timely fashion, as required by 751(a)(1) of the Act, we are rescinding the administrative review of the antidumping duty order on certain preserved mushrooms from the PRC with respect to these two companies, as requested by the petitioner.

Furthermore, as neither Raoping nor Shenzhen Qunxingyuan exported the subject merchandise to the United States during the POR, we are rescinding this review of the antidumping duty order on certain preserved mushrooms from the PRC as to both Raoping and Shenzhen Qunxingyuan. This review will continue with respect to Gerber, Green Fresh, China Processed, Guangxi Yulin, Shantou Hongda, Shenxian Dongxing and Jingxiang.

This notice is published in accordance with section 777(i) of the Tariff Act of 1930, as amended, and 19 CFR 351.213(d)(4).

Dated: November 3, 2003.

Jeffrey May,

Deputy Assistant Secretary for Import Administration.

[FR Doc. 03–28124 Filed 11–6–03; 8:45 am]

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Company, Southwood Farms, Sunny Dell Foods, Inc., and United Canning Corp.

[2] This request was originally filed on February 27, 2003, but was subsequently refiled on March 6, 2003, because the package containing the original request could not be located subsequent to the original filing.

[3] In response to the Department's questionnaire issued in the fourth administrative review, both companies claimed they had no shipments of the subject merchandise during the POR other than the transactions covered in the new shipper review.

DEPARTMENT OF COMMERCE

International Trade Administration

[A-570–851]

Notice of Decision of the Court of International Trade: Certain Preserved Mushrooms from the People's Republic of China

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

ACTION: Notice of Decision of the Court of International Trade.

SUMMARY: On October 17, 2003, in *Tak Fat Trading Company, et al., v. United States*, Consol. Court No. 00–07–00360, Slip Op. 03–134, a lawsuit challenging the Department of Commerce's final scope ruling that the marinated mushrooms manufactured or exported by the plaintiffs are within the scope of the antidumping duty order of certain preserved mushrooms from the People's

Republic of China, the Court of International Trade vacated the Department of Commerce's scope ruling and entered a judgement order. Consistent with the decision of the United States Court of Appeals for the Federal Circuit in *Timken Co. v. United States*, 893 F.2d 337 (Fed.Cir. 1990), the Department is notifying the public that this decision was "not in harmony" with the Department's original final scope ruling.

EFFECTIVE DATE: November 7, 2003.

FOR FURTHER INFORMATION CONTACT: David J. Goldberger at (202) 482–4136 or Rebecca Trainor at (202) 482–4007, Office of Antidumping and Countervailing Duty Enforcement, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, N.W., Washington, D.C. 20230.

SUPPLEMENTARY INFORMATION:

Background

On February 19, 1999, the Department of Commerce (the Department) published notice of its amended final determination of less-than-fair-value (LTFV) investigation of certain preserved mushrooms from the People's Republic of China (PRC) and the antidumping duty order. *See Notice of Amendment of Final Determination of Sales at Less Than Fair Value and Antidumping Duty Order: Certain Preserved Mushrooms from the People's Republic of China*, 64 FR 8308 (February 19, 1999).

On January 6, 2000, producers/exporters, Mei Wei Food Industry Co, Ltd, Tak Fat Trading Co., Leung Mi International, Tak Yeun Corp., and U.S. importer Genex International Corp. (collectively, Tak Fat), requested that the Department determine that certain marinated or acidified mushrooms produced in the People's Republic of China (PRC) are outside the scope of the antidumping duty order on certain preserved mushrooms. *See Request for Scope Determination: Certain Preserved Mushrooms from the People's Republic of China*, January 6, 2000. The Department made a final ruling on this scope request on June 19, 2000, finding that the "marinated or acidified" mushrooms produced, exported or imported by Tak Fat are within the scope of the antidumping duty order on certain preserved mushrooms from the PRC based on their acetic acid content level.

Tak Fat appealed this ruling to the Court of International Trade (CIT). On October 17, 2003, the CIT issued its decision granting Tak Fat's request to vacate the scope ruling. *See Tak Fat Trading Company, et al., v. United States*, Slip Op. 03–134.

Timken Notice

In its decision in *Timken Co. v. United States*, 893 F.2d 337 (Fed. Cir. 1990) (*Timken*), the Court of Appeals for the Federal Circuit (CAFC) held that, pursuant to 19 USC 1516(e), the Department must publish notice of a decision of the CIT or the CAFC which is "not in harmony" with the Department's determination. Therefore, publication of this notice fulfills this obligation of the Department. In addition, this notice will serve to continue the suspension of liquidation. If this decision is not appealed, or if appealed, if it is upheld, the Department will amend its scope ruling.

Dated: November 3, 2003.

James Jochum,

Assistant Secretary for Import Administration.

[FR Doc. 03–28125 Filed 11–6–03; 8:45 am]

BILLING CODE 3510–DS–S

DEPARTMENT OF COMMERCE

International Trade Administration

[A-583–830]

Stainless Steel Plate in Coils from Taiwan: Final Rescission of Antidumping Duty Administrative Review

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

ACTION: Notice of the Final Rescission of Antidumping Duty Administrative Review of Stainless Steel Plate in Coils from Taiwan.

SUMMARY: On June 4, 2003, the Department of Commerce ("the Department") published in the **Federal Register** the preliminary rescission of its administrative review of the antidumping duty order on stainless steel plate in coils from Taiwan. *See Notice of the Preliminary Rescission of Antidumping Duty Administrative Review of Stainless Steel Plate in Coils from Taiwan*, 68 FR 33472 (June 4, 2003) ("Preliminary Recession"). This review covers two manufacturers of the subject merchandise, Yieh United Steel Corporation ("YUSCO"), a Taiwanese producer of subject merchandise, and Ta Chen Stainless Pipe Co., Ltd. ("Ta Chen"), also a Taiwanese producer of subject merchandise. The period of review ("POR") is May 1, 2001 through April 30, 2002.

We preliminarily rescinded this review based on record evidence supporting the conclusion that there were no entries into the United States of subject merchandise during the POR by respondents. *See Preliminary Rescission*. We are now issuing our final rescission of this review based on evidence on the record indicating that there were no entries into the United States of subject merchandise during the POR from the respondents.

EFFECTIVE DATE: November 7, 2003.

FOR FURTHER INFORMATION CONTACT: Catherine Bertrand or Robert Bolling, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW, Washington, DC 20230; telephone: (202) 482–3207 or (202) 482–3434 respectively.

SUPPLEMENTARY INFORMATION:

Background

On May 21, 1999, the Department of Commerce ("Department") published the antidumping duty order on stainless steel plate in coils from Taiwan. *See Antidumping Duty Orders; Certain Stainless Steel Plate in Coils From Belgium, Canada, Italy, the Republic of Korea, South Africa, and Taiwan*, 64 FR 27756 (May 21, 1999). On May 6, 2002, the Department published a notice of opportunity to request an administrative review of this order for the period May 1, 2001 through April 30, 2002. *See Notice of Opportunity to Request Administrative Review of Antidumping or Countervailing Duty Order, Finding, or Suspended Investigation*, 67 FR 30356 (May 6, 2002). On May 7, 2002, Petitioners[1] timely requested that the Department conduct an administrative review of sales by YUSCO, a Taiwan producer and exporter of subject merchandise, and Ta Chen, also a Taiwan producer and exporter of subject merchandise. On June 25, 2002, in accordance with section 751(a) of the Tariff Act of 1930 as amended ("the Act"), the Department published in the **Federal Register** a notice of initiation of this antidumping duty administrative review of sales by YUSCO and Ta Chen for the period May 1, 2001 through April 30, 2002. *See Notice of Initiation of Antidumping and Countervailing Duty Administrative Reviews and Request for Revocation in Part*, 67 FR 42753 (June 25, 2002).

On July 10, 2002, the Department issued its antidumping duty

[1] Allegheny Ludlum, AK Steel Corporation, Butler Armco Independent Union, United Steelworkers of America, AFL-CIO/CLC, and Zanesville Armco Independent Organization are collectively "Petitioners" for this review.

questionnaire to YUSCO and Ta Chen. On July 15, 2002, Ta Chen stated that it did not have any U.S. sales, shipments or entries of subject merchandise during the POR, and requested that it not be required to answer the Department's questionnaire. On July 18, 2002, YUSCO stated that it did not have any U.S. sales, shipments or entries of subject merchandise during the POR. On October 8, 2002, the Department sent an inquiry to the U.S. Customs and Border Protection ("Customs") to confirm that YUSCO and Ta Chen had no shipments of subject merchandise into the United States during the POR.

On June 4, 2003, the Department preliminary rescinded the administrative review with respect to Ta Chen and YUSCO based on record evidence and the Customs inquiry, both of which it determined supported the conclusion that there were no entries of subject merchandise during the POR. *See Preliminary Rescission.* On August 15, 2003, Petitioners filed a case brief. Respondents did not file case briefs. On August 21, 2003, Respondent YUSCO filed a rebuttal brief. Respondent Ta Chen did not file a rebuttal brief. Neither Petitioners nor respondents requested a hearing in the instant review.

Scope of the Review

For purposes of this review, the product covered is certain stainless steel plate in coils. Stainless steel is an alloy steel containing, by weight, 1.2 percent or less of carbon and 10.5 percent or more of chromium, with or without other elements. The subject plate products are flat-rolled products, 254 mm or over in width and 4.75 mm or more in thickness, in coils, and annealed or otherwise heat treated and pickled or otherwise descaled. The subject plate may also be further processed (*e.g.*, cold-rolled, polished, etc.) provided that it maintains the specified dimensions of plate following such processing. Excluded from the scope of this review are the following: (1) Plate not in coils, (2) plate that is not annealed or otherwise heat treated and pickled or otherwise descaled, (3) sheet and strip, and (4) flat bars. In addition, certain cold-rolled stainless steel plate in coils is also excluded from the scope of these orders. The excluded cold-rolled stainless steel plate in coils is defined as that merchandise which meets the physical characteristics described above that has undergone a cold-reduction process that reduced the thickness of the steel by 25 percent or more, and has been annealed and pickled after this cold reduction process. The merchandise subject to this review is currently classifiable in the HTS at subheadings: 7219.11.00.30, 7219.11.00.60, 7219.12.00.05, 7219.12.00.20, 7219.12.00.25, 7219.12.00.50, 7219.12.00.55, 7219.12.00.65, 7219.12.0070, 7219.12.00.80, 7219.31.00.10, 7219.90.00.10, 7219.90.00.20, 7219.90.00.25, 7219.90.00.60, 7219.90.00.80, 7220.11.00.00, 7220.20.10.10, 7220.20.10.15, 7220.20.10.60, 7220.20.10.80, 7220.20.60.05, 7220.20.60.10, 7220.20.60.15, 7220.20.60.60, 7220.20.60.80, 7220.90.00.10, 7220.90.00.15, 7220.90.00.60, and 7220.90.00.80.

Although the HTS subheadings are provided for convenience and Customs purposes, the written description of the merchandise under investigation is dispositive.

Period of Review

The POR is May 1, 2001 through April 30, 2002.

Analysis of Comments Received

All issues raised in the case brief and rebuttal brief by parties to this administrative review are addressed in the "Issues and Decision Memorandum" ("*Decision Memorandum*") from Joseph A. Spetrini, Deputy Assistant Secretary, Import Administration, Group III, to James J. Jochum, Assistant Secretary for Import Administration, dated November 3, 2003, which is hereby adopted by this notice. Petitioners argue that the administrative review should not be rescinded because the Department failed to examine the affiliates of YUSCO and did not require Ta Chen to link its POR sales to pre-suspension entries. Respondent YUSCO argues that the administrative review should be rescinded because evidence on the record supports the conclusion that YUSCO had no entries during the POR. We have determined to rescind this administrative review because the Department's interpretation of its statute and regulations, as affirmed by the Court of Appeals for the Federal Circuit, supports not conducting a administrative review when the evidence on the record indicates that respondents had no entries of subject merchandise during the POR. This interpretation is further supported by the fact that the Department has determined that there have been no entries of respondent's merchandise since before the suspension of liquidation, which leads the Department to determine that merchandise resold by respondents during the POR did not constitute subject merchandise.

A complete list of the issues which parties have raised and to which we have responded, are in the *Decision Memorandum* which is attached to this notice as an Appendix. Parties can find a complete discussion of all issues raised in this review and the corresponding recommendations in this public memorandum which is on file in the Central Records Unit, Room B-099 of the main Department building. In addition, a complete version of the *Decision Memorandum* can be accessed directly on the Web at http://ia.ita.doc.gov/frn/summary/list.htm. The paper copy and electronic version of the *Decision Memorandum* are identical in content.

Final Rescission of Review

Pursuant to 19 CFR 351.213(d)(3), the Department may rescind an administrative review, in whole or only with respect to a particular exporter or producer, if the Secretary concludes that, during the period covered by the review, there were no entries, exports, or sales of the subject merchandise, as the case may be. In this case the Department is satisfied, after a review of information on the record, that there were no entries of stainless steel plate in coils produced and exported from Ta Chen or YUSCO during the POR. Therefore, we are rescinding this review with respect to Ta Chen and YUSCO in accordance with 19 CFR 351.213(d)(3). The cash deposit rate for YUSCO will remain at 8.02 percent, for Ta Chen the cash deposit rate will remain at 10.20 percent, and for "all other" producers/exporters of the subject merchandise the cash deposit rate will remain at 7.39 percent, the rates established in the most recently completed segment of this proceeding. *See Notice of Final Results and Rescission in Part of Antidumping Duty Administrative Review: Stainless Steel Plate in Coils From Taiwan*, 67 FR 40914 (June 14, 2002). These deposit requirements shall remain in effect until publication of the final results of the next administrative review

Changes Since the Preliminary Rescission

We have made no changes from the *Preliminary Rescission.*

Notification of Interested Parties

This notice serves as a final reminder to importers of their responsibility under 19 CFR 351.402(f)(2) to file a certificate regarding the reimbursement of antidumping duties prior to liquidation of the relevant entries during this review period. Failure to comply with this requirement could result in the Secretary's presumption

that reimbursement of the antidumping duties occurred and the subsequent assessment of double antidumping duties.

This notice also serves as a reminder to parties subject to administrative protective orders ("APOs") of their responsibility concerning the return or destruction of proprietary information disclosed under APO in accordance with 19 CFR 351.305, which continues to govern business proprietary information in this segment of the proceeding. Timely written notification of the return/destruction of APO materials or conversion to judicial protective order is hereby requested. Failure to comply with the regulations and terms of an APO is a violation which is subject to sanction.

This issuing and publishing this determination in accordance with sections 751(a)(1) and 777(i) of the Act.

Dated: November 3, 2003.

James J. Jochum,

Assistant Secretary for Import Administration.

APPENDIX I

LIST OF ISSUES FOR DISCUSSION

A. Issues with Respect to Ta Chen

Comment 1: Examining Alleged Middleman Dumping of Ta Chen
Comment 2: Commerce's Rescission Policy

B. Issues with Respect to YUSCO

Comment 3: YUSCO's Affiliated Parties
Comment 4: Alleged Error in the Selection of the Cash Deposit Rate

C. Issues with Respect to Ta Chen and YUSCO

Comment 5: Placing Information on the Record

[FR Doc. 03–28126 Filed 11–6–03; 8:45 am]

BILLING CODE 3510–DS–S

DEPARTMENT OF COMMERCE

International Trade Administration

Request for Nominations

AGENCY: International Trade Administration, Trade Development.

ACTION: Environmental Technologies Trade Advisory Committee (ETTAC), request for nominations.

SUMMARY: The Environmental Technologies Trade Advisory Committee (ETTAC) was established pursuant to provisions under Title IV of the Jobs Through Trade Expansion Act, 22. U.S.C. 2151, and under the Federal Advisory Committee Act, 5 U.S.C. App.2. ETTAC was first chartered on May 31, 1994. ETTAC serves as an advisory body to the Environmental Trade Working Group of the Trade Promotion Coordinating Committee (TPCC), reporting directly to the Secretary of Commerce in his capacity as Chairman of the TPCC. ETTAC advises on the development and administration of policies and programs to expand United States exports of environmental technologies, goods, and services and products that comply with United States environmental, safety, and related requirements.

Membership in a committee operating under the Federal Advisory Committee Act must be balanced in terms of economic subsector, geographic location, and company size. Committee members serve in a representative capacity, and must be able to generally represent the views and interests of a certain subsector of the U.S. environmental industry. We are seeking senior executive-level company or environmental technologies association candidates. Members of the ETTAC have experience in exporting the full range of environmental technologies products and services including:

(1) Air Pollution Control/Monitoring Equipment;
(2) Analytic Services;
(3) Environmental Energy Sources;
(4) Environmental Engineering and Consulting Services;
(5) Financial Services;
(6) Process and Prevention Technologies;
(7) Solid and Hazardous Waste Equipment and Management; and
(8) Water and Wastewater Equipment and Services.

The Secretary of Commerce invites nominations to ETTAC of U.S. citizens who will represent U.S. environmental goods and services companies that trade internationally, or trade associations whose members include U.S. companies that trade internationally. Companies must be at least 51 percent beneficially-owned by U.S. persons. U.S.-based subsidiaries of foreign companies in general do not qualify for representation on the committee.

Nominees will be considered based upon their ability to carry out the goals of ETTAC's enabling legislation as further articulated in its charter. ETTAC's Charter is available on the Internet at *http://www.environment.ita.doc.gov*. Priority will be given to a balanced representation in terms of point of view represented by various sectors, product lines, firm sizes, and geographic areas. Appointments are made without regard to political affiliation.

Nominees must be U.S. citizens, representing U.S. environmental goods and services firms that trade internationally or provide services in direct support of the international trading activities of other entities.

Self-nominations are accepted. If you are interested in nominating someone to become a member of ETTAC, please provide the following information (2 pages maximum):

(1) Name;
(2) Title;
(3) Work Phone, Fax, and, E-mail Address;
(4) Company or Trade Association Name and Address including Web site Address;
(5) Short Bio of nominee including credentials; and
(6) Brief description of the company or trade association and its business activities; company size (number of employees and annual sales); and export markets served.

Please, do not send company or trade association brochures or any other information.

This information may be e-mailed to *Corey_Wright@ita.doc.gov* or faxed to the attention of Corey Wright at 202–482–5665, and must be received before the deadline. Nominees selected to ETTAC will be notified.

Deadline: This request will be open until December 31, 2003, from the date of publication in the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: Corey Wright, Office of Environmental Technologies Industries, Room 1003, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW., Washington, DC 20230; phone 202–482–5225; fax 202–482–5665; e-mail *Corey_Wright@ita.doc.gov*.

Dated: November 4, 2003.

Carlos M. Montoulieu,

Director, Office of Environmental Technologies Industries.

[FR Doc. 03–28120 Filed 11–6–03; 8:45 am]

BILLING CODE 3510–DR–P

DEPARTMENT OF COMMERCE

International Trade Administration

Environmental Technologies Trade Advisory Committee (ETTAC)

AGENCY: International Trade Administration, U.S. Department of Commerce.

ACTION: Notice of open meeting.

DATE: December 12, 2003.

TIME: 9 a.m. to 12 p.m.

PLACE: U.S. Department of Commerce, 14th Street and Constitution Avenue,

NW., Washington, DC 20230, Room 3407.

SUMMARY: The Environmental Technologies Trade Advisory Committee (ETTAC) will hold a plenary meeting on December 12, 2003 at the U.S. Department of Commerce.

The ETTAC will discuss administrative and trade issues including the status of negotiations in regards to environmental technologies trade liberalization, the Asia Development Bank, and preparations for a paper on environmental technologies exports issues. Time will be permitted for public comment. The meeting is open to the public.

Written comments concerning ETTAC affairs are welcome anytime before or after the meeting. Minutes will be available within 30 days of this meeting.

The ETTAC is mandated by Public Law 103–392. It was created to advise the U.S. government on environmental trade policies and programs, and to help it to focus its resources on increasing the exports of the U.S. environmental industry. ETTAC operates as an advisory committee to the Secretary of Commerce and the Trade Promotion Coordinating Committee (TPCC). ETTAC was originally chartered in May of 1994. It was most recently rechartered until May 30, 2004.

For further information phone Corey Wright, Office of Environmental Technologies Industries (ETI), International Trade Administration, U.S. Department of Commerce at (202) 482–5225. This meeting is physically accessible to people with disabilities. Requests for sign language interpretation or other auxiliary aids should be directed to ETI at (202) 482–5225.

Dated: November 4, 2003.

Carlos F. Montoulieu,

Director, Office of Environmental Technologies Industries.

[FR Doc. 03–28121 Filed 11–6–03; 8:45 am]

BILLING CODE 3510–DR–P

COMMITTEE FOR THE IMPLEMENTATION OF TEXTILE AGREEMENTS

Adjustment of an Import Limit for Certain Cotton Textile Products Produced or Manufactured in the Federative Republic of Brazil

November 3, 2003.

AGENCY: Committee for the Implementation of Textile Agreements (CITA).

ACTION: Issuing a directive to the Commissioner, Bureau of Customs and Border Protection adjusting a limit.

EFFECTIVE DATE: November 7, 2003.

FOR FURTHER INFORMATION CONTACT: Roy Unger, International Trade Specialist, Office of Textiles and Apparel, U.S. Department of Commerce, (202) 482–4212. For information on the quota status of this limit, refer to the Quota Status Reports posted on the bulletin boards of each Customs port, call (202) 927–5850, or refer to the Bureau of Customs and Border Protection website at http://www.customs.gov. For information on embargoes and quota re-openings, refer to the Office of Textiles and Apparel website at http://otexa.ita.doc.gov.

SUPPLEMENTARY INFORMATION:

Authority: Section 204 of the Agricultural Act of 1956, as amended (7 U.S.C. 1854); Executive Order 11651 of March 3, 1972, as amended.

The current limit for Category 363 is being increased for carryforward.

A description of the textile and apparel categories in terms of HTS numbers is available in the CORRELATION: Textile and Apparel Categories with the Harmonized Tariff Schedule of the United States (see **Federal Register** notice 68 FR 1599, published on January 13, 2003). Also see 67 FR 57406, published on September 10, 2002.

James C. Leonard III,

Chairman, Committee for the Implementation of Textile Agreements.

Committee for the Implementation of Textile Agreements

November 3, 2003.

Commissioner,
Bureau of Customs and Border Protection, Washington, DC 20229

Dear Commissioner: This directive amends, but does not cancel, the directive issued to you on September 3, 2002, by the Chairman, Committee for the Implementation of Textile Agreements. That directive concerns imports of certain cotton, wool and man-made fiber textile products, produced or manufactured in Brazil and exported during the twelve-month period which began on January 1, 2003 and extends through December 31, 2003.

Effective on November 7, 2003, you are directed to increase the current limit for Category 363 to 49,503,927 numbers [1], as provided for under the Uruguay Round Agreement on Textiles and Clothing.

The Committee for the Implementation of Textile Agreements has determined that this action falls within the foreign affairs exception to the rulemaking provisions of 5 U.S.C. 553(a)(1).

[1] The limit has not been adjusted to account for any imports exported after December 31, 2002.

Sincerely,
James C. Leonard III,
Chairman, Committee for the Implementation of Textile Agreements.

[FR Doc. 03–28085 Filed 11–6–03; 8:45 am]

BILLING CODE 3510–DR–S

COMMITTEE FOR THE IMPLEMENTATION OF TEXTILE AGREEMENTS

Announcement of Import Restraint Limits and Guaranteed Access Levels for Certain Cotton, Wool and Man-Made Fiber Textile Products Produced or Manufactured in the Dominican Republic

November 4, 2003.

AGENCY: Committee for the Implementation of Textile Agreements (CITA).

ACTION: Issuing a directive to the Commissioner, Bureau of Customs and Border Protection establishing limits and guaranteed access levels

EFFECTIVE DATE: January 1, 2004.

FOR FURTHER INFORMATION CONTACT: Naomi Freeman, International Trade Specialist, Office of Textiles and Apparel, U.S. Department of Commerce, (202) 482–4212. For information on the quota status of these limits, refer to the Quota Status Reports posted on the bulletin boards of each Customs port, call (202) 927–5850, or refer to the Bureau of Customs and Border Protection website at http://www.customs.gov. For information on embargoes and quota re-openings, refer to the Office of Textiles and Apparel website at http://otexa.ita.doc.gov.

SUPPLEMENTARY INFORMATION:

Authority: Section 204 of the Agricultural Act of 1956, as amended (7 U.S.C. 1854); Executive Order 11651 of March 3, 1972, as amended.

The import restraint limits and Guaranteed Access Levels (GALs) for textile products, produced or manufactured in the Dominican Republic and exported during the period January 1, 2004 through December 31, 2004 are based on limits notified to the Textiles Monitoring Body pursuant to the Uruguay Round Agreement on Textiles and Clothing (ATC).

These specific limits and guaranteed access levels do not apply to goods that qualify for quota-free entry under the Trade and Development Act of 2000.

In the letter published below, the Chairman of CITA directs the Commissioner, Bureau of Customs and Border Protection to establish the 2004 limits and guaranteed access levels.

These limits are subject to adjustment pursuant to the provisions of the ATC and administrative arrangements notified to the Textiles Monitoring Body. However, as the ATC and all restrictions thereunder will terminate on January 1, 2005, no adjustment for carryforward (borrowing from next year's limits for use in the current year) will be available.

A description of the textile and apparel categories in terms of HTS numbers is available in the CORRELATION: Textile and Apparel Categories with the Harmonized Tariff Schedule of the United States (see **Federal Register** notice 68 FR 1599, published on January 13, 2003). Information regarding the availability of the 2004 CORRELATION will be published in the **Federal Register** at a later date.

Requirements for participation in the Special Access Program are available in **Federal Register** notice 63 FR 16474, published on April 3, 1998.

James C. Leonard III,

Chairman, Committee for the Implementation of Textile Agreements.

Committee for the Implementation of Textile Agreements

November 4, 2003.

Commissioner,
Bureau of Customs and Border Protection, Washington, DC 20229.

Dear Commissioner: Pursuant to section 204 of the Agricultural Act of 1956, as amended (7 U.S.C. 1854); Executive Order 11651 of March 3, 1972, as amended; and the Uruguay Round Agreement on Textiles and Clothing (ATC), you are directed to prohibit, effective on January 1, 2004, entry into the United States for consumption and withdrawal from warehouse for consumption of cotton, wool and man-made fiber textile products in the following categories, produced or manufactured in the Dominican Republic and exported during the twelve-month period beginning on January 1, 2004 and extending through December 31, 2004, in excess of the following levels of restraint:

Category	Restraint limit
338/638	1,607,332 dozen.
339/639	1,912,721 dozen.
340/640	1,654,659 dozen.
342/642	1,164,422 dozen.
347/348/647/ 648.	3,960,929 dozen of which not more than 2,092,563 dozen shall be in Categories 647/648.
351/651	1,983,653 dozen.
433	24,199 dozen.
442	82,158 dozen.
443	150,309 numbers.
444	82,158 numbers.
448	42,324 dozen.
633	242,787 dozen.

The limits set forth above are subject to adjustment pursuant to the provisions of the ATC and administrative arrangements notified to the Textiles Monitoring Body.

Products in the above categories exported during 2003 shall be charged to the applicable category limits for that year (see directive dated October 18, 2002) to the extent of any unfilled balances. In the event the limits established for that period have been exhausted by previous entries, such products shall be charged to the limits set forth in this directive.

Also pursuant to the ATC, and under the terms of the Special Access Program, as set forth in 63 FR 16474 (April 3, 1998), effective on January 1, 2004, you are directed to establish guaranteed access levels for properly certified textile products in the following categories which are assembled in the Dominican Republic from fabric formed and cut in the United States and re-exported to the United States from the Dominican Republic during the period January 1, 2004 through December 31, 2004:

Category	Guaranteed access level
338/638	1,150,000 dozen.
339/639	1,150,000 dozen.
340/640	1,000,000 dozen.
342/642	1,000,000 dozen.
347/348/647/ 648.	8,050,000 dozen.
351/651	1,000,000 dozen.
433	21,000 dozen.
442	65,000 dozen.
443	50,000 numbers.
444	30,000 numbers.
448	40,000 dozen.
633	60,000 dozen.

Any shipment for entry under the Special Access Program which is not accompanied by a valid and correct certification in accordance with the provisions of the certification requirements established in the directive of February 25, 1987 (52 FR 6595), as amended, shall be denied entry unless the Government of the Dominican Republic authorizes the entry and any charges to the appropriate specific limits. Any shipment which is declared for entry under the Special Access Program but found not to qualify shall be denied entry into the United States.

These specific limits and guaranteed access levels do not apply to goods that qualify for quota-free entry under the Trade and Development Act of 2000.

In carrying out the above directions, the Commissioner, Bureau of Customs and Border Protection should construe entry into the United States for consumption to include entry for consumption into the Commonwealth of Puerto Rico.

The Committee for the Implementation of Textile Agreements has determined that these actions fall within the foreign affairs exception of the rulemaking provisions of U.S.C.553(a)(1).

Sincerely,
James C. Leonard III,
Chairman, Committee for the Implementation of Textile Agreements.

[FR Doc.03–28086 Filed 11–6–03; 8:45 am]
BILLING CODE 3510–DR–S

COMMITTEE FOR THE IMPLEMENTATION OF TEXTILE AGREEMENTS

Announcement of an Import Restraint Limit for Certain Cotton and Man-Made Fiber Textile Products Produced or Manufactured in Fiji

November 3, 2003.

AGENCY: Committee for the Implementation of Textile Agreements (CITA).

ACTION: Issuing a directive to the Commissioner, Bureau of Customs and Border Protection establishing a limit.

EFFECTIVE DATE: January 1, 2004.

FOR FURTHER INFORMATION CONTACT: Ross Arnold, International Trade Specialist, Office of Textiles and Apparel, U.S. Department of Commerce, (202) 482–4212. For information on the quota status of these limits, refer to the Quota Status Reports posted on the bulletin boards of each Customs port, call (202) 927–5850, or refer to the Bureau of Customs and Border Protection website at http://www.customs.gov. For information on embargoes and quota re-openings, refer to the Office of Textiles and Apparel website at http://otexa.ita.doc.gov.

SUPPLEMENTARY INFORMATION:

Authority: Section 204 of the Agricultural Act of 1956, as amended (7 U.S.C. 1854); Executive Order 11651 of March 3, 1972, as amended.

The import restraint limit for textile products, produced or manufactured in Fiji and exported during the period January 1, 2004 through December 31, 2004 is based on a limit notified to the Textiles Monitoring Body pursuant to the Uruguay Round Agreement on Textiles and Clothing (ATC).

In the letter published below, the Chairman of CITA directs the Commissioner, Bureau of Customs and Border Protection to establish the limit for the 2004 period.

This limit is subject to adjustment pursuant to the provisions of the ATC and administrative arrangements notified to the Textiles Monitoring Body. However, as the ATC and all restrictions thereunder will terminate on January 1, 2005, no adjustment for carryforward (borrowing from next year's limits for use in the current year) will be available.

A description of the textile and apparel categories in terms of HTS numbers is available in the CORRELATION: Textile and Apparel Categories with the Harmonized Tariff Schedule of the United States (see **Federal Register** notice 68 FR 1599,

published on January 13, 2003). Information regarding the availability of the 2004 CORRELATION will be published in the **Federal Register** at a later date.

James C. Leonard III,

Chairman, Committee for the Implementation of Textile Agreements.

Committee for the Implementation of Textile Agreements

November 3, 2003.

Commissioner,
Bureau of Customs and Border Protection, Washington, DC 20229.

Dear Commissioner: Pursuant to section 204 of the Agricultural Act of 1956, as amended (7 U.S.C. 1854); Executive Order 11651 of March 3, 1972, as amended; and the Uruguay Round Agreement on Textiles and Clothing (ATC), you are directed to prohibit, effective on January 1, 2004, entry into the United States for consumption and withdrawal from warehouse for consumption of cotton and man-made fiber textile products in Categories 338/339/638/639, produced or manufactured in Fiji and exported during the twelve-month period beginning on January 1, 2004 and extending through December 31, 2004, in excess of 2,368,663 dozen of which not more than 1,973,889 dozen shall be in Categories 338–S/339–S/638–S/639–S [1]

The limit set forth above is subject to adjustment pursuant to the provisions of the ATC and administrative arrangements notified to the Textiles Monitoring Body.

Products in the above categories exported during 2003 shall be charged to the applicable category limit for that year (see directive dated October 8, 2002) to the extent of any unfilled balance. In the event the limit established for that period has been exhausted by previous entries, such products shall be charged to the limit set forth in this directive.

In carrying out the above directions, the Commissioner, Bureau of Customs and Border Protection should construe entry into the United States for consumption to include entry for consumption into the Commonwealth of Puerto Rico.

The Committee for the Implementation of Textile Agreements has determined that this action falls within the foreign affairs exception to the rulemaking provisions of 5 U.S.C. 553(a)(1).

Sincerely,
James C. Leonard III,
Chairman, Committee for the Implementation of Textile Agreements.

[FR Doc. 03–28087 Filed 11–6–03; 8:45 am]

BILLING CODE 3510–DR–S

[1] Category 338–S: only HTS numbers 6103.22.0050, 6105.10.0010, 6105.10.0030, 6105.90.8010, 6109.10.0027, 6110.20.1025, 6110.20.2040, 6110.20.2065, 6110.90.9068, 6112.11.0030 and 6114.20.0005; Category 339–S: only HTS numbers 6104.22.0060, 6104.29.2049, 6106.10.0010, 6106.10.0030, 6106.90.2510, 6106.90.3010, 6109.10.0070, 6110.20.1030, 6110.20.2045, 6110.20.2075, 6110.90.9070, 6112.11.0040, 6114.20.0010 and 6117.90.9020; Category 638–S: all HTS numbers in Category 638 except 6109.90.1007, 6109.90.1009, 6109.90.1013 and 6109.90.1025; Category 639–S: all HTS numbers in Category 639 except 6109.90.1050, 6109.90.1060, 6109.90.1065 and 6109.90.1070.

COMMITTEE FOR THE IMPLEMENTATION OF TEXTILE AGREEMENTS

Adjustment of Import Limits for Certain Cotton, Wool and Man-Made Fiber Textile Products Produced or Manufactured in the Socialist Republic of Vietnam

November 3, 2003.

AGENCY: Committee for the Implementation of Textile Agreements (CITA).

ACTION: Issuing a directive to the Commissioner, Bureau of Customs and Border Protection.

EFFECTIVE DATE: November 7, 2003.

FOR FURTHER INFORMATION CONTACT: Naomi Freeman, International Trade Specialist, Office of Textiles and Apparel, U.S. Department of Commerce, (202) 482–4212. For information on the quota status of these limits, refer to the Quota Status Reports posted on the bulletin boards of each Customs port, call (202) 927–5850, or refer to the Bureau of Customs and Border Protection website at http://www.customs.gov. For information on embargoes and quota re-openings, refer to the Office of Textiles and Apparel website at http://otexa.ita.doc.gov.

SUPPLEMENTARY INFORMATION:

Authority: Section 204 of the Agricultural Act of 1956, as amended (7 U.S.C. 1854); Executive Order 11651 of March 3, 1972, as amended.

The current limits for certain categories are being adjusted for swing.

A description of the textile and apparel categories in terms of HTS numbers is available in the CORRELATION: Textile and Apparel Categories with the Harmonized Tariff Schedule of the United States (see **Federal Register** notice 68 FR 1599, published on January 13, 2003). Also see 68 FR 26575, published on May 16, 2003.

James C. Leonard III,

Chairman, Committee for the Implementation of Textile Agreements.

Committee for the Implementation of Textile Agreements

November 3, 2003.

Commissioner,
Bureau of Customs and Border Protection, Washington, DC 20229

Dear Commissioner: This directive amends, but does not cancel, the directive issued to you on May 12, 2003, by the Chairman, Committee for the Implementation of Textile Agreements. That directive concerns imports of certain cotton, wool and man–made fiber textiles and textile products, produced or manufactured in Vietnam and exported during the twelve-month period which began on May 1, 2003 and extends through December 31, 2003.

Effective on November 7, 2003, you are directed to adjust the limits for the following categories, as provided for under the terms of the current bilateral textile agreement between the Governments of the United States and Vietnam:

Category	Restraint limit [1]
333	15,440 dozen.
338/339	10,063,083 dozen.
434	9,096 dozen.
435	26,267 dozen.
448	15,713 dozen.

[1] The limits have not been adjusted to account for any imports exported after April 30, 2003.

The Committee for the Implementation of Textile Agreements has determined that these actions fall within the foreign affairs exception to the rulemaking provisions of 5 U.S.C. 553(a)(1).

Sincerely,
James C. Leonard III,
Chairman, Committee for the Implementation of Textile Agreements.

[FR Doc. 03–28088 Filed 11–6–03; 8:45 am]

BILLING CODE 3510–DR–S

DEPARTMENT OF DEFENSE

[OMB Control Number 0704–0332]

Information Collection Requirement; Defense Federal Acquisition Regulation Supplement; DoD Pilot Mentor-Protege Program

AGENCY: Department of Defense (DoD).

ACTION: Notice and request for comments regarding a proposed extension of an approved information collection requirement.

SUMMARY: In compliance with section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35), DoD announces the proposed extension of a public information collection requirement and seeks public comment on the provisions thereof. DoD invites comments on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of DoD, including whether the information will have practical utility; (b) the accuracy of the estimate of the burden of the proposed information collection; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the

burden of the information collection on respondents, including the use of automated collection techniques or other forms of information technology. The Office of Management and Budget (OMB) has approved this information collection for use through March 31, 2004. DoD proposes that OMB extend its approval for three additional years.

DATES: DoD will consider all comments received by January 6, 2004.

ADDRESSES: Respondents may submit comments via the Internet at *http://emissary.acq.osd.mil/dar/dfars.nsf/pubcomm*. As an alternative, respondents may e-mail comments to *dfars@osd.mil*. Please cite OMB Control Number 0704–0332 in the subject line of e-mailed comments.

Respondents that cannot submit comments using either of the above methods may submit comments to: Defense Acquisition Regulations Council, Attn: Mrs. Karen Fischetti, OUSD(AT&L)DPAP(DAR), IMD 3C132, 3062 Defense Pentagon, Washington, DC 20301–3062. Facsimile (703) 602–0350. Please cite OMB Control Number 0704–0332.

At the end of the comment period, interested parties may view public comments on the Internet at *http://emissary.acq.osd.mil/dar/dfars.nsf*.

FOR FURTHER INFORMATION CONTACT: Mrs. Karen Fischetti, at (703) 602–0288. The information collection requirements addressed in this notice are available electronically via the Internet at: *http://www.acq.osd.mil/dp/dars/dfars.html*. Paper copies are available from Mrs. Karen Fischetti, OUSD(AT&L)DPAP(DAR), IMD 3C132, 3062 Defense Pentagon, Washington, DC 20301–3062.

SUPPLEMENTARY INFORMATION:

Title and OMB Number: Defense Federal Acquisition Regulation Supplement (DFARS) Appendix I, DoD Pilot Mentor-Protege Program; OMB Control Number 0704–0332.

Needs and Uses: DoD needs this information to evaluate whether the purposes of the DoD Pilot Mentor-Protege Program have been met. The purposes of the Program are to (1) provide incentives to major DoD contractors to assist protege firms in enhancing their capabilities to satisfy contract and subcontract requirements; (2) increase the overall participation of protege firms as subcontractors and suppliers; and (3) foster the establishment of long-term business relationships between protege firms and major DoD contractors. This Program implements Section 831 of the National Defense Authorization Act for Fiscal Year 1991 (Pub. L. 101–510) and section 811 of the National Defense Authorization Act for Fiscal Year 2000 (Pub. L. 106–65) (10 U.S.C. 2302 note). Participation in the Program is voluntary.

Affected Public: Businesses or other for-profit organizations.

Annual Burden Hours: 931 (includes 538 recordkeeping hours).

Number of Respondents: 269.

Responses Per Respondent: 1.5.

Annual Responses: 393.

Average Burden Per Response: 1 hour reporting; 3.7 hours recordkeeping.

Frequency: Semiannually (mentor); Annually (protege).

Summary of Information Collection

DFARS Appendix I–111(a) requires mentor firms to report on the progress made under active mentor-protege agreements semiannually for the periods ending March 31st and September 30th. The September 30th report must address the entire fiscal year. Reports must include—

(1) Data on performance under the mentor-protege agreement, including dollars obligated, expenditures, credit taken under the Program, applicable subcontract awards under DoD contracts, developmental assistance provided, impact of the agreement, and progress of the agreement; and

(2) For each contract where developmental assistance was credited toward an SDB subcontracting goal, a copy of Standard Form 294, Subcontracting Report for Individual Contracts, with a statement identifying—

(i) The amount of dollars credited to the applicable subcontracting goal as a result of developmental assistance provided to protege firms under the Program; and

(ii) The number and dollar value of subcontracts awarded to the protege firm(s), broken out per protege.

DFARS Appendix I–111(b) requires the mentor firm and the protege firm to annually provide data on the progress made by the protege firm in employment, revenues, and participation in DoD contracts during each fiscal year of the Program participation term and each of the two fiscal years following the expiration of the Program participation term. During the Program participation term, the firms may provide this data as part of the mentor report required by I–111(a) for the period ending September 30th.

Michele P. Peterson,

Executive Editor, Defense Acquisition Regulations Council.

[FR Doc. 03–28007 Filed 11–6–03; 8:45 am]

BILLING CODE 5001–08–P

DEPARTMENT OF DEFENSE

GENERAL SERVICES ADMINISTRATION

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[OMB Control No. 9000–0094]

Federal Acquisition Regulation; Information Collection; Debarment and Suspension

AGENCIES: Department of Defense (DOD), General Services Administration (GSA), and National Aeronautics and Space Administration (NASA).

ACTION: Notice of request for public comments regarding an extension to an existing OMB clearance.

SUMMARY: Under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35), the Federal Acquisition Regulation (FAR) Secretariat will be submitting to the Office of Management and Budget (OMB) a request to review and approve an extension of a currently approved information collection requirement concerning debarment and suspension. The OMB clearance expires January 31, 2004.

DATES: Submit comments on or before January 6, 2004.

ADDRESSES: Submit comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the General Services Administration, FAR Secretariat (MVA), 1800 F Street, NW., Room 4035, Washington, DC 20405. Please cite OMB Control No. 9000–0094, Debarment and Suspension, in all correspondence.

FOR FURTHER INFORMATION CONTACT: Craig Goral, Acquisition Policy Division, GSA (202) 501–3856.

SUPPLEMENTARY INFORMATION:

A. Purpose

The FAR requires contracts to be awarded to only those contractors determined to be responsible. Instances where a firm or its principals have been indicted, convicted, suspended, proposed for debarment, debarred, or had a contract terminated for default are critical factors to be considered by the contracting officer in making a responsibility determination. This certification requires the disclosure of this information.

B. Annual Reporting Burden

Respondents: 89,995.

Responses per respondent: 12.223.

Total Responses: 1,100,000.

Hours Per Response: 0.0833 hrs.
Total Burden Hours: 91,667.
Obtaining Copies of Proposals: Requesters may obtain a copy of the information collection documents from the General Services Administration, FAR Secretariat (MVA), Room 4035, Washington, DC 20405, telephone (202) 501–4755. Please cite OMB Control No. 9000–0094, Debarment and Suspension, in all correspondence.

Dated: November 3, 2003.

Laura Auletta,

Director, Acquisition Policy Division.

[FR Doc. 03–28079 Filed 11–6–03; 8:45 am]

BILLING CODE 6820–EP–P

DEPARTMENT OF EDUCATION

Submission for OMB Review; Comment Request

AGENCY: Department of Education.

SUMMARY: The Leader, Regulatory Information Management Group, Office of the Chief Information Officer invites comments on the submission for OMB review as required by the Paperwork Reduction Act of 1995.

DATES: Interested persons are invited to submit comments on or before December 8, 2003.

ADDRESSES: Written comments should be addressed to the Office of Information and Regulatory Affairs, Attention: Lauren Wittenberg, Desk Officer, Department of Education, Office of Management and Budget, 725 17th Street, NW., Room 10235, New Executive Office Building, Washington, DC 20503 or should be electronically mailed to the internet address *Lauren_Wittenberg@omb.eop.gov.*

SUPPLEMENTARY INFORMATION: Section 3506 of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35) requires that the Office of Management and Budget (OMB) provide interested Federal agencies and the public an early opportunity to comment on information collection requests. OMB may amend or waive the requirement for public consultation to the extent that public participation in the approval process would defeat the purpose of the information collection, violate State or Federal law, or substantially interfere with any agency's ability to perform its statutory obligations. The Leader, Regulatory Information Management Group, Office of the Chief Information Officer, publishes that notice containing proposed information collection requests prior to submission of these requests to OMB. Each proposed information collection, grouped by office, contains the following: (1) Type of review requested, *e.g.* new, revision, extension, existing or reinstatement; (2) Title; (3) Summary of the collection; (4) Description of the need for, and proposed use of, the information; (5) Respondents and frequency of collection; and (6) Reporting and/or Recordkeeping burden. OMB invites public comment.

Dated: November 3, 2003.

Angela C. Arrington,

Leader, Regulatory Information Management Group, Office of the Chief Information Officer.

Office of Special Education and Rehabilitative Services

Type of Review: Extension.
Title: Title I State Plan for Vocational Rehabilitation Services and Title VI-Part B Supplement for Supported Employment Services.
Frequency: Annually.
Affected Public: State, Local, or Tribal Gov't, SEAs or LEAs; Businesses or other for-profit; Not-for-profit institutions.
Reporting and Recordkeeping Hour Burden:
Responses: 80.
Burden Hours: 1,002,000.
Abstract: The Workforce Investment Act of 1998 (WIA) requires the submittal of a Title I State Plan for Vocational Rehabilitation Services and a Supplement to the Plan for Supported Employment Services on the same date that the State submits its State Plan under WIA. Program funding is contingent on Departmental approval of the State Plan and its Supplement.

Requests for copies of the submission for OMB review; comment request may be accessed from *http://edicsweb.ed.gov,* by selecting the "Browse Pending Collections" link and by clicking on link number 2340. When you access the information collection, click on "Download Attachments "to view. Written requests for information should be addressed to Vivian Reese, Department of Education, 400 Maryland Avenue, SW., Room 4050, Regional Office Building 3, Washington, DC 20202–4651 or to the e-mail address *vivan.reese@ed.gov.* Requests may also be electronically mailed to the internet address OCIO_RIMG@ed.gov or faxed to 202–708–9346. Please specify the complete title of the information collection when making your request.

Comments regarding burden and/or the collection activity requirements should be directed to Sheila Carey at her e-mail address *Sheila.Carey@ed.gov.* Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339.

[FR Doc. 03–28082 Filed 11–6–03; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF EDUCATION

Submission for OMB Review; Comment Request

AGENCY: Department of Education.

SUMMARY: The Leader, Regulatory Information Management Group, Office of the Chief Information Officer invites comments on the submission for OMB review as required by the Paperwork Reduction Act of 1995.

DATES: Interested persons are invited to submit comments on or before December 8, 2003.

ADDRESSES: Written comments should be addressed to the Office of Information and Regulatory Affairs, Attention: Lauren Wittenberg, Desk Officer, Department of Education, Office of Management and Budget, 725 17th Street, NW., Room 10235, New Executive Office Building, Washington, DC 20503 or should be electronically mailed to the internet address *Lauren_Wittenberg@omb.eop.gov.*

SUPPLEMENTARY INFORMATION: Section 3506 of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35) requires that the Office of Management and Budget (OMB) provide interested Federal agencies and the public an early opportunity to comment on information collection requests. OMB may amend or waive the requirement for public consultation to the extent that public participation in the approval process would defeat the purpose of the information collection, violate State or Federal law, or substantially interfere with any agency's ability to perform its statutory obligations. The Leader, Regulatory Information Management Group, Office of the Chief Information Officer, publishes that notice containing proposed information collection requests prior to submission of these requests to OMB. Each proposed information collection, grouped by office, contains the following: (1) Type of review requested, *e.g.* new, revision, extension, existing or reinstatement; (2) Title; (3) Summary of the collection; (4) Description of the need for, and proposed use of, the information; (5) Respondents and frequency of collection; and (6) Reporting and/or Recordkeeping burden. OMB invites public comment.

Dated: November 4, 2003.

Angela C. Arrington,

Leader, Regulatory Information Management Group, Office of the Chief Information Officer.

Office of Innovation and Improvement

Type of Review: Reinstatement.

Title: Magnet Schools Assistance Program Application for Grants.

Frequency: Comp/once every three years.

Affected Public: State, Local, or Tribal Gov't, SEAs or LEAs.

Reporting and Recordkeeping Hour Burden:

Responses: 150.

Burden Hours: 6,000.

Abstract: The application is used by local education agencies to apply for grants under the Magnet Schools Assistance Program. Information in funded applications is used to describe to the public how grant funds are being used, for program evaluation, and as a basis for project monitoring.

This information collection is being submitted under the Streamlined Clearance Process for Discretionary Grant Information Collections (1890–0001). Therefore, the 30-day public comment period notice will be the only public comment notice published for this information collection.

Requests for copies of the submission for OMB review; comment request may be accessed from *http://edicsweb.ed.gov*, by selecting the "Browse Pending Collections" link and by clicking on link number 2372. When you access the information collection, click on "Download Attachments" to view. Written requests for information should be addressed to Vivian Reese, Department of Education, 400 Maryland Avenue, SW., Room 4050, Regional Office Building 3, Washington, DC 20202–4651 or to the e-mail address vivan.reese@ed.gov. Requests may also be electronically mailed to the internet address *OCIO_RIMG@ed.gov* or faxed to 202–708–9346. Please specify the complete title of the information collection when making your request.

Comments regarding burden and/or the collection activity requirements should be directed to Kathy Axt at her e-mail address, *Kathy.Axt@ed.gov*. Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339.

[FR Doc. 03–28083 Filed 11–6–03; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF ENERGY

Office of Nonproliferation Policy; Proposed Subsequent Arrangement

AGENCY: Department of Energy.

ACTION: Notice of subsequent arrangement.

SUMMARY: This notice has been issued under the authority of Section 131 of the Atomic Energy Act of 1954, as amended (42 U.S.C. 2160). The Department is providing notice of a proposed "subsequent arrangement" under the Agreement for Cooperation Concerning Civil Uses of Atomic Energy between the United States and Canada and Agreement for Cooperation in the Peaceful Uses of Nuclear Energy between the United States and the European Atomic Energy Community (EURATOM).

This subsequent arrangement concerns the retransfer of 266,197 kg of U.S.-origin natural uranium hexafluoride, 180,000 kg of which is uranium, from Cogema Resources Inc., Saskatoon, Saskatchewan, Canada to Eurodif Production, Pierrelatte France. The material, which is now located at Cameco Corp., Port Hope, Ontario, will be transferred to Eurodif for enrichment. Upon completion of the enrichment, the material will be retransferred to the Kansai Electric Power Co. Inc, Osaka, Japan, the Chugoku Electric Power Co. Inc, Hiroshima, Japan, and the Tohoku Electric Power Co Inc., Miyagi, Japan for use as fuel. The uranium hexafluoride was originally obtained by the Cameco Corp. from Power Resources, Inc. pursuant to export license number XSOU8744.

In accordance with Section 131 of the Atomic Energy Act of 1954, as amended, we have determined that this subsequent arrangement is not inimical to the common defense and security.

This subsequent arrangement will take effect no sooner than fifteen days after the date of publication of this notice.

For the Department of Energy.

Trisha Dedik,

Director, Office of Nonproliferation Policy.

[FR Doc. 03–28211 Filed 11–6–03; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Office of Energy Efficiency and Renewable Energy

Energy Conservation Program for Consumer Products: Granting of the Application for Interim Waiver and Publishing of the Petition for Waiver of Fisher & Paykel Appliances Limited From the DOE Clothes Washer Test Procedure

AGENCY: Office of Energy Efficiency and Renewable Energy, Department of Energy.

ACTION: Notice of petition for waiver and solicitation of comments.

SUMMARY: Today's notice grants an Interim Waiver to Fisher & Paykel Appliances Limited (Fisher & Paykel), publishes Fisher & Paykel's Petition for Waiver from the existing Department of Energy (DOE or Department) clothes washer test procedure for its IW model clothes washer which has an adaptive control system, and seeks comment on that Petition for Waiver. The DOE clothes washer test procedure requires manufacturers of non-conventional clothes washers with adaptive control systems other than adaptive water fill control systems to seek such a waiver.

Fisher & Paykel seeks a waiver because its clothes washer model IW has an adaptive control system with two sensing modes, water level sensing and fabric sensing, to assess the type of load in the washer. This model does not have the conventional "normal" cycle used by the DOE clothes washer test procedure set forth in 10 CFR part 430, subpart B, appendix J, or the energy test cycle for washing cotton or linen clothes used in Appendix J1. Instead, Fisher & Paykel seeks to test the washer by determining a cycle that is equivalent to the normal cycle and the energy test cycle. The company proposes to test the default cycle that begins when a user pushes the power button to start the washer. This default cycle is the midpoint of the five settings controlled by the washer's "How Dirty" button, setting three. This waiver seeks only to confirm which test cycle to use. Fisher & Paykel will then follow the remaining steps of the existing test procedure to determine the energy consumption of the clothes washer. The Department is soliciting comments, data, and information regarding the Petition for Waiver.

DATES: The Department will accept comments, data, and information regarding this Petition for Waiver not later than December 8, 2003.

ADDRESSES: Please submit comments, data, and information electronically if possible. Comments should be sent to the following Internet address: *clotheswasherwaiver@ee.doe.gov*. Electronic comments must be submitted in a WordPerfect, Microsoft Word, or PDF format, and avoid the use of special characters or any form of encryption. Comments in electronic format should be identified by the case number CW–012, and wherever possible carry the electronic signature of the author. Absent an electronic signature, comments submitted electronically must be followed and authenticated by submitting the signed original paper document. No telefacsimiles (telefaxes) will be accepted.

Written (paper) comments may be submitted to: Ms. Brenda Edwards-Jones, U.S. Department of Energy, Office of Energy Efficiency and Renewable Energy, Building Technologies Program, EE–2J, Case Number CW–012, 1000 Independence Avenue, SW., Washington, DC 20585–0121, (202) 586–2945. Please submit one signed copy—no telefacsimiles.

You may read copies of the public comments received in the resource room of the appliance office of the Building Technologies Program, room 1J–018 of the Forrestal Building at the U.S. Department of Energy, 1000 Independence Avenue, SW., Washington, DC, between the hours of 9 a.m. and 4 p.m., Monday through Friday, except Federal holidays. Please call Ms. Brenda Edwards-Jones at the above telephone number for additional information regarding visiting the resource room.

FOR FURTHER INFORMATION CONTACT: Barbara Twigg, U.S. Department of Energy, Office of Energy Efficiency and Renewable Energy, EE–2J, 1000 Independence Avenue, SW., Washington, DC 20585–0121, (202) 586–8714, e-mail: *barbara.twigg@ee.doe.gov;* or Francine Pinto, Esq., U.S. Department of Energy, Office of General Counsel, GC–72, 1000 Independence Avenue, SW., Washington, DC 20585, (202) 586–7432, e-mail: *Francine.Pinto@hq.doe.gov*.

SUPPLEMENTARY INFORMATION: Title III of the Energy Policy and Conservation Act (EPCA) sets forth a variety of provisions designed to improve energy efficiency. Part B of title III (42 U.S.C. 6291–6309) provides for the Energy Conservation Program for Consumer Products Other Than Automobiles. Among its provisions, it requires DOE to prescribe standardized test procedures to measure the energy consumption of certain consumer products, including clothes washers. The intent of the test procedures is to provide a comparable measure of energy consumption that will assist consumers in making purchasing decisions. The test procedures for clothes washers are set forth in 10 CFR part 430, subpart B, appendix J and J1.

The Department's regulations in 10 CFR 430.27, set forth a process by which an interested person may seek a waiver and an interim waiver from the test procedure requirements for a covered consumer product. The waiver process allows the Assistant Secretary for Conservation and Renewable Energy (now known as the Assistant Secretary for Energy Efficiency and Renewable Energy) to waive temporarily test procedures for a particular basic model when a petitioner shows that the basic model contains one or more design characteristics which prevent testing according to the prescribed test procedures, or when the prescribed test procedures may evaluate the basic model in a manner so unrepresentative of its true energy consumption as to provide materially inaccurate comparative data. Waivers generally remain in effect until a revised test procedure becomes effective, thereby resolving the problem that is the subject of the waiver.

An Interim Waiver will be granted by the Assistant Secretary for Energy Efficiency and Renewable Energy if it is determined that the applicant will experience economic hardship if the Application for Interim Waiver is denied, if it appears likely that the Petition for Waiver will be granted, and/or the Assistant Secretary determines that it would be desirable for public policy reasons to grant immediate relief pending a determination on the Petition for Waiver. 10 CFR 430.27 (g). An Interim Waiver remains in effect for a period of 180 days from the date of issuance or until DOE issues its determination on the Petition for Waiver, whichever is sooner, and may be extended for an additional 180 days, if necessary. 10 CFR 430.27(h).

In addition to the waiver process outlined in 10 CFR 430.27, the clothes washer test procedure published August 27, 1997, specifically requires manufacturers of clothes washers with an adaptive control system, other than an adaptive water fill control system, to obtain a waiver to establish an acceptable test procedure for each such clothes washer. 62 FR 45501, 45514. Neither Appendix J (in effect through December 31, 2003) nor Appendix J1 (effective January 1, 2004) of that test procedure provides a means for determining the energy consumption of a clothes washer with an adaptive control system.

On March 26, 2003, Fisher & Paykel filed an Application for Interim Waiver and a Petition for Waiver regarding its clothes washer model IW which has an adaptive control system that affects more than the water fill and cannot be tested accurately using the existing test procedure. Instead of having a means to select a "normal" cycle for testing (per Appendix J) or an energy test cycle for washing cottons and linens for testing (per Appendix J1), the machine features two sensing modes, water level sensing and fabric sensing, to determine the wash action. Both sensing modes employ specific agitator strokes and then assess the load's response to those agitator strokes. When a customer pushes the start button, the IW washer will, like many washers, go through an automatic sensing process to determine the water level. However, it will also sense the fabric type of the load and assign an agitator profile for that cycle. With additional input from the "How Dirty" setting, the washer will automatically select the appropriate wash action. Although users can adjust the "How Dirty" setting according to their assessment of the dirtiness of the load of clothes, if no choice is made, the power/start button will automatically select the midpoint of the "How Dirty" response as the default setting. This midpoint, setting three out of five possible settings, instructs the washer to wash on a medium soil level, the soil level suggested in the Fisher & Paykel user guide for washing a normal wash load with the IW model. Fisher & Paykel proposes to test the IW clothes washer on this midpoint, default setting activated by the power/start button, believing that it is the closest equivalent to a "normal" cycle. After the initiation of the default cycle, Fisher & Paykel will conduct the remainder of the energy consumption test according to the established test procedure.

Fisher & Paykel states that the "How Dirty" setting only affects the energy consumed by the motor, a small proportion of the total energy consumed by the wash cycle. The company provided test data to show the energy used per cycle by the five "How Dirty" settings, ranging from 0.086 kWhr/cycle to 0.121 kWhr/cycle. Since the variation in energy consumption among the five "How Dirty" settings will be insignificant compared to the total energy consumption of the clothes washer, the selection of the default cycle at the midpoint setting would seem to provide a fair equivalent of the traditional "normal" cycle for testing.

On August 4, 2003, Fisher & Paykel certified to the Department that it had circulated copies of its Application for Interim Waiver and Petition for Waiver to all known clothes washer manufacturers for comment. On September 15, 2003, the Department received copies of questions submitted by members of the Association of Home Appliance Manufacturers (AHAM) to Fisher & Paykel, in response to the circulated waiver, along with minutes from a conference call held on August 21, 2003, between AHAM Home Laundry Specialists and Fisher & Paykel, to discuss the waiver. The AHAM members requested clarifications on two points: (1) Confirmation that the #3 "How Dirty" setting met the 70 percent minimum run time requirement for the test procedure, and (2) Fisher & Paykel's intent regarding the selection of both maximum and minimum spin cycles. Subsequent to this discussion, Fisher & Paykel made changes to the waiver to clarify these issues. It added a table to show the wash times for each "How Dirty" setting and language to make clear that both the maximum and minimum spin speeds would be included in the test. Fisher & Paykel resubmitted its waiver to the Department with the revisions requested by the AHAM clothes washer manufacturers on August 31, 2003. On September 15, 2003, AHAM reported to the Department that the changes made to the waiver by Fisher & Paykel were acceptable to its members. DOE received no additional comments.

Based on the above, the Department agrees that the Fisher & Paykel IW clothes washer, using an adaptive control system without a "normal" cycle, has a design characteristic which prevents the company from testing that model according to the prescribed test procedures. Because Fisher & Paykel has suggested a reasonable method for selecting an equivalent cycle for testing and will conduct the remainder of the test procedure according to the established DOE test procedure, the Department believes that it is likely that this Petition for Waiver will be granted. To deny Fisher & Paykel the ability to test and market an adaptive control clothes washer in the United States would discourage innovation, deny consumers new options in clothes washer features, and create economic hardship for the company.

The Department is therefore granting Fisher & Paykel the Interim Waiver it has requested for its IW clothes washer. Fisher & Paykel shall be permitted to test its adaptive control clothes washer using the default cycle which begins when a consumer presses the power/start button and does not manually select an alternative "How Dirty" setting.

This Interim Waiver is based upon the presumed validity of statements and all allegations submitted by the company. This Interim Waiver may be removed or modified at any time upon a determination that the factual basis underlying the Application is incorrect.

This Interim Waiver shall remain in effect for a period of 180 days after issuance or until DOE acts on the Petition for Waiver, whichever is sooner, and may be extended for an additional 180-day period, if necessary. Pursuant to 10 CFR 430.27(b), DOE is hereby publishing the "Petition for Waiver" in its entirety. The Petition contains no confidential information. The Department solicits comments, data, and information respecting the Petition. Any person submitting written comments to DOE concerning either the Petition for Waiver or Interim Waiver must also send a copy of such comments to the petitioner. 10 CFR 430.27(b)(1)(iv) and 430.27(d).

Issued in Washington, DC, on October 30, 2003.

David K. Garman,

Assistant Secretary, Energy Efficiency and Renewable Energy.

BILLING CODE 6450-01-P

Fisher & Paykel Appliances

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22nd August2003.

Assistant Secretary,
Conservation and Renewable Energy,
Department of Energy.
1000 Independence Ave, Washington, DC

Application for Interim Waiver and Petition for Waiver for App J and App J1 of Subpart B, CFR Part 430, Test Method for Clothes Washers with Adaptive Control.

Dear Assistant Secretary,

This application for an Interim Waiver and Petition for Waiver is submitted pursuant to 10 CFR 430.27, which provides for modification of the test method if the machine has characteristics that prevent it being tested to the relevant Appendix.

Clothes washers must be tested to App J for the EnergyGuide label and to App J1 for EnergyStar. Both these Appendices have a definition for Adaptive Control Clause 1.1. At the end of both of these definitions is a note stating that if a machine has adaptive control then a waiver to establish an acceptable test procedure, must be applied for.

Fisher & Paykel Appliances seeks to test its IW model washer to the DOE requirements and cannot do so as this model has adaptive control.

This waiver seeks to determine the equivalent of the Normal Cycle for J (and Energy Test Cycle for J1) and hence confirm the test cycle. Once this is determined then either J or J1 procedures can be applied as is and no deviations are sought in this waiver to either of the actual test procedures.

IW Washer Description.

IW is a vertical axis high efficiency clothes washer with 1000rpm spin speed. It is based on the GWL11 model that is currently marketed but has a different user interface. This model has 2 sensing modes:

- Water level sensing.
- Fabric sensing.

Both sensing modes employ special specific agitator strokes and then assess the load's response to those agitator strokes.

The washer has 4 main buttons: a 'Power', 'How Dirty', 'Fabric Care', and 'Start/Pause' buttons. The washer does not have a 'normal' cycle that the user can select as such. A console photo is attached at the end of this waiver application.

- The 'Power' button turns the washer on and sets it to 'How Dirty' setting 3 and 'Fabric Care' on Auto sensing. .
- 'How Dirty' button is the main customer input. The "How Dirty" level is indicated on the washer console by a column of LEDS ranging from 1 to 5. The washer is programmed to default to level 3 (midpoint) when the 'Power' button is pushed. It can then be increased or decreased by the customer to suit the requirements for the particular load being washed. The User Guide for this washer states: "For a normal wash load we suggest the medium soil level ..."
- 'Fabric Care' button defaults to 'Auto sensing' when the washer is turned on. This button is only used to select other (than normal) cycles such as Permanent Press, Wool or Handwash. As these are not cycles ever tested by DOE this button is not used for testing.
- 'Start/Pause' starts the washer with either the default settings or with any changes that the customer has made.

There is also an LCD screen with several buttons. This is used to enter other modes such as wash temperature selection, time delay, spin speed etc. The only use for these in J/J1 testing is for the wash temperature and spin speed selection. Different values of each of these parameters can be selected by using the LCD screen. The waiver is not required and has no effect on these selections. Hence the screen will be used for selecting both the wash temperature, and the maximum and minimum spin speeds to give values of RMC_{max} and RMC_{min} for use in the test method.

When the 'Start/Pause' button is pushed the washer will start to fill and go through an automatic sensing routine to determine the water level. The washer will then sense the fabric type of the load and assign an 'agitator profile' for that cycle.
The agitator profile determines the wash action depending on the 'How Dirty' setting, water level, and type of clothes load. This wash action will come from a table of standard, predetermined wash actions. The wash process is different to traditional washers. The wash sequence is as follows. Washing takes place during items b, c & d.

a) Fill with sufficient water to recirculate.
b) Begin the washing action by recirculating the high concentration detergent solution.
c) Fill to normal wash level.
d) Standard agitate wash.
e) Drain

The times for items b & d can vary for different 'How Dirty' settings but are incorporated in the software and are not independently variable by the customer. The 'How Dirty' button controls a number of parameters. These include agitator speed as well as recirculation and agitate times. There is no separate wash time setting or adjustment.

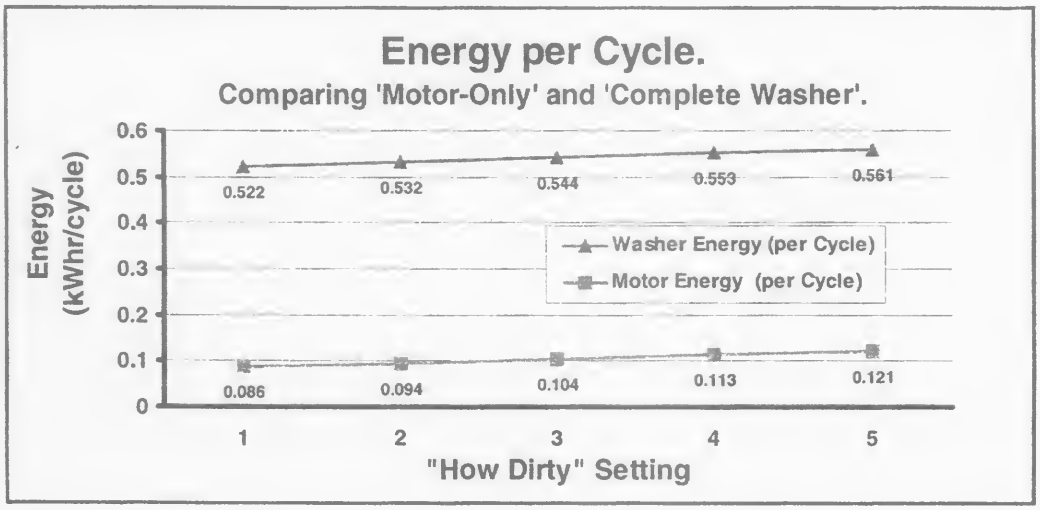
Below is a table showing the various wash times for our current production washer for the Australian/New Zealand market. The washer usually senses 'Medium' for the DOE load.

	'How Dirty' Setting – Wash Times.														
	1			2			3			4			5		
	Recirc. Time	Agitate Time	**Wash Time**	Recirc. Time	Agitate Time	**Wash Time**	Recirc. Time	Agitate Time	**Wash Time**	Recirc. Time	Agitate Time	**Wash Time**	Recirc. Time	Agitate Time	**Wash Time**
Medium (Minutes)	2	4	**6**	3	6	**9**	5	8	**13**	5	10	**15**	5	12	**17**

Hence Setting 3 wash time (13 minutes), is greater than 70% of the maximum wash time of Setting 5 (17 mins). See clause 2.10.

As stated the 'How Dirty' button has 5 settings. The current default is the midpoint, setting 3. This means that when the washer is turned on (push the 'Power' button), the '3' LED is illuminated and the washer will wash on this 'medium soil' level when the 'Start/Pause' button is pushed. A customer can adjust the 'How Dirty' setting by pushing either the 'Up' or 'Down' buttons. It is proposed to test the IW on this midpoint, which is the default setting.
Changing the 'How Dirty' setting only affects the energy consumed by the motor. This is a small proportion of the total energy consumed. The following graphs demonstrate this.

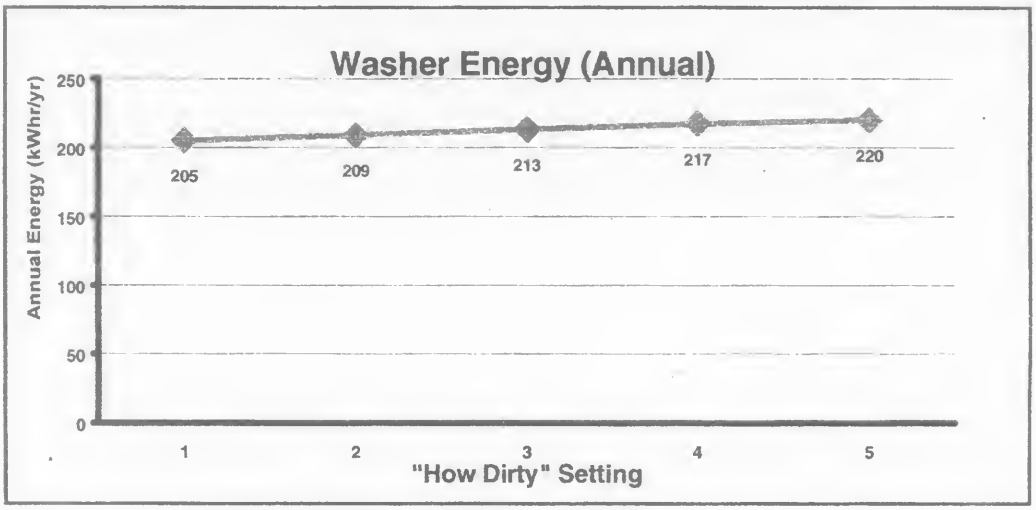
Graph 1: Energy/cycle for different "How Dirty" settings.
(Motor only and for complete washer)



The above figures are based on limited, early testing. While the final results may differ slightly, the relative differences should not vary.

The next graph shows the effect on annual consumption

Graph 2: Annual Energy (Equivalent to Energy on 'J1 Label').



CFR430 Subpart B, App J & J1

Current Status.
Fisher & Paykel Appliances intends to market a model of clothes washer that has adaptive control in North America. Adaptive control is not covered by these test methods. Many other washers on the US market have water level sensing but Fisher & Paykel Appliances knows of no other product that has fabric sensing and hence adaptive control.

Appendix J.
Appendix J defines the Normal Cycle as

> *Clause 1.14 Normal cycle means the cycle recommended by the manufacturer for washing cotton and/or linen clothes.*

The settings for the Normal Cycle are referred to in Clause 2.11.1 as part of the Testing Conditions.

Appendix J1.
Appendix J1 refers to that cycle as the Energy Test Cycle (Clause 1.7), which is called up in Clause 3.2

Proposal to Modify App J & J1:
App J, Clause 1.14 Normal Cycle.
For the Fisher & Paykel IW the Normal Cycle is Setting 3 on the 'How Dirty' button. As well as being the midpoint it is where the washer defaults to when turned on.

App J1, Clause 1.7 Energy Test Cycle.
For the Fisher & Paykel IW the Energy Test Cycle is Setting 3 on the 'How Dirty' button. As well as being the midpoint it is where the washer defaults to when turned on.

Other options considered were:

- To test on the highest possible 'How Dirty' setting. Clearly this is unfair as research has shown that about 65% of customers do not change the setting from default. Those that do change it can either increase it or decrease it. Note however changes to this setting only affect motor energy, which is a small percentage of the total energy.
- Testing to the lowest, midpoint and highest setting and then applying relevant usage factors. There is no relevant data on which to provide a basis for any Usage Factors.
- At the end of both J (Section 7) and J1 (Section 6), there is provision for a field test to provide comparative results. Consideration was given to this. However it is very difficult to test an adaptive control washer. Customers take some time to adapt to using the features especially ones that are totally different to those they have used before.

Interim Waiver.
Fisher & Paykel Appliances also requests immediate relief by the granting of an Interim Waiver for washer model IW.

Likely Success of Waiver.
The Petition for Waiver is likely to be granted as Fisher & Paykel Appliances is not seeking to drastically change a test method but merely to confirm the cycle to which the existing test method is applied. We do not feel that this is a particularly radical step and that such innovation must be allowed onto the market.

Economic Hardship.
Fisher & Paykel Appliances currently markets only 1 model of washer in the US. In its major other markets (Australia & New Zealand), many models are marketed, including the local equivalent of the IW. Experience there has proved the sensing technology in the IW is an innovation that provides customers with real benefits.

Fisher & Paykel Appliances needs to introduce a wider model range. Lack of a test method must never be allowed to hinder innovation.

Fisher & Paykel Appliances wishes to maintain its position as an innovator in the top loading clothes washer market and as such needs to keep producing control systems that optimize customer benefits.

Accompanying this application is the User Guide and an interactive CD that are supplied with the equivalent model locally. These will give a good understanding of the product function.

Richard Bollard
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[FR Doc. 03–28096 Filed 11–6–03; 8:45 am]
BILLING CODE 6450–01–C

DEPARTMENT OF ENERGY

Western Area Power Administration

Pacific Northwest-Pacific Southwest Intertie Project—Firm and Nonfirm Transmission Service Rates—Rate Order No. WAPA–108

AGENCY: Western Area Power Administration, DOE.

ACTION: Notice of rate order.

SUMMARY: This action is taken to extend the existing Pacific Northwest-Pacific Southwest Intertie Project (AC Intertie) firm point-to-point transmission service rate for the 230/345-kilovolt (kV) transmission system, Rate Order No. WAPA–76, and firm point-to-point transmission service rate for the 500-kV transmission system, and the nonfirm point-to-point transmission service rate for the 230/345/500-kV, Rate Order No. WAPA–91, through December 31, 2006. AC Intertie Project rates will expire December 31, 2003.

FOR FURTHER INFORMATION CONTACT: Mr. Jack Murray, Rates Team Lead, Desert Southwest Customer Service Region, Western Area Power Administration, P.O. Box 6457, Phoenix, AZ 85005–6457, (602) 352–2442, or e-mail *jmurray@wapa.gov*.

SUPPLEMENTARY INFORMATION: By Delegation Order No. 00–037.00 effective December 6, 2001, the Secretary of Energy delegated: (1) The authority to develop long-term power and transmission rates on a non-exclusive basis to Western's Administrator; (2) the authority to confirm, approve, and place such rates into effect on an interim basis to the Deputy Secretary; and (3) the authority to confirm, approve, and place into effect on a final basis, to remand, or to disapprove, such rates to the Federal Energy Regulatory Commission (FERC).

Western's firm point-to-point transmission service rate for the AC Intertie 230/345-kV transmission system was revised through Rate Order No. WAPA–76 and submitted to FERC for confirmation and approval on February 8, 1999. On June 22, 1999, in Docket No. EF99–5191–000, 87 FERC ¶ 61,346, FERC issued an order confirming, approving, and placing into effect on a final basis the firm point-to-point transmission service rate of $12.00/kilowattyear for the AC Intertie 230/345-kV transmission system. The rate was approved for 5 years from January 1, 1999, to December 31, 2003.

During the firm point-to-point transmission service rate development for the AC Intertie 230/345-kV transmission system (Rate Order No. WAPA–76), Western determined that it would take about 10 years for the AC Intertie 500-kV transmission system to be subscribed to a level sufficient to meet its own revenue repayment requirements. The ratesetting Power Repayment Study (PRS) established for the AC Intertie 230/345/500-kV transmission system (Rate Order No. WAPA–76) reflected the phasing-in of AC Intertie 500-kV transmission system revenues starting in fiscal year (FY) 1999 through FY 2008. The projected firm transmission sales in the 500-kV transmission system PRS assume that in 10 years the 500-kV Project will be economically viable and capable of demonstrating repayment. The PRS was programmed for first year sales of 62.5 megawatt (MW) and annual increases of 100 MW through the tenth year. Based on that projection, the total sales target projected at the end of fiscal year 2003 was 562.5 MW. The 500-kV system contractual commitments are currently 664 MW. The 230/345-kV system contractual commitments are 1,059 MW. The total combined firm transmission sales beginning in FY 2004 is projected to be 1,723 MW. This ratesetting PRS methodology remains valid. Projected revenue levels from sales of firm and nonfirm point-to-point transmission service and miscellaneous items will recover project expenses and capital requirements through FY 2049 for the AC Intertie 230/345/500-kV transmission system.

On August 15, 2000, the Deputy Secretary approved Rate Order WAPA–91. This extended the existing firm point-to-point transmission service rate of $17.23/kilowattyear for the AC Intertie 500-kV transmission system, and the existing nonfirm point-to-point transmission service rate of 2.00 mills/kWh for the AC Intertie 230/345/500-kV transmission system through December 31, 2003.

Western has decided to extend the existing firm point-to-point transmission service rate of $17.23/kilowattyear for the AC Intertie 500-kV transmission system, firm point-to-point transmission service rate of $12.00/kilowattyear for the AC Intertie 230/345-kV transmission system, and the nonfirm point-to-point transmission service rate of 2.00 mills/kilowatthour for the AC Intertie 230/345/500-kV transmission system through December 31, 2006. This extension will also allow Western time to evaluate impacts of combining revenue requirements of the Desert Southwest Region's transmission systems and to determine a methodology to put in place a multi-system transmission rate. Western proposes to extend the current rates pursuant to 10 CFR 903.23. Upon its approval, Rate Order No. WAPA–76 and Rate Order No. WAPA–91 will be extended under Rate Order No. WAPA–108. Under 10 CFR 903.23(a)(2), Western did not have a consultation and comment period. Western held an informal public information forum.

Following review of Western's proposal within the Department of Energy, I approved Rate Order No. WAPA–108, which extends the existing firm point-to-point transmission service rate of $17.23/kilowattyear for the AC Intertie 500-kV transmission system, the firm point-to-point transmission service rate of $12.00/kilowattyear for the AC Intertie 230/345-kV transmission system, and the nonfirm point-to-point transmission service rate of 2.00 mills/kilowatthour for the AC Intertie 230/345/500-kV transmission system on an interim basis through December 31, 2006. Rate Order No. WAPA–108 will be submitted to FERC for confirmation and approval on a final basis.

Dated: October 27, 2003.

Kyle E. McSlarrow,

Deputy Secretary.

Order Confirming and Approving an Extension of the Pacific Northwest-Pacific Southwest Intertie Project Firm and Nonfirm Transmission Service Rates

The Pacific Northwest-Pacific Southwest Intertie Project (AC Intertie) transmission service rates were established following section 302(a) of the Department of Energy (DOE) Organization Act (42 U.S.C. 7152(a)). This act transferred to and vested in the Secretary of Energy (Secretary) the power marketing functions of the Secretary of the Department of the Interior and the Bureau of Reclamation under the Reclamation Act of 1902, ch. 1093, 32 Stat. 388, as amended and supplemented by subsequent enactments, particularly section 9(c) of the Reclamation Project Act of 1939, 43 U.S.C. 485h(c), and other acts that specifically apply to the project system involved.

By Delegation Order No. 00–037.00 effective December 6, 2001, the Secretary of Energy delegated: (1) The authority to develop long-term power and transmission rates on a non-exclusive basis to Western's Administrator; (2) the authority to confirm, approve, and place such rates into effect on an interim basis to the Deputy Secretary; and (3) the authority to confirm, approve, and place into effect on a final basis, to remand, or to disapprove, such rates to the Federal Energy Regulatory Commission (FERC). This rate extension is issued following the Delegation Order and the DOE rate extension procedures at 10 CFR part 903.

Background

Western's firm point-to-point transmission service rate for the AC Intertie 230/345-kV transmission system was revised through Rate Order No. WAPA–76 and submitted to FERC for confirmation and approval on February 8, 1999. On June 22, 1999, in Docket No. EF99–5191–000, 87 FERC ¶ 61,346, FERC issued an order confirming, approving, and placing into effect on a final basis the firm point-to-point transmission service rate of $12.00/kilowattyear for the AC Intertie 230/345-kV transmission system. The rate was approved for 5 years from January 1, 1999, to December 31, 2003.

On August 15, 2000, the Deputy Secretary approved Rate Order WAPA–91. This extended the existing firm point-to-point transmission service rate of $17.23/kilowattyear for the AC Intertie 500-kV transmission system, and the existing nonfirm point-to-point transmission service rate of 2.00 mills/kWh for the AC Intertie 230/345/500-kV transmission system through December 31, 2003.

Discussion

During development of the firm point-to-point transmission service rate for the AC Intertie 230/345-kV transmission system (Rate Order No. WAPA–76), Western determined that it would take about 10 years for the AC Intertie 500-kV transmission system to be subscribed to a level sufficient to meet its own revenue repayment requirements. The ratesetting Power Repayment Study (PRS) established for the AC Intertie 230/345/500-kV transmission system (Rate Order No. WAPA–76) reflected the phasing-in of the AC Intertie 500-kV transmission system revenues starting in fiscal year (FY) 1999 through FY 2008. The projected firm transmission sales in the 500-kV transmission system PRS assume that in 10 years the 500-kV Project will be economically viable and capable of demonstrating repayment. The PRS was programmed for first year sales of 62.5 MW and annual increases of 100 MW through the tenth year. Based on that projection, the total sales target projected at the end of fiscal year 2003 is 562.5 MW. The 500-kV system contractual commitments are currently 664 MW. The 230/345-kV system contractual commitments are 1,059 MW. The total combined firm transmission sales beginning in FY 2004 is projected to be 1,723 MW. This ratesetting PRS methodology remains valid. Projected revenue levels from sales of firm and nonfirm point-to-point transmission service and miscellaneous items will recover project expenses and capital requirements through FY 2049 for the AC Intertie 230/345/500-kV transmission system.

Western has decided to extend the existing firm point-to-point transmission service rate of $17.23/kilowattyear for the AC Intertie 500-kV transmission system, the firm point-to-point transmission service rate of $12.00/kilowattyear for the AC Intertie 230/345-kV transmission system, and the nonfirm point-to-point transmission service rate of 2.00 mills/kilowatthour for the AC Intertie 230/345/500-kV transmission system through December 31, 2006. This extension will also allow Western time to evaluate impacts of combining revenue requirements of the Desert Southwest Region's transmission systems and to determine a methodology to put in place a multi-system transmission rate. Western proposes to extend the current rates pursuant to 10 CFR 903.23. Upon its approval, Rate Order No. WAPA–76 and Rate Order No. WAPA–91 will be extended under Rate Order No. WAPA–108. Under 10 CFR 903.23(a)(2), Western did not have a consultation and comment period.

Order

In view of the above and under the authority delegated to me by the Secretary, I hereby extend from December 31, 2003, to December 31, 2006, the existing firm point-to-point transmission service rate of $17.23/kilowattyear for the AC Intertie 500-kV transmission system, the firm point-to-point transmission service rate of $12.00/kilowattyear for the AC Intertie 230/345-kV transmission system, and the nonfirm point-to-point transmission service rate of 2.00 mills/kilowatthour for the AC Intertie 230/345/500-kV transmission system on an interim basis. The existing AC Intertie transmission system rates for transmission service shall remain in effect pending FERC confirmation and approval of their extension or substitute rates on a final basis through December 31, 2006.

Dated: October 27, 2003.

Kyle E. McSlarrow,

Deputy Secretary.

[FR Doc. 03–28095 Filed 11–6–03; 8:45 am]

BILLING CODE 6450–01–P

ENVIRONMENTAL PROTECTION AGENCY

[ER–FRL–6645–3]

Environmental Impact Statements and Regulations; Availability of EPA Comments

Availability of EPA comments prepared pursuant to the Environmental Review Process (ERP), under section 309 of the Clean Air Act and section 102(2)(c) of the National Environmental Policy Act as amended. Requests for copies of EPA comments can be directed to the Office of Federal Activities at (202) 564–7167. An explanation of the ratings assigned to draft environmental impact statements (EISs) was published in FR dated April 4, 2003 (68 FR 16511).

Draft EISs

ERP No. D–AFS–J65390–CO Rating EC1, Arapaho National Recreation Area Forest Health and Fuels Reduction Project, Pre-Suppression Measures for Mountain Pine Beetle Infestation Reduction in Stands of Lodgepole Pine, Implementation, Arapaho National Forest, Sulphur Ranger District, Grand County, CO.

Summary: EPA expressed environmental concern due to project impacts related to disturbances within roadless areas, contiguous terrestrial habitat and watersheds.

ERP No. D–FHW–G40177–LA Rating LO, Kansas Lane Connector Project, Construction between U.S. 80 (Desiard Street) and U.S. 165 and the Forsythe Avenue Extension, U.S. Army COE Section 10 and 404 Permits Issuance, City of Monroe, Quachita Parish, LA.

Summary: EPA has no objections to the selection of the preferred alternative.

ERP No. D–FRA–E40799–FL Rating EC1, Florida High Speed Rail from Tampa to Orlando, Transportation Improvement, NPDES Permit and US Army COE Section 404 Permit, Hillsborough, Orange, Osceola and Polk Counties, FL.

Summary: EPA has environmental concerns with the proposed project regarding noise, vibration. hazardous waste sites and potential environmental impacts to air quality, wetlands, floodplains and other aquatic resources.

ERP No. D–NOA–A91069–00 Rating EC2, Atlantic Tunas, Swordfish, and Sharks Fishery Management Plan, To Prevent Overfishing and Rebuild Overfished Species, Update Essential Fish Habitat, Atlantic, Gulf of Mexico and Caribbean Sea.

Summary: EPA expressed concern that the document had not adequately explained alternatives and impact analyses. EPA recommended that the final document summarize data and that it clearly connect to impacts analysis of the proposed action. EPA also requested information on bycatch and the effects of other fisheries on sharks.

Final EISs

ERP No. F–AFS–K26002–CA, South Tahoe Public Utility District (STPUD) B-Line Phase III Wastewater Export Pipeline Replacement Project, Luther Pass Pump Station to U.S. Forest Service Luther Pass Overflow Campground Access Road, Special Use Permit, U.S. Army COE Section 404 and U.S. Fish and Wildlife Service Permits Issuance and EPA Grant, El Dorado and Alpine Counties, CA.

Summary: No formal comment letter was sent to the preparing agency.

ERP No. F–DOD–A11077–00, Ground-Based Midcourse Defense (GMD) Extended Test Range (ETR) Project, Construction and Operation, CA, AK, AS, HI and WA.

Summary: EPA expressed environmental concern regarding how soil will be sampled for perchlorate and recommended that the ROD specify a perchlorate sampling plan.

ERP No. F–FHW–J40157–MT, US 89 from Fairfield to Dupuyer Corridors Study, Reconstruction, Widening,

Realignment and Route Connection between Yellowstone National Park to the South with Glacier National Park to the North, Teton and Pondera Counties, MT.

Summary: EPA expressed environmental concerns due to impacts to wetlands and floodplain encroachment. EPA requested a wetland mitigation plan be developed and that the project be designed to adequately pass flood flows, bedload, and provide opportunities for wildlife passage. EPA also suggested that the Montana Department of Environmental Quality be coordinated with to assure compatibility of proposed highway construction activities with TMDL development for impaired waters.

ERP No. F–NPS–F65031–MN, Grand Portage National Monument General Management Plan, Implementation, Cook County, MN.

Summary: EPA's previous concerns have been resolved; therefore, EPA has no objections to the proposed action. EPA did request that future environmental assessments on trails be made available for review.

Dated: November 4, 2003.

Joseph C. Montgomery,

Director, NEPA Compliance Division, Office of Federal Activities.

[FR Doc. 03–28106 Filed 11–6–03; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[ER–FRL–6645–2]

Environmental Impact Statements; Notice of Availability

Responsible Agency: Office of Federal Activities, General Information (202) 564–7167 orhttp://www.epa.gov/compliance/NEPA.

Weekly receipt of Environmental Impact Statements

Filed October 27, 2003 Through October 31, 2003

Pursuant to 40 CFR 1506.9.

EIS No. 030497, Draft EIS, NOA, GA, Gray's Reef National Marine Sanctuary Draft Management Plan (DMP), Address Current Resource Conditions and Compatible Multiple Uses, Located 17.5 Nautical mile off Sapelo Island, GA, Comment Period Ends: December 31, 2003, Contact: Reed Bohne (912) 598–2345. The above NOA EIS should have appeared in the 10/31/2003 **Federal Register**. The 60-day Comment Period is Calculated from 10/31/2003.

EIS No. 030498, Final EIS, NPS, AZ, Navajo National Monument, General Management Plan and Development Concept Plan, Implementation, Navajo Counties, AZ, Wait Period Ends: December 8, 2003, Contact: Rosemari Knoki (928) 672–2700.

EIS No. 030499, Final EIS, AFS, CA, Spalding Land Exchange Project, Proposed Land Exchange between Spalding Community Service District (SCSD) and Lassen National Forest (LNF), Special Use Permit, Lassen County, CA, Wait Period End: December 8, 2003, Contact: Lois Charlton (530) 257–2151.

EIS No. 030500, Draft EIS, FRA, MD, Baltimore-Washington Maglev Project, To Provide High-speed, State-of-the-Art Transportation from Union-Station in Washington, DC to Camden Yards in Baltimore, MD and Station at BWI Airport, Maglev Deployment Program (MDP), Baltimore, Prince George's, Anne Arundel, MD and DC, Comment Period Ends: January 30, 2004, Contact: David Valenstein (202) 493–6368.

This document is available on the Internet at: *http://www.bwmaglev.com.*

EIS No. 030501, Draft EIS, IBR, CA, Lake Berryessa Visitor Services Plan, Future Use and Operation, Solano Project Lake Berryessa, Napa County, CA, Comment Period Ends: February 4, 2004, Contact: Stephen Rodgers (707) 966–2111.

EIS No. 030502, Draft EIS, FRC, AK, Glacier Bay National Park and Preserve, Falls Creek Hydroelectric Project (FERC. NO. 11659) and Land Exchange Project, Issuance of License and Land Exchange, Kahtaheena River (Falls Creek) near Gustavus in Southeastern, AK, Comment Period Ends: January 6, 2004, Contact: Robert Easton (202) 502–6045. This document is available on the Internet at: *http://www.ferc.gov.*

EIS No. 030503, Draft EIS, AFS, WY, Woodrock Project, Proposal for Timber Sale, Travel Management and Watershed Restoration, Implementation, Bighorn National Forest, Tongue Ranger District, Sheridan County, WY, Comment Period Ends: January 9, 2004, Contact: Scott Hill (307) 674–2600.

This document is available on the Internet at: *http://www.fs.fed.us/r2/bighorn/.*

EIS No. 030504, Final EIS, AFS, WI, Hoffman-Sailor West Project, Timber Harvest, Regeneration Activities, Connected Road Construction and Decommissioning, Chequamegon-Nicolet National Forest, Medford/Park Falls Ranger District, Price County, WI, Wait Period Ends: December 8, 2003, Contact: Jane Darnell (715) 748–4875.

EIS No. 030505, Draft EIS, NRS, ID, Little Wood River Irrigation District, Gravity Pressurized Delivery System, Construction, U.S. Army COE Section 404 Permit, in the Township of 1 North, 1 South and 2 South of Range 21 East of the Boise Merridan, City of Carey, Blaine County, ID, Comment Period Ends: December 22, 2003, Contact: Richard Sims (208) 378–5700.

EIS No. 030506, Draft Supplement, FTA, VA, Dulles Corridor Rapid Transit Project, Additional Information Provide to Assist Decision-Makers, Business Community and Area Residents for Evaluation, High Quality and High-Capacity Transit Service in the Dulles Corridor, West Falls Church Metrorail Station in Fairfax County to the vicinity of Route 772 in Loudoun County, VA, Comment Period Ends: December 29, 2003, Contact: Karl Rohrer 1 (888) 566–7245.

Amended Notices

EIS No. 030417, Draft EIS, AFS, NM, Surface Management of Gas Leasing and Development in the Carson National Forest, Implementation, Jicarilla Ranger District, Rio Arriba County, NM, Comment Period Ends: January 2, 2004, Contact: Tom Dwyer (505) 758–6272.

Revision of FR Notice Published on 9/19/03: CEQ Comment Period Ending 11/03/2003 has been Extended to 1/2/2004.

Dated: November 4, 2003.

Joseph C. Montgomery,

Director, NEPA Compliance Division, Office of Federal Activities.

[FR Doc. 03–28107 Filed 11–6–03; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[OPP–2003–0367; FRL–7334–9]

Atrazine; Notice of Availability of Revised Atrazine Interim Reregistration Eligibility Decision (IRED)

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: This notice announces the availability of the revised Interim Reregistration Eligibility Decision (IRED) document for the pesticide active ingredient atrazine. EPA has completed its revised IRED for atrazine consistent with the August 8, 2002, consent decree

between the Natural Resources Defense Council and EPA and with the January 31, 2003, Atrazine IRED released to the public through notices published in the **Federal Register** on February 28, 2003 (68 FR 9652) (FRL–7456–2). As required in the consent decree, the revision to the January 31, 2003 IRED addresses the potential association between atrazine exposure and the incident of prostate cancer and other cancers in humans and the potential effects of atrazine on amphibian endocrinology and development. The revised IRED also includes an ecological level of concern consistent with the Office of Water's (OW) draft aquatic life criteria document that is being released concurrent with the revision to the IRED. In addition, the revised IRED includes a monitoring program in vulnerable watersheds to determine if atrazine levels exceed the Agency's level of concern. The revised IRED summarizes the conclusions in the January 31, 2003, IRED, developments since the IRED, and the Agency's next steps.

DATES: Comments, identified by docket ID number OPP–2003–0367, must be received on or before February 5, 2004.

ADDRESSES: Comments may be submitted electronically, by mail, or through hand delivery/courier. Follow the detailed instructions as provided in Unit I. of the **SUPPLEMENTARY INFORMATION**.

FOR FURTHER INFORMATION CONTACT: Eric R. Olson, Special Review and Reregistration Division (7508C), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001; telephone number: (703) 308–8067; fax number: (703) 308–8041; e-mail address: *olson.eric@epa.gov*.

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does this Action Apply to Me?

This action is directed to the public in general. This action may, however, be of interest to persons who are or may be required to conduct testing of chemical substances under the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA) or the Federal Food, Drug, and Cosmetic Act (FFDCA); environmental, human health, and agricultural advocates; pesticide users; and members of the public interested in the use of pesticides. Since other entities may also be interested, the Agency has not attempted to describe all the specific entities that may be affected by this action. If you have any questions regarding the applicability of this action to a particular entity, consult the person listed under **FOR FURTHER INFORMATION CONTACT.**

B. How Can I Get Copies of this Document and Other Related Information?

1. *Docket.* EPA has established an official public docket for this action under docket identification (ID) number OPP–2003–0367. The official public docket consists of the documents specifically referenced in this action, any public comments received, and other information related to this action. Although a part of the official docket, the public docket does not include Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. The official public docket is the collection of materials that is available for public viewing at the Public Information and Records Integrity Branch (PIRIB), Rm. 119, Crystal Mall #2, 1921 Jefferson Davis Hwy., Arlington, VA. This docket facility is open from 8:30 a.m. to 4 p.m., Monday through Friday, excluding legal holidays. The docket telephone number is (703) 305–5805.

2. *Electronic access.* You may access this **Federal Register** document electronically through the EPA Internet under the "**Federal Register**" listings at *http://www.epa.gov/fedrgstr/*.

An electronic version of the revision to the atrazine IRED is available electronically through the EPA Internet at *http://www.epa.gov/oppsrrd1/reregistration/atrazine/*.

An electronic version of the public docket is available through EPA's electronic public docket and comment system, EPA Dockets. You may use EPA Dockets at *http://www.epa.gov/edocket/* to submit or view public comments, access the index listing of the contents of the official public docket, and to access those documents in the public docket that are available electronically. Once in the system, select "search," then key in the appropriate docket ID number.

Certain types of information will not be placed in the EPA Dockets. Information claimed as CBI and other information whose disclosure is restricted by statute, which is not included in the official public docket, will not be available for public viewing in EPA's electronic public docket. EPA's policy is that copyrighted material will not be placed in EPA's electronic public docket but will be available only in printed, paper form in the official public docket. To the extent feasible, publicly available docket materials will be made available in EPA's electronic public docket. When a document is selected from the index list in EPA Dockets, the system will identify whether the document is available for viewing in EPA's electronic public docket. Although not all docket materials may be available electronically, you may still access any of the publicly available docket materials through the docket facility identified in Unit I.B. EPA intends to work towards providing electronic access to all of the publicly available docket materials through EPA's electronic public docket.

For public commenters, it is important to note that EPA's policy is that public comments, whether submitted electronically or in paper, will be made available for public viewing in EPA's electronic public docket as EPA receives them and without change, unless the comment contains copyrighted material, CBI, or other information whose disclosure is restricted by statute. When EPA identifies a comment containing copyrighted material, EPA will provide a reference to that material in the version of the comment that is placed in EPA's electronic public docket. The entire printed comment, including the copyrighted material, will be available in the public docket.

Public comments submitted on computer disks that are mailed or delivered to the docket will be transferred to EPA's electronic public docket. Public comments that are mailed or delivered to the docket will be scanned and placed in EPA's electronic public docket. Where practical, physical objects will be photographed, and the photograph will be placed in EPA's electronic public docket along with a brief description written by the docket staff.

C. How and to Whom Do I Submit Comments?

You may submit comments electronically, by mail, or through hand delivery/courier. To ensure proper receipt by EPA, identify the appropriate docket ID number in the subject line on the first page of your comment. Please ensure that your comments are submitted within the specified comment period. Comments received after the close of the comment period will be marked "late." EPA is not required to consider these late comments. If you wish to submit CBI or information that is otherwise protected by statute, please follow the instructions in Unit I.D. Do not use EPA Dockets or e-mail to submit CBI or information protected by statute.

1. *Electronically.* If you submit an electronic comment as prescribed in this unit, EPA recommends that you include your name, mailing address, and an e-

mail address or other contact information in the body of your comment. Also include this contact information on the outside of any disk or CD ROM you submit, and in any cover letter accompanying the disk or CD ROM. This ensures that you can be identified as the submitter of the comment and allows EPA to contact you in case EPA cannot read your comment due to technical difficulties or needs further information on the substance of your comment. EPA's policy is that EPA will not edit your comment, and any identifying or contact information provided in the body of a comment will be included as part of the comment that is placed in the official public docket, and made available in EPA's electronic public docket. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment.

i. *EPA Dockets.* Your use of EPA's electronic public docket to submit comments to EPA electronically is EPA's preferred method for receiving comments. Go directly to EPA Dockets at *http://www.epa.gov/edocket/*, and follow the online instructions for submitting comments. Once in the system, select "search," and then key in docket ID number OPP–2003–0367. The system is an "anonymous access" system, which means EPA will not know your identity, e-mail address, or other contact information unless you provide it in the body of your comment.

ii. *E-mail.* Comments may be sent by e-mail to *opp-docket@epa.gov*, Attention: Docket ID Number OPP–2003–0367. In contrast to EPA's electronic public docket, EPA's e-mail system is not an "anonymous access" system. If you send an e-mail comment directly to the docket without going through EPA's electronic public docket, EPA's e-mail system automatically captures your e-mail address. E-mail addresses that are automatically captured by EPA's e-mail system are included as part of the comment that is placed in the official public docket, and made available in EPA's electronic public docket.

iii. *Disk or CD ROM.* You may submit comments on a disk or CD ROM that you mail to the mailing address identified in Unit I.C.2. These electronic submissions will be accepted in WordPerfect or ASCII file format. Avoid the use of special characters and any form of encryption.

2. *By mail.* Send your comments to: Public Information and Records Integrity Branch (PIRIB) (7502C), Office of Pesticide Programs (OPP), Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001, Attention: Docket ID Number OPP–2003–0367.

3. *By hand delivery or courier.* Deliver your comments to: Public Information and Records Integrity Branch (PIRIB), Office of Pesticide Programs (OPP), Environmental Protection Agency, Rm. 119, Crystal Mall #2, 1921 Jefferson Davis Hwy., Arlington, VA, Attention: Docket ID Number OPP–2003–0367. Such deliveries are only accepted during the docket's normal hours of operation as identified in Unit I.B.1.

D. How Should I Submit CBI To the Agency?

Do not submit information that you consider to be CBI electronically through EPA's electronic public docket or by e-mail. You may claim information that you submit to EPA as CBI by marking any part or all of that information as CBI (if you submit CBI on disk or CD ROM, mark the outside of the disk or CD ROM as CBI and then identify electronically within the disk or CD ROM the specific information that is CBI). Information so marked will not be disclosed except in accordance with procedures set forth in 40 CFR part 2.

In addition to one complete version of the comment that includes any information claimed as CBI, a copy of the comment that does not contain the information claimed as CBI must be submitted for inclusion in the public docket and EPA's electronic public docket. If you submit the copy that does not contain CBI on disk or CD ROM, mark the outside of the disk or CD ROM clearly that it does not contain CBI. Information not marked as CBI will be included in the public docket and EPA's electronic public docket without prior notice. If you have any questions about CBI or the procedures for claiming CBI, please consult the person listed under **FOR FURTHER INFORMATION CONTACT.**

E. What Should I Consider as I Prepare My Comments for EPA?

You may find the following suggestions helpful for preparing your comments:

1. Explain your views as clearly as possible.

2. Describe any assumptions that you used.

3. Provide any technical information and/or data you used that support your views.

4. If you estimate potential burden or costs, explain how you arrived at your estimate.

5. Provide specific examples to illustrate your concerns.

6. Offer alternatives.

7. Make sure to submit your comments by the comment period deadline identified.

8. To ensure proper receipt by EPA, identify the appropriate docket ID number in the subject line on the first page of your response. It would also be helpful if you provided the name, date, and **Federal Register** citation related to your comments.

II. Background

A. What Action is the Agency Taking?

EPA has completed its revised IRED for atrazine consistent with the August 8, 2002, consent decree between the Natural Resources Defense Council and EPA and consistent with the January 31, 2003, Atrazine IRED released to the public through a notice published in the **Federal Register** on February 28, 2003 (68 FR 9652) (FRL–7456–2). As required in the consent decree, the revision to the January 31, 2003, IRED addresses the potential association between atrazine exposure and the incident of prostate cancer and other cancers in humans and the potential effects of atrazine on amphibian endocrinology and development. In each section, the document summarizes the conclusions in the January 31, 2003, IRED, developments since the IRED, including Scientific Advisory Panel meetings, and next steps, as appropriate.

The revised IRED also includes an ecological monitoring and mitigation program developed to address indirect ecological effects of atrazine in watersheds. The ecological level of concern and the monitoring and mitigation program were developed by a cross-Agency workshop that includes the Office of Pesticide Programs (OPP), Office of Water (OW), and the Office of Research and Development (ORD), along with Syngenta Crop Protection, Inc. Concurrent with the release of the revision to the atrazine IRED, EPA's OW is publishing its draft aquatic life criteria document for atrazine for comment elsewhere in this issue of the **Federal Register**. The OW Draft aquatic life criteria document for atrazine is available electronically through the EPA Internet at *http://www.epa.gov/waterscience/criteria/atrazine/*.

Provided that the measures outlined in the revised IRED are adopted, atrazine remains eligible for reregistration. EPA's next step under FQPA is to complete a cumulative risk assessment and risk management decision for the triazine pesticides, which share a common mechanism of toxicity. This revision to the IRED document for atrazine cannot be considered a final reregistration

eligibility decision until the cumulative assessment is complete.

When the cumulative risk assessment for the triazine pesticides has been completed, EPA will issue its final tolerance reassessment decision for atrazine and further risk mitigation measures may be needed.

B. What is the Agency's Authority for Taking this Action?

The legal authority for this IRED falls under FIFRA, as amended in 1988 and 1996. Section 4(g)(2)(A) of FIFRA directs that, after submission of all data concerning a pesticide active ingredient, "the Administrator shall determine whether pesticides containing such active ingredient are eligible for reregistration," before calling in product specific data on individual end-use products, and either reregistering products or taking "other appropriate regulatory action."

List of Subjects

Environmental protection, chemicals, pesticide(s) and pests.

Dated: November 3, 2003.

Betty Shackleford.

Acting Director, Special Review and Reregistration Division, Office of Pesticide Programs.

[FR Doc. 03–28101 Filed 11–6–03; 8:45 am]

BILLING CODE 6560–50–S

ENVIRONMENTAL PROTECTION AGENCY

[OPP–2003–0255; FRL–7331–7]

Paecilomyces Lilacinus Strain 251; Notice of Filing a Pesticide Petition to Establish a Tolerance for a Certain Pesticide Chemical in or on Food

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: This notice announces the initial filing of a pesticide petition proposing the establishment of regulations for residues of a certain pesticide chemical in or on various food commodities.

DATES: Comments, identified by docket ID number OPP–2003–0255, must be received on or before December 8, 2003.

ADDRESSES: Comments may be submitted electronically, by mail, or through hand delivery/courier. Follow the detailed instructions as provided in Unit I. of the **SUPPLEMENTARY INFORMATION**.

FOR FURTHER INFORMATION CONTACT: Barbara Mandula, Biopesticides and Pollution Prevention Division (7511C), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001; telephone number: (703) 308–7378; e-mail address: *mandula.barbara@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does this Action Apply to Me?

You may be potentially affected by this action if you are an agricultural producer, food manufacturer or pesticide manufacturer. Potentially affected entities may include, but are not limited to:

- Crop production (NAICS 111)
- Animal production on (NAICS 112)
- Food manufacturing (NAICS 311)
- Pesticide manufacturing (NAICS 32532)

This listing is not intended to be exhaustive, but rather provides a guide for readers regarding entities likely to be affected by this action. Other types of entities not listed in this unit could also be affected. The North American Industrial Classification System (NAICS) codes have been provided to assist you and others in determining whether this action might apply to certain entities. If you have any questions regarding the applicability of this action to a particular entity, consult the person listed under **FOR FURTHER INFORMATION CONTACT**.

B. How Can I Get Copies of this Document and Other Related Information?

1. *Docket.* EPA has established an official public docket for this action under docket ID number OPP–2003–0255. The official public docket consists of the documents specifically referenced in this action, any public comments received, and other information related to this action. Although, a part of the official docket, the public docket does not include Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. The official public docket is the collection of materials that is available for public viewing at the Public Information and Records Integrity Branch (PIRIB), Rm. 119, Crystal Mall #2, 1921 Jefferson Davis Hwy., Arlington, VA. This docket facility is open from 8:30 a.m. to 4 p.m., Monday through Friday, excluding legal holidays. The docket telephone number is (703) 305–5805.

2. *Electronic access.* You may access this **Federal Register** document electronically through the EPA Internet under the "**Federal Register**" listings at *http://www.epa.gov/fedrgstr/.*

An electronic version of the public docket is available through EPA's electronic public docket and comment system, EPA Dockets. You may use EPA Dockets at *http://www.epa.gov/edocket/* to submit or view public comments, access the index listing of the contents of the official public docket, and to access those documents in the public docket that are available electronically. Although, not all docket materials may be available electronically, you may still access any of the publicly available docket materials through the docket facility identified in Unit I.B.1. Once in the system, select "search," then key in the appropriate docket ID number.

Certain types of information will not be placed in the EPA Dockets. Information claimed as CBI and other information whose disclosure is restricted by statute, which is not included in the official public docket, will not be available for public viewing in EPA's electronic public docket. EPA's policy is that copyrighted material will not be placed in EPA's electronic public docket but will be available only in printed, paper form in the official public docket. To the extent feasible, publicly available docket materials will be made available in EPA's electronic public docket. When a document is selected from the index list in EPA Dockets, the system will identify whether the document is available for viewing in EPA's electronic public docket. Although, not all docket materials may be available electronically, you may still access any of the publicly available docket materials through the docket facility identified in Unit I.B.1. EPA intends to work towards providing electronic access to all of the publicly available docket materials through EPA's electronic public docket.

For public commenters, it is important to note that EPA's policy is that public comments, whether submitted electronically or on paper, will be made available for public viewing in EPA's electronic public docket as EPA receives them and without change, unless the comment contains copyrighted material, CBI, or other information whose disclosure is restricted by statute. When EPA identifies a comment containing copyrighted material, EPA will provide a reference to that material in the version of the comment that is placed in EPA's electronic public docket. The entire printed comment, including the copyrighted material, will be available in the public docket.

Public comments submitted on computer disks that are mailed or

delivered to the docket will be transferred to EPA's electronic public docket. Public comments that are mailed or delivered to the docket will be scanned and placed in EPA's electronic public docket. Where practical, physical objects will be photographed, and the photograph will be placed in EPA's electronic public docket along with a brief description written by the docket staff.

C. How and To Whom Do I Submit Comments?

You may submit comments electronically, by mail, or through hand delivery/courier. To ensure proper receipt by EPA, identify the appropriate docket ID number in the subject line on the first page of your comment. Please ensure that your comments are submitted within the specified comment period. Comments received after the close of the comment period will be marked "late." EPA is not required to consider these late comments. If you wish to submit CBI or information that is otherwise protected by statute, please follow the instructions in Unit I.D. Do not use EPA Dockets or e-mail to submit CBI or information protected by statute.

1. *Electronically.* If you submit an electronic comment as prescribed in this unit, EPA recommends that you include your name, mailing address, and an e-mail address or other contact information in the body of your comment. Also, include this contact information on the outside of any disk or CD ROM you submit, and in any cover letter accompanying the disk or CD ROM. This ensures that you can be identified as the submitter of the comment and allows EPA to contact you in case EPA cannot read your comment due to technical difficulties or needs further information on the substance of your comment. EPA's policy is that EPA will not edit your comment, and any identifying or contact information provided in the body of a comment will be included as part of the comment that is placed in the official public docket, and made available in EPA's electronic public docket. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment.

i. *EPA Dockets.* Your use of EPA's electronic public docket to submit comments to EPA electronically is EPA's preferred method for receiving comments. Go directly to EPA Dockets at *http://www.epa.gov/edocket/*, and follow the online instructions for submitting comments. Once in the system, select "search," and then key in docket ID number OPP–2003–0255. The system is an "anonymous access" system, which means EPA will not know your identity, e-mail address, or other contact information unless you provide it in the body of your comment.

ii. *E-mail.* Comments may be sent by e-mail to *opp-docket@epa.gov*, Attention: Docket ID number OPP–2003–0255. In contrast to EPA's electronic public docket, EPA's e-mail system is not an "anonymous access" system. If you send an e-mail comment directly to the docket without going through EPA's electronic public docket, EPA's e-mail system automatically captures your e-mail address. E-mail addresses that are automatically captured by EPA's e-mail system are included as part of the comment that is placed in the official public docket, and made available in EPA's electronic public docket.

iii. *Disk or CD ROM.* You may submit comments on a disk or CD ROM that you mail to the mailing address identified in Unit I.C.2. These electronic submissions will be accepted in WordPerfect or ASCII file format. Avoid the use of special characters and any form of encryption.

2. *By mail.* Send your comments to: Public Information and Records Integrity Branch (PIRIB) (7502C), Office of Pesticide Programs (OPP), Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001, Attention: Docket ID number OPP–2003–0255.

3. *By hand delivery or courier.* Deliver your comments to: Public Information and Records Integrity Branch (PIRIB), Office of Pesticide Programs (OPP), Environmental Protection Agency, Rm. 119, Crystal Mall #2, 1921 Jefferson Davis Hwy., Arlington, VA, Attention: Docket ID number OPP–2003–0255. Such deliveries are only accepted during the docket's normal hours of operation as identified in Unit I.B.1.

D. How Should I Submit CBI to the Agency?

Do not submit information that you consider to be CBI electronically through EPA's electronic public docket or by e-mail. You may claim information that you submit to EPA as CBI by marking any part or all of that information as CBI (if you submit CBI on disk or CD ROM, mark the outside of the disk or CD ROM as CBI and then identify electronically within the disk or CD ROM the specific information that is CBI). Information so marked will not be disclosed except in accordance with procedures set forth in 40 CFR part 2.

In addition to one complete version of the comment that includes any information claimed as CBI, a copy of the comment that does not contain the information claimed as CBI must be submitted for inclusion in the public docket and EPA's electronic public docket. If you submit the copy that does not contain CBI on disk or CD ROM, mark the outside of the disk or CD ROM clearly that it does not contain CBI. Information not marked as CBI will be included in the public docket and EPA's electronic public docket without prior notice. If you have any questions about CBI or the procedures for claiming CBI, please consult the person listed under **FOR FURTHER INFORMATION CONTACT.**

E. What Should I Consider as I Prepare My Comments for EPA?

You may find the following suggestions helpful for preparing your comments:

1. Explain your views as clearly as possible.

2. Describe any assumptions that you used.

3. Provide copies of any technical information and/or data you used that support your views.

4. If you estimate potential burden or costs, explain how you arrived at the estimate that you provide.

5. Provide specific examples to illustrate your concerns.

6. Make sure to submit your comments by the deadline in this notice.

7. To ensure proper receipt by EPA, be sure to identify the docket ID number assigned to this action in the subject line on the first page of your response. You may also provide the name, date, and **Federal Register** citation.

II. What Action is the Agency Taking?

EPA has received a pesticide petition as follows proposing the establishment and/or amendment of regulations for residues of a certain pesticide chemical in or on various food commodities under section 408 of the Federal Food, Drug, and Cosmetic Act (FFDCA), 21 U.S.C. 346a. EPA has determined that this petition contains data or information regarding the elements set forth in FFDCA section 408(d)(2); however, EPA has not fully evaluated the sufficiency of the submitted data at this time or whether the data support granting of the petition. Additional data may be needed before EPA rules on the petition.

List of Subjects

Environmental protection, Agricultural commodities, Feed additives, Food additives, Pesticides and pests, Reporting and recordkeeping requirements.

Dated: October 28, 2003.

Janet L. Andersen,

Director, Biopesticides and Pollution Prevention Division, Office of Pesticide Programs.

Summary of Petition

The petitioner summary of the pesticide petition is printed below as required by FFDCA section 408(d)(3). The summary of the petition was prepared by W. F. Stoneman Company LLC and represents the view of the petitioner. The petition summary announces the availability of a description of the analytical methods available to EPA for the detection and measurement of the pesticide chemical residues or an explanation of why no such method is needed.

W.F. Stoneman Company LLC

PP 3F6737

EPA has received a pesticide petition 3F6737 from W.F. Stoneman Company LLC (on behalf of Prophyta Biologischer Pflanzenschutz GmbH), 6307 Mourning Dove Drive, McFarland, Wisconsin 53558–9019, proposing pursuant to section 408(d) of the Federal Food, Drug, and Cosmetic Act (FFDCA), 21 U.S.C. 346a(d), to amend 40 CFR part 180, to establish an exemption from the requirement of a tolerance for residues of the microbial pesticide *Paecilomyces lilacinus strain 251 (P. lilacinus).*

Pursuant to section 408(d)(2)(A)(i) of the FFDCA, as amended, W.F. Stoneman Company LLC (on behalf of Prophyta Biologischer Pflanzenschutz GmbH) has submitted the following summary of information, data, and arguments in support of their pesticide petition. This summary was prepared by W.F. Stoneman Company LLC (on behalf of Prophyta Biologischer Pflanzenschutz GmbH) and EPA has not fully evaluated the merits of the pesticide petition. The summary may have been edited by EPA if the terminology used was unclear, the summary contained extraneous material, or the summary unintentionally made the reader conclude that the findings reflected EPA's position and not the position of the petitioner.

A. Product Name and Proposed Use Practices

MeloCon™ WG. For purposes of marketing the product in the U.S.A., the name MeloCon™ WG was chosen and a registered trademark will be sought. The same active ingredient in the same or similar formulations is sold under other trade names in other countries of the world including: Paecil, BioACT WG, and Nemachek.

Proposed use practices. MeloCon™ WG is a biological nematicide for the control of plant parasitic nematodes. The product is sold as water dispersible granules that are then mixed with water and applied as a soil spray, initially at a rate of 4 pounds per acre. Applications are made to soil before planting, to the soil of seedlings before transplanting, and as a post-plant soil drench.

B. Product Identity/Chemistry

1. *Identity of the pesticide and corresponding residues.*

- Product name. MeloCon™ WG
- Active ingredient. *Paecilomyces lilacinus* strain 251
- CAS No. Not applicable
- Color. Pink
- Physical state. Non-dusty, water dispersible granules
- Odor. Odorless
- Bulk density. 500–550 kg/cubic meter
- pH. Before storage, the pH of PBP-01001-I was 6.86 (mean of two replications). After storage at a temperature of 40°C for a period of 8 weeks, the pH of the product was 5.52 (mean of two replications).
- Mode of action. Control of plant-parasitic nematodes by *P. lilacinus* is basically achieved by parasitism and subsequent killing of eggs, juveniles and adult females of a range of nematode species. The infective units are spores and mycelia, enabling the fungus to parasitize the host epiphytically or as an endophyte, following penetration of cell walls.

Historical Background. Plant-parasitic nematodes infect a wide range of crops and cause reduction in yield and sometimes death of the crop plant. As early as 1877 parasitism of female nematodes of the species of *Heterodera schachtii* by a fungus was described, but it took several decades for researchers to discover that fungi play a major role as antagonists of parasitic nematodes. Numerous fungi are known to have nematophagous activity and to act by several mechanisms, including endoparasitic, predacious, and opportunistic parasitism. As opportunistic fungi, *P. lilacinus* and *Verticillium chlamydosporium* have been extensively studied as possible biocontrol agents.

In 1979. *P. lilacinus* was identified as an effective parasite of *Meloidogyne incognita and Globodera pallida* eggs on potatoes. Further study revealed that different strains of *P.lilacinus* differed considerably in their nematophagous potential. Efficient *P. lilacinus* strains have been registered as biocontrol agents for plant-parasitic nematodes in the Philippines and South Africa, while registration is pending in Australia.

2. *Magnitude of residue at the time of harvest and method used to determine the residue— Analytical method.* An analytical method of residues is not applicable.

3. *A statement of why an analytical method for detecting and measuring the levels of the pesticide residue are not needed.* An analytic method for residues is not applicable. *Paecilomyces lilacinus* strain 251 is active in the soil, applied to the soil, and incorporated into the soil prior to planting, or drenched onto the soil surrounding plants very early in the growing season. It is not applied directly to the food commodity. Residues of the active ingredient in MeloCon™ WG are not expected on agricultural commodities.

In most of the crops envisaged for use of the active ingredient no deposit is likely to occur, since soil drench applications rule out a direct contact between the applied product and the fruit. This applies to all crops with above ground harvest, such as grapes, tomato, and tobacco. After harvest any remaining fungal spores on potato, celery and carrots will be exposed to unfavorable conditions (e.g. dryness), and are not likely to germinate and grow on the harvested crop.

Any potentially occurring residual deposits on these crops will not harm humans because the strain shows no toxicity in appropriate tests and any such residues will be very low due to the low environmental concentration in soil predicted from maximum field use of the active ingredient.

P. lilacinus is not able to enter plants and infest them. In fact, it enhances plant health and growth. As a *saprophytic fungus* it would use the resources of the plant host in case access was possible.

C. Mammalian Toxicological Profile

MeloCon™ WG is the end use product of the active ingredient *P. lilacinus* strain 251. The active ingredient is in the end use product at a nominal concentration of 6% by weight (with a minimum concentration of 1 billion spores per gram). The active ingredient was tested for acute Toxicity/Pathogenicity through oral, dermal, IP injection, pulmonary, skin irritation, eye irritation, and skin sensitization. The results of these mammalian studies indicate no significant human health risks. The table below summarizes the results of the acute studies that were done.

TABLE 1.—SUMMARY OF MAMMALIAN TOXICITY/PATHOGENICITY STUDIES[1]

Study	Animal	Dose (mg)	Dose (cfu)	Result
Acute oral, LD_{50}	Rat	> 2,000 milligrams/kilogram body weight (mg/kg bwt)	> 4 x 10^9 colony forming units/kilogram body weight (cfu/kg bwt)	LD_{50} > 2,000 mg/kg
Acute dermal, LD_{50}	Rat	> 2,000 mg/kg body.wt	> 4 x 10^9 cfu/kg body wt	LD_{50} > 2,000 mg/kg
Acute IP injection	Rat	> 2,000 mg/kg body.wt	> 4 x 10^9 cfu/kg body wt	LD_{50} > 2,000 mg/kg Non-infectious; 100% clearance
Acute pulmonary (intratracheal)	Rat	> 125 mg/kg body.wt	> 2.5 x 10^8 cfu/kg body wt	LD_{50} > 125 mg/kg Non-infectious; 100% clearance
Acute skin irritation	Rabbit			Non-irritant
Acute eye irritation	Rabbit			Non-irritant
Skin sensitization (Buehler test)	Guinea pig			Not sensitizing

[1]The end product was test substance.

In addition, the temperature profile for this strain of *P. lilacinus* strain 251 indicates that it does not grow at 36°C or higher, and therefore, will not be pathogenic to humans. The strain does not produce paecilotoxins or other toxins. The acute toxicity/pathogenicity studies have determined that the end use product containing the organism is not toxic, irritating or sensitizing to the test animals. Strain 251 of *P. lilacinus* has not been reported as a pathogen to humans or as causing any type of adverse effects to humans in the published literature or through commercial manufacture or use.

In conclusion, all submitted toxicological studies and supplemental information on *P. lilacinus* strain 251, prove that this fungus is non-pathogenic and non-infectious to mammals and imposes no health risk for operators, workers, or consumers.

D. Aggregate Exposure

1. *Dietary exposure—i. food.* Dietary exposure from use of MeloCon™ WG and its active ingredient is minimal to non-existent. MeloCon™ WG is applied to the soil before planting and very early in the plant-growing season. After harvest any remaining fungal spores on potato, celery and carrots will be exposed to unfavorable conditions (e.g. dryness), and are not likely to germinate and grow on the harvested crop.

Any potentially occurring residual deposits on these crops are not relevant as a human health concern in view of the toxicological profile of this strain. The amount of residue, if any, is likely to be very low.

P. lilacinus is not able to enter plants and infest them. As a saprophytic fungus it would use the resources of the plant host in case access was possible.

Residues of the active ingredient are not expected on agricultural commodities.

ii. *Drinking water.* Exposure to humans from residues of *P. lilacinus* strain 251 in drinking water is unlikely. The active ingredient of MeloCon™ WG is not very soil mobile and will not leach to the water table. Following application of the active ingredient to the soil, spores of *P.lilacinus* strain 251 are likely to establish a population based on the prevailing environmental conditions of the relevant soil ecosystem. Unlimited growth is not expected, given that this species is not a "foreigner" to the naturally occurring soil micro-flora. The active ingredient is a spore and not soluble and therefore non-leaching. In addition, when the product is used as directed, the presence of spores in natural surface waters is not expected.

2. *Non-dietary exposure.* The potential for non dietary exposure to the general population, including infants and children, is minimal to non-existent. No approval for consumer uses is expected. The proposed uses are limited to commercial agricultural and horticultural applications. No exposure is expected to the general public during either manufacture or application of the product. If non-dietary exposures were to occur, they would not be expected to pose a risk due to a lack of pathogenicity and toxicity, as demonstrated for this strain in the studies conducted on MeloCon™ WG. The recommendations for use of personal protective equipment (PPE) will mitigate the potential exposure of workers.

E. Cumulative Exposure

No residues are expected to remain in human food and no cumulative effects of this microbial nematicide are expected.

F. Safety Determination

1. *U. S. population.* There have been no reports of *P. lilacinus* strain 251 infecting humans, and no reports that the microbe makes toxins or secondary metabolites that might be harmful to humans.

In most of the crops envisaged for use of the active ingredient no residue is expected on the food, since soil drench applications rule out a direct contact between the applied product and the fruit. This applies to all crops with above ground harvest, such as grapes, tomato, and tobacco. After harvest, any remaining fungal spores on potato, celery and carrots will be exposed to unfavorable conditions (e.g. dryness), and are not likely to germinate and grow on the harvested crop.

P. lilacinus strain 251 does not grow at 36°C or greater, and therefore, cannot grow in humans. It has been shown to be non-toxic/pathogenic to mammals in acute studies.

2. *Infants and children.* Residues of *P. lilacinus* strain 251 are not expected to occur on agricultural commodities. There is no reason to expect harm to infants and children from exposure to the active ingredient from the proposed uses on the proposed product label.

G. Effects on the Immune and Endocrine Systems

There is no reason to expect any effects of *P. lilacinus* strain 251 on the human endocrine system. The active ingredient in MeloCon™ WG does not function as a hormone nor does it produce any known hormones. *P. lilacinus* strain 251 in a naturally occurring, nonpathogenic soil organism.

H. Existing Tolerances

EPA no tolerance to date.

I. International Tolerances

Australia has granted a Certificate of an exemption for an active constituent (National Registration Authority, Australia 1998).

[FR Doc. 03–27956 Filed 11–6–03; 8:45 am]

BILLING CODE 6560–50–S

ENVIRONMENTAL PROTECTION AGENCY

[FRL–7583–4]

Administrative Order on Consent for Removal Action, Northwest Oil Drain Superfund Site, Salt Lake City, UT

AGENCY: Environmental Protection Agency (U.S. EPA).

ACTION: Administrative order on consent.

SUMMARY: In accordance with the requirements of the Comprehensive Environmental Response, Compensation, and Liability Act, as amended ("CERCLA"), 42 U.S.C. 9601 *et seq.*, notice is hereby given of an Administrative Order On Consent For Removal Action ("Order"), Northwest Oil Drain Superfund Site, Salt Lake City, UT. This Order provides for the performance of the Work by each Respondent (Salt Lake City Corporation (City), Salt Lake County (County), BP Amoco and Chevron Products Co. (Chevron)) and for the reimbursement of certain response costs incurred by the United States in connection with the property, known as the "Northwest Oil Drain Site" or "NWOD" or the "Site". The Respondents to this Order formed the Northwest Oil Drain Working group to study and implement a removal action at the Site. The total estimated capital cost for the removal action is approximately $5,102,700.00. The costs will be fully funded by the Respondents. Additionally, the Respondents will pay $200,000.00 for past costs incurred by EPA.

The NWOD is located in northern Salt Lake and in Davis Counties, northwest of downtown Salt Lake City, Utah. The NWOD is a series of former and existing unlined canals consisting of two systems, the 8.6 mile north west flowing and open section and the non-flowing section ¼ mile long). The NWOD was constructed in the 1920's and was used to convey stormwater and industrial and municipal discharges into the Great Salt Lake. The sludge/sediment in the NWOD contains elevated concentrations of organics and metals. The removal action consists of the complete physical removal of sediments from the Northwest Oil Drain. Some of these sediments will be deposited in a regulated land farm while other sediments will be side-cast in nearby agricultural and rangelands. The non-flowing section of the canal (¼ mile section) will be backfilled with clean fill material.

DATES: Comments must be submitted to EPA on or before 30 days from date of publication.

ADDRESSES: Comments should be addressed to Nancy A. Mangone, (8ENF-L), Enforcement Attorney, U.S. Environmental Protection Agency, Region VIII, 999 18th Street, Suite 300, Denver, Colorado 80202–2466, and should refer to: In the Matter of: Administrative Order On Consent For Removal Action, Northwest Oil Drain Superfund Site, Salt Lake City, UT.

FOR FURTHER INFORMATION CONTACT: Nancy A. Mangone, (8ENF–L), Enforcement Attorney, U.S. Environmental Protection Agency, Region VIII, 999 18th Street, Suite 300, Denver, Colorado, 80202–2466, (303) 312–6903.

Dated: October 16, 2003.

Andrew M. Gaydosh,

Acting Assistant Regional Administrator, Office of Enforcement, Compliance and Environmental Justice.

[FR Doc. 03–28105 Filed 11–6–03; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–OW–7584–6]

Notice of Availability of Revised Draft Aquatic Life Criteria Document for Atrazine and Request for Scientific Views

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of availability and request for scientific views.

SUMMARY: This action notifies the public about the availability of a revised draft aquatic life criteria document for atrazine and requests scientific views. The Clean Water Act (CWA) requires the Environmental Protection Agency (EPA) to develop and publish, and from time to time revise, criteria for water accurately reflecting the latest scientific knowledge. When final, these criteria will provide EPA's recommendations to States and authorized Tribes as they establish their water quality standards as State or Tribal law or regulation. At this time the Agency is not making a final recomendation, rather the Agency is requesting scientific views on the draft document.

DATES: All significant scientific information must be submitted to the Agency on or before February 5, 2004.

ADDRESSES: Scientific views must be submitted electronically, by mail, or through hand-delivery/courier. Follow detailed instructions as provided in section C of the **SUPPLEMENTARY INFORMATION** section. Copies of the criteria document entitled, Draft Ambient Aquatic Life Water Quality Criteria for Atrazine (EPA–822–R–03–023) may be obtained from EPA's Water Resource Center by phone at (202) 566–2426, or by e-mail to *center.water.resource@epa.gov* or by conventional mail to: EPA Water Resource Center, 4101T, 1200 Pennsylvania Avenue NW., Washington, DC 20460. You can also download the document from EPA's Web site at *http://www.epa.gov/waterscience/criteria/atrazine/*. OPP's risk assessment can be downloaded from *http://www.epa.gov/oppsrrd1/reregistration/atrazine/*.

FOR FURTHER INFORMATION CONTACT: Frank Gostomski, Health and Ecological Criteria Division (4304), U.S. EPA, 1200 Pennsylvania Avenue NW., Washington, DC 20460; (202) 566–1105; *gostomski.frank@epa.gov*.

SUPPLEMENTARY INFORMATION:

I. General Information

A. Interested Entities

Entities potentially interested in today's notice are those that produce, use, or regulate atrazine. Categories and entities interested in today's action include:

Category	Examples of interested entities
State/Local/Tribal Government.	Midwest "cornbelt" States and Tribes.
Herbicide Producers	Syngenta.
Herbicide Users	Growers of corn and sugarcane.

This table is not intended to be exhaustive, but rather provides a guide for readers regarding entities likely to be

interested by this action. This table lists the types of entities that EPA is now aware could potentially be interested by this action. Other types of entities not listed in the table could also be interested.

B. How Can I Get Copies of This Document and Other Related Information ?

1. *Docket.* EPA has established an official public docket for this action under Docket ID No. OW–2001–0010. The official public docket consists of the documents specifically referenced in this action, any scientific views received, and other information related to this action. Although a part of the official docket, the public docket does not include Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. The official public docket is the collection of materials that is available for public viewing at Water Docket in the EPA Docket Center, (EPA/DC) EPA West, Room B102, 1301 Constitution Ave., NW., Washington, DC. The EPA Docket Center Public Reading Room is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The telephone number for the Public Reading Room is (202) 566–1744, and the telephone number for the Water Docket is (202) 566–1744. To view these documents materials, please call ahead to schedule an appointment. Every user is entitled to copy 266 pages per day before incurring a charge. The Docket may charge 15 cents a page for each page over the 266-page limit plus an administrative fee of $25.00.

2. *Electronic Access.* You may access this **Federal Register** document electronically through the EPA Internet under the "**Federal Register**" listings at *http://www.epa.gov/fedrgstr/.*

An electronic version of the public docket is available through EPA's electronic public docket and comment system, EPA Dockets. You may use EPA Dockets at *http://www.epa.gov/edocket/* to submit or view scientific views, access the index listing of the contents of the official public docket, and to access those documents in the public docket that are available electronically. Once in the system, select "search," then key in the appropriate docket identification number.

Certain types of information will not be placed in the EPA Dockets. Information claimed as CBI and other information whose disclosure is restricted by statute, which is not included in the official public docket, will not be available for public viewing in EPA's electronic public docket. EPA's policy is that copyrighted material will not be placed in EPA's electronic public docket but will be available only in printed, paper form in the official public docket. To the extent feasible, publicly available docket materials will be made available in EPA's electronic public docket. When a document is selected from the index list in EPA Dockets, the system will identify whether the document is available for viewing in EPA's electronic public docket. Although not all docket materials may be available electronically, you may still access any of the publicly available docket materials through the docket facility identified in section I.B.

It is important to note that EPA's policy is that scientific views, whether submitted electronically or in paper, will be made available for public viewing in EPA's electronic public docket as EPA receives them and without change, unless your views and information contain copyrighted material, CBI, or other information whose disclosure is restricted by statute. When EPA identifies a scientific view containing copyrighted material, EPA will provide a reference to that material in the version of the scientific view that is placed in EPA's electronic public docket. The entire printed scientific view, including the copyrighted material, will be available in the public docket.

Scientific views submitted on computer disks that are mailed or delivered to the docket will be transferred to EPA's electronic public docket. Scientific views that are mailed or delivered to the Docket will be scanned and placed in EPA's electronic public docket. Where practical, physical objects will be photographed, and the photograph will be placed in EPA's electronic public docket along with a brief description written by the docket staff.

C. How and To Whom Do I Submit Scientific Views?

You may submit scientific views electronically, by mail, by facsimile, or through hand delivery/courier. To ensure proper receipt by EPA, identify the appropriate docket identification number in the subject line on the first page of your scientific views. Please ensure that your scientific views are submitted within the specified period. Scientific views received after the close of the review period will be marked "late." EPA is not required to consider these late scientific views.

1. *Electronically.* If you submit electronic information as prescribed below, EPA recommends that you include your name, mailing address, and an e-mail address or other contact information in the body of your scientific views. Also include this contact information on the outside of any disk or CD ROM you submit, and in any cover letter accompanying the disk or CD ROM. This ensures that you can be identified as the submitter of the scientific information and allows EPA to contact you in case EPA cannot read your scientific views due to technical difficulties or needs further information on the substance of your scientific views. EPA's policy is that EPA will not edit your scientific views, and any identifying or contact information provided in the body of the scientific views will be included as part of the scientific views that are placed in the official public docket, and made available in EPA's electronic public docket. If EPA cannot read your scientific views due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your scientific views.

i. *EPA Dockets.* Your use of EPA's electronic public docket to submit scientific views to EPA electronically is EPA's preferred method for receiving scientific views. Go directly to EPA Dockets at *http://www.epa.gov/edocket,* and follow the online instructions for submitting scientific views. To access EPA's electronic public docket from the EPA Internet Home Page, select "Information Sources," "Dockets," and "EPA Dockets." Once in the system, select "search," and then key in Docket ID No. OW–2001–0010. The system is an "anonymous access" system, which means EPA will not know your identity, e-mail address, or other contact information unless you provide it in the body of your information.

ii. *E-mail.* Scientific views may be sent by electronic mail (e-mail) to *OW-Docket@epa.gov,* Attention Docket No. OW–2001–0010. In contrast to EPA's electronic public docket, EPA's e-mail system is not an "anonymous access" system. If you send an e-mail scientific views directly to the Docket without going through EPA's electronic public docket, EPA's e-mail system automatically captures your e-mail address. E-mail addresses that are automatically captured by EPA's e-mail system are included as part of the information that is placed in the official public docket, and made available in EPA's electronic public docket.

iii. *Disk or CD ROM.* You may submit scientific views on a disk or CD ROM that you mail to the mailing address identified in section I.C.2. These electronic submissions will be accepted in WordPerfect or ASCII file format. Avoid the use of special characters and any form of encryption.

2. *By Mail.* Send your scientific views to: Water Docket in the EPA Docket Center, Environmental Protection Agency, Mailcode 4101T, 1200 Pennsylvania Ave., NW., Washington, DC 20460, Attention Docket ID No. OW–2001–0010.

3. *By Hand Delivery or Courier.* Deliver your scientific views to: Water Docket, EPA Docket Center, EPA West, Room B102, 1301 Constitution Ave., NW., Washington, DC, Attention Docket ID No. OW–2001–0010. Such deliveries are only accepted during the Docket's normal hours of operation as identified in section I.B.1.

D. What Should I Consider as I Prepare My Scientific Views for EPA?

You may find the following suggestions helpful for preparing your scientific views:

1. Explain your scientific views as clearly as possible.

2. Describe any assumptions that you used.

3. Provide any technical information and/or data you used that support your scientific views.

4. Provide specific examples to illustrate your concerns.

5. Offer alternatives.

6. Make sure to submit your scientific views by the deadline identified.

7. To ensure proper receipt by EPA, identify the appropriate docket identification number in the subject line on the first page of your response. It would also be helpful if you provided the name, date, and **Federal Register** citation related to your scientific views.

II. Background and Today's Action

A. What Are Recommended Water Quality Criteria?

Recommended water quality criteria are the concentrations of a chemical in water at or below which aquatic life are protected from acute and chronic adverse effects of the chemical. Section 304(a)(1) of the Clean Water Act requires EPA to develop and publish, and from time to time revise, criteria for water accurately reflecting the latest scientific knowledge. Water quality criteria developed under section 304(a) are based solely on data and scientific judgments. They do not consider economic impacts or the technological feasibility of meeting the criteria in ambient water. Section 304(a) criteria provide guidance to States and Tribes in adopting water quality standards. The criteria also provide a scientific basis for EPA to develop Federally promulgated water quality standards under section 303(c).

B. What Is Atrazine and Why Are We Concerned About It?

Atrazine is an organic chemical used as an herbicide throughout the U.S. for control of weeds in agricultural crops. Environmental exposure occurs mainly from its application as an herbicide but may also occur from industrial manufacture, distribution releases, precipitation, field runoff, and drift. Atrazine is moderately volatile and soluble in water, and resistant to natural degradation in water. Because of atrazine's chemical properties and widespread use as an herbicide, concerns have been raised over the potential risks posed by exposure of aquatic organisms to it. For these reasons, EPA has developed the following water quality criteria:

C. What Are the National Recommended Water Quality Criteria?

Freshwater

Aquatic life should not be affected unacceptably if the: One-hour average concentration of atrazine does not exceed 1,500 ug/l more than once every three years on the average (Acute Criterion) and if the Average Primary Producer Steinhaus Similarity deviation for a site is less than 5% (as determined using the Comprehensive Aquatic Systems Model (CASM) [1] or other appropriate model and index) and is not exceeded more than once every three years (or other appropriate return frequency sufficient to allow system recovery). The 5% index for the protection of aquatic plant community should also be protective of most freshwater animals (Chronic Criterion).

Saltwater

Aquatic life should not be affected unacceptably if the: One hour average concentration of atrazine does not exceed 760 ug/l more than once every three years on the average (Acute Criterion) and if the thirty-day average concentration of atrazine does not exceed 17 ug/l more than once every three years on the average (Chronic Criterion).

D. How Are the Revised Draft Criteria in Today's Publication Different From the 2001 Criteria?

The revised draft criteria in today's publication incorporate information on the toxicity of atrazine to aquatic plants and invertebrates that had not been available at the time of the 2001 publication. The change in critical endpoints reflects the scientific views of the Agency, the registrant, and those received from the public.

E. How Has EPA Coordinated Development of Ecological Risk Assessments on Atrazine Between the Office of Water (OW) and the Office of Pesticide Programs (OPP)?

Concurrent with OW's release of the Draft Aquatic Life Criteria Document for Atrazine at 66 FR 49186, OPP released its Preliminary Ecological Fate and Effects Risk Assessment of Atrazine at 66 FR 49180. Both offices shared their aquatic toxicity data bases for atrazine in the development of their risk assessment documents. OW and OPP also shared scientific views received on their respective risk assessment documents in response to their publication for review by the public.

Today, EPA is notifying the public about the availability of this aquatic life criteria document for atrazine to expand the public's involvement in the criteria development process. Simultaneously, EPA is publishing its Ecological Fate and Effects Risk Assessment for atrazine under FIFRA (*http://www.epa.gov/oppsrrd1/reregistration/atrazine/*).

EPA notified the public of its intent to develop aquatic life criteria for atrazine in the **Federal Register** on October 29, 1999 (64 FR 58409). At that time EPA made available to the public all references identified by a recent literature review and solicited any additional pertinent data or scientific views that would be useful in developing the draft aquatic life criteria for atrazine. EPA then made the draft aquatic life criteria document for atrazine available for public review.

The Office of Water and the Office of Pesticide Programs will continue to work together and with stakeholders (States, Tribes, manufacturers, growers, and other interested parties) to develop an implementation document for States and Tribes to use in their adoption of atrazine criteria in State and Tribal standards. The draft implementation document will be made available for public review. EPA's current thinking is that the document would include:

[1] CASM is an aquatic ecological food chain model, specifically, the Comprehensive Aquatic Systems Model (Bartell *et al.* 2000, Bartell *et al* 1999, DeAngelis *et al* 1989).

Bartell, S.M., K.R. Campbell, C.M. Lovelock, S.K. Nair, and J.L. Shaw. 2000. Characterizing aquatic ecological risk from pesticides using a diquat dibromide case study III. Ecological Process Models. Environ. Toxicol. Chem. 19(5):1441–1453.

Bartell, S.M., G. Lefebvre, G. Aminski, M. Carreau, and K.R. Campbell. 1999. An ecosystem model for assessing ecological risks in Quebec rivers, lakes, and reservoirs. Ecol. Model. 124:43–67.

DeAngelis, D.L., S.M. Bartell, and A.L. Brenkert. 1989. Effects of nutrient recycling and food-chain length on resilience. Amer. Nat. 134(5):778–805.

• Mechanisms for States and Tribes to refine the exposure duration and frequency components of the atrazine criteria to best meet their more specific needs;

• Mechanisms for States and Tribes to best define exposure duration and frequency components of their criteria to clearly establish when a water as impaired (*i.e.*, the water quality criteria are not being attained in stream) due to atrazine contamination;

• Mechanisms to establish screening levels (rolling average concentrations below the criteria) that if met would alleviate the need for States and Tribes to run complex models to determine if the chronic freshwater criteria is being met;

The Office of Water expects that it will obtain the necessary data to support the implementation document through a data generation agreement between the Office of Pesticides Programs and the Registrant. The Registrant will conduct a three year monitoring program in selected waters that will generate the data that EPA would use to provide additional information on how States and Tribes may adjust standards for more localized duration and frequency components of the criteria and more refined definitions of frequency and duration components of their criteria to clearly establish when a water is impaired waters for the purposes of CWA sections 305(b) and 303(d).

F. What Specific Questions of Science Does EPA Want Views on?

Though the public is welcome to submit scientific views on any component of the atrazine aquatic life criteria document, EPA is specifically interested in scientific views on the following issues of science:

• The use of the Average Primary Producer Steinhaus Similarity deviation of 5% (as determined using the Comprehensive Aquatic Systems Model (CASM)) as protective of chronic effects to freshwater aquatic life;

• The applicability of the same approach to the protection of chronic effects to salt water aquatic life in place of a Guidelines calculated concentration stated above in II.C. Conceptually, the approach used for fresh water chronic criteria should be equally applicable to salt water chronic criteria. To date, however, salt water toxicity data have not been employed in the model. Additionally, there are fewer atrazine toxicity data available for salt water species than for freshwater species.

G. Where Can I Find More Information on EPA's Revised Process for Developing New or Revised Draft Criteria?

The Agency published detailed information about its revised process for developing and revising criteria in the **Federal Register** on December 10, 1998 (63 FR 68354) and in the EPA document entitled, National Recommended Water Quality— Correction (EPA 822–Z–99–001, April 1999). The purpose of the revised process is to provide expanded opportunities for public input, and to make the criteria development process more efficient.

Dated: October 31, 2003.

G. Tracy Mehan,

Assistant Administrator, Office of Water.

[FR Doc. 03–28102 Filed 11–6–03; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL HOUSING FINANCE BOARD

Sunshine Act Meeting Notice; Announcing an Open Meeting of the Board of Directors

TIME AND DATE: The meeting of the Board of Directors is scheduled to begin at 10 a.m. on Wednesday, November 12, 2003.

PLACE: Board Room, Second Floor, Federal Housing Finance Board, 1777 F Street, NW., Washington, DC 20006.

STATUS: The entire meeting will be open to the public.

MATTERS TO BE CONSIDERED:

Capital Plan Amendment for the Federal Home Loan Bank of Dallas. Consideration of an amendment to the Dallas Bank capital plan to include an identification process for shares of Class B stock that are subject to a member's stock redemption notice.

Approval of the 2004 Administrative and Non-Administrative Budget for the Financing Corporation. 12 CFR 995.6(b) requires the Finance Board to approve the budget submitted by the Financing Corporation each year.

FOR FURTHER INFORMATION CONTACT: Mary Gottlieb, Paralegal Specialist, Office of General Counsel, by telephone at 202/408–2826 or by electronic mail at *gottliebm@fhfb.gov*.

Dated: November 5, 2003.

By the Federal Housing Finance Board.

Arnold Intrater,

General Counsel.

[FR Doc. 03–28207 Filed 11–5–03; 12:30 pm]

BILLING CODE 6725–01–P

FEDERAL RESERVE SYSTEM

Change in Bank Control Notices; Acquisition of Shares of Bank or Bank Holding Companies

The notificants listed below have applied under the Change in Bank Control Act (12 U.S.C. 1817(j)) and § 225.41 of the Board's Regulation Y (12 CFR 225.41) to acquire a bank or bank holding company. The factors that are considered in acting on the notices are set forth in paragraph 7 of the Act (12 U.S.C. 1817(j)(7)).

The notices are available for immediate inspection at the Federal Reserve Bank indicated. The notices also will be available for inspection at the office of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank indicated for that notice or to the offices of the Board of Governors. Comments must be received not later than November 21, 2003.

A. Federal Reserve Bank of Atlanta (Sue Costello, Vice President) 1000 Peachtree Street, N.E., Atlanta, Georgia 30303:

1. John Alfred Melancon, Jr., St. Martinville, Louisiana; to acquire shares of First Bankshares of St. Martin, Ltd., and its subsidiary, First Louisiana National Bank, both of Breaux Bridge, Louisiana.

B. Federal Reserve Bank of San Francisco (Tracy Basinger, Director, Regional and Community Bank Group) 101 Market Street, San Francisco, California 94105-1579:

1. David and Verla Sorensen, Salt Lake City, Utah, and Jeffrey and Sheila Smith, Midland, Texas; to retain voting shares of Community Bancorp, and thereby retain shares of Community Bank of Nevada, both of Las Vegas, Nevada. In addition, David and Verla Sorensen to acquire up to 25 percent of Community Bancorp, Las Vegas, Nevada.

Board of Governors of the Federal Reserve System, November 3, 2003.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. 03–28100 Filed 11–6–03; 8:45 am]

BILLING CODE 6210–01–S

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR Part

225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate inspection at the Federal Reserve Bank indicated. The application also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 4 of the BHC Act (12 U.S.C. 1843). Unless otherwise noted, nonbanking activities will be conducted throughout the United States. Additional information on all bank holding companies may be obtained from the National Information Center website at *www.ffiec.gov/nic/*.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than December 1, 2003.

A. Federal Reserve Bank of Cleveland (Nadine W. Wallman, Assistant Vice President) 1455 East Sixth Street, Cleveland, Ohio 44101-2566:

1. PSB Holdings, Inc., New Matamoras, Ohio; to become a bank holding company by acquiring 100 percent of the voting shares of The Peoples Savings Bank, New Matamoras, Ohio.

B. Federal Reserve Bank of Dallas (W. Arthur Tribble, Vice President) 2200 North Pearl Street, Dallas, Texas 75201-2272:

1. Tolleson Wealth Management, Inc., Dallas, Texas, and Tolleson Wealth Management of Delaware, Inc., Dallas, Texas; to become bank holding companies by acquiring 100 percent of the voting shares of Tolleson Tolleson Private Bank, Dallas, Texas.

In connection with this application, *Tolleson Wealth Management, Inc.*, and Tolleson Wealth Management of Delaware, Inc., Dallas, Texas, also have applied to acquire 100 percent of the voting shares of TTG Service, Inc.; Tolleson Private Wealth Management LP; and Tolleson Funding LP, all of Dallas, Texas, and thereby engage in extending and servicing extensions of credit and providing investment and advisory services pursuant to sections 225.28(b)(1) and 225.28(b)(6) of Regulation Y.

Board of Governors of the Federal Reserve System, November 3, 2003.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. 03–28098 Filed 11–6–03; 8:45 am]

BILLING CODE 6210–01–S

FEDERAL RESERVE SYSTEM

Notice of Proposals to Engage in Permissible Nonbanking Activities or to Acquire Companies that are Engaged in Permissible Nonbanking Activities

The companies listed in this notice have given notice under section 4 of the Bank Holding Company Act (12 U.S.C. 1843) (BHC Act) and Regulation Y (12 CFR Part 225) to engage *de novo*, or to acquire or control voting securities or assets of a company, including the companies listed below, that engages either directly or through a subsidiary or other company, in a nonbanking activity that is listed in § 225.28 of Regulation Y (12 CFR 225.28) or that the Board has determined by Order to be closely related to banking and permissible for bank holding companies. Unless otherwise noted, these activities will be conducted throughout the United States.

Each notice is available for inspection at the Federal Reserve Bank indicated. The notice also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the question whether the proposal complies with the standards of section 4 of the BHC Act. Additional information on all bank holding companies may be obtained from the National Information Center website at *www.ffiec.gov/nic/*.

Unless otherwise noted, comments regarding the applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than November 21, 2003.

A. Federal Reserve Bank of Atlanta (Sue Costello, Vice President) 1000 Peachtree Street, N.E., Atlanta, Georgia 30303:

1. Bonifay Holding Company, Inc., Bonifay, Florida; to engage *de novo*, in making, acquiring, brokering, or servicing loans or other extensions of credit, pursuant to section 225.28(b)(1) of Regulation Y.

Board of Governors of the Federal Reserve System, November 3, 2003.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc.03–28099 Filed 11–6–03; 8:45 am]

BILLING CODE 6210–01–S

FEDERAL RETIREMENT THRIFT INVESTMENT BOARD

Sunshine Act Notice

TIME AND DATE: 9 a.m. (e.s.t.)

PLACE: 4th Floor, Conference Room, 1250 H Street, NW., Washington, DC.

STATUS: Parts will be open to the public and parts closed to the public.

MATTERS TO BE CONSIDERED:

Parts Open to the Public

9 a.m. (EST) Convene Meeting.

1. Approval of the minutes of the October 20, 2003, Board member meeting.
2. Thrift Savings Plan activity report by the Executive Director.
3. Semiannual review of status of audit recommendations.
4. Presentation by the Department of Labor and KPMG LLP.
5. Investment policy review.
6. Annual ethics briefing.

Parts Closed to the Public

7. Personnel matters.

CONTACT PERSON FOR MORE INFORMATION: Thomas J. Trabucco, Director, Office of External Affairs, (202) 942–1640.

Dated: November 5, 2003.

Elizabeth S. Woodruff,

Secretary to the Board, Federal Retirement Thrift Investment Board.

[FR Doc. 03–28240 Filed 11–5–03; 2:58 pm]

BILLING CODE 6760–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

[Document Identifier: OS–0990–TANF]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Office of the Secretary, Department of Health and Human Services.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Office of the Secretary (OS), Department of Health and Human Services, is publishing the following summary of proposed collections for public

comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

#1 Type of Information Collection Request: New Collection;

Title of Information Collection: Survey of State and Locao Contracting Officials on Contracting for Social Services Under Charitable Choice;

Form/OMB No.: OS–0990-TANF;

Use: This data collection will enable HHS to document the extent to which state and local contracting officials in the Temporary Assistance for Needy Families and Substance Abuse Prevention and Treatment programs understand and implement federal charitable Choice regulations governing the provisions of social services by faith-based organizations. The information will be collected via a mail survey of a total of 173 respondents at the state and local levels.

Frequency: One time;

Affected Public: State, local, or tribal governments,

Annual Number of Respondents: 173;

Total Annual Responses: 173;

Average Burden Per Response: 30 to 90 minutes;

Total Annual Hours: 175.

#2 Type of Information Collection Request: New collection;

Title of Information Collection: Implementation of an Internet & Paper-Based Uniform Data Set for OMH-Funded Activities;

Form/OMB No.: OS–0990-OMH;

Use: Involves transitioning the developed paper-based UDS modules to the Web-based prototype and will be implemented among OMH-partners. Will be regular system for reporting program management and performance data for all OMH-funded activities.

Frequency: Quarterly;

Affected Public: Business or other for profit, not for profit institutions, State, local, or tribal government;

Annual Number of Respondents: 2,772;

Total Annual Responses: 2,772;

Average Burden Per Response: 1 hour;

Total Annual Hours: 2,772.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access the HHS Web site address at *http://www.hhs.gov/oirm/infocollect/pending/* or e-mail your request, including your address, phone number, OMB number, and OS document identifier, to *Naomi.Cook@hhs.gov,* or call the Reports Clearance Office on (202) 690–5522. Written comments and recommendations for the proposed information collections must be mailed within 60 days of this notice directly to the OS Paperwork Clearance Officer designated at the following address: Department of Health and Human Services, Office of the Secretary, Assistant Secretary for Budget, Technology, and Finance, Office of Information and Resource Management, Attention: Naomi Cook (0990–TANF/OMH), Room 531–H, 200 Independence Avenue, SW., Washington DC 20201.

Dated: October 24, 2003.

John P. Burke III,

Office of the Secretary, Paperwork Reduction Act Reports Clearance Officer.

[FR Doc. 03–28017 Filed 11–6–03; 8:45 am]

BILLING CODE 4168–17–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Innovative Administration Systems for Vaccines; Meeting

AGENCY: Office of the Assistant Secretary for Public Health Emergency Preparedness, HHS.

ACTION: Notice of meeting.

SUMMARY: The Department of Health and Human Services (DHHS) is announcing the following public meeting: Innovative Administration Systems for Vaccines. The topic to be discussed is the latest scientific and clinical developments in innovative administration systems for vaccines. These discussions will facilitate the development of vaccine delivery systems relative to the storage and deployment of vaccines and the rapid implementation of mass vaccination programs. The meeting will include sessions on Jet injector, Transdermal (microneedles, patches) and Transmucosal (oral, nasal, aerosol) systems. A detailed agenda, once finalized, will be posted on the meeting Web site.

DATES AND TIME: The meeting will be held on December 18,2003, from 8:30 a.m. to 5 p.m. and on December 19, 2003 from 8:30 a.m. to 4 p.m.

LOCATION: The meeting will be held at The DoubleTree Hotel, 1750 Rockville Pike, Rockville, Maryland.

FOR FURTHER INFORMATION CONTACT: Inquiries can be addressed to: the e-mail address *vaccine750@saic.com* or by telephone to 301–228–3124.

REGISTRATION: Registration is available at the following Web site until November 26, 2003: *http://www.seeuthere.com/event/m2c640–854475248370.* A nominal registration fee of $30 will be charged those registering up to November 26, 2003. After November 26 attendee registration will occur on-site at a $40 registration fee.

Limited space is available for exhibitors. Potential exhibitors are asked to inquire via the e-mail address or phone number listed above. An exhibitor fee of $125 will be charged.

Dated: November 1, 2003.

Jerome Donlon,

Senior Science Adviser, HHS.

[FR Doc. 03–28084 Filed 11–6–03; 8:45 am]

BILLING CODE 4150–37–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Agency for Toxic Substances and Disease Registry

[Program Announcement 04004]

Public Health Conference Grant Program; Notice of Availability of Funds-Amendment

A notice announcing the availability of fiscal year 2004 funds to support a Public Health Conference Grant Program was published in the **Federal Register** on August 28, 2003, Volume 68, Number 167, pages 51781–51785. The notice is amended as follows: page 51782, second column, Section D. Funding, third paragraph, delete lines 11 through 15, "Application requests that exceed $50,000 (CDC) or $10,000 (ATSDR) will be determined as non responsive and will be returned to the applicant without review".

Page 51783, second column, Section G. Content, after the second paragraph, insert:

The LOI should specifically describe the following requirements:

- The name of the organization
- Primary contact person's name
- Mailing address
- Telephone number and, if available, fax number and e-mail
- Title of the proposed conference—include the term "conference," "symposium," or similar designation
- Date(s) of conference—inclusive dates (not a series) of the conference

- Location of city, State, and physical facilities required for the conduct of the meeting
- Project topics, (no more than 2)
- Total conference cost and total requested from CDC
- Intended audience, approximate number, and profession of persons expected to attend.
- Justification for the conference

These changes apply only to Cycles B and C of the conference support application and funding process.

Dated: November 3, 2003.

Edward Schultz,

Acting Director, Procurement and Grants Office, Centers for Disease Control and Prevention.

[FR Doc. 03–28021 Filed 11–6–03; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Toxic Substances and Disease Registry

Citizens Advisory Committee on Public Health Service (PHS) Activities and Research at Department of Energy (DOE) Sites: Oak Ridge Reservation Health Effects Subcommittee

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Agency for Toxic Substances and Disease Registry (ATSDR) and the Centers for Disease Control and Prevention (CDC) announce the following meeting.

Name: Citizens Advisory Committee on PHS Activities and Research at DOE Sites: Oak Ridge Reservation Health Effects Subcommittee (ORRHES).

Time and Date: 12 p.m.–8 p.m., December 2, 2003.

Place: DOE Information Center, 475 Oak Ridge Turnpike, Oak Ridge, Tennessee, 37830. Telephone: (865) 241–4780.

Status: Open to the public, limited only by the space available. The meeting room accommodates approximately 50 people.

Background: A Memorandum of Understanding (MOU) was signed in October 1990 and renewed in September 2000 between ATSDR and DOE. The MOU delineates the responsibilities and procedures for ATSDR's public health activities at DOE sites required under sections 104, 105, 107, and 120 of the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA or "Superfund"). These activities include health consultations and public health assessments at DOE sites listed on, or proposed for, the Superfund National Priorities List and at sites that are the subject of petitions from the public; and other health-related activities such as epidemiologic studies, health surveillance, exposure and disease registries, health education, substance-specific applied research, emergency response, and preparation of toxicological profiles. In addition, under an MOU signed in December 1990 with DOE and replaced by an MOU signed in 2000, the Department of Health and Human Services (HHS) has been given the responsibility and resources for conducting analytic epidemiologic investigations of residents of communities in the vicinity of DOE facilities, workers at DOE facilities, and other persons potentially exposed to radiation or to potential hazards from non-nuclear energy production and use. HHS has delegated program responsibility to CDC.

Purpose: This subcommittee is charged with providing advice and recommendations to the Director, CDC, and the Administrator, ATSDR, pertaining to CDC's and ATSDR's public health activities and research at this DOE site. Activities shall focus on providing the public with a vehicle to express concerns and provide advice and recommendations to CDC and ATSDR. The purpose of this meeting is to receive updates from ATSDR and CDC, and to address other issues and topics, as necessary.

Matters to be Discussed: The agenda includes a discussion of the final public health assessment on Uranium Release from the Y–12 plant, presentation on the chemical screening process for biota, updates from the Public Health Assessment, Public Health Needs Assessment, Agenda, and Outreach and Communications Workgroup. Agenda items are subject to change as priorities dictate.

For Further Information Contact: Lorine Spencer, Designated Federal Official, or Marilyn Palmer, Committee Management Specialist, Division of Health Assessment and Consultation, ATSDR, 1600 Clifton Road, NE., M/S E–32, Atlanta, Georgia 30333, telephone 1–888–42–ATSDR(28737), fax (404) 498–1744.

The Director, Management Analysis and Services Office has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both CDC and ATSDR.

Dated: November 3, 2003.

Joseph E. Salter,

Acting Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 03–28027 Filed 11–6–03; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Toxic Substances and Disease Registry

[ATSDR–196]

Notice of the Revised Priority List of Hazardous Substances That Will Be the Subject of Toxicological Profiles

AGENCY: Agency for Toxic Substances and Disease Registry (ATSDR), U.S. Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: The Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA or Superfund), as amended by the Superfund Amendments and Reauthorization Act (SARA), requires that ATSDR and the Environmental Protection Agency (EPA) revise the Priority List of Hazardous Substances. This list includes substances most commonly found at facilities on the CERCLA National Priorities List (NPL) which have been determined to be of greatest concern to public health at or around these NPL hazardous waste sites. This announcement provides notice that the agencies have developed and are making available a revised CERCLA Priority List of 275 Hazardous Substances, based on the most recent information available. Each substance on the priority list is a candidate to become the subject of a toxicological profile prepared by ATSDR and subsequently a candidate for the identification of priority data needs.

In addition to the Priority List of Hazardous Substances, ATSDR has developed a Completed Exposure Pathway Site Count Report. This report lists the number of sites or events with ATSDR activities where a substance has been found in a completed exposure pathway (CEP). This report is included in the Support Document of the Priority List.

ADDRESSES: Requests for a copy of the report, the 2003 CERCLA Priority List of Hazardous Substances That Will Be The Subject of Toxicological Profiles and Support Document, including the CEP report, should bear the docket control number ATSDR–196, and should be submitted to: ATSDR Information Center, Division of Toxicology, Mail Stop E–29, 1600 Clifton Rd., N.E., Atlanta, Georgia 30333. Requests must be in writing.

Electronic Availability: The 2003 Priority List of Hazardous Substances will be posted on ATSDR's World-Wide Web server on the Internet located at *http://www.atsdr.cdc.gov/clist.html*. The CEP Report will also be posted at *http://www.atsdr.cdc.gov/cep.html*.

This is an informational notice only, and comments are not being solicited at this time. However, any comments received will be considered for inclusion in the next revision of the list and placed in a publicly accessible docket; therefore, please do not submit confidential business or other confidential information.

FOR FURTHER INFORMATION CONTACT: ATSDR, Division of Toxicology, Emergency Response and Scientific

Assessment Branch, 1600 Clifton Road, N.E., Mail Stop E–29, Atlanta, Georgia 30333, telephone 888–422–8737.

SUPPLEMENTARY INFORMATION: CERCLA establishes certain requirements for ATSDR and EPA with regard to hazardous substances that are most commonly found at facilities on the CERCLA NPL. Section 104(i)(2) of CERCLA, as amended [42 U.S.C. 9604(i)(2)], required that the two agencies prepare a list, in order of priority, of at least 100 hazardous substances that are most commonly found at facilities on the NPL and which, in their sole discretion, have been determined to pose the most significant potential threat to human health (see 52 FR 12866, April 17, 1987). CERCLA also required the agencies to revise the priority list to include 100 or more additional hazardous substances (see 53 FR 41280, October 20, 1988), and to include at least 25 additional hazardous substances in each of the three successive years following the 1988 revision (see 54 FR 43619, October 26, 1989; 55 FR 42067, October 17, 1990; 56 FR 52166, October 17, 1991). CERCLA also requires that ATSDR and EPA shall, at least annually thereafter, revise the list to include additional hazardous substances that have been determined to pose the most significant potential threat to human health. In 1995, the agencies altered the publication schedule of the priority list by moving to a 2-year publication schedule, reflecting the stability of this listing activity (60 FR 16478, March 30, 1995). As a result, the priority list is now on a 2-year publication schedule with a yearly informal review and revision. Each substance on the CERCLA Priority List of Hazardous Substances is a candidate to become the subject of a toxicological profile prepared by ATSDR and subsequently a candidate for the identification of priority data needs.

The initial priority lists of hazardous substances (1987–1990) were based on the most comprehensive and relevant information available when the lists were developed. More comprehensive sources of information on the frequency of occurrence and the potential for human exposure to substances at NPL sites became available for use in the 1991 priority list with the development of ATSDR's HazDat database. Utilizing this database, a revised approach and algorithm for ranking substances was developed in 1991, and a notice announcing the intention of ATSDR and EPA to revise and re-rank the Priority List of Hazardous Substances was published on June 27, 1991 (56 FR 29485). The subsequent 1991 Priority List and revised approach used for its compilation was summarized in the "Revised Priority List of Hazardous Substances" **Federal Register** notice published October 17, 1991 (56 FR 52166). The same approach and the same basic algorithm have been used in all subsequent activities, including the 2003 listing activity. The algorithm used in ranking hazardous substances on the priority list consists of three criteria, which are combined to result in the total score. The three criteria are: frequency of occurrence at NPL sites; toxicity; and potential for human exposure.

Since HazDat is a dynamic database with ongoing data collection, additional information from the HazDat database became available for the 2003 listing activity. This additional information has been entered into HazDat since the development of the 2001 Priority List of Hazardous Substances. The site-specific information from HazDat that is used in the listing activity has been collected from ATSDR public health assessments, health consultations, and from site file data packages that are used to develop these public health assessments. The new information may include more recent NPL frequency of occurrence data, additional concentration data, and more information on exposure to substances at NPL sites. With these additional data, 11 substances have been replaced on the list of 275 substances since the 2001 publication. Of the 11 replacement substances, 6 are new candidate substances, and 5 are substances that were previously under consideration. These replacement substances and changes in the order of substances appearing on the CERCLA Priority List of Hazardous Substances will be reflected in the program activities that rely on the list for future direction.

The 2003 Priority List of Hazardous Substances includes 275 substances that have been determined to be of greatest concern to public health based on the criteria of CERCLA Section 104(i)(2) [42 U.S.C. 9604(i)(2)]. A total of 863 candidate substances have been analyzed and ranked with the current algorithm. Of these candidates, the 275 substances on the priority list may become the subject of toxicological profiles in the future. The top 25 substances on the 2003 Priority List of Hazardous Substances are listed below.

Rank	Substance name
1	Arsenic.
2	Lead.
3	Mercury.
4	Vinyl Chloride.
5	Polychlorinated Biphenyls.
6	Benzene.
7	Cadmium.
8	Polycyclic Aromatic Hydrocarbons.
9	Benzo(a)Pyrene.
10	Benzo(b)Fluoranthene.
11	Chloroform.
12	DDT, P,P′-
13	Aroclor 1254.
14	Aroclor 1260.
15	Dibenzo(a,h)Anthracene.
16	Trichloroethylene.
17	Chromium, Hexavalent.
18	Dieldrin.
19	Phosphorus, White.
20	Chlordane.
21	DDE, P,P′-
22	Hexachlorobutadiene.
23	Coal Tar Creosote.
24	DDD, P′, P′-
25	Benzidine.

ATSDR and EPA intend to publish the next revised list of hazardous substances in two years, with an informal review and revision performed in one year. These revisions will reflect changes and improvements in data collection and availability. Additional information on the existing methodology used in the development of the CERCLA Priority List of Hazardous Substances can be found in the Support Document to the List and in the **Federal Register** notices mentioned above.

In addition to the revised priority list, ATSDR is also releasing a Completed Exposure Pathway Site Count Report. A completed exposure pathway (CEP) is an exposure pathway that links a contaminant source to a receptor population. The CEP ranking is very similar to a sub-component of the potential-for-human-exposure component of the listing algorithm. The CEP ranking is based on a site frequency count, and thus lists the number of sites at which a substance has been found in a CEP. ATSDR's HazDat database contains this information which is derived from ATSDR public health assessments and health consultations. Because exposure to hazardous substances is of significant concern, ATSDR is publishing this CEP report along with the CERCLA Priority List of Hazardous Substances. Since this CEP report focuses on documented exposure, it provides an important prioritization based on substances to which people are exposed.

The substances on the CEP report are similar to the substances on the CERCLA Priority List of Hazardous Substances. However, there are some substances that are on the CEP report

because they are frequently found in completed exposure pathways, but are not on the CERCLA Priority List because they have a very low toxicity (*e.g.*, sodium). Since the CERCLA Priority List incorporates three different components (toxicity, frequency of occurrence, and potential for human exposure) to determine its priority substances, substances with very low toxicity are not on the CERCLA Priority List and consequently are not the subject of toxicological profiles. In addition, since the Priority List is mandated by CERCLA, it only uses data from sites on the CERCLA National Priorities List, whereas the CEP report uses data from all sites with ATSDR activities that have a CEP. Of the 100 substances on the CEP report, the 25 substances found at the most number of sites in a CEP are presented below.

Substance name	Number of sites with substance in a CEP	
	All sites	NPL sites
Lead	386	251
Trichloroethylene	338	280
Arsenic	299	192
Tetrachloroethylene	251	198
Volatile Organic Compounds, Unspecified	187	129
Benzene	184	130
Cadmium	183	126
Chromium	178	121
Polychlorinated Biphenyls	168	111
Mercury	144	86
Manganese	144	84
Zinc	143	88
1, 1,1-Trichloroethane	128	108
Copper	125	73
Chloroform	116	90
1, 1-Dichloroethene	109	93
Polycyclic Aromatic Hydrocarbons	108	75
Benzo (A) Pyrene	105	55
Methylene Chloride	104	72
Nickel	102	65
Toluene	101	66
Vinyl Chloride	100	81
Barium	95	54
Antimony	92	58
1, 2-Dichloroethane	89	73

Note: Sorted by the ALL Sites column.

All Sites = all sites with ATSDR activities that have a CEP; NPL Sites = current and former sites on the National Priorities List, as mandated.

Dated: November 3, 2003.

Georgi Jones,

Director, Office of Policy and External Affairs, Agency for Toxic Substances and Disease Registry.

[FR Doc. 03–28094 Filed 11–6–03; 8:45 am]

BILLING CODE 4163–70–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention (CDC)

Advisory Committee on Childhood Lead Poisoning Prevention: Notice of Charter Renewal

This gives notice under the Federal Advisory Committee Act (Pub. L. 92–463) of October 6, 1972, that the Advisory Committee on Childhood Lead Poisoning Prevention, Centers for Disease Control and Prevention, of the Department of Health and Human Services, has been renewed for a 2-year period through October 31, 2005.

For information, contact Mary Jean Brown, R.N., ScD, Executive Secretary, Advisory Committee on Childhood Lead Poisoning Prevention, Centers for Disease Control and Prevention, of the Department of Health and Human Services, 4770 Buford Highway, M/S F 30 Chamblee, Georgia 30341, telephone 404–498–1442.

The Director, Management Analysis and Services Office has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry.

Dated: November 3, 2003.

Joseph E. Salter,

Acting Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 03–28030 Filed 11–6–03; 8:45 am]

BILLING CODE 4163–19–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Board of Scientific Counselors, National Center for Infectious Diseases: Notice of Charter Renewal

This gives notice under the Federal Advisory Committee Act (Pub. L. 92–463) of October 6, 1972, that the Board of Scientific Counselors, National Center for Infectious Diseases, Centers for Disease Control and Prevention (CDC), Department of Health and Human Services, has been renewed for a 2-year period, extending through October 31, 2005.

For further information, contact Steve Ostroff, Executive Secretary, Board of Scientific Counselors, National Center for Infectious Diseases, Centers for Disease Control and Prevention, of the Department of Health and Human Services, 1600 Clifton Road, NE, M/S C–12, Atlanta, Georgia 30333, telephone 404–639–3967 or fax 404–639–3039.

The Director, Management Analysis and Services Office, has been delegated

the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities for both CDC and ATSDR.

Dated: November 3, 2003.

Joseph E. Salter,

Acting Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 03–28029 Filed 11–6–03; 8:45 am]

BILLING CODE 4163–19–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Public Health Genetics Fellowship

Announcement Type: New.

Funding Opportunity Number: 04059.

Catalog of Federal Domestic Assistance Number: 93.283.

Key Dates:

Letter of Intent Deadline: November 26, 2003.

Application Deadline: December 22, 2003.

I. Funding Opportunity Description

Authority: This program is authorized under Sections 301, 317(C), and 317(G) of the Public Health Service Act, (42 U.S.C. Sections 241, 247b–4, and 247b–8, as amended).

Purpose: The purpose of the program is to establish a cooperative agreement for co-sponsoring a Public Health Genetics Fellowship Program for genetics professionals to be located at the Centers for Disease Control and Prevention (CDC), in Atlanta, GA or other CDC locations. The intent of this program is to introduce genetics professionals to opportunities in public health genetics through education, training and career-enhancing experiences.

Fellowship candidates will include genetics professionals who are at the doctoral (MD and PhD) and master's levels. Typical fellowships for genetics professionals who recently completed their training will be for a maximum of two years. For mid-career professionals, typical fellowships will be for one year, although appointments of less than one year may be made under special circumstances. Varying lengths of time for fellowship appointments will be considered on the basis of CDC and project needs.

This program addresses the "Healthy People 2010" focus areas of: Arthritis, Osteoporosis, and Chronic Back Conditions; Cancer; Chronic Kidney Disease; Diabetes; Disability and Secondary Conditions; Heart Disease and Stroke; HIV; Immunization and Infectious Diseases; Maternal, Infant, and Child Health; Mental Health and Mental Disorders; Nutrition and Overweight; Oral Health; Respiratory Diseases; and Vision and Hearing.

Measurable outcomes of the program will be in alignment with the following performance goal for CDC: To develop career opportunities for genetics professionals in association with the recipient organization to work across CDC program areas to improve knowledge concerning genetics-related disease and disability; and to identify causes and risk factors for these conditions in order to develop prevention strategies and evaluate their effectiveness.

Activities

Recipient activities for this program are as follows:

- In collaboration with CDC, assist with planning and implementation of a fellowship program for genetic professionals in public health. The target number of fellows for this project is up to two a year, although this may be increased if additional funds become available. This plan should include the recruitment, training and mentoring of fellows under the program.
- Provide a senior staff member to serve as co-director to lead fellowship recruitment and assist in the selection and mentoring of fellows.
- Identify and recruit fellowship candidates with expertise in appropriate topic areas and implement a recruitment plan through advertisements, announcements, professional associations, and complementary training programs.
- Assist CDC in the selection of candidates appropriate for the public health genetics fellowship program. Selection of candidates will be made by a committee comprised of members of the recipient organization in conjunction with CDC.
- Provide opportunities for fellows to present their fellowship work and participate in national networking, policy development conferences, and workshops to expand professional growth and skill levels.
- Provide salary and benefits commensurate with the background and experience for fellows selected in the program. This includes recipient support of related costs for the fellowships, including travel and training expenses; and for recipient staff salaries and related technical and administrative costs.
- Collect and report to CDC information on status of fellows for up to five years after completion of the fellowship program in order to assess the impact of the fellowship program on public health genetics.

In a cooperative agreement, CDC staff is substantially involved in the program activities, above and beyond routine grant monitoring. CDC Activities for this program are as follows:

- Assist in the development and implementation of the overall fellowship plan and training program. In that regard, CDC will provide a senior staff member to serve as fellowship co-director in the planning and conduct of the program.
- Provide formal and informal training opportunities to the recipient organization and the assigned fellows.
- Coordinate and facilitate the placement of fellows with appropriate advanced training opportunities at CDC.
- Provide supervisory and mentoring support to fellows to assure optimal developmental experiences under the fellowship assignments.

II. Award Information

Type of Award: Cooperative Agreement. CDC involvement in this program is listed in the Activities Section above.

Fiscal Year Funds: 2004.

Approximate Total Funding: $125,000. This funding level will be modified based on the number of fellowship positions available at CDC, and the capacity of the recipient to provide highly qualified candidates for the fellowship program.

Approximate Number of Awards: One.

Anticipated Award Date: March 1, 2004.

Budget Period Length: 12 months.

Project Period Length: Five years. Throughout the project period, CDC's commitment to continuation of awards will be conditioned on the availability of funds, evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the Federal Government.

III. Eligibility Information

Eligible applicants: Assistance will be provided only to a national non-profit organization. This announcement is limited to national non-profit organizations since they would have the capacity to recruit and place doctoral and master's level professionals in career-enhancing programs outside the individual educational institution or place of employment. A national

organization would also have the established ability to recruit throughout the nation.

Other Eligibility Requirements: If your application is incomplete or non-responsive to the requirements listed below, it will not be entered into the review process. You will be notified that your application did not meet the submission requirements.

CDC plans to make one award to a leading organization/institution which: (1) Has documented access to large number of doctoral students, genetics residents, and genetics professionals in a broad range of areas related to genetics and public health: including but not limited to; cytogenetics, molecular genetics, biochemical genetics, clinical genetics, genetic counseling, population genetics, and genetic epidemiology; and (2) demonstrates a well-established capacity through documented collaborations and affiliations with training programs such as genetic counseling training programs, genetics residencies, and association memberships to enable recruitment of highly qualified candidates for the fellowship program.

Cost Sharing or Matching: Matching funds are not required for this program.

Note: Title 2 of the United States Code Section 1611 states that an organization described in Section 501(c)(4) of the Internal Revenue Code that engages in lobbying activities is not eligible to receive Federal funds constituting an award, grant, or loan.

IV. Application and Submission Information

Letter of Intent (LOI)

CDC requests that you send a LOI if you intend to apply for this program. The LOI will be used only to gauge the level of interest in this program, and to allow CDC to plan the application review. Failure to submit a LOI does NOT preclude you from submitting an application. The LOI must be written in the following format:

- Maximum number of pages: Two.
- Font size: 12-point unreduced.
- Paper size: 8.5 by 11 inches.
- Page margin size: One-inch margins.
- Printed only on one side of page
- Single spaced
- Written in English, avoid jargon

The LOI must contain the following information: Name, address, and telephone number of the proposed Principal Investigator, number and title of this program announcement, names of other key personnel, designations of collaborating institutions and entities, and an outline of the proposed work, recruitment approach, and expected outcomes.

LOI Deadline Date: November 26, 2003.

LOI Submission Address: Submit your LOI by express delivery service, or e-mail to: Sonja Rasmussen, M.D., M.S., Associate Director for Science, National Center on Birth Defects and Developmental Disabilities, CDC, 1600 Clifton Road, Mailstop E–86, Atlanta, GA 30333, E-Mail Address: *skr9@cdc.gov,* Telephone: 404–498–3908.

How to Obtain Application Forms: To apply for this funding opportunity use application form PHS 5161. Forms, applications, and instructions are available on the CDC Web site, at the following Internet address: *http://www.cdc.gov/od/pgo/forminfo.htm*

If you do not have access to the Internet, or if you have difficulty accessing the forms on-line, you may contact the CDC Procurement and Grants Office Technical Information Management Section (PGO–TIM) staff at: 770–488–2700. Application forms can be mailed to you.

Content and Form of Submission: This program announcement is the definitive guide on application format, content, and deadlines. It supersedes information provided in the application instructions. If there are discrepancies between the application form instructions and the program announcement, adhere to the guidance in the program announcement.

You are required to have a Dun and Bradstreet Data Universal Numbering System (DUNS) number to apply for a grant or cooperative agreement from the Federal government. The DUNS number is a nine-digit identification number, which uniquely identifies business entities. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access *http://www.dunandbradstreet.com* or call 1–866–705–5711.

For more information, see the CDC Web site at: *http://www.cdc.gov/od/pgo/funding/pubcommt.htm* If your application form does not have a DUNS number field, please write your DUNS number at the top of the first page of your application, and/or include your DUNS number in your application cover letter.

You must submit a signed original and two copies of your application forms. The application should include a separate typed abstract of the proposal consisting of no more than one single-spaced page. The application should include a table of contents for the project narrative and all related attachments.

The application must include a project narrative with your application forms. Your narrative must be submitted in the following format:

- Maximum number of pages: 20. If your narrative exceeds the page limit, only the first pages which are within the page limit will be reviewed.
- Font size: 12 point unreduced
- Paper size: 8.5 by 11 inches
- Page margin size: one-inch margins
- Printed only on one side of page
- Single-spaced
- Held together only by rubber bands or metal clips; not bound in any other way.

Your narrative should address activities to be conducted over the entire project period, and must include the items cited under Evaluation Criteria.

Funding restrictions, which must be taken into account while writing your budget are that project funds cannot be used to supplant other available applicant or collaborating agency funds, for construction, or for lease or purchase of facilities or space.

If you are requesting indirect costs in your budget, you must include a copy of your indirect cost rate agreement. If your indirect cost rate is a provisional rate, the agreement must be less than 12 months from the application due date.

Guidance for completing your budget can be found on the CDC Web site, at the following Internet address: *http://www.cdc.gov/od/pgo/funding/budgetguide.htm*

Additional information may be included in the application appendices. The appendices will not be counted toward the narrative page limit. This additional information may include curriculum and resumes for key project staff, organizational charts, letters of support, *etc.;* and should be limited to those items relevant to the requirements of this announcement.

Submission Date, Time, and Address:

Application Deadline Date: December 22, 2003.

Application Submission Address: Submit your application by mail or express delivery service to: Technical Information Management—PA 04059, Procurement and Grants Office, 2920 Brandywine Road, Atlanta, GA 30341. Applications may not be submitted by fax or e-mail at this time.

Explanation of Deadlines: Applications must be received in the CDC Procurement and Grants Office by 4 p.m. Eastern Time on the deadline date. If you send your application by the United States Postal Service or commercial delivery service, you must ensure that the carrier will be able to guarantee delivery of the application by the closing date and time. If CDC receives your application after closing

due to: (1) Carrier error, when the carrier accepted the package with a guarantee for delivery by the closing date and time, or (2) significant weather delays or natural disasters, you will be given the opportunity to submit documentation of the carriers guarantee. If the documentation verifies a carrier problem, CDC will consider the application as having been received by the deadline.

This program announcement is the definitive guide on application format, content, and deadlines. It supersedes information provided in the application instructions. If your application does not meet the deadline above, it will not be eligible for review, and will be discarded. You will be notified that you did not meet the submission requirements.

If you have a question about the receipt of your application, first contact your courier. CDC will not notify you by mail upon receipt of your application, but if you still have any-questions, contact the PGO-TIM staff at: 770–488–2700. Before calling, please wait three days after the application deadline. This will allow time for applications to be processed and logged.

Intergovernmental Review of Applications: Executive Order 12372 does not apply to this program.

V. Application Review Information

Review Criteria: You are required to provide measures of outcome and effectiveness that will demonstrate the accomplishment of the various identified objectives of the cooperative agreement. Measures of effectiveness must relate to the performance goals stated in the "Purpose" section of this announcement. Measures must be objective and quantitative, and must measure the intended outcome. These measures of effectiveness must be submitted with the application and will be an element of evaluation.

Under the evaluation criteria noted below, applicants must describe precisely how they will conduct the project toward identifying and recruiting fellows in conjunction with placement opportunities at CDC, what collaborators and national affiliations are now in place to facilitate such recruitment, and how the proposed work plan will assure effective conduct of all components of the work in a timely and successful manner.

Your application will be evaluated against the following criteria:

- Organizational experience that indicates the extent of current work in the training and development of genetics professionals, and the documented capacity to identify potential fellows for inclusion in this program. (35 Points)
- Convincing evidence of, and the extent to which national collaborations, affiliations, association memberships, and internal and external outreach systems are in place for immediate and effective fellowship recruitment and placement. (25 Points)
- Approach and methods to be utilized to conduct all aspects of the project as required under this announcement. (20 Points)
- Project timelines, work plan, and the performance measures to be employed and measured. (10 Points)
- Evaluation plan to assess individual components and the overall goals and objectives of the cooperative agreement. (10 Points)
- Budget (Not Scored). This criteria includes the degree to which the budget is reasonable, clearly justified, accurate, and consistent with the purposes of this announcement. The budget justification will not be counted in the stated page limit.

Review and Selection Process: An objective review panel will evaluate your application according to the criteria listed above.

VI. Award Administration Information

Award Notices: If your application is to be funded, you will receive a Notice of Grant Award (NGA) from the CDC Procurement and Grants Office. The NGA shall be the only binding, authorizing document between the recipient and CDC. The NGA will be signed by an authorized Grants Management Officer, and mailed to the recipient fiscal officer identified in the application.

Administrative and National Policy Requirements

45 CFR Part 74 and 92

For more information on the Code of Federal Regulations, see the National Archives and Records Administration at the following Internet address: *http://www.access.gpo.gov/nara/cfr/cfr-table-search.html*

The following additional requirements apply to this project:

- AR–9 Paperwork Reduction Act Requirements.
- AR–10 Smoke-Free Workplace Requirements.
- AR–11 Healthy People 2010.
- AR–12 Lobbying Restrictions.
- AR–14 Accounting System Requirements.
- AR–15 Proof of Non-Profit Status.
- AR–16 Security Clearance Requirement.

Additional information on these requirements can be found on the CDC Web site at the following Internet address: *http://www.cdc.gov/od/pgo/funding/ARs.htm.*

Reporting Requirements

You must provide CDC with an original, plus two copies of the following reports:

1. Interim progress report, no less than 90 days before the end of the budget period. The progress report will serve as your non-competing continuation application, and must contain the following elements:

a. Current budget period activities objectives.

b. Current budget period financial progress.

c. New budget period program proposed activity objectives.

d. Detailed line-item budget and justification.

e. Additional requested information.

2. Financial status report, no more than 90 days after the end of the budget period.

3. Final financial and performance reports, no more than 90 days after the end of the project period.

VII. Agency Contacts

For general questions about this announcement, contact: Technical Information Management Section (PGO–TIM), Procurement and Grants Office, 2920 Brandywine Road, Atlanta, GA 30341, Telephone: 770–488–2700.

For program technical assistance, contact: Sonja Rasmussen, M.D., M.S., Associate Director for Science, National Center on Birth Defects and Developmental Disabilities, CDC, 1600 Clifton Road, Mailstop E–86, Atlanta, GA 30333, E-Mail Address: *skr9@cdc.gov,* Telephone: 404–498–3908.

For budget assistance, contact: Susan Kiddo, Grants Management Officer, CDC Procurement and Grants Office, 2920 Brandywine Road, Atlanta, GA 30341, Telephone: 770–488–2605, E-mail: *scb7@cdc.gov.*

Dated: November 3, 2003.

Edward Schultz,

Acting Director, Procurement and Grants Office, Centers for Disease Control and Prevention.

[FR Doc. 03–28022 Filed 11–6–03; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

The Advisory Committee to the Director of the National Center for Environmental Health of the Centers for Disease Control and Prevention: Meeting

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention (CDC) announce the following committee meeting.

NAME: Advisory Committee to the Director (ACD), National Center for Environmental Health (NCEH).

TIME AND DATES: 1 p.m.–5:30 p.m., December 1, 2003; 8:30 a.m.–4: 30 p.m., December 2, 2003.

PLACE: Hilton Atlanta Hotel, 255 Courtland Street, NE., Atlanta, GA 30303.

STATUS: Open to the public for observation, limited only by the space available. The meeting room accommodates approximately 100 people.

PURPOSE: The Secretary, and by delegation, the Director of the Centers for Disease Control and Prevention, are authorized under Section 301 (42 U.S.C. 241) and Section 311 (42 U.S.C. 243) of the Public Health Service Act, as amended, to (1) conduct, encourage, cooperate with, and assist other appropriate public authorities, scientific institutions, and scientists in the conduct of research, investigations, experiments, demonstrations, and studies relating to the causes, diagnosis, treatment, control, and prevention of physical and mental diseases and other impairments; (2) assist states and their political subdivisions in the prevention of infectious diseases and other preventable conditions and in the promotion of health and well being; and (3) train state and local personnel in health work.

MATTERS TO BE DISCUSSED: The agenda items for the meeting on December 1–2, 2003, will include but are not limited to an update and discussions on the consolidation of NCEH and the Agency for Toxic Substances and Disease Registry (ATSDR); review of discussions for consolidating the ATSDR Board of Scientific Counselors (BSC) and the ACD, NCEH; discussion on peer review background and process; and an overview of existing ACD and BSC subcommittees and working groups. Agenda items are tentative and subject to change.

FOR FURTHER INFORMATION CONTACT: Individuals interested in attending the meeting, please contact Priscilla Patin, CMP, Program Analyst, CDC, 4770 Buford Highway NE, MS F–29, Atlanta, Georgia 30341–3724; telephone 770–488–7629, fax 770–488–7024; e-mail: *ppatin@cdc.gov*. The deadline for notification of attendance is November 24, 2003.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities for both CDC and the Agency for Toxic Substances and Disease Registry.

Dated: November 3, 2003.

Joseph E. Salter,

Acting Director, Management Analysis and Services Office, Centers for Disease Control and Prevention (CDC).

[FR Doc. 03–28028 Filed 11–6–03; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention (CDC) announces the following Federal advisory committee meeting.

Name: National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect (NTFFASFAE).

Times and Dates: 8:30 a.m.–4:30 p.m., December 8, 2003. 8:30 a.m.–12:30 p.m., December 9, 2003.

Place: Swissotel, 3391 Peachtree Road, NE., Atlanta, Georgia 30326, telephone 404/365–0065, fax 404/365–8787.

Status: Open to the public, limited only by the space available. The meeting room accommodates approximately 65 people.

Purpose: The Secretary is authorized by the Public Health Service Act, Section 399G, (42 U.S.C. Section 280f, as added by Public Law 105–392) to establish a National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect to: (1) Foster coordination among all governmental agencies, academic bodies and community groups that conduct or support Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effect (FAE) research, programs and surveillance; and (2) to otherwise meet the general needs of populations actually or potentially impacted by FAS and FAE.

Matters to be Discussed: Agenda items include: Discussions will focus on defining essential services needed for children with FAS and other alcohol-related conditions, strategies for improving access to these services for affected children and families; presentations will include success stories of children with FAS that focus on their strengths. Additional agenda items include: An update on activities from the National Center on Birth Defects and Developmental Disabilities; the Interagency Coordinating Committee on Fetal Alcohol Syndrome; new research and program updates from the CDC and other Federal agencies; working group updates; future topics, and scheduling the next meeting. Agenda items are subject to change as priorities dictate.

FOR FURTHER INFORMATION CONTACT: R. Louise Floyd, DSN, RN, Designated Federal Official, National Center on Birth Defects and Developmental Disabilities, CDC, 1600 Clifton Road, NE., (E–86), Atlanta, Georgia 30333, telephone 404/498–3923, fax 404/498–3040.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities for both the CDC and ATSDR.

Dated: November 3, 2003.

Joseph E. Salter,

Acting Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 03–28025 Filed 11–6–03; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[Document Identifier: CMS–565, CMS–9044, CMS–P–0015A, CMS–1491, CMS–R–13, CMS–R–246, CMS–R–204, CMS–304 and 304a]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare and Medicaid Services.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare and Medicaid Services (CMS) (formerly known as the

Health Care Financing Administration (HCFA)), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

1. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare Qualification Statement for Federal Employees and Supporting Regulations in 42 CFR 406.15; *Form No.:* CMS–565 (OMB# 0938–0501); *Use:* The CMS–565 is completed by individuals filing for hospital insurance ([HI] Part A) benefits based upon their federal employment. This information is needed to determine if SSA/CMS can use (deem) federal employment prior to 1983 to provide quarters of coverage so the individual can qualify for free hospital insurance.; *Frequency:* Other: One-time-only; *Affected Public:* Individuals or Households, Federal Government, State, Local, or Tribal Government; *Number of Respondents:* 4,300; *Total Annual Responses:* 4,300; *Total Annual Hours:* 717.

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Provider Reimbursement Manual, Part 1—Chapter 27, Sections 2721, 2722 and 2725, Request for Exception to End Stage Renal Disease Composite Rates and Supporting Regulations in 42 CFR 413.170 and 413.184; *Form No.:* CMS–9044 (OMB# 0938–0296); *Use:* This information collection describes the information End Stage Renal Disease facilities must submit in justifying an exception request to their composite rate for outpatient dialysis services; *Frequency:* On occasion; *Affected Public:* Business or other for-profit, Not-for-profit institutions, and Federal Government; *Number of Respondents:* 125; *Total Annual Responses:* 125; *Total Annual Hours:* 6,000.

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare Current Beneficiary Survey (MCBS): Rounds 38–46; *Form No.:* CMS–P–0015A (OMB# 0938–0568); *Use:* The MCBS is a continuous, multipurpose survey of a nationally representative sample of aged and disabled persons enrolled in Medicare. The survey provides a comprehensive source of information on beneficiary characteristics, needs, utilization, and satisfaction with Medicare-related activities; *Frequency:* Other: 3 times a year; *Affected Public:* Individuals or Households, Business or other for-profit, and Not-for-profit institutions; *Number of Respondents:* 16,500; *Total Annual Responses:* 49,500; *Total Annual Hours:* 50,325.

4. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Request for Medicare Payment—Ambulance and Supporting Regulations in 42 CFR Sections 410.1, 410.40, 424.124, 414.601, 414.605, 414.610, 414.611, 414.615, 414.620, and 414.625; *Form No.:* CMS–1491 (OMB# 0938–0042); *Use:* This paper form is completed on an occasion basis by beneficiaries and/or ambulance suppliers. Also, it is submitted to a Medicare carrier to request payment for ambulance services; Frequency: On occasion; *Affected Public:* Business or other for-profit, Individuals or Households, and Not-for-profit institutions; *Number of Respondents:* 9,301,183; *Total Annual Responses:* 9,301,183; Total Annual Hours: 390,493.

5. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Conditions of Coverage for Organ Procurement Organizations (OPOs) and Supporting Regulations in 42 CFR, Sections 486.304, 486.306, 486.307, 486.310, 486.316, 486.318, and 486.325; *Form No.:* CMS–R–13 (OMB# 0938–0688); *Use:* Organ Procurement Organizations are required to submit accurate data to CMS concerning population and information on donors and organs on an annual basis in order to assure maximum effectiveness in the procurement and distribution of organs; *Frequency:* Annually; *Affected Public:* Not-for-profit institutions; *Number of Respondents:* 59; *Total Annual Responses:* 59; *Total Annual Hours:* 59,000.

6. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare Consumer Assessment of Health Plan Survey—Medicare + Choice (CAHPS–M+C); *Form No.:* CMS–R–246(OMB# 0938–0732); *Use:* Under the Balanced Budget Act of 1997, CMS is required to provide general and plan comparative information to beneficiaries that will help them make more informed health plan choices. A CAHPS fee-for-service survey is needed to provide information comparable to those data collected from the CAHPS managed care survey; *Frequency:* Annually; *Affected Public:* Individuals or Households; *Number of Respondents:* 168,000; *Total Annual Responses:* 168,000; *Total Annual Hours:* 55,450.

7. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Data Collection for the Second Generation Social Health Maintenance Organization Demonstration; *Form No.:* CMS–R–204 (OMB# 0938–0709; *Use:* The Centers for Medicare and Medicaid Services will continue to use the data collected under this effort to support the operational needs of the congressionally mandated and administratively extended Second Generation of the Social Health Maintenance Organization Demonstration.; *Frequency:* Annually; *Affected Public:* Individuals or Households; *Number of Respondents:* 15,000; *Total Annual Responses:* 15,000; *Total Annual Hours:* 4,950.

8. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicaid Drug Rebate; *Form No.:* CMS–304 and 304a (0938–0676); *Use:* Section 1927 of the Social Security Act requires State Medicaid agencies to report to drug manufacturers and CMS on the drug utilization for their State and the amount of rebate to be paid by the manufacturer; *Frequency:* Quarterly; *Affected Public:* State, local, or tribal government; *Number of Respondents:* 51; *Total Annual Responses:* 204; *Total Annual Hours:* 6,125.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS's Web site address at *http://cms.hhs.gov/regulations/pra/default.asp*, or e-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@hcfa.gov*, or call the Reports Clearance Office on (410) 786–1326. Written comments and recommendations for the proposed information collections must be mailed within 60 days of this notice directly to the CMS Paperwork Clearance Officer designated at the following address: CMS, Office of Strategic Operations and

Regulatory Affairs, Division of Regulations Development and Issuances, Attention: Melissa Musotto, Room C5–14–03, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: October 30, 2003.

Julie Brown,

CMS Reports Clearance Officer, Office of Strategic Operations and Strategic Affairs, Division of Regulations Development and Issuances.

[FR Doc. 03–28090 Filed 11–6–03; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[Document Identifier: CMS–576, CMS–3427, CMS–R–282, CMS–372S]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Centers for Medicare and Medicaid Services, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare and Medicaid Services (CMS) (formerly known as the Health Care Financing Administration (HCFA), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

1. *Type of Information Collection Request:* Extension of a currently approved collection;

Title of Information Collection: Organ Procurement Organization (OPO) Request for Designation and Supporting Regulations in 42 CFR 486.304, 486.306, and 486.307; *Form No.:* CMS–576 (OMB# 0938–0512); *Use:* The information provided on this form serves as a basis for certifying OPOs for participation in the Medicare and Medicaid programs and will indicate whether the OPO is meeting the specified performance standards for reimbursement of service; *Frequency:* Annually; *Affected Public:* Business or other for-profit, and Not-for-profit institutions; *Number of Respondents:* 59; *Total Annual Responses:* 59; *Total Annual Hours:* 118.

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* End Stage Renal Disease Application and Survey and Certification Report and Supporting Regulations in 42 CFR 488.60; *Form No.:* CMS–3427 (OMB# 0938–0360); *Use:* Part I of this form is a facility identification and screening measurement used to initiate the certification and recertification of ESRD facilities. Part II is completed by the Medicare/Medicaid State survey agency to determine facility compliance with ESRD conditions for coverage; *Frequency:* Every three years; *Affected Public:* Business or other for-profit institutions, Not-for-profit institutions; *Number of Respondents:* 4000; *Total Annual Responses:* 1,320; *Total Annual Hours:* 440.

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare + Choice (M+C) Organization Appeals and Grievance Data Disclosure Requirements and Supporting Regulations in 42 CFR 422.64, 422.111, and 422.560–422.626; *Form No.:* CMS–R–282 (OMB# 0938–0778); Use: M+C organizations will collect information on appeals and grievance dispositions to help CMS monitor plan performance and to provide information to beneficiaries to help them make informed decisions about their or potential health plans' performance; *Frequency:* Semi-Annually; *Affected Public:* Business or other for-profit; *Number of Respondents:* 211 T*Total Annual Responses:* 422 *Total Annual Hours:* 422.

4. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Annual Report on Home and Community Based Services Waivers and Supporting Regulations in 42 CFR 440.180 and 441.300-.310; *Form No.:* CMS–372(S) (OMB# 0938–0272); *Use:* States request waivers in order for beneficiaries to have the option of receiving hospital services in their homes. States with an approved waiver under section 1915(c) of the Act are required to submit the CMS–372(S) annually in order for CMS to: (1) Verify that State assurances regarding waiver cost-neutrality are met, and (2) determine the waiver's impact on the type, amount and cost of services provided under the State plan and health and welfare of recipients; *Frequency:* Annually; *Affected Public:* State, local or tribal government; *Number of Respondents:* 50; T*Total Annual Responses:* 277; *Total Annual Hours:* 20,775.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS Web site address at *http://cms.hhs.gov/regulations/pra/default.asp*, or E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@hcfa.gov*, or call the Reports Clearance Office on (410) 786–1326. Written comments and recommendations for the proposed information collections must be mailed within 30 days of this notice directly to the OMB desk officer: OMB Human Resources and Housing Branch, Attention: Brenda Aguilar, New Executive Office Building, Room 10235, Washington, DC 20503.

Dated: October 30, 2003.

Julie Brown,

CMS Reports Clearance Officer, Office of Strategic Operations and Strategic Affairs, Division of Regulations Development and Issuances.

[FR Doc. 03–28091 Filed 11–6–03; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 2003N–0482]

Agency Information Collection Activities; Proposed Collection; Comment Request; Mammography Facilities, Standards, and Lay Summaries for Patients

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing an opportunity for public comment on the proposed collection of certain information by the agency. Under the Paperwork Reduction Act of 1995 (the PRA), Federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension of an existing information collection, and to allow 60 days for public comment in response to the notice. This notice solicits comments on

information collection requirements for mammography facilities, standards, and lay summaries for patients under part 900 (21 CFR part 900).

DATES: Submit written or electronic comments on the collection of information by January 6, 2004.

ADDRESSES: Submit electronic comments on the collection of information to: *http://www.fda.gov/dockets/ecomments.* Submit written comments on the collection of information to the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852. All comments should be identified with the docket number found in brackets in the heading of this document.

FOR FURTHER INFORMATION CONTACT: Peggy Robbins, Office of Management Programs (HFA–250), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–827–1223.

SUPPLEMENTARY INFORMATION: Under the PRA (44 U.S.C. 3501–3520), Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. "Collection of information" is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires Federal agencies to provide a 60-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, FDA is publishing notice of the proposed collection of information listed below.

With respect to the following collection of information, FDA invites comments on these topics: (1) Whether the proposed collection of information is necessary for the proper performance of FDA's functions, including whether the information will have practical utility; (2) the accuracy of FDA's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques, when appropriate, and other forms of information technology.

Mammography Facilities, Standards, and Lay Summaries for Patients—21 CFR Part 900 (OMB Control Number 0910–0309)—Extension

Public Law 102–539, the Mammography Quality Standards Act of 1992 (MQSA) (42 U.S.C. 263b) as amended by the Mammography Quality Standards Reauthorization Act (MQSRA) of 1998 (Public Law 105–248) establishes the authority for a Federal certification and inspection program for mammography facilities; regulations and standards for accreditation bodies for mammography facilities; and standards for mammography equipment, personnel, and practices, including quality assurance. MQSRA extended the life of the MQSA program for 4 years from its original expiration date of 1998 until 2002, and also modified some of the provisions. The most significant modification from a report and recordkeeping viewpoint under § 900.12(c)(2) was that mammography facilities were required to send a lay summary of each examination to the patient.

FDA, under this regulation, collects information from accreditation bodies and mammography facilities by requiring each accreditation body to submit an application for approval and to establish a quality assurance program. On the basis of accreditation, facilities are certified by FDA and must prominently display their certificate. FDA uses the information to ensure that private, nonprofit organizations or State agencies meet the standards established by FDA for accreditation bodies to accredit facilities that provide mammography services. Information collected from mammography facilities has also been used to ensure that the personnel, equipment, and quality systems has and continues to meet the regulations under MQSA and will be used by patients to manage their health care properly. The intent of these regulations is to assure safe, reliable, and accurate mammography on a nationwide level. The most likely respondents to this information collection will be accreditation bodies and mammography facilities seeking certification.

FDA estimates the burden of this collection of information as follows:

TABLE 1.—ESTIMATED ANNUAL RECORDING BURDEN[1]

21 CFR Section	Number of Respondents	Annual Frequency per Response	Total Annual Responses	Hours per Response	Total Hours	Total Capital Costs	Total Operating and Maintenance Costs
900.3	1	0.33	0.33	60	20		
900.3(b)(3)	1	0.33	0.33	60	20	$50	
900.3(c)	5	0.33	1.67	15	25		
900.3(e)	1	0.1	0.1	1	0.1		
900.3(f)(2)	1	0.1	0.1	200	20		
900.4(c) and (d)	9,200	0.33	3,067	1	3,067		
900.4(e)	9,450	1	9,450	8	75,600		
900.4(f)	276	1	276	7	1,932		
900.4(h)	5	1	6,130	1	6,130		
900.4(i)(2)	1	0.33	0.33	1	0.33		

TABLE 1.—ESTIMATED ANNUAL RECORDING BURDEN[1]—Continued

21 CFR Section	Number of Respondents	Annual Frequency per Response	Total Annual Responses	Hours per Response	Total Hours	Total Capital Costs	Total Operating and Maintenance Costs
900.6(c)(1)	1	0.1	0.1	1	0.1		
900.11(b)(1)	9,200	0.33	3,067	2	6,134		
900.11(b)(2)	250	1	250	2	500		
900.11(b)(3)	5	1	5	.5	2.5		
900.11(c)	9,200	0.04	368	5	1,840		$1,000
900.12(c)(2)	9,200	3,478	36,000,000	5 Minutes	3,000,000		
900.12(j)(1)	25	1	25	1	25		
900.12(j)(2)	25	0.08	2	50	100		
900.15(c)	9,200	0.05	46	2	92		
900.15(d)(3)(ii)	9,200	0.0001	0.92	2	1.8		$10
900.18(c)	9,300	0.00032	3	2	6		$30
900.18(e)	10	0.0100	0.1	1	0.1		$10
FDA Form 3422	800	1	800	.25	200		
TOTAL					3,095,716	$50	$1,040

TABLE 2.—ESTIMATED ANNUAL RECORDKEEPING BURDEN[1]

21 CFR Section	Number of Recordkeepers	Annual Frequency of Recordkeeping	Total Annual Records	Hours per Recordkeeper	Total Hours	Total Operating and Maintenance Costs
900.3(f)(1)	5	0.02	0.1	200	20	
900.4(g)	1	0.33	0.33	1	0.33	
900.12(c)(4)	9,200	1	9,200	1	9,200	$18,400
900.12(e)(13)	9,200	52	478,400	0.125	59,800	
900.12(f)	9,200	1	9,200	5	46,000	
900.12(h)	9,200	2	18,400	0.5	9,200	
TOTAL					124,220	$18,400

The most likely respondents to this information collection will be accreditation bodies and mammography facilities seeking certification.

The total capital cost associated with these regulations is $50 (§ 900.3(b)(3)). This is a one-time start up cost associated with the application for approval as an accreditation body.

The total operating and maintenance cost associated with these requirements is: $19,440. This is the cost that facilities bear to maintain records under the initial and final mammography regulations.

Dated: November 3, 2003.

Jeffrey Shuren,

Assistant Commissioner for Policy.

[FR Doc. 03–28006 Filed 11–6–03; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 1999N–1168]

Relative Risk to Public Health From Foodborne Listeria Monocytogenes Among Selected Categories of Ready-to-Eat Foods; Quantitative Risk Assessment and Risk Management Action Plan; Notice of Public Meeting

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice of meeting.

SUMMARY: The Food and Drug Administration (FDA) of the Department of Health and Human Services (HHS) is announcing a public meeting to present the "Quantitative Assessment of the Relative Risk to Public Health from Foodborne *Listeria monocytogenes* Among Selected Categories of Ready-to-Eat Foods" and to present information relative to the risk management action plan that has been updated in light of the results of the risk assessment. The risk assessment was conducted by FDA in cooperation with the Food Safety and Inspection Service (FSIS) of the U.S. Department of Agriculture and in consultation with the Centers for Disease Control and Prevention (CDC) of HHS. The notice of availability of the risk assessment was published in the **Federal Register** on October 24, 2003 (68 FR 61006). This public meeting is intended to provide clarification about the results of the risk assessment and information as to how the risk assessment may be utilized. Stakeholders will have an opportunity to ask questions about the risk assessment and the risk management action plan. Questions may also be submitted in advance of the public meeting (see the *Contact* section of this document).

Date and Time: The meeting will be held on December 4, 2003, from at 8:30 a.m. to 5 p.m. Registration and requests for formal oral presentations by December 2, 2003.

Location: The meeting will be held at the FDA/CFSAN Harvey W. Wiley Building, 1500 Paint Branch Pkwy., College Park, MD 20740–3835.

Contact: Lori Pisciotta, Center for Food Safety and Applied Nutrition (CFSAN) (HFS–006), Food and Drug Administration, 5100 Paint Branch Pkwy., College Park, MD, 301–436–2279, FAX: 301–436–2630, e-mail: *lpisciot@cfsan.fda.gov*.

Registration and Requests for Oral Presentation: Send registration information (including name, title, firm name, address, telephone and fax number), to the contact person by December 2, 2003. Interested persons may present data, information, or views orally or in writing, on the issue. If you desire to make a formal oral presentation, you should notify the contact person before December 2, 2003, and be prepared to give a brief description of the general nature of the information you wish to present. Time allotted for each presentation may be limited. Written submissions must also be made to the contact person by December 2, 2003.

If you need special accommodations due to a disability, please contact Ms. Pisciotta (see the *Contact* section) at least 7 days in advance of the meeting.

Transcripts: Transcripts of the meeting may be requested in writing from the Freedom of Information Office (HFI–35), Food and Drug Administration, 5600 Fishers Lane, rm. 12A–16, Rockville, MD 20857, approximately 15 working days after the meeting at a cost of 10 cents per page.

SUPPLEMENTARY INFORMATION: FDA is announcing a public meeting on December 4, 2003, to present the "Quantitative Assessment of the Relative Risk to Public Health from Foodborne *Listeria monocytogenes* Among Selected Categories of Ready-to-Eat Foods" and the risk management action plan that has been updated in light of the risk assessment. In the **Federal Register** of January 19, 2001 (66 FR 5515), FDA and FSIS announced the availability of a draft *Listeria monocytogenes* risk assessment and a draft risk management plan based on the risk assessment. FDA, FSIS, and CDC held a public meeting on March 19, 2001, to receive comments on the technical aspects of the draft risk assessment on the relationship between foodborne *L. monocytogenes* and human health. Interested persons were given until March 20, 2001, with extensions to May 21, 2001, and to July 18, 2001, to comment on these documents. The risk assessment has been revised in response to public comments, newly available data, and updated modeling techniques, and was made available to the public in the **Federal Register** of October 24, 2003 (68 FR 61006). Comparable revisions also have been made to the draft risk management action plan.

Dated: October 31, 2003.

Jeffrey Shuren,

Assistant Commissioner for Policy.

[FR Doc. 03–28005 Filed 11–6–03; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 2003D–0493]

Draft Guidance for Industry on Powder Blends and Finished Dosage Units—Stratified In-Process Dosage Unit Sampling and Assessment; Availability

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the availability of a draft guidance for industry entitled "Powder Blends and Finished Dosage Units—Stratified In-Process Dosage Unit Sampling and Assessment." The draft guidance is intended to provide recommendations to manufacturers of human drug products on how to develop a single control procedure to demonstrate the adequacy of mix to ensure uniformity and homogeneity of in-process powder blends and finished dosage units.

DATES: Submit written or electronic comments on the draft guidance by March 8, 2004. General comments on agency draft guidance documents are welcome at any time.

ADDRESSES: Submit written requests for single copies of the draft guidance to the Division of Drug Information (HFD–240), Center for Drug Evaluation and Research, Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857. Send one self-addressed adhesive label to assist that office in processing your requests. Submit written comments on the draft guidance to the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852. Submit electronic comments to *http://www.fda.gov/dockets/ecomments*. See the **SUPPLEMENTARY INFORMATION** section for electronic access to the draft guidance document.

FOR FURTHER INFORMATION CONTACT: Jon Clark, Center for Drug Evaluation and Research (HFD–003), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–443–5103.

SUPPLEMENTARY INFORMATION:

I. Background

FDA is announcing the availability of a draft guidance for industry entitled "Powder Blends and Finished Dosage Units—Stratified In-Process Dosage Unit Sampling and Assessment." The draft guidance is intended to respond to industry concerns regarding FDA policies on demonstrating the adequacy of in-process powder mixing and uniform content in finished products under 21 CFR 211.110(a)(3).

In the **Federal Register** of August 27, 1999 (64 FR 46917), FDA published notice of the availability of a draft guidance for industry on blend uniformity analysis. Although FDA subsequently withdrew the draft guidance on May 17, 2002 (67 FR 35120), comments submitted on the draft guidance led to the formation of the Blend Uniformity Working Group (BUWG). The BUWG, which includes representatives from the agency, industry, and academia, conducted a public meeting on September 7 and 8,

2000, and developed a draft recommendation, "The Use of Stratified Sampling of Blend and Dosage Units to Demonstrate Adequacy of Mix for Powder Blends," which included the consensus reached by participants in this workshop. The *PDA Journal of Pharmaceutical Science and Technology* published the recommendation (March/April 2003, pp. 59–74). This draft guidance reflects CDER's effort to incorporate the recommendation into regulatory policy.

Stratified sampling is the selection of in-process dosage unit samples to specifically target locations in the compression/filling operation that have the greatest potential to yield extreme highs and lows in test results. The test results are used to monitor the manufacturing process output that is most responsible for causing finished product variability. These test results can be used to develop a single control procedure to ensure adequate powder mix and uniform content in finished products.

This draft guidance is being issued consistent with FDAs good guidance practices regulation (21 CFR 10.115). The draft guidance, when finalized, will represent the agency's current thinking on "Powder Blends and Finished Dosage Units—Stratified In-Process Dosage Unit Sampling and Assessment." It does not create or confer any rights for or on any person and does not operate to bind FDA or the public. An alternative approach may be used if such approach satisfies the requirements of the applicable statutes and regulations.

II. Comments

Interested persons may submit to the Division of Dockets Management (see **ADDRESSES**) written or electronic comments on the draft guidance. Two copies of mailed comments are to be submitted, except that individuals may submit one copy. Comments are to be identified with the docket number found in brackets in the heading of this document. The draft guidance and received comments are available for public examination in the Division of Dockets Management between 9 a.m. and 4 p.m., Monday through Friday.

III. Electronic Access

Persons with access to the Internet may obtain the document at either *http://www.fda.gov/cder/guidance/index.htm* or *http://www.fda.gov/ohrms/dockets/default.htm*.

Dated: October 31, 2003.

Jeffrey Shuren,

Assistant Commissioner for Policy.

[FR Doc. 03–28045 Filed 11–6–03; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 2003D–0204]

Guidance for Industry: Institutional Review Board Review of Stand-Alone Health Insurance Portability and Accountability Act Authorizations; Availability

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the availability of a document entitled "Guidance for Industry: IRB Review of Stand-Alone HIPAA Authorizations Under FDA Regulations," dated October 21, 2003. The guidance document provides clarification for institutional review boards (IRBs) of their responsibilities for reviewing and approving stand-alone authorizations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule. A stand-alone HIPAA authorization is a document used to obtain permission from an individual for a covered entity to use and/or disclose the individual's identifiable health information for a research study and that is not combined with an informed consent document to participate in the research itself. This guidance is intended to encourage IRBs to permit enrollment of subjects in clinical investigations without the IRB's prior review and/or approval of stand-alone HIPAA authorizations, even under circumstances in which the IRB's written procedures require such review and/or approval. Because FDA has determined that prior public participation is not feasible or appropriate, this guidance document will be implemented upon posting on FDA's Web site.

DATES: Submit written or electronic comments on agency guidances at any time.

ADDRESSES: Submit written comments on the guidance document to the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852.

Submit electronic comments to *http://www.fda.gov/dockets/ecomments*. See the **SUPPLEMENTARY INFORMATION** section for electronic access to the guidance document.

Submit requests for the guidance document to the Division of Dockets Management at the address provided. Your request should include the docket number in the heading of this document.

FOR FURTHER INFORMATION CONTACT: Catherine Lorraine, Office of the Commissioner (HF–11), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–827–3360.

SUPPLEMENTARY INFORMATION:

I. Background

FDA is announcing the availability of a document entitled "Guidance for Industry: IRB Review of Stand-Alone HIPAA Authorizations Under FDA Regulations," dated October 21, 2003. This guidance is similar to a guidance published by the Office of Civil Rights, Department of Health and Human Services (HHS), entitled "Privacy Guidance about Authorizations for Research and Institutional Review Boards," which is available on the HHS Web site at *http://www.hhs.gov/ocr/hipaa*. (FDA has verified the Web site address, but is not responsible for subsequent changes to the Web site after this document publishes in the **Federal Register**.) The Privacy Rule is a Federal regulation implementing certain provisions of the HIPAA (Public Law 104–191), that protects the privacy of certain health information (see 45 CFR parts 160 and 164). The Privacy Rule is a comprehensive set of minimum requirements intended to safeguard individually identifiable health information while permitting important research and health care activities to continue. The Privacy Rule went into effect on April 14, 2003.

The Privacy Rule establishes the right of individuals, including research subjects, to authorize the use and disclosure of their protected health information by signing an authorization form for uses and disclosures not otherwise permitted by the Privacy Rule (see 45 CFR 164.508). For example, in the context of a clinical investigation, a valid and properly executed HIPAA authorization explains the ways in which a subject's protected health information will be used and disclosed by the clinical investigator and permits the clinical investigator to use and disclose that information as specifically described in the authorization. An HIPAA authorization is different than a subject's informed consent in that an HIPAA authorization focuses on uses and disclosures of information that may

be made. Informed consent, on the other hand, apprises potential research subjects of the possible risks and benefits associated with participating in the clinical investigation and, when executed, indicates their willingness to participate in the clinical investigation and their understanding of those risks and benefits. The Privacy Rule permits but does not require clinical investigators to combine an HIPAA authorization with informed consent documents, known as a compound authorization (see 45 CFR 164.508(b)(3)).

FDA and the HHS Secretary received requests for clarification of IRBs' responsibilities to review and approve stand-alone HIPAA authorizations under the Privacy Rule, Federal regulations governing human subject protection and IRBs (see 45 CFR part 46 and parts 50 and 56 (21 CFR parts 50 and 56)), and international guidelines (see, for example, International Conference on Harmonisation (ICH) Good Clinical Practice guidelines (E6)). The requests expressed concern that when the Privacy Rule went into effect, clinical investigations might be impeded because IRBs would be backlogged with requests to review thousands of stand-alone HIPAA authorizations. The requests further stated that some IRBs would halt enrollment in clinical investigations pending their review of these stand-alone HIPAA authorizations.

In response, the Office of Civil Rights, HHS, issued a letter, dated April 15, 2003, clarifying that IRBs are not required to review and approve stand-alone HIPAA authorizations under the Privacy Rule, HHS Protection of Human Subjects Regulations at 45 CFR part 46, ICH guidelines, or FDA regulations, so long as an IRB's written procedures, adopted under § 56.108(a), do not require such review and approval. The letter also announced FDA's intent to publish guidance on this subject, in accordance with its good guidance practice regulations.

FDA is issuing this guidance to address those cases in which IRBs have adopted written procedures that would require them to review and approve stand-alone HIPAA authorizations. Under § 56.108(a), IRBs must follow their written procedures. The guidance announces FDA's intention to exercise ongoing enforcement discretion with respect to the requirements of § 56.108(a) to the extent that an IRB's written procedures require the review and/or approval of stand-alone HIPAA authorizations. FDA is exercising this discretion in order to encourage IRBs to permit the continued enrollment of subjects in clinical investigations without IRBs' prior review and approval of stand-alone HIPAA authorizations. FDA believes that enrollment in well-designed and well-conducted clinical investigations should not be interrupted for the purpose of IRB review and approval of stand-alone HIPAA authorizations. Accordingly, FDA does not intend to take enforcement actions against IRBs that decide not to review stand-alone HIPAA authorizations even though the IRB's written procedures would otherwise require this review and/or approval. FDA's exercise of enforcement discretion in these limited circumstances is intended to allow important studies to proceed in the best interests of the public health.

This guidance is being issued consistent with FDA's good guidance practices regulation § 10.115 (21 CFR 10.115). This guidance document represents the agency's current thinking on IRBs' responsibilities under FDA regulations for reviewing and approving stand-alone HIPAA authorizations. It does not create or confer any rights for or on any person and does not operate to bind FDA or the public. An alternative approach may be used if it satisfies the requirements of the applicable statutes and regulations.

II. Comments

FDA is issuing this document as a final guidance that will be implemented upon posting on FDA's Web site. In accordance with § 10.115(g)(2) and (g)(3), FDA is implementing this guidance prior to seeking public comment because the agency has determined that this guidance is needed in conjunction with the HHS Office of Civil Rights guidance to help ensure that ongoing clinical trials are not halted while IRBs review HIPAA stand-alone authorizations, and therefore, prior public participation is not feasible or appropriate. However, FDA will review comments received after issuance of the guidance and revise the document when appropriate.

Interested persons may, at any time, submit written or electronic comments to the Division of Dockets Management (see **ADDRESSES**) regarding this guidance document. Two paper copies of mailed comments are to be submitted, except individuals may submit one copy. Comments should be identified with the docket number found in the brackets in the heading of this document. A copy of the document and received comments are available for public examination in the Division of Dockets Management between 9 a.m. and 4 p.m., Monday through Friday.

III. Electronic Access

Persons with access to the Internet may obtain the document at either *http://www.fda.gov/oc/gcp/guidance.html* or *http://www.fda.gov/ohrms/dockets/default.htm*.

Dated: October 31, 2003.

Jeffrey Shuren,

Assistant Commissioner for Policy.

[FR Doc. 03–28044 Filed 11–6–03; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Government-Owned Inventions; Availability for Licensing

AGENCY: National Institutes of Health, Public Health Service, DHHS.

ACTION: Notice.

SUMMARY: The invention listed below is owned by an agency of the U.S. Government and is available for licensing in the U.S. in accordance with 35 U.S.C. 207 to achieve expeditious commercialization of results of federally-funded research and development. Foreign patent applications are filed on selected inventions to extend market coverage for companies and may also be available for licensing.

ADDRESSES: Licensing information and copies of the U.S. patent application listed below may be obtained by writing to the indicated licensing contact at the Office of Technology Transfer, National Institutes of Health, 6011 Executive Boulevard, Suite 325, Rockville, Maryland 20852–3804; telephone: 301/496–7057; fax: 301/402–0220. A signed Confidential Disclosure Agreement will be required to receive copies of the patent application.

Eosinophil-Derived Neurotoxin, an Antimicrobial Protein With Ribonuclease Activity, Is an Immunostimulant

De Yang *et al.* (NCI).

U.S. Provisional Patent Application Nos. 60/466,797 and 60/466,796, filed 29 Apr 2003 (DHHS Reference Nos. E–175–2003/0–US–01 and E–191–2003/0–US–01).

Licensing Contact: Brenda Hefti; 301/435–4632; *heftib@mail.nih.gov*.

Eosinophil-derived neurotoxin (EDN) has in vitro anti-viral activity that is dependent on its ribonuclease activity. This invention discloses that EDN is a selective chemoattractant and activator of dendritic cells, resulting in dendritic

cell migration, maturation, and a production of a wide variety of cytokines. Based on these potent chemotactic and activating effects on dendritic cells, EDN might be useful as a clinical immunoadjuvant for the promotion of immune responses to specific antigens of tumors or pathogenic organisms.

Protein Kinase C Inhibitor, Related Composition, and Method of Use

Shaomeng Wang, Peter Blumberg (NCI), Nancy Lewin (NCI).
U.S. Provisional Patent Application No. 60/451,214 filed 28 Feb 2003 (DHHS Reference No. E–073–2003/0–US–01).
Licensing Contact: Brenda Hefti; 301/435–4632; *heftib@mail.nih.gov.*

Protein kinase C is a critical component in cellular signaling, involved in cellular growth, differentiation, and apoptosis. It has been identified as a promising therapeutic target for cancer, diabetic retinopathy, and Alzheimer's disease, among other indications.

This invention relates to lead compounds that can inhibit protein kinase C isoforms through disruption of their C1 domains. The inventors also found that these compounds possess isoform selectivity, an important feature for therapeutic specificity. Finally, although the disclosed compounds are previously known molecules, novel structures are described in the invention that have further improved specificity.

Applications for the HMGN1 Pathway

Michael Bustin (NCI).
U.S. Provisional Patent Application No. 60/455,728 filed 17 Mar 2003 (DHHS Reference No. E–208–2002/0–US–01).
Licensing Contact: Brenda Hefti; 301/435–4632; *heftib@mail.nih.gov.*

HMGN1 is a protein that binds to nucleosomes, changes chromatin structure and affects transcription, and the expression of this protein changes during differentiation. Mice lacking this protein have increased growth capacity of several skin components, including epidermis, epidermal appendages, and dermis. Conceivably, this change could be related to an alteration of stem cell differentiation or to cell cycling events. The current invention relates to interference with this pathway, which might lead to increased stem cell differentiation and increased hair cycling and growth in humans as well. This invention might be useful to increase hair growth, enhance wound healing for epidermal and dermal wounds, and enhance stem cell populations for tissue regeneration, gene targeting, or gene therapeutic indications.

Novel Stable Anti-CD22 Antibodies

Susanna Rybak, Juergen Krauss, Michaela Arndt (NCI).
U.S. Provisional Application No. 60/387,306 filed 06 Jun 2002 (DHHS Reference No. E–055–2002/0–US–01); PCT Patent Application PCT/US03/18201 filed 06 Jun 2003 (DHHS Reference No. E–055–2002/0–PCT–02).
Licensing Contact: Brenda Hefti; 301/435–4632; *heftib@mail.nih.gov.*

The current invention relates to engineered LL2 single chain antibodies possessing improved and/or unexpected properties. The first embodiment includes engineered single chain antibodies that have enhanced stability. Specific VH and VL residues were identified which might contribute to the instability, and these were substituted to create scFv variants with improved stability and biological half-life. In the second embodiment, an LL2 single chain Fv antibody was engineered with no linker between the VH and VL sequences. The antibody exhibited the surprising property of acting as a monomer (rather than a trimer or tetramer) and retained specific binding to CD22. This invention might be useful as a general method to produce therapeutic antibodies or immunoconjugates more easily, and for such antibodies or immunoconjugates to be more stable *in vivo.*

Dated: October 30, 2003.

Steven M. Ferguson,

Director, Division of Technology Development and Transfer, Office of Technology Transfer, National Institutes of Health.

[FR Doc. 03–28054 Filed 11–6–03; 8:45 am]
BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Government-Owned Inventions; Availability for Licensing

AGENCY: National Institutes of Health, Public Health Service, DHHS.
ACTION: Notice.

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Isolation of Hybridomas Producing Monoclonal Antibodies (MAbs) Inhibitory to Human CYP2J2

Dr. Darryl Zeldin (NIEHS), Dr. Harry Gelboin (NCI), *et al.*
DHHS Reference No. E–337–2003/0—Research Tool.
Licensing Contact: Marlene Shinn-Astor; 301/435–4426; *shinnm@mail.nih.gov.*

Cytochromes P450 catalyze the NADPH-dependent oxidation of arachidonic acid to various eicosanoids found in several species. The eicosanoids are biosynthesized in numerous tissues including pancreas, intestine, kidney, heart, and lung where they are involved in many different biological activities.

The NIH announces three specific monoclonal antibodies that strongly inhibit and/or immunoblot the human cytochrome P450 2J2 (CYP2J2). MAb 6–5–20–8 selectively inhibits CYP2J2-mediated arachidonic acid metabolism by more than 80% and also immunoblots the enzyme. MAb 6–2–16–1 also selectively inhibits arachidonic acid metabolism by more than 80%, but does not immunoblot the enzyme. MAb 5–3–2–2 is not inhibitory, but selectively inmunoblots the enzyme. These antibodies can be used to identify and quantify inter-individual variation in physiological functions and to study pharmacological drug metabolism in various tissues.

This research is also described in: Sun *et al., Circ. Res.* 90: 1020–1027, 2002; King *et al., Mol. Pharmacol.* 61: 840–852, 2002; Yang *et al., Mol. Pharmacol.* 60: 310–320, 2001; Zeldin, *J. Biol. Chem.* 276: 36059–36062, 2001; Node *et al., J. Biol. Chem.* 276: 15983–15989, 2001; Node *et al., Science* 285: 1276–1279, 1999; Wu *et al., J. Biol. Chem.* 271: 3460–3468.

TNF-α Converting Enzyme Inhibitory Agents and Stimulatory Agents

Dr. Stewart Levine *et al.* (NHLBI).
U.S. Provisional Patent Application filed 24 Sep 2003 (DHHS Reference No. E–208–2003/0–US–01).
Licensing Contact: Marlene Shinn-Astor; 301/435–4426; *shinnm@mail.nih.gov.*

The action of Tumor Necrosis Factor alpha (TNF-α) has been implicated in such diseases as arthritis, sepsis, ulcerative colitis, multiple sclerosis, Crohn's disease, septic shock, graft rejection, cachexia, insulin resistance, post-ischemic reperfusion injury, tumor metastasis, tissue ulceration, abnormal wound healing, periodontal disease, bone disease, proteinuria, aneurismal aortic disease, degenerative cartilage loss, demyelinating diseases of the nervous system, and HIV infection. TNF-α converting enzyme (TACE) or ADAM 17 (A Disintegrin And Metalloprotease) is a member of a family of zinc metalloproteases, and is an important regulator of inflammation, immune regulation, and cellular proliferation as a consequence of its ability to catalyze the activation of TNF-α from a membrane bound to a soluble form.

The NIH announces the identification of a protein, corresponding to the amino-terminus of the TACE prodomain, that possesses a TACE inhibitory activity that is independent of a cysteine-switch mechanism. This TACE inhibitory protein could be used as a new therapeutic agent against chronic inflammatory diseases that are mediated by TNF-α.

Use of Smad3 Inhibitor in the Treatment of Fibrosis Dependent on Epithelial to Mesenchymal Transition as in the Eye and Kidney

Anita Roberts (NCI).
U.S. Provisional Patent Application No. 60/441,297 filed 17 Jan 2003 (DHHS Reference No. E–062–2003/0–US–01).
Licensing Contact: Marlene Shinn-Astor; 301/435–4426; *shinnm@od.nih.gov*.

Fibroid scar tissue has been associated with wound healing of the epithelial layer following tissue damage created by surgery or other means. Examples of which include the opaque scar tissue associated with cataract surgery and the fibroid scar tissue produced in several kidney diseases such as is seen in unilateral ureteral obstruction.

Smad2 and Smad3 are highly homologous cytoplasmic proteins which function to mediate signals from Transforming Growth Factor Beta (TGF-β) and activin receptors to promoters of target genes found in the nucleus. The NIH announces a technology wherein Smad 3 is now implicated in TGF-β-dependent transdifferentiation of epithelial cells to mesenchymal cells (EMT), which blocks the endpoint of fibrosis at an early stage of differentiation of epithelial cell precursors into interstitial fibroblasts. In particular, fibrosis was blocked following wounding of the lens of the eye and damage created to the kidney. It is believed that an inhibitor of Smad 3 could be used to block fibrosis following cataract surgery and lens implantation in patients, as well as slowing the progression of end-stage renal disease.

Dated: October 28, 2003.

Steven M. Ferguson,

Director, Division of Technology Development and Transfer, Office of Technology Transfer, National Institutes of Health.

[FR Doc. 03–28055 Filed 11–6–03; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Government-Owned Inventions; Availability for Licensing

AGENCY: National Institutes of Health, Public Health Service, DHHS.

ACTION: Notice.

SUMMARY: The invention listed below is owned by an agency of the U.S. Government and is available for licensing in the U.S. in accordance with 35 U.S.C. 207 to achieve expeditious commercialization of results of federally-funded research and development. Foreign patent applications are filed on selected inventions to extend market coverage for companies and may also be available for licensing.

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Cytotoxic Indeno- and Isoindenoisoquinoline Compounds

Yves G. Pommier (NCI).
U.S. Provisional Patent Application No. 60/469,718 filed 12 May 2003 (DHHS Reference No. E–253–2003/0–US–01).
Licensing Contact: George Pipia; 301/435–5560; *pipiag@mail.nih.gov*.

The present invention is directed to novel indeno- and isoindenoisoquinoline compounds, their derivatives and their pharmaceutical formulations having anticancer activity, as well as methods of treating cancer. The invention is also directed to methods of preparing these novel compounds. These compounds have been tested against 55 tumor cell lines and have been found to have a strong activity against a wide variety of tumor cell lines, including lung, colon, central nervous system, melanoma, ovarian, renal, prostate and breast cancers, compared with 2-methoxy estradiols. Some of these compounds target topoisomerase I and remain active in camptothecin-resistant cancer cells. It is expected that these compounds will be very useful in the treatment of a wide variety of cancers.

Identification of Novel Birt-Hogg-Dubé (BHD) Gene

Laura S. Schmidt (NCI).
PCT Application No. PCT/US03/17227 filed 30 May 2003 (DHHS Reference No. E–190–2002/2–PCT–01).
Licensing Contact: George Pipia; 301/435–5560; *pipiag@mail.nih.gov*.

Birt-Hogg-Dubé (BHD) syndrome is an inherited autosomal dominant neoplasia syndrome characterized by benign hair follicle tumors and is associated with a higher risk for developing renal cancer, spontaneous pneumothorax and/or lung cysts.

The present invention describes identification of the BHD syndrome associated germline mutations in a novel human gene, herein called BHD gene. This gene encodes for the protein, folliculin, functions of which remain currently unknown.

This discovery makes possible the development of a diagnostic method for BHD syndrome using a simple blood test. The test is particularly useful in detecting BHD mutations in asymptomatic carriers within BHD families.

Patients with kidney tumors can be evaluated for BHD gene mutations using a similar genetic diagnostic test, which will allow for a more accurate diagnosis of a kidney cancer and improved patient prognosis. The BHD encoding sequence is the third gene found to be responsible for inherited kidney cancer, and mutation testing allows for a correct diagnosis and initiation of the proper treatment, which is different for each of the types of kidney cancer caused by the three genes.

Methods of using BHD encoding sequence also allows for a differential genetic diagnosis of spontaneous pneumothorax, or collapsed lung. Since collapsed lung can be caused by several factors, a BHD diagnostic test allows a physician to determine predisposition to and possible recurrence of additional spontaneous pneumothoraces due to mutation(s) in the BHD gene.

The discovery should also lead to the development of novel pharmaceutical products and methods for treating BHD skin lesions using creams containing the BHD gene product, folliculin. Such products and methods of treatment are expected to reduce the size and appearance of the benign hair follicle tumors.

The disclosed technology will provide new and exciting methodologies to correctly diagnose BHD syndrome and should lead to the development of novel pharmaceutical reagents for treatment of BHD skin lesions as well as other skin diseases.

This research is also described in: Nickerson *et al., Cancer Cell* 2: 157, 2002; Zbar *et al., Cancer Epidem. Bio. Prev.* 11: 393, 2002; Schmidt *et al., Am. J. Hum. Genet.* 69: 876, 2001; Toro *et al., Arch. Dermatol.* 135: 1195, 1999.

Dated: October 27, 2003.

Steven M. Ferguson,

Director, Division of Technology Development and Transfer, Office of Technology Transfer, National Institutes of Health.

[FR Doc. 03–28056 Filed 11–6–03; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Government-Owned Inventions; Availability for Licensing

AGENCY: National Institutes of Health, Public Health Service, DHHS.

ACTION: Notice.

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B-Defensins as Activators of Dendritic Cells and Vaccine Carrier

Arya Biragyn and Larry Kwak (NCI).

U.S. Provisional Application No. 60/421,488 filed 25 Oct 2002 (DHHS Reference No. E–342–2002/0–US–01).

Licensing Contact: Catherine Joyce; 301/435–5031; e-mail: *joycec@mail.nih.gov.*

Tumor antigens are known to be poorly immunogenic and attempts to elicit immune responses against the epitopes of antigens specific to tumor cells have been largely unsuccessful. The inventors have developed a cancer vaccine comprising a defensin fused to a tumor antigen or viral antigen to enhance the immunogenicity of the . tumor antigen or viral antigen. The inventors have demonstrated, with animal data, that chimeric proteins comprising a defensin fused to a model tumor antigen (lymphoma-derived single-chain Fv) generate a measurable humoral and anti-tumor cellular immune response when administered to a subject. (Biragyn *et al.,* Mediators of innate immunity that target immature, but not mature, dendritic cells induce antitumor immunity when genetically fused with nonimmunogenic tumor antigens, *J. Immunology* 2001 Dec 1, 167(11):6644–6653. Also, Biragyn *et al.,* DNA vaccines encoding human immunodeficiency virus-1 glycoprotein 120 fusions with proinflammatory chemoattractants induce systemic and mucosal immune responses, *Blood* 2002 Aug 15 100(4):1153–1159.)

Recently the inventors have further discovered that murine beta-defensin 2 acts directly on immature dendritic cells as an endogenous ligand for Toll-like receptor 4 (TLR–4), inducing up-regulation of costimulatory molecules and dendritic cell maturation. (Biragyn *et al.,* Toll-like receptor 4-dependent activation of dendritic cells by beta-defensin 2, *Science* 2002 Nov 1, 298(5595):1025–1029).

The above-mentioned invention is available for licensing on an exclusive or a non-exclusive basis.

Dated: October 24, 2003.

Steven M. Ferguson,

Director, Division of Technology Development and Transfer, Office of Technology Transfer, National Institutes of Health.

[FR Doc. 03–28057 Filed 11–6–03; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Government-Owned Inventions; Availability for Licensing

AGENCY: National Institutes of Health, Public Health Service, DHHS.

ACTION: Notice.

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Putative PEDF Receptor

Sofia P. Becerra, Luigi Notari (NEI).

DHHS Reference No. E–314–2003/0–US–01 filed 07 Aug 2003.

Licensing Contact: Susan S. Rucker; 301/435–4478; *ruckersu@mail.nih.gov.*

This application describes compositions and methods related to Pigmented Epithelium Derived Factor (PEDF). PEDF is a protein, belonging to the serpin family, that has been demonstrated to have neurotrophic, gliastatic, neuronotrophic and anti-angiogenic properties. In particular, the compositions and methods described and claimed in this application are related to the isolation, cloning, expression and characterization of the putative receptor for PEDF. The PEDF receptor as described herein is a transmembrane protein having an extracellular ligand-binding domain, a transmembrane domain and an intracellular domain. The PEDF receptor shares some homology with an orphan receptor identified in the liver and the protein known as adiponutrin.

The isolation and cloning of the PEDF receptor will be useful in basic research to further elucidate the role of PEDF and its receptor in signal transduction

pathways. Furthermore, identification of the PEDF receptor will allow for the development of drug screening assays to identify agonists and antagonists of PEDF activity. In addition, isolation and identification of the PEDF receptor will allow new biological molecules such as monoclonal antibodies and chimeric IgG-receptor constructs to be developed.

This work has not yet been published.

Detection of Antigen-Specific T Cells and Novel T Cell Epitopes by Acquisition of Peptide/HLA–GFP Complexes

Steven Jacobson, Utano Tomaru, and Yoshihisa Yamano (NINDS).

U.S. Provisional Application No. 60/457,006 filed 24 Mar 2003 (DHHS Reference No. E–084–2003/0–US–01).

Licensing Contact: Brenda Hefti; 301/435–4632; *heftib@mail.nih.gov.*

This invention relates to a method for identifying specific T cell epitopes and antigen-specific T cells through labeling with an HLA–GFP complex expressed on an antigen-presenting cell. The T cells acquired the peptide-HLA–GFP complex through T cell mediated endocytosis upon specific antigen stimulation. This basic method can be used for several purposes. First, it can be used to generate a T-cell immune response through the attachment of a reporter peptide to the antigen-presenting cell. It can also be used as a way to assay a population of cells to determine whether any T cells specific for a particular antigen are present. This might be useful in applications related to autoimmunity, infectious disease, or cancer. Third, it can be used as a therapeutic to eliminate antigen-specific T cells associated with disease, if coupled to a toxic moiety.

Methods and Composition for the Diagnosis of Neuroendocrine Lung Cancer

Curtis Harris (NCI).

U.S. Provisional Application No. 60/423,380 filed 04 Nov 2002 (DHHS Reference No. E–248–2002/0–US–01).

Licensing Contact: Catherine Joyce; 301/435–5031; *joycec@mail.nih.gov.*

The technology relates to the use of cDNA microarrays to facilitate the identification of pulmonary neuroendocrine tumors. In order to identify molecular markers that could be used to classify pulmonary tumors, the inventors examined the gene expression profiles of clinical samples from patients with small cell lung cancer (SCLC), large cell neuroendocrine carcinoma (LCNEC), and typical carcinoma (TC) tumors by cDNA microarray analysis to detect hybridization between cDNA from tumor cells and DNA from a panel of 8,897 human genes. Gene expression was found to be nonrandom and to exhibit highly significant clustering that divided the tumors into their assigned World Health Organization (WH0) classification with 100% accuracy. The inventors concluded that pulmonary neuroendocrine tumors could be classified based on the genome-wide expression profile of the clinical samples without further manipulations.

The above-mentioned invention is available for licensing on an exclusive or non-exclusive basis.

Dated: October 24, 2003.

Steven M. Ferguson,

Director, Division of Technology Development and Transfer, Office of Technology Transfer, National Institutes of Health.

[FR Doc. 03–28058 Filed 11–6–03; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

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Enhanced HIV–1 Vaccine Cytotoxic T Cell Epitope From Conserved Region of HIV–1 Reverse Transcriptase

Jay Berzofsky, Takahiro Okazaki (NCI).

U.S. Provisional Application No. 60/459,507 filed 31 Mar 2003 (DHHS Reference No. E–044–2003/0–US–01).

Licensing Contact: Michael Ambrose; 301/594–6565; *ambrosem@mail.nih.gov.*

Polypeptides derived from the HIV–1 RT Catalytic site. Peptides are modified by replacement of certain key amino acid residues to increase binding to HLA–A2, the most common human class I HLA molecule. Such modified peptides are more immunogenic and can be used for further development of second-generation vaccines, therapeutics or diagnostic reagents. DNA encoding said modified polypeptides can be used as vaccines (naked DNA, bacterial or viral vector constructs).

Methods and Compositions for Selectively Enriching Microbes

Michael A. Grant (FDA/ORA).

U.S. Provisional Application No. 60/435,639 filed 20 Dec 2002 (DHHS Reference No. E–228–2002/0–US–01).

Licensing Contact: Michael Ambrose; 301/594–6565; *ambrosem@mail.nih.gov.*

The described technology provides for the methods, reagents and kits for the specific enrichment of microbes for further identification and diagnosis with particular emphasis on *E. coli* O157:H7 and other *E. coli.*

The technology details a 2-step process in which the primary sample is held under acid conditions to inhibit or kill competitor microbes within the sample. The acidic conditions can also contain selective agents such as phage or nutrient supplements for further selectivity. After a predetermined time, the sample is then incubated under unrestricted growth conditions for the enrichment of the remaining microbes. These are then carried through for further identification and potential diagnosis.

The technology can be used to selectively enrich for potential medically important bacteria, especially *E. coli* O157:H7, other pathogenic *E. coli, Shigella,* and other species.

Dated: October 24, 2003.

Steven M. Ferguson,

Director, Division of Technology Development and Transfer, Office of Technology Transfer, National Institutes of Health.

[FR Doc. 03–28059 Filed 11–6–03; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Government-Owned Inventions; Availability for Licensing

AGENCY: National Institutes of Health, Public Health Service, DHHS.

ACTION: Notice.

SUMMARY: The invention listed below is owned by an agency of the U.S. Government and is available for licensing in the U.S. in accordance with 35 U.S.C. 207 to achieve expeditious commercialization of results of federally-funded research and development. Foreign patent applications are filed on selected inventions to extend market coverage for companies and may also be available for licensing.

ADDRESSES: Licensing information and copies of the U.S. patents and patent applications listed below may be obtained by contacting Michael Ambrose, Ph.D., at the Office of Technology Transfer, National Institutes of Health, 6011 Executive Boulevard, Suite 325, Rockville, Maryland 20852–3804; telephone: 301/594–6565; fax: 301/402–0220; e-mail: *ambrosem@mail.nih.gov*. A signed Confidential Disclosure Agreement will be required to receive copies of any patent applications.

Efficient Inhibition of HIV–1 Viral Entry Through a Novel Fusion Protein Including CD4

James Arthos, Claudia Cicala, Anthony Fauci (NIAID).

U.S. Provisional Application No. 60/346,231 filed 25 Oct 2001 (DHHS Reference No. E–337–2001/0–US–01); PCT Application No. PCT/US02/34393 filed 24 Oct 2002 (DHHS Reference No. E–337–2001/0–PCT–01).

This invention relates to CD4 fusion proteins for use in the treatment of an immunodeficiency virus infection such as human immunodeficiency virus (HIV). These polypeptides have been shown by the inventors to inhibit the entry of primary isolates of HIV–1 into CD4+ T cells by targeting the gp120 subunit of the HIV–1 envelope. The invention claims recombinant polypeptides comprising a CD4 polypeptide ligated at its C-terminus with a portion of a human immunoglobulin comprising a hinge region and two constant domains of an immunoglobulin heavy chain. The portion of the IgG is fused at its C-terminus with a polypeptide comprising a tailpiece from the C terminus of the heavy chain of an IgA antibody. This protein is very large (greater than 800 kilodaltons), which may contribute to its ability to inhibit entry of primary isolates of HIV–1 into T cells. It presents twelve gp120 binding domains (D1D2) and can bind at least ten gp120s simultaneously. The inventors have shown that the construct efficiently neutralizes primary isolates from different HIV subgroups. Also claimed are use of the construct as a component of a vaccine and as a diagnostic.

Identification of New Small RNAs and ORFs

Susan Gottesman (NCI), Gisela Storz (NICHD), Karen Wassarman (NICHD), Francis Repoila (NCI), Carsten Rosenow (EM).

U.S. Provisional Application No. 60/266,402 filed 01 Feb 2001 (DHHS Reference No. E–072–2001/0–US–01); PCT Application No. PCT/US02/03147 filed 31 Jan 2002 (DHHS Reference No. E–072–2001/0–PCT–02); U.S. Patent Application filed 25 Jul 2003 (DHHS Reference No. E–072–2001/0–US–03).

The inventors have isolated a number of previously unknown sRNAs found in *E. coli*. Previous scientific publications by the inventors and others regarding sRNAs have shown these sRNAs to serve important regulatory roles in the cell, such as regulators of virulence and survival in host cells. Prediction of the presence of genes encoding sRNAs was accomplished by combining sequence information from highly conserved intergenic regions with information about the expected transcription of neighboring genes. Microarray analysis also was used to identify likely candidates. Northern blot analyses were then carried out to demonstrate the presence of the sRNAs. Three of the sRNAs claimed in the invention regulate (candidates 12 and 14, negatively and candidate 31, positively) expression of RpoS, a major transcription factor in bacteria that is important in many pathogens because it regulates (amongst other things) virulence. The inventors' data show that these sRNAs are highly conserved among closely related bacterial species, including Salmonella and Klebsiella, presenting a unique opportunity to develop both specific and broad-based antibiotic therapeutics. The invention contemplates a number of uses for the sRNAs, including, but not limited to, inhibition by antisense, manipulation of gene expression, and possible vaccine candidates.

A Novel Chimeric Protein for Prevention and Treatment of HIV Infection

Edward A. Berger (NIAID), Christie M. Del Castillo.

U.S. Provisional Application No. 60/124,681 filed 16 Mar 1999 (DHHS Reference No. E–039–1999/0–US–01); PCT Application No. PCT/US00/06946 filed 16 Mar 2000 (DHHS Reference No. E–039–1999/0–PCT–02); U.S. Patent Application No. 09/936,702 filed 13 Sep 2001 (DHHS Reference No. E–039–1999/0–US–03).

This invention relates to bispecific fusion proteins effective in viral neutralization. Specifically, the invention is a genetically engineered chimeric protein containing a soluble extracellular region of human CD4 attached via a flexible polypeptide linker to a single chain human monoclonal antibody directed against a CD4-induced, highly conserved HIV gp120 determinant involved in coreceptor interaction. Binding of the sCD4 moiety to gp120 induces a conformational change that enables the antibody moiety to bind, thereby blocking Env function and virus entry. This novel bispecific protein displays neutralizing activity against genetically diverse primary HIV–1 isolates, with potency at least 10-fold greater than the best described HIV–1 neutralizing monoclonal antibodies. The agent has considerable potential for prevention of HIV–1 infection, both as a topical microbicide and as a systemic agent to protect during and after acute exposure (*e.g.* vertical transmission, post-exposure prophylaxis). It also has potential utility for treatment of chronic infection. Such proteins, nucleic acid molecules encoding them, and their production and use in preventing or treating viral infections are claimed.

Novel Antimalarial Compounds, Methods of Synthesis Thereof, Pharmaceutical Compositions Comprising Same, and Methods of Using Same for Treatment and Prevention of Malaria

Michael R. Boyd (NCI), Gerhard Bringmann (EM), Sven Harmsen (EM) Roland Gotz (EM), T. Ross Kelly (EM), Matthias Wenzel (EM), Guido Francois (EM), J. D. Phillipson (EM), Laurent A. Assi (EM), Christopher Schneider (EM).

U.S. Patent 5,639,761 issued on 17 Jun 1997 (DHHS Reference No. E–090–1994/0–US–01); U.S. Patent 6,627,641 issued on 30 Sep 2003 (DHHS Reference No. E–090–1994/0–US–07); U.S. Patent 5,552,550 issued on 03 Sep 1996 (DHHS Reference No. E–

200–1994/0–US–01); U.S. Patent 5,763,613 issued on 09 Jun 1998 (DHHS Reference No. E–200–1994/0–US–02); U.S. Patent 6,140,339 issued on 31 Oct 2000 (DHHS Reference No. E–200–1994/2–US–01); U.S. Patent 6,331,630 issued on 18 Dec 2001 (DHHS Reference No. E–200–1994/2–US–08); U.S. Patent 5,571,919 issued on 05 Nov 1996 (DHHS Reference No. E–201–1994/0–US–01); U.S. Patent 5,789,594 issued on 04 Aug 1998 (DHHS Reference No. E–201–1994/0–US–02); U.S. Patent 5,578,729 issued on 26 Nov 1996 (DHHS Reference No. E–201–1994/1–US–01); U.S. Patent 5,786,482 issued on 28 Jul 1998 (DHHS Reference No. E–201–1994/1–US–03).

According to data recently reported by the World Health Organization (WHO), the death rate from malaria exceeds one million individuals per year. The Public Health Service seeks exclusive or non-exclusive licensee(s) to develop and commercialize the technology claimed within the portfolio of U.S. patents issued and pending, and corresponding international patents issued and pending. These patents and pending applications claim an exceptionally broad universe of novel naphthylisoquinoline alkaloid compounds, and methods of total synthesis thereof. Representative examples of these compounds have been shown to have potent in vitro activity against malaria parasites, including parasites that are highly resistant to available antimalarial drugs.

Representative examples have also been shown to have potent in vivo activity against malaria parasites in animal models. Pharmaceutical compositions comprising these compounds, as well as methods of using the compounds to treat or prevent a malarial infection of a host, are claimed. The relative structural simplicity of this class of compounds, and the ready synthetic access thereto, provide unprecedented opportunities for structure-activity relationship (SAR), lead-optimization and antimalarial drug development. The technology is further described in the following publications: J. Nat Prod. 1997 Jul.;60(7):677–83 and Bioorg. Med. Chem. Lett. 1998 Jul.;8(13): 1729–34.

Antimicrobial Magainin Peptides

Michael A. Zasloff, Hao-Chia Chen, Judith H. Brown, John L. Morell, Charng-Ming Huang (NICHD).

U.S. Patent 4,810,777 issued on 07 Mar 1989 (DHHS Reference No. E–145–1987/0–US–01); U.S. Patent 5,567,681 issued on 22 Oct 1996 (DHHS Reference No. E–145–1987/2–US–03); U.S. Patent 5,643,876 issued on 01 Jul 1997 (DHHS Reference No. E–145–1987/1–US–03); U.S. Patent 5,221,732 issued on 22 Jun 1993 (DHHS Reference No. E–217–1988/0–US–01).

First isolated from the skin of the African clawed frog Xenopus laevis, magainin peptides have been shown by the inventors to have broad-spectrum antimicrobial properties. Both synthetic and natural magainin peptides are active against many species of bacteria and fungi and induce osmotic lysis of protozoa. Magainin peptides are water soluble, nonhemolytic at effective antimicrobial concentrations, have molecular weights of 2500 or less and are amphiphilic. Compositions and methods for their use are claimed in the patents. These inventions are available for nonexclusive or exclusive licensing. The inventions are further described in Zasloff *et al.*, P.N.A.S. USA 1987 Aug.; 84(15):5449–53; Marion *et al.*, FEBS Lett. 1988 Jan.18;227(1):21–6; Soravia *et al.*, FEBS Lett. 1988 Feb. 15;228(2):337–40; Westerhoff *et al.*, P.N.A.S. USA 1989 Sep.; 86(17):6597–601; and Gwadz *et al.*, Infect. Immun. 1989 Sep.; 57(9):2628–33.

Dated: October 24, 2003.

Steven M. Ferguson,

Director, Division of Technology Development and Transfer, Office of Technology Transfer, National Institutes of Health.

[FR Doc. 03–28060 Filed 11–6–03; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Cancer Institute; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Cancer Institute Initial Review Group, Subcommittee C—Basic & Preclinical.

Date: December 9–10, 2003.

Time: 7 p.m. to 6 p.m.

Agenda: To review and evaluate grant applications.

Place: Holiday Inn Select Bethesda, 8120 Wisconsin Ave, Bethesda, MD 20814.

Contact Person: Michael B. Small, PhD., Scientific Review Administrator, Research Programs Review Branch, Division of Extramural Activities, National Cancer Institute, National Institutes of Health, 6116 Executive Boulevard, Room 8127, Bethesda, MD 20892, 301–402–0996, *smallm@mail.nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.392, Cancer Construction; 93.393, Cancer Cause and Prevention Research; 93.394, Cancer Detection and Diagnosis Research; 93.395, Cancer Treatment Research; 93.396, Cancer Biology Research; 93.397, Cancer Centers Support; 93.398, Cancer Research Manpower; 93.399, Cancer Control, National Institutes of Health, HHS)

Dated: October 30, 2003.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 03–28033 Filed 11–6–03; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Center for Research Resources; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Center for Research Resources Special Emphasis Panel Clinical Research.

Date: November 12–13, 2003.

Time: November 12, 2003, 7:45 a.m. to Adjournment.

Agenda: To review and evaluate grant applications.

Place: University Place, 850 West Michigan Street, Indianapolis, IN 46202.

Contact Person: Marc Rigas, PhD., Scientific Review Administrator, National Center For Research Resources, or, National Institutes of Health, 6701 Democracy Blvd., 1 Democracy Plaza, rm 1080, MSC 4874,

Bethesda, MD 20817–4874, 301–435–0806, *rigasm@mail.nih.gov*.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: National Center for Research Resources Special Emphasis Panel Clinical Research.

Date: December 3–4, 2003.

Time: December 3, 2003, 7:45 a.m. to Adjournment.

Agenda: To review and evaluate grant applications.

Place: Radisson Plaza Lord, Baltimore 20 W. Baltimore Street, Baltimore, MD 02115.

Contact Person: Mohan Viswanathan, PhD., Scientific Review Administrator, Office of Review, National Institutes of Health, 6701 Democracy Boulevard, 1 Democracy Plaza room 1084, Bethesda, MD 20892–4874, 301–435–0829, *viswanathanm@ncrr.nih.gov*.

Name of Committee: National Center for Research Resources Special Emphasis Panel Comparative Medicine.

Date: January 27–29, 2004.

Time: January 27, 2004, 8 a.m. to Adjournment.

Agenda: To review and evaluate grant applications.

Place: Hyatt Regency, 123 Lesoya Street, San Antonio, TX 78205.

Contact Person: Carol Lambert, PhD., Scientific Review Administrator, Office of Review, National Center for Research Resources, National Institute of Health, 6701 Democracy Boulevard, 1 Democracy Plaza, room 1076, Bethesda, MD 20892–4874, (301) 435–0814, *lambert@mail.nih.gov*.

(Catalogue of Federal Domestic Assistance Program Nos. 93.306, Comparative Medicine; 93.333, Clinical Research; 93.371, Biomedical Technology; 93.389, Research Infrastructure, 93.306, 93.333, National Institutes of Health, HHS)

Dated: October 31, 2003.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 03–28035 Filed 11–6–03; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Mental Health; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Mental Health Special Emphasis Panel NIMH COR Research Training and Education Grants.

Date: November 24, 2003.

Time: 9 a.m. to 1 p.m.

Agenda: To review and evaluate grant applications.

Place: Holiday Inn Select Bethesda, 8120 Wisconsin Ave, Bethesda, MD 20814.

Contact Person: Richard E. Weise, PhD., Scientific Review Administrator, Division of Extramural Activities, National Institute of Mental Health, NIH, Neuroscience Center, 6001 Executive Boulevard, room 6140, MS9606, Bethesda, MD 20892–9606, 301–443–1225, *rweise@mail.nih.gov*.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

(Catalogue of Federal Domestic Assistance Program Nos. 93.242, Mental Health Research Grants; 93.281, Scientist Development Award, Scientist Development Award for Clinicians, and Research Scientist Award; 93.282, Mental Health National Research Service Awards for Research Training, National Institutes of Health, HHS)

Dated: October 30, 2003.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 03–28032 Filed 11–6–03; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Environmental Health Sciences; Amended Notice of Meeting

Notice is hereby given of a change in the meeting of the National Institute of Environmental Health Sciences Special Emphasis Panel, November 19, 2003, 1:30 p.m. to November 19, 2003, 2:30 p.m., NIEHS/National Institutes of Health, Building 4401, East Campus, 79 T.W. Alexander Drive, 122, Research Triangle Park, NC 27709 which was published in the **Federal Register** on October 22, 2003, 68 FR 60404.

The meeting will be held on November 24, 2003 at 2 p.m. The meeting is closed to the public.

Dated: October 31, 2003.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 03–28036 Filed 11–6–03; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institutes of Environmental Health Sciences; Amended Notice of Meeting

Notice is hereby given of a change in the meeting of the National Institute of Environmental Health Sciences Special Emphasis Panel, November 12, 2003, 3 p.m. to November 12, 2003, 4 p.m., NIEHS/National Institutes of Health, Building 4401, East Campus, 79 T.W. Alexander Drive, 122, Research Triangle Park, NC, 27709 which was published in the **Federal Register** on November 22, 2003, 68 FR 60404.

The telephone conference meeting will be held November 20, 2003 at 3 p.m. The meeting is closed to the public.

Dated: October 31, 2003.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 03–28037 Filed 11–6–03; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Environmental Health Sciences; Amended Notice of Meeting

Notice is hereby given of a change in the meeting of the National Institute of Environmental Health Sciences Special Emphasis Panel, October 28, 2003, 10 a.m. to October 28, 2003, 1 p.m., NIEHS/National Institutes of Health, Building 4401, East Campus, 79 T.W. Alexander Drive, 122, Research Triangle Park, NC 27709 which was published in the **Federal Register** on September 25, 2003, 69 FR 55401.

The meeting will be held November 17, 2003 at 11 a.m. The meeting is closed to the public.

Dated: October 31, 2003.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 03–28038 Filed 11–6–03; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Diabetes and Digestive and Kidney Diseases; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Diabetes and Digestive and Kidney Diseases Special Emphasis Panel, Clinical Outcomes in Research: An Endoscopic Data Base.

Date: December 3, 2003.

Time: 1 p.m. to 2:30 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Two Democracy Plaza, 6707 Democracy Boulevard, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Ned Feder, MD, Scientific Review Administrator, Review Branch, DEA, NIDDK, Room 748, 6707 Democracy Boulevard, National Institutes of Health, Bethesda, MD 20892, (301) 594–8890, *federn@extra.niddk.nih.gov.*

Name of Committee: National Institute of Diabetes and Digestive and Kidney Diseases Special Emphasis Panel, Vasopressin and Hyperosmolality: Regulation of Aquaporin.

Date: December 9, 2003.

Time: 1 p.m. to 4 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Two Democracy Plaza, 6707 Democracy Boulevard, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Ned Feder, MD, Scientific Review Administrator, Review Branch, DEA, NIDDK, Room 748, 6707 Democracy Boulevard, National Institutes of Health, Bethesda, MD 20892, (301) 594–8890, *federn@extra.niddk.nih.gov.*

Name of Committee: National Institute of Diabetes and Digestive and Kidney Diseases Special Emphasis Panel, Cell and Molecular Pathobiology of Renal Disease.

Date: December 12, 2003.

Time: 1 p.m. to 4 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Two Democracy Plaza, 6707 Democracy Boulevard, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Ned Feder, MD, Scientific Review Administrator, Review Branch, DEA, NIDDK, Room 748, 6707 Democracy Boulevard, National Institutes of Health, Bethesda, MD 20892, (301) 594–8890, *federn@extra.niddk.nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.847, Diabetes, Endocrinology and Metabolic Research; 93.848, Digestive Diseases and Nutrition Research; 93.849, Kidney Diseases, Urology and Hematology Research, National Institutes of Health, HHS)

Dated: October 31, 2003.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 03–28040 Filed 11–6–03; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute on Drug Abuse; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute on Drug Abuse Special Emphasis Panel, Stress and Drug Abuse: Epidemiology, Etiology, Prevention, and Treatment.

Date: December 4–5, 2003.

Time: 9 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Ritz-Carlton Hotel at Pentagon City, 1250 South Hayes Street, Arlington, VA 22202.

Contact Person: Kesinee Nimit, MD, Health Scientist Administrator, Office of Extramural Affairs, National Institute on Drug Abuse, NIH, DHHS, Room 200, MSC 8401, 6101 Executive Boulevard, Bethesda, MD 20892–8401, (301) 435–1432.

Name of Committee: National Institute on Drug Abuse Special Emphasis Panel, Minority Institutions' Drug Abuse Research Development Program (MIDARP).

Date: December 11, 2003.

Time: 9:30 a.m. to 2 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Atrium Building, 6101 Executive Blvd., Bethesda, MD 20892.

Contact Person: Khursheed Asghar, PhD, Chief, Basic Sciences Review Branch, Office of Extramural Affairs, National Institute on Drug Abuse, NIH, DHHS, Room 200, MSC 8401, 6101 Executive Boulevard, Bethesda, MD 20892–8401, (301) 443–2755.

Name of Committee: National Institute on Drug Abuse Special Emphasis Panel, Neuroimaging the Effects of Drugs of Abuse on the Development of the Human Nervous System.

Date: December 16, 2003.

Time: 8 a.m. to 6 p.m.

Agenda: To review and evaluate grant applications.

Place: Hyatt Regency Bethesda, One Bethesda Metro Center, 7400 Wisconsin Avenue, Bethesda, MD 20814.

Contact Person: Eliane Lazar-Wesley, PhD, Health Scientist Administrator, Office of Extramural Affairs, National Institute on Drug Abuse, NIH, DHHS, room 200, MSC 8401, 6101 Executive Boulevard, Bethesda, MD 20892–8401, (301) 451–4530.

(Catalogue of Federal Domestic Assistance Program Nos. 93.277, Drug Abuse Scientist Development Award for Clinicians, Scientist Development Awards, and Research Scientist Awards; 92.278, Drug Abuse National Research Service Awards for Research Training; 93.279, Drug Abuse Research Programs, National Institutes of Health, HHS)

Dated: October 31, 2003.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 03–28041 Filed 11–6–03; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Center for Scientific Review Special Emphasis Panel, Addition Services and Youth Intervention Programs.

Date: November 7, 2003.

Time: 8:30 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Hyatt Regency Bethesda, One Bethesda Metro Center, 7400 Wisconsin Avenue, Bethesda, MD 20814.

Contact Person: Claire E. Gutkin, MPH, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, room 3138, MSC 7759, Bethesda, MD 20892, (301) 594–3139.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel Longitudinal Study of Antisocial Behavior.

Date: November 11, 2003.

Time: 11 a.m. to 12:30 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Victoria S. Levin, MSW, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, room 3172, MSC 7848, Bethesda, MD 20892, (301) 435–0912, *levinv@csr.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel Health Education and Disease Management.

Date: November 13–14, 2003.

Time: 8:30 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Holiday Inn Georgetown, 2101 Wisconsin Avenue, NW., Washington, DC 20007.

Contact Person: Claire E. Gutkin, MPH, PhD., Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 3138, MSC 7759, Bethesda, MD 20892, (301) 594–3139.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel Engineering of Enzymes.

Date: November 13–14, 2003.

Time: 5 p.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Four Points by Sheraton Bethesda, 8400 Wisconsin Avenue, Bethesda, MD 20814.

Contact Person: Michael M. Sveda, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, room 5152, MSC 7842, Bethesda, MD 20892, (301) 435–3565, *svedam@csr.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel Member Conflict: Chronic Disease Epidemiology.

Date: November 14, 2003.

Time: 8 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Holiday Inn Chevy Chase, 5520 Wisconsin Avenue, Chevy Chase, MD 20815.

Contact Person: Ann Hardy, DRPH, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, room 3158, MSC 7770, Bethesda, MD 20892, (301) 435–0695, *hardyan@csr.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel Software Maintenance.

Date: November 14, 2003.

Time: 8 a.m. to 6 p.m.

Agenda: To review and evaluate grant applications.

Place: Holiday Inn Select Bethesda, 8120 Wisconsin Ave, Bethesda, MD 20814.

Contact Person: George W. Chacko, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, room: 4186, MSC: 7806, Bethesda, MD 20892, (301) 435–1220, *chackoge@csr.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel, HT (10) B Hematology, Hematopoiesis and Transfusion.

Date: November 14, 2003.

Time: 8:30 a.m. to 4:30 p.m.

Agenda: To review and evaluate grant applications.

Place: Holiday Inn Chevy Chase, 5520 Wisconsin Avenue, Chevy Chase, MD 20815.

Contact Person: Chhanda L. Ganguly, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, room 4118, MSC 7802, Bethesda, MD 20892, (301) 435–1739, *gangulyc@csr.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel, Psychopathology and Adult Disorders.

Date: November 14, 2003.

Time: 8:30 a.m. to 6 p.m.

Agenda: To review and evaluate grant applications.

Place: Melrose Hotel, 2430 Pennsylvania Ave., NW., Washington, DC 20037.

Contact Person: Dana Plude, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (301) 435–1856, *pluded@csr.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel, ZRG1 REN (02).

Date: November 14, 2003.

Time: 9 a.m. to 11 a.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Abubakar A. Shaikh, DVM, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, room 6168, MSC 7892, Bethesda, MD 20892, (301) 435–1042, *shaikha@csr.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel, ZRG1 BCS (03) Lipid and Enzyme Biochemistry.

Date: November 14, 2003.

Time: 11 a.m. to 12:30 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Zakir Bengali, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, room 5150, MSC 7842, Bethesda, MD 20892, (301) 435–1742.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel, Member Conflict in Psychopathology and Adult Disorders.

Date: November 14, 2003.

Time: 1:30 p.m. to 2 p.m.

Agenda: To review and evaluate grant applications.

Place: Melrose Hotel, 2430 Pennsylvania Ave., NW., Washington, DC 20037.

Contact Person: Luci Roberts, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, room 3188, MSC 7848, Bethesda, MD 20892, (301) 435–0692, *roberlu@csr.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel, Cancer Biomarkers.

Date: November 14, 2003.

Time: 2 p.m. to 3:30 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Elaine Sierra-Rivera, PhD, Scientific Review Administrator, Center for

Scientific Review, National Institutes of Health, 6701 Rockledge Drive, room 6184, MSC 7804, Bethesda, MD 20892, (301) 435–1779, *riverase@csr.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel, Primate Behavior.

Date: November 14, 2003.

Time: 2 p.m. to 3:30 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, 3032C, Bethesda, MD 20814, (Telephone Conference Call).

Contact Person: Maribeth Champoux, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, room 3184, MSC 7848, (301) 402–4454, *champoum@mail.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel, Small Business Innovation and Bioengineering Research Grants.

Date: November 16–17, 2003.

Time: 7 p.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Embassy Suites Hotel, 4300 Military Road, Washington, DC 20015.

Contact Person: Marcia Steinberg, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, room 5140, MSC 7840, Bethesda, MD 20892, (301) 435–1023, *steinberm@csr.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel, Cardiovascular and Pharmacological Sciences.

Date: November 17, 2003.

Time: 8 a.m. to 4 p.m.

Agenda: To review and evaluate grant applications.

Place: Holiday Inn Select Bethesda, 8120 Wisconsin Ave., Bethesda, MD 20814.

Contact Person: Robert T. Su, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, room 4134, MSC 7802, Bethesda, MD 20892, (301) 435–1195.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel, ZRG1 ENR: Endocrinology and Reproductive Sciences.

Date: November 17, 2003.

Time: 8 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Holiday Inn Select Bethesda, 8120 Wisconsin Ave., Bethesda, MD 20814.

Contact Person: Harry Brodie, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Dr., room 6166, MSC 7892, Bethesda, MD 20892, (301) 402–6297.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel, Brain Disorders and Clinical Neuroscience/SBIR.

Date: November 17–18, 2003.

Time: 8:30 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Holiday Inn Select Bethesda, 8120 Wisconsin Ave., Bethesda, MD 20814.

Contact Person: Rene Etcheberrigaray, MD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, room 5196, MSC 7846, Bethesda, MD 20892, (301) 435–1246, *etcheber@csr.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel, Immunology: Small Business and Technology Applications.

Date: November 17–18, 2003.

Time: 8:30 a.m. to 4 p.m.

Agenda: To review and evaluate grant applications.

Place: The River Inn, 924 25th Street, NW., Room 105, Washington, DC 20037.

Contact Person: Stephen M. Nigida, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, room 4212, MSC 7812, Bethesda, MD 20892, (301) 435–3565, *nigidas@csr.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel ZRG1 VACC 02: Vaccines for Biodefense Pathogens.

Date: November 17–18, 2003.

Time: 8:30 a.m. to 6 p.m.

Agenda: To review and evaluate grant applications.

Place: Hyatt Regency Bethesda, One Bethesda Metro Center, 7400 Wisconsin Avenue, Bethesda, MD 20814.

Contact Person: Mary Clare Walker, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, room 5104, MSC 7852, Bethesda, MD 20892, (301) 435–1165, *walkermc@csr.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel Departmental Psychopathology and Behavioral Transitions.

Date: November 17, 2003.

Time: 9:30 a.m. to 11 a.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Room 3186, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Mariela Shirley, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, room 3186, MSC 7848, Bethesda, MD 20892, (301) 435–0913, *shirleym@csr.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel Reparative Medicine Study Section.

Date: November 17–18, 2003.

Time: 10 a.m. to 2 p.m.

Agenda: To review and evaluate grant applications.

Place: Ritz-Carlton Hotel at Pentagon City, 1250 South Hayes Street, Arlington, VA 22202.

Contact Person: Jean D. Sipe, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, rm. 4106, MSC 7814, Bethesda, MD 20892, (301) 435–1743, *sipej@csr.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel Cancer Biology

Date: November 17, 2003.

Time: 1 p.m. to 2 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Hungyi Shau, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, room 6214, MSC 7804, Bethesda, MD 20892, (301) 435–1720, *shauhung@csr.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel Urology R01/R21 Review.

Date: November 17–18, 2003.

Time: 1 p.m. to 11 a.m.

Agenda: To review and evaluate grant applications and/or proposals.

Place: Holiday Inn Georgetown, 2101 Wisconsin Avenue, NW., Washington, DC 20007.

Contact Person: Shirley Hilden, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, room 4218, MSC 7814, Bethesda, MD 20892, (301) 435–1198.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel ZRG1 CVB 03(M):Preconditioning.

Date: November 17, 2003.

Time: 2 p.m. to 3 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Russell T. Dowell, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Dr., rm. 4128, MSC 7814, Bethesda, MD 20892, (301) 435–1850, *dowellr@csr.nih.gov*.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel, Cardiovascular Bioengineering.

Date: November 17, 2003.

Time: 4 p.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Holiday Inn Select Bethesda, 8120 Wisconsin Ave., Bethesda, MD 20814.

Contact Person: Robert T. Su, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, room 4134. MSC 7802, Bethesda, MD 20892, (301) 435–1195.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel, Prostate Cancer Chemoprevention Studies.

Date: November 17, 2003.

Time: 4 p.m. to 5:30 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Angela Y. Ng, PhD, MBA, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, room 6200. MSC 7804, (For courier delivery, use MD 20817), Bethesda, MD 20892, (301) 435–1715, *nga@csr.nih.gov*.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

(Catalogue of Federal Domestic Assistance Program Nos. 93.306, Comparative Medicine; 93.333, Clinical Research, 93.306, 93.333, 93.337, 93.393–93.396, 93.837–93.844, 93.846–93.878, 93.892, 93.893, National Institutes of Health, HHS)

Dated: October 31, 2003.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 03–28034 Filed 11–6–03; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Office of the Director, National Institutes of Health; Amended Notice of Closed Meeting

Notice is hereby given of a change in the meeting of the Advisory Committee on Research on Women's Health, November 18, 2003, 9 a.m. to November 18, 2003, 5 p.m., Holiday Inn Select Bethesda, 8120 Wisconsin Ave., Bethesda, MD 20814 which was published in the **Federal Register** on October 28, 2003, FR68;208;61455–61456.

The meeting will be held at the NIH; 8600 Rockville Pike, Building 38; National Library of Medicine Conference Room. The meeting is open to the public.

Dated: October 30, 2003.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 03–28039 Filed 11–6–03; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

National Toxicology Program; The National Toxicology Program (NTP) Center for the Evaluation of Risks to Human Reproduction (CERHR), Announces Availability of Draft Expert Panel Report on Fluoxetine and Expert Panel Meeting on Fluoxetine; Requests Public Comment on the Draft Report

SUMMARY: The NTP CERHR announces—

(1) Availability of sections 1–4 of the draft expert panel report on fluoxetine and solicits written public comments on the report by January 6, 2004.

(2) The fluoxetine expert panel meeting on March 3–5, 2004 at the Holiday Inn Old Town Select, Alexandria, Virginia and invites the public to present oral comments at this meeting.

Questions about the draft expert panel report, submission of public comments, and the expert panel meeting should be directed to Dr. Michael Shelby, CERHR Director (contact information below).

Draft Expert Panel Report On Fluoxetine Available

The CERHR announces the availability of the draft expert panel report on fluoxetine hydrochloride (Prozac®; Sarafem™, CAS RN 59333–67–4; fluoxetine, CAS RN 54910–89–3). Fluoxetine, an antidepressant, is a widely prescribed drug in the United States. The CERHR selected fluoxetine for evaluation because of (1) sufficient reproductive and developmental studies, (2) human exposure information, (3) changing prescription patterns, and (4) public concern about potential reproductive and/or developmental hazards associated with exposure. Fluoxetine hydrochloride, under the name Sarafem ™, is prescribed to treat premenstrual dysphoric disorder (PMDD), potentially increasing the number of exposures for women of childbearing age. Furthermore, the Food and Drug Administration recently approved Prozac® for use in 7–17 year-olds thereby increasing exposures of children.

Each draft expert panel report has the following sections:

1.0 Chemistry, Use, and Human Exposure
2.0 General Toxicological and Biological Effects
3.0 Developmental Toxicity Data
4.0 Reproductive Toxicity Data
5.0 Summary, Conclusions, and Critical Data Needs (to be written at expert panel meeting)

Sections 1–4 will be available to the public by the publication date of this notice and can be obtained electronically on the CERHR Web site (*http://cerhr.niehs.nih.gov*) or in hard copy by contacting Dr. Michael Shelby, Director CERHR [NIEHS, 79 T.W. Alexander Drive, Building 4401, room 103, P.O. Box 12233, MD EC–32, Research Triangle Park, NC 27709, telephone: (919) 541–3455; facsimile: (919) 316–4511; *shelby@niehs.nih.gov*].

Request for Written Comments on Draft Expert Panel Report

The CERHR invites written public comments on sections 1–4 of the draft expert panel report on fluoxetine. Comments can be submitted in hard copy or electronic format and must be received by the CERHR by January 6, 2004. These comments will be distributed to the expert panel and CERHR staff for consideration in revising the draft report and in preparing for the expert panel meeting. They will be posted on the CERHR website prior to the expert panel meeting. These comments should be sent to Dr. Michael Shelby at the address provided above. Persons submitting written comments are asked to include their name and contact information (affiliation, mailing address,

telephone and facsimile numbers, e-mail, and sponsoring organization, if any).

Expert Panel Meeting Planned

The CERHR will hold an expert panel meeting March 3–5, 2004, at the Holiday Inn Old Town Select, 480 King Street, Alexandria, VA 22314 (telephone: 703–549–6080, facsimile: 684–6508). The CERHR has asked the expert panel to review the scientific evidence regarding the potential reproductive and/or developmental toxicity associated with exposure to fluoxetine. The expert panel will review and revise the draft expert panel report and reach conclusions regarding whether exposure to fluoxetine is a hazard to human development or reproduction. The expert panel will also identify data gaps and research needs.

This meeting is open to the public and attendance is limited only by the available meeting room space. The meeting will begin at 8:30 a.m. each day. On March 3 and 4, it is anticipated that a lunch break will occur from noon–1 p.m. and that the meeting will adjourn 5–6 p.m. The meeting is expected to adjourn by noon on March 5; however, adjournment may occur earlier or later depending upon the time needed by the expert panel to complete its work. Anticipated agenda topics for each day are listed below. Following the expert panel meeting and completion of the expert panel report, the CERHR will post the report on its website and solicit public comment through a **Federal Register** notice.

Preliminary Meeting Agenda

Meeting begins at 8:30 a.m. each day
Lunch break anticipated from noon–1 p.m.

March 3, 2004

Opening remarks
Oral public comments (7 minutes per speaker; one representative per group, see below)
Review of sections 1–4 of the draft expert panel report on fluoxetine
Discussion of Section 5.0 Summary, Conclusions, and Critical Data Needs

March 4, 2004

Discussion of Section 5.0 Summary, Conclusions, and Critical Data Needs
Preparation of draft summaries and conclusion statements

March 5, 2004

Presentation, discussion of, and agreement on summaries and conclusions
Closing comments

Oral Public Comments Welcome at Expert Panel Meeting

Time is set-aside on March 3, 2004, for the presentation of oral public comments at the expert panel meeting. To facilitate planning, those persons wishing to make oral public comments are asked to contact Dr. Shelby by February 25 (contact information provided above). Seven minutes will be available for each speaker (one speaker per organization). When registering to comment orally, please provide your name, affiliation, mailing address, telephone and facsimile numbers, e-mail and sponsoring organization (if any). If possible, also send a copy of the statement or talking points to Dr. Shelby by February 25. This information will be provided to the expert panel to assist them in identifying issues for discussion and will be noted in the meeting record. Registration for presentation of oral comments will also be available at the meeting on March 3, 2004 (7:30–8:30 a.m.). Those persons registering at the meeting are asked to bring 20 copies of their statement or talking points for distribution to the expert panel and for the record.

Fluoxetine Expert Panel

The CERHR expert panel is composed of independent scientists selected for their scientific expertise in reproductive and/or developmental toxicology and other areas of science relevant for this review.

Expert Panel Members and Affiliation

Ronald Hines, Ph.D., Chair, Medical College of Wisconsin, Milwaukee, WI
Jane Adams, Ph.D., University of Massachusetts, Boston, MA
Germaine M. Buck, Ph.D., National Institute of Child Health and Human Development Rockville, MD
Willem Faber, Ph.D., WFT Consulting, LLC, Victor, NY
Joseph F. Holson, Ph.D., WIL Research Laboratories, Inc., Ashland, OH
Sandra W. Jacobson, Ph.D., Wayne State University School of Medicine, Detroit, MI
Martin Keszler, M.D., Georgetown University Hospital, Washington, DC
Robert Taylor Segraves, M.D., Ph.D., MetroHealth Medical Center, Cleveland, OH
Lynn T. Singer, Ph.D., Case Western Reserve University, Cleveland, OH
I. Glen Sipes, Ph.D., University of Arizona, Tucson, AZ
Kennth McMartin, Ph.D., Louisiana State University, Shreveport, LA
Paige L. Williams, Ph.D., Harvard School of Public Health, Boston, MA

Background Information on the CERHR

The NTP established the NTP CERHR in June 1998 [**Federal Register**, December 14, 1998 (Volume 63, Number 239, page 68782)]. The CERHR is a publicly accessible resource for information about adverse reproductive and/or developmental health effects associated with exposure to environmental and/or occupational exposures. Expert panels conduct scientific evaluations of agents selected by the CERHR in public forums.

The CERHR invites the nomination of agents for review or scientists for its expert registry. Information about CERHR and the nomination process can be obtained from its Home page (*http://cerhr.niehs.nih.gov*) or by contacting Dr. Shelby (contact information provided above). The CERHR selects chemicals for evaluation based upon several factors including production volume, extent of human exposure, public concern, and published evidence of reproductive or developmental toxicity.

CERHR follows a formal, multi-step process for review and evaluation of selected chemicals. The formal evaluation process was published in the **Federal Register** notice July 16, 2001 (Volume 66, Number 136, pages 37047–37048) and is available on the CERHR Web site under "About CERHR" or in printed copy from the CERHR.

Dated: October 31, 2003.

Samuel H. Wilson,

Deputy Director, National Institute of Environmental Health Sciences.

[FR Doc. 03–28042 Filed 11–6–03; 8:45 am]
BILLING CODE 4140–01–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–4815–N–86]

Notice of Submission of Proposed Information Collection to OMB: Request for Occupied Conveyance

AGENCY: Office of the Chief Information Officer, HUD.

ACTION: Notice.

SUMMARY: The proposed information collection requirement described below has been submitted to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act. The Department is soliciting public comments on the subject proposal.

The information provides a basis for the management and administration of the property disposition program. In addition, information will determine if

occupants are granted a request of continued occupancy in a single-family property (1 to 4 units) after HUD acquires title.

DATES: Comments Due Date: December 8, 2003.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB approval number (2502–0268) and should be sent to: Lauren Wittenberg, OMB Desk Officer, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503; Fax number (202) 395–6974; e-mail *Lauren_Wittenberg@omb.eop.gov.*

FOR FURTHER INFORMATION CONTACT: Wayne Eddins, Reports Management Officer, AYO, Department of Housing and Urban Development, 451 Seventh Street, Southwest, Washington, DC 20410; e-mail *Wayne_Eddins@HUD.gov;* telephone (202) 708–2374. This is not a toll-free number. Copies of the proposed forms and other available documents submitted to OMB may be obtained from Mr. Eddins.

SUPPLEMENTARY INFORMATION: The Department has submitted the proposal for the collection of information, as described below, to OMB for review, as required by the Paperwork Reduction Act (44 U.S.C. Chapter 35). The Notice lists the following information: (1) The title of the information collection proposal; (2) the office of the agency to collect the information; (3) the OMB approval number, if applicable; (4) the description of the need for the information and its proposed use; (5) the agency form number, if applicable; (6) what members of the public will be affected by the proposal; (7) how frequently information submissions will be required; (8) an estimate of the total number of hours needed to prepare the information submission including number of respondents, frequency of response, and hours of response; (9) whether the proposal is new, an extension, reinstatement, or revision of an information collection requirement; and (10) the name and telephone number of an agency official familiar with the proposal and of the OMB Desk Officer for the Department.

This Notice also lists the following information:

Title of Proposal: Request to Occupied Conveyance.

OMB Approval Number: 2502–0268.

Form Numbers: Form HUD–9539.

Description of the Need for the Information and Its Proposed Use: The information provides a basis for the management and administration of the property disposition program. In addition, information will determine if occupants are granted a request of continued occupancy in a single-family property (1 to 4 units) after HUD acquires title.

Respondents: Individuals or households, Business or other for-profit, Not-for-profit institutions, State, local or tribal government.

Frequency of Submission: On occasion, to request occupied conveyance of property.

Reporting Burden: Number of Respondents 12,750; Average response per respondent 5.86;: Total annual responses 74,750; Average burden per response 0.28 hrs.

Total Estimated Burden Hours: 21,125.

Status: Extension of a currently approved collection.

Authority: Section 3507 of the Paperwork Reduction Act of 1995, 44 U.S.C. 35, as amended.

Dated: October 31, 2003.

Wayne Eddins,

Departmental Reports Management Officer, Office of the Chief Information Officer.

[FR Doc. 03–28008 Filed 11–6–03; 8:45 am]

BILLING CODE 4210–72–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–4809–N–45]

Federal Property Suitable as Facilities To Assist the Homeless

AGENCY: Office of the Assistant Secretary for Community Planning and Development, HUD.

ACTION: Notice.

SUMMARY: This Notice identifies unutilized, underutilized, excess, and surplus Federal property reviewed by HUD for suitability for possible use to assist the homeless.

FOR FURTHER INFORMATION CONTACT: Mark Johnston, room 7266, Department of Housing and Urban Development, 451 Seventh Street, SW., Washington, DC 20410; telephone (202) 708–1234; TTY number for the hearing- and speech-impaired (202) 708–2565 (these telephone numbers are not toll-free), or call the toll-free Title V information line at 1–800–927–7588.

SUPPLEMENTARY INFORMATION: In accordance with 24 CFR part 581 and section 501 of the Steward B. McKinney Homeless Assistance Act (42 U.S.C. 11411), as amended, HUD is publishing this Notice to identify Federal buildings and other real property that HUD has reviewed for suitability for use to assist the homeless. The properties were reviewed using information provided to HUD by Federal landholding agencies regarding unutilized and underutilized buildings and real property controlled by such agencies or by GSA regarding its inventory of excess or surplus Federal property. This Notice is also published in order to comply with the December 12, 1988 Court Order in *National Coalition for the Homeless* v. *Veterans Administration,* No. 88–2503–OG (D.D.C.).

Properties reviewed are listed in this Notice according to the following categories: Suitable/available, suitable/unavailable, suitable/to be excess, and unsuitable. The properties listed in the three suitable categories have been reviewed by the landholding agencies, and each agency has transmitted to HUD: (1) Its intention to make the property available for use to assist the homeless, (2) its intention to declare the property excess to the agency's needs, or (3) a statement of the reasons that the property cannot be declared excess or made available for use as facilities to assist the homeless.

Properties listed as suitable/available will be available exclusively for homeless use for a period of 60 days from the date of this Notice. Where property is described as for "off-site use only" recipients of the property will be required to relocate the building to their own site at their own expense. Homeless assistance providers interested in any such property should send a written expression of interest to HHS, addressed to Shirley Kramer, Division of Property Management, Program Support Center, HHS, room 5B–41, 5600 Fishers Lane, Rockville, MD 20857; (301) 443–2265 (this is not a toll-free number). HHS will mail to the interested provider an application packet, which will include instructions for completing the application. In order to maximize the opportunity to utilize a suitable property, providers should submit their written expressions of interest as soon as possible. For complete details concerning the processing of applications, the reader is encouraged to refer to the interim rule governing this program, 24 CFR part 581.

For properties listed as suitable/to be excess, that property may, if subsequently accepted as excess by GSA, be made available for use by the homeless in accordance with applicable law, subject to screening for other Federal use. At the appropriate time, HUD will publish the property in a Notice showing its as either suitable/available or suitable/unavailable.

For properties listed as suitable/unavailable, the landholding agency has decided that the property cannot be declared excess or made available for use to assist the homeless, and the property will not be available.

Properties listed as unsuitable will not be made available for any other purpose for 20 days from the date of this notice. Homeless assistance providers interested in a review by HUD of the determination of unsuitability should call the free information line at 1–800–927–7588 for detailed instructions or write a letter to Mark Johnston at the address listed at the beginning of this notice. Included in the request for review should be the property address (including ZIP Code), the date of publication in the **Federal Register**, the landholding agency, and the property number.

For more information regarding particular properties identified in this notice (*i.e.*, acreage, floor plan, existing sanitary facilities, exact street address), providers should contact the appropriate landholding agencies at the following addresses: *Army:* Ms. Julie Jones-Conte, Department of the Army, Office of the Assistant Chief of Staff for Installation Management, Attn: DAIM–ME, Room 1E677, 600 Army Pentagon, Washington, DC 20310–0600; (703) 692–9223; *GSA:* Mr. Brian K. Polly, Assistant Commissioner, General Services Administration, Office of Property Disposal, 18th and F Streets, NW., Washington, DC 20405; (202) 501–0052; *Navy:* Mr. Charles C. Cocks, Director, Department of the Navy, Real Estate Policy Division, Naval Facilities Engineering Command, Washington Navy Yard, 1322 Patterson Ave., SE., Suite 1000, Washington, DC 20374–5065; (202) 685–9200 (these are not toll-free numbers).

Dated: October 30, 2003.

John D. Garrity,

Director, Office of Special Needs Assistance Programs.

TITLE V, FEDERAL SURPLUS PROPERTY PROGRAM FEDERAL REGISTER REPORT FOR 11/7/2003

Suitable/Available Properties

Buildings (by State)

Alaska

Bldg. 00001
Kiana Natl Guard Armory
Kiana Co: AK 99749–
Landholding Agency: Army
Property Number: 21200340075
Status: Excess
Comment: 1200 sq. ft., butler bldg., needs repair, off-site use only

Arizona

Bldg. 00500
Yuma Proving Ground
Yuma Co: AZ 85365–9498
Landholding Agency: Army
Property Number: 21200340076
Status: Unutilized
Comment: 4171 sq. ft., needs rehab, possible asbestos/lead paint, most recent use—training, off-site use only

Colorado

Bldg. T–211
Fort Carson
Ft. Carson Co: El Paso CO 80913–
Landholding Agency: Army
Status: Unutilized
Comment: 4172 sq. ft., presence of asbestos/lead paint, most recent use—office, off-site use only

Bldg. S6250
Fort Carson
Ft. Carson Co: El Paso CO 80913–
Landholding Agency: Army
Property Number: 21200340083
Status: Unutilized
Comment: 22,125 sq. ft., presence of asbestos/lead paint, most recent use—office, off-site use only

Bldg. S6268
Fort Carson
Ft. Carson Co: El Paso CO 80913–
Landholding Agency: Army
Property Number: 21200340085
Status: Unutilized
Comment: 840 sq. ft., presence of asbestos/lead paint, most recent use—office, off-site use only

Maine

Bldg. 20
Naval Air Station
Brunswick Co: Cumberland ME
Landholding Agency: Navy
Property Number: 77200340026
Status: Excess
Comment: 25,871 sq. ft., most recent use—office, off-site use only

Bldg. 41
Naval Air Station
Brunswick Co: Cumberland ME
Landholding Agency: Navy
Property Number: 77200340027
Status: Excess
Comment: 10,526 sq. ft., most recent use—police station, off-site use only

Bldg. 109
Naval Air Station
Brunswick Co: Cumberland ME
Landholding Agency: Navy
Property Number: 77200340028
Status: Excess
Comment: 529 sq. ft., most recent use—dog kennel, off-site use only

Bldg. 225
Naval Air Station
Brunswick Co: Cumberland ME
Landholding Agency: Navy
Property Number: 77200340029
Status: Excess
Comment: 15,020 sq. ft., most recent use—auto maintenance, off-site use only

Bldg. 252
Naval Air Station
Brunswick Co: Cumberland ME
Landholding Agency: Navy
Property Number: 77200340030
Status: Excess
Comment: 5,100 sq. ft., most recent use—auto maintenance, off-site use only

Bldg. H–10
Portsmouth Naval Shipyard
Kittery Co: York ME
Landholding Agency: Navy
Property Number: 77200340031
Status: Excess
Comment: 27,201 sq. ft., presence of asbestos/lead paint, most recent use—support functions, off-site use only

Bldg. H–25
Portsmouth Naval Shipyard
Kittery Co: York ME
Landholding Agency: Navy
Property Number: 77200340032
Status: Excess
Comment: 1,573 sq. ft., presence of asbestos/lead paint, most recent use—storage, off-site use only

Bldg. H–30
Portsmouth Naval Shipyard
Kittery Co: York ME
Landholding Agency: Navy
Property Number: 77200340033
Status: Excess
Comment: 523 sq. ft., presence of asbestos/lead paint, most recent use—storage, off-site use only

Bldg. 46
Portsmouth Naval Shipyard
Kittery Co: York ME
Landholding Agency: Navy
Property Number: 77200340034
Status: Excess
Comment: 2,992 sq. ft., presence of asbestos/lead paint, most recent use—shredding facility, off-site use only

Bldg. 75
Portsmouth Naval Shipyard
Kittery Co: York ME 03904–
Landholding Agency: Navy
Property Number: 77200340035
Status: Excess
Comment: 44,818 sq. ft., presence of asbestos/lead paint, most recent use—shop, off-site use only

Bldg. 76
Portsmouth Naval Shipyard
Kittery Co: York ME
Landholding Agency: Navy
Property Number: 77200340036
Status: Excess
Comment: 37,466 sq. ft., presence of asbestos/lead paint, most recent use—shop, off-site use only

Bldg. 85
Portsmouth Naval Shipyard
Kittery Co: York ME
Landholding Agency: Navy
Property Number: 77200340037
Status: Excess
Comment: 742 sq. ft., presence of asbestos/lead paint, off-site use only

Bldg. 157
Portsmouth Naval Shipyard
Kittery Co: York ME
Landholding Agency: Navy
Property Number: 77200340038
Status: Excess
Comment: 640 sq. ft., presence of asbestos/lead paint, most recent use—office, off-site use only

Bldg. 184

Portsmouth Naval Shipyard
Kittery Co: York ME
Landholding Agency: Navy
Property Number: 77200340039
Status: Excess
Comment: 10,610 sq. ft., presence of asbestos/lead paint, most recent use—offices, off-site use only

Land (by State)

Ohio

Land
Defense Supply Center
Columbus Co: Franklin OH 43216–5000
Landholding Agency: Army
Property Number: 21200340094
Status: Excess
Comment: 11 acres, railroad access

Suitable/Unavailable Properties

Building (by State)

Arizona

Bldg. 00701
Yuma Proving Ground
Yuma Co: AZ 85365–9498
Landholding Agency: Army
Property Number: 21200340077
Status: Unutilized
Comment: 1548 sq. ft., needs repair, possible asbestos/lead paint, most recent use—police station, off-site use only

Bldg. 00702
Yuma Proving Ground
Yuma Co: AZ 85365–9498
Landholding Agency: Army
Property Number: 2100340078
Status: Unutilized
Comment: 3137 sq. ft., needs repair, possible asbestos/lead paint, most recent use—offices, off-site use only

Colorado

Bldg. T–203
Fort Carson
Ft. Carson Co: El Paso CO 80913–
Landholding Agency: Army
Property Number: 2120340078
Status: Unutilized
Comment: 1628 sq. ft., needs repair, possible asbestos/lead paint, most recent use—storage, off-site use only

Bldgs. T–223 thru T–227
Fort Carson
Ft. Carson Co: El Paso CO 80913–
Landholding Agency: Army
Property Number: 21200340081
Status: Unutilized
Comment: 9000 sq. ft., presence of asbestos/lead paint, most recent use—warehouse, off-site use only

Bldg. S6222
Fort Carson
Ft. Carson Co: El Paso CO 80913–
Landholding Agency: Army
Property Number: 21200340082
Status: Unutilized
Comment: 19,225 sq. ft., presence of asbestos/lead paint, most recent use—office, off-site use only

Bldg. S6264
Fort Carson
Ft. Carson Co: El Paso CO 80913–
Landholding Agency: Army
Property Number: 21200340084
Status: Unutilized
Comment: 19,499 sq. ft., most recent use—office, off-site use only

Kentucky

Bldg. 2843
Fort Campbell
Ft. Campbell Co: Christian KY 42223–
Landholding Agency: Army
Property Number: 21200340086
Status: Unutilized
Comment: 1,530 sq. ft., presence of asbestos, most recent use—office, off-site use only

Missouri

Bldg. 1230
Fort Leonard Wood
Ft. Leonard Wood Co: Pulaski MO 65743–8944
Landholding Agency: Army
Property Number: 21200340087
Status: Unutilized
Comment: 9,160 sq. ft., most recent use—training, off-site use only

Bldg. 1621
Fort Leonard Wood
Ft. Leonard Wood Co: Pulaski MO 65743–8944
Landholding Agency: Army
Property Number: 21200340088
Status: Unutilized
Comment: 2,400 sq. ft., most recent use—exchange branch, off-site use only

Bldg. 03289
Fort Leonard Wood
Ft. Leonard Wood Co: Pulaski MO 65743–8944
Landholding Agency: Army
Property Number: 21200340089
Status: Unutilized
Comment: 8,120 sq. ft., presence of lead paint, most recent use—storage, off-site use only

Bldg. 03291
Fort Leonard Wood
Ft. Leonard Wood Co: Pulaski MO 65743–8944
Landholding Agency: Army
Property Number: 21200340090
Status: Unutilized
Comment: 3,108 sq. ft., presence of lead paint, most recent use—motor repair shop, off-site use only

Bldg. 6822
Fort Leonard Wood
Ft. Leonard Wood Co: Pulaski MO 65743–8944
Landholding Agency: Army
Property Number: 21200340091
Status: Unutilized
Comment: 4,000 sq. ft., most recent use—storage, off-site use only

Bldg. 9000
Fort Leonard Wood
Ft. Leonard Wood Co: Pulaski MO 65743–8944
Landholding Agency: Army
Property Number: 21200340092
Status: Unutilized
Comment: 1,440 sq. ft., most recent use—welcome center, off-site use only

Bldg. 10201
Fort Leonard Wood
Ft. Leonard Wood Co: Pulaski MO 65743–8944
Landholding Agency: Army
Property Number: 21200340093
Status: Unutilized
Comment: 1,200 sq. ft., most recent use—storage, off-site use only

Unsuitable Properties

Buildings (by State)

Alabama

Bldgs. 8785, 8786
Redstone Arsenal
Redstone Arsenal Co: Madison AL 35898–5000
Landholding Agency: Army
Property Number: 21200340095
Status: Unutilized
Reasons: Secured Area, Extensive deterioration

Maine

Bldg. 150
Portsmouth Naval Shipyard
Kittery Co: York ME
Landholding Agency: Navy
Property Number: 77200340040
Status: Excess
Reason: Extensive deterioration

Maryland

Bldgs. 200068, 200069
JHU Applied Physics Lab
Laurel Co: Howard MD 20723–
Landholding Agency: Navy
Property Number: 77200340015
Status: Excess
Reason: Extensive deterioration

4 Bldgs.
JHU Applied Physics Lab
200075, 200076, 200077, 200079
Laurel Co: Howard MD 20723–
Landholding Agency: Navy
Property Number: 77200340016
Status: Excess
Reason: Extensive deterioration

Bldgs. 200083, 200086
JHU Applied Physics Lab
Laurel Co: Howard MD 20723–
Landholding Agency: Navy
Property Number: 77200340017
Status: Excess
Reason: Extensive deterioration

Bldgs. 200087, 200088, 200089
JHU Applied Physics Lab
Laurel Co: Howard MD 20723–
Landholding Agency: Navy
Property Number: 77200340018
Status: Excess
Reason: Extensive deterioration

5 Bldgs.
JHU Applied Physics Lab
200091, 200095, 200096, 200098, 200099
Laurel Co: Howard MD 20723–
Landholding Agency: Navy
Property Number: 77200340019
Status: Excess
Reason: Extensive deterioration

Bldgs. 200101, 200106, 200107
JHU Applied Physics Lab
Laurel Co: Howard MD 20723–
Landholding Agency: Navy
Property Number: 77200340020
Status: Excess
Reason: Extensive deterioration

Bldgs. 200108, 200109, 200110
JHU Applied Physics Lab
Laurel Co: Howard MD 20723–
Landholding Agency: Navy

Property Number: 77200340021
Status: Excess
Reason: Extensive deterioration

Bldgs. 200120, 200121, 200122
JHU Applied Physics Lab
Laurel Co: Howard MD 20773–
Landholding Agency: Navy
Property Number: 77200340022
Status: Excess
Reason: Extensive deterioration

Bldgs. 200124, 200125, 200126
JHU Applied Physics Lab
Laurel Co: Howard MD 20773–
Landholding Agency: Navy
Property Number: 77200340023
Status: Excess
Reason: Extensive deterioration

Bldgs. 200128, 200133
JHU Applied Physics Lab
Laurel Co: Howard MD 20723–
Landholding Agency: Navy
Property Number: 77200340024
Status: Excess
Reason: Extensive deterioration

Bldgs. 200137, 200138
JHU Applied Physics Lab
Laurel Co: Howard MD 20773–
Landholding Agency: Navy
Property Number: 77200340025
Status: Excess
Reason: Extensive deterioration

Land (by State)

Florida

Navy Site Alpha
Homestead Co: Miami/Dade FL
Landholding Agency: GSA
Property Number: 54200330009
Status: Surplus
Reason: Flooding
GSA Number: 4–N–FL–1079

[FR Doc. 03–27783 Filed 11–6–03; 8:45 am]
BILLING CODE 4210–29–M

DEPARTMENT OF THE INTERIOR

Bureau of Indian Affairs

Proposed Information Collection

AGENCY: Bureau of Indian Affairs, Interior.

ACTION: Notice of request for comments.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995, this notice announces that we are seeking comments from interested parties to renew the clearance for Application for Training or Employment, OMB No. 1076–0062.

DATES: Written comments must be received by January 6, 2004.

ADDRESSES: Written comments should be sent to: Lynn Forcia, Office of Self-Governance and Self-Determination, Department of the Interior, 1849 C Street, NW., Mail Stop 2412-MIB, Washington, DC 20240.

FOR FURTHER INFORMATION: For additional information or copies of the forms, call Lynn Forcia, Office of Self-Governance and Self-Determination, Department of the Interior, 1849 C Street NW., MS 2412–MIB, Washington, DC 20240 and (202) 219–5270 (This is not a toll-free number). You may send requests by facsimile to (202) 208–3664.

SUPPLEMENTARY INFORMATION: Pub.L. 84–959 and Pub.L. 88–230 authorize the Secretary of the Interior, to help adult Indians who reside on or near Indian reservations to obtain reasonable and satisfactory employment. The information collection documents provide information necessary to administer the program for Employment Assistance or Vocational Training. The Secretary is authorized to undertake a program of vocational training that provides vocational counseling, guidance, and training in any recognized vocation, apprenticeship, trade, or on-the-job training. The program is available to Indians who are not less than 18 years old and not more than 35 years old who reside on or near an Indian reservation. The acts authorize the Secretary to enter into contracts or agreements with Federal, State, local government agencies or associations with apprenticeship programs or on-the-job training that leads to skilled employment. The same application form is used for both 25 CFR parts 26 and 27. Information of a confidential nature is protected by the Privacy Act.

You are asked to comment on the necessity of the information collection to fulfill the functions of the bureau; whether the burden estimate is accurate and the methodology and assumptions are valid; the utility, quality, and clarity of information requested; and ways that the burden might be minimized for respondents. All comments are subject to review by the public during regular business hours. If you wish your name or address withheld, you must state this prominently at the beginning of your comments. We will honor your request to the extent allowed by the law. Individuals who represent businesses or companies will have comments available for review by the public. In some cases we may decide to withhold comments from review for good reason.

Please note that an agency may not sponsor or conduct, and a person need not respond to, an information collection unless a currently valid OMB Control Number is displayed.

Title: Application for Training or Employment Assistance 25 CFR 26 & 27.

OMB Control Number: 1076–0062.

Description of Respondents: Individual Indians living on or near a reservation who seek training or employment provide the information in order to receive a benefit.

Respondents: 4900.

Burden: 30 minutes to complete.

Total Annual Hourly Burden: 2450 hours.

Dated: October 27, 2003.

Aurene M. Martin,

Principal Deputy Assistant Secretary—Indian Affairs.

[FR Doc. 03–28004 Filed 11–6–03; 8:45 am]
BILLING CODE 4310–04–P

DEPARTMENT OF THE INTERIOR

Bureau of Indian Affairs

Notice of Intent To Prepare an Environmental Impact Statement for the Proposed Ione Band of Miwok Indians' Trust Acquisition and Casino Project, Amador County, CA

AGENCY: Bureau of Indian Affairs, Interior.

ACTION: Notice.

SUMMARY: This notice advises the public that the Bureau of Indian Affairs (BIA), with the cooperation of the Ione Band of Miwok Indians and the National Indian Gaming Commission (NIGC), intends to gather information necessary to prepare an Environmental Impact Statement (EIS) for a proposed casino project to be located within the City of Plymouth in Amador County, California. The purpose of the proposed project is to help provide for the economic development of the Ione Band. This notice also announces a public scoping meeting to identify potential issues and content for inclusion in the EIS.

DATES: Comments on the scope and implementation of this proposal must arrive by December 8, 2003. The public scoping meeting will be held on Wednesday, November 19, 2003, from 6 p.m. to 9 p.m. or until the last comment is received.

ADDRESSES: You may mail or hand carry written comments to Mr. Clay Gregory, Acting Regional Director, Pacific Region, Bureau of Indian Affairs, 2800 Cottage Way, Sacramento, California 95825. The public scoping meeting will be held at the Amador County Fairgrounds, 18621 Sherwood and School Streets, Plymouth, California.

FOR FURTHER INFORMATION CONTACT: Mr. William Allan, (916) 978–6043.

SUPPLEMENTARY INFORMATION: The Ione Band of Miwok Indians proposes that 208.06± acres of land be taken into trust and that a casino, parking, hotel and other facilities supporting the casino be

constructed on the trust acquisition property. The gaming facility would be managed by IKON Group, LLC on behalf of the tribal government, pursuant to the terms of a management agreement between the tribal government and IKON Group, LLC. The BIA serves as the Lead Agency for National Environmental Policy Act (NEPA) compliance, with the NIGC, which is responsible for approval of the gaming management contract, acting as a Cooperating Agency.

The project site is located immediately east of Highway 49, and is within 2½ miles of State Highway 16. The City of Placerville is located approximately 20 miles north of the project site, which is also accessible from State Highway 49. The project site consists of 10 parcels of land totaling 208.06± acres. Eight of the 10 parcels (10.28± acres) are located within the City of Plymouth, while the remaining 2 parcels (197.78± acres) are located on unincorporated land within Amador County.

Phase I of the Proposed Action includes the development of a 120,000± square foot casino complex, which would consist of a porte cochere, main gaming hall, food and beverage services, retail space, and administration space. Approximately 65,000 square feet of this building space would be devoted to the main gaming hall, while the balance of the facility would include administration space, small retail shops and food/beverage facilities and a small gift and art shop. The entire complex would be built on land currently within the City of Plymouth. Primary access to the casino complex would be via State Highway 49.

Phase II of the Proposed Action includes the construction of a hotel (250 rooms maximum), which will include small conference style facilities together with food and beverage services. The proposed hotel would also be fitted with a dual plumbing system for the use of potable and recycled water. In addition, site parking would be increased to supply adequate parking for hotel and conference patrons. The hotel is anticipated to be operational no sooner than the middle of year 3–4 of the project. Primary vehicle access to the hotel would be provided by the main casino and surface-parking driveway.

Areas of environmental concern to be addressed in the EIS include land use, geology and soils, water resources, agricultural resources, biological resources, cultural resources, mineral resources, paleontological resources, traffic and transportation, noise, air quality, public health/environmental hazards, public services and utilities, hazardous materials and waste/worker safety, socio-economics, environmental justice, and visual resources/aesthetics. The range of issues addressed may be expanded based on comments received during the scoping process.

Public Comment Availability

Comments, including names and addresses of respondents, will be available for public review at the mailing address shown in the **ADDRESSES** section, during regular business hours, 8 a.m. to 4:30 p.m., Monday through Friday, except holidays. Individual respondents may request confidentiality. If you wish us to withhold your name and/or address from public review or from disclosure under the Freedom of Information Act, you must state this prominently at the beginning of your written comment. Such requests will be honored to the extent allowed by law. We will not, however, consider anonymous comments. All submissions from organizations or businesses, and from individuals identifying themselves as representatives or officials of organizations or businesses will be made available for public inspection in their entirety.

Authority

This notice is published in accordance with section 1503.1 of the Council on Environmental Quality regulations (40 CFR parts 1500 through 1508) implementing the procedural requirements of the National Environmental Policy Act of 1969, as amended (42 U.S.C. 4321 *et seq.*), and the Department of the Interior Manual (516 DM 1–6), and is in the exercise of authority delegated to the Assistant Secretary—Indian Affairs by 209 DM 8.

Dated: October 9, 2003.

Aurene M. Martin,

Principal Deputy Assistant Secretary—Indian Affairs.

[FR Doc. 03–28118 Filed 11–6–03; 8:45 am]

BILLING CODE 4310–W7–P

DEPARTMENT OF THE INTERIOR

Bureau of Indian Affairs

Notice of Intent To Prepare an Environmental Impact Statement for the Proposed Mandan, Hidatsa, Arikara Nation Clean Fuels Refinery, Ward County, ND

AGENCY: Bureau of Indian Affairs, Interior.

ACTION: Notice.

SUMMARY: This notice advises the public that the Bureau of Indian Affairs (BIA), with the cooperation of the Mandan, Hidatsa, Arikara (MHA) Nation, intends to gather the information necessary for preparing an Environmental Impact Statement (EIS) for the proposed 468-acre Fee-to-Trust Transfer and Clean Fuels Refinery Project in Ward County, North Dakota. The purpose of the proposed action is to help meet the land base and economic needs of the MHA Nation.

DATES: You may submit written comments on the scope and implementation of this proposal through December 8, 2003.

ADDRESSES: You may mail or hand carry written comments to Horace Pipe, 25300 366 Street SW, Makoti, North Dakota 58756.

FOR FURTHER INFORMATION CONTACT: Horace Pipe, (701) 726–5894.

SUPPLEMENTARY INFORMATION: The MHA Nation proposes that 468 acres of land be taken into trust, that a clean fuels refinery be constructed on 160 acres of that land. The 468 acres of land to be taken into trust are in the northeast corner of the Fort Berthold Indian Reservation along the south side of North Dakota Highway 23, about 2 miles west of the turnoff to Makoti, North Dakota. The land and refinery, which will be owned and managed by the MHA Nation, will be in sections 19 and 20 of Township 152 North, Range 87 West.

The MHA Nation proposes to construct a petroleum refinery to process 10,000 barrels per stream day of synthetic crude from northern Alberta, obtained from a nearby, existing pipeline. The refinery will be a new state-of-the-art facility that will be able to meet current and proposed 2008 EPA regulations. The facility will be the most technologically advanced refinery in the United States and it will produce the cleanest gasoline and diesel fuel in the country. The project would employ 600 to 1000 positions during construction and 65 to 70 positions during operation.

The BIA will serve as the Lead Agency for compliance with the National Environmental Policy Act. The Environmental Protection Agency will be a Cooperating Agency.

The EIS will assess the environmental consequences of BIA approval of the fee-to-trust transfer of land and the refinery project. Areas of environmental concern include effects to socio-economics; air quality; transportation; ground and surface water; wildlife and their habitats; threatened, endangered, or special-status species; cultural

resources; aesthetics; land uses; and health and safety. The range of issues to be addressed may be further expanded based on comments received during the scoping process.

Public Comment Solicitation

Comments, including names and home addresses of respondents, will be available for public review at the address shown in the **ADDRESSES** section, during regular business hours, 7:30 a.m. to 4 p.m., Monday through Friday, except holidays. Individual respondents may request confidentiality. If you wish us to withhold your name and/or address from public review or from disclosure under the Freedom of Information Act, you must state this prominently at the beginning of your written comment. Such requests will be honored to the extent allowed by law. We will not, however, consider anonymous comments. All submissions from organizations or businesses, and from individuals identifying themselves as representatives or officials of organizations or businesses, will be made available for public inspection in their entirety.

Authority

This notice is published in accordance with section 1503.1 of the Council on Environmental Quality regulations (40 CFR parts 1500 through 1508), implementing the procedural requirements of the National Environmental Policy Act of 1969, as amended (42 U.S.C. 4321 *et seq.*), and the Department of the Interior Manual (516 DM 1–6), and is in the exercise of authority delegated to the Assistant Secretary—Indian Affairs by 209 DM 8.

Dated: October 12, 2003.

Aurene M. Martin,

Principal Deputy Assistant Secretary—Indian Affairs.

[FR Doc. 03–28119 Filed 11–6–03; 8:45 am]

BILLING CODE 4310–W7–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[OR–030–1020–XX; G 04–0020]

Meeting Notice for the National Historic Oregon Trail Interpretive Center (NHOTIC) Advisory Board

AGENCY: Bureau of Land Management (BLM), Vale District.

SUMMARY: The National Historic Oregon Trail Interpretive Center Advisory Board will meet in a conference room at the Best Western Sunridge Inn (541–523–6444), One Sunridge Way in Baker City, OR, from 8 a.m. to 12 p.m. (Pacific time), on Thursday, December 18, 2003.

The meeting topics include: Completing the revision of the strategic plan, a roundtable to allow members to introduce new issues to the board, and other matters as may reasonably come before the Board. The entire meeting is open to the public. For a copy of the information to be distributed to the Board members, please submit a written request to the Vale District Office 10 days prior to the meeting. Public comment is scheduled for 10:15 a.m. to 10:30 a.m., Pacific time.

FOR FURTHER INFORMATION CONTACT: Additional information concerning the NHOTIC Advisory Board may be obtained from Peggy Diegan, Management Assistant/Webmaster, Vale District Office, 100 Oregon Street, Vale, OR 97918 (541) 473–3144, or e-mail *Peggy_Diegan@or.blm.gov.*

Dated: November 3, 2003.

David R. Henderson,

District Manager.

[FR Doc. 03–28024 Filed 11–6–03; 8:45 am]

BILLING CODE 4310–33–P

DEPARTMENT OF THE INTERIOR

National Park Service

National Preservation Technology and Training Board: Meeting

AGENCY: National Park Service, Interior.

ACTION: Notice.

Notice is hereby given in accordance with the Federal Advisory Committee Act, 5 U.S.C. Appendix (1988), that the National Preservation Technology and Training Board (the Board) will meet November 14, 2003, in Natchitoches, LA.

The Board was established by Congress to provide leadership, policy advice, and professional oversight to the National Center for Preservation Technology and Training (NCPTT), as required under the National Historic Preservation Act of 1966, as amended (16 U.S.C. 470).

The Board will meet in Lee H. Nelson Hall, 645 College Ave., Natchitoches, LA 71457. On Friday, November 14, the meeting will start at 9:00 a.m. and end no later than 5:00 p.m. The Board meeting's agenda will include NCPTT operations, budget, and program development; NCPTT business and strategic plans; Preservation Technology and Training grants; and the Heritage Education program; PTT Board workgroup reports; and election of PTT Board chair and vice chair.

The Board meeting is open to the public. Facilities and space for accommodating members of the public are limited, however, and persons will be accommodated on a first-come, first-served basis. Any member of the public may file a written statement concerning the matters to be discussed.

Persons wishing more information concerning this meeting, or who wish to submit written statements, may contact Mr. de Teel Patterson Tiller, Acting Associate Director, Cultural Resources, 1849 C Street NW–3128 MIB, Washington, DC 20240, telephone (202) 208–7625. Increased security in the Washington, DC, area may cause delays in the delivery of U.S. Mail to government offices. In addition to mail or commercial delivery, please fax a copy of the written submission to Mr. Tiller at (202) 273–3237.

Minutes of the meeting will be available for public inspection no later than 90 days after the meeting at the office of the Acting Associate Director, Cultural Resources, 1849 C Street NW, Room 3128, Washington, DC.

Dated: October 3, 2003

de Teel Patterson Tiller

Acting Associate Director, Cultural Resources

[FR Doc. 03–28115 Filed 11–6–03; 8:45 am]

BILLING CODE 4310–50–S

DEPARTMENT OF THE INTERIOR

National Park Service

Clarification of the Term *the day* in the Definition of Substantial Restoration of Natural Quiet for Grand Canyon NP

AGENCY: National Park Service, Department of the Interior.

ACTION: Notice.

SUMMARY: This notice clarifies the meaning of the term *the day* as it is used in the National Park Service (NPS) definition of substantial restoration of natural quiet at Grand Canyon National Park (GCNP) pursuant to Public Law 100–91, the National Parks Overflights Act of 1987. It also helps to clarify the definition of substantial restoration of natural quiet recently the subject of litigation before the United States Court of Appeals, District of Columbia Circuit, in the case *United States Air Tour Association* v. *Federal Aviation Administration (Grand Canyon Trust, Interveners).* In this case, the Court declared that "* * * the Park Service is entitled to deference for its interpretation of its own definitions" (p. 19). The Court concluded "* * * the FAA's use of an "average annual day" for measuring "substantial restoration of

natural quiet" appears inconsistent with both the Park Service's definition of the term and with the premise upon which that definition was based. * * * We must therefore remand this issue for further consideration" (p. 22).

Several interpretations of the meaning of the term *the day* have been advanced by various parties over the past few years, and the different interpretations have major implications for calculating the percentage of substantial restoration of natural quiet achieved at GCNP. This notice clarifies that the term *the day* in the definition of substantial restoration of natural quiet means *any given day, every day,* and provides guidance to the Federal Aviation Administration (FAA) concerning the appropriate definition of the day as used in the measurement of substantial restoration of natural quiet at GCNP. Clarification of this term will provide a benchmark for the future alternative dispute resolution process between the FAA and NPS. This clarification does not change the definition of substantial restoration of natural quiet.

ADDRESSES: You may view a copy of this definition through the Internet at: *http://www.nps.gov/grca/overflights.*

FOR FURTHER INFORMATION CONTACT: Ken McMullen, Overflights and Natural Soundscape Program Manager, National Park Service, Grand Canyon NP, 823 N. San Francisco St., Suite B, Flagstaff, Arizona 86001. Telephone: (928) 779–2095, or by e-mail at *Ken_McMullen@nps.gov.*

SUPPLEMENTARY INFORMATION:

Background

Public Law 100–91 called for the "substantial restoration of natural quiet and experience of the park" at GCNP. The NPS in its "Report on Effects of Aircraft Overflights on the National Park System" (submitted to Congress in September, 1994, and published in July, 1995) determined that "* * * substantial restoration requires that 50% or more of the Park achieve 'natural quiet' (*i.e.*, no aircraft audible) for 75–100 percent of the day" (p. 182). Although the context of this definition suggested that *the day* implied *each day, every day,* or *any given day* (terms considered to mean the same thing in this context), the term was not further clarified in this report. However, the NPS analysis in the report was consistent with *any given day.*

In its "Review of Scientific Basis for Change in Noise Impact Assessment Method Used at Grand Canyon National Park" (2000), the NPS provided definitions of terms used, as well as rationale, for its noise impact assessment methods. In this review the NPS defined substantial restoration of natural quiet to be "* * * a threshold not to be exceeded on any given day. * * *" (p. 16).

The term *the day* in the definition of substantial restoration of natural quiet was recently the subject of litigation before the United States Court of Appeals, District of Columbia Circuit, in the case, *United States Air Tour Association* v. *Federal Aviation Administration* (Grand Canyon Trust, Intervenors). In this case, the Court declared that "* * * the Park Service is entitled to deference for its interpretation of its own definitions" (p. 19). The Court concluded "* * * the FAA's use of an "average annual day" for measuring "substantial restoration of natural quiet" appears inconsistent with both the Park Service's definition of the term and with the premise upon which that definition was based.* * * We must therefore remand this issue for further consideration" (p. 22).

Clarification of the Term

When used in the definition of substantial restoration of natural quiet, *the day* means *any given day;* that is, following the mandate of Public Law 100–91, natural quiet must be substantially restored at GCNP on *any given day* of the year. As further clarification, to achieve substantial restoration of natural quiet, 50% or more of the park must achieve "natural quiet" (*i.e.*, no aircraft audible) for 75–100 percent of *any given day.*

Clarification also provides the FAA the guidance from the NPS concerning the appropriate definition of this term and assists in the determination of how to address aircraft noise as discussed in the Department of Transportation/FAA **Federal Register** Notice of February 27, 2003, *Modification of the Dimensions of the Grand Canyon National Park Special Flight Rules Area and Flight Free Zones* (**Federal Register**/Vol. 68, No. 39, pgs. 9496–9498). Clarification of this term will provide a benchmark for the future alternative dispute resolution process between the FAA and NPS.

Significance of using *any given day* vs. other possible interpretations: Computer modeling of substantial restoration of natural quiet for previous FAA regulations followed FAA procedures and was based upon the number of air tour operations on an "average annual day," as determined by dividing the year's total operations by 365 days. The most recent computer modeling was done as a part of the Supplemental Environmental Assessment (Feb. 2000) accompanying the FAA final rule, "Commercial Air Tour Limitations in the Grand Canyon National Park Special Flight Rules Area" (65 FR 17,708). The modeling used the FAA's Integrated Noise Model (INM) and was based on air tour operations reported for the 12-month period May 1, 1997 through April 30, 1998. The model indicated that using the "peak day" (*any given day*) definition, substantial restoration would not occur during the high visitation season, and that restoration of natural quiet would occur in 19% of the park. In contrast, modeling on the "average annual day" indicated that substantial restoration of natural quiet would occur in 44 % of the park. Thus, when using an "average annual day" standard, substantial restoration of natural quiet would not be achieved during the five summer months and portions of the shoulder seasons'times when the majority of the people visit the park. As the Court observed, "* * * the use of an annual average does not correspond to the experience of the Park's actual visitors. People do not visit the Park on 'average days', nor do they stay long enough to benefit from averaging noise over an entire year. For the typical visitor, who visits the Grand Canyon for just a few days during the peak summer season, the fact that the Park is quiet 'on average' is cold comfort" (p. 21).

In summary, the National Parks Overflights Act of 1987 made clear that the visitors to GCNP are entitled to have the opportunity to experience substantial restoration of natural quiet. The Act did not limit that opportunity to only a portion of the park visitors or a portion of the year. The NPS, in its report to Congress, stated that such restoration would be for *the day* and, in its "Review of Scientific Basis for Change in Noise Impact Assessment Method * * *", the NPS further stated that it intended this to be "a threshold not to be exceeded on any given day." Thus, as suggested by the United States Court of Appeals, District of Columbia Circuit, the NPS clarifies *the day* to mean *any given day.* On each and every day, visitors to GCNP will have the opportunity to experience natural quiet, that is, 50% of the park naturally quiet 75–100% of the time.

Dated: May 15, 2003.

Michael D. Sunder,

Acting IMR-Regional Director.

[FR Doc. 03–28113 Filed 11–6–03; 8:45 am]

BILLING CODE 4312–ED–P

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Recommendation From the Aircraft Noise Model Validation Study

AGENCY: National Park Service, Department of Interior.

ACTION: Notice.

SUMMARY: Following the recommendation in the recently issued National Park Service Aircraft Noise Model Validation Study, released January 23, 2003, this announcement provides notice that the NOISEMAP Simulation Model is the model of choice for calculating aircraft audibility at Grand Canyon National Park and other National Park Service units.

ADDRESSES: Copies of the National Park Service Aircraft Noise Model Validation Study report are available on computer discs (CDs) and may be requested from Grand Canyon National Park, or viewed on the Grand Canyon National Park Webpage at *http://www.nps.gov/grca/overflights/index.htm.*

FOR FURTHER INFORMATION CONTACT: Ken McMullen, Overflights and Natural Soundscape Program Manager, National Park Service, Grand Canyon National Park, 823 N San Francisco Street, Flagstaff, Arizona 86001. Telephone 928–779–2095; or by e-mail at *ken_mcmullen@nps.gov.*

SUPPLEMENTARY INFORMATION:

Background

Public Law 100–91 (1987) tasked the National Park Service (NPS) and the Federal Aviation Administration (FAA) with developing a plan for aircraft use of Grand Canyon airspace that will succeed in "substantially restoring the natural quiet in the park". In its "Report on Effects of Aircraft Overflights on the National Park System" (1995), the NPS defined substantial restoration of natural quiet as occurring when "50% or more of the park achieve[s] 'natural quiet' (*i.e.*, no aircraft audible) for 75–100 percent of the day". Computer modeling was determined to be the most practical method to assess whether or not natural quiet had been substantially restored at Grand Canyon National Park.

Model Validation Study

Although models that compute when aircraft are audible over large land areas have not been widely used, two models have been employed to calculate the percent of time aircraft are audible at Grand Canyon National Park. The National Park Service Overflight Decision Support System model (NODSS) was developed for the NPS to calculate aircraft-produced noise in backcountry settings; NODSS was designed to account for park terrain features, its calculations are based on one-third octave band acoustic spectra information, and it calculates audibility directly. The results from NODSS have been used by the NPS to calculate the percent of substantial restoration of natural quiet achieved by various airspace and operations alternatives at Grand Canyon National Park. A second model, the Integrated Noise Model (INM), version 5.1, is the FAA-developed, aircraft noise computation model used internationally to calculate aircraft-produced noise in airport environments. INM bases its computations on A-weighted aircraft sound levels and accounts for differences in site elevation but does not account for shielding due to terrain. Results from INM have been presented in environmental assessments associated with FAA draft and final rules on Grand Canyon National Park airspace regulations. The two models, using Grand Canyon operations data but based on different metrics, produced somewhat different results. To comply with the National Environmental Protection Act's requirement to use "the best available science", a model validation study was designed to compare computer model results with measurements made on-site at the Grand Canyon. A third model, NOISEMAP Simulation Model (NMSIM) developed by Wyle Laboratories, the U.S. Air Force, and the National Aeronautics and Space Administration, was included in this study as was a second version of INM (Research Version). NMSIM, like NODSS, uses spectral information, accounts for park terrain, and computes aircraft audibility. In addition to these capabilities, NMSIM also simulates aircraft flying in the time sequence in which they occurred and includes the directivity of each aircraft type. The Research Version of INM uses spectral, rather than A-weighted, information but is in other major ways similar to INM.

The goal of the study was to: "Determine the degrees of accuracy and precision that existing computer models provide, in comparison with field measurement, in the calculation of the percent of time tour aircraft are audible in the Canyon. * * *" In this study, determining "accuracy and precision" is termed "validation".

The NPS Aircraft Noise Model Validation Study was designed through a cooperative process involving the NPS, the FAA, the Volpe National Transportation Systems Center, Wyle Laboratories, and Harris Miller Miller & Hansen Inc. After a draft research approach had been developed, a Technical Review Committee (TRC) consisting of internationally recognized experts reviewed and commented on the plan. Suggestions made by TRC members were incorporated into the study design. As results were produced the full team, including TRC members, were involved in review and comment. The full team has reviewed and commented on drafts of the study report. Their comments were incorporated extensively.

Acoustic data for the NPS Aircraft Noise Model Validation Study were collected from some 39 sites at Grand Canyon over a four-day period in September 1999. The collected data were reduced to provide hourly information for modeling tour aircraft audibility and sound levels for each hour of operations, and for then analyzing the results. Each of the four models (NODSS, INM in two versions, and NMSIM) were exercised with the same set of input data. The models were run to produce for each site the hourly values of both the percent of time tour aircraft were audible and the tour aircraft hourly equivalent sound level, L_{eq}. These values were then compared directly with measured values, site-by-site, hour-by-hour.

In August, 2002, as the NPS Aircraft Noise Model Validation Study report was nearing completion, the United States Court of Appeals, District of Columbia Circuit ((in United States Air Tour Association v. Federal Aviation Administration (Grand Canyon Trust, Intervenors)) declared that the FAA's practice of including only air tour aircraft-produced noise in the calculation of substantial restoration of natural quiet at GCNP should be remanded back to that agency for reconsideration. The Court indicated that noise from all aircraft overflying the park should be included in the noise calculations. Although the NPS Aircraft Noise Model Validation Study was based on data from tour aircraft conducting operations over Grand Canyon National Park, the inclusion of noise from other aircraft sources will not invalidate the results of this study. Similarly, as the models respond to the principles of acoustics and physics, the results of the NPS Aircraft Noise Model Validation Study are applicable to other National Park units.

Model Validation Study Recommendation

The study concluded, "We consider NMSIM to be the model most suited for immediate use in computing percent of

the time tour aircraft are audible" (p. 131).

Conclusion

Audibility is a fundamental component in the definition and measurement of natural quiet and natural sounds at Grand Canyon National Park and other NPS units. The NPS Aircraft Noise Model Validation study found NMSIM to be the model best suited for computing audibility. Further, the National Environmental Protection Act's requirement for the use of the "best available science" is met with the selection of NMSIM. Therefore, the NPS announces that the NOISEMAP Simulation Model (NMSIM) is the model of choice for calculating aircraft audibility at Grand Canyon National Park and other NPS units.

Dated: June 3, 2003.

Michael D. Sunder,

Acting Regional Director, Intermountain Region.

[FR Doc. 03–28114 Filed 11–6–03; 8:45 am]

BILLING CODE 4312–ED–P

DEPARTMENT OF LABOR

Employment Standards Administration

Wage and Hour Division

Minimum Wages for Federal and Federally Assisted Construction; General Wage Determination Decisions

General wage determination decisions of the Secretary of Labor are issued in accordance with applicable law and are based on the information obtained by the Department of Labor from its study of local wage conditions and data made available from other sources. They specify the basic hourly wage rates and fringe benefits which are determined to be prevailing for the described classes of laborers and mechanics employed on construction projects of a similar character and in the localities specified therein.

The determinations in these decisions of prevailing rates and fringe benefits have been made in accordance with 29 CFR part 1, by authority of the Secretary of Labor pursuant to the provisions of the Davis-Bacon Act of March 3, 1931, as amended (46 Stat. 1494, as amended, 40 U.S.C. 276a) and of other Federal statutes referred to in 29 CFR part 1, appendix, as well as such additional statutes as may from time to time be enacted containing provisions for the payment of wages determined to be prevailing by the Secretary of Labor in accordance with the Davis-Bacon Act. The prevailing rates and fringe benefits determined in these decisions shall, in accordance with the provisions of the foregoing statutes, constitute the minimum wage payable on Federal and federally assisted construction projects to laborers and mechanics of the specified classes engaged on contract work of the character and in the localities described therein.

Good cause is hereby found for not utilizing notice and public comment procedure thereon prior to the issuance of these determinations as prescribed in 5 U.S.C. 553 and not providing for delay in the effective date as prescribed in that section, because the necessity to issue current construction industry wage determinations frequently and in large volume causes procedures to be impractical and contrary to the public interest.

General wage determination decisions, and modifications and supersedeas decisions thereto, contain no expiration dates and are effective from their date of notice in the **Federal Register**, or on the date written notice is received by the agency, whichever is earlier. These decisions are to be used in accordance with the provisions of 29 CFR parts 1 and 5. Accordingly, the applicable decision, together with any modifications issued, must be made a part of every contract for performance of the described work within the geographic area indicated as required by an applicable Federal prevailing wage law and 29 CFR Part 5. The wage rates and fringe benefits, notice of which is published herein, and which are contained in the Government Printing Office (GPO) document entitled "General Wage Determinations Issued Under the Davis-Bacon And Related Acts," shall be the minimum paid by contractors and subcontractors to laborers and mechanics.

Any person, organization, or governmental agency having an interest in the rates determined as prevailing is encouraged to submit wage rate and fringe benefit information for consideration by the Department.

Further information and self-explanatory forms for the purpose of submitting this data may be obtained by writing to the U.S. Department of Labor, Employment Standards Administration, Wage and Hour Division, Division of Wage Determinations, 200 Constitution Avenue, NW., Room S–3014, Washington, DC 20210.

Modification to General Wage Determination Decisions

The number of the decisions listed to the Government Printing Office document entitled "General Wage Determinations Issued Under the Davis-Bacon and related Acts" being modified are listed by Volume and State. Dates of publication in the **Federal Register** are in parentheses following the decisions being modified.

Volume I

Maine
- ME0300001 (Jun. 13, 2003)
- ME0300002 (Jun. 13, 2003)
- ME0300008 (Jun. 13, 2003)

Volume II

West Virginia
- WV0300002 (Jun. 13, 2003)
- WV0300003 (Jun. 13, 2003)
- WV0300006 (Jun. 13, 2003)
- WV0300009 (Jun. 13, 2003)
- WV0300010 (Jun. 13, 2003)

Volume III

Kentucky
- KY0300003 (Jun. 13, 2003)
- KY0300025 (Jun. 13, 2003)
- KY0300027 (Jun. 13, 2003)
- KY0300028 (Jun. 13, 2003)
- KY0300029 (Jun. 13, 2003)

South Carolina
- SC030036 (Jun. 13, 2003)

Volume IV

None

Volume V

None

Volume VI

Montana
- MT0300001 (Jun. 13, 2003)
- MT0300002 (Jun. 13, 2003)
- MT0300003 (Jun. 13, 2003)
- MT0300004 (Jun. 13, 2003)
- MT0300005 (Jun. 13, 2003)
- MT030006 (Jun. 13, 2003)
- MT030007 (Jun. 13, 2003)
- MT030008 (Jun. 13, 2003)

North Dakota
- ND030004 (Jun. 13, 2003)
- ND030007 (Jun. 13, 2003)
- ND030018 (Jun. 13, 2003)

South Dakota
- SD030009 (Jun. 13, 2003)
- WY030008 (Jun. 13, 2003)
- WY030009 (Jun. 13, 2003)

Volume VII

None

General Wage Determination Publication

General Wage determinations issued under the Davis-Bacon and related Acts, including those noted above, may be found in the Government Printing Office (GPO) document entitled "General Wage determinations Issued Under the Davis-Bacon And Related Acts". This publication is available at each of the 50 Regional Government Depository Libraries and many of the 1,400 Government Depository Libraries across the country.

General wage determinations issued under the Davis-Bacon and related Acts are available electronically at no cost on

the Government Printing Office site at *http://www.access.gpo//davisbacon*. They are also available electronically by subscription to the Davis-Bacon Online service (*http://davisbacon.fedworld.gov*) of the National Technical Information Service (NTIS) of the U.S. Department of Commerce at 1–800–363–2068. This subscription offers value-added features such as electronic delivery of modified wage decisions directly to the user's desktop, the ability to access prior wage decisions issued during the year, extensive Help desk support, etc.

Hard-copy subscriptions may be purchased from: Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402, (202) 512–1800.

When ordering hard-copy subscription(s), be sure to specify the State(s) of interest, since subscriptions may be ordered for any or all of the six separate Volumes, arranged by State. Subscriptions include an annual edition (issued in January or February) which includes all current general wage determinations for the States covered by each volume. Throughout the remainder of the year, regular weekly updates will be distributed to subscribers.

Signed at Washington, DC, this 30th day of October, 2003.

Carl J. Poleskey,

Chief, Branch of Construction Wage Determinations.

[FR Doc. 03–27698 Filed 11–06–03; 8:45 am]

BILLING CODE 4510–27–M

DEPARTMENT OF LABOR

Occupational Safety and Health Administration

National Advisory Committee on Ergonomics, Call for Abstracts

AGENCY: Occupational Safety and Health Administration (OSHA), Labor.

ACTION: Notice; extension of time to submit abstracts.

SUMMARY: On October 6, 2003, OSHA published a notice (68 FR 57713) soliciting abstracts from persons wishing to make presentations at a symposium entitled "Musculoskeletal and Neurovascular Disorders—the State of the Research Regarding Workplace Etiology and Prevention." This symposium is scheduled to be held in conjunction with the fourth meeting of the National Advisory Committee on Ergonomics in January 2004. Abstracts were originally due on November 5, 2003. The Agency has decided to extend the deadline for submission of abstracts. Interested persons are asked to refer to the original October 6, 2003 notice for details on content and format for abstracts.

DATES: Abstracts are due December 1, 2003. The symposium will take place on January 27, 2004.

ADDRESSES: The Symposium will be held in Washington, DC. Submit abstracts to MaryAnn Garrahan, Director, Office of Technical Programs and Coordination Activities, OSHA, U.S. Department of Labor, Room N–3655, 200 Constitution Avenue, NW., Washington, DC 20210. Phone: (202) 693–2144; Fax: (202) 693–1644.

FOR FURTHER INFORMATION CONTACT: OSHA, Office of Communications, Room N–3647, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210. Phone: (202) 693–1999.

SUPPLEMENTARY INFORMATION: In conjunction with NACE's fourth meeting in January 2004, a symposium is being convened to enable the committee to hear from experts in ergonomics. In its October 6, 2003 **Federal Register** notice, OSHA provided the public with information on its plans for the symposium, along with detailed materials to help interested persons to submit abstracts for consideration. Abstracts were originally due on November 5, 2003. However, the Agency is now extending the period for submission of abstracts through December 1, 2003.

Rather than repeating all of the relevant information contained in the October 6, 2003 notice, OSHA asks interested persons to refer directly to that notice for guidance in submitting abstracts. The October 6 notice is available on OSHA's Web site at *http://www.osha.gov/FedReg_osha_pdf/FED20031006.pdf*.

Authority: This notice was prepared under the direction of John L. Henshaw, Assistant Secretary of Labor for Occupational Safety and Health. It is issued under the Federal Advisory Committee Act (5 U.S.C. App. 2), GSA's FACA Regulations (41 CFR Part 102–3), and DLMS 3 Chapter 1600.

Signed at Washington, DC, this 4th day of November, 2003.

John L. Henshaw,

Assistant Secretary of Labor.

[FR Doc. 03–28092 Filed 11–6–03; 8:45 am]

BILLING CODE 4510–26–P

NUCLEAR REGULATORY COMMISSION

[Docket Nos. 50–237 and 50–249]

Dresden Nuclear Power Station, Units 2 and 3; Notice of Withdrawal of Application for Amendment to Facility Operating License

The U.S. Nuclear Regulatory Commission (the Commission) has granted the request of Exelon Generation Company, LLC (the licensee) to withdraw its December 20, 2002, application for proposed amendment to Facility Operating License Nos. DPR–19 and DPR–25 for the Dresden Nuclear Power Station, Units 2 and 3, located in Grundy County, Illinois.

The proposed amendment would have revised the applicability of facility technical specifications pertaining to Reactor Protection System (RPS) instrumentation, main steam isolation valve closure and turbine condenser vacuum—low functions, to eliminate the requirement for these functions be operable while in Mode 2 with reactor pressure greater than or equal to 600 psig and delete the associated Required Action to align with the revised applicability of these functions.

The Commission had previously issued a Notice of Consideration of Issuance of Amendment published in the **Federal Register** on March 18, 2003, (68 FR 12952). However, by letter dated October 1, 2003, the licensee withdrew the proposed change.

For further details with respect to this action, see the application for amendment dated December 20, 2002, and the licensee's letter dated October 1, 2003, which withdrew the application for license amendment. Documents may be examined, and/or copied for a fee, at the NRC's Public Document Room (PDR), located at One White Flint North, Public File Area O1 F21, 11555 Rockville Pike (first floor), Rockville, Maryland. Publicly available records will be accessible electronically from the Agencywide Documents Access and Management Systems (ADAMS) Public Electronic Reading Room on the internet at the NRC Web site, *http://www.nrc.gov/reading-rm/adams/html*. Persons who do not have access to ADAMS or who encounter problems in accessing the documents located in ADAMS, should contact the NRC PDR Reference staff by telephone at 1–800–397–4209, or 301–415–4737 or by email to *pdr@nrc.gov*.

Dated at Rockville, Maryland, this 2nd day of November 2003.

For the Nuclear Regulatory Commission.

Maitri Banerjee,

Project Manager, Section 2, Project Directorate III, Division of Licensing Project Management, Office of Nuclear Reactor Regulation.

[FR Doc. 03–28067 Filed 11–6–03; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[Docket No. 40–7580]

Notice of Availability of Environmental Assessment and Finding of No Significant Impact for License Amendment for Fansteel, Inc.—Muskogee, Oklahoma License No. SMB–911

AGENCY: Nuclear Regulatory Commission.

ACTION: Notice of availability of Environmental Assessment and Finding of No Significant Impact.

FOR FURTHER INFORMATION, CONTACT: James C. Shepherd, Project Manager, Decommissioning Branch, Division of Waste Management, Office of Nuclear Material Safety and Safeguards, U.S. Nuclear Regulatory Commission, Mail Stop: T–7F27, Washington, DC 20555–0001. Telephone: (301) 415–6712; Fax number: (301) 415–5398; E-mail: *jcs2@nrc.gov.*

SUPPLEMENTARY INFORMATION:

I. Introduction

The U.S. Nuclear Regulatory Commission (NRC) is considering the issuance of a license amendment to Material License Number SMB–911, issued to Fansteel, Inc. (the licensee), to authorize decommissioning of its facility located in Muskogee, Oklahoma. NRC has prepared an Environmental Assessment (EA) in accordance with the requirements of 10 CFR part 51 and to determine the environmental impacts of approving the decommissioning plan (DP), subsequent release of the site for unrestricted use (as defined in 10 CFR 20.1402), and termination of the license.

II. EA Summary

The purpose of the proposed action is to authorize the decommissioning of Fansteel's Speciality Metals facility, in Muskogee, Oklahoma, for unrestricted use to allow for license termination. The Fansteel processing facility produced tantalum and columbium metals for approximately 33 years until operations ceased in 1990. The raw materials used for tantalum and columbium production contain uranium and thorium as naturally occurring trace constituents. The concentration of radioactive species present in the process raw materials is sufficient to cause the ores and slags to be classified by the NRC as source material. Consequently, Fansteel operated under NRC License No. SMB–911 for the possession of source material. Fansteel was authorized by the NRC on March 25, 1997, to complete the processing of ore residues, calcium fluoride residues, and wastewater treatment residues containing uranium and thorium, in various site impoundments.

On July 24, 2003, Fansteel requested that NRC approve the DP for the facility, which when complete, would permit the site to be released for unrestricted use. Final approval for release of the site for unrestricted use and license termination would be contingent upon NRC approval of the licensee's final status survey report and making the findings required by the Commission's regulations following completion of the licensee's decommissioning activities. Fansteel's request for the proposed action was previously noticed in the **Federal Register** on August 11, 2003 (68 FR 47621), along with a notice of an opportunity to request a hearing and an opportunity to provide comments on the action and its environmental impacts.

III. Finding of No Significant Impact

The staff has prepared the EA in support of the proposed license amendment to decommission the site, terminate the license, and release the site for unrestricted use. On the basis of the EA, NRC has concluded that there are no significant environmental impacts from the proposed action, and the license amendment does not warrant preparation of an Environmental Impact Statement. It has been determined that a Finding of No Significant Impact (FONSI) is appropriate. The amendment will be issued following the publication of this Notice.

IV. Further Information

The EA and the documents related to this proposed action, including the application for the license amendment and supporting documentation, are available for inspection at NRC's Public Electronic Reading Room at *http://www.nrc.gov/reading-rm.html* [ADAMS Accession Nos.: ML030240051, ML030240062, ML030240109, ML030240134, and ML030240432 (Decommissioning Plan); ML032100530 (request for license amendment); ML032100558 (revised Decommissioning Plan Sections 15.3–15.5); and ML033040204 (Environmental Assessment, Finding of No Significant Impact). These documents may also be examined, and/or copied for a fee, at the NRC Public Document Room (PDR), located at One White Flint North, 11555 Rockville Pike, Rockville, MD 20852.

Dated at Rockville, Maryland, this 31st day of October, 2003.

For the Nuclear Regulatory Commission.

Janet R. Schlueter,

Acting Director, Division of Waste Management, Office of Nuclear Material Safety and Safeguards.

[FR Doc. 03–28066 Filed 11–6–03; 8:45 am]

BILLING CODE 7590–01–P

SECURITIES AND EXCHANGE COMMISSION

Proposed Collection; Comment Request

Upon Written Request, Copies Available From: Securities and Exchange Commission, Office of Filings and Information Services, Washington, DC 20549.

Extension:

- Rule 17Ad–11; SEC File No. 270–261; OMB Control No. 3235–0274.

Notice is hereby given that pursuant to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*), the Securities and Exchange Commission ("Commission") is soliciting comments on the collection of information summarized below. The Commission plans to submit this existing collection of information to the Office of Management and Budget for extension and approval.

Rule 17Ad–11: Reports Regarding Aged Record Differences, Buy-ins, and Failure to Post Certificate Detail to Master Securityholder Files

Rule 17Ad–11 requires all registered transfer agents to report to issuers and the appropriate regulatory agency in the event that aged record differences exceed certain dollar value thresholds. An aged record difference occurs when an issuer's records do not agree with those of securityowners as indicated, for instance, on certificates presented to the transfer agent for purchase, redemption or transfer. In addition, the rule requires transfer agents to report to the appropriate regulatory agency in the event of a failure to post certificate detail to the master securityholder file within 5 business days of the time required by Rule 17Ad–10. Also, transfer agents must maintain a copy of each report prepared under Rule 17Ad–11 for a period of three years following the date of the report. These recordkeeping requirements assist the

Commission and other regulatory agencies with monitoring transfer agents and ensuring compliance with the rule.

Because the information required by Rule 17Ad–11 is already available to transfer agents, any collection burden for small transfer agents is minimal. The staff estimates that the average number of hours necessary to comply with Rule 17Ad–11 is one hour annually. Based upon past submissions, the total burden is 150 hours annually for transfer agents.

Written comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimates of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given to comments and suggestions submitted in writing within 60 days of this publication.

Please direct your written comments to Kenneth A. Fogash, Acting Associate Executive Director/CIO, Office of Information Technology, Securities and Exchange Commission, 450 5th Street, NW., Washington, DC 20549.

Dated: October 31, 2003.

Jill M. Peterson,

Assistant Secretary.

[FR Doc. 03–28068 Filed 11–6–03; 8:45 am]

BILLING CODE 8010–01–P

SECURITIES AND EXCHANGE COMMISSION

Proposed Collection; Comment Request

Upon Written Request, Copies Available From: Securities and Exchange Commission, Office of Filings and Information Services, Washington, DC 20549.

Extension:

Rule 17Ad–13; SEC File No. 270–263; OMB Control No. 3235–0275.

Notice is hereby given that pursuant to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*), the Securities and Exchange Commission ("Commission") is soliciting comments on the collection of information summarized below. The Commission plans to submit this existing collection of information to the Office of Management and Budget for extension and approval.

- Rule 17Ad–13 Annual Study and Evaluation of Internal Accounting Control

Rule 17Ad–13 requires approximately 200 registered transfer agents to obtain an annual report on the adequacy of internal accounting controls. In addition, transfer agents must maintain copies of any reports prepared pursuant to Rule 17Ad–13 plus any documents prepared to notify the Commission and appropriate regulatory agencies in the event that the transfer agent is required to take any corrective action. These recordkeeping requirements assist the Commission and other regulatory agencies with monitoring transfer agents and ensuring compliance with the rule. Small transfer agents are exempt from Rule 17Ad–13.

The staff estimates that the average number of hours necessary for each transfer agent to comply with Rule 17Ad–13 is one hundred seventy-five hours annually. The total burden is 35,000 hours annually for transfer agents, based upon past submissions.

Written comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimates of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given to comments and suggestions submitted in writing within 60 days of this publication.

Please direct your written comments to Kenneth A. Fogash, Acting Associate Executive Director/CIO, Office of Information Technology, Securities and Exchange Commission, 450 5th Street, NW., Washington, DC 20549.

Dated: October 31 , 2003.

Jill M. Peterson,

Assistant Secretary.

[FR Doc. 03–28069 Filed 11–6–03; 8:45 am]

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SECURITIES AND EXCHANGE COMMISSION

[Release No. IC–26246; 812–12860]

Vanguard International Equity Index Funds, et al.; Notice of Application

November 3, 2003.

AGENCY: Securities and Exchange Commission ("Commission")

ACTION: Notice of an application for an order under section 6(c) of the Investment Company Act of 1940 (the "Act") for exemptions from sections 2(a)(32), 18(f)(1), 18(i), 22(d), 22(e) and 24(d) of the Act and rule 22c–1 under the Act, and under sections 6(c) and 17(b) of the Act for exemptions from sections 17(a)(1) and (2) of the Act.

SUMMARY OF APPLICATION: Applicants request an order that would permit the following: (a) An open-end management investment company, the series of which consist of the component securities of certain foreign equity securities indices, to issue a class of shares ("VIPER Shares") that can be purchased from the investment company and redeemed only in large aggregations ("Creation Units"); (b) secondary market transactions in VIPER Shares to occur at negotiated prices on a national securities exchange, as defined in section 2(a)(26) of the Act ("Exchange"); (c) dealers to sell VIPER Shares to purchasers in the secondary market unaccompanied by a prospectus when prospectus delivery is not required by the Securities Act of 1933 ("Securities Act"); (d) certain affiliated persons of the series to deposit securities into, and receive securities from, the series in connection with the purchase and redemption of Creation Units; and, (e) the series to pay redemption proceeds, under certain circumstances, more than seven days after the tender of a Creation Unit of VIPER Shares for redemption.

APPLICANTS: Vanguard International Equity Index Funds ("Trust"), The Vanguard Group, Inc. ("VGI"), and Vanguard Marketing Corporation ("VMC").

FILING DATES: The application was filed on July 25, 2002, and amended on October 7, 2003.

HEARING OR NOTIFICATION OF HEARING: An order granting the application will be issued unless the Commission orders a hearing. Interested persons may request a hearing by writing to the Commission's Secretary and serving applicants with a copy of the request, personally or by mail. Hearing requests should be received by the Commission by 5:30 p.m. on November 28, 2003, and

should be accompanied by proof of service on applicants, in the form of an affidavit, or for lawyers, a certificate of service. Hearing requests should state the nature of the writer's interest, the reason for the request, and the issues contested. Persons who wish to be notified of a hearing may request notification by writing to the Commission's Secretary.

ADDRESSES: Secretary, Commission, 450 Fifth Street, NW., Washington, DC 20549–0609. Applicants, c/o Barry A. Mendelson, The Vanguard Group, Inc., P.O. Box 2600, Valley Forge, PA 19482.

FOR FURTHER INFORMATION CONTACT: Stacy L. Fuller, Senior Counsel, or Michael W. Mundt, Senior Special Counsel, at 202–942–0564 (Division of Investment Management, Office of Investment Company Regulation).

SUPPLEMENTARY INFORMATION: The following is a summary of the application. The complete application may be obtained for a fee at the Commission's Public Reference Branch, 450 Fifth Street, NW., Washington, DC 20549–0102 (telephone 202–942–8090).

Applicants' Representations

1. The Trust is an open-end management investment company registered under the Act and organized as a Delaware statutory trust. The Trust currently has three series ("Existing Funds"). Each Existing Fund currently offers separate classes of shares for retail and institutional investors (such classes of shares collectively, "Conventional Shares"). In the future, the Trust or another registered open-end management investment company may offer other series ("Future Funds," and together with Existing Funds, "Funds"). Any Future Fund will (a) be advised by VGI or an entity controlled by or under common control with VGI and (b) comply with the terms and conditions of any order granted pursuant to the application.

2. VGI is a Pennsylvania corporation that is wholly and jointly owned by 35 investment companies, and the series thereof (each, a "Vanguard Fund" and collectively, the "Vanguard Fund Complex"). VGI is registered as an investment adviser under the Investment Advisers Act of 1940 and as a transfer agent under the Securities Exchange Act of 1934 ("Exchange Act"). VGI provides each Vanguard Fund, with corporate management, administrative, and transfer agency services at cost. VGI also provides advisory services at cost to certain Vanguard Funds, including each of the Existing Funds. VMC, a wholly owned subsidiary of VGI, is registered as a broker-dealer under the Exchange Act. VMC provides all distribution and marketing services to the Vanguard Funds, including each of the Existing Funds.

3. Each Existing Fund seeks to track as closely as possible the performance of an international equity securities index (each, a "Target Index").[1] In seeking to track their Target Indexes, the Existing Funds use a replication strategy, pursuant to which each Existing Fund holds each of the component securities in the Target Index in about the same proportion as represented in the Target Index itself. Future Funds may use the replication strategy or a representative sampling strategy, pursuant to which they would hold a representative sample of the component securities in the relevant Target Index that resembles the full Target Index in terms of industry weightings, market capitalization, price/earnings ratio, dividend yield and other characteristics.[2] Applicants state that, measured over virtually any period, the difference between the performance of an Existing Fund and the performance of its Target Index rarely exceeds one percentage point per annum and in almost all cases is significantly less. Applicants expect that, in the future, the Funds will track the relevant Target Indexes with a similar degree of precision, and have a tracking error of less than 5% per annum. No entity that creates, compiles, sponsors or maintains a Target Index will be an affiliated person, as defined in section 2(a)(3) of the Act, or an affiliated person of an affiliated person, of the Trust, VGI, VMC, or any promoter of the Trust.

4. Applicants state that a small percentage of investors frequently trade in and out of the Existing Funds, often as part of a market timing strategy, and that to meet these investors' redemption requests, a Fund must buy and sell portfolio securities. Applicants state that such purchases and sales of portfolio securities are detrimental in that they can increase a Fund's realization of capital gains, increase expenses, and hinder a Fund's ability to achieve its investment objective of tracking the relevant Target Index as closely as possible. Applicants further state that the Existing Funds have adopted policies designed to deter these investors but that such policies have been insufficient.

5. Each Fund proposes to create VIPER (Vanguard Index Participation Equity Receipts) Shares, a class of shares that would be listed on an Exchange and trade in the secondary market at negotiated prices. Applicants state that, by creating an exchange-traded class of shares, the Funds will offer short-term investors an attractive means of investing in the Funds.[3] Applicants further assert that offering VIPER Shares will benefit holders of Conventional Shares by reducing the portfolio disruption and transaction costs caused by market timing activity.

6. Except in connection with the Conversion Privilege (as defined below) or the liquidation of a Fund (or of the VIPER Share class of a Fund), the Funds will issue VIPER Shares only in Creation Units, aggregations of a specified number of shares ranging from 20,000 to 250,000 shares. The price of a Creation Unit will range from $500,000 to $30,000,000.[4] Orders to purchase Creation Units must be placed with VMC by or through an "Authorized Participant," which is a Depository Trust Company ("DTC") participant that has executed a participant agreement with VMC. Creation Units will be issued in exchange for an in-kind deposit of securities and cash ("Creation Deposit"). The Creation Deposit will consist of a basket of securities selected by VGI from among the securities contained in the Fund's portfolio ("Deposit Securities"),[5] and a cash

[1] The Target Indexes are the Select Emerging Markets Free Index, Morgan Stanley Capital International Europe Index, and the Morgan Stanley Capital International Pacific Index. Each Fund reserves the right to substitute a different index for the Target Index that it currently tracks. Any substitute index will measure the same general market as the current Target Index. Investors will receive notification of any such substitution.

[2] Each Fund will invest at least 90% of its assets in the component securities of its Target Index but may invest up to 10% of its assets in convertible securities, stock and index futures, options on stock and index futures, swap agreements, cash investments, forward foreign currency investments, foreign currency exchange contracts, and other instruments not inconsistent with the investment policies described in its registration statement, which VGI believes will help the Fund to track its Target Index.

[3] Applicants expect VIPER Shares to appeal to short-term investors because they can be bought and sold continuously throughout the day at market price rather than at net asset value ("NAV"), which is calculated only once per day at the close of trading on the New York Stock Exchange ("NYSE"). Transactions in Conventional Shares will continue to be priced at NAV.

[4] A Fund may require investors to purchase a minimum number of Creation Units.

[5] Applicants state that, for Funds holding fewer than approximately one thousand portfolio securities, the Deposit Securities typically will be identical to the Fund's portfolio. For Funds holding more than that number of portfolio securities, VGI will select a subset of the Fund's portfolio using a representative sampling strategy, similar to that discussed above. American Depositary Receipts ("ADRs") will not be component securities of a Target Index and Authorized Participants will not be able, on their own initiative, to substitute the ADR of a Deposit Security in place of the actual Deposit Security. However, Applicants may include one or more ADRs in a list of Deposit Securities

payment to equalize any difference between the total aggregate market value of the Deposit Securities and the NAV per Creation Unit of the Fund ("Balancing Amount").[6] An investor purchasing a Creation Unit from a Fund will be charged a fee ("Transaction Fee") to prevent any dilution of the interests of remaining shareholders due to the Fund incurring costs in connection with the investor's purchase of the Creation Unit(s).[7] Each purchaser of a Creation Unit will receive a prospectus for the VIPER Shares (the "VIPER Prospectus") that discloses the maximum Transaction Fee, and the method of calculating Transaction Fees will be disclosed in the Fund's statement of additional information ("SAI"). A Fund's Conventional Shares will be covered by a separate prospectus (the "Conventional Prospectus").

7. All orders to purchase Creation Units must be received by VMC no later than the closing time of the NYSE on the date the order is placed in order to receive NAV as determined that day. VMC will transmit all purchase orders to the Funds, maintain a record of each Creation Unit purchaser, and send out a VIPER Prospectus and confirmation to such purchasers.

8. The purchaser of a Creation Unit will be able to separate the Creation Unit into individual VIPER Shares.[8] VIPER Shares will be listed on an Exchange and traded in the secondary market in the same manner as shares of other exchange-traded funds. One or more Exchange specialists ("Specialists") will be assigned to make a market in the VIPER Shares. The price of VIPER Shares traded on an Exchange will be based on a current bid/offer market, and each VIPER Share is expected to have an initial market value of between $10 and $150. Transactions involving the sale of VIPER Shares in the secondary market will be subject to customary brokerage commissions and charges.

9. Applicants expect that purchasers of Creation Units will include institutional investors and arbitrageurs. A Specialist, in providing for a fair and orderly secondary market for VIPER Shares, also may purchase Creation Units for use in its market making activities on the Exchange. Applicants expect that secondary market purchasers of VIPER Shares will include both institutional and retail investors.[9] Applicants believe that arbitrageurs will purchase or redeem Creation Units to take advantage of discrepancies between the VIPER Shares' market price and the VIPER Shares' NAV. Applicants expect that this arbitrage activity will provide a market discipline that will result in a close correspondence between the price at which the VIPER Shares trade and their NAV. Applicants do not expect VIPER Shares to trade at a significant premium or discount to their NAV.[10]

10. Applicants will make available a VIPER Shares product description ("Product Description") for distribution in accordance with an Exchange rule requiring Exchange members and member organizations effecting transactions in VIPER Shares to deliver a Product Description to investors purchasing VIPER Shares, whether on or away from the Exchange. Applicants state that any other Exchange that applies for unlisted trading privileges in VIPER Shares will have to adopt a similar rule, requiring delivery of the Product Description. The Product Description will provide a plain English overview of a Fund, including its investment objective and investment strategies, the identity of VGI, the material risks of investing in the Fund, and the composition and frequency of distributions. The Product Description also will provide a brief, plain English description of the salient features of VIPER Shares. The Product Description will advise investors that a VIPER Prospectus and SAI may be obtained, without charge, from the investor's broker or from VMC. The Product Description also will identify a Web site address where investors can obtain information about the composition and compilation methodology of the Target Index. Applicants expect that the number of purchases of VIPER Shares in which an investor will not receive a Product Description will not constitute a significant portion of the market activity in VIPER Shares.

11. Except in connection with the liquidation of a Fund (or of a Fund's VIPER Share class), VIPER Shares will only be redeemable in Creation Unit aggregations through each Fund. An investor redeeming a Creation Unit generally will receive (a) a basket of securities ("Redemption Securities"), which in most cases will be the same as the Deposit Securities required of investors purchasing Creation Units on the same day, and (b) a cash amount equal to the difference in the value of the Redemption Securities and the NAV of a Creation Unit, which in most cases will be the same as the Balancing Amount paid (or received) by investors purchasing Creation Units on the same day. A Fund may make redemptions partly or wholly in cash in lieu of transferring one or more Redemption Securities to a redeeming investor, if the Fund determines that such alternative is warranted. The Fund may make such a determination if, for example, a foreign country's regulations restrict or prohibit a redeeming investor from holding a particular issuer's securities. In order to cover the Fund's transaction costs, redeeming investors will pay a Transaction Fee.[11]

12. The Funds intend to offer holders of Conventional Shares (except those holding Conventional Shares through a 401(k) or other participant-directed employer-sponsored retirement plan) the opportunity to exchange some or all of those shares for the Fund's VIPER

when the security underlying the ADR is difficult or costly for Authorized Participants to obtain or designating the ADR as a Deposit Security will otherwise enhance pricing and liquidity.

[6] On each business day, prior to the opening of trading on the Exchange, VGI will make available through DTC or VMC the list of the names and the required number of shares of each Deposit Security to be included in the Creation Deposit for each Fund. Each Fund reserves the right to permit or require the purchaser of a Creation Unit to substitute cash or a different security to replace a Deposit Security under certain circumstances.

[7] When a Fund permits an investor to substitute cash for a Deposit Security, the investor may be assessed a higher Transaction Fee to offset the increased cost to the Fund of buying the necessary Deposit Security for its portfolio.

[8] Applicants state that persons purchasing Creation Units will be cautioned in the VIPER Prospectus that some activities on their part may, depending on the circumstances, result in their being deemed a statutory underwriter and subject them to the prospectus delivery and liability provisions of the Securities Act. For example, a broker-dealer firm and/or its client may be deemed a statutory underwriter if it purchases Creation Units from a Fund, breaks them down into the constituent VIPER Shares, and sells VIPER Shares directly to its customers, or if it chooses to couple the purchase of a supply of new VIPER Shares with an active selling effort involving solicitation of secondary market demand for VIPER Shares. The VIPER Prospectus will state that whether a person is an underwriter depends on all the facts and circumstances pertaining to that person's activities. The VIPER Prospectus also will state that broker-dealer firms should note that dealers who are not "underwriters" but are participating in a distribution (as contrasted to an ordinary secondary trading transaction), and thus dealing with VIPER Shares that are part of an "unsold allotment" within the meaning of section 4(3)(C) of the Securities Act, would be unable to take advantage of the prospectus delivery exemption provided by section 4(3) of the Securities Act.

[9] VIPER Shares will be registered in book-entry form only. DTC or its nominee will be the registered owner of all outstanding VIPER Shares. Records reflecting the beneficial owners of VIPER Shares will be maintained by DTC or its participants.

[10] Every 15 seconds throughout the trading day, the Exchange will disseminate via the facilities of the Consolidated Tape Association the market value of a VIPER Share and, separate from the consolidated tape, a calculation of the estimated NAV of a VIPER Share. Applicants state that an investor comparing the two figures will be able to determine whether, and to what extent, VIPER Shares are selling at a premium or discount to NAV.

[11] Investors who redeem for cash, rather than in kind, may pay a higher Transaction Fee.

Shares ("Conversion Privilege").[12] A Fund would not offer holders of VIPER Shares the opportunity to exchange some or all of their shares for Conventional Shares.[13] Applicants state that the Conversion Privilege would facilitate the movement of investors, who currently hold Conventional Shares but desire intraday trading flexibility, out of Conventional Shares and into VIPER Shares in an expeditious and tax efficient manner.[14] Around the time that a Fund's VIPER Shares begin trading, VGI may send to existing holders of the Fund's Conventional Shares a notice describing the Conversion Privilege and explaining the process by which an investor may exchange his or her Conventional Shares for VIPER Shares. The notice will comply with section 10(b) of the Securities Act and rule 482 under the Securities Act. Comparable information about a Fund's Conversion Privilege also will be contained in a separate section of the Conventional Prospectus. To effect an exchange through the Conversion Privilege, the investor must have a brokerage account and must contact his or her broker to initiate the exchange. The investor will receive a VIPER Prospectus in connection with the exchange transaction, as required by the Securities Act. Subsequent to the exchange, the investor will have to contact his or her broker for account information relating to the VIPER Share holdings.

Applicants' Legal Analysis

1. Applicants request an order under section 6(c) of the Act for exemptions from sections 2(a)(32), 18(f)(1), 18(i), 22(d), 22(e) and 24(d) of the Act and rule 22c–1 under the Act; and under sections 6(c) and 17(b) of the Act for exemptions from sections 17(a)(1) and (2) of the Act.

2. Section 6(c) of the Act provides that the Commission may exempt any person, security, or transaction, or any class or classes of persons, securities, or transactions, from any provision or provisions of the Act, or any rule or regulation thereunder, if and to the extent that such exemption is necessary or appropriate in the public interest and consistent with the protection of investors and the purposes fairly intended by the policy and provisions of the Act.

Section 2(a)(32) of the Act

3. Section 2(a)(32) of the Act defines "redeemable security" as any security, other than short-term paper, under the terms of which the holder, upon its presentation to the issuer, is entitled to receive approximately his proportionate share of the issuer's current net assets, or the cash equivalent. Applicants request an order under section 6(c) to permit VIPER Shares to be redeemed in Creation Units only. Applicants note that because of the arbitrage possibilities created by the redeemability of Creation Units, it is expected that the market price of a VIPER Share will not vary much from its NAV.

Section 18(f)(1) and 18(i) of the Act

4. Section 18(f)(1) of the Act, in relevant part, prohibits a registered open-end company from issuing any class of "senior security," which is defined in section 18(g) to include any stock of a class having a priority over any other class as to the distribution of assets or payment of dividends. Section 18(i) of the Act requires that every share of stock issued by a registered management company be voting stock, with the same voting rights as every other outstanding voting stock. Rule 18f–3 permits an open-end fund to issue multiple classes of shares representing interests in the same portfolio without seeking exemptive relief from section 18(f)(1) and 18(i), provided that the fund complies with certain requirements. Applicants state that they will comply in all respects with rule 18f–3, except the requirements that (a) each class have the same rights and obligations as each other class (other than the differences allowed by the rule), and (b) if a class has a different distribution arrangement, the class must pay all of the expenses of the arrangement. Because applicants, therefore, may not rely on rule 18f–3, they request an exemption under section 6(c) from sections 18(f)(1) and 18(i).

5. Applicants state that there are three ways in which the Conventional Shares and VIPER Shares of each Fund will have different rights: (a) Conventional Shares will be individually redeemable, while VIPER Shares will be redeemable in Creation Units only; (b) VIPER Shares will be traded on an Exchange, while Conventional Shares will not; and (c) Conventional Shares may be exchanged for VIPER Shares through the Conversion Privilege, while VIPER Shares may not be exchanged for Conventional Shares. Applicants assert that these different rights are necessary if their proposal is to have the desired benefits. Applicants note that a Fund's VIPER Shares will be tradable on an Exchange and redeemable only in large aggregations, and that its Conventional Shares will be exchangeable for VIPER Shares in order to encourage short-term investors to conduct their trading activities in a way that does not disrupt the management of the Fund's portfolio. Applicants assert that there is no reason to make Conventional Shares tradable and that it would be counterproductive to facilitate the ability of market timers to disrupt a Fund by making VIPER Shares individually redeemable or exchangeable for Conventional Shares.

6. Applicants assert that the different rights do not implicate the concerns underlying section 18 of the Act, including conflicts of interest and investor confusion. With respect to the potential for investor confusion, applicants will take a variety of steps to ensure that investors understand the key differences between Conventional Shares and VIPER Shares. Applicants state that the VIPER Shares will not be marketed as a mutual fund investment. Marketing materials may refer to VIPER Shares as an interest in an investment company or fund, but will not make reference to an "open-end fund" or "mutual fund," except to compare or contrast the VIPER Shares with the shares of a conventional open-end management investment company. Any marketing or advertising materials addressed primarily to prospective investors will emphasize that (a) VIPER Shares are not redeemable from a Fund other than in Creation Units, (b) VIPER Shares, other than in Creation Units, may be sold only through a broker, and the shareholder may have to pay brokerage commissions in connection with the sale, and (c) a selling shareholder may receive less than NAV in connection with the sale of VIPER Shares. The same type of disclosure will be provided in the Conventional Prospectus, VIPER Prospectus, Product

[12] Investors who own Conventional Shares through an employer-sponsored retirement plan can sell those shares and use the proceeds to buy VIPER Shares without tax consequences. It is therefore unnecessary to offer such investors the Conversion Privilege.

[13] The terms of an exchange made pursuant to the Conversion Privilege will comply with section 11(a) of the Act and rule 11a–3 under the Act. The Conversion Privilege would offer a "one way" exchange only. Therefore, a holder of a Fund's VIPER Shares who wishes to shift to the Fund's Conventional Shares would have to sell the VIPER Shares in the secondary market and use the sale proceeds (less any brokerage commission) to purchase Conventional Shares from the Fund. The sale of VIPER Shares would be a taxable transaction.

[14] Applicants note that an exchange of Conventional Shares for VIPER Shares of the same Fund generally would not be a taxable transaction. Applicants note that because DTC's systems are unable to handle fractional shares, exchange requests will be rounded down to the nearest whole VIPER Share. If an investor wishes to exchange all of his or her Conventional Shares, however, any fractional VIPER Share that results from the exchange will be liquidated and the cash will be sent to the investor's broker for the benefit of the investor.

Description, SAI and reports to shareholders. Applicants also note that (a) all references to a Fund's exchange-traded class of shares will use a form of the name "VIPERS" rather than the Fund name, (b) the cover and summary page of the VIPER Prospectus will state that the VIPER Shares are listed on an Exchange and are not individually redeemable, (c) VMC will only market Conventional Shares and VIPER Shares in the same advertisement or marketing material when the advertisement or marketing material contains appropriate disclosure explaining the relevant features of each class of shares and highlighting the differences between the share classes, and (d) applicants have prepared educational materials describing the VIPER Shares.

7. Applicants currently allocate distribution expenses among funds in the Vanguard Fund Complex according to a cost-sharing formula approved by the Commission in 1981 as part of an order allowing the Vanguard Fund Complex to internalize its distribution services ("1981 Order").[15] For those funds in the Vanguard Fund Complex offering multiple classes of shares, applicants apply the formula in the 1981 Order by treating each class as a separate fund ("Multi-Class Distribution Formula").

8. Applicants propose to apply the Multi-Class Distribution Formula to each Fund's class of VIPER Shares. Applicants acknowledge that, because VIPER Shares may have a distribution arrangement that differs from that for Conventional Shares, the proposed allocation method is inconsistent with rule 18f–3. Applicants contend, however, that the Multi-Class Distribution Formula is a fundamental feature of Vanguard's unique, internally-managed structure, and that the proposed allocation method is consistent with the method approved by the Commission in the 1981 Order. The Multi-Class Distribution Formula has been approved by the board of trustees ("Board") of each Fund, and the Board of each Fund, including a majority of the trustees who are not interested persons, as defined in section 2(a)(19) of the Act ("Disinterested Trustees"), will review the application of the Multi-Class Distribution Formula on an annual basis and determine that the proposed allocation is in the best interests of each class of shareholders and of the Fund as a whole.

Section 22(d) of the Act and Rule 22c–1 under the Act

9. Section 22(d), among other things, prohibits a dealer from selling a redeemable security that is currently being offered to the public by or through an underwriter, except at a current public offering price described in the prospectus. Rule 22c–1 generally requires that a dealer selling, redeeming, or repurchasing a redeemable security do so only at a price based on its NAV. Applicants state that secondary market trading in VIPER Shares will take place at negotiated prices, not at a current offering price described in the VIPER Prospectus, and not at a price based on NAV. Thus, purchases and sales of VIPER Shares in the secondary market will not comply with section 22(d) and rule 22c–1. Accordingly, applicants request exemptions from these provisions under section 6(c) of the Act.

10. Applicants assert that the sale of VIPER Shares at negotiated prices does not present the opportunity for any of the abuses that section 22(d) and rule 22c–1 were designed to prevent. Applicants maintain that while there is little legislative history regarding section 22(d), its provisions, as well as those of rule 22c–1, appear to have been designed to (a) prevent dilution caused by certain riskless trading schemes by principal underwriters and contract dealers, (b) prevent unjust discrimination or preferential treatment among buyers resulting from sales at different prices, and (c) ensure an orderly distribution of investment company shares by eliminating price competition from dealers offering shares at less than the published sales price and repurchasing shares at more than the published redemption price. Applicants state that secondary market trading in VIPER Shares would not cause dilution for existing Fund shareholders because such transactions would not directly or indirectly affect the Fund's assets. Applicants further state that secondary market trading in VIPER Shares would not lead to discrimination or preferential treatment among purchasers because, to the extent that different prices exist during a given trading day or from day to day, these variances will occur as a result of market forces. Finally, applicants contend that the proposed distribution system will be orderly because, among other things, arbitrage activity will ensure that the difference between the market price of VIPER Shares and their NAV remains narrow.

Section 22(e) of the Act

11. Section 22(e) generally prohibits a registered investment company from suspending the right of redemption or postponing the date of payment of redemption proceeds for more than seven days after the tender of a security for redemption. The principal reason for the requested exemption is that settlement of redemptions for the Funds is contingent not only on the settlement cycle of the United States market, but also on currently practicable delivery cycles in local markets for underlying foreign securities held by the Funds. Applicants state that local market delivery cycles for transferring certain foreign securities to investors redeeming Creation Units of VIPER Shares, together with local market holiday schedules, will under certain circumstances require a delivery process in excess of seven calendar days for the Funds. Applicants request relief under section 6(c) of the Act from section 22(e) to allow the Funds to pay redemption proceeds up to 12 calendar days after the tender of VIPER Shares for redemption. At all other times and except as disclosed in the relevant SAI, applicants expect that each Fund will be able to deliver redemption proceeds within seven days.[16] With respect to Future Funds, applicants seek the same relief from section 22(e) only to the extent that circumstances similar to those described in the application exist.

12. Applicants state that section 22(e) was designed to prevent unreasonable, undisclosed and unforeseen delays in the payment of redemption proceeds. Applicants assert that their requested relief will not lead to the problems that section 22(e) was designed to prevent. Applicants state that the SAI for each Fund will disclose those local holidays (over the period of at least one year following the date of the SAI), if any, that are expected to prevent the delivery of redemption proceeds in seven calendar days, and the maximum number of days needed to deliver the proceeds for the Fund.

[15] Investment Company Act Release No. 11645 (Feb. 25, 1981) (Opinion of the Commission and Final Order). Under the formula, each Vanguard Fund's contribution is based 50% on its average month-end net assets during the preceding quarter relative to the average month-end net assets of the other Vanguard Funds, and 50% on its sales of new shares relative to the sales of new shares of the other Vanguard Funds during the preceding 24 months. So that a new fund is not unduly burdened, the formula caps each Vanguard Fund's contribution at 125% of the average expenses of the Vanguard Funds collectively, with any amounts above the cap redistributed among the other Vanguard Funds. In addition, no fund may pay more than 0.2% of its average month-end net assets for distribution.

[16] Rule 15c6–1 under the Exchange Act requires that most securities transactions be settled within three business days of the trade. Applicants acknowledge that no relief obtained from the requirements of section 22(e) will affect any obligations applicants may have under rule 15c6–1.

Section 24(d) of the Act

13. Section 24(d) provides, in relevant part, that the prospectus delivery exemption provided to dealer transactions by section 4(3) of the Securities Act does not apply to transactions in a redeemable security issued by an open-end investment company. Applicants request an exemption under section 6(c) of the Act from section 24(d) to permit dealers selling VIPER Shares to rely on the prospectus delivery exemption provided by section 4(3) of the Securities Act.[17]

14. Applicants state that VIPER Shares will be listed on an Exchange and will be traded in a manner similar to other equity securities, including the shares of closed-end investment companies. Applicants note that dealers selling shares of closed-end investment companies in the secondary market generally are not required to deliver a prospectus to the purchaser. Applicants contend that VIPER Shares, as a listed security, merit similar treatment, reducing compliance costs and regulatory burdens that result from the imposition of a prospectus delivery requirement on secondary market transactions. Applicants state that because VIPER Shares will be exchange-listed, prospective investors will have access to several types of market information about the VIPER Shares. Applicants state that information regarding market price and volume will be continually available on a real-time basis throughout the day on brokers' computer screens and other electronic services. The previous day's price and volume information also will be published daily in the financial section of newspapers.

15. Applicants further state that investors that purchase VIPER Shares in the secondary market will receive a Product Description, describing the Fund and its VIPER Shares. Applicants state that, while not intended as a substitute for a prospectus, the Product Description will contain information about VIPER Shares that is tailored to meet the needs of investors purchasing VIPER Shares in the secondary market.

Sections 17(a)(1) and (2) of the Act

16. Sections 17(a)(1) and (2) generally prohibit an affiliated person of a registered investment company, or an affiliated person of an affiliated person, acting as principal, from selling any security to, or purchasing any security from, the company. Sections 2(a)(3)(A) and (C) of the Act define "affiliated person," respectively, as any person who owns 5% or more of an issuer's outstanding voting securities and any person who controls the fund. Section 2(a)(9) of the Act provides that a control relationship will be presumed where one person owns 25% or more of another person's voting securities. Applicants state that a large institutional investor or the Specialist could own 5% or more, or more than 25%, of a Fund's outstanding voting securities and, as a result, be deemed to be an affiliated person of the Fund under section 2(a)(3)(A) or (C). Applicants further state that, because purchases and redemptions of Creation Units would be in-kind, rather than for cash, those investors would be precluded by sections 17(a)(1) and (2) from purchasing or redeeming Creation Units from the Fund. Accordingly, applicants request an exemption under sections 6(c) and 17(b) of the Act to permit these affiliated persons, and affiliated persons of such affiliated persons who are not otherwise affiliated with the Fund, to purchase and redeem Creation Units through in-kind transactions.

17. Section 17(b) of the Act authorizes the Commission to exempt a proposed transaction from section 17(a) if evidence establishes that the terms of the transaction, including the consideration to be paid or received, are reasonable and fair and do not involve overreaching, and the proposed transaction is consistent with the policies of the registered investment company involved and the general purposes of the Act. Applicants contend that no useful purpose would be served by prohibiting persons affiliated with a Fund, as described above, from purchasing or redeeming Creation Units from the Fund. Applicants represent that Fund affiliates making in-kind purchases and redemptions would be treated no differently from non-affiliates making the same types of transactions. Applicants state that all purchases and redemptions of Creation Units would be at the Fund's next calculated NAV. Applicants also state that, in all cases, Deposit Securities and Redemption Securities will be valued in the same manner and using the same standards as those securities are valued for purposes of calculating the Fund's NAV. Applicants assert that, for these reasons, the requested relief meets the standards of sections 6(c) and 17(b).

Applicants' Conditions

Applicants agree that the order granting the requested relief will be subject to the following conditions:

1. No Future Fund will issue a class of VIPER Shares unless (a) applicants have requested and received with respect to such Future Fund either exemptive relief from the Commission or a no-action letter from the Division of Investment Management of the Commission, or (b) the Future Fund's VIPER Shares will be listed on an Exchange without the need for a filing pursuant to rule 19b–4 under the Exchange Act.

2. The VIPER Prospectus and the Product Description for each Fund will clearly disclose that, for purposes of the Act, VIPER Shares are issued by the Fund and the acquisition of VIPER Shares by investment companies is subject to the restrictions of section 12(d)(1) of the Act.

3. As long as a Fund operates in reliance on the requested order, the VIPER Shares will be listed on an Exchange.

4. The VIPER Shares of a Fund will not be advertised or marketed as shares of an open-end investment company or mutual fund. The VIPER Prospectus of each Fund will prominently disclose that VIPER Shares are not individually redeemable and will disclose that holders of VIPER Shares may acquire the shares from the Fund and tender the shares for redemption to the Fund in Creation Units only. Any advertising material that describes the purchase or sale of Creation Units or refers to redeemability will prominently disclose that VIPER Shares are not individually redeemable and that holders of VIPER Shares may acquire the shares from the Fund and tender the shares for redemption to the Fund in Creation Units only.

5. Before a Fund may rely on the order, the Commission will have approved pursuant to rule 19b–4 under the Exchange Act, an Exchange rule requiring Exchange members and member organizations effecting transactions in VIPER Shares to deliver a Product Description to purchasers of VIPER Shares.

6. On an annual basis the Board of each Fund, including a majority of Disinterested Trustees, must determine, for each Fund, that the allocation of distribution expenses among the classes of Conventional Shares and VIPER Shares in accordance with the Multi-Class Distribution Formula is in the best interests of each class and of the Fund as a whole. Each Fund will preserve for a period of not less than six years from

[17] Applicants do not seek relief from the prospectus delivery requirement for non-secondary market transactions, including purchases of Creation Units or those involving an underwriter and transactions pursuant to the Conversion Privilege.

the date of a Board determination, the first two years in an easily accessible place, a record of the determination and the basis and information upon which the determination was made. This record will be subject to examination by the Commission and its staff.

7. For six years following the issuance of a Fund's VIPER Shares, the Fund will (a) record and preserve any investor complaints or reports of confusion concerning the Conversion Privilege that are communicated to the Fund, VGI and/or VMC and (b) record data tracking the number of investors that, after VIPER Shares are offered, purchase the Fund's Conventional Shares and, within 90 days, convert those shares into VIPER Shares. The Fund will preserve this information in an easily accessible place, and the information will be subject to examination by the Commission and its staff.

8. Applicants' Web site, which is and will be publicly accessible at no charge, will contain the following information, on a per VIPER Share basis, for each Fund: (a) The prior business day's closing NAV and the midpoint of the bid-asked spread at the time the Fund's NAV is calculated ("Bid-Asked Price") and a calculation of the premium or discount of the Bid-Asked Price in relation to the closing NAV; and (b) data for a period covering at least the four previous calendar quarters (or the life of a Fund, if shorter) indicating how frequently each Fund's VIPER Shares traded at a premium or discount to NAV based on the Bid-Asked Price and closing NAV, and the magnitude of such premiums and discounts. In addition, the Product Description for each Fund will state that applicants' Web site has information about the premiums and discounts at which the Fund's VIPER Shares have traded.

9. The VIPER Prospectus and annual report will include, for each Fund: (a) The information listed in condition 8(b), (i) in the case of the VIPER Prospectus, for the most recently completed calendar year (and the most recently completed quarter or quarters, as applicable), and (ii) in the case of the annual report, for no less than the immediately preceding five fiscal years (or the life of the Fund, if shorter); and (b) the cumulative total return and the average annual total return for one, five and ten year periods (or the life of the Fund, if shorter) of (i) a VIPER Share based on NAV and Bid-Asked Price and (ii) the Fund's Target Index.

For the Commission, by the Division of Investment Management, pursuant to delegated authority.

Jill M. Peterson,

Assistant Secretary.

[FR Doc. 03–28070 Filed 11–6–03; 8:45 am]

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SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–48740; File No. SR–Amex–2002–09]

Self-Regulatory Organizations; Order Approving a Proposed Rule Change and Amendments No. 1 through 11 thereto by the American Stock Exchange LLC Relating to Registered Options Traders Use of the Electronic Entry Device

November 3, 2003.

I. Introduction

On February 12, 2002, the American Stock Exchange LLC ("Amex" or "Exchange") filed with the Securities and Exchange Commission ("Commission" or "SEC"), pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 ("Act")[1] and Rule 19b–4 thereunder,[2] a proposed rule change relating to registered options traders use of the electronic entry device. The Exchange submitted Amendments No. 1, 2, 3, 4, 5, 6, 7, 8[3] 9,[4] 10,[5] and 11[6] on February 25, 2002, May 6, 2002, May 29, 2002, June 18, 2002, July 17, 2002, September 16, 2002, January 21, 2003, July 15, 2003, July 25, 2003, August 26, 2003, and September 12, 2003, respectively. The proposed rule change and Amendments No. 1 through 11 were published for comment in the **Federal Register** on September 25, 2003.[7] The Commission received no comments on the proposal. This order approves the proposed rule change and Amendments No. 1 through 11.

II. Description of the Proposed Rule Change

Given the number of series traded for each option class and the necessity for the re-calculating and re-quoting of each series in response to changes in the price of the underlying security, the Exchange developed an automated quotation updating system known as XTOPS. The specialist and registered options traders rely upon XTOPS to calculate and disseminate a single immediately updated quotation for each option series. XTOPS uses option valuation formulas (such as the Black-Scholes Model) to generate options quotations based on a number of variables.[8] It is the specialist's responsibility to determine for each option class the variables used in the XTOPS formula. However, the quotations generated and displayed by XTOPS may result in firm quote obligations of both the specialist and registered options traders to buy or sell options at quoted prices and sizes.[9] The dissemination of an XTOPS quote can be overridden when a customer limit order represents the best bid or offer or when a registered options trader chooses on a series-by-series basis to better the disseminated bid or offer.

The Exchange is now proposing new Commentary .04 to Amex Rule 933, to allow registered options traders' direct access to the Electronic Entry Device ("EE Device") to input their own quotes for dissemination as the best bid or offer.[10] The EE Device would be

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] For Amendments No. 1 through 8, the Exchange filed a new Form 19b–4 each time, which replaced and superseded the original proposal and all previous amendments in their entirety.

[4] Letter from Claire P. McGrath, Senior Vice President and Deputy General Counsel, Amex, to Elizabeth King, Associate Director, Division of Market Regulation ("Division"), Commission, dated July 24, 2003 ("Amendment No. 9"). Amendment No. 9 transfers to the list of rules enforced by the Amex Enforcement Department under paragraph (g) of Amex Rule 590 the requirement set forth in proposed Amex Rule 933, Commentary .04(d) that the specialist use his best efforts to attempt to ensure that the registered options trader responsible for disseminating the best bid or offer receives an allocation of the next automatic execution.

[5] The Exchange filed a new Form 19b–4, which replaced and superseded the original proposal and all previous amendments in their entirety.

[6] Letter from Claire P. McGrath, Senior Vice President and Deputy General Counsel, Amex, to Elizabeth King, Associate Director, Division, Commission, dated September 11, 2003 ("Amendment No. 11"). Amendment No. 11 revises proposed changes to Amex Rule 590(g) to clarify that a specialist who fails to properly allocate executed contracts to the price-improving registered options trader must pay restitution in amount calculated by multiplying the number of contracts that should have been allocated to the price-improving registered options trader by the number of underlying shares represented by each contract, which would then be multiplied by half of the spread between the option's bid and offer at the time the order was executed.

[7] Securities Exchange Act Release No. 48495 (September 16, 2003), 68 FR 55422.

[8] These variables include the price of the underlying stock, time remaining to expiration, interest rates (or "cost to carry", the amount of interest on the money used to pay for the options position during the period prior to expiration of the option series), dividends (both declared and anticipated) and volatility.

[9] *See* Rule 11Ac1–1 under the Act ("Quote Rule"), 17 CFR 240.11Ac1–1, and Amex Rule 958A.

[10] The Exchange submitted the proposed rule change in response to subparagraph IV.B.h(i)(aa) of the Commission's September 11, 2000 Order ("Order"), which requires the Exchange to "adopt new, or amend existing, rules concerning its

Continued

available for registered options traders to use in all option classes traded on the Exchange.[11] In active option classes where there is currently an Exchange-employed systems clerk, registered options traders would either input their own quotes or instruct a systems clerk to do so on their behalf. Only registered options traders physically located in the trading crowd would be permitted to directly input quotes into the EE Device or give such instructions to a systems clerk.

Once the registered options trader or systems clerk inputs the quote into the EE Device, the proposed rule would require that: (i) The price improving registered options trader announce loudly and audibly in the crowd that he has improved the displayed market to ensure that other crowd participants are aware that the market has been improved, enabling other crowd participants to also quote competitively; and (ii) the specialist be specifically alerted so that a "book bid or offer" indicator is activated and the next otherwise Auto-Ex eligible trade is routed directly to the Amex Options Display Book ("AODB") for allocation to the registered options trader that caused the improved quote to be disseminated. In addition to blocking an otherwise eligible Auto-Ex order from being executed and allocated by the Auto-Ex system, activation of the "book bid or offer" indicator would block an XTOPS calculated quote that is worse than the registered options trader's disseminated quote from being disseminated. Activation would not, however, block a quote that is better than the registered options trader's disseminated quote from being disseminated.

Once an execution occurs and/or the price improving registered options trader is no longer entitled to priority, the specialist would be required to remove the "best bid or offer" indicator so that Auto-Ex eligible orders would again be sent to Auto-Ex and the dissemination of XTOPS calculated quotes is resumed. The EE Device would not automatically decrement the size of the disseminated quote when an execution occurs. The quote would be required to be manually adjusted to reflect any revision to the disseminated size.

The price improving registered options trader would be permitted to cancel his quote at any time prior to the execution of a trade through the use of the EE Device (regardless of whether inputted by the registered options trader or the systems clerk), if that was the method in which the quote was entered, or through the specialist, if that was the method chosen. The registered options trader would be required also to alert the specialist that he is removing his quote, so the specialist can in turn remove the "book bid or offer" indicator in XTOPS, and announce loudly and audibly that he is canceling his quote.

Pursuant to the requirements of the Quote Rule and Exchange Rule 958A, the registered options trader as the responsible broker or dealer is obligated to execute any customer order at his bid or offer up to the disseminated size. To be relieved of that obligation with respect to a specific quote, one of the exceptions to the Quote Rule must apply, which generally provide that the responsible broker or dealer must communicate a revised quotation to the Exchange prior to the presentation of an order. Thus, a registered options trader using the EE Device to disseminate quotes would continue to be obligated pursuant to the Quote Rule until he has communicated a revised quote to the Exchange through the removal or cancellation of the quote on the EE Device.

Registered options traders would be required to improve the best bid or offer by an amount equal to at least the minimum price variation as set forth in Exchange Rule 952 for the quote to be inputted into the EE Device. The minimum size quote that could be inputted into the EE Device by or on behalf of a registered options trader would be 20 contracts, unless the Auto-Ex eligible size parameter for that option class is less than 20 contracts, in which case the minimum quote size would be the same as the lesser Auto-Ex eligible size parameter for that option class. Currently, the EE Device disseminates a default size for each new quote. The disseminated size may be set at a higher or lower amount or increased by the specialist to reflect additional liquidity at that quote. The default size would be set at the minimum quote size as discussed above.

The Exchange represents that there is at least one EE Device unit at every trading post and multiple units at posts where active option classes trade and that the number of devices currently in place on the trading floor would be sufficient to provide registered options traders with ready and easy access to a means for disseminating their quotes. However, since this is a new use for the EE Device, the Exchange represents that it will monitor the uses of the EE Device by registered options traders and activity in the option classes at each trading post and will add additional devices when necessary. The Exchange is able to install additional EE Devices at the trading posts with, preferably, a one-day notice so that they can be installed either before or after trading hours.

The specialist in a given option class may also disseminate or cause to be disseminated his own individual, price improving quote separate from the XTOPS calculated quote, provided he is physically located at the trading post at the time he inputs his quote, has only disseminated one quote per series on the same side of the market, has announced loudly and audibly to the crowd that he has improved the disseminated bid or offer, has improved the best bid or offer by an amount equal to at least the minimum price variation set forth in Rule 952, and has disseminated the minimum quote size. The specialist would not be able to use the EE Device to disseminate his individual price improving quote since he already has the means to input a quote into the Market Data System through XTOPS in the same manner used today to disseminate a customer limit order. Once the specialist has caused his individual quote to be disseminated, he will activate the "book bid or offer" indicator and the next otherwise Auto-Ex eligible trade is routed directly to the AODB for allocation to the specialist.

The specialist would be required to use best efforts to attempt to ensure that the registered option trader responsible for disseminating the best bid or offer receives an allocation of the next incoming order for the amount he is entitled to pursuant to Exchange rules. A specialist who failed to use best efforts to attempt to ensure that the next Auto-Ex execution is appropriately allocated to the price improving registered options trader would be fined pursuant Amex Rule 590(g) of the Exchange's Minor Rule Violation Fine System. In addition to the fine assessed pursuant to the Minor Floor Violation Fine System, violations of this provision would require the payment of

automated quotation and execution systems which substantially enhance incentives to quote competitively and substantially reduce disincentives for market participants to act competitively." Order Instituting Public Administrative Proceedings Pursuant to Section 19(h)(1) of the Securities Exchange Act of 1934, Making Findings and Imposing Remedial Sanctions. Securities Exchange Act Release No. 43268 (September 11, 2000).

[11] The EE Device is currently used by Exchange-employed systems clerks in busy option classes to input individual quotes from the specialist on a series by series basis that better the quote being calculated and disseminated by XTOPS. A quote entered using the EE Device is sent directly to the Exchange's Market Data System for immediate dissemination to the Options Price Reporting Authority. This quote, when it betters the market being disseminated by XTOPS, will override or displace the XTOPS quote.

restitution. Restitution would be calculated by multiplying the number of contracts that should have been allocated to the price-improving registered options trader by the number of underlying shares represented by each contract, which would then be multiplied by half of the spread between the option's bid and offer at the time the order was executed.

If more than one registered options trader and/or the specialist has disseminated or caused to be disseminated the same price improving quote, priority would be established for the registered options traders in the order in which the quotes were announced loudly and audibly to the trading crowd. If, however, the sequence in which the disseminated quotes were made cannot be reasonably determined, priority would be afforded to the price improving registered options traders and/or specialist as a group. Exchange Rule 950(d), Commentary .06 and Exchange Rule 950(n), Commentary .03 govern allocations of contracts when more than one registered options trader and/or the specialist has disseminated the same price improving quote and time priority cannot be established.

However, pursuant to the proposed rule change, the price improving registered options traders' quote would retain priority until one of the following occurs: (i) Auto-Ex execution depleted the disseminated size; (ii) an amount equal to the minimum quote size has been allocated; (iii) the registered options trader withdraws the quote; (iv) the quote is matched or improved by the specialist's automated quotation system quote, provided specialists using an Exchange-approved proprietary automated quotation updating system have not programmed the system to immediately match or improve the price improving registered options trader's quote; (v) the quote is improved by another registered options trader; or (vi) the market is improved by an order placed on the limit order display book. With respect to subparagraph (iv) above, the Exchange represents that it will monitor the use of proprietary automated quotation updating systems through the review of complaints from members in the trading crowd as well as observations of Floor Officials and Exchange personnel to determine if the system has been programmed to immediately match or improve the price improving registered options trader's quote.

The Exchange notes that Exchange rules regarding customer priority and parity would continue to apply to the allocation of trades pursuant to the proposed rule change. Exchange Rule 111, Commentary .07 provides that a registered options trader, when establishing or increasing a position, may not retain priority over or have parity with an off-Floor order. Thus, only registered options traders closing or decreasing a position may be on parity with a customer order.

III. Discussion

After careful review, the Commission finds that the proposed rule change, as amended, is consistent with the Act and the rules and regulations promulgated thereunder applicable to a national securities exchange and, in particular, with the requirements of Section 6(b) of the Act.[12] Specifically, the Commission finds that approval of the proposed rule change, as amended, is consistent with Section 6(b)(5) of the Act[13] in that it is designed to facilitate transactions in securities; to prevent fraudulent and manipulative acts and practices; to promote just and equitable principles of trade; to foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in securities; to remove impediments to and perfect the mechanism of a free and open market and a national market system; and in general, to protect investors and the public interest.

The Commission believes that the proposed rule change, by permitting registered options traders to use an EE Device at the trading post to input their own quotes for dissemination as the best bid or offer and then providing price improving registered options traders with an allocation of the next Auto-Ex execution, should help to encourage competitive quoting. In addition, the Commission believes that providing a method for specialists to input their own price improving quotes separate from the autoquote, and then routing the next otherwise Auto-Ex eligible order to the AODB for allocation to the specialist, should provide an additional incentive for specialists to quote competitively. The Commission believes that the proposal is an important first step towards achieving compliance with the Order's directive to substantially enhance incentives to quote competitively and substantially reduce disincentives for market participants to act competitively.

The Commission notes that the proposal requires the specialist to use best efforts to ensure that a price improving registered options trader receives his allocation. The Commission believes that imposition of a fine, under the Exchange's Minor Rule Violation Plan, on a specialist who fails to use best efforts to ensure that the next Auto-Ex execution is appropriately allocated, as well as the requirement that such specialist pay restitution to the injured registered options trader, should provide sufficient safeguards to help ensure that the manual allocation to the appropriate registered options trader occurs.

IV. Conclusion

For the foregoing reasons, the Commission finds that the proposed rule change, as amended, is consistent with the Act and the rules and regulations thereunder applicable to a national securities exchange, and, in particular, with Section 6(b)(5) of the Act.[14]

It is therefore ordered, pursuant to Section 19(b)(2) of the Act,[15] that the proposed rule change (SR–Amex–2002–09) and Amendments No. 1 through 11 are approved.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[16]

Jill M. Peterson,

Assistant Secretary.

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[12] 15 U.S.C. 78f(b). In approving this proposal, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. 15 U.S.C. 78c(f).

[13] 15 U.S.C. 78f(b)(5).

[14] 15 U.S.C. 78f(b)(5).

[15] 15 U.S.C. 78s(b)(2).

[16] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–48733; File No. SR–BSE–2003–16]

Self-Regulatory Organizations; Notice of Filing of a Proposed Rule Change and Amendment Nos. 1 and 2 Thereto and Order Granting Accelerated Approval to a Proposed Rule Change and Amendment Nos. 1 and 2 Thereto by the Boston Stock Exchange, Inc. Relating to Shareholder Approval of Equity Compensation Plans

October 31, 2003.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 ("Act"),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on September 15, 2003, the Boston Stock Exchange, Inc. ("BSE" or "Exchange") filed with the Securities and Exchange Commission ("SEC" or "Commission") the proposed rule change as described

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

in Items I and II below, which Items have been prepared by the Exchange. On October 2, 2003, the Exchange filed Amendment No. 1 to the proposed rule change.[3] On October 29, 2003, the Exchange filed Amendment No. 2 to the proposed rule change.[4] The Commission is publishing this notice to solicit comments on the proposed rule change, as amended, from interested persons and is approving the proposal, as amended, on an accelerated basis.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange is proposing to adopt a new section entitled "Equity Compensation Plans" in Chapter XXVII. *Listed Securities—Requirements*, regarding shareholder approval of equity compensation plans and to amend its rules related to the voting of proxies.

Below is the text of the proposed rule change, as amended.[5] Proposed new language is *italicized*; proposed deleted language is [bracketed].

* * * * *

Chapter XXXVI: Proxies

Secs. 1–2, no change.

Sec. 3(a)–(d), no change.

Proxy Voting on Equity Compensation Plans

(e) A member organization may not give a proxy to vote without instructions from beneficial owners when the matter to be voted upon authorizes the implementation of any equity compensation plan, or any material revision to the terms of any existing equity compensation plan (whether or not stockholder approval of such plan is required by Chapter XXVII, Listed Securities, Equity Compensation Plans, of these Rules).

Secs. 4–6, no change.

* * * * *

[3] Amendment No. 1 replaces the Exchange's original Rule 19b–4 filing in its entirety.

[4] *See* letter from John Boese, Vice President, Legal Compliance, BSE, to Nancy Sanow, Assistant Director, Division of Market Regulation, Commission, dated October 29, 2003 ("Amendment No. 2"). In Amendment No. 2, the Exchange made a technical correction to its proposed rule language by underlining proposed BSE Rule 3(e), *Proxy Voting on Equity Compensation Plans*, to indicate that it is proposed new language. Because this is a technical amendment, it is not subject to notice and comment.

[5] The Exchange's rules under Chapter XXVII, *Listed Securities—Requirements*, are not numbered, so the Exchange is adding its proposed section entitled "Equity Compensation Plans" to the end of the chapter.

Chapter XXVII: Listed Securities—Requirements

* * * * *

Equity Compensation Plans

Shareholders must be given the opportunity to vote on all equity-compensation plans and material revisions thereto, with limited exemptions explained below.

Equity-compensation plans can help align shareholder and management interests, and equity-based awards are often very important components of employee compensation. To provide checks and balances on the potential dilution resulting from the process of earmarking shares to be used for equity-based awards, the Exchange requires that all equity-compensation plans, and any material revisions to the terms of such plans, be subject to shareholder approval, with the limited exemptions explained below.

Definition of Equity-Compensation Plan

An "equity-compensation plan" is a plan or other arrangement that provides for the delivery of equity securities (either newly issued or treasury shares) of the listed company to any employee, director or other service provider as compensation for services. Even a compensatory grant of options or other equity securities that is not made under a plan is, nonetheless, an "equity-compensation plan" for these purposes.

However, the following are not "equity-compensation plans" even if the brokerage and other costs of the plan are paid for by the listed company:

- *Plans that are made available to shareholders generally, such as a typical dividend reinvestment plan.*
- *Plans that merely allow employees, directors or other service providers to elect to buy shares on the open market or from the listed company for their current fair market value, regardless of whether:*
- *The shares are delivered immediately or on a deferred basis; or*
- *The payments for the shares are made directly or by giving up compensation that is otherwise due (for example, through payroll deductions).*

Material Revisions

A "material revision" of an equity-compensation plan includes (but is not limited to), the following:

- *A material increase in the number of shares available under the plan (other than an increase solely to reflect a reorganization, stock split, merger, spinoff or similar transaction).*
- *If a plan contains a formula for automatic increases in the shares available (sometimes called an "evergreen formula") or for automatic grants pursuant to a formula, each such increase or grant will be considered a revision requiring shareholder approval unless the plan has a term of not more than ten years.*

This type of plan (regardless of its term) is referred to below as a "formula plan." Examples of automatic grants pursuant to a formula are (1) annual grants to directors of restricted stock having a certain dollar value, and (2) "matching contributions," whereby stock is credited to a participant's account based upon the amount of compensation the participant elects to defer.

- *If a plan contains no limit on the number of shares available and is not a formula plan, then each grant under the plan will require separate shareholder approval regardless of whether the plan has a term of not more than ten years.*

This type of plan is referred to below as a "discretionary plan." A requirement that grants be made out of treasury shares or repurchased shares will not, in itself, be considered a limit or pre-established formula so as to prevent a plan from being considered a discretionary plan.

- *An expansion of the types of awards available under the plan.*
- *A material expansion of the class of employees, directors or other service providers eligible to participate in the plan.*
- *A material extension of the term of the plan.*
- *A material change to the method of determining the strike price of options under the plan.*
- *A change in the method of determining "fair market value" from the closing price on the date of grant to the average of the high and low price on the date of grant is an example of a change that the Exchange would not view as material.*
- *The deletion or limitation of any provision prohibiting repricing of options. See the next section for details.*

Note that an amendment will not be considered a "material revision" if it curtails rather than expands the scope of the plan in question.

Repricings

A plan that does not contain a provision that specifically permits repricing of options will be considered for purposes of this listing standard as prohibiting repricing. Accordingly any actual repricing of options will be considered a material revision of a plan even if the plan itself is not revised. This consideration will not apply to a repricing through an exchange offer that

commenced before the date this listing standard became effective.

"Repricing" means any of the following or any other action that has the same effect:

• Lowering the strike price of an option after it is granted.

• Any other action that is treated as a repricing under generally accepted accounting principles.

• Canceling an option at a time when its strike price exceeds the fair market value of the underlying stock, in exchange for another option, restricted stock, or other equity, unless the cancellation and exchange occurs in connection with a merger, acquisition, spin-off or other similar corporate transaction.

Exemptions

This listing standard does not require shareholder approval of employment inducement awards, certain grants, plans and amendments in the context of mergers and acquisitions, and certain specific types of plans, all as described below. However, these exempt grants, plans and amendments may be made only with the approval of the company's independent compensation committee or the approval of a majority of the company's independent directors. Companies must also notify the Exchange in writing when they use one of these exemptions.

Employment Inducement Awards

An employment inducement award is a grant of options or other equity-based compensation as a material inducement to a person or persons being hired by the listed company or any of its subsidiaries, or being rehired following a bona fide period of interruption of employment. Inducement awards include grants to new employees in connection with a merger or acquisition. Promptly following a grant of any inducement award in reliance on this exemption, the listed company must disclose in a press release the material terms of the award, including the recipient(s) of the award and the number of shares involved.

Mergers and Acquisitions

Two exemptions apply in the context of corporate acquisitions and mergers.

First, shareholder approval will not be required to convert, replace or adjust outstanding options or other equity-compensation awards to reflect the transaction.

Second, shares available under certain plans acquired in corporate acquisitions and mergers may be used for certain post-transaction grants without further shareholder approval. This exemption applies to situations where a party that is not a listed company following the transaction has shares available for grant under pre-existing plans that were previously approved by shareholders. A plan adopted in contemplation of the merger or acquisition transaction would not be considered "pre-existing" for purposes of this exemption.

Shares available under such a pre-existing plan may be used for post-transaction grants of options and other awards with respect to equity of the entity that is the listed company after the transaction, either under the pre-existing plan or another plan, without further shareholder approval, so long as:

• The number of shares available for grants is appropriately adjusted to reflect the transaction;

• The time during which those shares are available is not extended beyond the period when they would have been available under the pre-existing plan, absent the transaction; and

• The options and other awards are not granted to individuals who were employed, immediately before the transaction, by the post-transaction listed company or entities that were its subsidiaries immediately before the transaction.

Any shares reserved for listing in connection with a transaction pursuant to either of these exemptions would be counted by the Exchange in determining whether the transaction involved the issuance of 20% or more of the company's outstanding common stock and thus required shareholder approval.

These merger-related exemptions will not result in any increase in the aggregate potential dilution of the combined enterprise. Further, mergers or acquisitions are not routine occurrences, and are not likely to be abused. Therefore, the Exchange considers both of these exemptions to be consistent with the fundamental policy involved in this standard.

Qualified Plans, Parallel Excess Plans and Section 423 Plans

The following types of plans (and material revisions thereto) are exempt from the shareholder approval requirement:

• Plans intended to meet the requirements of Section 401(a) of the Internal Revenue Code (e.g., ESOPs);

• Plans intended to meet the requirements of Section 423 of the Internal Revenue Code; and

• "Parallel excess plans" as defined below.

Section 401(a) plans and Section 423 plans are already regulated under the Internal Revenue Code and Treasury regulations. Section 423 plans, which are stock purchase plans under which an employee can purchase no more than $25,000 worth of stock per year at a plan-specified discount capped at 15%, are also required by the Internal Revenue Code to receive shareholder approval. While Section 401(a) plans and parallel excess plans are not required to be approved by shareholders, U.S. GAAP requires that the shares issued under these plans be "expensed" (i.e., treated as a compensation expense on the income statement) by the company issuing the shares. An equity-compensation plan that provides non-U.S. employees with substantially the same benefits as a comparable Section 401(a) plan, Section 423 plan or parallel excess plan that the listed company provides to its U.S. employees, but for features necessary to comply with applicable foreign tax law, are also exempt from shareholder approval under this section. The term "parallel excess plan" means a plan that is a "pension plan" within the meaning of the Employee Retirement Income Security Act ("ERISA") that is designed to work in parallel with a plan intended to be qualified under Internal Revenue Code Section 401(a) to provide benefits that exceed the limits set forth in Internal Revenue Code Section 402(g) (the section that limits an employee's annual pre-tax contributions to a 401(k) plan), Internal Revenue Code Section 401(a)(17) (the section that limits the amount of an employee's compensation that can be taken into account for plan purposes) and/or Internal Revenue Code Section 415 (the section that limits the contributions and benefits under qualified plans) and/or any successor or similar limitations that may hereafter be enacted. A plan will not be considered a parallel excess plan unless (1) it covers all or substantially all employees of an employer who are participants in the related qualified plan whose annual compensation is in excess of the limit of Code Section 401(a)(17) (or any successor or similar limits that may hereafter be enacted); (2) its terms are substantially the same as the qualified plan that it parallels except for the elimination of the limits described in the preceding sentence and the limitation described in clause (3); and (3) no participant receives employer equity contributions under the plan in excess of 25% of the participant's cash compensation.

Transition Rules

Except as provided below, a plan that was adopted before the date of the Securities and Exchange Commission order approving this listing standard

will not be subject to shareholder approval under this section unless and until it is materially revised.

In the case of a discretionary plan (as defined in "Material Revisions" above), whether or not previously approved by shareholders, additional grants may be made after the effective date of this listing standard without further shareholder approval only for a limited transition period, defined below, and then only in a manner consistent with past practice. See also "Material Revisions" above. In applying this rule, if a plan can be separated into a discretionary plan portion and a portion that is not discretionary, the non-discretionary portion of the plan can continue to be used separately, under the appropriate transition rule. For example, if a shareholder-approved plan permits both grants pursuant to a provision that makes available a specific number of shares, and grants pursuant to a provision authorizing the use of treasury shares without regard to the specific share limit, the former provision (but not the latter) may continue to be used after the transition period, under the general rule above. Similarly, in the case of a formula plan (as defined in "Material Revisions" above) that either (1) has not previously been approved by shareholders or (2) does not have a term of ten years or less, additional grants may be made after the effective date of this listing standard without further shareholder approval only for a limited transition period, defined below.

The limited transition period described in the preceding two paragraphs will end upon the first to occur of:

- *The listed company's next annual meeting at which directors are elected that occurs more than 180 days after the effective date of this listing standard;*
- *The first anniversary of the effective date of this listing standard; and*
- *The expiration of the plan.*

A shareholder-approved formula plan may continue to be used after the end of this transition period if it is amended to provide for a term of ten years or less from the date of its original adoption or, if later, the date of its most recent shareholder approval. Such an amendment may be made before or after the effective date of this listing standard, and would not itself be considered a "material revision" requiring shareholder approval.

In addition, a formula plan may continue to be used, without shareholder approval, if the grants after the effective date of this listing standard are made only from the shares available immediately before the effective date, in other words, based on formulaic increases that occurred prior to such effective date.

Transiti on Rules for Proxy Voting on Equity Compensation Plans

Members or member-organizations are precluded from giving a proxy to vote on equity compensation plans unless the beneficial owner of the shares has given voting instructions, as set forth in Chapter XXVI, Proxies, Section 3(e), Proxy Voting on Equity Compensation Plans, of these Rules. This provision regarding equity compensation plans will be effective for any meeting of shareholders that occurs on or after the 90th day following the date of the Securities and Exchange Commission order approving this provision.

* * * * *

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item III below. The Exchange has prepared summaries, set forth in Sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basisfor, the Proposed Rule Change

1. Purpose

In conjunction with a review of its corporate listing standards with the goal of enhancing accountability, integrity and transparency of listed companies, the Exchange is proposing listing standards related to shareholder approval of equity compensation plans.[6]

The Exchange is proposing to adopt a new section entitled "Equity Compensation Plans" in Chapter XXVII, *Listed Securities—Requirements*, which would require shareholder approval of all equity-compensation plans and material revisions to such plans, subject to limited exemptions. Under the Exchange's proposal, as amended, an equity compensation plan is defined as a plan or other arrangement that provides for the delivery of equity securities (either newly issued or treasury shares) of the listed company to any employee, director or other service provider as compensation for services, including a compensatory grant of options or other equity securities that is not made under a plan. The Exchange is also proposing to provide clarification on certain plans that would not be considered equity compensation plans under this definition, such as plans that do not provide for delivery of equity securities of the issuer (*e.g.*, plans that pay in cash) and deferred compensation plans under which employees pay full current market value for deferred shares.

In addition, the proposal, as amended, provides for certain types of grants that are exempted from shareholder approval. These limited exemptions include: (1) Inducement awards to person's first becoming an employee of an issuer or any of its subsidiaries, to rehires following a bona fide period of employment interruption, and for grants to new employees in connection with a merger or acquisition;[7] (2) mergers and acquisitions, when conversions, replacements or adjustments of outstanding options or other equity compensation awards are necessary to reflect the transaction, and when shares available under certain plans acquired in corporate acquisitions and mergers may be used for certain post-transaction grants without further shareholder approval; and (3) plans intended to meet the requirements of Section 401(a) of the Internal Revenue Code[8] (*e.g.*, ESOPs), plans intended to meet the requirements of Section 423 of the Internal Revenue Code,[9] and parallel excess plans that meet certain conditions. The Exchange also proposes that, in circumstances in which equity compensation plans and amendments to plans are not subject to

[6] The Commission notes that the Exchange is proposing to adopt listing standards relating to shareholder approval of equity compensation plans that are similar to those that the Commission recently approved for the New York Stock Exchange, Inc. ("NYSE") and the National Association of Securities Dealers, Inc. ("NASD"), through its subsidiary, The Nasdaq Stock Market, Inc. ("Nasdaq"). *See also* Securities Exchange Act Release No. 48627 (October 14, 2003), 68 FR 60426 (October 22, 2003) (notice of filing and order granting accelerated approval to File No. SR–NASD–2003–130, incorporating amendments to the NASD's recently approved shareholder approval rules for equity compensation plans applicable to Nasdaq quoted securities). The Commission also published a correction to the notice of File No. SR–NASD–2003–130. *See* Securities Exchange Act Release No. 48627A (October 22, 2003), 68 FR 61532 (October 28, 2003). The Commission notes that these additional amendments by Nasdaq make the NYSE and Nasdaq proposals more consistent and uniform. *See also infra* note 14 (regarding the Commission's recent approval of a similar proposal by the American Stock Exchange LLC ("Amex")).

[7] The Exchange is also proposing to include a requirement that listed companies provide prompt public disclosure following the grant of any inducement award in reliance on the exemption.

[8] 26 U.S.C. 401(a).

[9] 26 U.S.C. 423.

shareholder approval, the plans and amendments still must be subject to the approval of the company's independent compensation committee or a majority of the company's independent directors. In addition, the Exchange proposes that an issuer must notify the Exchange in writing when it uses any of the exemptions from the shareholder approval requirements (assuming that such repricing would not require shareholder approval under other Exchange rules).

The Exchange is also proposing to provide a non-exclusive list of "material revisions" to a plan that would require shareholder approval. Within this list of revisions, the Exchange proposed to define the concepts of "evergreen plans" (*i.e.*, plans that contain a formula for automatic increases in the shares available), "formula plans" (*i.e.*, plans that provide for automatic grants pursuant to a formula), and "discretionary plans" (*i.e.*, plans that contain no limit on the number of shares available and are not a formula plan). The Exchange proposes that each grant under a discretionary plan require shareholder approval regardless of whether the plan has a term of not more than 10 years.

Shareholder approval will be required for plans adopted before the effective date of these proposed amendments that have not been approved by shareholders and have neither an evergreen formula nor a specific number of shares available under the plan. The Exchange is proposing to provide transition rules to clarify when shareholder approval will be required for these pre-existing plans. In addition, during the period prior to the approval, pre-existing plans may be utilized, but only in a manner consistent with past practice. The transition rules provide that an evergreen plan that was approved by shareholders but does not have a ten-year term must be: (1) Approved by shareholders before any shares that become available as a result of a formulaic increase are utilized, or (2) amended to include a term of no more than ten years from the date the plan was adopted or last approved by shareholders. If the plan were amended to include such term, shareholder approval would not be required. No action would be required, however, if a plan were frozen at the level of shares available at the time the rule becomes effective. The transition rules also provide that repricings that have commenced prior to the effectiveness of the proposal (*i.e.*, exchange offers to optionees) will not be subject to shareholder approval.

Finally, the Exchange is also proposing to amend Section 3 in Chapter XXXVI, *Proxies*, to prohibit member organizations from giving a proxy to vote on the implementation of, or material changes to, equity compensation plans unless the beneficial owner of the shares has given voting instructions. The Exchange proposes a transition period that will make this provision applicable only to shareholder meetings that occur on or after the 90th day following the date of the Commission order approving this rule.

2. Statutory Basis

The Exchange believes that the proposed rule change, as amended, is consistent with Section 6 of the Act,[10] in general, and furthers the objectives of Section 6(b)(5) of the Act,[11] in particular, in that it is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments on the proposed rule change were neither solicited nor received.

III. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change, as amended, is consistent with the Act. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, NW, Washington, DC 20549–0609. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying at the Commission's Public Reference Room. Copies of such filing will also be available for inspection and copying at the principal office of the Exchange. All submissions should refer to File No. SR-BSE–2003–16 and should be submitted by November 28, 2003.

IV. Commission's Findings and Order Granting Accelerated Approval to the Proposed Rule Change, As Amended

After careful review, the Commission finds that the Exchange's proposal, as amended, is consistent with the Act and the rules and regulations promulgated thereunder applicable to a national securities exchange and, in particular, with the requirements of Section 6(b) of the Act.[12] Specifically, the Commission finds that approval of the Exchange's proposal, as amended, is consistent with Section 6(b)(5) of the Act[13] in that it is designed to, among other things, facilitate transactions in securities; to prevent fraudulent and manipulative acts and practices; to promote just and equitable principles of trade; to remove impediments to and perfect the mechanism of a free and open market and a national market system; and, in general, to protect investors and the public interest; and does not permit unfair discrimination among issuers.

The Commission has long encouraged exchanges to adopt and strengthen their corporate governance listing standards in order to, among other things, restore investor confidence in the national marketplace. The Commission believes that the Exchange's proposal, as amended, which requires shareholder approval of equity compensation plans and which follows the Commission's approval of similar proposals by the NYSE, Nasdaq, and Amex[14] is the first step under this directive because it should have the effect of safeguarding the interests of shareholders, while placing certain restrictions on Exchange-listed companies.

In addition, the Commission notes that the Exchange's proposal, as amended, is similar and almost

[10] 15 U.S.C. 78f(b).

[11] 15 U.S.C. 78f(b)(5).

[12] 15 U.S.C. 78f(b). In approving the Exchange's proposal, as amended, the Commission has considered the proposed rule's impact on efficiency, competition and capital formation. 15 U.S.C. 78c(f).

[13] 15 U.S.C. 78f(b)(5).

[14] See *supra* note 6. The Commission notes that it has recently approved similar rules requiring shareholder approval of equity compensation plans for the American Stock Exchange LLC ("Amex"). *See* Securities Exchange Act Release No. 48610 (October 9, 2003), 68 FR 59650 (October 16, 2003).

identical to proposals by NYSE and Nasdaq requiring shareholder approval of equity compensation plans that have previously been approved by the Commission.[15] The Commission believes that it has already considered and addressed the issues that may be raised by the Exchange's proposal when it approved these proposals. The Commission notes that approval of the Exchange's proposal, as amended, will conform the Exchange's shareholder approval requirements for equity compensation plans with those of the NYSE and Nasdaq, and will immediately impose the same requirements on the Exchange's issuers as those imposed upon NYSE, Nasdaq, and Amex issuers. The adoption of these standards by the Exchange is an important step to ensure that issuers will not be able to avoid shareholder approval requirements for equity compensation plans based on their listed marketplace.

A. Exemption From Shareholder Approval for Inducement Grants

The Commission believes that the requirement that the issuance of all inducement grants be subject to review by either the issuer's independent compensation committee or a majority of the board's independent directors, under the Exchange's amended proposal, should prevent abuse of this exemption from shareholder approval. In addition, the Exchange proposes to limit its exemption for inducement grants to new employees or to previous employees being rehired after a bona fide period of interruption of employment, and to new employees in connection with an acquisition or merger. The Commission believes that these limitations should help to prevent the inducement exemption from being used inappropriately.

The Commission notes that the Exchange is proposing to include a requirement, similar to the requirement under the NYSE and Nasdaq's recently approved shareholder approval rules, that, promptly following the grant of any inducement award, companies must disclose in a press release the material terms of the award, including the recipient(s) of the award and the number of shares involved.[16] The Commission notes that the Exchange is also proposing a requirement, similar to the requirements under the NYSE and Nasdaq's recently approved shareholder approval rules,[17] that an issuer must notify it in writing when it uses this exemption, and/or any other exemption, from its shareholder approval requirement. The Commission believes that these disclosure and notification requirements will provide transparency to investors and should reduce the potential for abuse of this exemption for inducement grants.

B. Exemption From Shareholder Approval for Mergers and Acquisitions

The Commission notes that the Exchange's exemption from shareholder approval for mergers and acquisitions contains safeguards that should prevent abuse in this area. First, only pre-existing plans that were previously approved by the acquired company's shareholders would be available to the listed company for post-transactional grants. In addition, shares under those previously approved plans could not be granted to individuals who were employed, immediately before the transaction, by the post-transaction listed company or its subsidiaries. The Commission also notes that, under the Exchange's proposal, as amended, any shares reserved for listing in connection with a merger or acquisition pursuant to this exemption would be counted by the Exchange in determining whether the transaction involved the issuance of 20% or more of the company's outstanding common stock, thereby requiring shareholder approval. Finally, the Commission notes that the Exchange proposes an additional requirement that an issuer must notify it in writing when it uses this exemption, and/or any other exemption, from its shareholder approval requirement. Based on the above, the Commission believes that the Exchange has provided measures to ensure that the exemption for mergers and acquisitions is only used in limited circumstances, which should help reduce the potential for dilution of shareholder interests.

C. Exemption From Shareholder Approval for Tax Qualified and Parallel Nonqualified Plans

The Commission believes that, given the extensive government regulation—the Internal Revenue Code and Treasury regulations—for tax qualified plans and the general limitations associated with parallel nonqualified plans, shareholders should not experience significant dilution as a result of this exemption. In addition, the Commission notes that the Exchange proposes to add a limitation under this exemption that a plan would not be considered a nonqualified parallel plan under its proposal if employees who are participants in such a plan receive employer contributions under the plan in excess of 25% of the participants' cash compensation. The Commission further notes that the Exchange proposes an additional requirement that an issuer must notify it in writing when it uses this exemption, and/or any other exemption, from its shareholder approval requirement. The Commission believes that, taken together, these limitations should reduce concerns regarding abuse of this exemption from the shareholder approval requirements.

In addition, the Commission notes that, similar to the exemptions in the NYSE and Nasdaq's recently approved shareholder approval rules, the Exchange proposes to adopt an exemption from the shareholder approval requirements for an equity compensation plan that provides non-U.S. employees with substantially the same benefits as a comparable Section 401(a) plan, Section 423 plan or parallel excess plan that the listed company provides to its U.S. employees, but for features necessary to comply with applicable foreign tax law. The Commission believes that this change will conform the Exchange's shareholder approval rule to that of the NYSE and Nasdaq and will provide greater clarity for issuers regarding tax qualified, non-discriminatory employee benefit plans and parallel nonqualified plans for their non-U.S. employees.

D. Material Revisions to Plans

The Commission notes that the Exchange proposes to provide a non-exclusive list, similar to lists found in the NYSE and Nasdaq's shareholder approval rules,[18] as to what constitutes a material revision to a plan. As noted above, material revisions to plans will require shareholder approval under Exchange rules. A material revision under the Exchange's amended proposal would include, but is not limited to: a material increase in the number of shares to be issued under the plan (other than to reflect a reorganization, stock split, merger, spinoff or similar transaction); an expansion of the type of awards available under the plan; a material expansion of the class of participants eligible to participate in the

[15] *See supra* notes 6 and 14.

[16] This disclosure would, of course, be in addition to any information that is required to be disclosed in annual reports filed with the Commission. For example, Item 201(d) of Regulation S–K [17 CFR 229.201(d)] and Item 201(d) of Regulation S–B [17 CFR 228.201(d)] require issuers to present—in their annual reports on Form 10–K or Form 10–KSB—separate, tabular disclosure concerning equity compensation plans that have been approved by shareholders and equity compensation plans that have not been approved by shareholders.

[17] *See* Section 303A(8) of the NYSE's *Listed Company Manual* and NASD Rules 4310(c)(17)(A) and 4320(e)(15)(A).

[18] *See supra* note 6; *see also supra* note 14.

plan; a material extension of the term of the plan; a material change to limit or delete any provisions prohibiting repricing of options in a plan or for determining the strike or exercise price of options under a plan. The Exchange's proposal, as amended, also describes what would constitute a material revision for plans containing a formula for automatic increases (such as evergreen plans) and automatic grants requiring shareholder approval.

The Commission believes that the Exchange's non-exclusive list of what would constitute a material revision to a plan provides companies with clarity and guidance for when certain amendments and revisions to plans would require shareholder approval. The Commission also believes that the Exchange's amended proposal to conform its non-exclusive list with the NYSE and Nasdaq's rules on material amendments/revisions should help to ensure that the concept of material amendments/revisions is consistent among the markets so that differences between the markets cannot be abused.

E. Repricing of Plans

The Commission notes that the Exchange's proposal, as amended, provides that, if a plan explicitly contains a repricing provision, shareholder approval would be required to delete or limit the repricing provisions. The Commission further notes that the Exchange's proposal, as amended, provides that, if a plan is silent on repricing, it will be considered as prohibiting repricing and shareholder approval would be required to permit repricing under the plan. The Exchange's proposal, as amended, also clarifies that repricings that have commenced prior to the date of effectiveness of its proposal would not be subject to shareholder approval, provided that such repricing does not require shareholder approval under the Exchange's existing shareholder approval rules.

The Commission believes that the Exchange's proposal, as amended, should benefit shareholders by ensuring that companies cannot do a repricing of options, which can have a dilutive effect on shares, without explicit shareholder approval of such provisions and their terms. The Commission also believes that the Exchange's approach to repricings is similar to the NYSE and Nasdaq's respective approaches to repricings, and should offer companies clarity and guidance as to when a change in a plan regarding the repricing of options would trigger a shareholder approval requirement.

F. Evergreen or Formula Plans and Plans Without a Formula or Limit on the Number of Shares Available

The Commission notes the Exchange's proposal, as amended, provides guidance for the treatment of evergreen/formula plans. More specifically, under the Exchange's proposal, as amended, if a plan contains a formula for automatic increases in the shares available or for automatic grants pursuant to a formula, such plans cannot have a term in excess of ten years unless shareholder approval is obtained every ten years. In addition, under the Exchange's amended proposal, if a plan contains no limit on the number of shares available and is not a formula plan, then each grant under the plan will require separate shareholder approval. Furthermore, the Exchange's proposal, as amended, provides that a requirement that grants be made out of treasury or repurchased shares will not alleviate the need for shareholder approval for additional grants.

The Commission believes that these provisions should help to ensure that certain terms of a plan cannot be drafted so broad as to avoid shareholder scrutiny and approval. The Commission also believes that the Exchange's proposed rules relating to the treatment of evergreen/formula plans and plans that do not contain a formula or place a limit on the number of shares available should provide more clarity and transparency to issuers as to when shareholder approval would be required for such plans. Finally, the Commission believes that the provision ensuring that treasury and repurchased shares cannot be used to avoid these additional shareholder approval requirements strengthens the proposal and ensures that companies cannot avoid compliance with the rule.

The Commission further notes that the Exchange has proposed a transition period for evergreen/formula plans and discretionary plans. The limited transition period would end on the first to occur of the following: (1) The listed company's next annual meeting at which directors are elected that occurs more than 180 days after the date of the effective date of the Exchange's proposal; (2) the first anniversary of the effective date of the Exchange's proposal; or (3) the expiration of the plan. The Commission believes that the Exchange's proposed transition period for evergreen/formula and discretionary plans should provide companies with additional clarity and guidance as to when shareholder approval would be required for such plans while in the transition period, and should provide companies with more time to comply with the Exchange's new shareholder approval requirements for evergreen/formula type plans. The Commission believes that this period is not so long as to permit abuse of the shareholder approval requirement, and at most, will last one year from the date of this Commission approval order.

G. Miscellaneous Provisions

The Commission notes that the Exchange's amended proposal similar to the NYSE and Nasdaq's recently approved shareholder approval rules [19]—incorporates the term "equity compensation" and proposes that plans that merely provide a convenient way to purchase shares in the open market or from the issuer at fair market price on equal terms to all security holders would not require shareholder approval. The Commission believes that the Exchange's proposal, as amended, is consistent with the NYSE and Nasdaq's rules in this area and should provide greater clarity with respect to which plans would and would not require shareholder approval.

The Commission notes that the Exchange's proposal, as amended, provides that pre-existing plans, which were adopted prior to the SEC's approval of the Exchange's proposal, would essentially be "grandfathered" and would not require shareholder approval unless the plans were materially amended. Under the Exchange's amended proposal, however, shareholder approval is required for each grant made pursuant to any pre-existing plans that were not approved by shareholders and that do not have an evergreen formula or a specific number of shares available under the plan. This is consistent with the NYSE, Nasdaq, and Amex shareholder approval rules on this matter. The Commission believes that this clarification should provide companies with guidance as to which plans would be subject to the Exchange's new shareholder approval requirements.

H. Elimination of Broker-Dealer Voting on Equity Compensation Plans

The Commission believes that the Exchange's proposed provision, BSE Section 3(e), to preclude broker voting on equity compensation plans is consistent with the Act. The Commission notes that equity compensation plans have become an important issue for shareholders. Because of the potential for dilution from issuances under such plans, shareholders should be making the

[19] *See supra* note 6; *see also supra* note 14.

determination rather than brokers on their behalf. The Commission further notes that NASD rules do not provide for broker voting on any matters and NYSE rules prohibit broker voting on equity compensation plans.[20] Therefore, the Exchange's proposed provision would be consistent with NASD and NYSE rules regarding broker voting on equity compensation plans. The Commission has considered the impact on smaller issuers, such as those listed on Nasdaq and the Amex, in response to the comments on this issue.[21] The Commission believes that the benefit of ensuring that the votes reflect the views of beneficial shareholders on equity compensation plans outweighs the potential difficulties in obtaining the vote.

The Commission also notes that the Exchange proposes to implement a transition period that would make the new rule eliminating broker voting on equity compensation plans applicable only to shareholder meetings that occur on or after the 90th day from the effective date of the Exchange's proposal.

I. Summary

Overall, the Commission believes that the Exchange's proposal, as amended, is similar to the NYSE and Nasdaq's recently approved shareholder approval rules.[22] The Commission therefore believes that the Exchange's amended proposal should provide for more clear and uniform standards for shareholder approval of equity compensation plans. The Commission notes that, even with the availability of the proposed limited exemptions from shareholder approval under the Exchange's amended proposal, shareholder approval under the new standards would be required in more circumstances than under existing Exchange rules. The Commission further notes that the Exchange proposes to adopt a requirement that an issuer must notify it in writing when it uses one of the exemptions from the shareholder approval requirements. The Commission believes that such a requirement, coupled with the additional disclosure requirements for inducement grants, should reduce the potential for abuse of any of the exemptions.[23] In addition, the Exchange's proposed amendment to BSE Section 3, which would preclude broker-dealers from voting on equity compensation plans without explicit instructions from the beneficial owner, is consistent with the standard under current NYSE and NASD rules.

The Commission believes that the Exchange's proposal, as amended, which is similar to the NYSE and Nasdaq's shareholder approval rules,[24] sets a consistent, minimum standard for shareholder approval of equity compensation plans. The Commission believes that the Exchange's proposal, as amended, should help to ensure that companies will not make listing decisions simply to avoid shareholder approval requirements for equity compensation plans and should provide shareholders with greater protection from the potential dilutive effect of equity compensation plans. Based on the above, the Commission finds that the Exchange's proposal, as amended, should help to protect investors, is in the public interest, and does not unfairly discriminate among issuers, consistent with Section 6(b)(5) of the Act.[25] The Commission therefore finds the Exchange's proposal, as amended, to be consistent with the Act and the rules and regulations thereunder.

V. Accelerated Approval of the Exchange's Proposal and Amendment Nos. 1 and 2

The Commission finds good cause for approving the Exchange's proposal and Amendment Nos. 1 and 2 thereto prior to the thirtieth day after the date of publication of notice thereof in the **Federal Register**. The Commission notes that the Exchange's proposal, as amended, is similar to the NYSE and Nasdaq's proposals requiring shareholder approval of equity compensation plans. Both the NYSE and Nasdaq's proposals were published for comment in the **Federal Register** and recently approved by the Commission.[26] The Commission believes that it already considered and addressed the issues that may be raised by the Exchange's amended proposal in its approval of the NYSE and Nasdaq's proposals.[27]

The Commission believes that accelerated approval of the Exchange's proposal, as amended, is essential to allow for immediate harmonization of, and consistency in, the shareholder approval requirements for equity compensation plans among the markets. This will prevent issuers from making listing decisions based on differences in self-regulatory organization shareholder approval requirements and should provide equal investor protection to shareholders on the dilutive effects of plans irrespective of where the security trades. The Commission further believes that making the Exchange's new shareholder approval rules effective upon Commission approval will immediately impose the same requirements on the Exchange's issuers as those imposed upon NYSE, Nasdaq, and Amex issuers. Based on the above, the Commission finds good cause, consistent with Sections 6(b)(5) and 19(b)(2) of the Act, [28] to approve the Exchange's proposal and Amendment Nos. 1 and 2 thereto on an accelerated basis.

VI. Conclusion

It Is Therefore Ordered, pursuant to Section 19(b)(2) of the Act,[29] that the proposed rule change (SR–BSE–2003–16) and Amendment Nos. 1 and 2 thereto are hereby approved on an accelerated basis.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[30]

Jill M. Peterson,

Assistant Secretary.

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[20] *See* NASD Rule 2260; NYSE Rule 452; and Section 402.08 of the NYSE's *Listed Company Manual.*

[21] *See supra* notes 6 and 20.

[22] *See supra* note 6; *see alsa supra* note 14.

[23] *See alsa supra* note 16 and accompanying text.

[24] *See supra* note 6; *see also supra* note 14.

[25] 15 U.S.C. 78f(b)(5).

[26] *See* Securities Exchange Act Release No. 46620 (October 8, 2002), 67 FR 63486 (notice of the NYSE's proposal). The Commission also published a correction to the notice of the NYSE's proposal. *See* Securities Exchange Act Release No. 44620A (October 21, 2002), 67 FR 65617 (October 25, 2002). *See* Securities Exchange Act Release No. 46649 (October 11, 2002), 67 FR 64173 (notice of Nasdaq's proposal). *See supra* note 6; *see alsa supra* note 14.

[27] Some of the substantive provisions ultimately adopted by the NYSE and Nasdaq, and now being proposed for adoption by the Exchange, were in response to these comments. The comments on the NYSE and Nasdaq proposals were also discussed in detail in the Commission's approval order of the NYSE and Nasdaq proposals. *See supra* note 6; *see alsa supra* note 14.

[28] 15 U.S.C. 78f(b)(5) and 78s(b)(2).

[29] 15 U.S.C. 78s(b)(2).

[30] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–48737; File No. SR–CBOE–2003–45]

Self-Regulatory Organizations; Notice of Filing and Order Granting Accelerated Approval to a Proposed Rule Change by the Chicago Board Options Exchange, Inc. and Amendment No. 1 Thereto Relating to Shareholder Approval of Equity Compensation Plans and the Voting of Proxies

October 31, 2003.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934

("Act"),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on October 6, 2003, the Chicago Board Options Exchange, Inc. ("CBOE" or "Exchange") filed with the Securities and Exchange Commission ("SEC" or "Commission") the proposed rule change as described in Items I and II below, which Items have been prepared by the Exchange. On October 29, 2003, the Exchange filed Amendment No. 1 to the proposed rule change.[3] The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons and is approving the proposal and Amendment No. 1 thereto on an accelerated basis.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to amend CBOE Rules 31.79, 31.80, 31.85 and 31.96, and CBOE Form 1 under "Forms For Listing," to strengthen listing standards relating to shareholder approval for stock option plans or other equity compensation arrangements and to adopt interpretative material pertaining to shareholder approval for stock option plans or other equity compensation arrangements.

Below is the text of the proposed rule change.[4] Proposed new language is *italicized;* proposed deleted language is [bracketed].

* * * * *

Chicago Board Options Exchange, Incorporated

Rules

* * * * *

Chapter XXXI

* * * * *

Shareholders' Approval

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Rule 31.79 Options to Officers, Directors, [or Key] Employees *or Consultants*

Approval of shareholders is required [(unless exempted under paragraphs (a) and (b) below) as a prerequisite to approval of applications to list additional shares reserved for] *with respect to the establishment of (or material amendment to) a stock* option[s] *or purchase plan or other equity compensation arrangement pursuant to which options or stock may be acquired by officers, directors, employees, or consultants* [granted or to be granted to officers, directors or key employees], regardless of whether or not such authorization is required by law or by the company's charter, *except for*:[.] [The Exchange requires that such shareholder's approval be solicited pursuant to a proxy statement conforming to SEC proxy rules which discloses all of the essential details of the options or of the plan pursuant to which the options will be granted.]

[**Note:** This policy does not preclude the adoption of a stock option plan, or the granting of options, subject to ratification by shareholders, prior to the filing of an application for the listing of the shares reserved for such purpose.

The Exchange will not require shareholder's approval as a condition to listing shares reserved for the exercise of options when:]

(a) [such options are issued] *issuances* to an individual, not previously *an* employee[d] *or director of* [by] the company, *or following a bonafide period of non-employment,* as an inducement [essential] *material* to entering into [a contract of] employment with the company, provided [that] *(i) such issuances are approved by either a majority of the company's independent directors or the company's independent compensation committee and (ii) the company discloses in a press release the material terms of the grant, including the recipient(s) of the grant and the number of shares involved, promptly following an issuance of any employment inducement grant in reliance on this exception* [the potential issuance of shares pursuant to such options does not exceed 5% of the company's outstanding common stock]; or

(b) [such options are to be granted:]

[(i)] [under a] *tax qualified, non-discrininatory employee benefit* plans [or arrangement] (*e.g., plans that meet the requirements of Section 401(a) or 423 of the Internal Revenue Code) or parallel nonqualified plans, provided such plans are approved by a majority of the company's independent directors or the company's independent compensation committee, or plans that merely provide a convenient way to purchase shares on the open market or from the company at fair market value* [in which all, or substantially all, of the company's employees participate, in a fair and equitable manner,]; or

(c) Plans or arrangements relating to an acquisition or merger; or

(d) Warrants or rights issued generally to all security holders of the company or stock purchase plans available on equal terms to all security holders of the company (such as a typical dividend reinvestment plan).

The Exchange requires that such shareholder's approval be solicited pursuant to a proxy statement conforming to SEC proxy rules which discloses all of the essential details of the options or of the plan pursuant to which the options will be granted.

[(ii) under a plan or arrangement for officers, directors or key employees provided such incentive arrangement for officers, directors or key employees do not authorize the issuance in any one year of more than the lesser of 1% of the number of shares outstanding common stock, 1% of the voting power outstanding, or 25,000 shares and provided that all arrangements adopted without shareholder approval in any five-year period do not authorize, in the aggregate, the issuance of more than 10% of outstanding common stock or voting power outstanding. (For the purpose of calculating the percentage of stock issued in the aggregate, stock to be issued pursuant to options which have expired and/or been canceled shall not be included.)

For purposes of the above policy, the term "options" includes not only the usual type of nontransferable options granted in consideration of continued employment but also any other arrangement under which controlling shareholders, officers, directors or key employees may acquire (other than as part of a public offering) stock or convertible securities of a company at a price below market price at the time such stock is acquired or through the use of credit extended, directly or indirectly, by the company. Thus, the sale to such a person(s) of common stock purchase warrants or rights (not part of a public offering) or the sale of stock to such person who has borrowed money from the company, will normally necessitate shareholder approval.]

* * * * *

*** * * *Interpretations and Policies:***

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[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* letter from David Doherty, Attorney, Legal Division, CBOE, to Sapna C. Patel, Special Counsel, Division of Market Regulation ("Division"), Commission, dated October 29, 2003 ("Amendment No. 1"). In Amendment No. 1, the Exchange made a technical correction to its proposed rule language by underlining the heading "Interpretations and Policies" under CBOE Rule 31.79 to indicate that it is proposed new language. Because this is a technical amendment, it is not subject to notice and comment.

[4] With respect to implementation of revised CBOE Rules 31.79, 31.80, 31.85 and 31.96, and CBOE Form 1 under "Forms For Listing," the Exchange notes that they become effective upon SEC approval, and that existing plans would be grandfathered. However, any material modification to plans in place or adopted after the effective date would require shareholder approval. Telephone conversation between David Doherty, Attorney, Legal Division, CBOE, and Sapna C. Patel, Special Counsel, Division, Commission, on October 28, 2003.

.01 Rule 31.79 requires shareholder approval when a plan or other equity compensation arrangement is established or materially amended. For these purposes, a material amendment would include, but not be limited to, the following:

(1) Any material increase in the number of shares to be issued under the plan (other than to reflect a reorganization, stock split, merger, spinoff or similar transaction);

(2) Any material increase in benefits to participants, including any material change to:

(i) permit a repricing (or decrease in the exercise price) of outstanding options, (ii) reduce the price at which shares or options to purchase shares may be offered, or (iii) extend the duration of a plan;

(3) Any material expansion of the class of participants eligible to participate in the plan; and

(4) Any expansion in the types of options or awards provided under the plan.

While general authority to amend a plan would not obviate the need for shareholder approval, if a plan permits a specific action without further shareholder approval, then no such approval would generally be required. However, if a plan contains a formula for automatic increases in the shares available (sometimes called an "evergreen formula"), or for automatic grants pursuant to a dollar-based formula (such as annual grants based on a certain dollar value, or matching contributions based upon the amount of compensation the participant elects to defer), such plans cannot have a term in excess of ten years unless shareholder approval is obtained every ten years. However, plans that do not contain a formula and do not impose a limit on the number of shares available for grant would require shareholder approval of each grant under the plan. A requirement that grants be made out of treasury shares or repurchased shares will not alleviate these additional shareholder approval requirements.

As a general matter, when preparing plans and presenting them for shareholder approval, issuers should strive to make plan terms easy to understand. In that regard, it is recommended that plans meant to permit repricing use explicit terminology to make this clear.

Rule 31.79 provides an exception to the requirement for shareholder approval for warrants or rights offered generally to all shareholders. An exception is also provided for tax qualified, non-discriminatory employee benefit plans as well as parallel nonqualified plans as these plans are regulated under the Internal Revenue Code and Treasury Department regulations. An equity compensation plan that provides non-U.S. employees with substantially the same benefits as a comparable tax qualified non-discriminatory employee benefit plan or parallel nonqualified plan that the issuer provides to its U.S. employees, but for features necessary to comply with applicable foreign tax law, are also exempt from shareholder approval under this section. The term "parallel nonqualified plan" means a plan that is a "pension plan" within the meaning of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1002 (1999), that is designed to work in parallel with a plan intended to be qualified under Internal Revenue Code Section 401(a), to provide benefits that exceed the limits set forth in Internal Revenue Code Section 402(g) (the section that limits an employee's annual pre-tax contributions to a 401(k) plan), Internal Revenue Code Section 401(a)(17) (the section that limits the amount of an employee's compensation that can be taken into account for plan purposes) and/or Internal Revenue Code Section 415 (the section that limits the contributions and benefits under qualified plans) and/or any successor or similar limitations that may thereafter be enacted. However, a plan will not be considered a parallel nonqualified plan unless: (i) It covers all or substantially all employees of an employer who are participants in the related qualified plan whose annual compensation is in excess of the limit of Code Section 401(a)(17) (or any successor or similar limitation that may hereafter be enacted); (ii) its terms are substantially the same as the qualified plan that it parallels except for the elimination of the limitations described in the preceding sentence; and (iii) no participant receives employer equity contributions under the plan in excess of 25% of the participant's cash compensation.

Further, there is an exception for inducement grants to new employees because in these cases a company has an arm's length relationship with the new employees. Inducement grants for these purposes include grants of options or stock to new employees in connection with a merger or acquisition. Rule 31.79 requires that such issuances must be approved by the issuer's independent compensation committee or a majority of the issuer's independent directors. The rule further requires that promptly following an issuance of any employment inducement grant in reliance on this exception, the listed company must disclose in a press release the material terms of the grant, including the recipient(s) of the grant and the number of shares involved.

In addition, plans or arrangements involving a merger or acquisition do not require shareholder approval in two situations. First, shareholder approval will not be required to convert, replace or adjust outstanding options or other equity compensation awards to reflect the transaction. Second, shares available under certain plans acquired in acquisitions and mergers may be used for certain post-transaction grants without further shareholder approval. This exception applies to situations where the party which is not a listed company following the transaction has shares available for grant under pre-existing plans that were previously approved by shareholders pursuant to Rule 31.79. These shares may be used for post-transaction grants of options and other equity awards by the listed company (after appropriate adjustment of the number of shares to reflect the transaction), either under the pre-existing plan or arrangement or another plan or arrangement, without further shareholder approval, provided: (1) The time during which those shares are available for grants is not extended beyond the period when they would have been available under the pre-existing plan, absent the transaction, and (2) such options and other awards are not granted to individuals who were employed by the granting company or its subsidiaries at the time the merger or acquisition was consummated. A plan or arrangement adopted in contemplation of the merger or acquisition transaction would not be viewed as pre-existing for purposes of this exception. This exception is appropriate because it will not result in any increase in the aggregate potential dilution of the combined enterprise. In this regard, any additional shares available for issuance under a plan or arrangement acquired in connection with a merger or acquisition would be counted in determining whether the transaction involved the issuance of 20% or more of the company's outstanding common stock, thus triggering the shareholder approval requirements of Rule 31.80(b).

A listed company is not permitted to use repurchased shares to fund option plans or grants without prior shareholder approval.

Pursuant to Rule 31.96(H), a listed company is required to notify the Exchange in writing prior to the use of any of the exceptions set forth in

paragraphs (a) through (d) of Rule 31.79.

* * * * *

Rule 31.80 Acquisitions

* * * * *

*** * * Interpretations and Policies**

.01 Any additional shares available for issuance under a stock option or purchase plan or other equity compensation arrangement acquired in connection with a merger or acquisition are counted in determining whether the transaction involved the issuance of 20% or more of the company's outstanding common stock as provided in Rule 31.80(b).

* * * * *

Rule 31.85 Giving Proxies by Member Organizations

(a) No change.

(b) When a member organization may not vote without customer instructions—A member organization may not give a proxy to vote without instructions from beneficial owners when the matter to be voted upon:

(1)–(8) No change.

(9) involves a waiver or modification of preemptive rights[, except when the company's proposal is to waive such rights with respect to shares being offered pursuant to stock options or purchase plans involving the additional issuance of not more than 5% of the company's outstanding common shares];

(10)–(11) No change.

(12) [authorizes the issuance of stock, or options to purchase stock to directors, officers or employees in an amount which exceeds 5% of the total amount of the class outstanding] *authorizes the implementation of any equity compensation plan, or any material revision to the terms of any existing equity compensation plan (whether or not shareholder approval of such plan is required by Rule 31.79);*

(13)–(18) No change.

(c)–(h) No change.

* * * * *

Rule 31.96 Notices to Exchange

(A)–(G) No change.

(H) Reliance on Shareholder Approval Exceptions

A listed company is required to notify the Exchange in writing prior to the use of any of the exceptions set forth in paragraphs (a) through (d) of Rule 31.79.

* * * * *

Forms for Listing

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Form 1

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Listing Agreement

_____ (the "Company"), in consideration of the listing of its securities, hereby agrees with the Chicago Board Options Exchange, Incorporated (the "Exchange"), that it will:

1. Promptly notify the Exchange of the following:

(a)–(i) No change.

(j) Any diminution in the supply of the security available for trading caused by deposit of the security under voting trust, tender offer or other agreements; [and]

(k) The existence of any technical default or default in interest or principal payment, cumulative dividends, sinking funds, or redemption fund requirements of the Company or any controlled corporation, whether consolidated or unconsolidated*; and[.]*

(l) the use of any of the exceptions set forth in paragraphs (a) through (d) of Rule 31.79, which notice must be sent to the Exchange in writing prior to such use.

(2)–(28) No change.

* * * * *

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item III below. The Exchange has prepared summaries, set forth in Sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basisfor, the Proposed Rule Change

1. Purpose

The Exchange proposes to amend its non-option rules (*i.e.*, equity rules) that apply to listing standards for stocks that may be listed on the Exchange. CBOE Rule 31.79 currently requires listed companies to obtain shareholder approval for stock option plans and other arrangements in which officers, directors, and key employees participate. However, the current Rule contains two exceptions, one for "broadly based plans," which, under CBOE Rule 31.79, is a plan in which all or substantially all of the company's employees participate in a fair and equitable manner, even if officers, directors and key employees receive options grants under the plan, and one for de minimis grants. To enhance investor confidence in the national securities markets, the Exchange now proposes to require shareholder approval of all stock option and equity compensation plans, including "broad based plans." The proposed rule change would also provide four exceptions to the shareholder approval requirement based on the proposals set forth in a recent approval order of the New York Stock Exchange, Inc. ("NYSE") and the National Association of Securities Dealers, Inc. ("NASD")/The Nasdaq Stock Market, Inc. ("Nasdaq") proposals related to equity compensation plans.[5] In addition, the Exchange proposes to eliminate the de minimis exception currently reflected in CBOE Rule 31.79(b)(ii), which generally allows for the grant of the lesser of 1% of the number of outstanding shares of common stock, 1% of the voting power outstanding or 25,000 shares without shareholder approval, as this exception is not in accord with the concept of restricting the use of unapproved options.

Proposed CBOE Rule 31.79(a) amends the current exception set forth in CBOE Rule 31.79(a) to provide for inducement grants to new employees or to previous employees following a bonafide period of non-employment with the listed company. The proposed rule change would delete the reference that limits the grant to five percent of the company's outstanding common stock, which would align proposed CBOE Rule 31.79(a) with the Nasdaq/NYSE Proposals. The Exchange does not believe that shareholder approval is necessary for these types of inducement grants since in these cases a company has an arm's length relationship with

[5] *See* Securities Exchange Act Release No. 48108 (June 30, 2003), 68 FR 39995 (July 3, 2003) (order approving File Nos. SR–NYSE–2002–46 and SR–NASD–2002–140) (the "Nasdaq/NYSE Proposals"). *See also* Securities Exchange Act Release No. 48627 (October 14, 2003), 68 FR 60426 (October 22, 2003) (notice of filing and order granting accelerated approval to File No. SR–NASD–2003–130, incorporating amendments to the NASD's recently approved shareholder approval rules for equity compensation plans applicable to Nasdaq quoted securities). The Commission also published a correction to the notice of File No. SR–NASD–2003–130. *See* Securities Exchange Act Release No. 48627A (October 22, 2003), 68 FR 61532 (October 28, 2003). The Commission notes that these additional amendments by Nasdaq make the NYSE and Nasdaq proposals more consistent and uniform. *See also infra* note 11 (regarding the Commission's recent approval of a similar proposal by the American Stock Exchange LLC ("Amex")).

the new employees, and its interests are directly aligned with those of shareholders. The Exchange believes that any potential abuse of the inducement exception would be mitigated by the requirement that the company's independent compensation committee or a majority of the company's independent directors approve the inducement grant. In addition, a listed company relying on the inducement award exception, as set forth in Rule 31.79(a), must disclose in a press release the material terms of the award, including the recipient(s) of the award and the number of shares involved.

Proposed CBOE Rule 31.79(b), a new exception based on the Nasdaq/NYSE Proposals, does not require shareholder approval for tax qualified, nondiscriminatory benefit plans, as these plans are regulated under the Internal Revenue Code and Treasury Department regulations. However, the listed company's independent compensation committee or a majority of the listed company's independent directors must approve these plans. Along with tax qualified, non-discriminatory employee benefit plans, proposed CBOE Rule 31.79(b) also proposes an exception for parallel nonqualified plans. The proposed rule change would not impact any shareholder approval or other requirements under the Internal Revenue Code or other applicable laws or requirements for such plans. Additionally, an equity compensation plan that provides non-U.S. employees with substantially the same benefits as a comparable tax qualified, non-discriminatory employee benefit plan or parallel nonqualified plan that the issuer provides to its U.S. employees, but for features necessary to comply with applicable foreign tax law, is also exempt from the shareholder approval requirements.

Proposed Interpretation .01 to CBOE Rule 31.79 makes clear that a company would not be permitted to use repurchased shares to fund options plans without prior shareholder approval. However, plans that merely provide a convenient way to purchase shares on the open market or from the issuer at fair market value would not require shareholder approval.

With respect to plans or arrangements relating to an acquisition or merger, as set forth in proposed CBOE Rule 31.79(c), proposed Interpretation .01 to CBOE Rule 31.79 makes clear that these plans or arrangements would not require shareholder approval in two situations. First, shareholder approval will not be required to convert, replace or adjust outstanding options or other equity compensation awards to reflect the transaction. Second, shares available under certain plans acquired in acquisitions and mergers may be used for certain post-transaction grants without further shareholder approval. This exception applies to situations where the party that is not a listed company following the transaction has shares available for grant under pre-existing plans that were previously approved by shareholders. These shares may be used for post-transaction grants of options and other equity awards by the listed company (after appropriate adjustment of the number of shares to reflect the transaction), either under the pre-existing plan or another plan, without further shareholder approval, so long as (1) the time during which those shares are available for grants is not extended beyond the period when they would have been available under the pre-existing plan, absent the transaction, and (2) such options and other awards are not granted to individuals who were employed by the granting company or its subsidiaries at the time the merger or acquisition was consummated. The Exchange would view a plan adopted in contemplation of the merger or acquisition transaction as not pre-existing for purposes of this exception. The Exchange believes that this exception is appropriate because it believes that it would not result in any increase in the aggregate potential dilution of the combined enterprise.

Finally, proposed CBOE Rule 31.79(d) sets forth a new exception for warrants or rights offered generally to all shareholders. The Exchange believes that this issuance does not raise the same concerns regarding self-dealing and dilution as other, more exclusive stock option plans or arrangements may create.

The Exchange's proposal also clarifies that only material amendments to plans (including existing plans) will require shareholder approval. Proposed Interpretation .01 to CBOE Rule 31.79 specifies a non-exclusive list of plan amendments that would be considered material. While broad, general authority to amend a plan would not obviate the need for shareholder approval, if a plan permits a specific action without further shareholder approval, then no such approval would be required.[6] Certain provisions in a plan, however, cannot be amended without shareholder approval. For example, plans that contain a formula for automatic increases in the shares available (sometimes called an "evergreen formula") or that automatically grant shares pursuant to a dollar-based formula cannot have a term in excess of ten years, unless shareholder approval is obtained every ten years. In addition, plans that do not contain a formula and do not impose a limit on the number of shares available for grant would require shareholder approval of each grant under the plan. A requirement that grants be made out of treasury shares or repurchased shares will not alleviate these additional shareholder approval requirements. Proposed Interpretation .01 to CBOE Rule 31.79 also provides that issuers should strive to make plan terms easily understandable and that plans meant to permit repricing should use explicit terminology in this regard.

Proposed Interpretation .01 to CBOE Rule 31.80 reflects the concept set forth in proposed Interpretation .01 to CBOE Rule 31.79, that additional shares available for issuance under a stock option or purchase plan or other equity compensation arrangement acquired in connection with a merger or acquisition are counted in determining whether the transaction involved the issuance of 20% or more of the company's outstanding common stock. Furthermore, the Exchange proposes to amend CBOE Rule 31.96 and the Listing Agreement set forth on CBOE Form 1 to require issuers to notify the Exchange in writing prior to the use of any of the exceptions set forth in paragraphs (a) through (d) of CBOE Rule 31.79.

In addition, the Exchange proposes to amend CBOE Rule 31.85 to preclude the Exchange's member organizations from giving a proxy to vote on equity compensation plans unless the beneficial owner of the shares has given voting instructions.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with Section 6 of the Act,[7] in general, and furthers the objectives of Section 6(b)(5) of the Act,[8] in particular, in that it is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest. As previously noted, the Exchange believes that the proposed rule change will strengthen shareholder approval

[6] The Commission notes that if a plan permits a specific action without further shareholder approval, it must be clear and specific enough to provide meaningful shareholder approval of those provisions.

[7] 15 U.S.C. 78f(b).

[8] 15 U.S.C. 78f(b)(5).

requirements with respect to stock option plans.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments on the proposed rule change were neither solicited nor received.

III. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549–0609. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying at the Commission's Public Reference Room. Copies of such filing will also be available for inspection and copying at the principal office of the Exchange. All submissions should refer to File No. SR–CBOE–2003–45 and should be submitted by November 28, 2003.

IV. Commission's Findings and Order Granting Accelerated Approval to the Proposed Rule Change

After careful review, the Commission finds that the Exchange's proposal is consistent with the Act and the rules and regulations promulgated thereunder applicable to a national securities exchange and, in particular, with the requirements of Section 6(b) of the Act.[9] Specifically, the Commission finds that approval of the Exchange's proposal is consistent with Section 6(b)(5) of the Act[10] in that it is designed to, among other things, facilitate transactions in securities; to prevent fraudulent and manipulative acts and practices; to promote just and equitable principles of trade; to remove impediments to and perfect the mechanism of a free and open market and a national market system; and, in general, to protect investors and the public interest; and does not permit unfair discrimination among issuers.

The Commission has long encouraged exchanges to adopt and strengthen their corporate governance listing standards in order to, among other things, restore investor confidence in the national marketplace. The Commission believes that the Exchange's proposal, which requires shareholder approval of equity compensation plans and which follows the Commission's approval of similar proposals by the NYSE, Nasdaq, and Amex[11] is the first step under this directive because it should have the effect of safeguarding the interests of shareholders, while placing certain restrictions on Exchange-listed companies.

In addition, the Commission notes that the Exchange's proposal is similar and almost identical to proposals by NYSE and Nasdaq requiring shareholder approval of equity compensation plans that have previously been approved by the Commission.[12] The Commission believes that it has already considered and addressed the issues that may be raised by the Exchange's proposal when it approved these proposals. The Commission notes that approval of the Exchange's proposal will conform the Exchange's shareholder approval requirements for equity compensation plans with those of the NYSE and Nasdaq, and will immediately impose the same requirements on the Exchange's issuers as those imposed upon NYSE, Nasdaq, and Amex issuers. The adoption of these standards by the Exchange is an important step to ensure that issuers will not be able to avoid shareholder approval requirements for equity compensation plans based on their listed marketplace.

A. Exception From Shareholder Approval for Inducement Grants

The Commission believes that the requirement that the issuance of all inducement grants be subject to review by either the issuer's independent compensation committee or a majority of the board's independent directors, under the Exchange's proposal, should prevent abuse of this exception from shareholder approval. In addition, the Exchange proposes to limit its exception for inducement grants to new employees or to previous employees being rehired after a bona fide period of interruption of employment, and to new employees in connection with an acquisition or merger. The Commission believes that these limitations should help to prevent the inducement exception from being used inappropriately.

The Commission notes that the Exchange is proposing to include a requirement, similar to the requirement under the NYSE and Nasdaq's recently approved shareholder approval rules, that, promptly following the grant of any inducement award, companies must disclose in a press release the material terms of the award, including the recipient(s) of the award and the number of shares involved.[13] The Commission notes that the Exchange is also proposing a requirement, similar to the requirements under the NYSE and Nasdaq's recently approved shareholder approval rules,[14] that an issuer must notify it in writing when it uses this exception, and/or any other exception, from its shareholder approval requirement. The Commission believes that these disclosure and notification requirements will provide transparency to investors and should reduce the potential for abuse of this exception for inducement grants.

B. Exception From Shareholder Approval for Mergers and Acquisitions

The Commission notes that the Exchange's exception from shareholder approval for mergers and acquisitions contains safeguards that should prevent abuse in this area. First, only pre-existing plans that were previously approved by the acquired company's shareholders would be available to the listed company for post-transactional grants. In addition, shares under those previously approved plans could not be granted to individuals who were

[9] 15 U.S.C. 78f(b). In approving the Exchange's proposal, the Commission has considered the proposed rule's impact on efficiency, competition and capital formation. 15 U.S.C. 78c(f).

[10] 15 U.S.C. 78f(b)(5).

[11] *See supra* note 5. The Commission notes that it has recently approved similar rules requiring shareholder approval of equity compensation plans for the Amex on an accelerated basis. The Amex's proposal is almost identical to, and based on, the NYSE and Nasdaq proposals. *See* Securities Exchange Act Release No. 48610 (October 9, 2003), 68 FR 59650 (October 16, 2003).

[12] *See supra* notes 5 and 11.

[13] This disclosure would, of course, be in addition to any information that is required to be disclosed in annual reports filed with the Commission. For example, Item 201(d) of Regulation S–K [17 CFR 229.201(d)] and Item 201(d) of Regulation S–B [17 CFR 228.201(d)] require issuers to present—in their annual reports on Form 10–K or Form 10–KSB—separate, tabular disclosure concerning equity compensation plans that have been approved by shareholders and equity compensation plans that have not been approved by shareholders.

[14] *See* Section 303A(8) of the NYSE's *Listed Company Manual* and NASD Rules 4310(c)(17)(A) and 4320(e)(15)(A).

employed, immediately before the transaction, by the post-transaction listed company or its subsidiaries. The Commission also notes that, under the Exchange's proposal, any shares reserved for listing in connection with a merger or acquisition pursuant to this exception would be counted by the Exchange in determining whether the transaction involved the issuance of 20% or more of the company's outstanding common stock, thereby requiring shareholder approval under CBOE Rule 31.80(b). Finally, the Commission notes that the Exchange proposes an additional requirement that an issuer must notify it in writing when it uses this exception, and/or any other exception, from its shareholder approval requirement. Based on the above, the Commission believes that the Exchange has provided measures to ensure that the exception for mergers and acquisitions is only used in limited circumstances, which should help reduce the potential for dilution of shareholder interests.

C. Exception From Shareholder Approval for Tax Qualified and Parallel Nonqualified Plans

The Commission believes that, given the extensive government regulation—the Internal Revenue Code and Treasury regulations—for tax qualified plans and the general limitations associated with parallel nonqualified plans, shareholders should not experience significant dilution as a result of this exception. In addition, the Commission notes that the Exchange proposes to add a limitation under this exception that a plan would not be considered a nonqualified parallel plan under its proposal if employees who are participants in such a plan receive employer contributions under the plan in excess of 25% of the participants' cash compensation. The Commission further notes that the Exchange proposes an additional requirement that an issuer must notify it in writing when it uses this exception, and/or any other exception, from its shareholder approval requirement. The Commission believes that, taken together, these limitations should reduce concerns regarding abuse of this exception from the shareholder approval requirements.

In addition, the Commission notes that, similar to the exceptions in the NYSE and Nasdaq's recently approved shareholder approval rules, the Exchange proposes to adopt an exception from the shareholder approval requirements for an equity compensation plan that provides non-U.S. employees with substantially the same benefits as a comparable tax qualified, non-discriminatory employee benefit plan or parallel nonqualified plan that the issuer provides to its U.S. employees, but for features necessary to comply with applicable foreign tax law. The Commission believes that this change will conform the Exchange's shareholder approval rule to that of the NYSE and Nasdaq and will provide greater clarity for issuers regarding tax qualified, non-discriminatory employee benefit plans and parallel nonqualified plans for their non-U.S. employees.

D. Material Amendments/Revisions to Plans

The Commission notes that the Exchange proposes to provide a non-exclusive list, similar to lists found in the NYSE and Nasdaq's shareholder approval rules,[15] as to what constitutes a material amendment/revision to a plan. As noted above, material amendments/revisions to plans will require shareholder approval under Exchange rules. A material amendment/revision under the Exchange's proposal would include, but is not limited to: A material increase in the number of shares to be issued under the plan (other than to reflect a reorganization, stock split, merger, spinoff or similar transaction); a material increase in benefits to participants, including any material change to (1) permit a repricing (or decrease in exercise price) of outstanding options, (2) reduce the price at which shares or options to purchase shares may be offered, or (3) extend the duration of the plan; a material expansion of the class of participants eligible to participate in the plan; and an expansion of the type of options or awards available under the plan. The Exchange's proposal also describes what would constitute a material amendment/revision for plans containing a formula for automatic increases (such as evergreen plans) and automatic grants requiring shareholder approval.

The Commission believes that the Exchange's non-exclusive list of what would constitute a material amendment/revision to a plan provides companies with clarity and guidance for when certain amendments and revisions to plans would require shareholder approval. The Commission also believes that the Exchange's proposal to conform its non-exclusive list with the NYSE and Nasdaq's rules on material amendments/revisions should help to ensure that the concept of material amendments/revisions is consistent among the markets so that differences between the markets cannot be abused.

[15] *See supra* note 5; *see also supra* note 11.

E. Repricing of Plans

The Commission notes that, under the Exchange's proposal, if a plan is amended to permit repricing, such an amendment would be considered a material amendment to a plan requiring shareholder approval. In addition, the Exchange recommended in its proposal that plans meant to permit repricing should explicitly and clearly state that repricing is permitted.

The Commission believes that the Exchange's proposal should benefit shareholders by ensuring that companies cannot do a repricing of options, which can have a dilutive effect on shares, without explicit shareholder approval of such provisions and their terms. The Commission also believes that the Exchange's approach to repricings is similar to the NYSE and Nasdaq's respective approaches to repricings, and should offer companies clarity and guidance as to when a change in a plan regarding the repricing of options would trigger a shareholder approval requirement.

F. Evergreen or Formula Plans and Plans Without a Formula or Limit on the Number of Shares Available

The Commission notes the Exchange's proposal provides guidance for the treatment of evergreen/formula plans. More specifically, under the Exchange's proposal, if a plan contains a formula for automatic increases in the shares available or for automatic grants pursuant to a formula, such plans cannot have a term in excess of ten years unless shareholder approval is obtained every ten years. In addition, under the Exchange's proposal, if a plan contains no limit on the number of shares available and is not a formula plan, then each grant under the plan will require separate shareholder approval. Furthermore, the Exchange's proposal provides that a requirement that grants be made out of treasury or repurchased shares will not alleviate the need for shareholder approval for additional grants.

The Commission believes that these provisions should help to ensure that certain terms of a plan cannot be drafted so broad as to avoid shareholder scrutiny and approval. The Commission also believes that the Exchange's proposed rules relating to the treatment of evergreen/formula plans and plans that do not contain a formula or place a limit on the number of shares available should provide more clarity and transparency to issuers as to when shareholder approval would be required for such plans. Finally, the Commission believes that the provision ensuring that

treasury and repurchased shares cannot be used to avoid these additional shareholder approval requirements strengthens the proposal and ensures that companies cannot avoid compliance with the rule.

G. Miscellaneous Provisions

The Commission notes that the Exchange's proposal—similar to the NYSE and Nasdaq's recently approved shareholder approval rules [16]—incorporates the term "equity compensation" and proposes that plans that merely provide a convenient way to purchase shares in the open market or from the issuer at fair market price on equal terms to all security holders would not require shareholder approval. The Commission believes that the Exchange's proposal is consistent with the NYSE and Nasdaq's rules in this area and should provide greater clarity with respect to which plans would and would not require shareholder approval.

The Commission notes that the Exchange's proposal provides that pre-existing plans, which were adopted prior to the SEC's approval of the Exchange's proposal, would essentially be "grandfathered" and would not require shareholder approval unless the plans were materially amended. Under the Exchange's proposal, however, shareholder approval is required for each grant made pursuant to any pre-existing plans that were not approved by shareholders and that do not have an evergreen formula or a specific number of shares available under the plan. This is consistent with the NYSE, Nasdaq, and Amex shareholder approval rules on this matter. The Commission believes that this clarification should provide companies with guidance as to which plans would be subject to the Exchange's new shareholder approval requirements.

The Commission further notes that the Exchange proposes to adopt an exception from the shareholder approval requirement for warrants or rights offered generally to all shareholders. This exception would exclude stock purchase plans available on equal terms to all security holders of the company (*e.g.*, a dividend reinvestment plan). The Commission believes that the adoption of such an exception would make the Exchange's proposal consistent with the rules of other markets in this area.

Finally, the Commission notes that the proposed amendments to CBOE Form 1 concerning Listing Agreements, which requires advance written notice to the Exchange when issuers use any of the exceptions from shareholder approval, should help the Exchange to ensure that the use of any exception is consistent with the intent of the shareholder approval requirements for equity compensation plans.

H. Elimination of Broker-Dealer Voting on Equity Compensation Plans

The Commission believes that the Exchange's proposed amendment to CBOE Rule 31.85 to preclude broker voting on equity compensation plans is consistent with the Act. The Commission notes that equity compensation plans have become an important issue for shareholders. Because of the potential for dilution from issuances under such plans, shareholders should be making the determination rather than brokers on their behalf. The Commission further notes that NASD rules do not provide for broker voting on any matters and NYSE rules prohibit broker voting on equity compensation plans.[17] Therefore, the Exchange's proposed provision would be consistent with NASD and NYSE rules regarding broker voting on equity compensation plans. The Commission has considered the impact on smaller issuers, such as those listed on Nasdaq and the Amex, in response to the comments on this issue.[18] The Commission believes that the benefit of ensuring that the votes reflect the views of beneficial shareholders on equity compensation plans outweighs the potential difficulties in obtaining the vote.[19]

I. Summary

Overall, the Commission believes that the Exchange's proposal is similar to the NYSE and Nasdaq's recently approved shareholder approval rules.[20] The Commission therefore believes that the Exchange's proposal should provide for more clear and uniform standards for shareholder approval of equity compensation plans. The Commission notes that, even with the availability of the proposed limited exceptions from shareholder approval under the Exchange's proposal, shareholder approval under the new standards would be required in more circumstances than under existing Exchange rules. The Commission further notes that the Exchange proposes to adopt a requirement that an issuer must notify it in writing when it uses one of the exceptions from the shareholder approval requirements. The Commission believes that such a requirement, coupled with the additional disclosure requirements for inducement grants, should reduce the potential for abuse of any of the exceptions.[21] In addition, the Exchange's proposed amendment to CBOE Rule 31.85, which would preclude broker-dealers from voting on equity compensation plans without explicit instructions from the beneficial owner, is consistent with the standard under current NYSE and NASD rules.

The Commission believes that the Exchange's proposal, which is similar to the NYSE and Nasdaq's shareholder approval rules,[22] sets a consistent, minimum standard for shareholder approval of equity compensation plans. The Commission believes that the Exchange's proposal should help to ensure that companies will not make listing decisions simply to avoid shareholder approval requirements for equity compensation plans and should provide shareholders with greater protection from the potential dilutive effect of equity compensation plans. Based on the above, the Commission finds that the Exchange's proposal should help to protect investors, is in the public interest, and does not unfairly discriminate among issuers, consistent with Section 6(b)(5) of the Act.[23] The Commission therefore finds the Exchange's proposal to be consistent with the Act and the rules and regulations thereunder.

V. Accelerated Approval of the Exchange's Proposal and Amendment No. 1

The Commission finds good cause for approving the Exchange's proposal and Amendment No. 1 thereto prior to the thirtieth day after the date of publication of notice thereof in the **Federal Register**. The Exchange has requested that the Commission approve the proposed rule change on an accelerated basis so that the proposed corporate governance listing standards relating to shareholder approval of equity compensation plans may be implemented as soon as possible. The Commission notes that the Exchange's

[16] *See supra* note 5; *see also supra* note 11.

[17] *See* NASD Rule 2260; NYSE Rule 452; and Section 402.08 of the NYSE's *Listed Company Manual*.

[18] *See supra* notes 5 and 17.

[19] The Commission notes that the Exchange did not propose to implement a transition period on the elimination of the broker vote, similar to the NYSE's 90-day transition period, because the proposed amendment will not impact any issuers currently listed on the Exchange. Telephone conversation between David Doherty, Attorney, Legal Division, CBOE, and Sapna C. Patel, Special Counsel, Division, Commission, on October 28, 2003.

[20] *See supra* note 5; *see also supra* note 11.

[21] *See also supra* note 13 and accompanying text.

[22] *See supra* note 5; *see also supra* note 11.

[23] 15 U.S.C. 78f(b)(5).

proposal is similar to the NYSE and Nasdaq's proposals requiring shareholder approval of equity compensation plans. Both the NYSE and Nasdaq's proposals were published for comment in the **Federal Register** and recently approved by the Commission.[24] The Commission believes that it already considered and addressed the issues that may be raised by the Exchange's proposal in its approval of the NYSE and Nasdaq's proposals.[25]

The Commission believes that accelerated approval of the Exchange's proposal is essential to allow for immediate harmonization of, and consistency in, the shareholder approval requirements for equity compensation plans among the markets. This will prevent issuers from making listing decisions based on differences in self-regulatory organization shareholder approval requirements and should provide equal investor protection to shareholders on the dilutive effects of plans irrespective of where the security trades. The Commission further believes that making the Exchange's new shareholder approval rules effective upon Commission approval will immediately impose the same requirements on the Exchange's issuers as those imposed upon NYSE, Nasdaq, and Amex issuers. Based on the above, the Commission finds good cause, consistent with Sections 6(b)(5) and 19(b)(2) of the Act,[26] to approve the Exchange's proposal and Amendment No. 1 thereto on an accelerated basis.

VI. Conclusion

It is therefore ordered, pursuant to section 19(b)(2) of the Act,[27] that the proposed rule change (SR–CBOE–2003–45) and Amendment No. 1 thereto are hereby approved on an accelerated basis.

[24] *See* Securities Exchange Act Release No. 46620 (October 8, 2002), 67 FR 63486 (notice of the NYSE's proposal). The Commission also published a correction to the notice of the NYSE's proposal. *See* Securities Exchange Act Release No. 44620A (October 21, 2002), 67 FR 65617 (October 25, 2002). *See* Securities Exchange Act Release No. 46649 (October 11, 2002), 67 FR 64173 (notice of Nasdaq's proposal). *See supra* note 5; *see also supra* note 11.

[25] Some of the substantive provisions ultimately adopted by the NYSE and Nasdaq, and now being proposed for adoption by the Exchange, were in response to these comments. The comments on the NYSE and Nasdaq proposals were also discussed in detail in the Commission's approval order of the NYSE and Nasdaq proposals. *See supra* note 5; *see also supra* note 11.

[26] 15 U.S.C. 78f(b)(5) and 78s(b)(2).

[27] 15 U.S.C. 78s(b)(2).

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[28]

Jill M. Peterson,

Assistant Secretary.

[FR Doc. 03–28075 Filed 11–6–03; 8:45 am]

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SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–48721; File No. SR–CBOE–2003–42]

Self-Regulatory Organizations; Notice of Filing of Proposed Rule Change by Chicago Board Options Exchange, Inc. To Amend Rule 6.8, Interpretation and Policy .01, Relating to the Retail Automatic Execution System

October 30, 2003.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 ("Act")[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on October 1, 2003, the Chicago Board Options Exchange, Inc. ("CBOE" or "Exchange") filed with the Securities and Exchange Commission ("Commission") the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the CBOE. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The CBOE proposes to amend CBOE Rule 6.8, Interpretation and Policy .01 to allow broker-dealer orders that are eligible for execution on CBOE's Retail Automatic Execution System ("RAES") to automatically execute against limit orders on the CBOE book in classes designated by the appropriate Floor Procedure Committee. The text of the proposed rule change is set forth below. Proposed new language is in italics.

* * * * *

Rule 6.8 RAES Operations

(a)–(g) No change.

* * * Interpretations and Policies

.01 (a) Notwithstanding Rule 6.8(c)(ii), the appropriate Floor Procedure Committee ("FPC") may determine, by class and/or series to allow the following types of orders to be executed on RAES in accordance with the requirements of Rule 6.8, subject to the conditions set forth below in subparagraphs (b) and (c):

1. Broker-dealer orders; or

2. Broker-dealer orders that are not for the accounts of market-makers or specialists on an exchange who are exempt from the provisions of Regulation T of the Federal Reserve Board pursuant to section 7(c)(2) of the Securities Exchange Act of 1934.

(b) The appropriate FPC may permit broker-dealer orders to be automatically executed pursuant to this Interpretation and Policy .01, subject to the following provisions:

1. Broker-dealer orders entered through the Exchange's order routing system will not be automatically executed against orders in the limit order book *unless permitted on a class-by-class basis by the appropriate Floor Procedure Committee.* Broker-dealer orders may interact with orders in the limit order book only after being re-routed to a floor broker for representation in the trading crowd. Broker-dealer orders are not eligible to be placed in the limit order book pursuant to Rule 7.4.

2. The maximum order size eligibility for the broker-dealer orders may be less than the applicable order size eligibility for non-broker-dealer orders.

3. Non-broker-dealer orders may be eligible for automatic execution at the NBBO pursuant to Interpretations and Policies .02 of Rule 6.8, while broker-dealer orders may not be so eligible. In the event broker-dealer orders are not so eligible, they shall instead route to either PAR or BART.

4. The appropriate FPC may determine, by class and/or series, to prohibit access to RAES for broker-dealer orders after 3 pm.

(c) CBOE market-makers must assure that orders for their own accounts are not entered on the Exchange and represented or executed in violation of the following provisions: Interpretations and Policies .02 of Rule 6.55 and Interpretations and Policies .06 of Rule 8.9 (concurrent representation of a joint account), Rule 6.55 (concurrent representation of a market-maker account), and section 9 of the Securities Exchange Act of 1934 (wash sales).

.02–.09 No change.

* * * * *

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the CBOE included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed

[28] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

rule change. The text of these statements may be examined at the places specified in Item IV below. The CBOE has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange's RAES system was created to allow for the automatic execution of retail customer options orders against CBOE market makers at their disseminated prices. In 1999, the Exchange expanded the RAES system to allow incoming RAES orders to execute against customer limit orders on the CBOE book when such booked orders constitute the CBOE's best bid/offer.[3] Recently, the Exchange has allowed broker-dealer orders to be executed on RAES in classes/series designated by the appropriate Floor Procedure Committee.[4]

The Exchange now proposes to allow broker-dealer orders that are eligible for execution on RAES pursuant to CBOE Rule 6.8, Interpretation and Policy .01 to automatically execute against customer limit orders on the CBOE's book in classes designated by the appropriate Floor Procedure Committee.

2. Statutory Basis

Because the proposed rule change will expand the number of orders eligible to trade automatically with booked customer limit orders, the Exchange believes the proposed rule change is consistent with section 6(b)[5] of the Act in general, and furthers the objectives of section 6(b)(5)[6] of the Act in particular, because it is designed to promote just and equitable principles of trade, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange believes that the proposed rule change will not impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants or Others

No written comments were solicited or received with respect to the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 35 days of the date of publication of this notice in the **Federal Register** or within such longer period (i) as the Commission may designate up to 90 days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the CBOE consents, the Commission will:

(A) By order approve such proposed rule change, or

(B) Institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing, including whether the proposal is consistent with the Act. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street NW., Washington, DC 20549–0609. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room. Copies of such filing will also be available for inspection and copying at the principal office of CBOE. All submissions should refer to File No. SR–CBOE–2003–42 and should be submitted by November 28, 2003.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[7]

Jill M. Peterson,

Assistant Secretary.

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[3] *See* Securities Exchange Act Release No. 41995 (October 8, 1999), 64 FR 56547 (October 20, 1999) (SR–CBOE–99–29).

[4] *See* Securities Exchange Act Release Nos. 45967 (May 20, 2002), 67 FR 37888 (May 30, 2002) (SR–CBOE–2002–22); 46113 (June 25, 2002), 67 FR 44486 (July 2, 2002) (SR–CBOE–2002–35); and 46598 (October 3, 2002), 67 FR 63478 (October 11, 2002) (SR–CBOE–2002–56).

[5] 15 U.S.C. 78f.

[6] 15 U.S.C. 78f(b)(5).

[7] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–48734; File No. SR–CHX–2003–31]

Self-Regulatory Organizations; Notice of Filing of a Proposed Rule Change and Amendment No. 1 Thereto and Order Granting Accelerated Approval to a Proposed Rule Change and Amendment No. 1 Thereto by the Chicago Stock Exchange, Inc. Relating to Shareholder Approval of Equity Compensation Plans and the Voting of Proxies

October 31, 2003.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 ("Act"),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on October 6, 2003, the Chicago Stock Exchange, Inc. ("CHX" or "Exchange") filed with the Securities and Exchange Commission ("SEC" or "Commission") the proposed rule change as described in Items I and II below, which Items have been prepared by the Exchange. On October 30, 2003, the Exchange filed Amendment No. 1 to the proposed rule change.[3] The Commission is publishing this notice to solicit comments on the proposed rule change, as amended, from interested persons and is approving the proposal, as amended, on an accelerated basis.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to amend certain provisions of its rules to strengthen listing standards relating to shareholder approval for equity compensation plans.[4]

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] Amendment No. 1 replaces the Exchange's original Rule 19b-4 filing in its entirety.

[4] The Commission notes that the Exchange is proposing to adopt listing standards relating to shareholder approval of equity compensation plans that are similar to those that the Commission recently approved for the New York Stock Exchange, Inc. ("NYSE") and the National Association of Securities Dealers, Inc. ("NASD"), through its subsidiary, The Nasdaq Stock Market, Inc. ("Nasdaq"). *See* Securities Exchange Act Release No. 48108 (June 30, 2003), 68 FR 39995 (July 3, 2003) (order approving File Nos. SR–NYSE–2002–46 and SR–NASD–2002–140). *See also* Securities Exchange Act Release No. 48627 (October 14, 2003), 68 FR 60426 (October 22, 2003) (notice of filing and order granting accelerated approval to File No. SR–NASD–2003–130, incorporating amendments to the NASD's recently approved shareholder approval rules for equity compensation plans applicable to Nasdaq quoted securities). The Commission also published a correction to the notice of File No. SR–NASD–2003–130. *See* Securities Exchange Act Release No. 48627A (October 22, 2003), 68 FR 61532 (October 28, 2003).

Continued

Below is the text of the proposed rule change, as amended. Proposed new language is *italicized;* proposed deleted language is [bracketed].

* * * * *

Chicago Stock Exchange Rules

ARTICLE XXVIII

Listed Securities

Tier I Corporate Governance and Disclosure Standards

Corporate Governance

RULE 19. The following Rule 19 applies [only] to Tier I issuers: (a)–(i)No change to text.

(j) *Shareholder Approval.* Each issuer shall require shareholder approval [of a plan or arrangement under (i) below, or] prior to the issuance of securities under *(1), (2), (3) or (4)*[(ii), (iii) or (iv)] below[, when]:

(1) *Equity Compensation Plans. When an equity compensation plan, pursuant to which options or stock may be acquired by officers, directors, employees or consultants, is established or materially amended, except for:*

(A) Warrants or rights issued generally to all security holders of the company or stock purchase plans available on equal terms to all security holders of the company (such as a typical dividend reinvestment plan); or

(B)(i) Tax qualified, non-discriminatory employee benefit plans or parallel non-qualified plans, provided such plans are approved by the issuer's independent compensation committee or a majority of the issuer's independent directors; or (ii) plans that provide non-U.S. employees with substantially the same benefits as a comparable tax qualified, non-discriminatory employee benefit plan or parallel nonqualified plan that the issuer provides to U.S. employees, but for features necessary to comply with applicable foreign tax law; or (iii) plans that merely provide a convenient way to purchase shares on the open market or from the issuer at fair market value; or

(C) Plans or arrangements relating to an acquisition or merger where: (i) The issuer is converting, replacing or adjusting outstanding options or other equity compensation awards to reflect the transaction; or (ii) the issuer is using shares available under certain plans acquired in acquisitions or mergers for certain post-transaction grants, as set out in Interpretation and Policy .06; or

(D) Issuances to a person not previously an employee or director of the company, or following a bona fide period of non-employment or non-service, as an inducement material to the individual's entering into employment with the issuer, provided such issuances are approved by the issuer's independent compensation committee or by a majority of the issuer's independent directors. Promptly following an issuance of any employment inducement grant in reliance on this exception, a company must disclose in a press release the material terms of the grant, including the recipient(s) of the grant and the number of shares.

(E) Each issuer must notify the Exchange, in writing, when it uses one of the exemptions set forth in paragraphs (A) through (D) above.

[(i) A stock option or purchase plan is to be established or other arrangement made pursuant to which stock may be acquired by officers or directors, except for warrants or rights issued generally to security holders of the company or broadly based plans or arrangements including other employees (*e.g.*, ESOPs). In a case where the shares or options are to be issued to a person not previously employed by the company, as an inducement essential to the individual's entering into an employment contract with the company, provided that the potential issuance of shares pursuant to the options does not exceed 5% of the company's outstanding stock, shareholder approval will generally not be required.]

[In the case of the establishment of a plan or arrangement under which the amount of securities which may be issued does not exceed the lesser of 1% of the number of shares of common stock outstanding, 1% of the voting power outstanding or 25,000 shares, shareholder approval will generally not be required, provided that all arrangements adopted without shareholder approval in any five-year period do not authorize, in the aggregate, the issuance of more than 10% of outstanding common stock or voting power outstanding. (For the purpose of calculating the percentage of stock issued in the aggregate, stock to be issued pursuant to options which have expired and/or been cancelled shall not be included).]

([ii]*2* No change to text.

([iii]*3* No change to text.

([iv]*4* No change to text.

([v]*5* No change to text.

([vi]*6* No change to text.

([vii]*7* No change to text.

* * * * *

*** * * Interpretations and Policies**

.01 No change to text.

.02–.05 Reserved.

.06 Shareholder approval of equity compensation plans.

(1) An "equity compensation plan" is a plan or other arrangement that provides for the delivery of equity securities (either newly issued or treasury shares) of the listed company to any officer, director, employee or consultant as compensation for services. Even a compensatory grant of options or other equity securities that is not made under a formal plan is an equity compensation plan, for purposes of this rule.

(2) A "material revision" of an equity compensation plan includes, but is not limited to:

(a) any material increase in the number of shares to be issued under the plan (other than to reflect a reorganization, stock split, merger, spinoff or similar transaction);

(b) Any material increase in benefits to participants, including any material change that (i) permits a repricing (or decrease in exercise price) of outstanding options (ii) reduces the price at which shares or options to purchase shares may be offered or (iii) extends the duration of a plan;

(c) Any material expansion of the class of participants eligible to participate in the plan; and

(d) Any expansion in the types of options or awards provided under the plan.

(3) In general, if a plan contains a formula for automatic increases in the shares available (sometimes called an "evergreen formula"), or for automatic grants pursuant to a dollar-based formula (such as annual grants based on a certain dollar value, or matching contributions based upon the amount of compensation the participant elects to defer), the plan cannot have a term in excess of ten years unless shareholder approval is obtained every ten years. However, if a plan does not contain a formula and does not impose a limit on the number of shares available for grant, each grant under the plan must be approved by shareholders. A requirement that grants be made out of treasury shares or repurchased shares will not alleviate the shareholder approval requirements set out in this paragraph.

(4) When preparing-plans and presenting them for shareholder approval, issuers should strive to make plan terms easy to understand. Plans meant to permit repricing should use explicit terminology to make this intent clear.

The Commission notes that these additional amendments by Nasdaq make the NYSE and Nasdaq proposals more consistent and uniform. *See also infra* note (regarding the Commission's recent approval of a similar proposal by the American Stock Exchange LLC ("Amex")).

(5) An issuer is not permitted to use repurchased shares to fund option plans or grants without prior shareholder approval.

(6) Rule 19(j)(1)(C)(ii) provides that plans or arrangements relating to an acquisition or merger do not require shareholder approval where the issuer is using shares available under certain plans acquired in acquisitions or mergers for certain post-transaction grants. This exception applies to situations where the party which is not a listed company following the transaction has shares available for grant under pre-existing plans that were previously approved by shareholders that meet the requirements of Rule 19(j). These shares may be used for post-transaction grants of options and other equity awards by the listed company (after appropriate adjustment of the number of shares to reflect the transaction), either under the pre-existing plan or under another plan, without further shareholder approval, provided (a) the time during which those shares are available for grants is not extended beyond the period when they would have been available under the pre-existing plan, absent the transaction, and (b) such options and other awards are not granted to individuals who were employed by the granting company or its subsidiaries at the time the merger or acquisition was consummated. A plan adopted in contemplation of the merger or acquisition is not considered a pre-existing plan for purposes of this exception. Any shares available for issuance under an equity compensation plan acquired in connection with a merger or acquisition would be counted in determining whether the transaction involved the issuance of 20% or more of the company's outstanding common stock, thus triggering the shareholder requirements under Rule 19(j)(3)(b).

(7) A "tax qualified, non-discriminatory employee benefit plan" is one that meets the requirements of Section 401(a) or 423 of the Internal Revenue Code and applicable Treasury Department regulations.

(8) A "parallel nonqualified plan" means a plan that is a "pension plan" within the meaning of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1002, that is designed to work in parallel with a plan intended to be qualified under Internal Revenue Code Section 401(a), to provide benefits that exceed the limits set forth in Internal Revenue Code Section 402(g) (the section that limits an employee's annual pre-tax contributions to a 401(k) plan), Internal Revenue Code Section 401(a)(17) (the section that limits the amount of an employee's compensation that can be taken into account for plan purposes) and/or Internal Revenue Code Section 415 (the section that limits the contributions and benefits under qualified plans) and/or any successor or similar limitations that may be enacted. However, a plan will not be considered a parallel nonqualified plan unless: (a) it covers all or substantially all employees of an employer who are participants in the related qualified plan whose annual compensation is in excess of the limit of Code Section 401(a)(17) (or any successor or similar limitation that may be enacted); (b) its terms are substantially the same as the qualified plan that it parallels except for the elimination of the limitations described in the preceding sentence; and (c) no participant receives employer equity contributions under the plan in excess of 25% of the participant's cash compensation.

(9) The Exchange precludes its member organizations from giving a proxy to vote on equity compensation plans unless the beneficial owner of the shares has given voting instructions. This prohibition is codified in Article XXXIII, Rule 3 and will become effective for any meeting of shareholders that occurs on or after the 90th day following Commission approval of the change.

* * * * *

Tier II Corporate Governance, Disclosure, and Miscellaneous Requirements

RULE 21. The following Rule 21 applies only to Tier II issuers:

([1]*a*) No change to text.

(b) Each issuer shall comply with the shareholder approval requirements relating to equity compensation plans set out in Rule 19(j) of this Article and is subject to Interpretation .06 of that rule.

([2]*c*) No change to text.
([3]*d*) No change to text.
([4]*e*) No change to text.
([a]*1*) No change to text.
([b]*2*) No change to text.
([c]*3*) No change to text.
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([m]*13*) No change to text.
([n]*14*) No change to text.
([o]*15*) No change to text.
([p]*16*) No change to text.
([q]*17*) No change to text.
([r]*18*) No change to text.

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ARTICLE XXXIII

Proxies

* * * * *

Instructions of Beneficial Owner

RULE 3. A member organization shall give a proxy for stock registered in its name, at the direction of the beneficial owner. If the stock is not in the control or possession of the member organization, satisfactory proof of the beneficial ownership as of the record date may be required.

A member organization may give a proxy to vote any stock registered in its name if such organization holds such stock as executor, administrator, guardian, trustee, or in a similar representative or fiduciary capacity with authority to vote.

A member organization which was transmitted proxy soliciting material to the beneficial owner of stock and solicited voting instructions in accordance with the provisions of Rule 2, and which has not received instructions from the beneficial owner by the date specified in the statement accompanying such material may give a proxy to vote such stock, *except for voting on equity compensation plans as set forth below,* provided the person signing the proxy has no knowledge of any contest as to the action to be taken at the meeting and provided such action does not include authorization for a merger, consolidation or any other matter which may affect substantially the legal rights or privileges of such stock.

A member organization may not give a proxy to vote without instructions from beneficial owners when the matter to be voted upon authorizes the implementation of any equity compensation plan, or any material revision to the terms of any existing equity compensation plan (whether or not shareholder approval of such plan is required by Article XXVIII, Rules 19 or 21). The provision will become effective for any meeting of shareholders that occurs on or after the 90th day following Commission approval of the change.

* * * * *

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the

places specified in Item III below. The Exchange has prepared summaries, set forth in Sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to amend certain provisions of the Exchange's rules to strengthen listing standards relating to shareholder approval for equity compensation plans.

Current CHX Article XXVIII, Rule 19, generally requires issuers to seek shareholder approval of stock option or purchase plans pursuant to which officers or directors might acquire stock. The Rule, however, contains an exception for broadly based plans or arrangements that include other employees, as well as for plans that meet a specific *de minimis* standard. To enhance investor confidence and to ensure that the Exchange's requirements for shareholder approval of equity compensation plans are not less stringent than those of other markets, the Exchange now proposes to delete both the *de minimis* exception and the exception for broadly based plans and proposes to expand the rule to require that shareholder approval be obtained whenever an equity compensation plan is established or materially amended, unless a specifically-defined exception applies.[5] The Exchange proposes to make these requirements applicable to both its Tier I and Tier II issuers.[6]

Exceptions. The Exchange's revised rule would provide exceptions for: (1) Warrants or rights issued generally to all security holders of the company or stock purchase plans available on equal terms to all security holders;[7] (2) certain tax qualified, non-discriminatory employee benefit plans, parallel non-qualified plans, plans that provide non-U.S. employees with the same benefits as tax qualified, nondiscriminatory employee benefit plans or parallel non-qualified plans or plans that merely provide a convenient way to purchase shares on the open market or from the issuer;[8] (3) certain plans or arrangements relating to an acquisition or merger;[9] and (4) certain issuances given as material inducements to a person's decision to become an employee of the issuer, so long as the issuances are approved by the issuer's independent compensation committee or by a majority of its independent directors.[10] Under the Exchange's proposal, as amended, each issuer must notify the Exchange, in writing, when it uses one of these exceptions.[11]

The Exchange believes that these exceptions are narrowly-tailored and appropriate. The Exchange believes that shareholder approval should not be separately required under the Exchange's listing standards for tax qualified, nondiscriminatory employee benefit plans because those plans are regulated under the Internal Revenue Code and Treasury Department regulations, which may already contain provisions requiring shareholder approval. Where that approval is not required, the Exchange believes that the additional protections from any inappropriate use of these plans and parallel non-qualified plans is provided through the requirement that these plans be approved by the issuer's independent compensation committee or a majority of the issuer's independent directors. Similarly, the Exchange believes that shareholder approval of inducement grants to new employees and directors is not appropriate because of the impracticality of seeking shareholder approval during the recruiting process and because these transactions occur when the company has an arm's-length relationship with the new employee and its interests are directly aligned with the interests of its shareholders. The Exchange believes that the exceptions associated with mergers and acquisitions are appropriate because they do not result in any increase in the aggregate potential dilution of the combined enterprise.

In its proposed rules, the Exchange includes a definition of the types of "material revisions" of a plan that would cause shareholder approval to be required. Specifically, the rules confirm that a material revision includes, but is not limited to, a material increase in the number of shares to be issued under the plan (other than to reflect a reorganization, stock split, merger or similar transaction); a material increase in benefits to participants; a material expansion of the class of participants eligible to participate in the plan; and an expansion in the types of options or awards provided under the plan.[12] Additional provisions of the proposed rules provide issuers with further guidance about situations that require (or do not require) shareholder approval.[13]

As a final change, the Exchange proposes to amend CHX Article XXXIII, Rule 3, to mirror requirements now set out in NYSE Rule 452 to prohibit a member from giving a proxy to vote on a matter that establishes or materially amends an equity compensation plan, unless the member has instructions from the beneficial owners of those shares.

Effective date. The Exchange proposes that the changes to CHX Rules 19 and 21 become effective upon Commission approval and that existing equity compensation plans be grandfathered. Any material modifications to existing (*i.e.*, grandfathered) plans would be subject to applicable shareholder approval requirements of these rules. The Exchange proposes that its changes to Article XXXIII, Rule 3, take effect for any meeting of shareholders that occurs on or after the 90th day following Commission approval of the change.

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[5] Under the Exchange's proposal, as amended, an equity compensation plan is any plan or other arrangement that provides for the delivery of equity securities (either newly issued or treasury shares) of the listed company to any officer, director, employee or consultant as compensation for services. *See* proposed Interpretation and Policy .06(1) to CHX Rule 19(j).

[6] Tier II governance standards are set out in CHX Rule 21.

[7] This exception exists in the current CHX rule.

[8] Sections (7) and (8) of proposed new Interpretation and Policy .06 to CHX Rule 19(j) contain definitions of the terms "tax qualified, non-discriminatory employee benefit plan" and "parallel nonqualified plan." *See* proposed CHX Rule 19(j)(1)(B).

[9] This exception applies to plans or arrangements where an issuer is converting, replacing or adjusting outstanding options or other equity compensation awards to reflect a merger or acquisition or where the issuer is using shares available under certain plans acquired in acquisitions or mergers for certain post-transaction grants, as set out in proposed Interpretation and Policy .06(6) to CHX Rule 19(j). *See* proposed CHX Rule 19(j)(1)(C).

[10] These issuances only qualify for the exception if they are made to a person not previously an employee or director of the issuer or following a bona fide period of non-employment or non-service. If an issuer uses this exception, it must promptly disclose, in a press release, the material terms of the grant, including the recipient of the grant and the number of shares included in the grant. *See* proposed CHX Rule 19(j)(1)(D).

[11] *See* proposed CHX Rule 19(j)(1)(E).

[12] *See* proposed Interpretation and Policy .06(2) to CHX Rule 19(j).

[13] For example, proposed Interpretation and Policy .06(3) to CHX Rule 19(j) confirms that where a plan contains an evergreen formula (for automatic increases in the shares available) or an automatic grant pursuant to a dollar-based formula, the plan cannot have a term in excess of ten years unless shareholder approval is obtained every ten years. Other provisions confirm that issuers should strive to make plan terms easy to understand when preparing plans and presenting them for shareholder approval and that an issuer is not permitted to use repurchased shares to fund option plans or grants without prior shareholder approval. *See* proposed Interpretation and Policy .06(4) and (5) to CHX Rule 19(j). The Commission notes that if a plan permits a specific action without further shareholder approval, it must be clear and specific enough to provide meaningful shareholder approval of those provisions.

2. Statutory Basis

The Exchange believes that the proposed rule change, as amended, is consistent with Section 6 of the Act,[14] in general, and furthers the objectives of Section 6(b)(5) of the Act,[15] in particular, in that it is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest. The Exchange believes that its proposal, as amended, is intended to be essentially identical to those submitted by the NYSE and Nasdaq and approved by the Commission.[16]

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments on the proposed rule change were neither solicited nor received. The Exchange, however, did notify its issuers of the types of proposed rule changes that it was contemplating and has not received any objections to those proposals.

III. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change, as amended, is consistent with the Act. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549–0609. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying at the Commission's Public Reference Room. Copies of such filing will also be available for inspection and copying at the principal office of the Exchange. All submissions should refer to File No. SR–CHX–2003–31 and should be submitted by November 28, 2003.

IV. Commission's Findings and Order Granting Accelerated Approval to the Proposed Rule Change, As Amended

After careful review, the Commission finds that the Exchange's proposal, as amended, is consistent with the Act and the rules and regulations promulgated thereunder applicable to a national securities exchange and, in particular, with the requirements of Section 6(b) of the Act.[17] Specifically, the Commission finds that approval of the Exchange's proposal, as amended, is consistent with Section 6(b)(5) of the Act[18] in that it is designed to, among other things, facilitate transactions in securities; to prevent fraudulent and manipulative acts and practices; to promote just and equitable principles of trade; to remove impediments to and perfect the mechanism of a free and open market and a national market system; and, in general, to protect investors and the public interest; and does not permit unfair discrimination among issuers.

The Commission has long encouraged exchanges to adopt and strengthen their corporate governance listing standards in order to, among other things, restore investor confidence in the national marketplace. The Commission believes that the Exchange's amended proposal, which requires shareholder approval of equity compensation plans and which follows the Commission's approval of similar proposals by the NYSE, Nasdaq, and Amex[19] is the first step under this directive because it should have the effect of safeguarding the interests of shareholders, while placing certain restrictions on Exchange-listed companies.[20]

In addition, the Commission notes that the Exchange's proposal, as amended, is similar and almost identical to proposals by NYSE and Nasdaq requiring shareholder approval of equity compensation plans that have previously been approved by the Commission.[21] The Commission believes that it has already considered and addressed the issues that may be raised by the Exchange's amended proposal when it approved these proposals. The Commission notes that approval of the Exchange's proposal, as amended, will conform the Exchange's shareholder approval requirements for equity compensation plans with those of the NYSE and Nasdaq, and will immediately impose the same requirements on the Exchange's issuers as those imposed upon NYSE, Nasdaq, and Amex issuers. The adoption of these standards by the Exchange is an important step to ensure that issuers will not be able to avoid shareholder approval requirements for equity compensation plans based on their listed marketplace.

A. Exception From Shareholder Approval for Inducement Grants

The Commission believes that the requirement that the issuance of all inducement grants be subject to review by either the issuer's independent compensation committee or a majority of the board's independent directors, under the Exchange's amended proposal, should prevent abuse of this exception from shareholder approval. In addition, the Exchange proposes to limit its exception for inducement grants to new employees or to previous employees being rehired after a bona fide period of interruption of employment, and to new employees in connection with an acquisition or merger. The Commission believes that these limitations should help to prevent the inducement exception from being used inappropriately.

The Commission notes that the Exchange is proposing to include a requirement, similar to the requirement under the NYSE and Nasdaq's recently approved shareholder approval rules, that, promptly following the grant of any inducement award, companies must disclose in a press release the material terms of the award, including the recipient(s) of the award and the number of shares involved.[22] The

[14] 15 U.S.C. 78f(b).

[15] 15 U.S.C. 78f(b)(5).

[16] *See supra* note 4.

[17] 15 U.S.C. 78f(b). In approving the Exchange's proposal, as amended, the Commission has considered the proposed rule's impact on efficiency, competition and capital formation. 15 U.S.C. 78c(f).

[18] 15 U.S.C. 78f(b)(5).

[19] *See supra* note 4. The Commission notes that it has recently approved similar rules requiring shareholder approval of equity compensation plans for the Amex on an accelerated basis. The Amex's proposal is almost identical to, and based on, the NYSE and Nasdaq proposals. *See* Securities Exchange Act Release No. 48610 (October 9, 2003), 68 FR 59650 (October 16, 2003).

[20] The Commission notes that these new listing standards will apply to all companies listed on the CHX and will include both CHX's Tier I and Tier II designations.

[21] *See supra* notes 4 and 19.

[22] This disclosure would, of course, be in addition to any information that is required to be disclosed in annual reports filed with the Commission. For example, Item 201(d) of Regulation S–K [17 CFR 229.201(d)] and Item 201(d) of Regulation S–B [17 CFR 228.201(d)] require issuers to present—in their annual reports on Form 10—K or Form 10–KSB—separate, tabular disclosure concerning equity compensation plans that have been approved by

Continued

Commission notes that the Exchange is also proposing a requirement, similar to the requirements under the NYSE and Nasdaq's recently approved shareholder approval rules,[23] that an issuer must notify it in writing when it uses this exception, and/or any other exception, from its shareholder approval requirement. The Commission believes that these disclosure and notification requirements will provide transparency to investors and should reduce the potential for abuse of this exception for inducement grants.

B. Exception From Shareholder Approval for Mergers and Acquisitions

The Commission notes that the Exchange's exception from shareholder approval for mergers and acquisitions contains safeguards that should prevent abuse in this area. First, only pre-existing plans that were previously approved by the acquired company's shareholders would be available to the listed company for post-transactional grants. In addition, shares under those previously approved plans could not be granted to individuals who were employed, immediately before the transaction, by the post-transaction listed company or its subsidiaries. The Commission also notes that, under the Exchange's amended proposal, any shares reserved for listing in connection with a merger or acquisition pursuant to this exception would be counted by the Exchange in determining whether the transaction involved the issuance of 20% or more of the company's outstanding common stock, thereby requiring shareholder approval under CHX Rule 19(j)(3)(B). Finally, the Commission notes that the Exchange proposes an additional requirement that an issuer must notify it in writing when it uses this exception, and/or any other exception, from its shareholder approval requirement. Based on the above, the Commission believes that the Exchange has provided measures to ensure that the exception for mergers and acquisitions is only used in limited circumstances, which should help reduce the potential for dilution of shareholder interests.

C. Exception From Shareholder Approval for Tax Qualified and Parallel Nonqualified Plans

The Commission believes that, given the extensive government regulation—the Internal Revenue Code and Treasury regulations—for tax qualified plans and the general limitations associated with parallel nonqualified plans, shareholders should not experience significant dilution as a result of this exception. In addition, the Commission notes that the Exchange proposes to add a limitation under this exception that a plan would not be considered a nonqualified parallel plan under its proposal if employees who are participants in such a plan receive employer contributions under the plan in excess of 25% of the participants' cash compensation. The Commission further notes that the Exchange proposes an additional requirement that an issuer must notify it in writing when it uses this exception, and/or any other exception, from its shareholder approval requirement. The Commission believes that, taken together, these limitations should reduce concerns regarding abuse of this exception from the shareholder approval requirements.

In addition, the Commission notes that, similar to the exceptions in the NYSE and Nasdaq's recently approved shareholder approval rules, the Exchange proposes to adopt an exception from the shareholder approval requirements for an equity compensation plan that provides non-U.S. employees with substantially the same benefits as a comparable tax qualified, non-discriminatory employee benefit plan or parallel nonqualified plan that the issuer provides to its U.S. employees, but for features necessary to comply with applicable foreign tax law. The Commission believes that this change will conform the Exchange's shareholder approval rule to that of the NYSE and Nasdaq and will provide greater clarity for issuers regarding tax qualified, non-discriminatory employee benefit plans and parallel nonqualified plans for their non-U.S. employees.

D. Material Revisions to Plans

The Commission notes that the Exchange proposes to provide a non-exclusive list, similar to lists found in the NYSE and Nasdaq's shareholder approval rules,[24] as to what constitutes a material revision to a plan. As noted above, material revisions to plans will require shareholder approval under Exchange rules. A material revision under the Exchange's amended proposal would include, but is not limited to: A material increase in the number of shares to be issued under the plan (other than to reflect a reorganization, stock split, merger, spinoff or similar transaction); a material increase in benefits to participants, including any material change to (1) permit a repricing (or decrease in exercise price) of outstanding options, (2) reduce the price at which shares or options to purchase shares may be offered, or (3) extend the duration of the plan; a material expansion of the class of participants eligible to participate in the plan; and an expansion of the type of options or awards available under the plan. The Exchange's proposal, as amended, also describes what would constitute a material revision for plans containing a formula for automatic increases (such as evergreen plans) and automatic grants requiring shareholder approval.

The Commission believes that the Exchange's non-exclusive list of what would constitute a material revision to a plan provides companies with clarity and guidance for when certain amendments and revisions to plans would require shareholder approval. The Commission also believes that the Exchange's proposal to conform its non-exclusive list with the NYSE and Nasdaq's rules on material amendments/revisions should help to ensure that the concept of material amendments/revisions is consistent among the markets so that differences between the markets cannot be abused.

E. Repricing of Plans

The Commission notes that, under the Exchange's proposal, as amended, if a plan is amended to permit repricing, such an amendment would be considered a material amendment to a plan requiring shareholder approval. In addition, the Exchange recommended in its proposal that plans meant to permit repricing should explicitly and clearly state that repricing is permitted.

The Commission believes that the Exchange's proposal, as amended, should benefit shareholders by ensuring that companies cannot do a repricing of options, which can have a dilutive effect on shares, without explicit shareholder approval of such provisions and their terms. The Commission also believes that the Exchange's approach to repricings is similar to the NYSE and Nasdaq's respective approaches to repricings, and should offer companies clarity and guidance as to when a change in a plan regarding the repricing of options would trigger a shareholder approval requirement.

F. Evergreen or Formula Plans and Plans Without a Formula or Limit on the Number of Shares Available

The Commission notes the Exchange's proposal, as amended, provides guidance for the treatment of evergreen/formula plans. More specifically, under the Exchange's proposal, as amended, if a plan contains a formula for automatic

shareholders and equity compensation plans that have not been approved by shareholders.

[23] *See* Section 303A(8) of the NYSE's *Listed Company Manual* and NASD Rules 4310(c)(17)(A) and 4320(e)(15)(A).

[24] *See supra* note 4; *see also supra* note 19.

increases in the shares available or for automatic grants pursuant to a formula, such plans cannot have a term in excess of ten years unless shareholder approval is obtained every ten years. In addition, under the Exchange's proposal, as amended, if a plan contains no limit on the number of shares available and is not a formula plan, then each grant under the plan will require separate shareholder approval. Furthermore, the Exchange's proposal, as amended, provides that a requirement that grants be made out of treasury or repurchased shares will not alleviate the need for shareholder approval for additional grants.

The Commission believes that these provisions should help to ensure that certain terms of a plan cannot be drafted so broad as to avoid shareholder scrutiny and approval. The Commission also believes that the Exchange's proposed rules relating to the treatment of evergreen/formula plans and plans that do not contain a formula or place a limit on the number of shares available should provide more clarity and transparency to issuers as to when shareholder approval would be required for such plans. Finally, the Commission believes that the provision ensuring that treasury and repurchased shares cannot be used to avoid these additional shareholder approval requirements strengthens the proposal and ensures that companies cannot avoid compliance with the rule.

G. Miscellaneous Provisions

The Commission notes that the Exchange's amended proposal—similar to the NYSE and Nasdaq's recently approved shareholder approval rules [25]—incorporates the term "equity compensation" and proposes that plans that merely provide a convenient way to purchase shares in the open market or from the issuer at fair market price on equal terms to all security holders would not require shareholder approval. The Commission believes that the Exchange's proposal, as amended, is consistent with the NYSE and Nasdaq's rules in this area and should provide greater clarity with respect to which plans would and would not require shareholder approval.

The Commission notes that the Exchange's proposal, as amended, provides that pre-existing plans, which were adopted prior to the SEC's approval of the Exchange's amended proposal, would essentially be "grandfathered" and would not require shareholder approval unless the plans were materially amended. Under the Exchange's amended proposal, however, shareholder approval is required for each grant made pursuant to any pre-existing plans that were not approved by shareholders and that do not have an evergreen formula or a specific number of shares available under the plan. This is consistent with the NYSE, Nasdaq, and Amex shareholder approval rules on this matter. The Commission believes that this clarification should provide companies with guidance as to which plans would be subject to the Exchange's new shareholder approval requirements.

H. Elimination of Broker-Dealer Voting on Equity Compensation Plans

The Commission believes that the Exchange's proposed amendment to CHX Article XXXIII, Rule 3, to preclude broker voting on equity compensation plans is consistent with the Act. The Commission notes that equity compensation plans have become an important issue for shareholders. Because of the potential for dilution from issuances under such plans, shareholders should be making the determination rather than brokers on their behalf. The Commission further notes that NASD rules do not provide for broker voting on any matters and NYSE rules prohibit broker voting on equity compensation plans.[26] Therefore, the Exchange's proposed provision would be consistent with NASD and NYSE rules regarding broker voting on equity compensation plans. The Commission has considered the impact on smaller issuers, such as those listed on Nasdaq and the Amex, in response to the comments on this issue.[27] The Commission believes that the benefit of ensuring that the votes reflect the views of beneficial shareholders on equity compensation plans outweighs the potential difficulties in obtaining the vote.

The Commission also notes that the Exchange proposes to implement a transition period that would make the new rule eliminating broker voting on equity compensation plans applicable only to shareholder meetings that occur on or after the 90th day from the effective date of the Exchange's proposal.

I. Summary

Overall, the Commission believes that the Exchange's proposal, as amended, is similar to the NYSE and Nasdaq's recently approved shareholder approval rules.[28] The Commission therefore believes that the Exchange's proposal, as amended, should provide for more clear and uniform standards for shareholder approval of equity compensation plans. The Commission notes that, even with the availability of the proposed limited exceptions from shareholder approval under the Exchange's amended proposal, shareholder approval under the new standards would be required in more circumstances than under existing Exchange rules. The Commission further notes that the Exchange proposes to adopt a requirement that an issuer must notify it in writing when it uses one of the exceptions from the shareholder approval requirements. The Commission believes that such a requirement, coupled with the additional disclosure requirements for inducement grants, should reduce the potential for abuse of any of the exceptions.[29] In addition, the Exchange's proposed amendment to CHX Article XXXIII, Rule 3, which would preclude broker-dealers from voting on equity compensation plans without explicit instructions from the beneficial owner, is consistent with the standard under current NYSE and NASD rules.

The Commission believes that the Exchange's proposal, as amended, which is similar to the NYSE and Nasdaq's shareholder approval rules,[30] sets a consistent, minimum standard for shareholder approval of equity compensation plans. The Commission believes that the Exchange's proposal, as amended, should help to ensure that companies will not make listing decisions simply to avoid shareholder approval requirements for equity compensation plans and should provide shareholders with greater protection from the potential dilutive effect of equity compensation plans. Based on the above, the Commission finds that the Exchange's proposal, as amended, should help to protect investors, is in the public interest, and does not unfairly discriminate among issuers, consistent with Section 6(b)(5) of the Act.[31] The Commission therefore finds the Exchange's proposal, as amended, to be consistent with the Act and the rules and regulations thereunder.

V. Accelerated Approval of the Exchange's Proposal and Amendment No. 1

The Commission finds good cause for approving the Exchange's proposal and

[25] *See supra* note 4; *see also supra* note 19.

[26] *See* NASD Rule 2260; NYSE Rule 452; and Section 402.08 of the NYSE's *Listed Company Manual*.

[27] *See supra* notes 4 and 26.

[28] *See supra* note 4; *see also supra* note 19.

[29] *See also supra* note 22 and accompanying text.

[30] *See supra* note 4; *see also supra* note 19.

[31] 15 U.S.C. 78f(b)(5).

Amendment No. 1 thereto prior to the thirtieth day after the date of publication of notice thereof in the **Federal Register**. The Commission notes that the Exchange's proposal, as amended, is similar to the NYSE and Nasdaq's proposals requiring shareholder approval of equity compensation plans. Both the NYSE and Nasdaq's proposals were published for comment in the **Federal Register** and recently approved by the Commission.[32] The Commission believes that it already considered and addressed the issues that may be raised by the Exchange's proposal in its approval of the NYSE and Nasdaq's proposals.[33]

The Commission believes that accelerated approval of the Exchange's proposal, as amended, is essential to allow for immediate harmonization of. and consistency in, the shareholder approval requirements for equity compensation plans among the markets. This will prevent issuers from making listing decisions based on differences in self-regulatory organization shareholder approval requirements and should provide equal investor protection to shareholders on the dilutive effects of plans irrespective of where the security trades. The Commission further believes that making the Exchange's new shareholder approval rules effective upon Commission approval will immediately impose the same requirements on the Exchange's issuers as those imposed upon NYSE, Nasdaq, and Amex issuers. Based on the above, the Commission finds good cause, consistent with Sections 6(b)(5) and 19(b)(2) of the Act,[34] to approve the Exchange's proposal and Amendment No. 1 thereto on an accelerated basis.

VI. Conclusion

It is therefore ordered, pursuant to Section 19(b)(2) of the Act,[35] that the proposed rule change (SR–CHX–2003–31) and Amendment No. 1 thereto are hereby approved on an accelerated basis.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[36]

Jill M. Peterson,

Assistant Secretary.

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[32] *See* Securities Exchange Act Release No. 46620 (October 8, 2002), 67 FR 63486 (notice of the NYSE's proposal). The Commission also published a correction to the notice of the NYSE's proposal. *See* Securities Exchange Act Release No. 44620A (October 21, 2002), 67 FR 65617 (October 25, 2002). *See* Securities Exchange Act Release No. 46649 (October 11, 2002), 67 FR 64173 (notice of Nasdaq's proposal). *See supra* note 4; *see also supra* note 19.

[33] Some of the substantive provisions ultimately adopted by the NYSE and Nasdaq, and now being proposed for adoption by the Exchange, were in response to these comments. The comments on the NYSE and Nasdaq proposals were also discussed in detail in the Commission's approval order of the NYSE and Nasdaq proposals. *See supra* note 4; *see also supra* note 19.

[34] 15 U.S.C. 78f(b)(5) and 78s(b)(2).

[35] 15 U.S.C. 78s(b)(2).

[36] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–48738; File No. SR–CSE–2003–11]

Self-Regulatory Organizations; Notice of Filing and Order Granting Accelerated Approval to a Proposed Rule Change and Amendment No. 1 Thereto by the Cincinnati Stock Exchange Relating to Shareholder Approval of Equity Compensation Plans

October 31, 2003.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 ("Act"),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on October 1, 2003, the Cincinnati Stock Exchange ("CSE" or "Exchange") filed with the Securities and Exchange Commission ("SEC" or "Commission") the proposed rule change as described in Items I and II below, which Items have been prepared by the Exchange. On October 29, 2003, the Exchange filed Amendment No. 1 to the proposed rule change.[3] The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons and is approving the proposal and Amendment No. 1 thereto on an accelerated basis.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange is proposing to implement changes to its listing standards to adopt requirements related to shareholder approval of equity compensation plans and to amend its rules related to the voting of proxies. The Exchange represents that this proposed rule change is part of an ongoing review of the Exchange's listing standards aimed at helping to restore investor confidence by strengthening corporate governance practices.

Below is the text of the proposed rule change. Proposed new language is *italicized*; proposed deleted language is [bracketed].

* * * * *

Rule 13.3 Proxies

(a)–(c) No change to text.

(d) Notwithstanding the provisions of this Rule 13.3, a member may not give a proxy to vote without instructions from beneficial owners when the matter to be voted upon authorizes the implementation of any equity compensation plan, or any material revision to the terms of any existing equity compensation plan (whether or not stockholder approval of such plan is required pursuant to Rule 13.6). This provision will be effective for any meeting of shareholders that occurs on or after the 90th day following the effective date of this provision.

* * * * *

Rule 13.6 Shareholder Approval of Equity Compensation Plans

Equity compensation plans can help align shareholder and management interests, and equity-based awards are often very important components of employee compensation. To provide checks and balances on the potential dilution resulting from the process of earmarking shares to be used for equity-based awards, the Exchange requires that all equity compensation plans, and any material revisions to the terms of such plans, be subject to shareholder approval, with limited exemptions identified in this rule.

(a) Definition of Equity Compensation Plan. An "equity compensation plan" is a plan or other arrangement that provides for the delivery of equity securities (either newly issued or treasury shares) of the listed company to any employee, director or other service provider as compensation for services. A compensatory grant of options or other equity securities that is not made under a plan is considered an "equity compensation plan" for purposes of these rules.

(b) Exceptions to Equity Compensation Plan Definition. The following are not equity compensation plans, even if the brokerage and other costs of the plan are paid for by the listed company:

(1) Plans that are made available to shareholders generally, such as a typical dividend reinvestment plan;

(2) Plans that merely allow employees, directors or other service

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* letter from Jennifer M. Lamie, Assistant General Counsel and Secretary, CSE, to Sapna C. Patel, Special Counsel, Division of Market Regulation, Commission, dated October 29, 2003 ("Amendment No. 1"). In Amendment No. 1, the Exchange made a technical correction to its proposed rule language to fix two typographical errors in proposed CSE Rule 13.6(e)(2). Because this is a technical amendment, it is not subject to notice and comment.

providers to elect to buy shares on the open market or from the listed company for their current fair market value, regardless of whether: (i) The shares are delivered immediately or on a deferred basis; or (ii) the payments for the shares are made directly or by giving up compensation that is otherwise due (for example, through payroll deductions).

(c) Material Revisions. A "material revision" of an equity compensation plan includes, but is not limited to, the following:

(1) A material increase in the number of shares available under the plan, other than an increase solely to reflect a reorganization, stock split, merger, spinoff or similar transaction.

(i) If a plan contains a formula for automatic increases in the number of shares available (sometimes referred to as an "evergreen formula") or for automatic grants pursuant to a formula, each such increase or grant will be considered a revision requiring shareholder approval unless the plan has a term of not more than ten years. Regardless of the term, this type of plan is referred to below as a "formula plan." Examples of automatic grants pursuant to a formula are: (A) annual grants to directors of restricted stock having a certain dollar value, and (B) "Matching contributions," whereby stock is credited to a participant's account based upon the amount of compensation the participant elects to defer.

(ii) If a plan contains no limit on the number of shares available and it is not a formula plan, then each grant under the plan will require separate shareholder approval regardless of whether the plan has a term of not more than ten years. This type of plan is referred to below as a "discretionary plan." A requirement that grants be made out of treasury shares or repurchased shares will not, in itself, be considered a limit or pre-established formula so as to prevent a plan from being considered a discretionary plan.

(2) An expansion of the types of awards available under the plan.

(3) A material expansion of the class of employees, directors or other service providers eligible to participate in the plan.

(4) A material extension of the term of the plan.

(5) A material change to the method of determining the strike price of options under the plan.

(i) A change in the method of determining "fair market value" from the closing price on the date of the grant to the average of the high and low price on the date of grant is an example of a change that the Exchange would not review as material.

(6) The deletion or limitation of any provision prohibiting repricing of options. An amendment will not be considered a "material revision" if it curtails rather than expands the scope of the plan in question.

(d) Repricings. A plan that does not contain a provision that specifically permits repricing of options will be considered for purposes of this listing standard as prohibiting repricing. Accordingly, any actual repricing of options will be considered a material revision of a plan even if the plan itself is not revised. This consideration will not apply to a repricing through an exchange offer that commenced before the date this listing standard became effective. "Repricing" means any of the following or any other action that has the same effect:

(1) Lowering the strike price of an option after it is granted.

(2) Any other action that is treated as a repricing under generally accepted accounting principles.

(3) Canceling an option at a time when its strike price exceeds the fair market value of the underlying stock, in exchange for another option, restricted stock, or other equity, unless the cancellation and exchange occurs in connection with a merger, acquisition, spin-off or other similar corporate transaction.

(e) Exemptions. The listing standard does not require shareholder approval of employment inducement awards; certain grants, plans and amendments in the context of mergers and acquisitions; and certain specific types of plans, all described below. However, these exempt grants, plans and amendments may be made only with the approval of the company's independent compensation committee or the approval of a majority of the company's independent directors. Companies must also notify the Exchange in writing when they use one of these exemptions.

(1) Employment Inducement Awards. An employment inducement award is a grant of options or other equity-based compensation as a material inducement to a person or persons being hired by the listed company or any of its subsidiaries, or being rehired following a bona fide period of interruption of employment. Inducement awards include grants to new employees in connection with a merger or acquisition. Promptly following a grant of any inducement award in reliance on this exemption, the listed company must disclose in a press release the material terms of the award, including the recipient(s) of the award and the number of shares involved.

(2) Mergers and Acquisitions. Two exemptions apply in the context of corporate acquisitions and mergers. First, shareholder approval will not be required to convert, replace or adjust outstanding options or other equity compensation awards to reflect the transaction. Second, shares available under certain plans acquired in corporate acquisitions and mergers may be used for certain post-transaction grants without further shareholder approval. This exemption applies to situations where a party that is not a listed company following the transaction has shares available for grant under pre-existing plans that were previously approved by shareholders. A plan adopted in contemplation of the merger or acquisition transaction would not be considered "pre-existing" for purposes of this exemption. Shares available under such a pre-existing plan may be used for post-transaction grants of options and other awards with respect to equity of the entity that is the listed company after the transaction, either under the pre-existing plan or another plan, without further shareholder approval, so long as:

(i) The number of shares available for grants is appropriately adjusted to reflect the transaction;

(ii) The time during which those shares are available is not extended beyond the period when they would have been available under the pre-existing plan, absent the transaction; and

(iii) The options and other awards are not granted to individuals who were employed, immediately before the transaction, by the post-transaction listed company or entities that were its subsidiaries immediately before the transaction.

Any shares reserved for listing in connection with a transaction pursuant to either of these exemptions would be counted by the Exchange in determining whether the transaction involved the issuance of 20% or more of the company's outstanding common stock, and thus require shareholder approval. These merger-related exemptions will not result in any increase in the aggregate potential dilution of the combined enterprise. Further, mergers or acquisitions are not routine occurrences and are not likely to be abused. Therefore, the Exchange considers both of these exemptions to be consistent with the fundamental policy involved in this standard.

(3) Qualified Plans, Section 423 Plans and Parallel Excess Plans.

(i) The following types of plans, and material revisions thereto, are exempt from the shareholder approval requirement: (A) Plans intended to meet the requirements of Section 401(a) of the Internal Revenue Code (e.g., ESOPs); (B) plans intended to meet the requirements of Section 423 of the Internal Revenue Code; and (C) "parallel excess plans" as defined below.

(ii) Section 401(a) plans and Section 423 plans are already regulated under the Internal Revenue Code and Treasury regulations. Section 423 plans, which are stock purchase plans under which an employee can purchase no more than $25,000 worth of stock per year at a plan-specified discount capped at 15% are also required by the Internal Revenue Code to receive shareholder approval. While Section 401(a) plans and parallel plans are not required to be approved by shareholders, U.S. GAAP requires that the shares issued under these plans be "expensed" (i.e., treated as a compensation expense on the income statement) by the company issuing the shares. An equity compensation plan that provides non-U.S. employees with substantially the same benefits as a comparable Section 401(a) plan, Section 423 plan or parallel excess plan that the listed company provides to its U.S. employees, but for features necessary to comply with applicable foreign tax law, are also exempt from shareholder approval under this section.

(iii) The term "parallel excess plan" means a plan that is a "pension plan" within the meaning of the Employee Retirement Income Security Act ("ERISA") that is designed to work in parallel with a plan intended to be qualified under Internal Revenue Code Section 401(a) to provide benefits that exceed the limits set forth in Internal Revenue Code Section 402(g)(the section that limits an employee's annual pre-tax contributions to a 401(k) plan), Internal Revenue Code Section 401(a)(17)(the section that limits the amount of an employee's compensation that can be taken into account for plan purposes) and/or Internal Revenue Code Section 415 (the section that limits the contributions and benefits under qualified plans) and/or any successor or similar limitations that may hereafter be enacted. A plan will not be considered a parallel excess plan unless: (A) it covers all or substantially all employees of an employer who are participants in the related qualified plan whose annual compensation is in excess of the limit of Internal Revenue Code Section 401(a)(17)(or any successor or similar limits that may hereafter be enacted); (B) its terms are substantially the same as the qualified plan that it parallels except for the elimination of the limits described in the proceeding sentence and the limitation described in clause (C); and (C) no participant receives employer equity contributions under the plan in excess of 25% of the participant's cash compensation.

(f) Transition Rules. Except as provided below, a plan that was adopted before the date the Commission order approving this listing standard will not be subject to shareholder approval under this Rule 13.6 unless and until it is materially revised.

(1) In the case of a discretionary plan, as defined in "Material Revisions" above, whether or not previously approved by shareholders, additional grants may be made after the effective date of this Rule 13.6 without further shareholder approval only for a limited transaction period, defined below, and then only in a manner consistent with past practice. In applying this rule, if a plan can be separated into a discretionary plan portion and a portion that is not discretionary, the non-discretionary portion of the plan can continue to be used separately, under the appropriate transition rule. For example, if a shareholder-approved plan permits both grants pursuant to a provision that makes available a specific number of shares, and grants pursuant to provision authorizing the use of treasury shares without regard to the specific share limit, the former provision (but not the latter) may continue to be used after the transition period, under the general rule above.

(2) In the case of a formula plan, as defined in "Material Revisions" above, that either (i) has not previously been approved by shareholders or (ii) does not have a term of ten years or less, additional grants may be made after the effective date of this Rule 13.6 without further shareholder approval only for a limited transition period, defined below.

(3) The limited transition period described in subparagraphs (f)(1) and (f)(2) above will end upon the first to occur of: (i) The listed company's next annual meeting at which directors are elected that occurs more than 180 days after the effective date of this listing standard; (ii) the first anniversary of the effective date this Rule 13.6; and (iii) the expiration of the plan.

(4) A shareholder-approved formula plan may continue to be used after the end of this transition period if it is amended to provide for a term of ten years or less from the date of its original adoption or, if later, the date of its most recent shareholder approval. Such an amendment may be made before or after the effective date of this Rule 13.6, and would not itself be considered a "material revision" requiring shareholder approval. In addition, a formula plan may continue to be used, without shareholder approval, if the grants after the effective date of this Rule 13.6 are made only from the shares available immediately before the effective date (i.e., based on formulaic increases that occurred prior to such effective date).

(g) Broker Voting. For member proxy requirements with respect to the implementation of any equity compensation plan, or any material revisions to the terms of any existing equity compensation plan, refer to Rule 13.3.

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II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item III below. The Exchange has prepared summaries, set forth in Sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

In conjunction with a review of its corporate listing standards with the goal of enhancing accountability, integrity and transparency of listed companies, the Exchange is proposing to adopt listing standards related to shareholder approval of equity compensation plans and to amend its rules related to the voting of proxies.[4]

[4] The Commission notes that the Exchange is proposing to adopt listing standards relating to shareholder approval of equity compensation plans that are similar to those that the Commission recently approved for the New York Stock Exchange, Inc. ("NYSE") and the National Association of Securities Dealers, Inc. ("NASD"), through its subsidiary, The Nasdaq Stock Market, Inc. ("Nasdaq"). *See* Securities Exchange Act Release No. 48108 (June 30, 2003), 68 FR 39995 (July 3, 2003) (order approving File Nos. SR–NYSE–2002–46 and SR–NASD–2002–140). *See also* Securities Exchange Act Release No. 48627 (October 14, 2003), 68 FR 60426 (October 22, 2003) (notice of filing and order granting accelerated approval to File No. SR–NASD–2003–130, incorporating amendments to the NASD's recently approved shareholder approval rules for equity compensation plans applicable to Nasdaq quoted securities). The Commission also published a correction to the

The Exchange is proposing to adopt new CSE Rule 13.6, which would require shareholder approval of all equity-compensation plans and material revisions to such plans, subject to limited exemptions. Under the Exchange's proposal, an equity compensation plan is defined as a plan or other arrangement that provides for the delivery of equity securities (either newly issued or treasury shares) of the listed company to any employee, director or other service provider as compensation for services, including a compensatory grant of options or other equity securities that is not made under a plan. The Exchange is also proposing to provide clarification on certain plans that would not be considered equity compensation plans under this definition, such as plans that do not provide for delivery of equity securities of the issuer (*e.g.*, plans that pay in cash) and deferred compensation plans under which employees pay full current market value for deferred shares.

In addition, the proposal provides for certain types of grants that are exempted from shareholder approval. These limited exemptions include: (1) Inducement awards to person's first becoming an employee of an issuer or any of its subsidiaries, to rehires following a *bona fide* period of employment interruption, and for grants to new employees in connection with a merger or acquisition;[5] (2) mergers and acquisitions, when conversions, replacements or adjustments of outstanding options or other equity compensation awards are necessary to reflect the transaction, and when shares available under certain plans acquired in corporate acquisitions and mergers may be used for certain post-transaction grants without further shareholder approval; and (3) plans intended to meet the requirements of Section 401(a) of the Internal Revenue Code[6] (*e.g.*, ESOPs), plans intended to meet the requirements of Section 423 of the Internal Revenue Code,[7] and parallel excess plans that meet certain conditions. The Exchange also proposes that, in circumstances in which equity compensation plans and amendments to plans are not subject to shareholder approval, the plans and amendments still must be subject to the approval of the company's independent compensation committee or a majority of the company's independent directors. In addition, the Exchange proposes that an issuer must notify the Exchange in writing when it uses any of the exemptions from the shareholder approval requirements.

The Exchange is also proposing to provide a non-exclusive list of "material revisions" to a plan that would require shareholder approval. Within this list of revisions, the Exchange proposes to define the concepts of "evergreen plans" (*i.e.*, plans that contain a formula for automatic increases in the shares available), "formula plans" (*i.e.*, plans that provide for automatic grants pursuant to a formula), and "discretionary plans" (*i.e.*, plans that contain no limit on the number of shares available and plans that are not formula plans). The Exchange proposes that each grant under a discretionary plan require shareholder approval regardless of whether the plan has a term of not more than 10 years.

Shareholder approval will be required for plans adopted before the effective date of these proposed amendments that have not been approved by shareholders and have neither an evergreen formula nor a specific number of shares available under the plan. The Exchange is proposing to provide transition rules to clarify when shareholder approval will be required for these pre-existing plans. In addition, during the period prior to the approval, pre-existing plans may be utilized, but only in a manner consistent with past practice. The transition rules provide that an evergreen plan that was approved by shareholders but does not have a ten-year term must be: (1) Approved by shareholders before any shares that become available as a result of a formulaic increase are utilized, or (2) amended to include a term of no more than ten years from the date the plan was adopted or last approved by shareholders. If the plan were amended to include such term, shareholder approval would not be required. No action would be required, however, if a plan were frozen at the level of shares available at the time the rule becomes effective. The transition rules also provide that repricings that have commenced prior to the effectiveness of the proposal (*i.e.*, exchange offers to optionees) will not be subject to shareholder approval (assuming that such repricing would not require shareholder approval under other Exchange By-Laws or Rules).

Finally, the Exchange is also proposing to amend CSE Rule 13.3 to prohibit members from voting on equity compensation plans unless the beneficial owner of the shares has given voting instructions. The Exchange proposes a transition period that will make these provisions of CBOE Rule 13.3 applicable only to shareholder meetings that occur on or after the 90th day following the date of the Commission order approving the rule.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with Section 6 of the Act,[8] in general, and furthers the objectives of Section 6(b)(5) of the Act,[9] in particular, in that it is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments on the proposed rule change were neither solicited nor received.

III. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549–0609. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be

notice of File No. SR–NASD–2003–130. *See* Securities Exchange Act Release No. 48627A (October 22, 2003), 68 FR 61532 (October 28, 2003). The Commission notes that these additional amendments by Nasdaq make the NYSE and Nasdaq proposals more consistent and uniform. *See also infra* note (regarding the Commission's recent approval of a similar proposal by the American Stock Exchange LLC ("Amex")).

[5] The Exchange is also proposing to include a requirement that listed companies provide prompt public disclosure following the grant of any inducement award in reliance on the exemption.

[6] 26 U.S.C. 401(a).

[7] 26 U.S.C. 423.

[8] 15 U.S.C. 78f(b).

[9] 15 U.S.C. 78f(b)(5).

available for inspection and copying at the Commission's Public Reference Room. Copies of such filing will also be available for inspection and copying at the principal office of the Exchange. All submissions should refer to File No. SR-CSE-2003-11 and should be submitted by November 28, 2003.

IV. Commission's Findings and Order Granting Accelerated Approval to the Proposed Rule Change

After careful review, the Commission finds that the Exchange's proposal is consistent with the Act and the rules and regulations promulgated thereunder applicable to a national securities exchange and, in particular, with the requirements of Section 6(b) of the Act.[10] Specifically, the Commission finds that approval of the Exchange's proposal is consistent with Section 6(b)(5) of the Act [11] in that it is designed to, among other things, facilitate transactions in securities; to prevent fraudulent and manipulative acts and practices; to promote just and equitable principles of trade; to remove impediments to and perfect the mechanism of a free and open market and a national market system; and, in general, to protect investors and the public interest; and does not permit unfair discrimination among issuers.

The Commission has long encouraged exchanges to adopt and strengthen their corporate governance listing standards in order to, among other things, restore investor confidence in the national marketplace. The Commission believes that the Exchange's proposal, which requires shareholder approval of equity compensation plans and which follows the Commission's approval of similar proposals by the NYSE, Nasdaq, and Amex [12] is the first step under this directive because it should have the effect of safeguarding the interests of shareholders, while placing certain restrictions on Exchange-listed companies.

In addition, the Commission notes that the Exchange's proposal is similar and almost identical to proposals by NYSE and Nasdaq requiring shareholder approval of equity compensation plans that have previously been approved by the Commission.[13] The Commission believes that it has already considered and addressed the issues that may be raised by the Exchange's proposal when it approved these proposals. The Commission notes that approval of the Exchange's proposal will conform the Exchange's shareholder approval requirements for equity compensation plans with those of the NYSE and Nasdaq, and will immediately impose the same requirements on the Exchange's issuers as those imposed upon NYSE, Nasdaq, and Amex issuers. The adoption of these standards by the Exchange is an important step to ensure that issuers will not be able to avoid shareholder approval requirements for equity compensation plans based on their listed marketplace.

A. Exemption From Shareholder Approval for Inducement Grants

The Commission believes that the requirement that the issuance of all inducement grants be subject to review by either the issuer's independent compensation committee or a majority of the board's independent directors, under the Exchange's proposal, should prevent abuse of this exemption from shareholder approval. In addition, the Exchange proposes to limit its exemption for inducement grants to new employees or to previous employees being rehired after a bona fide period of interruption of employment, and to new employees in connection with an acquisition or merger. The Commission believes that these limitations should help to prevent the inducement exemption from being used inappropriately.

The Commission notes that the Exchange is proposing to include a requirement, similar to the requirement under the NYSE and Nasdaq's recently approved shareholder approval rules, that, promptly following the grant of any inducement award, companies must disclose in a press release the material terms of the award, including the recipient(s) of the award and the number of shares involved.[14] The Commission notes that the Exchange is also proposing a requirement, similar to the requirements under the NYSE and Nasdaq's recently approved shareholder approval rules,[15] that an issuer must notify it in writing when it uses this exemption, and/or any other exemption, from its shareholder approval requirement. The Commission believes that these disclosure and notification requirements will provide transparency to investors and should reduce the potential for abuse of this exemption for inducement grants.

B. Exemption From Shareholder Approval for Mergers and Acquisitions

The Commission notes that the Exchange's exemption from shareholder approval for mergers and acquisitions contains safeguards that should prevent abuse in this area. First, only pre-existing plans that were previously approved by the acquired company's shareholders would be available to the listed company for post-transactional grants. In addition, shares under those previously approved plans could not be granted to individuals who were employed, immediately before the transaction, by the post-transaction listed company or its subsidiaries. The Commission also notes that, under the Exchange's proposal, any shares reserved for listing in connection with a merger or acquisition pursuant to this exemption would be counted by the Exchange in determining whether the transaction involved the issuance of 20% or more of the company's outstanding common stock, thereby requiring shareholder approval. Finally, the Commission notes that the Exchange proposes an additional requirement that an issuer must notify it in writing when it uses this exemption, and/or any other exemption, from its shareholder approval requirement. Based on the above, the Commission believes that the Exchange has provided measures to ensure that the exemption for mergers and acquisitions is only used in limited circumstances, which should help reduce the potential for dilution of shareholder interests.

C. Exemption From Shareholder Approval for Tax Qualified and Parallel Nonqualified Plans

The Commission believes that, given the extensive government regulation—the Internal Revenue Code and Treasury regulations—for tax qualified plans and the general limitations associated with parallel nonqualified plans, shareholders should not experience significant dilution as a result of this exemption. In addition, the Commission notes that the Exchange proposes to add

[10] 15 U.S.C. 78f(b). In approving the Exchange's proposal, the Commission has considered the proposed rule's impact on efficiency, competition and capital formation. 15 U.S.C. 78c(f).

[11] 15 U.S.C. 78f(b)(5).

[12] *See supra* note 4. The Commission notes that it has recently approved similar rules requiring shareholder approval of equity compensation plans for the Amex on an accelerated basis. The Amex's proposal is almost identical to, and based on, the NYSE and Nasdaq proposals. *See* Securities Exchange Act Release No. 48610 (October 9, 2003), 68 FR 59650 (October 16, 2003).

[13] *See supra* notes 4 and 12.

[14] This disclosure would, of course, be in addition to any information that is required to be disclosed in annual reports filed with the Commission. For example, Item 201(d) of Regulation S-K (17 CFR 229.201(d)) and Item 201(d) of Regulation S-B (17 CFR 228.201(d)) require issuers to present—in their annual reports on Form 10-K or Form 10-KSB—separate, tabular disclosure concerning equity compensation plans that have been approved by shareholders and equity compensation plans that have not been approved by shareholders.

[15] *See* Section 303A(8) of the NYSE's *Listed Company Manual* and NASD Rules 4310(c)(17)(A) and 4320(e)(15)(A).

a limitation under this exemption that a plan would not be considered a nonqualified parallel plan under its proposal if employees who are participants in such a plan receive employer contributions under the plan in excess of 25% of the participants' cash compensation. The Commission further notes that the Exchange proposes an additional requirement that an issuer must notify it in writing when it uses this exemption, and/or any other exemption, from its shareholder approval requirement. The Commission believes that, taken together, these limitations should reduce concerns regarding abuse of this exemption from the shareholder approval requirements.

In addition, the Commission notes that, similar to the exemptions in the NYSE and Nasdaq's recently approved shareholder approval rules, the Exchange proposes to adopt an exemption from the shareholder approval requirements for an equity compensation plan that provides non-U.S. employees with substantially the same benefits as a comparable Section 401(a) plan, Section 423 plan or parallel excess plan that the listed company provides to its U.S. employees, but for features necessary to comply with applicable foreign tax law. The Commission believes that this change will conform the Exchange's shareholder approval rule to that of the NYSE and Nasdaq and will provide greater clarity for issuers regarding tax qualified, non-discriminatory employee benefit plans and parallel nonqualified plans for their non-U.S. employees.

D. Material Revisions to Plans

The Commission notes that the Exchange proposes to provide a non-exclusive list, similar to lists found in the NYSE and Nasdaq's shareholder approval rules,[16] as to what constitutes a material revision to a plan. As noted above, material revisions to plans will require shareholder approval under Exchange rules. A material revision under the Exchange's proposal would include, but is not limited to: a material increase in the number of shares to be issued under the plan (other than to reflect a reorganization, stock split, merger, spinoff or similar transaction); an expansion of the type of awards available under the plan; a material expansion of the class of participants eligible to participate in the plan; a material extension of the term of the plan; a material change to limit or delete any provisions prohibiting repricing of options in a plan or for determining the strike or exercise price of options under a plan. The Exchange's proposal also describes what would constitute a material revision for plans containing a formula for automatic increases (such as evergreen plans) and automatic grants requiring shareholder approval.

The Commission believes that the Exchange's non-exclusive list of what would constitute a material revision to a plan provides companies with clarity and guidance for when certain amendments and revisions to plans would require shareholder approval. The Commission also believes that the Exchange's proposal to conform its non-exclusive list with the NYSE and Nasdaq's rules on material amendments/revisions should help to ensure that the concept of material amendments/revisions is consistent among the markets so that differences between the markets cannot be abused.

E. Repricing of Plans

The Commission notes that the Exchange's proposal provides that, if a plan explicitly contains a repricing provision, shareholder approval would be required to delete or limit the repricing provisions. The Commission further notes that the Exchange's proposal provides that, if a plan is silent on repricing, it will be considered as prohibiting repricing and shareholder approval would be required to permit repricing under the plan. The Exchange's proposal also clarifies that repricings that have commenced prior to the date of effectiveness of its proposal would not be subject to shareholder approval, provided that such repricing does not require shareholder approval under the Exchange's existing shareholder approval rules.

The Commission believes that the Exchange's proposal should benefit shareholders by ensuring that companies cannot do a repricing of options, which can have a dilutive effect on shares, without explicit shareholder approval of such provisions and their terms. The Commission also believes that the Exchange's approach to repricings is similar to the NYSE and Nasdaq's respective approaches to repricings, and should offer companies clarity and guidance as to when a change in a plan regarding the repricing of options would trigger a shareholder approval requirement.

F. Evergreen or Formula Plans and Plans Without a Formula or Limit on the Number of Shares Available

The Commission notes the Exchange's proposal provides guidance for the treatment of evergreen/formula plans. More specifically, under the Exchange's proposal, if a plan contains a formula for automatic increases in the shares available or for automatic grants pursuant to a formula, such plans cannot have a term in excess of ten years unless shareholder approval is obtained every ten years. In addition, under the Exchange's proposal, if a plan contains no limit on the number of shares available and is not a formula plan, then each grant under the plan will require separate shareholder approval. Furthermore, the Exchange's proposal provides that a requirement that grants be made out of treasury or repurchased shares will not alleviate the need for shareholder approval for additional grants.

The Commission believes that these provisions should help to ensure that certain terms of a plan cannot be drafted so broad as to avoid shareholder scrutiny and approval. The Commission also believes that the Exchange's proposed rules relating to the treatment of evergreen/formula plans and plans that do not contain a formula or place a limit on the number of shares available should provide more clarity and transparency to issuers as to when shareholder approval would be required for such plans. Finally, the Commission believes that the provision ensuring that treasury and repurchased shares cannot be used to avoid these additional shareholder approval requirements strengthens the proposal and ensures that companies cannot avoid compliance with the rule.

The Commission further notes that the Exchange has proposed a transition period for evergreen/formula plans and discretionary plans. The limited transition period would end on the first to occur of the following: (1) The listed company's next annual meeting at which directors are elected that occurs more than 180 days after the date of the effective date of the Exchange's proposal; (2) the first anniversary of the effective date of the Exchange's proposal; or (3) the expiration of the plan. The Commission believes that the Exchange's proposed transition period for evergreen/formula and discretionary plans should provide companies with additional clarity and guidance as to when shareholder approval would be required for such plans while in the transition period, and should provide companies with more time to comply with the Exchange's new shareholder approval requirements for evergreen/formula type plans. The Commission believes that this period is not so long as to permit abuse of the shareholder approval requirement, and at most, will last one year from the date of this Commission approval order.

[16] *See supra* note 4; *see also supra* note 12.

G. Miscellaneous Provisions

The Commission notes that the Exchange's proposal—similar to the NYSE and Nasdaq's recently approved shareholder approval rules [17]—incorporates the term "equity compensation" and proposes that plans that merely provide a convenient way to purchase shares in the open market or from the issuer at fair market price on equal terms to all security holders would not require shareholder approval. The Commission believes that the Exchange's proposal is consistent with the NYSE and Nasdaq's rules in this area and should provide greater clarity with respect to which plans would and would not require shareholder approval.

The Commission notes that the Exchange's proposal provides that pre-existing plans, which were adopted prior to the SEC's approval of the Exchange's proposal, would essentially be "grandfathered" and would not require shareholder approval unless the plans were materially amended. Under the Exchange's proposal, however, shareholder approval is required for each grant made pursuant to any pre-existing plans that were not approved by shareholders and that do not have an evergreen formula or a specific number of shares available under the plan. This is consistent with the NYSE, Nasdaq, and Amex shareholder approval rules on this matter. The Commission believes that this clarification should provide companies with guidance as to which plans would be subject to the Exchange's new shareholder approval requirements.

H. Elimination of Broker-Dealer Voting on Equity Compensation Plans

The Commission believes that the Exchange's proposed provision, CSE Rule 3.3(d), to preclude broker voting on equity compensation plans is consistent with the Act. The Commission notes that equity compensation plans have become an important issue for shareholders. Because of the potential for dilution from issuances under such plans, shareholders should be making the determination rather than brokers on their behalf. The Commission further notes that NASD rules do not provide for broker voting on any matters, and NYSE rules prohibit broker voting on equity compensation plans.[18] Therefore, the Exchange's proposed provision would be consistent with NASD and NYSE rules regarding broker voting on equity compensation plans. The Commission has considered the impact on smaller issuers, such as those listed on Nasdaq and the Amex, in response to the comments on this issue.[19] The Commission believes that the benefit of ensuring that the votes reflect the views of beneficial shareholders on equity compensation plans outweighs the potential difficulties in obtaining the vote.

The Commission also notes that the Exchange proposes to implement a transition period that would make the new rule eliminating broker voting on equity compensation plans applicable only to shareholder meetings that occur on or after the 90th day from the effective date of the Exchange's proposal.

I. Summary

Overall, the Commission believes that the Exchange's proposal is similar to the NYSE and Nasdaq's recently approved shareholder approval rules.[20] The Commission therefore believes that the Exchange's proposal should provide for more clear and uniform standards for shareholder approval of equity compensation plans. The Commission notes that, even with the availability of the proposed limited exemptions from shareholder approval under the Exchange's proposal, shareholder approval under the new standards would be required in more circumstances than under existing Exchange rules. The Commission further notes that the Exchange proposes to adopt a requirement that an issuer must notify it in writing when it uses one of the exemptions from the shareholder approval requirements. The Commission believes that such a requirement, coupled with the additional disclosure requirements for inducement grants, should reduce the potential for abuse of any of the exemptions.[21] In addition, the Exchange's proposed amendment to CSE Rule 13.3, which would preclude broker-dealers from voting on equity compensation plans without explicit instructions from the beneficial owner, is consistent with the standard under current NYSE and NASD rules.

The Commission believes that the Exchange's proposal, which is similar to the NYSE and Nasdaq's shareholder approval rules,[22] sets a consistent, minimum standard for shareholder approval of equity compensation plans. The Commission believes that the Exchange's proposal should help to ensure that companies will not make listing decisions simply to avoid shareholder approval requirements for equity compensation plans and should provide shareholders with greater protection from the potential dilutive effect of equity compensation plans. Based on the above, the Commission finds that the Exchange's proposal should help to protect investors, is in the public interest, and does not unfairly discriminate among issuers, consistent with Section 6(b)(5) of the Act.[23] The Commission therefore finds the Exchange's proposal to be consistent with the Act and the rules and regulations thereunder.

V. Accelerated Approval of the Exchange's Proposal and Amendment No. 1

The Commission finds good cause for approving the Exchange's proposal and Amendment No. 1 thereto prior to the thirtieth day after the date of publication of notice thereof in the **Federal Register**. The Exchange has requested accelerated approval of the proposed rule change so as to avoid a delay in the implementation of these listing standards designed to protect investors and the public interest, which standards the Exchange represents are substantially similar to standards recently approved by the Commission for the NYSE and Nasdaq. The Exhange therefore believes that the Exchange's adoption of the proposed listing standards presents no novel issues. The Commission notes that the Exchange's proposal is similar to the NYSE and Nasdaq's proposals requiring shareholder approval of equity compensation plans. Both the NYSE and Nasdaq's proposals were published for comment in the **Federal Register** and recently approved by the Commission.[24] The Commission believes that it already considered and addressed the issues that may be raised by the Exchange's proposal in its approval of the NYSE and Nasdaq's proposals.[25]

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[17] *See supra* note 4; *see also supra* note 12.

[18] *See* NASD Rule 2260; NYSE Rule 452; and Section 402.08 of the NYSE's *Listed Company Manual*.

[19] *See supra* notes 4 and 18.

[20] *See supra* note 4; *see also supra* note 12.

[21] *See also supra* note 14 and accompanying text.

[22] *See supra* note 4; *see also supra* note 12.

[23] 15 U.S.C. 78f(b)(5).

[24] *See* Securities Exchange Act Release No. 46620 (October 8, 2002), 67 FR 63486 (notice of the NYSE's proposal). The Commission also published a correction to the notice of the NYSE's proposal. *See* Securities Exchange Act Release No. 44620A (October 21, 2002), 67 FR 65617 (October 25, 2002). *See* Securities Exchange Act Release No. 46649 (October 11, 2002), 67 FR 64173 (notice of Nasdaq's proposal). *See supra* note 4; *see also supra* note 12.

[25] Some of the substantive provisions ultimately adopted by the NYSE and Nasdaq, and now being proposed for adoption by the Exchange, were in response to these comments. The comments on the NYSE and Nasdaq proposals were also discussed in detail in the Commission's approval order of the NYSE and Nasdaq proposals. *See supra* note 4; *see also supra* note 12.

The Commission believes that accelerated approval of the Exchange's proposal is essential to allow for immediate harmonization of, and consistency in, the shareholder approval requirements for equity compensation plans among the markets. This will prevent issuers from making listing decisions based on differences in self-regulatory organization shareholder approval requirements and should provide equal investor protection to shareholders on the dilutive effects of plans irrespective of where the security trades. The Commission further believes that making the Exchange's new shareholder approval rules effective upon Commission approval will immediately impose the same requirements on the Exchange's issuers as those imposed upon NYSE, Nasdaq, and Amex issuers. Based on the above, the Commission finds good cause, consistent with Sections 6(b)(5) and 19(b)(2) of the Act,[26] to approve the Exchange's proposal and Amendment No. 1 thereto on an accelerated basis.

VI. Conclusion

It Is Therefore Ordered, pursuant to Section 19(b)(2) of the Act,[27] that the proposed rule change (SR–CSE–2003–11) and Amendment No. 1 thereto are hereby approved on an accelerated basis.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[28]

Jill M. Peterson,

Assistant Secretary.

[FR Doc. 03–28074 Filed 10–30–03; 8:45 am]

BILLING CODE 8010–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–48735; File No. SR–PCX–2003–50]

Self-Regulatory Organizations; Notice of Filing and Order Granting Accelerated Approval to a Proposed Rule Change by the Pacific Exchange, Inc. Relating to its Shareholder Approval Policy for Its Listed Companies Regarding Stock Option Plans and Other Equity Compensation Arrangements

October 31, 2003.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 ("Act"),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on September 22, 2003, the Pacific Exchange, Inc. ("PCX" or "Exchange"), through its wholly owned subsidiary PCX Equities, Inc. ("PCXE"), filed with the Securities and Exchange Commission ("SEC" or "Commission") the proposed rule change as described in Items I and II below, which Items have been prepared by the Exchange. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons and is approving the proposal on an accelerated basis.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange, through PCXE, is proposing to amend its Section 3, Corporate Governance and Disclosure Policies, and more specifically PCXE Rule 5.3(d), Shareholder Approval Policy, relating to stock option plans and other equity compensation arrangements. The Exchange, through PCXE. is also proposing to amend PCXE Rule 9.4, Proxies Voting, to prohibit the holder of an Equity Trading Permit ("ETP") from voting on equity compensation plans unless the beneficial owner of the shares has given voting instructions. The Exchange believes that the proposed changes are aimed at helping to restore investor confidence by strengthening listed companies' corporate governance practices.

Below is the text of the proposed rule change.[3] Proposed new language is *italicized*; proposed deleted language is [bracketed].

* * * * *

PCX Equities, Inc.

Rule 5

Listings

Rules 5.1–5.2—No change.

Section 3. Corporate Governance and Disclosure Policies

Corporate Governance and Disclosure Policies

Rule 5.3—No Change.

Rule 5.3(a)–5.3(c)—No Change.

Shareholder Approval Policy

Rule 5.3(d) Shareholder Approval Policy

Each issuer shall require shareholder approval of a plan or arrangement *pursuant to* [under] subparagraphs (1) *through (7)* below or, prior to the issuance of designated securities under subparagraphs *(8)* [(2)] through *(11)* [(4)] below.[, when:]

(1) *Shareholder Approval. Except as provided for in this Rule 5.3(d) all equity-compensation plans, and any material revisions to the terms of such plans, must be approved by the shareholders of the listed company.* [A stock option or purchase plan is to be established or other arrangement made pursuant to which stock may be acquired by officers or directors, except for warrants or rights issued generally to security holders of the company or broadly based plans or arrangements including other employees (*e.g.*, ESOPs).

The Corporation will generally not require shareholder's approval as a condition to listing shares reserved for the exercise of options when:

(i) such options are issued to an individual, not previously employed by the company, as an inducement essential to the individual's entering into an employment contract with the company provided that the potential issuance of shares pursuant to such options does not exceed 5% of the company's outstanding common stock; or

(ii) the establishment of a plan or arrangement under which the amount of securities which may be issued does not exceed the lesser of 1% of the number of shares outstanding common stock, 1% of the voting power outstanding, or 25,000 shares and provided that all arrangements adopted without shareholder approval in any five-year period do not authorize, in the aggregate, the issuance of more than 10% of outstanding common stock or voting power outstanding. (For the purpose of calculating the percentage of stock issued in aggregate, stock to be issued pursuant to options which have expired and/or been cancelled shall not be included.)]

(2) Equity Compensation Plan Defined. An equity compensation plan is a plan or other arrangement that provides for the delivery of equity securities (either newly issued or treasury shares) of the listed company to any employee, director or other service provider as compensation for services. For purposes of this rule, a compensatory grant of options or other equity securities that is not made under

[26] 15 U.S.C. 78f(b)(5) and 78s(b)(2).

[27] 15 U.S.C. 78s(b)(2).

[28] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] Upon the Exchange's request, the Commission made a technical correction to the proposed rule text. Telephone conversation between Steven B. Matlin, Senior Counsel, Regulatory Policy, PCX, and Sapna C. Patel, Special Counsel, Division of Market Regulation, Commission, on October 17, 2003.

a plan is, nonetheless, an equity compensation plan.

(A) Exceptions. The following are not equity compensation plans even if the brokerage and other costs of the plan are paid for by the listed company:

(i) Plans that are made available to shareholders generally, such as a typical dividend reinvestment plan.

(ii) Plans that merely allow employees, directors or other service providers to elect to buy shares on the open market or from the listed company for their current fair market value, regardless of whether:

(a) The shares are delivered immediately or on a deferred basis; or

(b) The payments for the shares are made directly or by giving up compensation that is otherwise due (for example, through payroll deductions).

(3) Material Revisions. A material revision of an equity compensation plan includes, but is not limited to, the following:

(A) A material increase in the number of shares available under the plan (other than an increase solely to reflect a reorganization, stock split, merger, spinoff or similar transaction).

(i) If a plan contains a formula for automatic increases in the shares available (sometimes called an evergreen formula) or for automatic grants pursuant to a formula, each such increase or grant will be considered a revision requiring shareholder approval unless the plan has a term of not more than ten years.

This type of plan (regardless of its term) is referred to as a formula plan. Examples of automatic grants pursuant to a formula plan are:

(a) Annual grants to directors of restricted stock having a certain dollar value; and

(b) Matching contributions, whereby stock is credited to a participant's account based upon the amount of compensation the participant elects to defer.

(ii) If a plan contains no limit on the number of shares available and is not a formula plan, then each grant under the plan will require separate shareholder approval regardless of whether the plan has a term of not more than ten years.

This type of plan is referred to as a discretionary plan. A requirement that grants be made out of treasury shares or repurchased shares will not, in itself, be considered a limit or preestablished formula so as to prevent a plan from being considered a discretionary plan.

(B) An expansion of the types of awards available under the plan.

(C) A material expansion of the class of employees, directors or other service providers eligible to participate in the plan.

(D) A material extension of the term of the plan.

(E) A material change to the method of determining the strike price of options under the plan.

(F) The deletion or limitation of any provision prohibiting repricing of options. An amendment will not be considered a Material Revision if it curtails rather than expands the scope of the plan in question.

(4) Repricings. Repricing means any of the following or any other action that has the same effect:

(A) Lowering the strike price of an option after it is granted.

(B) Any other action that is treated as a repricing under generally accepted accounting principles.

(C) Canceling an option at a time when its strike price exceeds the fair market value of the underlying stock, in exchange for another option, restricted stock, or other equity, unless the cancellation occurs in connection with a merger, acquisition, spin-off or other similar corporate transaction.

A plan that does not contain a provision that specifically permits repricing of options will be considered for purposes of this rule as prohibiting repricing. Therefore, any actual repricing of options will be considered a material revision of a plan even if the plan itself is not revised. This consideration will not apply to a repricing through an exchange offer that commenced before the date this rule became effective.

(5) Exemptions. This rule does not require shareholder approval of employment inducement awards, certain grants, plans and amendments in the context of mergers and acquisitions, and certain specific types of plans, as described below. These exempt grants, plans and amendments may be made only with the approval of the listed company's independent compensation committee or the approval of a majority of the company's independent directors. Listed companies must notify the Exchange in writing when they use these exemptions.

(A) Employment Inducement Awards. An employment inducement award is a grant of options or other equity based compensation as a material inducement to a person or persons being hired by the listed company or any of its subsidiaries, or being rehired following a bona fide period of interruption of employment. Inducement awards include grants to new employees in connection with a merger or acquisition. Promptly following a grant of any inducement award in reliance of this exemption, the listed company must disclose in a press release the material terms of the award, including the recipient(s) of the award and the number of shares involved.

(B) Mergers and Acquisitions. In the context of corporate acquisitions and mergers, the following exemptions apply:

(i) Shareholder approval is not required to convert, replace or adjust outstanding options or other equity compensations awards to reflect the transaction.

(ii) Shares available under certain plans acquired in corporate acquisitions and mergers may be used for certain post-transaction grants without further shareholder approval. This exemption applies where a party that is not a listed company following the transaction has shares available for grant under pre-existing plans that were previously approved by shareholders. A plan adopted in contemplation of the merger or acquisition transaction would not be considered pre-existing for purposes of this exemption.

Shares available under a pre-existing plan may be used for post-transaction grants of options and other awards with respect to equity of the entity that is the listed company after the transaction, either under the pre-existing plan or another plan, without further shareholder approval, so long as:

(a) The number of shares available for grants is appropriately adjusted to reflect the transaction;

(b) The time during which those shares are available is not extended beyond the period when they would have been available under the pre-existing plan, absent the transaction; and

(c) The options and other awards are not granted to individuals who were employed, immediately before the transaction, by the post-transaction listed company or entities that were its subsidiaries immediately before the transaction.

Any shares reserved for listing in connection with a transaction pursuant to either of these exemptions would be counted by the Exchange in determining whether the transaction involved the issuance of 20% or more of the company's outstanding common stock and thus requires shareholder approval pursuant to Rule 5.3(d)(9)(B).

(D) Qualified Plans, Parallel Excess Plans and Section 423 Plans. The following types of plans, and material revisions thereto, are exempt from the shareholder approval requirement:

(i) Plans intended to meet the requirement of Section 401(a) of the Internal Revenue Code (e.g. ESOP);

(ii) Plans intended to meet the requirements of Section 423 of the Internal Revenue Code;

(iii) Parallel excess plans. A parallel excess plan is a plan that is a pension plan within the meaning of the Employee Retirement Income Security Act that is designed to work in parallel with a plan intended to be qualified under Internal Revenue Code Section 401(a) to provide benefits that exceed the limits set forth in Internal Revenue Code Section 402(g) (the section that limits the contributions and benefits under qualified plans), Internal Revenue Code Section 401(a)(17) (the section that limits the amount of an employee's compensation that can be taken into account for plan purposes) and/or Internal Revenue Code Section 415 (the section that limits the contributions and benefits under qualified plans) and/or any successor or similar limitations that may hereafter be enacted.

A plan will not be considered a parallel excess plan unless:

(a) It covers all or substantially all employees of an employer who are participants in the related qualified plan whose annual compensation is in excess of the limit of Internal Revenue Code Section 401(a)(17) or any successor or similar limits that may hereafter be enacted;

(b) Its terms are substantially the same as the qualified plan that it parallels except for the elimination of the limits described in the preceding sentence and the limitation described in clause (c) below; and

(c) No participant receives employer equity contributions under the plan in excess of 25% of the participant's cash compensation.

(iv) An equity compensation plan that provides non-U.S. employees with substantially the same benefits as a comparable Section 401(a) plan, Section 423 plan or parallel excess plan that the listed company provides to its U.S. employees, but for features necessary to comply with applicable foreign tax law, are also exempt from shareholder approval under this section.

(6) Transition Rules. Except as provided below, a plan that was adopted before the date of the Securities and Exchange Commission order approving this rule will not be subject to shareholder approval under this section unless and until it is materially revised.

In the case of a discretionary plan, as defined in Rule 5.3(d)(3)(A)(ii), whether or not previously approved by shareholders, additional grants may be made after the effective date of this rule without further shareholder approval only for a limited transition period, defined below, and then only in a manner consistent with past practice. In applying this rule, if a plan can be separated into a discretionary plan portion and a portion that is not discretionary, the non-discretionary portion of the plan can continue to be used separately, under the appropriate transition rule. For example, if a shareholder approved plan permits both grants pursuant to a provision that makes available a specific number of shares, and grants pursuant to a provision authorizing the use of treasury shares without regard to the specific share limit, the former provision (but not the latter) may continue to be used after the transition period, under the general rule.

In the case of a formula plan, as defined in Rule 5.3(d)(3)(A)(i), that either has not previously been approved by shareholders or does not have a term of ten years or less, additional grants may be made after the effective date of this rule without further shareholder approval only for a limited transition period defined below.

The limited transition period will end upon the first to occur of:

(A) The listed company's next annual meeting at which directors are elected that occurs more than 180 days after the effective date of this rule;

(B) The first anniversary of the effective date of this rule; and

(C) The expiration of the plan.

A shareholder approved formula plan may continue to be used after the end of this transition period if it is amended to provide for a term of ten years or less from the date of its original adoption or, if later, the date of its most recent shareholder approval. Such an amendment may be made before or after the effective date of this rule, and would not itself be considered a material revision requiring shareholder approval.

A formula plan may continue to be used, without shareholder approval, if the grants after the effective date of this rule are made only from the shares available immediately before the effective date, in other words, based on formulaic increases that occurred prior to such effective date.

(7) Broker Voting. The Exchange will preclude its ETP Holders from giving a proxy to vote on equity compensation plans unless the beneficial owner of the shares has given voting instructions. This is codified in Rule 9.4 (Proxy Voting). Amended Rule 9.4 will be effective for any meeting of shareholders that occurs on or after the 90th day following the date of the Securities and Exchange Commission order approving the rule change.

(8)[(2)] The issuance will result in a change of control of the issuer.

(9)[(3)] In connection with the acquisition of the stock or assets of another company, shareholder approval is needed in the following circumstances:

(A)[(i)] If any director, officer, or substantial shareholder of the listed company has a 5% or greater interest (or such persons collectively have a 10% or greater interest), directly or indirectly, in the company or assets to be acquired or in the consideration to be paid in the transaction (or series of related transactions) and the present or potential issuance of common stock, or securities convertible into or exercisable for common stock, could result in an increase in outstanding common shares or voting power of 5% or more; or

(B)[(ii)] Where the present or potential issuance of common stock, or securities convertible into or exercisable for common stock (other than in a public offering for cash), could result in an increase in outstanding common shares of 20% or more or could represent 20% or more of the voting power outstanding before the issuance of such stock or securities.

(10)[(4)] In connection with a transaction other than a public offering involving:

(A)[(i)] The sale or issuance by the company of common stock (or securities convertible into or exercisable for common stock) at a price less than the greater of book or market value, which together with sales by officers, directors or principal shareholders of the company equals 20% or more of presently outstanding common stock, or 20% or more of the presently outstanding voting power; or

(B)[(ii)] The sale or issuance by the company of common stock (or securities convertible into or exercisable for common stock) equal to 20% or more of presently outstanding stock or voting power for less than the greater of book or market value of the stock.

(11)[(5)] Exceptions may be made upon application to the Corporation when:

(A)[(i)] The delay in securing shareholder approval would seriously jeopardize the financial viability of the enterprise; and

(B)[(ii)] Reliance by the company on this exception is expressly approved by the audit committee of the board or a comparable body.

A company relying on this exception must mail to all shareholders, no later than ten days before issuance of the securities, a letter alerting them to its omission to seek the shareholder approval that would otherwise be required and indicating that the audit committee of the board or a comparable

body has expressly approved the exception.

Commentary:

.01–.02—No Change.

Rule 5.3(e)–5.3(o)No Change.

* * * * *

Rule 9

Conducting Business With the Public

* * * * *

¶ 7963M Proxies Voting

Rule 9.4. No ETP Holder shall *give a proxy vote that authorizes the implementation of any equity compensation plan, or any material revision to the terms of any existing equity compensation plan (whether or not stockholder approval of such plan is required by Rule 5.3(d)(1)–(7)), unless the beneficial owner of the shares has given voting instructions. This provision for equity compensation plans shall be effective for any meeting of shareholders that occurs on or after the 90th day following the date of the Securities and Exchange Commission order approving the rule change. In all other matters besides equity compensation plans, no ETP Holder shall* sign or give a proxy to vote any stock registered in the name or control of such ETP Holder unless (a) the ETP Holder is the actual owner thereof, (b) pursuant to the written instructions of such actual owner, or (c) pursuant to the rules of another national securities exchange to which he or she or his or her firm is responsible.

* * * * *

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item III below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

In light of the recent failures of a number of significant companies due to the lack of diligence, ethics and controls, the Exchange, through PCXE, chose to review its corporate governance and disclosure policies. In September 2002, the PCXE Board of Directors formed a subcommittee to review the PCXE's current corporate governance and disclosure standards. The Exchange represents that the goal of the subcommittee was to enhance the accountability, integrity and transparency of the Exchange's listed companies. The Exchange further represents that it took its first step towards improving the corporate governance and disclosure standards for its listed companies by proposing revisions to PCXE Rule 5.3 to comply with the requirements of the Sarbanes-Oxley Act of 2002.[4]

At the request of Commission staff, the Exchange reviewed its Shareholder Approval Policy for its listed companies. The subcommittee reviewed the New York Stock Exchange, Inc. ("NYSE") and the National Association of Securities Dealers, Inc.("NASD")/The Nasdaq Stock Market, Inc. ("Nasdaq")'s new shareholder approval requirements for equity compensation plans.[5] The Exchange proposes to adopt a shareholder approval requirement for equity compensation plans that is almost identical to the policy adopted by the NYSE.

The Exchange proposes to amend PCXE Rule 5.3(d) to require shareholder approval of all equity compensation plans and material revisions to such plans, subject to limited exemptions. The Exchange represents that the new standards in PCXE Rule 5.3(d) will apply to all companies listed under PCX's Tier I and Tier II designations.

Under the Exchange's proposal, an equity compensation plan is defined as a plan or other arrangement that provides for the delivery of equity securities (either newly issued or treasury shares) of the listed company to any employee, director or other service provider as compensation for services, including a compensatory grant of options or other equity securities that is not made under a plan. The Exchange is also proposing to provide clarification on certain plans that would not be considered equity compensation plans under this definition, such as plans that do not provide for delivery of equity securities of the issuer (*e.g.*, plans that pay in cash) and deferred compensation plans under which employees pay full current market value for deferred shares.

In addition, the proposal provides for certain types of grants that are exempted from shareholder approval. These limited exemptions include: (1) Inducement awards to person's first becoming an employee of an issuer or any of its subsidiaries, to rehires following a bona fide period of employment interruption, and for grants to new employees in connection with a merger or acquisition;[6] (2) mergers and acquisitions, when conversions, replacements or adjustments of outstanding options or other equity compensation awards are necessary to reflect the transaction, and when shares available under certain plans acquired in corporate acquisitions and mergers may be used for certain post-transaction grants without further shareholder approval; and (3) plans intended to meet the requirements of Section 401(a) of the Internal Revenue Code[7] (*e.g.*, ESOPs), plans intended to meet the requirements of Section 423 of the Internal Revenue Code,[8] and parallel excess plans that meet certain conditions. The Exchange also proposes that, in circumstances in which equity compensation plans and amendments to plans are not subject to shareholder approval, the plans and amendments still must be subject to the approval of the company's independent compensation committee or a majority of the company's independent directors. In addition, the Exchange proposes that an issuer must notify the Exchange in writing when it uses any of the exemptions from the shareholder approval requirements.

The Exchange is also proposing to provide a non-exclusive list of "material revisions" to a plan that would require shareholder approval. Within this list of revisions, the Exchange proposes to define the concepts of "evergreen plans" (*i.e.*, plans that contain a formula for automatic increases in the shares available), "formula plans" (*i.e.*, plans that provide for automatic grants pursuant to a formula), and "discretionary plans" (*i.e.*, plans that contain no limit on the number of shares available and plans that are not

[4] *See* File No. SR–PCX–2003–35.

[5] *See* Securities Exchange Act Release No. 48108 (June 30, 2003), 68 FR 39995 (July 3, 2003) (order approving File Nos. SR–NYSE–2002–46 and SR–NASD–2002–140). *See also* Securities Exchange Act Release No. 48627 (October 14, 2003), 68 FR 60426 (October 22, 2003) (notice of filing and order granting accelerated approval to File No. SR–NASD–2003–130, incorporating amendments to the NASD's recently approved shareholder approval rules for equity compensation plans applicable to Nasdaq quoted securities). The Commission also published a correction to the notice of File No. SR–NASD–2003–130. *See* Securities Exchange Act Release No. 48627A (October 22, 2003), 68 FR 61532 (October 28, 2003). The Commission notes that these additional amendments by Nasdaq make the NYSE and Nasdaq proposals more consistent and uniform. *See also infra* note 13 (regarding the Commission's recent approval of a similar proposal by the American Stock Exchange LLC ("Amex")).

[6] The Exchange is also proposing to include a requirement that listed companies provide prompt public disclosure following the grant of any inducement award in reliance on the exemption.

[7] 26 U.S.C. 401(a).

[8] 26 U.S.C. 423.

formula plans). The Exchange proposes that each grant under a discretionary plan require shareholder approval regardless of whether the plan has a term of not more than ten years.

Shareholder approval will be required for plans adopted before the effective date of these proposed amendments that have not been approved by shareholders and have neither an evergreen formula nor a specific number of shares available under the plan. The Exchange is proposing to provide transition rules to clarify when shareholder approval will be required for these pre-existing plans. In addition, during the period prior to the approval, pre-existing plans may be utilized, but only in a manner consistent with past practice. The transition rules provide that an evergreen plan that was approved by shareholders but does not have a ten-year term must be: (1) Approved by shareholders before any shares that become available as a result of a formulaic increase are utilized, or (2) amended to include a term of no more than ten years from the date the plan was adopted or last approved by shareholders. If the plan were amended to include such term, shareholder approval would not be required. No action would be required, however, if a plan were frozen at the level of shares available at the time the rule becomes effective. The transition rules also provide that repricings that have commenced prior to the effectiveness of the proposal (*i.e.*, exchange offers to optionees) will not be subject to shareholder approval (assuming that such repricing did not require shareholder approval under existing Exchange rules).

Finally, the Exchange is also proposing to prohibit the holder of an ETP from voting on equity compensation plans unless the beneficial owner of the shares has given voting instructions. The Exchange proposes a transition period that will make these provisions of PCXE Rule 9.4 applicable only to shareholder meetings that occur on or after the 90th day following the date of the Commission order approving this rule.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with Section 6 of the Act,[9] in general, and furthers the objectives of Section 6(b)(5) of the Act,[10] in particular, in that it is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments on the proposed rule change were neither solicited nor received.

III. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, NW, Washington, DC 20549–0609. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying at the Commission's Public Reference Room. Copies of such filing will also be available for inspection and copying at the principal office of the Exchange. All submissions should refer to File No. SR–PCX–2003–50 and should be submitted by November 28, 2003.

IV. Commission's Findings and Order Granting Accelerated Approval to the Proposed Rule Change

After careful review, the Commission finds that the Exchange's proposal is consistent with the Act and the rules and regulations promulgated thereunder applicable to a national securities exchange and, in particular, with the requirements of Section 6(b) of the Act.[11] Specifically, the Commission finds that approval of the Exchange's proposal is consistent with Section 6(b)(5) of the Act[12] in that it is designed to, among other things, facilitate transactions in securities; to prevent fraudulent and manipulative acts and practices; to promote just and equitable principles of trade; to remove impediments to and perfect the mechanism of a free and open market and a national market system; and, in general, to protect investors and the public interest; and does not permit unfair discrimination among issuers.

The Commission has long encouraged exchanges to adopt and strengthen their corporate governance listing standards in order to, among other things, restore investor confidence in the national marketplace. The Commission believes that the Exchange's proposal, which requires shareholder approval of equity compensation plans and which follows the Commission's approval of similar proposals by the NYSE, Nasdaq, and Amex[13] is the first step under this directive because it should have the effect of safeguarding the interests of shareholders, while placing certain restrictions on Exchange-listed companies.[14]

In addition, the Commission notes that the Exchange's proposal is similar and almost identical to proposals by NYSE and Nasdaq requiring shareholder approval of equity compensation plans that have previously been approved by the Commission.[15] The Commission believes that it has already considered and addressed the issues that may be raised by the Exchange's proposal when it approved these proposals. The Commission notes that approval of the Exchange's proposal will conform the Exchange's shareholder approval requirements for equity compensation plans with those of the NYSE and Nasdaq, and will immediately impose the same requirements on the Exchange's issuers as those imposed upon NYSE, Nasdaq, and Amex issuers. The adoption of these standards by the Exchange is an important step to ensure that issuers will not be able to avoid shareholder approval requirements for

[9] 15 U.S.C. 78f(b).

[10] 15 U.S.C. 78f(b)(5).

[11] 15 U.S.C. 78f(b). In approving the Exchange's proposal, the Commission has considered the proposed rule's impact on efficiency, competition and capital formation. 15 U.S.C. 78c(f).

[12] 15 U.S.C. 78f(b)(5).

[13] *See supra* note 5. The Commission notes that it has recently approved similar rules requiring shareholder approval of equity compensation plans for the Amex on an accelerated basis. The Amex's proposal is almost identical to, and based on, the NYSE and Nasdaq proposals. *See* Securities Exchange Act Release No. 48610 (October 9, 2003), 68 FR 59650 (October 16, 2003).

[14] The Commission notes that these new listing standards in PCXE Rule 5.3(d) will apply to all companies listed on the PCX and will include both PCX's Tier I and Tier II designations.

[15] *See supra* notes 5 and 13.

equity compensation plans based on their listed marketplace.

A. Exemption from Shareholder Approval for Inducement Grants

The Commission believes that the requirement that the issuance of all inducement grants be subject to review by either the issuer's independent compensation committee or a majority of the board's independent directors, under the Exchange's proposal, should prevent abuse of this exemption from shareholder approval. In addition, the Exchange proposes to limit its exemption for inducement grants to new employees or to previous employees being rehired after a bona fide period of interruption of employment, and to new employees in connection with an acquisition or merger. The Commission believes that these limitations should help to prevent the inducement exemption from being used inappropriately.

The Commission notes that the Exchange is proposing to include a requirement, similar to the requirement under the NYSE and Nasdaq's recently approved shareholder approval rules, that, promptly following the grant of any inducement award, companies must disclose in a press release the material terms of the award, including the recipient(s) of the award and the number of shares involved.[16] The Commission notes that the Exchange is also proposing a requirement, similar to the requirements under the NYSE and Nasdaq's recently approved shareholder approval rules,[17] that an issuer must notify it in writing when it uses this exemption, and/or any other exemption, from its shareholder approval requirement. The Commission believes that these disclosure and notification requirements will provide transparency to investors and should reduce the potential for abuse of this exemption for inducement grants.

B. Exemption From Shareholder Approval for Mergers and Acquisitions

The Commission notes that the Exchange's exemption from shareholder approval for mergers and acquisitions contains safeguards that should prevent abuse in this area. First, only pre-existing plans that were previously approved by the acquired company's shareholders would be available to the listed company for post-transactional grants. In addition, shares under those previously approved plans could not be granted to individuals who were employed, immediately before the transaction, by the post-transaction listed company or its subsidiaries. The Commission also notes that, under the Exchange's proposal, any shares reserved for listing in connection with a merger or acquisition pursuant to this exemption would be counted by the Exchange in determining whether the transaction involved the issuance of 20% or more of the company's outstanding common stock, thereby requiring shareholder approval under PCXE Rule 5.3(d)(9)(B). Finally, the Commission notes that the Exchange proposes an additional requirement that an issuer must notify it in writing when it uses this exemption, and/or any other exemption, from its shareholder approval requirement. Based on the above, the Commission believes that the Exchange has provided measures to ensure that the exemption for mergers and acquisitions is only used in limited circumstances, which should help reduce the potential for dilution of shareholder interests.

C. Exemption From Shareholder Approval for Tax Qualified and Parallel Nonqualified Plans

The Commission believes that, given the extensive government regulation—the Internal Revenue Code and Treasury regulations—for tax qualified plans and the general limitations associated with parallel nonqualified plans, shareholders should not experience significant dilution as a result of this exemption. In addition, the Commission notes that the Exchange proposes to add a limitation under this exemption that a plan would not be considered a nonqualified parallel plan under its proposal if employees who are participants in such a plan receive employer contributions under the plan in excess of 25% of the participants' cash compensation. The Commission further notes that the Exchange proposes an additional requirement that an issuer must notify it in writing when it uses this exemption, and/or any other exemption, from its shareholder approval requirement. The Commission believes that, taken together, these limitations should reduce concerns regarding abuse of this exemption from the shareholder approval requirements.

In addition, the Commission notes that, similar to the exemptions in the NYSE and Nasdaq's recently approved shareholder approval rules, the Exchange proposes to adopt an exemption from the shareholder approval requirements for an equity compensation plan that provides non-U.S. employees with substantially the same benefits as a comparable Section 401(a) plan, Section 423 plan or parallel excess plan that the listed company provides to its U.S. employees, but for features necessary to comply with applicable foreign tax law. The Commission believes that this change will conform the Exchange's shareholder approval rule to that of the NYSE and Nasdaq and will provide greater clarity for issuers regarding tax qualified, non-discriminatory employee benefit plans and parallel nonqualified plans for their non-U.S. employees.

D. Material Revisions to Plans

The Commission notes that the Exchange proposes to provide a non-exclusive list, similar to lists found in the NYSE and Nasdaq's shareholder approval rules,[18] as to what constitutes a material revision to a plan. As noted above, material revisions to plans will require shareholder approval under Exchange rules. A material revision under the Exchange's proposal would include, but is not limited to: A material increase in the number of shares to be issued under the plan (other than to reflect a reorganization, stock split, merger, spinoff or similar transaction); an expansion of the type of awards available under the plan; a material expansion of the class of participants eligible to participate in the plan; a material extension of the term of the plan; a material change to limit or delete any provisions prohibiting repricing of options in a plan or for determining the strike or exercise price of options under a plan. The Exchange's proposal also describes what would constitute a material revision for plans containing a formula for automatic increases (such as evergreen plans) and automatic grants requiring shareholder approval.

The Commission believes that the Exchange's non-exclusive list of what would constitute a material revision to a plan provides companies with clarity and guidance for when certain amendments and revisions to plans would require shareholder approval. The Commission also believes that the Exchange's proposal to conform its non-exclusive list with the NYSE and Nasdaq's rules on material amendments/revisions should help to

[16] This disclosure would, of course, be in addition to any information that is required to be disclosed in annual reports filed with the Commission. For example, item 201(d) of Regulation S–K [17 CFR 229.201(d)] and item 201(d) of Regulation S–B [17 CFR 228.201(d)] require issuers to present—in their annual reports on Form 10–K or Form 10–KSB—separate, tabular disclosure concerning equity compensation plans that have been approved by shareholders and equity compensation plans that have not been approved by shareholders.

[17] *See* Section 303A(8) of the NYSE's *Listed Company Manual* and NASD Rules 4310(c)(17)(A) and 4320(e)(15)(A).

[18] *See supra* note 5; *see alsa supra* note 13.

ensure that the concept of material amendments/revisions is consistent among the markets so that differences between the markets cannot be abused.

E. Repricing of Plans

The Commission notes that the Exchange's proposal provides that, if a plan explicitly contains a repricing provision, shareholder approval would be required to delete or limit the repricing provisions. The Commission further notes that the Exchange's proposal provides that, if a plan is silent on repricing, it will be considered as prohibiting repricing and shareholder approval would be required to permit repricing under the plan. The Exchange's proposal also clarifies that repricings that have commenced prior to the date of effectiveness of its proposal would not be subject to shareholder approval, provided that such repricing does not require shareholder approval under the Exchange's existing shareholder approval rules.

The Commission believes that the Exchange's proposal should benefit shareholders by ensuring that companies cannot do a repricing of options, which can have a dilutive effect on shares, without explicit shareholder approval of such provisions and their terms. The Commission also believes that the Exchange's approach to repricings is similar to the NYSE and Nasdaq's respective approaches to repricings, and should offer companies clarity and guidance as to when a change in a plan regarding the repricing of options would trigger a shareholder approval requirement.

F. Evergreen or Formula Plans and Plans Without a Formula or Limit on the Number of Shares Available

The Commission notes the Exchange's proposal provides guidance for the treatment of evergreen/formula plans. More specifically, under the Exchange's proposal, if a plan contains a formula for automatic increases in the shares available or for automatic grants pursuant to a formula, such plans cannot have a term in excess of ten years unless shareholder approval is obtained every ten years. In addition, under the Exchange's proposal, if a plan contains no limit on the number of shares available and is not a formula plan, then each grant under the plan will require separate shareholder approval. Furthermore, the Exchange's proposal provides that a requirement that grants be made out of treasury or repurchased shares will not alleviate the need for shareholder approval for additional grants.

The Commission believes that these provisions should help to ensure that certain terms of a plan cannot be drafted so broad as to avoid shareholder scrutiny and approval. The Commission also believes that the Exchange's proposed rules relating to the treatment of evergreen/formula plans and plans that do not contain a formula or place a limit on the number of shares available should provide more clarity and transparency to issuers as to when shareholder approval would be required for such plans. Finally, the Commission believes that the provision ensuring that treasury and repurchased shares cannot be used to avoid these additional shareholder approval requirements strengthens the proposal and ensures that companies cannot avoid compliance with the rule.

The Commission further notes that the Exchange has proposed a transition period for evergreen/formula plans and discretionary plans. The limited transition period would end on the first to occur of the following: (1) The listed company's next annual meeting at which directors are elected that occurs more than 180 days after the date of the effective date of the Exchange's proposal; (2) the first anniversary of the effective date of the Exchange's proposal; or (3) the expiration of the plan. The Commission believes that the Exchange's proposed transition period for evergreen/formula and discretionary plans should provide companies with additional clarity and guidance as to when shareholder approval would be required for such plans while in the transition period, and should provide companies with more time to comply with the Exchange's new shareholder approval requirements for evergreen/formula type plans. The Commission believes that this period is not so long as to permit abuse of the shareholder approval requirement, and at most, will last one year from the date of this Commission approval order.

G. Miscellaneous Provisions

The Commission notes that the Exchange's proposal'similar to the NYSE and Nasdaq's recently approved shareholder approval rules [19]—incorporates the term "equity compensation" and proposes that plans that merely provide a convenient way to purchase shares in the open market or from the issuer at fair market price on equal terms to all security holders would not require shareholder approval. The Commission believes that the Exchange's proposal is consistent with the NYSE and Nasdaq's rules in this area and should provide greater clarity with respect to which plans would and would not require shareholder approval.

The Commission notes that the Exchange's proposal provides that pre-existing plans, which were adopted prior to the SEC's approval of the Exchange's proposal, would essentially be "grandfathered" and would not require shareholder approval unless the plans were materially amended. Under the Exchange's proposal, however, shareholder approval is required for each grant made pursuant to any pre-existing plans that were not approved by shareholders and that do not have an evergreen formula or a specific number of shares available under the plan. This is consistent with the NYSE, Nasdaq, and Amex shareholder approval rules on this matter. The Commission believes that this clarification should provide companies with guidance as to which plans would be subject to the Exchange's new shareholder approval requirements.

H. Elimination of Broker-Dealer Voting on Equity Compensation Plans

The Commission believes that the Exchange's proposed amendment to PCX Rule 9.4 to preclude broker voting on equity compensation plans is consistent with the Act. The Commission notes that equity compensation plans have become an important issue for shareholders. Because of the potential for dilution from issuances under such plans, shareholders should be making the determination rather than brokers on their behalf. The Commission further notes that NASD rules do not provide for broker voting on any matters and NYSE rules prohibit broker voting on equity compensation plans.[20] Therefore, the Exchange's proposed provision would be consistent with NASD and NYSE rules regarding broker voting on equity compensation plans. The Commission has considered the impact on smaller issuers, such as those listed on Nasdaq and the Amex, in response to the comments on this issue.[21] The Commission believes that the benefit of ensuring that the votes reflect the views of beneficial shareholders on equity compensation plans outweighs the potential difficulties in obtaining the vote.

The Commission also notes that the Exchange proposes to implement a transition period that would make the new rule eliminating broker voting on

[19] *See supra* note 5; *see also supra* note 13.

[20] *See* NASD Rule 2260; NYSE Rule 452; and Section 402.08 of the NYSE's *Listed Company Manual*.

[21] *See supra* notes 5 and 20.

equity compensation plans applicable only to shareholder meetings that occur on or after the 90th day from the effective date of the Exchange's proposal.

I. Summary

Overall, the Commission believes that the Exchange's proposal is similar to the NYSE and Nasdaq's recently approved shareholder approval rules.[22] The Commission therefore believes that the Exchange's proposal should provide for more clear and uniform standards for shareholder approval of equity compensation plans. The Commission notes that, even with the availability of the proposed limited exemptions from shareholder approval under the Exchange's proposal, shareholder approval under the new standards would be required in more circumstances than under existing Exchange rules. The Commission further notes that the Exchange proposes to adopt a requirement that an issuer must notify it in writing when it uses one of the exemptions from the shareholder approval requirements. The Commission believes that such a requirement, coupled with the additional disclosure requirements for inducement grants, should reduce the potential for abuse of any of the exemptions.[23] In addition, the Exchange's proposed amendment to PCXE Rule 9.4, which would preclude broker-dealers from voting on equity compensation plans without explicit instructions from the beneficial owner, is consistent with the standard under current NYSE and NASD rules.

The Commission believes that the Exchange's proposal, which is similar to the NYSE and Nasdaq's shareholder approval rules,[24] sets a consistent, minimum standard for shareholder approval of equity compensation plans. The Commission believes that the Exchange's proposal should help to ensure that companies will not make listing decisions simply to avoid shareholder approval requirements for equity compensation plans and should provide shareholders with greater protection from the potential dilutive effect of equity compensation plans. Based on the above, the Commission finds that the Exchange's proposal should help to protect investors, is in the public interest, and does not unfairly discriminate among issuers, consistent with Section 6(b)(5) of the Act.[25] The Commission therefore finds the Exchange's proposal to be consistent with the Act and the rules and regulations thereunder.

V. Accelerated Approval of the Exchange's Proposal

The Commission finds good cause for approving the Exchange's proposal prior to the thirtieth day after the date of publication of notice thereof in the **Federal Register**. The Commission notes that the Exchange's proposal is similar to the NYSE and Nasdaq's proposals requiring shareholder approval of equity compensation plans. Both the NYSE and Nasdaq's proposals were published for comment in the **Federal Register** and recently approved by the Commission.[26] The Commission believes that it already considered and addressed the issues that may be raised by the Exchange's proposal in its approval of the NYSE and Nasdaq's proposals.[27]

The Commission believes that accelerated approval of the Exchange's proposal is essential to allow for immediate harmonization of, and consistency in, the shareholder approval requirements for equity compensation plans among the markets. This will prevent issuers from making listing decisions based on differences in self-regulatory organization shareholder approval requirements and should provide equal investor protection to shareholders on the dilutive effects of plans irrespective of where the security trades. The Commission further believes that making the Exchange's new shareholder approval rules effective upon Commission approval will immediately impose the same requirements on the Exchange's issuers as those imposed upon NYSE, Nasdaq, and Amex issuers. Based on the above, the Commission finds good cause, consistent with Sections 6(b)(5) and 19(b)(2) of the Act,[28] to approve the Exchange's proposal on an accelerated basis.

VI. Conclusion

It Is Therefore Ordered, pursuant to Section 19(b)(2) of the Act,[29] that the proposed rule change (SR–PCX–2003–50) is hereby approved on an accelerated basis.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[30]

Jill M. Peterson,

Assistant Secretary.

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[22] *See supra* note 5; *see also supra* note 13.

[23] *See also supra* note 16 and accompanying text.

[24] *See supra* note 5; *see also supra* note 13.

[25] 15 U.S.C. 78f(b)(5).

[26] *See* Securities Exchange Act Release No. 46620 (October 8, 2002), 67 FR 63486 (notice of the NYSE's proposal). The Commission also published a correction to the notice of the NYSE's proposal. *See* Securities Exchange Act Release No. 44620A (October 21, 2002), 67 FR 65617 (October 25, 2002). *See* Securities Exchange Act Release No. 46649 (October 11, 2002), 67 FR 64173 (notice of Nasdaq's proposal). *See supra* note 5; *see also supra* note 13.

[27] Some of the substantive provisions ultimately adopted by the NYSE and Nasdaq, and now being proposed for adoption by the Exchange, were in response to these comments. The comments on the NYSE and Nasdaq proposals were also discussed in detail in the Commission's approval order of the NYSE and Nasdaq proposals. *See supra* note 5; *see also supra* note 13.

[28] 15 U.S.C. 78f(b)(5) and 78s(b)(2).

[29] 15 U.S.C. 78s(b)(2).

[30] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–48736; File No. SR–Phlx–2003–67]

Self-Regulatory Organizations; Notice of Filing and Order Granting Accelerated Approval to a Proposed Rule Change by the Philadelphia Stock Exchange, Inc. Relating to Shareholder Approval of Equity Compensation Plans and the Voting of Proxies

October 31, 2003.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 ("Act"),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on September 30, 2003, the Philadelphia Stock Exchange, Inc. ("Phlx" or "Exchange") filed with the Securities and Exchange Commission ("SEC" or "Commission") the proposed rule change as described in Items I and II below, which Items have been prepared by the Exchange. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons and is approving the proposal on an accelerated basis.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to delete the introductory language and subsection (a) of Phlx Rule 850, *Shareholder Approval Policy*, and replace it with rule text and commentary regarding shareholder approval of equity compensation plans that tracks the National Association of Securities Dealers, Inc.'s ("NASD") Rule 4350(i) and NASD IM 4350–5.[3] The Exchange

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] The Commission notes that the Exchange is proposing to adopt listing standards relating to shareholder approval of equity compensation plans that are similar to those that the Commission

also proposes to amend Phlx Rule 862, *Proxies at Direction of Owner*, to preclude broker voting on equity compensation plans.

Below is the text of the proposed rule change.[4] Proposed new language is *italicized*; proposed deleted language is [bracketed].

* * * * *

Rule 850, Shareholder Approval Policy

Rule 850. [A listed company shall require shareholder approval of the issuance of securities in connection with the following:

(a) Options plans or other special remunerations plans for directors, officers or key employees.] *Each issuer shall require shareholder approval prior to the issuance of designated securities under subparagraph (a), (b), or (c) below:*

(a) When a stock option or purchase plan is to be established or materially amended or other equity compensation arrangement made or materially amended pursuant to which options or stock may be acquired by officers, directors, employees, or consultants, except for:

(i) Warrants or rights issued generally to all security holders of the company or stock purchase plans available on equal terms to all security holders of the company (such as a dividend reinvestment plan); or

(ii) Tax qualified, non-discriminatory employee benefit plans (e.g., plans that meet the requirements of Section 401(a) or 423 of the Internal Revenue Code) or parallel nonqualified plans, provided such plans are approved by the issuer's independent compensation committee or a majority of the issuer's independent directors; or plans that merely provide a convenient way to purchase shares on the open market or from the issuer at fair market value; or

(iii) Plans or arrangements relating to an acquisition or merger as permitted under the Commentary to this rule; or

(iv) Issuances to a person not previously an employee or director of the company, or following a bonafide period of non-employment, as an inducement material to the individual's entering into employment with the company, provided such issuances are approved by either the issuer's independent compensation committee or a majority of the issuer's independent directors. Promptly following an issuance of any employment inducement grant in reliance on this exception, a company must disclose in a press release the material terms of the grant, including the recipient(s) of the grant and the number of the shares involved.

Issuers shall notify the Exchange no later than 15 calendar days prior to establishing or materially amending a stock option plan, purchase plan or other equity compensation arrangement pursuant to which stock may be acquired by officers, directors, employees, or consultants without shareholder approval.

(b) No change.

(c) No change.

* * * * *

Commentary

Employee ownership of company stock can be an effective tool to align employee interests with those of other shareholders. Stock option plans or other equity compensation arrangements can also assist in the recruitment and retention of employees, which is especially critical to young, growing companies, or companies with insufficient cash resources to attract and retain highly qualified employees. However, these plans can potentially dilute shareholder interests. As such, Rule 850(a) ensures that shareholders have a voice in these situations, given this potential for dilution.

Rule 850(a) requires shareholder approval when a plan or other equity compensation arrangement is established or materially amended. For these purposes, a material amendment would include, but not be limited to, the following:

(1) Any material increase in the number of shares to be issued under the plan (other than to reflect a reorganization, stock split, merger, spinoff or similar transaction);

(2) Any material increase in benefits to participants, including any material change to: (i) permit a repricing (or decrease in exercise price) of outstanding options, (ii) reduce the price at which shares or options to purchase shares may be offered, or (iii) extend the duration of a plan;

(3) Any material expansion of the class of participants eligible to participate in the plan; and

(4) Any expansion in the types of options or awards provided under the plan.

While general authority to amend a plan would not obviate the need for shareholder approval, if a plan permits a specific action without further shareholder approval, then no such approval would generally be required. However, if a plan contains a formula for automatic increases in the shares available (sometimes called an "evergreen formula"), or for automatic grants pursuant to a dollar-based formula (such as, annual grants based on a certain dollar value, or matching contributions based upon the amount of compensation the participant elects to defer), such plans cannot have a term in excess of ten years unless shareholder approval is obtained every ten years. However, plans that do not contain a formula and do not impose a limit on the number of shares available for grant would require shareholder approval of each grant under the plan. A requirement that grants be made out of treasury shares or repurchased shares will not alleviate these additional shareholder approval requirements.

As a general matter, when preparing plans and presenting them for shareholder approval, issuers should strive to make plan terms easy to understand. In that regard, it is recommended that plans meant to permit repricing use explicit terminology to make this clear.

Rule 850(a) provides an exception to the requirement for shareholder approval for warrants or rights offered generally to all shareholders. In addition, an exception is provided for tax qualified, non-discriminatory employee benefit plans as well as parallel nonqualified plans as these plans are regulated under the Internal Revenue Code and Treasury Department regulations. An equity compensation plan that provides non-U.S. employees with substantially the same benefits as a comparable tax qualified, non-discriminatory employee benefit plan that the issuer provides to its U.S. employees, but for features necessary to comply with applicable foreign tax law, are also exempt from shareholder approval under this section.

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recently approved for the New York Stock Exchange, Inc. ("NYSE") and the NASD, through its subsidiary, The Nasdaq Stock Market, Inc. ("Nasdaq"). *See* Securities Exchange Act Release No. 48108 (June 30, 2003), 68 FR 39995 (July 3, 2003) (order approving File Nos. SR–NYSE–2002–46 and SR–NASD–2002–140). *See also* Securities Exchange Act Release No. 48627 (October 14, 2003), 68 FR 60426 (October 22, 2003) (notice of filing and order granting accelerated approval to File No. SR–NASD–2003–130, incorporating amendments to the NASD's recently approved shareholder approval rules for equity compensation plans applicable to Nasdaq quoted securities). The Commission also published a correction to the notice of File No. SR–NASD–2003–130. *See* Securities Exchange Act Release No. 48627A (October 22, 2003), 68 FR 61532 (October 28, 2003). The Commission notes that these additional amendments by Nasdaq make the NYSE and Nasdaq proposals more consistent and uniform. *See also infra* note (regarding the Commission's recent approval of a similar proposal by the American Stock Exchange LLC ("Amex")).

[4] Upon the Exchange's request, the Commission made a technical correction to the proposed rule text. Telephone conversation between Carla Behnfeldt, Director, Legal Department New Product Development Group, Phlx, and Sapna C. Patel, Special Counsel, Division of Market Regulation, Commission, on October 31, 2003.

Further, there is an exception for inducement grants to new employees because in these cases a company has an arm's length relationship with the new employees. Inducement grants for these purposes include grants of options or stock to new employees in connection with a merger or acquisition. The rule requires that such issuances must be approved by the issuer's independent compensation committee or a majority of the issuer's independent directors. The rule further requires that promptly following an issuance of any employment inducement grant in reliance on this exception, a company must disclose in a press release the material terms of the grant, including the recipient(s) of the grant and the number of shares involved.

In addition, plans or arrangements involving a merger or acquisition do not require shareholder approval in two situations. First, shareholder approval will not be required to convert, replace or adjust outstanding options or other equity compensation awards to reflect the transaction. Second, shares available under certain plans acquired in acquisitions and mergers may be used for certain post-transaction grants without further shareholder approval. This exception applies to situations where the party which is not a listed company following the transaction has shares available for grant under pre-existing plans that were previously approved by shareholders and meet the requirements of this Rule 850(a). These shares may be used for post-transaction grants of options and other equity awards by the listed company (after appropriate adjustment of the number of shares to reflect the transaction), either under the pre-existing plan or arrangement or another plan or arrangement, without further shareholder approval, provided: (1) The time during which those shares are available for grants is not extended beyond the period when they would have been available under the pre-existing plan, absent the transaction, and (2) such options and other awards are not granted to individuals who were employed by the granting company or its subsidiaries at the time the merger or acquisition was consummated. The Exchange would view a plan or arrangement adopted in contemplation of the merger or acquisition transaction as not pre-existing for purposes of this exception. This exception is appropriate because it will not result in any increase in the aggregate potential dilution of the combined enterprise. In this regard, any additional shares available for issuance under a plan or arrangement acquired in connection with a merger or acquisition would be counted by the Exchange in determining whether the transaction involved the issuance of 20% or more of the company's outstanding common stock, thus triggering the shareholder approval requirements under Rule 850(c).

Inducement grants, tax qualified non-discriminatory benefit plans, and parallel nonqualified plans are subject to approval by either the issuer's independent compensation committee, or a majority of the issuer's independent directors. It should also be noted that a company would not be permitted to use repurchased shares to fund option plans or grants without prior shareholder approval.

For purposes of Rule 850(a), including this Commentary, the term "parallel nonqualified plan" means a plan that is a "pension plan" within the meaning of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1002 (1999), that is designed to work in parallel with a plan intended to be qualified under Internal Revenue Code Section 401(a), to provide benefits that exceed the limits set forth in Internal Revenue Code Section 402(g) (the section that limits an employee's annual pre-tax contributions to a 401(k) plan), Internal Revenue Code Section 401(a)(17) (the section that limits the amount of an employee's compensation that can be taken into account for plan purposes) and/or Internal Revenue Code Section 415 (the section that limits the contributions and benefits under qualified plans) and/or any successor or similar limitations that may thereafter be enacted. However, a plan will not be considered a parallel nonqualified plan unless: (i) It covers all or substantially all employees of an employer who are participants in the related qualified plan whose annual compensation is in excess of the limit of Code Section 401(a)(17) (or any successor or similar limitation that may hereafter be enacted); (ii) its terms are substantially the same as the qualified plan that it parallels except for the elimination of the limitations described in the preceding sentence; and, (iii) no participant receives employer equity contributions under the plan in excess of 25% of the participant's cash compensation.

Rule 850(a) and this Commentary will become effective upon Securities and Exchange Commission approval; however, existing plans will be grandfathered. Any material modification to plans in place or adopted after the effective date will require shareholder approval.

The Exchange will preclude its member organizations from giving a proxy to vote on equity-compensation plans unless the beneficial owner of the shares has given voting instructions. This is codified in Exchange Rule 862. Amended Rule 862 will be effective for any meeting of shareholders that occurs on or after the 90th day following the effective date of the Securities and Exchange Commission order approving the rule change.

* * * * *

Rule 862, Proxies at Direction of Owner

Rule 862. A member organization shall give a proxy for stock registered in its name, at the direction of the beneficial owner. If the stock is not in the control or possession of the member organization, satisfactory proof of the beneficial ownership as of the record date may be required.

Member organization holdings as executor, etc.

A member organization may give a proxy to vote any stock registered in its name if the member organization holds such stock as executor, administrator, guardian, trustee, or in a similar representative or fiduciary capacity with authority to vote.

Procedure without instructions—Instructions on stock in names of other member organizations

A member organization which has transmitted proxy soliciting material to the beneficial owner of stock in accordance with the provisions of Rule 861, and which has not received instructions from the beneficial owner by the date specified in the statement accompanying such material, may give a proxy to vote such stock, provided the person signing the proxy has no knowledge of any contest as to the action to be taken at the meeting and provided such action does not include authorization for a merger, consolidation or any other matter which may affect substantially the legal rights or privileges of such stock.

A member organization which has in its possession or control stock registered in the name of another member organization shall:

(1) Forward to such other member organization any voting instructions received from the beneficial owner, or

(2) If the proxy-soliciting material has been transmitted to the beneficial owner of the stock in accordance with Rule 861 and no instructions have been received by the date specified in the statement accompanying such material, notify such other member organization of such fact in order that such organization may give the proxy as provided in the first paragraph of this Rule.

Notwithstanding the foregoing, a member organization may not give a proxy to vote without instructions from beneficidl owners when the matter to be voted upon authorizes the implementation of any equity compensation plan, or any material revision to the terms of any existing equity compensation plan (whether or not stockholder approval of such plan is required by Rule 850.)

* * * * *

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item III below. The Exchange has prepared summaries, set forth in Sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to revise Exchange Rule 850 to require shareholder approval for stock option plans or other equity compensation arrangements (subject to exceptions specified in the rule), to adopt a "Commentary" pertaining to shareholder approval for stock option plans or other equity compensation arrangements, and to revise Exchange Rule 862 to preclude broker voting in connection with shareholder approval of equity compensation plans.

Specifically, the Exchange proposes to adopt an exception for warrants or rights offered generally to all shareholders. The exception would exclude stock purchase plans available on equal terms to all security holders of the company (such as a dividend reinvestment plan) from the shareholder approval requirement. In addition, the proposal would not require shareholder approval for tax qualified, non-discriminatory benefit plans as these plans are regulated under the Internal Revenue Code and Treasury Department regulations. Along with tax qualified, non-discriminatory employee benefit plans, the Exchange's proposal also provides an exception for parallel nonqualified plans, which are plans that work parallel with plans intended to qualify under the Internal Revenue Code. Additionally, an equity compensation plan that provides non-U.S. employees with substantially the same benefits as a comparable tax qualified, non-discriminatory employee benefit plan or parallel nonqualified plan that the issuer provides to its U.S. employees, but for features necessary to comply with applicable foreign tax law, is also exempt from the shareholder approval requirements.

Furthermore, the Exchange proposes to adopt an exception for inducement grants to new employees because, in these cases, a company has an arm's length relationship with the new employees, and its interests are directly aligned with the shareholders. This exception would apply to persons previously employed by the issuer following a bona fide period of non-employment. In addition, for these purposes, inducement grants would include grants of options or stock to new employees in connection with a merger or acquisition. The proposal would require that, promptly following an issuance of any employment inducement grant in reliance on this exception, a company must disclose in a press release the material terms of the grant, including the recipient(s) of the grant and the number of shares involved.

In addition, the proposal would provide that plans involving a merger or acquisition would not require shareholder approval in two situations. First, the Exchange will not require shareholder approval to convert, replace or adjust outstanding options or other equity compensation awards to reflect the transaction. Second, the shares available under certain plans acquired in corporate acquisitions and mergers may be used for certain post-transaction grants without further shareholder approval. This exception would apply to situations where the target/acquired company, which is no longer a listed company following the transaction, has shares available for grant under its pre-existing plans that were previously approved by its shareholders. These shares may be used for post-transaction grants of options and other equity awards by the acquiring/listed company (after appropriate adjustment of the number of shares to reflect the transaction), either under the pre-existing plan or another plan, without further shareholder approval, so long as: (1) The time during which those shares are available for grants is not extended beyond the period when they would have been available under the pre-existing plan, absent the transaction, and (2) such options and other awards are only granted to individuals who were employed by the target/acquired company at the time the merger or acquisition was consummated. The Exchange would view a plan adopted in contemplation of the merger or acquisition transaction as not pre-existing for purposes of this exception. The Exchange believes that this exception is appropriate because it believes that it will not result in any increase in the aggregate potential dilution of the combined enterprise.

Under the Exchange's proposal, inducement grants, tax qualified, non-discriminatory benefit plans, and parallel nonqualified plans are subject to approval by either the issuer's independent compensation committee, or a majority of the issuer's independent directors. The Exchange also notes that a company would not be permitted to use repurchased shares to fund options without prior shareholder approval. Plans that merely provide a convenient way to purchase shares on the open market or from the issuer at fair market value would not require shareholder approval.

The Exchange proposal further clarifies that material amendments to plans would require shareholder approval. The accompanying proposed "Commentary" also provides a non-exclusive list of plan amendments that are considered material, and clarifies that, while general authority to amend a plan would not obviate the need for shareholder approval, if a plan permits a specific action without further shareholder approval, then no such approval would generally be required.[5] Certain provisions in a plan, however, cannot be amended without shareholder approval. For example, stock option plans that contain a formula for automatic increases in the shares available or for automatic grants pursuant to a dollar-based formula cannot have a term in excess of ten years unless shareholder approval is obtained every ten years. Plans that do not contain a formula and do not impose a limit on the number of shares available for grant would require shareholder approval of each grant under the plan. A requirement that grants be made out of treasury shares or repurchased shares will not alleviate these additional shareholder approval requirements.

The proposed "Commentary" also provides that, as a general matter, when preparing plans and presenting them for

[5] The Exchange notes that if a plan permits a specific action without further shareholder approval, it must be clear and specific enough to provide meaningful shareholder approval of those provisions.

shareholder approval, issuers should strive to make plan terms easy to understand. In that regard, the Exchange recommends that plans meant to permit repricing use explicit terminology to make this clear.

With respect to implementation of revised Rule 850 and the accompanying Commentary, the Exchange proposes that they become effective upon SEC approval, and that existing plans be grandfathered. Any material modification to plans in place or adopted after the effective date of revised Rule 850 and the accompanying Commentary would require shareholder approval.

Under the Exchange's proposal, issuers would be required to notify the Exchange no later than 15 calendar days prior to establishing or materially amending a stock option plan, purchase plan or other equity compensation arrangement pursuant to which stock may be acquired by officers, directors, employees, or consultants without shareholder approval.

Finally, the Exchange proposes to amend Exchange Rule 862 to prohibit member organizations from voting on equity compensation plans unless the beneficial owner of the shares has given voting instructions. The Exchange proposes, however, a transition period that will make the amended rule applicable only to shareholder meetings that occur on or after the 90th day following the date of the Commission's order approving the amended rule.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with Section 6 of the Act,[6] in general, and furthers the objectives of Section 6(b)(5) of the Act,[7] in particular, in that it is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest, and does not permit unfair discrimination among issuers.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

[6] 15 U.S.C. 78f(b).

[7] 15 U.S.C. 78f(b)(5).

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments on the proposed rule change were neither solicited nor received.

III. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549–0609. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying at the Commission's Public Reference Room. Copies of such filing will also be available for inspection and copying at the principal office of the Exchange. All submissions should refer to File No. SR–Phlx-2003–67 and should be submitted by November 28, 2003.

IV. Commission's Findings and Order Granting Accelerated Approval to the Proposed Rule Change

After careful review, the Commission finds that the Exchange's proposal is consistent with the Act and the rules and regulations promulgated thereunder applicable to a national securities exchange and, in particular, with the requirements of Section 6(b) of the Act.[8] Specifically, the Commission finds that approval of the Exchange's proposal is consistent with Section 6(b)(5) of the Act[9] in that it is designed to, among other things, facilitate transactions in securities; to prevent fraudulent and manipulative acts and practices; to promote just and equitable principles of trade; to remove impediments to and perfect the mechanism of a free and open market and a national market system; and, in general, to protect investors and the public interest; and does not permit unfair discrimination among issuers.

The Commission has long encouraged exchanges to adopt and strengthen their corporate governance listing standards in order to, among other things, restore investor confidence in the national marketplace. The Commission believes that the Exchange's proposal, which requires shareholder approval of equity compensation plans and which follows the Commission's approval of similar proposals by the NYSE, Nasdaq, and Amex[10] is the first step under this directive because it should have the effect of safeguarding the interests of shareholders, while placing certain restrictions on Exchange-listed companies.

In addition, the Commission notes that the Exchange's proposal is similar and almost identical to proposals by NYSE and Nasdaq requiring shareholder approval of equity compensation plans that have previously been approved by the Commission.[11] The Commission believes that it has already considered and addressed the issues that may be raised by the Exchange's proposal when it approved these proposals. The Commission notes that approval of the Exchange's proposal will conform the Exchange's shareholder approval requirements for equity compensation plans with those of the NYSE and Nasdaq, and will immediately impose the same requirements on the Exchange's issuers as those imposed upon NYSE, Nasdaq, and Amex issuers. The adoption of these standards by the Exchange is an important step to ensure that issuers will not be able to avoid shareholder approval requirements for equity compensation plans based on their listed marketplace.

A. Exception From Shareholder Approval for Inducement Grants

The Commission believes that the requirement that the issuance of all inducement grants be subject to review by either the issuer's independent compensation committee or a majority of the board's independent directors, under the Exchange's proposal, should prevent abuse of this exception from shareholder approval. In addition, the Exchange proposes to limit its exception for inducement grants to new employees or to previous employees being rehired

[8] 15 U.S.C. 78f(b). In approving the Exchange's proposal, the Commission has considered the proposed rule's impact on efficiency, competition and capital formation. 15 U.S.C. 78c(f).

[9] 15 U.S.C. 78f(b)(5).

[10] *See supra* note 3. The Commission notes that it has recently approved similar rules requiring shareholder approval of equity compensation plans for the Amex on an accelerated basis. The Amex's proposal is almost identical to, and based on, the NYSE and Nasdaq proposals. *See* Securities Exchange Act Release No. 48610 (October 9, 2003), 68 FR 59650 (October 16, 2003).

[11] *See supra* notes 3 and 10.

after a bona fide period of interruption of employment, and to new employees in connection with an acquisition or merger. The Commission believes that these limitations should help to prevent the inducement exception from being used inappropriately.

The Commission notes that the Exchange is proposing to include a requirement, similar to the requirement under the NYSE and Nasdaq's recently approved shareholder approval rules, that, promptly following the grant of any inducement award, companies must disclose in a press release the material terms of the award, including the recipient(s) of the award and the number of shares involved.[12] The Commission notes that the Exchange is also proposing a requirement, similar to the requirements under the NYSE and Nasdaq's recently approved shareholder approval rules,[13] that an issuer must notify it in writing when it uses this exception, and/or any other exception, from its shareholder approval requirement. The Commission believes that these disclosure and notification requirements will provide transparency to investors and should reduce the potential for abuse of this exception for inducement grants.

B. Exception From Shareholder Approval for Mergers and Acquisitions

The Commission notes that the Exchange's exception from shareholder approval for mergers and acquisitions contains safeguards that should prevent abuse in this area. First, only pre-existing plans that were previously approved by the acquired company's shareholders would be available to the listed company for post-transactional grants. In addition, shares under those previously approved plans could not be granted to individuals who were employed, immediately before the transaction, by the post-transaction listed company or its subsidiaries. The Commission also notes that, under the Exchange's proposal, any shares reserved for listing in connection with a merger or acquisition pursuant to this exception would be counted by the Exchange in determining whether the transaction involved the issuance of 20% or more of the company's outstanding common stock, thereby requiring shareholder approval under Phlx Rule 850(c). Finally, the Commission notes that the Exchange proposes an additional requirement that an issuer must notify it in writing when it uses this exception, and/or any other exception, from its shareholder approval requirement. Based on the above, the Commission believes that the Exchange has provided measures to ensure that the exception for mergers and acquisitions is only used in limited circumstances, which should help reduce the potential for dilution of shareholder interests.

C. Exception From Shareholder Approval for Tax Qualified and Parallel Nonqualified Plans

The Commission believes that, given the extensive government regulation—the Internal Revenue Code and Treasury regulations—for tax qualified plans and the general limitations associated with parallel nonqualified plans, shareholders should not experience significant dilution as a result of this exception. In addition, the Commission notes that the Exchange proposes to add a limitation under this exception that a plan would not be considered a nonqualified parallel plan under its proposal if employees who are participants in such a plan receive employer contributions under the plan in excess of 25% of the participants' cash compensation. The Commission further notes that the Exchange proposes an additional requirement that an issuer must notify it in writing when it uses this exception, and/or any other exception, from its shareholder approval requirement. The Commission believes that, taken together, these limitations should reduce concerns regarding abuse of this exception from the shareholder approval requirements.

In addition, the Commission notes that, similar to the exceptions in the NYSE and Nasdaq's recently approved shareholder approval rules, the Exchange proposes to adopt an exception from the shareholder approval requirements for an equity compensation plan that provides non-U.S. employees with substantially the same benefits as a comparable tax qualified, non-discriminatory employee benefit plan or parallel nonqualified plan that the issuer provides to its U.S. employees, but for features necessary to comply with applicable foreign tax law. The Commission believes that this change will conform the Exchange's shareholder approval rule to that of the NYSE and Nasdaq and will provide greater clarity for issuers regarding tax qualified, non-discriminatory employee benefit plans and parallel nonqualified plans for their non-U.S. employees.

D. Material Amendments/Revisions to Plans

The Commission notes that the Exchange proposes to provide a non-exclusive list, similar to lists found in the NYSE and Nasdaq's shareholder approval rules,[14] as to what constitutes a material amendment/revision to a plan. As noted above, material amendments/revisions to plans will require shareholder approval under Exchange rules. A material amendment/revision under the Exchange's proposal would include, but is not limited to: A material increase in the number of shares to be issued under the plan (other than to reflect a reorganization, stock split, merger, spinoff or similar transaction); a material increase in benefits to participants, including any material change to (1) permit a repricing (or decrease in exercise price) of outstanding options, (2) reduce the price at which shares or options to purchase shares may be offered, or (3) extend the duration of the plan; a material expansion of the class of participants eligible to participate in the plan; and an expansion of the type of options or awards available under the plan. The Exchange's proposal also describes what would constitute a material amendment/revision for plans containing a formula for automatic increases (such as evergreen plans) and automatic grants requiring shareholder approval.

The Commission believes that the Exchange's non-exclusive list of what would constitute a material amendment/revision to a plan provides companies with clarity and guidance for when certain amendments and revisions to plans would require shareholder approval. The Commission also believes that the Exchange's proposal to conform its non-exclusive list with the NYSE and Nasdaq's rules on material amendments/revisions should help to ensure that the concept of material amendments/revisions is consistent among the markets so that differences between the markets cannot be abused.

E. Repricing of Plans

The Commission notes that, under the Exchange's proposal, if a plan is amended to permit repricing, such an amendment would be considered a

[12] This disclosure would, of course, be in addition to any information that is required to be disclosed in annual reports filed with the Commission. For example, item 201(d) of Regulation S–K [17 CFR 229.201(d)] and item 201(d) of Regulation S–B [17 CFR 228.201(d)] require issuers to present—in their annual reports on Form 10–K or Form 10–KSB—separate, tabular disclosure concerning equity compensation plans that have been approved by shareholders and equity compensation plans that have not been approved by shareholders.

[13] *See* Section 303A(8) of the NYSE's Listed Company Manual and NASD Rules 4310(c)(17)(A) and 4320(e)(15)(A). Under the Exchange's proposed rules, issuers have to notify the Exchange no later than 15 calendar days prior to the use of any exceptions from the shareholder approval requirement.

[14] *See supra* note 3; *see also supra* note 10.

material amendment to a plan requiring shareholder approval. In addition, the Exchange recommended in its proposal that plans meant to permit repricing should explicitly and clearly state that repricing is permitted.

The Commission believes that the Exchange's proposal should benefit shareholders by ensuring that companies cannot do a repricing of options, which can have a dilutive effect on shares, without explicit shareholder approval of such provisions and their terms. The Commission also believes that the Exchange's approach to repricings is similar to the NYSE and Nasdaq's respective approaches to repricings, and should offer companies clarity and guidance as to when a change in a plan regarding the repricing of options would trigger a shareholder approval requirement.

F. Evergreen or Formula Plans and Plans Without a Formula or Limit on the Number of Shares Available

The Commission notes the Exchange's proposal provides guidance for the treatment of evergreen/formula plans. More specifically, under the Exchange's proposal, if a plan contains a formula for automatic increases in the shares available or for automatic grants pursuant to a formula, such plans cannot have a term in excess of ten years unless shareholder approval is obtained every ten years. In addition, under the Exchange's proposal, if a plan contains no limit on the number of shares available and is not a formula plan, then each grant under the plan will require separate shareholder approval. Furthermore, the Exchange's proposal provides that a requirement that grants be made out of treasury or repurchased shares will not alleviate the need for shareholder approval for additional grants.

The Commission believes that these provisions should help to ensure that certain terms of a plan cannot be drafted so broad as to avoid shareholder scrutiny and approval. The Commission also believes that the Exchange's proposed rules relating to the treatment of evergreen/formula plans and plans that do not contain a formula or place a limit on the number of shares available should provide more clarity and transparency to issuers as to when shareholder approval would be required for such plans. Finally, the Commission believes that the provision ensuring that treasury and repurchased shares cannot be used to avoid these additional shareholder approval requirements strengthens the proposal and ensures that companies cannot avoid compliance with the rule.

G. Miscellaneous Provisions

The Commission notes that the Exchange's proposal—similar to the NYSE and Nasdaq's recently approved shareholder approval rules [15]—incorporates the term "equity compensation" and proposes that plans that merely provide a convenient way to purchase shares in the open market or from the issuer at fair market price on equal terms to all security holders would not require shareholder approval. The Commission believes that the Exchange's proposal is consistent with the NYSE and Nasdaq's rules in this area and should provide greater clarity with respect to which plans would and would not require shareholder approval.

The Commission notes that the Exchange's proposal provides that pre-existing plans, which were adopted prior to the SEC's approval of the Exchange's proposal, would essentially be "grandfathered" and would not require shareholder approval unless the plans were materially amended. Under the Exchange's proposal, however, shareholder approval is required for each grant made pursuant to any pre-existing plans that were not approved by shareholders and that do not have an evergreen formula or a specific number of shares available under the plan. This is consistent with the NYSE, Nasdaq, and Amex shareholder approval rules on this matter. The Commission believes that this clarification should provide companies with guidance as to which plans would be subject to the Exchange's new shareholder approval requirements.

The Commission further notes that the Exchange proposes to adopt an exception from the shareholder approval requirement for warrants or rights offered generally to all shareholders. This exception would exclude stock purchase plans available on equal terms to all security holders of the company (*e.g.*, a dividend reinvestment plan). The Commission believes that the adoption of such an exception would make the Exchange's proposal consistent with the rules of other markets in this area.

H. Elimination of Broker-Dealer Voting on Equity Compensation Plans

The Commission believes that the Exchange's proposed amendment to Phlx Rule 862 to preclude broker voting on equity compensation plans is consistent with the Act. The Commission notes that equity compensation plans have become an important issue for shareholders. Because of the potential for dilution from issuances under such plans, shareholders should be making the determination rather than brokers on their behalf. The Commission further notes that NASD rules do not provide for broker voting on any matters and NYSE rules prohibit broker voting on equity compensation plans.[16] Therefore, the Exchange's proposed provision would be consistent with NASD and NYSE rules regarding broker voting on equity compensation plans. The Commission has considered the impact on smaller issuers, such as those listed on Nasdaq and the Amex, in response to the comments on this issue.[17] The Commission believes that the benefit of ensuring that the votes reflect the views of beneficial shareholders on equity compensation plans outweighs the potential difficulties in obtaining the vote.

The Commission also notes that the Exchange proposes to implement a transition period that would make the new rule eliminating broker voting on equity compensation plans applicable only to shareholder meetings that occur on or after the 90th day from the effective date of the Exchange's proposal.

I. Summary

Overall, the Commission believes that the Exchange's proposal is similar to the NYSE and Nasdaq's recently approved shareholder approval rules.[18] The Commission therefore believes that the Exchange's proposal should provide for more clear and uniform standards for shareholder approval of equity compensation plans. The Commission notes that, even with the availability of the proposed limited exceptions from shareholder approval under the Exchange's proposal, shareholder approval under the new standards would be required in more circumstances than under existing Exchange rules. The Commission further notes that the Exchange proposes to adopt a requirement that an issuer must notify it in writing when it uses one of the exceptions from the shareholder approval requirements. The Commission believes that such a requirement, coupled with the additional disclosure requirements for inducement grants, should reduce the potential for abuse of any of the exceptions.[19] In addition, the Exchange's proposed amendment to

[15] *See supra* note 3; *see also supra* note 10.

[16] *See* NASD Rule 2260; NYSE Rule 452; and Section 402.08 of the NYSE's Listed Company Manual.

[17] *See supra* notes 3 and 16.

[18] *See supra* note 3; *see also supra* note 10.

[19] *See also supra* note 12 and accompanying text.

Phlx Rule 862, which would preclude broker-dealers from voting on equity compensation plans without explicit instructions from the beneficial owner, is consistent with the standard under current NYSE and NASD rules.

The Commission believes that the Exchange's proposal, which is similar to the NYSE and Nasdaq's shareholder approval rules,[20] sets a consistent, minimum standard for shareholder approval of equity compensation plans. The Commission believes that the Exchange's proposal should help to ensure that companies will not make listing decisions simply to avoid shareholder approval requirements for equity compensation plans and should provide shareholders with greater protection from the potential dilutive effect of equity compensation plans. Based on the above, the Commission finds that the Exchange's proposal should help to protect investors, is in the public interest, and does not unfairly discriminate among issuers, consistent with Section 6(b)(5) of the Act.[21] The Commission therefore finds the Exchange's proposal to be consistent with the Act and the rules and regulations thereunder.

V. Accelerated Approval of the Exchange's Proposal

The Commission finds good cause for approving the Exchange's proposal prior to the thirtieth day after the date of publication of notice thereof in the **Federal Register**. The Commission notes that the Exchange's proposal is similar to the NYSE and Nasdaq's proposals requiring shareholder approval of equity compensation plans. Both the NYSE and Nasdaq's proposals were published for comment in the **Federal Register** and recently approved by the Commission.[22] The Commission believes that it already considered and addressed the issues that may be raised by the Exchange's proposal in its approval of the NYSE and Nasdaq's proposals.[23]

The Commission believes that accelerated approval of the Exchange's proposal is essential to allow for immediate harmonization of, and consistency in, the shareholder approval requirements for equity compensation plans among the markets. This will prevent issuers from making listing decisions based on differences in self-regulatory organization shareholder approval requirements and should provide equal investor protection to shareholders on the dilutive effects of plans irrespective of where the security trades. The Commission further believes that making the Exchange's new shareholder approval rules effective upon Commission approval will immediately impose the same requirements on the Exchange's issuers as those imposed upon NYSE, Nasdaq, and Amex issuers. Based on the above, the Commission finds good cause, consistent with Sections 6(b)(5) and 19(b)(2) of the Act, [24] to approve the Exchange's proposal on an accelerated basis.

VI. Conclusion

It is therefore ordered, pursuant to Section 19(b)(2) of the Act,[25] that the proposed rule change (SR–Phlx–2003–67) is hereby approved on an accelerated basis.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[26]

Jill M. Peterson,

Assistant Secretary.

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[20] *See supra* note 3; *see also supra* note 10.

[21] 15 U.S.C. 78f(b)(5).

[22] *See* Securities Exchange Act Release No. 46620 (October 8, 2002), 67 FR 63486 (notice of the NYSE's proposal). The Commission also published a correction to the notice of the NYSE's proposal. *See* Securities Exchange Act Release No. 44620A (October 21, 2002), 67 FR 65617 (October 25, 2002). *See* Securities Exchange Act Release No. 46649 (October 11, 2002), 67 FR 64173 (notice of Nasdaq's proposal). *See supra* note 3; *see also supra* note 10.

[23] Some of the substantive provisions ultimately adopted by the NYSE and Nasdaq, and now being proposed for adoption by the Exchange, were in response to these comments. The comments on the NYSE and Nasdaq proposals were also discussed in detail in the Commission's approval order of the NYSE and Nasdaq proposals. *See supra* note 3; *see also supra* note 10.

[24] 15 U.S.C. 78f(b)(5) and 78s(b)(2).

[25] 15 U.S.C. 78s(b)(2).

[26] 17 CFR 200.30–3(a)(12).

SMALL BUSINESS ADMINISTRATION

[Declaration of Disaster #3555]

State of California (Amendment #1)

In accordance with a notice received from the Department of Homeland Security—Federal Emergency Management Agency, effective October 30, 2003, the above numbered declaration is hereby amended to include Riverside County as a disaster area due to damages caused by wildfires occurring on October 21, 2003, and continuing.

All other counties contiguous to the above named primary county have been previously declared.

All other information remains the same, *i.e.*, the deadline for filing applications for physical damage is December 26, 2003, and for economic injury the deadline is July 27, 2004.

(Catalog of Federal Domestic Assistance Program Nos. 59002 and 59008)

Dated: October 31, 2003.

Cheri L. Cannon,

Acting Associate Administrator for Disaster Assistance.

[FR Doc. 03–28110 Filed 11–6–03; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

Connecticut District Advisory Council Public Meeting

The U.S. Small Business Administration Connecticut District Advisory Council, located in the geographical area of Hartford, Connecticut will hold a public meeting at 8:30 a.m., on Monday, November 17, 2003, Connecticut District Office, 330 Main Street, Hartford, Connecticut 06106, to discuss such matters as may be presented. For further information, write or call Marie Record, District Director, U.S. Small Business Administration, 330 Main Street, Hartford, Connecticut—(860) 240–4700.

Anyone wishing to attend and make an oral presentation to the Board must contact Marie A. Record, no later than Friday, November 14, 2003, via e-mail or fax. Marie A. Record, District Director, U.S. Small Business Administration, Connecticut District Office 339 Main Street, Hartford, CT 06106 (860) 240–4670 phone or (860) 240–4714 fax or e-mail *marie.record@sba.gov.*

Scott R. Morris,

Deputy Chief of Staff.

[FR Doc. 03–28109 Filed 11–6–03; 8.45 am]

BILLING CODE 8025–01–P

TENNESSEE VALLEY AUTHORITY

Paperwork Reduction Act of 1995, as Amended by Pub. L. 104–13; Submission for Office of Management and Budget (OMB) Review; Comment Request

AGENCY: Tennessee Valley Authority.

ACTION: Submission for Office of Management and Budget (OMB) Review; comment request.

SUMMARY: The proposed information collection described below will be submitted to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35, as amended). The Tennessee Valley

Authority is soliciting public comments on this proposed collection as provided by 5 CFR Section 1320.8(d)(1). Requests for information, including copies of the information collection proposed and supporting documentation, should be directed to the Agency Clearance Officer: Alice D. Witt, Tennessee Valley Authority, 1101 Market Street (EB 5B), Chattanooga, Tennessee 37402–2801; (423) 751–6832. (SC:0019QYX)

Comments should be sent to the OMB Office of Information and Regulatory Affairs, Attention: Desk Officer for Tennessee Valley Authority no later than December 8, 2003.

SUPPLEMENTARY INFORMATION:

Type of Request: Regular submission, proposal to reinstate, with changes, a previously approved collection for which approval has expired.

Title of Information Collection: Employment Application.

Frequency of Use: On Occasion.

Type of Affected Public: Individuals.

Small Businesses or Organizations Affected: No.

Federal Budget Functional Category Code: 999.

Estimated Number of Annual Responses: 17,543.

Estimated Total Annual Burden Hours: 17,543.

Estimated Average Burden Hours Per Response: 1.

Need For and Use of Information: Applications for employment are needed to collect information on qualifications, suitability for employment, and eligibility for veterans preference. The information is used to make comparative appraisals and to assist in selections. The affected public consists of individuals who apply for TVA employment.

Jacklyn J. Stephenson,

Senior Manager, Enterprise Operations Information Services.

[FR Doc. 03–28023 Filed 11–6–03; 8:45 am]

BILLING CODE 8120–08–P

TENNESSEE VALLEY AUTHORITY

Paperwork Reduction Act of 1995, as Amended by Pub. L. 104–13; Submission for OMB Review, Comment Request

AGENCY: Tennessee Valley Authority.

ACTION: Submission for Office of Management & Budget (OMB) review; comment request.

SUMMARY: The proposed information collection described below will be submitted to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35, as amended). The Tennessee Valley Authority is soliciting public comments on this proposed collection as provided by 5 CFR section 1320.8(d)(1). Requests for information, including copies of the information collection proposed and supporting documentation, should be directed to the Agency Clearance Officer: Alice D. Witt, Tennessee Valley Authority, 1101 Market Street (EB 5B), Chattanooga, Tennessee 37402–2801; (423) 751–6832 (SC: 0001MYJ). Comments should be sent to the OMB, Office of Information and Regulatory Affairs, Attention: Desk Officer for Tennessee Valley Authority no later than December 8, 2003.

SUPPLEMENTARY INFORMATION:

Type of Request: Regular submission, proposal to reinstate with no changes, a previously approved collection for which approval has expired..

Title of Information Collection: Foreign Line Crossing Data.

Frequency of Use: On Occasion.

Type of Affected Public: State or local governments, small businesses or organizations, businesses or other for-profit.

Small Businesses or Organizations Affected: Yes.

Federal Budget Functional Category Code: 271.

Estimated Number of Annual Responses: 100.

Estimated Total Annual Burden Hours: 1000.

Estimated Average Burden Hours Per Response: 10.

Need For and Use of Information: When a company wishes to build a line over or under a power transmission line owned by TVA, TVA must review certain engineering data to ensure reliability of the power system and to protect the public by ensuring that the crossing meets the National Electrical Safety Code. The information collection provides such engineering data.

Jacklyn J. Stephenson,

Senior Manager, Enterprise Operations, Information Services.

[FR Doc. 03–28026 Filed 11–6–03; 8:45 am]

BILLING CODE 8120–08–P

DEPARTMENT OF TRANSPORTATION

Office of the Secretary

Notice of Meeting

AGENCY: Office of the Secretary (OST), DOT.

ACTION: Notice of meeting.

SUMMARY: The U.S. Department of Transportation (DOT) announces a meeting of the Transportation Labor-Management Board (Board). Notice of the meeting is required under the Federal Advisory Committee Act.

Time and Place: The Board will meet on Tuesday, November 25, 2003, at 2 p.m., at the U.S. Department of Transportation, Nassif Building, Room 4400, 400 Seventh Street, SW., Washington, DC 20590. The room is located on the 4th floor.

Type of Meeting: The meeting is open to the public. Please note that visitors without a government identification badge should enter the Nassif Building at the Southwest lobby, for clearance at the Visitor's Desk. Seating will be available on a first-come, first-served basis. Handicapped individuals wishing to attend should contact DOT to obtain appropriate accommodations.

Point of Contact: Stephen Gomez, Executive Secretary, Transportation Labor-Management Board, U.S. Department of Transportation, Nassif Building, 400 Seventh Street, SW., Room 7411, Washington, DC 20590, (202) 366–9455 or 4088.

SUPPLEMENTARY INFORMATION: The Board will be briefed on DOT's migration to the Federal Personnel and Payroll System, the Common Access Architecture project, and the activities of the subcommittees on Human Capital, Competitive Sourcing, and the DOT Labor Relations Climate Survey.

Public Participation: We invite interested persons and organizations to submit comments. Mail or deliver your comments or recommendations to Stephen Gomez at the address shown above. Comments should be received by November 17, 2003 in order to be considered at the November 25th meeting.

Issued in Washington, DC, on October 31, 2003.

For the Department of Transportation.

Linda Moody,

Associate Director, Workforce Environment and Pay Division.

[FR Doc. 03–28051 Filed 11–6–03; 8:45 am]

BILLING CODE 4910–62–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Notice of Intent to Rule on Request to Release Airport Property at the Pueblo Memorial Airport, Pueblo, Colorado

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of request to release airport property.

SUMMARY: The FAA proposes to rule and invite public comment on the release of land at the Pueblo Memorial Airport under the provisions of Section 125 of the Wendell H. Ford Aviation Investment Reform Act for the 21st Century (AIR 21).

DATES: Comments must be received on or before November 21, 2003.

ADDRESSES: Comments on this application may be mailed or delivered to the FAA at the following address: Mr. Craig Sparks, Manager, Federal Aviation Administration, Northwest Mountain Region, Airports Division, Denver Airports District Office, 26805 E. 68th Ave., Suite 224, Denver, Colorado, 80249.

In addition, one copy of any comments submitted to the FAA must be mailed or delivered to Mr. John O'Neal, Director of Aviation, Pueblo Memorial Airport, 31201 Bryan Circle, Pueblo, Colorado, 81001.

FOR FURTHER INFORMATION CONTACT: Ms. Cynthia Nelson, Project Manager, Federal Aviation Administration, Northwest Mountain Region, Airports Division, Denver Airports District Office, 26805 E. 68th Ave., Suite 224, Denver, Colorado 80249.

The request to release property may be reviewed in person at this same location.

SUPPLEMENTARY INFORMATION: The FAA invites public comment on the request to release property at the Pueblo Memorial Airport under the provisions of the AIR 21. On September 19, 2003, the FAA determined that the request to release property at the Pueblo Memorial Airport submitted by the City of Pueblo met the procedural requirements of the Federal Aviation Regulations, Part 155. The FAA may approve the request, in whole or in part, no later than December 31, 2003.

The following is a brief overview of the request:

The Pueblo Memorial Airport requests the release of 34.07 acres of non-aeronautical airport property to the City of Pueblo, Colorado. The purpose of this release is to allow the City of Pueblo to sell the subject land that was conveyed to the City by the United States acting through the War Assets Administration by Quit Claim Deed dated July 20, 1948. The sale of this parcel will provide funds for airport improvements.

Any person may inspect the request by appointment at the FAA office listed above under **FOR FURTHER INFORMATION CONTACT.**

In addition, any person may inspect the application, notice and other documents germane to the application in person at Pueblo Memorial Airport 31201 Bryan Circle, Pueblo, CO 81001.

Issued in Denver, Colorado, on October 29, 2003.

Craig Sparks,

Manager, Denver Airports District Office.

[FR Doc. 03–28015 Filed 11–6–03; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF TRANSPORTATION

Federal Highway Administration

[Docket No. FHWA–2003–16310]

Notice of Request for Renewal of a Currently Approved Information Collection; Statement of Materials and Labor Used by Contractors on Highway Construction Involving Federal Funds, OMB Control Number: 2125–0033

AGENCY: U.S. Department of Transportation, Federal Highway Administration (FHWA).

ACTION: Notice and request for comments.

SUMMARY: In accordance with the requirements in Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, this notice announces the intention of the FHWA to request the Office of Management and Budget (OMB) to renew its clearance for the currently approved FHWA collection of information identified below under Supplementary Information.

DATES: Please submit comments by January 6, 2004.

ADDRESSES: You may submit comments identified by DOT DMS Docket Number FHWA–2003–16310 by any of the following methods:

- *Web site: http://dms.dot.gov.* Follow the instructions for submitting comments on the DOT electronic docket site.
- *Fax:* 1–202–493–2251.
- *Mail:* Docket Management Facility; U.S. Department of Transportation, 400 Seventh Street, SW., Nassif Building, Room PL–401, Washington, DC 20590.
- *Hand Delivery:* Room PL–401 on the plaza level of the Nassif Building, 400 Seventh Street, SW., Washington, DC, between 9 am and 5 pm, Monday through Friday, except Federal holidays.

Docket: For access to the docket to read background documents or comments received, go to *http://dms.dot.gov* at any time or to Room PL–401 on the plaza level of the Nassif Building, 400 Seventh Street, SW., Washington, DC, between 9 am and 5 pm, Monday through Friday, except Federal holidays.

Public Comments Invited: Interested parties are invited to send comments regarding any aspect of this information collection, including, but not limited to: (1) The necessity and utility of the information collection for the proper performance of the functions of the FHWA; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the collected information; and (4) ways to minimize the collection burden without reducing the quality of the collected information. Comments submitted in response to this notice will be summarized and/or included in the requests for OMB's clearance of the following collection of information.

SUPPLEMENTARY INFORMATION:

Title: Statement of Materials and Labor Used by Contractors on Highway Construction Involving Federal Funds.

OMB Control Number: 2125–0033.

Background: The State highway agencies and contractors who work on highway projects are required to submit data regarding the usage of materials and labor in highway construction (23 CFR 635.126). This data is submitted to the FHWA on Form FHWA–47, "Statement of Materials and Labor Used by Contractors on Highway Construction Involving Federal Funds." Title 29 U.S.C. 2 authorizes the Department of Labor (DOL) to collect the labor-related information using its own forces or by getting the information from other Federal agencies. An informal agreement has been reached for the FHWA to collect the desired data for DOL. The data is used by the FHWA for estimating current materials usage and cost distribution on Federal-aid highway construction contracts to aid in planning for future requirements based on anticipated program levels. The information is also used by the Department of Labor in its studies on the highway construction industry's labor and materials requirements, and by the industry, including the materials suppliers. This information is made available to other Federal, State and local agencies, universities, businesses, and industry for their own uses.

Estimated Annual Burden: The FHWA estimates that the total annual burden imposed on the public by this collection is 7,475 hours and the estimated time to complete each report is 5 hours.

Number of Respondents: 650 State highway agencies and Federal-Aid highway contractors.

Frequency: Approximately 650 State highway agencies and Federal-Aid highway contractors complete and submit an average of 2.3 reports on Form FHWA–47 each year.

FOR FURTHER INFORMATION CONTACT: Ms. Claretta Duren, (202) 366–4636, Department of Transportation, Federal Highway Administration, Office of Pavement Technology, 400 Seventh Street, SW., Washington, DC 20590. Office hours are from 7:45 a.m. to 4:15 p.m., Monday through Friday, except Federal holidays.

Issued on: October 30, 2003.

James R. Kabel,

Chief, Management Programs and Analysis Division.

[FR Doc. 03–28052 Filed 11–6–03; 8:45 am]

BILLING CODE 4910–22–P

DEPARTMENT OF TRANSPORTATION

Federal Highway Administration

[Docket No. FHWA–2003–16313]

Notice of Request for Renewal of a Currently Approved Information Collection; Federal-Aid Highway Construction Equal Employment Opportunity, OMB Control Number: 2125–0019

AGENCY: U.S. Department of Transportation, Federal Highway Administration (FHWA).

ACTION: Notice and request for public comments.

SUMMARY: In accordance with the requirements in section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, this notice announces the intention of the FHWA to request the Office of Management and Budget (OMB) to renew its clearance for the currently approved FHWA collection of information identified below under Supplementary Information.

DATES: Please submit comments by January 6, 2004.

ADDRESSES: You may submit comments identified by DOT DMS Docket Number FHWA–2003–16313 by any of the following methods:

- *Web site: http://dms.dot.gov.* Follow the instructions for submitting comments on the DOT electronic docket site.
- *Fax:* 1–202–493–2251.
- *Mail:* Docket Management Facility; U.S. Department of Transportation, 400 Seventh Street, SW., Nassif Building, Room PL–401, Washington, DC 20590.
- *Hand Delivery:* Room PL–401 on the plaza level of the Nassif Building, 400 Seventh Street, SW., Washington, DC, between 9 am and 5 pm, Monday through Friday, except Federal Holidays.

Docket: For access to the docket to read background documents or comments received, go to *http://dms.dot.gov* at any time or to Room PL–401 on the plaza level of the Nassif Building, 400 Seventh Street, SW., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

Public Comments Invited: Interested parties are invited to send comments regarding any aspect of this information collection, including, but not limited to: (1) The necessity and utility of the information collection for the proper performance of the functions of the FHWA; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the collected information; and (4) ways to minimize the collection burden without reducing the quality of the collected information. Comments submitted in response to this notice will be summarized and/or included in the requests for OMB's clearance of the following collection of information.

SUPPLEMENTARY INFORMATION:

Title: Federal-Aid Highway Construction Equal Employment Opportunity.

OMB Control Number: 2125–0019 (Expiration Date: January 31, 2004).

Background: Title 23, part 140(a), requires the FHWA to ensure equal opportunity regarding contractors' employment practices on Federal-aid highway projects. To carry out this requirement the contractors must submit to the State highway agencies an annual report providing employment work force data, which includes the number of minorities, women, and non-minorities in each construction craft. This information is reported on Form PR–1391, Federal-Aid Highway Construction Contractors Summary of Employment Data. The statute also requires the State highway agencies to submit a report to the FHWA summarizing the data entered on the PR–1391 forms. This summary data is provided on Form PR–1392, Federal-Aid Highway Construction Contractors Summary of Employment Data. The FHWA uses this data to identify patterns and trends of employment in the highway construction industry, and to determine the adequacy and impacts of the FHWA's contract compliance and on-the-job training programs.

Estimated Annual Burden: The FHWA estimates the total annual burden hours imposed on the public by this collection is 6,580 hours; *i.e.*, 2,080 hours is required by the 52 State highway agencies to complete and submit the Form PR–1392, and an additional 4,500 hours is required for 4,500 Federal-aid highway construction contractors to complete and submit the Form PR–1391.

Number of Respondents: 52 State highway agencies and 4,500 Federal-aid highway construction contractors.

FOR FURTHER INFORMATION CONTACT: Mr. Charles Klemstine, (202) 366–6753, Department of Transportation, Federal Highway Administration, Office of Civil Rights, 400 Seventh Street, SW., Washington, DC 20590. Office hours are from 7:45 a.m. to 4:15 p.m., Monday through Friday, except Federal holidays.

Authority: 23 U.S.C. 140(a); 23 CFR 635.126; 29 U.S.C. 2; 23 U.S.C. 123; 23 U.S.C. 116; 23 U.S.C. 130; 49 CFR 1.48.

Issued on: November 3, 2003.

James R. Kabel,

Chief, Management Programs and Analysis Division.

[FR Doc. 03–28053 Filed 11–6–03; 8:45 am]

BILLING CODE 4910–22–P

DEPARTMENT OF TRANSPORTATION

Surface Transportation Board

[STB Finance Docket No. 34305]

The Burlington Northern and Santa Fe Railway Company—Construction and Operation Exemption—in Merced County, CA

AGENCY: Surface Transportation Board, Transportation.

ACTION: Notice of Availability of Environmental Assessment and request for comments.

SUMMARY: The Surface Transportation Board's (Board) Section of Environmental Analysis (SEA) has prepared an Environmental Assessment (EA) in response to a petition filed by the Burlington Northern and Santa Fe Railway Company. The petition seeks an exemption under 49 U.S.C. 10502 from the prior approval requirements of 49 U.S.C. 10901 for authority to construct and operate an 850-foot long rail line in Merced, California. The EA identifies the natural and man-made resources in the area of the proposed rail line and analyzes the potential impacts of the rail line construction and operation on these resources. Based on the information provided from all sources to date and its independent analysis, SEA preliminarily concludes that construction and operation of the proposed rail line would have no significant environmental impacts if the Board imposes and the Burlington Northern and Santa Fe Railway Company implements the recommended mitigation measures set forth in this EA. Copies of the EA have been served on

all interested parties and will be made available to additional parties upon request. The entire EA is also available on the Board's Web site (*http://www.stb.dot.gov*) by clicking on the "Decisions & Notices" button and searching by Service Date (November 7, 2003), Docket Number (FD 34305) or Full Text (key word "Quebecor"). SEA will consider all comments received when making its final environmental recommendations to the Board. The Board will then consider SEA's final recommendations and the complete environmental record in making its final decision in this proceeding.

DATES: The EA is available for public review and comment. Comments must be postmarked December 10, 2003.

ADDRESSES: Comments (an original and 10 copies) should be sent in writing to: Surface Transportation Board, Case Control Unit, 1925 K Street, NW., Washington, DC 20423. The lower left corner of the envelope should be marked: Attention: Mr. David Navecky, Environmental Comments, Finance Docket No. 34305.

FOR FURTHER INFORMATION CONTACT: David Navecky by mail at the address above, by telephone at (202) 565–1593 (FIRS for the hearing impaired (1–800–877–8339)), or by e-mail at *naveckyd@stb.dot.gov*.

By the Board, Victoria Rutson, Chief, Section of Environmental Analysis.

Vernon Williams,

Secretary.

[FR Doc. 03–27970 Filed 11–6–03; 8:45 am]

BILLING CODE 4915–00–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

[REG–209682–94]

Proposed Collection: Comment Request for Regulation Project

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995, Pub. L. 104–13 (44 U.S.C. 3506(c)(2)(A)). Currently, the IRS is soliciting comments concerning final regulation, REG–209682–94 (TD 8847), Adjustments Following Sales of Partnership Interests, (§§ 1.732–1 and 1.743–1).

DATES: Written comments should be received on or before January 6, 2004, to be assured of consideration.

ADDRESSES: Direct all written comments to R. Joseph Durbala, Internal Revenue Service, room 6411, 1111 Constitution Avenue NW., Washington, DC 20224.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of regulations should be directed to Carol Savage at Internal Revenue Service, room 6407, 1111 Constitution Avenue NW., Washington, DC 20224, or at (202) 622–3945, or through the internet at *carol.a.savage@irs.gov*.

SUPPLEMENTARY INFORMATION:

Title: Adjustments Following Sales of Partnership Interests.

OMB Number: 1545–1588.

Regulation Project Number: REG–209682–94.

Abstract: Partnerships, with a section 754 election in effect, are required to adjust the basis of partnership property following certain transfers of partnership interests. This regulation relates to the optional adjustments to the basis of partnership property following certain transfers of partnership interests under section 743, the calculation of gain or loss under section 751(a) following the sale or exchange of a partnership interest, the allocation of basis adjustments among partnership assets under section 755, the allocation of a partner's basis in its partnership interest to properties distributed to the partner by the partnership under section 732(c), and the computation of a partner's proportionate share of the adjusted basis of depreciable property (or depreciable real property) under section 1017.

Current Actions: There are no changes being made to the regulation at this time.

Type of Review: Extension of a currently approved collection.

Affected Public: Business or other for-profit organizations.

Estimated Number of Respondents/Recordkeepers: 226,000.

Estimated Time Per Respondent/Recordkeeper: 4 hrs.

Estimated Total Annual Burden Hours: 904,000.

The following paragraph applies to all of the collections of information covered by this notice:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number. Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Request for Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Approved: October 31, 2003.

R. Joseph Durbala,

IRS Reports Clearance Officer.

[FR Doc. 03–28010 Filed 11–6–03; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Information Reporting Program Advisory Committee; Renewal of Charter

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice.

SUMMARY: The Charter for the Information Reporting Program Advisory Committee will renew for a two-year period beginning November 5, 2003.

FOR FURTHER INFORMATION CONTACT: Ms. Lorenza Wilds, National Public Liaison, 202–622–6440 (not a toll-free number).

SUPPLEMENTARY INFORMATION: Notice is hereby given pursuant to section 10(a)(2) of the Federal Advisory Committee Act, 5 U.S.C. App. (1988), and with the approval of the Secretary of the Treasury to announce the renewal of the Information Reporting Program Advisory Committee (IRPAC). The primary purpose of the Advisory Committee is to provide an organized public forum for senior Internal Revenue Service executives and

representatives of the public to consider relevant information reporting issues. The IRPAC: (i) Conveys the public's perception of IRS activities; (ii) advises with respect to specific information reporting administration issues; (iii) provides constructive observations regarding current or proposed IRS policies, programs, and procedures; and (iv) proposes significant improvements in information reporting operations. Because each Operating Division relies on the Information Reporting Program, the IRS must ensure application of a coordinated approach when addressing information reporting issues. Therefore, acknowledging the critical role of information reporting, emphasizing its commitment to the Information Reporting Program, and as a measure of the IRPAC's importance, a centralized coordinating mechanism, the Information Reporting Program Policy Council (IRP Policy Council) was established to formulate and coordinate strategic and crosscutting information reporting issues. A counterpart to the IRPAC consisting of IRS executives from each Operating Division, the IRP Policy Council facilitates cross-divisional consistency in information reporting and provides strategic leadership for the Service-wide direction of the Information Reporting Program. In addition, the IRP Policy Council considers and prioritizes the recommendations of the IRPAC as part of the strategic planning process, and meets regularly with Committee members to identify and recommend strategic issues for consideration. To accomplish its objective of close alignment with the needs and strategic goals of the IRS while remaining a strong external feedback mechanism, it is essential that IRPAC members comprise a diverse group of dedicated and talented professionals who bring substantial disparate experience and backgrounds to the Committee activities. Membership is balanced to include representation from the taxpaying public, the tax professional community, small and large businesses, state tax administrators, academics, preparers, and the payroll community.

Dated: November 3, 2003.

Cynthia Vanderpool,

Designated Federal Official, Branch Chief, Liaison Tax Forum.

[FR Doc. 03–28009 Filed 11–6–03; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Advisory Group to the Commissioner of Internal Revenue; Renewal of Charter

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice.

SUMMARY: The Charter for the Internal Revenue Service Advisory Council (IRSAC) will renew for a two-year period beginning November 5, 2003.

FOR FURTHER INFORMATION CONTACT: Ms. Lorenza Wilds, National Public Liaison, 202–622–6440 (not a toll-free number).

SUPPLEMENTARY INFORMATION: Notice is hereby given pursuant to section 10(a)(2) of the Federal Advisory Committee Act, 5 U.S.C. App. (1988), and with the approval of the Secretary of the Treasury to announce the renewal of the Internal Revenue Service Advisory Council (IRSAC). The primary purpose of the Advisory Council is to provide an organized public forum for senior Internal Revenue Service executives and representatives of the public to discuss relevant tax administration issues. As an advisory body designed to focus on broad policy matters, the IRSAC reviews existing tax policy and/or makes recommendations with respect to emerging tax administration issues. The IRSAC suggests operational improvements, offers constructive observations regarding current or proposed IRS policies, programs, and procedures, and suggest improvements with respect to issues having substantive effect on federal tax administration. Conveying the public's perception of IRS activities to Internal Revenue Service executives, the IRSAC is comprised of individuals who bring substantial, disparate experience and diverse backgrounds. Membership is balanced to include representation from the taxpaying public, the tax professional community, small and large businesses, state tax administration, and the payroll community.

Dated: November 3, 2003.

Cynthia Vanderpool,

Designated Federal Official, Branch Chief, Liaison Tax Forum.

[FR Doc. 03–28011 Filed 11–6–03; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Electronic Tax Administration Advisory Committee (ETAAC)

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of open meeting.

SUMMARY: In 1998 the Internal Revenue Service established the Electronic Tax Administration Advisory Committee (ETAAC). The primary purpose of ETAAC is to provide an organized public forum for discussion of electronic tax administration issues in support of the overriding goal that paperless filing should be the preferred and most convenient method of filing tax and information returns. ETAAC offers constructive observations about current or proposed policies, programs, and procedures, and suggests improvements. Listed is a summary of the agenda along with the planned discussion topics.

Summarized Agenda

9 a.m. Meeting Opens

12:30 p.m. Meeting Adjourns

The planned discussion topics are:

(1) Modernized e-File Update

(2) e-Services Update

(3) Filing Season Readiness

(4) Overview of IRS Operations Support Organization

Note: Last-minute changes to these topics are possible and could prevent advance notice.

DATES: There will be a meeting of ETAAC on Thursday, December 4, 2003. This meeting will be open to the public, and will be in a room that accommodates approximately 40 people, including members of ETAAC and IRS officials. Seats are available to members of the public on a first-come, first-served basis.

ADDRESSES: The meeting will be held at the Ritz-Carlton Hotel "Pentagon City, Diplomat Meeting Room, 1250 South Hayes Street, Arlington, VA 22202.

FOR FURTHER INFORMATION CONTACT: To get on the access list to attend this meeting, to have a copy of the agenda faxed to you or to receive general information about ETAAC, contact Kim Logan at (202) 283–1947 by November 26, 2003. Notification of intent should include your name, organization and telephone number. If you leave information for Ms. Logan in a voice-mail message, please spell out all names. A draft of the agenda will be available via e-mail or facsimile transmission the week prior to the meeting. Please call Ms. Logan on or

after November 24, 2003 to have a copy of the agenda faxed to you. Please note that a draft agenda will not be available until that date.

SUPPLEMENTARY INFORMATION: ETAAC reports to the Director, Electronic Tax Administration, who is the executive responsible for the electronic tax administration program. Increasing participation by external stakeholders in the development and implementation of the Internal Revenue Service's strategy for electronic tax administration will help achieve the goal that paperless filing should be the preferred and most convenient method of filing tax and information returns.

ETAAC members are not paid for their time or services, but consistent with Federal regulations, they are reimbursed for their travel and lodging expenses to attend the public meetings, working sessions, and an orientation each year.

Dated: November 3, 2003.

Kathleen Upton,

Acting Director Strategic Services Division, Electronic Tax Administration.

[FR Doc. 03–28116 Filed 11–6–03; 8:45 am]

BILLING CODE 4830–01–P

UNITED STATES INSTITUTE OF PEACE

Sunshine Act; Notice of Meeting

AGENCY: United States Institute of Peace.

DATE/TIME: Thursday, November 20, 2003, 9:30 a.m.–5 p.m.

LOCATION: 1200 17th Street, NW., Suite 200—Conference Room, Washington, DC 20036.

STATUS: Open Session—Portions may be closed pursuant to Subsection (c) of Section 552(b) of Title 5, United States Code, as provided in subsection 1706(h)(3) of the United States Institute of Peace Act, Pub. L. 98–525.

AGENDA: November 2003 Board Meeting; Approval of Minutes of the One Hundred Eleventh Meeting (September 18, 2003) of the Board of Directors; Chairman's Report; President's Report; Program Reports; Other General Issues.

FOR FURTHER INFORMATION CONTACT: Ms. Tessie Higgs, Executive Office, Telephone: (202) 429–3836.

Dated: October 31, 2003.

Harriet Hentges,

Executive Vice President, United States Institute of Peace.

[FR Doc. 03–28208 Filed 11–5–03; 12:36 pm]

BILLING CODE 6820–AR–M

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0376]

Proposed Information Collection Activity: Proposed Collection; Comment Request

AGENCY: Veterans Health Administration, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: The Veterans Health Administration (VHA) is announcing an opportunity for public comment on the proposed collection of certain information by the agency. Under the Paperwork Reduction Act (PRA) of 1995, Federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension of a currently approved collection, and allow 60 days for public comment in response to the notice. This notice solicits comments on the information needed to maintain an up-to-date Agent Orange Registry.

DATES: Written comments and recommendations on the proposed collection of information should be received on or before January 6, 2004.

ADDRESSES: Submit written comments on the collection of information to Ann Bickoff, Veterans Health Administration (191A1), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420 or e-mail *ann.bickoff@mail.va.gov*. Please refer to "OMB Control No. 2900–0376" in any correspondence.

FOR FURTHER INFORMATION CONTACT: Ann Bickoff at (202) 273–8310.

SUPPLEMENTARY INFORMATION: Under the PRA of 1995 (Public Law 104–13; 44 U.S.C. 3501 "3520), Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. This request for comment is being made pursuant to Section 3506(c)(2)(A) of the PRA.

With respect to the following collection of information, VHA invites comments on: (1) Whether the proposed collection of information is necessary for the proper performance of VHA's functions, including whether the information will have practical utility; (2) the accuracy of VHA's estimate of the burden of the proposed collection of information; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or the use of other forms of information technology.

Title: Agent Orange Registry Code Sheet, VA Form 10–9009.

OMB Control Number: 2900–0376.

Type of Review: Extension of a currently approved collection.

Abstract: VA in an on-going effort to maintain an Agent Orange Registry (AOR) developed a reporting format to facilitate the collection of information obtained from veterans during the Agent Orange registry examination process. VA is required to organize and update the information contained in AOR to enable VA to notify Vietnam era veterans who served in the Republic of Vietnam of any increased health risks resulting from exposure to dioxin or other toxic agents. VA may also provide, upon request, a health examination, consultation, and counseling to a veteran who is eligible for listing or inclusion in any health-related registry administrated by VA that is similar to the Persian Gulf War Veterans Health Registry. Registry examinations is provided to veterans who served in Korea in 1968 or 1969, and/or any U.S. veteran who may have been exposed to dioxin, or other toxic substance in a herbicide or defoliant, during the conduct of, or as a result of, the testing, transporting, or spraying of herbicides, and who requests an Agent Orange Registry examination. The information obtained from the veteran during the interview is entered on VA Form 10–9009, Agent Orange Registry Code Sheet. The registry will provide a mechanism to catalogue prominent symptoms, reproductive health, and diagnoses and to communicate with Agent Orange veterans. VA informs the veterans on research finding or new compensation policies through periodic newsletters. The registry is not designed or intended to be a research tool and therefore the results cannot be generalized to represent all Agent Orange veterans.

Affected Public: Individuals or Households.

Estimated Total Annual Burden: 12,000 hours.

Estimated Average Burden Per Respondent: 20 minutes.

Frequency of Response: On occasion.

Estimated Number of Respondents: 36,000.

Dated: October 30, 2003.

By direction of the Secretary.

Jacqueline Parks,

IT Specialist, Records Management Service.

[FR Doc. 03–28127 Filed 11–6–03; 8:45 am]

BILLING CODE 8320–01–P

Corrections

Federal Register
Vol. 68, No. 216
Friday, November 7, 2003

This section of the FEDERAL REGISTER contains editorial corrections of previously published Presidential, Rule, Proposed Rule, and Notice documents. These corrections are prepared by the Office of the Federal Register. Agency prepared corrections are issued as signed documents and appear in the appropriate document categories elsewhere in the issue.

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

18 CFR Part 4

[Docket No. RM02–16–000]

Hydroelectric Licensing Under the Federal Power Act; Correction

Correction

In rule document 03–27405 beginning on page 61742 in the issue of Thursday, October 30, 2003, make the following correction:

§ 4.41 [Corrected]

On page 61742, in the second column, in § 4.41, in amendatory instruction 10b., in the fifth line, "+40" should read "±40".

[FR Doc. C3–27405 Filed 11–6–03; 8:45 am]

BILLING CODE 1505–01–D

FEDERAL RESERVE SYSTEM

[Docket No. R–1152]

Federal Reserve Bank Services Imputed Investment Income on Clearing Balances

Correction

In notice document 03–27124 beginning on page 61413 in the issue of Tuesday, October 28, 2003, make the following corrections:

1. On page 61417, in the second column, in footnote 27, in the first line, "$5.473" should read "$5,473".

2. On the same page, in the same column, in the same footnote, in the second line, "$5.892" should read "$5,892".

3. On the same page, in the same column, in the same footnote, in the fifth line, "$10.302" should read "$10,302".

[FR Doc. C3–27124 Filed 11–6–03; 8:45 am]

BILLING CODE 1505–01–D

Federal Register

Friday,
November 7, 2003

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 410 and 414

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2004; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410 and 414

[CMS–1476–FC]

RIN 0938–AL96

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2004

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

ACTION: Final rule with comment period.

SUMMARY: This final rule will refine the resource-based practice expense relative value units (RVUs) and make other changes to Medicare Part B payment policy. The policy changes concern: Medicare Economic Index, practice expense for professional component services, definition of diabetes for diabetes self-management training, supplemental survey data for practice expense, geographic practice cost indices, and several coding issues. In addition, this rule updates the codes subject to the physician self-referral prohibition. We also make revisions to the sustainable growth rate and the anesthesia conversion factor.

These changes will ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services.

We are also finalizing the calendar year (CY) 2003 interim RVUs and are issuing interim RVUs for new and revised procedure codes for CY 2004.

As required by the statute, we are announcing that the physician fee schedule update for CY 2004 is -4.5 percent, the initial estimate of the sustainable growth rate for CY 2004 is 7.4 percent, and the conversion factor for CY 2004 is $35.1339.

We published a proposed rule (68 FR 50428) in the **Federal Register** on Part B drug payment reform on August 20, 2003. This proposed rule would also make changes to Medicare payment for furnishing or administering certain drugs and biologicals. We have not finalized these proposals to take into account that the Congress is considering legislation that would address these issues. We will continue to monitor legislative activity that would reform the Medicare Part B drug payment system. If legislation is not enacted soon on this issue, we remain committed to completing the regulatory process.

DATES: *Effective date:* These regulations are effective on January 1, 2004.

Comment date: We will consider comments on the physician self-referral designated health services additions and deletions identified in Tables 8 and 9, and the interim work RVUs for selected procedure codes identified in Addendum C if we receive them at the appropriate address, as provided in the addresses section, no later than 5 p.m. on January 6, 2004.

ADDRESSES: In commenting, please refer to file code CMS–1476–FC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. Mail written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1476–FC, P.O. Box 8013, Baltimore, MD 21244–8013.

Please allow sufficient time for us to receive mailed comments on time in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) to one of the following addresses:

Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–8013.

(Because access to the interior of the HHH 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 if you wish to retain proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Pam West (410) 786–2302 (for issues related to practice expense.)

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

Rick Ensor (410) 786–5617 (for issues related to Geographic Cost Price Index (GPCI).)

Mary Stojak (410) 786–6939 (for issues related to the definition of diabetes for diabetes self-management training (DSMT).)

Shannon Martin (410) 786–7939 (for issues related to rebasing of the Medicare Economic Index (MEI).)

Craig Dobyski, (410) 786–4584 (for issues related to telehealth).

Joanne Sinsheimer, (410) 786–4620 (for issues related to updates to the list of certain services subject to the physician self-referral prohibitions).

Diane Milstead (410) 786–3355, Latesha Walker (410) 786–1101, or Gaysha Brooks (410) 786–3355 (for all other issues.)

SUPPLEMENTARY INFORMATION:

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

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

Accessing Physician Fee Schedule Web Site and Pricing Information

Information on the physician fee schedule and pricing files can be found on our homepage. You can access this data by typing the following: *http://cms.hhs.gov/physicians/pfs* or you can access this data by using the following directions:

1. Go to the CMS homepage (*http://www.cms.hhs.gov*).

2. Place your cursor over the word "Professionals" in the blue area near the top of the page. Select "Physicians" from the drop-down menu.

3. Scroll down and under "Payment/Billing" select "Physician Fee Schedule'.

The Physician Fee Schedule pricing information is contained in two public use files.

(1) National Physician Fee Schedule Relative Value File—This file contains all CPT/HCPCS (excluding codes beginning with B, E, L, K, and O), their short descriptions and a status indicator, which denotes whether or not the service is priced under the physician fee schedule. The file also contains the components used in the calculation of the annual pricing amount (that is., the RVUs, GPCIs, and

conversion factor), anesthesia conversion factors, and the payment policy indicators used to price the claims with surgical modifiers. This file does not contain the calculated pricing amounts.

(2) Physician Fee Schedule Payment Amount File National/Carrier—This file contains the CPT code and the Medicare price for all services priced under the Physician Fee Schedule. These data can be downloaded for (a) the entire country, or (b) for a selected carrier (in most cases carriers correlate with states). There is no option of requesting data for selected HCPCS codes. The zip file, which is downloaded, contains a file named PF04pc.doc, which explains the data contained in each column. This file also contains a description of pricing localities used in the Physician Fee Schedule. Due to the size of the national file (as well as many of the carrier-specific files), these data are provided in a comma-delimited format, which can be used to populate database applications. Generally speaking, these data are too large for Excel, however if a carrier specific file has 3 or fewer localities, Excel can be used.

Another file that providers may find useful is the Zipcode to Carrier Locality File. This file will map ZIP Codes to CMS carriers and localities and map Zip Codes to their State and determine whether the ZIP Code has a rural designation as determined by CMS. You can access this file by typing the following: *http://cms.hhs.gov/providers/pufdownload/default.asp#alphanu* or you can access this data by using the following directions:

1. Go to the CMS homepage (*http://www.cms.hhs.gov*).
2. Place your cursor over the word "Professionals" in the blue area near the top of the page. Select "Physicians" from the drop-down menu.
3. Scroll down and under "Payment/Billing" select "Medicare Payment Systems."
4. Scroll down and under Coding Files select "Zipcode to Carrier Locality File."

Table of Contents

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:

AMA American Medical Association
APC Ambulatory Payment Classification
BBA Balanced Budget Act of 1997
BBRA Balanced Budget Refinement Act of 1999
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
CF Conversion factor
CFR Code of Federal Regulations
CMS Centers for Medicare & Medicaid Services
CNS Clinical Nurse Specialist
CPT [Physicians'] Current Procedural Terminology [4th Edition, 2002, copyrighted by the American Medical Association]
CPEP Clinical Practice Expert Panel
CRNA Certified Registered Nurse Anesthetist
DHHS Department of Health and Human Services
E/M Evaluation and management
ESRD End-Stage Renal Disease
GAF Geographic adjustment factor
GPCI Geographic practice cost index
HCPCS Healthcare Common Procedure Coding System
HHA Home health agency
IDTFs Independent Diagnostic Testing Facilities
MCM Medicare Carrier Manual
MedPAC Medicare Payment Advisory Commission
MEI Medicare Economic Index
MGMA Medical Group Management Association
MPFS Medicare Physician Fee Schedule
MSA Metropolitan Statistical Area
OMB Office of Management and Budget
PC Professional component
PEAC Practice Expense Advisory Committee
PPO Preferred Provider Organization
PPS Prospective payment system
PRA Paperwork Reduction Act of 1995
RUC [AMA's Specialty Society] Relative [Value] Update Committee
RVU Relative value unit
SGR Sustainable growth rate
SMS [AMA's] Socioeconomic Monitoring System
SNF Skilled Nursing Facility
TC Technical component

I. Background

A. Legislative History

Since January 1, 1992, Medicare has paid for physicians' services under section 1848 of the Social Security Act (the Act), "Payment for Physicians" Services." This section provides for three major elements: (1) A fee schedule for the payment of physicians' services; (2) limits on the amounts that nonparticipating physicians can charge beneficiaries; and (3) a sustainable growth rate (SGR) for the rates of increase in Medicare expenditures for physicians' services. The Act requires that payments under the fee schedule be based on national uniform relative value units (RVUs) that are based on the resources used in furnishing a service. Section 1848(c) of the Act requires that national RVUs be established for physician work, practice expense, and malpractice expense. Section 1848(c)(2)(B)(ii)(II) of the Act provides that adjustments in RVUs may not cause total physician fee schedule payments to differ by more than $20 million from what they would have been had the adjustments not been made. If adjustments to RVUs cause expenditures to change by more than

$20 million, we must make adjustments to ensure that they do not increase or decrease by more than $20 million.

B. Published Changes to the Fee Schedule

In the July 2000 proposed rule, (65 FR 44177), we listed all of the final rules published through November 1999. In the August 2001 proposed rule (66 FR 40372) we discussed the November 2000 final rule relating to the updates to the RVUs and revisions to payment policies under the physician fee schedule.

In the November 2001 final rule with comment period (66 FR 55246), we made revisions to resource-based practice expense RVUs; services and supplies incident to a physician's professional service; anesthesia base unit variations; recognition of Physicians' Current Procedural Terminology (CPT) tracking codes; and nurse practitioners, physician assistants, and clinical nurse specialists performing screening sigmoidoscopies. We also addressed comments received on the June 8, 2001 proposed notice (66 FR 31028) for the 5-year review of work RVUs and finalized these work RVUs. In addition, we acknowledged comments received in response to a discussion of modifier-62, which is used to report the work of co-surgeons. The November 2001 final rule also updated the list of services that are subject to the physician self-referral prohibitions in order to reflect CPT and Healthcare Common Procedure Coding System (HCPCS) code changes that were effective January 1, 2002. All these revisions ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. This final rule also conformed our regulations to reflect statutory provisions of Medicare, Medicaid, and State Child Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554) (BIPA) concerning: the mammography screening benefit; biennial screening pelvic examinations for certain beneficiaries; expanded coverage for screening colonoscopies to all beneficiaries; annual glaucoma screenings for high-risk beneficiaries; coverage for medical nutrition therapy services for certain beneficiaries; expanded payment for telehealth services; payment for certain Indian Health Service for some services under the physician fee schedule; and revision of the payment for certain physician pathology services.

In the December 31, 2002 final rule with comment period (67 FR 79966), we refined resource-based practice expense RVUs and made other changes to Medicare Part B policy. These included: The pricing of the technical component for positron emission tomography (PET) scans, Medicare qualifications for clinical nurse specialists, a process to add or delete services to the definition of telehealth, the definition for ZZZ global periods, global period for surface radiation, and application of endoscopic reduction rules for certain codes. In addition, this rule: Updated the codes subject to physician self-referral prohibitions, expanded the definition of a screening fecal-occult blood test, and modified our regulations to expand coverage for additional colorectal cancer screening tests through our national coverage determination process. We also made revisions to the SGR, the anesthesia conversion factor (CF), and the work values for some gastroenterologic services. We finalized the calendar year (CY) 2002 interim RVUs and assigned interim RVUs for new and revised procedure codes for CY 2003, clarified the enrollment of therapists in private practice and the policy regarding services and supplies incident to a physician's professional services, and made technical changes to the definition of outpatient rehabilitation services.

This final rule also revised the regulations at § 485.618 to allow registered nurses (RNs) to provide emergency care in certain critical access hospitals (CAHs) in frontier areas (an area with fewer than six residents per square mile) or remote locations (locations designated in a State's rural health plan that we have approved).

As required by statute this final rule also announced that the physician fee schedule update for CY 2003 was −4.4 percent, the initial estimate of the SGR for CY 2003 was 7.6 percent, and the CF for CY 2003 was $34.5920, effective March 1, 2003. However, on February 28, 2003 (68 FR 9567), after enactment of the Consolidated Appropriations Resolution of 2003 (Pub. L. 108–7), we published a final rule that revised the estimates used to establish the SGRs for fiscal years 1998 and 1999 and announced a 1.6 percent increase in the CY 2003 physician fee schedule CF for March 1 to December 31, 2003. The CF from March 1 to December 31, 2003 is $36.7856 and the anesthesia CF for this period is $17.05. All other provisions of the December 31, 2002 final rule were unchanged by the rule published February 28, 2003.

C. Components of the Fee Schedule Payment Amounts

Under the formula set forth in section 1848(b)(1) of the Act, the payment amount for each service paid under the physician fee schedule is the product of three factors—(1) a nationally uniform relative value for the service; (2) a geographic adjustment factor (GAF) for each physician fee schedule area; and (3) a nationally uniform conversion factor (CF) for the service. The CF converts the relative values into payment amounts.

For each physician fee schedule service, there are three relative values—(1) an RVU for physician work; (2) an RVU for practice expense; and (3) an RVU for malpractice expense. For each of these components of the fee schedule, there is a geographic practice cost index (GPCI) for each fee schedule area. The GPCIs reflect the relative costs of practice expenses, malpractice insurance, and physician work in an area compared to the national average for each component.

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

Payment = [(RVU work × GPCI work) + (RVU practice expense × GPCI practice expense) + (RVU malpractice × GPCI malpractice)] × CF

The CF for CY 2004 appears in section IX. The RVUs for CY 2004 are in Addendum B. The GPCIs for CY 2004 can be found in Addendum D.

Section 1848(e) of the Act requires us to develop GAFs for all physician fee schedule areas. The total GAF for a fee schedule area is equal to a weighted average of the individual GPCIs for each of the three components of the service. In accordance with the statute, however, the GAF for the physician's work reflects one-quarter of the relative cost of physician's work compared to the national average.

D. Development of the Relative Value System

1. Work Relative Value Units (RVUs)

Approximately 7,500 codes represent services included in the physician fee schedule. The 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 work RVUs for most codes in a cooperative agreement with us. In constructing the vignettes for the original RVUs, Harvard worked with expert panels of physicians and obtained input from physicians from numerous specialties.

The RVUs for radiology services were based on the American College of Radiology (ACR) relative value scale,

which we integrated into the overall physician fee schedule. The RVUs for anesthesia services were based on RVUs from a uniform relative value guide. We established a separate CF for anesthesia services, and we continue to recognize time as a factor in determining payment for these services. As a result, there is a separate payment system for anesthesia services.

2. Practice Expense and Malpractice Expense Relative Value Units

Section 1848(c)(2)(C) of the Act required that the practice expense and malpractice expense RVUS equal the product of the base allowed charges and the practice expense and malpractice percentages for the service. Base allowed charges are defined as the national average allowed charges for the service furnished during 1991, as estimated using the most recent data available. For most services, we used 1989 charge data aged to reflect the 1991 payment rules, since those were the most recent data available for the 1992 fee schedule.

Section 121 of the Social Security Act Amendments of 1994 (Pub. L. 103–432), enacted on October 31, 1994, required us to develop a methodology for a resource-based system for determining practice expense RVUs for each physician service. As amended by the BBA, section 1848(c) required the new payment methodology to be phased in over 4 years, effective for services furnished in 1999, with resource-based practice expense RVUs becoming fully effective in 2002. The BBA also required us to implement resource-based malpractice RVUs for services furnished beginning in 2000.

II. Specific Provisions for Calendar Year 2004

In response to the publication of the August 15, 2003 proposed rule, (68 FR 49030), and the December 2002 interim final rule, (67 FR 79966), we received approximately 2,433 comments. We received comments from individual physicians, health care workers, and professional associations and societies. The majority of comments addressed the physician fee schedule proposals related to the dialysis G codes, "incident to" therapy services, and the geographic practice cost indices locality payment discussion issue.

The proposed rule discussed policies that affected the RVUs on which payment for certain services would be based. Certain changes implemented through this final rule are subject to the $20 million limitation on annual adjustments contained in section 1848(c)(2)(B)(ii)(II) of the Act.

After reviewing the comments and determining the policies we would implement, we have estimated the costs and savings of these policies and added those costs and savings to the estimated costs associated with any other changes in RVUs for 2004. We discuss in detail the effects of these changes in the Regulatory Impact Analysis in section XIII.

For the convenience of the reader, the headings for the policy issues correspond to the headings used in the August 15, 2003 proposed rule. More detailed background information for each issue can be found in the December 2002 interim final rule with comment period and the August 2003 proposed rule.

A. Resource-Based Practice Expense Relative Value Units

1. Resource-Based Practice Expense Legislation

Section 121 of the Social Security Act Amendments of 1994 (Pub. L. 103–432), enacted on October 31, 1994, required us to develop a methodology for a resource-based system for determining practice expense RVUs for each physician's service beginning in 1998. In developing the methodology, we were to consider the staff, equipment, and supplies used in providing medical and surgical services in various settings. The legislation specifically required that, in implementing the new system of practice expense RVUs, we apply the same budget-neutrality provisions that we apply to other adjustments under the physician fee schedule.

Section 4505(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), enacted on August 5, 1997, amended section 1848(c)(2)(B)(ii) of the Act and delayed the effective date of the resource-based practice expense RVU system until January 1, 1999. In addition, section 4505(b) of the BBA provided for a 4-year transition period from charge-based practice expense RVUs to resource-based RVUs.

Further legislation affecting resource-based practice expense RVUs was included in the Medicare, Medicaid and State Child Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) enacted on November 29, 1999. Section 212 of the BBRA amended section 1848(c)(2)(B)(ii) of the Act by directing us 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. These data would supplement the data we normally collect in determining the practice expense component of the physician fee schedule for payments in CY 2001 and CY 2002. (In the 1999 final rule (64 FR 59380), we extended, for an additional 2 years, the period during which we would accept supplementary data.)

2. Current Methodology for Computing the Practice Expense Relative Value Unit System

Effective with services furnished on or after January 1, 1999, we established a new methodology for computing resource-based practice expense RVUs that used the two significant sources of actual practice expense data we have available—the Clinical Practice Expert Panel (CPEP) data and the American Medical Association's (AMA) Socioeconomic Monitoring System (SMS) data. The methodology was based on an assumption that current aggregate specialty practice costs are a reasonable way to establish initial estimates of relative resource costs for physicians' services across specialties. The methodology allocated these aggregate specialty practice costs to specific procedures and, thus, can be seen as a "top-down" approach.

a. Major Steps

A brief discussion of the major steps involved in the determination of the practice expense RVUs follows. (Please see the November 1, 2001 final rule (66 FR 55249) for a more detailed explanation of the top-down methodology.)

- *Step 1*—Determine the specialty specific practice expense per hour of physician direct patient care. We used the AMA's SMS survey of actual aggregate cost data by specialty to determine the practice expenses per hour for each specialty. We calculated the practice expenses per hour for the specialty by dividing the aggregate practice expenses for the specialty by the total number of hours spent in patient care activities.
- *Step 2*—Create a specialty specific practice expense pool of practice expense costs for treating Medicare patients. To calculate the total number of hours spent treating Medicare patients for each specialty, we used the physician time assigned to each procedure code and the Medicare utilization data. We then calculated the specialty specific practice expense pools by multiplying the specialty practice expenses per hour by the total physician hours.
- *Step 3*—Allocate the specialty specific practice expense pool to the specific services performed by each specialty. For each specialty, we

divided the practice expense pool into two groups based on whether direct or indirect costs were involved and used a different allocation basis for each group.

(i) Direct costs—For direct costs (which include clinical labor, medical supplies, and medical equipment), we used the procedure specific CPEP data on the staff time, supplies, and equipment as the allocation basis.

(ii) Indirect costs—To allocate the cost pools for indirect costs, including administrative labor, office expenses, and all other expenses, we used the total direct costs combined with the physician fee schedule work RVUs. We converted the work RVUs to dollars using the Medicare CF (expressed in 1995 dollars for consistency with the SMS survey years).

• *Step 4*—For procedures performed by more than one specialty, the final procedure code allocation was a weighted average of allocations for the specialties that perform the procedure, with the weights being the frequency with which each specialty performs the procedure on Medicare patients.

b. Other Methodological Issues

(i) Nonphysician Work Pool

For services with physician work RVUs equal to zero (including the technical components of radiology services and other diagnostic tests), we created a separate practice expense pool using the average clinical staff time from the CPEP data and the "all physicians" practice expense per hour.

We then used the adjusted 1998 practice expense RVUs to allocate this pool to each service. We have removed services from the nonphysician work pool if the requesting specialty predominates utilization of the service. Also, for all radiology services that are assigned physician work RVUs, we used the adjusted 1998 practice expense RVUs for radiology services as an interim measure to allocate the direct practice expense cost pool for radiology specialties to the most appropriate SMS specialty.

(ii) Crosswalks for Specialties Without Practice Expense Survey Data

Since many specialties identified in our claims data did not correspond exactly to the specialties included in the SMS survey data, it was necessary to crosswalk these specialties to the most appropriate SMS specialty.

(iii) Physical Therapy Services

Because we believe that most physical therapy services furnished in physicians' offices are performed by physical therapists, we crosswalked all utilization for therapy services in the CPT 97000 series to the physical and occupational therapy practice expense pool.

3. Practice Expense Proposals for Calendar Year 2004

a. Nonphysician Workpool

The nonphysician work pool is a special methodology that we used to determine practice expense RVUs for many services that do not have physician work RVUs. While the nonphysician work pool is of benefit to many of the services that were originally included, we have allowed specialties to request that their services be removed from the pool. Because the nonphysician work pool includes a variety of services performed by many different specialties, we use the "all physician" average practice expense per hour in place of a specialty-specific practice expense per hour.

As discussed in the August 15, 2003 proposed rule, we are continuing to study the alternatives that are available and any modifications to the nonphysician workpool would be published in proposed rulemaking.

Comment: Several specialty societies expressed support for the ongoing study of this complex issue and appreciate that any modifications to the nonphysician workpool would be published as proposed rulemaking for review and comment prior to implementation. A biopharmaceutical company commented that we should move forward to develop a new methodology that better recognizes actual resource consumption so that we can develop a preferable alternative.

Response: We are appreciative of the support and will continue to study this issue.

b. Supplemental Practice Expense Survey Data

i. Survey Criteria and Submission Dates

As required by the BBRA, we established criteria to evaluate data collected by organizations to supplement the data normally used in determining the practice expense component of the physician fee schedule. We have required supplementary survey data to be submitted by August 1 to be considered for computing practice expense RVUs for the following year. We proposed to change the required submission date to March 1, which would allow us to publish our decisions regarding survey data in the proposed rule and provide an opportunity for public comment on survey results. We also proposed to extend for an additional 2 years the period for accepting survey data that meets the criteria set forth in the November 2000 final rule (as modified in the December 31, 2002 final rule). The deadline for submission of the supplemental data to be considered in CY 2005 and CY 2006 would be March 1, 2004 and March 1, 2005, respectively.

Comment: Specialty societies expressed appreciation for our proposal to extend the deadline for submission of surveys. Commenters also approved of our proposal to change the due date for submission of supplemental practice expense survey data to March 1, so that the implications of the use of the survey data could be discussed in the proposed rule.

Response: We will implement the change in the submission dates for supplementary surveys as proposed. The deadline for submission of the supplemental data to be considered in CY 2005 and CY 2006 would be March 1, 2004 and March 1, 2005, respectively. We will revise § 414.22(b)(6)(ii) to reflect this change.

ii. Submission of Supplemental Surveys

The College of American Pathologists (CAP) submitted supplemental survey data for independent laboratories for consideration for CY 2004. Our contractor, The Lewin Group, evaluated the data and has recommended acceptance.

Comment: Based on our proposal to revise the date for submission of supplemental survey data, CAP requested that we delay incorporation of this survey data until next year's proposed rule. CAP also expressed an interest in being able to evaluate the combined effects of the use of the new survey data along with the technical change for pathology services before the changes are implemented. Therefore, CAP requested that we also extend the moratorium on calculating the technical component as the difference between the global and professional component practice expense RVUs by one additional year, as discussed in the August 15, 2003 proposed rule. This request for a delay in incorporating the new survey data, as well as extending the moratorium was supported by the AMA and several specialty societies.

Response: We agree with the comments that suggest extending by one year the moratorium on calculating the technical component practice expense RVU as the difference between the global and professional component RVUs for pathology services. We also agree with comments suggesting that we not incorporate the CAP survey into the practice expense methodology until next year. We will evaluate the CAP

survey in next year's proposed rule at the same time we show the effect of the above described change for pathology services.

c. Practice Expense for a professional component service

While we typically assign all staff, equipment and supply costs for services with professional and technical components (PC and TC) to the technical portion of the service, in the proposed rule we discussed limited instances where it is appropriate to assign direct inputs to a PC service. We proposed to modify the practice expense methodology to allow direct inputs to be added to PC services when these inputs are clearly associated with the professional service, including when the PEAC makes such recommendations. Specifically we proposed to add the PEAC recommended staff times to the PC of the following cardiac services: CPT codes 93508, 93510, 93511, 93514, 93524, 93526, 93527, 93528, 93529, 93530, 93531, 93532, 93533 and 93624.

Comment: The RUC, the AMA, the American College of Physicians and societies representing cardiologists, cardiac rhythm specialists, interventional radiologists, nuclear medicine, chest physicians, radiation oncologists, radiologists, endocrinologists and dermatologists expressed support for this change in methodology. Commenters were also in agreement with the specific CPT codes mentioned in the proposed rule, but requested that direct inputs also be added to the PC of CPT codes 93619, 93620 and 93642, which were reviewed at the January PEAC meeting. The RUC comment indicated that additional codes might be identified at future PEAC/RUC meetings.

Response: We will finalize the proposed assignment of direct practice expense to the proposed 14 cardiac services and will add the PEAC recommended inputs to the PC of CPT codes 93619, 93620 and 93642, as requested by the commenters.

d. Utilization Data

We use Medicare utilization data in the development of specialty-specific practice expense RVUs that are then weight averaged to determine a single practice expense RVU per code. Prior to 2003, we used the most recent complete year of utilization data to determine the practice expense RVUs. In the December 31, 2002 final rule (67 FR 79982), we adopted a policy of using the 1997 through 2000 Medicare utilization in the practice expense methodology. For new codes created since 2000, there are no Medicare utilization data. In the August 15, 2003 rule we proposed to follow a similar practice to the one described above and use specialty-specific Medicare utilization data for codes created after 2000 at the first opportunity they become available to us. Since we will not have any utilization data at the time we first establish practice expense RVUs for a new code, we proposed that we continue, whenever possible, to make an assumption about the specialty that will likely provide the service or to use the "all physician" average when we do not have sufficient information to assign any given specialty.

Comment: The specialty societies representing internal medicine, rheumatology and pulmonary medicine supported our proposal to use 1997 through 2000 Medicare utilization data for all codes that were in existence at that time and to use specialty-specific Medicare utilization data for codes created after 2000 when utilization data first become available, using the "all physician" average when we do not have sufficient information to assign a given specialty. These commenters, as well as several others, suggested that the RUC and the specialty societies could provide information on the specialties that will likely perform a new service to minimize the potential changes to the practice expense RVUs that will occur when we substitute actual for estimated utilization. However, a specialty society representing gastroenterology expressed concern that we are moving forward with plans to shift the basis of our methodology for compiling data to a five-year basis. The commenter urged us to not make changes until extensive impact comparisons are conducted that can be evaluated by physician community.

Response: We will implement our proposal to use specialty-specific Medicare utilization data for codes created after 2000 at the first opportunity they become available to us. We will also continue, whenever possible, to make an assumption about the specialty that will likely provide the service or to use the "all physician" average when we do not have sufficient information to assign any given specialty. Information about the specialty we assign to a code that has no utilization data can be found in the utilization data files we make available on the CMS web site following final rule publication. With respect to the comment about shifting to a 5-year basis of utilization data for the practice expense methodology, we are making no change in policy for codes that existed in the 1997 to 2000 period. We are using only the later year utilization data for codes that have been created since that time. Any information from the RUC that could assist us in this process would be welcomed.

Comment: A specialty society representing colon and rectal surgeons agreed with our general utilization methodology, but disagreed that averaged 1997–2000 utilization data should be used for all codes that were not in existence for the entire period. The commenter argued that the frequency for these codes might be artificially low because the coding was new and that this may impact the relativity between new and old codes in the same family with similar inputs. The society suggested that any code that did not exist during the entire 1997–2000 period default to 2002 or most recent data.

Response: As we have explained, the Medicare utilization is important to the practice expense methodology because it determines which specialty scaling factors will be applied to the estimated practice expense input values in determining the practice expense RVUs for each service. The proportion of the volume billed by each specialty is more important to determining the practice expense RVU for a given service than the total volume. If the code is low in volume but the proportion of the code's volume billed by each specialty is generally consistent over time, there will be little or no difference in a code's practice expense RVUs, whether we use its initial year of utilization or a later year to determine its value.

Comment: Commenters representing dermatology as well as a pharmaceutical company expressed concern regarding the decrease in payment for photodynamic therapy, CPT code 95657. The commenters noted our discussion in the proposed rule indicating that this reduction in the practice expense RVUs is occurring because of updates to the Medicare utilization data used in the practice expense methodology. As a result of the updated utilization data, the practice expense methodology now uses the dermatology scaling factor (0.54) for supplies instead of the all physician average (1.29), and this change leads to the reduction in payment for the code. The commenters urged us to reconsider the proposal and at least to reinstate physicians' ability to bill separately in 2004 for the light-activating agent under the appropriate J code and also to remove the drug from the practice expense portion of the procedure.

Response: One of the functions of the utilization data in our practice expense methodology is to assign all procedures to the specialty-specific cost pools of the

specialty or specialties performing them. Each cost pool has its own scaling factor. This scaling factor is used to scale the aggregate CPEP procedure-level costs for a specialty to the aggregate costs for the same specialty as determined by the SMS practice expense data. As we indicated in the proposed rule, we do not have utilization data upon which to determine the practice expense RVUs for a new code at the time it is created. As a default, we have assigned many new codes the "all physician" scaling factor until we have the data to move these codes into the appropriate specialty cost pools. Because it allows us to apply the appropriate specialty scaling factor, the use of the updated utilization data in the practice expense methodology can lead to increases or decreases in the value of a code, even though its practice expenses remain unchanged. In this case, the supplies scaling factor for dermatology is lower than that for "all physicians," leading to a decrease in practice expense RVUs when the dermatology scaling factor was applied to the CPEP data of the photodynamic therapy service.

We believe the initial practice RVUs for photodynamic therapy were too high, because the later information on Medicare utilization indicates that we should have used the dermatology scaling factor which would have produced a lower practice expense value. As we indicate above, we are working to minimize changes that will occur in the practice expense RVUs for a service by making an initial assumption about which specialty will likely bill us for a service. However, we believe our policy for new codes should be consistent with how we determine the practice expense RVUs for existing codes, even if updates to the Medicare utilization data lead to increases or decreases in the practice expense RVUs.

Though we believe that it is appropriate to use the updated utilization that results in a reduction in payment for CPT code 96567, we will pay separately for the light activating agent beginning January 1, 2004. However, we are also further considering whether Medicare should pay separately for certain topical drugs in certain circumstances. Any change in policy would be discussed in future rulemaking.

Comment: Specialty societies representing radiation oncology, as well as individual commenters, expressed concern about the decrease in payment for the intensity modulated radiation therapy (IMRT) treatment service, CPT code 77418. The commenters stated that this was due to a "quirk" in the utilization data relating to new codes and requested that this code be priced by the non-physician work pool methodology.

Response: We will calculate the practice expense RVUs for the IMRT treatment service, CPT code 77418, using the nonphysician workpool methodology. This will be consistent with the way we currently calculate the practice expense for all other radiation therapy services with no physician work RVUs.

Comment: The specialty society representing radiation oncology also noted that there was a reduction in the practice expense RVUs for the intensity modulated radiation therapy planning procedure, CPT code 77301. A remote cardiac monitoring service questioned why the use of new utilization data could decrease the value of a code such as HCPCS code G0249 for the provision of test material and equipment for home INR monitoring.

Response: Both CPT code 77301 and HCPCS code G0249 were new codes for which we did not have utilization data and which were initially assigned the "all physician" scaling factor. As described above, now that we have the utilization data, the services have been placed in the specialty-specific cost pools based on how the service is billed to Medicare, which have lower scaling factors than the "all physician." This shift has led to the reduced practice expense RVUs for CPT code 77301. If we had placed this code in the radiation oncology cost pool to begin with, it would have had the reduced practice expense payments for the past two years as well. HCPCS code G0249 will actually have increased practice expense RVUs in 2004 due to the effect of the repricing of supplies.

Comment: We received one comment that questioned how updated utilization data could have such a huge and direct effect on specific codes. The commenter requested clarification from us on the workings of the utilization data within the practice expense methodology so that the public will understand how utilization data will affect new technologies in the future.

Response: As explained above, one of the functions of the utilization data in our practice expense methodology is to assign all procedures to the specialty-specific cost pools of the specialty or specialties performing them. If we do not know the specialty, we have used "all physician" scaling factors. The "all physician" scaling factors could be higher or lower than the specialty-specific scaling factor and produce different RVUs for the code. For instance, CPT code 77301–26 is a PC service that has no direct cost inputs. Thus, its practice expense RVUs are affected only by the indirect cost scaling factor. To develop the 2003 practice expense RVUs for this code, we adjusted indirect costs allocated to this code by the "all physician" indirect cost scaling factor of 0.57. However, for 2004, we have Medicare utilization data from 2002 for this procedure code. Radiation oncologists and radiologists respectively billed Medicare for 67 percent and 30 percent of the total volume of services provided to Medicare patients in 2002. The weighted average scaling factor for all the specialties that bill Medicare for this procedure code is 0.48. Since we are adjusting indirect costs by 0.48 instead of 0.57, the final practice expense value is lower.

e. Practice Expense Advisory Committee (PEAC)

The PEAC, a subcommittee of the RUC, has, since 1999, been providing us with recommendations for refining the direct practice expense inputs (clinical staff, supplies, and equipment) for existing CPT codes.

1. Recommendations on CPEP Inputs for 2003

In the December 31, 2002 proposed rule, we responded to the PEAC recommendations for the refinement to the CPEP direct practice expense inputs for over 1200 codes, including refinements to codes from almost every major specialty. In addition, the recommendations included standardized times for office-based clinical staff for services provided during a patient's hospitalization and for discharge day management services, as well as pre-service clinical staff times for 323 neurosurgery procedures. We reviewed and accepted all of the recommendations. We received the following comments on these revisions.

Comment: We received comments from specialty societies representing dermatology, dermatolgic surgery and Mohs surgery expressing concern regarding the decrease in practice expense RVUs for skin biopsy procedures, CPT codes 11100 and 11101 and the destruction of benign or premalignant lesion services, CPT codes 17000 and 17003. The commenters questioned whether the reductions reflect errors in the validated practice expense inputs used in the practice expense calculations.

Response: We have checked the practice expense inputs and found that these match the clinical staff, supply and equipment inputs as recommended by the RUC. The reduction in practice expense RVUs was caused by the

refinement of these inputs, which, in turn, was based on the presentation made to the PEAC by the dermatology specialty society. We will, therefore, not make any further revisions to the practice expense inputs for these services in this final rule.

2. Recommendations on CPEP Inputs for 2004

In the August 15, 2003 proposed rule we included the PEAC recommendations from meetings held in September of 2002 and January 2003 as well as recommendations on the refinements to the clinical staff time for all 90-day global services. In addition, the PEAC convened a workgroup to make recommendations on the refinement of all the 116 remaining evaluation and management codes. We reviewed the submitted PEAC recommendations and proposed to accept them.

Comment: The American Osteopathic Association expressed appreciation that we supported the recommended changes for the osteopathic manipulative treatment codes and commended us for accepting the PEAC recommendations for the clinical staff times for 90-day global codes. The American College of Obstetricians and Gynecologists stated that our acceptance of the PEAC recommendations is an example of exceptional cooperation and collaboration in meeting the healthcare needs of Americans served by the Medicare program. The American Academy of Dermatology applauded our acceptance of the year's PEAC recommendations. The AMA and the American College of Radiology stated that they appreciate our recognition of the significant resources specialty societies have devoted to the practice expense refinement process and is thankful that our practice expense staff avail themselves of specialty society input. The American College of Surgeons also supported our acceptance of the PEAC recommendations, including the decision to permit exceptions to the standard pre-service times for some surgical procedures. The College other specialty societies also expressed appreciation for our commitment to the refinement process.

Response: We, in turn, are appreciative of these positive comments. We believe that it is only because of the cooperative working relationship between the specialty societies, the AMA and CMS that there has been such a high level of success in tackling practice expense refinement.

Comment: The American College of Physicians as well as other specialty societies representing surgeons, otolaryngologists, podiatrists, geriatric psychiatrists, obstetricians and gynecologists, cataract and refractive surgeons, neurosurgeons, dermatologists, rheumatologists, radiologists and radiation oncologists supported our inclusion of the PEAC recommendations in the proposed rule because this would better enable specialty societies to address their impact and make comments prior to publication of the final rule.

However, specialty societies representing chest physicians and thoracic physicians disagreed with our decision to change our previous practice of including the PEAC recommendations in the final, rather than the proposed rule, because this meant that the recommendations from the March PEAC meeting were not included for this year. The society argued that changing this long-standing policy without announcing it in the **Federal Register** is inappropriate. The comment also contended that the specialty societies agreed to the inputs at the PEAC meeting; therefore, negative comments would not be forthcoming.

Response: We discussed this issue at the January PEAC meeting and indicated that we were considering including the PEAC recommendations in the proposed rule and that the March recommendations would most likely not be included. We made this decision because, now that the PEAC is refining such a large number of codes, the revisions to the inputs were not only changing the practice expense RVUs of the refined codes, but also the values of services that were not refined. Therefore, we believed it was prudent that revisions be subject to comment before the revisions were implemented.

Comment: The specialty society representing podiatry identified some discrepancies between the PEAC recommendations and the inputs in the CPEP database for CPT codes 10060, 11000, 11055, 11056, 11057 and 11752 and requested that these be corrected.

Response: We have made the corrections as requested.

Comment: The American Society of Transplant Surgeons (ASTS) commented that it is not appropriate to apply either the PEAC-approved standard clinical staff times or RN/LPN/MTA staff blend for 90-day global procedures to the transplant recipient or living donor services. ASTS stated that it had been unaware that the PEAC was applying the standard to all 90-day services unless a case was made to the PEAC that the times should be increased. ASTS argued that there are substantial atypical staff times required for transplant recipients due, in large part, to the intensive education required for the transplant patient. The commenter noted that the three new CPT codes for living donor hepatectomies, CPT codes 47140–47142, were given increased pre-service clinical staff time by the RUC and have an RN as the staff type. ASTS requested that the current clinical staff times be retained and that an RN be assigned rather than the blended staff type to the following transplant services: CPT codes 32851, 32852, 32853, 32854, 33935, 33945, 47135, 47136, 48554, 48556, 50320, 50360, 50365, 50380, 50547.

Response: It does seem reasonable that at least some of these services would have increased pre-times as do the living donor hepatectomies recently reviewed by the RUC. Therefore, we will restore the original CPEP clinical staff pre-times and use the RN staff type for the above services on an interim basis for the coming year. We anticipate that the society will bring all of these codes to the PEAC for review for either the January or March meeting to ensure that the times for the codes receive the same scrutiny as did the new transplant codes. It should be noted that a few of the codes have lower original CPEP pre-time than the PEAC standard of 60 minutes; for those codes we did not change the PEAC standard time. We also are not revising the post-procedure clinical staff times for these codes, because the current times are in line with the post-service times assigned to the new living donor hepatectomy codes recently reviewed by the RUC.

Comment: A commenter noted that high dose rate (HDR) brachytherapy CPT codes 77781, 77782, 77783 and 77784 were not listed in Addendum C of the proposed rule. Since these codes were approved by the PEAC and forwarded to CMS, ACR questioned why these codes were not listed.

Response: The CPEP data base files had been revised to reflect the PEAC recommendations for these codes. It was an oversight that they were not included in Addendum C.

Comment: The American College of Surgeons listed several possible errors in the CPEP database:

CPT code 11450—missing 1 minute of staff time

CPT codes 10080, 10081, 11770, 12032, 12035, 12046, 12047, 21550, 21920, 37609, 38300, 45300–45327, and 46600–46615—missing correct number of gloves.

CPT codes 45900, 45905, 45910, 47382, 49320, 49321, 49322, 49422, 49429—supplies listed incorrectly—have nonfacility inputs when PEAC recommended none in office setting.

Response: We thank the College for checking the database so carefully. We have made the suggested corrections, with the following notes: For CPT codes 10080, 10081 and 11770, the PEAC recommendation listed 5 gloves, not 6. For CPT codes 45300–45327 and 46600–46615, we adjusted the quantity of unsterile gloves to reflect that there are 2 pair in the minimum visit supply package; in addition, CPT codes 45321 and 45327 were not priced in the nonfacility setting.

Comment: The American Society of Colon and Rectal Surgeons noted a few errors in the CPEP supply database. The supply inputs had not been changed to match the accepted new recommendations for CPT codes 45900, 45905, 45910, 47382, 49320, 49321, 49322, 49422 and 49429.

Response: We have made the corrections to the supply database and thank the specialty for bringing this to our attention.

Comment: The American Speech-Language-Hearing Association (ASHA) questioned the proposed 28 percent reduction in the practice expense for CPT code 92507, *Treatment of speech, language, voice, communication, auditory processing and/or aural rehabilitation status.* The reduction is attributable to a decrease in clinical staff time. ASHA contended that the PEAC recommendation was based on a vignette for a child receiving such therapy, but that the time involved with a typical adult patient receiving this treatment is much longer. ASHA stated that a more reasonable time for clinical staff for this service is 69 minutes compared to the proposed 46 minutes.

Response: We understand that the scenario for performing this service for a child might be very different than for an adult because an adult can participate in a more protracted therapy session. Because it is not clear to us at this time what would be the typical scenario, we will, on an interim basis, average the clinical staff time needed during a speech therapy session for a child with that suggested by ASHA for an adult. We will, therefore, assign 58 minutes of clinical staff time to this service, with the expectation that ASHA will present CPT code 92507 for further discussion and review at the PEAC.

Comment: We received several comments in response to our acceptance of PEAC recommendations for evaluation and management (E/M) codes that reduced payment rates for six nursing home services (CPT codes 99301–99303 and 99311–99313) and two home visit codes (CPT codes 99348 and 99350). This payment reduction is primarily due to a decrease in the clinical staff time assigned to these services.

The American Academy of Family Physicians (AAFP) supported our acceptance of the PEAC recommendations for the E/M nursing facility services. The commenter noted that current practice expenses are higher for services provided in the non-SNF nursing facility than those provided in the SNF facility. The commenter contended that the direct practice expense inputs should not vary based on the type of nursing facility setting and supported the elimination of the current differential in the practice expense RVUs between the SNF and non-SNF facility setting.

However, the American Medical Directors Association (AMDA) representing long term care physicians, the American Geriatrics Society (AGS) and a health care management company, Health Essentials, all disagreed with our decision to accept the E/M nursing facility PEAC recommendations and asked us to reconsider our decision to implement them in 2004. The request to delay implementation was echoed by the American Academy of Home Care Physicians and AGS relating to the two E/M home visit codes.

The home care physicians argued that the PEAC recommendations for the two home visit codes are flawed because these codes have not yet been surveyed by the specialty performing this service. The commenters also contended that their views were not represented when the PEAC considered the refinements of the E/M home visit codes. Similarly, the AMDA noted that the PEAC workgroup responsible for formulating the recommendations for the nursing facility codes did not include long term care physicians. The AMA also commented on this issue and expressed concern that the PEAC recommendations did not include the views of all the relevant medical specialties and requested that we delay implementation of these E/M code recommendations to allow impacted medical specialties an opportunity to present new information to the PEAC.

In addition, the AMDA expressed concern regarding the current work RVUs for nursing home visit services.

Response: At the time the PEAC recommendations were forwarded to CMS, we agreed with the views expressed by the AFPP as to the reasonableness of the practice expense recommendations for the E/M codes for the nursing facility and home visits. However, we are also of the opinion that the relevant medical specialties should be given the opportunity to have their views considered by the PEAC. Consequently, we will not go forward with these E/M recommendations in 2004. This will allow time for the PEAC to reconsider the eight E/M codes with input from representatives from the nursing home and home visit specialties. We will use current CPEP practice expense inputs to price these codes for 2004.

With regard to the concern expressed about the work RVUs for the nursing home visits, in the 2004 final rule we will solicit recommendations on codes to be reviewed during the next 5-year review of work and we suggest that the society recommend review of these codes.

Comment: A specialty society representing gastroenterologists commented that the increased clinical staff pre-time added to certain colorectal procedures needs to be applied equally to gastroenterologists who provide those services.

Response: We have a single payment for each procedure regardless of the specialty performing the service. Therefore, gastroenterologists will be paid the same as colorectal surgeons when performing those services for which we allowed increased pre-service clinical staff time.

Comment: The American College of Radiology submitted several corrections to the CPEP database for those instances where the database differed from the PEAC recommendations that we accepted. The College stated its appreciation for the opportunity to review the practice expense data file for completeness and accuracy and applauded our efforts to ensure that the database captures correct and complete practice expense data.

Response: We thank the College for the time and effort expended in checking this detailed data. We have made revisions to 19 codes: We changed the quantity of sodium chloride injection for CPT codes 78306, 78315, 78460, 78461, 78464, and 78465; adjusted the quantity of films for CPT code 76812; added missing supplies to CPT codes 77408, 77409, 77411, 77412, 77414, 77416, 76830 and 77290; removed equipment that had been deleted from CPT codes 78478 and 78480; and corrected a typographical error in the pre-service clinical staff time for CPT codes 73218 and 75555.

g. Repricing of Clinical Practice Expense Inputs—Supplies

We use the practice expense inputs (the clinical staff, supplies, and equipment assigned to each procedure) to allocate the specialty-specific practice expense cost pools to the procedures

performed by each specialty. The costs of the original inputs assigned by the Clinical Practice Expert Panels (CPEP) were determined by our contractor, Abt Associates, based primarily on 1994 and 1995 pricing data from supply catalogs. In addition, for many items on the equipment and supply list, the associated costs were based on the recommendations of a CPEP panel member, rather than on actual catalog prices. Subsequent to the CPEP panels, equipment and supply items have also been added to the CPEP data, with the costs of the inputs provided by the relevant specialty society.

We contracted with a consultant to assist in obtaining current pricing information and also to recommend revisions to improve the uniformity and consistency of the CPEP supply database. On the basis of these recommendations, in the August 15, 2003 proposed rule, we proposed updates to the cost information for supplies in the database. In addition, we proposed the following database revisions:

—*Assignment of supply categories.*

We proposed that supplies be assigned to one of 14 categories.

—*Consolidation/standardization of item descriptions.*

We proposed combining items which appeared to be duplicative and modifiying descriptions using a key first word when possible for easier identification of items. For example, "mayo stand cover" and "drape, sterile Mayo" have both been changed to "drape, sterile, for Mayo stand."

—*Standardization of unit descriptions.*

The current CPEP database contains over 72 unit descriptions associated with supplies (for example, item, gram, and cup). To provide consistency and ensure that inputs in the database accurately reflect the quantity of an item used, we proposed to standardize the unit description of items. We also proposed to specifically identify items intended for single use through the use of "uou" (unit of use) following the unit. These changes were reflected in Addendum D of the proposed rule.

There were also items that had not been identified or for which pricing information was not found that were included in Table 1 in the August 15 proposed rule. Items that we proposed to delete from the database were also identified in this table. We requested that commenters, particularly the relevant specialty groups, provide us with the needed pricing information with appropriate documentation. We also stated if we did not obtain verified pricing information for an item, it would be eliminated from the database.

Comment: The RUC expressed appreciation for the enormity of the repricing project and stated that the proposed approach was well organized and comprehensive. The American Association of Orthopedic Surgeons also agreed that the assignment of supply categories would be helpful in future refinement activities. The American College of Physicians, the American College of Surgeons, and the American Urological Association expressed support for our proposal to create a numbering system and to standardize the descriptions of supply items to increase accuracy of use. The American Academy of Dermatology also supported this standardization of proposed "unit of use" as long as its application does not assume that "one size fits all" as some supplies may go from milliliter to liter in usage. The American Society of Cataract and Refractive Surgery and the Outpatient Ophthalmic Surgery Society thanked us for the repricing proposal because this will ensure that we are using the more accurate and up-to-date supply costs, thus reimbursing physicians more fairly. The American College of Radiology recognized the need to update supply and pricing information in the practice expense database and commended us for committing to this extensive project. The American College of Surgeons also agreed that the update of prices for supplies will improve the accuracy of the direct practice expense data. The Society of Nuclear Medicine commended us for committing to this extensive project. The American Urological Association also appreciated this effort and acknowledged it as a huge undertaking.

Response: We appreciate the positive feedback and would like to thank all the staff of the specialty societies who worked with our contractor to obtain the most representative prices for all of the supplies in the CPEP input database.

Comment: A specialty society representing podiatrists agreed with removal of hallux implant and the broach kit from the list of supplies to be included under practice expense as both are separately billable and the broach kit is also reusable. The commenter did not agree with removal of the sterile ankle tourniquet since this is packaged as a single use item. The comment included pricing information at $42.87 each (with documentation) for this supply.

Response: We will delete the hallux implant and the broach kit from the CPEP supply data. We will retain the ankle tourniquet using the pricing information supplied by the society.

Comment: Several commenters expressed concern about the reduction in nonfacility practice expense for the interstitial laser coagulation of the prostate procedure, CPT code 52647. A manufacturer of endo-surgery equipment stated that the main reason for this decrease was the decrease in the price assigned to the laser fiber used in this procedure. We had proposed a price of $290 for this item, but the commenter submitted documentation that indicated that the laser fiber should be priced at $850 for CPT code 52647. In addition, the commenter noted that we had proposed in Table 1 to delete the laser fiber because it was reusable; however, this was incorrect as the laser fiber used in this procedure could not be reused and should not be deleted from our supply list.

Response: When the laser fiber was repriced, we believed the item included in the supply list for CPT code 52647 was the same as a "laser tip," which was priced at $290. We thank the commenters for clarifying the issue. We agree that the laser fiber used in this procedure is a disposable supply that we will retain in our CPEP supply data at the $850 price documented by the commenter.

Comment: Commenters representing cardiac arrhythmia specialists and a remote cardiac monitoring system recommend that we not delete the transtelephonic monitor as a supply even though we are correct that the patient and physician re-use this supply during the course of the pacemaker's life. The specialty society commenter requested that the expense of this supply, which costs $190, should be spread out over approximately 5 years.

Response: The transtelephonic monitor as described would be considered a piece of equipment, rather than a reusable supply. However, unless the equipment costs over $500, we consider it as an indirect cost and it is not included as a direct input. Therefore, we will delete the item from our list of direct practice expense inputs as proposed.

Comment: A specialty society representing chest physicians agreed that the oximetry sensory probe, CPAP nasal pillow and flow sensor are reusable and should be deleted from the list of CPEP supply inputs. The society also agreed that albuterol is separately billable and should also be deleted. Another commenter, representing sleep medicine, agreed that the nasal pillow should be deleted. However, the commenter representing chest physicians and a commenter representing thoracic physicians disagreed with the proposal to delete

methacholine chloride because there is no "J" code to use when billing, thus forcing physicians to used an unlisted service code. The commenters also contended that the aerochamber should not be deleted because, although reusable, it has a life of only about six months and should be costed out accordingly. In addition, the commenters disagreed that the inhaler is separately billable because a multi-use canister is utilized for this test; therefore, the amount used from the canister for each test should be included in the practice expense.

Response: We will delete the oximetry sensory probe, CPAP nasal pillow and flow sensor and albuterol from the list of CPEP supply inputs. We will also delete the aerochamber, because an item that is reusable over a six-month period cannot be classified as a disposable supply. The commenter is correct that there is not a HCPCS "J" code for methacholine chloride. Therefore, we will keep this in the supply database as requested so that physicians can avoid the burden of submitting paper claims. We also will keep the inhalant in the database using the quantity of 1 gram per procedure at $0.788.

Comment: Specialty societies representing radiologists and interventional radiologists disagreed with the classification of the Arrow mechanical thrombectomy device as reusable. The commenter contended that this device is single-use because the difficulty in cleaning the intra-luminary surface areas could lead to a risk of contamination if the device is reused. Moreover, reprocessing the thrombectomy device may result in fatigue-related failure.

The societies also disagreed with our contention that a Seldinger needle is reusable; rather a Seldinger needle is single-use and should not be removed as a supply item. It is the commenter's understanding that hospitals are not in the practice of resterilizing Seldinger needles.

While generally favoring reorganization of CMS' supply listing for ease of use and not directly opposed to supply categories, one of the commenters was concerned over the potential loss of granularity of cost data associated with the use of supply categories and would oppose the averaging of costs for the supply categories unless it is appropriate to average from a cost and clinical standpoint. A similar comment was sent by the radiology specialty society.

Response: We will retain the thrombectomy device and the Seldinger needle as disposable supplies in our CPEP input database. With regard to the classification of supplies, the commenter misunderstands the purpose of assigning a classification to each supply. This will not be used for pricing purposes in any way. Rather, the classifications can be useful as a way to sort the long list of supplies in the database to make it easier to find a particular item.

Comment: The contractor responsible for helping us with the repricing of supplies informed us that a supply assigned to the endometrial ablation procedure, CPT code 58353, was listed as a catheter tray when it should be described as a thermal ablation balloon catheter at a price of $727. In addition, our contractor supplied us with prices for several new supply and equipment items mainly for otolaryngology, that were not priced in the proposed rule but were included in the PEAC recommendations.

Response: We will make the appropriate changes in the CPEP supply and equipment databases.

Comment: Commenters representing pediatricians, pulmonary physicians and family physicians pointed out that the new price we had assigned to the safety syringe and needle did not cover the actual cost of purchasing the entire needle stick device that is required by the Occupational Safety and Health Administration.

Response: Our repricing contractor researched this issue for us and agreed that the price we were proposing was too low for the appropriate item. Based on documentation for a 10 ml Syringe with SafetyGlide Needle, the safety syringe and needle will be priced at $.435 each, instead of the $.28 that was proposed.

Comment: A surgical society commenter pointed out that we listed an achalasia balloon in Table 1 in the proposed rule and indicated that it was a supply used with CPT codes 45905 and 45910. The commenter stated that both of these codes were refined in January and that they were not priced in the office setting; therefore the balloon should no longer be listed as a supply used with these services.

Response: Our CPEP database currently has these codes priced only in the facility setting. However, these services had previously been priced in the office and Table 1 was apparently developed before the last of the PEAC recommendations were entered. The achalasia balloon no longer appears on the CPEP supply database.

Comment: We received comments from the American College of Physicians and another medical society representing allergy and immunology with concerns about reductions in reimbursement for the five venom immunology CPT Codes (95145–95149). The commenters believe the reductions are due, in part, to the use of incorrect supply costs for venom extracts that we priced at $5.18 per ml. The commenters provided documentation of current prices of five different venoms from two of the largest manufacturers of venom extracts. They proposed a price-averaging methodology utilizing the small and large quantities of venoms that are available from the two suppliers. A price of $12.22 per milliliter of venom antigen results from using this methodology, and the commenters suggest that this price be used in valuing four of the five CPT Codes for venom immunology, with the exception of CPT Code 95147. When a patient requires three stinging insect venoms, as for CPT 95147, the commenters believe the 3-Vespid mix is typically used. Again, the commenters suggested the same price-averaging method noted above using cost information from the two vendors, which results in a price of $23.49 per ml. This 3-vespid mix price could also be used to value CPT Codes 95148 (four venoms) and 96149 (five venoms) with the single venom, priced at $12.22, added once to CPT code 97148 and twice to CPT Code 97149.

Response: We were pleased to receive the comments, as well as the requested documentation, on the price for various venom extracts, because the venom pricing information was not included in the PEAC recommendations forwarded after the September 2002 meeting for these CPT Codes. This lack of data necessitated the use of a generic stinging insect venom price of $5.18 per ml. We accept the pricing information supplied by these specialty societies, although we do not agree with their proposed averaging of prices from both the small (5ml and 6ml) and larger (10ml and 12ml) quantities of venoms. We believe it is more appropriate to average the venom prices using the larger (10ml and 12ml) quantities because of the volume that is used in an accepted venom immunotherapy program, which consists of a build up period of about four months followed by monthly maintenance therapy. The following prices result from this approach: $10.70 per ml of venom and $21.26 for the 3-Vespid Mix. Venom pricing for the five CPT codes would be as follows: CPT Code 95145 (one venom) at $10.70, CPT Code 95146 (two venoms) at $21.40, 95147 (three venoms using 3-vespid mix), would be $21.26; CPT Code 97148 (four venoms), $21.26 + $10.70 = $31.96; and the venom antigen price for

CPT Code 97149 (five venoms) would be $42.66 ($21.26 + $10.70 + $10.70).

Comment: JCAAI also supplied pricing information for the multi-tine device that was requested in Table 1 of our proposed rule. As was suggested above, the commenters again proposed we average costs for high and low volume purchases, excluding bulk pricing, to obtain the price for each test.

Response: We appreciate the pricing information forwarded by JCAAI and selected a purchase quantity that is in the middle of the suggested range. For percutaneous allergy testing, CPT code 95004. This purchase quantity represents testing 200 typical patients, each receiving 40 tests. We have added this Multi-tine per test price, $0.233,to the CPEP database for CPT codes 95004 and 95010.

Comment: The American Speech-Language-Hearing Association (ASHA) provided pricing information for the following items accompanied by the requested documentation: Aphasia assessment treatment forms—$2.84 (for a diagnostic aphasia examination form and aphasia diagnostic profile), communication books/treatment notebook—$1.50 and eartip insert—$0.65 each or $0.39 each (two sources). The American Academy of Otolaryngology—Head and Neck Surgery (AAO–HNS) submitted a price for the eartip insert of $0.23 each and suggested that the communication books/treatment notebook be deleted. The (AAO–HNS)also submitted a price for cottonoids at $0.875 each and for the phenol applicator kit at $15.95 each.

Response: We will use the submitted price for the aphasia forms and will price the eartip insert at $0.423, which is the average of the three prices submitted. The notebook, which is assigned to the speech-language therapy code, would be used over a course of treatment, and is not a disposable supply that is used or priced for a single service. Therefore, we will delete this item from our CPEP supply data. For the phenol applicator kit, we will use the price of $15.152 per kit that represents an average price for a 6-kit and a 24-kit quantity purchase. Because these kits contain the phenol that is used in the procedures, phenol has been deleted as a separate supply from the 11 CPT codes that are assigned the kit. AAO–HNS used a 10-pack quantity to assign a price to each cottonoid, but we are using a 200-pack quantity that reflects the high usage of this item. Therefore, we are using $0.773 as the price for each cottonoid.

Comment: Specialty societies representing radiation oncology and radiology disagreed that the fiducial screws used with the intensity modulated radiation therapy procedure should be deleted from the CPEP input supply list. The society argued that the screws are typically used for this procedure and that they are not separately billable.

Response: We will retain the fiducial screws in the list of supplies assigned to the intensity modulated radiation therapy procedure.

Comment: The American Society of Colon and Rectal Surgeons offered description changes for two services, CPT codes 46917 and 46924. The society recommended that the descriptor for the laser tip for both codes be changed to "laser tip, bare (single use)" at $150. The commenter also requested that an ablation laser generator at $59,890 be added to both codes and the existing laser, diode laser, and laser generator be deleted.

Response: A note from our contractor who is working on our repricing effort verified the above changes and we have revised our supply and equipment databases to reflect them.

Comment: The American Association of Orthopaedic Surgeons agreed with the proposed supply deletions listed in Table 1 of the proposed rule that are used in orthopaedic surgery. In addition, the association agreed with the concept of standardization of unit descriptions. However, the comment contends that the term "unit of use (uou)" is unclear and that we should consider alternative terms and abbreviations that would be more intuitive.

Response: The supply items in Table 1 that were listed for orthopaedic surgery are broach kit, hallux implant, sterile hand table drape, sterile cuff tourniquet, cephalosporin and sterile ankle tourniquet. As stated above, we will be deleting the broach kit and hallux implant and will also delete the hand table drape, cuff tourniquet and cephalosporin. As also noted above, we will retain the sterile ankle tourniquet in the supply database because the comment from the podiatry society argued that this item was not typically reused.

With regard to the comment on the use of "unit of use," we selected the "unit of use" (uou) term to indicate any item that is packaged for single use, even if the item is not completely used up. This most often occurs with items that are packaged sterile. For example, "bacitracin (0.9gm uou)" refers to one 0.9gm foil package. The quantity entered would be 1 and not a smaller amount such as 0.3. Once this foil package is broken, it is considered "used up" and therefore the unit of use is 0.9gm. Specifically, any item with a "unit of use" designation is meant to be indicated in whole number "unit of use" quantities, not partials (*e.g.,* entered as 1, 2, 3, etc, and not 0.5, 1.5, etc.).

Comment: A commenter representing sleep medicine stated that our proposed price of $25 is significantly below prices for standard CPAP masks used in the polysomnography service, CPT code 95811. The commenter submitted prices from two manufacturers that average to $88.

Response: It appears that the commenter has submitted prices for a reusable CPAP mask that would not be included in our CPEP data as a disposable supply. Therefore, we will price the disposable mask at $25.135, as proposed.

Comment: We received a comment from the American Physical Therapy Association (APTA) that contended there is a rank order anomaly caused by the increased price for the electrode used for CPT code 97033, iontophoresis. APTA noted that the price of a "pair" of electrodes was $16 in 2001 but has increased to $23.98 under our current supply repricing initiative. APTA has asked that we review the proposed cost of this item as a means to moderate the rank order anomaly.

Response: We appreciate the comments offered by APTA and have reviewed the cost of the supplies assigned to the iontophoresis service. We determined that the electrodes for this service are packaged and priced as "kits" that contain the complete set of electrodes needed to provide one iontophoresis treatment. Therefore, only one electrode "kit" is needed for this code, as opposed to the two electrode "pairs" currently in our supply database. Consequently, we have changed the supply list for iontophoresis in our database to reflect that there is one kit, not two electrodes, at the proposed price of $11.99. We believe that this should correct the rank order anomaly.

The following table, "Table 1 Items Needing Specialty Input," lists those items on which we had requested specialty input, comments we received and the actions we are taking.

TABLE 1.—ITEMS NEEDING SPECIALTY INPUT

2003 PE supply description	2003 PE unit	2003 PE price	Primary specialties	Prior status of supply item	Commenter response	CMS action taken
Acetylcholine 10%	1 gram	$0.40	Nurse practitioner, neurology.	See Note C. Need patient-use item, not R&D item.	None	See Note D.
Aerochamber	1 item	.....	Cardiology, internal medicine.	Item may be deleted. May not be typical and may be separately billable.	Agree—reusable. Requests item be retained.	Disagree—Deleted.
Albuterol	1 ampule	.....	Family practice, internal medicine.	See Note B	Agree—separately billable.	Deleted
Anthralin ointment	1 g	2.75	Dermatology	See Note C	None	See Note D.
Aphasia assessment—forms average.	1 item	0.95	Psychiatry, neurology.	See Note C	Pricing information submitted at $2.84.	Retained at submitted price.
Balloon, achalasia	1 item	255.00	General surgery, colon and rectal surgery.	See Note C. (Codes utilizing this item being reviewed by CPT).	NA in non-facility	Deleted.
Blood dress package	1 item	.....	Neurosurgery	Item may be deleted. Gowning items listed separately.	None	Deleted.
Broach kit	1 item	.....	Podiatry, orthopaedic surgery.	See Note A	Agree—separately billable and reusable.	Deleted.
Cable for EMG needle electrode.	1 item	1.20	Neurology, PM&R ...	See Note A	None	Deleted.
Centimeter ruler	1 each	2.39	Radiation oncology, dermatology.	See Note A	None	Deleted.
Cephalosporin	1 gm	.....	Podiatry, orthopedic surgery.	See Note B	Agree—separately billable.	Deleted
Chordae Villae sampling kit.	1 item	.....	Obstetrics, gynecology.	Item may be deleted. Duplicated item with catheter-stylet kit.	None	Deleted.
Collagen kit	1 each	1383.00	Urology	Need kit contents. Collagen sold as individual syringe. No commercial kit available.	NA in non-facility	Deleted.
Communication book/ Treatment notebooks.	1 each	.....	Otolaryngology, audiology.	See Note C	Audiology priced at $1.50 or $3.50. ENT proposed to delete.	Deleted—reusable.
Cottonoids	1 item	.....	Otolaryngology	See Note C	Submitted price of $0.875.	Retained at $0.73.
CPAP nasal pillow	1 each	.....	Pulmonary medicine	Item may be deleted. Disposable CPAP face mask also included in code 95811. Nasal pillows used with reusable mask.	Agree—not typical ..	Deleted.
Cysto-catheter kit	1 item	9.04	Urology, general practice.	Need kit contents and source/pricing information.	None	Deleted.
Detection kit	1 slide	8.50	Pathology, neurology.	See Note C	None	See Note D.
Developmental testing—forms average.	1 item	2.64	Clinical psychologist, multiple other specialties.	See Note C. (Original item price estimated by CPEP member.).	Submitted price of $0.40 for 96110 and $2.44 for 96111.	Retained at submitted prices.
Eartip insert with sound tube.	1 item	.....	Otolaryngology, audiology.	See Note C	Pricing information submitted by two specialties.	Retained at $0.423.
EEG electrode, gold DIN.	1 item	0.07	Neurology	See Note A	None	See Note E.
Electrode, ring	1 item	475.00	Obstetrics, gynecology, urology.	See Note A	None	Deleted.

TABLE 1.—ITEMS NEEDING SPECIALTY INPUT—Continued

2003 PE supply description	2003 PE unit	2003 PE price	Primary specialties	Prior status of supply item	Commenter response	CMS action taken
Electrodes, pickup, black tin, 9mm.	1 item	0.42	Podiatry, neurology	See Note A	None	See Note E.
Electrodes, pickup, red tin, 9mm.	1 item	0.42	Podiatry, neurology	See Note A	None	See Note E.
Fiducial screws, set of 4.	1 set	558.00	Radiation oncology	Item may be deleted. May not be typical and may be separately billable. (Screws used for IMRT head fixation device, but typical patient vignette is prostate cancer.).	Disagree—not separately billable. Specialty requests item be retained.	Agree—Retained.
Film, fluoroscopic	1 sheet	3.51	Diagnostic radiology, anesthesia.	See Note C	None	See Note D.
Flow sensors	1 item	1.51	Pulmonary medicine, internal medicine.	See Note A	Agree—reusable	Deleted.
Gold-palladium target	1 item	0.59	Pathology	See Note A	None	Deleted.
Hallux implant	1 item		Podiatry, orthopaedic surgery.	See Note B	Agree—separately billable.	Deleted.
Headcover for MRI	1 item	0.05	Diagnostic radiology	See Note C	None	See Note D.
Inhalant	1 ml	0.75	Cardiology, internal medicine.	Item may be deleted (May not be "typical" for service.).	Use is typical	Retained at $0.788.
Laryngeal mirror	1 item		Diagnostic radiology, otolaryngology.	See Note A	None	Deleted.
Laser fiber	1 item	595.00	Urology	See Note A	Disagree—not reusable. Submitted price of $850.	Agree—retained at submitted price.
Laser fiber cleaving tool.	1 item	200.00	Urology	See Note A	None	Deleted.
Methylcholine chloride.	1 dose	48.50	Pulmonary medicine, internal medicine.	See Note B	Disagree—not separately billable. Requests item be retained.	Agree—Retained at $39.95.
Mounting tray	1 each	40.00	Radiation oncology, diagnostic radiology.	See Note A	None	Deleted.
Multi-tine device	1 item		Allergy/immunology	See Note C	Submitted pricing information.	Retained at $0.23.
Needle, 4 inch	1 item		Obstetrics, gynecology.	See Note C	None	Deleted.
Needle, 4–6 inch	1 item		Obstetrics, gynecology.	See Note C	None	Deleted.
Needle, seldinger	1 item	72.90	Diagnostic radiology, multiple other specialties.	See Note A	Disagree—not reusable.	Agree—Retained.
Neurobehavioral status—forms average.	1 item	5.77	Clinical psychologist, multiple other specialites.	See Note C. (Original item price estimated by CPEP member.).	None	See Note D.
Oximetry sensor probe.	1 item	15.00	Multiple specialties	See Note A	Agree—resuable	Deleted.
Penile clamp	1 item	40.70	Urology	See Note A	None	Deleted.
Phenol applicator kit	1 unit		Otolaryngology	See Note C	Pricing information submitted.	Retained at $15.152.
Primary antibodies	1 slide	3.52	Pathology, neurology.	See Note C	None	See Note D.
Psych testing—forms average.	1 item	2.30	Clinical psychologist	See Note C	None	See Note D.
Receive coil			Diagnostic radiology	See Note A	None	Deleted.
Ruler	1 each	2.67	Radiation oncology, diagnostic radiology.	See Note A	None	Deleted.
Scissors and clamp, disposable.	1 each	0.62	Radiation oncology, diagnostic radiology.	Need clamp description and source/pricing.	None	See Note D.

TABLE 1.—ITEMS NEEDING SPECIALTY INPUT—Continued

2003 PE supply description	2003 PE unit	2003 PE price	Primary specialties	Prior status of supply item	Commenter response	CMS action taken
Sealant spray			Radiation oncology, diagnostic.	See Note C	None	See Note D.
Silverman needle	1 item	66.35	Urology	See Note A	None	Deleted.
Skin prep, one step	1 item	26.00	Cardiology	Need inches used per procedure (196in per roll).	None	See Note D.
Smoke evacuation cartridge.	1 item	146.50	Obstetrics, gynecology.	See Note A	None	Deleted.
Sterile, hand table drape (24x43).			Orthopaedic surgery, hand surgery.	Item Deleted. Integral part of hand/upper extremity drape supply item.	Agree	Deleted.
Sterilizing tray	1 each	64.00	Radiation oncology, diagnostic radiology.	See Note A	None	Deleted.
Steroid	1 cc	1.29	Urology	See Note B	None	Deleted.
Sweat cells, 4 in a set.	1 set	260.00	Neurology	See Note A	None	Deleted.
Thrombectomy device.	1 item	600.00	Diagnostic radiology	Additional information required. Device is reusable. Need to identify specific PTD single-use accessories (e.g. sheath rotator drive basket).	Disagree—device is not reusable.	Agree—Retained.
Tourniquet, ankle, sterile.	1 item		Podiatry, orthopaedic surgery.	See Note A	Disagree—packaged for single use. Price submitted at $42.87.	Agree—retained at submitted price.
Tourniquet, cuff sterile.			Orthopaedic surgery, hand surgery.	See Note A	Agree	Deleted.
Traction straps	1 item	60.00	Radiation oncology, diagnostic radiology.	See Note A	None	Deleted.
Transtelephonic monitor.		10.56	Cardiology	See Note A	Agree—resuable, but requests item be retained.	Disagree—Deleted.

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Notes:

A. Item deleted. Reusable
B. Item deleted. Separately Billable
C. Additional information required.
D. Issue is pending. Still under review.
E. Issue is pending. Reuse discussion needed.

h. Miscellaneous Practice Expense Issues

Hyperbaric Oxygen Services

We proposed to assign, on an interim basis, the following practice expense inputs to CPT code 99183, *Physician attendance and supervision of hyperbaric oxygen therapy, per session,* when performed in the office setting:

Staff: Respiratory Therapist for 135 minutes (for a 2 hour treatment); Supplies: Minimum Visit Supply Package, 180 liters of oxygen, 187 cubic feet of air; Equipment: Hyperbaric chamber.

Comment: A freestanding hyperbaric oxygen center expressed appreciation that we priced this procedure in the non-facility setting. The commenter also requested that we add certain staff time and some supplies to the practice expense inputs assigned to this service.

The additional supplies requested include disinfectant for cleaning the hyperbaric chamber after each patient, two otoscope covers to check patients' ears pre and post treatment, and a denture cup and urinal. An additional 24 minutes of clinical staff time (using the standard staff blend) was also requested for preparing the room, greeting and gowning the patient, patient education, taking vital signs before and after treatment, positioning the patient and cleaning the room.

Response: We believe that the request for the above additional practice expense inputs is reasonable. Currently, we have assigned clinical staff time only for assisting during the procedure itself; additional time was calculated using the times used by the PEAC for the tasks listed. Therefore, we are adding these inputs to those already assigned to the hyperbaric oxygen service. We have also requesting that the PEAC review these inputs at a future meeting and the RUC has stated that the PEAC will be reviewing this CPT code at the January or March 2004 meeting.

Comment: A commenter from another freestanding hyperbaric center expressed concern that the proposed physician fee schedule payment for CPT 99183 is approximately 25 percent of the payment in the hospital setting. The commenter lists additional costs that

should be considered such as special cleaners and solvents for cleaning the chamber, the costs of adherence to quality standards and costs for laundering patients' clothing, sheets and blankets. The commenter also stated that the hyperbaric chamber costs more than the $125,000 we have assigned the item.

Response: As mentioned above, we have added disinfectant solution for cleaning the chamber. We will be proposing the repricing of all equipment in our CPEP database next year, which should ensure that the price for the hyperbaric chamber reflects the typical cost. The cost of laundering and much of the quality assurance costs are considered indirect and are not reflected in our direct cost database. However, if the PEAC does refine this code as planned, we will review any recommendation submitted.

Maxillofacial Prosthetics PE/hour

We proposed to eliminate the special practice expense pool for maxillofacial prosthetic services and to use otolaryngology as the crosswalk for oral surgeons and maxillofacial surgeons as a more appropriate approximation of the specialties' practice expense per hour.

Comment: The American Association of Oral and Maxillofacial Surgeons expressed appreciation for our work on this issue over the past three years and heartily concurred with the decision to crosswalk maxillofacial prosthetics to otolaryngology. The American Academy of Otolaryngology-Head and Neck Surgery also supported our proposed crosswalk.

Response: We will implement the crosswalk of maxillofacial prosthetics to otolaryngology as proposed.

Holter Monitoring Codes

We proposed revising the practice expense inputs for holter monitoring codes to remove items that were not needed to perform the services. Specifically, we proposed deleting the ECG electrodes and laser paper, as well as the electric bed, computer and holter monitor from CPT codes 93225 and 93231 and deleting the razor, nonsterile gloves, alcohol swab and tape, as well as the electric bed and exam table from CPT codes 93226 and 93232.

Comment: A commenter representing an independent diagnostic testing facility and another representing cardiologists expressed support for the proposed revisions to the holter monitor codes.

We also received a comment from the RUC stating that the direct practice expense inputs for these above holter monitoring services will be reviewed by the PEAC at the January 2004 meeting.

Response: We will make the proposed changes to the holter monitoring codes on an interim basis and will be glad to review the recommendations from the PEAC when we receive them next year.

Other Practice Expense Issues

Comment: We have received requests from several commenters that we value certain procedures currently priced only in the facility setting in the non-facility setting as well. A manufacturer commented that there is a need to price the hysteroscopic endometrial ablation procedure, CPT code 58563, in the office to ensure Medicare patient access to this alternative to hysterectomy in the least intrusive and least costly setting. Several individual gynecologists have expressed concern about the absence of a nonfacility rate for this service because the facility payment does not cover the costs of performing this procedure in the office.

A manufacturer of endoscopic and surgical supplies and equipment expressed concern that several urology services which had previously been priced in the non-facility setting, are no longer priced in that setting. The commenter contended that the procedures can be performed safely in the office and that patients will be forced to go to a hospital or ambulatory surgical center for these procedures if the office payment does not reflect the direct costs incurred by the physician. The services in question are three cystourethroscopy procedures, CPT codes 52224, 52275, 52276, and two destruction of penile lesion procedures, CPT codes 54057 and 54065.

A consultant representing non-hospital based providers of LDL apheresis, CPT code 36516, requested that we price this procedure in the nonfacility setting and provided some cost data for this code. The commenter stated that this procedure is commonly provided outside of hospitals. A medical technology company requested that we price the percutaneous implantation of neurostimulator electrodes procedure, CPT code 64561, in the nonfacility setting. This service had previously been priced in the office.

Response: We are aware that technological advances make it now possible for more procedures to be safely performed in a physician's office. However, CPT code 58563 has recently been reviewed by the PEAC, and neither the gynecology specialty society nor the PEAC recommended pricing this code in the office setting. Likewise, the urology procedures and the neurostimulator service were reviewed this year by the PEAC and the apheresis services last year by the RUC, and the PEAC and the RUC recommended that these services not be priced in the office setting based on the presentation made by the specialty societies. We would not rule out working further with the commenters on these requests, but we believe that it would not be appropriate to take such an action in this final rule. We will be willing to discuss this issue further to determine whether any action should be proposed in the future.

Comment: The RUC comment identified the following anomalies in the CPEP database for the clinical staff time for a few codes with 000 day global periods:

B. (1) Percutaneous Abscess Drainage Codes

In 1997, CPT created new codes to differentiate between open and percutaneous abscess drainage. Unlike their open procedure counterparts, all of the percutaneous codes were assigned a global period of 000 days with no follow-up visits assigned. However, CMS crosswalked the direct inputs from the open codes, which have a different global period, to the percutaneous codes, including the time assigned for post-procedure office visits. The percutaneous abscess drainage codes identified are CPT codes 32201, 44901, 47011, 48511, 49021, 49041, 49061, 50021, 58823. The comment stated that each of these codes is currently priced in the facility setting only. Because these procedures are predominately performed in the inpatient setting, the comment further recommended that we assign zero direct practice expense inputs for these codes.

(2) Closure of Eyelid by Suture

The commenter also pointed out that CPT code 67875, Closure of eyelid by suture, has an assigned global period of 000 and includes no post-procedure visits in the work relative value. However, the original CPEP process appears to have assigned the code clinical staff time, supplies, and equipment related to a follow up visit.

Response: We agree with the RUC that these 0-day global codes should not have any direct costs assigned for post-procedure follow up visits. Therefore, we are deleting from the database all the inputs related to such visits.

Comment: Several commenters have expressed concern with the unexplained reduction in nonfacility practice expense RVUs for HCPCS code G0166, *External counterpulsation.*

Response: We have examined the practice expense data files and have

discovered an error in the database. This has now been corrected.

Comment: A specialty society representing dermatology commented that the practice expense RVUS for laser treatment of psoriasis procedures, CPT codes 96920–96922, appear overvalued.

Response: The practice expense has increased for these codes because we did not have a price for the laser tip used in these procedures until this year. The laser tip is now priced at $240. We have made adjustments to ensure the practice expense RVUs reflect the correct pricing of supplies as well as the specialty performing the service.

Comment: One specialty society that represents gastroenterologists commented that we cut the payment rate for the colonoscopy procedure, CPT 45385, by 10 percent in the nonfacility setting without explanation or justification.

Response: The decrease in payment for this code is due to the decreased practice expense inputs now assigned to the service. The PEAC submitted recommendations for the direct practice expense inputs for this service that were based on a presentation made by two other gastroenterological specialty societies, and we have accepted these recommendations because we believe them to be reasonable. The code was included on Addendum C, "Codes for Which We Received PEAC Recommendation on Practice Expense Direct Cost Inputs." in the proposed rule.

Comment: Several commenters representing pediatricians, family physicians and chest physicians stated their concern with the proposed decrease in the practice expense RVUs for immunization services, CPT codes 90471 and 90472, which were removed from the non-physician work pool and priced under the top-down methodology starting in 2003.

Response: We will return the two immunization services to the nonphysician work pool. As discussed above, we are increasing the price assigned to the needle stick prevention device that is in the supply list for the immunization codes. However, the practice expense RVUs for these codes would still be less than the current values. As discussed above, the price for the needle stick prevention device is still fluctuating as new manufacturers enter the market. In addition, it is still not clear exactly which device is optimal for the protection of medical staff. Therefore, until these issues are settled, we will price these immunization services in the nonphysician work pool. This will prevent any sharp decrease in payment for these codes, as well as for payments for the HCPCS G-codes for administration of influenza, hepatitis and pneumococcal vaccines, which are crosswalked to the payment for CPT code 90471.

Comment: We received a comment from Venable, a diathermy manufacturer, who voiced concerns about previous decreases in both the work and the practice expense RVUs for the diathermy procedure, CPT code 97024. According to the commenter, the PEAC recommendations we accepted for 2002 included a substantial reduction in clinical labor time, the elimination of supplies, and the undervaluing of the diathermy equipment, including the assignment of inadequate time for equipment use. Citing our current CPEP price of $3,120 as too low, the commenter noted the cost of the diathermy machines they manufacture range from $19,000 to $30,000 and noted the actual time of a typical treatment is 20 minutes, and not 15, as currently listed. A previous comment from the electrophysiology specialty section of the American Physical Therapy Association (APTA) stated that the average cost of diathermy ranges between $10,000 and $15,000.

Response: We believe the practice expense recommendation we accepted from the PEAC in 2001 for the clinical labor and supplies is appropriate. We would note here that the resultant PEAC recommendation for clinical labor was just one minute less than that proposed by the American Physical Therapy Association at the 2001 PEAC meeting. We continue to support the PEAC's decision to eliminate the supplies for some of the modality procedures, including diathermy, since these services are typically performed with other therapy procedures where the supply costs are captured. However, we agree with the commenter that the current pricing of the diathermy equipment in our CPEP database appears too low, and we will price the diathermy, on an interim basis, at $10,000 for the 2004 fee schedule. In addition, we will assign the requested 20 minutes as the typical time the diathermy equipment is in use for each service. We are planning to propose a repricing of all of the equipment included in our database next year and will revisit the pricing of the diathermy equipment at that time.

In response to the commenter's work RVU concern, next year's final rule will solicit recommendations of codes to be considered for review under the five-year review of work that is to occur in 2005.

Comment: A commenter representing prosthetic urology focused on reductions in payment for several 90-day global prosthetic urology procedures. The commenter contended that these procedures were affected by the adoption of the standard clinical staff times for 90-day global procedures that did not reflect the extra staff time required for patient training during post-procedure visits. In addition, almost half of the prosthetic urology services were established in 2002 and this appeared to have a negative effect on these codes. The commenter strongly recommended that the standard clinical staff times not be applied to the prosthetic urology codes and that we reinstate the "benchmark" clinical staff times.

Response: The commenter is correct that the major cause of the decrease in practice expense RVUs for these services is the use of the standard clinical staff time for 90-day global services. We do not have "benchmark" clinical staff times to reinstate for any of these services. Rather, the current staff times are from the original CPEP panel estimates that have not been reviewed by any multi-specialty panel, such as the PEAC. We accepted the PEAC recommendation to apply the standard clinical staff time to all 90-day global services that had not been reviewed by the PEAC as having exceptions to the standard times. All specialties, including urology, had ample opportunity to present any codes for which they believed the standards did not apply; these urology codes were not brought to the PEAC for review. We do not believe we have a sufficient factual basis for changing the clinical staff times for these services in this final rule. However, we would consider any recommendations for revising the pre- and post-service clinical staff times in the future. As to the effect of using the most recent utilization data in calculating the practice expense RVUs for the new prosthetic urology services, please see the discussion on "Utilization Data" earlier in this section.

Comment: A specialty society representing emergency medicine, an emergency medicine practice management association and an emergency medicine physician practice management organization all commented that the adjustment made in the November 2, 1998 final rule (63 FR 58821) to use the "all physician" practice expense per hour to calculate two indirect cost pools does not make up for the uncompensated care costs of emergency medicine physicians. The practice management association questioned our previous claim that this

adjustment was made as a proxy for uncompensated care and asserted it was rather a generic measure to address the low practice expense per hour for emergency medicine. The specialty society commented that it would be difficult to design a supplementary survey to capture the needed data on the levels of uncompensated care.

Response: It is amply clear from reading our entire response in the November 2, 1998 final rule that we considered the adjustment to the indirect costs to serve as a proxy for the uncompensated care experienced by emergency medicine physicians. We believe that, if this adjustment is seen by the specialty as insufficient, the best recourse is for the specialty to undertake a supplementary practice expense survey. By working with our contractor, the Lewin Group, the specialty society should be able to modify the survey in such a way that more accurate data on uncompensated care could be obtained. The data from such a survey could then take the place of the current adjustment to the practice expense per hour for emergency medicine because a proxy for uncompensated care would no longer be needed.

Comment: We received comments from a provider of extracorporeal photopheresis therapy, CPT code 36522, requesting a refinement of the practice expenses of this service in the office setting. Believing this service to be undervalued, the commenter supplied a comprehensive listing of the direct inputs, for the labor, equipment and supplies deemed necessary for the provision of this in-office service. Of particular note among the various suggested supply items was the inclusion of a photopheresis procedural kit.

Response: We want to thank the photopheresis provider for the practice expense suggestions. At this time, we do not have sufficient information regarding the typical resources needed to proceed with a comprehensive refinement of the practice expenses for the in-office provision of photopheresis. However, in reviewing the commenter's various practice expense proposals, we were struck by the obvious absence of the photopheresis procedural kit in our supply database. Consequently, this kit has been added to our CPEP database on an interim basis. We note that there are general similarities between the commenter's proposed inputs for clinical labor and equipment and our current data. We would anticipate a future discussion regarding this service in order to fully refine the practice expense direct cost inputs for photopheresis.

B. Geographic Practice Cost Index Changes

1. Background

The Act requires that payments vary among Medicare physician fee schedule (MPFS) areas according to the extent that resource costs vary, as measured by the Geographic Practice Cost Indices (GPCIs). 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 of the Act also requires us to phase in the adjustment and implement only ½ of any adjustment if more than 1 year has elapsed since the last GPCI revision. The GPCIs were first implemented in 1992. The first review and revision was implemented in 1995, the second review was implemented in 1998, and the third review was implemented in 2001. As explained in the August 15, 2003 proposed rule, the fourth GPCI review and revision was scheduled for implementation in 2004. However, because the work and practice expense GPCIs rely primarily on special tabulations of U.S. Census data not yet available, review and revision of only the malpractice GPCI component would occur for implementation in January 2004.

2. Malpractice GPCI Proposal

The malpractice GPCI is the most volatile of the three indices with relatively large variations existing between geographic payment localities. We proposed using actual 1999 through 2002 malpractice premium data and forecasting the malpractice premium rates for 2003. We were unable to include proposed malpractice GPCIs based upon this revised malpractice premium data in the August 15, 2003 proposed rule because we were still in the process of collecting the data. We stated that the revised malpractice GPCIs published in this year's final physician fee schedule regulation would be considered interim and subject to public comment.

3. Collection and Review of Malpractice Premium Data

For purposes of the 2004 update to the malpractice GPCIs we collected actual malpractice premium data for years 1999 through 2001. For 2002 we were able to obtain actual malpractice premium data for 32 states plus Puerto Rico. Where actual malpractice premium data were obtained, premiums were collected from the 20 physician specialties with the largest share of total Medicare RVUs for 2002. Premiums were collected from those insurers with the largest market share and those insurers that when summed with other large insurers comprised at least 50 percent of the state market share for claims-made policies with a $1 million individual case limit and $3 million aggregate case limit.

For those 18 states plus the District of Columbia for which we were unable to obtain actual 2002 premium data, we estimated the 2002 premium based upon an examination of growth rates from 1999 to 2001.

Malpractice premium data were not available for 2003. Two statistical approaches were examined to forecast 2003 malpractice premiums, simple extrapolation and projections based upon the average of historical year-to-year changes (mean rate of change). In most instances, the forecast 2003 premiums were similar using either approach. There was a tendency for the linear extrapolation method to yield slightly more extreme values (positive and negative) so the more conservative, mean rate of change approach was chosen.

Comment: Several commenters expressed concern about the continued use of proxy data, especially HUD residential rent data and nonphysician professional wage data, in the GPCI methodology.

Response: This final rule does not update the work or practice expense GPCIs. Any questions related to the use of proxy data in the calculation of the work and practice expense GPCIs will be responded to as part of future rulemaking.

Comment: One commenter stated that there should be no geographic differences under the physician fee schedule. This commenter felt that the data sources utilized for the construction of the locality specific GPCI indices do not accurately reflect legitimate differences in physician practice costs and that the current methodology did not appropriately reflect the variation that might be caused by case mix, availability of health care resources, and individual practice styles.

Response: Section 1848(e)(1)(A) of the Act requires that payments vary among areas as resources costs vary as reflected by the GPCIs. We agree that there will be some variation in case mix and practice styles between different specialties and individual practitioners. The physician fee schedule was established in 1992 to eliminate the large unjustifiable payment differences that existed among services, specialties, and geographic areas by establishing a national uniform payment system that can vary only as area resource costs vary as measured by the GPCIs. The GPCI component weights represent the

average physician expense weights across all physician specialties and are intended to reflect the average costs across all services and specialties in a geographic area and not to reflect exactly the costs of each individual practitioner.

Comment: One commenter stated that there should be no geographic payment differentials because these payment differentials operate as a disincentive for practitioners to practice medicine in rural areas.

Response: Section 1848(e)(1)(A) of the Act requires that payments vary among areas as resources costs vary as reflected by the GPCIs. It should be recognized that the current methodology associated with the calculation of GPCIs partially benefits practitioners in rural areas. This is because the law requires that only *one-quarter* of area cost differences in physician work, the largest of the three fee schedule components, be recognized. Thus, about 40 percent of fee schedule payments are by statute not adjusted for area cost differences. When combined with the index of 1.000 for medical equipment, supplies, and miscellaneous (which represents about 13 percent of total physician resource costs) this means that there is a national fee schedule for about 53 percent of the average physician payment. That is, only about 47 percent of overall physician payments are adjusted for area resource cost differences. In addition, 34 states have a single statewide GPCI wherein all physicians, whether urban or rural, are paid the same. All of these factors shift payments from higher cost, usually urban, areas to lower cost, usually rural, areas.

Comment: One commenter felt that we should not use projected 2003 premium data and instead should actually collect 2003 premium data.

Response: Currently, 2003 premium data is not available. This is why we will utilize projected 2003 premium data in this update. We plan to utilize more current premium data as it becomes available.

Comment: Although several commenters expressed their support for the use of more current malpractice premium data, a few commenters had concerns about the use of 2001 through projected 2003 premium data and felt that we should use only projected 2004 premium data in place of the three year average.

Response: Since the malpractice index has proven to be the most volatile of the indices in past updates, with significant changes from year-to-year, we will not base the malpractice GPCI upon just one year of projected data. In order to protect against aberrant premiums for any given year, we will utilize a three-year average. We will use 2001 through projected 2003 premium data for the three-year average.

The current methodology projects 2003 malpractice premiums based upon actual malpractice premiums for 1999 through 2002. Since we will continue to collect updated malpractice premium data, we do not think it is appropriate to project through 2004 absent actual 2003 malpractice premium data.

Comment: One commenter suggested that due to the volatility associated with malpractice insurance premium data, we should collect premium data and re-scale the Malpractice GPCI annually.

Response: We agree that, because malpractice insurance premiums are volatile, the Malpractice GPCI is also the most volatile of the three indices. We also agree with the commenter's suggestion regarding annual collection of malpractice premium data. We plan to undertake this collection for 2003 premium data in early 2004. If premium data suggest a re-scaling is warranted, we may revise the GPCIs more frequently than every three years.

Comment: Several commenters requested that we make available to the public the malpractice premium data that was utilized in the calculation of the revised malpractice GPCIs.

Response: Since some of the data upon which the GPCIs were constructed is based upon the reporting of individual malpractice insurance companies, there are some confidentiality issues associated with making the malpractice premium data public. We will attempt to make available any information that is appropriate on our Web site at *http://www.cms.hhs.gov*.

Comment: The American Medical Association's Relative Value Update Committee (RUC) has requested that CMS work with the RUC's Professional Liability Insurance Workgroup to explore the utilization of premium data that might be collected by the RUC.

Response: We agree with the RUC request and look forward to working with the RUC to obtain more current professional liability premium data.

4. Interim 2004 Malpractice GPCIs

Acquiring data on malpractice insurance rates and using that data to adjust Medicare payments for future malpractice insurance prices is a difficult task. Malpractice insurance rates are quite volatile due to a variety of factors. Some of these factors are changes in State insurance laws, business decisions of malpractice insurance carriers, and changes in how medicine is practiced.

The volatility of malpractice premium data was quite evident in the data we collected in conducting our review of malpractice GPCIs. Based on these data and the comments received on the August 15, 2003 proposed rule, we have modified some of our GPCI calculations and assumptions.

We are very concerned about implementing sharp changes in malpractice GPCIs for 2004, which directly impact physician fee schedule payment amounts. At the same time, we recognize the importance of updating malpractice GPCIs to ensure local differences in physician costs are included in payment amounts. To be sensitive to both of these considerations, we decided to apply a modulating factor of .5 to the changes in the malpractice GPCIs. In other words, as part of our review and analysis of the malpractice GPCIs, we reduced the difference between the new and previous malpractice GPCIs by 50 percent.

As directed by the statute, we will implement ½ of this change in the first year (CY 2004) and ½ of this change in the second year (CY 2005). During this two-year phase-in, we will continue to monitor local malpractice markets, work with the State Departments of Insurance, and collaborate with the RUC to obtain the most current and best malpractice premium data available. As better data are obtained, we will review, propose changes, and revise the malpractice GPCIs as appropriate. The transitional 2004 and full 2005 GPCIs can be found at Addendum D and Addendum E, respectively. These malpractice GPCI revisions necessitate a budget neutrality adjustment, as required by law. Therefore, we adjusted the 2004 through 2006 malpractice GPCIs by 1.0021.

5. Payment Localities

In the August 15, 2003 proposed rule we requested comments on the composition of the current 89 Medicare physician payment localities to which the GPCIs are applied.

Comment: We received numerous comments from professional medical associations, beneficiaries, and practitioners requesting that the specific counties in which they practice medicine or receive medical care be removed from their current locality assignment.

Response: We will continue to examine alternatives for reconfiguring the current locality structure. We expect to further consider this issue as part of future rulemaking.

C. Coding Issues

1. Payment Policy for CPT Tracking Codes

The November 1, 2001 final rule (66 FR 55269) included a discussion of CPT Category III codes (also known as CPT tracking codes) and stated that carriers have discretion for coverage and payment of services described by these CPT tracking codes unless we have made a national coverage determination (NCD). We have received requests to create national payment amounts for some CPT tracking codes even if there has been no NCD. Based on these requests, we proposed to change our policy regarding payment for CPT tracking codes and create national payment policy and determine national payment amounts for CPT tracking codes when there is a significant programmatic need for us to do so. This policy change would not change the contractor's discretion over coverage for the CPT tracking codes, but could establish a payment level to be used if the contractor finds that coverage is warranted. In addition, carriers would not be required to establish a payment amount for a tracking code until they receive a claim for the code.

Comment: Several commenters expressed concerns about this proposal. They believe that establishing a national payment rate for these codes risks premature creation of payment levels of reimbursement and creates an expectation for the future value of the code. The commenters also stated that establishment of a national price could also subvert the RUC process because such pricing could influence subsequent RUC valuation or our acceptance of the RUC's recommendations. Other commenters were supportive of the proposal, with some suggesting that we work with the specialty societies and the RUC in determining appropriate payment rates. One commenter suggested that an alternative to the proposal would be to use the existing refinement panel process because these refinement panels are multispecialty and feature the relevant specialty expertise. One commenter also requested we establish RVUs for specific tracking codes in the final rule.

Response: We understand the reservations and concerns of the commenters. As we indicated in the proposed rule, we would determine national payment amounts for CPT tracking codes *only* when there is a significant programmatic need for us to do so. If there is a need to establish payment amounts for a tracking code, we would appreciate the assistance of the relevant specialty societies and the RUC and such pricing would be subject to public comment. However, in some instances, interim values might need to be established if timing does not permit us to obtain prior input from the medical community.

Final Decision

We will finalize our proposal to create national payment policies and determine national payment amounts for CPT tracking codes when there is a significant programmatic need for us to do so. We note that, as discussed in the August 15, 2003 proposed rule, this policy change would not change the contractor's discretion over coverage for CPT tracking codes, but would establish a payment level if the contractor finds that coverage is warranted.

2. Excision of Benign and Malignant Lesions

The definitions for excision of benign lesions (CPT codes 11400 through 11446 inclusive) and excision of malignant lesions (CPT codes 11600 through 11646 inclusive) were substantively changed for 2003. These codes are now reported based on the excised diameter (actual skin removed) rather than on the size of the lesion. Based on these changes to the code descriptors, we proposed to make the work RVUs the same for removal of all skin lesions with the same excised diameters that are from the same area of the body, whether the lesions are benign or malignant. For example, the work RVUs for the removal of benign skin lesions from the trunk, arms or legs with excised diameter 1.1–2.0 cm, CPT code 11402, would be the same as the work RVUs for CPT code 11602, which is the removal of *malignant* skin lesions from trunk, arms or legs with excised diameter of 1.1–2.0 cm.

Comment: The specialty society representing dermatology objected to this proposal and contended that the excision of malignant lesions generally goes deeper and is more time-consuming than the excision of benign lesions and that malignant lesion excision also requires greater skill and embodies greater risk. The society stated that this proposal ignores a multi-specialty effort by a CPT Integumentary Workgroup, the CPT Editorial Panel and the RUC to revise the code descriptors and to assign work RVUs to these services. This view was supported by a joint comment from the heads of several surgical specialties. The RUC also urged us to delay finalizing this proposal until the RUC has the opportunity to provide further recommendations related to these services. In addition, the specialty societies representing podiatry, general surgery, colon and rectal surgery, osteopathy, ophthalmology, plastic surgery, otolaryngology as well as the AMA, the Mayo Foundation and individual physicians also urged us to withdraw this proposal. Medical Group Management Association requested the policy rationale for equating the work RVUs for the benign and malignant code pairs. The specialty society representing family physicians agreed with and supported our position that there is no difference in physician work involved in excising a benign or malignant lesion. However, the commenter did not support our proposal to implement such RVU changes unilaterally and stated that we should utilize the CPT and RUC process.

Response and Final Decision: We still believe that the physician work for these services is sufficiently similar not to warrant differences in the work RVUs. However, we will maintain the 2003 work RVUs as interim values for 2004 to allow opportunity for the specialty to resurvey these services. Note: That due to the adjustments to work RVUs to match the MEI weights, the work RVUs in Addendum B may differ from the values in 2003.

3. Create G Codes for Monitoring Heart Rhythms

As explained in the August 15, 2003 proposed rule, technological advances have made cardiac telemetry equipment, typically used in hospitals, available in the home setting. Coverage of this technology is currently at the discretion of the local Medicare contractors because there is no national coverage determination for this service. We proposed to establish new HCPCS codes to specifically describe this service along with proposed RVUs and PE inputs for payment as follows:

GXXX1—Electrocardiographic monitoring for diagnosis of arrhythmias, utilizing a home computerized telemetry station and trans-telephonic transmission, with automatic activation and real time notification of monitoring station, 24-hour attended monitoring, per 30-day period of time; includes recording, monitoring, receipt of transmissions, analysis, and physician review and interpretation. (global)

We proposed 0.52 physician work RVUs and 0.24 malpractice RVUs for this service and proposed crosswalking the practice expense inputs from CPT Code 93268 *Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; includes transmission physician review and interpretation.*

GXXX2—*Electrocardiographic monitoring for diagnosis of arrhythmias, utilizing a home computerized telemetry station and trans-telephonic transmission, with automatic activation and real time notification of monitoring station, 24-hour attended monitoring, per 30-day period of time; recording (includes hook-up, recording and disconnection).*

We proposed 0.07 malpractice RVUs and crosswalked the practice expense inputs from CPT Code 93270, *Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; recording (includes hook-up, recording, and disconnection).*

GXXX3—*Electrocardiographic monitoring for diagnosis of arrhythmias, utilizing a home computerized telemetry station and trans-telephonic transmission, with automatic activation and real time notification of monitoring station, 24-hour attended monitoring, per 30-day period of time; monitoring, receipt of transmissions, and analysis*

We proposed 0.15 malpractice RVUs and crosswalked the practice expense inputs from CPT Code 93271, *Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; monitoring, receipt of transmission, and analysis.*

GXXX4—Electrocardiographic monitoring for diagnosis of arrhythmias, utilizing a home computerized telemetry station and trans-telephonic transmission, with automatic activation and real time notification of monitoring station, 24-hour attended monitoring, per 30-day period of time; physician review and interpretation.

We proposed 0.52 physician work RVUs and 0.02 malpractice RVUs and also crosswalked the practice expense inputs, from *CPT code 93272 Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; physician review and interpretation only.*

Comment: Commenters representing cardiac arrhythmia specialists and cardiologists recommended that we withdraw the proposal to create new G codes for monitoring heart rhythms. The commenters stated that this request was not made by the medical community nor from the manufacturers of these heart rhythm monitoring systems. The commenters contended that the proposal appears to address specifically one manufacturer and specifies a particular mode of transmission and patient location, even though there are other new systems of this type that are not captured by this proposal.

The commenters recommended that we allow this technology to be utilized on a local level before implementing a national coding solution. The commenters further supported that when this new technology warrants a national coding solution, a CPT coding application should be initiated and then the code should be sent to the RUC for review. The commenting specialties stated their willingness to provide medical input into the evaluation, coding and reimbursement for this new technology. Two commenters also stated that the descriptors and the proposed reimbursement do not reflect the monitoring systems that have been developed. Other commenters also requested that we withdraw or reconsider our proposal, as it did not follow the established process for creating and valuing new codes. One specialty society representing clinical endocrinologists supported the establishment of these HCPCS codes, while another commenter, a cardiac monitoring company, provided a general outline of how the various cardiac monitoring technologies can best be used for maximum quality and value. Another commenter suggested that until efficiency of the new technology is demonstrated this proposal should be postponed.

Response: Our intention in proposing these G codes was to recognize and nationally price all currently available real time cardiac telemetry monitoring technology. It was not intended to address only one system currently in use. Based on the concerns raised by commenters, we will not proceed with these proposed HCPCS codes because we want to ensure that any HCPCS codes developed encompass the various technologies that are being utilized for such monitoring.

4. CPT Code 88180 (Flow Cytometry; Each Cell Surface, Cytoplasmic or Nuclear Marker)

Flow cytometry is a technique to analyze single cell suspensions from blood, bone marrow, body fluids, lymph nodes, and other tissues. The technique, currently coded as CPT code 88180, *Flow cytometry, each cell surface, cytoplasmic or nuclear marker,* quantifies cell surface, cytoplasmic, and nuclear antigens. The August 15, 2003 proposed rule discussed our concerns that the current coding scheme (payment on a per marker basis) may encourage the performance of more markers than may be medically necessary because the pathologist determines what markers to perform and when to perform them. We indicated that we understood the laboratory community would be reviewing this issue and considering whether to recommend changes to the current coding for the procedure. We also requested recommendations on appropriate values for the procedure should we wish to develop a future proposal.

Comments: Commenters, both individuals and organizations, asked that we not put forth a proposal for payment of flow cytometry. The College of American Pathologists (CAP) has proposed coding revisions to both the immunology and anatomic pathology section of CPT and is working with other groups to establish practice guidelines for flow cytometry. CAP asked that we not establish new "G" codes for 2004, but work with CAP and allow the CPT and RUC evaluation process to be used to determine appropriate coding and relative value units for flow cytometry.

Decision: We agree with the commenters. We will work with CAP, the CPT and the RUC to develop appropriate coding and payment policies for flow cytometry.

5. Change in Payments to Physicians Managing Patients on Dialysis

In the August 15, 2003 rule, we proposed to make CPT codes 90918, 90919, 90920, and 90921 for the monthly capitation payments (MCP) invalid for Medicare. We also proposed to create 3 new G codes in place of each CPT code with payments varying with the number of visits provided within each month to an end stage renal disease (ESRD) patient. Under our proposal, there would be separate codes when the physician provides 1 visit per month, 2–3 visits per month and 4 or more visits per month. The code for 1 visit per month would have the lowest payment while a higher payment will be provided for 2 to 3 visits per month and the highest payment for 4 or more visits per month. These new codes would be reported once per month for services performed in an outpatient setting that are related to the patient's ESRD. These physician services would continue to include the establishment of a dialyzing cycle, outpatient evaluation and management of the dialysis visits, telephone calls, and patient management provided during a full month. These codes would not be used if a hospitalization occurred during the month.

The proposed codes are as follows:

GXXX5—End Stage Renal Disease (ESRD) related services per full month, for patients under 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.

GXXX6—End Stage Renal Disease (ESRD) related services per full month, for patients under 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2 or 3 face-to-face physician visits per month.

GXXX7—End Stage Renal Disease (ESRD) related services per full month, for patients under 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.

GXXX8—End Stage Renal Disease (ESRD) related services per full month, for patients between 2 and 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.

GXXX9—End Stage Renal Disease (ESRD) related services per full month, for patients between 2 and 11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2 or 3 face-to-face physician visits per month.

GXX10—End Stage Renal Disease (ESRD) related services per full month, for patients between 2 and 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.

GXX11—End Stage Renal Disease (ESRD) related services per full month, for patients between 12 and 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.

GXX12—End Stage Renal Disease (ESRD) related services per full month, for patients between 12 and 19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2 or 3 face-to-face physician visits per month.

GXX13—End Stage Renal Disease (ESRD) related services per full month, for patients between 12 and 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.

GXX14—End Stage Renal Disease (ESRD) related services per full month, for patients 20 years of age and over; with 4 or more face-to-face physician visits per month.

GXX15—End Stage Renal Disease (ESRD) related services per full month, for patients 20 years of age and over; with 2 or 3 face-to-face physician visits per month.

GXX16—End Stage Renal Disease (ESRD) related services per full month, for patients 20 years of age and over; with 1 face-to-face physician visit per month.

We based the proposed payments on the assumption that many physicians would provide 4 or more visits to their ESRD patients and a smaller proportion would provide 2–3 visits or only 1 visit per month. Using Medicare utilization data from 2002, we proposed the following relative value units for the new G codes that would make Medicare's aggregate payments for ESRD related services under the physician fee schedule approximately equal to current payments for procedure codes 90918 to 90921:

TABLE 2

Code	Physician work	Practice expense	Malpractice
GXXX5	12.92	8.70	0.60
GXXX6	5.19	3.49	0.24
GXXX7	3.39	2.29	0.16
GXXX8	9.91	4.86	0.43
GXXX9	3.55	1.74	0.15
GXX10	2.32	1.14	0.10
GXX11	8.47	4.54	0.35
GXX12	3.14	1.68	0.13
GXX13	2.05	1.10	0.08
GXX14	5.16	2.94	0.22
GXX15	1.94	1.10	0.08
GXX16	1.27	0.73	0.06

As part of the proposed rule we also solicited comments on how to further revise our payment methodology to improve quality of care and outcomes. We requested information that could help us design future demonstrations that would study both dimensions of care (quality and utilization) and help ensure that payment is based on appropriate patient-specific care that has been shown to lead to improved outcomes for this complex patient population.

Comment: We received many comments from physicians, the RUC, specialty societies, dialysis centers and nephrologists, as well as other individuals and organizations who expressed concerns with our proposal to alter the way physicians are reimbursed for services provided to End Stage Renal Disease (ESRD) patients and who urged us to withdraw the proposal. The RUC and the AMA, as well as other specialty organizations, expressed disappointment that we developed this proposal without consultation from the medical community and outside the usual CPT and RUC process. The Renal Physicians Association (RPA), the American Society for Nephrology (ASN), the American Association for Kidney Patients (AAKP), and the National Kidney Foundation (NKF) all supported the principle of optimizing nephrologist-dialysis patient interaction, which is included in the proposal. However, the RPA contended that the proposal as currently constituted is unworkable, may negatively impact some dialysis patients and is being put on an unreasonably precipitous implementation schedule. The AAKP outlined similar concerns but believed that increased nephrologist-dialysis patient interaction will lead to improved outcomes and also urged that an advisory committee be established to assist in the effort to further improve quality and coordination of care for dialysis

patients. The Medicare Payment Advisory Commission (MedPAC) agreed that the current payment method lacks accountability and quality incentives, and thus encouraged CMS to address these issues. However, MedPAC also expressed concern that without baseline data it was unclear how we could determine and measure the impact of the proposed changes on quality and access. MedPAC further stated that the adjustments to payment should be made subsequent to the collection of information on resource costs and clinical guidelines. Together with these adjustments, further incentives should be added to the monthly payment to reward and improve the quality and access of dialysis-related physician care, which is consistent with MedPAC's June 2003 recommendations. Below are the specific issues raised by commenters:

Disproportionate Payment Differences

Many comments concerned the large variation in proposed payments to physicians who see a patient only once a month, compared to the proposed payment for seeing a patient either two or three times during the month or four or more times during the month. In addition, commenters stated there is more work involved in managing care of the ESRD patients between visits.

Response: Based on our review of the comments, we agree that a significant amount of physician work for patients with ESRD occurs outside of the face-to-face visit with the patients. Since there may be significant physician work associated with providing physician services to ESRD patients between visits, we agree that there should be less difference in the payment levels than we proposed. By raising the minimum payment level, we are accounting for the extensive patient care coordination and other non-face-to-face management required by ESRD patients. However, we continue to believe that more physician work is associated with more frequent face-to-face visits with the patient, and any variation in the payment amounts should reflect this difference.

First, we determined the appropriate relative relationship among different codes. For instance, we believe that approximately 25 percent more physician work is involved with providing two to three visits than with a single visit, and 50 percent more physician work is associated with providing four or more visits. By paying a single amount regardless of how often the patient is seen, we believe our current policy pays too much if the patient is seen fewer than four times per month. Thus, we revised our payment to be consistent with different levels of physician work associated with providing monthly management of dialysis patients. We are setting our aggregate revised payments equal to aggregate current payments. Consistent with these assumptions, we determined the following RVUs:

TABLE 3.—RELATIVE VALUES FOR NEW MONTHLY CAPITATION CODES

Age of patient	HCPCS	Number of visits	Work	Practice expense	Malpractice	Total
Patients Other Than Home Dialysis						
<2	G0308	4+	12.69	8.58	0.42	21.69
	G0309	2 to 3	10.57	7.13	0.36	18.06
	G0310	One Visit	8.45	5.72	0.28	14.45
2 to 11	G0311	4+	9.68	4.74	0.34	14.76
	G0312	2 to 3	8.07	3.94	0.29	12.30
	G0313	One visit	6.46	3.16	0.22	9.84
12 to 19	G0314	4+	8.24	4.45	0.26	12.95
	G0315	2 to 3	6.87	3.69	0.23	10.79
	G0316	One visit	5.50	2.96	0.17	8.63
20 +	G0317	4+	5.07	2.88	0.17	8.12
	G0318	2 to 3	4.23	2.39	0.14	6.76
	G0319	One Visit	3.38	1.92	0.11	5.41
Home dialysis patients (entire month)						
<2	G0320		10.57	7.13	0.36	18.06
12 to 19	G0321		6.87	3.69	0.23	10.79
2 to 11	G0322		8.07	3.94	0.29	12.30
20 +	G0323		4.23	2.39	0.14	6.76
Home dialysis patients (partial month only—per day)						
<2	G0324		0.35	0.24	0.01	0.60
12 to 19	G0325		0.23	0.12	0.01	0.36
2 to 11	G0326		0.27	0.13	0.01	0.41
20 +	G0327		0.14	0.08	0.01	0.23

We used the above principles to establish our monthly capitation payments (MCP) for patients 20 or older. For patients younger than 20, we are using the same relationship that exists among the current MCP codes for different age groups for the new codes that we are creating. For example, the current MCP code for a patient under 2 (CPT code 90918) has work RVUs that are approximately 2.5 times the work RVU for a patient 20 or older (CPT code 90921). Thus, Medicare's work RVU for each code for a patient 2 years or younger will be 2.5 times the amount of the corresponding service provided to a patient 20 or older. These values can be considered as interim and we plan to seek the advice of the RUC in evaluating these codes once the policy has been implemented. There are efforts underway (for example, in their 2004 workplan, the OIG has indicated they will conduct a review of ESRD monthly capitation payments and physician services) which will provide data on the type frequency and content of physician

encounters as suggested by MedPAC. However, we believe a change should be made in the interim to improve care and accountability. The use of these new codes will also enable us to collect data about the frequency of physician visits.

Regulatory Impact of Proposal on SGR and Conversion Factor

We received comments regarding the impact of these proposed changes on the sustainable growth rate (SGR) calculations. Commenters expressed concern that, if physician behavior changes and physicians increase the number of visits provided per month, actual expenditures would surpass the target projection, resulting in a future payment reduction for all of medicine.

Response: Section 1848(c)(2)(B)(ii)(II) of the Act requires that changes to RVUs cannot cause the amount of expenditures to increase or decrease by more than $20 million from the amount of expenditures that would have been made if such adjustments had not been made. As indicated above, we have established RVUs for the new monthly capitation codes so that Medicare's aggregate payments for these services are equal to what we would have paid in the absence of these changes. We are not expecting any impact on payment for other physician fee schedule services. However, we will continue to review this issue as we work with the medical community to further refine Medicare policy for treating patients needing dialysis services.

Home Dialysis

Many comments were received regarding home dialysis because patients who dialyze at home typically see their physicians less frequently than other ESRD patients. One commenter suggested that home dialysis patients be excluded from the proposed change and that we continue to pay the current MCP rate for services to these patients.

Response: We have created four G codes for the management of home dialysis patients in each of the age groups and will pay for the home dialysis patients at the same rate as codes G0309, G0312, G0315, and G0318 respectively. Although the codes for home dialysis patients will pay physicians slightly less than the former MCP, physicians will still have a relative incentive to increase the use of home dialysis. We believe this is consistent with Section 1881(b)(3)(B) of the Social Security Act which states "With respect to payments for physicians' services furnished to individuals determined to have end stage renal disease, the Secretary shall pay 80 percent of the amounts calculated for such services on a comprehensive monthly fee or other basis (which effectively encourages the efficient delivery of dialysis services and provides incentives for the increased use of home dialysis) for an aggregate of services provided over a period of time (as defined in regulations)."

The new G codes for the monthly management of home dialysis patients will be as follows:

G0320—End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients under two years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents.

G0321—End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients two to eleven years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents.

G0322—End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients twelve to nineteen years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents.

G0323—End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients twenty years of age and older.

The American Society of Nephrology also commented that "reimbursement should be constructed so that home dialysis patients should see their nephrologist at least monthly, with further visits on an as needed basis." We will not specify the frequency of required visits at this time but expect physicians to provide clinically appropriate care to manage the home dialysis patient.

If home dialysis patients are hospitalized during the month, four new G codes have been created: G0324, G0325, G0326, and G0327. These codes will be used to report daily management of home dialysis patients for the days the patient is not in the hospital. CPT codes 90922, 90923, 90924, and 90925 will be considered inactive for Medicare because they are now redundant as other codes are to be used by physicians billing for services to ESRD patients.

The new G codes are as follows:

G0324—End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients under two years of age.

G0325—End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients between two and eleven years of age.

G0326—End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients between twelve and nineteen years of age.

G0327—End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients twenty years of age and over.

For example, if a home dialysis patient is in the hospital for 10 days (counting the calendar day of admission and the calendar day of discharge) and is cared for 20 days in his or her home, then 20 units of the code for the appropriate aged patient is billed.

If a home dialysis patient receives dialysis in a dialysis center or other facility during the month, the physician is still paid the management fee for the home dialysis patient and cannot bill the codes in the range of G0308 through G0319 or CPT codes 90935 or 90937, even though the physician may see the patient during his/her center dialysis.

Role of Non-Physician Practitioners or Physicians Other Than the MCP Physician

We received comments about the role of nonphysician practitioners. It was not clear to the commenters whether visits by these practitioners could count as face-to-face encounters by the MCP physician. The commenters also asked about billing by physicians (for example, a "rounding" physician or fellow) other than the physician who is billing the monthly capitation rate.

Response: Physicians may utilize nonphysician practitioners: nurse practitioners, physician assistants, and clinical nurse specialists, who are able under the Medicare statute to furnish services that would be physician services if furnished by a physician and who are eligible to enroll in the Medicare program, to deliver some of the visits during the month. The rules for the use of these physician extenders would be consistent with the rules for split/shared evaluation and management visits: The nonphysician practitioners and physician must be in the same group practice or employed by the same employer/entity; and the physician must perform some portion of the service in a face-to-face encounter, in this case one or more visits during the month with the patient. In this situation, to bill the service under the physician's UPIN/PIN, the physician and not the physician extender should be the practitioner to perform the visit with the complete assessment of the patient and to establish the patient's

plan of care. If the nonphysician practitioner is the practitioner who performs the complete assessment and establishes the plan of care, then the MCP service should be billed under the UPIN/PIN of the nurse practitioner, physician assistant, or clinical nurse specialist.

It is also possible for the physician to use another physician to provide some of the visits during the month, but the physician who provides the complete assessment, establishes the patient's plan of care and provides the ongoing management should be the physician who submits the bill for the monthly service. The non-MCP physician must have a relationship with the billing physician such as a partner, employees of the same practice, or supervising physician and fellow doing sub-specialty training.

Each practitioner should document in a shared medical record services he/she personally performed. Only one practitioner can bill for the management of the ESRD patient in any month. In addition, when a nonphysician practitioner or a "rounding physician" sees a dialysis patient for management of ESRD, they cannot bill an evaluation and management service for the same patient unless there is a separate, substantial and documented service evaluating the patient for care unrelated to the patient's dialysis.

Geographic Issues

Commenters indicated that the lack of geographic considerations would negatively impact physicians and patients in rural and some urban settings where physician visits require significant travel time. Extended travel time can make it difficult for physicians to see patients as often as patients can be seen when the physician's office is near the dialysis facility.

Response: We believe that the policy to allow nurse practitioners, physician's assistants, clinical nurse specialists, and other physicians to deliver some of the visits to patients as well as changes in the payment to more accurately reflect non-visit services and the relative value of additional visits will ameliorate these access issues.

Lack of Clarity Regarding Hospitalization

Commenters noted that the proposed rule did not provide enough detail regarding alternative billing procedures if hospitalization occurs during the month.

Response: For ESRD patients (other than home dialysis patients) who are hospitalized during the month, the physician may bill the code that reflects the number of face-to-face visits during the month on days when the patient was not in the hospital (either admitted as an inpatient or in observation status).

Documentation Requirements

Comment: Many commenters asked for clarification regarding the documentation requirements, if any, associated with the new codes.

Response: We have chosen not to include specific documentation guidelines in this rule. Instead, physicians should document what is clinically relevant, including but not limited to the patient's current status and complaints, a clinically appropriate physical examination, assessment of the patient's treatment for ESRD that includes assessment of the adequacy of the dialysis treatment, the status of the patient's vascular access, assessment and treatment of the other conditions associated with ESRD, such as anemia, electrolyte management, and bone density, as well as changes to the patient's management.

HIPAA Compliance

Comment: A comment was received that HIPAA transaction and code set rules may not be met if these new codes were implemented.

Response: G codes are part of the HCPCS coding system and are in compliance with the HIPAA transaction and code set rules.

Outpatient Settings

Comment: Commenters asked for additional clarification on whether visits counted toward the MCP can be provided in settings other than the dialysis facility.

Response: The visits for management of ESRD patients may occur in the physician's office, in an outpatient hospital or other outpatient setting or even in the patient's home as well as in the dialysis facility.

Transient Patients

Comment: Commenters inquired how physicians would deal with visits and related billing for traveling patients who receive their treatment away from their usual site of treatment.

Response: If the physician manages the care of a patient who is receiving treatment away from the patient's usual site of treatment, the physician who bills for managing the care of the patient is still paid according to the number of times the physician has a face-to-face visit with the patient. If the patient is to be away for an extended period of time, the patient would be managed by the physician who has face-to-face visits with the patient, and that physician would be the one billing for the patient's care management.

Quality of Care and Outcomes

Comment: Commenters representing the American Osteopathic Association, the American Academy of Family Physicians, the National Coalition for Quality Diagnostic Imaging Services, the American Society for Echocardiography and Focus on Therapeutic Outcomes, Inc., provided information on quality initiatives their respective organizations have undertaken or suggestions for relating quality to payment. The National Kidney Foundation recommended the use of technology and other forms of communication to care for ESRD patients and to support constant attention to quality. In addition, the Society for Interventional Radiology commended our efforts to increase the use of arteriovenous fistulae for vascular access in dialysis patients as part of its National Vascular Access Improvement Initiative, but indicated there might be a need to clarify certain policies. The American Association of Kidney Patients (AAKP) also recommended the establishment of a commission or advisory group with representation of the kidney community that could be charged with recommending proposals to tie reimbursement to outcomes. AAKP stated that although the proposed changes are important, these changes remain a change in process of delivery of care that may improve actual outcomes, rather than a change in actual outcomes, that is, in rehabilitation, morbidity, mortality, and quality of life. MedPAC agreed with CMS that the proposed change to provide incentives for additional nephrologist-dialysis patient interactions may not be the ideal method to improve patient outcomes and to achieve this goal, CMS should partner with the ESRD community and work toward a long-term solution. MedPAC suggested that we investigate and incorporate physician clinical practice guidelines into our payment approach, and measure physician quality directly. MedPAC also suggested that we examine whether physician resources vary based on patient complexity, stating that to the extent that resources do vary, a case-mix adjustment—similar to the one MEDPAC recommended for payment to dialysis facilities in its June 2003 report—would be desirable.

Response: We appreciate the information and suggestions provided by the commenters and will take these into consideration. We plan to investigate the use of new technology to improve the management of ESRD

patients as part of our overall focus on quality.

Final Decision—We will create the following G Codes to be used for ESRD patients other than home dialysis, based on the age of the patient and number of visits:

G0308—End Stage Renal Disease (ESRD) related services during the course of treatment, for patients under 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.

G0309—End Stage Renal Disease (ESRD) related services during the course of treatment, for patients under 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2 or 3 face-to-face physician visits per month.

G0310—End Stage Renal Disease (ESRD) related services during the course of treatment, for patients under 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.

G0311—End Stage Renal Disease (ESRD) related services during the course of treatment, for patients between 2 and 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.

G0312—End Stage Renal Disease (ESRD) related services during the course of treatment, for patients between 2 and 11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2 or 3 face-to-face physician visits per month.

G0313—End Stage Renal Disease (ESRD) related services during the course of treatment, for patients between 2 and 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.

G0314—End Stage Renal Disease (ESRD) related services during the course of treatment, for patients between 12 and 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.

G0315—End Stage Renal Disease (ESRD) related services during the course of treatment, for patients between 12 and 19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2 or 3 face-to-face physician visits per month.

G0316—End Stage Renal Disease (ESRD) related services during the course of treatment, for patients between 12 and 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.

G0317—End Stage Renal Disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 4 or more face-to-face physician visits per month.

G0318—End Stage Renal Disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 2 or 3 face-to-face physician visits per month.

G0319—End Stage Renal Disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 1 face-to-face physician visit per month.

In addition we have created the following G codes for home dialysis patients:

G0320—End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients under two years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents.

G0321—End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients two to eleven years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents.

G0322—End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients twelve to nineteen years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents.

G0323—End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients twenty years of age and older.

G0324—End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients under two years of age.

G0325—End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients between two and eleven years of age.

G0326—End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients between twelve and nineteen years of age.

G0327—End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients twenty years of age and over.

6. Miscellaneous Coding Issues

Bioimpedance

Comment: We received several comments concerning the pricing of CPT code 93701, electrical bioimpedance. One commenter, a carrier medical director, requested that this service be considered a technical component service as there is no physician work (professional component) required to produce the results. The commenter referenced the RUC recommendation of 0.00 work that was not accepted by CMS in November 2001. Other commenters stated that pricing of this service should be revisited and the American College of Cardiology recommended work component of 0.25 RVUs be accepted. Commenters also questioned the valuation of the practice expense component, particularly in light of the escalating costs associated with this service.

Response: In next year's final rule we will be accepting recommendations for codes to be considered under the five-year review of work that will occur in 2005. The commenters will be able to respond to that solicitation, and submit this CPT code, as well as any other services they believe need to be reviewed to ensure they are appropriately valued. We are currently in the process of reviewing and obtaining updated pricing for equipment contained in the practice expense data files and proposed changes to pricing for equipment will be included in next year's proposed rule. We would suggest that the commenters review this information when published to ensure that the cost of the equipment is accurately reflected in the database.

Ablation Procedures

Comment: One commenter, a manufacturer, suggested that the work RVUs of certain codes for the ablation of liver tumors (CPT codes 47380, 47370 and 47382) appeared to be undervalued.

Response: As discussed in the previous response, in next year's final rule we will be accepting recommendations for codes to be considered under the five-year review of work that will occur in 2005. The

commenter will be able to respond to that solicitation and submit these codes, as well as any additional services they believe need to be reviewed to ensure they are appropriately valued.

Stereotactic Radiosurgery and Stereotactic Radiotherapy

Comment: Two commenters requested that HCPCS codes G0173 and G0251, which are used for reporting stereotactic radiotherapy and stereotactic radiosurgery under the hospital outpatient prospective payment system, be activated for payment under the physician fee schedule.

Response: We are reluctant to establish payment for these services under the physician fee schedule at this time absent specific information on freestanding centers providing this service. We would welcome information and data from these commenters, and other individuals and providers, on the provision of these services in freestanding centers so that we can fully evaluate this issue.

Creation of G Codes

Comment: The AMA and several specialty organizations expressed concern about the establishment of the numerous G codes that were contained in the proposed rule. The commenters state that continual development of G codes, without consultation with the CPT Editorial Panel, the RUC or the physician community undermines the annual review process that CMS has established in the final rule. Further, the commenters argue that the establishment of G Codes undermines the requirements of the Health Insurance Portability and Accountability Act (HIPAA) for coding standardization and an open process for establishing codes.

Response: As we have stated in previous rulemaking, it is sometimes necessary to develop G codes to accommodate changes in legislation, regulation, coverage, and payment policy. We appreciate the input of the medical community and to the extent possible, will work with the CPT Editorial Panel, the RUC and the physician community prior to establishment of these codes.

Pain Management

Comment: The American Society of Interventional Pain Management commented on the differences in payment allowances for various pain management services and other non-pain management services furnished in conjunction with pain management services in various settings, including the physician's office, the OPD and the ASC.

Response: In accordance with the law, we have established payment rates for office-based procedures, using the non-facility practice expense relative value units. However, the office does not represent a practice site where these services are usually performed.

Medicare payment under the physician fee schedule for the physician work is the same in all practice settings. However, the practice expenses are reimbursed differently depending on the practice site. Practice expenses associated with procedures performed in the outpatient departments (OPDs) or ambulatory surgical centers (ASCs) are paid under the OPD or ASC payment system respectively. Practice expenses associated with procedures performed in the physician's office are paid through the physician fee schedule payment system.

III. Other Issues

A. Definition of Diabetes for Diabetes Self-Management Training

In the August 15, 2003 rule we proposed to adopt the definition of diabetes used to determine beneficiary eligibility for Medical Nutrition Therapy (MNT) for purposes of coverage for outpatient diabetes self-management training when the beneficiary has a diagnosis of diabetes. Specifically, we stated that the criteria currently set forth at § 410.141(d), would be replaced with definition of diabetes used for medical nutrition therapy at § 410.130 which reads as follows:

Diabetes means diabetes mellitus consisting of two types. Type 1 is an autoimmune disease that destroys the beta cells of the pancreas, leading to insulin deficiency. Type 2 is familial hyperglycemia that occurs primarily in adults but can also occur in children and adolescents. It is caused by an insulin resistance whose etiology is multiple and not totally understood. Gestational diabetes is any degree of glucose intolerance with onset or first recognition during pregnancy. The diagnostic criterion for a diagnosis of diabetes for a fasting glucose intolerance test is greater than or equal to 126 mg/dL.

A technical error in the proposed rule on page 49070, placed the revised eligibility requirements in § 410.141(f). The eligibility requirements will replace those currently in § 410.141(d).

Comment: We received comment noting that the language for the actual regulatory language had the wrong section letter.

Response: As noted above, this was a technical error.

Final Decision: The following language will replace what was in the proposed rule. "Section 410.141 is amended by replacing paragraph (d) to read as follows: § 410.141 Outpatient diabetes self-management training. (d) Beneficiaries who may be covered. Medicare Part B covers outpatient diabetes self-management training for a beneficiary who has been diagnosed with diabetes."

Comment: The comments were very supportive of our efforts to streamline this requirement. Several commenters recommended that the definition of diabetes be revised to include patients who might not be classified as Type 1, Type 2, or gestational diabetes in the definition. Most commenters recommended the use of a fasting glucose test of greater than or equal to 126 mg/dL. One commenter suggested the measurement be taken on two occasions. Most commenters also recommended the addition of a random glucose test of greater than 200 mg/dL, with one commenter adding with symptoms of uncontrolled diabetes. Several commenters suggested use of an abnormal glucose tolerance test (GTT). One commenter also suggested the use of a 2 hour post-glucose challenge of greater than or equal to 200 mg/dL test on two different occasions. The American Association of Clinical Endocrinologists (AACE) also suggested that coverage of medical nutrition therapy be expanded to those with impaired fasting glucose.

Response: The definition of diabetes used in the MNT regulation was based on language found in the 2000 Institute of Medicine report entitled, "The Role of Nutrition in Maintaining Health in the Nation's Elderly. We did not have any other generally recognized definition of diabetes at that time and did not intend to limit our definition of diabetes. Regarding the laboratory tests, the characteristics of the commenters' suggestions are generally the same. The base measurement that is already in our MNT regulation, a fasting glucose of 126 mg/dL, is a common measure. Three commenters also noted the use of 200 mg/dL for a random glucose test. The major variation between the commenters was that one suggested multiple measurements. Also, we note that patients with an impaired fasting glucose level do not necessarily meet any of the popular definitions of diabetes.

Final Decision: We agree that in some ways our proposed definition may not include some patients diagnosed with diabetes. We also agree that our clinical

laboratory measurements used to determine the presence of diabetes should be expanded. The definition provided by AACE appears to meet the clinical concerns of the medical community and our concerns that no individuals have their treatments delayed unduly if they have obvious symptoms of uncontrolled diabetes. Therefore, we are adopting their clinical definition. We will also broaden our general language to include diabetes of other types. Our final language will be, "Diabetes is diabetes mellitus, a condition of abnormal glucose metabolism diagnosed using the following criteria: A fasting blood sugar greater than or equal to 126 mg/dL on two different occasions; a 2 hour post-glucose challenge greater than or equal to 200 mg/dL on 2 different occasions; or a random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes." We will also make a conforming amendment to 410.130 for MNT. However, we are constrained from covering MNT for anyone who is not diagnosed with diabetes by the section 1861(s)(2)(V) of the Act that limits coverage of MNT to beneficiaries with diabetes or renal disease.

Outpatient Therapy Services Performed "Incident To" Physicians" Services—Discussion Only

In almost all settings, our regulations specify that outpatient therapy services can be delivered only by qualified physical therapists, occupational therapists, physical therapy assistants, occupational therapy assistants, and speech-language pathologists as defined by § 484.4. Section 1862(a)(20) of the Act requires that any therapy services furnished incident to a physician's professional services must meet the standards and conditions that would apply to such therapy services if they were furnished by a therapist, with the exception of the licensing requirement. While there are currently no national standards for qualifications of individuals providing outpatient therapy services incident to physicians' services, we believe that standards similar to those in § 484.4 are appropriate. In the proposed rule, we stated that we are considering adopting the existing qualification and training standards (with the exception of licensure) in § 484.4 for individuals providing therapy services independently and incident to physicians' services. While we did not propose a change at this time, we requested comments from the public, particularly physicians and staff who would be affected, on adoption of the existing standards in § 484.4, for services of independent therapists and "incident to" services, as well as comments regarding alternatives that we might use to ensure that qualified staff are providing "incident to" therapy services.

We received comments from major therapy organizations and individual therapists representing therapy services, physician organizations and individual physicians and associations and individuals representing other health care professionals, such as athletic trainers, kinesiotherapists and exercise physiologists. A wide spectrum of views was expressed by these commenters. Commenters representing therapists were supportive of establishing consistent training standards in all settings, while physicians favored reliance on the individual physician for quality control. The non-therapist health care providers were concerned about their role in providing therapy services and cardiac rehabilitation and pulmonary service providers were concerned that their services might be affected.

We will review and consider these comments as we determine whether to make a future proposal. Meanwhile, contractors may continue to develop local medical review policies that are consistent with the statute, applying to physical therapy, occupational therapy and speech-language pathology services the same standards and conditions that would apply to such therapy services if they were furnished by an independent therapist, with the exception of the licensing requirement.

D. Status of Anesthesia Work and Five-Year Review

In the December 2002 final rule, we modestly increased the work of anesthesia services. These changes were based on the analysis submitted by the RUC of its review of the work of 19 high volume anesthesia codes. The RUC had provided us with its analysis but did not furnish us with a definitive recommendation. The increase in anesthesia work resulted in an increase in the national anesthesia conversion factor. (We increased the physician work component of the anesthesia conversion factor by 2.10 percent to reflect a 9.13 percent increase in anesthesia work applied to 23 percent of anesthesia allowed charges represented by the 19 codes. As a result of this increase, we applied a 1.6 percent increase to the anesthesia CF.) The American Society of Anesthesiologists expressed concern about the completeness of the review of anesthesia codes under the five-year review. Therefore, in February 2003 we asked the RUC to continue its review of anesthesia work values so that we could develop a final recommendation for a change in the anesthesia CF involving all anesthesia codes. In the proposed rule we stated we were waiting on the RUC's response to our request.

The RUC has spent a considerable amount of effort of studying this issue. The RUC's anesthesia workgroups consisted of a range of physician specialists, including various surgical specialists, who have knowledge about the anesthesia services studied. As a result of their review, the RUC approved and presented the following recommendations to CMS:

1. The RUC position is that the 5-year review has been completed.

2. The RUC anesthesia workgroup analysis only applies to the 19 anesthesia codes and associated 19 surgical codes.

3. The Workgroup recommendations to the RUC stated that there are structural differences between the anesthesia coding system and the remainder of the physician coding system, which contributes to the difficulties in making extrapolations to the entire set of anesthesia services. Among other things, the workgroups and the RUC were concerned that the anesthesia codes cover too large a number of surgical codes making it necessary to examine surgical codes within the anesthesia code, and the 19 selected anesthesia codes may not be the most representative codes.

The ASA disagrees with the RUC's recommendations and asked that we extrapolate from the 19 surveyed procedures to all anesthesia codes.

Decision

When we developed the 2002 final physician fee schedule rule on the second five-year review, one of our concerns was that the RUC's initial findings were not presented as specific recommendations. We wanted to pursue approaches consistent with RUC recommendations. Therefore, in early 2003, we asked the RUC to more clearly present their recommendations.

Based on our review of the history and analysis of this issue and the final recommendation of the RUC, we have decided not to extrapolate from the surveyed procedures to the entire universe of anesthesia procedures; we will make no further adjustments to anesthesia work under the second five-year review.

Payment Policies for Anesthesia Services

There are differences in Medicare payment policies between a teaching anesthesiologist involved with two concurrent cases with residents and a teaching CRNA involved with two concurrent cases with student nurse anesthetists.

Currently, if a teaching anesthesiologist is involved with two concurrent cases with anesthesia residents, the medical direction rules apply. Payment for the physician's medical direction is based on 50 percent of the allowance otherwise allowed if the anesthesiologist performed the anesthesia case alone.

For anesthesia services furnished prior to July 1, 2002, we allowed full payment if a non-medically directed certified registered nurse anesthetist (CRNA) supervised a single case involving a student nurse anesthetist. No payment was made if the teaching CRNA supervised two cases involving student nurse anesthetists. In August 2002, we released the Medicare Carriers Manual Transmittal 1766 relating to the involvement of a non-medically directed teaching CRNA with two student nurse anesthetists. The American Association of Nurse Anesthetists (AANA) noted that their standards for approved nurse anesthesia training programs allow the teaching CRNA to supervise two concurrent cases involving student nurse anesthetists. The new policy allows the teaching CRNA to be paid, for his/her involvement with two concurrent cases with student nurse anesthetists, but not at the full fee level. If a teaching CRNA is involved with two concurrent cases with student nurse anesthetists, payment may be based on the base unit plus the time that the teaching CRNA is present with the student nurse anesthetist. To bill the base unit, the teaching CRNA must be present with the student nurse anesthetist throughout the pre- and post-anesthesia care. This payment per case is usually higher than the 50 percent paid to the teaching anesthesiologist for medically directing resident cases.

In the proposed rule, we asked for comments on the appropriateness of applying the CRNA teaching/resident policy to teaching anesthesiologists.

Comment: The American Association of Nurse Anesthetists commented that it was unclear how the new rule for teaching anesthesiologists would operate with the medical direction rules, particularly if there were more than two concurrent anesthesia cases.

Response: The new policy for teaching anesthesiologists would apply only when there are two concurrent cases, and the cases involve residents. The medical direction payment policy would continue to apply, as it has previously, for three or four concurrent anesthesia cases regardless of the qualified individual (for example, CRNA, resident, or anesthesiologist assistant) who is administering and monitoring anesthesia under the physician's medical direction.

Comment: The ASA requested that the teaching anesthesiology payment regulations be revised so that the teaching anesthesiologists be paid in a similar manner to teaching surgeons. Under the teaching physician rules, the teaching surgeon can be paid the full fee for each of two overlapping surgeries involving residents. The ASA understands that such a proposal would require a revision to Medicare regulations and would require rulemaking.

The ASA requested that, at least, in the interim, we allow teaching anesthesiologists to be paid similarly to teaching CRNAs for two concurrent cases. However, ASA specifically requested that this policy be used in addition to the current medical direction payment policy. In other words, the ASA wants the teaching anesthesiologist to be able to choose case-by-case, whether to seek payment similar to the teaching CRNA (that is, full base units and time units based only on actual presence with the resident) or based on the medical direction rules (that is, 50 percent of the full base and time units).

According to the ASA, a number of anesthesiology department heads believe the nurse anesthesia payment rule is not appropriate to the teaching of already-licensed physicians. They question the need for the teaching physician to participate in the pre- and post-op anesthesia care (to obtain full base units), they think that participation of the teaching anesthesiologist in the key portions of the procedure is far more important than the number of minutes present with the resident (which is the relevant consideration under the teaching physician policy for a single case with a resident).

Response and Final Decision

We have decided to allow teaching anesthesiologists to bill, similarly to teaching CRNAs, for their involvement in two concurrent cases involving residents. This will apply to anesthesia services furnished on or after January 1, 2004.

The anesthesiologist can bill base units and actual time, based on the amount of time the physician is present with the resident during each of two concurrent cases. To bill base units, the physician must be present with the resident during the pre- and post-anesthesia care included in the base units. If the physician is not present with the resident during the pre- and post-anesthesia care, the physician may bill the case as a medically directed case.

The anesthesiologist must document his/her involvement in cases with anesthesia residents. The documentation must be sufficient to support the payment of the fee and available for review upon request. We have revised § 414.46 to incorporate this change.

F. Technical Correction

CPT Code 96155 *(Health and behavior intervention, each 15 minutes,face-to-face; family (without the patient present))*

This code describes a visit with a patient's family without the patient being present and was first included in the November 1, 2001 final rule. It was incorrectly listed as an active code for which payment could be made under the physician fee schedule. Our longstanding payment policy is that we do not pay for visits with family where the patient is not present. Payment for such visits is included in the pre- and post-service work of a visit where the patient is present. Consistent with this policy, this code is not payable under the physician fee schedule.

Comment: A few commenters urged us to continue to list this code as an active code under the fee schedule as they do not agree with our policy. The commenters do not agree with our assertion that payment for such visits is included in the pre- and post-service work of a visit when the patient is present and believe that not covering the service could result in diminished quality of care. One commenter disagreed that this was a technical correction since this code is currently being paid for under the fee schedule.

Response: As we indicated in the proposed rule, this was erroneously listed as an active code, contrary to longstanding Medicare policy. To be consistent with our policy, no payment may be made for this service under Medicare, and the code will be assigned a status indicator of "N".

G. Incomplete Screening Colonoscopy

Section 1834(d)(3) of the Act requires that the payment amount for a screening colonoscopy be set at the level for a

diagnostic colonoscopy. We have established RVUs for an incomplete diagnostic colonoscopy (CPT code 45378–53) However, an incomplete screening colonoscopy (HCPCS G0105 with modifier '53' or HCPCS G0121 with modifier '53') is currently carrier priced. To make payment for screening colonoscopy consistent with payment for a diagnostic colonoscopy, effective January 1, 2004, Medicare will make payment for an incomplete screening colonoscopy, HCPCS G0105 with modifier '53' and HCPCS G0121 with modifier '53', at the same rate as an incomplete diagnostic colonoscopy (CPT 45378–53). The Medicare carriers will no longer manually price the practitioner payment for an incomplete screening colonoscopy.

H. Publication Issues

Comment: Several commenters noted that section 1871 of the Act requires a 60-day public comment period. Such period traditionally starts with the date the proposed rule is published in the **Federal Register**. However, for the Physician Fee Schedule Proposed rule, CMS began the start of the 60-day comment period on August 8, the date the proposal was put on display at the **Federal Register**, rather than August 15, the date the proposal was published in the **Federal Register**. The commenters request that CMS revert to the traditional start of the comment period, that is, the date of publication in the **Federal Register**. One commenter suggested that CMS should accept electronically submitted comments when the comment period begins earlier than the publication date.

In addition, several commenters urged CMS to resolve the process issues associated with publishing the proposed and final rule. They indicated that the delayed publication of the proposed rule, combined with missing information from addendums and impact tables, makes review and analysis problematic. The commenters also expressed concern that CMS has insufficient time to evaluate public comments and this is contrary to the spirit of the Administrative Procedures Act.

Response: CMS is keenly aware of the tight time frame between publication of the proposed and final rules. We make every effort to respond to requests from physician specialty groups and providers to include items in the proposed rule that affect payment levels, such as assigning RVUs to new CPT codes and revising RVUs for existing codes. It is difficult to both address numerous concerns and publish the proposed rule in a timely fashion. We will continue to make every effort to publish the proposed rule as early as possible. However, despite the short time frame for issuing the final rule, we take the review and analysis of comments very seriously. CMS devotes the necessary staff resources to ensure that every comment is properly considered.

Furthermore, the statute does not provide that the comment period commences with publication in the **Federal Register**. Section 1871(b)(1) of the Act states that before issuing a regulation in final form, "the Secretary shall provide for notice of the proposed regulation in the **Federal Register** and a period of not less than 60 days for public comment thereon." While the proposed rule did not actually appear in the **Federal Register** until August 15, 2003, it was filed and went on public display at the **Federal Register** several days earlier on August 8, 2003. Accordingly, the contents of the proposed rule were, in fact, publicly available for the full 60-day comment period.

IV. Refinement of Relative Value Units for Calendar Year 2004 and Response to Public Comments on Interim Relative Value Units for 2003

A. Summary of Issues Discussed Related to the Adjustment of Relative Value Units

Section IV.B of this final rule describes the methodology used to review the comments received on the RVUs for physician work and the process used to establish RVUs for new and revised CPT codes. Changes to codes on the physician fee schedule reflected in Addendum B are effective for services furnished beginning January 1, 2004. The tables and discussions in this section concerning the work RVUs do not reflect the effect of the adjustment to work RVUs to match the MEI weights as discussed in section VI. The referenced work RVUs may differ from the work RVUs in Addenda B and C that reflect this adjustment.

B. Process for Establishing Work Relative Value Units for the 2004 Physician Fee Schedule

Our December 31, 2002 final rule (67 FR 79966) announced the final work RVUs for Medicare payment for existing procedure codes under the physician fee schedule and interim RVUs for new and revised codes. The RVUs contained in the final rule applied to physician services furnished beginning March 1, 2003. We announced that we considered the RVUs for the interim codes to be subject to public comment under the annual refinement process. In this section, we summarize the refinements to the interim work RVUs published in the December 2002 final rule and our establishment of the work RVUs for new and revised codes for the 2004 physician fee schedule.

C. Work Relative Value Unit Refinements of Interim Relative Value Units

1. Methodology (Includes Table titled "Work Relative Value Unit Refinements of the 2003 Interim and Related Relative Value Units")

Although the RVUs in the December 2002 final rule were used to calculate 2003 payment amounts, we considered the RVUs for the new or revised codes to be interim. We accepted comments for a period of 60 days. We received substantive comments from many individual physicians and several specialty societies on approximately 10 CPT codes with interim work RVUs. Only comments on codes listed in Addendum C of the December 2002 final rule were considered.

To evaluate these comments we used a process similar to the process used in 1997. (See the October 31, 1997 final rule (62 FR 59084) for the discussion of refinement of CPT codes with interim work RVUs.) We convened a multispecialty panel of physicians to assist us in the review of the comments. The comments that we did not submit to panel review are discussed at the end of this section, as well as those that were reviewed by the panel. We invited representatives from the organization from which we received substantive comments to attend a panel for discussion of the code on which they had commented. The panel was moderated by our medical staff, and consisted of the following voting members:

- One or two clinicians representing the commenting organization.
- One primary care clinician nominated by the American College of Physicians/American Society of Internal Medicine.
- Four carrier medical directors.
- Four clinicians with practices in related specialties, who were expected to have knowledge of the service under review.

The panel discussed the work involved in the procedure under review in comparison to the work associated with other services under the physician fee schedule. We assembled a set of 300 reference services and asked the panel members to compare the clinical aspects of the work of the service a commenter believed was incorrectly valued to one

or more of the reference services. In compiling the set, we attempted to include—(1) services that are commonly performed whose work RVUs are not controversial; (2) services that span the entire spectrum from the easiest to the most difficult; and (3) at least three services performed by each of the major specialties so that each specialty would be represented. The intent of the panel process was to capture each participant's independent judgment based on the discussion and his or her clinical experience. Following the discussion, each participant rated the work for the procedure. Ratings were individual and confidential, and there was no attempt to achieve consensus among the panel members.

We then analyzed the ratings based on a presumption that the interim RVUs were correct. To overcome this presumption, the inaccuracy of the interim RVUs had to be apparent to the broad range of physicians participating in each panel.

Ratings of work were analyzed for consistency among the groups represented on each panel. In addition, we used statistical tests to determine whether there was enough agreement among the groups of the panel and whether the agreed-upon RVUs were significantly different from the interim RVUs published in Addendum C of the December 2002 final rule. We did not modify the RVUs unless there was a clear indication for a change. If there was agreement across groups for change, but the groups did not agree on what the new RVUs should be, we eliminated the outlier group and looked for agreement among the remaining groups as the basis for new RVUs. We used the same methodology in analyzing the ratings that we first used in the refinement process for the 1993 physician fee schedule. The statistical tests were described in detail in the November 25, 1992 final rule (57 FR 55938).

Our decision to convene multispecialty panels of physicians and to apply the statistical tests described above was based on our need to balance the interests of those who commented on the work RVUs against the redistributive effects that would occur in other specialties.

We also received comments on RVUs that were interim for 2003, but for which we did not submit the RVUs to the panel for review for a variety of reasons. These comments and our decisions on those RVUs commented upon are discussed in further detail below.

The table below lists those interim codes reviewed under the refinement panel process described in this section. This table includes the following information:

- CPT Code. This is the CPT code for a service.
- Description. This is an abbreviated version of the narrative description of the code.
- 2003 Work RVU. The work RVUs that appeared in the December 2002 rule are shown for each reviewed code.
- Requested Work RVU. This column identifies the work RVUs requested by commenters.
- 2004 Work RVU. This column contains the final RVUs for physician work. (These work RVUs may differ from the work RVUs in Addenda B that reflect the adjustment to work RVUs to match the MEI weights.)

TABLE 4.—CODES REVIEWED UNDER THE REFINEMENT PANEL PROCESS

CPT code [1]	Mod	Descriptor	2003 work RVU	Requested work RVU	2004 work RVU
17310		Mohs any stage > 5spec each	0.62	0.95	0.95
43219*		Esophagus endoscopy	2.80		2.80
43256*		Uppr gi endoscopy w stent	4.35		4.35
44383*		Ileoscopy w/stent	2.94		2.94
45340		Sig w/balloon dilation	1.66	1.96	1.89
51798		Us urine capacity measure	0.00	0.38	0.00
75954		Illiac aneurysm endovas rpr	1.36	2.93	2.25
92613		Endoscopy swallow tst (fees)	0.00	0.99	0.71
92615		Eval laryngoscopy sense test	0.00	0.88	0.63
92617		Interprt fees/laryngeal test	0.00	1.10	0.79

[1] All CPT codes and descriptions copyright 2003 American Medical Association. All rights are reserved and applicable FARS/DFARS clauses apply.

*The work RVUs for these codes were revised for 2003 by CMS to finalize outstanding issues related to the five-year review of the gastroenterology codes.

2. Interim 2003 Codes

CPT code 17310 *Chemosurgery (Mohs micrographic technique) including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histopathological preparation including the first routine stain (e.g. hematoxylin and eosin, toluidine blue); each additional specimen after the first 5 specimens, fixed or fresh tissue, any stage (List separately in addition to code for primary procedure).*

Prior to 2003, this code was reported once for all specimens over five generated during a particular stage of Mohs surgery. Beginning in 2003, the code is used to report each specimen over five during a particular stage of Mohs surgery. The RUC recommended maintaining 0.95 work RVUs for this code as an interim value. We disagreed and assigned a work value of 0.62 work RVUs to this code pending further recommendations from the RUC. We believed this value was appropriate for the new descriptor since it allows reporting of CPT code 17310 for each specimen rather than reporting once for all specimens. It also places this code in the correct rank with the other Mohs surgery services, CPT codes 17304–17307, and with the codes for pathology consultation during surgery, CPT codes 88331 and 88332.

Commenters disagreed with the rationale we had used to arrive at the interim work value and indicated that we used inappropriate time/intensity data and failed to include surgery work, focusing only on pathology work. Commenters also stated that the intent of this code has not changed and that CMS had ignored past policy which recognizes CPT code 17310 as an add-on service and thus allows the separate billing of services for each additional specimen beyond the first five. Based on these comments, we referred this code to the multispecialty validation panel for review.

Final decision: As a result of the statistical analysis of the 2003 multispecialty validation panel ratings, we have assigned 0.95 work RVUs to CPT code 17310.

CPT Code 38204 *Management of recipient hematopoietic progenitor cell donor search and cell acquisition.*

We disagreed with the RUC recommendation of 2.00 work RVUs for CPT code 38204. We believed we are already making payment for any physician work associated with this service as part of our payment for other bone marrow transplant codes (that is, CPT codes 38205, 38206, 38240, 38241, and 38242) and have significant concerns about how this code would be used in actual practice. Therefore, we assigned CPT code 38204 a status indicator of "B," meaning that we will not make separate payment for this service.

Comments: Some commenters urged us to reconsider the RUC recommendation. In addition, the RUC submitted a comment disagreeing with our contention that the physician work associated with this code is included in other transplant codes. The RUC also asserted that discussions of this issue at the RUC meetings provided substantive information on how this code would be used.

Response: We continue to believe that the work of this service is contained in other transplant codes and are maintaining the status indicator of "B." Therefore, we will not make separate payment for this service.

CPT Codes 43219 *Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent,* 43256 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic stent placement (includes predilation),* and 44383 *Ileoscopy, through stoma; with transendoscopic stent placement (includes predilation).*

As explained in the December 31, 2002 final rule, the work RVUs for these codes were revised by CMS to finalize outstanding issues related to the five-year review of the gastroenterology codes. For CPT code 43219, we maintained the work RVU of 2.80. Review of information supplied by specialty societies did not provide compelling evidence that the work RVUs should be changed. Based on a review of the physician time data and a comparison to other stent placement codes, we assigned 4.35 work RVUs to CPT code 43256 and 2.94 work RVUs to CPT code 44383, in order to place these services in proper rank order to the other stent placement codes.

Comment: Some commenters felt that we improperly intervened in assigning work RVUs to these services albeit to correct rank order anomalies. Based on these comments we referred these codes to the multispecialty validation panel for review.

Response: As a result of the statistical analysis of the 2003 multispecialty validation panel ratings, we are retaining work RVUs of 2.80 for CPT code 43219, 4.35 for CPT code 43256 and 2.94 for CPT code 44383.

CPT code 45335 *Sigmoidoscopy, flexible; with directed submucosal injections any substance.*

The RUC recommended work RVUs of 1.46 for CPT code 45335 based on a comparison to CPT code 45330, with incremental work RVUs added to reflect increased pre-, intra-, and post-service work. We disagreed with the RUC recommendation and compared this service to the analysis and recommendation provided by the RUC for CPT code 43201, which is also a new submucosal injection code. Based on the increased risk of complications (resulting in higher intra-service intensities) and the fact that several sites are being injected instead of one, we assigned a work RVU of 1.36 to CPT code 45335.

Comment: Some commenters expressed concern about the rejection of the RUC recommendation for this service and believed that we had misinterpreted the RUC findings.

Response: Upon further review and consideration of the RUC recommendation we will accept the RUC recommended work RVU of 1.46 for this service.

CPT Code 45340 *Sigmoidoscopy, flexible; with dilation by balloon, each stricture.*

The RUC recommended a work RVU of 1.96 for this code, which includes 1.00 RVU for the incremental work based on the need for conscious sedation to perform this procedure. (Other flexible sigmoidoscopies do not require conscious sedation.) In the December 31, 2002 rule we stated that we did not believe it is appropriate to assign a work RVU for CPT code 45340 that is based on the presumption that a portion of the work value is for the provision of conscious sedation. Rather, we compared the RUC recommendations for work and physician time for other endoscopic dilation codes to the incremental times for CPT code 45340 and assigned a work RVU of 1.66 to CPT code 45340.

Comment: Some commenters urged us to accept the RUC recommendation, noting that our characterization of RUC recommendations on conscious sedation was inaccurate. The commenters stated that the RUC has concluded that there is an increase in the amount of physician work relating to conscious sedation, but has been unable to identify a specific numerical value for that additional increment. The RUC is in the process of determining the universe of codes that include conscious sedation as an inherent part of the service provided by the operating physician to ensure these services are appropriately valued. Based on these comments we referred this code to the multispecialty validation panel for review.

Response: As a result of the statistical analysis of the 2003 multispecialty validation panel ratings, we have assigned 1.89 work RVUs to CPT code 45340.

CPT Code 51798 *Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, nonimaging.*

The RUC recommended 0.38 work RVUs based on a urology survey that reported that this procedure is performed 75 percent of the time by the physician and also based on a comparison of this procedure to CPT code 76857, *Ultrasound, pelvic (nonobstetric, B-scan and/or real time with image documentation; complete.* We disagreed. This code is replacing a HCPCS level two code that was assigned 0.00 work RVUs because it is typically performed by a nurse or other clinical staff. We believed that CPT code 51798 is, therefore, also a nonphysician service and assigned 0.00 work RVUs to this service.

Comment: Some commenters requested that we reconsider our decision to assign 0.00 work RVUS to this service. The commenters argued that our reason for disagreeing with the RUC recommendation is based on a stated belief that there is no physician work involved, not on actual survey data as presented by the American Urological Association (AUA) and accepted by the RUC. Commenters urged that CMS work with AUA to review this decision or include this code as part of the multi-specialty validation panel for refinement of work RVUs. Based on these comments, we referred this code to the multispecialty validation panel for review.

Response: As a result of the statistical analysis of the 2003 multispecialty validation panel ratings, we will retain 0.00 work RVUs for CPT code 51798.

CPT Codes 58545–58554 *Laproscopic hysterectomy/myonectomy procedures.*

We accepted the RUC recommendations for work RVUs for these services.

Comment: Some commenters stated that new values have been established for these services based on new survey data and that the RUC has new recommendations for these services. In their comments on the December 31, 2002 rule, the RUC included these new work RVU recommendations and urged us to review these during the refinement process.

Response: We are in agreement with the RUC recommended values for these services. However, to provide an opportunity for public comment we are including these in the RUC Recommendations for New and Revised codes for 2004 (table xx) and will consider the RVUs interim for 2004.

CPT code 75954 *Endovascular graft placement for repair of iliac artery (e.g. aneurysm, pseudoaneurysm, ateriovenous malformation, trauma) radiological supervision and interpretation.*

The RUC agreed with the specialty societies and recommended a value of 2.93 work RVUs based on comparing this code to CPT codes 75952, *Endovascular repair of infrarenal abdominal aortic anuerysm or dissection, radiological supervision and interpretation,* (work RVU of 4.5) and 75953, *Placement of proximal or distal extension prosthesis for endovascular repair of infra renal abdominal aortic aneurysm, radiological supervision and interpretation,* (work RVU of 1.36). The recommended RVU was midway between the RVUs of the reference procedures. We did not agree with the RUC recommendation. Based on the specialty societies' description of the work of CPT code 75954 (which is virtually identical to the description of the work for CPT code 75953) and in order to maintain correct rank order in this family of codes, we assigned a work RVU of 1.36 to CPT code 75954.

Comment: Some commenters expressed concern about the rejection of the RUC recommendation, particularly since the recommendation was based on data presented by several specialty societies. The commenters stated that the data reflected the proper rank order of this service and indicated that physicians in those specialties that perform ileac aneurysm endorepair may be in a better position to judge the relationship of this code to other imaging services. Based on these comments, we referred this code to the multispecialty validation panel for review.

Response: As a result of the statistical analysis of the 2003 multispecialty validation panel ratings, we have assigned 2.25 work RVUs to CPT code 75954.

CPT code 92610 *Clinical Evaluation of swallowing function.*

In the December 2002 final rule, this CPT code replaced HCPCS code G0195, which had a work RVU of 1.50 in 2002. The Healthcare Professionals Advisory Committee (HCPAC) recommendation of a work RVU of 0.00 for CPT code 92610 was accepted by CMS.

Comment: Some commenters representing the long term care industry expressed concern with the reduction in work for this service. The rule provided no explanation of the HCPAC recommendation of 0.00 work RVUs for this service and the commenters requested that this issue be addressed.

Response: As requested by the commenters, a discussion of the HCPAC recommendation of 0.00 work RVUS was provided as part of the multispecialty validation panel, which was attended by the commenters.

CPT codes 92613 *Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording; physician interpretation and report only,* 92615 *Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording; physician interpretation and report only,* and 92617 *Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording; physician interpretation and report only.*

We did not accept the RUC recommendations for work RVUs for these services (0.99 for 92613, 0.88 for 92615 and 1.10 for 92617) and assigned each of these CPT codes a work RVU of 0.00. We stated that these three services refer only to a separately identified physician review and interpretation of the fiberoptic endoscopic evaluation and that we consider this physician interpretation and report bundled into an E/M service. We stated that the physician who does not perform the testing should only bill for the patient when performing an E/M service, not as the supervisor of another professional performing and reviewing the initial fiberoptic endoscopic evaluation. The interpretation is an integral part of the testing itself and, if a nonphysician professional has the credentials and experience to perform this testing, then that professional should also provide the interpretation of the findings.

Comment: Some commenters urged us to reconsider the RVUs and payment policies related to these services and to accept the RUC recommendations for these codes. The commenters asserted that the physician's detailed frame-by-frame analysis of the video recorded procedure needed to develop the diagnosis and report following this testing is not related to an E/M service. Rather, this is similar to other services where there is a report and interpretation by the physician that is separate from an E/M service. The commenters further stated that the RUC valued each procedure code and physician interpretation and report code separately, based on the coding structure created by CPT. As a result, the interpretation and reporting is separated from each test, and the RUC recommendations do not combine the interpretation with the testing. If the code were to combine the work of interpretation and the testing then the code descriptor would need to be modified and work RVUs revalued. As a final point, commenters disputed our assertion that a nonphysician professional with the credentials and experience to perform this testing should also provide the interpretation of the findings. Based on these comments we referred this code to the multispecialty validation panel for review.

Response: As a result of the statistical analysis of the 2003 multispecialty validation panel ratings, we have assigned 0.71 work RVUs to CPT code 92613; 0.63 work RVUs to CPT code 92615; 0.79 work RVUs to CPT code 92617.

In the December 31, 2002 final rule (67 FR 79966), we also responded to the RUC recommendations on the practice expense inputs for the new and revised CPT codes for CY 2003. There were no comments received on these and therefore we are finalizing our proposals.

Late RUC Recommendations

As we indicated in the August 15, 2003 proposed rule, RUC recommendations for RVUs for 23 new CPT codes for 2003 were received too late for incorporation in the December 31, 2002 final rule. We proposed interim RVUs for these codes and, as with all interim values, these were subject to comment. In their comments on the December 2002 final rule, the AMA–RUC requested that we consider their late recommendations for these codes during refinement. Several specialties also requested that we consider the late RUC recommendations. We had considered addressing these as part of the refinement process, but determined that we should follow the process used for all RUC recommendations and solicit public comment on the valuation

of these services. Therefore, we are including the RVUs for codes listed in the table below, along with the codes that are new and revised for 2004, as interim for 2004. Following is a discussion of those codes for which did not accept the RUC recommendation.

TABLE 5.—2003 LATE RUC RECOMMENDATIONS

CPT code [1]	Short descriptor	CMS assigned 2003 work RVU	RUC recommendation	CMS decision	2004 work RVU
21030	Excise max/zygoma b9 tumor.	3.89	4.50	Agree	4.50
21040	Removal of jaw bone lesion.	3.89	4.50	Agree	4.50
21742	Repair sternum/nuss w/ o scope.	[2]	[2]	Agree	[2]
21743	Repair sternum/nuss w/ o scope.	[2]	[2]	Agree	[2]
36511	Apheresis wbc	1.74	1.74	Agree	1.74
36512	Apheresis rbc	1.74	1.74	Agree	1.74
36513	Apheresis platelets	1.74	1.74	Agree	1.74
36514	Apheresis plasma	1.74	1.74	Agree	1.74
36515	Apheresis, adsorp/re-infuse.	1.74	1.74	Agree	1.74
36516	Apheresis, selective	1.74	1.22	Agree	1.22
38207 (Lab Codes)	Cryopreserve stem cells.	[3]	0.47	Disagree	[4]
38210 (Lab Codes)	T-cell depletion of harvest.	[3]	0.94	Disagree	[4]
38211 (Lab Codes)	Tumor cell deplete of harvest.	[3]	0.71	Disagree	[4]
38212 (Lab Codes)	Rbc depletion of harvest.	[3]	0.47	Disagree	[4]
38213 (Lab Codes)	Platelet deplete of harvest.	[3]	0.24	Disagree	[4]
38214 (Lab Codes)	Volume deplete of harvest.	[3]	0.24	Disagree	[4]
38215 (Lab Codes)	Harvest Stem cell concentrate.	[3]	0.55	Disagree	[4]
93784	Ambulatory BP monitoring.	0.17	0.38	Agree	0.38
93786	Ambulatory BP recording.	0.00	0.00	Agree	0.00
93788	Ambulatory BP analysis	[5]	0.00	Agree	0.00
93790	Review/report BP recording.	0.17	0.38	Agree	0.38

[1] All CPT codes and descriptions copyright 2003 American Medical Association. All rights are reserved and applicable FARS/DFARS clauses apply.
[2] Carrier Priced.
[3] Assigned Status Indicator of "I".
[4] Maintain Status Indicator of "I".
[5] Assigned Status Indicator of "N"

Note : CPT codes 38208, 38209 and 95990 are addressed later in this section (new and revised codes for 2004)and are also included in table 4. Also these work RVUs may differ from the work RVUs in Addenda B and C that reflect the adjustment to match the MEI weights.

CPT codes 38207 *Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage,* 38210 *Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion,* 38211 *Transplant preparation of hematopoietic progenitor cells; tumor cell depletion,* 38212 *Transplant preparation of hematopoietic progenitor cells; red blood cell removal,* 38213 *Transplant preparation of hematopoietic progenitor cells; platelet depletion,* 38214 *Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion,* 38215 *Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer.*

We continue to have the same concerns as outlined in the December 31, 2002 final rule (67 FR 80007) with respect to moving these codes off of the laboratory fee schedule. We are maintaining a status indicator "I" for these services making them not valid for Medicare purposes.

CPT Codes 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,* and 93790 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; physician review with interpretation and report.*

The RUC recommendations for these codes were received too late for inclusion in the 2003 final rule. We had established the following work RVUs for these services during 2002 in response to a national coverage determination: CPT code 93784–0.17 work RVUs; 93786–0.00 work RVUs; 93790–0.17 work RVUs and had indicated that CPT code 93788 was not covered. We stated we would maintain these work RVUs until we receive a RUC recommendation.

Comment: Some commenters urged us to consider the RUC recommendations during the refinement process and also questioned the noncovered status of CPT code 93788. CPT codes 93786 and 93788 are two separate codes for the technical component and the coding format is identical to the coding used for Holter monitoring, which also has two codes for the TC of the service. Commenters also requested that CPT code 93788 be listed as a covered service.

Response: We are accepting the RUC recommendation of 0.38 work RVUs for CPT codes 93784 and 93790 and 0.00 work RVUs for CPT code 93786. We have reviewed the issue of noncoverage of CPT code 93788 and based upon the information provided by the commenters will recognize CPT code 93788 for coverage and payment under the physician fee schedule. We are also accepting the RUC recommendation of 0.00 for CPT code 93788.

We received the following comments on HCPCS codes established in the December 31, 2002 final rule.

GO262 *Small intestinal imaging; intraluminal, from ligament of Treitz to the ileocecal valve, includes physician interpretation and report.*

We created this code to describe a new diagnostic test for which we will make separate payment under the physician fee schedule. We assigned a work RVU of 2.12 to the code based on a comparison to the work of other diagnostic tests and procedures that require review of significant amounts of data.

Comment: Some commenters stated that that the time we used to establish the work RVU was greatly underestimated and may have been based on a misunderstanding of some of the time data contained in published literature. Based on limited survey data of physicians performing this procedure and comparison to the intensity of other services, commenters recommended a work RVU of 7.80.

Response: We are deleting HCPCS code G0262 since there is a new CPT code 91110, *Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus through ileum, with physician interpretation and report,* which will be used to report this service in 2004. We note that we accepted the RUC recommendation of 3.65 work RVUs for CPT 91110. If the commenters do not agree with the valuation of this service they may submit comments on this issue.

GO268 *Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing.*

This code was created to allow payment to a physician who removes impacted cerumen on the same date as his or her employed audiologist performs audiologic function testing. We noted that routine removal of cerumen is not paid separately, because it is considered to be part of the procedure with which it is billed (for example, audiologic function testing). This code is to be used only in those unusual circumstances when an employed audiologist who bills under a physician uniform provider identifier number (UPIN) performs audiologic function testing on the same day as removal of impacted cerumen requiring physician expertise for removal. This code should not be used when the audiologist removes cerumen, because removal of cerumen is considered to be part of the diagnostic testing and is not paid separately.

Comment: Commenters stated that creation of this G code was problematic because there could be many other "incident to" services in which a physician performs a separate medically necessary procedure, that, if less extensive, would be considered to be included in a nonphysician provider service. The commenters suggested that a modifier could be used to describe this situation, avoiding the creation of a G code.

Response: We disagree and believe that this is a unique situation that is most appropriately handled through the use of a G code.

GO269 *Placement of occlusive device into either a venous or arterial access site, post surgical or interventional procedure (e.g., angioseal plug, vascular plug.)*

We created this code due to the inappropriate reporting of this service with codes for such procedures as "blood vessel repair" and "repair of arterial pseudoaneurysm", and indicated that there would be no separate payment for this service as the work, practice expense, and malpractice risk is included in the main invasive procedure.

Comment: Commenters disagreed with the creation of this G code because it is intended to report a service that is a required component of another service and believed that the creation of this code may lead to the creation of many codes for reporting inclusive procedures separately. Some commenters suggested that the creation of parenthetical

instructions in CPT to instruct that "referenced procedures (*i.e.*, blood vessel repair, repair of arterial pseudoaneurysm) would not be appropriately reported in addition to the interventional vascular procedure" would address our concerns. Other commenters disagreed with our assertion that closure devices are included in the practice expense payment, as such devices are not typically used in every interventional or surgical case. Commenters suggested this code be a technical component service only and have RVUs commensurate with the cost of the device.

Response: As we indicated in the December 31, 2002, final rule, this code was created to address a specific concern about inappropriate reporting of this service using such procedures as "blood vessel repair" and "repair of arterial pseudoaneurysm." Since this service is considered part of the main invasive procedure, to the extent this is typically part of the invasive procedure, it is accounted for under the practice expense methodology. We will continue to consider this code bundled for Medicare purposes, that is, no separate payment will be made under the physician fee schedule.

GO272 *Naso/oro gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)*

We indicated we were creating this code for use until an identical CPT code can become effective. We assigned this code a work RVU of 0.32.

Comment: Commenters disagreed with the 0.32 value assigned to this service and recommended that we replace the work RVUs with the RUC recommended work value for CPT code 43752.

Response: We are deleting HCPCS code G0272 and CPT code 43752, *Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)*, will be used to report this service.

GO273 *Radiopharmaceutical biodistribution, single or multiple scans on one or more days, pre-treatment planning for radiopharmaceutical therapy of non-Hodgkin's lymphoma, includes administration of radiopharmaceutical (e.g., radiolabeled antibodies)* and GO274 *Radiopharmaceutical therapy, non-Hodgkin's lymphoma, includes administration of radiopharmaceutical (e.g., radiolabeled antibodies)*

We created G0273 to describe radionuclide scanning to determine the biodistribution of Zevulin. We assigned 0.86 work RVUs to this code based on a comparison to CPT code 78802, *Radiopharmaceutical localization of tumor; whole body.* We established G0274 to allow appropriate reporting of this new service and assigned a work RVU of 2.07 to this code.

Comment: Commenters urged us to reevaluate the RVUs assigned to these codes and expressed concern that a lack of understanding about this service has led to its inappropriate valuation. Additionally, commenters requested that we present these codes to the AMA for consideration by the CPT Editorial Panel and RUC.

Response: We are deleting HCPCS codes G0273 and G0274. CPT codes 79403, *Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion*, and 78802, *Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body single day imaging*, will be used to report these services.

GO275 *Renal artery angiography (unilateral or bilateral) performed at the time of cardiac catheterization, includes catheter placement in the renal artery, injection of dye, flush aortogram and radiologic supervision and interpretation and production of images (List separately in addition to primary procedure)* and GO278 *Iliac artery angiography performed at the same time of cardiac catheterization, includes catheter placement, injection of dye, radiologic supervision and interpretation and production of images (List separately in addition to primary procedure)*

We created these add-on codes to assure proper reporting of and payment for renal and iliac angiography performed at the time of cardiac angiography. We determined the work value of 0.25 for these two add-on procedures by using the work values for CPT codes 75625, *Aortography, abdominal, by serialography, radiological supervision and interpretation* and 93544 *Injection procedure during cardiac catherization; for aortography* and adjusting for the procedure time.

Comment: Commenters suggested that, if the true intention for the creation of G0275 was to assure correct coding of selective renal angiography performed in conjunction with cardiac catheterization, the RVUs are too low and not commensurate with the work associated with selective unilateral and/or bilateral renal angiography. However, if CMS" intention for G0275 is non-selective renal angiography, then this should be stated clearly in the code descriptor. Commenters also considered the work RVUs assigned to G0278 to be too low. If G0278 is meant to be a selective procedure, then the work RVU should take into consideration the selective catheterization codes (CPT codes 36425 and 36425) and associated imaging codes (CPT codes 75710 and 75716).

Response: As announced in Program Memorandum, Transmittal AB–03–119, Change Request 2853) issued August 8, 2003, the descriptors for these two services specify that they apply to non-selective angiography and have been revised as follows:

GO275 *Renal artery angiography, non-selective, one or both kidneys, performed at the time of cardiac catheterization and/or coronary angiography, includes positioning or placement of any catheter in the abdominal aorta at or near the origins (ostia) of the renal arteries, injection of dye, flush aortogram, production of permanent images, and radiologic supervision and interpretation (List separately in addition to primary procedure).* and

GO278 *Iliac and/or femoral artery angiography, non-selective, bilateral or ipsilateral to catheter insertion, performed at the same time as cardiac catheterization and/or coronary angiography, includes positioning or placement of the catheter in the distal aorta or ipsilateral femoral or iliac artery, inkjecton of dye, production of permanent images, and radioogic supervision and interpretation (List separately in addition to primary procedure).* We will be retaining the work RVU of 0.25 for these two codes.

GO279 *Extracorporeal shock wave therapy; involving elbow epicondylitis*

GO280 *Extracorporeal shock wave therapy; involving other than elbow epicondylitis or plantar fascitis*

In the December 31, 2002 final rule we incorrectly established RVUs for CPT code 0020T, *Extracorporeal shock*

wave therapy; involving musculoskeletal system, which is an emerging technology code and also created two new HCPCS codes (G0279 and G0280) with payments based on our valuation of this CPT code. In the August 15, 2003 proposed rule we also requested additional information on these services.

Comment: Commenters on the December 2002 rule indicated that assignment of RVUs for CPT code 0020T is contrary to national policy established in the November 1, 2001 (66 FR 55269) final rule. They also indicated that the assumptions used to assign RVUs to these services were incorrect and undervalued these services.

Response: In a correction notice published May 30, 2003 (68 FR 32400) we indicated that we had incorrectly assigned RVUs to these services and they would be carrier priced.

Comment: Commenters on the December 2002 rule expressed concern that the G codes were not reflective of the changes in technology and FDA approval of ESWT. Commenters also disagreed with our categorization and portrayal of CPT 0020T as a procedure similar to other physical therapy modalities. Commenters urged us to correct and clarify that CPT 0020T is not physical therapy service but a physician procedure and thus should be removed from the list of codes identifying certain designated health services.

Response: We understand that this is a changing technology and believe the current descriptors accommodate these changes. We are removing CPT 0020T from the list of designated health services in Addendum F since we agree that, at this time, this service is predominantly performed by medical specialties such as orthopedists and podiatrists.

Comment: Commenters on the August 15, 2003 proposed rule urged us to continue to have these services priced by the carrier and expressed concern that our request for additional information indicated we would be establishing national payment amounts for these services. In addition, several physicians provided information on how this service is used in their offices, including cost information as well as a description of the procedure. Some commenters recommended that separate G codes be established to differentiate between the high and low energy levels that are currently used, as this impacts the treatment protocols as well as the resources used in these procedures.

Response: The purpose for soliciting information in the proposed rule was to gain a better understanding of the use of the various systems as well as the resources involved with this procedure. We appreciate the information the commenters provided and will continue to review this issue to determine if coding changes are warranted. We are retaining the current codes, G0279, G0280 and CPT code 0020T under the fee schedule and these will continue to be carrier priced. We believe this will enable the carriers to make appropriate payment for these services based on resources used. In addition, as previously discussed, we are removing CPT code 0020T from the list of designated health services in Addendum F.

GO288 *Reconstruction, computed tomographic angiography of aorta for surgical planning for vascular surgery.*

We created this code, which is a technical component code, to assure accurate reporting of this service by independent diagnostic testing facilities (IDTFs) that perform this service. This service includes receipt of a Computed Tomographic Angiogram (CTA), post-CTA processing using specialized software, and burning the 3D model onto a CD and returning it to the operating surgeon. This 3D only model is used to assist vascular surgeons in planning for, or monitoring the results of, endovascular aneurysm repair. The service is a technical service provided under the general supervision of a physician according to the supervision requirements for IDTFs.

Comment: Commenters requested clarification on whether this code could be used for the treatment planning both prior to surgery as well as for post-surgical monitoring. They also indicated that it should be expanded to include the use of enhanced computed tomography scans or magnetic resonance images and not just those generated by CTA. In addition, one commenter suggested that CMS ensure that this HCPCS code is used only for those technologies that meet the following criteria: (1) The ability to perform precise modeling of multiple clinically-relevant objects; (2) the ability to generate specific measurements essential for surgical planning and follow-up; (3) built-in quality control and self-validation capabilities; (4) FDA marketing clearance for use in surgical planning and follow-up treatment; and (5) conformance to standards adopted by the International Standards of Organization (ISO).

Commenters also suggested that the payment for this code be revised so that it is more in line with the payment for these services when administered in the outpatient setting.

Response: We agree that this service can be used for treatment planning prior to surgery as well as for post-surgical monitoring and have revised the code descriptor to clarify this point. The descriptor for this code is revised as follows:

G0288 *Reconstruction, computed tomographic angiography of aorta for preoperative planning and evaluation post vascular surgery.*

However, we are not expanding this service to include the use of enhanced computed tomography scans or magnetic resonance, as we have not been presented with information to support its use with these other data sources. We assume that physicians providing this service will abide by the FDA labeling requirements for the specific equipment used. Payment for services under the outpatient prospective payment system is based on a different methodology than services paid under the physician fee schedule. As required by section 1848 of the Act, payment under the physician fee schedule is based on national relative value units based on resources used in furnishing the service. We believe the RVUs established for this service are reflective of the resources used, and therefore do not believe this should be carrier priced.

GO289 *Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage (chrondroplasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee.*

We created this add-on code to permit appropriate reporting of arthroscopic procedures performed in different compartments of the same knee during the same operative session. We stated that this code should be reported only when the physician spends at least 15 minutes in the additional compartment performing the procedure. It should not be reported if the reason for performing the procedure is due to a problem caused by the arthroscopic procedure itself. We noted that this code is to be used when a procedure is performed in the lateral, medial, or patellar compartments in addition to the main procedure. We assigned a work RVU of 1.48 to this code RVUs based on a comparison to CPT codes 29874, 29877 and 29870, the base procedure for this family of codes.

Comment: Commenters appreciated our efforts to address the issue of reimbursement for this procedure. However, they expressed concern about the specific reference to a 15 minute time requirement. The commenters believed that this was inappropriate because using time in this manner

rewards and encourages inefficient work and penalizes efficient physicians, which ultimately has an impact on the quality of care delivered to Medicare beneficiaries.

Response: We understand the concerns expressed by the commenters and regret any confusion that the time reference may have created. This reference to time was intended as a guideline to ensure that this add-on code is used only when the procedure performed is a substantive procedure needed to produce a significant improvement in the patient's condition. Documentation supporting this should be reflected in the operative note.

Establishment of Interim Work Relative Value Units for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System Codes (HCPCS) for 2004 (Includes Table titled American Medical Association Specialty Relative Value Update Committee and Health Care Professionals Advisory Committee Recommendations and CMS's Decisions for New and Revised 2004 CPT Codes)

One aspect of establishing RVUs for 2004 was related to the assignment of interim work RVUs for all new and revised CPT codes. As described in our November 25, 1992 notice on the 1993 physician fee schedule (57 FR 55983) and in section III.B. of the November 22, 1996 final rule (61 FR 59505 through 59506), we established a process, based on recommendations received from the AMA's RUC, for establishing interim work RVUs for new and revised codes.

This year we received work RVU recommendations for approximately 132 new and revised CPT codes from the RUC. Our staff and medical officers reviewed the RUC recommendations by comparing them to our reference set or to other comparable services for which work RVUs had previously been established, or to both of these criteria. We also considered the relationships among the new and revised codes for which we received RUC recommendations. We agreed with the majority of the relative relationships reflected in the RUC values. In some instances, when we agreed with the relationships, we nonetheless revised the work RVUs to achieve work neutrality within families of codes. That is, the work RVUs have been adjusted so that the sum of the new or revised work RVUs (weighted by projected frequency of use) for a family will be the same as the sum of the current work RVUs (weighted by projected frequency of use). We reviewed all the RUC recommendations. We accepted approximately 95 percent and we disagreed with approximately 5 percent of the RUC recommended values. In the majority of these instances, we agreed with the relativity established by the RUC, but needed to adjust work RVUs to retain budget neutrality.

We received 2 recommendations from the HCPAC. We agreed with both of the HCPAC recommendations.

Table 5, titled "AMA RUC and HCPAC Recommendations and CMS Decisions for New and Revised 2004 CPT Codes", lists the new or revised CPT codes, and their associated work RVUs, that will be interim in 2004. This table includes the following information:

- A "#" identifies a new code for 2004.
- CPT code. This is the CPT code for a service.
- Modifier. A "26" in this column indicates that the work RVUs are for the professional component of the code.
- Description. This is an abbreviated version of the narrative description of the code.
- RUC recommendations. This column identifies the work RVUs recommended by the RUC.
- HCPAC recommendations. This column identifies the work RVUs recommended by the HCPAC.
- CMS decision. This column indicates whether we agreed with the RUC recommendation ("agree") or we disagreed with the RUC recommendation ("disagree"). Codes for which we did not accept the RUC recommendation are discussed in greater detail following this table. An "(a)" indicates that no RUC recommendation was provided.
- 2004 Work RVUs. This column establishes the 2004 work RVUs for physician work. These work RVUs may differ from the work RVUs in Addenda B and C that reflect the adjustments to work RVUs to match the MEI weights.

TABLE 6.—AMA RUC AND HCPAC RECOMMENDATIONS AND CMS DECISIONS FOR NEW AND REVISED 2004 CPT CODES

*CPT code	Mod	Description	RUC recommendation	HCPAC recommendation	CMS decision	2004 work RVU
#20982		Ablate, bone tumor(s) perq	7.27		Agree	7.27
#21685		Hyoid myotomy & suspension	13.00		Agree	13.00
#22532		Lat thorax spine fusion	24.00		Agree	24.00
#22533		Lat lumbar spine fusion	23.12		Agree	23.12
#22534		Lat thor/lumb, add'l seg	6.00		Agree	6.00
31622		Dx bronchoscope/wash	2.78		Agree	2.78
31623		Dx bronchoscope/brush	2.88		Agree	2.88
31624		Dx bronchoscope/lavage	2.88		Agree	2.88
31625		Bronchoscopy w/biopsy (s)	3.37		Agree	3.37
31628		Bronchoscopy/lung bx, each	3.81		Agree	3.81
31629		Bronchoscopy/needle bx, each	4.10		Agree	4.10
31630		Bronchoscopy dilate/fx repr	3.82		Agree	3.82
31631		Bronchoscopy, dilate w/stent	4.37		Agree	4.37
#31632		Bronchoscopy/lung bx, add'l	1.03		Agree	1.03
#31633		Bronchoscopy/needle bx add'l	1.32		Agree	1.32
31635		Bronchoscopy w/fb removal	3.68		Agree	3.68
31640		Bronchoscopy w/tumor excise	4.94		Agree	4.94
33310		Exploratory heart surgery	18.51		Agree	18.51
33315		Exploratory heart surgery	22.37		Agree	22.37
#34805		Endovasc abdo repair w/pros	21.88		Agree	21.88
#35510		Artery bypass graft	23.00		Agree	23.00
#35512		Artery bypass graft	22.50		Agree	22.50
#35522		Artery bypass graft	21.76		Agree	21.76
#35525		Artery bypass graft	20.63		Agree	20.63
#35697		Reimplant artery each	3.00		Agree	3.00

TABLE 6.—AMA RUC AND HCPAC RECOMMENDATIONS AND CMS DECISIONS FOR NEW AND REVISED 2004 CPT CODES—Continued

*CPT code	Mod	Description	RUC recommendation	HCPAC recommendation	CMS decision	2004 work RVU
#36555		Insert non-tunnel cv cath	2.68		Agree	2.68
#36556		Insert non-tunnel cv cath	2.50		Agree	2.50
#36557		Insert tunneled cv cath	5.10		Agree	5.10
#36558		Insert tunneled cv cath	4.80		Agree	4.80
#36560		Insert tunneled cv cath	6.25		Agree	6.25
#36561		Insert tunneled cv cath	6.00		Agree	6.00
#36563		Insert tunneled cv cath	6.20		Agree	6.20
#36565		Insert tunneled cv cath	6.00		Agree	6.00
#36566		Insert tunneled cv cath	6.50		Agree	6.50
#36568		Insert tunneled cv cath	1.92		Agree	1.92
#36569		Insert tunneled cv cath	1.82		Agree	1.82
#36570		Insert tunneled cv cath	5.32		Agree	5.32
#36571		Insert tunneled cv cath	5.30		Agree	5.30
#36575		Repair tunneled cv cath	0.67		Agree	0.67
#36576		Repair tunneled cv cath	3.19		Agree	3.19
#36578		Repair tunneled cv cath	3.50		Agree	3.50
#36580		Replace tunneled cv cath	1.31		Agree	1.31
#36581		Replace tunneled cv cath	3.44		Agree	3.44
#36582		Replace tunneled cv cath	5.20		Agree	5.20
#36583		Replace tunneled cv cath	5.25		Agree	5.25
#36584		Replace tunneled cv cath	1.20		Agree	1.20
#36585		Replace tunneled cv cath	4.80		Agree	4.80
#36589		Removal tunneled cv cath	2.27		Agree	2.27
#36590		Removal tunneled cv cath	3.30		Agree	3.30
#36595		Mech remov tunneled cv cath	3.60		Agree	3.60
#36596		Mech remov tunneled cv cath	0.75		Agree	0.75
#36597		Repositoin venous catheter	1.21		Agree	1.21
#36838		Dist revas ligation, hemo	20.63		Agree	20.63
#37765		Phleb veins—extrem—to 20	7.35		Agree	7.35
#37766		Phleb veins—extrem 20 +	9.30		Agree	9.30
37785		Ligate/divide/excise vein	3.84		Agree	3.84
38208		Thaw preserved stem cells	0.56		Disagree	0.00
38209		Wash harvest stem cells	0.24		Disagree	0.00
43235		Uppr gi endoscopy, diagnosis	2.39		Agree	2.39
#43237		Endoscopic us exam, esoph	3.99		Agree	3.99
#43238		Uppr gi endoscopy w/us fn bx	5.03		Agree	5.03
43242		Uppr gi endoscopy w/us fn bx	7.31		Agree	7.31
43259		Endoscopic ultrasound exam	5.20		Agree	5.20
43752		Nasal/orogastric w/stent	0.82		Disagree	0.68
47133		Removal of donor liver	†		Agree	†
#47140		Partial removal, donor liver	55.00		Agree	55.00
#47141		Partial removal, donor liver	67.50		Agree	67.50
#47142		Partial removal, donor liver	75.00		Agree	75.00
#53500		Urethrlys, transvag w/scope	12.21		Agree	12.21
#57425		Laparoscopy, surg, colpopexy	15.75		Agree	15.75
58545		Laparoscopic myomectomy	14.21		Agree	14.21
58546		Laparo-myomectomy, complex	19.00		Agree	19.00
58550		Laparo-asst vag hysterectomy	14.19		Agree	14.19
58552		Laparo-vag hyst incl t/o	16.00		Agree	16.00
58553		Laparo-vag hyst, complex	20.00		Agree	20.00
58554		Laparo-vag hyst w/t/o, compl	22.00		Agree	22.00
#59070		Transabdom amnioinfus w/us	5.25		Agree	5.25
#59072		Umbilical cord occlud w/us	9.00		Agree	9.00
#59074		Fetal fluid drainage w/us	5.25		Agree	5.25
#59076		Fetal shunt placement, w/us	9.00		Agree	9.00
#59897	†	Fetal invas px w/us	†		Agree	†
#61537		Removal of brain tissue	25.00		Agree	25.00
61538		Removal of brain tissue	26.81		Agree	26.81
61539		Removal of brain tissue	32.08		Agree	32.08
#61540		Removal of brain tissue	30.00		Agree	30.00
61543		Removal of brain tissue	29.22		Agree	29.22
#61566		Removal of brain tissue	31.00		Agree	31.00
#61567		Incision of brain tissue	35.50		Agree	35.50
#61863		Implant neuroelectrode	19.00		Disagree	13.92
#61864		Implant neuroelectrode, add'l	4.50		Agree	4.50
#61867		Implant neuroelectrode	31.34		Disagree	22.96
#61868		Implant neuroelectrde, add'l	7.92		Agree	7.92
#63101		Removal of vertebral boby	32.00		Agree	32.00
#63102		Removal of vertebral body	32.00		Agree	32.00

TABLE 6.—AMA RUC AND HCPAC RECOMMENDATIONS AND CMS DECISIONS FOR NEW AND REVISED 2004 CPT CODES—Continued

*CPT code	Mod	Description	RUC recommendation	HCPAC recommendation	CMS decision	2004 work RVU
#63103		Removal vertebral body add-on	5.00		Disagree	3.90
#64449		N block inj, lumbar plexus	3.00		Agree	3.00
#64517		N block inj, hypogas plxs	2.20		Agree	2.20
64680		Injection treatment of nerve	2.62		Agree	2.62
#64681		Injection treatment of nerve	3.55		Agree	3.55
#65780		Ocular reconst, transplant	10.25		Agree	10.25
#65781		Ocular reconst, transplant	17.67		Agree	17.67
#65782		Ocular reconst, transplant	15.00		Agree	15.00
#67912		Correction eyelid w/ implant	5.68		Agree	5.68
#68371		Harvest eye tissue, alograft	4.90		Agree	4.90
#70557		Mri brain w/o dye	2.90		Agree	2.90
#70558		Mri brain w/dye	3.20		Agree	3.20
#70559		Mri brain w/o & w/dye	3.20		Agree	3.20
75901		Remove cva device obstruct	0.49		Agree	0.49
75902		Remove cva lumen obstruct	0.39		Agree	0.39
#75998		Fluoroguide for vein device	0.38		Agree	0.38
#76082		Computer mammogram add-on	0.06		Agree	0.06
#76083		Computer mammogram add-on	0.06		Agree	0.06
#76514		Echo exam of eye, thickness	0.17		Agree	0.17
#76937		Us guide, vascular access	0.30		Agree	0.30
78800		Tumor imaging, limited area	0.66		Agree	0.66
78801		Tumor imaging, mult areas	0.79		Agree	0.79
78802		Tumor imaging, whole body	0.86		Agree	0.86
78803		Tumor imaging (3D)	1.09		Agree	1.09
#78804		Tumor imaging, whole body	1.07		Agree	1.07
79100		Repeat hyperthyroid therapy	1.32		Agree	1.32
79400		Nonhemato nuclear therapy	1.96		Agree	1.96
#79403		Hematopoetic nuclear therapy	2.25		Agree	2.25
#85396		Clotting assay, whole blood	0.37		Agree	0.37
#88112		Cytopath, cell enhance blood	1.18		Agree	1.18
88342		Immunohistochemistry	0.85		Agree	0.85
88358		Analysis, tumor	0.95		Agree	0.95
#88361		Immunohistochemistry, tumor	0.94		Agree	0.94
#91110		Gi tract capsule endoscopy	3.65		Agree	3.65
95990		Spin/brain pump refil & main	0.00		Agree	0.00
#95991		Spin/brain pump refil & main	0.77		Agree	0.77
96110		Developmental test, lim	0.00		Agree	0.00
96111		Developmental test, extend	2.60		Agree	2.60
97537		Community/Work reintegration		0.45	Agree	0.45
#97755		Assistive technology assess		0.62	Agree	0.62

(a) No Final RUC recommendation provided.
#New CPT codes.
*All CPT codes copyright 2004 American Medical Association.
†Carrier.

Table 6, which is titled "AMA RUC ANESTHESIA RECOMMENDATIONS AND CMS DECISIONS FOR NEW AND REVISED 2004 CPT CODES", lists the new or revised CPT codes for anesthesia and their base units that will be interim in 2004. This table includes the following information:

- CPT code. This is the CPT code for a service.
- Description. This is an abbreviated version of the narrative description of the code.
- RUC recommendations. This column identifies the base units recommended by the RUC.
- CMS decision. This column indicates whether we agreed with the RUC recommendation ("agree") or we disagreed with the RUC recommendation ("disagree"). Codes for which we did not accept the RUC recommendation are discussed in greater detail following this table.
- 2004 Base Units. This column establishes the 2004 base units for these services.

TABLE 7.—AMA RUC ANESTHSIA RECOMMENDATIONS AND CMS DECISIONS FOR NEW AND REVISED CPT CODES

*CPT code	Description	RUC recommendation	CMS decision	2003 base units
00529#	ANESTH, CHEST PARTITION VIEW	11	Agree	11
01173#	ANESTH, FX REPAIR, PELVIS	12	Agree	12

TABLE 7.—AMA RUC ANESTHSIA RECOMMENDATIONS AND CMS DECISIONS FOR NEW AND REVISED CPT CODES—Continued

*CPT code	Description	RUC recommendation	CMS decision	2003 base units
01958#	ANESTH, ANTEPARTUM MANIPUL	5	Agree	5

*All CPT codes copyright 2004 American Medical Association.
New CPT code.

Discussion of Codes for Which There Were No RUC Recommendations or for Which the RUC Recommendations Were Not Accepted

The following is a summary of our rationale for not accepting particular RUC work RVU or base unit recommendations. It is arranged by type of service in CPT order. Additionally, we also discuss those CPT codes for which we received no RUC recommendations for physician work RVUs. This summary refers only to work RVUs or base units.

CPT code 43752 *Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)*

The RUC recommended a work RVU of 0.82 for this service based on a comparison of this procedure to CPT code 44500. While we agree that CPT code 43752 is similar in work intensity to CPT code 44500, we feel the intra-service time is more appropriately valued at the 25th percentile (15 minutes of intra-service time vs. 20 minutes of intra-service time). This reduces the total time associated with CPT code 43752 from 30 minutes to 25 minutes. We applied the ratio of the RUC recommended value of 0.82 work RVU over 30 minutes to the revised intra-service time of 25 minutes to assign 0.68 interim work RVUs for CPT code 43752.

CPT code 63103 *Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (e.g., for tumor or retropulsed bone fragments); thoracic or lumbar, each additional segment. (List separately in addition to code for primary procedure)*

The RUC recommended a work RVU of 5.00 for this service based on a comparison of this procedure to CPT code 63088. It was unclear from the clinical vignettes supplied by the specialty society whether the additional corpectomy would more commonly involve the lumbar or the thoracic region of the spine. There is a significant difference in work intensity associated with the resection of an additional corpus in the thoracic region as opposed to the lumbar region. For this reason we applied the ratio of the reference service (CPT code 63088) to its primary service (CPT code 63087) to CPT code 63101 (primary service associated with CPT 63103) to assign 3.90 interim work RVUs for CPT code 63103.

CPT code 61863 *Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (e.g., thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array and CPT code 61867 Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (e.g., thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array*

The RUC recommended a work RVU of 19.00 for CPT code 61863 and 31.34 work RVUs for CPT code 61867. These two new CPT codes replace existing CPT code 61862 (work RVU=19.34). Although we agree with the relative relationship established by the RUC for these services, in order to retain budget neutrality, we adjusted the RUC recommended values. Thus, the recommended values were adjusted in order that the total relative values remain constant before and after the inclusion of the new CPT codes.

We assigned 13.92 work RVUs to CPT code 61863 and 22.96 work RVUs to CPT code 61867.

CPT code 38208 *Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing and CPT code 38209 Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing*

We continue to have the same concerns as outlined in the December 31, 2002 final rule (67 FR 80007) with respect to moving these codes from the laboratory fee schedule and thus establishing relative values under the physician fee schedule. We are maintaining a status indicator "I" for these services, making them not valid for payment under the Medicare Physician Fee Schedule.

CPT code 96111 *Developmental testing extended (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments, eg Bayley Scales of Infant Development) with interpretation and report, per hour*

Although we agree with the RUC recommended work RVU of 2.60 for CPT code 96111, we note that the tests under this code will no longer be paid on a per hour basis. That is, total payment for the services under CPT code 96111 is based on one hour of provision of the tests. It is our understanding that these tests can be completed typically in one hour. That is, some of the tests can be administered in less than one hour and some may require a little more than one hour, so that the average time for all of the tests works out to be one hour. Therefore, regardless of the total number of hours it takes to complete the services under CPT code 96111 or whether the services are split up and spread over a number of days, payment will be made for 96111 based on only one unit/hour at 2.6 RVUs.

Establishment of Interim Practice Expense RVUs for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System (HCPCS) Codes for 2004.

We have developed a process for establishing interim practice expense RVUs for new and revised codes that is similar to that used for work RVUs. Under this process, the RUC recommends the practice expense direct inputs, that is, the staff time, supplies and equipment, associated with each new code. We then review the recommendations in a manner similar to our evaluation of the recommended work RVUs.

The RUC recommendations on the practice expense inputs for the new and revised 2004 codes were submitted to us as interim recommendations. We, therefore, consider that these recommendations are still subject to further refinement by the PEAC, or by us, if it is determined that such future review is needed. We may also revisit these inputs in light of future decisions of the PEAC regarding supply and equipment packages and standardized approaches to pre- and post-service clinical staff times.

We have accepted, in the interim, almost all of the practice expense recommendations submitted by the RUC for the codes listed in the following table titled "AMA RUC and HCPAC RVU Recommendations and CMS Decisions for New and Revised 2004 CPT Codes."

We made the following minor changes to the inputs where relevant:

- We deleted the 3-minute phone calls in the post service period to conform to our established standard for all codes with 10 and 90-day global periods.
- We also deleted equipment when individual items did not meet the minimum $500 requirement.
- We deleted certain equipment items that represent indirect, rather than direct costs, including lead shielding, lead lined radioactive waste box and lead-lined sharps box.
- We deleted the L–Block table shield because it is included in the price and description of the dose calibrator, another CPEP equipment item.
- We made minor changes to clinical labor and supplies, for several central venous access (CVA) codes in order to bring uniformity to this new family of codes.
- We assigned, on an interim basis, the clinical labor RN designation for CPT code 95991, physician administered refilling and maintenance of spinal or brain implantable pump, until the PEAC has an opportunity to review the necessity for this clinical assignment.

V. Update to the Codes for Physician Self-Referral Prohibition

A. Background

On January 4, 2001 we published in the **Federal Register** a final rule with comment period, "Medicare and Medicaid Programs; Physicians Referrals to Health Care Entities With Which They Have Financial Relationships" (66 FR 856). That final rule incorporated into regulations the provisions in paragraphs (a), (b) and (h) of section 1877 of the Act. Section 1877 of the Act prohibits a physician from referring a Medicare beneficiary for certain "designated health services" to a health care entity with which the physician (or a member of the physician's immediate family) has a financial relationship, unless an exception applies. In the final rule, we published an attachment listing all of the CPT and HCPCS codes that defined the entire scope of the following designated health services for purposes of section 1877 of the Act: clinical laboratory services; physical therapy services (including speech-language pathology services); occupational therapy services; radiology and certain other imaging services; and radiation therapy services and supplies.

In the January 2001 final rule, we stated that we would update the list of codes used to define these designated health services (the "Code List") in an addendum to the annual physician fee schedule final rule. The purpose of the update is to conform the Code List to the most recent publications of CPT and HCPCS codes. The last update of the Code List was included in the December 31, 2002 physician fee schedule final rule in Addendum E and was subsequently corrected in a notice that was published in the **Federal Register** (68 FR 32400) on May 30, 2003.

The updated all-inclusive Code List effective January 1, 2004 is presented in Addendum F in this final rule. We intend to publish annually the all-inclusive Code List in an addendum to the physician fee schedule final rule. The updated all-inclusive Code List will also be available on our Web site at *http://www.cms.hhs.gov/medlearn/refphys.asp*.

B. Response to Comments

We received public comments on three issues relating to the most recent Code List. The comments and our responses are stated below.

Comment: One commenter noted that we added three new "Q" codes (Q3021, Q3022, and Q3023) for hepatitis B vaccines. Program Memorandum AB–02–185 issued on December 31, 2002 deleted these HCPCS codes. However, the Program Memorandum also reactivated the following CPT codes for hepatitis B vaccine: 90740, 90743, 90744, 90746 and 90747.

Response: The commenter is correct. We erred in adding the "Q" codes to the list of services that may qualify for an exception under 42 CFR 411.355(h) concerning exceptions for preventive screening tests, immunizations, and vaccines. This was corrected in the correction notice published on May 30, 2003 (68 FR 32400).

Comment: Some commenters objected to the addition of CPT code 0020T (Extracorporeal shock wave therapy; involving plantar fascia) to the list of physical therapy services for purposes of the physician self-referral prohibition. The commenters stated that CPT 0020T is currently a physician service involving anesthesia and therefore, should not be characterized as a physical therapy service.

Response: We agree with the commenters and have removed CPT code 0020T from the list of designated health services. Further discussion of this comment and response is included in section IV.C.2 of this preamble concerning the HCPCS codes G0279 and G0280 relating to extracorporeal shock wave therapy.

Comment: One commenter noted that the annual Code List update does not include codes for the following designated health services: Durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics and prothestic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. The commenter recommended that we include the CPT and HCPCS codes for these designated health services in the annual update and in the quarterly updated Microsoft Excel spreadsheet of RVU values, global periods and supervision levels for Medicare covered-services posted on the CMS Web site. Alternatively, the commenter requested that we clarify that the Code List is not exhaustive and indicate where providers can obtain more information on the remaining categories.

Response: As explained in the January 4, 2001 final rule with comment (66 FR 923), we believe that the regulatory definitions of the designated health services at issue are sufficiently clear to permit entities and physicians to identify them readily. Moreover, some of these designated health services are not amenable to definition solely through codes. Regardless, to define these services through codes or to change the frequency of the Code List update would require a change in the text of the regulatory definitions for the various designated health services found in § 411.351. The purpose of this Code List is simply to make those ministerial changes necessary to conform the Code List to the current CPT and HCPCS code publications. Making substantive changes to the regulatory definitions is beyond the scope of this update and cannot be accomplished without first proposing

the changes in a Notice of Proposed Rulemaking. Lastly, we cannot accept the commenter's suggestion that we explain that the Code List is not exhaustive because such a statement is false. The Code List is exhaustive with respect to the specific designated health services that it defines, and for the reasons noted above, we are not defining the remaining designated health services through codes.

C. Revisions Effective for 2004

Tables 7 and 8, below, identify the additions and deletions, respectively, to the comprehensive Code List last published in Addendum E of the December 2002 physician fee schedule final rule and subsequently corrected in the May 30, 2003 correction notice (68 FR 32400). Tables 7 and 8 also identify the additions and deletions to the lists of codes used to identify the items and services that may qualify for the exceptions in § 411.355(g) (regarding EPO and other dialysis-related outpatient prescription drugs furnished in or by an end-stage renal dialysis (ESRD) facility) and in § 411.355(h) (regarding preventive screening tests, immunizations and vaccines).

We will consider comments with respect to the codes listed in Tables 8 and 9 below, if we receive them by the date specified in the **DATES** section of this final rule.

TABLE 8.—ADDITIONS TO THE PHYSICIAN SELF-REFERRAL HCPCS/CPT [1] CODES

Clinical Laboratory Services	
0058T	Cryopreservation, ovary tiss.
0059T	Cryopreservation, oocyte.
G0027	Semen analysis.
G0306	CBC/diffwbc w/o platelet.
G0307	CBC without platelet.
G0328	Fecal blood scrn immunoassay.
Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services	
97755	Assistive technology assess.
Radiology and Certain Other Imaging Services	
72198	Mr angio pelvis w/o & w/dye.
76082	Computer mammogram add-on.
76083	Computer mammogram add-on.
76514	Echo exam of eye, thickness.
91110	Gi tract capsule endoscopy.
Radiation Therapy Services and Supplies	
G0173	Stereo radiosurgery, complete.
G0251	Linear acc based stero radio.
G0338	Linear accelerator stero pln.
G0339	Robot lin-radsurg com, first.
G0340	Robt lin-radsurg fractx 2–5.

TABLE 8.—ADDITIONS TO THE PHYSICIAN SELF-REFERRAL HCPCS/CPT [1] CODES—Continued

Drugs Used by Patients Undergoing Dialysis	
Q4054	Darbepoetin alfa, esrd use.
Q4055	Epoetin alfa, esrd use.
Preventive Screening Tests, Immunizations and Vaccines	
76083	Computer mammogram add-on.
90655	Flu vaccine, 6–35 mo, im.

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TABLE 9.—DELETIONS TO THE PHYSICIAN SELF-REFERRAL HCPCS/CPT [1] CODES

Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services	
0020T	Extracorp shock wave tx, ft.
Q0086	Physical therapy evaluation.
Radiology and Certain Other Imaging Services	
76085	Computer mammogram add-on.
76831	Echo exam, uterus.
G0236	Digital film conv.
GO262	Sm intestinal image capsule.
Radiation Therapy Services and Supplies	
G0274	Radiopharm tx, non-Hodgkins.
Drugs Used by Patients Undergoing Dialysis	
Q9920	Epoetin with hct < = 20.
Q9921	Epoetin with hct = 21.
Q9922	Epoetin with hct = 22.
Q9923	Epoetin with hct = 23.
Q9924	Epoetin with hct = 24.
Q9925	Epoetin with hct = 25.
Q9926	Epoetin with hct = 26.
Q9927	Epoetin with hct = 27.
Q9928	Epoetin with hct = 28.
Q9929	Epoetin with hct = 29.
Q9930	Epoetin with hct = 30.
Q9931	Epoetin with hct = 31.
Q9932	Epoetin with hct = 32.
Q9933	Epoetin with hct = 33.
Q9934	Epoetin with hct = 34.
Q9935	Epoetin with hct = 35.
Q9936	Epoetin with hct = 36.
Q9937	Epoetin with hct = 37.
Q9938	Epoetin with hct = 38.
Q9939	Epoetin with hct = 39.
Q9940	Epoetin with hct > = 40.
Preventive Screening Tests, Immunizations and Vaccines	
76085	Computer mammogram add-on.

TABLE 9.—DELETIONS TO THE PHYSICIAN SELF-REFERRAL HCPCS/CPT [1] CODES—Continued

90659	Flu vacine, whole, im.

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The additions specified in Table 8 generally reflect new CPT and HCPCS codes that become effective January 1, 2004 or that became effective since our last update. It also reflects the addition of codes recently recognized by Medicare for payment purposes.

Additionally, we are adding two G-codes (G0173, "Stereo radiosurgery, complete" and G0251, "Linear acc based stero radio") to the category of radiation therapy services and supplies. These codes became effective for Medicare payment purposes in August 2000 and July 2002, respectively and should have been reflected in previous Code Lists.

Table 8 also reflects the addition of 2 new HCPCS codes (Q4054 and Q4055) to the list of dialysis-related outpatient prescription drugs that may qualify for the exception described in § 411.355(g) regarding those items. The physician self-referral prohibition will not apply to these drugs if they meet the conditions set forth in § 411.355(g). Table X also reflects the addition of a screening mammography code (CPT 76083) and a flu vaccine code (CPT 90655) to the list that identifies preventive screening tests, immunizations and vaccines that may qualify for the exception described in § 411.355(h) for such items and services. The physician self-referral prohibition will not apply to these services if they meet the conditions set forth in § 411.355(h) concerning the exception for preventive screening tests, immunizations, and vaccines.

Table 8 reflects the deletions necessary to conform the Code List to the most recent publications of CPT and HCPCS codes, as well as additional deletions that we have determined are necessary as described below.

Under the category of physical therapy, occupational therapy and speech-language pathology services, we are removing CPT code 0020T, extracorporeal shock wave therapy for plantar fascia consistent with the response to the comment discussed in section IV.C.2 and VI.B of this preamble.

Under the category of radiology and certain other imaging services, we are deleting CPT code 76831 for an echo exam of the uterus. This code should never have appeared on the Code List.

Our definition of "radiology and certain other imaging services" at § 411.351 specifically excludes any x-ray, fluoroscopy or ultrasonic procedure that requires "the insertion of a needle, catheter, tube, or probe". The type of procedure described by CPT code 76831 involves infusion tubing and should be removed from the Code List.

Under the category of radiation therapy services and supplies, we are removing HCPCS code G0274 for radiopharmaceutical therapy for non-Hodgkin's lymphoma because it is a nuclear medicine service. Our definition of "radiation therapy services and supplies" at § 411.351 specifically excludes nuclear medicine procedures. Thus, HCPCS code G0274 should never have appeared on the Code List.

VI. Physician Fee Schedule Update for Calendar Year 2004

A. Physician Fee Schedule Update

The physician fee schedule update is determined using a formula specified by statute. Under section 1848(d)(4) of the Act, the update is equal to the product of 1 plus the percentage increase in the Medicare Economic Index (MEI) (divided by 100) and 1 plus the update adjustment factor (UAF). For CY 2004, the MEI is equal to 2.9 percent (1.029). The UAF is −7.0 percent (0.930). Section 1848(d)(4)(F) of the Act requires an additional −0.2 percent (0.998) reduction to the update for 2004. Thus, the product of the MEI (1.029), the UAF (0.930), and the statutory adjustment factor (0.998) equals the CY 2004 update of −4.5 percent (0.9551).

The negative physician fee schedule update occurs under a mandatory statutory formula. The law gives us no alternative to reducing the physician fee schedule rates. Only Congress can change the law and avert a reduction in 2004 physician fee schedule rates. Without a congressional act to change the law, the Department is compelled to announce a physician fee schedule update for CY 2004 of −4.5 percent. The Department's calculations are explained below.

B. Rebasing and Revising of the Medicare Economic Index

1. 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 a 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 sum of the annual price changes of the inputs used to produce physicians' services. As such, the MEI attempts to be an equitable measure of price changes associated with physician time and operating expenses.

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 two 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 adjusting for productivity was revised in 2002 (67 FR 80019) to reflect the percentage change in the 10-year moving average of economy-wide multifactor productivity.

We are rebasing and revising the MEI for the 2004 physician fee schedule update. The terms "rebasing" and "revising", while often used interchangeably, actually denote different activities. Rebasing means moving the base year for the structure of costs of an input price index, while revising means 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 MEI cost category weights and price proxies. We detail below the updated cost weights for the MEI expense categories, our rationale for selecting the price proxies in the MEI, and the results of rebasing and revising the MEI.

2. Use of More Current Data

The MEI was last rebased and revised in 1998 for the 1999 physician fee schedule update (63 FR 58845). The base year for that version of the MEI was 1996, which means that the cost weights in the index reflect physicians' expenses in 1996. However, we believe it is desirable to periodically rebase and revise the index so that the expense shares and price proxies reflect more current conditions. For this reason, we are rebasing the MEI to reflect physicians' expenses in 2000. In addition, we are revising the cost categories in the MEI and changing three of the proxies we currently use to ensure that the index is appropriately reflecting price changes. We will continue to adjust the MEI using economy-wide multifactor productivity.

The expense categories in the rebased and revised MEI were primarily derived from the 2003 AMA Physician Socioeconomic Characteristics publication (2003 Patient Care Physician Survey data), which measures physicians' earnings and overall practice expenses for 2000. The AMA data were used to determine expenditure weights for total expenses, physicians' earnings, and malpractice expenses, the only information detailed in this survey. To further disaggregate the weights into subcategories reflecting more detailed expenses, we used data from previous AMA surveys, the 1997 Bureau of Economic Analysis Benchmark Input-Output table (I/O), the 2003 Bureau of Labor Statistics (BLS) Employment Cost Index (ECI), and the 2002 Bureau of the Census Current Population Survey (CPS).

3. Rebasing and Revising Expense Categories in the MEI

a. Developing the Weights for Use in the MEI

Developing a rebased and revised MEI requires selecting a base year and determining the number and composition of expense categories and their associated price proxies. We are rebasing the MEI to CY 2000. CY 2000 was chosen as the base year for two main reasons: (1) CY 2000 was the most recent year for which data were available from the AMA, and (2) we believed that the CY 2000 data were representative of the changing distribution of physicians' earnings and practice expenses over time.

Comment: One commenter suggested that we update the weights in the MEI to a more recent base year, possibly CY 2004. While the commenter agreed with us that there is a lack of data to do so, the commenter suggested using the price change in each of the proxies to estimate weights for 2004 as an alternative to 2000 data.

Response: We selected CY 2000 as the base year for two reasons: (1) CY 2000 data were the most recent data available from the AMA, and (2) we felt the CY 2000 data were representative of the changing distribution of physician earnings and practice expenses over time. We do not expect that the experience of the past 3 or 4 years would have a significant impact on the MEI for the CY 2004 update, particularly since changing the weights from 1996 to 2000 had such a minimal effect. In addition, the price proxies that we use capture the current price changes in each of the categories that make up the MEI.

While we agree that it would be optimal to develop MEI weights based on more recent data, we recognize the lack of data to do so. We also recognize that an alternative would be to use price changes in each of the proxies to update the weights to a more recent base year, similar to the methodology we used to develop the distribution of detailed practice expense categories in the current structure. In that case, we used price changes from 1998 to 2000 to develop weights for 2000.

However, as we indicated in the proposed rule, this method has a major drawback in that it assumes that the quantity of inputs would increase at the same rate as the price of those inputs. This may not be the case over longer time periods (for instance, 2000–2004) where there is likely to be substitution away from more costly inputs toward those which are less costly. Our experience with rebasing indexes has also shown that the weights for major categories do not change very much over time, even though the individual price changes for those categories can differ significantly. In addition, because the MEI is a Laspeyres-type index, the price changes between the base period and the current period are reflected in the relative importance of each category in determining the overall increase. Therefore, we feel that basing the index on CY 2000 data and reflecting current price changes likely represents a reasonable estimate of physicians' current experience.

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. For more information on these criteria, see the May 9, 2002 **Federal Register** (67 FR 31444) and the detail later in this preamble. Table 10 lists the set of mutually exclusive and exhaustive cost categories that make up the rebased and revised MEI.

TABLE 10.—REBASED AND REVISED MEDICARE ECONOMIC INDEX EXPENDITURE CATEGORIES, WEIGHTS, AND PRICE PROXIES

Expense category	2000—Expense weights[1] [2]	1996—Expense weights	Price proxy
Total	100.000	100.000	
Physician Earnings[3]	52.466	54.460	
Wages and Salaries	42.730	44.197	AHE—Private.
Benefits[4]	9.735	10.263	ECI—Ben: Private.
Physician Practice Expenses	47.534	45.540	
Nonphysician Employee Compensation	18.653	16.812	
Employee Wages and Salaries	13.808	12.424	
Prof/Tech Wages	5.887	5.662	ECI—W/S: Private P&T.
Managerial Wages	3.333	2.410	ECI—W/S: Private Admin.
Clerical Wages	3.892	3.830	ECI—W/S: Private Clerical.
Services Wages	0.696	0.522	ECI—W/S: Private Service.
Employee Benefits[4]	4.845	4.388	ECI—Ben: Priv. White Collar.
Other Practice Expenses	18.129		
Office Expenses	12.209	11.581	CPI(U)—Housing.
Professional Liability Insurance	3.865	3.152	CMS—Prof. Liab. Phys. Premiums.
Medical Equipment	2.055	1.878	PPI—Medical Instruments & Equip.
Pharmaceuticals and Medical Materials and Supplies.	4.319	4.516	
Medical Materials and Supplies	2.011		PPI Surg. Appliances and Supplies/CPI (U) Med Supplies.
Pharmaceuticals	2.308		PPI Pharmaceutical Preparations.
Other Expenses	6.433	7.601	CPI–U All Items Less Food and Energy.

[1] Due to rounding, weights may not sum to 100.000 percent.
[2] Sources: Physician Socioeconomic Statistics, 2000–2002 Edition (SMS Survey), Physician Socioeconomic Statistics, 2003 Edition (PCPS Survey), Center for Health Policy Research, American Medical Association; 2003 Employment Cost Index, U.S. Department of Labor, Bureau of Labor Statistics; U.S. Department of Commerce, Bureau of Economic Analysis 1997 Benchmark Input Output Tables, and U.S. Department of Commerce, Bureau of the Census, 2002 Current Population Survey.
[3] Includes employee physician payroll.
[4] Includes paid leave.

To determine the expenditure weights for the rebased and revised MEI, we used currently available and statistically valid data sources on physician earnings and practice expenses. While we consulted numerous data sources, we used five data sources to determine the MEI expenditure weights: (1) The 2003 AMA Physician Socioeconomic Statistics (2000 survey data) for self-employed physicians, (2) the 2000–2002 AMA Physician Socioeconomic Statistics (1998 data) for self-employed physicians, (3) the March 2003 BLS Employment Cost Index, (4) the 2002 Bureau of the Census Current Population Survey, and (5) the Bureau of Economic Analysis (BEA) 1997 Benchmark Input-Output tables (I/O). No one data source provided all of the information needed to determine expenditure weights according to our criteria. The development of each of the cost categories using these sources is described in detail below.

b. Physician Earnings

The rebased and revised MEI uses AMA data on mean physician net income (physician earnings) for self-employed physicians to develop a weight for physician earnings. The weight for this expense category is based on AMA data for 2000 and is calculated as a percentage of total mean expenses (physician earnings and practice expenses, including malpractice). The physician earnings expenditure category also includes employee physician compensation.

Currently, physician earnings and overhead expenses generated by employee physicians are included in the AMA practice expenses category. However, we believe it is appropriate, for our purposes, to place employee physician compensation in the MEI cost category of physician earnings. Including employee physician payroll in physician earnings in the MEI is consistent with the current payment methodologies in accordance with the physician fee schedule, where the work RVU is computed based on what service is provided and not on who provides the service. Since employee physicians perform the same services as self-employed physicians, employee physician time is reflected in the work RVU. By including the compensation of employee physicians in the physician earnings expense category, these expenses will be adjusted by the appropriate price proxies for time spent by a physician.

To obtain further detail for both wages/salaries and benefits, the ratio between these categories for 1996 (based on the 1996-based MEI) was updated to 2000 using the growth in the overall Employment Cost Index for private employees for wages/salaries and benefits. Alternative data for determining this split were not readily available from any other source. The main shortcoming of this method is that any changes in quantity and intensity (mix of physicians) are not reflected. However, faced with the lack of alternative data, we deemed this approach to be the most feasible, and the results appear to be consistent with anecdotal evidence on this ratio. Its application resulted in a wage-fringe benefit split of 81.4 and 18.6 percent, respectively, in the revised and rebased MEI compared with a wage-fringe benefit split of 81.2 and 18.8 percent, respectively, in the 1996-based MEI.

c. Physician Practice Expenses

To determine the remaining individual practice expense weights other than malpractice expense, we updated AMA expense data from 1998 to 2000 using the relative price change in an appropriate price index. After the levels were updated to 2000 values, it was necessary to normalize these levels to equal the 2000 mean total expense data provided by the 2003 AMA survey. The detailed explanations for the derivation of the individual weights are listed below.

(i) Nonphysician Employee Compensation

The cost share for nonphysician employee compensation was developed by updating the 1998 AMA Socioeconomic Survey data on nonphysician employee compensation costs for self-employed physicians to 2000, using the current proxy for this category, and dividing the resulting amount into total expenses (physician earnings plus practice expenses) for 2000 from the AMA survey. We further divided this cost share into wages/salaries and benefits using BLS Employment Cost Index data. The ECI survey contains data on the proportion of total compensation accounted for by wages/salaries and benefits (including paid leave) by private industry health services occupational category. These proportions can be used to distribute the total nonphysician employee compensation weight to wages/salaries and benefits for non-physician employees. We used 2000 data from the March 2003 publication. Although this survey does not contain data specifically for offices of physicians, data are available on wage/fringe shares for private industry health services, which include hospitals, nursing homes, offices of physicians, and offices of dentists. We believe the data for health services from the survey do provide a reasonable estimate of the split between wages and fringe benefits for employees in physicians' offices. Data for 2000 in the ECI survey for total health services indicate that wages and fringe benefits are 74.02 percent and 25.98 percent of compensation, respectively. As in the 1996-based MEI, we will use CPS data on earnings by occupation to develop cost shares for wages for nonphysician occupational groups shown in Table 6. To arrive at a distribution for these separate categories, we multiplied the overall share for nonphysician employee wages/salaries by each of the occupational proportions from the 2000 CPS. This distribution for the 1996-based and 2000-based MEI are presented in Table 10.

TABLE 11.—PERCENT DISTRIBUTION OF NONPHYSICIAN PAYROLL EXPENSE BY OCCUPATIONAL GROUP: 2000 AND 1996

BLS occupational group	2000 expenditure shares	1996 expenditure shares
Total	100.000	100.000
Professional & Technical Workers	42.635	45.573
Managers	24.138	19.398
Clerical Workers	28.187	30.827
Service Workers	5.040	4.202

[1] Due to rounding, weights may not sum to 100.000 percent.

(ii) Professional Liability Expense

The weight for professional liability expense was derived from the 2003 AMA survey (2000 data) and was calculated as the mean professional liability expense expressed as a percentage of total expenses (physician earnings plus practice expenses). This calculation resulted in a 3.865 percent share of total costs in 2000 compared to a 3.152 percent share in the 1996-based index. The increase in weight for professional liability insurance represents the increases in both premiums and the amount of coverage purchased by physicians in 2000 compared to 1996. While the weight does not reflect the cost experience for 2001 and 2002, the proxy used in the rebased and revised index does reflect the price increases associated with the recent rise in malpractice costs.

Comment: Some commenters were concerned that the rebased and revised MEI does not appropriately reflect the recent increase in professional liability insurance (PLI) premiums that physicians are experiencing.

Response: As we indicated in the proposed rule, the weights in the rebased and revised MEI reflect the distribution of physicians' costs in CY 2000 and do not reflect the more recent experience of physicians, particularly as it pertains to PLI. While it would be optimal to base the weights on more recent data, there is not a more recent, comprehensive measure that would meet our criteria for determining weights in the MEI.

We also indicated that while the weights do not reflect the more recent

experience, the proxy we use to measure the price change in this category does reflect more recent price changes in premiums and is the most current data available through the second quarter of 2003. This MEI PLI data, like that used in the development of the GPCIs, does not reflect total expenditures on PLI, which would be needed to develop more current weights for the MEI. In order to develop cost weights, expenditure data for all costs facing physicians are needed.

(iii) Office, Medical Equipment, Pharmaceuticals and Medical Materials and Supplies Expenses, and Other Expenses

The 2003 AMA survey provides less detail for expenses with respect to prior years' publications. Therefore, we calculated the share of each of the above categories by updating the AMA data for 1998 to 2000 using an appropriate price proxy. The primary reason for using the price proxy was that we lacked other data to develop cost weights for each of these categories. As stated previously, the main deficiency of this method is that it does not directly account for changes in the quantity or intensity associated with these expenses. Our belief, however, was that it was important to continue using these detailed breakouts so that each would be proxied by an appropriate price index and that the quantity/intensity effects over a short period of time are not likely to be large. In fact, we have found that even over longer periods of time, the distribution of costs tends to be relatively similar.

Office expenses and medical equipment levels were moved to 2000 using the growth from 1998 to 2000 in their respective MEI price proxies. In the case of office expenses, we used the growth in the CPI–U Housing; for medical equipment expenses, we used the growth in the PPI for Medical Instruments and Equipment.

The share for pharmaceuticals (prescription drugs) and medical materials and supplies was calculated by separating out pharmaceuticals and other medical materials and supplies using 1997 BEA Benchmark Input-Output data. First, the sum of all the pharmaceuticals and medical supplies categories from the Benchmark Input-Output tables for 1997 was calculated. The share of pharmaceuticals and medical supplies was then calculated as a percentage of this total and applied to the 1997 AMA medical supplies data. These calculated levels were then aged to 2000 using the growth in an appropriate price proxy. We thought it was important and appropriate to account for each of these categories separately so that differences in relative price growth between pharmaceuticals (prescription drugs) and other medical materials and supplies would be more accurately represented. The resulting 2000 data for the two separate categories were then aggregated (summed) together to form the overall total for the share for the pharmaceuticals and medical materials and supplies category in the rebased and revised MEI. The pharmaceuticals category was aged using the Producer Price Index (PPI) for Pharmaceutical preparations and the medical materials and supplies category was updated using the PPI for surgical appliances and supplies.

Finally, the Other Expenses category was calculated as a residual (total expenses less the percentage of all categories currently accounted for). The additional detail for transportation expenses found in the 1996-based MEI was removed because the data were not readily available for measurement of a cost share for 2000. The effect on the MEI of removing the detail is negligible.

Comment: One commenter suggested for the purposes of future changes to the MEI, that CMS consider inputs that are vastly different than when the MEI was first developed, such as costs of complying with government regulatory requirements and interpreter services for patients.

Response: We thoroughly research many of the known data sources on a regular basis to determine the appropriate number of detailed categories that make up the MEI. If we determine that a different combination of inputs is needed we will revise the MEI to reflect a more current cost distribution. However, CMS does not have the detailed expenditure and price data for the types of expenditures the commenter indicated. CMS will continue to work with other outside entities in the future to ensure the MEI is as accurate and representative as possible. It should also be noted that these costs are already captured in the MEI, as all costs are captured in the index, just not separately broken out for the reasons previously stated.

4. Selection of Price Proxies for Use in the MEI

After the 2000 cost weights for the rebased and revised MEI were developed, we reviewed the current set of price proxies to determine whether they were still the most appropriate for each expenditure category. As was the case in the development of the 1996-based MEI (57 FR 55901), most of the indicators we considered are based on BLS data and are grouped into one of the following five categories:

Producer Price Indices (PPIs)

Producer price indices (PPIs) measure price changes for goods sold in other than retail markets. They are the preferred proxies for physician purchases at the wholesale level. These fixed-weight indices are a measure of price change at the producer or at the intermediate stage of production, a more likely mode of purchase for physicians.

Consumer Price Indices (CPIs)

Consumer price indices (CPIs) measure change in the prices of final goods and services purchased by consumers. Like the PPIs, they are fixed-weight. Since they may not represent the price changes faced by producers, CPIs were used if there were no appropriate PPI or if the expenditure category was similar to expenditure of retail consumers in general.

Average Hourly Earnings (AHEs)

Average hourly earnings (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 indices are not affected by shifts in industry or occupation employment levels and 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 changes in industry output or occupational shifts.

When choosing wage and price proxies for each expense category, we evaluate the strengths and weaknesses of each proxy variable using four criteria. The first criterion is relevance. The price variable 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.

The second criterion is reliability or low sampling variability. If the proxy wage-price variable has a high sampling variability or inexplicable erratic patterns over time, its value is greatly diminished, since it is unlikely to accurately reflect price changes in its associated expenditure category. 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 sampling variability.

The third criterion is timeliness of actual published data. For this reason, we prefer monthly and quarterly data to annual data. The length of time the time series data have been published is also important. A well-established time series is needed to assess the reasonableness of the series and to provide a solid base from which to forecast future price changes in the series. We need to forecast the MEI to make Federal budget and Trustees Report estimates.

The fourth criterion is public availability. We prefer to use data sources that are publicly available for our indices so that the public may track each of the individual components in the MEI.

The BLS price proxy categories previously described meet the criteria of relevance, reliability, timeliness, and public availability. Below we discuss the price-wage proxies for the rebased and revised MEI (shown in Table 5).

(a) Expense Categories in the MEI

Physician Time

In the rebased and revised MEI, we are using the AHE for the private nonfarm economy as the proxy for the physician wages/salaries component; this is the same price measure used in the 1996-based MEI. In our judgment, this proxy still most closely comports with Congressional intent as expressed in the Senate Finance Committee's 1972 report (S. Rept. No. 92–1230 at 191 (1972)). It should be noted that AHEs change in accordance with changes in the type and mix of workers.

As we 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 the current price proxy for physicians' earnings—AHE in the nonfarm business economy—is the most appropriate proxy to 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. Using this measure as the proxy for physicians' earnings ensures parity in the rate of change in wages for the average worker and those for physicians. In addition, use of this proxy is consistent with the original legislative intent that the change in the physicians' earnings portion of the MEI parallel 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. The use of the AHE data is also consistent with our using the BLS economy-wide multifactor productivity measures since economy-wide wage increases reflect economy-wide productivity increases.

Using the ECI for professional and technical workers or other occupational-specific wage proxies has a major shortcoming; in many instances, occupations such as engineering, computer science, and nursing have unique characteristics that are not representative of the overall economy or the physician market. Specifically, wage changes for such occupations can be influenced by excess supply or demand for these types of workers. We believe it would not be appropriate to proxy the physician earnings portion of the MEI with a wage proxy that reflects these other occupation's unique characteristics. The 2000-based MEI will use the ECI for fringe benefits for total private industry as the price proxy for physician fringe benefits, the same proxy used for the 1996-based MEI. This means that both the wage and fringe benefit proxies for physician earnings are derived from the nonfarm private sector and are computed on a per-hour basis.

Nonphysician Employee Compensation

As in the 1996-based MEI, we used Current Population Survey data on earnings and employment by occupation to develop labor cost shares for the nonphysician occupational groups shown in Table 10. BLS maintains an ECI for each occupational group, and we use these ECIs as price proxies for nonphysician employee wages in the 2000-based MEI.

The skill mix shift in employees of physician offices in the last few years has been towards managerial occupations. While these skill mix shifts are captured in the expenditure weights, they are appropriately held constant in a Laspeyres price index such as the MEI. Skill mix shifts, which may reflect the changing intensity of services provided in physicians' offices, are accounted for in the payment system outside of the MEI. The 2000-based MEI will use the ECI for fringe benefits for white collar employees in the private sector as a proxy for nonphysician benefits since most nonphysician employees in physicians' offices are white-collar employees. This is the same proxy used for the 1996-based MEI.

Office Expense

Office expenses include rent or mortgage for office space, furnishings, insurance, utilities, and telephone. We continue to use the CPI–U for housing because it is a comprehensive measure of the cost of housing, including rent, owner's equivalent rent, and the types of goods and services associated with running an office. This proxy covers about 80 percent of the population.

Pharmaceuticals and Medical Materials and Supplies

This cost category includes drugs, outside laboratory work, x-ray films, and other related services. There is not one price proxy that includes this complete mix of materials and supplies. In the absence of one index, we separately accounted for pharmaceuticals and medical materials and supplies in the 2000-based MEI.

- *Medical Materials and Supplies*

We equally weighted two proxies together (the PPI Surgical Appliances and Supplies and the CPI–U for Medical Equipment and Supplies) since one proxy does not accurately measure the price change associated with these types of products used nor the mode of purchase used in physicians' offices. While both indexes include such items as bandages, dressings, catheters, I.V. equipment, syringes, and other general disposable medical supplies and nonprescription equipment, the indexes reflect significant differences in the mode of purchase. The PPI measures actual transaction prices at the wholesale level, the mode most likely used by physicians, while the CPI measures prices at the retail level or the final stage of production. The price movements in these two indexes can be different and we believe that it is appropriate to combine these indexes into one proxy since physicians likely use both purchasing methods when obtaining medical supplies.

- *Pharmaceuticals*

The PPI for pharmaceutical preparations is used to proxy pharmaceutical prices in other CMS market baskets and reflects the price change associated with the average mix of pharmaceuticals purchased economy-wide. We use the PPI for pharmaceutical preparations, rather than the CPI for prescription drugs, because physicians generally purchase drugs directly from a

wholesaler. The PPIs we use measure price changes at the final stage of production and not intermediate production, however.

Professional Liability Insurance

It is vital that the MEI accurately reflect the price changes associated with professional liability costs. Accordingly, we continue to incorporate into the MEI a price proxy that accomplishes this goal by making the maximum use of available data on professional liability premiums.

Each year, we solicit professional liability premium data for physicians from a small sample of commercial carriers. This information is not collected through a survey form but instead is requested, on a voluntary basis, from a few national commercial carriers via letter. Generally between 5 and 8 carriers volunteer this information. For the CY 2004 update we were able to obtain data from 7 carriers, all of which were in the top 15 companies in 2001 in terms of market share. While the sample size certainly does not cover the entire professional liability insurance market, we have attempted to maximize the market share in terms of both national coverage and coverage within States.

As we require for our other price proxies, the professional liability price proxy should reflect the pure price change associated with this particular cost category. Thus, it should not capture changes in the mix or level of liability coverage. To accomplish this result, we obtain premium information from 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. From this series, quarterly and annual percent changes in professional liability insurance are estimated for inclusion in the MEI.

Our research has indicated that 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, therefore, the data currently incorporated into the MEI are much more timely. We believe that, given the limited data available on professional liability premiums, this methodology adequately reflects the price trends facing physicians.

Comment: Several commenters were concerned about the 6.6 percent increase in the PLI component of the MEI published in the proposed rule and felt that this did not represent the actual increase in premiums physicians are experiencing.

Response: We indicated in the proposed rule that the 6.6 percent increase in the PLI component of the index was based on a forecast. For this final rule we have incorporated actual data (through the second quarter of 2003) that indicates that the increase in the proxy for the PLI component of the MEI is 16.9 percent.

Medical Equipment

Medical equipment includes depreciation, leases, and rent on medical equipment. We will use the PPI for medical instruments and equipment as the price proxy for this category, consistent with the price proxy used in the 1996-based MEI and other CMS input price indexes.

Other Expenses

This category includes the residual subcategory of other expenses such as accounting services, legal services, office management services, continuing education, professional association memberships, journals, professional car expenses, and other professional expenses. In the absence of one price proxy or even a group of price proxies that might reflect this heterogeneous mix of goods and services, we use the CPI–U for all items less food and energy, consistent with the price proxy used in the 1996-based MEI. We also condensed the structure compared to that used in the 1996-based MEI because we lack the data to develop a representative weight for transportation, as discussed above. This change resulted in only a negligible effect on the overall MEI over the past 8 years; the average annual increase differs by less than a tenth of a percentage point over that time.

(b) Productivity Adjustment to the MEI

In the December 2002 final rule, we indicated that we were changing the methodology for adjusting for productivity in the MEI. The MEI used for the 2003 physician payment update reflected changes in the 10-year moving average of private nonfarm business (economy-wide) multifactor productivity applied to the entire index; we had previously used economy-wide private nonfarm business labor productivity applied to the labor portions of the index. We will continue to use the new method, adjusting for multifactor productivity applied to the entire index, in the rebased and revised MEI.

As described in the December 31, 2002 (68 FR 9568) final rule, we use multifactor productivity because: (1) It is theoretically more appropriate to explicitly reflect the productivity gains associated with all inputs (both labor and nonlabor); (2) the recent growth rate in economy-wide multifactor productivity appears to be more consistent with the current market conditions facing physicians; and (3) the MEI still uses economy-wide wage changes as a proxy for physician wage changes. We also believe that using a 10-year moving average change in economy-wide multifactor productivity produces a stable and predictable adjustment and is consistent with the moving-average methodology used in the 1996-based MEI. The adjustment will be based on the latest available actual historical economy-wide multifactor productivity data, as measured by BLS. For the 2004 update, this means using the multifactor productivity data through 2001, the latest available information.

5. Results of Rebasing

Because the rebased and revised MEI is similar in structure to the 1996-based MEI, updating the MEI from a 1996 base year to a 2000 base year resulted in small changes in expense category weights. Physicians' earnings dropped slightly, from 54.5 percent of the index in 1996 to 52.5 percent in 2000. The expense shares for non-physician employee compensation, office expenses, professional liability insurance, and medical equipment all rose slightly, while expense shares for medical materials and supplies and other expenses declined.

The update using the rebased and revised MEI for the 2004 Physician Fee Schedule is an increase of 2.9 percent. This incorporates historical data through the second quarter of 2003.

TABLE 12.—ANNUAL PERCENT CHANGE IN THE REVISED AND REBASED MEDICARE ECONOMIC INDEX, 2004—ALL CATEGORIES

Cost categories and price measures	2000 weights [2]	2004 percent changes
Increase in the Medicare Economic Index Update for Calendar Year 2004 [1]		
Medicare Economic Index Total, productivity adjusted	n/a	2.9
Productivity: 10-year moving average of Multifactor productivity, private nonfarm business sector	n/a	0.9
Medicare Economic Index Total, without productivity adjustment	100.000	3.8
1. Physician's Own Time [3]	52.466	3.6
a. Wages and Salaries: Average Hourly Earnings, private Nonfarm	42.730	3.2
b. Fringe Benefits: Employment Cost Index, benefits, private nonfarm	9.735	5.4
2. Physician's Practice Expense [3]	47.534	4.0
a. Nonphysician Employee Compensation	18.653	3.4
1. Wages and Salaries: Employment Cost Index, wages and salaries, weighted by occupation	13.808	2.8
2. Fringe Benefits: Employment Cost Index, fringe benefits, white collar	4.845	5.0
b. Office Expense: Consumer Price Index (CPI–U), housing	12.209	2.5
c. Drugs and Medical Materials and Supplies	4.319	3.1
1. Medical Materials and Supplies: Producer Price Index, surgical appliances and supplies/Consumer Price Index (CPI–U), medical equipment and supplies (equally weighted)	2.011	1.0
2. Pharmaceuticals: Producer Price Index (PPI pharmaceutical preparations)	2.308	4.9
d. Professional Liability Insurance: premiums [4]	3.865	16.9
e. Medical Equipment: PPI, medical instruments and equipment	2.055	2.3
f. Other Expenses	6.433	1.9

[1] The rates of historical change are estimated for the 12-month period ending June 30, 2002, which is the period used for computing the calendar year 2004 update. The price proxy values are based upon the latest available Bureau of Labor Statistics data as of September 22, 2002.

[2] The weights shown for the MEI components are the 2000 base-year weights, which may not sum to subtotals or totals because of rounding. The MEI is a fixed-weight, Laspeyres-type input price index whose category weights indicate the distribution of expenditures among the inputs to physicians' services for calendar year 2000. To determine the MEI level for a given year, the price proxy level for each component is multiplied by its 2000 weight. The sum of these products (weights multiplied by the price index levels) over all cost categories yields the composite MEI level for a given year. The annual percent change in the MEI levels is an estimate of price change over time for a fixed market basket of inputs to physicians' services. Due to rounding, weights may not sum to 100.000 percent.

[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 *http://stats.bls.gov*.

[4] Derived from data collected from several major insurers (the latest available historical percent change data are for the period ending second quarter of 2003).

[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.

As is the case with this index rebasing, our experience in previous rebasing and revising indexes has been that there is usually a very small effect on the overall percent change. The difference is typically between zero and 0.3 percentage points per year on average. The rebased and revised MEI overall percent increase for the CY 2004 update is only 0.1 percentage point higher compared to the 1996-based MEI. This is also the case for this final rule. When the MEI was last rebased, there was no difference in the average annual percentage change from 1985 to 1998. When the PPS hospital indices were rebased, the average difference in the percentage change was less than one-tenth of a percentage point from 1995 to 2002.

The first reason for this small difference between the 1996-based and 2000-based MEI percent changes is that the weight of professional liability insurance increased, giving it a higher relative importance in the index in 2000. This category also increased at a faster pace than other index categories during 2002 and projected for 2003, resulting in an even greater relative importance for this index by 2004 and causing it to have a larger effect on the overall index compared to the 1996-based MEI.

In addition, the pharmaceuticals from the medical materials and supplies category grew faster than the overall medical materials and supplies in the 1996-based MEI. In addition, the faster growth in the aggregate medical materials and supplies category combined with a higher weight in the 2000-based index gave the category a higher relative importance. However, these increases were mostly offset by declines in weight of some of the other categories, most notably physician earnings.

6. Adjustments to RVUs To Match the New MEI Weights

As discussed in the August 15, 2003 proposed rule, section 1848(c)(2)(B)(ii)(II) of the Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, we make across-the-board adjustments to preserve budget neutrality. Therefore, if we adjust the work, practice expense and malpractice RVUs to match the new MEI weights, we are required by statute to ensure that the adjustments do not increase or decrease Medicare expenditures by more than $20 million. To meet the requirements of the statute and ensure that aggregate pools of RVUs match the proposed new MEI weights, we considered two options. We considered either making no adjustments to the physician work RVUs and adjusting only the practice expense and malpractice RVUs or adjusting all 3 categories of RVUs. We proposed adjusting all 3 categories of RVUs rather than adjusting only the practice expense and malpractice RVUs, which would have resulted in a reduction to the physician fee schedule conversion factor in addition to the -4.2 percent reduction that was forecasted. Specifically, we proposed to reduce the physician work RVUs by an estimated 0.35 percent (0.9965) and the practice expense RVUs by an estimated 1.15 percent (0.9885) and to increase the malpractice RVUs by an estimated 21.7 percent (1.217) to match the rebased MEI weights.

Comment: We received comments from a number of physician organizations opposing any adjustment to the physician work RVUs. Several of the comments appreciated our reluctance to reduce the physician fee schedule conversion factor by an additional 0.3 percentage points when there will already be a large reduction in the physician fee schedule update. One commenter stated that any additional reduction to the physician fee schedule conversion factor would be inappropriate. However, these comments also stated that that the physician work RVUs should remain constant and stable. There were a number of comments that stated that across-the-board adjustments should never be applied to the work component of the Resource Based Relative Value System. One comment indicated that we should not make any adjustments to the work RVUs unless they are recommended by the RUC. Several of the comments stated that the proposed adjustments to the RVUs to match the MEI weights would not assist the physician community in addressing the professional liability crisis since any increase in physician fees for some services will be offset by reductions in other services. Additional payments by Medicare to cover increased professional liability costs, or congressional action, are necessary to alleviate this problem. Some of the comments indicated that CMS did not provide sufficient information to make a determination as to how the two proposals would affect individual codes because the adjustments were not applied to the RVUs shown in Addendum B of the proposed rule. Several of the comments stated that the stability of work RVUs is essential since they are used by private payors, physician compensation systems, and in productivity analysis. The RUC commented that they depend upon the stability in these values as they review new and revised codes, both in magnitude estimation and in any calculations regarding intra-work per unit of time (IWPUT). One comment suggested CMS create a separate adjustment factor to adjust payments without changing the conversion factor or the RVUs, as it did for the first five-year review of the Medicare physician fee schedule in 1995. We also received a comment urging us to review the Secretary's "ancillary policies" authority under section 1848(c)(4) of Act to determine whether CMS has statutory authority to increase PLI relative value units without reducing the work and practice expense relative value units.

We also received several comments that expressed support for maintaining stability in the practice expense RVUs. The comment stated "much like what is done with work relative values, any code-level refinements due to annual coding changes that result in a non-budget neutral impact should not result in a reduction of all practice expense relative values. The comment requested that CMS present an analysis of this issue in an upcoming proposed rule and recommended that adjustments related to the MEI rebasing not be applied to the practice expense relative values.

Response: We share the concern about establishing stability in the practice expense RVUs. As we indicated in the June 28, 2002 proposed rule (67 FR 43851), "once the refinement process is complete, we believe the physician community has a reasonable expectation that the practice expense RVUs will not change from year to year unless further refinement is undertaken." We plan to analyze in an upcoming proposed rule whether there are any alternatives to our current practice of rescaling the practice expense RVUs to apply budget neutrality. However, we disagree with the comments that suggest we only increase the malpractice expense RVUs and not apply any adjustments to the work and practice expense RVUs to match the MEI weights. It is not possible to match the aggregate RVUs to the new MEI weights if we make no adjustments to both work and practice expense and adjust only the malpractice RVUs and the conversion factor. While it would be possible to maintain budget neutrality for the increase in malpractice RVUs by reducing the conversion factor, the aggregate number of RVUs for work and practice expense would not match the MEI weights unless we could adjust at least two of the three RVUs in combination with applying a compensating adjustment to the CF.

We have considered the comment suggesting that we use the Secretary's section 1848(c) "ancillary" policies authority to adjust the RVUs to match the MEI weights but not maintain budget neutrality. Section 1848(c) states that the Secretary may establish ancillary policies (with respect to the use of modifiers, local codes, and other matters) as may be necessary to implement this section." We believe that this section of the statute must, nonetheless, be read consistently with the requirements of section 1848(c)(2)(B)(ii)(II) of the Act requiring that changes to RVUs cannot cause the amount of expenditures to increase or decrease by more than $20 million from the amount of expenditures that would have been made if such adjustments had not been made. We believe the statute is clear and any increase in the malpractice expense RVUs must be offset by decreases to the work and practice expense RVUs or the conversion factor.

We also do not believe that the work RVUs should be maintained and a separate "work adjustor" established. While such policy was adopted following the 5-year review of physician work in 1997, we used this procedure only because the effect of the work adjustor could be removed once resource-based practice expense RVUs were adopted in 1999. We did not find the work adjustor to be desirable. It added an extra element to the physician fee schedule payment calculation and created confusion and questions among the public who had difficulty using the RVUs determine a payment amount that matched the amount actually paid by Medicare.

We acknowledge the comments that indicate that the work RVUs are used for many purposes other than Medicare payment. While our proposal would slightly reduce the absolute value of the physician work RVUs, it would not change their relative values since there would be a uniform decrease to all of the RVUs. We believe the relative relationship among the values for the services makes them useful for analysis for purposes other than Medicare payment. Since the relative values will be left unchanged, we do not believe the work RVUs will lose their utility for these other uses.

We disagree that our proposed rule did not provide enough information upon which to determine the impact on payment for a given service. The proposed rule provided the specific level of the estimated adjustments. While we did not actually apply the adjustments to the RVUs shown in Addendum B, any interested party could determine the effect of our proposal on any given service with the information we provided. We further noted that the adjustments we provided were estimated and would change once we made final determinations of the work, practice expense and malpractice RVUs for 2004. For the final rule, we will reduce the work RVUs by 0.57 percent (0.9943), the practice expense by 0.77 (0.9923) percent and increase the malpractice RVUs by 19.86 percent (1.1986). We have also modeled the impact of our proposal by specialty in the impact section of this final rule.

With respect to the comments about our proposal and the large increases in professional liability premiums, we

have not asserted that our policy to adjust the RVUs will resolve this issue. While the comments that our policy will increase payments for some service and decrease payments for payments for others are correct, we note that payments for services with high malpractice RVUs will increase the most in payment while there will be negligible impact on payment for most other services. Such a policy will improve our payment policies by giving more weight to the malpractice RVU in determining Medicare total payment consistent with the proportion that professional liability expenses represent of total physician expenses. As indicated in the impact section, services provided by cardiac and thoracic surgeons, neurosurgeons, orthopedic surgeons, vascular surgeons and emergency physicians are increasing in payment as a result of this proposal. There will be little impact of these adjustments on all other specialties.

C. The Update Adjustment Factor

Section 1848(d) of the Act provides that the physician fee schedule update is equal to the product of the MEI and an "update adjustment factor" or UAF. The UAF is applied to make actual and target expenditures (referred to in the law as "allowed expenditures") equal. Allowed expenditures are equal to actual expenditures in a base period updated each year by the SGR. The SGR sets the annual rate of growth in allowed expenditures and is determined by a formula specified in section 1848(f) of the Act.

1. Calculation Under Current Law

Under section 1848(d)(4)(A) of the Act, the physician fee schedule update for a year is equal to the product of—(1) 1 plus the Secretary's estimate of the percentage increase in the MEI for the year, divided by 100 and (2) 1 plus the Secretary's estimate of the UAF for the year. Under section 1848(d)(4)(B) of the Act, the UAF for a year beginning with 2001 is equal to the sum of the following—

- Prior Year Adjustment Component. An amount determined by—
- Computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services for the prior year (the year prior to the year for which the update is being determined) and the amount of the actual expenditures for such services for that year;
- Dividing that difference by the amount of the actual expenditures for such services for that year; and
- Multiplying that quotient by 0.75.
- Cumulative Adjustment Component. An amount determined by—
- Computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services from April 1, 1996, through the end of the prior year and the amount of the actual expenditures for such services during that period;
- Dividing that difference by actual expenditures for such services for the prior year as increased by the sustainable growth rate for the year for which the update adjustment factor is to be determined; and
- Multiplying that quotient by 0.33.

Section 1848(d)(4)(E) of the Act requires the Secretary to recalculate allowed expenditures consistent with section 1848(f)(3) of the Act. Section 1848(f)(3) specifies that the SGR (and, in turn, allowed expenditures) for the upcoming calendar year (2004 in this case), the current calendar year (2003) and the preceding calendar year (2002) are to be determined on the basis of the best data available as of September 1 of the current year. Allowed expenditures are initially estimated and subsequently revised twice. The second revision occurs after the calendar year has ended (that is, we are making the final revision to 2002 allowed expenditures in this final rule). Once the SGR and allowed expenditures for a year have been revised twice, they are final.

Table 13 shows annual and cumulative allowed expenditures for physicians' services from April 1, 1996 through the end of the current calendar year, including the transition period to a calendar year system that occurred in 1999.

TABLE 13

Period	Annual allowed expenditures ($ in billions)	Cumulative allowed expenditures ($ in billions)	FY/CY SGR
4/1/96–3/31/97	48.9	48.9	N/A
4/1/97–3/31/98	50.5	99.4	FY 1998 = 3.2%
4/1/98–3/31/99	52.6	152.0	FY 1999 = 4.2%
1/1/99–3/31/99	13.3	(1)	FY 1999 = 4.2%
4/1/99–12/31/99	42.1	(2)	FY 2000 = 6.9%
1/1/99–12/31/99	55.3	194.1	FY 1999/2000[3]
1/1/00–12/31/00	59.4	253.4	CY 2000 = 7.3%
1/1/01–12/31/01	62.0	315.5	CY 2001 = 4.5%
1/1/02–12/31/02	67.2	382.6	CY 2002 = 8.2%
1/1/03–12/31/03	71.7	454.2	CY 2003 = 6.7%
1/1/04–12/31/04	77.0	528.6	CY 2004 = 7.4%

[1] Allowed expenditures for the first quarter of 1999 are based on the FY 1999 SGR.
[2] Allowed expenditures for the last three quarters of 1999 are based on the FY 2000 SGR.
[3] Allowed expenditures in the first year (April 1, 1996–March 31, 1997) are equal to actual expenditures. All subsequent figures are equal to quarterly allowed expenditure figures increased by the applicable SGR. Cumulative allowed expenditures are equal to the sum of annual allowed expenditures. We provide more detailed quarterly allowed and actual expenditure data on our Web site under the Medicare Actuary's publications at the following address: *http://www.cms.hhs.gov/statistics/actuary/*. We expect to update the web site with the most current information later this month.

Consistent with section 1848(d)(4)(E) of the Act, table 13 includes our final revision of allowed expenditures for 2002, a recalculation of allowed expenditures for 2003, and our initial estimate of allowed expenditures for 2004. To determine the update adjustment factor for 2004, the statute requires that we use allowed and actual expenditures from April 1, 1996 through December 31, 2003 and the 2004 SGR. Consistent with section 1848(d)(4)(E), we will be making further revisions to 2003 and 2004 SGRs and 2003 allowed expenditures. Because we have

incomplete actual expenditure data for 2003, we are using an estimate for this period. Any difference between current estimates and final figures will be taken into account in determining the update adjustment factor for future years.

We are using figures from table 13 in the statutory formula illustrated below:

$$UAF = \frac{Target_{03} - Actual_{03}}{Actual_{03}} \times .75 + \frac{Target_{4/96-12/03} - Actual_{4/96-12/03}}{Actual_{03} \times SGR_{04}} \times .33$$

UAF = Update Adjustment Factor
$Target_{03}$ = Allowed Expenditures for 2003 or $71.7 billion
$Actual_{03}$ = Estimated Actual Expenditures for 2003 = $77.8 billion
$Target_{4/96-12/03}$ = Allowed Expenditures from 4/1/1996–12/31/2002 = $454.2 billion
$Actual_{4/96-12/02}$ = Estimated Actual Expenditures from 4/1/1996–12/31/2003 = $462.0 billion
SGR_{03} = 7.4 percent (1.074)

$$\frac{\$71.7 - \$77.8}{\$77.8} \times .75 + \frac{\$454.2 - \$462.0}{\$77.8 \times 1.074} \times .33 = -.090$$

Section 1848(d)(4)(D) of the Act indicates that the UAF determined under section 1848(d)(4)(B) of the Act for a year may not be less than −0.070 or greater than 0.03. The calculated UAF of −0.090 is less than the statutory limit of −0.070. Therefore, the UAF for 2004 will be −0.70.

Section 1848(d)(4)(A)(ii) of the Act indicates that 1 should be added to the UAF determined under section 1848(d)(4)(B) of the Act. Thus, adding 1 to −0.070 makes the update adjustment factor equal to 0.930.

VII. Allowed Expenditures for Physicians' Services and the Sustainable Growth Rate

A. Medicare Sustainable Growth Rate

The SGR is an annual growth rate that applies to physicians' services paid for by Medicare. The use of the SGR is intended to control growth in aggregate Medicare expenditures for physicians' services. Payments for services are not withheld if the percentage increase in actual expenditures exceeds the SGR. Rather, the physician fee schedule update, as specified in section 1848(d)(4) of the Act, is adjusted based on a comparison of allowed expenditures (determined using the SGR) and actual expenditures. If actual expenditures exceed allowed expenditures, the update is reduced. If actual expenditures are less than allowed expenditures, the update is increased.

Section 1848(f)(2) of the Act specifies that the SGR for a year (beginning with 2001) is equal to the product of the following four factors:

(1) The estimated change in fees for physicians' services.

(2) The estimated change in the average number of Medicare fee-for-service beneficiaries.

(3) The estimated projected growth in real GDP per capita.

(4) The estimated change in expenditures due to changes in law or regulations.

In general, section 1848(f)(3) of the Act requires us to publish SGRs for 3 different time periods, no later than November 1 of each year, using the best data available as of September 1 of each year. Under section 1848(f)(3)(C)(i) of the Act, the SGR is estimated and subsequently revised twice (beginning with the FY and CY 2000 SGRs) based on later data. (The Consolidated Appropriations Reduction Resolution of 2003 (P.L. 108–7) contained a provision permitting revision of the FY 1998 and FY 1999 SGRs. See the February 28, 2003 **Federal Register** (68 FR 9567) for a discussion of these SGRs. Under section 1848(f)(3)(C)(ii) of the Act, there are no further revisions to the SGR once it has been estimated and subsequently revised in each of the 2 years following the preliminary estimate. In this final rule, we are making our preliminary estimate of the 2004 SGR, a revision to the 2003 SGR, and our final revision to the 2002 SGR.

B. Physicians' Services

Section 1848(f)(4)(A) of the Act defines the scope of physicians' services covered by the SGR. The statute indicates that the term "physicians' services" includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare+Choice plan enrollee. We published a definition of physicians' services for use in the SGR in the **Federal Register** (66 FR 55316) on November 1, 2001. We defined "physicians' services" to include many of the medical and other health services listed in section 1861(s) of the Act. For purposes of determining allowed expenditures, actual expenditures, and SGRs through December 31, 2002, we have specified that "physicians' services" include the following medical and other health services if bills for the items and services are processed and paid by Medicare carriers (and those items and services paid through intermediaries where specified):

- Physicians' services.
- Services and supplies furnished incident to physicians' services.
- Outpatient physical therapy services and outpatient occupational therapy services.
- Antigens prepared by or under the direct supervision of a physician.
- Services of physician assistants, certified registered nurse anesthetists, certified nurse midwives, clinical psychologists, clinical social workers, nurse practitioners, and clinical nurse specialists.
- Screening tests for prostate cancer, colorectal cancer, and glaucoma.
- Screening mammography, screening pap smears, and screening pelvic exams.
- Diabetes outpatient self-management training services.
- Medical nutrition therapy services.
- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests (including outpatient diagnostic laboratory tests paid through intermediaries).
- X-ray, radium, and radioactive isotope therapy.
- Surgical dressings, splints, casts, and other devices used for the reduction of fractures and dislocations.
- Bone mass measurements.

C. Provisions Related to the Sustainable Growth Rate

Section 211(b)(1) of the BBRA amended section 1848(f)(1) of the Act to require that three SGR estimates be published in the **Federal Register** not later than November 1 of every year. In this final rule, we are publishing our preliminary estimate of the SGR for 2004, a revised estimate of the SGR for 2003, and our final determination of the SGR for 2002. Consistent with section 1848(f)(3)(C) of the Act, we are using the best data available to us as of September 1, 2003 for all of the figures.

D. Preliminary Estimate of the SGR for 2004

Our preliminary estimate of the 2004 SGR is 7.4 percent. We first estimated the 2004 SGR in March and made the estimate available to the Medicare Payment Advisory Commission and on our website. Table 13 shows our March estimates and our current estimates of the factors included in the SGR:

TABLE 14

Statutory factors	March estimate	Current estimate
Fees	2.3% (1.023)	2.7% (1.027)
Enrollment	1.3% (1.013)	1.7% (1.017)
Real Per Capita GDP	2.7% (1.027)	2.8% (1.028)
Law and Regulation	0.0% (1.000)	0.0% (1.000)
Total	6.4% (1.064)	7.4% (1.074)

Note: Consistent with section 1848(f)(2) of the Act, the statutory factors are multiplied, not added, to produce the total (that is, 1.027 × 1.017 × 1.028 × 1.000 = 1.074.) A more detailed explanation of each figure is provided below in section G.1.

E. Revised SGR for 2003

Our current estimate of the 2003 SGR is 6.7 percent. Table 14 shows our preliminary estimate of the 2003 SGR that was published in the **Federal Register** on December 1, 2002 (67 FR 80027) and our current estimate:

TABLE 15

Statutory factors	12/31/02 estimate	Current estimate
Fees	2.9% (1.029)	2.8% (1.028)
Enrollment	1.2% (1.012)	2.4% (1.024)
Real Per Capita GDP	3.3% (1.033)	1.4% (1.014)
Law and Regulation	0.0% (1.000)	0.0% (1.000)
Total	7.6% (1.076)	6.7% (1.067)

A more detailed explanation of each figure is provided below in section G.2.

F. Final Sustainable Growth Rate for 2002

The SGR for 2002 is 8.3 percent. Table 16 shows our preliminary estimate of the SGR published in the **Federal Register** on November 1, 2001 (66 FR 55317), our revised estimate published in the **Federal Register** on December 31, 2001 (67 FR 80028) and the final figures determined using the latest available data:

TABLE 16

Statutory factors	11/1/01 estimate	12/31/02 estimate [1]	Final
Fees	2.3% (1.023)	2.5% (1.025)	2.5% (1.025)
Enrollment	0.7% (1.007)	2.8% (1.028)	3.2% (1.032)
Real Per Capita GDP	1.7% (1.027)	2.3% (1.023)	1.4% (1.014)
Law and Reg	0.8% (1.008)	1.1% (1.011)	1.0% (1.010)
Total	5.6% (1.056)	9.0% (1.090)	8.3% (1.083)

[1] The figures for fees, enrollment and real per capita GDP from the 12/31/02 final rule are shown here. We made a subsequent change to the law and regulations factor and the total in the February 28, 2003 **Federal Register** (68 FR 9572). We show the revised law and regulation factor and total in the above table.

A more detailed explanation of each figure is provided below in section G.2.

G. Calculation of 2004, 2003, and 2002 Sustainable Growth Rates

1. Detail on the 2004 SGR

All of the figures used to determine the 2004 SGR are estimates that will be revised based on subsequent data. Any differences between these estimates and the actual measurement of these figures will be included in future revisions of the SGR and allowed expenditures and incorporated into subsequent physician fee schedule updates.

Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for CY 2004

This factor is calculated as a weighted average of the 2004 fee increases for the different types of services included in the definition of physicians' services for the SGR. Medical and other health services paid using the physician fee schedule are estimated to account for approximately 80.3 percent of total allowed charges included in the SGR in 2004 and are updated using the MEI. The MEI for 2004 is 2.9 percent. Diagnostic laboratory tests are estimated to represent approximately 7.4 percent of Medicare allowed charges included in the SGR in 2004 and the costs of these tests are updated by the CPI-U. The CPI-U for 2004 that will be used to update clinical diagnostic laboratory tests is 2.1 percent. Drugs represent 12.3 percent of Medicare allowed charges included in the SGR. We are projecting a weighted average change in fees for drugs that are included in the SGR of 2.0 percent. Table 16 shows the weighted average of the MEI, laboratory and drug price increases for 2004:

TABLE 17

	Weight	Update
Physician	0.803	2.9
Laboratory	0.074	2.1
Drugs	0.123	2.0
Weighted Average	1.000	2.7

After taking into account the elements described in table 16, we estimate that the weighted-average increase in fees for physicians' services in 2004 under the SGR (before applying any legislative adjustments) will be 2.7 percent.

Factor 2—The Percentage Change in the Average Number of Part B Enrollees from 2003 to 2004

This factor is our estimate of the percent change in the average number of fee-for-service enrollees from 2003 to 2004. Services provided to Medicare+Choice (M+C) plan enrollees are outside the scope of the SGR and are excluded from this estimate. Our actuaries estimate that the average number of Medicare Part B fee-for-service enrollees will increase by 1.7 percent from 2003 to 2004. Table 18 illustrates how this figure was determined:

TABLE 18

	2003	2004
Overall	[1] 38.535	[1] 39.013
Medicare +Choice	[1] 4.689	[1] 4.606
Net	[1] 33.847	[1] 34.407
Percent Increase		[2] 1.7

[1] Millions.
[2] Percent.

An important factor affecting fee-for-service enrollment is beneficiary enrollment in Medicare+Choice plans. Because it is difficult to estimate the size of the Medicare+Choice enrollee population before the start of a calendar year, at this time, we do not know how actual enrollment in Medicare+Choice plans will compare to current estimates. For this reason, the estimate may change substantially as actual Medicare fee-for-service enrollment for 2004 becomes known.

Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in 2004

We estimate that the growth in real per capita GDP from 2003 to 2004 will be 2.8 percent. Our past experience indicates that there have also been large changes in estimates of real per capita GDP growth made before the year begins and the actual change in GDP computed after the year is complete. Thus, it is likely that this figure will change as actual information on economic performance becomes available to us in 2004.

Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Law or Regulations in CY 2004 Compared With CY 2003

We are not projecting any change in spending in 2004 due to changes in law or regulations.

2. Detail on the 2003 SGR

A more detailed discussion of our revised estimates of the four elements of the 2003 SGR follows.

Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for 2003

This factor was calculated as a weighted average of the 2003 fee increases that apply for the different types of services included in the definition of physicians' services for the SGR.

We estimate that services paid using the physician fee schedule account for approximately 82.7 percent of total allowed charges included in the SGR in 2003. These services were updated using the 2003 MEI of 3.0 percent. We estimate that diagnostic laboratory tests represent approximately 7.1 percent of total allowed charges included in the SGR in 2003. These services were updated by the 2003 CPI-U of 1.1 percent. We estimate that drugs represent 10.2 percent of Medicare allowed charges included in the SGR in 2003. Pursuant to section 1842(o) of the Act, Medicare pays for drugs based on 95 percent of AWP. Using wholesale pricing information and Medicare utilization for drugs included in the SGR, we estimate weighted average fee increases for drugs of 1.9 percent in 2003. Table 19 shows the weighted average of the MEI, laboratory and drug price increases for 2003:

TABLE 19

	Weight	Update
Physician	0.827	3.0
Laboratory	0.071	1.1
Drugs	0.102	1.9
Weighted Average	1.000	2.8

After taking into account the elements described in table 19, we estimate that the weighted-average increase in fees for physicians' services in 2003 under the SGR (before applying any legislative adjustments) will be 2.8 percent.

Factor 2—The Percentage Change in the Average Number of Part B Enrollees from 2002 to 2003

Our actuaries estimate that the average number of Medicare Part B fee-for-service enrollees (excluding beneficiaries enrolled in M+C plans) increased by 2.4 percent in 2003. Table 20 illustrates how we determined this figure:

TABLE 20

[In millions]

	2002	2003
Overall	38.074	38.535

TABLE 20—Continued
[In millions]

	2002	2003
Medicare +Choice	5.005	4.689
Net	33.069	33.847
Percent Increase		2.4%

Our actuaries' estimate of the 2.8 percent change in the average number of fee-for-service enrollees, net of Medicare+Choice enrollment for 2003, compared to 2002 is different from our preliminary estimate (1.2 percent for 2003 from the December 31, 2002 final rule (67 FR 80029)) because the historical base from which our actuarial estimate is made has changed. We now have complete information on Medicare fee-for-service enrollment for 2002 that is different than the figure we used one year ago. Further, we now have information on actual fee-for-service enrollment for the first 8 months of 2003. We would caution that our estimate of fee-for-service enrollment for 2003 could change again once we have complete information for the entire year.

Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in 2003

We estimate that the growth in real per capita GDP will be 1.4 percent in 2003. Our past experience indicates that there have also been large differences between our estimates of real per capita GDP growth made prior to the year's end and the actual change in this factor. Thus, it is likely that this figure will change further as complete actual information on 2003 economic performance becomes available to us in 2004.

Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Law or Regulations in 2003 Compared With 2002

There were no statutory or regulatory changes that affected Medicare expenditures for services included in the SGR in 2003.

3. Detail on the 2002 SGR

A more detailed discussion of our revised estimates of the four elements of the 2002 SGR follows.

Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for 2002

This factor was calculated as a weighted average of the 2002 fee increases that apply for the different types of services included in the definition of physicians' services for the SGR.

Services paid using the physician fee schedule accounted for approximately 84.1 percent of total Medicare allowed charges included in the SGR in 2002, and are updated using the MEI. The MEI for 2002 was 2.6 percent. Diagnostic laboratory tests represent approximately 7.2 of total Medicare allowed charges included in the SGR, and are typically updated by the CPI-U. However, the BBA required a 0.0 percent update in 2002 for laboratory services. Drugs represented approximately 8.7 percent of total Medicare allowed charges included in the SGR in 2002. Pursuant to section 1842(o) of the Act, Medicare pays for drugs based on 95 percent of AWP. Using wholesale pricing information and Medicare utilization for drugs included in the SGR, we estimate a weighted average fee increase for drugs of 2.8 percent in 2002. Table 21 shows the weighted average of the MEI, laboratory and drug price increases for 2002:

TABLE 21

	Weight	Update
Physician	0.841	2.6
Laboratory	0.072	0.0
Drugs	0.087	2.8
Weighted Average	1.000	2.5

After taking into account the elements described in table 21, we estimate that the weighted-average increase in fees for physicians' services in 2002 under the SGR (before applying any legislative adjustments) was 2.5 percent.

Factor 2—The Percentage Change in the Average Number of Part B Enrollees from 2001 to 2002

We estimate the increase in the average number of fee-for-service enrollees (excluding beneficiaries enrolled in M+C plans) from 2001 to 2002 was 3.2 percent. Our calculation of this factor is based on complete data from 2002. Table 22 illustrates the calculation of this factor:

TABLE 22
[In millions]

	2001	2002
Overall	37.650	38.074
Medicare +Choice	5.608	5.005
Net	32.041	33.069
Percent Increase		3.2%

Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in 2002

We estimate that the growth in real per capita GDP was 1.4 percent in 2002. This is a final figure based on complete data for 2002.

Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Law or Regulations in 2002 Compared With 2001

Sections 101 through 104 of the BIPA added Medicare coverage for a variety of new services that will affect the 2002 SGR. In addition, section 112 of BIPA made changes that will result in additional Medicare coverage for certain drugs that will affect 2002 spending for services included in the SGR. Prior to the enactment of the BIPA, Medicare paid only for drugs that cannot be self-administered by the patient. BIPA allows Medicare to pay for drugs that can be, but are not usually, self-administered. Accordingly, we are accounting for the increased Medicare drug expenditures that will result from implementation of section 112 of the BIPA. We are also adjusting this factor to account for including screening mammography services in the SGR consistent with our discussion of this issue in the November 1, 2001 **Federal Register** (66 FR 55318). After taking these provisions into account, our final estimate of the percentage change in expenditures for physicians' services resulting from changes in law or regulations is 1.0 percent for 2002.

VIII. Anesthesia and Physician Fee Schedule Conversion Factors for Calendar Year 2004

The 2004 physician fee schedule CF will be $35.1339. The 2004 national average anesthesia conversion factor is $16.43.

The specific calculations to determine the physician fee schedule and anesthesia CFs for 2004 are explained below.

Detail on Calculation of the 2004 Physician Fee Schedule Conversion Factor

Physician Fee Schedule Conversion Factor

Under section 1848(d)(1)(A) of the Act, the physician fee schedule CF is equal to the CF for the previous year multiplied by the update determined under section 1848(d)(4) of the Act.

We are illustrating the calculation for the 2004 physician fee schedule CF in table 23:

TABLE 23

2003 Conversion Factor	$36.7856
2004 Update	0.9551
2004 Conversion Factor	$35.1339

Anesthesia Fee Schedule Conversion Factor

Anesthesia services do not have RVUs like other physician fee schedule services. Therefore, we account for any necessary RVU adjustments through an adjustment to the anesthesia fee schedule CF. We are adjusting the anesthesia CF to reflect the RVUs adjustments being made to all other physician fee schedule services to match the revised MEI weights. The 2003 anesthesia CF is $17.05. Physician work represents 79.02 percent of the anesthesia CF (0.7902). We are decreasing this portion of the anesthesia CF by 0.57 percent (0.9943). Practice expenses represent 13.75 percent (0.1375) of the anesthesia CF. We are reducing this portion of the anesthesia conversion factor by 0.77 percent (0.9923) for the adjustment to match the RVUs with the MEI weights. In addition, we are increasing the practice expense portion of the anesthesia CF by 0.18 percent (1.0018) for changes to anesthesia practice expenses resulting from the refinement of practice expense RVUs. Taken together, we are reducing the practice expense portion of the anesthesia fee schedule CF by 0.59 percent ($0.9923 \times 1.0018 = 0.9941$). Professional liability insurance represents 7.23 percent (0.0723) of the anesthesia CF. We are increasing this portion of the anesthesia CF by 19.86 percent (1.1986). Taken together, the adjustments to the work, practice expense and malpractice portions of the anesthesia CF result in a total adjustment of 1.090 percent ($0.7903 * 0.9943) + ((0.1347 \times 0.9941) + (0.0723 \times 1.1986) = 1.0090$. To determine the anesthesia fee schedule CF for 2004, we used the following figures:

TABLE 24

2003 Anesthesia Conversion Factor	$17.0522
Adjustments to match MEI weights and practice expense factor	1.0090
2004 Update	0.9551
2004 Anesthesia Conversion Factor	$16.4339

IX. Telehealth Originating Site Facility Fee Payment Amount Update

Section 1834(m) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the MEI as defined in section 1842(i)(3) of the Act. The MEI increase for 2004 is 2.9 percent.

Therefore, for CY 2004, the payment amount for HCPCS code "Q3014, telehealth originating site facility fee" is 80 percent of the lesser of the actual charge or $21.20.

The Medicare telehealth originating site facility fee and MEI increase by the applicable time period is shown below.

TABLE 25

Facility fee	MEI increase (percent)	Period
$20.00	N/A	10/01/2001–12/31/2002
$20.60	3.0	01/01/2003–12/31/2003
$21.20	2.9	01/01/2004–12/31/2004

X. Provisions of the Final Regulations

This final rule with comment period adopts the provisions of the August 2003 proposed rule except as noted elsewhere in the preamble. The following is a highlight of the changes made from the proposed rule.

For geographic practice cost indices, based upon the volatility of the premium data collected, our review of the comments received on the August 15, 2003 proposed rule, and our review of malpractice GPCIs, we have modified some of our GPCI calculations and assumptions. We reduced the overall impact associated with revision to the malpractice GPCIs by a factor of 50 percent to mitigate for the volatility of the data. As directed by the statute, we will implement half of this change in the first year (CY 2004) and half of this change in the second year (CY 2005).

For the creation G codes for monitoring heart rhythms issue, based on concerns raised by commenters, we will not proceed with the proposed HCPCS codes because we want to ensure that any HCPCS codes developed, encompass the various technologies that are being utilized for such monitoring.

For changes in payments to physicians managing patients on dialysis, we are moving forward with our proposals and we are adjusting the payment rates for the established G codes. In addition we are adding additional codes to address the concerns raised about home dialysis.

For the definition of diabetes for diabetes self-management training we adopted the AACE clinical definition. We also expanded our general language to include other types of diabetes.

For excision of benign and malignant lesions, we are not moving forward with our proposal, however, we will maintain the 2003 work RVUs as interim values for 2004 to allow opportunity for the specialty to resurvey these services.

For payment policies for anesthesia services we have decided to allow teaching anesthesiologists to bill, similarly to teaching CRNAs, for their involvement in two concurrent cases involving residents.

XI. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

XII. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, if we proceed with a subsequent document, we will respond to the major comments in the preamble to that document.

XIII. Regulatory Impact Analysis

We have examined the impact of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980 Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132. Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when 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 must be prepared for final rules with economically significant effects (that is, a final rule that would have an annual effect on the economy of $100

million or more in any 1 year, or would adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities).

We have simulated the effect of the physician fee schedule changes that we are adopting in this final rule. We are making several changes to the physician fee schedule RVUs in this final rule. In general, section 1848(c)(2)(B)(ii)(II) requires that changes to RVUs cannot increase or decrease expenditures more than $20 million. Thus, changes to the RVUs made pursuant to section 1848(c)(2)(B)(ii)(II) must be budget neutral. That is, increases in payments resulting from RVU changes must be offset by decreases in payments for other services and there will be redistribution in payment among physicians, practitioners and suppliers that bill Medicare for physician fee schedule services. We expect that the changes we are making to the physician fee schedule RVUs under section 1848(c) will result in a redistribution of Medicare allowed charges of more than $100 million in one year. For this reason, we are considering this final rule to be economically significant. Therefore, this final rule is a major rule and we have prepared a regulatory impact analysis.

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 and less significant adverse economic impact on the small entities.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has fewer than 100 beds.

For purposes of the RFA, physicians, non-physician practitioners, and suppliers are considered small businesses if they generate revenues of $6 million or less. Approximately 95 percent of physicians (except mental health specialists) are considered to be small entities. There are about 900,000 physicians, other practitioners and medical suppliers that receive Medicare payment under the physician fee schedule.

The analysis and discussion provided in this section as well as elsewhere in this final rule complies with the RFA requirements. Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This final rule would not impose unfunded mandates on State, local, or tribal governments, or on the private sector of more than $110 million dollars.

We have examined this final rule in accordance with Executive Order 13132 and have determined that this regulation would not have any significant impact on the rights, roles, or responsibilities of State, local, or tribal governments.

We have prepared the following analysis, which together with the rest of this preamble, meets all assessment requirements. It explains the rationale for, and purposes of, the rule, details the costs and benefits of the rule, analyzes alternatives, and presents the measures we propose to use to minimize the burden on small entities. As indicated elsewhere in this final rule, we are making changes to the Medicare Economic Index, refining resource-based practice based practice expense RVUs, creating new codes for dialysis patient visits to their physicians and making a variety of other changes to our regulations, payments or payment policy to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. We provide information for each of the policy changes in the relevant sections in this final rule. While this rule revises the definition of diabetes for the purposes of outpatient diabetes self-management training, it does not impose reporting, record-keeping and other compliance requirements. We are unaware of any relevant Federal rules that duplicate, overlap or conflict with this proposed rule. The relevant sections of this final rule contain a description of significant alternatives.

A. Physician Fee Schedule Relative Value Units

As indicated above, we are making changes to the work and practice expense RVUs under the provisions of section 1848(c)(2) of the Act and section 429(b) of BIPA. Under section 1848(c)(2) of the Act, adjustments to RVUs may not cause the amount of expenditures to differ by more than $20 million from the amount of expenditures that would have resulted without such adjustments. We are making several changes under section 1848(c)(2) that would result in a change of expenditures that would exceed $20 million threshold if we made no offsetting adjustments to either the conversion factor or RVUs.

With respect to practice expense, our policy has been to meet the budget neutrality requirements in the statute by incorporating a rescaling adjustment in the practice expense methodology. That is, we estimate the aggregate number of practice expense relative values that will be paid under current and revised policy in CY 2004. We apply a uniform adjustment factor to make the aggregate number of revised practice expense relative values equal the estimated number that would be paid under current policy. We are applying this policy for all changes that we are making under section 1848(c).

Table 26 shows the specialty level impact on payment of changes being made for CY 2004. The payment impacts reflect averages for each specialty based on Medicare utilization. The payment impact for an individual physician would be different from the average, based on the mix of services the physician provides. The average change in total revenues would be less than the impact displayed here since 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 physician fee schedule. For instance, independent laboratories receive 17 of their revenues from physician schedule services and the remainder for laboratory fee schedule services that are unaffected by this rule. We modeled the impact of all changes to the relative value units and illustrated their effect in table 26. The column labeled "NPRM" shows the combined effect of all of the changes contained in the August 15, 2003 proposed rule (see 68 FR 49033 to 49038 for a detailed discussion of each provision).

The column labeled "Practice Expense Refinements" shows the impact on payment from further changes to the practice expense inputs that we made using information that became available to us since the proposed rule. In some cases, we made changes to the practice expense inputs in response to public comments. In other situations, we may have received

a price for an item of medical equipment or supplies where we previously did not have one. In most cases, these changes may increase or decrease the practice expense RVU for a given code but will have very little impact across all of the services provided by a specialty. However, in one case, we include prices for several items of equipment and supplies that are generally used by otolaryngologists. The addition of this new information increased payment for many procedural services provided by otolaryngologists and reduced payment for their diagnostic services. The net effect of these changes is to increase payments to otolaryngologists by the 1 percent shown in table x. Audiologists provide many of the same diagnostic services that are billed to Medicare by otolaryngologists resulting in the approximate 2 percent decrease in payment shown in table 26 for audiologists. Similarly, there may be some very small additional impact on allergy from the additional practice expense refinements. There were a number of coding changes made by CPT to central venous access codes. It is possible there may be small impact on payment from these coding changes for interventional radiology.

The "Practice Expense Refinements" column also shows an increase in payment of 2 percent for radiation oncology and 1 percent for portable x-ray suppliers. These impacts are a result of our decision to use the non-physician work pool methodology to develop the practice expense RVUs for procedure code 77418 (Intensity Modulated Radiation Therapy).

We also modeled the effect of adjusting the RVUs to match the new MEI weights. Because we are increasing the malpractice RVUs by approximately 20 percent, adjusting the RVUs to match the new MEI weights will result in an increase in payment for those specialties that perform services with high malpractice RVUs. Payments to cardiac surgery, neurosurgery, orthopedic surgery, thoracic surgery and vascular surgery will increase by approximately 1 percent. The column labeled "Total" shows the impact of all changes that we are making to the work and practice expense RVUs for 2004.

TABLE 26.—IMPACT OF PHYSICIAN FEE SCHEDULE CHANGES ON TOTAL MEDICARE ALLOWED CHARGES BY PHYSICIAN, PRACTITIONER AND SUPPLIER SUBCATEGORY

Specialty	Medicare allowed charges (millions)	NPRM (percent)	Practice expense refinements (percent)	Adjusting RVUs to match MEI weights (percent)	Total (percent)
Physicians:					
ALLERGY/IMMUNOLOGY	$153	−1	−1	0	−2
ANESTHESIOLOGY	1,327	0	0	0	0
CARDIAC SURGERY	321	0	0	1	0
CARDIOLOGY	5,759	0	0	0	0
CLINICS	1,167	0	0	0	0
COLON AND RECTAL SURGERY	101	1	0	0	1
CRITICAL CARE	108	−1	0	0	−1
DERMATOLOGY	1,708	0	0	0	0
EMERGENCY MEDICINE	1,444	0	0	0	0
ENDOCRINOLOGY	246	1	0	0	1
FAMILY PRACTICE	4,005	1	0	0	1
GASTROENTEROLOGY	1,513	−1	0	0	−1
GENERAL PRACTICE	954	0	0	0	0
GENERAL SURGERY	2,110	−1	0	0	0
GERIATRICS	97	−1	1	0	0
HAND SURGERY	46	−2	0	0	−2
HEMATOLOGY/ONCOLOGY	1,086	1	0	0	1
INFECTIOUS DISEASE	336	0	0	0	0
INTERNAL MEDICINE	7,917	1	0	0	1
INTERVENTIONAL RADIOLOGY	155	0	−1	0	0
NEPHROLOGY	1,187	0	0	0	0
NEUROLOGY	1,072	1	0	0	1
NEUROSURGERY	433	0	0	1	1
OBSTETRICS/GYNECOLOGY	550	1	0	0	1
OPHTHALMOLOGY	4,291	−1	0	0	−1
ORTHOPEDIC SURGERY	2,645	−2	0	1	−1
OTOLARNGOLOGY	735	2	1	0	3
PATHOLOGY	799	0	0	0	0
PEDIATRICS	58	0	0	0	0
PHYSICAL MEDICINE	594	1	0	0	1
PLASTIC SURGERY	274	0	0	0	0
PSYCHIATRY	1,073	0	0	0	0
PULMONARY DISEASE	1,305	−1	0	0	−1
RADIATION ONCOLOGY	1,002	−3	2	0	0
RADIOLOGY	4,230	0	0	0	0
RHEUMATOLOGY	352	1	0	0	1
THORACIC SURGERY	446	−1	0	1	0
UROLOGY	1,540	2	0	0	1
VASCULAR SURGERY	429	−1	0	1	0
Practitioners:					
AUDIOLOGIST	25	−1	−2	1	−1
CHIROPRACTOR	589	0	0	0	0
CLINICAL PSYCHOLOGIST	449	0	0	0	0
CLINICAL SOCIAL WORKER	277	0	0	0	0
NURSE ANESTHETIST	452	0	0	1	1
NURSE PRACTITIONER	434	−1	1	0	0
OPTOMETRY	611	1	0	0	0
ORAL/MAXILLOFACIAL SURGERY	33	8	0	0	8
PHYSICAL/OCCUPATIONAL THERAPY	835	0	0	1	0
PHYSICIANS ASSISTANT	322	0	0	0	0
PODIATRY	1,307	−1	0	0	−1
Suppliers:					
DIAGNOSTIC TESTING FACILITY	728	0	0	0	0
INDEPENDENT LABORATORY	508	2	0	0	1
PORTABLE X-RAY SUPPLIER	82	−1	1	0	0
Other:					
ALL OTHER	54	0	0	0	0
ALL PHYSICIAN FEE SCHEDULE	60,385	0	0	0	0

The statutory methodology for updating physician fee schedule conversion factor is specified in section 1848(d)(4) of the Act. Consistent with the requirements of section 1848(d)(4) of the Act, as explained in section VI of this final rule, we are reducing the physician fee schedule conversion factor by approximately 4.5 percent. In table 27, we are showing the estimated change in average payments by specialty based on provisions of this final rule

and the estimated physician fee schedule update.

TABLE 27.—IMPACT OF PHYSICIAN FEE SCHEDULE CHANGES ON TOTAL MEDICARE ALLOWED CHARGES BY PHYSICIAN, PRACTITIONER, AND SUPPLIER SUBCATEGORY INCLUDING THE EFFECT OF THE PHYSICIAN FEE SCHEDULE UPDATE

Specialty	Medicare allowed charges (millions)	Impact of RVU changes (percent)	Physician fee schedule update (percent)	Total (percent)
Physicians:				
ALLERGY/IMMUNOLOGY	$153	−2	−4.5	−6
ANESTHESIOLOGY	1,327	0	−4.5	−4
CARDIAC SURGERY	321	0	−4.5	−4
CARDIOLOGY	5,759	0	−4.5	−4
CLINICS	1,167	0	−4.5	−4
COLON AND RECTAL SURGERY	101	1	−4.5	−4
CRITICAL CARE	108	−1	−4.5	−5
DERMATOLOGY	1,708	0	−4.5	−5
EMERGENCY MEDICINE	1,444	0	−4.5	−4
ENDOCRINOLOGY	246	1	−4.5	−4
FAMILY PRACTICE	4,005	1	−4.5	−4
GASTROENTEROLOGY	1,513	−1	−4.5	−5
GENERAL PRACTICE	954	0	−4.5	−4
GENERAL SURGERY	2,110	0	−4.5	−5
GERIATRICS	97	0	−4.5	−5
HAND SURGERY	46	−2	−4.5	−7
HEMATOLOGY/ONCOLOGY	1,086	1	−4.5	−4
INFECTIOUS DISEASE	336	0	−4.5	−5
INTERNAL MEDICINE	7,917	1	−4.5	−4
INTERVENTIONAL RADIOLOGY	155	0	−4.5	−5
NEPHROLOGY	1,187	0	−4.5	−5
NEUROLOGY	1,072	1	−4.5	−3
NEUROSURGERY	433	1	−4.5	−4
OBSTETRICS/GYNECOLOGY	550	1	−4.5	−4
OPHTHALMOLOGY	4,291	−1	−4.5	−5
ORTHOPEDIC SURGERY	2,645	−1	−4.5	−6
OTOLARNGOLOGY	735	3	−4.5	−2
PATHOLOGY	799	0	−4.5	−4
PEDIATRICS	58	0	−4.5	−4
PHYSICAL MEDICINE	594	1	−4.5	−4
PLASTIC SURGERY	274	0	−4.5	−4
PSYCHIATRY	1,073	0	−4.5	−5
PULMONARY DISEASE	1,305	−1	−4.5	−6
RADIATION ONCOLOGY	1,002	0	−4.5	−5
RADIOLOGY	4,230	0	−4.5	−5
RHEUMATOLOGY	352	1	−4.5	−3
THORACIC SURGERY	446	0	−4.5	−4
UROLOGY	1,540	1	−4.5	−3
VASCULAR SURGERY	429	0	−4.5	−5
Practitioners:				
AUDIOLOGIST	25	−1	−4.5	−6
CHIROPRACTOR	589	0	−4.5	−4
CLINICAL PSYCHOLOGIST	449	0	−4.5	−5
CLINICAL SOCIAL WORKER	277	0	−4.5	−5
NURSE ANESTHETIST	452	1	−4.5	−4
NURSE PRACTITIONER	434	0	−4.5	−4
OPTOMETRY	611	0	−4.5	−4
ORAL/MAXILLOFACIAL SURGERY	33	8	−4.5	3
PHYSICAL/OCCUPATIONAL THERAPY	835	0	−4.5	−4
PHYSICIANS ASSISTANT	322	0	−4.5	−4
PODIATRY	1,307	−1	−4.5	−5
Suppliers:				
DIAGNOSTIC TESTING FACILITY	728	0	−4.5	−5
INDEPENDENT LABORATORY	508	1	−4.5	−3
PORTABLE X–RAY SUPPLIER	82	0	−4.5	−4
Other:				
ALL OTHER	54	0	−4.5	−4
ALL PHYSICIAN FEE SCHEDULE	60,385	0	−4.5	−4

Table 28 shows the impact on payments for selected high volume procedures of all of the changes previously discussed. This table shows the combined impact of the change in the work, practice expense and malpractice RVUs and the estimated physician fee schedule update on total payment for the procedure. There are separate columns that show the change in the facility rates and the non-facility rates. For an explanation of facility and non-facility practice expense refer to § 414.22(b)(5)(i).

TABLE 28.—IMPACT OF FINAL RULE AND PHYSICIAN FEE SCHEDULE UPDATE ON MEDICARE PAYMENT FOR SELECTED PROCEDURES

HCPCS	MOD	DESC	Non-Facility			Facility		
			Old	New	% change	Old	New	% change
11721		Debride nail, 6 or more	$37.52	$36.19	−4	29.06	28.11	−3
17000		Destroy benign/premlg lesion	61.43	57.27	−7	33.11	33.73	2
27130		Total hip arthroplasty	N/A	N/A	N/A	1,343.41	1,290.82	−4
27236		Treat thigh fracture	N/A	N/A	N/A	1,068.99	1,024.86	−4
27244		Treat thigh fracture	N/A	N/A	N/A	1,155.44	1,050.15	−9
27447		Total knee arthroplasty	N/A	N/A	N/A	1,445.67	1,390.25	−4
33533		CABG, arterial, single	N/A	N/A	N/A	1,799.18	1,742.99	−3
35301		Rechanneling of artery	N/A	N/A	N/A	1,073.77	1,043.83	−3
43239		Upper GI endoscopy, biopsy	337.69	305.31	−10	155.97	150.02	−4
45385		Lesion removal colonoscopy	545.53	471.85	−14	290.61	271.23	−7
66821		After cataract laser surgery	231.01	227.32	−2	214.83	224.15	4
66984		Cataract surg w/iol, 1 stage	N/A	N/A	N/A	672.81	645.06	−4
67210		Treatment of retinal lesion	604.39	544.58	−10	548.47	528.41	−4
71010	26	Chest x-ray	9.20	8.78	−5	9.20	8.78	−5
71020	26	Chest x-ray	11.04	10.54	−5	11.04	10.54	−5
76091		Mammogram, both breasts	94.17	89.94	−4	N/A	N/A	N/A
76091	26	Mammogram, both breasts	44.14	42.16	−4	44.14	42.16	−4
76092		Mammogram, screening	82.77	79.40	−4	N/A	N/A	N/A
76092	26	Mammogram, screening	36.05	34.08	−5	36.05	34.08	−5
77427		Radiation tx management, x5	168.11	158.81	−6	168.11	158.81	−6
78465	26	Heart image (3d), multiple	75.41	71.67	−5	75.41	71.67	−5
88305	26	Tissue exam by pathologist	40.83	39.00	−4	40.83	39.00	−4
90801		Psy dx interview	148.98	141.94	−5	140.52	133.16	−5
90806		Psytx, off, 45–50 min	96.38	91.70	−5	92.70	88.54	−4
90807		Psytx, off, 45–50 min w/e&m	102.63	97.32	−5	100.06	95.21	−5
90862		Medication management	50.76	48.13	−5	47.82	45.32	−5
90935		Hemodialysis, one evaluation	N/A	N/A	N/A	71.36	67.81	−5
92004		Eye exam, new patient	123.60	119.46	−3	88.29	83.62	−5
92012		Eye exam established pat	61.43	60.08	−2	36.05	34.08	−5
92014		Eye exam & treatment	91.60	88.19	−4	58.86	55.86	−5
92980		Insert intracoronary stent	N/A	N/A	N/A	800.45	763.81	−5
92982		Coronary artery dilation	N/A	N/A	N/A	594.46	566.71	−5
93000		Electrocardiogram, complete	26.12	24.95	−2	N/A	N/A	N/A
93010		Electrocardiogram report	8.83	8.43	−5	8.83	8.43	−5
93015		Cardiovascular stress test	104.10	99.78	−4	N/A	N/A	N/A
93307	26	Echo exam of heart	48.19	46.03	−4	48.19	46.03	−4
93510	26	Left heart catheterization	231.38	237.86	3	231.38	237.86	3
98941		Chiropractic manipulation	35.68	34.08	−4	31.27	29.86	−5
99203		Office/outpatient visit, new	92.70	90.65	−2	70.26	67.46	−4
99204		Office/outpatient visit, new	132.06	128.24	−3	103.74	99.08	−4
99205		Office/outpatient visit, new	168.48	161.97	−4	137.58	130.70	−5
99211		Office/outpatient visit, est	20.60	20.73	1	8.83	8.43	−5
99212		Office/outpatient visit, est	36.42	36.19	−1	23.17	22.13	−4
99213		Office/outpatient visit, est	51.13	49.89	−2	34.58	33.03	−4
99214		Office/outpatient visit, est	79.82	77.29	−3	56.65	53.75	−5
99215		Office/outpatient visit, est	116.98	112.43	−4	91.23	86.78	−5
99221		Initial hospital care	N/A	N/A	N/A	65.85	62.54	−5
99222		Initial hospital care	N/A	N/A	N/A	109.25	104.00	−5
99223		Initial hospital care	N/A	N/A	N/A	151.92	144.75	−5
99231		Subsequent hospital care	N/A	N/A	N/A	32.74	31.27	−4
99232		Subsequent hospital care	N/A	N/A	N/A	54.07	51.30	−5
99233		Subsequent hospital care	N/A	N/A	N/A	76.88	73.43	−4
99236		Observ/hosp same date	N/A	N/A	N/A	216.67	211.86	−2
99238		Hospital discharge day	N/A	N/A	N/A	69.16	65.70	−5
99239		Hospital discharge day	N/A	N/A	N/A	93.80	89.24	−5
99241		Office consultation	47.45	47.08	−1	33.11	31.97	−3
99242		Office consultation	88.29	86.08	−3	68.05	65.35	−4
99243		Office consultation	116.61	113.83	−2	90.49	86.43	−4
99244		Office consultation	165.90	160.91	−3	134.27	127.89	−5
99245		Office consultation	215.20	206.94	−4	177.67	169.35	−5
99251		Initial inpatient consult	N/A	N/A	N/A	34.95	33.73	−3
99252		Initial inpatient consult	N/A	N/A	N/A	70.26	67.46	−4
99253		Initial inpatient consult	N/A	N/A	N/A	96.01	91.35	−5

TABLE 28.—IMPACT OF FINAL RULE AND PHYSICIAN FEE SCHEDULE UPDATE ON MEDICARE PAYMENT FOR SELECTED PROCEDURES—Continued

HCPCS	MOD	DESC	Non-Facility			Facility		
			Old	New	% change	Old	New	% change
99254		Initial inpatient consult	N/A	N/A	N/A	137.95	131.05	−5
99255		Initial inpatient consult	N/A	N/A	N/A	189.81	180.94	−5
99261		Follow-up inpatient consult	N/A	N/A	N/A	22.07	20.73	−6
99262		Follow-up inpatient consult	N/A	N/A	N/A	43.77	42.16	−4
99263		Follow-up inpatient consult	N/A	N/A	N/A	65.11	62.19	−4
99282		Emergency dept visit	N/A	N/A	N/A	26.85	26.00	−3
99283		Emergency dept visit	N/A	N/A	N/A	60.33	57.62	−4
99284		Emergency dept visit	N/A	N/A	N/A	94.17	89.94	−4
99285		Emergency dept visit	N/A	N/A	N/A	146.77	140.18	−4
99291		Critical care, first hour	210.05	229.07	9	200.11	191.13	−4
99292		Critical care, add'l 30 min	107.78	101.19	−6	100.06	95.21	−5
99301		Nursing facility care	71.00	67.46	−5	61.06	57.97	−5
99302		Nursing facility care	96.75	92.05	−5	81.30	77.65	−4
99303		Nursing facility care	119.92	114.19	−5	101.16	96.27	−5
99311		Nursing fac care, subseq	40.83	39.00	−4	30.53	28.81	−6
99312		Nursing fac care, subseq	62.54	59.38	−5	50.40	48.13	−5
99313		Nursing fac care, subseq	85.71	81.16	−5	71.73	68.16	−5
99348		Home visit, est patient	74.31	70.62	−5	N/A	N/A	N/A
99350		Home visit, est patient	167.74	160.21	−4	N/A	N/A	N/A
G0317		ESRDrelsvc 4+/mo; 20+yr	262.28	285.29	9	262.28	285.29	9
G0318		ESRDrelsvc 2–3/mo; 20+yr	262.28	237.51	−9	262.28	237.51	−9
G0319		ESRDrelsvc 1/mo; 20+yr	262.28	190.07	−28	262.28	190.07	−28

B. Geographic Practice Cost Index Changes

Section 1848(e)(1)(A) of the Act requires that payments under the Medicare physician fee schedule vary among payment areas only to the extent that area costs vary as reflected by the area GPCIs. The GPCIs measure areas cost differences in the three components of the physician fee schedule: Physician work, practice expenses, and malpractice insurance. Section 1848(e)(1)(C) of the Act requires that the GPCIs be reviewed and, if necessary, revised at least every 3 years. Due to problems with the availability of U.S. Census Bureau data, which is the major resource utilized in both the work and practice expense GPCIs, we have updated only the malpractice GPCI in this regulation.

The first GPCI revision was implemented in 1995. The second revision was implemented in 1998. The third revision was implemented in 2001. This constitutes the fourth revision to the GPCIs. Section 1848(e)(1)(C) of the Act also requires that GPCI revisions be phased in equally over a 2-year period if more than one year has elapsed since the last adjustment.

In order to mitigate the volatility associated with malpractice insurance premiums, we reduced the percent change in the malpractice GPCIs by a factor of 50 percent. As directed by the statute, we will implement ½ of this change in the first year (CY 2004) and ½ of this change in the second year (CY 2005). During this two-year phase-in, we will continue to work with the State Departments of Insurance to obtain the most current malpractice premium data available. As more current data are obtained, we will review and revise the malpractice GPCIs as appropriate.

An estimate of the 2004 proposed malpractice GPCI changes can be demonstrated by a comparison of area geographic adjustment factors (GAFs). The GAFs are a weighted composite of each area's work, practice expense, and malpractice expense GPCIs using the national GPCI cost share weights. While we do not actually use the GAFs in computing the fee schedule payment for a specific service, they are useful in comparing overall area costs and payments. The actual effect on payment for any specific service will deviate from the GAF to the extent that the service's proportions of work, practice expenses, and malpractice expense RVUs differ from those of the GAF. Table 27 shows the estimated effects of the revised 2004 malpractice GPCIs on area GAFs. As directed by statute, the 2004 GAFs reflect only ½ of the impact of the revision to the malpractice GPCIs.

With the exception of Detroit, Michigan, no locality experienced an increase of more than 1 percent in total payments due to the revision of their malpractice GPCI for 2004. Alternatively, locality specific decreases in total payments due to the revision of the malpractice GPCIs do not exceed 1 percent for any given locality in 2004.

TABLE 29.—REVISED GEOGRAPHIC ADJUSTMENT FACTORS FROM FINAL RULE

Carrier No.	Locality No	Locality name	2003 GAF	2004 GAF	Percent difference
00510	00	Alabama	0.927	0.923	−0.4
00831	01	Alaska	1.115	1.113	−0.1
00832	00	Arizona	0.991	0.991	0.0
00520	13	Arkansas	0.889	0.885	−0.4
31146	26	Anaheim/Santa Ana, CA	1.096	1.098	0.1
31146	18	Los Angeles, CA	1.088	1.088	0.0
31140	03	Marin/Napa/Solano, CA	1.103	1.104	0.0
31140	07	Oakland/Berkeley, CA	1.112	1.111	0.0

TABLE 29.—REVISED GEOGRAPHIC ADJUSTMENT FACTORS FROM FINAL RULE—Continued

Carrier No.	Locality No.	Locality name	2003 GAF	2004 GAF	Percent difference
31140	05	San Francisco, CA	1.221	1.223	0.2
31140	06	San Mateo, CA	1.199	1.201	0.2
31140	09	Santa Clara, CA	1.184	1.184	0.1
31146	17	Ventura, CA	1.061	1.060	−0.1
31146	99	Rest of California*	1.010	1.008	−0.2
31140	99	Rest of California*	1.010	1.008	−0.2
00824	01	Colorado	0.983	0.982	−0.2
00591	00	Connecticut	1.092	1.092	0.0
00902	01	Delaware	1.016	1.018	0.2
00903	01	DC + MD/VA Suburbs	1.094	1.095	0.1
00590	03	Fort Lauderdale, FL	1.034	1.036	0.3
00590	04	Miami, FL	1.079	1.085	0.5
00590	99	Rest of Florida	0.972	0.974	0.2
00511	01	Atlanta, GA	1.026	1.027	0.1
00511	99	Rest of Georgia	0.936	0.935	−0.1
00833	01	Hawaii/Guam	1.046	1.046	0.0
05130	00	Idaho	0.912	0.907	−0.5
00952	16	Chicago, IL	1.079	1.087	0.7
00952	12	East St. Louis, IL	0.983	0.988	0.5
00952	15	Suburban Chicago, IL	1.054	1.059	0.5
00952	99	Rest of Illinois	0.939	0.940	0.1
00630	00	Indiana	0.940	0.935	−0.5
00826	00	Iowa	0.912	0.909	−0.4
00650	00	Kansas*	0.928	0.925	−0.3
00740	02	Kansas*	0.928	0.925	−0.3
00660	00	Kentucky	0.923	0.921	−0.2
00528	01	New Orleans, LA	0.985	0.984	0.0
00528	99	Rest of Louisiana	0.930	0.929	−0.1
31142	03	Southern Maine	0.977	0.975	−0.2
31142	99	Rest of Maine	0.930	0.927	−0.3
00901	01	Baltimore/Surr. Cntys, MD	1.025	1.025	0.0
00901	99	Rest of Maryland	0.972	0.970	−0.2
31143	01	Metropolitan Boston	1.117	1.118	0.2
31143	99	Rest of Massachusetts	1.053	1.054	0.1
00953	01	Detroit, MI	1.095	1.106	1.0
00953	99	Rest of Michigan	0.990	0.992	0.2
00954	00	Minnesota	0.966	0.962	−0.5
00512	00	Mississippi	0.900	0.896	−0.4
00740	04	Metropolitan Kansas City, MO	0.974	0.975	0.1
00523	01	Metropolitan St. Louis, MO	0.965	0.966	0.0
00740	99	Rest of Missouri*	0.890	0.889	−0.1
00523	99	Rest of Missouri*	0.890	0.889	−0.1
00751	01	Montana	0.912	0.913	0.1
00655	00	Nebraska	0.902	0.898	−0.4
00834	00	Nevada	1.026	1.025	−0.1
31144	40	New Hampshire	0.999	1.001	0.2
00805	01	Northern NJ	1.109	1.111	0.2
00805	99	Rest of New Jersey	1.058	1.060	0.2
00521	05	New Mexico	0.940	0.938	−0.2
00803	01	Manhattan, NY	1.221	1.225	0.3
00803	02	Nyc Suburbs/Long I., NY	1.174	1.179	0.4
00803	03	Poughkpsie/N Nyc Suburbs, NY	1.046	1.047	0.1
14330	04	Queens, NY	1.156	1.161	0.4
00801	99	Rest of New York	0.968	0.964	−0.4
05535	00	North Carolina	0.941	0.939	−0.2
00820	01	North Dakota	0.911	0.907	−0.4
00883	00	Ohio	0.968	0.968	0.0
00522	00	Oklahoma	0.912	0.907	−0.7
00835	01	Portland, OR	1.000	0.998	−0.3
00835	99	Rest of Oregon	0.932	0.929	−0.4
00865	01	Metropolitan Philadelphia, PA	1.064	1.067	0.3
00865	99	Rest of Pennsylvania	0.957	0.955	−0.2
00973	20	Puerto Rico	0.790	0.784	−0.8
00870	01	Rhode Island	1.033	1.033	0.0
00880	01	South Carolina	0.922	0.919	−0.4
00820	02	South Dakota	0.894	0.889	−0.6
05440	35	Tennessee	0.931	0.928	−0.3
00900	31	Austin, TX	0.986	0.988	0.2
00900	20	Beaumont, TX	0.960	0.960	0.0
00900	09	Brazoria, TX	0.997	0.999	0.1
00900	11	Dallas, TX	1.031	1.033	0.3

TABLE 29.—REVISED GEOGRAPHIC ADJUSTMENT FACTORS FROM FINAL RULE—Continued

Carrier No.	Locality No.	Locality name	2003 GAF	2004 GAF	Percent difference
00900	28	Fort Worth, TX	0.983	0.985	0.2
00900	15	Galveston, TX	0.991	0.992	0.1
00900	18	Houston, TX	1.025	1.026	0.1
00900	99	Rest of Texas	0.929	0.932	0.2
00910	09	Utah	0.951	0.948	−0.2
31145	50	Vermont	0.965	0.962	−0.3
00973	50	Virgin Islands	0.991	0.992	0.1
00904	00	Virginia	0.949	0.947	−0.2
00836	02	Seattle (King Cnty), WA	1.038	1.038	0.0
00836	99	Rest of Washington	0.971	0.970	−0.1
00884	16	West Virginia	0.929	0.933	0.5
00951	00	Wisconsin	0.958	0.954	−0.4
00825	21	Wyoming	0.938	0.936	−0.2

C. Tracking Codes

We are adopting a policy that will allow CMS to create national payment policy and determine national payment amounts for CPT tracking codes regardless of whether a national coverage determination for a specific service has been made. Our policy will have no effect on Medicare expenditures but will allow for more flexibility in determining payment rates for new services.

D. G Codes for Managing Dialysis Patients

As previously discussed in section II.D., we have reviewed our current payment policy for the monthly dialysis capitation payment in response to concerns that have been raised over whether our payment policy is consistent with current medical practice. We are establishing new G codes for these services and are aligning Medicare's payment to recognize the higher amount of physician work associated with more frequent face-to-face visits. Aggregated Medicare payments to physicians for treating dialysis patients will not be increased or decreased by the establishment of these new procedure codes. Relative to payment based on the current CPT codes, Medicare payments to physicians for providing fewer than four visits per month will decrease. If the physician provides four or more visits per month, payment will increase. The net effect of these payment changes will not increase or decrease aggregate Medicare payment for physician services provided to dialysis patients.

E. Rebasing and Revising the MEI

Section IV.B. of this final rule discusses rebasing and revising the MEI for the CY 2004 physician fee schedule. Substituting the 2000 MEI weights in place of the 1996 weights increases the MEI by 0.1 percent for 2004. After 2004, the MEI in some years is likely to be unaffected by using more recent year weights while other years may have slightly higher increases (between 0.1 to 0.2 percentage points).

F. Definition of Diabetes for Diabetes Self-Management Training

In section III.A., we revised the definition of diabetes for purposes of the Outpatient Diabetes Self-Management Training benefit and are using this definition to determine beneficiary eligibility for Medical Nutrition Therapy when the beneficiary has a diagnosis of diabetes. The streamlining of the beneficiary eligibility requirements for Outpatient Diabetes Self-Management Training will reduce administrative burden for the referring physician or qualified non-physician practitioner and for the accredited Outpatient Diabetes Self-Management Training programs by simplifying documentation requirements and eliminating the need for reconsiderations and appeals to clarify that the requirements have been met. As indicated in the February 28, 2003 **Federal Register** (68 FR 9572), we incorporated an adjustment to the SGR consistent with our original estimates of expenditures associated with this new benefit. Our experience is that expenditures have been less than originally estimated. We expect that simplifying administrative requirements associated with this new benefit will make it more likely that expenditures for diabetes self-management training will be consistent with original estimates and there will be no increase in Medicare expenditures from making these modifications.

G. Payment Policies for Anesthesia Services

In section III.D. of this final rule, we discussed Medicare payment for anesthesia services involving anesthesiologists and residents. Effective January 1, 2004, we are revising our teaching anesthesia rules to allow teaching anesthesiologists to bill, similar to teaching CRNAs, for their involvement in two concurrent cases with residents. The policy change will allow anesthesiologists to be paid either under the rules for medical direction or the same way that teaching CRNAs are paid for two concurrent cases. We are uncertain how the practice arrangements of teaching anesthesiologists will change as a result of this new policy. We believe that most teaching anesthesiologists will continue to function under the medical direction practice model for concurrent cases involving residents. Therefore, we believe there will be minimal change in Medicare program expenditures as a result of this change.

H. Alternatives Considered

This proposed rule contains a range of policies. The preamble identifies those policies when discretion has been exercised and presents rationale for our decisions, including a presentation of nonselected options.

I. Impact on Beneficiaries

Although changes in physicians' payments were large when the physician fee schedule was implemented in 1992, we detected no problems with beneficiary access to care. While it has been suggested that the negative update for 2004 may affect beneficiary access to care, we note that the formula to determine this update is set by statute and this regulation cannot, and does not, change it. Nevertheless, we remain concerned about the issue and will continue to study the issue to the best of our ability with available resources.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 410

Health facilities, Health professions, Kidney diseases,

42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as follows:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

■ 1. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 2. Section 410.130 is amended by revising the definition of "Diabetes" to read as follows:

§ 410.130 Definitions

* * * * *

Diabetes means diabetes mellitus, a condition of abnormal glucose metabolism diagnosed using the following criteria: A fasting blood sugar greater than or equal to 126 mg/dL on two different occasions; a 2 hour post-glucose challenge greater than or equal to 200 mg/dL on 2 different occasions; or a random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

* * * * *

■ 3. Section 410.140 is amended by adding the definition of "Diabetes" in alphabetical order to read as follows:

§ 410.140 Definitions

* * * * *

Diabetes means diabetes mellitus, a condition of abnormal glucose metabolism diagnosed using the following criteria: A fasting blood sugar greater than or equal to 126 mg/dL on two different occasions; a 2 hour post-glucose challenge greater than or equal to 200 mg/dL on 2 different occasions; or a random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

* * * * *

■ 4. Section 410.141 is amended by revising paragraph (d) to read as follows:

§ 410.141 Outpatient diabetes self-management training.

* * * * *

(d) Beneficiaries who may be covered. Medicare Part B covers outpatient diabetes self-management training for a beneficiary who has been diagnosed with diabetes.

* * * * *

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

■ 1. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(1)).

■ 2. Section 414.22(b)(6)(iii) is revised to read as follows:

§ 414.22 Relative value units (RVUs).

* * * * *

(b) * * *

(6) * * *

(iii) CMS will consider for use in determining practice expense RVUs for the physician fee schedule survey data and related materials submitted to CMS by March 1, 2004 to determine CY 2005 practice expense RVUs and by March 1, 2005 to determine CY 2006 practice expense RVUs.

* * * * *

■ 3. Section 414.46 is amended to—

■ a. Redesignate paragraphs (e) through (g) as paragraphs (f) through (h), respectively.

■ b. Add new paragraph (e).

■ The addition reads as follows:

§ 414.46 Additional rules for payment of anesthesia services.

* * * * *

(e) *Physicians involved with two concurrent cases with residents.* The physician can bill base units and time units based on the amount of time the physician is actually present with the resident during each of two concurrent cases furnished on or after January 1, 2004.

(1) To bill the base units, the physician must be present with the resident during the pre- and post-anesthesia care included in the base units.

(2) If the physician is not present with the resident during pre- and post-anesthesia care, then the physician may bill the case as a medically directed case in accordance with paragraph (d) of this section.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: October 28, 2003.

Thomas A Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: October 28, 2003.

Tommy G. Thompson,

Secretary.

Note: These addenda will not appear in the Code of Federal Regulations.

Addendum A—Explanation and Use of Addenda B

The addenda on the following pages provide various data pertaining to the Medicare fee schedule for physicians' services furnished in 2003. Addendum B contains the RVUs for work, non-facility practice expense, facility practice expense, and malpractice expense, and other information for all services included in the physician fee schedule.

In previous years, we have listed many services in Addendum B that are not paid under the physician fee schedule. To avoid publishing as many pages of codes for these services, we are not including clinical laboratory codes and most alphanumeric codes (Healthcare Common Procedure Coding System (HCPCS) codes not included in CPT) in Addendum B.

Addendum B—2003 Relative Value Units and Related Information Used in Determining Medicare Payments for 2003

This addendum contains the following information for each CPT code and alphanumeric HCPCS code, except for alphanumeric codes beginning with B (enteral and parenteral therapy), E (durable medical equipment), K (temporary codes for non-physicians' services or items), or L (orthotics), and codes for anesthesiology.

1. *CPT/HCPCS code.* This is the CPT or alphanumeric HCPCS number for the service. Alphanumeric HCPCS codes are included at the end of this addendum.

2. *Modifier.* A modifier is shown if there is a technical component (modifier TC) and a professional component (PC) (modifier −26) for the service. If there is a PC and a TC for the service, Addendum B contains three entries for the code: One for the global values (both professional and technical); one for modifier −26 (PC); and one for 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. There will be RVUs for the code (CPT code 45378) with this modifier.

3. *Status indicator.* This indicator shows whether the CPT/HCPCS code is in the physician fee schedule and whether it is separately payable if the service is covered.

A = Active code. These codes are separately payable under the fee schedule 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 decision regarding the coverage of

the service. Carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payment for covered services is 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 = Carrier-priced code. Carriers will establish RVUs and payment amounts for these services, generally on a case-by-case basis following review of documentation, such as an operative report.

D = Deleted code. These codes are deleted effective with the beginning of the calendar year.

E = Excluded from physician fee schedule by regulation. These codes are for items or services that we chose to exclude from the physician fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the physician fee schedule for these codes. Payment for them, if they are covered, continues under reasonable charge or other payment procedures.

F = Deleted/discontinued codes. Code not subject to a 90-day grace period.

G = Code not valid for Medicare purposes. Medicare does not recognize codes assigned this status. Medicare uses another code for reporting of, and payment for, these services.

H = Deleted modifier. Either the TC or PC component shown for the code has been deleted, and the deleted component is shown in the data base with the H status indicator. (Code subject to a 90-day grace period.)

I = Not valid for Medicare purposes. Medicare uses another code for the reporting of, and the payment for, these services. (Code NOT subject to a 90-day grace period.)

N = Non-covered service. These codes are non-covered services. Medicare payment may not be made for these codes. If RVUs are shown, they are not used for Medicare payment.

P = Bundled or excluded code. There are no RVUs for these services. No separate payment should be made for them under the physician fee schedule.

—If the item or service is covered as incident to a physician's service and is furnished on the same day as a physician's service, payment for it is bundled into the payment for the physician's service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician's service).

—If the item or service is covered as other than incident to a physician's service, it is excluded from the physician fee schedule (for example, colostomy supplies) and is paid under the other payment provisions of the Act.

R = Restricted coverage. Special coverage instructions apply. If the service is covered and no RVUs are shown, it is carrier-priced.

T = Injections. There are RVUs for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the service(s) for which payment is made.

X = Exclusion by law. These codes represent an item or service that is not within the definition of "physicians' services" for physician fee schedule payment purposes. No RVUs are shown for these codes, and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)

4. *Description of code.* This is an abbreviated version of the narrative description of the code.

5. *Physician work RVUs.* These are the RVUs for the physician work for this service in 2003. Codes that are not used for Medicare payment are identified with a "+".

6. *Facility practice expense RVUs.* These are the fully implemented resource-based practice expense RVUs for facility settings.

7. *Non-facility practice expense RVUs.* These are the fully implemented resource-based practice expense RVUs for non-facility settings.

8. *Malpractice expense RVUs.* These are the RVUs for the malpractice expense for the service for 2003.

9. *Facility total.* This is the sum of the work, fully implemented facility practice expense, and malpractice expense RVUs.

10. *Non-facility total.* This is the sum of the work, fully implemented non-facility practice expense, and malpractice expense RVUs.

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 = The code describes a service furnished in uncomplicated maternity cases including antepartum care, delivery, and postpartum care. The usual global surgical concept does not apply. See the 1999 Physicians' Current Procedural Terminology for specific definitions.

XXX = The global concept does not apply.

YYY = The global period is to be set by the carrier (for example, unlisted surgery codes).

ZZZ = Code related to another service that is always included in the global period of the other service. (Note: Physician work and practice expense are associated with intra-service time and in some instances the post-service time.)

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
0001T		C	Endovas repr abdo ao aneurys	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0002T		D	endo repair abd aa aorto uni	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0003T		C	Cervicography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0005T		C	Perc cath stent/brain cv art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0006T		C	Perc cath stent/brain cv art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0007T		C	Perc cath stent/brain cv art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0008T		C	Upper gi endoscopy w/suture	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0009T		C	Endometrial cryoablation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0010T		C	Tb test, gamma interferon	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0012T		C	Osteochondral knee autograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0013T		C	Osteochondral knee allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0014T		C	Meniscal transplant, knee	0.00	0.00	0.00	0.00	0.00	0.00	XXX
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
0018T		C	Transcranial magnetic stimul	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0019T		I	Extracorp shock wave tx, ms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0020T		C	Extracorp shock wave tx, ft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0021T		C	Fetal oximetry, trnsvag/cerv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0023T		C	Phenotype drug test, hiv 1	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0024T		C	Transcath cardiac reduction	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0025T		D	Ultrasonic pachymetry	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0026T		C	Measure remnant lipoproteins	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
0027T		C	Endoscopic epidural lysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0028T		C	Dexa body composition study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0029T		C	Magnetic tx for incontinence	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
0031T		C	Speculoscopy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0032T		C	Speculoscopy w/direct sample	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0033T		C	Endovasc taa repr incl subcl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0034T		C	Endovasc taa repr w/o subcl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0035T		C	Insert endovasc prosth, taa	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0036T		C	Endovasc prosth, taa, add-on	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0037T		C	Artery transpose/endovas taa	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0038T		C	Rad endovasc taa rpr w/cover	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0039T		C	Rad s/i, endovasc taa repair	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0040T		C	Rad s/i, endovasc taa prosth	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0041T		C	Detect ur infect agnt w/cpas	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
0043T		C	Co expired gas analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0044T		C	Whole body photography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0045T		C	Whole body photography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0046T		C	Cath lavage, mammary duct(s	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0047T		C	Cath lavage, mammary duct(s)	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
0049T		C	External circulation assist	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
0056T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0057T		C	Uppr gi scope w/ thrml txmnt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0058T		C	Cryopreservation, ovary tiss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0059T		C	Cryopreservation, oocyte	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0060T		C	Electrical impedance scan	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0061T		C	Destruction of tumor, breast	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10021		A	Fna w/o image	1.26	2.22	0.55	0.08	3.56	1.89	XXX
10022		A	Fna w/image	1.26	2.65	0.43	0.06	3.97	1.75	XXX
10040		A	Acne surgery	1.17	1.02	0.68	0.06	2.25	1.91	010
10060		A	Drainage of skin abscess	1.16	1.22	0.95	0.10	2.48	2.21	010
10061		A	Drainage of skin abscess	2.39	1.84	1.53	0.20	4.43	4.12	010
10080		A	Drainage of pilonidal cyst	1.16	3.19	1.16	0.11	4.46	2.43	010
10081		A	Drainage of pilonidal cyst	2.44	4.16	1.53	0.23	6.83	4.20	010
10120		A	Remove foreign body	1.21	1.48	0.42	0.12	2.81	1.75	010
10121		A	Remove foreign body	2.67	3.36	1.91	0.30	6.33	4.88	010
10140		A	Drainage of hematoma/fluid	1.52	1.53	0.91	0.18	3.23	2.61	010
10160		A	Puncture drainage of lesion	1.19	0.73	0.47	0.13	2.05	1.79	010
10180		A	Complex drainage, wound	2.24	3.27	2.09	0.30	5.81	4.63	010
11000		A	Debride infected skin	0.60	0.58	0.22	0.06	1.24	0.88	000
11001		A	Debride infected skin add-on	0.30	0.23	0.11	0.02	0.55	0.43	ZZZ
11010		A	Debride skin, fx	4.18	6.80	2.35	0.54	11.52	7.07	010
11011		A	Debride skin/muscle, fx	4.92	8.12	2.39	0.64	13.68	7.95	000
11012		A	Debride skin/muscle/bone, fx	6.84	12.02	3.90	1.07	19.93	11.81	000
11040		A	Debride skin, partial	0.50	0.52	0.21	0.06	1.08	0.77	000
11041		A	Debride skin, full	0.82	0.65	0.33	0.07	1.54	1.22	000
11042		A	Debride skin/tissue	1.11	0.98	0.47	0.11	2.20	1.69	000
11043		A	Debride tissue/muscle	2.37	3.47	2.63	0.29	6.13	5.29	010
11044		A	Debride tissue/muscle/bone	3.04	4.58	3.80	0.41	8.03	7.25	010
11055		R	Trim skin lesion	0.43	0.56	0.17	0.02	1.01	0.62	000
11056		R	Trim skin lesions, 2 to 4	0.61	0.64	0.24	0.04	1.29	0.89	000
11057		R	Trim skin lesions, over 4	0.79	0.73	0.31	0.05	1.57	1.15	000
11100		A	Biopsy, skin lesion	0.81	1.27	0.37	0.05	2.13	1.23	000
11101		A	Biopsy, skin add-on	0.41	0.34	0.19	0.02	0.77	0.62	ZZZ
11200		A	Removal of skin tags	0.77	1.07	0.78	0.05	1.89	1.60	010
11201		A	Remove skin tags add-on	0.29	0.16	0.12	0.02	0.47	0.43	ZZZ
11300		A	Shave skin lesion	0.51	1.01	0.22	0.04	1.56	0.77	000
11301		A	Shave skin lesion	0.85	1.13	0.38	0.05	2.03	1.28	000
11302		A	Shave skin lesion	1.04	1.32	0.47	0.06	2.42	1.57	000
11303		A	Shave skin lesion	1.23	1.61	0.53	0.07	2.91	1.83	000
11305		A	Shave skin lesion	0.67	0.85	0.27	0.05	1.57	0.99	000
11306		A	Shave skin lesion	0.98	1.12	0.43	0.06	2.16	1.47	000
11307		A	Shave skin lesion	1.13	1.31	0.50	0.06	2.50	1.69	000
11308		A	Shave skin lesion	1.40	1.47	0.61	0.08	2.95	2.09	000
11310		A	Shave skin lesion	0.73	1.14	0.33	0.05	1.92	1.11	000
11311		A	Shave skin lesion	1.04	1.26	0.50	0.06	2.36	1.60	000
11312		A	Shave skin lesion	1.19	1.46	0.56	0.07	2.72	1.82	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
11313		A	Shave skin lesion	1.61	1.84	0.72	0.11	3.56	2.44	000
11400		A	Exc tr-ext b9+marg 0.5 < cm	0.85	2.04	0.90	0.07	2.96	1.82	010
11401		A	Exc tr-ext b9+marg 0.6–1 cm	1.22	2.10	1.04	0.11	3.43	2.37	010
11402		A	Exc tr-ext b9+marg 1.1–2 cm	1.50	2.27	1.10	0.14	3.91	2.74	010
11403		A	Exc tr-ext b9+marg 2.1–3 cm	1.78	2.45	1.35	0.19	4.42	3.32	010
11404		A	Exc tr-ext b9+marg 3.1–4 cm	2.05	2.77	1.43	0.22	5.04	3.70	010
11406		A	Exc tr-ext b9+marg 4.0 cm	2.74	3.14	1.69	0.30	6.18	4.73	010
11420		A	Exc h-f-nk-sp b9+marg 0.5 <	0.97	1.80	0.94	0.10	2.87	2.01	010
11421		A	Exc h-f-nk-sp b9+marg 0.6–1	1.41	2.10	1.13	0.13	3.64	2.67	010
11422		A	Exc h-f-nk-sp b9+marg 1.1–2	1.62	2.30	1.36	0.17	4.09	3.15	010
11423		A	Exc h-f-nk-sp b9+marg 2.1–3	2.00	2.64	1.48	0.20	4.84	3.68	010
11424		A	Exc h-f-nk-sp b9+marg 3.1–4	2.42	2.86	1.63	0.25	5.53	4.30	010
11426		A	Exc h-f-nk-sp b9+marg > 4 cm	3.76	3.57	2.13	0.41	7.74	6.30	010
11440		A	Exc face-mm b9+marg 0.5 < cm	1.05	2.31	1.35	0.10	3.46	2.50	010
11441		A	Exc face-mm b9+marg 0.6–1 cm	1.47	2.42	1.53	0.13	4.02	3.13	010
11442		A	Exc face-mm b9+marg 1.1–2 cm	1.71	2.62	1.60	0.17	4.50	3.48	010
11443		A	Exc face-mm b9+marg 2.1–3 cm	2.28	3.01	1.85	0.22	5.51	4.35	010
11444		A	Exc face-mm b9+marg 3.1–4 cm	3.12	3.58	2.21	0.30	7.00	5.63	010
11446		A	Exc face-mm b9+marg > 4 cm	4.46	4.16	2.82	0.36	8.98	7.64	010
11450		A	Removal, sweat gland lesion	2.71	5.20	2.06	0.31	8.22	5.08	090
11451		A	Removal, sweat gland lesion	3.93	6.84	2.59	0.47	11.24	6.99	090
11462		A	Removal, sweat gland lesion	2.50	5.29	2.04	0.28	8.07	4.82	090
11463		A	Removal, sweat gland lesion	3.93	7.08	2.73	0.48	11.49	7.14	090
11470		A	Removal, sweat gland lesion	3.23	5.23	2.30	0.36	8.82	5.89	090
11471		A	Removal, sweat gland lesion	4.38	6.96	2.82	0.48	11.82	7.68	090
11600		A	Exc tr-ext mlg+marg 0.5 < cm	1.30	2.70	0.99	0.11	4.11	2.40	010
11601		A	Exc tr-ext mlg+marg 0.6–1 cm	1.79	2.76	1.24	0.14	4.69	3.17	010
11602		A	Exc tr-ext mlg+marg 1.1–2 cm	1.94	2.90	1.29	0.16	5.00	3.39	010
11603		A	Exc tr-ext mlg+marg 2.1–3 cm	2.18	3.15	1.35	0.19	5.52	3.72	010
11604		A	Exc tr-ext mlg+marg 3.1–4 cm	2.39	3.46	1.42	0.22	6.07	4.03	010
11606		A	Exc tr-ext mlg+marg > 4 cm	3.41	4.16	1.77	0.34	7.91	5.52	010
11620		A	Exc h-f-nk-sp mlg+marg 0.5 <	1.18	2.66	0.97	0.11	3.95	2.26	010
11621		A	Exc h-f-nk-sp mlg+marg 0.6–1	1.75	2.77	1.26	0.14	4.66	3.15	010
11622		A	Exc h-f-nk-sp mlg+marg 1.1–2	2.08	3.04	1.41	0.18	5.30	3.67	010
11623		A	Exc h-f-nk-sp mlg+marg 2.1–3	2.60	3.41	1.61	0.24	6.25	4.45	010
11624		A	Exc h-f-nk-sp mlg+marg 3.1–4	3.04	3.83	1.80	0.30	7.17	5.14	010
11626		A	Exc h-f-nk-sp mlg+mar > 4 cm	4.28	4.74	2.43	0.42	9.44	7.13	010
11640		A	Exc face-mm malig+marg 0.5 <	1.34	2.73	1.13	0.12	4.19	2.59	010
11641		A	Exc face-mm malig+marg 0.6–1	2.15	3.10	1.55	0.18	5.43	3.88	010
11642		A	Exc face-mm malig+marg 1.1–2	2.58	3.48	1.75	0.22	6.28	4.55	010
11643		A	Exc face-mm malig+marg 2.1–3	3.08	3.89	1.98	0.29	7.26	5.35	010
11644		A	Exc face-mm malig+marg 3.1–4	4.01	4.79	2.49	0.40	9.20	6.90	010
11646		A	Exc face-mm mlg+marg > 4 cm	5.92	5.87	3.53	0.55	12.34	10.00	010
11719		R	Trim nail(s)	0.17	0.25	0.07	0.01	0.43	0.25	000
11720		A	Debride nail, 1–5	0.32	0.34	0.13	0.02	0.68	0.47	000
11721		A	Debride nail, 6 or more	0.54	0.44	0.21	0.05	1.03	0.80	000
11730		A	Removal of nail plate	1.12	1.03	0.44	0.11	2.26	1.67	000
11732		A	Remove nail plate, add-on	0.57	0.45	0.23	0.06	1.08	0.86	ZZZ
11740		A	Drain blood from under nail	0.37	0.86	0.14	0.04	1.27	0.55	000
11750		A	Removal of nail bed	1.85	2.15	1.75	0.19	4.19	3.79	010
11752		A	Remove nail bed/finger tip	2.65	2.99	2.99	0.40	6.04	6.04	010
11755		A	Biopsy, nail unit	1.30	1.10	0.56	0.07	2.47	1.93	000
11760		A	Repair of nail bed	1.57	1.86	1.23	0.20	3.63	3.00	010
11762		A	Reconstruction of nail bed	2.87	2.29	1.85	0.38	5.54	5.10	010
11765		A	Excision of nail fold, toe	0.69	1.16	0.53	0.06	1.91	1.28	010
11770		A	Removal of pilonidal lesion	2.60	3.58	1.53	0.29	6.47	4.42	010
11771		A	Removal of pilonidal lesion	5.71	5.79	3.36	0.67	12.17	9.74	090
11772		A	Removal of pilonidal lesion	6.94	7.27	3.90	0.82	15.03	11.66	090
11900		A	Injection into skin lesions	0.52	0.66	0.22	0.02	1.20	0.76	000
11901		A	Added skin lesions injection	0.80	0.67	0.36	0.04	1.51	1.20	000
11920		R	Correct skin color defects	1.60	2.01	0.78	0.20	3.81	2.58	000
11921		R	Correct skin color defects	1.92	2.38	0.98	0.25	4.55	3.15	000
11922		R	Correct skin color defects	0.49	0.38	0.25	0.06	0.93	0.80	ZZZ
11950		R	Therapy for contour defects	0.84	1.17	0.42	0.07	2.08	1.33	000
11951		R	Therapy for contour defects	1.18	1.51	0.52	0.12	2.81	1.82	000
11952		R	Therapy for contour defects	1.68	1.89	0.69	0.20	3.77	2.57	000
11954		R	Therapy for contour defects	1.84	2.46	0.91	0.23	4.53	2.98	000
11960		A	Insert tissue expander(s)	9.03	NA	10.65	1.05	NA	20.73	090
11970		A	Replace tissue expander	7.02	NA	6.16	0.92	NA	14.10	090
11971		A	Remove tissue expander(s)	2.12	7.20	4.81	0.25	9.57	7.18	090
11975		N	Insert contraceptive cap	+1.47	1.43	0.58	0.17	3.07	2.22	XXX
11976		R	Removal of contraceptive cap	1.77	1.72	0.69	0.20	3.69	2.66	000
11977		N	Removal/reinsert contra cap	+3.28	2.28	1.27	0.37	5.93	4.92	XXX
11980		A	Implant hormone pellet(s)	1.47	1.11	0.56	0.12	2.70	2.15	000
11981		A	Insert drug implant device	1.47	1.76	0.69	0.17	3.40	2.33	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
11982	.....	A	Remove drug implant device	1.77	1.99	0.85	0.20	3.96	2.82	XXX
11983	.....	A	Remove/insert drug implant	3.28	2.34	1.49	0.37	5.99	5.14	XXX
12001	.....	A	Repair superficial wound(s)	1.69	2.04	0.50	0.16	3.89	2.35	010
12002	.....	A	Repair superficial wound(s)	1.85	2.10	0.95	0.18	4.13	2.98	010
12004	.....	A	Repair superficial wound(s)	2.23	2.40	1.06	0.20	4.83	3.49	010
12005	.....	A	Repair superficial wound(s)	2.84	2.90	1.25	0.28	6.02	4.37	010
12006	.....	A	Repair superficial wound(s)	3.65	3.48	1.56	0.37	7.50	5.58	010
12007	.....	A	Repair superficial wound(s)	4.10	3.91	1.86	0.44	8.45	6.40	010
12011	.....	A	Repair superficial wound(s)	1.75	2.20	0.51	0.17	4.12	2.43	010
12013	.....	A	Repair superficial wound(s)	1.98	2.35	0.98	0.19	4.52	3.15	010
12014	.....	A	Repair superficial wound(s)	2.45	2.65	1.11	0.22	5.32	3.78	010
12015	.....	A	Repair superficial wound(s)	3.17	3.23	1.30	0.29	6.69	4.76	010
12016	.....	A	Repair superficial wound(s)	3.91	3.65	1.58	0.38	7.94	5.87	010
12017	.....	A	Repair superficial wound(s)	4.68	NA	1.93	0.47	NA	7.08	010
12018	.....	A	Repair superficial wound(s)	5.50	NA	2.30	0.55	NA	8.35	010
12020	.....	A	Closure of split wound	2.61	2.70	1.77	0.29	5.60	4.67	010
12021	.....	A	Closure of split wound	1.83	1.77	1.42	0.23	3.83	3.48	010
12031	.....	A	Layer closure of wound(s)	2.14	2.33	0.82	0.18	4.65	3.14	010
12032	.....	A	Layer closure of wound(s)	2.46	3.93	1.86	0.18	6.57	4.50	010
12034	.....	A	Layer closure of wound(s)	2.90	3.21	1.43	0.25	6.36	4.58	010
12035	.....	A	Layer closure of wound(s)	3.41	5.34	2.21	0.36	9.11	5.98	010
12036	.....	A	Layer closure of wound(s)	4.03	5.43	2.41	0.49	9.95	6.93	010
12037	.....	A	Layer closure of wound(s)	4.64	6.52	2.81	0.59	11.75	8.04	010
12041	.....	A	Layer closure of wound(s)	2.36	2.50	0.87	0.20	5.06	3.43	010
12042	.....	A	Layer closure of wound(s)	2.72	3.24	1.39	0.20	6.16	4.31	010
12044	.....	A	Layer closure of wound(s)	3.12	3.24	1.58	0.29	6.65	4.99	010
12045	.....	A	Layer closure of wound(s)	3.62	3.72	2.20	0.41	7.75	6.23	010
12046	.....	A	Layer closure of wound(s)	4.23	6.68	2.80	0.48	11.39	7.51	010
12047	.....	A	Layer closure of wound(s)	4.62	6.54	3.13	0.49	11.65	8.24	010
12051	.....	A	Layer closure of wound(s)	2.46	3.26	1.38	0.19	5.91	4.03	010
12052	.....	A	Layer closure of wound(s)	2.75	3.21	1.36	0.20	6.16	4.31	010
12053	.....	A	Layer closure of wound(s)	3.10	3.25	1.52	0.24	6.59	4.86	010
12054	.....	A	Layer closure of wound(s)	3.44	3.59	1.62	0.30	7.33	5.36	010
12055	.....	A	Layer closure of wound(s)	4.40	4.59	2.16	0.42	9.41	6.98	010
12056	.....	A	Layer closure of wound(s)	5.21	6.85	3.11	0.52	12.58	8.84	010
12057	.....	A	Layer closure of wound(s)	5.93	6.18	3.80	0.60	12.71	10.33	010
13100	.....	A	Repair of wound or lesion	3.10	3.55	1.80	0.25	6.90	5.15	010
13101	.....	A	Repair of wound or lesion	3.90	3.79	2.24	0.26	7.95	6.40	010
13102	.....	A	Repair wound/lesion add-on	1.23	0.74	0.58	0.12	2.09	1.93	ZZZ
13120	.....	A	Repair of wound or lesion	3.28	3.65	1.84	0.28	7.21	5.40	010
13121	.....	A	Repair of wound or lesion	4.31	4.01	2.34	0.30	8.62	6.95	010
13122	.....	A	Repair wound/lesion add-on	1.43	0.87	0.64	0.14	2.44	2.21	ZZZ
13131	.....	A	Repair of wound or lesion	3.77	3.92	2.16	0.30	7.99	6.23	010
13132	.....	A	Repair of wound or lesion	5.92	4.73	3.21	0.38	11.03	9.51	010
13133	.....	A	Repair wound/lesion add-on	2.18	1.21	1.04	0.20	3.59	3.42	ZZZ
13150	.....	A	Repair of wound or lesion	3.79	5.56	2.63	0.35	9.70	6.77	010
13151	.....	A	Repair of wound or lesion	4.42	5.46	3.07	0.34	10.22	7.83	010
13152	.....	A	Repair of wound or lesion	6.29	6.14	3.97	0.46	12.89	10.72	010
13153	.....	A	Repair wound/lesion add-on	2.37	1.36	1.15	0.22	3.95	3.74	ZZZ
13160	.....	A	Late closure of wound	10.42	NA	7.19	1.43	NA	19.04	090
14000	.....	A	Skin tissue rearrangement	5.86	8.61	5.18	0.55	15.02	11.59	090
14001	.....	A	Skin tissue rearrangement	8.42	10.06	6.66	0.78	19.26	15.86	090
14020	.....	A	Skin tissue rearrangement	6.55	9.27	6.05	0.60	16.42	13.20	090
14021	.....	A	Skin tissue rearrangement	10.00	10.56	7.82	0.83	21.39	18.65	090
14040	.....	A	Skin tissue rearrangement	7.83	8.35	6.94	0 66	16.84	15.43	090
14041	.....	A	Skin tissue rearrangement	11.42	10.76	8.78	0.85	23.03	21.05	090
14060	.....	A	Skin tissue rearrangement	8.45	9.18	7.77	0.71	18.34	16.93	090
14061	.....	A	Skin tissue rearrangement	12.22	11.79	9.62	0.90	24.91	22.74	090
14300	.....	A	Skin tissue rearrangement	11.69	11.31	9.27	1.05	24.05	22.01	090
14350	.....	A	Skin tissue rearrangement	9.56	NA	7.20	1.31	NA	18.07	090
15000	.....	A	Skin graft	3.98	3.85	2.22	0.44	8.27	6.64	000
15001	.....	A	Skin graft add-on	0.99	1.38	0.42	0.13	2.50	1.54	ZZZ
15050	.....	A	Skin pinch graft	4.28	6.03	4.78	0.55	10.86	9.61	090
15100	.....	A	Skin split graft	9.00	12.77	7.88	1.13	22.90	18.01	090
15101	.....	A	Skin split graft add-on	1.71	3.88	1.68	0.22	5.81	3.61	ZZZ
15120	.....	A	Skin split graft	9.77	10.90	7.86	1.08	21.75	18.71	090
15121	.....	A	Skin split graft add-on	2.65	4.63	1.90	0.32	7.60	4.87	ZZZ
15200	.....	A	Skin full graft	7.98	10.83	6.06	0.87	19.68	14.91	090
15201	.....	A	Skin full graft add-on	1.31	1.05	0.63	0.17	2.53	2.11	ZZZ
15220	.....	A	Skin full graft	7.83	10.71	6.51	0.82	19.36	15.16	090
15221	.....	A	Skin full graft add-on	1.18	0.91	0.58	0.14	2.23	1.90	ZZZ
15240	.....	A	Skin full graft	8.99	10.27	7.73	0.96	20.22	17.68	090
15241	.....	A	Skin full graft add-on	1.85	1.46	0.92	0.20	3.51	2.97	ZZZ
15260	.....	A	Skin full graft	10.00	9.98	8.70	0.76	20.74	19.46	090
15261	.....	A	Skin full graft add-on	2.22	2.75	1.44	0.20	5.17	3.86	ZZZ

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
15342		A	Cultured skin graft, 25 cm	0.99	1.84	0.56	0.11	2.94	1.66	010
15343		A	Culture skn graft addl 25 cm	0.25	0.27	0.10	0.02	0.54	0.37	ZZZ
15350		A	Skin homograft	3.98	8.31	4.88	0.50	12.79	9.36	090
15351		A	Skin homograft add-on	0.99	0.95	0.40	0.13	2.07	1.52	ZZZ
15400		A	Skin heterograft	3.98	4.21	4.13	0.48	8.67	8.59	090
15401		A	Skin heterograft add-on	0.99	1.23	0.45	0.13	2.35	1.57	ZZZ
15570		A	Form skin pedicle flap	9.16	9.27	6.74	1.15	19.58	17.05	090
15572		A	Form skin pedicle flap	9.22	8.48	6.32	1.11	18.81	16.65	090
15574		A	Form skin pedicle flap	9.82	8.89	7.02	1.10	19.81	17.94	090
15576		A	Form skin pedicle flap	8.64	9.51	6.49	0.86	19.01	15.99	090
15600		A	Skin graft	1.90	7.17	2.73	0.23	9.30	4.86	090
15610		A	Skin graft	2.41	3.78	3.07	0.30	6.49	5.78	090
15620		A	Skin graft	2.92	7.54	3.71	0.34	10.80	6.97	090
15630		A	Skin graft	3.25	6.92	3.98	0.34	10.51	7.57	090
15650		A	Transfer skin pedicle flap	3.95	6.79	4.06	0.43	11.17	8.44	090
15732		A	Muscle-skin graft, head/neck	17.74	18.24	12.34	1.80	37.78	31.88	090
15734		A	Muscle-skin graft, trunk	17.69	18.13	12.44	2.29	38.11	32.42	090
15736		A	Muscle-skin graft, arm	16.18	18.35	11.33	2.13	36.66	29.64	090
15738		A	Muscle-skin graft, leg	17.82	18.14	11.86	2.34	38.30	32.02	090
15740		A	Island pedicle flap graft	10.19	9.92	7.97	0.74	20.85	18.90	090
15750		A	Neurovascular pedicle graft	11.34	NA	9.09	1.39	NA	21.82	090
15756		A	Free myo/skin flap microvasc	35.03	NA	20.93	3.73	NA	59.69	090
15757		A	Free skin flap, microvasc	35.03	NA	21.96	4.04	NA	61.03	090
15758		A	Free fascial flap, microvasc	34.90	NA	21.95	4.22	NA	61.07	090
15760		A	Composite skin graft	8.69	9.82	7.09	0.86	19.37	16.64	090
15770		A	Derma-fat-fascia graft	7.48	NA	6.77	0.93	NA	15.18	090
15775		R	Hair transplant punch grafts	3.94	2.82	1.34	0.52	7.28	5.80	000
15776		R	Hair transplant punch grafts	5.51	5.44	2.85	0.72	11.67	9.08	000
15780		A	Abrasion treatment of skin	7.25	7.16	7.16	0.49	14.90	14.90	090
15781		A	Abrasion treatment of skin	4.82	5.41	5.41	0.32	10.55	10.55	090
15782		A	Abrasion treatment of skin	4.30	4.38	4.38	0.25	8.93	8.93	090
15783		A	Abrasion treatment of skin	4.27	4.98	4.22	0.31	9.56	8.80	090
15786		A	Abrasion, lesion, single	2.02	1.65	1.29	0.13	3.80	3.44	010
15787		A	Abrasion, lesions, add-on	0.33	0.32	0.16	0.02	0.67	0.51	ZZZ
15788		R	Chemical peel, face, epiderm	2.08	3.38	2.29	0.13	5.59	4.50	090
15789		R	Chemical peel, face, dermal	4.89	6.48	5.02	0.32	11.69	10.23	090
15792		R	Chemical peel, nonfacial	1.85	3.21	2.79	0.12	5.18	4.76	090
15793		A	Chemical peel, nonfacial	3.72	NA	4.20	0.20	NA	8.12	090
15810		A	Salabrasion	4.71	3.94	3.94	0.50	9.15	9.15	090
15811		A	Salabrasion	5.36	6.37	5.58	0.62	12.35	11.56	090
15819		A	Plastic surgery, neck	9.33	NA	7.28	0.92	NA	17.53	090
15820		A	Revision of lower eyelid	5.12	6.92	5.40	0.36	12.40	10.88	090
15821		A	Revision of lower eyelid	5.69	7.31	5.58	0.37	13.37	11.64	090
15822		A	Revision of upper eyelid	4.42	5.87	4.41	0.26	10.55	9.09	090
15823		A	Revision of upper eyelid	7.01	7.86	6.29	0.38	15.25	13.68	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
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
15831		A	Excise excessive skin tissue	12.33	NA	8.32	1.56	NA	22.21	090
15832		A	Excise excessive skin tissue	11.52	NA	8.46	1.45	NA	21.43	090
15833		A	Excise excessive skin tissue	10.58	NA	8.18	1.40	NA	20.16	090
15834		A	Excise excessive skin tissue	10.79	NA	7.75	1.41	NA	19.95	090
15835		A	Excise excessive skin tissue	11.60	11.58	7.71	1.35	24.53	20.66	090
15836		A	Excise excessive skin tissue	9.29	NA	6.88	1.14	NA	17.31	090
15837		A	Excise excessive skin tissue	8.38	8.01	7.08	0.93	17.32	16.39	090
15838		A	Excise excessive skin tissue	7.09	NA	6.15	0.70	NA	13.94	090
15839		A	Excise excessive skin tissue	9.33	7.95	6.27	1.05	18.33	16.65	090
15840		A	Graft for face nerve palsy	13.18	NA	10.15	1.38	NA	24.71	090
15841		A	Graft for face nerve palsy	23.13	NA	15.24	3.18	NA	41.55	090
15842		A	Flap for face nerve palsy	37.74	NA	23.29	4.78	NA	65.81	090
15845		A	Skin and muscle repair, face	12.50	NA	9.47	0.96	NA	22.93	090
15850		B	Removal of sutures	+0.78	1.61	0.30	0.05	2.44	1.13	XXX
15851		A	Removal of sutures	0.86	1.75	0.34	0.06	2.67	1.26	000
15852		A	Dressing change not for burn	0.86	1.88	0.36	0.08	2.82	1.30	000
15860		A	Test for blood flow in graft	1.94	1.29	0.79	0.16	3.39	2.89	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	7.90	NA	5.66	0.99	NA	14.55	090
15922		A	Removal of tail bone ulcer	9.84	NA	7.39	1.27	NA	18.50	090
15931		A	Remove sacrum pressure sore	9.19	NA	5.80	1.14	NA	16.13	090
15933		A	Remove sacrum pressure sore	10.79	NA	8.03	1.37	NA	20.19	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
15934		A	Remove sacrum pressure sore	12.62	NA	8.24	1.62	NA	22.48	090
15935		A	Remove sacrum pressure sore	14.49	NA	10.52	1.87	NA	26.88	090
15936		A	Remove sacrum pressure sore	12.31	NA	8.44	1.58	NA	22.33	090
15937		A	Remove sacrum pressure sore	14.13	NA	10.06	1.81	NA	26.00	090
15940		A	Remove hip pressure sore	9.29	NA	6.29	1.17	NA	16.75	090
15941		A	Remove hip pressure sore	11.36	NA	9.68	1.47	NA	22.51	090
15944		A	Remove hip pressure sore	11.39	NA	8.80	1.45	NA	21.64	090
15945		A	Remove hip pressure sore	12.62	NA	9.84	1.65	NA	24.11	090
15946		A	Remove hip pressure sore	21.45	NA	14.57	2.78	NA	38.80	090
15950		A	Remove thigh pressure sore	7.50	NA	5.52	0.96	NA	13.98	090
15951		A	Remove thigh pressure sore	10.66	NA	8.04	1.37	NA	20.07	090
15952		A	Remove thigh pressure sore	11.33	NA	7.91	1.43	NA	20.67	090
15953		A	Remove thigh pressure sore	12.56	NA	9.16	1.65	NA	23.37	090
15956		A	Remove thigh pressure sore	15.43	NA	10.95	1.97	NA	28.35	090
15958		A	Remove thigh pressure sore	15.39	NA	11.24	1.99	NA	28.62	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)	0.88	0.87	0.27	0.07	1.82	1.22	000
16010		A	Treatment of burn(s)	0.87	0.67	0.64	0.08	1.62	1.59	000
16015		A	Treatment of burn(s)	2.34	NA	1.17	0.26	NA	3.77	000
16020		A	Treatment of burn(s)	0.80	1.30	0.62	0.07	2.17	1.49	000
16025		A	Treatment of burn(s)	1.84	1.82	0.98	0.19	3.85	3.01	000
16030		A	Treatment of burn(s)	2.07	2.23	1.14	0.22	4.52	3.43	000
16035		A	Incision of burn scab, initi	3.73	NA	1.48	0.43	NA	5.64	090
16036		A	Escharotomy; addl incision	1.49	NA	0.61	0.13	NA	2.23	ZZZ
17000		A	Destroy benign/premlg lesion	0.60	0.99	0.32	0.04	1.63	0.96	010
17003		A	Destroy lesions, 2–14	0.15	0.11	0.07	0.01	0.27	0.23	ZZZ
17004		A	Destroy lesions, 15 or more	2.77	2.34	1.31	0.14	5.25	4.22	010
17106		A	Destruction of skin lesions	4.56	4.93	3.37	0.34	9.83	8.27	090
17107		A	Destruction of skin lesions	9.11	7.60	5.51	0.64	17.35	15.26	090
17108		A	Destruction of skin lesions	13.12	9.72	7.76	1.07	23.91	21.95	090
17110		A	Destruct lesion, 1–14	0.65	1.65	0.51	0.05	2.35	1.21	010
17111		A	Destruct lesion, 15 or more	0.91	1.71	0.61	0.05	2.67	1.57	010
17250		A	Chemical cautery, tissue	0.50	1.25	0.36	0.05	1.80	0.91	000
17260		A	Destruction of skin lesions	0.90	1.30	0.46	0.05	2.25	1.41	010
17261		A	Destruction of skin lesions	1.16	1.64	0.60	0.06	2.86	1.82	010
17262		A	Destruction of skin lesions	1.57	1.92	0.79	0.08	3.57	2.44	010
17263		A	Destruction of skin lesions	1.78	2.09	0.86	0.10	3.97	2.74	010
17264		A	Destruction of skin lesions	1.93	2.26	0.89	0.10	4.29	2.92	010
17266		A	Destruction of skin lesions	2.33	2.55	1.00	0.13	5.01	3.46	010
17270		A	Destruction of skin lesions	1.31	1.74	0.64	0.07	3.12	2.02	010
17271		A	Destruction of skin lesions	1.48	1.81	0.75	0.07	3.36	2.30	010
17272		A	Destruction of skin lesions	1.76	2.02	0.88	0.08	3.86	2.72	010
17273		A	Destruction of skin lesions	2.04	2.24	0.99	0.11	4.39	3.14	010
17274		A	Destruction of skin lesions	2.58	2.60	1.22	0.13	5.31	3.93	010
17276		A	Destruction of skin lesions	3.18	3.00	1.46	0.18	6.36	4.82	010
17280		A	Destruction of skin lesions	1.16	1.64	0.58	0.06	2.86	1.80	010
17281		A	Destruction of skin lesions	1.71	1.93	0.86	0.08	3.72	2.65	010
17282		A	Destruction of skin lesions	2.03	2.19	1.02	0.11	4.33	3.16	010
17283		A	Destruction of skin lesions	2.62	2.59	1.27	0.13	5.34	4.02	010
17284		A	Destruction of skin lesions	3.19	2.98	1.53	0.17	6.34	4.89	010
17286		A	Destruction of skin lesions	4.41	3.75	2.21	0.26	8.42	6.88	010
17304		A	1 stage mohs, up to 5 spec	7.56	8.19	3.61	0.37	16.12	11.54	000
17305		A	2 stage mohs, up to 5 spec	2.83	3.86	1.36	0.14	6.83	4.33	000
17306		A	3 stage mohs, up to 5 spec	2.83	3.88	1.37	0.14	6.85	4.34	000
17307		A	Mohs addl stage up to 5 spec	2.83	3.82	1.38	0.14	6.79	4.35	000
17310		A	Mohs any stage > 5 spec each	0.62	1.50	0.31	0.06	2.18	0.99	ZZZ
17340		A	Cryotherapy of skin	0.76	0.38	0.31	0.05	1.19	1.12	010
17360		A	Skin peel therapy	1.42	1.48	0.75	0.07	2.97	2.24	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	2.05	0.36	0.08	2.97	1.28	000
19001		A	Drain breast lesion add-on	0.42	0.80	0.14	0.04	1.26	0.60	ZZZ
19020		A	Incision of breast lesion	3.55	6.08	2.81	0.42	10.05	6.78	090
19030		A	Injection for breast x-ray	1.52	3.37	0.51	0.08	4.97	2.11	000
19100		A	Bx breast percut w/o image	1.26	2.17	0.43	0.12	3.55	1.81	000
19101		A	Biopsy of breast, open	3.16	4.72	1.70	0.24	8.12	5.10	010
19102		A	Bx breast percut w/image	1.99	4.01	0.66	0.16	6.16	2.81	000
19103		A	Bx breast percut w/device	3.68	12.14	1.25	0.19	16.01	5.12	000
19110		A	Nipple exploration	4.28	5.90	3.10	0.53	10.71	7.91	090
19112		A	Excise breast duct fistula	3.65	5.93	2.72	0.46	10.04	6.83	090
19120		A	Removal of breast lesion	5.53	4.63	3.11	0.67	10.83	9.31	090
19125		A	Excision, breast lesion	6.03	4.89	3.33	0.73	11.65	10.09	090
19126		A	Excision, addl breast lesion	2.91	NA	1.01	0.36	NA	4.28	ZZZ
19140		A	Removal of breast tissue	5.11	7.37	3.46	0.62	13.10	9.19	090
19160		A	Removal of breast tissue	5.96	NA	3.49	0.73	NA	10.18	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
19162	.....	A	Remove breast tissue, nodes	13.45	NA	6.45	1.65	NA	21.55	090
19180	.....	A	Removal of breast	8.75	NA	5.13	1.05	NA	14.93	090
19182	.....	A	Removal of breast	7.69	NA	4.85	0.95	NA	13.49	090
19200	.....	A	Removal of breast	15.40	NA	8.12	1.81	NA	25.33	090
19220	.....	A	Removal of breast	15.63	NA	8.38	1.87	NA	25.88	090
19240	.....	A	Removal of breast	15.91	NA	8.37	1.94	NA	26.22	090
19260	.....	A	Removal of chest wall lesion	15.35	NA	11.13	1.97	NA	28.45	090
19271	.....	A	Revision of chest wall	18.79	NA	17.58	2.72	NA	39.09	090
19272	.....	A	Extensive chest wall surgery	21.43	NA	18.37	3.04	NA	42.84	090
19290	.....	A	Place needle wire, breast	1.26	3.02	0.43	0.07	4.35	1.76	000
19291	.....	A	Place needle wire, breast	0.63	1.75	0.21	0.04	2.42	0.88	ZZZ
19295	.....	A	Place breast clip, percut	0.00	2.81	NA	0.01	2.82	NA	ZZZ
19316	.....	A	Suspension of breast	10.63	NA	7.67	1.38	NA	19.68	090
19318	.....	A	Reduction of large breast	15.53	NA	11.32	2.03	NA	28.88	090
19324	.....	A	Enlarge breast	5.82	NA	4.98	0.76	NA	11.56	090
19325	.....	A	Enlarge breast with implant	8.40	NA	6.67	1.08	NA	16.15	090
19328	.....	A	Removal of breast implant	5.65	NA	5.13	0.73	NA	11.51	090
19330	.....	A	Removal of implant material	7.55	NA	6.13	0.97	NA	14.65	090
19340	.....	A	Immediate breast prosthesis	6.29	NA	3.16	0.82	NA	10.27	ZZZ
19342	.....	A	Delayed breast prosthesis	11.14	NA	9.07	1.45	NA	21.66	090
19350	.....	A	Breast reconstruction	8.87	14.35	7.19	1.14	24.36	17.20	090
19355	.....	A	Correct inverted nipple(s)	7.53	12.94	5.07	0.96	21.43	13.56	090
19357	.....	A	Breast reconstruction	18.06	NA	14.01	2.35	NA	34.42	090
19361	.....	A	Breast reconstruction	19.15	NA	11.91	2.49	NA	33.55	090
19364	.....	A	Breast reconstruction	40.77	NA	23.88	4.69	NA	69.34	090
19366	.....	A	Breast reconstruction	21.16	NA	11.35	2.72	NA	35.23	090
19367	.....	A	Breast reconstruction	25.58	NA	16.74	3.33	NA	45.65	090
19368	.....	A	Breast reconstruction	32.24	NA	20.48	4.21	NA	56.93	090
19369	.....	A	Breast reconstruction	29.65	NA	19.99	3.88	NA	53.52	090
19370	.....	A	Surgery of breast capsule	8.00	NA	7.03	1.03	NA	16.06	090
19371	.....	A	Removal of breast capsule	9.30	NA	7.96	1.21	NA	18.47	090
19380	.....	A	Revise breast reconstruction	9.09	NA	7.84	1.17	NA	18.10	090
19396	.....	A	Design custom breast implant	2.16	5.84	1.00	0.28	8.28	3.44	000
19499	.....	C	Breast surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
20000	.....	A	Incision of abscess	2.11	2.38	1.63	0.20	4.69	3.94	010
20005	.....	A	Incision of deep abscess	3.40	3.37	2.14	0.41	7.18	5.95	010
20100	.....	A	Explore wound, neck	10.02	5.86	4.42	1.19	17.07	15.63	010
20101	.....	A	Explore wound, chest	3.20	2.99	1.61	0.29	6.48	5.10	010
20102	.....	A	Explore wound, abdomen	3.92	3.56	1.82	0.42	7.90	6.16	010
20103	.....	A	Explore wound, extremity	5.27	4.19	3.25	0.68	10.14	9.20	010
20150	.....	A	Excise epiphyseal bar	13.61	NA	7.30	1.15	NA	22.06	090
20200	.....	A	Muscle biopsy	1.45	3.17	0.79	0.20	4.82	2.44	000
20205	.....	A	Deep muscle biopsy	2.34	4.19	1.22	0.28	6.81	3.84	000
20206	.....	A	Needle biopsy, muscle	0.98	3.21	0.35	0.07	4.26	1.40	000
20220	.....	A	Bone biopsy, trocar/needle	1.26	4.80	2.82	0.07	6.13	4.15	000
20225	.....	A	Bone biopsy, trocar/needle	1.86	4.38	2.99	0.13	6.37	4.98	000
20240	.....	A	Bone biopsy, excisional	3.21	NA	2.54	0.40	NA	6.15	010
20245	.....	A	Bone biopsy, excisional	7.74	NA	6.33	0.53	NA	14.60	010
20250	.....	A	Open bone biopsy	5.00	NA	4.59	0.60	NA	10.19	010
20251	.....	A	Open bone biopsy	5.53	NA	5.24	0.95	NA	11.72	010
20500	.....	A	Injection of sinus tract	1.22	6.00	3.94	0.12	7.34	5.28	010
20501	.....	A	Inject sinus tract for x-ray	0.76	3.02	0.25	0.04	3.82	1.05	000
20520	.....	A	Removal of foreign body	1.84	2.28	1.83	0.20	4.32	3.87	010
20525	.....	A	Removal of foreign body	3.48	3.43	2.69	0.48	7.39	6.65	010
20526	.....	A	Ther injection, carp tunnel	0.93	0.97	0.52	0.07	1.97	1.52	000
20550	.....	A	Inj tendon sheath/ligament	0.75	0.72	0.24	0.07	1.54	1.06	000
20551	.....	A	Inj tendon origin/insertion	0.75	0.69	0.34	0.07	1.51	1.16	000
20552	.....	A	Inj trigger point, 1/2 muscl	0.66	0.74	0.21	0.07	1.47	0.94	000
20553	.....	A	Inject trigger points, =/> 3	0.75	0.85	0.23	0.07	1.67	1.05	000
20600	.....	A	Drain/inject, joint/bursa	0.66	0.65	0.36	0.07	1.38	1.09	000
20605	.....	A	Drain/inject, joint/bursa	0.68	0.76	0.37	0.07	1.51	1.12	000
20610	.....	A	Drain/inject, joint/bursa	0.79	0.95	0.43	0.10	1.84	1.32	000
20612	.....	A	Aspirate/inj ganglion cyst	0.70	0.72	0.34	0.07	1.49	1.11	000
20615	.....	A	Treatment of bone cyst	2.27	2.57	1.85	0.23	5.07	4.35	010
20650	.....	A	Insert and remove bone pin	2.22	2.44	1.96	0.34	5.00	4.52	010
20660	.....	A	Apply, rem fixation device	2.50	3.11	1.72	0.58	6.19	4.80	000
20661	.....	A	Application of head brace	4.86	NA	5.03	1.10	NA	10.99	090
20662	.....	A	Application of pelvis brace	6.04	NA	5.51	0.97	NA	12.52	090
20663	.....	A	Application of thigh brace	5.40	NA	4.82	0.92	NA	11.14	090
20664	.....	A	Halo brace application	8.01	NA	7.12	1.79	NA	16.92	090
20665	.....	A	Removal of fixation device	1.30	2.09	1.33	0.20	3.59	2.83	010
20670	.....	A	Removal of support implant	1.73	6.77	3.95	0.28	8.78	5.96	010
20680	.....	A	Removal of support implant	3.33	3.24	3.24	0.55	7.12	7.12	090
20690	.....	A	Apply bone fixation device	3.50	NA	2.49	0.56	NA	6.55	090
20692	.....	A	Apply bone fixation device	6.37	NA	3.78	0.72	NA	10.87	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
20693	.....	A	Adjust bone fixation device	5.83	NA	5.59	1.02	NA	12.44	090
20694	.....	A	Remove bone fixation device	4.14	6.94	4.53	0.68	11.76	9.35	090
20802	.....	A	Replantation, arm, complete	40.92	NA	21.66	6.96	NA	69.54	090
20805	.....	A	Replant forearm, complete	49.72	NA	35.31	4.73	NA	89.76	090
20808	.....	A	Replantation hand, complete	61.30	NA	43.88	7.78	NA	112.96	090
20816	.....	A	Replantation digit, complete	30.76	NA	39.66	3.61	NA	74.03	090
20822	.....	A	Replantation digit, complete	25.44	NA	36.34	3.68	NA	65.46	090
20824	.....	A	Replantation thumb, complete	30.76	NA	38.52	4.17	NA	73.45	090
20827	.....	A	Replantation thumb, complete	26.26	NA	38.35	3.85	NA	68.46	090
20838	.....	A	Replantation foot, complete	41.17	NA	22.95	7.01	NA	71.13	090
20900	.....	A	Removal of bone for graft	5.55	7.42	5.85	0.92	13.89	12.32	090
20902	.....	A	Removal of bone for graft	7.51	NA	6.94	1.27	NA	15.72	090
20910	.....	A	Remove cartilage for graft	5.31	7.21	5.49	0.60	13.12	11.40	090
20912	.....	A	Remove cartilage for graft	6.31	NA	6.15	0.66	NA	13.12	090
20920	.....	A	Removal of fascia for graft	5.28	NA	4.45	0.65	NA	10.38	090
20922	.....	A	Removal of fascia for graft	6.57	6.83	5.13	1.05	14.45	12.75	090
20924	.....	A	Removal of tendon for graft	6.44	NA	5.98	0.98	NA	13.40	090
20926	.....	A	Removal of tissue for graft	5.50	NA	4.99	0.87	NA	11.36	090
20930	.....	B	Spinal bone allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20931	.....	A	Spinal bone allograft	1.80	NA	0.94	0.41	NA	3.15	ZZZ
20936	.....	B	Spinal bone autograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20937	.....	A	Spinal bone autograft	2.77	NA	1.47	0.52	NA	4.76	ZZZ
20938	.....	A	Spinal bone autograft	3.00	NA	1.58	0.62	NA	5.20	ZZZ
20950	.....	A	Fluid pressure, muscle	1.25	1.38	1.01	0.19	2.82	2.45	000
20955	.....	A	Fibula bone graft, microvasc	38.99	NA	25.26	5.21	NA	69.46	090
20956	.....	A	Iliac bone graft, microvasc	39.05	NA	25.12	6.92	NA	71.09	090
20957	.....	A	Mt bone graft, microvasc	40.42	NA	19.28	6.88	NA	66.58	090
20962	.....	A	Other bone graft, microvasc	39.05	NA	26.68	6.22	NA	71.95	090
20969	.....	A	Bone/skin graft, microvasc	43.67	NA	27.76	5.20	NA	76.63	090
20970	.....	A	Bone/skin graft, iliac crest	42.81	NA	26.14	5.56	NA	74.51	090
20972	.....	A	Bone/skin graft. metatarsal	42.74	22.01	20.35	7.28	72.03	70.37	090
20973	.....	A	Bone/skin graft, great toe	45.50	NA	25.54	5.57	NA	76.61	090
20974	.....	A	Electrical bone stimulation	0 62	0.63	0.56	0.11	1.36	1.29	000
20975	.....	A	Electrical bone stimulation	2.59	NA	1.75	0.50	NA	4.84	000
20979	.....	A	Us bone stimulation	0.62	0.78	0.34	0.05	1.45	1.01	000
20982	.....	A	Ablate, bone tumor(s) perq	7.24	106.25	3.02	0.68	114.17	10.94	000
20999	.....	C	Musculoskeletal surgery	0.00	0 00	0.00	0.00	0.00	0.00	YYY
21010	.....	A	Incision of jaw joint	10.08	NA	7.33	0.65	NA	18.06	090
21015	.....	A	Resection of facial tumor	5.26	NA	5.59	0.62	NA	11.47	090
21025	.....	A	Excision of bone, lower jaw	10.00	10.33	8.32	0.95	21.28	19.27	090
21026	.....	A	Excision of facial bone(s)	4.82	7.03	5.59	0.48	12.33	10.89	090
21029	.....	A	Contour of face bone lesion	7.67	8.70	6.33	0.89	17.26	14.89	090
21030	.....	A	Excise max/zygoma b9 tumor	3.87	6.57	4.05	0.72	11.16	8.64	090
21031	.....	A	Remove exostosis, mandible	3.22	4.64	3.18	0.34	8.20	6.74	090
21032	.....	A	Remove exostosis, maxilla	3.22	4.68	3.29	0.32	8.22	6.83	090
21034	.....	A	Excise max/zygoma mlg tumor	16.08	13.73	11.44	1.64	31.45	29.16	090
21040	.....	A	Excise mandible lesion	3.87	6.61	3.88	0.23	10.71	7.98	090
21044	.....	A	Removal of jaw bone lesion	11.79	NA	8.80	1.04	NA	21.63	090
21045	.....	A	Extensive jaw surgery	16.08	NA	11.56	1.44	NA	29.08	090
21046	.....	A	Remove mandible cyst complex	12.93	NA	12.85	1.21	NA	26.99	090
21047	.....	A	Excise lwr jaw cyst w/repair	18.64	NA	13.60	1.83	NA	34.07	090
21048	.....	A	Remove maxilla cyst complex	13.42	NA	13.13	1.21	NA	27.76	090
21049	.....	A	Excis uppr jaw cyst w/repair	17.90	NA	13.19	1.21	NA	32.30	090
21050	.....	A	Removal of jaw joint	10.71	NA	10.40	1.01	NA	22.12	090
21060	.....	A	Remove jaw joint cartilage	10.17	NA	9.92	1.39	NA	21.48	090
21070	.....	A	Remove coronoid process	8.15	NA	7.11	0.80	NA	16.06	090
21076	.....	A	Prepare face/oral prosthesis	13.34	12.86	10.30	1.63	27.83	25.27	010
21077	.....	A	Prepare face/oral prosthesis	33.56	32.61	26.51	4.11	70.28	64.18	090
21079	.....	A	Prepare face/oral prosthesis	22.21	22.50	17.70	1.91	46.62	41.82	090
21080	.....	A	Prepare face/oral prosthesis	24.96	25.54	20.02	3.06	53.56	48.04	090
21081	.....	A	Prepare face/oral prosthesis	22.75	23.24	18.01	2.24	48.23	43.00	090
21082	.....	A	Prepare face/oral prosthesis	20.75	20.13	16.18	1.75	42.63	38.68	090
21083	.....	A	Prepare face/oral prosthesis	19.19	19.60	14.91	2.35	41.14	36.45	090
21084	.....	A	Prepare face/oral prosthesis	22.38	22.97	17.87	1.88	47.23	42.13	090
21085	.....	A	Prepare face/oral prosthesis	8.95	8.62	6.97	0.78	18.35	16.70	010
21086	.....	A	Prepare face/oral prosthesis	24.78	24.61	19.86	2.23	51.62	46.87	090
21087	.....	A	Prepare face/oral prosthesis	24.78	24.19	19.66	2.66	51.63	47.10	090
21088	.....	C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	090
21089	.....	C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	090
21100	.....	A	Maxillofacial fixation	4.20	5.71	4.68	0.22	10.13	9.10	090
21110	.....	A	Interdental fixation	5.18	7.10	5.74	0.34	12.62	11.26	090
21116	.....	A	Injection, jaw joint x-ray	0.81	7.40	0.34	0.06	8.27	1.21	000
21120	.....	A	Reconstruction of chin	4.90	8.97	5.36	0.35	14.22	10.61	090
21121	.....	A	Reconstruction of chin	7.60	10.56	6.73	0.67	18.83	15.00	090
21122	.....	A	Reconstruction of chin	8.47	NA	7.16	0.71	NA	16.34	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
21123		A	Reconstruction of chin	11.10	NA	8.36	1.39	NA	20.85	090
21125		A	Augmentation, lower jaw bone	10.56	11.94	8.38	0.86	23.36	19.80	090
21127		A	Augmentation, lower jaw bone	11.06	14.70	9.23	0.91	26.67	21.20	090
21137		A	Reduction of forehead	9.76	NA	7.52	0.64	NA	17.92	090
21138		A	Reduction of forehead	12.12	NA	9.41	1.76	NA	23.29	090
21139		A	Reduction of forehead	14.53	NA	9.88	1.22	NA	25.63	090
21141		A	Reconstruct midface, lefort	18.00	NA	14.06	1.95	NA	34.01	090
21142		A	Reconstruct midface, lefort	18.70	NA	13.25	1.39	NA	33.34	090
21143		A	Reconstruct midface, lefort	19.47	NA	14.29	1.08	NA	34.84	090
21145		A	Reconstruct midface, lefort	19.83	NA	14.33	2.51	NA	36.67	090
21146		A	Reconstruct midface, lefort	20.59	NA	15.80	2.55	NA	38.94	090
21147		A	Reconstruct midface, lefort	21.65	NA	15.47	1.82	NA	38.94	090
21150		A	Reconstruct midface, lefort	25.10	NA	14.27	1.31	NA	40.68	090
21151		A	Reconstruct midface, lefort	28.14	NA	18.00	2.37	NA	48.51	090
21154		A	Reconstruct midface, lefort	30.35	NA	20.41	5.83	NA	56.59	090
21155		A	Reconstruct midface, lefort	34.25	NA	22.55	6.57	NA	63.37	090
21159		A	Reconstruct midface, lefort	42.14	NA	24.74	8.08	NA	74.96	090
21160		A	Reconstruct midface, lefort	46.18	NA	24.69	5.26	NA	76.13	090
21172		A	Reconstruct orbit/forehead	27.64	NA	14.22	2.29	NA	44.15	090
21175		A	Reconstruct orbit/forehead	32.98	NA	18.51	6.18	NA	57.67	090
21179		A	Reconstruct entire forehead	22.12	NA	15.02	2.97	NA	40.11	090
21180		A	Reconstruct entire forehead	25.05	NA	16.24	2.58	NA	43.87	090
21181		A	Contour cranial bone lesion	9.84	NA	7.61	1.16	NA	18.61	090
21182		A	Reconstruct cranial bone	32.01	NA	19.87	3.03	NA	54.91	090
21183		A	Reconstruct cranial bone	35.11	NA	21.59	3.30	NA	60.00	090
21184		A	Reconstruct cranial bone	38.02	NA	22.79	4.94	NA	65.75	090
21188		A	Reconstruction of midface	22.33	NA	15.34	2.22	NA	39.89	090
21193		A	Reconst lwr jaw w/o graft	17.05	NA	13.13	1.83	NA	32.01	090
21194		A	Reconst lwr jaw w/graft	19.73	NA	14.25	1.67	NA	35.65	090
21195		A	Reconst lwr jaw w/o fixation	17.14	NA	13.43	1.44	NA	32.01	090
21196		A	Reconst lwr jaw w/fixation	18.80	NA	14.05	1.94	NA	34.79	090
21198		A	Reconstr lwr jaw segment	14.08	NA	11.03	1.26	NA	26.37	090
21199		A	Reconstr lwr jaw w/advance	15.91	NA	9.29	1.51	NA	26.71	090
21206		A	Reconstruct upper jaw bone	14.02	NA	10.95	1.21	NA	26.18	090
21208		A	Augmentation of facial bones	10.17	14.68	9.39	1.10	25.95	20.66	090
21209		A	Reduction of facial bones	6.68	12.02	7.32	0.72	19.42	14.72	090
21210		A	Face bone graft	10.17	13.85	9.53	1.05	25.07	20.75	090
21215		A	Lower jaw bone graft	10.71	13.65	9.72	1.25	25.61	21.68	090
21230		A	Rib cartilage graft	10.71	NA	8.66	1.15	NA	20.52	090
21235		A	Ear cartilage graft	6.68	11.49	7.17	0.62	18.79	14.47	090
21240		A	Reconstruction of jaw joint	13.97	NA	12.87	1.38	NA	28.22	090
21242		A	Reconstruction of jaw joint	12.88	NA	12.35	1.68	NA	26.91	090
21243		A	Reconstruction of jaw joint	20.67	NA	18.10	2.22	NA	40.99	090
21244		A	Reconstruction of lower jaw	11.79	NA	10.17	1.14	NA	23.10	090
21245		A	Reconstruction of jaw	11.79	16.29	9.83	1.05	29.13	22.67	090
21246		A	Reconstruction of jaw	12.40	14.73	9.96	1.45	28.58	23.81	090
21247		A	Reconstruct lower jaw bone	22.50	NA	18.15	2.65	NA	43.30	090
21248		A	Reconstruction of jaw	11.41	13.18	9.42	1.21	25.80	22.04	090
21249		A	Reconstruction of jaw	17.42	16.78	12.81	1.67	35.87	31.90	090
21255		A	Reconstruct lower jaw bone	16.62	NA	12.90	1.35	NA	30.87	090
21256		A	Reconstruction of orbit	16.10	NA	12.29	1.25	NA	29.64	090
21260		A	Revise eye sockets	16.43	NA	9.04	1.50	NA	26.97	090
21261		A	Revise eye sockets	31.31	NA	19.43	2.64	NA	53.38	090
21263		A	Revise eye sockets	28.26	NA	13.03	2.59	NA	43.88	090
21267		A	Revise eye sockets	18.79	NA	13.35	1.62	NA	33.76	090
21268		A	Revise eye sockets	24.34	NA	15.50	0.95	NA	40.79	090
21270		A	Augmentation, cheek bone	10.17	12.06	8.19	0.87	23.10	19.23	090
21275		A	Revision, orbitofacial bones	11.18	NA	8.84	1.23	NA	21.25	090
21280		A	Revision of eyelid	6.00	NA	6.13	0.32	NA	12.45	090
21282		A	Revision of eyelid	3.47	NA	4.72	0.25	NA	8.44	090
21295		A	Revision of jaw muscle/bone	1.52	NA	2.86	0.16	NA	4.54	090
21296		A	Revision of jaw muscle/bone	4.23	NA	4.49	0.36	NA	9.08	090
21299		C	Cranio/maxillofacial surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21300		A	Treatment of skull fracture	0.72	2.43	0.26	0.11	3.26	1.09	000
21310		A	Treatment of nose fracture	0.58	2.38	0.15	0.06	3.02	0.79	000
21315		A	Treatment of nose fracture	1.50	3.08	1.29	0.14	4.72	2.93	010
21320		A	Treatment of nose fracture	1.84	4.30	1.86	0.18	6.32	3.88	010
21325		A	Treatment of nose fracture	3.75	NA	3.80	0.37	NA	7.92	090
21330		A	Treatment of nose fracture	5.35	NA	5.34	0.58	NA	11.27	090
21335		A	Treatment of nose fracture	8.56	NA	6.88	0.77	NA	16.21	090
21336		A	Treat nasal septal fracture	5.69	NA	6.14	0.54	NA	12.37	090
21337		A	Treat nasal septal fracture	2.68	5.17	3.73	0.26	8.11	6.67	090
21338		A	Treat nasoethmoid fracture	6.42	NA	6.04	0.64	NA	13.10	090
21339		A	Treat nasoethmoid fracture	8.04	NA	6.83	0.91	NA	15.78	090
21340		A	Treatment of nose fracture	10.71	NA	8.80	1.02	NA	20.53	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
21343		A	Treatment of sinus fracture	12.88	NA	10.26	1.27	NA	24.41	090
21344		A	Treatment of sinus fracture	19.61	NA	13.85	2.06	NA	35.52	090
21345		A	Treat nose/jaw fracture	8.11	11.68	8.00	0.72	20.51	16.83	090
21346		A	Treat nose/jaw fracture	10.55	13.35	9.12	1.02	24.92	20.69	090
21347		A	Treat nose/jaw fracture	12.62	NA	9.87	1.37	NA	23.86	090
21348		A	Treat nose/jaw fracture	16.59	NA	11.44	1.80	NA	29.83	090
21355		A	Treat cheek bone fracture	3.75	4.76	2.40	0.35	8.86	6.50	010
21356		A	Treat cheek bone fracture	4.13	11.83	3.25	0.43	16.39	7.81	010
21360		A	Treat cheek bone fracture	6.42	14.06	6.26	0.62	21.10	13.30	090
21365		A	Treat cheek bone fracture	14.86	NA	11.91	1.56	NA	28.33	090
21366		A	Treat cheek bone fracture	17.67	NA	11.78	1.69	NA	31.14	090
21385		A	Treat eye socket fracture	9.11	NA	7.14	0.77	NA	17.02	090
21386		A	Treat eye socket fracture	9.11	NA	7.56	0.91	NA	17.58	090
21387		A	Treat eye socket fracture	9.64	NA	7.62	0.93	NA	18.19	090
21390		A	Treat eye socket fracture	10.07	NA	8.11	0.84	NA	19.02	090
21395		A	Treat eye socket fracture	12.61	NA	9.43	1.31	NA	23.35	090
21400		A	Treat eye socket fracture	1.39	3.77	2.14	0.14	5.30	3.67	090
21401		A	Treat eye socket fracture	3.24	5.15	3.91	0.41	8.80	7.56	090
21406		A	Treat eye socket fracture	6.97	NA	6.42	0.71	NA	14.10	090
21407		A	Treat eye socket fracture	8.56	NA	7.22	0.80	NA	16.58	090
21408		A	Treat eye socket fracture	12.31	NA	9.31	1.49	NA	23.11	090
21421		A	Treat mouth roof fracture	5.11	10.04	6.23	0.50	15.65	11.84	090
21422		A	Treat mouth roof fracture	8.27	11.42	7.18	0.83	20.52	16.28	090
21423		A	Treat mouth roof fracture	10.34	NA	8.58	1.14	NA	20.06	090
21431		A	Treat craniofacial fracture	7.01	10.79	6.93	0.70	18.50	14.64	090
21432		A	Treat craniofacial fracture	8.56	NA	6.24	0.66	NA	15.46	090
21433		A	Treat craniofacial fracture	25.21	NA	17.03	2.95	NA	45.19	090
21435		A	Treat craniofacial fracture	17.15	NA	13.11	1.99	NA	32.25	090
21436		A	Treat craniofacial fracture	27.88	NA	18.63	2.78	NA	49.29	090
21440		A	Treat dental ridge fracture	2.68	8.15	4.17	0.26	11.09	7.11	090
21445		A	Treat dental ridge fracture	5.35	10.58	6.36	0.66	16.59	12.37	090
21450		A	Treat lower jaw fracture	2.95	10.78	3.82	0.28	14.01	7.05	090
21451		A	Treat lower jaw fracture	4.84	8.88	5.83	0.47	14.19	11.14	090
21452		A	Treat lower jaw fracture	1.97	7.96	3.61	0.17	10.10	5.75	090
21453		A	Treat lower jaw fracture	5.51	10.64	6.92	0.59	16.74	13.02	090
21454		A	Treat lower jaw fracture	6.42	NA	6.63	0.66	NA	13.71	090
21461		A	Treat lower jaw fracture	8.04	12.68	8.39	0.87	21.59	17.30	090
21462		A	Treat lower jaw fracture	9.73	14.24	9.13	0.96	24.93	19.82	090
21465		A	Treat lower jaw fracture	11.84	NA	10.17	1.01	NA	23.02	090
21470		A	Treat lower jaw fracture	15.25	NA	12.39	1.63	NA	29.27	090
21480		A	Reset dislocated jaw	0.61	1.98	0.19	0.06	2.65	0.86	000
21485		A	Reset dislocated jaw	3.97	6.01	4.86	0.37	10.35	9.20	090
21490		A	Repair dislocated jaw	11.79	NA	10.02	1.57	NA	23.38	090
21493		A	Treat hyoid bone fracture	1.26	NA	2.89	0.12	NA	4.27	090
21494		A	Treat hyoid bone fracture	6.24	NA	5.78	0.53	NA	12.55	090
21495		A	Treat hyoid bone fracture	5.66	NA	6.05	0.49	NA	12.20	090
21497		A	Interdental wiring	3.84	6.62	5.08	0.37	10.83	9.29	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	3.79	4.74	3.92	0.43	8.96	8.14	090
21502		A	Drain chest lesion	7.08	NA	5.63	0.95	NA	13.66	090
21510		A	Drainage of bone lesion	5.71	NA	5.62	0.80	NA	12.13	090
21550		A	Biopsy of neck/chest	2.05	3.68	1.75	0.16	5.89	3.96	010
21555		A	Remove lesion, neck/chest	4.33	5.12	3.20	0.49	9.94	8.02	090
21556		A	Remove lesion, neck/chest	5.54	NA	4.15	0.61	NA	10.30	090
21557		A	Remove tumor, neck/chest	8.83	NA	5.48	1.02	NA	15.33	090
21600		A	Partial removal of rib	6.85	NA	5.71	0.97	NA	13.53	090
21610		A	Partial removal of rib	14.53	NA	9.16	2.22	NA	25.91	090
21615		A	Removal of rib	9.81	NA	6.61	1.44	NA	17.86	090
21616		A	Removal of rib and nerves	11.97	NA	7.98	1.57	NA	21.52	090
21620		A	Partial removal of sternum	6.75	NA	5.98	0.92	NA	13.65	090
21627		A	Sternal debridement	6.77	NA	6.29	0.98	NA	14.04	090
21630		A	Extensive sternum surgery	17.28	NA	11.99	2.34	NA	31.61	090
21632		A	Extensive sternum surgery	18.04	NA	10.79	2.59	NA	31.42	090
21685		A	Hyoid myotomy & suspension	12.93	NA	10.21	1.51	NA	24.65	090
21700		A	Revision of neck muscle	6.15	6.14	4.82	0.37	12.66	11.34	090
21705		A	Revision of neck muscle/rib	9.55	NA	5.68	1.10	NA	16.33	090
21720		A	Revision of neck muscle	5.65	5.53	4.68	0.96	12.14	11.29	090
21725		A	Revision of neck muscle	6.95	NA	5.58	1.08	NA	13.61	090
21740		A	Reconstruction of sternum	16.41	NA	8.38	2.43	NA	27.22	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	10.71	NA	5.91	1.62	NA	18.24	090
21800		A	Treatment of rib fracture	0.95	2.13	1.44	0.11	3.19	2.50	090
21805		A	Treatment of rib fracture	2.73	NA	3.30	0.35	NA	6.38	090
21810		A	Treatment of rib fracture(s)	6.82	NA	4.96	0.72	NA	12.50	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
21820	.....	A	Treat sternum fracture	1.27	2.67	1.85	0.18	4.12	3.30	090
21825	.....	A	Treat sternum fracture	7.37	NA	6.50	1.01	NA	14.88	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	2.05	3.31	1.50	0.14	5.50	3.69	010
21925	.....	A	Biopsy soft tissue of back	4.46	6.70	3.37	0.53	11.69	8.36	090
21930	.....	A	Remove lesion, back or flank	4.97	5.55	3.50	0.59	11.11	9.06	090
21935	.....	A	Remove tumor, back	17.86	NA	10.32	2.24	NA	30.42	090
22100	.....	A	Remove part of neck vertebra	9.67	NA	7.72	1.86	NA	19.25	090
22101	.....	A	Remove part, thorax vertebra	9.75	NA	7.93	1.81	NA	19.49	090
22102	.....	A	Remove part, lumbar vertebra	9.75	NA	8.18	1.75	NA	19.68	090
22103	.....	A	Remove extra spine segment	2.33	NA	1.23	0.44	NA	4.00	ZZZ
22110	.....	A	Remove part of neck vertebra	12.67	NA	9.39	2.64	NA	24.70	090
22112	.....	A	Remove part, thorax vertebra	12.74	NA	9.41	2.35	NA	24.50	090
22114	.....	A	Remove part, lumbar vertebra	12.74	NA	9.41	2.37	NA	24.52	090
22116	.....	A	Remove extra spine segment	2.31	NA	1.18	0.48	NA	3.97	ZZZ
22210	.....	A	Revision of neck spine	23.68	NA	15.71	5.07	NA	44.46	090
22212	.....	A	Revision of thorax spine	19.31	NA	13.41	3.33	NA	36.05	090
22214	.....	A	Revision of lumbar spine	19.34	NA	13.92	3.33	NA	36.59	090
22216	.....	A	Revise, extra spine segment	6.01	NA	3.18	1.17	NA	10.36	ZZZ
22220	.....	A	Revision of neck spine	21.25	NA	13.95	4.37	NA	39.57	090
22222	.....	A	Revision of thorax spine	21.40	NA	11.74	3.69	NA	36.83	090
22224	.....	A	Revision of lumbar spine	21.40	NA	14.39	3.84	NA	39.63	090
22226	.....	A	Revise, extra spine segment	6.01	NA	3.14	1.21	NA	10.36	ZZZ
22305	.....	A	Treat spine process fracture	2.04	3.22	2.41	0.35	5.61	4.80	090
22310	.....	A	Treat spine fracture	2.60	4.94	4.17	0.44	7.98	7.21	090
22315	.....	A	Treat spine fracture	8.79	13.58	7.63	1.64	24.01	18.06	090
22318	.....	A	Treat odontoid fx w/o graft	21.38	NA	13.70	5.11	NA	40.19	090
22319	.....	A	Treat odontoid fx w/graft	23.86	NA	15.09	5.71	NA	44.66	090
22325	.....	A	Treat spine fracture	18.20	NA	12.28	3.13	NA	33.61	090
22326	.....	A	Treat neck spine fracture	19.48	NA	12.99	4.24	NA	36.71	090
22327	.....	A	Treat thorax spine fracture	19.09	NA	12.58	3.30	NA	34.97	090
22328	.....	A	Treat each add spine fx	4.58	NA	2.30	0.79	NA	7.67	ZZZ
22505	.....	A	Manipulation of spine	1.86	NA	0.95	0.32	NA	3.13	010
22520	.....	A	Percut vertebroplasty thor	8.86	103.00	4.39	1.19	113.05	14.44	010
22521	.....	A	Percut vertebroplasty lumb	8.29	91.36	4.23	1.11	100.76	13.63	010
22522	.....	A	Percut vertebroplasty addl	4.29	NA	1.71	0.40	NA	6.40	ZZZ
22532	.....	A	Lat thorax spine fusion	23.86	NA	14.92	4.53	NA	43.31	090
22533	.....	A	Lat lumbar spine fusion	22.99	NA	13.60	3.81	NA	40.40	090
22534	.....	A	Lat thor/lumb, addl seg	5.97	NA	3.08	1.17	NA	10.22	ZZZ
22548	.....	A	Neck spine fusion	25.67	NA	16.03	5.97	NA	47.67	090
22554	.....	A	Neck spine fusion	18.51	NA	12.47	4.21	NA	35.19	090
22556	.....	A	Thorax spine fusion	23.33	NA	14.81	4.53	NA	42.67	090
22558	.....	A	Lumbar spine fusion	22.15	NA	13.37	3.81	NA	39.33	090
22585	.....	A	Additional spinal fusion	5.50	NA	2.83	1.17	NA	9.50	ZZZ
22590	.....	A	Spine & skull spinal fusion	20.39	NA	13.47	4.57	NA	38.43	090
22595	.....	A	Neck spinal fusion	19.28	NA	12.96	4.34	NA	36.58	090
22600	.....	A	Neck spine fusion	16.05	NA	11.28	3.46	NA	30.79	090
22610	.....	A	Thorax spine fusion	15.93	NA	11.46	3.19	NA	30.58	090
22612	.....	A	Lumbar spine fusion	20.88	NA	14.25	3.93	NA	39.06	090
22614	.....	A	Spine fusion, extra segment	6.40	NA	3.40	1.25	NA	11.05	ZZZ
22630	.....	A	Lumbar spine fusion	20.72	NA	13.71	4.54	NA	38.97	090
22632	.....	A	Spine fusion, extra segment	5.20	NA	2.70	1.08	NA	8.98	ZZZ
22800	.....	A	Fusion of spine	18.15	NA	12.78	3.25	NA	34.18	090
22802	.....	A	Fusion of spine	30.70	NA	19.68	5.30	NA	55.68	090
22804	.....	A	Fusion of spine	36.06	NA	22.81	6.27	NA	65.14	090
22808	.....	A	Fusion of spine	26.12	NA	16.42	5.23	NA	47.77	090
22810	.....	A	Fusion of spine	30.10	NA	18.47	5.38	NA	53.95	090
22812	.....	A	Fusion of spine	32.51	NA	20.13	5.60	NA	58.24	090
22818	.....	A	Kyphectomy, 1–2 segments	31.65	NA	19.07	6.00	NA	56.72	090
22819	.....	A	Kyphectomy, 3 or more	36.23	NA	20.21	6.23	NA	62.67	090
22830	.....	A	Exploration of spinal fusion	10.79	NA	7.98	2.07	NA	20.84	090
22840	.....	A	Insert spine fixation device	12.47	NA	6.58	2.43	NA	21.48	ZZZ
22841	.....	B	Insert spine fixation device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
22842	.....	A	Insert spine fixation device	12.51	NA	6.60	2.45	NA	21.56	ZZZ
22843	.....	A	Insert spine fixation device	13.38	NA	6.70	2.52	NA	22.60	ZZZ
22844	.....	A	Insert spine fixation device	16.35	NA	8.87	2.90	NA	28.12	ZZZ
22845	.....	A	Insert spine fixation device	11.89	NA	6.16	2.66	NA	20.71	ZZZ
22846	.....	A	Insert spine fixation device	12.35	NA	6.42	2.71	NA	21.48	ZZZ
22847	.....	A	Insert spine fixation device	13.72	NA	7.12	2.83	NA	23.67	ZZZ
22848	.....	A	Insert pelv fixation device	5.97	NA	3.23	1.05	NA	10.25	ZZZ
22849	.....	A	Reinsert spinal fixation	18.40	NA	11.89	3.44	NA	33.73	090
22850	.....	A	Remove spine fixation device	9.47	NA	7.08	1.81	NA	18.36	090
22851	.....	A	Apply spine prosth device	6.67	NA	3.40	1.33	NA	11.40	ZZZ
22852	.....	A	Remove spine fixation device	8.96	NA	6.87	1.68	NA	17.51	090
22855	.....	A	Remove spine fixation device	15.04	NA	9.83	3.28	NA	28.15	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
22899		C	Spine surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
22900		A	Remove abdominal wall lesion	5.77	NA	3.31	0.70	NA	9.78	090
22999		C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
23000		A	Removal of calcium deposits	4.34	5.27	4.21	0.60	10.21	9.15	090
23020		A	Release shoulder joint	8.88	NA	7.65	1.47	NA	18.00	090
23030		A	Drain shoulder lesion	3.41	3.05	2.97	0.50	6.96	6.88	010
23031		A	Drain shoulder bursa	2.72	2.74	2.74	0.40	5.86	5.86	010
23035		A	Drain shoulder bone lesion	8.56	NA	8.59	1.43	NA	18.58	090
23040		A	Exploratory shoulder surgery	9.15	NA	7.93	1.53	NA	18.61	090
23044		A	Exploratory shoulder surgery	7.08	NA	6.56	1.16	NA	14.80	090
23065		A	Biopsy shoulder tissues	2.26	2.85	1.56	0.17	5.28	3.99	010
23066		A	Biopsy shoulder tissues	4.14	5.15	4.11	0.60	9.89	8.85	090
23075		A	Removal of shoulder lesion	2.38	2.27	1.84	0.30	4.95	4.52	010
23076		A	Removal of shoulder lesion	7.59	NA	5.84	1.04	NA	14.47	090
23077		A	Remove tumor of shoulder	16.00	NA	10.88	2.17	NA	29.05	090
23100		A	Biopsy of shoulder joint	6.00	NA	5.76	0.97	NA	12.73	090
23101		A	Shoulder joint surgery	5.55	NA	5.44	0.92	NA	11.91	090
23105		A	Remove shoulder joint lining	8.18	NA	7.25	1.35	NA	16.78	090
23106		A	Incision of collarbone joint	5.93	NA	5.80	0.98	NA	12.71	090
23107		A	Explore treat shoulder joint	8.57	NA	7.46	1.43	NA	17.46	090
23120		A	Partial removal, collar bone	7.07	NA	6.55	1.19	NA	14.81	090
23125		A	Removal of collar bone	9.34	NA	7.69	1.52	NA	18.55	090
23130		A	Remove shoulder bone, part	7.51	NA	7.18	1.27	NA	15.96	090
23140		A	Removal of bone lesion	6.85	NA	5.46	0.98	NA	13.29	090
23145		A	Removal of bone lesion	9.04	NA	7.66	1.49	NA	18.19	090
23146		A	Removal of bone lesion	7.79	NA	7.21	1.33	NA	16.33	090
23150		A	Removal of humerus lesion	8.43	NA	7.05	1.37	NA	16.85	090
23155		A	Removal of humerus lesion	10.29	NA	8.55	1.44	NA	20.28	090
23156		A	Removal of humerus lesion	8.63	NA	7.46	1.41	NA	17.50	090
23170		A	Remove collar bone lesion	6.82	NA	6.38	1.01	NA	14.21	090
23172		A	Remove shoulder blade lesion	6.86	NA	6.47	1.14	NA	14.47	090
23174		A	Remove humerus lesion	9.46	NA	8.46	1.56	NA	19.48	090
23180		A	Remove collar bone lesion	8.48	NA	9.29	1.41	NA	19.18	090
23182		A	Remove shoulder blade lesion	8.10	NA	8.94	1.29	NA	18.33	090
23184		A	Remove humerus lesion	9.33	NA	9.65	1.49	NA	20.47	090
23190		A	Partial removal of scapula	7.20	NA	6.29	1.16	NA	14.65	090
23195		A	Removal of head of humerus	9.75	NA	7.85	1.65	NA	19.25	090
23200		A	Removal of collar bone	12.01	NA	9.00	1.77	NA	22.78	090
23210		A	Removal of shoulder blade	12.42	NA	9.37	1.93	NA	23.72	090
23220		A	Partial removal of humerus	14.48	NA	10.99	2.43	NA	27.90	090
23221		A	Partial removal of humerus	17.64	NA	11.96	3.01	NA	32.61	090
23222		A	Partial removal of humerus	23.78	NA	16.00	4.04	NA	43.82	090
23330		A	Remove shoulder foreign body	1.84	2.07	1.91	0.22	4.13	3.97	010
23331		A	Remove shoulder foreign body	7.34	NA	6.86	1.22	NA	15.42	090
23332		A	Remove shoulder foreign body	11.55	NA	9.41	1.94	NA	22.90	090
23350		A	Injection for shoulder x-ray	0.99	3.84	0.34	0.06	4.89	1.39	000
23395		A	Muscle transfer,shoulder/arm	16.75	NA	12.87	2.74	NA	32.36	090
23397		A	Muscle transfers	16.04	NA	11.50	2.68	NA	30.22	090
23400		A	Fixation of shoulder blade	13.46	NA	10.24	2.29	NA	25.99	090
23405		A	Incision of tendon & muscle	8.32	NA	7.04	1.34	NA	16.70	090
23406		A	Incise tendon(s) & muscle(s)	10.73	NA	8.49	1.77	NA	20.99	090
23410		A	Repair rotator cuff, acute	12.38	NA	9.51	2.06	NA	23.95	090
23412		A	Repair rotator cuff, chronic	13.23	NA	10.00	2.23	NA	25.46	090
23415		A	Release of shoulder ligament	9.91	NA	8.06	1.67	NA	19.64	090
23420		A	Repair of shoulder	13.22	NA	10.89	2.23	NA	26.34	090
23430		A	Repair biceps tendon	9.92	NA	8.20	1.68	NA	19.80	090
23440		A	Remove/transplant tendon	10.42	NA	8.38	1.76	NA	20.56	090
23450		A	Repair shoulder capsule	13.32	NA	9.97	2.23	NA	25.52	090
23455		A	Repair shoulder capsule	14.29	NA	10.56	2.41	NA	27.26	090
23460		A	Repair shoulder capsule	15.28	NA	11.49	2.60	NA	29.37	090
23462		A	Repair shoulder capsule	15.21	NA	10.89	2.59	NA	28.69	090
23465		A	Repair shoulder capsule	15.76	NA	11.42	1.93	NA	29.11	090
23466		A	Repair shoulder capsule	14.14	NA	11.39	2.40	NA	27.93	090
23470		A	Reconstruct shoulder joint	17.05	NA	12.25	2.88	NA	32.18	090
23472		A	Reconstruct shoulder joint	20.98	NA	14.42	2.84	NA	38.24	090
23480		A	Revision of collar bone	11.12	NA	8.87	1.87	NA	21.86	090
23485		A	Revision of collar bone	13.35	NA	10.01	2.21	NA	25.57	090
23490		A	Reinforce clavicle	11.79	NA	8.79	1.33	NA	21.91	090
23491		A	Reinforce shoulder bones	14.13	NA	10.81	2.40	NA	27.34	090
23500		A	Treat clavicle fracture	2.07	3.70	2.60	0.31	6.08	4.98	090
23505		A	Treat clavicle fracture	3.67	5.39	3.80	0.60	9.66	8.07	090
23515		A	Treat clavicle fracture	7.37	NA	6.60	1.23	NA	15.20	090
23520		A	Treat clavicle dislocation	2.15	3.70	2.75	0.31	6.16	5.21	090
23525		A	Treat clavicle dislocation	3.58	5.34	3.93	0.53	9.45	8.04	090
23530		A	Treat clavicle dislocation	7.27	NA	6.05	1.02	NA	14.34	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
23532		A	Treat clavicle dislocation	7.96	NA	6.99	1.35	NA	16.30	090
23540		A	Treat clavicle dislocation	2.22	4.31	2.51	0.29	6.82	5.02	090
23545		A	Treat clavicle dislocation	3.23	4.56	3.43	0.47	8.26	7.13	090
23550		A	Treat clavicle dislocation	7.20	NA	6.46	1.13	NA	14.79	090
23552		A	Treat clavicle dislocation	8.40	NA	7.34	1.41	NA	17.15	090
23570		A	Treat shoulder blade fx	2.22	3.71	2.91	0.35	6.28	5.48	090
23575		A	Treat shoulder blade fx	4.04	5.83	4.30	0.64	10.51	8.98	090
23585		A	Treat scapula fracture	8.91	NA	7.68	1.50	NA	18.09	090
23600		A	Treat humerus fracture	2.91	5.80	3.87	0.47	9.18	7.25	090
23605		A	Treat humerus fracture	4.84	6.67	5.01	0.80	12.31	10.65	090
23615		A	Treat humerus fracture	9.30	NA	8.79	1.57	NA	19.66	090
23616		A	Treat humerus fracture	21.15	NA	14.28	3.57	NA	39.00	090
23620		A	Treat humerus fracture	2.39	5.26	3.27	0.38	8.03	6.04	090
23625		A	Treat humerus fracture	3.91	6.39	4.60	0.64	10.94	9.15	090
23630		A	Treat humerus fracture	7.31	NA	6.67	1.23	NA	15.21	090
23650		A	Treat shoulder dislocation	3.37	4.75	2.94	0.37	8.49	6.68	090
23655		A	Treat shoulder dislocation	4.54	NA	4.23	0.62	NA	9.39	090
23660		A	Treat shoulder dislocation	7.45	NA	6.44	1.21	NA	15.10	090
23665		A	Treat dislocation/fracture	4.44	6.66	4.99	0.72	11.82	10.15	090
23670		A	Treat dislocation/fracture	7.85	NA	6.90	1.32	NA	16.07	090
23675		A	Treat dislocation/fracture	6.02	7.65	6.13	0.99	14.66	13.14	090
23680		A	Treat dislocation/fracture	10.00	NA	8.18	1.67	NA	19.85	090
23700		A	Fixation of shoulder	2.51	NA	2.32	0.42	NA	5.25	010
23800		A	Fusion of shoulder joint	14.08	NA	10.58	2.36	NA	27.02	090
23802		A	Fusion of shoulder joint	16.51	NA	10.38	2.80	NA	29.69	090
23900		A	Amputation of arm & girdle	19.61	NA	12.05	2.96	NA	34.62	090
23920		A	Amputation at shoulder joint	14.53	NA	10.21	2.30	NA	27.04	090
23921		A	Amputation follow-up surgery	5.46	5.28	5.28	0.93	11.67	11.67	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	2.92	2.75	2.36	0.38	6.05	5.66	010
23931		A	Drainage of arm bursa	1.78	2.46	2.21	0.25	4.49	4.24	010
23935		A	Drain arm/elbow bone lesion	6.06	NA	6.18	1.01	NA	13.25	090
24000		A	Exploratory elbow surgery	5.79	NA	5.42	0.92	NA	12.13	090
24006		A	Release elbow joint	9.26	NA	7.77	1.52	NA	18.55	090
24065		A	Biopsy arm/elbow soft tissue	2.07	2.12	1.80	0.17	4.36	4.04	010
24066		A	Biopsy arm/elbow soft tissue	5.18	5.81	4.33	0.73	11.72	10.24	090
24075		A	Remove arm/elbow lesion	3.90	5.11	3.71	0.52	9.53	8.13	090
24076		A	Remove arm/elbow lesion	6.26	NA	5.14	0.84	NA	12.24	090
24077		A	Remove tumor of arm/elbow	11.69	NA	8.75	1.58	NA	22.02	090
24100		A	Biopsy elbow joint lining	4.90	NA	4.52	0.74	NA	10.16	090
24101		A	Explore/treat elbow joint	6.10	NA	5.92	1.01	NA	13.03	090
24102		A	Remove elbow joint lining	7.98	NA	6.91	1.31	NA	16.20	090
24105		A	Removal of elbow bursa	3.59	NA	4.41	0.59	NA	8.59	090
24110		A	Remove humerus lesion	7.35	NA	6.78	1.19	NA	15.32	090
24115		A	Remove/graft bone lesion	9.58	NA	7.43	1.38	NA	18.39	090
24116		A	Remove/graft bone lesion	11.74	NA	9.21	1.99	NA	22.94	090
24120		A	Remove elbow lesion	6.61	NA	5.94	1.04	NA	13.59	090
24125		A	Remove/graft bone lesion	7.85	NA	6.25	1.05	NA	15.15	090
24126		A	Remove/graft bone lesion	8.26	NA	7.04	1.08	NA	16.38	090
24130		A	Removal of head of radius	6.21	NA	6.01	1.04	NA	13.26	090
24134		A	Removal of arm bone lesion	9.67	NA	9.27	1.57	NA	20.51	090
24136		A	Remove radius bone lesion	7.94	NA	7.49	1.02	NA	16.45	090
24138		A	Remove elbow bone lesion	8.00	NA	7.75	1.34	NA	17.09	090
24140		A	Partial removal of arm bone	9.13	NA	9.60	1.47	NA	20.20	090
24145		A	Partial removal of radius	7.54	NA	8.24	1.21	NA	16.99	090
24147		A	Partial removal of elbow	7.50	NA	8.73	1.25	NA	17.48	090
24149		A	Radical resection of elbow	14.12	NA	11.54	2.28	NA	27.94	090
24150		A	Extensive humerus surgery	13.19	NA	10.22	2.17	NA	25.58	090
24151		A	Extensive humerus surgery	15.49	NA	11.81	2.62	NA	29.92	090
24152		A	Extensive radius surgery	10.00	NA	7.96	1.43	NA	19.39	090
24153		A	Extensive radius surgery	11.47	NA	5.90	0.77	NA	18.14	090
24155		A	Removal of elbow joint	11.66	NA	8.48	1.70	NA	21.84	090
24160		A	Remove elbow joint implant	7.79	NA	6.85	1.28	NA	15.92	090
24164		A	Remove radius head implant	6.19	NA	5.73	1.01	NA	12.93	090
24200		A	Removal of arm foreign body	1.75	1.99	1.69	0.18	3.92	3.62	010
24201		A	Removal of arm foreign body	4.53	5.75	4.37	0.67	10.95	9.57	090
24220		A	Injection for elbow x-ray	1.30	10.48	0.45	0.08	11.86	1.83	000
24300		A	Manipulate elbow w/anesth	3.73	NA	5.54	0.59	NA	9.86	090
24301		A	Muscle/tendon transfer	10.14	NA	8.27	1.56	NA	19.97	090
24305		A	Arm tendon lengthening	7.41	NA	6.75	1.17	NA	15.33	090
24310		A	Revision of arm tendon	5.95	NA	5.79	0.89	NA	12.63	090
24320		A	Repair of arm tendon	10.50	NA	7.82	1.20	NA	19.52	090
24330		A	Revision of arm muscles	9.55	NA	7.96	1.45	NA	18.96	090
24331		A	Revision of arm muscles	10.59	NA	8.68	1.69	NA	20.96	090
24332		A	Tenolysis, triceps	7.41	NA	6.66	0.92	NA	14.99	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
24340	.....	A	Repair of biceps tendon	7.85	NA	6.99	1.29	NA	16.13	090
24341	.....	A	Repair arm tendon/muscle	7.85	NA	7.83	1.29	NA	16.97	090
24342	.....	A	Repair of ruptured tendon	10.56	NA	8.54	1.77	NA	20.87	090
24343	.....	A	Repr elbow lat ligmnt w/tiss	8.60	NA	8.02	1.35	NA	17.97	090
24344	.....	A	Reconstruct elbow lat ligmnt	13.92	NA	11.43	2.19	NA	27.54	090
24345	.....	A	Repr elbw med ligmnt w/tissu	8.60	NA	7.91	1.35	NA	17.86	090
24346	.....	A	Reconstruct elbow med ligmnt	13.92	NA	11.28	2.19	NA	27.39	090
24350	.....	A	Repair of tennis elbow	5.22	NA	5.57	0.86	NA	11.65	090
24351	.....	A	Repair of tennis elbow	5.88	NA	5.92	0.98	NA	12.78	090
24352	.....	A	Repair of tennis elbow	6.39	NA	6.18	1.08	NA	13.65	090
24354	.....	A	Repair of tennis elbow	6.44	NA	6.14	1.05	NA	13.63	090
24356	.....	A	Revision of tennis elbow	6.64	NA	6.32	1.08	NA	14.04	090
24360	.....	A	Reconstruct elbow joint	12.27	NA	9.46	2.03	NA	23.76	090
24361	.....	A	Reconstruct elbow joint	14.00	NA	10.56	2.34	NA	26.90	090
24362	.....	A	Reconstruct elbow joint	14.90	NA	10.08	2.30	NA	27.28	090
24363	.....	A	Replace elbow joint	18.38	NA	13.67	3.02	NA	35.07	090
24365	.....	A	Reconstruct head of radius	8.34	NA	7.15	1.33	NA	16.82	090
24366	.....	A	Reconstruct head of radius	9.08	NA	7.51	1.53	NA	18.12	090
24400	.....	A	Revision of humerus	11.00	NA	9.00	1.83	NA	21.83	090
24410	.....	A	Revision of humerus	14.74	NA	10.54	2.27	NA	27.55	090
24420	.....	A	Revision of humerus	13.36	NA	10.77	2.18	NA	26.31	090
24430	.....	A	Repair of humerus	12.74	NA	9.85	2.16	NA	24.75	090
24435	.....	A	Repair humerus with graft	13.09	NA	10.95	2.21	NA	26.25	090
24470	.....	A	Revision of elbow joint	8.69	NA	7.69	1.47	NA	17.85	090
24495	.....	A	Decompression of forearm	8.07	NA	9.03	1.10	NA	18.20	090
24498	.....	A	Reinforce humerus	11.85	NA	9.38	2.00	NA	23.23	090
24500	.....	A	Treat humerus fracture	3.19	5.46	3.66	0.49	9.14	7.34	090
24505	.....	A	Treat humerus fracture	5.14	7.37	5.34	0.86	13.37	11.34	090
24515	.....	A	Treat humerus fracture	11.58	NA	9.44	1.95	NA	22.97	090
24516	.....	A	Treat humerus fracture	11.58	NA	9.21	1.95	NA	22.74	090
24530	.....	A	Treat humerus fracture	3.48	5.45	3.99	0.56	9.49	8.03	090
24535	.....	A	Treat humerus fracture	6.83	8.47	6.48	1.15	16.45	14.46	090
24538	.....	A	Treat humerus fracture	9.38	NA	8.79	1.50	NA	19.67	090
24545	.....	A	Treat humerus fracture	10.40	NA	8.50	1.76	NA	20.66	090
24546	.....	A	Treat humerus fracture	15.60	NA	11.43	2.61	NA	29.64	090
24560	.....	A	Treat humerus fracture	2.78	5.13	3.26	0.42	8.33	6.46	090
24565	.....	A	Treat humerus fracture	5.53	7.37	5.46	0.89	13.79	11.88	090
24566	.....	A	Treat humerus fracture	7.75	NA	8.21	1.32	NA	17.28	090
24575	.....	A	Treat humerus fracture	10.60	NA	8.38	1.73	NA	20.71	090
24576	.....	A	Treat humerus fracture	2.84	5.00	3.64	0.46	8.30	6.94	090
24577	.....	A	Treat humerus fracture	5.76	7.65	5.76	0.97	14.38	12.49	090
24579	.....	A	Treat humerus fracture	11.53	NA	8.93	1.94	NA	22.40	090
24582	.....	A	Treat humerus fracture	8.50	NA	9.10	1.44	NA	19.04	090
24586	.....	A	Treat elbow fracture	15.12	NA	11.23	2.54	NA	28.89	090
24587	.....	A	Treat elbow fracture	15.07	NA	11.04	2.57	NA	28.68	090
24600	.....	A	Treat elbow dislocation	4.21	5.63	3.58	0.59	10.43	8.38	090
24605	.....	A	Treat elbow dislocation	5.39	NA	5.32	0.86	NA	11.57	090
24615	.....	A	Treat elbow dislocation	9.37	NA	7.81	1.57	NA	18.75	090
24620	.....	A	Treat elbow fracture	6.94	NA	6.18	1.08	NA	14.20	090
24635	.....	A	Treat elbow fracture	13.11	NA	14.37	2.21	NA	29.69	090
24640	.....	A	Treat elbow dislocation	1.19	1.96	0.88	0.13	3.28	2.20	010
24650	.....	A	Treat radius fracture	2.15	4.60	2.78	0.34	7.09	5.27	090
24655	.....	A	Treat radius fracture	4.37	6.84	4.74	0.70	11.91	9.81	090
24665	.....	A	Treat radius fracture	8.09	NA	7.56	1.35	NA	17.00	090
24666	.....	A	Treat radius fracture	9.44	NA	8.14	1.58	NA	19.16	090
24670	.....	A	Treat ulnar fracture	2.53	4.50	3.06	0.40	7.43	5.99	090
24675	.....	A	Treat ulnar fracture	4.69	6.80	4.87	0.78	12.27	10.34	090
24685	.....	A	Treat ulnar fracture	8.75	NA	7.60	1.47	NA	17.82	090
24800	.....	A	Fusion of elbow joint	11.14	NA	8.81	1.69	NA	21.64	090
24802	.....	A	Fusion/graft of elbow joint	13.61	NA	10.44	2.27	NA	26.32	090
24900	.....	A	Amputation of upper arm	9.55	NA	7.43	1.41	NA	18.39	090
24920	.....	A	Amputation of upper arm	9.49	NA	7.59	1.46	NA	18.54	090
24925	.....	A	Amputation follow-up surgery	7.03	NA	6.34	1.14	NA	14.51	090
24930	.....	A	Amputation follow-up surgery	10.19	NA	7.59	1.47	NA	19.25	090
24931	.....	A	Amputate upper arm & implant	12.65	NA	6.19	1.87	NA	20.71	090
24935	.....	A	Revision of amputation	15.47	NA	8.50	1.89	NA	25.86	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	3.36	NA	7.03	0.54	NA	10.93	090
25001	.....	A	Incise flexor carpi radialis	3.36	NA	4.13	0.54	NA	8.03	090
25020	.....	A	Decompress forearm 1 space	5.89	NA	10.04	0.91	NA	16.84	090
25023	.....	A	Decompress forearm 1 space	12.89	NA	15.51	1.82	NA	30.22	090
25024	.....	A	Decompress forearm 2 spaces	9.45	NA	7.49	1.49	NA	18.43	090
25025	.....	A	Decompress forearm 2 spaces	16.45	NA	10.06	2.61	NA	29.12	090
25028	.....	A	Drainage of forearm lesion	5.22	NA	8.54	0.73	NA	14.49	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
25031	.....	A	Drainage of forearm bursa	4.12	NA	8.35	0.60	NA	13.07	090
25035	.....	A	Treat forearm bone lesion	7.32	NA	14.20	1.17	NA	22.69	090
25040	.....	A	Explore/treat wrist joint	7.14	NA	7.42	1.15	NA	15.71	090
25065	.....	A	Biopsy forearm soft tissues	1.98	2.83	2.83	0.14	4.95	4.95	010
25066	.....	A	Biopsy forearm soft tissues	4.11	NA	7.33	0.59	NA	12.03	090
25075	.....	A	Removel forearm lesion subcu	3.72	NA	6.19	0.48	NA	10.39	090
25076	.....	A	Removel forearm lesion deep	4.89	NA	10.08	0.71	NA	15.68	090
25077	.....	A	Remove tumor, forearm/wrist	9.70	NA	12.84	1.32	NA	23.86	090
25085	.....	A	Incision of wrist capsule	5.47	NA	7.38	0.85	NA	13.70	090
25100	.....	A	Biopsy of wrist joint	3.88	NA	5.46	0.60	NA	9.94	090
25101	.....	A	Explore/treat wrist joint	4.66	NA	6.02	0.72	NA	11.40	090
25105	.....	A	Remove wrist joint lining	5.82	NA	7.57	0.92	NA	14.31	090
25107	.....	A	Remove wrist joint cartilage	6.39	NA	8.50	0.98	NA	15.87	090
25110	.....	A	Remove wrist tendon lesion	3.90	NA	7.34	0.58	NA	11.82	090
25111	.....	A	Remove wrist tendon lesion	3.37	NA	4.88	0.50	NA	8.75	090
25112	.....	A	Reremove wrist tendon lesion	4.50	NA	5.49	0.65	NA	10.64	090
25115	.....	A	Remove wrist/forearm lesion	8.77	NA	14.60	1.33	NA	24.70	090
25116	.....	A	Remove wrist/forearm lesion	7.07	NA	13.67	1.08	NA	21.82	090
25118	.....	A	Excise wrist tendon sheath	4.35	NA	5.94	0.66	NA	10.95	090
25119	.....	A	Partial removal of ulna	6.01	NA	7.85	0.96	NA	14.82	090
25120	.....	A	Removal of forearm lesion	6.07	NA	12.58	0.97	NA	19.62	090
25125	.....	A	Remove/graft forearm lesion	7.44	NA	13.37	1.22	NA	22.03	090
25126	.....	A	Remove/graft forearm lesion	7.51	NA	13.46	1.20	NA	22.17	090
25130	.....	A	Removal of wrist lesion	5.23	NA	6.58	0.79	NA	12.60	090
25135	.....	A	Remove & graft wrist lesion	6.85	NA	7.61	1.07	NA	15.53	090
25136	.....	A	Remove & graft wrist lesion	5.94	NA	6.76	0.70	NA	13.40	090
25145	.....	A	Remove forearm bone lesion	6.33	NA	12.61	0.98	NA	19.92	090
25150	.....	A	Partial removal of ulna	7.05	NA	8.49	1.15	NA	16.69	090
25151	.....	A	Partial removal of radius	7.35	NA	13.23	1.11	NA	21.69	090
25170	.....	A	Extensive forearm surgery	11.03	NA	15.64	1.82	NA	28.49	090
25210	.....	A	Removal of wrist bone	5.92	NA	6.98	0.87	NA	13.77	090
25215	.....	A	Removal of wrist bones	7.85	NA	8.99	1.22	NA	18.06	090
25230	.....	A	Partial removal of radius	5.20	NA	6.29	0.79	NA	12.28	090
25240	.....	A	Partial removal of ulna	5.14	NA	7.16	0.83	NA	13.13	090
25246	.....	A	Injection for wrist x-ray	1.44	10.14	0.49	0.08	11.66	2.01	000
25248	.....	A	Remove forearm foreign body	5.11	NA	8.83	0.65	NA	14.59	090
25250	.....	A	Removal of wrist prosthesis	6.56	NA	6.06	1.01	NA	13.63	090
25251	.....	A	Removal of wrist prosthesis	9.52	NA	7.90	1.38	NA	18.80	090
25259	.....	A	Manipulate wrist w/anesthes	3.73	NA	5.53	0.60	NA	9.86	090
25260	.....	A	Repair forearm tendon/muscle	7 76	NA	14.06	1.16	NA	22.98	090
25263	.....	A	Repair forearm tendon/muscle	7.78	NA	13.95	1.13	NA	22.86	090
25265	.....	A	Repair forearm tendon/muscle	9.82	NA	14.83	1.43	NA	26.08	090
25270	.....	A	Repair forearm tendon/muscle	5.97	NA	12.74	0.91	NA	19.62	090
25272	.....	A	Repair forearm tendon/muscle	7.00	NA	13.45	1.07	NA	21.52	090
25274	.....	A	Repair forearm tendon/muscle	8.70	NA	14.17	1.37	NA	24.24	090
25275	.....	A	Repair forearm tendon sheath	8.45	NA	7.54	1.35	NA	17.34	090
25280	.....	A	Revise wrist/forearm tendon	7.18	NA	13.17	1.09	NA	21.44	090
25290	.....	A	Incise wrist/forearm tendon	5.26	NA	15.71	0.79	NA	21.76	090
25295	.....	A	Release wrist/forearm tendon	6.51	NA	12.73	1.03	NA	20.27	090
25300	.....	A	Fusion of tendons at wrist	8.75	NA	8.61	1.28	NA	18.64	090
25301	.....	A	Fusion of tendons at wrist	8.35	NA	8.25	1.29	NA	17.89	090
25310	.....	A	Transplant forearm tendon	8.09	NA	13.59	1.21	NA	22.89	090
25312	.....	A	Transplant forearm tendon	9.52	NA	14.49	1.46	NA	25.47	090
25315	.....	A	Revise palsy hand tendon(s)	10.14	NA	15.05	1.51	NA	26.70	090
25316	.....	A	Revise palsy hand tendon(s)	12.26	NA	16.80	2.09	NA	31.15	090
25320	.....	A	Repair/revise wrist joint	10.71	NA	11.33	1.58	NA	23.62	090
25332	.....	A	Revise wrist joint	11.34	NA	9.16	1.75	NA	22.25	090
25335	.....	A	Realignment of hand	12.81	NA	11.84	1.99	NA	26.64	090
25337	.....	A	Reconstruct ulna/radioulnar	10.11	NA	11.19	1.57	NA	22.87	090
25350	.....	A	Revision of radius	8.73	NA	14.43	1.40	NA	24.56	090
25355	.....	A	Revision of radius	10.11	NA	15.08	1.73	NA	26.92	090
25360	.....	A	Revision of ulna	8.38	NA	14.33	1.40	NA	24.11	090
25365	.....	A	Revise radius & ulna	12.33	NA	16.13	2.00	NA	30.46	090
25370	....	A	Revise radius or ulna	13.28	NA	16.47	2.25	NA	32.00	090
25375	.....	A	Revise radius & ulna	12.97	NA	16.95	2.21	NA	32.13	090
25390	.....	A	Shorten radius or ulna	10.34	NA	15.08	1.65	NA	27.07	090
25391	....	A	Lengthen radius or ulna	13.57	NA	17.06	2.07	NA	32.70	090
25392	.....	A	Shorten radius & ulna	13.87	NA	16.41	2.07	NA	32.35	090
25393	.....	A	Lengthen radius & ulna	15.78	NA	18.06	2.24	NA	36.08	090
25394	.....	A	Repair carpal bone, shorten	10.34	NA	8.33	1.68	NA	20.35	090
25400	.....	A	Repair radius or ulna	10.86	NA	15.66	1.80	NA	28.32	090
25405	.....	A	Repair/graft radius or ulna	14.30	NA	17.77	2.34	NA	34.41	090
25415	.....	A	Repair radius & ulna	13.27	NA	17.01	2.24	NA	32.52	090
25420	.....	A	Repair/graft radius & ulna	16.24	NA	18.76	2.64	NA	37.64	090
25425	.....	A	Repair/graft radius or ulna	13.13	NA	22.34	1.93	NA	37.40	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
25426	.....	A	Repair/graft radius & ulna	15.73	NA	17.43	2.67	NA	35.83	090
25430	.....	A	Vasc graft into carpal bone	9.20	NA	7.36	1.28	NA	17.84	090
25431	.....	A	Repair nonunion carpal bone	10.38	NA	8.32	0.67	NA	19.37	090
25440	.....	A	Repair/graft wrist bone	10.38	NA	9.53	1.69	NA	21.60	090
25441	.....	A	Reconstruct wrist joint	12.83	NA	9.99	2.19	NA	25.01	090
25442	.....	A	Reconstruct wrist joint	10.79	NA	8.86	1.49	NA	21.14	090
25443	.....	A	Reconstruct wrist joint	10.33	NA	8.74	1.56	NA	20.63	090
25444	.....	A	Reconstruct wrist joint	11.09	NA	9.16	1.71	NA	21.96	090
25445	.....	A	Reconstruct wrist joint	9.63	NA	7.97	1.51	NA	19.11	090
25446	.....	A	Wrist replacement	16.46	NA	11.94	2.64	NA	31.04	090
25447	.....	A	Repair wrist joint(s)	10.31	NA	8.62	1.61	NA	20.54	090
25449	.....	A	Remove wrist joint implant	14.41	NA	10.69	2.12	NA	27.22	090
25450	.....	A	Revision of wrist joint	7.83	NA	10.54	1.05	NA	19.42	090
25455	.....	A	Revision of wrist joint	9.44	NA	11.45	1.28	NA	22.17	090
25490	.....	A	Reinforce radius	9.49	NA	14.19	1.43	NA	25.11	090
25491	.....	A	Reinforce ulna	9.90	NA	14.92	1.69	NA	26.51	090
25492	.....	A	Reinforce radius and ulna	12.26	NA	15.79	1.94	NA	29.99	090
25500	.....	A	Treat fracture of radius	2.44	4.04	2.76	0.34	6.82	5.54	090
25505	.....	A	Treat fracture of radius	5.18	7.31	5.31	0.83	13.32	11.32	090
25515	.....	A	Treat fracture of radius	9.13	NA	7.55	1.46	NA	18.14	090
25520	.....	A	Treat fracture of radius	6.22	7.52	5.93	1.02	14.76	13.17	090
25525	.....	A	Treat fracture of radius	12.17	NA	10.04	2.01	NA	24.22	090
25526	.....	A	Treat fracture of radius	12.91	NA	13.74	2.16	NA	28.81	090
25530	.....	A	Treat fracture of ulna	2.08	4.19	2.84	0.32	6.59	5.24	090
25535	.....	A	Treat fracture of ulna	5.11	6.93	5.23	0.82	12.86	11.16	090
25545	.....	A	Treat fracture of ulna	8.85	NA	7.73	1.47	NA	18.05	090
25560	.....	A	Treat fracture radius & ulna	2.43	4.09	2.70	0.32	6.84	5.45	090
25565	.....	A	Treat fracture radius & ulna	5.60	7.44	5.38	0.91	13.95	11.89	090
25574	.....	A	Treat fracture radius & ulna	6.97	NA	7.21	1.15	NA	15.33	090
25575	.....	A	Treat fracture radius/ulna	10.39	NA	9.50	1.75	NA	21.64	090
25600	.....	A	Treat fracture radius/ulna	2.62	4.52	2.99	0.41	7.55	6.02	090
25605	.....	A	Treat fracture radius/ulna	5.78	8.12	6.08	0.97	14.87	12.83	090
25611	.....	A	Treat fracture radius/ulna	7.73	NA	8.94	1.29	NA	17.96	090
25620	.....	A	Treat fracture radius/ulna	8.50	NA	7.36	1.40	NA	17.26	090
25622	.....	A	Treat wrist bone fracture	2.60	4.69	3.18	0.40	7.69	6.18	090
25624	.....	A	Treat wrist bone fracture	4.50	7.06	4.96	0.73	12.29	10.19	090
25628	.....	A	Treat wrist bone fracture	8.38	NA	7.89	1.37	NA	17.64	090
25630	.....	A	Treat wrist bone fracture	2.86	4.61	2.99	0.44	7.91	6.29	090
25635	.....	A	Treat wrist bone fracture	4.36	6.83	3.97	0.47	11.66	8.80	090
25645	.....	A	Treat wrist bone fracture	7.21	NA	6.86	1.11	NA	15.18	090
25650	.....	A	Treat wrist bone fracture	3.03	4.88	3.27	0.44	8.35	6.74	090
25651	.....	A	Pin ulnar styloid fracture	5.33	NA	5.45	0.86	NA	11.64	090
25652	.....	A	Treat fracture ulnar styloid	7.56	NA	6.93	1.22	NA	15.71	090
25660	.....	A	Treat wrist dislocation	4.73	NA	4.71	0.71	NA	10.15	090
25670	.....	A	Treat wrist dislocation	7.87	NA	7.15	1.28	NA	16.30	090
25671	.....	A	Pin radioulnar dislocation	5.97	NA	6.04	0.97	NA	12.98	090
25675	.....	A	Treat wrist dislocation	4.64	6.57	4.66	0.68	11.89	9.98	090
25676	.....	A	Treat wrist dislocation	7.99	NA	7.40	1.32	NA	16.71	090
25680	.....	A	Treat wrist fracture	5.96	NA	4.80	0.73	NA	11.49	090
25685	.....	A	Treat wrist fracture	9.72	NA	7.96	1.50	NA	19.18	090
25690	.....	A	Treat wrist dislocation	5.47	NA	5.45	0.93	NA	11.85	090
25695	.....	A	Treat wrist dislocation	8.29	NA	7.27	1.28	NA	16.84	090
25800	.....	A	Fusion of wrist joint	9.70	NA	9.20	1.56	NA	20.46	090
25805	.....	A	Fusion/graft of wrist joint	11.22	NA	10.35	1.81	NA	23.38	090
25810	.....	A	Fusion/graft of wrist joint	10.51	NA	9.99	1.64	NA	22.14	090
25820	.....	A	Fusion of hand bones	7.41	NA	7.96	1.15	NA	16.52	090
25825	.....	A	Fuse hand bones with graft	9.22	NA	9.32	1.44	NA	19.98	090
25830	.....	A	Fusion, radioulnar jnt/ulna	10.00	NA	14.86	1.52	NA	26.38	090
25900	.....	A	Amputation of forearm	8.96	NA	13.02	1.29	NA	23.27	090
25905	.....	A	Amputation of forearm	9.07	NA	12.99	1.27	NA	23.33	090
25907	.....	A	Amputation follow-up surgery	7.76	NA	12.36	1.21	NA	21.33	090
25909	.....	A	Amputation follow-up surgery	8.91	NA	12.89	1.28	NA	23.08	090
25915	.....	A	Amputation of forearm	16.98	NA	19.72	2.89	NA	39.59	090
25920	.....	A	Amputate hand at wrist	8.63	NA	8.09	1.27	NA	17.99	090
25922	.....	A	Amputate hand at wrist	7.38	NA	7.25	1.11	NA	15.74	090
25924	.....	A	Amputation follow-up surgery	8.41	NA	8.31	1.28	NA	18.00	090
25927	.....	A	Amputation of hand	8.75	NA	12.27	1.22	NA	22.24	090
25929	.....	A	Amputation follow-up surgery	7.55	NA	6.09	1.07	NA	14.71	090
25931	.....	A	Amputation follow-up surgery	7.77	NA	12.18	1.05	NA	21.00	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	1.53	5.77	1.69	0.17	7.47	3.39	010
26011	.....	A	Drainage of finger abscess	2.18	9.17	2.33	0.30	11.65	4.81	010
26020	.....	A	Drain hand tendon sheath	4.64	NA	5.63	0.71	NA	10.98	090
26025	.....	A	Drainage of palm bursa	4.79	NA	5.42	0.72	NA	10.93	090
26030	.....	A	Drainage of palm bursa(s)	5.90	NA	6.06	0.86	NA	12.82	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
26034		A	Treat hand bone lesion	6.19	NA	6.33	0.95	NA	13.47	090
26035		A	Decompress fingers/hand	9.46	NA	8.20	1.34	NA	19.00	090
26037		A	Decompress fingers/hand	7.21	NA	6.67	1.04	NA	14.92	090
26040		A	Release palm contracture	3.31	NA	4.03	0.54	NA	7.88	090
26045		A	Release palm contracture	5.53	NA	5.62	0.89	NA	12.04	090
26055		A	Incise finger tendon sheath	2.67	14.70	3.89	0.43	17.80	6.99	090
26060		A	Incision of finger tendon	2.79	NA	3.49	0.42	NA	6.70	090
26070		A	Explore/treat hand joint	3.67	NA	3.40	0.42	NA	7.49	090
26075		A	Explore/treat finger joint	3.77	NA	3.81	0.48	NA	8.06	090
26080		A	Explore/treat finger joint	4.22	NA	4.83	0.62	NA	9.67	090
26100		A	Biopsy hand joint lining	3.65	NA	4.14	0.54	NA	8.33	090
26105		A	Biopsy finger joint lining	3.69	NA	4.22	0.54	NA	8.45	090
26110		A	Biopsy finger joint lining	3.51	NA	4.02	0.53	NA	8.06	090
26115		A	Removel hand lesion subcut	3.84	13.49	4.72	0.58	17.91	9.14	090
26116		A	Removel hand lesion, deep	5.50	NA	5.98	0.83	NA	12.31	090
26117		A	Remove tumor, hand/finger	8.50	NA	7.10	1.21	NA	16.81	090
26121		A	Release palm contracture	7.50	NA	6.97	1.13	NA	15.60	090
26123		A	Release palm contracture	9.24	NA	8.84	1.40	NA	19.48	090
26125		A	Release palm contracture	4.58	NA	2.48	0.68	NA	7.74	ZZZ
26130		A	Remove wrist joint lining	5.39	NA	5.36	0.78	NA	11.53	090
26135		A	Revise finger joint, each	6.92	NA	6.47	1.04	NA	14.43	090
26140		A	Revise finger joint, each	6.13	NA	6.03	0.91	NA	13.07	090
26145		A	Tendon excision, palm/finger	6.28	NA	6.05	0.92	NA	13.25	090
26160		A	Remove tendon sheath lesion	3.13	12.84	4.08	0.47	16.44	7.68	090
26170		A	Removal of palm tendon, each	4.74	NA	4.94	0.72	NA	10.40	090
26180		A	Removal of finger tendon	5.15	NA	5.41	0.77	NA	11.33	090
26185		A	Remove finger bone	5.22	NA	5.97	0.80	NA	11.99	090
26200		A	Remove hand bone lesion	5.48	NA	5.35	0.85	NA	11.68	090
26205		A	Remove/graft bone lesion	7.66	NA	6.91	1.14	NA	15.71	090
26210		A	Removal of finger lesion	5.12	NA	5.42	0.77	NA	11.31	090
26215		A	Remove/graft finger lesion	7.06	NA	6.32	0.92	NA	14.30	090
26230		A	Partial removal of hand bone	6.29	NA	5.91	1.01	NA	13.21	090
26235		A	Partial removal, finger bone	6.15	NA	5.81	0.93	NA	12.89	090
26236		A	Partial removal, finger bone	5.29	NA	5.34	0.79	NA	11.42	090
26250		A	Extensive hand surgery	7.51	NA	6.46	1.10	NA	15.07	090
26255		A	Extensive hand surgery	12.36	NA	9.45	1.26	NA	23.07	090
26260		A	Extensive finger surgery	6.99	NA	6.20	0.99	NA	14.18	090
26261		A	Extensive finger surgery	9.04	NA	6.28	1.01	NA	16.33	090
26262		A	Partial removal of finger	5.64	NA	5.35	0.84	NA	11.83	090
26320		A	Removal of implant from hand	3.96	NA	4.30	0.59	NA	8.85	090
26340		A	Manipulate finger w/anesth	2.49	NA	4.79	0.36	NA	7.64	090
26350		A	Repair finger/hand tendon	5.96	NA	15.67	0.87	NA	22.50	090
26352		A	Repair/graft hand tendon	7.64	NA	16.25	1.11	NA	25.00	090
26356		A	Repair finger/hand tendon	8.02	NA	19.11	1.19	NA	28.32	090
26357		A	Repair finger/hand tendon	8.53	NA	16.71	1.22	NA	26.46	090
26358		A	Repair/graft hand tendon	9.09	NA	17.61	1.28	NA	27.98	090
26370		A	Repair finger/hand tendon	7.07	NA	16.11	1.08	NA	24.26	090
26372		A	Repair/graft hand tendon	8.71	NA	17.50	1.27	NA	27.48	090
26373		A	Repair finger/hand tendon	8.11	NA	17.07	1.17	NA	26.35	090
26390		A	Revise hand/finger tendon	9.14	NA	14.07	1.31	NA	24.52	090
26392		A	Repair/graft hand tendon	10.20	NA	17.86	1.51	NA	29.57	090
26410		A	Repair hand tendon	4.60	NA	12.74	0.68	NA	18.02	090
26412		A	Repair/graft hand tendon	6.27	NA	14.08	0.96	NA	21.31	090
26415		A	Excision, hand/finger tendon	8.29	NA	12.43	0.92	NA	21.64	090
26416		A	Graft hand or finger tendon	9.32	NA	15.37	1.44	NA	26.13	090
26418		A	Repair finger tendon	4.23	NA	13.10	0.60	NA	17.93	090
26420		A	Repair/graft finger tendon	6.73	NA	14.43	0.99	NA	22.15	090
26426		A	Repair finger/hand tendon	6.11	NA	13.92	0.92	NA	20.95	090
26428		A	Repair/graft finger tendon	7.17	NA	14.73	1.01	NA	22.91	090
26432		A	Repair finger tendon	4.00	NA	10.81	0.58	NA	15.39	090
26433		A	Repair finger tendon	4.53	NA	11.49	0.67	NA	16.69	090
26434		A	Repair/graft finger tendon	6.06	NA	12.20	0.85	NA	19.11	090
26437		A	Realignment of tendons	5.79	NA	12.12	0.89	NA	18.80	090
26440		A	Release palm/finger tendon	4.99	NA	14.34	0.74	NA	20.07	090
26442		A	Release palm & finger tendon	8.11	NA	16.79	1.13	NA	26.03	090
26445		A	Release hand/finger tendon	4.29	NA	14.09	0.65	NA	19.03	090
26449		A	Release forearm/hand tendon	6.96	NA	16.57	1.01	NA	24.54	090
26450		A	Incision of palm tendon	3.65	NA	7.66	0.55	NA	11.86	090
26455		A	Incision of finger tendon	3.62	NA	7.59	0.56	NA	11.77	090
26460		A	Incise hand/finger tendon	3.44	NA	7.40	0.53	NA	11.37	090
26471		A	Fusion of finger tendons	5.70	NA	11.79	0.87	NA	18.36	090
26474		A	Fusion of finger tendons	5.29	NA	11.97	0.83	NA	18.09	090
26476		A	Tendon lengthening	5.15	NA	11.49	0.74	NA	17.38	090
26477		A	Tendon shortening	5.12	NA	11.66	0.72	NA	17.50	090
26478		A	Lengthening of hand tendon	5.77	NA	12.37	0.92	NA	19.06	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
26479	.....	A	Shortening of hand tendon	5.71	NA	12.22	0.91	NA	18.84	090
26480	.....	A	Transplant hand tendon	6.65	NA	15.85	1.01	NA	23.51	090
26483	.....	A	Transplant/graft hand tendon	8.24	NA	16.31	1.23	NA	25.78	090
26485	.....	A	Transplant palm tendon	7.66	NA	16.18	1.13	NA	24.97	090
26489	.....	A	Transplant/graft palm tendon	9.50	NA	12.70	1.17	NA	23.37	090
26490	.....	A	Revise thumb tendon	8.36	NA	13.32	1.26	NA	22.94	090
26492	.....	A	Tendon transfer with graft	9.57	NA	14.14	1.43	NA	25.14	090
26494	.....	A	Hand tendon/muscle transfer	8.42	NA	13.76	1.35	NA	23.53	090
26496	.....	A	Revise thumb tendon	9.54	NA	13.75	1.40	NA	24.69	090
26497	.....	A	Finger tendon transfer	9.52	NA	14.12	1.40	NA	25.04	090
26498	.....	A	Finger tendon transfer	13.92	NA	16.73	2.09	NA	32.74	090
26499	.....	A	Revision of finger	8.93	NA	13.66	1.13	NA	23.72	090
26500	.....	A	Hand tendon reconstruction	5.93	NA	12.24	0.79	NA	18.96	090
26502	.....	A	Hand tendon reconstruction	7.10	NA	12.72	1.04	NA	20.86	090
26504	.....	A	Hand tendon reconstruction	7.43	NA	13.15	1.01	NA	21.59	090
26508	.....	A	Release thumb contracture	5.98	NA	12.24	0.91	NA	19.13	090
26510	.....	A	Thumb tendon transfer	5.40	NA	11.93	0.85	NA	18.18	090
26516	.....	A	Fusion of knuckle joint	7.11	NA	12.79	1.08	NA	20.98	090
26517	.....	A	Fusion of knuckle joints	8.78	NA	14.12	1.15	NA	24.05	090
26518	.....	A	Fusion of knuckle joints	8.97	NA	13.93	1.35	NA	24.25	090
26520	.....	A	Release knuckle contracture	5.27	NA	14.80	0.78	NA	20.85	090
26525	.....	A	Release finger contracture	5.30	NA	14.91	0.79	NA	21.00	090
26530	.....	A	Revise knuckle joint	6.65	NA	6.08	1.03	NA	13.76	090
26531	.....	A	Revise knuckle with implant	7.86	NA	7.07	1.21	NA	16.14	090
26535	.....	A	Revise finger joint	5.21	NA	3.73	0.79	NA	9.73	090
26536	.....	A	Revise/implant finger joint	6.33	NA	9.84	0.96	NA	17.13	090
26540	.....	A	Repair hand joint	6.39	NA	12.49	0.97	NA	19.85	090
26541	.....	A	Repair hand joint with graft	8.57	NA	13.99	1.34	NA	23.90	090
26542	.....	A	Repair hand joint with graft	6.74	NA	12.54	1.04	NA	20.32	090
26545	.....	A	Reconstruct finger joint	6.88	NA	12.93	0.95	NA	20.76	090
26546	.....	A	Repair nonunion hand	8.87	NA	15.37	1.37	NA	25.61	090
26548	.....	A	Reconstruct finger joint	7.98	NA	13.55	1.17	NA	22.70	090
26550	.....	A	Construct thumb replacement	21.12	NA	18.39	2.16	NA	41.67	090
26551	.....	A	Great toe-hand transfer	46.31	NA	34.09	7.87	NA	88.27	090
26553	.....	A	Single transfer, toe-hand	46.01	NA	23.43	2.39	NA	71.83	090
26554	.....	A	Double transfer, toe-hand	54.64	NA	38.69	9.30	NA	102.63	090
26555	.....	A	Positional change of finger	16.54	NA	18.86	2.55	NA	37.95	090
26556	.....	A	Toe joint transfer	46.99	NA	34.88	7.99	NA	89.86	090
26560	.....	A	Repair of web finger	5.35	NA	10.41	0.72	NA	16.48	090
26561	.....	A	Repair of web finger	10.86	NA	13.07	0.83	NA	24.76	090
26562	.....	A	Repair of web finger	14.91	NA	17.78	1.17	NA	33.86	090
26565	.....	A	Correct metacarpal flaw	6.70	NA	12.60	1.01	NA	20.31	090
26567	.....	A	Correct finger deformity	6.78	NA	12.53	1.01	NA	20.32	090
26568	.....	A	Lengthen metacarpal/finger	9.03	NA	16.27	1.32	NA	26.62	090
26580	.....	A	Repair hand deformity	18.08	NA	13.88	1.75	NA	33.71	090
26587	.....	A	Reconstruct extra finger	13.97	NA	9.14	1.34	NA	24.45	090
26590	.....	A	Repair finger deformity	17.86	NA	14.56	1.58	NA	34.00	090
26591	.....	A	Repair muscles of hand	3.23	NA	10.56	0.44	NA	14.23	090
26593	.....	A	Release muscles of hand	5.28	NA	11.63	0.77	NA	17.68	090
26596	.....	A	Excision constricting tissue	8.90	NA	9.12	1.04	NA	19.06	090
26600	.....	A	Treat metacarpal fracture	1.95	4.13	2.69	0.30	6.38	4.94	090
26605	.....	A	Treat metacarpal fracture	2.83	5.31	3.62	0.46	8.60	6.91	090
26607	.....	A	Treat metacarpal fracture	5.33	NA	6.41	0.84	NA	12.58	090
26608	.....	A	Treat metacarpal fracture	5.33	NA	6.42	0.87	NA	12.62	090
26615	.....	A	Treat metacarpal fracture	5.30	NA	5.59	0.84	NA	11.73	090
26641	.....	A	Treat thumb dislocation	3.92	5.47	3.64	0.50	9.89	8.06	090
26645	.....	A	Treat thumb fracture	4.38	6.17	4.23	0.65	11.20	9.26	090
26650	.....	A	Treat thumb fracture	5.69	NA	6.84	0.92	NA	13.45	090
26665	.....	A	Treat thumb fracture	7.56	NA	6.88	1.16	NA	15.60	090
26670	.....	A	Treat hand dislocation	3.67	4.96	3.09	0.43	9.06	7.19	090
26675	.....	A	Treat hand dislocation	4.61	6.30	4.47	0.67	11.58	9.75	090
26676	.....	A	Pin hand dislocation	5.49	NA	6.87	0.91	NA	13.27	090
26685	.....	A	Treat hand dislocation	6.94	NA	6.32	1.14	NA	14.40	090
26686	.....	A	Treat hand dislocation	7.89	NA	7.10	1.26	NA	16.25	090
26700	.....	A	Treat knuckle dislocation	3.67	4.71	3.02	0.42	8.80	7.11	090
26705	.....	A	Treat knuckle dislocation	4.17	6.10	4.31	0.60	10.87	9.08	090
26706	.....	A	Pin knuckle dislocation	5.09	NA	5.15	0.77	NA	11.01	090
26715	.....	A	Treat knuckle dislocation	5.71	NA	5.78	0.90	NA	12.39	090
26720	.....	A	Treat finger fracture, each	1.65	3.94	2.65	0.24	5.83	4.54	090
26725	.....	A	Treat finger fracture, each	3.31	6.16	4.09	0.52	9.99	7.92	090
26727	.....	A	Treat finger fracture, each	5.20	NA	6.48	0.83	NA	12.51	090
26735	.....	A	Treat finger fracture, each	5.95	NA	5.92	0.92	NA	12.79	090
26740	.....	A	Treat finger fracture, each	1.93	3.60	2.73	0.29	5.82	4.95	090
26742	.....	A	Treat finger fracture, each	3.83	5.88	3.90	0.59	10.30	8.32	090
26746	.....	A	Treat finger fracture, each	5.78	NA	5.97	0.89	NA	12.64	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
26750	.....	A	Treat finger fracture, each	1.69	3.18	2.12	0.23	5.10	4.04	090
26755	.....	A	Treat finger fracture, each	3.08	4.85	3.10	0.44	8.37	6.62	090
26756	.....	A	Pin finger fracture, each	4.36	NA	6.10	0.67	NA	11.13	090
26765	.....	A	Treat finger fracture, each	4.15	NA	4.82	0.61	NA	9.58	090
26770	.....	A	Treat finger dislocation	3.00	4.47	2.60	0.32	7.79	5.92	090
26775	.....	A	Treat finger dislocation	3.69	5.92	3.88	0.52	10.13	8.09	090
26776	.....	A	Pin finger dislocation	4.77	NA	6.27	0.76	NA	11.80	090
26785	.....	A	Treat finger dislocation	4.19	NA	4.85	0.65	NA	9.69	090
26820	.....	A	Thumb fusion with graft	8.21	NA	13.77	1.33	NA	23.31	090
26841	.....	A	Fusion of thumb	7.09	NA	13.67	1.16	NA	21.92	090
26842	.....	A	Thumb fusion with graft	8.19	NA	13.85	1.32	NA	23.36	090
26843	.....	A	Fusion of hand joint	7.57	NA	12.79	1.19	NA	21.55	090
26844	.....	A	Fusion/graft of hand joint	8.68	NA	13.82	1.34	NA	23.84	090
26850	.....	A	Fusion of knuckle	6.93	NA	12.70	1.07	NA	20.70	090
26852	.....	A	Fusion of knuckle with graft	8.41	NA	13.41	1.26	NA	23.08	090
26860	.....	A	Fusion of finger joint	4.66	NA	11.68	0.72	NA	17.06	090
26861	.....	A	Fusion of finger jnt, add-on	1.73	NA	0.94	0.26	NA	2.93	ZZZ
26862	.....	A	Fusion/graft of finger joint	7.33	NA	12.89	1.10	NA	21.32	090
26863	.....	A	Fuse/graft added joint	3.88	NA	2.14	0.61	NA	6.63	ZZZ
26910	.....	A	Amputate metacarpal bone	7.56	NA	11.83	1.08	NA	20.47	090
26951	.....	A	Amputation of finger/thumb	4.56	NA	10.74	0.67	NA	15.97	090
26952	.....	A	Amputation of finger/thumb	6.27	NA	12.35	0.89	NA	19.51	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	7.44	NA	7.70	1.10	NA	16.24	090
26991	.....	A	Drainage of pelvis bursa	6.64	7.56	6.00	1.02	15.22	13.66	090
26992	.....	A	Drainage of bone lesion	12.95	NA	11.00	2.10	NA	26.05	090
27000	.....	A	Incision of hip tendon	5.59	NA	5.35	0.91	NA	11.85	090
27001	.....	A	Incision of hip tendon	6.90	NA	6.21	1.14	NA	14.25	090
27003	.....	A	Incision of hip tendon	7.30	NA	6.62	1.11	NA	15.03	090
27005	.....	A	Incision of hip tendon	9.60	NA	7.93	1.63	NA	19.16	090
27006	.....	A	Incision of hip tendons	9.62	NA	8.08	1.59	NA	19.29	090
27025	.....	A	Incision of hip/thigh fascia	11.10	NA	8.67	1.65	NA	21.42	090
27030	.....	A	Drainage of hip joint	12.94	NA	9.76	2.17	NA	24.87	090
27033	.....	A	Exploration of hip joint	13.31	NA	10.03	2.24	NA	25.58	090
27035	.....	A	Denervation of hip joint	16.59	NA	12.45	2.04	NA	31.08	090
27036	.....	A	Excision of hip joint/muscle	12.81	NA	10.13	2.16	NA	25.10	090
27040	.....	A	Biopsy of soft tissues	2.85	2.65	2.07	0.25	5.75	5.17	010
27041	.....	A	Biopsy of soft tissues	9.83	NA	6.80	1.21	NA	17.84	090
27047	.....	A	Remove hip/pelvis lesion	7.41	6.62	5.05	0.95	14.98	13.41	090
27048	.....	A	Remove hip/pelvis lesion	6.21	NA	5.10	0.87	NA	12.18	090
27049	.....	A	Remove tumor, hip/pelvis	13.58	NA	8.93	1.92	NA	24.43	090
27050	.....	A	Biopsy of sacroiliac joint	4.34	NA	4.52	0.64	NA	9 50	090
27052	.....	A	Biopsy of hip joint	6.19	NA	5.95	1.02	NA	13.16	090
27054	.....	A	Removal of hip joint lining	8.49	NA	7.44	1.40	NA	17.33	090
27060	.....	A	Removal of ischial bursa	5.40	NA	4.88	0.72	NA	11.00	090
27062	.....	A	Remove femur lesion/bursa	5.34	NA	5.28	0.89	NA	11.51	090
27065	.....	A	Removal of hip bone lesion	5.87	NA	5.60	0.91	NA	12.38	090
27066	.....	A	Removal of hip bone lesion	10.27	NA	8.59	1.70	NA	20.56	090
27067	.....	A	Remove/graft hip bone lesion	13.75	NA	10.79	2.34	NA	26.88	090
27070	.....	A	Partial removal of hip bone	10.66	NA	9.88	1.63	NA	22.17	090
27071	.....	A	Partial removal of hip bone	11.39	NA	10.86	1.81	NA	24.06	090
27075	.....	A	Extensive hip surgery	34.80	NA	19.89	2.66	NA	57.35	090
27076	.....	A	Extensive hip surgery	21.99	NA	14.93	3.43	NA	40.35	090
27077	.....	A	Extensive hip surgery	39.77	NA	23.36	3.81	NA	66.94	090
27078	.....	A	Extensive hip surgery	13.36	NA	10.54	2.00	NA	25.90	090
27079	.....	A	Extensive hip surgery	13.67	NA	10.20	2.23	NA	26.10	090
27080	.....	A	Removal of tail bone	6.35	NA	5.14	0.96	NA	12.45	090
27086	.....	A	Remove hip foreign body	1.86	2.03	1.89	0.20	4.09	3.95	010
27087	.....	A	Remove hip foreign body	8.49	NA	6.79	1.31	NA	16.59	090
27090	.....	A	Removal of hip prosthesis	11.09	NA	8.74	1.86	NA	21.69	090
27091	.....	A	Removal of hip prosthesis	22.01	NA	14.02	3.73	NA	39.76	090
27093	.....	A	Injection for hip x-ray	1.29	12.36	0.49	0.11	13.76	1.89	000
27095	.....	A	Injection for hip x-ray	1.49	10.91	0.53	0.12	12.52	2.14	000
27096	.....	A	Inject sacroiliac joint	1.39	9.63	0.34	0.10	11.12	1.83	000
27097	.....	A	Revision of hip tendon	8.75	NA	6.56	1.46	NA	16.77	090
27098	.....	A	Transfer tendon to pelvis	8.78	NA	7.16	1.49	NA	17.43	090
27100	.....	A	Transfer of abdominal muscle	11.02	NA	8.83	1.88	NA	21.73	090
27105	.....	A	Transfer of spinal muscle	11.70	NA	9.31	1.99	NA	23.00	090
27110	.....	A	Transfer of iliopsoas muscle	13.18	NA	9.54	1.65	NA	24.37	090
27111	.....	A	Transfer of iliopsoas muscle	12.08	NA	9.28	1.77	NA	23.13	090
27120	.....	A	Reconstruction of hip socket	17.91	NA	11.87	2.94	NA	32.72	090
27122	.....	A	Reconstruction of hip socket	14.89	NA	11.02	2.49	NA	28.40	090
27125	.....	A	Partial hip replacement	14.61	NA	10.60	2.46	NA	27.67	090
27130	.....	A	Total hip arthroplasty	20.01	NA	13.35	3.38	NA	36.74	090
27132	.....	A	Total hip arthroplasty	23.17	NA	15.65	3.91	NA	42.73	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
27134		A	Revise hip joint replacement	28.36	NA	17.88	4.76	NA	51.00	090
27137		A	Revise hip joint replacement	21.05	NA	13.96	3.56	NA	38.57	090
27138		A	Revise hip joint replacement	22.04	NA	14.44	3.73	NA	40.21	090
27140		A	Transplant femur ridge	12.17	NA	9.52	2.00	NA	23.69	090
27146		A	Incision of hip bone	17.33	NA	12.38	2.72	NA	32.43	090
27147		A	Revision of hip bone	20.46	NA	13.49	3.13	NA	37.08	090
27151		A	Incision of hip bones	22.38	NA	8.38	3.74	NA	34.50	090
27156		A	Revision of hip bones	24.49	NA	16.27	4.17	NA	44.93	090
27158		A	Revision of pelvis	19.63	NA	11.37	3.12	NA	34.12	090
27161		A	Incision of neck of femur	16.61	NA	12.21	2.78	NA	31.60	090
27165		A	Incision/fixation of femur	17.81	NA	12.99	3.01	NA	33.81	090
27170		A	Repair/graft femur head/neck	15.98	NA	11.42	2 64	NA	30.04	090
27175		A	Treat slipped epiphysis	8.41	NA	6.65	1.43	NA	16.49	090
27176		A	Treat slipped epiphysis	11.98	NA	9.09	2.01	NA	23.08	090
27177		A	Treat slipped epiphysis	14.99	NA	10.95	2.53	NA	28.47	090
27178		A	Treat slipped epiphysis	11.92	NA	8.51	2.01	NA	22.44	090
27179		A	Revise head/neck of femur	12.91	NA	10.02	2.21	NA	25.14	090
27181		A	Treat slipped epiphysis	14.60	NA	10.26	2.09	NA	26.95	090
27185		A	Revision of femur epiphysis	9.13	NA	7.66	1.55	NA	18.34	090
27187		A	Reinforce hip bones	13.46	NA	10.44	2.27	NA	26.17	090
27193		A	Treat pelvic ring fracture	5.53	7.18	5.80	0.92	13.63	12.25	090
27194		A	Treat pelvic ring fracture	9.59	8.86	7.58	1.58	20.03	18.75	090
27200		A	Treat tail bone fracture	1.83	3.08	2.21	0.26	5.17	4.30	090
27202		A	Treat tail bone fracture	7.00	NA	17.89	0.83	NA	25.72	090
27215		A	Treat pelvic fracture(s)	9.99	NA	7.25	1.64	NA	18.88	090
27216		A	Treat pelvic ring fracture	15.10	NA	9.84	2.58	NA	27.52	090
27217		A	Treat pelvic ring fracture	14.03	NA	10.27	2.34	NA	26.64	090
27218		A	Treat pelvic ring fracture	20.04	NA	11.64	3.42	NA	35.10	090
27220		A	Treat hip socket fracture	6.14	7.13	5.57	1.02	14.29	12.73	090
27222		A	Treat hip socket fracture	12.63	NA	9.98	2.12	NA	24.73	090
27226		A	Treat hip wall fracture	14.83	NA	8.05	2.48	NA	25.36	090
27227		A	Treat hip fracture(s)	23.32	NA	15.52	3.88	NA	42.72	090
27228		A	Treat hip fracture(s)	27.01	NA	17.76	4.52	NA	49.29	090
27230		A	Treat thigh fracture	5.47	6.59	5.11	0.87	12.93	11.45	090
27232		A	Treat thigh fracture	10.62	NA	7.26	1.74	NA	19.62	090
27235		A	Treat thigh fracture	12.09	NA	9.50	2.05	NA	23.64	090
27236		A	Treat thigh fracture	15.51	NA	11.05	2.61	NA	29.17	090
27238		A	Treat thigh fracture	5.49	NA	5.15	0.91	NA	11.55	090
27240		A	Treat thigh fracture	12.43	NA	9.47	2.03	NA	23.93	090
27244		A	Treat thigh fracture	15.85	NA	11.37	2.67	NA	29.89	090
27245		A	Treat thigh fracture	20.19	NA	13.84	3.42	NA	37.45	090
27246		A	Treat thigh fracture	4.68	5.73	4.47	0.79	11.20	9.94	090
27248		A	Treat thigh fracture	10.39	NA	8.28	1.74	NA	20.41	090
27250		A	Treat hip dislocation	6.91	NA	4.84	0.82	NA	12.57	090
27252		A	Treat hip dislocation	10.33	NA	7.47	1.64	NA	19.44	090
27253		A	Treat hip dislocation	12.85	NA	9.82	2.17	NA	24.84	090
27254		A	Treat hip dislocation	18.16	NA	12.16	3.02	NA	33.34	090
27256		A	Treat hip dislocation	4.10	3.47	2.11	0.59	8.16	6.80	010
27257		A	Treat hip dislocation	5.19	NA	2.92	0.67	NA	8.78	010
27258		A	Treat hip dislocation	15.34	NA	11.03	2.47	NA	28.84	090
27259		A	Treat hip dislocation	21.43	NA	14.27	3.58	NA	39.28	090
27265		A	Treat hip dislocation	5.02	NA	4.81	0.78	NA	10.61	090
27266		A	Treat hip dislocation	7.45	NA	6.33	1.25	NA	15.03	090
27275		A	Manipulation of hip joint	2.26	NA	2.15	0.37	NA	4.78	010
27280		A	Fusion of sacroiliac joint	13.31	NA	10.41	2.37	NA	26.09	090
27282		A	Fusion of pubic bones	11.28	NA	8.33	1.37	NA	20.98	090
27284		A	Fusion of hip joint	23.32	NA	14.99	2 83	NA	41.14	090
27286		A	Fusion of hip joint	23.32	NA	15.98	2.84	NA	42.14	090
27290		A	Amputation of leg at hip	23.15	NA	14.32	3.52	NA	40.99	090
27295		A	Amputation of leg at hip	18.54	NA	11.65	2.82	NA	33.01	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	6.45	7.42	5.91	0.96	14.83	13.32	090
27303		A	Drainage of bone lesion	8.23	NA	7.32	1.37	NA	16.92	090
27305		A	Incise thigh tendon & fascia	5.89	NA	5.40	0.92	NA	12.21	090
27306		A	Incision of thigh tendon	4.59	NA	4.85	0.74	NA	10.18	090
27307		A	Incision of thigh tendons	5.77	NA	5.58	0.93	NA	12.28	090
27310		A	Exploration of knee joint	9.22	NA	7.62	1.55	NA	18.39	090
27315		A	Partial removal, thigh nerve	6.93	NA	4.88	0.95	NA	12.76	090
27320		A	Partial removal, thigh nerve	6.26	NA	5.18	0.93	NA	12.37	090
27323		A	Biopsy, thigh soft tissues	2.27	2.22	1.94	0.20	4.69	4.41	010
27324		A	Biopsy, thigh soft tissues	4.87	NA	4.40	0.71	NA	9.98	090
27327		A	Removal of thigh lesion	4.44	5.40	3.95	0.60	10.44	8.99	090
27328		A	Removal of thigh lesion	5.54	NA	4.61	0.79	NA	10.94	090
27329		A	Remove tumor, thigh/knee	14.06	NA	9.62	2.01	NA	25.69	090
27330		A	Biopsy, knee joint lining	4.94	NA	4.69	0.79	NA	10.42	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
27331	.....	A	Explore/treat knee joint	5.85	NA	5.57	0.97	NA	12.39	090
27332	.....	A	Removal of knee cartilage	8.22	NA	7.14	1.38	NA	16.74	090
27333	.....	A	Removal of knee cartilage	7.26	NA	6.68	1.23	NA	15.17	090
27334	.....	A	Remove knee joint lining	8.65	NA	7.46	1.45	NA	17.56	090
27335	.....	A	Remove knee joint lining	9.94	NA	8.27	1.69	NA	19.90	090
27340	.....	A	Removal of kneecap bursa	4.16	NA	4.57	0.70	NA	9.43	090
27345	.....	A	Removal of knee cyst	5.89	NA	5.66	0.97	NA	12.52	090
27347	.....	A	Remove knee cyst	5.75	NA	5.48	0.91	NA	12.14	090
27350	.....	A	Removal of kneecap	8.12	NA	7.26	1.38	NA	16.76	090
27355	.....	A	Remove femur lesion	7.61	NA	6.88	1.28	NA	15.77	090
27356	.....	A	Remove femur lesion/graft	9.43	NA	7.97	1.55	NA	18.95	090
27357	.....	A	Remove femur lesion/graft	10.47	NA	8.80	1.77	NA	21.04	090
27358	.....	A	Remove femur lesion/fixation	4.71	NA	2.56	0.80	NA	8.07	ZZZ
27360	.....	A	Partial removal, leg bone(s)	10.44	NA	10.04	1.70	NA	22.18	090
27365	.....	A	Extensive leg surgery	16.18	NA	11.80	2.71	NA	30.69	090
27370	.....	A	Injection for knee x-ray	0.95	12.16	0.33	0.07	13.18	1.35	000
27372	.....	A	Removal of foreign body	5.04	6.08	4.73	0.74	11.86	10.51	090
27380	.....	A	Repair of kneecap tendon	7.12	NA	7.33	1.20	NA	15.65	090
27381	.....	A	Repair/graft kneecap tendon	10.28	NA	9.14	1.73	NA	21.15	090
27385	.....	A	Repair of thigh muscle	7.72	NA	7.67	1.31	NA	16.70	090
27386	.....	A	Repair/graft of thigh muscle	10.50	NA	9.57	1.79	NA	21.86	090
27390	.....	A	Incision of thigh tendon	5.30	NA	5.31	0.83	NA	11.44	090
27391	.....	A	Incision of thigh tendons	7.16	NA	6.70	1.19	NA	15.05	090
27392	.....	A	Incision of thigh tendons	9.15	NA	7.80	1.47	NA	18.42	090
27393	.....	A	Lengthening of thigh tendon	6.35	NA	5.91	1.08	NA	13.34	090
27394	.....	A	Lengthening of thigh tendons	8.45	NA	7.35	1.40	NA	17.20	090
27395	.....	A	Lengthening of thigh tendons	11.66	NA	9.49	1.95	NA	23.10	090
27396	.....	A	Transplant of thigh tendon	7.82	NA	7.13	1.33	NA	16.28	090
27397	.....	A	Transplants of thigh tendons	11.22	NA	9.14	1.89	NA	22.25	090
27400	.....	A	Revise thigh muscles/tendons	8.97	NA	7.42	1.41	NA	17.80	090
27403	.....	A	Repair of knee cartilage	8.28	NA	7.22	1.39	NA	16.89	090
27405	.....	A	Repair of knee ligament	8.60	NA	7.54	1.45	NA	17.59	090
27407	.....	A	Repair of knee ligament	10.22	NA	8.39	1.65	NA	20.26	090
27409	.....	A	Repair of knee ligaments	12.83	NA	10.01	2.10	NA	24.94	090
27418	.....	A	Repair degenerated kneecap	10.79	NA	8.95	1.81	NA	21.55	090
27420	.....	A	Revision of unstable kneecap	9.77	NA	8.15	1.65	NA	19.57	090
27422	.....	A	Revision of unstable kneecap	9.72	NA	8.16	1.64	NA	19.52	090
27424	.....	A	Revision/removal of kneecap	9.75	NA	8.13	1.65	NA	19.53	090
27425	.....	A	Lat retinacular release open	5.19	NA	5.55	0.87	NA	11.61	090
27427	.....	A	Reconstruction, knee	9.31	NA	7.82	1.55	NA	18.68	090
27428	.....	A	Reconstruction, knee	13.92	NA	11.21	2.34	NA	27.47	090
27429	.....	A	Reconstruction, knee	15.43	NA	12.47	2.61	NA	30.51	090
27430	.....	A	Revision of thigh muscles	9.61	NA	8.05	1.62	NA	19.28	090
27435	.....	A	Incision of knee joint	9.44	NA	8.45	1.59	NA	19.48	090
27437	.....	A	Revise kneecap	8.41	NA	7.19	1.41	NA	17.01	090
27438	.....	A	Revise kneecap with implant	11.17	NA	8.51	1.87	NA	21.55	090
27440	.....	A	Revision of knee joint	10.37	NA	6.08	1.70	NA	18.15	090
27441	.....	A	Revision of knee joint	10.76	NA	6.76	1.79	NA	19.31	090
27442	.....	A	Revision of knee joint	11.82	NA	8.90	2.01	NA	22.73	090
27443	.....	A	Revision of knee joint	10.87	NA	8.67	1.82	NA	21.36	090
27445	.....	A	Revision of knee joint	17.58	NA	12.35	2.98	NA	32.91	090
27446	.....	A	Revision of knee joint	15.75	NA	11.26	2.66	NA	29.67	090
27447	.....	A	Total knee arthroplasty	21.36	NA	14.61	3.60	NA	39.57	090
27448	.....	A	Incision of thigh	11.00	NA	8.74	1.81	NA	21.55	090
27450	.....	A	Incision of thigh	13.90	NA	10.71	2.35	NA	26.96	090
27454	.....	A	Realignment of thigh bone	17.46	NA	12.62	2.95	NA	33.03	090
27455	.....	A	Realignment of knee	12.75	NA	9.96	2.13	NA	24.84	090
27457	.....	A	Realignment of knee	13.37	NA	10.01	2.25	NA	25.63	090
27465	.....	A	Shortening of thigh bone	13.79	NA	10.45	2.23	NA	26.47	090
27466	.....	A	Lengthening of thigh bone	16.24	NA	12.00	2.30	NA	30.54	090
27468	.....	A	Shorten/lengthen thighs	18.86	NA	12.58	3.21	NA	34.65	090
27470	.....	A	Repair of thigh	15.98	NA	11.96	2.68	NA	30.62	090
27472	.....	A	Repair/graft of thigh	17.62	NA	12.86	2.98	NA	33.46	090
27475	.....	A	Surgery to stop leg growth	8.59	NA	7.30	1.35	NA	17.24	090
27477	.....	A	Surgery to stop leg growth	9.79	NA	7.82	1.57	NA	19.18	090
27479	.....	A	Surgery to stop leg growth	12.73	NA	9.96	2.17	NA	24.86	090
27485	.....	A	Surgery to stop leg growth	8.79	NA	7.46	1.49	NA	17.74	090
27486	.....	A	Revise/replace knee joint	19.16	NA	13.48	3.24	NA	35.88	090
27487	.....	A	Revise/replace knee joint	25.13	NA	16.59	4.24	NA	45.96	090
27488	.....	A	Removal of knee prosthesis	15.65	NA	11.66	2.65	NA	29.96	090
27495	.....	A	Reinforce thigh	15.46	NA	11.59	2.61	NA	29.66	090
27496	.....	A	Decompression of thigh/knee	6.08	NA	5.77	0.92	NA	12.77	090
27497	.....	A	Decompression of thigh/knee	7.13	NA	5.71	1.01	NA	13.85	090
27498	.....	A	Decompression of thigh/knee	7.94	NA	6.13	1.16	NA	15.23	090
27499	.....	A	Decompression of thigh/knee	8.95	NA	7.06	1.41	NA	17.42	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
27500		A	Treatment of thigh fracture	5.89	7.09	5.05	0.96	13.94	11.90	090
27501		A	Treatment of thigh fracture	5.89	7.65	5.73	0.99	14.53	12.61	090
27502		A	Treatment of thigh fracture	10.52	NA	8.20	1.79	NA	20.51	090
27503		A	Treatment of thigh fracture	10.52	NA	8.35	1.79	NA	20.66	090
27506		A	Treatment of thigh fracture	17.35	NA	12.84	2.79	NA	32.98	090
27507		A	Treatment of thigh fracture	13.91	NA	9.98	2.34	NA	26.23	090
27508		A	Treatment of thigh fracture	5.80	7.05	5.38	0.96	13.81	12.14	090
27509		A	Treatment of thigh fracture	7.67	NA	7.99	1.29	NA	16.95	090
27510		A	Treatment of thigh fracture	9.08	NA	7.25	1.51	NA	17.84	090
27511		A	Treatment of thigh fracture	13.56	NA	11.31	2.29	NA	27.16	090
27513		A	Treatment of thigh fracture	17.82	NA	13.97	3.01	NA	34.80	090
27514		A	Treatment of thigh fracture	17.20	NA	13.44	2.89	NA	33.53	090
27516		A	Treat thigh fx growth plate	5.34	7.35	5.44	0.89	13.58	11.67	090
27517		A	Treat thigh fx growth plate	8.73	8.99	7.42	1.46	19.18	17.61	090
27519		A	Treat thigh fx growth plate	14.93	NA	11.75	2.51	NA	29.19	090
27520		A	Treat kneecap fracture	2.84	5.29	3.46	0.46	8.59	6.76	090
27524		A	Treat kneecap fracture	9.94	NA	8.23	1.68	NA	19.85	090
27530		A	Treat knee fracture	3.76	5.95	4.32	0.61	10.32	8.69	090
27532		A	Treat knee fracture	7.26	7.90	6.32	1.22	16.38	14.80	090
27535		A	Treat knee fracture	11.43	NA	10.20	1.93	NA	23.56	090
27536		A	Treat knee fracture	15.56	NA	11.60	2.62	NA	29.78	090
27538		A	Treat knee fracture(s)	4.84	7.14	5.14	0.80	12.78	10.78	090
27540		A	Treat knee fracture	13.03	NA	9.57	2.16	NA	24.76	090
27550		A	Treat knee dislocation	5.73	6.66	4.99	0.82	13.21	11.54	090
27552		A	Treat knee dislocation	7.85	NA	6.94	1.32	NA	16.11	090
27556		A	Treat knee dislocation	14.33	NA	11.78	2.41	NA	28.52	090
27557		A	Treat knee dislocation	16.67	NA	13.26	2.64	NA	32.77	090
27558		A	Treat knee dislocation	17.62	NA	13.22	3.01	NA	33.85	090
27560		A	Treat kneecap dislocation	3.80	5.65	3.35	0.48	9.93	7.63	090
27562		A	Treat kneecap dislocation	5.76	NA	4.85	0.83	NA	11.44	090
27566		A	Treat kneecap dislocation	12.16	NA	9.35	2.07	NA	23.58	090
27570		A	Fixation of knee joint	1.73	NA	1.83	0.29	NA	3.85	010
27580		A	Fusion of knee	19.26	NA	14.91	3.24	NA	37.41	090
27590		A	Amputate leg at thigh	11.96	NA	7.14	1.62	NA	20.72	090
27591		A	Amputate leg at thigh	12.61	NA	8.95	1.95	NA	23.51	090
27592		A	Amputate leg at thigh	9.96	NA	6.64	1.40	NA	18.00	090
27594		A	Amputation follow-up surgery	6.88	NA	5.48	0.98	NA	13.34	090
27596		A	Amputation follow-up surgery	10.54	NA	7.28	1.49	NA	19.31	090
27598		A	Amputate lower leg at knee	10.47	NA	7.38	1.49	NA	19.34	090
27599		C	Leg surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
27600		A	Decompression of lower leg	5.62	NA	4.72	0.82	NA	11.16	090
27601		A	Decompression of lower leg	5.61	NA	5.05	0.83	NA	11.49	090
27602		A	Decompression of lower leg	7.31	NA	5.34	1.02	NA	13.67	090
27603		A	Drain lower leg lesion	4.91	10.78	4.88	0.67	16.36	10.46	090
27604		A	Drain lower leg bursa	4.44	8.71	4.57	0.65	13.80	9.66	090
27605		A	Incision of achilles tendon	2.85	8.89	2.36	0.46	12.20	5.67	010
27606		A	Incision of achilles tendon	4.12	10.17	3.44	0.68	14.97	8.24	010
27607		A	Treat lower leg bone lesion	7.92	NA	6.65	1.29	NA	15.86	090
27610		A	Explore/treat ankle joint	8.29	NA	7.13	1.38	NA	16.80	090
27612		A	Exploration of ankle joint	7.29	NA	6.18	1.21	NA	14.68	090
27613		A	Biopsy lower leg soft tissue	2.16	3.81	1.78	0.19	6.16	4.13	010
27614		A	Biopsy lower leg soft tissue	5.63	8.89	4.67	0.74	15.26	11.04	090
27615		A	Remove tumor, lower leg	12.49	NA	10.68	1.67	NA	24.84	090
27618		A	Remove lower leg lesion	5.06	9.20	4.26	0.65	14.91	9.97	090
27619		A	Remove lower leg lesion	8.35	10.73	6.23	1.21	20.29	15.79	090
27620		A	Explore/treat ankle joint	5.95	NA	5.55	0.99	NA	12.49	090
27625		A	Remove ankle joint lining	8.25	NA	6.61	1.39	NA	16.25	090
27626		A	Remove ankle joint lining	8.86	NA	7.08	1.47	NA	17.41	090
27630		A	Removal of tendon lesion	4.77	9.12	4.51	0.72	14.61	10.00	090
27635		A	Remove lower leg bone lesion	7.74	NA	6.92	1.27	NA	15.93	090
27637		A	Remove/graft leg bone lesion	9.79	NA	8.43	1.65	NA	19.87	090
27638		A	Remove/graft leg bone lesion	10.51	NA	8.48	1.76	NA	20.75	090
27640		A	Partial removal of tibia	11.31	NA	10.93	1.85	NA	24.09	090
27641		A	Partial removal of fibula	9.19	NA	8.92	1.46	NA	19.57	090
27645		A	Extensive lower leg surgery	14.09	NA	12.47	2.37	NA	28.93	090
27646		A	Extensive lower leg surgery	12.59	NA	11.45	1.86	NA	25.90	090
27647		A	Extensive ankle/heel surgery	12.17	NA	7.91	1.97	NA	22.05	090
27648		A	Injection for ankle x-ray	0.95	9.54	0.33	0.06	10.55	1.34	000
27650		A	Repair achilles tendon	9.63	NA	7.59	1.62	NA	18.84	090
27652		A	Repair/graft achilles tendon	10.27	NA	8.10	1.74	NA	20.11	090
27654		A	Repair of achilles tendon	9.96	NA	7.30	1.69	NA	18.95	090
27656		A	Repair leg fascia defect	4.54	10.07	4.04	0.58	15.19	9.16	090
27658		A	Repair of leg tendon, each	4.95	9.29	4.82	0.82	15.06	10.59	090
27659		A	Repair of leg tendon, each	6.77	11.42	5.85	1.15	19.34	13.77	090
27664		A	Repair of leg tendon, each	4.56	11.39	4.79	0.76	16.71	10.11	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
27665		A	Repair of leg tendon, each	5.37	11.17	5.24	0.90	17.44	11.51	090
27675		A	Repair lower leg tendons	7.14	NA	5.85	1.21	NA	14.20	090
27676		A	Repair lower leg tendons	8.37	NA	6.85	1.38	NA	16.60	090
27680		A	Release of lower leg tendon	5.71	NA	5.25	0.96	NA	11.92	090
27681		A	Release of lower leg tendons	6.78	NA	6.02	1.10	NA	13.90	090
27685		A	Revision of lower leg tendon	6.46	8.21	5.57	1.09	15.76	13.12	090
27686		A	Revise lower leg tendons	7.42	12.67	6.66	1.26	21.35	15.34	090
27687		A	Revision of calf tendon	6.20	NA	5.48	1.05	NA	12.73	090
27690		A	Revise lower leg tendon	8.66	NA	6.52	1.46	NA	16.64	090
27691		A	Revise lower leg tendon	9.90	NA	7.90	1.68	NA	19.48	090
27692		A	Revise additional leg tendon	1.86	NA	0.94	0.31	NA	3.11	ZZZ
27695		A	Repair of ankle ligament	6.47	NA	5.98	1.08	NA	13.53	090
27696		A	Repair of ankle ligaments	8.22	NA	6.57	1.39	NA	16.18	090
27698		A	Repair of ankle ligament	9.31	NA	7.06	1.57	NA	17.94	090
27700		A	Revision of ankle joint	9.24	NA	5.69	1.49	NA	16.42	090
27702		A	Reconstruct ankle joint	13.59	NA	10.43	2.30	NA	26.32	090
27703		A	Reconstruction, ankle joint	15.78	NA	11.20	2.68	NA	29.66	090
27704		A	Removal of ankle implant	7.58	NA	5.61	0.73	NA	13.92	090
27705		A	Incision of tibia	10.32	NA	8.33	1.73	NA	20.38	090
27707		A	Incision of fibula	4.35	NA	5.07	0.72	NA	10.14	090
27709		A	Incision of tibia & fibula	9.89	NA	8.25	1.67	NA	19.81	090
27712		A	Realignment of lower leg	14.17	NA	10.84	2.40	NA	27.41	090
27715		A	Revision of lower leg	14.31	NA	10.95	2.40	NA	27.66	090
27720		A	Repair of tibia	11.72	NA	9.56	1.99	NA	23.27	090
27722		A	Repair/graft of tibia	11.75	NA	9.32	1.98	NA	23.05	090
27724		A	Repair/graft of tibia	18.10	NA	12.58	2.52	NA	33.20	090
27725		A	Repair of lower leg	15.50	NA	12.01	2.64	NA	30.15	090
27727		A	Repair of lower leg	13.93	NA	10.52	2.21	NA	26.66	090
27730		A	Repair of tibia epiphysis	7.37	17.94	6.52	0.90	26.21	14.79	090
27732		A	Repair of fibula epiphysis	5.29	11.72	5.06	0.76	17.77	11.11	090
27734		A	Repair lower leg epiphyses	8.43	NA	6.49	1.02	NA	15.94	090
27740		A	Repair of leg epiphyses	9.25	20.84	8.01	1.57	31.66	18.83	090
27742		A	Repair of leg epiphyses	10.24	12.64	7.34	1.86	24.74	19.44	090
27745		A	Reinforce tibia	10.01	NA	8.30	1.65	NA	19.96	090
27750		A	Treatment of tibia fracture	3.17	5.43	3.81	0.52	9.12	7.50	090
27752		A	Treatment of tibia fracture	5.81	7.46	5.55	0.98	14.25	12.34	090
27756		A	Treatment of tibia fracture	6.74	NA	6.60	1.13	NA	14.47	090
27758		A	Treatment of tibia fracture	11.60	NA	9.29	1.82	NA	22.71	090
27759		A	Treatment of tibia fracture	13.68	NA	10.43	2.31	NA	26.42	090
27760		A	Treatment of ankle fracture	2.99	5.31	3.59	0.47	8.77	7.05	090
27762		A	Treatment of ankle fracture	5.22	7.20	5.22	0.85	13.27	11.29	090
27766		A	Treatment of ankle fracture	8.31	NA	7.24	1.40	NA	16.95	090
27780		A	Treatment of fibula fracture	2.63	4.98	3.25	0.40	8.01	6.28	090
27781		A	Treatment of fibula fracture	4.37	6.42	4.54	0.68	11.47	9.59	090
27784		A	Treatment of fibula fracture	7.07	NA	6.53	1.17	NA	14.77	090
27786		A	Treatment of ankle fracture	2.82	5.15	3.37	0.44	8.41	6.63	090
27788		A	Treatment of ankle fracture	4.42	6.54	4.54	0.73	11.69	9.69	090
27792		A	Treatment of ankle fracture	7.62	NA	6.98	1.28	NA	15.88	090
27808		A	Treatment of ankle fracture	2.81	5.76	3.65	0.46	9.03	6.92	090
27810		A	Treatment of ankle fracture	5.10	7.03	5.05	0.85	12.98	11.00	090
27814		A	Treatment of ankle fracture	10.62	NA	8.63	1.80	NA	21.05	090
27816		A	Treatment of ankle fracture	2.87	5.05	3.45	0.44	8.36	6.76	090
27818		A	Treatment of ankle fracture	5.47	7.14	5.10	0.89	13.50	11.46	090
27822		A	Treatment of ankle fracture	10.94	NA	10.75	1.55	NA	23.24	090
27823		A	Treatment of ankle fracture	12.93	NA	11.61	1.98	NA	26.52	090
27824		A	Treat lower leg fracture	2.87	5.63	3.78	0.47	8.97	7.12	090
27825		A	Treat lower leg fracture	6.15	8.28	5.92	1.02	15.45	13.09	090
27826		A	Treat lower leg fracture	8.49	NA	8.96	1.43	NA	18.88	090
27827		A	Treat lower leg fracture	13.98	NA	12.85	2.35	NA	29.18	090
27828		A	Treat lower leg fracture	16.14	NA	14.00	2.72	NA	32.86	090
27829		A	Treat lower leg joint	5.46	NA	6.85	0.92	NA	13.23	090
27830		A	Treat lower leg dislocation	3.77	5.19	3.88	0.53	9.49	8.18	090
27831		A	Treat lower leg dislocation	4.53	NA	4.50	0.73	NA	9.76	090
27832		A	Treat lower leg dislocation	6.45	NA	6.22	1.09	NA	13.76	090
27840		A	Treat ankle dislocation	4.55	NA	3.95	0.56	NA	9.06	090
27842		A	Treat ankle dislocation	6.17	NA	5.15	0.91	NA	12.23	090
27846		A	Treat ankle dislocation	9.73	NA	8.01	1.63	NA	19.37	090
27848		A	Treat ankle dislocation	11.14	NA	9.81	1.86	NA	22.81	090
27860		A	Fixation of ankle joint	2.33	NA	2.03	0.37	NA	4.73	010
27870		A	Fusion of ankle joint, open	13.83	NA	10.61	2.34	NA	26.78	090
27871		A	Fusion of tibiofibular joint	9.12	NA	7.70	1.55	NA	18.37	090
27880		A	Amputation of lower leg	11.78	NA	7.51	1.65	NA	20.94	090
27881		A	Amputation of lower leg	12.27	NA	9.09	1.91	NA	23.27	090
27882		A	Amputation of lower leg	8.89	NA	7.00	1.23	NA	17.12	090
27884		A	Amputation follow-up surgery	8.16	NA	6.13	1.14	NA	15.43	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
27886	.....	A	Amputation follow-up surgery	9.27	NA	6.88	1.35	NA	17.50	090
27888	.....	A	Amputation of foot at ankle	9.61	NA	7.67	1.51	NA	18.79	090
27889	.....	A	Amputation of foot at ankle	9.92	NA	6.79	1.43	NA	18.14	090
27892	.....	A	Decompression of leg	7.35	NA	5.89	1.03	NA	14.27	090
27893	.....	A	Decompression of leg	7.31	NA	5.80	1.08	NA	14.19	090
27894	.....	A	Decompression of leg	10.43	NA	7.99	1.50	NA	19.92	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	2.71	5.88	3.54	0.37	8.96	6.62	010
28002	.....	A	Treatment of foot infection	4.59	7.30	4.68	0.67	12.56	9.94	010
28003	.....	A	Treatment of foot infection	8.36	7.75	6.10	1.23	17.34	15.69	090
28005	.....	A	Treat foot bone lesion	8.63	NA	6.43	1.37	NA	16.43	090
28008	.....	A	Incision of foot fascia	4.42	5.75	3.59	0.67	10.84	8.68	090
28010	.....	A	Incision of toe tendon	2.82	5.59	2.94	0.47	8.88	6.23	090
28011	.....	A	Incision of toe tendons	4.12	7.50	4.29	0.70	12.32	9.11	090
28020	.....	A	Exploration of foot joint	4.98	7.14	4.25	0.77	12.89	10.00	090
28022	.....	A	Exploration of foot joint	4.64	6.16	3.97	0.74	11.54	9.35	090
28024	.....	A	Exploration of toe joint	4.36	6.26	4.03	0.60	11.22	8.99	090
28030	.....	A	Removal of foot nerve	6.11	NA	3.62	1.02	NA	10.75	090
28035	.....	A	Decompression of tibia nerve	5.06	5.59	4.07	0.85	11.50	9.98	090
28043	.....	A	Excision of foot lesion	3.52	5.85	3.31	0.54	9.91	7.37	090
28045	.....	A	Excision of foot lesion	4.69	6.19	3.75	0.74	11.62	9.18	090
28046	.....	A	Resection of tumor, foot	10.12	9.53	7.42	1.35	21.00	18.89	090
28050	.....	A	Biopsy of foot joint lining	4.23	5.84	3.70	0.66	10.73	8.59	090
28052	.....	A	Biopsy of foot joint lining	3.92	6.05	3.60	0.61	10.58	8.13	090
28054	.....	A	Biopsy of toe joint lining	3.43	5.88	3.40	0.54	9.85	7.37	090
28060	.....	A	Partial removal, foot fascia	5.20	6.46	4.07	0.83	12.49	10.10	090
28062	.....	A	Removal of foot fascia	6.48	7.21	4.24	1.02	14.71	11.74	090
28070	.....	A	Removal of foot joint lining	5.07	6.02	3.93	0.82	11.91	9.82	090
28072	.....	A	Removal of foot joint lining	4.55	6.50	4.37	0.77	11.82	9.69	090
28080	.....	A	Removal of foot lesion	3.56	5.99	3.74	0.60	10.15	7.90	090
28086	.....	A	Excise foot tendon sheath	4.75	9.60	4.74	0.79	15.14	10.28	090
28088	.....	A	Excise foot tendon sheath	3.84	7.13	4.04	0.62	11.59	8.50	090
28090	.....	A	Removal of foot lesion	4.38	6.09	3.59	0.68	11.15	8.65	090
28092	.....	A	Removal of toe lesions	3.62	6.40	3.65	0.55	10.57	7.82	090
28100	.....	A	Removal of ankle/heel lesion	5.63	9.33	4.86	0.91	15.87	11.40	090
28102	.....	A	Remove/graft foot lesion	7.69	NA	6.09	1.16	NA	14.94	090
28103	.....	A	Remove/graft foot lesion	6.46	8.50	4.81	1.07	16.03	12.34	090
28104	.....	A	Removal of foot lesion	5.09	6.41	4.09	0.83	12.33	10.01	090
28106	.....	A	Remove/graft foot lesion	7.12	NA	4.64	1.21	NA	12.97	090
28107	.....	A	Remove/graft foot lesion	5.53	7.33	4.37	0.89	13.75	10.79	090
28108	.....	A	Removal of toe lesions	4.14	5.50	3.38	0.62	10.26	8.14	090
28110	.....	A	Part removal of metatarsal	4.06	6.09	3.72	0.59	10.74	8.37	090
28111	.....	A	Part removal of metatarsal	4.98	7.28	4.23	0.76	13.02	9.97	090
28112	.....	A	Part removal of metatarsal	4.46	6.77	4.10	0.72	11.95	9.28	090
28113	.....	A	Part removal of metatarsal	4.76	6.89	4.71	0.76	12.41	10.23	090
28114	.....	A	Removal of metatarsal heads	9.73	12.06	8.60	1.63	23.42	19.96	090
28116	.....	A	Revision of foot	7.71	7.28	5.28	1.23	16.22	14.22	090
28118	.....	A	Removal of heel bone	5.93	7.20	4.57	0.95	14.08	11.45	090
28119	.....	A	Removal of heel spur	5.36	6.27	3.91	0.89	12.52	10.16	090
28120	.....	A	Part removal of ankle/heel	5.37	8.79	5.12	0.83	14.99	11.32	090
28122	.....	A	Partial removal of foot bone	7.25	7.98	5.75	1.15	16.38	14.15	090
28124	.....	A	Partial removal of toe	4.78	6.14	4.10	0.78	11.70	9.66	090
28126	.....	A	Partial removal of toe	3.50	5.39	3.55	0.59	9.48	7.64	090
28130	.....	A	Removal of ankle bone	8.06	NA	6.78	1.33	NA	16.17	090
28140	.....	A	Removal of metatarsal	6.87	8.35	5.05	1.01	16.23	12.93	090
28150	.....	A	Removal of toe	4.07	6.04	3.82	0.62	10.73	8.51	090
28153	.....	A	Partial removal of toe	3.64	5.46	3.11	0.59	9.69	7.34	090
28160	.....	A	Partial removal of toe	3.72	5.75	3.87	0.61	10.08	8.20	090
28171	.....	A	Extensive foot surgery	9.55	NA	5.76	1.35	NA	16.66	090
28173	.....	A	Extensive foot surgery	8.75	8.35	5.70	1.25	18.35	15.70	090
28175	.....	A	Extensive foot surgery	6.02	6.75	4.13	0.90	13.67	11.05	090
28190	.....	A	Removal of foot foreign body	1.95	6.60	3.55	0.19	8.74	5.69	010
28192	.....	A	Removal of foot foreign body	4.61	6.51	3.76	0.62	11.74	8.99	090
28193	.....	A	Removal of foot foreign body	5.70	6.42	4.16	0.76	12.88	10.62	090
28200	.....	A	Repair of foot tendon	4.57	6.00	3.75	0.71	11.28	9.03	090
28202	.....	A	Repair/graft of foot tendon	6.80	8.17	4.67	1.03	16.00	12.50	090
28208	.....	A	Repair of foot tendon	4.35	5.79	3.50	0.71	10.85	8.56	090
28210	.....	A	Repair/graft of foot tendon	6.31	7.20	4.25	0.92	14.43	11.48	090
28220	.....	A	Release of foot tendon	4.50	5.62	3.60	0.76	10.88	8.86	090
28222	.....	A	Release of foot tendons	5.59	6.01	4.28	0.92	12.52	10.79	090
28225	.....	A	Release of foot tendon	3.64	5.32	3.11	0.60	9.56	7.35	090
28226	.....	A	Release of foot tendons	4.50	5.67	3.89	0.74	10.91	9.13	090
28230	.....	A	Incision of foot tendon(s)	4.22	5.69	3.84	0.71	10.62	8.77	090
28232	.....	A	Incision of toe tendon	3.37	5.73	3.48	0.58	9.68	7.43	090
28234	.....	A	Incision of foot tendon	3.35	5.89	3.51	0.55	9.79	7.41	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
28238	.....	A	Revision of foot tendon	7.69	8.06	5.12	1.29	17.04	14.10	090
28240	.....	A	Release of big toe	4.34	5.65	3.67	0.73	10.72	8.74	090
28250	.....	A	Revision of foot fascia	5.89	6.60	4.31	0.97	13.46	11.17	090
28260	.....	A	Release of midfoot joint	7.91	7.15	5.19	1.29	16.35	14.39	090
28261	.....	A	Revision of foot tendon	11.66	9.00	7.41	1.99	22.65	21.06	090
28262	.....	A	Revision of foot and ankle	15.74	14.48	11.56	2.66	32.88	29.96	090
28264	.....	A	Release of midfoot joint	10.29	8.59	7.90	1.75	20.63	19.94	090
28270	.....	A	Release of foot contracture	4.73	5.96	4.24	0.80	11.49	9.77	090
28272	.....	A	Release of toe joint, each	3.78	5.20	3.07	0.62	9.60	7.47	090
28280	.....	A	Fusion of toes	5.16	7.33	4.56	0.86	13.35	10.58	090
28285	.....	A	Repair of hammertoe	4.56	6.02	3.88	0.77	11.35	9.21	090
28286	.....	A	Repair of hammertoe	4.53	5.80	3.71	0.77	11.10	9.01	090
28288	.....	A	Partial removal of foot bone	4.71	6.76	5.36	0.78	12.25	10.85	090
28289	.....	A	Repair hallux rigidus	7.00	9.07	6.27	1.15	17.22	14.42	090
28290	.....	A	Correction of bunion	5.63	7.09	5.34	0.95	13.67	11.92	090
28292	.....	A	Correction of bunion	7.00	7.88	5.81	1.17	16.05	13.98	090
28293	.....	A	Correction of bunion	9.10	10.95	6.07	1.53	21.58	16.70	090
28294	.....	A	Correction of bunion	8.51	7.72	5.14	1.39	17.62	15.04	090
28296	.....	A	Correction of bunion	9.13	8.23	5.86	1.53	18.89	16.52	090
28297	.....	A	Correction of bunion	9.13	9.21	6.83	1.57	19.91	17.53	090
28298	.....	A	Correction of bunion	7.89	7.38	5.46	1.34	16.61	14.69	090
28299	.....	A	Correction of bunion	10.52	8.80	6.48	1.49	20.81	18.49	090
28300	.....	A	Incision of heel bone	9.49	13.25	7.14	1.57	24.31	18.20	090
28302	.....	A	Incision of ankle bone	9.50	13.25	7.03	1.38	24.13	17.91	090
28304	.....	A	Incision of midfoot bones	9.11	8.25	5.86	1.20	18.56	16.17	090
28305	.....	A	Incise/graft midfoot bones	10.44	11.00	6.88	0.66	22.10	17.98	090
28306	.....	A	Incision of metatarsal	5.83	7.27	4.30	0.97	14.07	11.10	090
28307	.....	A	Incision of metatarsal	6.29	11.70	5.39	0.85	18.84	12.53	090
28308	.....	A	Incision of metatarsal	5.26	6.13	3.80	0.89	12.28	9.95	090
28309	.....	A	Incision of metatarsals	12.71	NA	8.14	1.97	NA	22.82	090
28310	.....	A	Revision of big toe	5.40	6.30	4.00	0.91	12.61	10.31	090
28312	.....	A	Revision of toe	4.52	6.03	4.15	0.74	11.29	9.41	090
28313	.....	A	Repair deformity of toe	4.98	6.50	5.51	0.82	12.30	11.31	090
28315	.....	A	Removal of sesamoid bone	4.83	5.88	3.70	0.79	11.50	9.32	090
28320	.....	A	Repair of foot bones	9.13	NA	6.83	1.52	NA	17.48	090
28322	.....	A	Repair of metatarsals	8.29	10.24	6.39	1.40	19.93	16.08	090
28340	.....	A	Resect enlarged toe tissue	6.94	7.12	4.47	1.17	15.23	12.58	090
28341	.....	A	Resect enlarged toe	8.36	7.30	5.00	1.41	17.07	14.77	090
28344	.....	A	Repair extra toe(s)	4.24	6.85	3.73	0.72	11.81	8.69	090
28345	.....	A	Repair webbed toe(s)	5.89	7.07	4.83	1.01	13.97	11.73	090
28360	.....	A	Reconstruct cleft foot	13.26	NA	10.61	2.25	NA	26.12	090
28400	.....	A	Treatment of heel fracture	2.15	4.33	3.03	0.35	6.83	5.53	090
28405	.....	A	Treatment of heel fracture	4.54	5.57	4.58	0.76	10.87	9.88	090
28406	.....	A	Treatment of heel fracture	6.27	NA	6.87	1.04	NA	14.18	090
28415	.....	A	Treat heel fracture	15.88	NA	13.39	2.68	NA	31.95	090
28420	.....	A	Treat/graft heel fracture	16.55	NA	13.10	2.74	NA	32.39	090
28430	.....	A	Treatment of ankle fracture	2.08	4.12	2.65	0.32	6.52	5.05	090
28435	.....	A	Treatment of ankle fracture	3.38	4.56	3.68	0.56	8.50	7.62	090
28436	.....	A	Treatment of ankle fracture	4.68	NA	5.96	0.79	NA	11.43	090
28445	.....	A	Treat ankle fracture	15.53	NA	11.14	1.55	NA	28.22	090
28450	.....	A	Treat midfoot fracture, each	1.89	4.12	2.55	0.30	6.31	4.74	090
28455	.....	A	Treat midfoot fracture, each	3.07	4.01	3.45	0.52	7.60	7.04	090
28456	.....	A	Treat midfoot fracture	2.66	NA	4.26	0.43	NA	7.35	090
28465	.....	A	Treat midfoot fracture, each	6.97	NA	6.44	1.04	NA	14.45	090
28470	.....	A	Treat metatarsal fracture	1.98	3.92	2.52	0.31	6.21	4.81	090
28475	.....	A	Treat metatarsal fracture	2.95	4.10	3.22	0.49	7.54	6.66	090
28476	.....	A	Treat metatarsal fracture	3.36	NA	5.05	0.55	NA	8.96	090
28485	.....	A	Treat metatarsal fracture	5.68	NA	5.61	0.96	NA	12.25	090
28490	.....	A	Treat big toe fracture	1.08	2.23	1.77	0.16	3.47	3.01	090
28495	.....	A	Treat big toe fracture	1.57	2.52	2.10	0.23	4.32	3.90	090
28496	.....	A	Treat big toe fracture	2.32	9.82	3.67	0.38	12.52	6.37	090
28505	.....	A	Treat big toe fracture	3.79	9.82	4.75	0.60	14.21	9.14	090
28510	.....	A	Treatment of toe fracture	1.08	2.00	1.73	0.16	3.24	2.97	090
28515	.....	A	Treatment of toe fracture	1.45	2.36	2.02	0.20	4.01	3.67	090
28525	.....	A	Treat toe fracture	3.30	9.41	4.30	0.53	13.24	8.13	090
28530	.....	A	Treat sesamoid bone fracture	1.05	2.10	1.49	0.16	3.31	2.70	090
28531	.....	A	Treat sesamoid bone fracture	2.34	9.07	2.53	0.40	11.81	5.27	090
28540	.....	A	Treat foot dislocation	2.03	2.90	2.71	0.29	5.22	5.03	090
28545	.....	A	Treat foot dislocation	2.44	2.89	2.89	0.40	5.73	5.73	090
28546	.....	A	Treat foot dislocation	3.18	8.02	4.88	0.55	11.75	8.61	090
28555	.....	A	Repair foot dislocation	6.26	11.64	6.62	1.05	18.95	13.93	090
28570	.....	A	Treat foot dislocation	1.65	2.92	2.31	0.26	4.83	4.22	090
28575	.....	A	Treat foot dislocation	3.29	4.43	4.08	0.54	8.26	7.91	090
28576	.....	A	Treat foot dislocation	4.15	10.33	5.57	0.67	15.15	10.39	090
28585	.....	A	Repair foot dislocation	7.94	8.23	6.61	1.35	17.52	15.90	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
28600		A	Treat foot dislocation	1.88	3.32	2.70	0.29	5.49	4.87	090
28605		A	Treat foot dislocation	2.69	3.79	3.65	0.42	6.90	6.76	090
28606		A	Treat foot dislocation	4.87	16.21	6.07	0.82	21.90	11.76	090
28615		A	Repair foot dislocation	7.73	NA	8.08	1.31	NA	17.12	090
28630		A	Treat toe dislocation	1.69	1.24	1.14	0.20	3.13	3.03	010
28635		A	Treat toe dislocation	1.90	1.68	1.51	0.29	3.87	3.70	010
28636		A	Treat toe dislocation	2.75	6.22	3.10	0.47	9.44	6.32	010
28645		A	Repair toe dislocation	4.20	5.73	3.54	0.70	10.63	8.44	090
28660		A	Treat toe dislocation	1.22	1.63	1.19	0.13	2.98	2.54	010
28665		A	Treat toe dislocation	1.91	1.67	1.65	0.29	3.87	3.85	010
28666		A	Treat toe dislocation	2.64	6.07	2.26	0.46	9.17	5.36	010
28675		A	Repair of toe dislocation	2.90	8.92	3.81	0.49	12.31	7.20	090
28705		A	Fusion of foot bones	18.69	NA	12.56	2.55	NA	33.80	090
28715		A	Fusion of foot bones	13.03	NA	9.84	2.21	NA	25.08	090
28725		A	Fusion of foot bones	11.54	NA	8.39	1.95	NA	21.88	090
28730		A	Fusion of foot bones	10.70	NA	8.56	1.81	NA	21.07	090
28735		A	Fusion of foot bones	10.79	NA	7.96	1.81	NA	20.56	090
28737		A	Revision of foot bones	9.59	NA	6.94	1.63	NA	18.16	090
28740		A	Fusion of foot bones	7.97	11.72	6.51	1.35	21.04	15.83	090
28750		A	Fusion of big toe joint	7.26	13.11	6.66	1.23	21.60	15.15	090
28755		A	Fusion of big toe joint	4.71	6.90	3.90	0.79	12.40	9.40	090
28760		A	Fusion of big toe joint	7.71	8.14	5.69	1.28	17.13	14.68	090
28800		A	Amputation of midfoot	8.16	NA	6.09	1.17	NA	15.42	090
28805		A	Amputation thru metatarsal	8.34	NA	5.94	1.16	NA	15.44	090
28810		A	Amputation toe & metatarsal	6.17	NA	4.79	0.84	NA	11.80	090
28820		A	Amputation of toe	4.38	8.58	4.12	0.61	13.57	9.11	090
28825		A	Partial amputation of toe	3.57	8.00	3.82	0.52	12.09	7.91	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	2.24	3.14	1.75	0.36	5.74	4.35	000
29010		A	Application of body cast	2.05	3.33	1.75	0.32	5.70	4.12	000
29015		A	Application of body cast	2.40	3.04	1.60	0.25	5.69	4.25	000
29020		A	Application of body cast	2.10	3.33	1.43	0.19	5.62	3.72	000
29025		A	Application of body cast	2.39	3.30	1.86	0.31	6.00	4.56	000
29035		A	Application of body cast	1.76	3.49	1.56	0.29	5.54	3.61	000
29040		A	Application of body cast	2.21	2.60	1.53	0.42	5.23	4.16	000
29044		A	Application of body cast	2.11	3.84	1.87	0.35	6.30	4.33	000
29046		A	Application of body cast	2.40	3.33	2.05	0.41	6.14	4.86	000
29049		A	Application of figure eight	0.88	1.26	0.55	0.14	2.28	1.57	000
29055		A	Application of shoulder cast	1.77	2.85	1.45	0.29	4.91	3.51	000
29058		A	Application of shoulder cast	1.30	1.52	0.73	0.17	2.99	2.20	000
29065		A	Application of long arm cast	0.87	1.28	0.74	0.14	2.29	1.75	000
29075		A	Application of forearm cast	0.77	1.22	0.67	0.13	2.12	1.57	000
29085		A	Apply hand/wrist cast	0.87	1.25	0.64	0.13	2.25	1.64	000
29086		A	Apply finger cast	0.62	0.94	0.53	0.07	1.63	1.22	000
29105		A	Apply long arm splint	0.87	1.20	0.53	0.13	2.20	1.53	000
29125		A	Apply forearm splint	0.59	1.00	0.41	0.07	1.66	1.07	000
29126		A	Apply forearm splint	0.77	1.22	0.48	0.07	2.06	1.32	000
29130		A	Application of finger splint	0.50	0.47	0.17	0.06	1.03	0.73	000
29131		A	Application of finger splint	0.55	0.74	0.25	0.04	1.33	0.84	000
29200		A	Strapping of chest	0.65	0.76	0.37	0.05	1.46	1.07	000
29220		A	Strapping of low back	0.64	0.73	0.40	0.08	1.45	1.12	000
29240		A	Strapping of shoulder	0.71	0.87	0.39	0.06	1.64	1.16	000
29260		A	Strapping of elbow or wrist	0.55	0.76	0.34	0.05	1.36	0.94	000
29280		A	Strapping of hand or finger	0.51	0.83	0.35	0.05	1.39	0.91	000
29305		A	Application of hip cast	2.02	3.22	1.73	0.35	5.59	4.10	000
29325		A	Application of hip casts	2.31	3.40	1.92	0.37	6.08	4.60	000
29345		A	Application of long leg cast	1.39	1.71	1.05	0.23	3.33	2.67	000
29355		A	Application of long leg cast	1.52	1.67	1.11	0.24	3.43	2.87	000
29358		A	Apply long leg cast brace	1.42	1.98	1.08	0.23	3.63	2.73	000
29365		A	Application of long leg cast	1.17	1.60	0.93	0.20	2.97	2.30	000
29405		A	Apply short leg cast	0.86	1.19	0.70	0.14	2.19	1.70	000
29425		A	Apply short leg cast	1.00	1.19	0.73	0.17	2.36	1.90	000
29435		A	Apply short leg cast	1.17	1.51	0.91	0.20	2.88	2.28	000
29440		A	Addition of walker to cast	0.57	0.67	0.28	0.08	1.32	0.93	000
29445		A	Apply rigid leg cast	1.77	1.77	0.97	0.29	3.83	3.03	000
29450		A	Application of leg cast	2.07	1.47	1.10	0.16	3.70	3.33	000
29505		A	Application, long leg splint	0.69	1.17	0.48	0.07	1.93	1.24	000
29515		A	Application lower leg splint	0.73	0.86	0.49	0.08	1.67	1.30	000
29520		A	Strapping of hip	0.54	0.89	0.47	0.02	1.45	1.03	000
29530		A	Strapping of knee	0.57	0.81	0.35	0.05	1.43	0.97	000
29540		A	Strapping of ankle and/or ft	0.51	0.42	0.32	0.05	0.98	0.88	000
29550		A	Strapping of toes	0.47	0.42	0.28	0.06	0.95	0.81	000
29580		A	Application of paste boot	0.57	0.66	0.36	0.06	1.29	0.99	000
29590		A	Application of foot splint	0.76	0.51	0.30	0.07	1.34	1.13	000
29700		A	Removal/revision of cast	0.57	0.88	0.29	0.08	1.53	0.94	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
29705		A	Removal/revision of cast	0.76	0.80	0.39	0.12	1.68	1.27	000
29710		A	Removal/revision of cast	1.33	1.51	0.70	0.20	3.04	2.23	000
29715		A	Removal/revision of cast	0.93	1.16	0.41	0.10	2.19	1.44	000
29720		A	Repair of body cast	0.68	1.11	0.39	0.12	1.91	1.19	000
29730		A	Windowing of cast	0.75	0.79	0.36	0.12	1.66	1.23	000
29740		A	Wedging of cast	1.11	1.12	0.50	0.18	2.41	1.79	000
29750		A	Wedging of clubfoot cast	1.25	1.05	0.59	0.19	2.49	2.03	000
29799		C	Casting/strapping procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
29800		A	Jaw arthroscopy/surgery	6.39	NA	7.20	1.01	NA	14.60	090
29804		A	Jaw arthroscopy/surgery	8.09	NA	8.51	0.79	NA	17.39	090
29805		A	Shoulder arthroscopy, dx	5.86	NA	5.72	1.01	NA	12.59	090
29806		A	Shoulder arthroscopy/surgery	14.29	NA	11.06	2.40	NA	27.75	090
29807		A	Shoulder arthroscopy/surgery	13.82	NA	10.89	2.33	NA	27.04	090
29819		A	Shoulder arthroscopy/surgery	7.58	NA	6.74	1.28	NA	15.60	090
29820		A	Shoulder arthroscopy/surgery	7.03	NA	6.18	1.19	NA	14.40	090
29821		A	Shoulder arthroscopy/surgery	7.68	NA	6.76	1.29	NA	15.73	090
29822		A	Shoulder arthroscopy/surgery	7.39	NA	6.64	1.25	NA	15.28	090
29823		A	Shoulder arthroscopy/surgery	8.12	NA	7.16	1.38	NA	16.66	090
29824		A	Shoulder arthroscopy/surgery	8.20	NA	7.41	1.38	NA	16.99	090
29825		A	Shoulder arthroscopy/surgery	7.58	NA	6.72	1.27	NA	15.57	090
29826		A	Shoulder arthroscopy/surgery	8.94	NA	7.49	1.51	NA	17.94	090
29827		A	Arthroscop rotator cuff repr	15.27	NA	11.44	2.23	NA	28.94	090
29830		A	Elbow arthroscopy	5.73	NA	5.31	0.95	NA	11.99	090
29834		A	Elbow arthroscopy/surgery	6.24	NA	5.79	1.03	NA	13.06	090
29835		A	Elbow arthroscopy/surgery	6.44	NA	5.83	1.05	NA	13.32	090
29836		A	Elbow arthroscopy/surgery	7.51	NA	6.73	1.27	NA	15.51	090
29837		A	Elbow arthroscopy/surgery	6.83	NA	6.08	1.15	NA	14.06	090
29838		A	Elbow arthroscopy/surgery	7.67	NA	6.84	1.28	NA	15.79	090
29840		A	Wrist arthroscopy	5.51	NA	5.30	0.83	NA	11.64	090
29843		A	Wrist arthroscopy/surgery	5.98	NA	5.60	0.98	NA	12.56	090
29844		A	Wrist arthroscopy/surgery	6.33	NA	5.79	1.03	NA	13.15	090
29845		A	Wrist arthroscopy/surgery	7.48	NA	6.46	1.01	NA	14.95	090
29846		A	Wrist arthroscopy/surgery	6.71	NA	6.01	1.07	NA	13.79	090
29847		A	Wrist arthroscopy/surgery	7.04	NA	6.16	1.09	NA	14.29	090
29848		A	Wrist endoscopy/surgery	5.41	NA	5.55	0.86	NA	11.82	090
29850		A	Knee arthroscopy/surgery	8.14	NA	5.10	0.89	NA	14.13	090
29851		A	Knee arthroscopy/surgery	13.03	NA	9.76	2.17	NA	24.96	090
29855		A	Tibial arthroscopy/surgery	10.56	NA	8.69	1.80	NA	21.05	090
29856		A	Tibial arthroscopy/surgery	14.06	NA	10.63	2.40	NA	27.09	090
29860		A	Hip arthroscopy, dx	8.00	NA	6.90	1.37	NA	16.27	090
29861		A	Hip arthroscopy/surgery	9.10	NA	7.31	1.55	NA	17.96	090
29862		A	Hip arthroscopy/surgery	9.84	NA	8.48	1.67	NA	19.99	090
29863		A	Hip arthroscopy/surgery	9.84	NA	8.42	1.68	NA	19.94	090
29870		A	Knee arthroscopy, dx	5.04	NA	4.85	0.80	NA	10.69	090
29871		A	Knee arthroscopy/drainage	6.51	NA	5.83	1.05	NA	13.39	090
29873		A	Knee arthroscopy/surgery	5.97	NA	6.45	0.87	NA	13.29	090
29874		A	Knee arthroscopy/surgery	7.01	NA	6.04	1.04	NA	14.09	090
29875		A	Knee arthroscopy/surgery	6.27	NA	5.80	1.05	NA	13.12	090
29876		A	Knee arthroscopy/surgery	7.87	NA	6.96	1.33	NA	16.16	090
29877		A	Knee arthroscopy/surgery	7.31	NA	6.67	1.23	NA	15.21	090
29879		A	Knee arthroscopy/surgery	7.99	NA	7.05	1.35	NA	16.39	090
29880		A	Knee arthroscopy/surgery	8.45	NA	7.29	1.43	NA	17.17	090
29881		A	Knee arthroscopy/surgery	7.72	NA	6.89	1.31	NA	15.92	090
29882		A	Knee arthroscopy/surgery	8.60	NA	7.18	1.31	NA	17.09	090
29883		A	Knee arthroscopy/surgery	10.99	NA	9.00	1.59	NA	21.58	090
29884		A	Knee arthroscopy/surgery	7.29	NA	6.63	1.23	NA	15.15	090
29885		A	Knee arthroscopy/surgery	9.04	NA	7.89	1.52	NA	18.45	090
29886		A	Knee arthroscopy/surgery	7.50	NA	6.77	1.27	NA	15.54	090
29887		A	Knee arthroscopy/surgery	8.99	NA	7.86	1.52	NA	18.37	090
29888		A	Knee arthroscopy/surgery	13.82	NA	10.19	2.34	NA	26.35	090
29889		A	Knee arthroscopy/surgery	15.91	NA	12.36	2.53	NA	30.80	090
29891		A	Ankle arthroscopy/surgery	8.35	NA	7.42	1.40	NA	17.17	090
29892		A	Ankle arthroscopy/surgery	8.95	NA	7.68	1.51	NA	18.14	090
29893		A	Scope, plantar fasciotomy	5.19	6.20	3.96	0.89	12.28	10.04	090
29894		A	Ankle arthroscopy/surgery	7.17	NA	5.45	1.21	NA	13.83	090
29895		A	Ankle arthroscopy/surgery	6.95	NA	5.45	1.16	NA	13.56	090
29897		A	Ankle arthroscopy/surgery	7.14	NA	5.85	1.21	NA	14.20	090
29898		A	Ankle arthroscopy/surgery	8.27	NA	6.17	1.37	NA	15.81	090
29899		A	Ankle arthroscopy/surgery	13.83	NA	9.94	2.34	NA	26.11	090
29900		A	Mcp joint arthroscopy, dx	5.39	NA	5.77	0.90	NA	12.06	090
29901		A	Mcp joint arthroscopy, surg	6.10	NA	6.15	1.02	NA	13.27	090
29902		A	Mcp joint arthroscopy, surg	6.66	NA	6.45	1.11	NA	14.22	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	1.42	4.24	1.43	0.12	5.78	2.97	010
30020		A	Drainage of nose lesion	1.42	3.39	1.50	0.10	4.91	3.02	010

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
30100		A	Intranasal biopsy	0.93	2.07	0.82	0.07	3.07	1.82	000
30110		A	Removal of nose polyp(s)	1.62	3.40	1.60	0.14	5.16	3.36	010
30115		A	Removal of nose polyp(s)	4.33	NA	4.06	0.37	NA	8.76	090
30117		A	Removal of intranasal lesion	3.14	4.43	3.31	0.26	7.83	6.71	090
30118		A	Removal of intranasal lesion	9.63	NA	7.35	0.79	NA	17.77	090
30120		A	Revision of nose	5.24	5.59	5.54	0.49	11.32	11.27	090
30124		A	Removal of nose lesion	3.08	NA	3.07	0.24	NA	6.39	090
30125		A	Removal of nose lesion	7.12	NA	5.98	0.65	NA	13.75	090
30130		A	Removal of turbinate bones	3.36	NA	3.55	0.26	NA	7.17	090
30140		A	Removal of turbinate bones	3.41	NA	4.01	0.29	NA	7.71	090
30150		A	Partial removal of nose	9.09	NA	7.74	0.91	NA	17.74	090
30160		A	Removal of nose	9.53	NA	7.73	0.93	NA	18.19	090
30200		A	Injection treatment of nose	0.78	1.72	0.78	0.07	2.57	1.63	000
30210		A	Nasal sinus therapy	1.07	2.19	1.34	0.10	3.36	2.51	010
30220		A	Insert nasal septal button	1.53	4.55	1.56	0.13	6.21	3.22	010
30300		A	Remove nasal foreign body	1.03	4.89	2.00	0.08	6.00	3.11	010
30310		A	Remove nasal foreign body	1.95	NA	3.22	0.17	NA	5.34	010
30320		A	Remove nasal foreign body	4.49	NA	4.53	0.43	NA	9.45	090
30400		R	Reconstruction of nose	9.77	NA	9.27	0.96	NA	20.00	090
30410		R	Reconstruction of nose	12.91	NA	11.06	1.29	NA	25.26	090
30420		R	Reconstruction of nose	15.79	NA	12.55	1.49	NA	29.83	090
30430		R	Revision of nose	7.17	NA	8.20	0.74	NA	16.11	090
30435		R	Revision of nose	11.64	NA	10.74	1.32	NA	23.70	090
30450		R	Revision of nose	18.54	NA	14.26	1.83	NA	34.63	090
30460		A	Revision of nose	9.90	NA	7.81	1.02	NA	18.73	090
30462		A	Revision of nose	19.46	NA	13.83	2.30	NA	35.59	090
30465		A	Repair nasal stenosis	11.57	NA	7.76	1.16	NA	20.49	090
30520		A	Repair of nasal septum	5.67	NA	5.21	0.49	NA	11.37	090
30540		A	Repair nasal defect	7.71	NA	5.70	0.64	NA	14.05	090
30545		A	Repair nasal defect	11.32	NA	8.73	0.96	NA	21.01	090
30560		A	Release of nasal adhesions	1.25	4.99	2.18	0.11	6.35	3.54	010
30580		A	Repair upper jaw fistula	6.65	7.26	6.19	0.60	14.51	13.44	090
30600		A	Repair mouth/nose fistula	5.99	6.39	5.58	0.84	13.22	12.41	090
30620		A	Intranasal reconstruction	5.94	NA	5.84	0.54	NA	12.32	090
30630		A	Repair nasal septum defect	7.08	NA	6.25	0.61	NA	13.94	090
30801		A	Cauterization, inner nose	1.08	2.20	2.09	0.10	3.38	3.27	010
30802		A	Cauterization, inner nose	2.02	2.74	2.60	0.18	4.94	4.80	010
30901		A	Control of nosebleed	1.20	1.38	0.33	0.11	2.69	1.64	000
30903		A	Control of nosebleed	1.53	2.84	0.51	0.14	4.51	2.18	000
30905		A	Control of nosebleed	1.96	3.62	0.77	0.18	5.76	2.91	000
30906		A	Repeat control of nosebleed	2.44	4.00	1.22	0.20	6.64	3.86	000
30915		A	Ligation, nasal sinus artery	7.16	NA	5.89	0.60	NA	13.65	090
30920		A	Ligation, upper jaw artery	9.77	NA	7.56	0.83	NA	18.16	090
30930		A	Therapy, fracture of nose	1.25	NA	1.67	0.11	NA	3.03	010
30999		C	Nasal surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31000		A	Irrigation, maxillary sinus	1.14	2.96	1.43	0.10	4.20	2.67	010
31002		A	Irrigation, sphenoid sinus	1.90	NA	3.34	0.17	NA	5.41	010
31020		A	Exploration, maxillary sinus	2.92	4.18	3.55	0.24	7.34	6.71	090
31030		A	Exploration, maxillary sinus	5.89	5.73	4.85	0.50	12.12	11.24	090
31032		A	Explore sinus, remove polyps	6.53	NA	5.66	0.56	NA	12.75	090
31040		A	Exploration behind upper jaw	9.37	NA	6.35	0.85	NA	16.57	090
31050		A	Exploration, sphenoid sinus	5.25	NA	4.55	0.47	NA	10.27	090
31051		A	Sphenoid sinus surgery	7.07	NA	5.92	0.66	NA	13.65	090
31070		A	Exploration of frontal sinus	4.26	NA	4.25	0.36	NA	8.87	090
31075		A	Exploration of frontal sinus	9.11	NA	7.29	0.77	NA	17.17	090
31080		A	Removal of frontal sinus	11.35	NA	8.53	0.93	NA	20.81	090
31081		A	Removal of frontal sinus	12.68	NA	9.59	2.21	NA	24.48	090
31084		A	Removal of frontal sinus	13.43	NA	10.15	1.15	NA	24.73	090
31085		A	Removal of frontal sinus	14.12	NA	10.52	1.41	NA	26.05	090
31086		A	Removal of frontal sinus	12.79	NA	9.96	1.08	NA	23.83	090
31087		A	Removal of frontal sinus	13.03	NA	9.89	1.38	NA	24.30	090
31090		A	Exploration of sinuses	9.48	NA	8.67	0.79	NA	18.94	090
31200		A	Removal of ethmoid sinus	4.94	NA	5.07	0.30	NA	10.31	090
31201		A	Removal of ethmoid sinus	8.32	NA	6.89	0.70	NA	15.91	090
31205		A	Removal of ethmoid sinus	10.18	NA	7.71	0.70	NA	18.59	090
31225		A	Removal of upper jaw	19.12	NA	13.88	1.65	NA	34.65	090
31230		A	Removal of upper jaw	21.81	NA	15.29	1.88	NA	38.98	090
31231		A	Nasal endoscopy, dx	1.09	3.59	0.92	0.10	4.78	2.11	000
31233		A	Nasal/sinus endoscopy, dx	2.17	4.53	1.53	0.19	6.89	3.89	000
31235		A	Nasal/sinus endoscopy, dx	2.62	5.16	1.78	0.22	8.00	4.62	000
31237		A	Nasal/sinus endoscopy, surg	2.96	5.46	1.93	0.25	8.67	5.14	000
31238		A	Nasal/sinus endoscopy, surg	3.24	5.51	2.14	0.28	9.03	5.66	000
31239		A	Nasal/sinus endoscopy, surg	8.65	NA	8.37	0.55	NA	17.57	010
31240		A	Nasal/sinus endoscopy, surg	2.60	NA	1.78	0.22	NA	4.60	000
31254		A	Revision of ethmoid sinus	4.62	NA	2.92	0.38	NA	7.92	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
31255		A	Removal of ethmoid sinus	6.92	NA	4.20	0.59	NA	11.71	000
31256		A	Exploration maxillary sinus	3.27	NA	2.16	0.28	NA	5.71	000
31267		A	Endoscopy, maxillary sinus	5.43	NA	3.36	0.46	NA	9.25	000
31276		A	Sinus endoscopy, surgical	8.80	NA	5.22	0.74	NA	14.76	000
31287		A	Nasal/sinus endoscopy, surg	3.90	NA	2.51	0.32	NA	6.73	000
31288		A	Nasal/sinus endoscopy, surg	4.55	NA	2.88	0.38	NA	7.81	000
31290		A	Nasal/sinus endoscopy, surg	17.14	NA	12.27	1.44	NA	30.85	010
31291		A	Nasal/sinus endoscopy, surg	18.09	NA	12.68	2.07	NA	32.84	010
31292		A	Nasal/sinus endoscopy, surg	14.68	NA	10.83	1.19	NA	26.70	010
31293		A	Nasal/sinus endoscopy, surg	16.12	NA	11.63	1.16	NA	28.91	010
31294		A	Nasal/sinus endoscopy, surg	18.95	NA	13.14	1.25	NA	33.34	010
31299		C	Sinus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31300		A	Removal of larynx lesion	14.21	NA	12.17	1.19	NA	27.57	090
31320		A	Diagnostic incision, larynx	5.23	NA	7.36	0.48	NA	13.07	090
31360		A	Removal of larynx	16.98	NA	14.11	1.44	NA	32.53	090
31365		A	Removal of larynx	24.02	NA	17.82	2.06	NA	43.90	090
31367		A	Partial removal of larynx	21.74	NA	17.57	1.88	NA	41.19	090
31368		A	Partial removal of larynx	26.94	NA	21.23	2.28	NA	50.45	090
31370		A	Partial removal of larynx	21.26	NA	17.21	1.81	NA	40.28	090
31375		A	Partial removal of larynx	20.09	NA	15.53	1.71	NA	37.33	090
31380		A	Partial removal of larynx	20.09	NA	15.47	1.68	NA	37.24	090
31382		A	Partial removal of larynx	20.40	NA	16.74	1.73	NA	38.87	090
31390		A	Removal of larynx & pharynx	27.37	NA	21.47	2.34	NA	51.18	090
31395		A	Reconstruct larynx & pharynx	30.91	NA	25.41	2.72	NA	59.04	090
31400		A	Revision of larynx	10.25	NA	10.13	0.86	NA	21.24	090
31420		A	Removal of epiglottis	10.16	NA	9.91	0.85	NA	20.92	090
31500		A	Insert emergency airway	2.32	NA	0.56	0.18	NA	3.06	000
31502		A	Change of windpipe airway	0.65	1.52	0.26	0.05	2.22	0.96	000
31505		A	Diagnostic laryngoscopy	0.61	1.59	0.64	0.05	2.25	1.30	000
31510		A	Laryngoscopy with biopsy	1.91	3.46	1.30	0.18	5.55	3.39	000
31511		A	Remove foreign body, larynx	2.15	3.28	1.12	0.19	5.62	3.46	000
31512		A	Removal of larynx lesion	2.06	3.36	1.41	0.19	5.61	3.66	000
31513		A	Injection into vocal cord	2.09	NA	1.51	0.18	NA	3.78	000
31515		A	Laryngoscopy for aspiration	1.79	3.77	1.11	0.14	5.70	3.04	000
31520		A	Diagnostic laryngoscopy	2.55	NA	1.62	0.20	NA	4.37	000
31525		A	Diagnostic laryngoscopy	2.62	3.90	1.71	0.22	6.74	4.55	000
31526		A	Diagnostic laryngoscopy	2.56	NA	1.77	0.22	NA	4.55	000
31527		A	Laryngoscopy for treatment	3.25	NA	1.93	0.25	NA	5.43	000
31528		A	Laryngoscopy and dilation	2.36	NA	1.47	0.19	NA	4.02	000
31529		A	Laryngoscopy and dilation	2.66	NA	1.73	0.22	NA	4.61	000
31530		A	Operative laryngoscopy	3.37	NA	2.00	0.29	NA	5.66	000
31531		A	Operative laryngoscopy	3.57	NA	2.33	0.30	NA	6.20	000
31535		A	Operative laryngoscopy	3.14	NA	2.04	0.26	NA	5.44	000
31536		A	Operative laryngoscopy	3.54	NA	2.31	0.30	NA	6.15	000
31540		A	Operative laryngoscopy	4.11	NA	2.61	0.35	NA	7.07	000
31541		A	Operative laryngoscopy	4.50	NA	2.85	0.38	NA	7.73	000
31560		A	Operative laryngoscopy	5.43	NA	3.20	0.46	NA	9.09	000
31561		A	Operative laryngoscopy	5.97	NA	3.41	0.50	NA	9.88	000
31570		A	Laryngoscopy with injection	3.85	5.81	2.45	0.29	9.95	6.59	000
31571		A	Laryngoscopy with injection	4.25	NA	2.66	0.36	NA	7.27	000
31575		A	Diagnostic laryngoscopy	1.09	1.91	0.92	0.10	3.10	2.11	000
31576		A	Laryngoscopy with biopsy	1.96	3.66	1.33	0.16	5.78	3.45	000
31577		A	Remove foreign body, larynx	2.46	3.78	1.59	0.20	6.44	4.25	000
31578		A	Removal of larynx lesion	2.82	4.30	1.58	0.24	7.36	4.64	000
31579		A	Diagnostic laryngoscopy	2.25	3.84	1.54	0.19	6.28	3.98	000
31580		A	Revision of larynx	12.31	NA	11.24	1.04	NA	24.59	090
31582		A	Revision of larynx	21.50	NA	17.63	1.82	NA	40.95	090
31584		A	Treat larynx fracture	19.53	NA	14.73	1.70	NA	35.96	090
31585		A	Treat larynx fracture	4.61	NA	5.65	0.36	NA	10.62	090
31586		A	Treat larynx fracture	7.98	NA	8.44	0.67	NA	17.09	090
31587		A	Revision of larynx	11.92	NA	10.16	1.05	NA	23.13	090
31588		A	Revision of larynx	13.04	NA	13.26	1.10	NA	27.40	090
31590		A	Reinnervate larynx	6.93	NA	8.92	0.60	NA	16.45	090
31595		A	Larynx nerve surgery	8.29	NA	7.73	0.74	NA	16.76	090
31599		C	Larynx surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31600		A	Incision of windpipe	7.14	NA	3.22	0.41	NA	10.77	000
31601		A	Incision of windpipe	4.42	NA	2.42	0.47	NA	7.31	000
31603		A	Incision of windpipe	4.13	NA	1.74	0.42	NA	6.29	000
31605		A	Incision of windpipe	3.56	NA	1.20	0.40	NA	5.16	000
31610		A	Incision of windpipe	8.71	NA	7.51	0.83	NA	17.05	090
31611		A	Surgery/speech prosthesis	5.61	NA	6.02	0.48	NA	12.11	090
31612		A	Puncture/clear windpipe	0.90	1.13	0.36	0.07	2.10	1.33	000
31613		A	Repair windpipe opening	4.56	NA	5.43	0.44	NA	10.43	090
31614		A	Repair windpipe opening	7.08	NA	7.87	0.61	NA	15.56	090
31615		A	Visualization of windpipe	2.08	2.66	1.22	0.17	4.91	3.47	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
31622		A	Dx bronchoscope/wash	2.76	4.20	0.89	0.17	7.13	3.82	000
31623		A	Dx bronchoscope/brush	2.86	5.09	0.90	0.17	8.12	3.93	000
31624		A	Dx bronchoscope/lavage	2.86	4.32	0.90	0.16	7.34	3.92	000
31625		A	Bronchoscopy w/biopsy(s)	3.35	5.41	1.27	0.19	8.95	4.81	000
31628		A	Bronchoscopy/lung bx, each	3.79	5.62	1.36	0.17	9.58	5.32	000
31629		A	Bronchoscopy/needle bx, each	3.35	NA	1.24	0.16	NA	4.75	000
31630		A	Bronchoscopy dilate/fx repr	3.80	NA	1.98	0.36	NA	6.14	000
31631		A	Bronchoscopy, dilate w/stent	4.35	NA	2.01	0.37	NA	6.73	000
31632		A	Bronchoscopy/lung bx, addl	1.02	0.76	0.32	0.17	1.95	1.51	ZZZ
31633		A	Bronchoscopy/needle bx addl	1.31	0.92	0.41	0.17	2.40	1.89	ZZZ
31635		A	Bronchoscopy w/fb removal	3.66	NA	1.68	0.25	NA	5.59	000
31640		A	Bronchoscopy w/tumor excise	4.91	NA	2.33	0.44	NA	7.68	000
31641		A	Bronchoscopy, treat blockage	5.00	NA	2.12	0.36	NA	7.48	000
31643		A	Diag bronchoscope/catheter	3.48	NA	1.32	0.18	NA	4.98	000
31645		A	Bronchoscopy, clear airways	3.14	NA	1.22	0.16	NA	4.52	000
31646		A	Bronchoscopy, reclear airway	2.70	NA	1.09	0.14	NA	3.93	000
31656		A	Bronchoscopy, inj for x-ray	2.16	NA	0.93	0.12	NA	3.21	000
31700		A	Insertion of airway catheter	1.33	2.08	0.69	0.08	3.49	2.10	000
31708		A	Instill airway contrast dye	1.40	NA	0.60	0.07	NA	2.07	000
31710		A	Insertion of airway catheter	1.29	NA	0.71	0.07	NA	2.07	000
31715		A	Injection for bronchus x-ray	1.10	NA	0.61	0.07	NA	1.78	000
31717		A	Bronchial brush biopsy	2.11	2.89	0.87	0.11	5.11	3.09	000
31720		A	Clearance of airways	1.05	1.48	0.33	0.07	2.60	1.45	000
31725		A	Clearance of airways	1.95	1.84	0.59	0.12	3.91	2.66	000
31730		A	Intro, windpipe wire/tube	2.83	2.24	1.09	0.18	5.25	4.10	000
31750		A	Repair of windpipe	12.95	NA	11.61	1.22	NA	25.78	090
31755		A	Repair of windpipe	15.84	NA	14.34	1.38	NA	31.56	090
31760		A	Repair of windpipe	22.22	NA	10.50	1.77	NA	34.49	090
31766		A	Reconstruction of windpipe	30.26	NA	13.52	3.79	NA	47.57	090
31770		A	Repair/graft of bronchus	22.38	NA	10.01	2.72	NA	35.11	090
31775		A	Reconstruct bronchus	23.41	NA	11.67	3.49	NA	38.57	090
31780		A	Reconstruct windpipe	17.62	NA	11.05	1.86	NA	30.53	090
31781		A	Reconstruct windpipe	23.40	NA	12.06	2.45	NA	37.91	090
31785		A	Remove windpipe lesion	17.13	NA	10.32	1.63	NA	29.08	090
31786		A	Remove windpipe lesion	23.84	NA	13.13	2.64	NA	39.61	090
31800		A	Repair of windpipe injury	7.39	NA	4.88	0.80	NA	13.07	090
31805		A	Repair of windpipe injury	13.06	NA	7.10	1.74	NA	21.90	090
31820		A	Closure of windpipe lesion	4.46	5.59	4.96	0.42	10.47	9.84	090
31825		A	Repair of windpipe defect	6.77	7.68	7.11	0.60	15.05	14.48	090
31830		A	Revise windpipe scar	4.47	5.74	5.33	0.43	10.64	10.23	090
31899		C	Airways surgical procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
32000		A	Drainage of chest	1.53	3.13	0.49	0.08	4.74	2.10	000
32002		A	Treatment of collapsed lung	2.18	3.34	0.84	0.13	5.65	3.15	000
32005		A	Treat lung lining chemically	2.18	6.45	0.69	0.20	8.83	3.07	000
32020		A	Insertion of chest tube	3.96	NA	1.45	0.43	NA	5.84	000
32035		A	Exploration of chest	8.62	NA	5.71	1.22	NA	15.55	090
32036		A	Exploration of chest	9.62	NA	6.23	1.44	NA	17.29	090
32095		A	Biopsy through chest wall	8.31	NA	5.22	1.19	NA	14.72	090
32100		A	Exploration/biopsy of chest	15.15	NA	7.65	1.74	NA	24.54	090
32110		A	Explore/repair chest	22.87	NA	10.54	1.95	NA	35.36	090
32120		A	Re-exploration of chest	11.47	NA	6.87	1.70	NA	20.04	090
32124		A	Explore chest free adhesions	12.65	NA	7.04	1.81	NA	21.50	090
32140		A	Removal of lung lesion(s)	13.85	NA	7.50	2.01	NA	23.36	090
32141		A	Remove/treat lung lesions	13.92	NA	7.38	2.06	NA	23.36	090
32150		A	Removal of lung lesion(s)	14.07	NA	7.47	1.92	NA	23.46	090
32151		A	Remove lung foreign body	14.13	NA	7.85	1.79	NA	23.77	090
32160		A	Open chest heart massage	9.25	NA	5.21	1.21	NA	15.67	090
32200		A	Drain, open, lung lesion	15.20	NA	8.48	1.75	NA	25.43	090
32201		A	Drain, percut, lung lesion	3.98	NA	1.32	0.22	NA	5.52	000
32215		A	Treat chest lining	11.27	NA	6.69	1.61	NA	19.57	090
32220		A	Release of lung	23.86	NA	12.56	2.86	NA	39.28	090
32225		A	Partial release of lung	13.88	NA	7.47	2.04	NA	23.39	090
32310		A	Removal of chest lining	13.36	NA	7.22	1.98	NA	22.56	090
32320		A	Free/remove chest lining	23.86	NA	11.88	3.00	NA	38.74	090
32400		A	Needle biopsy chest lining	1.75	1.73	0.56	0.08	3.56	2.39	000
32402		A	Open biopsy chest lining	7.52	NA	4.96	1.09	NA	13.57	090
32405		A	Biopsy, lung or mediastinum	1.92	2.14	0.64	0.11	4.17	2.67	000
32420		A	Puncture/clear lung	2.17	NA	0.83	0.13	NA	3.13	000
32440		A	Removal of lung	24.86	NA	12.56	3.07	NA	40.49	090
32442		A	Sleeve pneumonectomy	26.09	NA	14.29	3.74	NA	44.12	090
32445		A	Removal of lung	24.95	NA	13.70	3.73	NA	42.38	090
32480		A	Partial removal of lung	23.61	NA	11.77	2.68	NA	38.06	090
32482		A	Bilobectomy	24.86	NA	12.62	2.82	NA	40.30	090
32484		A	Segmentectomy	20.57	NA	11.08	3.04	NA	34.69	090
32486		A	Sleeve lobectomy	23.78	NA	12.84	3.60	NA	40.22	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
32488	.....	A	Completion pneumonectomy ...	25.56	NA	13.39	3.81	NA	42.76	090
32491	.....	R	Lung volume reduction	21.13	NA	12.19	3.19	NA	36.51	090
32500	.....	A	Partial removal of lung	21.87	NA	11.98	2.12	NA	35.97	090
32501	.....	A	Repair bronchus add-on	4.66	NA	1.52	0.67	NA	6.85	ZZZ
32520	.....	A	Remove lung & revise chest	21.56	NA	10.98	3.25	NA	35.79	090
32522	.....	A	Remove lung & revise chest	24.06	NA	11.81	3.40	NA	39.27	090
32525	.....	A	Remove lung & revise chest	26.35	NA	12.50	3.90	NA	42.75	090
32540	.....	A	Removal of lung lesion	14.56	NA	9.33	2.21	NA	26.10	090
32601	.....	A	Thoracoscopy, diagnostic	5.43	NA	2.36	0.76	NA	8.55	000
32602	.....	A	Thoracoscopy, diagnostic	5.93	NA	2.52	0.84	NA	9.29	000
32603	.....	A	Thoracoscopy, diagnostic	7.77	NA	3.06	0.91	NA	11.74	000
32604	.....	A	Thoracoscopy, diagnostic	8.73	NA	3.46	1.16	NA	13.35	000
32605	.....	A	Thoracoscopy, diagnostic	6.89	NA	2.89	1.03	NA	10.81	000
32606	.....	A	Thoracoscopy, diagnostic	8.35	NA	3.33	1.19	NA	12.87	000
32650	.....	A	Thoracoscopy, surgical	10.69	NA	6.57	1.50	NA	18.76	090
32651	.....	A	Thoracoscopy, surgical	12.84	NA	7.08	1.80	NA	21.72	090
32652	.....	A	Thoracoscopy, surgical	18.55	NA	9.87	2.76	NA	31.18	090
32653	.....	A	Thoracoscopy, surgical	12.80	NA	6.80	1.86	NA	21.46	090
32654	.....	A	Thoracoscopy, surgical	12.37	NA	7.29	1.81	NA	21.47	090
32655	.....	A	Thoracoscopy, surgical	13.03	NA	7.09	1.83	NA	21.95	090
32656	.....	A	Thoracoscopy, surgical	12.84	NA	7.66	1.93	NA	22.43	090
32657	.....	A	Thoracoscopy, surgical	13.57	NA	7.48	1.97	NA	23.02	090
32658	.....	A	Thoracoscopy, surgical	11.56	NA	7.09	1.76	NA	20.41	090
32659	.....	A	Thoracoscopy, surgical	11.52	NA	7.21	1.67	NA	20.40	090
32660	.....	A	Thoracoscopy, surgical	17.33	NA	9.17	2.51	NA	29.01	090
32661	.....	A	Thoracoscopy, surgical	13.17	NA	7.55	1.99	NA	22.71	090
32662	.....	A	Thoracoscopy, surgical	16.35	NA	8.57	2.41	NA	27.33	090
32663	.....	A	Thoracoscopy, surgical	18.36	NA	10.42	2.73	NA	31.51	090
32664	.....	A	Thoracoscopy, surgical	14.12	NA	7.51	2.04	NA	23.67	090
32665	.....	A	Thoracoscopy, surgical	15.45	NA	8.04	2.15	NA	25.64	090
32800	.....	A	Repair lung hernia	13.61	NA	7.29	1.81	NA	22.71	090
32810	.....	A	Close chest after drainage	12.98	NA	7.35	1.86	NA	22.19	090
32815	.....	A	Close bronchial fistula	23.02	NA	10.69	3.40	NA	37.11	090
32820	.....	A	Reconstruct injured chest	21.36	NA	11.99	2.77	NA	36.12	090
32850	.....	X	Donor pneumonectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32851	.....	A	Lung transplant, single	38.41	NA	26.78	5.87	NA	71.06	090
32852	.....	A	Lung transplant with bypass	41.56	NA	31.65	6.20	NA	79.41	090
32853	.....	A	Lung transplant, double	47.54	NA	30.49	7.35	NA	85.38	090
32854	.....	A	Lung transplant with bypass	50.69	NA	33.59	7.68	NA	91.96	090
32900	.....	A	Removal of rib(s)	20.15	NA	9.75	2.90	NA	32.80	090
32905	.....	A	Revise & repair chest wall	20.63	NA	9.95	3.04	NA	33.62	090
32906	.....	A	Revise & repair chest wall	26.62	NA	11.85	3.96	NA	42.43	090
32940	.....	A	Revision of lung	19.32	NA	9.22	2.96	NA	31.50	090
32960	.....	A	Therapeutic pneumothorax	1.83	1.80	0.58	0.14	3.77	2.55	000
32997	.....	A	Total lung lavage	5.97	NA	1.92	0.66	NA	8.55	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	2.23	NA	0.97	0.16	NA	3.36	000
33011	.....	A	Repeat drainage of heart sac	2.23	NA	1.00	0.16	NA	3.39	000
33015	.....	A	Incision of heart sac	6.76	NA	4.83	0.77	NA	12.36	090
33020	.....	A	Incision of heart sac	12.54	NA	6.61	1.80	NA	20.95	090
33025	.....	A	Incision of heart sac	12.02	NA	6.17	1.80	NA	19.99	090
33030	.....	A	Partial removal of heart sac	18.60	NA	9.24	2.88	NA	30.72	090
33031	.....	A	Partial removal of heart sac	21.67	NA	9.74	3.33	NA	34.74	090
33050	.....	A	Removal of heart sac lesion	14.28	NA	7.63	2.07	NA	23.98	090
33120	.....	A	Removal of heart lesion	24.42	NA	11.27	3.67	NA	39.36	090
33130	.....	A	Removal of heart lesion	21.27	NA	9.93	3.01	NA	34.21	090
33140	.....	A	Heart revascularize (tmr)	19.89	NA	10.53	2.72	NA	33.14	090
33141	.....	A	Heart tmr w/other procedure	4.81	NA	1.55	0.66	NA	7.02	ZZZ
33200	.....	A	Insertion of heart pacemaker	12.41	NA	6.84	1.40	NA	20.65	090
33201	.....	A	Insertion of heart pacemaker	10.12	NA	6.48	1.45	NA	18.05	090
33206	.....	A	Insertion of heart pacemaker	6.63	NA	4.54	0.60	NA	11.77	090
33207	.....	A	Insertion of heart pacemaker	7.99	NA	4.75	0.68	NA	13.42	090
33208	.....	A	Insertion of heart pacemaker	8.08	NA	4.87	0.65	NA	13.60	090
33210	.....	A	Insertion of heart electrode	3.28	NA	1.27	0.20	NA	4.75	000
33211	.....	A	Insertion of heart electrode	3.38	NA	1.33	0.20	NA	4.91	000
33212	.....	A	Insertion of pulse generator	5.49	NA	3.40	0.53	NA	9.42	090
33213	.....	A	Insertion of pulse generator	6.33	NA	3.78	0.55	NA	10.66	090
33214	.....	A	Upgrade of pacemaker system	7.71	NA	4.99	0.62	NA	13.32	090
33215	.....	A	Reposition pacing-defib lead	4.73	NA	3.19	0.43	NA	8.35	090
33216	.....	A	Insert lead pace-defib, one	5.75	NA	4.30	0.43	NA	10.48	090
33217	.....	A	Insert lead pace-defib, dual	5.72	NA	4.34	0.43	NA	10.49	090
33218	.....	A	Repair lead pace-defib, one	5.41	NA	4.35	0.48	NA	10.24	090
33220	.....	A	Repair lead pace-defib, dual	5.49	NA	4.34	0.47	NA	10.30	090
33222	.....	A	Revise pocket, pacemaker	4.93	NA	4.34	0.47	NA	9.74	090
33223	.....	A	Revise pocket, pacing-defib	6.42	NA	4.61	0.53	NA	11.56	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
33224		A	Insert pacing lead & connect	9.00	NA	4.05	0.43	NA	13.48	000
33225		A	L ventric pacing lead add-on	8.29	NA	3.24	0.43	NA	11.96	ZZZ
33226		A	Reposition l ventric lead	8.64	NA	3.91	0.43	NA	12.98	000
33233		A	Removal of pacemaker system	3.27	NA	3.28	0.26	NA	6.81	090
33234		A	Removal of pacemaker system	7.78	NA	4.93	0.67	NA	13.38	090
33235		A	Removal pacemaker electrode	9.35	NA	6.80	0.82	NA	16.97	090
33236		A	Remove electrode/thoracotomy	12.53	NA	7.22	1.79	NA	21.54	090
33237		A	Remove electrode/thoracotomy	13.63	NA	7.61	1.88	NA	23.12	090
33238		A	Remove electrode/thoracotomy	15.13	NA	8.06	1.87	NA	25.06	090
33240		A	Insert pulse generator	7.56	NA	4.62	0.64	NA	12.82	090
33241		A	Remove pulse generator	3.22	NA	2.97	0.25	NA	6.44	090
33243		A	Remove eltrd/thoracotomy	22.51	NA	11.15	3.03	NA	36.69	090
33244		A	Remove eltrd, transven	13.68	NA	8.87	1.26	NA	23.81	090
33245		A	Insert epic eltrd pace-defib	14.22	NA	7.86	1.53	NA	23.61	090
33246		A	Insert epic eltrd/generator	20.59	NA	10.15	2.66	NA	33.40	090
33249		A	Eltrd/insert pace-defib	14.15	NA	8.51	0.96	NA	23.62	090
33250		A	Ablate heart dysrhythm focus	21.73	NA	11.22	1.21	NA	34.16	090
33251		A	Ablate heart dysrhythm focus	24.74	NA	11.33	2.89	NA	38.96	090
33253		A	Reconstruct atria	30.88	NA	13.44	4.41	NA	48.73	090
33261		A	Ablate heart dysrhythm focus	24.74	NA	11.46	3.38	NA	39.58	090
33282		A	Implant pat-active ht record	4.15	NA	4.11	0.47	NA	8.73	090
33284		A	Remove pat-active ht record	2.49	NA	3.52	0.28	NA	6.29	090
33300		A	Repair of heart wound	17.82	NA	9.06	2.29	NA	29.17	090
33305		A	Repair of heart wound	21.32	NA	10.30	3.21	NA	34.83	090
33310		A	Exploratory heart surgery	18.40	NA	9.27	2.71	NA	30.38	090
33315		A	Exploratory heart surgery	22.24	NA	10.53	3.48	NA	36.25	090
33320		A	Repair major blood vessel(s)	16.69	NA	8.14	1.99	NA	26.82	090
33321		A	Repair major vessel	20.08	NA	9.53	3.24	NA	32.85	090
33322		A	Repair major blood vessel(s)	20.50	NA	10.07	3.01	NA	33.58	090
33330		A	Insert major vessel graft	21.31	NA	10.06	2.98	NA	34.35	090
33332		A	Insert major vessel graft	23.82	NA	10.37	2.94	NA	37.13	090
33335		A	Insert major vessel graft	29.84	NA	12.98	4.54	NA	47.36	090
33400		A	Repair of aortic valve	28.34	NA	15.16	3.70	NA	47.20	090
33401		A	Valvuloplasty, open	23.77	NA	13.23	3.25	NA	40.25	090
33403		A	Valvuloplasty, w/cp bypass	24.75	NA	13.87	2.97	NA	41.59	090
33404		A	Prepare heart-aorta conduit	28.38	NA	14.06	3.97	NA	46.41	090
33405		A	Replacement of aortic valve	34.60	NA	17.66	4.63	NA	57.09	090
33406		A	Replacement of aortic valve	37.29	NA	18.47	4.88	NA	60.64	090
33410		A	Replacement of aortic valve	32.27	NA	16.11	4.93	NA	53.31	090
33411		A	Replacement of aortic valve	36.04	NA	18.11	4.99	NA	59.14	090
33412		A	Replacement of aortic valve	41.76	NA	19.84	5.59	NA	67.19	090
33413		A	Replacement of aortic valve	43.25	NA	20.20	5.11	NA	68.56	090
33414		A	Repair of aortic valve	30.18	NA	13.72	4.54	NA	48.44	090
33415		A	Revision, subvalvular tissue	27.00	NA	11.75	3.90	NA	42.65	090
33416		A	Revise ventricle muscle	30.18	NA	13.11	4.61	NA	47.90	090
33417		A	Repair of aortic valve	28.37	NA	13.21	4.29	NA	45.87	090
33420		A	Revision of mitral valve	22.57	NA	9.71	1.77	NA	34.05	090
33422		A	Revision of mitral valve	25.79	NA	13.17	3.96	NA	42.92	090
33425		A	Repair of mitral valve	26.85	NA	12.64	3.60	NA	43.09	090
33426		A	Repair of mitral valve	32.81	NA	16.57	4.64	NA	54.02	090
33427		A	Repair of mitral valve	39.77	NA	18.74	5.15	NA	63.66	090
33430		A	Replacement of mitral valve	33.31	NA	16.71	4.73	NA	54.75	090
33460		A	Revision of tricuspid valve	23.47	NA	10.93	3.62	NA	38.02	090
33463		A	Valvuloplasty, tricuspid	25.47	NA	12.51	3.80	NA	41.78	090
33464		A	Valvuloplasty, tricuspid	27.17	NA	13.09	4.16	NA	44.42	090
33465		A	Replace tricuspid valve	28.63	NA	12.58	4.33	NA	45.54	090
33468		A	Revision of tricuspid valve	29.95	NA	13.23	4.79	NA	47.97	090
33470		A	Revision of pulmonary valve	20.69	NA	10.65	3.37	NA	34.71	090
33471		A	Valvotomy, pulmonary valve	22.12	NA	9.70	3.60	NA	35.42	090
33472		A	Revision of pulmonary valve	22.12	NA	11.73	3.50	NA	37.35	090
33474		A	Revision of pulmonary valve	22.91	NA	10.68	3.40	NA	36.99	090
33475		A	Replacement, pulmonary valve	32.81	NA	14.87	3.16	NA	50.84	090
33476		A	Revision of heart chamber	25.62	NA	11.87	2.88	NA	40.37	090
33478		A	Revision of heart chamber	26.59	NA	12.58	4.27	NA	43.44	090
33496		A	Repair, prosth valve clot	27.09	NA	12.39	4.12	NA	43.60	090
33500		A	Repair heart vessel fistula	25.40	NA	11.23	3.36	NA	39.99	090
33501		A	Repair heart vessel fistula	17.68	NA	8.20	2.46	NA	28.34	090
33502		A	Coronary artery correction	20.92	NA	10.72	3.01	NA	34.65	090
33503		A	Coronary artery graft	21.66	NA	9.77	1.70	NA	33.13	090
33504		A	Coronary artery graft	24.52	NA	11.59	3.64	NA	39.75	090
33505		A	Repair artery w/tunnel	26.69	NA	12.78	1.82	NA	41.29	090
33506		A	Repair artery, translocation	35.30	NA	14.37	3.82	NA	53.49	090
33508		A	Endoscopic vein harvest	0.31	NA	0.10	0.04	NA	0.45	ZZZ
33510		A	CABG, vein, single	28.83	NA	15.76	3.75	NA	48.34	090
33511		A	CABG, vein, two	29.83	NA	16.46	4.00	NA	50.29	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
33512		A	CABG, vein, three	31.62	NA	17.00	4.43	NA	53.05	090
33513		A	CABG, vein, four	31.82	NA	17.16	4.78	NA	53.76	090
33514		A	CABG, vein, five	32.56	NA	17.41	5.24	NA	55.21	090
33516		A	Cabg, vein, six or more	34.80	NA	18.15	5.54	NA	58.49	090
33517		A	CABG, artery-vein, single	2.56	NA	0.82	0.38	NA	3.76	ZZZ
33518		A	CABG, artery-vein, two	4.82	NA	1.56	0.73	NA	7.11	ZZZ
33519		A	CABG, artery-vein, three	7.08	NA	2.28	1.07	NA	10.43	ZZZ
33521		A	CABG, artery-vein, four	9.35	NA	3.02	1.41	NA	13.78	ZZZ
33522		A	CABG, artery-vein, five	11.60	NA	3.74	1.77	NA	17.11	ZZZ
33523		A	Cabg, art-vein, six or more	13.87	NA	4.45	2.13	NA	20.45	ZZZ
33530		A	Coronary artery, bypass/reop	5.83	NA	1.88	0.87	NA	8.58	ZZZ
33533		A	CABG, arterial, single	29.83	NA	15.90	3.88	NA	49.61	090
33534		A	CABG, arterial, two	32.02	NA	17.07	4.35	NA	53.44	090
33535		A	CABG, arterial, three	34.30	NA	17.54	4.76	NA	56.60	090
33536		A	Cabg, arterial, four or more	37.29	NA	17.82	3.94	NA	59.05	090
33542		A	Removal of heart lesion	28.69	NA	12.64	4.33	NA	45.66	090
33545		A	Repair of heart damage	36.57	NA	15.30	5.27	NA	57.14	090
33572		A	Open coronary endarterectomy	4.42	NA	1.43	0.66	NA	6.51	ZZZ
33600		A	Closure of valve	29.34	NA	12.45	2.76	NA	44.55	090
33602		A	Closure of valve	28.38	NA	12.53	3.48	NA	44.39	090
33606		A	Anastomosis/artery-aorta	30.56	NA	13.45	4.30	NA	48.31	090
33608		A	Repair anomaly w/conduit	30.91	NA	13.70	5.00	NA	49.61	090
33610		A	Repair by enlargement	30.44	NA	13.96	4.82	NA	49.22	090
33611		A	Repair double ventricle	33.81	NA	13.75	3.93	NA	51.49	090
33612		A	Repair double ventricle	34.80	NA	14.79	5.32	NA	54.91	090
33615		A	Repair, modified fontan	33.81	NA	14.85	3.78	NA	52.44	090
33617		A	Repair single ventricle	36.79	NA	15.61	4.90	NA	57.30	090
33619		A	Repair single ventricle	44.74	NA	20.07	5.65	NA	70.46	090
33641		A	Repair heart septum defect	21.27	NA	9.32	3.20	NA	33.79	090
33645		A	Revision of heart veins	24.68	NA	11.44	3.92	NA	40.04	090
33647		A	Repair heart septum defects	28.57	NA	13.42	4.04	NA	46.03	090
33660		A	Repair of heart defects	29.83	NA	13.16	3.38	NA	46.37	090
33665		A	Repair of heart defects	28.44	NA	13.26	4.57	NA	46.27	090
33670		A	Repair of heart chambers	34.80	NA	13.40	2.61	NA	50.81	090
33681		A	Repair heart septum defect	30.44	NA	14.21	4.23	NA	48.88	090
33684		A	Repair heart septum defect	29.48	NA	13.35	4.52	NA	47.35	090
33688		A	Repair heart septum defect	30.45	NA	10.80	4.66	NA	45.91	090
33690		A	Reinforce pulmonary artery	19.44	NA	9.98	3.07	NA	32.49	090
33692		A	Repair of heart defects	30.57	NA	13.73	4.52	NA	48.82	090
33694		A	Repair of heart defects	33.81	NA	14.16	5.12	NA	53.09	090
33697		A	Repair of heart defects	35.79	NA	14.34	5.44	NA	55.57	090
33702		A	Repair of heart defects	26.39	NA	12.18	4.14	NA	42.71	090
33710		A	Repair of heart defects	29.54	NA	13.76	4.61	NA	47.91	090
33720		A	Repair of heart defect	26.41	NA	12.04	3.85	NA	42.30	090
33722		A	Repair of heart defect	28.25	NA	13.28	4.55	NA	46.08	090
33730		A	Repair heart-vein defect(s)	34.05	NA	14.14	3.42	NA	51.61	090
33732		A	Repair heart-vein defect	28.00	NA	13.31	3.33	NA	44.64	090
33735		A	Revision of heart chamber	21.27	NA	10.06	1.34	NA	32.67	090
33736		A	Revision of heart chamber	23.39	NA	11.67	3.24	NA	38.30	090
33737		A	Revision of heart chamber	21.64	NA	10.87	3.51	NA	36.02	090
33750		A	Major vessel shunt	21.29	NA	10.32	2.09	NA	33.70	090
33755		A	Major vessel shunt	21.67	NA	8.65	3.51	NA	33.83	090
33762		A	Major vessel shunt	21.67	NA	10.35	1.91	NA	33.93	090
33764		A	Major vessel shunt & graft	21.67	NA	10.20	2.31	NA	34.18	090
33766		A	Major vessel shunt	22.63	NA	11.20	3.64	NA	37.47	090
33767		A	Major vessel shunt	24.36	NA	11.60	3.76	NA	39.72	090
33770		A	Repair great vessels defect	36.79	NA	14.56	5.38	NA	56.73	090
33771		A	Repair great vessels defect	34.45	NA	12.62	5.60	NA	52.67	090
33774		A	Repair great vessels defect	30.80	NA	13.96	5.01	NA	49.77	090
33775		A	Repair great vessels defect	32.02	NA	14.42	5.20	NA	51.64	090
33776		A	Repair great vessels defect	33.85	NA	15.16	5.49	NA	54.50	090
33777		A	Repair great vessels defect	33.27	NA	15.09	5.41	NA	53.77	090
33778		A	Repair great vessels defect	39.77	NA	16.27	5.79	NA	61.83	090
33779		A	Repair great vessels defect	36.00	NA	15.45	2.88	NA	54.33	090
33780		A	Repair great vessels defect	41.51	NA	18.87	6.24	NA	66.62	090
33781		A	Repair great vessels defect	36.24	NA	13.78	5.89	NA	55.91	090
33786		A	Repair arterial trunk	38.78	NA	16.09	5.62	NA	60.49	090
33788		A	Revision of pulmonary artery	26.47	NA	12.05	3.98	NA	42.50	090
33800		A	Aortic suspension	16.15	NA	7.73	1.33	NA	25.21	090
33802		A	Repair vessel defect	17.56	NA	8.97	1.87	NA	28.40	090
33803		A	Repair vessel defect	19.49	NA	9.53	3.15	NA	32.17	090
33813		A	Repair septal defect	20.53	NA	10.55	3.33	NA	34.41	090
33814		A	Repair septal defect	25.62	NA	12.26	3.02	NA	40.90	090
33820		A	Revise major vessel	16.20	NA	8.05	2.52	NA	26.77	090
33822		A	Revise major vessel	17.22	NA	8.58	2.79	NA	28.59	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
33824		A	Revise major vessel	19.41	NA	9.68	3.13	NA	32.22	090
33840		A	Remove aorta constriction	20.51	NA	9.99	2.83	NA	33.33	090
33845		A	Remove aorta constriction	21.99	NA	10.97	3.48	NA	36.44	090
33851		A	Remove aorta constriction	21.15	NA	10.36	3.43	NA	34.94	090
33852		A	Repair septal defect	23.57	NA	11.20	3.82	NA	38.59	090
33853		A	Repair septal defect	31.54	NA	14.32	5.07	NA	50.93	090
33860		A	Ascending aortic graft	37.78	NA	16.02	5.15	NA	58.95	090
33861		A	Ascending aortic graft	41.76	NA	17.27	5.08	NA	64.11	090
33863		A	Ascending aortic graft	44.74	NA	18.23	5.51	NA	68.48	090
33870		A	Transverse aortic arch graft	43.75	NA	17.93	6.10	NA	67.78	090
33875		A	Thoracic aortic graft	32.87	NA	13.80	4.89	NA	51.56	090
33877		A	Thoracoabdominal graft	42.36	NA	16.28	6.08	NA	64.72	090
33910		A	Remove lung artery emboli	24.45	NA	11.15	3.67	NA	39.27	090
33915		A	Remove lung artery emboli	20.90	NA	9.60	1.44	NA	31.94	090
33916		A	Surgery of great vessel	25.68	NA	11.18	3.64	NA	40.50	090
33917		A	Repair pulmonary artery	24.36	NA	11.85	3.80	NA	40.01	090
33918		A	Repair pulmonary atresia	26.30	NA	12.22	4.10	NA	42.62	090
33919		A	Repair pulmonary atresia	39.77	NA	17.13	4.17	NA	61.07	090
33920		A	Repair pulmonary atresia	31.77	NA	13.76	4.33	NA	49.86	090
33922		A	Transect pulmonary artery	23.39	NA	10.81	2.76	NA	36.96	090
33924		A	Remove pulmonary shunt	5.47	NA	1.80	0.89	NA	8.16	ZZZ
33930		X	Removal of donor heart/lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33935		R	Transplantation, heart/lung	60.61	NA	28.07	9.77	NA	98.45	090
33940		X	Removal of donor heart	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33945		R	Transplantation of heart	41.86	NA	20.81	6.50	NA	69.17	090
33960		A	External circulation assist	19.25	NA	4.91	2.57	NA	26.73	000
33961		A	External circulation assist	10.87	NA	3.60	1.76	NA	16.23	ZZZ
33967		A	Insert ia percut device	4.82	NA	1.86	0.34	NA	7.02	000
33968		A	Remove aortic assist device	0.64	NA	0.23	0.08	NA	0.95	000
33970		A	Aortic circulation assist	6.71	NA	2.25	0.84	NA	9.80	000
33971		A	Aortic circulation assist	9.63	NA	5.90	1.16	NA	16.69	090
33973		A	Insert balloon device	9.70	NA	3.27	1.21	NA	14.18	000
33974		A	Remove intra-aortic balloon	14.33	NA	7.80	1.77	NA	23.90	090
33975		A	Implant ventricular device	20.88	NA	6.20	2.06	NA	29.14	XXX
33976		A	Implant ventricular device	22.87	NA	7.42	3.38	NA	33.67	XXX
33977		A	Remove ventricular device	19.18	NA	10.69	2.92	NA	32.79	090
33978		A	Remove ventricular device	21 61	NA	11.38	3.19	NA	36.18	090
33979		A	Insert intracorporeal device	45.74	NA	14.63	4.77	NA	65.14	XXX
33980		A	Remove intracorporeal device	55.93	NA	24.64	5.51	NA	86.08	090
33999		C	Cardiac surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
34001		A	Removal of artery clot	12.84	NA	6.70	1.75	NA	21.29	090
34051		A	Removal of artery clot	15.12	NA	7.59	2.28	NA	24.99	090
34101		A	Removal of artery clot	9.94	NA	5.35	1.33	NA	16.62	090
34111		A	Removal of arm artery clot	9.94	NA	5.37	1.02	NA	16.33	090
34151		A	Removal of artery clot	24.86	NA	10.50	2.21	NA	37.57	090
34201		A	Removal of artery clot	9.97	NA	5.41	1.22	NA	16.60	090
34203		A	Removal of leg artery clot	16.41	NA	8.09	1.64	NA	26.14	090
34401		A	Removal of vein clot	24.86	NA	10.71	1.44	NA	37.01	090
34421		A	Removal of vein clot	11.93	NA	6.29	1.14	NA	19.36	090
34451		A	Removal of vein clot	26.85	NA	11.43	1.91	NA	40.19	090
34471		A	Removal of vein clot	10.12	NA	5.38	1.08	NA	16.58	090
34490		A	Removal of vein clot	9.80	NA	5.43	0.87	NA	16.10	090
34501		A	Repair valve, femoral vein	15.91	NA	8.34	1.64	NA	25.89	090
34502		A	Reconstruct vena cava	26.80	NA	12.20	3.58	NA	42.58	090
34510		A	Transposition of vein valve	18.84	NA	9.29	1.92	NA	30.05	090
34520		A	Cross-over vein graft	17.85	NA	8.74	1.69	NA	28.28	090
34530		A	Leg vein fusion	16.55	NA	8.63	2.47	NA	27.65	090
34800		A	Endovasc abdo repair w/tube	20.63	NA	9.19	1.79	NA	31.61	090
34802		A	Endovasc abdo repr w/device	22.87	NA	9.88	1.98	NA	34.73	090
34804		A	Endovasc abdo repr w/device	22.87	NA	9.88	1.98	NA	34.73	090
34805		A	Endovasc abdo repair w/pros	21.76	NA	9.51	1.98	NA	33.25	090
34808		A	Endovasc abdo occlud device	4.11	NA	1.38	0.35	NA	5.84	ZZZ
34812		A	Xpose for endoprosth, femorl	6.71	NA	2.25	0.59	NA	9.55	000
34813		A	Femoral endovas graft add-on	4.77	NA	1.58	0.41	NA	6.76	ZZZ
34820		A	Xpose for endoprosth, iliac	9.69	NA	3.26	0.84	NA	13.79	000
34825		A	Endovasc extend prosth, init	11.93	NA	6.20	1.03	NA	19.16	090
34826		A	Endovasc exten prosth, addl	4.11	NA	1.39	0.35	NA	5.85	ZZZ
34830		A	Open aortic tube prosth repr	32.40	NA	13.68	2.80	NA	48.88	090
34831		A	Open aortoiliac prosth repr	35.14	NA	11.90	3.03	NA	50.07	090
34832		A	Open aortofemor prosth repr	35.14	NA	14.67	3.03	NA	52.84	090
34833		A	Xpose for endoprosth, iliac	11.93	NA	4.54	0.84	NA	17.31	000
34834		A	Xpose, endoprosth, brachial	5.32	NA	2.25	0.59	NA	8.16	000
34900		A	Endovasc iliac repr w/graft	16.29	NA	7.90	1.79	NA	25.98	090
35001		A	Repair defect of artery	19.53	NA	9.52	2.92	NA	31.97	090
35002		A	Repair artery rupture, neck	20.88	NA	9.78	2.18	NA	32.84	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
35005		A	Repair defect of artery	18.02	NA	8.88	1.62	NA	28.52	090
35011		A	Repair defect of artery	17.90	NA	8.00	1.56	NA	27.46	090
35013		A	Repair artery rupture, arm	21.87	NA	9.71	2.29	NA	33.87	090
35021		A	Repair defect of artery	19.54	NA	9.25	2.31	NA	31.10	090
35022		A	Repair artery rupture, chest	23.05	NA	10.01	2.39	NA	35.45	090
35045		A	Repair defect of arm artery	17.47	NA	7.61	1.50	NA	26.58	090
35081		A	Repair defect of artery	27.85	NA	11.45	3.84	NA	43.14	090
35082		A	Repair artery rupture, aorta	38.28	NA	15.35	4.88	NA	58.51	090
35091		A	Repair defect of artery	35.20	NA	13.61	4.90	NA	53.71	090
35092		A	Repair artery rupture, aorta	44.74	NA	17.73	5.17	NA	67.64	090
35102		A	Repair defect of artery	30.58	NA	12.40	4.12	NA	47.10	090
35103		A	Repair artery rupture, groin	40.27	NA	15.95	4.54	NA	60.76	090
35111		A	Repair defect of artery	24.86	NA	10.53	2.17	NA	37.56	090
35112		A	Repair artery rupture,spleen	29.83	NA	12.07	2.34	NA	44.24	090
35121		A	Repair defect of artery	29.83	NA	12.41	3.51	NA	45.75	090
35122		A	Repair artery rupture, belly	34.80	NA	13.93	4.24	NA	52.97	090
35131		A	Repair defect of artery	24.86	NA	10.76	2.53	NA	38.15	090
35132		A	Repair artery rupture, groin	29.83	NA	12.42	2.97	NA	45.22	090
35141		A	Repair defect of artery	19.89	NA	8.89	1.98	NA	30.76	090
35142		A	Repair artery rupture, thigh	23.17	NA	10.39	2.10	NA	35.66	090
35151		A	Repair defect of artery	22.51	NA	10.02	2.31	NA	34.84	090
35152		A	Repair artery rupture, knee	25.47	NA	11.34	2.31	NA	39.12	090
35161		A	Repair defect of artery	18.65	NA	9.08	2.65	NA	30.38	090
35162		A	Repair artery rupture	19.67	NA	9.57	2.65	NA	31.89	090
35180		A	Repair blood vessel lesion	13.54	NA	6.99	1.73	NA	22.26	090
35182		A	Repair blood vessel lesion	29.83	NA	12.76	2.25	NA	44.84	090
35184		A	Repair blood vessel lesion	17.90	NA	8.31	1.61	NA	27.82	090
35188		A	Repair blood vessel lesion	14.20	NA	7.61	1.83	NA	23.64	090
35189		A	Repair blood vessel lesion	27.84	NA	11.94	2.54	NA	42.32	090
35190		A	Repair blood vessel lesion	12.68	NA	6.49	1.59	NA	20.76	090
35201		A	Repair blood vessel lesion	16.05	NA	7.99	1.40	NA	25.44	090
35206		A	Repair blood vessel lesion	13.17	NA	6.60	1.25	NA	21.02	090
35207		A	Repair blood vessel lesion	10.09	NA	7.59	1.38	NA	19.06	090
35211		A	Repair blood vessel lesion	21.99	NA	10.31	3.39	NA	35.69	090
35216		A	Repair blood vessel lesion	18.64	NA	8.81	2.60	NA	30.05	090
35221		A	Repair blood vessel lesion	24.25	NA	10.02	2.15	NA	36.42	090
35226		A	Repair blood vessel lesion	14.42	NA	7.51	1.01	NA	22.94	090
35231		A	Repair blood vessel lesion	19.89	NA	9.79	1.58	NA	31.26	090
35236		A	Repair blood vessel lesion	17.01	NA	7.96	1.43	NA	26.40	090
35241		A	Repair blood vessel lesion	22.99	NA	10.74	3.48	NA	37.21	090
35246		A	Repair blood vessel lesion	26.30	NA	11.29	2.66	NA	40.25	090
35251		A	Repair blood vessel lesion	30.03	NA	11.91	2.24	NA	44.18	090
35256		A	Repair blood vessel lesion	18.26	NA	8.43	1.58	NA	28.27	090
35261		A	Repair blood vessel lesion	17.70	NA	8.03	1.61	NA	27.34	090
35266		A	Repair blood vessel lesion	14.83	NA	7.04	1.39	NA	23.26	090
35271		A	Repair blood vessel lesion	21.99	NA	10.21	3.32	NA	35.52	090
35276		A	Repair blood vessel lesion	24.11	NA	11.01	2.84	NA	37.96	090
35281		A	Repair blood vessel lesion	27.84	NA	11.79	2.18	NA	41.81	090
35286		A	Repair blood vessel lesion	16.07	NA	8.08	1.63	NA	25.78	090
35301		A	Rechanneling of artery	18.59	NA	8.45	2.67	NA	29.71	090
35311		A	Rechanneling of artery	26.85	NA	11.49	3.30	NA	41.64	090
35321		A	Rechanneling of artery	15.91	NA	7.34	1.63	NA	24.88	090
35331		A	Rechanneling of artery	26.05	NA	11.22	3.25	NA	40.52	090
35341		A	Rechanneling of artery	24.97	NA	10.93	3.44	NA	39.34	090
35351		A	Rechanneling of artery	22.87	NA	9.64	2.74	NA	35.25	090
35355		A	Rechanneling of artery	18.39	NA	8.13	2.16	NA	28.68	090
35361		A	Rechanneling of artery	28.04	NA	11.77	3.19	NA	43.00	090
35363		A	Rechanneling of artery	30.03	NA	12.58	3.32	NA	45.93	090
35371		A	Rechanneling of artery	14.64	NA	6.98	1.58	NA	23.20	090
35372		A	Rechanneling of artery	17.90	NA	8.09	1.83	NA	27.82	090
35381		A	Rechanneling of artery	15.72	NA	7.83	2.16	NA	25.71	090
35390		A	Reoperation, carotid add-on	3.17	NA	1.06	0.46	NA	4.69	ZZZ
35400		A	Angioscopy	2.98	NA	1.04	0.41	NA	4.43	ZZZ
35450		A	Repair arterial blockage	10.01	NA	4.05	1.01	NA	15.07	000
35452		A	Repair arterial blockage	6.87	NA	3.15	0.91	NA	10.93	000
35454		A	Repair arterial blockage	6.01	NA	2.84	0.80	NA	9.65	000
35456		A	Repair arterial blockage	7.31	NA	3.27	0.98	NA	11.56	000
35458		A	Repair arterial blockage	9.44	NA	3.98	1.31	NA	14.73	000
35459		A	Repair arterial blockage	8.58	NA	3.64	1.15	NA	13.37	000
35460		A	Repair venous blockage	6.01	NA	2.68	0.79	NA	9.48	000
35470		A	Repair arterial blockage	8.58	NA	3.88	0.60	NA	13.06	000
35471		A	Repair arterial blockage	10.01	NA	4.50	0.60	NA	15.11	000
35472		A	Repair arterial blockage	6.87	NA	3.26	0.47	NA	10.60	000
35473		A	Repair arterial blockage	6.01	NA	2.94	0.41	NA	9.36	000
35474		A	Repair arterial blockage	7.32	NA	2.91	0.48	NA	10.71	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
35475	.....	R	Repair arterial blockage	9.44	NA	4.10	0.56	NA	14.10	000
35476	.....	A	Repair venous blockage	6.01	NA	2.88	0.32	NA	9.21	000
35480	.....	A	Atherectomy, open	11.02	NA	4.51	1.35	NA	16.88	000
35481	.....	A	Atherectomy, open	7.57	NA	3.44	1.01	NA	12.02	000
35482	.....	A	Atherectomy, open	6.61	NA	3.09	0.90	NA	10.60	000
35483	.....	A	Atherectomy, open	8.05	NA	3.53	0.97	NA	12.55	000
35484	.....	A	Atherectomy, open	10.38	NA	4.23	1.35	NA	15.96	000
35485	.....	A	Atherectomy, open	9.44	NA	4.06	1.27	NA	14.77	000
35490	.....	A	Atherectomy, percutaneous	11.02	NA	4.75	0.66	NA	16.43	000
35491	.....	A	Atherectomy, percutaneous	7.57	NA	3.32	0.59	NA	11.48	000
35492	.....	A	Atherectomy, percutaneous	6.61	NA	3.22	0.52	NA	10.35	000
35493	.....	A	Atherectomy, percutaneous	8.05	NA	3.83	0.56	NA	12.44	000
35494	.....	A	Atherectomy, percutaneous	10.38	NA	4.45	0.58	NA	15.41	000
35495	.....	A	Atherectomy, percutaneous	9.44	NA	4.42	0.61	NA	14.47	000
35500	.....	A	Harvest vein for bypass	6.41	NA	2.04	0.76	NA	9.21	ZZZ
35501	.....	A	Artery bypass graft	19.08	NA	8.43	2.79	NA	30.30	090
35506	.....	A	Artery bypass graft	19.56	NA	9.39	2.79	NA	31.74	090
35507	.....	A	Artery bypass graft	19.56	NA	9.36	2.72	NA	31.64	090
35508	.....	A	Artery bypass graft	18.54	NA	9.28	2.80	NA	30.62	090
35509	.....	A	Artery bypass graft	17.97	NA	8.76	2.54	NA	29.27	090
35510	.....	A	Artery bypass graft	22.87	NA	10.22	2.09	NA	35.18	090
35511	.....	A	Artery bypass graft	21.08	NA	9.34	2.09	NA	32.51	090
35512	.....	A	Artery bypass graft	22.37	NA	10.05	2.09	NA	34.51	090
35515	.....	A	Artery bypass graft	18.54	NA	9.23	2.71	NA	30.48	090
35516	.....	A	Artery bypass graft	16.23	NA	6.87	2.25	NA	25.35	090
35518	.....	A	Artery bypass graft	21.08	NA	9.04	2.13	NA	32.25	090
35521	.....	A	Artery bypass graft	22.07	NA	9.81	2.18	NA	34.06	090
35522	.....	A	Artery bypass graft	21.64	NA	9.79	2.09	NA	33.52	090
35525	.....	A	Artery bypass graft	20.51	NA	9.41	2.09	NA	32.01	090
35526	.....	A	Artery bypass graft	29.78	NA	12.37	2.61	NA	44.76	090
35531	.....	A	Artery bypass graft	35.99	NA	14.57	3.49	NA	54.05	090
35533	.....	A	Artery bypass graft	27.84	NA	11.77	2.82	NA	42.43	090
35536	.....	A	Artery bypass graft	31.52	NA	13.06	3.14	NA	47.72	090
35541	.....	A	Artery bypass graft	25.65	NA	11.17	3.28	NA	40.10	090
35546	.....	A	Artery bypass graft	25.39	NA	10.90	3.40	NA	39.69	090
35548	.....	A	Artery bypass graft	21.45	NA	9.45	2.94	NA	33.84	090
35549	.....	A	Artery bypass graft	23.22	NA	10.30	3.32	NA	36.84	090
35551	.....	A	Artery bypass graft	26.52	NA	11.41	3.82	NA	41.75	090
35556	.....	A	Artery bypass graft	21.64	NA	9.73	2.97	NA	34.34	090
35558	.....	A	Artery bypass graft	21.08	NA	9.56	1.89	NA	32.53	090
35560	.....	A	Artery bypass graft	31.82	NA	13.31	3.27	NA	48.40	090
35563	.....	A	Artery bypass graft	24.06	NA	10.53	2.01	NA	36.60	090
35565	.....	A	Artery bypass graft	23.07	NA	10.18	2.05	NA	35.30	090
35566	.....	A	Artery bypass graft	26.77	NA	11.46	3.62	NA	41.85	090
35571	.....	A	Artery bypass graft	23.92	NA	10.93	2.57	NA	37.42	090
35572	.....	A	Harvest femoropopliteal vein	6.78	NA	2.35	0.76	NA	9.89	ZZZ
35582	.....	A	Vein bypass graft	26.98	NA	11.61	3.73	NA	42.32	090
35583	.....	A	Vein bypass graft	22.24	NA	10.22	3.03	NA	35.49	090
35585	.....	A	Vein bypass graft	28.23	NA	12.35	3.85	NA	44.43	090
35587	.....	A	Vein bypass graft	24.61	NA	11.53	2.60	NA	38.74	090
35600	.....	A	Harvest artery for cabg	4.92	NA	1.60	0.72	NA	7.24	ZZZ
35601	.....	A	Artery bypass graft	17.40	NA	8.59	2.49	NA	28.48	090
35606	.....	A	Artery bypass graft	18.60	NA	8.97	2.60	NA	30.17	090
35612	.....	A	Artery bypass graft	15.67	NA	7.83	2.06	NA	25.56	090
35616	.....	A	Artery bypass graft	15.61	NA	8.02	2.21	NA	25.84	090
35621	.....	A	Artery bypass graft	19.89	NA	8.69	2.01	NA	30.59	090
35623	.....	A	Bypass graft, not vein	23.86	NA	10.51	2.29	NA	36.66	090
35626	.....	A	Artery bypass graft	27.59	NA	11.78	3.46	NA	42.83	090
35631	.....	A	Artery bypass graft	33.81	NA	13.90	3.39	NA	51.10	090
35636	.....	A	Artery bypass graft	29.33	NA	12.43	2.84	NA	44.60	090
35641	.....	A	Artery bypass graft	24.43	NA	11.00	3.39	NA	38.82	090
35642	.....	A	Artery bypass graft	17.88	NA	8.70	2.21	NA	28.79	090
35645	.....	A	Artery bypass graft	17.37	NA	8.35	2.29	NA	28.01	090
35646	.....	A	Artery bypass graft	30.82	NA	13.10	4.35	NA	48.27	090
35647	.....	A	Artery bypass graft	27.84	NA	11.78	3.93	NA	43.55	090
35650	.....	A	Artery bypass graft	18.89	NA	8.38	1.97	NA	29.24	090
35651	.....	A	Artery bypass graft	24.90	NA	10.86	3.03	NA	38.79	090
35654	.....	A	Artery bypass graft	24.86	NA	10.70	2.52	NA	38.08	090
35656	.....	A	Artery bypass graft	19.42	NA	8.60	2.65	NA	30.67	090
35661	.....	A	Artery bypass graft	18.89	NA	8.93	1.80	NA	29.62	090
35663	.....	A	Artery bypass graft	21.87	NA	9.96	1.86	NA	33.69	090
35665	.....	A	Artery bypass graft	20.88	NA	9.49	2.11	NA	32.48	090
35666	.....	A	Artery bypass graft	22.06	NA	10.68	2.62	NA	35.36	090
35671	.....	A	Artery bypass graft	19.22	NA	9.40	2.01	NA	30.63	090
35681	.....	A	Composite bypass graft	1.59	NA	0.54	0.22	NA	2.35	ZZZ

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
35682	.....	A	Composite bypass graft	7.16	NA	2.41	0.99	NA	10.56	ZZZ
35683	.....	A	Composite bypass graft	8.45	NA	2.84	1.17	NA	12.46	ZZZ
35685	.....	A	Bypass graft patency/patch	4.03	NA	1.36	0.30	NA	5.69	ZZZ
35686	.....	A	Bypass graft/av fist patency	3.33	NA	1.14	0.25	NA	4.72	ZZZ
35691	.....	A	Arterial transposition	17.95	NA	8.46	2.47	NA	28.88	090
35693	.....	A	Arterial transposition	15.27	NA	7.67	2.16	NA	25.10	090
35694	.....	A	Arterial transposition	19.05	NA	8.69	2.55	NA	30.29	090
35695	.....	A	Arterial transposition	19.05	NA	8.61	2.62	NA	30.28	090
35697	.....	A	Reimplant artery each	2.98	NA	1.03	0.41	NA	4.42	ZZZ
35700	.....	A	Reoperation, bypass graft	3.06	NA	1.02	0.43	NA	4.51	ZZZ
35701	.....	A	Exploration, carotid artery	8.45	NA	5.16	0.77	NA	14.38	090
35721	.....	A	Exploration, femoral artery	7.14	NA	4.43	0.71	NA	12.28	090
35741	.....	A	Exploration popliteal artery	7.95	NA	4.69	0.72	NA	13.36	090
35761	.....	A	Exploration of artery/vein	5.34	NA	4.05	0.72	NA	10.11	090
35800	.....	A	Explore neck vessels	6.98	NA	4.63	0.95	NA	12.56	090
35820	.....	A	Explore chest vessels	12.81	NA	6.93	1.93	NA	21.67	090
35840	.....	A	Explore abdominal vessels	9.71	NA	5.31	1.27	NA	16.29	090
35860	.....	A	Explore limb vessels	5.52	NA	4.03	0.76	NA	10.31	090
35870	.....	A	Repair vessel graft defect	22.04	NA	9.81	2.96	NA	34.81	090
35875	.....	A	Removal of clot in graft	10.07	NA	5.24	1.16	NA	16.47	090
35876	.....	A	Removal of clot in graft	16.90	NA	7.59	2.25	NA	26.74	090
35879	.....	A	Revise graft w/vein	15.91	NA	7.74	1.62	NA	25.27	090
35881	.....	A	Revise graft w/vein	17.90	NA	8.71	1.73	NA	28.34	090
35901	.....	A	Excision, graft, neck	8.14	NA	5.34	1.08	NA	14.56	090
35903	.....	A	Excision, graft, extremity	9.34	NA	5.99	1.23	NA	16.56	090
35905	.....	A	Excision, graft, thorax	31.07	NA	13.14	2.58	NA	46.79	090
35907	.....	A	Excision, graft, abdomen	34.80	NA	14.15	2.60	NA	51.55	090
36000	.....	A	Place needle in vein	0.18	0.62	0.05	0.01	0.81	0.24	XXX
36002	.....	A	Pseudoaneurysm injection trt	1.95	2.92	1.00	0.12	4.99	3.07	000
36005	.....	A	Injection ext venography	0.94	8.42	0.32	0.05	9.41	1.31	000
36010	.....	A	Place catheter in vein	2.42	NA	0.79	0.19	NA	3.40	XXX
36011	.....	A	Place catheter in vein	3.12	NA	1.04	0.20	NA	4.36	XXX
36012	.....	A	Place catheter in vein	3.50	NA	1.16	0.20	NA	4.86	XXX
36013	.....	A	Place catheter in artery	2.51	NA	0.66	0.20	NA	3.37	XXX
36014	.....	A	Place catheter in artery	3.00	NA	1.00	0.17	NA	4.17	XXX
36015	.....	A	Place catheter in artery	3.50	NA	1.16	0.19	NA	4.85	XXX
36100	.....	A	Establish access to artery	3.00	NA	1.11	0.22	NA	4.33	XXX
36120	.....	A	Establish access to artery	2.00	NA	0.65	0.13	NA	2.78	XXX
36140	.....	A	Establish access to artery	2.00	NA	0.64	0.14	NA	2.78	XXX
36145	.....	A	Artery to vein shunt	2.00	NA	0.66	0.12	NA	2.78	XXX
36160	.....	A	Establish access to aorta	2.51	NA	0.84	0.24	NA	3.59	XXX
36200	.....	A	Place catheter in aorta	3.00	77.01	1.02	0.18	80.19	4.20	XXX
36215	.....	A	Place catheter in artery	4.65	NA	1.59	0.26	NA	6.50	XXX
36216	.....	A	Place catheter in artery	5.25	NA	1.78	0.29	NA	7.32	XXX
36217	.....	A	Place catheter in artery	6.26	NA	2.16	0.38	NA	8.80	XXX
36218	.....	A	Place catheter in artery	1.00	NA	0.35	0.06	NA	1.41	ZZZ
36245	.....	A	Place catheter in artery	4.65	NA	1.67	0.28	NA	6.60	XXX
36246	.....	A	Place catheter in artery	5.25	NA	1.81	0.31	NA	7.37	XXX
36247	.....	A	Place catheter in artery	6.26	NA	2.12	0.38	NA	8.76	XXX
36248	.....	A	Place catheter in artery	1.00	NA	0.35	0.07	NA	1.42	ZZZ
36260	.....	A	Insertion of infusion pump	9.65	NA	4.96	1.20	NA	15.81	090
36261	.....	A	Revision of infusion pump	5.42	NA	3.62	0.60	NA	9.64	090
36262	.....	A	Removal of infusion pump	4.00	NA	2.80	0.52	NA	7.32	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	0.29	0.09	0.01	0.68	0.48	XXX
36405	.....	A	Bl draw < 3 yrs scalp vein	0.31	0.27	0.08	0.01	0.59	0.40	XXX
36406	.....	A	Bl draw < 3 yrs other vein	0.18	0.31	0.05	0.01	0.50	0.24	XXX
36410	.....	A	Non-routine bl draw > 3 yrs	0.18	0.31	0.05	0.01	0.50	0.24	XXX
36415	.....	I	Routine venipuncture	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36416	.....	I	Capillary blood draw	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36420	.....	A	Vein access cutdown < 1 yr	1.00	3.16	0.28	0.11	4.27	1.39	XXX
36425	.....	A	Vein access cutdown > 1 yr	0.76	NA	0.22	0.06	NA	1.04	XXX
36430	.....	A	Blood transfusion service	0.00	0.99	NA	0.06	1.05	NA	XXX
36440	.....	A	Bl push transfuse, 2 yr or <	1.02	NA	0.29	0.10	NA	1.41	XXX
36450	.....	A	Bl exchange/transfuse, nb	2.22	NA	0.70	0.19	NA	3.11	XXX
36455	.....	A	Bl exchange/transfuse non-nb	2.42	NA	0.83	0.12	NA	3.37	XXX
36460	.....	A	Transfusion service, fetal	6.55	NA	2.24	0.67	NA	9.46	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	1.08	2.75	0.45	0.12	3.95	1.65	010
36471	.....	A	Injection therapy of veins	1.56	3.10	0.61	0.18	4.84	2.35	010
36481	.....	A	Insertion of catheter, vein	6.95	7.00	2.76	0.48	14.43	10.19	000
36488	.....	D	Insertion of catheter, vein	0.00	0.00	0.00	0.00	0.00	0.00	000
36489	.....	D	Insertion of catheter, vein	0.00	0.00	0.00	0.00	0.00	0.00	000
36490	.....	D	Insertion of catheter, vein	0.00	0.00	0.00	0.00	0.00	0.00	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
36491		D	Insertion of catheter, vein	0.00	0 00	0.00	0.00	0.00	0.00	000
36493		D	Repositioning of cvc	0.00	0.00	0.00	0.00	0.00	0.00	000
36500		A	Insertion of catheter, vein	3.50	NA	1.24	0.17	NA	4.91	000
36510		A	Insertion of catheter, vein	1.08	3.81	0.63	0.07	4.96	1.78	000
36511		A	Apheresis wbc	1.73	NA	0.69	0.07	NA	2.49	000
36512		A	Apheresis rbc	1.73	NA	0.69	0.07	NA	2.49	000
36513		A	Apheresis platelets	1.73	NA	0.69	0.07	NA	2.49	000
36514		A	Apheresis plasma	1.73	NA	0.69	0.07	NA	2.49	000
36515		A	Apheresis, adsorp/reinfuse	1.73	NA	0.73	0.07	NA	2.53	000
36516		A	Apheresis, selective	1.73	NA	0.73	0.07	NA	2.53	000
36522		A	Photopheresis	1.66	30.38	1.14	0.08	32.12	2.88	000
36530		D	Insertion of infusion pump	0.00	0.00	0.00	0.00	0.00	0.00	010
36531		D	Revision of infusion pump	0.00	0.00	0.00	0.00	0.00	0.00	010
36532		D	Removal of infusion pump	0.00	0.00	0.00	0.00	0.00	0.00	010
36533		D	Insertion of access device	0.00	0.00	0.00	0.00	0.00	0.00	010
36534		D	Revision of access device	0.00	0.00	0.00	0.00	0.00	0.00	010
36535		D	Removal of access device	0.00	0.00	0.00	0.00	0.00	0.00	010
36536		D	Remove cva device obstruct	0.00	0.00	0.00	0.00	0.00	0.00	000
36537		D	Remove cva lumen obstruct	0.00	0.00	0.00	0.00	0.00	0.00	000
36540		B	Collect blood venous device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36550		A	Declot vascular device	0.00	0.41	NA	0.37	0.78	NA	XXX
36555		A	Insert non-tunnel cv cath	2.66	6.06	0.82	0.20	8.92	3.68	000
36556		A	Insert non-tunnel cv cath	2.49	5.06	0.75	0.10	7.65	3.34	000
36557		A	Insert tunneled cv cath	5.07	13.64	2.59	0.59	19.30	8.25	010
36558		A	Insert tunneled cv cath	4.77	13.54	2.48	0.59	18.90	7.84	010
36560		A	Insert tunneled cv cath	6.21	29.38	2.98	0.59	36.18	9.78	010
36561		A	Insert tunneled cv cath	5.97	29.29	2.89	0.59	35.85	9.45	010
36563		A	Insert tunneled cv cath	6.16	26.75	2.99	0.67	33.58	9.82	010
36565		A	Insert tunneled cv cath	5.97	22.30	2.89	0.59	28.86	9.45	010
36566		A	Insert tunneled cv cath	6.46	23.11	3.06	0.59	30.16	10.11	010
36568		A	Insert tunneled cv cath	1.91	8.29	0.60	0.20	10.40	2.71	000
36569		A	Insert tunneled cv cath	1.81	6.77	0.58	0.16	8.74	2.55	000
36570		A	Insert tunneled cv cath	5.29	40.53	2.66	0.59	46.41	8.54	010
36571		A	Insert tunneled cv cath	5.27	35.86	2.65	0.59	41.72	8.51	010
36575		A	Repair tunneled cv cath	0.67	3.35	0.26	0.59	4.61	1.52	000
36576		A	Repair tunneled cv cath	3.17	7.73	1.77	0.59	11.49	5.53	010
36578		A	Replace tunneled cv cath	3.48	10.57	2.21	0.59	14.64	6.28	010
36580		A	Replace tunneled cv cath	1.30	5.88	0.42	0.16	7.34	1.88	000
36581		A	Replace tunneled cv cath	3.42	13.30	1.85	0.59	17.31	5.86	010
36582		A	Replace tunneled cv cath	5.17	26.69	2.78	0.59	32.45	8.54	010
36583		A	Replace tunneled cv cath	5.22	13.17	2.80	0.59	18.98	8.61	010
36584		A	Replace tunneled cv cath	1.19	6.33	0.56	0.16	7.68	1.91	000
36585		A	Replace tunneled cv cath	4.77	35.52	2.65	0.59	40.88	8.01	010
36589		A	Removal tunneled cv cath	2.26	2.13	1.42	0.25	4.64	3.93	010
36590		A	Removal tunneled cv cath	3.28	6.34	1.64	0.41	10.03	5.33	010
36595		A	Mech remov tunneled cv cath	3.58	18.94	1.47	0.28	22.80	5.33	000
36596		A	Mech remov tunneled cv cath	0.75	4.43	0.50	0.05	5.23	1.30	000
36597		A	Reposition venous catheter	1.20	3.18	0.44	0.07	4.45	1.71	000
36600		A	Withdrawal of arterial blood	0.32	0.49	0.09	0.02	0.83	0.43	XXX
36620		A	Insertion catheter, artery	1.14	NA	0.24	0.07	NA	1.45	000
36625		A	Insertion catheter, artery	2.10	NA	0.53	0.19	NA	2.82	000
36640		A	Insertion catheter, artery	2.09	NA	1.03	0.22	NA	3.34	000
36660		A	Insertion catheter, artery	1.39	NA	0.44	0.10	NA	1.93	000
36680		A	Insert needle, bone cavity	1.19	NA	0.50	0.10	NA	1.79	000
36800		A	Insertion of cannula	2.42	NA	1.82	0.20	NA	4.44	000
36810		A	Insertion of cannula	3.95	NA	1.69	0.48	NA	6.12	000
36815		A	Insertion of cannula	2.61	NA	1.18	0.31	NA	4.10	000
36819		A	Av fusion/uppr arm vein	13.92	NA	6.43	1.87	NA	22.22	090
36820		A	Av fusion/forearm vein	13.92	NA	6.43	1.87	NA	22.22	090
36821		A	Av fusion direct any site	8.88	NA	4.72	1.16	NA	14.76	090
36822		A	Insertion of cannula(s)	5.39	NA	4.31	0.76	NA	10.46	090
36823		A	Insertion of cannula(s)	20.88	NA	9.56	2.61	NA	33.05	090
36825		A	Artery-vein autograft	9.78	NA	5.13	1.31	NA	16.22	090
36830		A	Artery-vein nonautograft	11.93	NA	5.30	1.58	NA	18.81	090
36831		A	Open thrombect av fistula	7.95	NA	3.98	0.95	NA	12.88	090
36832		A	Av fistula revision, open	10.44	NA	4.79	1.35	NA	16.58	090
36833		A	Av fistula revision	11.88	NA	5.27	1.55	NA	18.70	090
36834		A	Repair A-V aneurysm	9.87	NA	4.81	1.27	NA	15.95	090
36835		A	Artery to vein shunt	7.11	NA	4.34	0.96	NA	12.41	090
36838		A	Dist revas ligation, hemo	20.51	NA	9.41	2.97	NA	32.89	090
36860		A	External cannula declotting	2.00	2.54	1.36	0.12	4.66	3.48	000
36861		A	Cannula declotting	2.51	NA	1.50	0.17	NA	4.18	000
36870		A	Percut thrombect av fistula	5.13	47.27	3.17	0.28	52.68	8.58	090
37140		A	Revision of circulation	23.47	NA	10.60	1.45	NA	35.52	090
37145		A	Revision of circulation	24.47	NA	11.07	2.97	NA	38.51	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
37160	.....	A	Revision of circulation	21.48	NA	9.38	2.59	NA	33.45	090
37180	.....	A	Revision of circulation	24.47	NA	10.45	3.15	NA	38.07	090
37181	.....	A	Splice spleen/kidney veins	26.53	NA	11.13	3.20	NA	40.86	090
37182	.....	A	Insert hepatic shunt (tips)	16.90	NA	6.32	1.79	NA	25.01	000
37183	.....	A	Remove hepatic shunt (tips)	7.95	NA	3.11	0.52	NA	11.58	000
37195	.....	A	Thrombolytic therapy, stroke	0.00	7.99	NA	0.46	8.45	NA	XXX
37200	.....	A	Transcatheter biopsy	4.53	NA	1.52	0.23	NA	6.28	000
37201	.....	A	Transcatheter therapy infuse	4.97	NA	2.54	0.29	NA	7.80	000
37202	.....	A	Transcatheter therapy infuse	5.65	NA	3.07	0.46	NA	9.18	000
37203	.....	A	Transcatheter retneval	5.00	NA	2.55	0.28	NA	7.83	000
37204	.....	A	Transcatheter occlusion	18.04	NA	5.99	1.09	NA	25.12	000
37205	.....	A	Transcatheter stent	8.23	NA	3.77	0.52	NA	12.52	000
37206	.....	A	Transcatheter stent add-on	4.11	NA	1.46	0.26	NA	5.83	ZZZ
37207	.....	A	Transcatheter stent	8.23	NA	3.18	1.07	NA	12.48	000
37208	.....	A	Transcatheter stent add-on	4.11	NA	1.40	0.53	NA	6.04	ZZZ
37209	.....	A	Exchange arterial catheter	2.26	NA	0.75	0.13	NA	3.14	000
37250	.....	A	Iv us first vessel add-on	2.09	NA	0.75	0.20	NA	3.04	ZZZ
37251	.....	A	Iv us each add vessel add-on	1.59	NA	0.56	0.17	NA	2.32	ZZZ
37500	.....	A	Endoscopy ligate perf veins	10.94	NA	7.09	0.48	NA	18.51	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	10.82	NA	5.69	0.54	NA	17.05	090
37600	.....	A	Ligation of neck artery	11.19	NA	6.71	0.48	NA	18.38	090
37605	.....	A	Ligation of neck artery	13.04	NA	6.98	0.92	NA	20.94	090
37606	.....	A	Ligation of neck artery	6.24	NA	4.62	0.95	NA	11.81	090
37607	.....	A	Ligation of a-v fistula	6.12	NA	3.60	0.80	NA	10.52	090
37609	.....	A	Temporal artery procedure	2.98	4.74	1.99	0.25	7.97	5.22	010
37615	.....	A	Ligation of neck artery	5.70	NA	4.14	0.68	NA	10.52	090
37616	.....	A	Ligation of chest artery	16.40	NA	7.96	2.31	NA	26.67	090
37617	.....	A	Ligation of abdomen artery	21.93	NA	9.30	2.03	NA	33.26	090
37618	.....	A	Ligation of extremity artery	4.81	NA	3.60	0.65	NA	9.06	090
37620	.....	A	Revision of major vein	10.50	NA	5.75	0.90	NA	17.15	090
37650	.....	A	Revision of major vein	7.76	NA	4.70	0.67	NA	13.13	090
37660	.....	A	Revision of major vein	20.88	NA	9.10	1.40	NA	31.38	090
37700	.....	A	Revise leg vein	3.71	NA	2.83	0.48	NA	7.02	090
37720	.....	A	Removal of leg vein	5.63	NA	3.74	0.73	NA	10.10	090
37730	.....	A	Removal of leg veins	7.29	NA	4.31	0.92	NA	12.52	090
37735	.....	A	Removal of leg veins/lesion	10.47	NA	5.56	1.40	NA	17.43	090
37760	.....	A	Ligation, leg veins, open	10.41	NA	5.40	1.33	NA	17.14	090
37765	.....	A	Phleb veins—extrem—to 20	7.31	NA	4.56	0.48	NA	12.35	090
37766	.....	A	Phleb veins—extrem 20+	9.25	NA	5.28	0.48	NA	15.01	090
37780	.....	A	Revision of leg vein	3.82	NA	2.88	0.49	NA	7.19	090
37785	.....	A	Ligate/divide/excise vein	3.82	5.16	2.66	0.49	9.47	6.97	090
37788	.....	A	Revascularization, penis	21.88	NA	9.39	1.62	NA	32.89	090
37790	.....	A	Penile venous occlusion	8.29	NA	4.52	0.76	NA	13.57	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	14.42	NA	6.28	1.56	NA	22.26	090
38101	.....	A	Removal of spleen, partial	15.22	NA	6.64	1.65	NA	23.51	090
38102	.....	A	Removal of spleen, total	4.77	NA	1.66	0.59	NA	7.02	ZZZ
38115	.....	A	Repair of ruptured spleen	15.73	NA	6.76	1.68	NA	24.17	090
38120	.....	A	Laparoscopy, splenectomy	16.90	NA	7.51	2.07	NA	26.48	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	2.62	NA	0.90	0.14	NA	3.66	000
38204	.....	B	Bl donor search management	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38205	.....	R	Harvest allogenic stem cells	1.49	NA	0.61	0.06	NA	2.16	000
38206	.....	R	Harvest auto stem cells	1.49	NA	0.61	0.06	NA	2.16	000
38207	.....	I	Cryopreserve stem cells	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38208	.....	I	Thaw preserved stem cells	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38209	.....	I	Wash harvest stem cells	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38210	.....	I	T-cell depletion of harvest	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38211	.....	I	Tumor cell deplete of harvst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38212	.....	I	Rbc depletion of harvest	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38213	.....	I	Platelet deplete of harvest	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38214	.....	I	Volume deplete of harvest	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38215	.....	I	Harvest stem cell concentrte	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38220	.....	A	Bone marrow aspiration	1.07	3.97	0.43	0.04	5.08	1.54	XXX
38221	.....	A	Bone marrow biopsy	1.36	4.15	0.54	0.05	5.56	1.95	XXX
38230	.....	R	Bone marrow collection	4.51	NA	2.51	0.30	NA	7.32	010
38240	.....	R	Bone marrow/stem transplant	2.23	NA	0.82	0.10	NA	3.15	XXX
38241	.....	R	Bone marrow/stem transplant	2.23	NA	0.82	0.10	NA	3.15	XXX
38242	.....	A	Lymphocyte infuse transplant	1.70	NA	0.68	0.06	NA	2.44	000
38300	.....	A	Drainage, lymph node lesion	1.98	4.50	2.10	0.18	6.66	4.26	010
38305	.....	A	Drainage, lymph node lesion	5.97	6.06	4.42	0.43	12.46	10.82	090
38308	.....	A	Incision of lymph channels	6.41	5.81	3.77	0.61	12.83	10.79	090
38380	.....	A	Thoracic duct procedure	7.42	NA	5.75	0.82	NA	13.99	090
38381	.....	A	Thoracic duct procedure	12.81	NA	6.72	1.89	NA	21.42	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
38382		A	Thoracic duct procedure	10.02	NA	5.81	1.29	NA	17.12	090
38500		A	Biopsy/removal, lymph nodes	3.73	3.83	2.12	0.34	7.90	6.19	010
38505		A	Needle biopsy, lymph nodes	1.13	2.16	0.79	0.11	3.40	2.03	000
38510		A	Biopsy/removal, lymph nodes	6.39	5.71	3.54	0.46	12.56	10.39	010
38520		A	Biopsy/removal, lymph nodes	6.63	NA	4.09	0.62	NA	11.34	090
38525		A	Biopsy/removal, lymph nodes	6.04	NA	3.39	0.58	NA	10.01	090
38530		A	Biopsy/removal, lymph nodes	7.93	NA	4.45	0.76	NA	13.14	090
38542		A	Explore deep node(s), neck	5.88	NA	4.53	0.60	NA	11.01	090
38550		A	Removal, neck/armpit lesion	6.88	NA	4.04	0.83	NA	11.75	090
38555		A	Removal, neck/armpit lesion	14.06	NA	8.52	1.75	NA	24.33	090
38562		A	Removal, pelvic lymph nodes	10.43	NA	5.99	1.16	NA	17.58	090
38564		A	Removal, abdomen lymph nodes	10.77	NA	5.39	1.27	NA	17.43	090
38570		A	Laparoscopy, lymph node biop	9.20	NA	4.00	1.07	NA	14.27	010
38571		A	Laparoscopy, lymphadenectomy	14.60	NA	5.67	0.96	NA	21.23	010
38572		A	Laparoscopy, lymphadenectomy	16.50	NA	7.24	1.58	NA	25.32	010
38589		C	Laparoscope proc, lymphatic	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38700		A	Removal of lymph nodes, neck	8.19	NA	8.19	0.72	NA	17.10	090
38720		A	Removal of lymph nodes, neck	13.53	NA	11.18	1.23	NA	25.94	090
38724		A	Removal of lymph nodes, neck	14.46	NA	11.70	1.32	NA	27.48	090
38740		A	Remove armpit lymph nodes	9.97	NA	5.06	0.83	NA	15.86	090
38745		A	Remove armpit lymph nodes	13.03	NA	6.25	1.08	NA	20.36	090
38746		A	Remove thoracic lymph nodes	4.86	NA	1.59	0.66	NA	7.11	ZZZ
38747		A	Remove abdominal lymph nodes	4.86	NA	1.69	0.60	NA	7.15	ZZZ
38760		A	Remove groin lymph nodes	12.88	NA	6.29	1.05	NA	20.22	090
38765		A	Remove groin lymph nodes	19.87	NA	9.05	1.80	NA	30.72	090
38770		A	Remove pelvis lymph nodes	13.15	NA	5.91	1.19	NA	20.25	090
38780		A	Remove abdomen lymph nodes	16.50	NA	8.53	1.92	NA	26.95	090
38790		A	Inject for lymphatic x-ray	1.28	10.81	0.80	0.11	12.20	2.19	000
38792		A	Identify sentinel node	0.52	NA	0.45	0.05	NA	1.02	000
38794		A	Access thoracic lymph duct	4.42	NA	3.43	0.20	NA	8.05	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	6.07	NA	4.51	0.87	NA	11.45	090
39010		A	Exploration of chest	11.72	NA	6.43	1.75	NA	19.90	090
39200		A	Removal chest lesion	13.54	NA	6.61	1.98	NA	22.13	090
39220		A	Removal chest lesion	17.32	NA	8.31	2.52	NA	28.15	090
39400		A	Visualization of chest	5.58	NA	4.65	0.83	NA	11.06	010
39499		C	Chest procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
39501		A	Repair diaphragm laceration	13.11	NA	6.53	1.65	NA	21.29	090
39502		A	Repair paraesophageal hernia	16.24	NA	7.25	2.01	NA	25.50	090
39503		A	Repair of diaphragm hernia	94.46	NA	33.85	4.22	NA	132.53	090
39520		A	Repair of diaphragm hernia	16.01	NA	7.99	2.19	NA	26.19	090
39530		A	Repair of diaphragm hernia	15.32	NA	7.16	1.99	NA	24.47	090
39531		A	Repair of diaphragm hernia	16.33	NA	7.41	2.19	NA	25.93	090
39540		A	Repair of diaphragm hernia	13.24	NA	6.28	1.65	NA	21.17	090
39541		A	Repair of diaphragm hernia	14.33	NA	6.66	1.82	NA	22.81	090
39545		A	Revision of diaphragm	13.29	NA	7.41	1.86	NA	22.56	090
39560		A	Resect diaphragm, simple	11.93	NA	6.34	1.62	NA	19.89	090
39561		A	Resect diaphragm, complex	17.40	NA	9.31	2.36	NA	29.07	090
39599		C	Diaphragm surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
40490		A	Biopsy of lip	1.21	1.87	0.62	0.07	3.15	1.90	000
40500		A	Partial excision of lip	4.26	6.15	4.95	0.37	10.78	9.58	090
40510		A	Partial excision of lip	4.67	6.90	4.84	0.46	12.03	9.97	090
40520		A	Partial excision of lip	4.64	7.41	5.09	0.50	12.55	10.23	090
40525		A	Reconstruct lip with flap	7.51	NA	6.98	0.82	NA	15.31	090
40527		A	Reconstruct lip with flap	9.08	NA	7.94	0.98	NA	18.00	090
40530		A	Partial removal of lip	5.37	6.65	5.25	0.56	12.58	11.18	090
40650		A	Repair lip	3.62	5.62	3.86	0.37	9.61	7.85	090
40652		A	Repair lip	4.24	6.59	5.30	0.47	11.30	10.01	090
40654		A	Repair lip	5.28	7.24	6.03	0.58	13.10	11.89	090
40700		A	Repair cleft lip/nasal	12.72	NA	9.63	1.11	NA	23.46	090
40701		A	Repair cleft lip/nasal	15.76	NA	11.92	1.63	NA	29.31	090
40702		A	Repair cleft lip/nasal	12.97	NA	8.56	1.21	NA	22.74	090
40720		A	Repair cleft lip/nasal	13.47	NA	10.62	1.57	NA	25.66	090
40761		A	Repair cleft lip/nasal	14.64	NA	10.93	1.69	NA	27.26	090
40799		C	Lip surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
40800		A	Drainage of mouth lesion	1.16	2.24	1.16	0.11	3.51	2.43	010
40801		A	Drainage of mouth lesion	2.52	3.21	2.05	0.22	5.95	4.79	010
40804		A	Removal, foreign body, mouth	1.23	2.58	1.13	0.11	3.92	2.47	010
40805		A	Removal, foreign body, mouth	2.67	3.44	2.00	0.20	6.31	4.87	010
40806		A	Incision of lip fold	0.31	1.39	0.96	0.02	1.72	1.29	000
40808		A	Biopsy of mouth lesion	0.95	2.32	1.09	0.08	3.35	2.12	010
40810		A	Excision of mouth lesion	1.30	2.41	1.23	0.11	3.82	2.64	010
40812		A	Excise/repair mouth lesion	2.30	3.27	1.80	0.20	5.77	4.30	010
40814		A	Excise/repair mouth lesion	3.40	4.79	3.32	0.31	8.50	7.03	090
40816		A	Excision of mouth lesion	3.65	4.98	3.43	0.32	8.95	7.40	090

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[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
40818	.....	A	Excise oral mucosa for graft	2.40	5.23	3.58	0.17	7.80	6.15	090
40819	.....	A	Excise lip or cheek fold	2.40	4.45	2.96	0.20	7.05	5.56	090
40820	.....	A	Treatment of mouth lesion	1.27	2.74	2.37	0.10	4.11	3.74	010
40830	.....	A	Repair mouth laceration	1.75	3.12	2.56	0.17	5.04	4.48	010
40831	.....	A	Repair mouth laceration	2.45	3.66	3.12	0.25	6.36	5.82	010
40840	.....	R	Reconstruction of mouth	8.68	8.69	7.45	0.95	18.32	17.08	090
40842	.....	R	Reconstruction of mouth	8.68	8.79	7.19	0.78	18.25	16.65	090
40843	.....	R	Reconstruction of mouth	12.03	11.01	8.71	1.01	24.05	21.75	090
40844	.....	R	Reconstruction of mouth	15.92	13.98	11.90	1.95	31.85	29.77	090
40845	.....	R	Reconstruction of mouth	18.47	16.03	13.70	1.76	36.26	33.93	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	1.29	2.50	1.42	0.11	3.90	2.82	010
41005	.....	A	Drainage of mouth lesion	1.25	2.71	1.64	0.11	4.07	3.00	010
41006	.....	A	Drainage of mouth lesion	3.22	4.44	3.49	0.30	7.96	7.01	090
41007	.....	A	Drainage of mouth lesion	3.08	4.23	3.34	0.26	7.57	6.68	090
41008	.....	A	Drainage of mouth lesion	3.35	4.58	3.53	0.29	8.22	7.17	090
41009	.....	A	Drainage of mouth lesion	3.57	4.92	3.90	0.30	8.79	7.77	090
41010	.....	A	Incision of tongue fold	1.05	3.51	3.51	0.07	4.63	4.63	010
41015	.....	A	Drainage of mouth lesion	3.94	5.43	4.11	0.35	9.72	8.40	090
41016	.....	A	Drainage of mouth lesion	4.05	5.51	4.12	0.34	9.90	8.51	090
41017	.....	A	Drainage of mouth lesion	4.05	5.43	4.20	0.38	9.86	8.63	090
41018	.....	A	Drainage of mouth lesion	5.07	5.87	4.32	0.42	11.36	9.81	090
41100	.....	A	Biopsy of tongue	1.62	2.58	1.44	0.14	4.34	3.20	010
41105	.....	A	Biopsy of tongue	1.41	2.48	1.33	0.12	4.01	2.86	010
41108	.....	A	Biopsy of floor of mouth	1.04	2.23	1.14	0.10	3.37	2.28	010
41110	.....	A	Excision of tongue lesion	1.50	2.55	1.35	0.13	4.18	2.98	010
41112	.....	A	Excision of tongue lesion	2.71	4.30	2.74	0.24	7.25	5.69	090
41113	.....	A	Excision of tongue lesion	3.17	4.66	3.02	0.28	8.11	6.47	090
41114	.....	A	Excision of tongue lesion	8.42	8.86	6.37	0.77	18.05	15.56	090
41115	.....	A	Excision of tongue fold	1.73	3.47	2.60	0.16	5.36	4.49	010
41116	.....	A	Excision of mouth lesion	2.43	4.28	2.81	0.20	6.91	5.44	090
41120	.....	A	Partial removal of tongue	9.71	NA	7.67	0.84	NA	18.22	090
41130	.....	A	Partial removal of tongue	11.09	NA	8.45	0.97	NA	20.51	090
41135	.....	A	Tongue and neck surgery	22.96	NA	14.99	1.99	NA	39.94	090
41140	.....	A	Removal of tongue	25.35	NA	16.24	2.22	NA	43.81	090
41145	.....	A	Tongue removal, neck surgery	29.89	NA	19.39	2.53	NA	51.81	090
41150	.....	A	Tongue, mouth, jaw surgery	22.91	NA	15.66	2.00	NA	40.57	090
41153	.....	A	Tongue, mouth, neck surgery	23.63	NA	16.13	2.05	NA	41.81	090
41155	.....	A	Tongue, jaw, & neck surgery	27.56	NA	18.18	2.42	NA	48.16	090
41250	.....	A	Repair tongue laceration	1.90	3.12	1.65	0.18	5.20	3.73	010
41251	.....	A	Repair tongue laceration	2.26	3.63	1.96	0.22	6.11	4.44	010
41252	.....	A	Repair tongue laceration	2.95	4.22	2.31	0.28	7.45	5.54	010
41500	.....	A	Fixation of tongue	3.69	NA	3.67	0.31	NA	7.67	090
41510	.....	A	Tongue to lip surgery	3.40	NA	3.15	0.29	NA	6.84	090
41520	.....	A	Reconstruction, tongue fold	2.71	4.12	3.25	0.23	7.06	6.19	090
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	1.16	2.70	1.47	0.11	3.97	2.74	010
41805	.....	A	Removal foreign body, gum	1.23	2.77	2.38	0.11	4.11	3.72	010
41806	.....	A	Removal foreign body,jawbone	2.67	3.66	3.19	0.26	6.59	6.12	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	2.30	4.14	1.34	0.29	6.73	3.93	010
41823	.....	R	Excision of gum lesion	3.28	5.89	4.15	0.35	9.52	7.78	090
41825	.....	A	Excision of gum lesion	1.30	3.30	2.38	0.12	4.72	3.80	010
41826	.....	A	Excision of gum lesion	2.30	3.89	2.93	0.20	6.33	5.43	010
41827	.....	A	Excision of gum lesion	3.40	5.68	3.89	0.30	9.38	7.59	090
41828	.....	R	Excision of gum lesion	3.07	4.44	3.38	0.26	7.77	6.71	010
41830	.....	R	Removal of gum tissue	3.33	4.98	3.62	0.28	8.59	7.23	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	2.58	4.68	3.57	0.22	7.48	6.37	090
41874	.....	R	Repair tooth socket	3.07	4.74	3.32	0.28	8.09	6.67	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	1.22	2.76	1.27	0.12	4.10	2.61	010
42100	.....	A	Biopsy roof of mouth	1.30	2.30	1.38	0.12	3.72	2.80	010
42104	.....	A	Excision lesion, mouth roof	1.63	2.80	1.57	0.14	4.57	3.34	010
42106	.....	A	Excision lesion, mouth roof	2.09	3.76	2.85	0.19	6.04	5.13	010
42107	.....	A	Excision lesion, mouth roof	4.41	6.14	4.24	0.38	10.93	9.03	090
42120	.....	A	Remove palate/lesion	6.13	NA	5.62	0.53	NA	12.28	090
42140	.....	A	Excision of uvula	1.61	2.50	2.39	0.14	4.25	4.14	090
42145	.....	A	Repair palate, pharynx/uvula	8.00	NA	6.69	0.67	NA	15.36	090
42160	.....	A	Treatment mouth roof lesion	1.79	3.63	2.69	0.16	5.58	4.64	010
42180	.....	A	Repair palate	2.49	3.43	2.15	0.23	6.15	4.87	010
42182	.....	A	Repair palate	3.81	4.29	3.09	0.32	8.42	7.22	010
42200	.....	A	Reconstruct cleft palate	11.93	NA	9.10	1.16	NA	22.19	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
42205		A	Reconstruct cleft palate	13.21	NA	9.46	0.98	NA	23.65	090
42210		A	Reconstruct cleft palate	14.42	NA	10.65	1.49	NA	26.56	090
42215		A	Reconstruct cleft palate	8.77	NA	7.65	1.15	NA	17.57	090
42220		A	Reconstruct cleft palate	6.98	NA	5.71	0.49	NA	13.18	090
42225		A	Reconstruct cleft palate	9.49	NA	7.76	0.90	NA	18.15	090
42226		A	Lengthening of palate	9.95	NA	7.97	0.87	NA	18.79	090
42227		A	Lengthening of palate	9.47	NA	7.43	0.84	NA	17.74	090
42235		A	Repair palate	7.83	NA	5.42	0.59	NA	13.84	090
42260		A	Repair nose to lip fistula	9.74	9.34	7.53	1.02	20.10	18.29	090
42280		A	Preparation, palate mold	1.53	2.03	0.89	0.14	3.70	2.56	010
42281		A	Insertion, palate prosthesis	1.92	2.96	1.92	0.17	5.05	4.01	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	1.92	2.99	1.85	0.18	5.09	3.95	010
42305		A	Drainage of salivary gland	6.04	NA	5.00	0.55	NA	11.59	090
42310		A	Drainage of salivary gland	1.55	2.37	1.56	0.13	4.05	3.24	010
42320		A	Drainage of salivary gland	2.34	3.56	2.13	0.20	6.10	4.67	010
42325		A	Create salivary cyst drain	2.73	3.59	2.26	0.20	6.52	5.19	090
42326		A	Create salivary cyst drain	3.76	4.60	3.15	0.41	8.77	7.32	090
42330		A	Removal of salivary stone	2.20	3.33	1.89	0.19	5.72	4.28	010
42335		A	Removal of salivary stone	3.29	3.94	3.40	0.28	7.51	6.97	090
42340		A	Removal of salivary stone	4.57	5.20	4.33	0.41	10.18	9.31	090
42400		A	Biopsy of salivary gland	0.78	1.77	0.72	0.07	2.62	1.57	000
42405		A	Biopsy of salivary gland	3.27	4.21	2.50	0.29	7.77	6.06	010
42408		A	Excision of salivary cyst	4.51	5.11	4.10	0.41	10.03	9.02	090
42409		A	Drainage of salivary cyst	2.79	3.59	3.13	0.24	6.62	6.16	090
42410		A	Excise parotid gland/lesion	9.29	NA	6.71	0.92	NA	16.92	090
42415		A	Excise parotid gland/lesion	16.79	NA	11.38	1.51	NA	29.68	090
42420		A	Excise parotid gland/lesion	19.48	NA	12.90	1.74	NA	34 12	090
42425		A	Excise parotid gland/lesion	12.95	NA	9.17	1.17	NA	23.29	090
42426		A	Excise parotid gland/lesion	21.14	NA	13.57	1.88	NA	36.59	090
42440		A	Excise submaxillary gland	6.93	NA	5.12	0.61	NA	12.66	090
42450		A	Excise sublingual gland	4.59	5.73	4.29	0.41	10.73	9.29	090
42500		A	Repair salivary duct	4.28	5.52	4.24	0.36	10.16	8.88	090
42505		A	Repair salivary duct	6.14	6.99	5.42	0.53	13.66	12.09	090
42507		A	Parotid duct diversion	6.08	NA	5.26	0.79	NA	12.13	090
42508		A	Parotid duct diversion	9.05	NA	7.10	0.77	NA	16.92	090
42509		A	Parotid duct diversion	11.47	NA	8.50	1.49	NA	21.46	090
42510		A	Parotid duct diversion	8.10	NA	6.17	0.68	NA	14.95	090
42550		A	Injection for salivary x-ray	1.24	13.07	0.42	0.07	14.38	1.73	000
42600		A	Closure of salivary fistula	4.79	5.90	4.57	0.41	11.10	9.77	090
42650		A	Dilation of salivary duct	0.77	1.18	0.72	0.07	2.02	1.56	000
42660		A	Dilation of salivary duct	1.12	1.50	0.85	0.08	2.70	2.05	000
42665		A	Ligation of salivary duct	2.52	3.60	3.01	0.20	6.32	5.73	090
42699		C	Salivary surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
42700		A	Drainage of tonsil abscess	1.61	2.78	1.75	0.14	4.53	3.50	010
42720		A	Drainage of throat abscess	5.39	5.10	3.86	0.47	10.96	9.72	010
42725		A	Drainage of throat abscess	10.66	NA	8.08	0.96	NA	19.70	090
42800		A	Biopsy of throat	1.38	2.25	1.42	0.12	3.75	2.92	010
42802		A	Biopsy of throat	1.53	4.43	1.96	0.13	6.09	3.62	010
42804		A	Biopsy of upper nose/throat	1.23	4.01	1.81	0.11	5.35	3.15	010
42806		A	Biopsy of upper nose/throat	1.57	4.16	1.94	0.14	5.87	3.65	010
42808		A	Excise pharynx lesion	2.29	3.21	1.95	0.20	5.70	4.44	010
42809		A	Remove pharynx foreign body	1.80	2.39	1.39	0.16	4.35	3.35	010
42810		A	Excision of neck cyst	3.23	4.90	3.41	0.30	8.43	6.94	090
42815		A	Excision of neck cyst	7.03	NA	5.47	0.64	NA	13.14	090
42820		A	Remove tonsils and adenoids	3.89	NA	3.51	0.34	NA	7.74	090
42821		A	Remove tonsils and adenoids	4.27	NA	3.72	0.36	NA	8.35	090
42825		A	Removal of tonsils	3.40	NA	3.35	0.29	NA	7.04	090
42826		A	Removal of tonsils	3.36	NA	3.24	0.28	NA	6.88	090
42830		A	Removal of adenoids	2.56	NA	2.65	0.22	NA	5.43	090
42831		A	Removal of adenoids	2.69	NA	2.90	0.23	NA	5.82	090
42835		A	Removal of adenoids	2.29	NA	2.66	0.20	NA	5.15	090
42836		A	Removal of adenoids	3.16	NA	3.17	0.26	NA	6.59	090
42842		A	Extensive surgery of throat	8.71	NA	6.82	0.73	NA	16.26	090
42844		A	Extensive surgery of throat	14.23	NA	10.13	1.25	NA	25.61	090
42845		A	Extensive surgery of throat	24.15	NA	16.28	2.11	NA	42.54	090
42860		A	Excision of tonsil tags	2.21	NA	2.60	0.19	NA	5.00	090
42870		A	Excision of lingual tonsil	5.37	NA	4.83	0.46	NA	10.66	090
42890		A	Partial removal of pharynx	12.87	NA	9.44	1.09	NA	23.40	090
42892		A	Revision of pharyngeal walls	15.74	NA	11.01	1.37	NA	28.12	090
42894		A	Revision of pharyngeal walls	22.75	NA	15.23	1.97	NA	39.95	090
42900		A	Repair throat wound	5.22	NA	3.73	0.47	NA	9.42	010
42950		A	Reconstruction of throat	8.05	NA	6.68	0.70	NA	15.43	090
42953		A	Repair throat, esophagus	8.91	NA	7.59	0.87	NA	17.37	090
42955		A	Surgical opening of throat	7.35	NA	5.62	0.76	NA	13.73	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
42960	.....	A	Control throat bleeding	2.32	NA	2.03	0.20	NA	4.55	010
42961	.....	A	Control throat bleeding	5.56	NA	4.90	0.48	NA	10.94	090
42962	.....	A	Control throat bleeding	7.10	NA	5.80	0.61	NA	13.51	090
42970	.....	A	Control nose/throat bleeding	5.40	NA	3.66	0.44	NA	9.50	090
42971	.....	A	Control nose/throat bleeding	6.17	NA	5.03	0.54	NA	11.74	090
42972	.....	A	Control nose/throat bleeding	7.16	NA	5.53	0.65	NA	13.34	090
42999	.....	C	Throat surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43020	.....	A	Incision of esophagus	8.04	NA	5.68	0.84	NA	14.56	090
43030	.....	A	Throat muscle surgery	7.65	NA	5.85	0.72	NA	14.22	090
43045	.....	A	Incision of esophagus	20.01	NA	10.48	2.58	NA	33.07	090
43100	.....	A	Excision of esophagus lesion	9.14	NA	6.27	0.95	NA	16.36	090
43101	.....	A	Excision of esophagus lesion	16.15	NA	7.79	2.17	NA	26.11	090
43107	.....	A	Removal of esophagus	39.77	NA	16.94	3.94	NA	60.65	090
43108	.....	A	Removal of esophagus	34.00	NA	14.23	4.53	NA	52.76	090
43112	.....	A	Removal of esophagus	43.25	NA	17.98	4.40	NA	65.63	090
43113	.....	A	Removal of esophagus	35.07	NA	15.06	5.19	NA	55.32	090
43116	.....	A	Partial removal of esophagus	31.04	NA	16.90	3.14	NA	51.08	090
43117	.....	A	Partial removal of esophagus	39.77	NA	16.17	4.21	NA	60.15	090
43118	.....	A	Partial removal of esophagus	33.01	NA	13.76	4.27	NA	51.04	090
43121	.....	A	Partial removal of esophagus	29.02	NA	12.51	4.12	NA	45.65	090
43122	.....	A	Partial removal of esophagus	39.77	NA	16.38	3.92	NA	60.07	090
43123	.....	A	Partial removal of esophagus	33.01	NA	13.98	4.75	NA	51.74	090
43124	.....	A	Removal of esophagus	27.16	NA	13.02	3.54	NA	43.72	090
43130	.....	A	Removal of esophagus pouch	11.68	NA	7.61	1.27	NA	20.56	090
43135	.....	A	Removal of esophagus pouch	16.01	NA	7.96	2.22	NA	26.19	090
43200	.....	A	Esophagus endoscopy	1.58	4.05	1.10	0.13	5.76	2.81	000
43201	.....	A	Esoph scope w/submucous inj	2.08	4.75	1.28	0.14	6.97	3.50	000
43202	.....	A	Esophagus endoscopy, biopsy	1.88	5.47	0.97	0.14	7.49	2.99	000
43204	.....	A	Esoph scope w/sclerosis inj	3.75	NA	1.56	0.22	NA	5.53	000
43205	.....	A	Esophagus endoscopy/ligation	3.77	NA	1.57	0.20	NA	5.54	000
43215	.....	A	Esophagus endoscopy	2.59	NA	1.24	0.20	NA	4.03	000
43216	.....	A	Esophagus endoscopy/lesion	2.39	NA	1.20	0.18	NA	3.77	000
43217	.....	A	Esophagus endoscopy	2.88	6.89	1.23	0.20	9.97	4.31	000
43219	.....	A	Esophagus endoscopy	2.78	NA	1.38	0.19	NA	4.35	000
43220	.....	A	Esoph endoscopy, dilation	2.09	NA	0.99	0.14	NA	3.22	000
43226	.....	A	Esoph endoscopy, dilation	2.33	NA	1.06	0.14	NA	3.53	000
43227	.....	A	Esoph endoscopy, repair	3.58	NA	1.49	0.22	NA	5.29	000
43228	.....	A	Esoph endoscopy, ablation	3.75	NA	1.59	0.30	NA	5.64	000
43231	.....	A	Esoph endoscopy w/us exam	3.17	NA	1.34	0.24	NA	4.75	000
43232	.....	A	Esoph endoscopy w/us fn bx	4.45	NA	1.86	0.31	NA	6.62	000
43234	.....	A	Upper GI endoscopy, exam	2.00	5.30	0.90	0.16	7.46	3.06	000
43235	.....	A	Uppr gi endoscopy, diagnosis	2.38	5.12	1.08	0.16	7.66	3.62	000
43236	.....	A	Uppr gi scope w/submuc inj	2.90	6.42	1.27	0.17	9.49	4.34	000
43237	.....	A	Endoscopic us exam, esoph	3.97	NA	1.63	0.26	NA	5.86	000
43238	.....	A	Uppr gi endoscopy w/us fn bx	5.00	NA	1.99	0.26	NA	7.25	000
43239	.....	A	Upper GI endoscopy, biopsy	2.85	5.67	1.25	0.17	8.69	4.27	000
43240	.....	A	Esoph endoscope w/drain cyst	6.82	NA	2.69	0.43	NA	9.94	000
43241	.....	A	Upper GI endoscopy with tube	2.58	NA	1.15	0.17	NA	3.90	000
43242	.....	A	Uppr gi endoscopy w/us fn bx	7.27	NA	2.82	0.35	NA	10.44	000
43243	.....	A	Upper gi endoscopy & inject	4.54	NA	1.86	0.25	NA	6.65	000
43244	.....	A	Upper GI endoscopy/ligation	5.02	NA	2.03	0.25	NA	7.30	000
43245	.....	A	Uppr gi scope dilate strictr	3.16	NA	1.36	0.22	NA	4.74	000
43246	.....	A	Place gastrostomy tube	4.31	NA	1.76	0.29	NA	6.36	000
43247	.....	A	Operative upper GI endoscopy	3.37	NA	1.44	0.20	NA	5.01	000
43248	.....	A	Uppr gi endoscopy/guide wire	3.13	NA	1.37	0.18	NA	4.68	000
43249	.....	A	Esoph endoscopy, dilation	2.88	NA	1.27	0.18	NA	4.33	000
43250	.....	A	Upper GI endoscopy/tumor	3.18	NA	1.37	0.20	NA	4.75	000
43251	.....	A	Operative upper GI endoscopy	3.68	NA	1.55	0.23	NA	5.46	000
43255	.....	A	Operative upper GI endoscopy	4.79	NA	1.94	0.24	NA	6.97	000
43256	.....	A	Uppr gi endoscopy w stent	4.33	NA	1.78	0.28	NA	6.39	000
43258	.....	A	Operative upper GI endoscopy	4.52	NA	1.86	0.26	NA	6.64	000
43259	.....	A	Endoscopic ultrasound exam	5.17	NA	2.06	0.26	NA	7.49	000
43260	.....	A	Endo cholangiopancreatograph	5.93	NA	2.33	0.32	NA	8.58	000
43261	.....	A	Endo cholangiopancreatograph	6.23	NA	2.44	0.35	NA	9.02	000
43262	.....	A	Endo cholangiopancreatograph	7.35	NA	2.84	0.41	NA	10.60	000
43263	.....	A	Endo cholangiopancreatograph	7.25	NA	2.82	0.34	NA	10.41	000
43264	.....	A	Endo cholangiopancreatograph	8.85	NA	3.37	0.49	NA	12.71	000
43265	.....	A	Endo cholangiopancreatograph	9.96	NA	3.76	0.50	NA	14.22	000
43267	.....	A	Endo cholangiopancreatograph	7.35	NA	2.84	0.41	NA	10.60	000
43268	.....	A	Endo cholangiopancreatograph	7.35	NA	2.94	0.41	NA	10.70	000
43269	.....	A	Endo cholangiopancreatograph	8.16	NA	3.13	0.34	NA	11.63	000
43271	.....	A	Endo cholangiopancreatograph	7.35	NA	2.83	0.41	NA	10.59	000
43272	.....	A	Endo cholangiopancreatograph	7.35	NA	2.84	0.41	NA	10.60	000
43280	.....	A	Laparoscopy, fundoplasty	17.15	NA	7.40	2.11	NA	26.66	090
43289	.....	C	Laparoscope proc, esoph	0.00	0.00	0.00	0.00	0.00	0.00	YYY

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
43300		A	Repair of esophagus	9.09	NA	6.53	1.02	NA	16.64	090
43305		A	Repair esophagus and fistula	17.29	NA	10.84	1.63	NA	29.76	090
43310		A	Repair of esophagus	25.25	NA	10.95	3.81	NA	40.01	090
43312		A	Repair esophagus and fistula	28.26	NA	11.79	4.05	NA	44.10	090
43313		A	Esophagoplasty congenital	45.02	NA	20.35	6.51	NA	71.88	090
43314		A	Tracheo-esophagoplasty cong	49.98	NA	22.27	6.63	NA	78.88	090
43320		A	Fuse esophagus & stomach	19.82	NA	9.21	1.91	NA	30.94	090
43324		A	Revise esophagus & stomach	20.45	NA	8.88	2.06	NA	31.39	090
43325		A	Revise esophagus & stomach	19.95	NA	8.87	1.98	NA	30.80	090
43326		A	Revise esophagus & stomach	19.63	NA	9.22	2.21	NA	31.06	090
43330		A	Repair of esophagus	19.66	NA	8.64	1.82	NA	30.12	090
43331		A	Repair of esophagus	20.02	NA	9.66	2.31	NA	31.99	090
43340		A	Fuse esophagus & intestine	19.50	NA	8.99	1.83	NA	30.32	090
43341		A	Fuse esophagus & intestine	20.73	NA	9.91	2.57	NA	33.21	090
43350		A	Surgical opening, esophagus	15.69	NA	8.47	1.38	NA	25.54	090
43351		A	Surgical opening, esophagus	18.25	NA	9.65	1.81	NA	29.71	090
43352		A	Surgical opening, esophagus	15.17	NA	8.37	1.53	NA	25.07	090
43360		A	Gastrointestinal repair	35.50	NA	15.02	3.60	NA	54.12	090
43361		A	Gastrointestinal repair	40.27	NA	16.86	4.22	NA	61.35	090
43400		A	Ligate esophagus veins	21.08	NA	9.54	1.19	NA	31.81	090
43401		A	Esophagus surgery for veins	21.96	NA	9.63	2.07	NA	33.66	090
43405		A	Ligate/staple esophagus	19.90	NA	9.56	1.95	NA	31.41	090
43410		A	Repair esophagus wound	13.39	NA	7.58	1.38	NA	22.35	090
43415		A	Repair esophagus wound	24.66	NA	11.65	2.30	NA	38.81	090
43420		A	Repair esophagus opening	14.27	NA	7.51	1.03	NA	22.81	090
43425		A	Repair esophagus opening	20.91	NA	9.84	2.43	NA	33.18	090
43450		A	Dilate esophagus	1.37	2.54	0.74	0.08	3.99	2.19	000
43453		A	Dilate esophagus	1.50	6.04	0.78	0.10	7.64	2.38	000
43456		A	Dilate esophagus	2.56	13.88	1.16	0.17	16.61	3.89	000
43458		A	Dilate esophagus	3.04	6.64	1.35	0.20	9.88	4.59	000
43460		A	Pressure treatment esophagus	3.78	NA	1.50	0.25	NA	5.53	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	10.99	NA	5.05	1.01	NA	17.05	090
43501		A	Surgical repair of stomach	19.93	NA	8.43	1.86	NA	30.22	090
43502		A	Surgical repair of stomach	23.00	NA	9.59	2.19	NA	34.78	090
43510		A	Surgical opening of stomach	13.01	NA	6.63	1.08	NA	20.72	090
43520		A	Incision of pyloric muscle	9.93	NA	5.22	1.01	NA	16.16	090
43600		A	Biopsy of stomach	1.90	NA	1.04	0.13	NA	3.07	000
43605		A	Biopsy of stomach	11.91	NA	5.37	1.11	NA	18.39	090
43610		A	Excision of stomach lesion	14.52	NA	6.25	1.37	NA	22.14	090
43611		A	Excision of stomach lesion	17.74	NA	7.69	1.65	NA	27.08	090
43620		A	Removal of stomach	29.87	NA	11.96	2.74	NA	44.57	090
43621		A	Removal of stomach	30.55	NA	12.17	2.83	NA	45.55	090
43622		A	Removal of stomach	32.34	NA	12.76	2.97	NA	48.07	090
43631		A	Removal of stomach, partial	22.46	NA	9.29	2.39	NA	34.14	090
43632		A	Removal of stomach, partial	22.46	NA	9.30	2.40	NA	34.16	090
43633		A	Removal of stomach, partial	22.97	NA	9.47	2.46	NA	34.90	090
43634		A	Removal of stomach, partial	24.98	NA	10.22	2.61	NA	37.81	090
43635		A	Removal of stomach, partial	2.05	NA	0.71	0.25	NA	3.01	ZZZ
43638		A	Removal of stomach, partial	28.83	NA	12.02	2.68	NA	43.53	090
43639		A	Removal of stomach, partial	29.48	NA	11.82	2.77	NA	44.07	090
43640		A	Vagotomy & pylorus repair	16.92	NA	7.37	1.81	NA	26.10	090
43641		A	Vagotomy & pylorus repair	17.17	NA	7.48	1.83	NA	26.48	090
43651		A	Laparoscopy, vagus nerve	10.09	NA	4.81	1.23	NA	16.13	090
43652		A	Laparoscopy, vagus nerve	12.08	NA	5.46	1.50	NA	19.04	090
43653		A	Laparoscopy, gastrostomy	7.69	NA	4.27	0.93	NA	12.89	090
43659		C	Laparoscope proc, stom	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43750		A	Place gastrostomy tube	4.46	NA	2.75	0.40	NA	7.61	010
43752		A	Nasal/orogastric w/stent	0.68	0.26	0.26	0.02	0.96	0.96	000
43760		A	Change gastrostomy tube	1.09	1.67	0.46	0.08	2.84	1.63	000
43761		A	Reposition gastrostomy tube	2.00	NA	0.79	0.12	NA	2.91	000
43800		A	Reconstruction of pylorus	13.61	NA	5.98	1.28	NA	20.87	090
43810		A	Fusion of stomach and bowel	14.57	NA	6.28	1.32	NA	22.17	090
43820		A	Fusion of stomach and bowel	15.28	NA	6.52	1.41	NA	23.21	090
43825		A	Fusion of stomach and bowel	19.11	NA	8.14	1.80	NA	29.05	090
43830		A	Place gastrostomy tube	9.48	NA	4.93	0.83	NA	15.24	090
43831		A	Place gastrostomy tube	7.80	NA	4.57	0.97	NA	13.34	090
43832		A	Place gastrostomy tube	15.51	NA	6.97	1.35	NA	23.83	090
43840		A	Repair of stomach lesion	15.47	NA	6.88	1.44	NA	23.79	090
43842		A	Gastroplasty for obesity	18.36	NA	8.22	1.81	NA	28.39	090
43843		A	Gastroplasty for obesity	18.54	NA	8.21	1.83	NA	28.58	090
43846		A	Gastric bypass for obesity	23.91	NA	10.49	2.35	NA	36.75	090
43847		A	Gastric bypass for obesity	26.77	NA	11.43	2.57	NA	40.77	090
43848		A	Revision gastroplasty	29.22	NA	12.36	2.86	NA	44.44	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
43850		A	Revise stomach-bowel fusion	24.58	NA	9.97	2.36	NA	36.91	090
43855		A	Revise stomach-bowel fusion	26.01	NA	10.48	2.41	NA	38.90	090
43860		A	Revise stomach-bowel fusion	24.86	NA	10.12	2.43	NA	37.41	090
43865		A	Revise stomach-bowel fusion	26.37	NA	10.65	2.58	NA	39.60	090
43870		A	Repair stomach opening	9.63	NA	4.59	0.85	NA	15.07	090
43880		A	Repair stomach-bowel fistula	24.51	NA	10.06	2.33	NA	36.90	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	16.14	NA	6.84	1.67	NA	24.65	090
44010		A	Incision of small bowel	12.45	NA	5.55	1.26	NA	19.26	090
44015		A	Insert needle cath bowel	2.61	NA	0.89	0.30	NA	3.80	ZZZ
44020		A	Explore small intestine	13.91	NA	6.04	1.44	NA	21.39	090
44021		A	Decompress small bowel	14.00	NA	6.07	1.41	NA	21.48	090
44025		A	Incision of large bowel	14.20	NA	6.13	1.45	NA	21.78	090
44050		A	Reduce bowel obstruction	13.95	NA	6.06	1.38	NA	21.39	090
44055		A	Correct malrotation of bowel	21.87	NA	8.87	1.58	NA	32.32	090
44100		A	Biopsy of bowel	2.00	NA	1.10	0.14	NA	3.24	000
44110		A	Excise intestine lesion(s)	11.74	NA	5.34	1.20	NA	18.28	090
44111		A	Excision of bowel lesion(s)	14.21	NA	6.24	1.46	NA	21.91	090
44120		A	Removal of small intestine	16.90	NA	7.20	1.75	NA	25.85	090
44121		A	Removal of small intestine	4.42	NA	1.54	0.55	NA	6.51	ZZZ
44125		A	Removal of small intestine	17.44	NA	7.38	1.79	NA	26.61	090
44126		A	Enterectomy w/o taper, cong	35.30	NA	14.31	0.43	NA	50.04	090
44127		A	Enterectomy w/taper, cong	40.77	NA	15.95	0.49	NA	57.21	090
44128		A	Enterectomy cong, add-on	4.42	NA	1.56	0.54	NA	6.52	ZZZ
44130		A	Bowel to bowel fusion	14.41	NA	6.33	1.47	NA	22.21	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
44139		A	Mobilization of colon	2.22	NA	0.77	0.25	NA	3.24	ZZZ
44140		A	Partial removal of colon	20.88	NA	8.78	2.57	NA	32.23	090
44141		A	Partial removal of colon	19.40	NA	10.27	2.34	NA	32.01	090
44143		A	Partial removal of colon	22.86	NA	10.91	2.42	NA	36.19	090
44144		A	Partial removal of colon	21.41	NA	9.79	2.27	NA	33.47	090
44145		A	Partial removal of colon	26.27	NA	10.98	2.66	NA	39.91	090
44146		A	Partial removal of colon	27.38	NA	13.13	2.64	NA	43.15	090
44147		A	Partial removal of colon	20.59	NA	8.82	2.09	NA	31.50	090
44150		A	Removal of colon	23.81	NA	12.28	2.46	NA	38.55	090
44151		A	Removal of colon/ileostomy	26.73	NA	13.68	2.36	NA	42.77	090
44152		A	Removal of colon/ileostomy	27.67	NA	11.81	2.83	NA	42.31	090
44153		A	Removal of colon/ileostomy	30.42	NA	14.72	2.79	NA	47.93	090
44155		A	Removal of colon/ileostomy	27.70	NA	13.58	2.71	NA	43.99	090
44156		A	Removal of colon/ileostomy	30.61	NA	15.30	2.62	NA	48.53	090
44160		A	Removal of colon	18.51	NA	7.87	2.23	NA	28.61	090
44200		A	Laparoscopy, enterolysis	14.36	NA	6.29	1.75	NA	22.40	090
44201		A	Laparoscopy, jejunostomy	9.72	NA	4.73	1.16	NA	15.61	090
44202		A	Lap resect s/intestine singl	21.91	NA	9.07	2.59	NA	33.57	090
44203		A	Lap resect s/intestine, addl	4.42	NA	1.52	0.55	NA	6.49	ZZZ
44204		A	Laparo partial colectomy	24.94	NA	10.09	3.06	NA	38.09	090
44205		A	Lap colectomy part w/ileum	22.10	NA	8.97	2.67	NA	33.74	090
44206		A	Lap part colectomy w/stoma	26.85	NA	11.48	2.42	NA	40.75	090
44207		A	L colectomy/coloproctostomy	29.83	NA	11.72	2.66	NA	44.21	090
44208		A	L colectomy/coloproctostomy	31.82	NA	13.42	2.64	NA	47.88	090
44210		A	Laparo total proctocolectomy	27.34	NA	12.16	2.46	NA	42.46	090
44211		A	Laparo total proctocolectomy	34.80	NA	14.90	2.79	NA	52.49	090
44212		A	Laparo total proctocolectomy	32.31	NA	14.04	2.71	NA	49.06	090
44238		C	Laparoscope proc, intestine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44239		C	Laparoscope proc, rectum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44300		A	Open bowel to skin	12.04	NA	5.58	1.05	NA	18.67	090
44310		A	Ileostomy/jejunostomy	15.86	NA	6.80	1.35	NA	24.01	090
44312		A	Revision of ileostomy	7.97	NA	4.07	0.65	NA	12.69	090
44314		A	Revision of ileostomy	14.96	NA	6.67	1.19	NA	22.82	090
44316		A	Devise bowel pouch	20.97	NA	8.68	1.69	NA	31.34	090
44320		A	Colostomy	17.54	NA	7.79	1.53	NA	26.86	090
44322		A	Colostomy with biopsies	11.91	NA	8.82	1.41	NA	22.14	090
44340		A	Revision of colostomy	7.68	NA	4.36	0.67	NA	12.71	090
44345		A	Revision of colostomy	15.34	NA	7.01	1.33	NA	23.68	090
44346		A	Revision of colostomy	16.89	NA	7.51	1.44	NA	25.84	090
44360		A	Small bowel endoscopy	2.58	NA	1.13	0.17	NA	3.88	000
44361		A	Small bowel endoscopy/biopsy	2.85	NA	1.23	0.18	NA	4.26	000
44363		A	Small bowel endoscopy	3.48	NA	1.42	0.23	NA	5.13	000
44364		A	Small bowel endoscopy	3.72	NA	1.54	0.25	NA	5.51	000
44365		A	Small bowel endoscopy	3.29	NA	1.40	0.22	NA	4.91	000
44366		A	Small bowel endoscopy	4.38	NA	1.78	0.26	NA	6.42	000
44369		A	Small bowel endoscopy	4.49	NA	1.78	0.28	NA	6.55	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
44370		A	Small bowel endoscopy/stent	4.77	NA	2.01	0.25	NA	7.03	000
44372		A	Small bowel endoscopy	4.38	NA	1.77	0.32	NA	6.47	000
44373		A	Small bowel endoscopy	3.48	NA	1.46	0.23	NA	5.17	000
44376		A	Small bowel endoscopy	5.23	NA	2.06	0.35	NA	7.64	000
44377		A	Small bowel endoscopy/biopsy	5.50	NA	2.18	0.34	NA	8.02	000
44378		A	Small bowel endoscopy	7.09	NA	2.75	0.44	NA	10.28	000
44379		A	S˙bowel endoscope w/stent	7.43	NA	2.97	0.46	NA	10.86	000
44380		A	Small bowel endoscopy	1.04	NA	0.58	0.10	NA	1.72	000
44382		A	Small bowel endoscopy	1.26	NA	0.65	0.11	NA	2.02	000
44383		A	Ileoscopy w/stent	2.92	NA	1.30	0.16	NA	4.38	000
44385		A	Endoscopy of bowel pouch	1.81	5.03	0.97	0.14	6.98	2.92	000
44386		A	Endoscopy, bowel pouch/biop	2.11	6.60	1.13	0.18	8.89	3.42	000
44388		A	Colonoscopy	2.80	5.22	1.18	0.22	8.24	4.20	000
44389		A	Colonoscopy with biopsy	3.11	6.59	1.30	0.22	9.92	4.63	000
44390		A	Colonoscopy for foreign body	3.81	6.84	1.53	0.26	10.91	5.60	000
44391		A	Colonoscopy for bleeding	4.30	8.84	1.74	0.28	13.42	6.32	000
44392		A	Colonoscopy & polypectomy	3.80	6.64	1.53	0.28	10.72	5.61	000
44393		A	Colonoscopy, lesion removal	4.81	7.01	1.91	0.32	12.14	7.04	000
44394		A	Colonoscopy w/snare	4.40	7.87	1.77	0.31	12.58	6.48	000
44397		A	Colonoscopy w/stent	4.68	NA	2.08	0.34	NA	7.10	000
44500		A	Intro, gastrointestinal tube	0.49	NA	0.36	0.02	NA	0.87	000
44602		A	Suture, small intestine	15.94	NA	6.49	1.28	NA	23.71	090
44603		A	Suture, small intestine	18.55	NA	7.39	1.67	NA	27.61	090
44604		A	Suture, large intestine	15.94	NA	6.56	1.70	NA	24.20	090
44605		A	Repair of bowel lesion	19.42	NA	8.55	1.85	NA	29.82	090
44615		A	Intestinal stricturoplasty	15.84	NA	6.79	1.67	NA	24.30	090
44620		A	Repair bowel opening	12.13	NA	5.42	1.26	NA	18.81	090
44625		A	Repair bowel opening	14.96	NA	6.41	1.56	NA	22.93	090
44626		A	Repair bowel opening	25.22	NA	9.96	3.03	NA	38.21	090
44640		A	Repair bowel-skin fistula	21.53	NA	8.71	1.75	NA	31.99	090
44650		A	Repair bowel fistula	22.44	NA	9.01	1.79	NA	33.24	090
44660		A	Repair bowel-bladder fistula	21.24	NA	8.48	1.37	NA	31.09	090
44661		A	Repair bowel-bladder fistula	24.67	NA	9.69	1.83	NA	36.19	090
44680		A	Surgical revision, intestine	15.31	NA	6.56	1.64	NA	23.51	090
44700		A	Suspend bowel w/prosthesis	16.02	NA	6.77	1.45	NA	24.24	090
44701		A	Intraop colon lavage add-on	3.08	NA	1.07	0.25	NA	4.40	ZZZ
44799		C	Unlisted procedure intestine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44800		A	Excision of bowel pouch	11.17	NA	5.49	1.33	NA	17.99	090
44820		A	Excision of mesentery lesion	12.02	NA	5.58	1.23	NA	18.83	090
44850		A	Repair of mesentery	10.68	NA	5.07	1.19	NA	16.94	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	10.08	NA	4.78	1.01	NA	15.87	090
44901		A	Drain app abscess, percut	3.36	NA	1.13	0.20	NA	4.69	000
44950		A	Appendectomy	9.94	NA	4.40	1.05	NA	15.39	090
44955		A	Appendectomy add-on	1.52	NA	0.55	0.19	NA	2.26	ZZZ
44960		A	Appendectomy	12.27	NA	5.44	1.31	NA	19.02	090
44970		A	Laparoscopy, appendectomy	8.65	NA	4.29	1.05	NA	13.99	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	4.49	NA	3.02	0.44	NA	7.95	090
45005		A	Drainage of rectal abscess	1.98	4.90	1.72	0.22	7.10	3.92	010
45020		A	Drainage of rectal abscess	4.69	NA	3.34	0.49	NA	8.52	090
45100		A	Biopsy of rectum	3.66	NA	2.41	0.40	NA	6.47	090
45108		A	Removal of anorectal lesion	4.73	NA	2.94	0.55	NA	8.22	090
45110		A	Removal of rectum	27.84	NA	12.63	2.71	NA	43.18	090
45111		A	Partial removal of rectum	16.39	NA	7.30	1.92	NA	25.61	090
45112		A	Removal of rectum	30.37	NA	11.95	2.82	NA	45.14	090
45113		A	Partial proctectomy	30.41	NA	12.84	2.55	NA	45.80	090
45114		A	Partial removal of rectum	27.16	NA	11.12	2.73	NA	41.01	090
45116		A	Partial removal of rectum	24.44	NA	10.20	2.40	NA	37.04	090
45119		A	Remove rectum w/reservoir	30.66	NA	12.68	2.55	NA	45.89	090
45120		A	Removal of rectum	24.46	NA	10.30	2.73	NA	37.49	090
45121		A	Removal of rectum and colon	26.89	NA	11.28	3.19	NA	41.36	090
45123		A	Partial proctectomy	16.61	NA	6.99	1.25	NA	24.85	090
45126		A	Pelvic exenteration	44.90	NA	19.71	3.87	NA	68.48	090
45130		A	Excision of rectal prolapse	16.35	NA	6.87	1.34	NA	24.56	090
45135		A	Excision of rectal prolapse	19.17	NA	8.56	1.82	NA	29.55	090
45136		A	Excise ileoanal reservior	27.14	NA	12.66	3.26	NA	43.06	090
45150		A	Excision of rectal stricture	5.64	NA	3.02	0.55	NA	9.21	090
45160		A	Excision of rectal lesion	15.23	NA	6.75	1.28	NA	23.26	090
45170		A	Excision of rectal lesion	11.42	NA	5.33	1.07	NA	17.82	090
45190		A	Destruction, rectal tumor	9.68	NA	4.73	0.91	NA	15.32	090
45300		A	Proctosigmoidoscopy dx	0.38	1.50	0.31	0.06	1.94	0.75	000
45303		A	Proctosigmoidoscopy dilate	0.44	19.47	0.36	0.07	19.98	0.87	000
45305		A	Proctosigmoidoscopy w/bx	1.00	2.62	0.53	0.11	3.73	1.64	000
45307		A	Proctosigmoidoscopy fb	0.93	3.06	0.51	0.18	4.17	1.62	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
45308		A	Proctosigmoidoscopy removal	0.83	1.96	0.47	0.16	2.95	1.46	000
45309		A	Proctosigmoidoscopy removal	2.00	2.82	0.86	0.20	5.02	3.06	000
45315		A	Proctosigmoidoscopy removal	1.39	2.85	0.66	0.24	4.48	2.29	000
45317		A	Proctosigmoidoscopy bleed	1.49	2.41	0.69	0.24	4.14	2.42	000
45320		A	Proctosigmoidoscopy ablate	1.57	2.88	0.73	0.24	4.69	2.54	000
45321		A	Proctosigmoidoscopy volvul	1.16	NA	0.60	0.20	NA	1.96	000
45327		A	Proctosigmoidoscopy w/stent	1.64	NA	0.71	0.12	NA	2.47	000
45330		A	Diagnostic sigmoidoscopy	0.95	2.24	0.53	0.06	3.25	1.54	000
45331		A	Sigmoidoscopy and biopsy	1.14	2.98	0.64	0.08	4.20	1.86	000
45332		A	Sigmoidoscopy w/fb removal	1.78	4.96	0.85	0.13	6.87	2.76	000
45333		A	Sigmoidoscopy & polypectomy	1.78	4.80	0.85	0.14	6.72	2.77	000
45334		A	Sigmoidoscopy for bleeding	2.71	NA	1.20	0.19	NA	4.10	000
45335		A	Sigmoidoscopy w/submuc inj	1.35	3.45	0.65	0.08	4.88	2.08	000
45337		A	Sigmoidoscopy & decompress	2.35	NA	1.06	0.18	NA	3.59	000
45338		A	Sigmoidoscopy w/tumr remove	2.33	5.12	1.06	0.18	7.63	3.57	000
45339		A	Sigmoidoscopy w/ablate tumr	3.12	3.38	1.34	0.20	6.70	4.66	000
45340		A	Sig w/balloon dilation	1.65	6.74	0.76	0.08	8.47	2.49	000
45341		A	Sigmoidoscopy w/ultrasound	2.59	NA	1.14	0.24	NA	3.97	000
45342		A	Sigmoidoscopy w/us guide bx	4.04	NA	1.62	0.28	NA	5.94	000
45345		A	Sigmoidoscopy w/stent	2.90	NA	1.22	0.18	NA	4.30	000
45355		A	Surgical colonoscopy	3.50	NA	1.42	0.31	NA	5.23	000
45378		A	Diagnostic colonoscopy	3.68	6.13	1.60	0.24	10.05	5.52	000
45378	53	A	Diagnostic colonoscopy	0.95	2.24	0.53	0.06	3.25	1.54	000
45379		A	Colonoscopy w/fb removal	4.66	7.70	1.88	0.30	12.66	6.84	000
45380		A	Colonoscopy and biopsy	4.41	7.17	1.80	0.25	11.83	6.46	000
45381		A	Colonoscopy, submucous inj	4.18	8.26	1.71	0.25	12.69	6.14	000
45382		A	Colonoscopy/control bleeding	5.66	9.86	2.25	0.32	15.84	8.23	000
45383		A	Lesion removal colonoscopy	5.84	7.96	2.29	0.38	14.18	8.51	000
45384		A	Lesion remove colonoscopy	4.67	6.79	1.90	0.29	11.75	6.86	000
45385		A	Lesion removal colonoscopy	5.28	7.81	2.10	0.34	13.43	7.72	000
45386		A	Colonoscopy dilate stricture	4.55	13.86	1.85	0.25	18.66	6.65	000
45387		A	Colonoscopy w/stent	5.88	NA	2.38	0.40	NA	8.66	000
45500		A	Repair of rectum	7.25	NA	3.64	0.67	NA	11.56	090
45505		A	Repair of rectum	7.54	NA	3.91	0.60	NA	12.05	090
45520		A	Treatment of rectal prolapse	0.55	0.86	0.19	0.05	1.46	0.79	000
45540		A	Correct rectal prolapse	16.18	NA	6.94	1.40	NA	24.52	090
45541		A	Correct rectal prolapse	13.32	NA	6.06	1.05	NA	20.43	090
45550		A	Repair rectum/remove sigmoid	22.87	NA	9.39	1.89	NA	34.15	090
45560		A	Repair of rectocele	10.52	NA	5.19	0.87	NA	16.58	090
45562		A	Exploration/repair of rectum	15.29	NA	7.13	1.38	NA	23.80	090
45563		A	Exploration/repair of rectum	23.34	NA	10.73	2.21	NA	36.28	090
45800		A	Repair rect/bladder fistula	17.67	NA	7.59	1.37	NA	26.63	090
45805		A	Repair fistula w/colostomy	20.66	NA	9.71	1.76	NA	32.13	090
45820		A	Repair rectourethral fistula	18.37	NA	7.77	1.40	NA	27.54	090
45825		A	Repair fistula w/colostomy	21.13	NA	10.02	1.16	NA	32.31	090
45900		A	Reduction of rectal prolapse	2.60	NA	1.54	0.20	NA	4.34	010
45905		A	Dilation of anal sphincter	2.29	NA	1.45	0.17	NA	3.91	010
45910		A	Dilation of rectal narrowing	2.78	NA	1.68	0.17	NA	4.63	010
45915		A	Remove rectal obstruction	3.12	4.80	1.19	0.20	8.12	4.51	010
45999		C	Rectum surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
46020		A	Placement of seton	2.88	2.30	1.88	0.26	5.44	5.02	010
46030		A	Removal of rectal marker	1.22	1.37	0.72	0.13	2.72	2.07	010
46040		A	Incision of rectal abscess	4.93	5.36	3.21	0.58	10.87	8.72	090
46045		A	Incision of rectal abscess	4.30	NA	2.96	0.48	NA	7.74	090
46050		A	Incision of anal abscess	1.18	2.60	0.87	0.13	3.91	2.18	010
46060		A	Incision of rectal abscess	5.66	NA	3.33	0.62	NA	9.61	090
46070		A	Incision of anal septum	2.69	NA	1.91	0.32	NA	4.92	090
46080		A	Incision of anal sphincter	2.48	2.41	1.14	0.28	5.17	3.90	010
46083		A	Incise external hemorrhoid	1.39	2.54	0.96	0.14	4.07	2.49	010
46200		A	Removal of anal fissure	3.40	3.69	2.45	0.36	7.45	6.21	090
46210		A	Removal of anal crypt	2.65	4.88	2.17	0.31	7.84	5.13	090
46211		A	Removal of anal crypts	4.23	5.16	2.98	0.44	9.83	7.65	090
46220		A	Removal of anal tag	1.55	2.30	0.94	0.17	4.02	2.66	010
46221		A	Ligation of hemorrhoid(s)	2.03	1.64	1.14	0.14	3.81	3.31	010
46230		A	Removal of anal tags	2.56	3.08	1.30	0.26	5.90	4.12	010
46250		A	Hemorrhoidectomy	3.87	4.93	2.48	0.52	9.32	6.87	090
46255		A	Hemorrhoidectomy	4.57	5.48	2.71	0.61	10.66	7.89	090
46257		A	Remove hemorrhoids & fissure	5.37	NA	2.95	0.71	NA	9.03	090
46258		A	Remove hemorrhoids & fistula	5.70	NA	3.34	0.77	NA	9.81	090
46260		A	Hemorrhoidectomy	6.33	NA	3.28	0.82	NA	10.43	090
46261		A	Remove hemorrhoids & fissure	7.04	NA	3.69	0.84	NA	11.57	090
46262		A	Remove hemorrhoids & fistula	7.46	NA	3.83	0.91	NA	12.20	090
46270		A	Removal of anal fistula	3.70	4.72	2.40	0.43	8.85	6.53	090
46275		A	Removal of anal fistula	4.53	4.42	2.60	0.48	9.43	7.61	090
46280		A	Removal of anal fistula	5.95	NA	3.34	0.60	NA	9.89	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
46285		A	Removal of anal fistula	4.07	3.64	2.38	0.41	8.12	6.86	090
46288		A	Repair anal fistula	7.09	NA	3.78	0.72	NA	11.59	090
46320		A	Removal of hemorrhoid clot	1.60	2.15	0.86	0.17	3.92	2.63	010
46500		A	Injection into hemorrhoid(s)	1.60	2.82	0.63	0.14	4.56	2.37	010
46600		A	Diagnostic anoscopy	0.50	1.61	0.39	0.05	2.16	0.94	000
46604		A	Anoscopy and dilation	1.30	9.49	0.64	0.11	10.90	2.05	000
46606		A	Anoscopy and biopsy	0.81	3.90	0.46	0.08	4.79	1.35	000
46608		A	Anoscopy, remove for body	1.50	4.51	0.69	0.16	6.17	2.35	000
46610		A	Anoscopy, remove lesion	1.31	4.14	0.64	0.14	5.59	2.09	000
46611		A	Anoscopy	1.80	3.40	0.80	0.18	5.38	2.78	000
46612		A	Anoscopy, remove lesions	2.33	5.26	1.01	0.22	7.81	3.56	000
46614		A	Anoscopy, control bleeding	2.00	2.30	0.87	0.17	4.47	3.04	000
46615		A	Anoscopy	2.66	2.55	1.10	0.28	5.49	4.04	000
46700		A	Repair of anal stricture	9.08	NA	4.29	0.67	NA	14.04	090
46705		A	Repair of anal stricture	6.86	NA	3.79	0.87	NA	11.52	090
46706		A	Repr of anal fistula w/glue	2.38	NA	1.26	0.20	NA	3.84	010
46715		A	Repair of anovaginal fistula	7.16	NA	3.68	0.91	NA	11.75	090
46716		A	Repair of anovaginal fistula	14.98	NA	8.07	1.56	NA	24.61	090
46730		A	Construction of absent anus	26.60	NA	12.21	2.43	NA	41.24	090
46735		A	Construction of absent anus	31.99	NA	13.72	3.16	NA	48.87	090
46740		A	Construction of absent anus	29.83	NA	13.36	2.39	NA	45.58	090
46742		A	Repair of imperforated anus	35.60	NA	17.98	3 15	NA	56.73	090
46744		A	Repair of cloacal anomaly	52.33	NA	21.44	2.72	NA	76.49	090
46746		A	Repair of cloacal anomaly	57.89	NA	25.48	3.01	NA	86.38	090
46748		A	Repair of cloacal anomaly	63.84	NA	24.12	3.32	NA	91.28	090
46750		A	Repair of anal sphincter	10.19	NA	5.18	0.83	NA	16.20	090
46751		A	Repair of anal sphincter	8.72	NA	5.70	0.93	NA	15.35	090
46753		A	Reconstruction of anus	8.24	NA	3.92	0.70	NA	12.86	090
46754		A	Removal of suture from anus	2.19	3.68	1.71	0.14	6.01	4.04	010
46760		A	Repair of anal sphincter	14.35	NA	7.19	1.03	NA	22.57	090
46761		A	Repair of anal sphincter	13.76	NA	6.16	1.01	NA	20.93	090
46762		A	Implant artificial sphincter	12.64	NA	5.62	0.85	NA	19.11	090
46900		A	Destruction, anal lesion(s)	1.90	3.57	0.80	0.16	5.63	2.86	010
46910		A	Destruction, anal lesion(s)	1.85	2.72	1.11	0.17	4.74	3.13	010
46916		A	Cryosurgery, anal lesion(s)	1.85	3.10	1.42	0.11	5.06	3.38	010
46917		A	Laser surgery, anal lesions	1.85	9.33	1.14	0.19	11.37	3.18	010
46922		A	Excision of anal lesion(s)	1.85	3.36	1.10	0.20	5.41	3.15	010
46924		A	Destruction, anal lesion(s)	2.74	8.54	1.38	0.24	11.52	4.36	010
46934		A	Destruction of hemorrhoids	3.49	5.09	2.74	0.31	8.89	6.54	090
46935		A	Destruction of hemorrhoids	2.42	3.50	1.23	0.20	6.12	3.85	010
46936		A	Destruction of hemorrhoids	3.67	4.51	2.28	0.36	8.54	6.31	090
46937		A	Cryotherapy of rectal lesion	2.67	2.77	1.24	0.14	5.58	4.05	010
46938		A	Cryotherapy of rectal lesion	4.63	4.27	2.74	0.48	9.38	7.85	090
46940		A	Treatment of anal fissure	2.31	2.01	1.10	0.20	4.52	3.61	010
46942		A	Treatment of anal fissure	2.03	1.86	1.02	0.17	4.06	3.22	010
46945		A	Ligation of hemorrhoids	1.83	3.59	1.91	0.20	5.62	3.94	090
46946		A	Ligation of hemorrhoids	2.57	4.26	1.87	0.26	7.09	4.70	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	1.89	3.28	0.64	0.11	5.28	2.64	000
47001		A	Needle biopsy, liver add-on	1.89	NA	0.65	0.22	NA	2.76	ZZZ
47010		A	Open drainage, liver lesion	15.92	NA	8.62	0.78	NA	25.32	090
47011		A	Percut drain, liver lesion	3.68	NA	1.23	0.20	NA	5.11	000
47015		A	Inject/aspirate liver cyst	15.02	NA	7.62	1.03	NA	23.67	090
47100		A	Wedge biopsy of liver	11.60	NA	6.16	0.90	NA	18.66	090
47120		A	Partial removal of liver	35.30	NA	15.44	2.74	NA	53.48	090
47122		A	Extensive removal of liver	54.82	NA	21.84	4.31	NA	80.97	090
47125		A	Partial removal of liver	48.91	NA	19.85	3.81	NA	72.57	090
47130		A	Partial removal of liver	53.05	NA	21.32	4.16	NA	78.53	090
47133		X	Removal of donor liver	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47134		D	Partial removal, donor liver	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47135		R	Transplantation of liver	81.06	NA	32.43	9.74	NA	123.23	090
47136		R	Transplantation of liver	68.21	NA	27.78	8.31	NA	104.30	090
47140		A	Partial removal, donor liver	54.69	NA	22.98	4.77	NA	82.44	090
47141		A	Partial removal, donor liver	67.12	NA	27.70	4.77	NA	99.59	090
47142		A	Partial removal, donor liver	74.57	NA	30.29	4.77	NA	109.63	090
47300		A	Surgery for liver lesion	14.99	NA	7.36	1.16	NA	23.51	090
47350		A	Repair liver wound	19.45	NA	9.01	1.50	NA	29.96	090
47360		A	Repair liver wound	26.77	NA	11.78	2.05	NA	40.60	090
47361		A	Repair liver wound	46.85	NA	18.81	3.73	NA	69.39	090
47362		A	Repair liver wound	18.40	NA	8.90	1.46	NA	28.76	090
47370		A	Laparo ablate liver tumor rf	19.58	NA	8.28	1.02	NA	28.88	090
47371		A	Laparo ablate liver cryosurg	19.58	NA	8.29	1.02	NA	28.89	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	22.87	NA	9.50	1.02	NA	33.39	090
47381		A	Open ablate liver tumor cryo	23.14	NA	9.77	1.02	NA	33.93	090

[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
47382		A	Percut ablate liver rf	15.10	NA	6.16	1.37	NA	22.63	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	32.30	NA	13.69	2.18	NA	48.17	090
47420		A	Incision of bile duct	19.77	NA	8.90	2.04	NA	30.71	090
47425		A	Incision of bile duct	19.72	NA	8.95	1.92	NA	30.59	090
47460		A	Incise bile duct sphincter	17.94	NA	8.50	1.49	NA	27.93	090
47480		A	Incision of gallbladder	10.76	NA	6.03	1.02	NA	17.81	090
47490		A	Incision of gallbladder	7.19	NA	5.87	0.40	NA	13.46	090
47500		A	Injection for liver x-rays	1.95	NA	0.64	0.11	NA	2.70	000
47505		A	Injection for liver x-rays	0.76	2.58	0.25	0.04	3.38	1.05	000
47510		A	Insert catheter, bile duct	7.79	NA	5.05	0.43	NA	13.27	090
47511		A	Insert bile duct drain	10.44	NA	5.13	0.56	NA	16.13	090
47525		A	Change bile duct catheter	5.52	NA	3.28	0.29	NA	9.09	010
47530		A	Revise/reinsert bile tube	5.82	NA	4.36	0.35	NA	10.53	090
47550		A	Bile duct endoscopy add-on	3.00	NA	1.04	0.36	NA	4.40	ZZZ
47552		A	Biliary endoscopy thru skin	6.01	NA	2.42	0.50	NA	8.93	000
47553		A	Biliary endoscopy thru skin	6.31	NA	2.62	0.36	NA	9.29	000
47554		A	Biliary endoscopy thru skin	9.01	NA	3.41	0.89	NA	13.31	000
47555		A	Biliary endoscopy thru skin	7.52	NA	3.04	0.42	NA	10.98	000
47556		A	Biliary endoscopy thru skin	8.51	NA	3.35	0.46	NA	12.32	000
47560		A	Laparoscopy w/cholangio	4.86	NA	1.84	0.59	NA	7.29	000
47561		A	Laparo w/cholangio/biopsy	5.15	NA	2.15	0.59	NA	7.89	000
47562		A	Laparoscopic cholecystectomy	11.03	NA	5.06	1.35	NA	17.44	090
47563		A	Laparo cholecystectomy/graph	11.87	NA	5.37	1.45	NA	18.69	090
47564		A	Laparo cholecystectomy/explr	14.15	NA	6.03	1.73	NA	21.91	090
47570		A	Laparo cholecystoenterostomy	12.51	NA	5.45	1.53	NA	19.49	090
47579		C	Laparoscope proc, biliary	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47600		A	Removal of gallbladder	13.50	NA	6.25	1.39	NA	21.14	090
47605		A	Removal of gallbladder	14.61	NA	6.61	1.50	NA	22.72	090
47610		A	Removal of gallbladder	18.71	NA	8.07	1.93	NA	28.71	090
47612		A	Removal of gallbladder	18.67	NA	8.02	1.92	NA	28.61	090
47620		A	Removal of gallbladder	20.52	NA	8.66	2.12	NA	31.30	090
47630		A	Remove bile duct stone	9.06	NA	4.84	0.55	NA	14.45	090
47700		A	Exploration of bile ducts	15.53	NA	7.55	1.68	NA	24.76	090
47701		A	Bile duct revision	27.65	NA	11.71	3.60	NA	42.96	090
47711		A	Excision of bile duct tumor	22.90	NA	10.12	2.37	NA	35.39	090
47712		A	Excision of bile duct tumor	30.07	NA	12.65	3.20	NA	45.92	090
47715		A	Excision of bile duct cyst	18.69	NA	8.57	1.91	NA	29.17	090
47716		A	Fusion of bile duct cyst	16.35	NA	8.00	1.69	NA	26.04	090
47720		A	Fuse gallbladder & bowel	15.82	NA	7.61	1.64	NA	25.07	090
47721		A	Fuse upper gi structures	19.01	NA	8.72	1.95	NA	29.68	090
47740		A	Fuse gallbladder & bowel	18.37	NA	8.52	1.91	NA	28.80	090
47741		A	Fuse gallbladder & bowel	21.22	NA	9.45	2.18	NA	32.85	090
47760		A	Fuse bile ducts and bowel	25.70	NA	11.02	2.65	NA	39.37	090
47765		A	Fuse liver ducts & bowel	24.74	NA	11.02	2.61	NA	38.37	090
47780		A	Fuse bile ducts and bowel	26.35	NA	11.39	2.72	NA	40.46	090
47785		A	Fuse bile ducts and bowel	31.00	NA	13.16	3.22	NA	47.38	090
47800		A	Reconstruction of bile ducts	23.17	NA	10.23	2.34	NA	35.74	090
47801		A	Placement, bile duct support	15.08	NA	8.38	0.83	NA	24.29	090
47802		A	Fuse liver duct & intestine	21.43	NA	9.86	2.21	NA	33.50	090
47900		A	Suture bile duct injury	19.79	NA	9.02	1.98	NA	30.79	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	27.91	NA	11.68	1.58	NA	41.17	090
48001		A	Placement of drain, pancreas	35.25	NA	14.09	2.28	NA	51.62	090
48005		A	Resect/debride pancreas	41.93	NA	16.80	2.71	NA	61.44	090
48020		A	Removal of pancreatic stone	15.61	NA	7.43	1.63	NA	24.67	090
48100		A	Biopsy of pancreas, open	12.16	NA	5.71	1.29	NA	19.16	090
48102		A	Needle biopsy, pancreas	4.65	9.11	2.47	0.24	14.00	7.36	010
48120		A	Removal of pancreas lesion	15.76	NA	6.98	1.62	NA	24.36	090
48140		A	Partial removal of pancreas	22.81	NA	9.69	2.54	NA	35.04	090
48145		A	Partial removal of pancreas	23.88	NA	10.01	2.70	NA	36.59	090
48146		A	Pancreatectomy	26.25	NA	12.20	2.91	NA	41.36	090
48148		A	Removal of pancreatic duct	17.24	NA	7.76	1.93	NA	26.93	090
48150		A	Partial removal of pancreas	47.73	NA	19.86	5.31	NA	72.90	090
48152		A	Pancreatectomy	43.50	NA	18.53	4.88	NA	66.91	090
48153		A	Pancreatectomy	47.62	NA	19.96	5.27	NA	72.85	090
48154		A	Pancreatectomy	43.85	NA	18.59	4.91	NA	67.35	090
48155		A	Removal of pancreas	24.50	NA	11.96	2.76	NA	39.22	090
48160		N	Pancreas removal/transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48180		A	Fuse pancreas and bowel	24.58	NA	10.32	2.68	NA	37.58	090
48400		A	Injection, intraop add-on	1.94	NA	0.65	0.12	NA	2.71	ZZZ
48500		A	Surgery of pancreatic cyst	15.19	NA	7.48	1.62	NA	24.29	090
48510		A	Drain pancreatic pseudocyst	14.23	NA	7.60	1.28	NA	23.11	090
48511		A	Drain pancreatic pseudocyst	3.98	NA	1.33	0.20	NA	5.51	000
48520		A	Fuse pancreas cyst and bowel	15.50	NA	6.82	1.69	NA	24.01	090

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[2] Copyright 2003 American Dental Association. All rights reserved.
[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
48540	.....	A	Fuse pancreas cyst and bowel	19.61	NA	8.25	2.18	NA	30.04	090
48545	.....	A	Pancreatorrhaphy	18.08	NA	8.11	1.93	NA	28.12	090
48547	.....	A	Duodenal exclusion	25.68	NA	10.65	2.76	NA	39.09	090
48550	.....	X	Donor pancreatectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48554	.....	R	Transpl allograft pancreas	33.98	NA	17.51	3.96	NA	55.45	090
48556	.....	A	Removal, allograft pancreas	15.62	NA	8.38	1.82	NA	25.82	090
48999	.....	C	Pancreas surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49000	.....	A	Exploration of abdomen	11.61	NA	5.48	1.40	NA	18.49	090
49002	.....	A	Reopening of abdomen	10.43	NA	5.13	1.27	NA	16.83	090
49010	.....	A	Exploration behind abdomen	12.21	NA	5.99	1.46	NA	19.66	090
49020	.....	A	Drain abdominal abscess	22.71	NA	10.35	1.57	NA	34.63	090
49021	.....	A	Drain abdominal abscess	3.36	NA	1.12	0.19	NA	4.67	000
49040	.....	A	Drain, open, abdom abscess	13.44	NA	6.54	1.01	NA	20.99	090
49041	.....	A	Drain, percut, abdom abscess	3.98	NA	1.33	0.22	NA	5.53	000
49060	.....	A	Drain, open, retrop abscess	15.77	NA	7.55	0.92	NA	24.24	090
49061	.....	A	Drain, percut, retroper absc	3.68	NA	1.23	0.20	NA	5.11	000
49062	.....	A	Drain to peritoneal cavity	11.30	NA	5.54	1.29	NA	18.13	090
49080	.....	A	Puncture, peritoneal cavity	1.34	4.14	0.46	0.08	5.56	1.88	000
49081	.....	A	Removal of abdominal fluid	1.25	2.66	0.58	0.07	3.98	1.90	000
49085	.....	A	Remove abdomen foreign body	12.07	NA	5.61	1.05	NA	18.73	090
49180	.....	A	Biopsy, abdominal mass	1.72	3.34	0.58	0.10	5.16	2.40	000
49200	.....	A	Removal of abdominal lesion	10.19	NA	5.16	1.10	NA	16.45	090
49201	.....	A	Remove abdom lesion, complex	14.76	NA	7.26	1.76	NA	23.78	090
49215	.....	A	Excise sacral spine tumor	33.31	NA	14.24	2.97	NA	50.52	090
49220	.....	A	Multiple surgery, abdomen	14.80	NA	6.76	1.81	NA	23.37	090
49250	.....	A	Excision of umbilicus	8.30	NA	4.40	1.01	NA	13.71	090
49255	.....	A	Removal of omentum	11.08	NA	5.78	1.34	NA	18.20	090
49320	.....	A	Diag laparo separate proc	5.07	NA	2.69	0.60	NA	8.36	010
49321	.....	A	Laparoscopy, biopsy	5.37	NA	2.69	0.64	NA	8.70	010
49322	.....	A	Laparoscopy, aspiration	5.67	NA	3.03	0.68	NA	9.38	010
49323	.....	A	Laparo drain lymphocele	9.43	NA	4.57	1.05	NA	15.05	090
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	1.87	NA	0.79	0.13	NA	2.79	000
49419	.....	A	Insrt abdom cath for chemotx	6.61	NA	3.59	0.66	NA	10.86	090
49420	.....	A	Insert abdom drain, temp	2.21	NA	1 12	0.16	NA	3.49	000
49421	.....	A	Insert abdom drain, perm	5.51	NA	3.22	0.66	NA	9.39	090
49422	.....	A	Remove perm cannula/catheter	6.21	NA	2.94	0.76	NA	9.91	010
49423	.....	A	Exchange drainage catheter	1.45	NA	0.67	0.08	NA	2.20	000
49424	.....	A	Assess cyst, contrast inject	0.76	NA	0.45	0.04	NA	1.25	000
49425	.....	A	Insert abdomen-venous drain	11.31	NA	5.66	1.45	NA	18.42	090
49426	.....	A	Revise abdomen-venous shunt	9.58	NA	4.86	1.11	NA	15.55	090
49427	.....	A	Injection, abdominal shunt	0.88	NA	0.49	0.06	NA	1.43	000
49428	.....	A	Ligation of shunt	6.03	NA	3.31	0.37	NA	9.71	010
49429	.....	A	Removal of shunt	7.36	NA	3.44	0.97	NA	11.77	010
49491	.....	A	Rpr hern preemie reduc	11.07	NA	5.13	1.32	NA	17.52	090
49492	.....	A	Rpr ing hern premie, blocked	13.95	NA	6.21	1.76	NA	21.92	090
49495	.....	A	Rpr ing hernia baby, reduc	5.86	NA	3.02	0.70	NA	9.58	090
49496	.....	A	Rpr ing hernia baby, blocked	8.74	NA	4.41	1.10	NA	14.25	090
49500	.....	A	Rpr ing hernia, init, reduce	5.45	NA	3.19	0.55	NA	9.19	090
49501	.....	A	Rpr ing hernia, init blocked	8.83	NA	4.28	0.91	NA	14.02	090
49505	.....	A	Prp i/hern init reduc>5 yr	7.56	4.15	3.91	0.78	12.49	12.25	090
49507	.....	A	Prp i/hern init block>5 yr	9.52	NA	4.58	0.99	NA	15.09	090
49520	.....	A	Rerepair ing hernia, reduce	9.58	NA	4.53	1.01	NA	15.12	090
49521	.....	A	Rerepair ing hernia, blocked	11.90	NA	5.34	1.25	NA	18.49	090
49525	.....	A	Repair ing hernia, sliding	8.52	NA	4.18	0.89	NA	13.58	090
49540	.....	A	Repair lumbar hernia	10.33	NA	4.84	1.08	NA	16.25	090
49550	.....	A	Rpr fem hernia, init, reduce	8.58	NA	4.21	0.90	NA	13.69	090
49553	.....	A	Rpr fem hernia, init blocked	9.39	NA	4.51	0.99	NA	14.89	090
49555	.....	A	Rerepair fem hernia, reduce	8.98	NA	4.37	0.95	NA	14.30	090
49557	.....	A	Rerepair fem hernia, blocked	11.09	NA	5.09	1.16	NA	17.34	090
49560	.....	A	Rpr ventral hern init, reduc	11.50	NA	5.26	1.20	NA	17.96	090
49561	.....	A	Rpr ventral hern init, block	14.17	NA	6.17	1.47	NA	21.81	090
49565	.....	A	Rerepair ventrl hern, reduce	11.50	NA	5.33	1.20	NA	18.03	090
49566	.....	A	Rerepair ventrl hern, block	14.32	NA	6.24	1.49	NA	22.05	090
49568	.....	A	Hernia repair w/mesh	4.86	NA	1.70	0.60	NA	7.16	ZZZ
49570	.....	A	Rpr epigastric hern, reduce	5.66	NA	3.22	0.60	NA	9.48	090
49572	.....	A	Rpr epigastric hern, blocked	6.69	NA	3.54	0.70	NA	10.93	090
49580	.....	A	Rpr umbil hern, reduc < 5 yr	4.09	NA	2.68	0.41	NA	7.18	090
49582	.....	A	Rpr umbil hern, block < 5 yr	6.61	NA	3.57	0.68	NA	10.86	090
49585	.....	A	Rpr umbil hern, reduc > 5 yr	6.19	NA	3.38	0.64	NA	10.21	090
49587	.....	A	Rpr umbil hern, block > 5 yr	7.52	NA	3.82	0.78	NA	12.12	090
49590	.....	A	Repair spigilian hernia	8.49	NA	4.18	0.89	NA	13.56	090
49600	.....	A	Repair umbilical lesion	10.90	NA	5.42	1.35	NA	17.67	090
49605	.....	A	Repair umbilical lesion	75.57	NA	28.95	3.08	NA	107.60	090
49606	.....	A	Repair umbilical lesion	18.49	NA	7.82	2.66	NA	28.97	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
49610	.....	A	Repair umbilical lesion	10.44	NA	5.34	0.92	NA	16.70	090
49611	.....	A	Repair umbilical lesion	8.87	NA	6.56	0.78	NA	16.21	090
49650	.....	A	Laparo hernia repair initial	6.23	NA	3.26	0.77	NA	10.26	090
49651	.....	A	Laparo hernia repair recur	8.19	NA	4.13	1.01	NA	13.33	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	12.21	NA	6.34	1.47	NA	20.02	090
49904	.....	A	Omental flap, extra-abdom	19.89	NA	15.64	2.29	NA	37.82	090
49905	.....	A	Omental flap, intra-abdom	6.51	NA	2.31	0.73	NA	9.55	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	10.92	NA	5.48	0.95	NA	17.35	090
50020	.....	A	Renal abscess, open drain	14.58	NA	8.90	0.96	NA	24.44	090
50021	.....	A	Renal abscess, percut drain	3.36	NA	1.11	0.18	NA	4.65	000
50040	.....	A	Drainage of kidney	14.85	NA	8.51	0.98	NA	24.34	090
50045	.....	A	Exploration of kidney	15.37	NA	6.88	1.27	NA	23.52	090
50060	.....	A	Removal of kidney stone	19.19	NA	8.13	1.37	NA	28.69	090
50065	.....	A	Incision of kidney	20.67	NA	6.38	1.35	NA	28.40	090
50070	.....	A	Incision of kidney	20.20	NA	8.52	1.44	NA	30.16	090
50075	.....	A	Removal of kidney stone	25.20	NA	10.30	1.81	NA	37.31	090
50080	.....	A	Removal of kidney stone	14.63	NA	7.92	1.03	NA	23.58	090
50081	.....	A	Removal of kidney stone	21.68	NA	10.46	1.56	NA	33.70	090
50100	.....	A	Revise kidney blood vessels	16.00	NA	8.01	1.97	NA	25.98	090
50120	.....	A	Exploration of kidney	15.82	NA	7.06	1.25	NA	24.13	090
50125	.....	A	Explore and drain kidney	16.43	NA	7.21	1.28	NA	24.92	090
50130	.....	A	Removal of kidney stone	17.19	NA	7.46	1.25	NA	25.90	090
50135	.....	A	Exploration of kidney	19.07	NA	8.08	1.41	NA	28.56	090
50200	.....	A	Biopsy of kidney	2.62	NA	0.91	0.14	NA	3.67	000
50205	.....	A	Biopsy of kidney	11.25	NA	5.30	1.13	NA	17.68	090
50220	.....	A	Remove kidney, open	17.05	NA	7.52	1.39	NA	25.96	090
50225 ...	.....	A	Removal kidney open, complex	20.11	NA	8.45	1.51	NA	30.07	090
50230	.....	A	Removal kidney open, radical	21.94	NA	8.93	1.62	NA	32.49	090
50234	.....	A	Removal of kidney & ureter	22.27	NA	9.14	1.64	NA	33.05	090
50236	.....	A	Removal of kidney & ureter	24.72	NA	11.52	1.80	NA	38.04	090
50240	.....	A	Partial removal of kidney	21.87	NA	10.61	1.63	NA	34.11	090
50280	.....	A	Removal of kidney lesion	15.58	NA	6.97	1.19	NA	23.74	090
50290	.....	A	Removal of kidney lesion	14.65	NA	6.73	1.33	NA	22.71	090
50300	.....	X	Removal of donor kidney	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50320	.....	A	Removal of donor kidney	22.08	NA	10.07	2.13	NA	34.28	090
50340	.....	A	Removal of kidney	12.08	NA	7.00	1.38	NA	20.46	090
50360	.....	A	Transplantation of kidney	31.35	NA	15.95	3.56	NA	50.86	090
50365	.....	A	Transplantation of kidney	36.60	NA	18.88	4.21	NA	59.69	090
50370	.....	A	Remove transplanted kidney	13.64	NA	7.60	1.51	NA	22.75	090
50380	.....	A	Reimplantation of kidney	20.64	NA	13.46	2.16	NA	36.26	090
50390	.....	A	Drainage of kidney lesion	1.95	NA	0.64	0.11	NA	2.70	000
50392	.....	A	Insert kidney drain	3.36	NA	1.11	0.18	NA	4.65	000
50393	.....	A	Insert ureteral tube	4.14	NA	1.37	0.22	NA	5.73	000
50394	.....	A	Injection for kidney x-ray	0.76	2.53	0.25	0.05	3.34	1.06	000
50395	.....	A	Create passage to kidney	3.36	NA	1.11	0.19	NA	4.66	000
50396	.....	A	Measure kidney pressure	2.08	NA	0.86	0.12	NA	3.06	000
50398	.....	A	Change kidney tube	1.45	1.21	0.48	0.08	2.74	2.01	000
50400	.....	A	Revision of kidney/ureter	19.39	NA	7.81	1.45	NA	28.65	090
50405	.....	A	Revision of kidney/ureter	23.79	NA	10.53	1.74	NA	36.06	090
50500	.....	A	Repair of kidney wound	19.46	NA	8.84	1.74	NA	30.04	090
50520	.....	A	Close kidney-skin fistula	17.13	NA	8.84	1.51	NA	27.48	090
50525	.....	A	Repair renal-abdomen fistula	22.14	NA	10.28	1.81	NA	34.23	090
50526	.....	A	Repair renal-abdomen fistula	23.88	NA	10.99	1.94	NA	36.81	090
50540	.....	A	Revision of horseshoe kidney	19.82	NA	8.59	1.53	NA	29.94	090
50541	.....	A	Laparo ablate renal cyst	15.91	NA	6.49	1.19	NA	23.59	090
50542	.....	A	Laparo ablate renal mass	19.89	NA	8.23	1.63	NA	29.75	090
50543	.....	A	Laparo partial nephrectomy	25.35	NA	10.39	1.63	NA	37.37	090
50544	.....	A	Laparoscopy, pyeloplasty	22.27	NA	8.56	1.69	NA	32.52	090
50545	.....	A	Laparo radical nephrectomy	23.86	NA	9.22	1.83	NA	34.91	090
50546	.....	A	Laparoscopic nephrectomy	20.36	NA	8.39	1.64	NA	30.39	090
50547	.....	A	Laparo removal donor kidney	25.35	NA	10.56	2.45	NA	38.36	090
50548	.....	A	Laparo remove w/ ureter	24.26	NA	9.20	1.79	NA	35.25	090
50549	.....	C	Laparoscope proc, renal	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50551	.....	A	Kidney endoscopy	5.57	4.99	1.81	0.40	10.96	7.78	000
50553	.....	A	Kidney endoscopy	5.96	18.71	1.96	0.42	25.09	8.34	000
50555	.....	A	Kidney endoscopy & biopsy	6.49	19.36	2.13	0.46	26.31	9.08	000
50557	.....	A	Kidney endoscopy & treatment	6.58	20.15	2.14	0.47	27.20	9.19	000
50559	.....	A	Renal endoscopy/radiotracer	6.74	NA	2.21	0.32	NA	9.27	000
50561	.....	A	Kidney endoscopy & treatment	7.55	17.84	2.46	0.53	25.92	10.54	000
50562	.....	A	Renal scope w/tumor resect	10.86	NA	3.88	1.01	NA	15.75	090
50570	.....	A	Kidney endoscopy	9.49	NA	3.09	0.67	NA	13.25	000
50572	.....	A	Kidney endoscopy	10.29	NA	3.35	0.77	NA	14.41	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
50574	.....	A	Kidney endoscopy & biopsy	10.96	NA	3.58	0.78	NA	15.32	000
50575	.....	A	Kidney endoscopy	13.90	NA	4.52	1.01	NA	19.43	000
50576	.....	A	Kidney endoscopy & treatment	10.93	NA	3.54	0.79	NA	15.26	000
50578	.....	A	Renal endoscopy/radiotracer	11.29	NA	3.67	0.80	NA	15.76	000
50580	.....	A	Kidney endoscopy & treatment	11.79	NA	3.83	0.84	NA	16.46	000
50590	.....	A	Fragmenting of kidney stone	9.04	10.92	5.11	0.65	20.61	14.80	090
50600	.....	A	Exploration of ureter	15.75	NA	7.07	1.19	NA	24.01	090
50605	.....	A	Insert ureteral support	15.37	NA	7.09	1.35	NA	23.81	090
50610	.....	A	Removal of ureter stone	15.83	NA	7.32	1.29	NA	24.44	090
50620	.....	A	Removal of ureter stone	15.07	NA	6.69	1.09	NA	22.85	090
50630	.....	A	Removal of ureter stone	14.85	NA	6.63	1.08	NA	22.56	090
50650	.....	A	Removal of ureter	17.31	NA	7.59	1.28	NA	26.18	090
50660	.....	A	Removal of ureter	19.44	NA	8.33	1.43	NA	29.20	090
50684	.....	A	Injection for ureter x-ray	0.76	15.43	0.25	0.05	16.24	1.06	000
50686	.....	A	Measure ureter pressure	1.50	4.60	0.65	0.11	6.21	2.26	000
50688	.....	A	Change of ureter tube	1.16	NA	1.76	0.07	NA	2.99	010
50690	.....	A	Injection for ureter x-ray	1.15	15.92	0.38	0.07	17.14	1.60	000
50700	.....	A	Revision of ureter	15.12	NA	7.39	1.03	NA	23.54	090
50715	.....	A	Release of ureter	18.79	NA	9.28	2.01	NA	30.08	090
50722	.....	A	Release of ureter	16.26	NA	8.18	1.69	NA	26.13	090
50725	.....	A	Release/revise ureter	18.38	NA	8.41	1.73	NA	28.52	090
50727	.....	A	Revise ureter	8.13	NA	5.29	0.61	NA	14.03	090
50728	.....	A	Revise ureter	11.95	NA	6.82	1.05	NA	19.82	090
50740	.....	A	Fusion of ureter & kidney	18.32	NA	8.06	1.79	NA	28.17	090
50750	.....	A	Fusion of ureter & kidney	19.40	NA	8.36	1.49	NA	29.25	090
50760	.....	A	Fusion of ureters	18.32	NA	8.05	1.50	NA	27.87	090
50770	.....	A	Splicing of ureters	19.40	NA	8.35	1.50	NA	29.25	090
50780	.....	A	Reimplant ureter in bladder	18.26	NA	7.96	1.44	NA	27.66	090
50782	.....	A	Reimplant ureter in bladder	19.43	NA	9.73	1.35	NA	30.51	090
50783	.....	A	Reimplant ureter in bladder	20.43	NA	9.48	1.62	NA	31.53	090
50785	.....	A	Reimplant ureter in bladder	20.40	NA	8.68	1.56	NA	30.64	090
50800	.....	A	Implant ureter in bowel	14.44	NA	7.08	1.10	NA	22.62	090
50810	.....	A	Fusion of ureter & bowel	19.94	NA	9.70	2.13	NA	31.77	090
50815	.....	A	Urine shunt to intestine	19.82	NA	9.07	1.57	NA	30.46	090
50820	.....	A	Construct bowel bladder	21.77	NA	9.25	1.65	NA	32.67	090
50825	.....	A	Construct bowel bladder	28.02	NA	11.81	2.17	NA	42.00	090
50830	.....	A	Revise urine flow	31.10	NA	12.81	2.64	NA	46.55	090
50840	.....	A	Replace ureter by bowel	19.89	NA	9.03	1.51	NA	30.43	090
50845	.....	A	Appendico-vesicostomy	20.77	NA	8.99	1.51	NA	31.27	090
50860	.....	A	Transplant ureter to skin	15.27	NA	6.98	1.21	NA	23.46	090
50900	.....	A	Repair of ureter	13.54	NA	6.44	1.17	NA	21.15	090
50920	.....	A	Closure ureter/skin fistula	14.25	NA	6.87	1.01	NA	22.13	090
50930	.....	A	Closure ureter/bowel fistula	18.61	NA	8.30	1.88	NA	28.79	090
50940	.....	A	Release of ureter	14.43	NA	6.72	1.25	NA	22.40	090
50945	.....	A	Laparoscopy ureterolithotomy	16.90	NA	7.04	1.38	NA	25.32	090
50947	.....	A	Laparo new ureter/bladder	24.36	NA	9.76	2.39	NA	36.51	090
50948	.....	A	Laparo new ureter/bladder	22.37	NA	8.72	2.19	NA	33.28	090
50949	.....	C	Laparoscope proc, ureter	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50951	.....	A	Endoscopy of ureter	5.81	5.41	1.89	0.42	11.64	8.12	000
50953	.....	A	Endoscopy of ureter	6.20	18.72	2.02	0.44	25.36	8.66	000
50955	.....	A	Ureter endoscopy & biopsy	6.71	19.64	2.22	0.46	26.81	9.39	000
50957	.....	A	Ureter endoscopy & treatment	6.75	18.38	2.20	0.48	25.61	9.43	000
50959	.....	A	Ureter endoscopy & tracer	4.37	NA	1.39	0.22	NA	5.98	000
50961	.....	A	Ureter endoscopy & treatment	6.02	25.58	1.95	0.42	32.02	8.39	000
50970	.....	A	Ureter endoscopy	7.10	NA	2.32	0.52	NA	9.94	000
50972	.....	A	Ureter endoscopy & catheter	6.85	NA	2.28	0.47	NA	9.60	000
50974	.....	A	Ureter endoscopy & biopsy	9.12	NA	2.96	0.64	NA	12.72	000
50976	.....	A	Ureter endoscopy & treatment	8.99	NA	2.94	0.64	NA	12.57	000
50978	.....	A	Ureter endoscopy & tracer	5.07	NA	1.69	0.36	NA	7.12	000
50980	.....	A	Ureter endoscopy & treatment	6.81	NA	2.22	0.49	NA	9.52	000
51000	.....	A	Drainage of bladder	0.78	2.01	0.24	0.06	2.85	1.08	000
51005	.....	A	Drainage of bladder	1.01	4.88	0.34	0.10	5.99	1.45	000
51010	.....	A	Drainage of bladder	3.51	5.80	1.93	0.28	9.59	5.72	010
51020	.....	A	Incise & treat bladder	6.67	NA	4.04	0.50	NA	11.21	090
51030	.....	A	Incise & treat bladder	6.73	NA	4.14	0.50	NA	11.37	090
51040	.....	A	Incise & drain bladder	4.37	NA	2.92	0.32	NA	7.61	090
51045	.....	A	Incise bladder/drain ureter	6.73	NA	4.13	0.56	NA	11.42	090
51050	.....	A	Removal of bladder stone	6.88	NA	3.79	0.50	NA	11.17	090
51060	.....	A	Removal of ureter stone	8.80	NA	4.68	0.65	NA	14.13	090
51065	.....	A	Remove ureter calculus	8.80	NA	4.53	0.64	NA	13.97	090
51080	.....	A	Drainage of bladder abscess	5.93	NA	3.70	0.42	NA	10.05	090
51500	.....	A	Removal of bladder cyst	10.08	NA	5.14	1.05	NA	16.27	090
51520	.....	A	Removal of bladder lesion	9.24	NA	4.86	0.70	NA	14.80	090
51525	.....	A	Removal of bladder lesion	13.89	NA	6.32	1.02	NA	21.23	090
51530	.....	A	Removal of bladder lesion	12.31	NA	5.95	0.98	NA	19.24	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
51535		A	Repair of ureter lesion	12.50	NA	6.34	1.08	NA	19.92	090
51550		A	Partial removal of bladder	15.57	NA	6.94	1.26	NA	23.77	090
51555		A	Partial removal of bladder	21.11	NA	8.91	1.64	NA	31.66	090
51565		A	Revise bladder & ureter(s)	21.50	NA	9.23	1.68	NA	32.41	090
51570		A	Removal of bladder	24.10	NA	10.05	1.91	NA	36.06	090
51575		A	Removal of bladder & nodes	30.28	NA	12.38	2.25	NA	44.91	090
51580		A	Remove bladder/revise tract	30.90	NA	12.85	2.33	NA	46.08	090
51585		A	Removal of bladder & nodes	35.03	NA	14.08	2.61	NA	51.72	090
51590		A	Remove bladder/revise tract	32.47	NA	12.97	2.41	NA	47.85	090
51595		A	Remove bladder/revise tract	36.93	NA	14.51	2.67	NA	54.11	090
51596		A	Remove bladder/create pouch	39.29	NA	15.64	2.86	NA	57.79	090
51597		A	Removal of pelvic structures	38.13	NA	15.24	2.98	NA	56.35	090
51600		A	Injection for bladder x-ray	0.87	5.86	0.29	0.05	6.78	1.21	000
51605		A	Preparation for bladder xray	0.64	10.87	0.35	0.05	11.56	1.04	000
51610		A	Injection for bladder x-ray	1.04	1.75	0.62	0.06	2.85	1.72	000
51700		A	Irrigation of bladder	0.87	1.67	0.29	0.06	2.60	1.22	000
51701		A	Insert bladder catheter	0.50	1.66	0.19	0.04	2.20	0.73	000
51702		A	Insert temp bladder cath	0.50	2.36	0.26	0.04	2.90	0.80	000
51703		A	Insert bladder cath, complex	1.46	3.08	0.58	0.11	4.65	2.15	000
51705		A	Change of bladder tube	1.01	2.36	0.63	0.07	3.44	1.71	010
51710		A	Change of bladder tube	1.48	3.46	0.78	0.11	5.05	2.37	010
51715		A	Endoscopic injection/implant	3.72	4.04	1.37	0.29	8.05	5.38	000
51720		A	Treatment of bladder lesion	1.95	1.80	0.71	0.14	3.89	2.80	000
51725		A	Simple cystometrogram	1.50	5.83	NA	0.16	7.49	NA	000
51725	26	A	Simple cystometrogram	1.50	0.50	0.50	0.12	2.12	2.12	000
51725	TC	A	Simple cystometrogram	0.00	5.33	NA	0.04	5.37	NA	000
51726		A	Complex cystometrogram	1.70	7.91	NA	0.18	9.79	NA	000
51726	26	A	Complex cystometrogram	1.70	0.57	0.57	0.13	2.40	2.40	000
51726	TC	A	Complex cystometrogram	0.00	7.34	NA	0.05	7.39	NA	000
51736		A	Urine flow measurement	0.61	0.60	NA	0.06	1.27	NA	000
51736	26	A	Urine flow measurement	0.61	0.20	0.20	0.05	0.86	0.86	000
51736	TC	A	Urine flow measurement	0.00	0.40	NA	0.01	0.41	NA	000
51741		A	Electro-uroflowmetry, first	1.13	0.83	NA	0.10	2.06	NA	000
51741	26	A	Electro-uroflowmetry, first	1.13	0.38	0.38	0.08	1.59	1.59	000
51741	TC	A	Electro-uroflowmetry, first	0.00	0.45	NA	0.02	0.47	NA	000
51772		A	Urethra pressure profile	1.60	5.86	NA	0.19	7.65	NA	000
51772	26	A	Urethra pressure profile	1.60	0.56	0.56	0.14	2.30	2.30	000
51772	TC	A	Urethra pressure profile	0.00	5.30	NA	0.05	5.35	NA	000
51784		A	Anal/urinary muscle study	1.52	4.16	NA	0.16	5.84	NA	000
51784	26	A	Anal/urinary muscle study	1.52	0.51	0.51	0.12	2.15	2.15	000
51784	TC	A	Anal/urinary muscle study	0.00	3.65	NA	0.04	3.69	NA	000
51785		A	Anal/urinary muscle study	1.52	4.68	NA	0.15	6.35	NA	000
51785	26	A	Anal/urinary muscle study	1.52	0.51	0.51	0.11	2.14	2.14	000
51785	TC	A	Anal/urinary muscle study	0.00	4.17	NA	0.04	4.21	NA	000
51792		A	Urinary reflex study	1.09	6.06	NA	0.24	7.39	NA	000
51792	26	A	Urinary reflex study	1.09	0.42	0.42	0.11	1.62	1.62	000
51792	TC	A	Urinary reflex study	0.00	5.64	NA	0.13	5.77	NA	000
51795		A	Urine voiding pressure study	1.52	7.69	NA	0.22	9.43	NA	000
51795	26	A	Urine voiding pressure study	1.52	0.51	0.51	0.12	2.15	2.15	000
51795	TC	A	Urine voiding pressure study	0.00	7.18	NA	0.10	7.28	NA	000
51797		A	Intraabdominal pressure test	1.59	6.02	NA	0.17	7.78	NA	000
51797	26	A	Intraabdominal pressure test	1.59	0.54	0.54	0.12	2.25	2.25	000
51797	TC	A	Intraabdominal pressure test	0.00	5.48	NA	0.05	5.53	NA	000
51798		A	Us urine capacity measure	0.00	0.36	NA	0.08	0.44	NA	XXX
51800		A	Revision of bladder/urethra	17.32	NA	7.79	1.40	NA	26.51	090
51820		A	Revision of urinary tract	17.79	NA	8.58	1.74	NA	28.11	090
51840		A	Attach bladder/urethra	10.65	NA	5.65	1.04	NA	17.34	090
51841		A	Attach bladder/urethra	12.96	NA	6.46	1.25	NA	20.67	090
51845		A	Repair bladder neck	9.67	NA	4.93	0.74	NA	15.34	090
51860		A	Repair of bladder wound	11.95	NA	5.98	1.07	NA	19.00	090
51865		A	Repair of bladder wound	14.95	NA	6.91	1.21	NA	23.07	090
51880		A	Repair of bladder opening	7.62	NA	4.15	0.65	NA	12.42	090
51900		A	Repair bladder/vagina lesion	12.90	NA	6.30	1.04	NA	20.24	090
51920		A	Close bladder-uterus fistula	11.74	NA	5.82	1.03	NA	18.59	090
51925		A	Hysterectomy/bladder repair	15.49	NA	8.82	1.77	NA	26.08	090
51940		A	Correction of bladder defect	28.27	NA	12.51	2.36	NA	43.14	090
51960		A	Revision of bladder & bowel	22.88	NA	9.98	1.69	NA	34.55	090
51980		A	Construct bladder opening	11.30	NA	5.56	0.89	NA	17.75	090
51990		A	Laparo urethral suspension	12.43	NA	6.26	1.22	NA	19.91	090
51992		A	Laparo sling operation	13.93	NA	6.32	1.11	NA	21.36	090
52000		A	Cystoscopy	2.00	3.41	0.76	0.14	5.55	2.90	000
52001		A	Cystoscopy, removal of clots	5.42	5.22	1.89	0.38	11.02	7.69	000
52005		A	Cystoscopy & ureter catheter	2.36	6.01	0.90	0.18	8.55	3.44	000
52007		A	Cystoscopy and biopsy	3.00	NA	1.17	0.22	NA	4.39	000
52010		A	Cystoscopy & duct catheter	3.00	NA	1.15	0.22	NA	4.37	000

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[3] + Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
52204		A	Cystoscopy	2.36	3.67	0.92	0.18	6.21	3.46	000
52214		A	Cystoscopy and treatment	3.69	NA	1.35	0.26	NA	5.30	000
52224		A	Cystoscopy and treatment	3.12	NA	1.17	0.22	NA	4.51	000
52234		A	Cystoscopy and treatment	4.60	NA	1.65	0.32	NA	6.57	000
52235		A	Cystoscopy and treatment	5.42	NA	1.93	0.38	NA	7.73	000
52240		A	Cystoscopy and treatment	9.66	NA	3.33	0.70	NA	13.69	000
52250		A	Cystoscopy and radiotracer	4.47	NA	1.69	0.32	NA	6.48	000
52260		A	Cystoscopy and treatment	3.90	NA	1.45	0.28	NA	5.63	000
52265		A	Cystoscopy and treatment	2.92	3.79	1.13	0.22	6.93	4.27	000
52270		A	Cystoscopy & revise urethra	3.35	NA	1.26	0.24	NA	4.85	000
52275		A	Cystoscopy & revise urethra	4.67	NA	1.69	0.34	NA	6.70	000
52276		A	Cystoscopy and treatment	4.97	NA	1.81	0.36	NA	7.14	000
52277		A	Cystoscopy and treatment	6.13	NA	2.28	0.46	NA	8.87	000
52281		A	Cystoscopy and treatment	2.78	7.47	1.09	0.20	10.45	4.07	000
52282		A	Cystoscopy, implant stent	6.36	NA	2.26	0.46	NA	9.08	000
52283		A	Cystoscopy and treatment	3.72	4.06	1.41	0.26	8.04	5.39	000
52285		A	Cystoscopy and treatment	3.59	4.14	1.36	0.26	7.99	5.21	000
52290		A	Cystoscopy and treatment	4.56	NA	1.68	0.32	NA	6.56	000
52300		A	Cystoscopy and treatment	5.28	NA	1.93	0.38	NA	7.59	000
52301		A	Cystoscopy and treatment	5.48	NA	2.02	0.47	NA	7.97	000
52305		A	Cystoscopy and treatment	5.28	NA	1.88	0.37	NA	7.53	000
52310		A	Cystoscopy and treatment	2.79	3.56	1.04	0.20	6.55	4.03	000
52315		A	Cystoscopy and treatment	5.18	NA	1.86	0.37	NA	7.41	000
52317		A	Remove bladder stone	6.68	NA	2.31	0.48	NA	9.47	000
52318		A	Remove bladder stone	9.14	NA	3.14	0.65	NA	12.93	000
52320		A	Cystoscopy and treatment	4.67	NA	1.66	0.34	NA	6.67	000
52325		A	Cystoscopy, stone removal	6.12	NA	2.13	0.44	NA	8.69	000
52327		A	Cystoscopy, inject material	5.16	NA	1.85	0.38	NA	7.39	000
52330		A	Cystoscopy and treatment	5.01	NA	1.78	0.36	NA	7.15	000
52332		A	Cystoscopy and treatment	2.81	NA	1.07	0.20	NA	4.08	000
52334		A	Create passage to kidney	4.80	NA	1.78	0.34	NA	6.92	000
52341		A	Cysto w/ureter stricture tx	5.97	NA	2.24	0.44	NA	8.65	000
52342		A	Cysto w/up stricture tx	6.46	NA	2.38	0.48	NA	9.32	000
52343		A	Cysto w/renal stricture tx	7.16	NA	2.62	0.53	NA	10.31	000
52344		A	Cysto/uretero, stone remove	7.66	NA	2.84	0.56	NA	11.06	000
52345		A	Cysto/uretero w/up stricture	8.15	NA	3.00	0.60	NA	11.75	000
52346		A	Cystouretero w/renal strict	9.18	NA	3.32	0.68	NA	13.18	000
52347		A	Cystoscopy, resect ducts	5.25	NA	1.73	0.40	NA	7.38	000
52351		A	Cystouretero & or pyeloscope	5.83	NA	2.17	0.43	NA	8.43	000
52352		A	Cystouretero w/stone remove	6.84	NA	2.54	0.50	NA	9.88	000
52353		A	Cystouretero w/lithotripsy	7.92	NA	2.90	0.59	NA	11.41	000
52354		A	Cystouretero w/biopsy	7.30	NA	2.71	0.54	NA	10.55	000
52355		A	Cystouretero w/excise tumor	8.77	NA	3.19	0.66	NA	12.62	000
52400		A	Cystouretero w/congen repr	9.62	NA	3.83	0.72	NA	14.17	090
52450		A	Incision of prostate	7.60	NA	3.77	0.55	NA	11.92	090
52500		A	Revision of bladder neck	8.42	NA	4.02	0.60	NA	13.04	090
52510		A	Dilation prostatic urethra	6.68	NA	3.20	0.48	NA	10.36	090
52601		A	Prostatectomy (TURP)	12.30	NA	5.22	0.89	NA	18.41	090
52606		A	Control postop bleeding	8.08	NA	3.63	0.59	NA	12.30	090
52612		A	Prostatectomy, first stage	7.93	NA	3.83	0.58	NA	12.34	090
52614		A	Prostatectomy, second stage	6.80	NA	3.43	0.49	NA	10.72	090
52620		A	Remove residual prostate	6.57	NA	3.06	0.47	NA	10.10	090
52630		A	Remove prostate regrowth	7.22	NA	3.25	0.52	NA	10.99	090
52640		A	Relieve bladder contracture	6.58	NA	3.03	0.47	NA	10.08	090
52647		A	Laser surgery of prostate	10.30	77.33	4.63	0.73	88.36	15.66	090
52648		A	Laser surgery of prostate	11.15	NA	4.90	0.79	NA	16.84	090
52700		A	Drainage of prostate abscess	6.76	NA	3.25	0.49	NA	10.50	090
53000		A	Incision of urethra	2.27	NA	1.58	0.16	NA	4.01	010
53010		A	Incision of urethra	3.62	NA	3.07	0.24	NA	6.93	090
53020		A	Incision of urethra	1.76	3.12	0.68	0.13	5.01	2.57	000
53025		A	Incision of urethra	1.12	3.88	0.52	0.08	5.08	1.72	000
53040		A	Drainage of urethra abscess	6.36	11.42	6.38	0.49	18.27	13.23	090
53060		A	Drainage of urethra abscess	2.62	NA	1.48	0.28	NA	4.38	010
53080		A	Drainage of urinary leakage	6.25	NA	6.22	0.50	NA	12.97	090
53085		A	Drainage of urinary leakage	10.21	NA	7.71	0.80	NA	18.72	090
53200		A	Biopsy of urethra	2.58	4.35	0.99	0.20	7.13	3.77	000
53210		A	Removal of urethra	12.50	NA	6.11	0.97	NA	19.58	090
53215		A	Removal of urethra	15.49	NA	6.85	1.11	NA	23.45	090
53220		A	Treatment of urethra lesion	6.96	NA	3.92	0.53	NA	11.41	090
53230		A	Removal of urethra lesion	9.53	NA	4.89	0.72	NA	15.14	090
53235		A	Removal of urethra lesion	10.08	NA	5.09	0.72	NA	15.89	090
53240		A	Surgery for urethra pouch	6.41	NA	3.69	0.50	NA	10.60	090
53250		A	Removal of urethra gland	5.86	NA	3.43	0.42	NA	9.71	090
53260		A	Treatment of urethra lesion	2.96	3.32	1.83	0.28	6.56	5.07	010
53265		A	Treatment of urethra lesion	3.10	NA	1.86	0.24	NA	5.20	010

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
53270		A	Removal of urethra gland	3.07	NA	1.91	0.25	NA	5.23	010
53275		A	Repair of urethra defect	4.50	NA	2.30	0.34	NA	7.14	010
53400		A	Revise urethra, stage 1	12.70	NA	6.17	1.02	NA	19.89	090
53405		A	Revise urethra, stage 2	14.40	NA	6.53	1.09	NA	22.02	090
53410		A	Reconstruction of urethra	16.35	NA	7.29	1.19	NA	24.83	090
53415		A	Reconstruction of urethra	19.30	NA	7.58	1.39	NA	28.27	090
53420		A	Reconstruct urethra, stage 1	14.00	NA	6.55	1.08	NA	21.63	090
53425		A	Reconstruct urethra, stage 2	15.89	NA	7.12	1.16	NA	24.17	090
53430		A	Reconstruction of urethra	16.25	NA	7.23	1.21	NA	24.69	090
53431		A	Reconstruct urethra/bladder	19.78	NA	8.28	1.56	NA	29.62	090
53440		A	Male sling procedure	13.54	NA	6.11	0.87	NA	20.52	090
53442		A	Remove/revise male sling	11.50	NA	5.58	0.66	NA	17.74	090
53444		A	Insert tandem cuff	13.32	NA	5.98	1.05	NA	20.35	090
53445		A	Insert uro/ves nck sphincter	13.98	NA	7.34	1.01	NA	22.33	090
53446		A	Remove uro sphincter	10.17	NA	5.34	0.80	NA	16.31	090
53447		A	Remove/replace ur sphincter	13.41	NA	6.56	0.95	NA	20.92	090
53448		A	Remov/replc ur sphinctr comp	21.03	NA	9.23	1.67	NA	31.93	090
53449		A	Repair uro sphincter	9.64	NA	4.91	0.68	NA	15.23	090
53450		A	Revision of urethra	6.11	NA	3.45	0.44	NA	10.00	090
53460		A	Revision of urethra	7.08	NA	3.87	0.52	NA	11.47	090
53500		A	Urethrlys, transvag w/ scope	12.14	NA	6.27	0.89	NA	19.30	090
53502		A	Repair of urethra injury	7.59	NA	4.19	0.60	NA	12.38	090
53505		A	Repair of urethra injury	7.59	NA	4.04	0.55	NA	12.18	090
53510		A	Repair of urethra injury	10.05	NA	5.35	0.72	NA	16.12	090
53515		A	Repair of urethra injury	13.23	NA	6.12	0.99	NA	20.34	090
53520		A	Repair of urethra defect	8.63	NA	4.65	0.64	NA	13.92	090
53600		A	Dilate urethra stricture	1.20	1.19	0.45	0.08	2.47	1.73	000
53601		A	Dilate urethra stricture	0.97	1.32	0.39	0.07	2.36	1.43	000
53605		A	Dilate urethra stricture	1.27	NA	0.42	0.10	NA	1.79	000
53620		A	Dilate urethra stricture	1.61	2.06	0.62	0.12	3.79	2.35	000
53621		A	Dilate urethra stricture	1.34	2.14	0.51	0.10	3.58	1.95	000
53660		A	Dilation of urethra	0.71	1.36	0.33	0.05	2.12	1.09	000
53661		A	Dilation of urethra	0.72	1.36	0.31	0.05	2.13	1.08	000
53665		A	Dilation of urethra	0.76	NA	0.26	0.06	NA	1.08	000
53850		A	Prostatic microwave thermotx	9.40	99.30	4.37	0.67	109.37	14.44	090
53852		A	Prostatic rf thermotx	9.82	93.70	4.75	0.70	104.22	15.27	090
53853		A	Prostatic water thermother	5.21	58.09	3.23	0.32	63.62	8.76	090
53899		C	Urology surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
54000		A	Slitting of prepuce	1.53	NA	1.35	0.12	NA	3.00	010
54001		A	Slitting of prepuce	2.18	4.35	1.53	0.17	6.70	3.88	010
54015		A	Drain penis lesion	5.29	NA	2.61	0.40	NA	8.30	010
54050		A	Destruction, penis lesion(s)	1.23	1.71	1.06	0.08	3.02	2.37	010
54055		A	Destruction, penis lesion(s)	1.21	1.62	0.82	0.08	2.91	2.11	010
54056		A	Cryosurgery, penis lesion(s)	1.23	2.50	1.39	0.07	3.80	2.69	010
54057		A	Laser surg, penis lesion(s)	1.23	NA	0.88	0.10	NA	2.21	010
54060		A	Excision of penis lesion(s)	1.92	3.92	1.47	0.14	5.98	3.53	010
54065		A	Destruction, penis lesion(s)	2.41	NA	1.74	0.16	NA	4.31	010
54100		A	Biopsy of penis	1.89	2.90	0.83	0.12	4.91	2.84	000
54105		A	Biopsy of penis	3.48	NA	1.99	0.25	NA	5.72	010
54110		A	Treatment of penis lesion	10.07	NA	5.71	0.72	NA	16.50	090
54111		A	Treat penis lesion, graft	13.49	NA	6.77	0.95	NA	21.21	090
54112		A	Treat penis lesion, graft	15.77	NA	7.78	1.13	NA	24.68	090
54115		A	Treatment of penis lesion	6.11	8.61	4.52	0.47	15.19	11.10	090
54120		A	Partial removal of penis	9.91	NA	5.67	0.72	NA	16.30	090
54125		A	Removal of penis	13.45	NA	6.83	0.97	NA	21.25	090
54130		A	Remove penis & nodes	20.03	NA	9.20	1.43	NA	30.66	090
54135		A	Remove penis & nodes	26.21	NA	11.22	1.89	NA	39.32	090
54150		A	Circumcision	1.80	NA	0.99	0.20	NA	2.99	010
54152		A	Circumcision	2.30	NA	1.23	0.19	NA	3.72	010
54160		A	Circumcision	2.47	NA	1.12	0.19	NA	3.78	010
54161		A	Circumcision	3.25	NA	1.60	0.24	NA	5.09	010
54162		A	Lysis penil circumic lesion	2.98	NA	2.03	0.24	NA	5.25	010
54163		A	Repair of circumcision	2.98	NA	2.04	0.24	NA	5.26	010
54164		A	Frenulotomy of penis	2.49	NA	1.88	0.19	NA	4.56	010
54200		A	Treatment of penis lesion	1.05	1.87	1.02	0.07	2.99	2.14	010
54205		A	Treatment of penis lesion	7.88	NA	4.89	0.56	NA	13.33	090
54220		A	Treatment of penis lesion	2.41	3.98	0.97	0.18	6.57	3.56	000
54230		A	Prepare penis study	1.33	1.13	0.64	0.10	2.56	2.07	000
54231		A	Dynamic cavernosometry	2.03	1.42	0.88	0.17	3.62	3.08	000
54235		A	Penile injection	1.18	0.99	0.60	0.08	2.25	1.86	000
54240		A	Penis study	1.30	1.04	NA	0.16	2.50	NA	000
54240	26	A	Penis study	1.30	0.43	0.43	0.10	1.83	1.83	000
54240	TC	A	Penis study	0.00	0.61	NA	0.06	0.67	NA	000
54250		A	Penis study	2.21	0.93	NA	0.19	3.33	NA	000
54250	26	A	Penis study	2.21	0.71	0.71	0.17	3.09	3.09	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
54250	TC	A	Penis study	0.00	0.22	NA	0.02	0.24	NA	000
54300	.....	A	Revision of penis	10.35	NA	5.81	0.77	NA	16.93	090
54304	.....	A	Revision of penis	12.42	NA	6.62	0.89	NA	19.93	090
54308	.....	A	Reconstruction of urethra	11.76	NA	6.24	0.84	NA	18.84	090
54312	.....	A	Reconstruction of urethra	13.49	NA	7.28	0.97	NA	21.74	090
54316	.....	A	Reconstruction of urethra	16.72	NA	8.28	1.20	NA	26.20	090
54318	.....	A	Reconstruction of urethra	11.19	NA	6.06	1.38	NA	18.63	090
54322	.....	A	Reconstruction of urethra	12.94	NA	6.71	0.92	NA	20.57	090
54324	.....	A	Reconstruction of urethra	16.22	NA	8.31	1.23	NA	25.76	090
54326	.....	A	Reconstruction of urethra	15.63	NA	8.10	1.11	NA	24.84	090
54328	.....	A	Revise penis/urethra	15.56	NA	7.53	1.10	NA	24.19	090
54332	.....	A	Revise penis/urethra	16.98	NA	8.03	1.21	NA	26.22	090
54336	.....	A	Revise penis/urethra	19.93	NA	10.83	2.28	NA	33.04	090
54340	.....	A	Secondary urethral surgery	8.86	NA	5.32	0.86	NA	15.04	090
54344	.....	A	Secondary urethral surgery	15.85	NA	8.07	1.32	NA	25.24	090
54348	.....	A	Secondary urethral surgery	17.05	NA	8.71	1.22	NA	26.98	090
54352	.....	A	Reconstruct urethra/penis	24.60	NA	11.62	1.94	NA	38.16	090
54360	.....	A	Penis plastic surgery	11.86	NA	6.25	0.86	NA	18.97	090
54380	.....	A	Repair penis	13.10	NA	6.91	1.39	NA	21.40	090
54385	.....	A	Repair penis	15.30	NA	8.57	0.85	NA	24.72	090
54390	.....	A	Repair penis and bladder	21.49	NA	9.71	1.53	NA	32.73	090
54400	.....	A	Insert semi-rigid prosthesis	8.94	NA	4.52	0.64	NA	14.10	090
54401	.....	A	Insert self-contd prosthesis	10.22	NA	5.92	0.73	NA	16.87	090
54405	.....	A	Insert multi-comp penis pros	13.35	NA	6.13	0.96	NA	20.44	090
54406	.....	A	Remove muti-comp penis pros	12.03	NA	5.53	0.90	NA	18.46	090
54408	.....	A	Repair multi-comp penis pros	12.68	NA	5.84	0.95	NA	19.47	090
54410	.....	A	Remove/replace penis prosth	15.41	NA	6.75	1.15	NA	23.31	090
54411	.....	A	Remov/replc penis pros, comp	15.91	NA	7.17	0.96	NA	24.04	090
54415	.....	A	Remove self-contd penis pros	8.15	NA	4.29	0.65	NA	13.09	090
54416	.....	A	Remv/repl penis contain pros	10.81	NA	5.49	0.66	NA	16.96	090
54417	.....	A	Remv/replc penis pros, compl	14.11	NA	6.28	0.66	NA	21.05	090
54420	.....	A	Revision of penis	11.35	NA	5.78	0.86	NA	17.99	090
54430	.....	A	Revision of penis	10.09	NA	5.32	0.72	NA	16.13	090
54435	.....	A	Revision of penis	6.09	NA	3.78	0.43	NA	10.30	090
54440	.....	C	Repair of penis	0.00	0.00	0.00	0.00	0.00	0.00	090
54450	.....	A	Preputial stretching	1.11	1.12	0.48	0.08	2.31	1.67	000
54500	.....	A	Biopsy of testis	1.30	0.62	0.58	0.10	2.02	1.98	000
54505	.....	A	Biopsy of testis	3.44	NA	1.96	0.25	NA	5.65	010
54512	.....	A	Excise lesion testis	8.53	NA	4.21	0.67	NA	13.41	090
54520	.....	A	Removal of testis	5.20	NA	2.89	0.40	NA	8.49	090
54522	.....	A	Orchiectomy, partial	9.45	NA	4.97	0.74	NA	15.16	090
54530	.....	A	Removal of testis	8.53	NA	4.38	0.64	NA	13.55	090
54535	.....	A	Extensive testis surgery	12.09	NA	5.74	0.99	NA	18.82	090
54550	.....	A	Exploration for testis	7.74	NA	3.94	0.59	NA	12.27	090
54560	.....	A	Exploration for testis	11.07	NA	5.33	0.95	NA	17.35	090
54600	.....	A	Reduce testis torsion	6.97	NA	3.66	0.54	NA	11.17	090
54620	.....	A	Suspension of testis	4.87	NA	2.50	0.37	NA	7.74	010
54640	.....	A	Suspension of testis	6.86	NA	3.85	0.59	NA	11.30	090
54650	.....	A	Orchiopexy (Fowler-Stephens)	11.38	NA	5.60	0.97	NA	17.95	090
54660	.....	A	Revision of testis	5.08	NA	3.11	0.42	NA	8.61	090
54670	.....	A	Repair testis injury	6.37	NA	3.65	0.49	NA	10.51	090
54680	.....	A	Relocation of testis(es)	12.58	NA	6.36	1.13	NA	20.07	090
54690	.....	A	Laparoscopy, orchiectomy	10.90	NA	5.12	1.19	NA	17.21	090
54692	.....	A	Laparoscopy, orchiopexy	12.81	NA	5.52	1.04	NA	19.37	090
54699	.....	C	Laparoscope proc, testis	0.00	0.00	0.00	0.00	0.00	0.00	YYY
54700	.....	A	Drainage of scrotum	3.41	NA	1.97	0.28	NA	5.66	010
54800	.....	A	Biopsy of epididymis	2.32	0.95	0.91	0.17	3.44	3.40	000
54820	.....	A	Exploration of epididymis	5.11	NA	3.05	0.40	NA	8.56	090
54830	.....	A	Remove epididymis lesion	5.35	NA	3.13	0.41	NA	8.89	090
54840	.....	A	Remove epididymis lesion	5.17	NA	2.88	0.37	NA	8.42	090
54860	.....	A	Removal of epididymis	6.28	NA	3.42	0.46	NA	10.16	090
54861	.....	A	Removal of epididymis	8.85	NA	4.44	0.62	NA	13.91	090
54900	.....	A	Fusion of spermatic ducts	13.12	NA	5.93	1.61	NA	20.66	090
54901	.....	A	Fusion of spermatic ducts	17.84	NA	7.65	2.19	NA	27.68	090
55000	.....	A	Drainage of hydrocele	1.42	2.13	0.65	0.12	3.67	2.19	000
55040	.....	A	Removal of hydrocele	5.33	NA	3.00	0.42	NA	8.75	090
55041	.....	A	Removal of hydroceles	7.70	NA	4.09	0.60	NA	12.39	090
55060	.....	A	Repair of hydrocele	5.49	NA	3.17	0.44	NA	9.10	090
55100	.....	A	Drainage of scrotum abscess	2.12	3.81	1.61	0.18	6.11	3.91	010
55110	.....	A	Explore scrotum	5.67	NA	3.22	0.43	NA	9.32	090
55120	.....	A	Removal of scrotum lesion	5.06	5.81	3.03	0.40	11.27	8.49	090
55150	.....	A	Removal of scrotum	7.18	NA	4.01	0.56	NA	11.75	090
55175	.....	A	Revision of scrotum	5.21	NA	3.11	0.40	NA	8.72	090
55180	.....	A	Revision of scrotum	10.66	NA	5.53	0.86	NA	17.05	090
55200	.....	A	Incision of sperm duct	4.22	5.58	2.45	0.30	10.10	6.97	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
55250		A	Removal of sperm duct(s)	3.27	9.14	2.82	0.25	12.66	6.34	090
55300		A	Prepare, sperm duct x-ray	3.49	NA	1.33	0.24	NA	5.06	000
55400		A	Repair of sperm duct	8.44	NA	4.24	0.60	NA	13.28	090
55450		A	Ligation of sperm duct	4.10	7.26	1.91	0.29	11.65	6.30	010
55500		A	Removal of hydrocele	5.56	NA	3.19	0.52	NA	9.27	090
55520		A	Removal of sperm cord lesion	6.00	NA	3.34	0.67	NA	10.01	090
55530		A	Revise spermatic cord veins	5.63	NA	3.11	0.43	NA	9.17	090
55535		A	Revise spermatic cord veins	6.52	NA	3.50	0.50	NA	10.52	090
55540		A	Revise hernia & sperm veins	7.63	NA	3.90	0.89	NA	12.42	090
55550		A	Laparo ligate spermatic vein	6.53	NA	3.36	0.56	NA	10.45	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	6.34	NA	3.44	0.46	NA	10.24	090
55605		A	Incise sperm duct pouch	7.91	NA	4.42	0.65	NA	12.98	090
55650		A	Remove sperm duct pouch	11.73	NA	5.42	0.86	NA	18.01	090
55680		A	Remove sperm pouch lesion	5.16	NA	3.07	0.37	NA	8.60	090
55700		A	Biopsy of prostate	1.56	4.37	0.72	0.12	6.05	2.40	000
55705		A	Biopsy of prostate	4.54	NA	2.34	0.31	NA	7.19	010
55720		A	Drainage of prostate abscess	7.60	NA	4.00	0.53	NA	12.13	090
55725		A	Drainage of prostate abscess	8.63	NA	4.68	0.61	NA	13.92	090
55801		A	Removal of prostate	17.70	NA	7.47	1.29	NA	26.46	090
55810		A	Extensive prostate surgery	22.45	NA	8.82	1.62	NA	32.89	090
55812		A	Extensive prostate surgery	27.35	NA	11.27	2.03	NA	40.65	090
55815		A	Extensive prostate surgery	30.29	NA	12.20	2.21	NA	44.70	090
55821		A	Removal of prostate	14.17	NA	6.39	1.02	NA	21.58	090
55831		A	Removal of prostate	15.53	NA	6.85	1.13	NA	23.51	090
55840		A	Extensive prostate surgery	22.56	NA	9.55	1.64	NA	33.75	090
55842		A	Extensive prostate surgery	24.24	NA	10.11	1.77	NA	36.12	090
55845		A	Extensive prostate surgery	28.39	NA	11.22	2.05	NA	41.66	090
55859		A	Percut/needle insert, pros	12.45	NA	5.98	0.89	NA	19.32	090
55860		A	Surgical exposure, prostate	14.37	NA	6.52	0.98	NA	21.87	090
55862		A	Extensive prostate surgery	18.29	NA	8.07	1.37	NA	27.73	090
55865		A	Extensive prostate surgery	22.74	NA	9.49	1.64	NA	33.87	090
55866		A	Laparo radical prostatectomy	30.56	NA	11.95	1.64	NA	44.15	090
55870		A	Electroejaculation	2.57	1.58	1.10	0.17	4.32	3.84	000
55873		A	Cryoablate prostate	19.36	NA	9.12	1.22	NA	29.70	090
55899		C	Genital surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
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	1.43	1.36	1.17	0.17	2.96	2.77	010
56420		A	Drainage of gland abscess	1.38	2.34	1.10	0.16	3.88	2.64	010
56440		A	Surgery for vulva lesion	2.82	NA	1.74	0.34	NA	4.90	010
56441		A	Lysis of labial lesion(s)	1.96	1.86	1.45	0.20	4.02	3.61	010
56501		A	Destroy, vulva lesions, sim	1.52	1.83	1.29	0.18	3.53	2.99	010
56515		A	Destroy vulva lesion/s compl	2.74	2.60	1.87	0.22	5.56	4.83	010
56605		A	Biopsy of vulva/perineum	1.09	1.11	0.47	0.13	2.33	1.69	000
56606		A	Biopsy of vulva/perineum	0.55	0.51	0.22	0.07	1.13	0.84	ZZZ
56620		A	Partial removal of vulva	7.43	NA	5.06	0.91	NA	13.40	090
56625		A	Complete removal of vulva	8.35	NA	5.66	1.01	NA	15.02	090
56630		A	Extensive vulva surgery	12.29	NA	7.32	1.47	NA	21.08	090
56631		A	Extensive vulva surgery	16.11	NA	9.38	1.95	NA	27.44	090
56632		A	Extensive vulva surgery	20.17	NA	10.07	2.43	NA	32.67	090
56633		A	Extensive vulva surgery	16.38	NA	9.16	1.99	NA	27.53	090
56634		A	Extensive vulva surgery	17.78	NA	10.04	2.13	NA	29.95	090
56637		A	Extensive vulva surgery	21.84	NA	11.70	2.61	NA	36.15	090
56640		A	Extensive vulva surgery	22.04	NA	11.12	2.71	NA	35.87	090
56700		A	Partial removal of hymen	2.51	NA	1.77	0.29	NA	4.57	010
56720		A	Incision of hymen	0.68	NA	0.41	0.08	NA	1.17	000
56740		A	Remove vagina gland lesion	4.54	NA	2.51	0.44	NA	7.49	010
56800		A	Repair of vagina	3.87	NA	2.23	0.44	NA	6.54	010
56805		A	Repair clitoris	18.75	NA	9.55	2.18	NA	30.48	090
56810		A	Repair of perineum	4.11	NA	2.34	0.49	NA	6.94	010
56820		A	Exam of vulva w/scope	1.49	1.39	0.64	0.12	3.00	2.25	000
56821		A	Exam/biopsy of vulva w/scope	2.04	1.82	0.91	0.16	4.02	3.11	000
57000		A	Exploration of vagina	2.95	NA	1.77	0.34	NA	5.06	010
57010		A	Drainage of pelvic abscess	6.00	NA	3.93	0.68	NA	10.61	090
57020		A	Drainage of pelvic fluid	1.49	0.97	0.61	0.18	2.64	2.28	000
57022		A	I & d vaginal hematoma, pp	2.55	NA	1.54	0.29	NA	4.38	010
57023		A	I & d vag hematoma, non-ob	4.72	NA	2.64	0.29	NA	7.65	010
57061		A	Destroy vag lesions, simple	1.24	1.70	1.16	0.16	3.10	2.56	010
57065		A	Destroy vag lesions, complex	2.60	2.36	1.75	0.31	5.27	4.66	010
57100		A	Biopsy of vagina	1.19	1.13	0.49	0.12	2.44	1.80	000
57105		A	Biopsy of vagina	1.68	1.99	1.37	0.20	3.87	3.25	010
57106		A	Remove vagina wall, partial	6.32	NA	4.37	0.70	NA	11.39	090
57107		A	Remove vagina tissue, part	22.87	NA	10.76	2.60	NA	36.23	090
57109		A	Vaginectomy partial w/nodes	26.85	NA	11.55	2.36	NA	40.76	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
57110	.....	A	Remove vagina wall, complete	14.21	NA	7.44	1.71	NA	23.36	090
57111	.....	A	Remove vagina tissue, compl	26.85	NA	12.84	3.25	NA	42.94	090
57112	.....	A	Vaginectomy w/nodes, compl	28.83	NA	12.38	2.62	NA	43.83	090
57120	.....	A	Closure of vagina	7.37	NA	4.71	0.90	NA	12.98	090
57130	.....	A	Remove vagina lesion	2.42	2.22	1.59	0.28	4.92	4.29	010
57135	.....	A	Remove vagina lesion	2.65	2.31	1.69	0.31	5.27	4.65	010
57150	.....	A	Treat vagina infection	0.55	1.12	0.22	0.07	1.74	0.84	000
57155	.....	A	Insert uteri tandems/ovoids	6.23	NA	4.31	0.71	NA	11.25	090
57160	.....	A	Insert pessary/other device	0.88	1.11	0.40	0.11	2.10	1.39	000
57170	.....	A	Fitting of diaphragm/cap	0.90	1.52	0.34	0.11	2.53	1.35	000
57180	.....	A	Treat vaginal bleeding	1.57	2.26	1.35	0.19	4.02	3.11	010
57200	.....	A	Repair of vagina	3.92	NA	2.98	0.46	NA	7.36	090
57210	.....	A	Repair vagina/perineum	5.14	NA	3.51	0.60	NA	9.25	090
57220	.....	A	Revision of urethra	4.29	NA	3.19	0.50	NA	7.98	090
57230	.....	A	Repair of urethral lesion	5.61	NA	3.47	0.60	NA	9.68	090
57240	.....	A	Repair bladder & vagina	6.04	NA	3.90	0.64	NA	10.58	090
57250	.....	A	Repair rectum & vagina	5.50	NA	3.65	0.65	NA	9.80	090
57260	.....	A	Repair of vagina	8.22	NA	4.93	0.99	NA	14.14	090
57265	.....	A	Extensive repair of vagina	11.28	NA	6.16	1.37	NA	18.81	090
57268	.....	A	Repair of bowel bulge	6.72	NA	4.30	0.79	NA	11.81	090
57270	.....	A	Repair of bowel pouch	12.04	NA	6.39	1.40	NA	19.83	090
57280	.....	A	Suspension of vagina	14.95	NA	7.51	1.73	NA	24.19	090
57282	.....	A	Repair of vaginal prolapse	8.81	NA	5.41	1.03	NA	15.25	090
57284	.....	A	Repair paravaginal defect	12.63	NA	7.29	1.40	NA	21.32	090
57287	.....	A	Revise/remove sling repair	10.65	NA	5.60	0.89	NA	17.14	090
57288	.....	A	Repair bladder defect	12.95	NA	6.02	1.03	NA	20.00	090
57289	.....	A	Repair bladder & vagina	11.51	NA	6.16	1.14	NA	18.81	090
57291	.....	A	Construction of vagina	7.90	NA	5.04	0.93	NA	13.87	090
57292	.....	A	Construct vagina with graft	13.02	NA	7.11	1.55	NA	21.68	090
57300	.....	A	Repair rectum-vagina fistula	7.57	NA	4.37	0.84	NA	12.78	090
57305	.....	A	Repair rectum-vagina fistula	13.69	NA	6.37	1.59	NA	21.65	090
57307	.....	A	Fistula repair & colostomy	15.84	NA	7.14	1.91	NA	24.89	090
57308	.....	A	Fistula repair, transperine	9.88	NA	5.24	1.09	NA	16.21	090
57310	.....	A	Repair urethrovaginal lesion	6.74	NA	3.95	0.54	NA	11.23	090
57311	.....	A	Repair urethrovaginal lesion	7.93	NA	4.28	0.61	NA	12.82	090
57320	.....	A	Repair bladder-vagina lesion	7.96	NA	4.51	0.72	NA	13.19	090
57330	.....	A	Repair bladder-vagina lesion	12.28	NA	5.87	1.03	NA	19.18	090
57335	.....	A	Repair vagina	18.62	NA	9.31	1.99	NA	29.92	090
57400	.....	A	Dilation of vagina	2.26	NA	1.15	0.26	NA	3.67	000
57410	.....	A	Pelvic examination	1.74	2.05	0.90	0.17	3.96	2.81	000
57415	.....	A	Remove vaginal foreign body	2.16	NA	1.46	0.23	NA	3.85	010
57420	.....	A	Exam of vagina w/scope	1.59	1.43	0.68	0.12	3.14	2.39	000
57421	.....	A	Exam/biopsy of vag w/scope	2.19	1.92	0.97	0.16	4.27	3.32	000
57425	.....	A	Laparoscopy, surg, colpopexy	15.66	NA	6.76	1.73	NA	24.15	090
57452	.....	A	Exam of cervix w/scope	1.49	1.45	0.64	0.12	3.06	2.25	000
57454	.....	A	Bx/curett of cervix w/scope	2.32	1.80	1.01	0.16	4.28	3.49	000
57455	.....	A	Biopsy of cervix w/scope	1.98	1.80	0.88	0.16	3.94	3.02	000
57456	.....	A	Endocerv curettage w/scope	1.84	1.72	0.83	0.16	3.72	2.83	000
57460	.....	A	Bx of cervix w/scope, leep	2.81	6.18	1.23	0.34	9.33	4.38	000
57461	.....	A	Conz of cervix w/scope, leep	3.42	6.43	1.42	0.34	10.19	5.18	000
57500	.....	A	Biopsy of cervix	0.96	2.73	0.48	0.12	3.81	1.56	000
57505	.....	A	Endocervical curettage	1.13	1.51	1.13	0.14	2.78	2.40	010
57510	.....	A	Cautenzation of cervix	1.89	1.60	1.06	0.22	3.71	3.17	010
57511	.....	A	Cryocautery of cervix	1.89	1.87	1.41	0.22	3.98	3.52	010
57513	.....	A	Laser surgery of cervix	1.89	1.92	1.44	0.23	4.04	3.56	010
57520	.....	A	Conization of cervix	4.02	5.00	2.84	0.49	9.51	7.35	090
57522	.....	A	Conization of cervix	3.34	4.46	2.74	0.41	8.21	6.49	090
57530	.....	A	Removal of cervix	4.76	NA	3.52	0.58	NA	8.86	090
57531	.....	A	Removal of cervix, radical	27.84	NA	13.51	2.95	NA	44.30	090
57540	.....	A	Removal of residual cervix	12.15	NA	6.38	1.45	NA	19.98	090
57545	.....	A	Remove cervix/repair pelvis	12.96	NA	6.83	1.56	NA	21.35	090
57550	.....	A	Removal of residual cervix	5.50	NA	3.93	0.66	NA	10.09	090
57555	.....	A	Remove cervix/repair vagina	8.90	NA	5.23	1.07	NA	15.20	090
57556	.....	A	Remove cervix, repair bowel	8.32	NA	4.96	0.96	NA	14.24	090
57700	.....	A	Revision of cervix	3.53	NA	3.16	0.40	NA	7.09	090
57720	.....	A	Revision of cervix	4.11	NA	3.21	0.49	NA	7.81	090
57800	.....	A	Dilation of cervical canal	0.77	0.78	0.49	0.10	1.65	1.36	000
57820	.....	A	D & c of residual cervix	1.66	1.51	1.16	0.20	3.37	3.02	010
58100	.....	A	Biopsy of uterus lining	1.52	1.36	0.73	0.08	2.96	2.33	000
58120	.....	A	Dilation and curettage	3.25	2.35	1.91	0.40	6.00	5.56	010
58140	.....	A	Myomectomy abdom method	14.52	NA	7.22	1.75	NA	23.49	090
58145	.....	A	Myomectomy vag method	7.99	NA	4.91	0.96	NA	13.86	090
58146	.....	A	Myomectomy abdom complex	18.89	NA	8.89	1.75	NA	29.53	090
58150	.....	A	Total hysterectomy	15.15	NA	7.64	1.88	NA	24.67	090
58152	.....	A	Total hysterectomy	20.48	NA	10.02	1.82	NA	32.32	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
58180	.....	A	Partial hysterectomy	15.20	NA	7.61	1.85	NA	24.66	090
58200	.....	A	Extensive hysterectomy	21.47	NA	10.29	2.58	NA	34.34	090
58210	.....	A	Extensive hysterectomy	28.69	NA	13.63	3.49	NA	45.81	090
58240	.....	A	Removal of pelvis contents	38.17	NA	18.22	4.51	NA	60.90	090
58260	.....	A	Vaginal hysterectomy	12.91	NA	6.82	1.47	NA	21.20	090
58262	.....	A	Vag hyst including t/o	14.69	NA	7.51	1.70	NA	23.90	090
58263	.....	A	Vag hyst w/t/o & vag repair	15.97	NA	8.03	1.86	NA	25.86	090
58267	.....	A	Vag hyst w/urinary repair	16.94	NA	8.52	1.81	NA	27.27	090
58270	.....	A	Vag hyst w/enterocele repair	14.18	NA	7.19	1.64	NA	23.01	090
58275	.....	A	Hysterectomy/revise vagina	15.67	NA	7.91	1.81	NA	25.39	090
58280	.....	A	Hysterectomy/revise vagina	16.91	NA	8.40	1.85	NA	27.16	090
58285	.....	A	Extensive hysterectomy	22.13	NA	10.33	2.25	NA	34.71	090
58290	.....	A	Vag hyst complex	18.89	NA	9.01	1.47	NA	29.37	090
58291	.....	A	Vag hyst incl t/o, complex	20.67	NA	10.01	1.70	NA	32.38	090
58292	.....	A	Vag hyst t/o & repair, compl	21.95	NA	10.55	1.86	NA	34.36	090
58293	.....	A	Vag hyst w/uro repair, compl	22.93	NA	11.04	1.81	NA	35.78	090
58294	.....	A	Vag hyst w/enterocele, compl	20.16	NA	9.79	1.64	NA	31.59	090
58300	.....	N	Insert intrauterine device	+1.00	1.43	0.39	0.12	2.55	1.51	XXX
58301	.....	A	Remove intrauterine device	1.26	1.36	0.49	0.16	2.78	1.91	000
58321	.....	A	Artificial insemination	0.91	1.18	0.38	0.12	2.21	1.41	000
58322	.....	A	Artificial insemination	1.09	1.23	0.42	0.13	2.45	1.64	000
58323	.....	A	Sperm washing	0.23	0.24	0.10	0.02	0.49	0.35	000
58340	.....	A	Catheter for hysterography	0.87	6.20	0.65	0.10	7.17	1.62	000
58345	.....	A	Reopen fallopian tube	4.63	NA	2.46	0.43	NA	7.52	010
58346	.....	A	Insert heyman uteri capsule	6.71	NA	4.02	0.77	NA	11.50	090
58350	.....	A	Reopen fallopian tube	1.00	1.53	0.94	0.12	2.65	2.06	010
58353	.....	A	Endometr ablate, thermal	3.54	37.17	2.08	0.44	41.15	6.06	010
58400	.....	A	Suspension of uterus	6.32	NA	4.06	0.74	NA	11.12	090
58410	.....	A	Suspension of uterus	12.66	NA	6.57	1.31	NA	20.54	090
58520	.....	A	Repair of ruptured uterus	11.85	NA	6.12	1.40	NA	19.37	090
58540	.....	A	Revision of uterus	14.56	NA	7.07	1.53	NA	23.16	090
58545	.....	A	Laparoscopic myomectomy	14.52	NA	7.31	1.74	NA	23.57	090
58546	.....	A	Laparo-myomectomy, complex	18.89	NA	9.12	1.74	NA	29.75	090
58550	.....	A	Laparo-asst vag hysterectomy	14.11	NA	7.44	1.73	NA	23.28	090
58552	.....	A	Laparo-vag hyst incl t/o	14.11	NA	7.42	1.73	NA	23.26	090
58553	.....	A	Laparo-vag hyst, complex	18.89	NA	9.08	1.47	NA	29.44	090
58554	.....	A	Laparo-vag hyst w/t/o, compl	18.89	NA	9.38	1.47	NA	29.74	090
58555	.....	A	Hysteroscopy, dx, sep proc	3.31	2.13	1.48	0.41	5.85	5.20	000
58558	.....	A	Hysteroscopy, biopsy	4.72	NA	2.09	0.59	NA	7.40	000
58559	.....	A	Hysteroscopy, lysis	6.13	NA	2.65	0.74	NA	9.52	000
58560	.....	A	Hysteroscopy, resect septum	6.96	NA	3.01	0.85	NA	10.82	000
58561	.....	A	Hysteroscopy, remove myoma	9.94	NA	4.23	1.22	NA	15.39	000
58562	.....	A	Hysteroscopy, remove fb	5.18	NA	2.23	0.62	NA	8.03	000
58563	.....	A	Hysteroscopy, ablation	6.13	NA	2.67	0.74	NA	9.54	000
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	5.57	NA	3.41	0.47	NA	9.45	090
58605	.....	A	Division of fallopian tube	4.97	NA	3.20	0.40	NA	8.57	090
58611	.....	A	Ligate oviduct(s) add-on	1.44	NA	0.58	0.08	NA	2.10	ZZZ
58615	.....	A	Occlude fallopian tube(s)	3.88	NA	2.77	0.48	NA	7.13	010
58660	.....	A	Laparoscopy, lysis	11.23	NA	5.35	1.37	NA	17.95	090
58661	.....	A	Laparoscopy, remove adnexa	10.99	NA	5.22	1.34	NA	17.55	010
58662	.....	A	Laparoscopy, excise lesions	11.72	NA	5.88	1.41	NA	19.01	090
58670	.....	A	Laparoscopy, tubal cautery	5.57	NA	3.33	0.66	NA	9.56	090
58671	.....	A	Laparoscopy, tubal block	5.57	NA	3.34	0.67	NA	9.58	090
58672	.....	A	Laparoscopy, fimbrioplasty	12.81	NA	6.30	1.46	NA	20.57	090
58673	.....	A	Laparoscopy, salpingostomy	13.66	NA	6.71	1.68	NA	22.05	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	11.98	NA	6.09	0.77	NA	18.84	090
58720	.....	A	Removal of ovary/tube(s)	11.30	NA	5.91	1.37	NA	18.58	090
58740	.....	A	Revise fallopian tube(s)	13.92	NA	7.28	0.71	NA	21.91	090
58750	.....	A	Repair oviduct	14.76	NA	7.50	1.82	NA	24.08	090
58752	.....	A	Revise ovarian tube(s)	14.76	NA	7.16	1.81	NA	23.73	090
58760	.....	A	Remove tubal obstruction	13.06	NA	6.84	1.61	NA	21.51	090
58770	.....	A	Create new tubal opening	13.89	NA	7.06	1.70	NA	22.65	090
58800	.....	A	Drainage of ovarian cyst(s)	4.12	4.55	3.04	0.43	9.10	7.59	090
58805	.....	A	Drainage of ovarian cyst(s)	5.85	NA	3.59	0.67	NA	10.11	090
58820	.....	A	Drain ovary abscess, open	4.20	NA	3.38	0.35	NA	7.93	090
58822	.....	A	Drain ovary abscess, percut	10.07	NA	5.32	1.10	NA	16.49	090
58823	.....	A	Drain pelvic abscess, percut	3.36	NA	1.14	0.22	NA	4.72	000
58825	.....	A	Transposition, ovary(s)	10.92	NA	5.91	0.74	NA	17.57	090
58900	.....	A	Biopsy of ovary(s)	5.96	NA	3.67	0.67	NA	10.30	090
58920	.....	A	Partial removal of ovary(s)	11.30	NA	5.70	0.82	NA	17.82	090
58925	.....	A	Removal of ovarian cyst(s)	11.30	NA	5.79	1.37	NA	18.46	090
58940	.....	A	Removal of ovary(s)	7.25	NA	4.20	0.87	NA	12.32	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
58943		A	Removal of ovary(s)	18.32	NA	8.94	2.23	NA	29.49	090
58950		A	Resect ovarian malignancy	16.83	NA	8.77	1.86	NA	27.46	090
58951		A	Resect ovarian malignancy	22.25	NA	10.83	2.64	NA	35.72	090
58952		A	Resect ovarian malignancy	24.87	NA	12.21	3.08	NA	40.16	090
58953		A	Tah, rad dissect for debulk	31.82	NA	14.92	3.96	NA	50.70	090
58954		A	Tah rad debulk/lymph remove	34.80	NA	16.08	4.27	NA	55.15	090
58960		A	Exploration of abdomen	14.57	NA	7.68	1.76	NA	24.01	090
58970		A	Retrieval of oocyte	3.51	2.35	1.53	0.43	6.29	5.47	000
58974		C	Transfer of embryo	0.00	0.00	0.00	0.00	0.00	0.00	000
58976		A	Transfer of embryo	3.81	2.67	1.85	0.47	6.95	6.13	000
58999		C	Genital surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59000		A	Amniocentesis, diagnostic	1.29	2.14	0.69	0.28	3.71	2.26	000
59001		A	Amniocentesis, therapeutic	2.98	NA	1.43	0.28	NA	4.69	000
59012		A	Fetal cord puncture,prenatal	3.43	NA	1.58	0.74	NA	5.75	000
59015		A	Chorion biopsy	2.19	1.60	1.07	0.48	4.27	3.74	000
59020		A	Fetal contract stress test	0.66	0.79	NA	0.24	1.69	NA	000
59020	26	A	Fetal contract stress test	0.66	0.27	0.27	0.14	1.07	1.07	000
59020	TC	A	Fetal contract stress test	0.00	0.52	NA	0.10	0.62	NA	000
59025		A	Fetal non-stress test	0.53	0.44	NA	0.14	1.11	NA	000
59025	26	A	Fetal non-stress test	0.53	0.21	0.21	0.12	0.86	0.86	000
59025	TC	A	Fetal non-stress test	0.00	0.23	NA	0.02	0.25	NA	000
59030		A	Fetal scalp blood sample	1.98	NA	1.05	0.43	NA	3.46	000
59050		A	Fetal monitor w/report	0.88	NA	0.36	0.19	NA	1.43	XXX
59051		A	Fetal monitor/interpret only	0.74	NA	0.30	0.17	NA	1.21	XXX
59070		A	Transabdom amnioinfus w/ us	5.22	5.19	2.43	0.28	10.69	7.93	000
59072		A	Umbilical cord occlud w/ us	8.95	NA	3.17	0.67	NA	12.79	000
59074		A	Fetal fluid drainage w/ us	5.22	4.66	2.43	0.28	10.16	7.93	000
59076		A	Fetal shunt placement, w/ us	8.95	NA	3.17	0.67	NA	12.79	000
59100		A	Remove uterus lesion	12.28	NA	6.57	2.65	NA	21.50	090
59120		A	Treat ectopic pregnancy	11.42	NA	6.36	2.47	NA	20.25	090
59121		A	Treat ectopic pregnancy	11.60	NA	6.43	2.51	NA	20.54	090
59130		A	Treat ectopic pregnancy	14.14	NA	5.08	3.04	NA	22.26	090
59135		A	Treat ectopic pregnancy	13.80	NA	7.34	2.98	NA	24.12	090
59136		A	Treat ectopic pregnancy	13.10	NA	6.72	2.83	NA	22.65	090
59140		A	Treat ectopic pregnancy	5.43	5.29	3.65	1.17	11.89	10.25	090
59150		A	Treat ectopic pregnancy	11.60	NA	6.13	1.47	NA	19.20	090
59151		A	Treat ectopic pregnancy	11.42	NA	6.17	1.69	NA	19.28	090
59160		A	D & c after delivery	2.69	3.31	2.14	0.59	6.59	5.42	010
59200		A	Insert cervical dilator	0.79	1.24	0.31	0.18	2.21	1.28	000
59300		A	Episiotomy or vaginal repair	2.40	2.19	0.97	0.52	5.11	3.89	000
59320		A	Revision of cervix	2.47	NA	1.28	0.54	NA	4.29	000
59325		A	Revision of cervix	4.05	NA	1.94	0.87	NA	6.86	000
59350		A	Repair of uterus	4.92	NA	1.97	1.05	NA	7.94	000
59400		A	Obstetrical care	22.93	NA	15.73	4.96	NA	43.62	MMM
59409		A	Obstetrical care	13.42	NA	5.37	2.90	NA	21.69	MMM
59410		A	Obstetrical care	14.70	NA	6.40	3.18	NA	24.28	MMM
59412		A	Antepartum manipulation	1.70	NA	0.82	0.37	NA	2.89	MMM
59414		A	Deliver placenta	1.60	NA	0.64	0.35	NA	2.59	MMM
59425		A	Antepartum care only	4.78	4.34	1.88	1.03	10.15	7.69	MMM
59426		A	Antepartum care only	8.23	7.78	3.25	1.79	17.80	13.27	MMM
59430		A	Care after delivery	2.12	1.26	0.95	0.46	3.84	3.53	MMM
59510		A	Cesarean delivery	26.07	NA	17.69	5.63	NA	49.39	MMM
59514		A	Cesarean delivery only	15.88	NA	6.29	3.43	NA	25.60	MMM
59515		A	Cesarean delivery	17.27	NA	7.97	3.74	NA	28.98	MMM
59525		A	Remove uterus after cesarean	8.49	NA	3.34	1.83	NA	13.66	ZZZ
59610		A	Vbac delivery	24.48	NA	16.29	5.29	NA	46.06	MMM
59612		A	Vbac delivery only	14.97	NA	6.13	3.24	NA	24.34	MMM
59614		A	Vbac care after delivery	16.25	NA	7.04	3.51	NA	26.80	MMM
59618		A	Attempted vbac delivery	27.62	NA	18.81	5.97	NA	52.40	MMM
59620		A	Attempted vbac delivery only	17.43	NA	6.85	3.78	NA	28.06	MMM
59622		A	Attempted vbac after care	18.82	NA	8.77	4.06	NA	31.65	MMM
59812		A	Treatment of miscarriage	3.99	NA	2.60	0.70	NA	7.29	090
59820		A	Care of miscarriage	3.99	NA	3.59	0.86	NA	8.44	090
59821		A	Treatment of miscarriage	4.44	NA	3.51	0.96	NA	8.91	090
59830		A	Treat uterus infection	6.08	NA	4.08	1.32	NA	11.48	090
59840		R	Abortion	2.99	NA	2.16	0.65	NA	5.80	010
59841		R	Abortion	5.21	2.60	2.60	1.13	8.94	8.94	010
59850		R	Abortion	5.88	NA	3.30	1.27	NA	10.45	090
59851		R	Abortion	5.90	NA	3.79	1.27	NA	10.96	090
59852		R	Abortion	8.19	NA	5.40	1.77	NA	15.36	090
59855		R	Abortion	6.09	NA	3.62	1.32	NA	11.03	090
59856		R	Abortion	7.44	NA	4.12	1.61	NA	13.17	090
59857		R	Abortion	9.24	NA	4.63	1.99	NA	15.86	090
59866		R	Abortion (mpr)	3.98	NA	1.85	0.86	NA	6.69	000
59870		A	Evacuate mole of uterus	5.98	NA	4.51	0.92	NA	11.41	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
59871		A	Remove cerclage suture	2.12	1.79	1.15	0.46	4.37	3.73	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	1.75	2.20	2.07	0.17	4.12	3.99	010
60001		A	Aspirate/inject thyriod cyst	0.96	1.52	0.35	0.07	2.55	1.38	000
60100		A	Biopsy of thyroid	1.55	1.44	0.54	0.06	3.05	2.15	000
60200		A	Remove thyroid lesion	9.50	NA	6.18	1.01	NA	16.69	090
60210		A	Partial thyroid excision	10.82	NA	5.83	1.21	NA	17.86	090
60212		A	Partial thyroid excision	15.94	NA	7.88	1.81	NA	25.63	090
60220		A	Partial removal of thyroid	11.83	NA	6.35	1.16	NA	19.34	090
60225		A	Partial removal of thyroid	14.11	NA	7.62	1.57	NA	23.30	090
60240		A	Removal of thyroid	15.97	NA	7.82	1.80	NA	25.59	090
60252		A	Removal of thyroid	20.45	NA	10.39	1.95	NA	32.79	090
60254		A	Extensive thyroid surgery	26.84	NA	14.52	2.35	NA	43.71	090
60260		A	Repeat thyroid surgery	17.37	NA	8.93	1.67	NA	27.97	090
60270		A	Removal of thyroid	20.15	NA	10.57	2.13	NA	32.85	090
60271		A	Removal of thyroid	16.73	NA	8.82	1.62	NA	27.17	090
60280		A	Remove thyroid duct lesion	5.64	NA	4.88	0.54	NA	11.26	090
60281		A	Remove thyroid duct lesion	8.48	NA	6.05	0.80	NA	15.33	090
60500		A	Explore parathyroid glands	16.14	NA	7.60	1.93	NA	25.67	090
60502		A	Re-explore parathyroids	20.23	NA	9.58	2.40	NA	32.21	090
60505		A	Explore parathyroid glands	21.37	NA	11.08	2.57	NA	35.02	090
60512		A	Autotransplant parathyroid	4.42	NA	1.64	0.53	NA	6.59	ZZZ
60520		A	Removal of thymus gland	16.71	NA	8.28	2.21	NA	27.20	090
60521		A	Removal of thymus gland	18.76	NA	9.29	2.80	NA	30.85	090
60522		A	Removal of thymus gland	22.96	NA	11.00	3.39	NA	37.35	090
60540		A	Explore adrenal gland	16.93	NA	7.72	1.70	NA	26.35	090
60545		A	Explore adrenal gland	19.77	NA	8.68	2.10	NA	30.55	090
60600		A	Remove carotid body lesion	17.83	NA	10.90	2.24	NA	30.97	090
60605		A	Remove carotid body lesion	20.12	NA	12.83	2.73	NA	35.68	090
60650		A	Laparoscopy adrenalectomy	19.89	NA	8.08	2.37	NA	30.34	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
61000		A	Remove cranial cavity fluid	1.57	NA	0.97	0.16	NA	2.70	000
61001		A	Remove cranial cavity fluid	1.48	NA	1.08	0.18	NA	2.74	000
61020		A	Remove brain cavity fluid	1.50	NA	1.38	0.31	NA	3.19	000
61026		A	Injection into brain canal	1.68	NA	1.45	0.25	NA	3.38	000
61050		A	Remove brain canal fluid	1.50	NA	1.28	0.16	NA	2.94	000
61055		A	Injection into brain canal	2.09	NA	1.44	0.16	NA	3.69	000
61070		A	Brain canal shunt procedure	0.88	NA	1.05	0.11	NA	2.04	000
61105		A	Twist drill hole	5.11	NA	4.01	1.26	NA	10.38	090
61107		A	Drill skull for implantation	4.97	NA	3.36	1.22	NA	9.55	000
61108		A	Drill skull for drainage	10.13	NA	7.25	2.45	NA	19.83	090
61120		A	Burr hole for puncture	8.71	NA	6.09	2.17	NA	16.97	090
61140		A	Pierce skull for biopsy	15.81	NA	10.04	3.78	NA	29.63	090
61150		A	Pierce skull for drainage	17.47	NA	10.54	4.22	NA	32.23	090
61151		A	Pierce skull for drainage	12.35	NA	7.95	2.94	NA	23.24	090
61154		A	Pierce skull & remove clot	14.90	NA	9.64	3.66	NA	28.20	090
61156		A	Pierce skull for drainage	16.23	NA	9.98	4.10	NA	30.31	090
61210		A	Pierce skull, implant device	5.81	NA	3.76	1.39	NA	10.96	000
61215		A	Insert brain-fluid device	4.86	NA	4.08	1.19	NA	10.13	090
61250		A	Pierce skull & explore	10.36	NA	6.96	2.42	NA	19.74	090
61253		A	Pierce skull & explore	12.29	NA	7.84	2.71	NA	22.84	090
61304		A	Open skull for exploration	21.83	NA	13.04	5.19	NA	40.06	090
61305		A	Open skull for exploration	26.46	NA	15.56	6.29	NA	48.31	090
61312		A	Open skull for drainage	24.43	NA	15.27	5.98	NA	45.68	090
61313		A	Open skull for drainage	24.79	NA	15.04	6.08	NA	45.91	090
61314		A	Open skull for drainage	24.09	NA	13.26	4.79	NA	42.14	090
61315		A	Open skull for drainage	27.52	NA	16.26	6.74	NA	50.52	090
61316		A	Implt cran bone flap to abdo	1.38	NA	0.58	0.52	NA	2.48	ZZZ
61320		A	Open skull for drainage	25.47	NA	14.98	6.23	NA	46.68	090
61321		A	Open skull for drainage	28.34	NA	16.37	6.41	NA	51.12	090
61322		A	Decompressive craniotomy	29.33	NA	14.64	5.98	NA	49.95	090
61323		A	Decompressive lobectomy	30.82	NA	14.82	5.98	NA	51.62	090
61330		A	Decompress eye socket	23.19	NA	13.95	3.09	NA	40.23	090
61332		A	Explore/biopsy eye socket	27.12	NA	15.84	4.97	NA	47.93	090
61333		A	Explore orbit/remove lesion	27.79	NA	15.83	2.68	NA	46.30	090
61334		A	Explore orbit/remove object	18.17	NA	10.82	3.62	NA	32.61	090
61340		A	Subtemporal decompression	18.55	NA	11.30	4.39	NA	34.24	090
61343		A	Incise skull (press relief)	29.60	NA	17.09	7.24	NA	53.93	090
61345		A	Relieve cranial pressure	27.04	NA	15.66	6.27	NA	48.97	090
61440		A	Incise skull for surgery	26.48	NA	14.46	6.68	NA	47.62	090
61450		A	Incise skull for surgery	25.80	NA	14.53	6.12	NA	46.45	090
61458		A	Incise skull for brain wound	27.13	NA	15.77	6.33	NA	49.23	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
61460	.....	A	Incise skull for surgery	28.23	NA	16.68	6.15	NA	51.06	090
61470	.....	A	Incise skull for surgery	25.91	NA	14.08	5.57	NA	45.56	090
61480	.....	A	Incise skull for surgery	26.34	NA	15.53	6.64	NA	48.51	090
61490	.....	A	Incise skull for surgery	25.51	NA	14.57	6.44	NA	46.52	090
61500	.....	A	Removal of skull lesion	17.82	NA	10.99	3.91	NA	32.72	090
61501	.....	A	Remove infected skull bone	14.76	NA	9.37	3.15	NA	27.28	090
61510	.....	A	Removal of brain lesion	28.29	NA	16.97	6.92	NA	52.18	090
61512	.....	A	Remove brain lining lesion	34.89	NA	19.99	8.56	NA	63.44	090
61514	.....	A	Removal of brain abscess	25.12	NA	14.68	6.14	NA	45.94	090
61516	.....	A	Removal of brain lesion	24.47	NA	14.51	5.92	NA	44.90	090
61517	.....	A	Implt brain chemotx add-on	1.37	NA	0.57	0.10	NA	2.04	ZZZ
61518	.....	A	Removal of brain lesion	37.11	NA	21.45	9.03	NA	67.59	090
61519	.....	A	Remove brain lining lesion	41.15	NA	23.01	9.77	NA	73.93	090
61520	.....	A	Removal of brain lesion	54.53	NA	30.81	12.11	NA	97.45	090
61521	.....	A	Removal of brain lesion	44.23	NA	24.61	10.61	NA	79.45	090
61522	.....	A	Removal of brain abscess	29.28	NA	16.70	6.35	NA	52.33	090
61524	.....	A	Removal of brain lesion	27.70	NA	15.93	6.00	NA	49.63	090
61526	.....	A	Removal of brain lesion	51.87	NA	29.95	8.05	NA	89.87	090
61530	.....	A	Removal of brain lesion	43.61	NA	25.47	7.40	NA	76.48	090
61531	.....	A	Implant brain electrodes	14.55	NA	9.30	3.40	NA	27.25	090
61533	.....	A	Implant brain electrodes	19.60	NA	11.75	4.55	NA	35.90	090
61534	.....	A	Removal of brain lesion	20.85	NA	12.31	4.97	NA	38.13	090
61535	.....	A	Remove brain electrodes	11.56	NA	7.56	2.74	NA	21.86	090
61536	.....	A	Removal of brain lesion	35.32	NA	20.11	8.01	NA	63.44	090
61537	.....	A	Removal of brain tissue	24.86	NA	14.63	6.45	NA	45.94	090
61538	.....	A	Removal of brain tissue	26.66	NA	15.58	6.45	NA	48.69	090
61539	.....	A	Removal of brain tissue	31.90	NA	18.07	7.93	NA	57.90	090
61540	.....	A	Removal of brain tissue	29.83	NA	17.69	7.93	NA	55.45	090
61541	.....	A	Incision of brain tissue	28.69	NA	16.48	6.59	NA	51.76	090
61542	.....	A	Removal of brain tissue	30.84	NA	18.12	7.78	NA	56.74	090
61543	.....	A	Removal of brain tissue	29.05	NA	16.65	7.32	NA	53.02	090
61544	.....	A	Remove & treat brain lesion	25.35	NA	14.08	5.89	NA	45.32	090
61545	.....	A	Excision of brain tumor	43.55	NA	24.63	10.64	NA	78.82	090
61546	.....	A	Removal of pituitary gland	31.12	NA	17.79	7.26	NA	56.17	090
61548	.....	A	Removal of pituitary gland	21.41	NA	13.00	4.35	NA	38.76	090
61550	.....	A	Release of skull seams	14.57	NA	7.10	1.37	NA	23.04	090
61552	.....	A	Release of skull seams	19.45	NA	9.31	1.05	NA	29.81	090
61556	.....	A	Incise skull/sutures	22.13	NA	11.57	4.28	NA	37.98	090
61557	.....	A	Incise skull/sutures	22.25	NA	13.85	5.61	NA	41.71	090
61558	.....	A	Excision of skull/sutures	25.43	NA	14.43	3.13	NA	42.99	090
61559	.....	A	Excision of skull/sutures	32.60	NA	19.63	8.22	NA	60.45	090
61563	.....	A	Excision of skull tumor	26.68	NA	15.51	5.35	NA	47.54	090
61564	.....	A	Excision of skull tumor	33.64	NA	18.59	8.49	NA	60.72	090
61566	.....	A	Removal of brain tissue	30.82	NA	17.62	6.45	NA	54.89	090
61567	.....	A	Incision of brain tissue	35.30	NA	20.98	6.45	NA	62.73	090
61570	.....	A	Remove foreign body, brain	24.46	NA	14.15	5.51	NA	44.12	090
61571	.....	A	Incise skull for brain wound	26.24	NA	15.39	6.27	NA	47.90	090
61575	.....	A	Skull base/brainstem surgery	34.16	NA	19.96	6.02	NA	60.14	090
61576	.....	A	Skull base/brainstem surgery	52.13	NA	30.00	5.61	NA	87.74	090
61580	.....	A	Craniofacial approach, skull	30.18	NA	25.77	3.30	NA	59.25	090
61581	.....	A	Craniofacial approach, skull	34.40	NA	23.50	4.04	NA	61.94	090
61582	.....	A	Craniofacial approach, skull	31.48	NA	27.43	7.55	NA	66.46	090
61583	.....	A	Craniofacial approach, skull	36.00	NA	25.34	8.32	NA	69.66	090
61584	.....	A	Orbitocranial approach/skull	34.45	NA	24.75	7.83	NA	67.03	090
61585	.....	A	Orbitocranial approach/skull	38.39	NA	26.79	7.42	NA	72.60	090
61586	.....	A	Resect nasopharynx, skull	24.96	NA	22.67	4.22	NA	51.85	090
61590	.....	A	Infratemporal approach/skull	41.54	NA	29.15	5.13	NA	75.82	090
61591	.....	A	Infratemporal approach/skull	43.43	NA	30.09	6.30	NA	79.82	090
61592	.....	A	Orbitocranial approach/skull	39.41	NA	26.96	9.05	NA	75.42	090
61595	.....	A	Transtemporal approach/skull	29.40	NA	22.78	3.66	NA	55.84	090
61596	.....	A	Transcochlear approach/skull	35.43	NA	24.89	5.09	NA	65.41	090
61597	.....	A	Transcondylar approach/skull	37.74	NA	23.37	7.97	NA	69.08	090
61598	.....	A	Transpetrosal approach/skull	33.22	NA	23.66	5.51	NA	62.39	090
61600	.....	A	Resect/excise cranial lesion	25.70	NA	20.16	3.74	NA	49.60	090
61601	.....	A	Resect/excise cranial lesion	27.73	NA	20.86	6.34	NA	54.93	090
61605	.....	A	Resect/excise cranial lesion	29.16	NA	22.42	3.01	NA	54.59	090
61606	.....	A	Resect/excise cranial lesion	38.61	NA	25.55	8.16	NA	72.32	090
61607	.....	A	Resect/excise cranial lesion	36.06	NA	24.19	6.82	NA	67.07	090
61608	.....	A	Resect/excise cranial lesion	41.86	NA	27.02	9.96	NA	78.84	090
61609	.....	A	Transect artery, sinus	9.83	NA	4.92	2.48	NA	17.23	ZZZ
61610	.....	A	Transect artery, sinus	29.50	NA	13.33	4.22	NA	47.05	ZZZ
61611	.....	A	Transect artery, sinus	7.38	NA	3.87	1.86	NA	13.11	ZZZ
61612	.....	A	Transect artery, sinus	27.72	NA	13.50	4.26	NA	45.48	ZZZ
61613	.....	A	Remove aneurysm, sinus	40.63	NA	26.68	9.97	NA	77.28	090
61615	.....	A	Resect/excise lesion, skull	31.89	NA	23.11	5.56	NA	60.56	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
61616	.....	A	Resect/excise lesion, skull	43.08	NA	29.13	8.41	NA	80.62	090
61618	.....	A	Repair dura	16.89	NA	10.64	3.50	NA	31.03	090
61619	.....	A	Repair dura	20.59	NA	12.46	4.10	NA	37.15	090
61623	.....	A	Endovasc tempory vessel occl	9.90	NA	4.28	0.60	NA	14.78	000
61624	.....	A	Transcath occlusion, cns	20.04	NA	7.00	1.38	NA	28.42	000
61626	.....	A	Transcath occlusion, non-cns	16.53	NA	5.59	1.01	NA	23.13	000
61680	.....	A	Intracranial vessel surgery	30.53	NA	17.73	7.24	NA	55.50	090
61682	.....	A	Intracranial vessel surgery	61.22	NA	32.72	15.21	NA	109.15	090
61684	.....	A	Intracranial vessel surgery	39.58	NA	22.37	9.43	NA	71.38	090
61686	.....	A	Intracranial vessel surgery	64.12	NA	35.28	15.82	NA	115.22	090
61690	.....	A	Intracranial vessel surgery	29.14	NA	17.00	6.60	NA	52.74	090
61692	.....	A	Intracranial vessel surgery	51.57	NA	27.93	12.19	NA	91.69	090
61697	.....	A	Brain aneurysm repr, complx	50.23	NA	28.47	12.36	NA	91.06	090
61698	.....	A	Brain aneurysm repr, complx	48.13	NA	27.12	11.97	NA	87.22	090
61700	.....	A	Brain aneurysm repr, simple	50.23	NA	28.25	12.20	NA	90.68	090
61702	.....	A	Inner skull vessel surgery	48.13	NA	26.44	11.69	NA	86.26	090
61703	.....	A	Clamp neck artery	17.37	NA	10.66	4.34	NA	32.37	090
61705	.....	A	Revise circulation to head	35.99	NA	19.57	7.99	NA	63.55	090
61708	.....	A	Revise circulation to head	35.10	NA	15.35	2.61	NA	53.06	090
61710	.....	A	Revise circulation to head	29.50	NA	13.80	2.90	NA	46.20	090
61711	.....	A	Fusion of skull arteries	36.12	NA	20.14	8.86	NA	65.12	090
61720	.....	A	Incise skull/brain surgery	16.67	NA	10.15	4.21	NA	31.03	090
61735	.....	A	Incise skull/brain surgery	20.31	NA	12.37	4.99	NA	37.67	090
61750	.....	A	Incise skull/brain biopsy	18.10	NA	10.80	4.45	NA	33.35	090
61751	.....	A	Brain biopsy w/ct/mr guide	17.52	NA	11.01	4.28	NA	32.81	090
61760	.....	A	Implant brain electrodes	22.14	NA	8.91	5.50	NA	36.55	090
61770	.....	A	Incise skull for treatment	21.32	NA	12.45	4.90	NA	38.67	090
61790	.....	A	Treat trigeminal nerve	10.80	NA	6.05	2.18	NA	19.03	090
61791	.....	A	Treat trigeminal tract	14.53	NA	9.07	3.63	NA	27.23	090
61793	.....	A	Focus radiation beam	17.14	NA	10.29	4.21	NA	31.64	090
61795	.....	A	Brain surgery using computer	4.02	NA	2.06	0.97	NA	7.05	ZZZ
61850	.....	A	Implant neuroelectrodes	12.32	NA	7.81	2.67	NA	22.80	090
61860	.....	A	Implant neuroelectrodes	20.75	NA	12.27	4.84	NA	37.86	090
61862	.....	D	Implant neurostimul, subcort	0.00	0.00	0.00	0.00	0.00	0.00	090
61863	.....	A	Implant neuroelectrode	13.84	NA	9.34	4.76	NA	27.94	090
61864	.....	A	Implant neuroelectrde, addl	4.47	NA	2.31	1.13	NA	7.91	ZZZ
61867	.....	A	Implant neuroelectrode	22.83	NA	13.98	4.76	NA	41.57	090
61868	.....	A	Implant neuroelectrde, addl	7.87	NA	4.07	1.20	NA	13.14	ZZZ
61870	.....	A	Implant neuroelectrodes	14.85	NA	9.95	2.04	NA	26.84	090
61875	.....	A	Implant neuroelectrodes	14.97	NA	8.72	2.90	NA	26.59	090
61880	.....	A	Revise/remove neuroelectrode	6.25	NA	4.67	1.57	NA	12.49	090
61885	.....	A	Implant neurostim one array	5.82	NA	5.42	1.46	NA	12.70	090
61886	.....	A	Implant neurostim arrays	7.95	NA	6.47	1.97	NA	16.39	090
61888	.....	A	Revise/remove neuroreceiver	5.04	NA	3.94	1.25	NA	10.23	010
62000	.....	A	Treat skull fracture	12.46	NA	5.62	1.04	NA	19.12	090
62005	.....	A	Treat skull fracture	16.08	NA	8.95	2.79	NA	27.82	090
62010	.....	A	Treatment of head injury	19.70	NA	11.91	4.85	NA	36.46	090
62100	.....	A	Repair brain fluid leakage	21.90	NA	13.01	4.88	NA	39.79	090
62115	.....	A	Reduction of skull defect	21.54	NA	11.84	5.43	NA	38.81	090
62116	.....	A	Reduction of skull defect	23.46	NA	13.58	5.81	NA	42.85	090
62117	.....	A	Reduction of skull defect	26.45	NA	15.63	6.66	NA	48.74	090
62120	.....	A	Repair skull cavity lesion	23.22	NA	14.49	3.68	NA	41.39	090
62121	.....	A	Incise skull repair	21.46	NA	12.89	2.96	NA	37.31	090
62140	.....	A	Repair of skull defect	13.43	NA	8.47	3.12	NA	25.02	090
62141	.....	A	Repair of skull defect	14.83	NA	9.21	3.42	NA	27.46	090
62142	.....	A	Remove skull plate/flap	10.73	NA	7.12	2.52	NA	20.37	090
62143	.....	A	Replace skull plate/flap	12.98	NA	8.19	3.06	NA	24.23	090
62145	.....	A	Repair of skull & brain	18.71	NA	11.09	4.57	NA	34.37	090
62146	.....	A	Repair of skull with graft	16.03	NA	9.80	3.52	NA	29.35	090
62147	.....	A	Repair of skull with graft	19.23	NA	11.51	4.36	NA	35.10	090
62148	.....	A	Retr bone flap to fix skull	1.99	NA	0.83	0.52	NA	3.34	ZZZ
62160	.....	A	Neuroendoscopy add-on	2.98	NA	1.15	0.62	NA	4.75	ZZZ
62161	.....	A	Dissect brain w/scope	19.89	NA	9.66	4.43	NA	33.98	090
62162	.....	A	Remove colloid cyst w/scope	25.11	NA	11.82	6.92	NA	43.85	090
62163	.....	A	Neuroendoscopy w/fb removal	15.41	NA	7.93	4.43	NA	27.77	090
62164	.....	A	Remove brain tumor w/scope	27.34	NA	13.03	6.92	NA	47.29	090
62165	.....	A	Remove pituit tumor w/scope	21.87	NA	10.61	4.35	NA	36.83	090
62180	.....	A	Establish brain cavity shunt	20.94	NA	12.49	5.18	NA	38.61	090
62190	.....	A	Establish brain cavity shunt	11.01	NA	7.21	2.61	NA	20.83	090
62192	.....	A	Establish brain cavity shunt	12.18	NA	7.76	2.95	NA	22.89	090
62194	.....	A	Replace/irrigate catheter	5.00	NA	2.86	0.60	NA	8.46	010
62200	.....	A	Establish brain cavity shunt	18.22	NA	11.03	4.43	NA	33.68	090
62201	.....	A	Brain cavity shunt w/scope	14.78	NA	9.62	3.02	NA	27.42	090
62220	.....	A	Establish brain cavity shunt	12.93	NA	8.13	3.03	NA	24.09	090
62223	.....	A	Establish brain cavity shunt	12.80	NA	8.39	3.09	NA	24.28	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
62225		A	Replace/irrigate catheter	5.38	NA	4.18	1.31	NA	10.87	090
62230		A	Replace/revise brain shunt	10.48	NA	6.61	2.52	NA	19.61	090
62252		A	Csf shunt reprogram	0.74	1.47	NA	0.21	2.42	NA	XXX
62252	26	A	Csf shunt reprogram	0.74	0.38	0.38	0.19	1.31	1.31	XXX
62252	TC	A	Csf shunt reprogram	0.00	1.09	NA	0.02	1.11	NA	XXX
62256		A	Remove brain cavity shunt	6.56	NA	4.79	1.61	NA	12.96	090
62258		A	Replace brain cavity shunt	14.46	NA	8.86	3.49	NA	26.81	090
62263		A	Epidural lysis mult sessions	6.11	12.19	2.44	0.50	18.80	9.05	010
62264		A	Epidural lysis on single day	4.40	7.90	1.43	0.36	12.66	6.19	010
62268		A	Drain spinal cord cyst	4.71	10.72	2.20	0.35	15.78	7.26	000
62269		A	Needle biopsy, spinal cord	4.99	12.34	2.03	0.35	17.68	7.37	000
62270		A	Spinal fluid tap, diagnostic	1.12	3.06	0.50	0.07	4.25	1.69	000
62272		A	Drain cerebro spinal fluid	1.34	3.68	0.64	0.16	5.18	2.14	000
62273		A	Treat epidural spine lesion	2.14	2.81	0.59	0.17	5.12	2.90	000
62280		A	Treat spinal cord lesion	2.62	6.70	0.89	0.20	9.52	3.71	010
62281		A	Treat spinal cord lesion	2.64	5.86	0.78	0.19	8.69	3.61	010
62282		A	Treat spinal canal lesion	2.32	8.27	0.80	0.17	10.76	3.29	010
62284		A	Injection for myelogram	1.53	4.92	0.61	0.12	6.57	2.26	000
62287		A	Percutaneous diskectomy	8.03	NA	5.60	0.79	NA	14.42	090
62290		A	Inject for spine disk x-ray	2.98	6.87	1.30	0.24	10.09	4.52	000
62291		A	Inject for spine disk x-ray	2.89	5.75	1.15	0.20	8.84	4.24	000
62292		A	Injection into disk lesion	7.82	NA	4.57	0.78	NA	13.17	090
62294		A	Injection into spinal artery	11.76	NA	5.70	1.02	NA	13.48	090
62310		A	Inject spine c/t	1.90	4.93	0.52	0.13	6.96	2.55	000
62311		A	Inject spine l/s (cd)	1.53	5.01	0.46	0.11	6.55	2.10	000
62318		A	Inject spine w/cath, c/t	2.03	5.63	0.53	0.14	7.80	2.70	000
62319		A	Inject spine w/cath l/s (cd)	1.86	4.92	0.49	0.13	6.91	2.48	000
62350		A	Implant spinal canal cath	6.83	NA	4.09	0.77	NA	11.69	090
62351		A	Implant spinal canal cath	9.94	NA	7.19	2.15	NA	19.28	090
62355		A	Remove spinal canal catheter	5.42	NA	3.28	0.56	NA	9.26	090
62360		A	Insert spine infusion device	2.61	NA	2.80	0.25	NA	5.66	090
62361		A	Implant spine infusion pump	5.39	NA	4.00	0.60	NA	9.99	090
62362		A	Implant spine infusion pump	7.00	NA	4.49	1.03	NA	12.52	090
62365		A	Remove spine infusion device	5.39	NA	3.68	0.70	NA	9.77	090
62367		C	Analyze spine infusion pump	0.00	0.00	0.00	0.00	0.00	0.00	XXX
62367	26	A	Analyze spine infusion pump	0.48	0.13	0.13	0.04	0.65	0.65	XXX
62367	TC	C	Analyze spine infusion pump	0.00	0.00	0.00	0.00	0.00	0.00	XXX
62368		C	Analyze spine infusion pump	0.00	0.00	0.00	0.00	0.00	0.00	XXX
62368	26	A	Analyze spine infusion pump	0.75	0.19	0.19	0.06	1.00	1.00	XXX
62368	TC	C	Analyze spine infusion pump	0.00	0.00	0.00	0.00	0.00	0.00	XXX
63001		A	Removal of spinal lamina	15.73	NA	9.65	3.63	NA	29.01	090
63003		A	Removal of spinal lamina	15.86	NA	9.98	3.57	NA	29.41	090
63005		A	Removal of spinal lamina	14.83	NA	10.05	3.14	NA	28.02	090
63011		A	Removal of spinal lamina	14.44	NA	8.38	1.71	NA	24.53	090
63012		A	Removal of spinal lamina	15.31	NA	10.21	3.25	NA	28.77	090
63015		A	Removal of spinal lamina	19.24	NA	12.05	4.60	NA	35.89	090
63016		A	Removal of spinal lamina	19.09	NA	11.94	4.34	NA	35.37	090
63017		A	Removal of spinal lamina	15.85	NA	10.49	3.49	NA	29.83	090
63020		A	Neck spine disk surgery	14.73	NA	9.79	3.46	NA	27.98	090
63030		A	Low back disk surgery	11.93	NA	8.49	2.65	NA	23.07	090
63035		A	Spinal disk surgery add-on	3.13	NA	1.61	0.68	NA	5.42	ZZZ
63040		A	Laminotomy, single cervical	18.70	NA	11.64	4.03	NA	34.37	090
63042		A	Laminotomy, single lumbar	17.37	NA	11.44	3.73	NA	32.54	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	16.41	NA	10.49	3.82	NA	30.72	090
63046		A	Removal of spinal lamina	15.71	NA	10.29	3.46	NA	29.46	090
63047		A	Removal of spinal lamina	14.53	NA	9.96	3.13	NA	27.62	090
63048		A	Remove spinal lamina add-on	3.24	NA	1.69	0.70	NA	5.63	ZZZ
63055		A	Decompress spinal cord	21.86	NA	13.31	4.90	NA	40.07	090
63056		A	Decompress spinal cord	20.24	NA	12.69	4.00	NA	36.93	090
63057		A	Decompress spine cord add-on	5.23	NA	2.67	0.97	NA	8.87	ZZZ
63064		A	Decompress spinal cord	24.47	NA	14.62	5.66	NA	44.75	090
63066		A	Decompress spine cord add-on	3.24	NA	1.69	0.76	NA	5.69	ZZZ
63075		A	Neck spine disk surgery	19.30	NA	12.24	4.47	NA	36.01	090
63076		A	Neck spine disk surgery	4.03	NA	2.08	0.93	NA	7.04	ZZZ
63077		A	Spine disk surgery, thorax	21.32	NA	12.86	4.12	NA	38.30	090
63078		A	Spine disk surgery, thorax	3.26	NA	1.66	0.60	NA	5.52	ZZZ
63081		A	Removal of vertebral body	23.59	NA	14.50	5.35	NA	43.44	090
63082		A	Remove vertebral body add-on	4.35	NA	2.25	0.98	NA	7.58	ZZZ
63085		A	Removal of vertebral body	26.77	NA	15.58	5.63	NA	47.98	090
63086		A	Remove vertebral body add-on	3.17	NA	1.61	0.66	NA	5.44	ZZZ
63087		A	Removal of vertebral body	35.37	NA	19.63	7.04	NA	62.04	090
63088		A	Remove vertebral body add-on	4.31	NA	2.20	0.92	NA	7.43	ZZZ
63090		A	Removal of vertebral body	28.00	NA	16.14	5.12	NA	49.26	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
63091	.....	A	Remove vertebral body add-on	3.01	NA	1.47	0.54	NA	5.02	ZZZ
63101	.....	A	Removal of vertebral body	31.82	NA	19.57	5.66	NA	57.05	090
63102	.....	A	Removal of vertebral body	31.82	NA	19.57	5.66	NA	57.05	090
63103	.....	A	Remove vertebral body add-on	3.88	NA	2.03	0.76	NA	6.67	ZZZ
63170	.....	A	Incise spinal cord tract(s)	19.72	NA	12.22	4.66	NA	36.60	090
63172	.....	A	Drainage of spinal cyst	17.56	NA	10.99	4.15	NA	32.70	090
63173	.....	A	Drainage of spinal cyst	21.86	NA	13.19	4.96	NA	40.01	090
63180	.....	A	Revise spinal cord ligaments	18.17	NA	11.35	4.59	NA	34.11	090
63182	.....	A	Revise spinal cord ligaments	20.38	NA	11.31	4.17	NA	35.86	090
63185	.....	A	Incise spinal column/nerves	14.95	NA	8.38	2.49	NA	25.82	090
63190	.....	A	Incise spinal column/nerves	17.35	NA	10.45	3.45	NA	31.25	090
63191	.....	A	Incise spinal column/nerves	17.44	NA	10.84	4.20	NA	32.48	090
63194	.....	A	Incise spinal column & cord	19.08	NA	12.05	4.81	NA	35.94	090
63195	.....	A	Incise spinal column & cord	18.73	NA	11.36	4.12	NA	34.21	090
63196	.....	A	Incise spinal column & cord	22.17	NA	13.74	5.59	NA	41.50	090
63197	.....	A	Incise spinal column & cord	20.99	NA	12.55	5.30	NA	38.84	090
63198	.....	A	Incise spinal column & cord	25.24	NA	8.77	6.36	NA	40.37	090
63199	.....	A	Incise spinal column & cord	26.74	NA	15.42	6.74	NA	48.90	090
63200	.....	A	Release of spinal cord	19.07	NA	11.62	4.33	NA	35.02	090
63250	.....	A	Revise spinal cord vessels	40.53	NA	20.27	9.17	NA	69.97	090
63251	.....	A	Revise spinal cord vessels	40.97	NA	22.95	9.56	NA	73.48	090
63252	.....	A	Revise spinal cord vessels	40.96	NA	22.59	9.29	NA	72.84	090
63265	.....	A	Excise intraspinal lesion	21.44	NA	12.97	5.14	NA	39.55	090
63266	.....	A	Excise intraspinal lesion	22.17	NA	13.39	5.36	NA	40.92	090
63267	.....	A	Excise intraspinal lesion	17.85	NA	11.23	4.20	NA	33.28	090
63268	.....	A	Excise intraspinal lesion	18.41	NA	10.56	3.81	NA	32.78	090
63270	.....	A	Excise intraspinal lesion	26.65	NA	15.71	6.48	NA	48.84	090
63271	.....	A	Excise intraspinal lesion	26.77	NA	15.82	6.66	NA	49.25	090
63272	.....	A	Excise intraspinal lesion	25.18	NA	14.91	6.08	NA	46.17	090
63273	.....	A	Excise intraspinal lesion	24.15	NA	14.56	6.09	NA	44.80	090
63275	.....	A	Biopsy/excise spinal tumor	23.55	NA	13.99	5.61	NA	43.15	090
63276	.....	A	Biopsy/excise spinal tumor	23.32	NA	13.88	5.55	NA	42.75	090
63277	.....	A	Biopsy/excise spinal tumor	20.71	NA	12.69	4.83	NA	38.23	090
63278	.....	A	Biopsy/excise spinal tumor	20.44	NA	12.55	4.82	NA	37.81	090
63280	.....	A	Biopsy/excise spinal tumor	28.19	NA	16.57	6.95	NA	51.71	090
63281	.....	A	Biopsy/excise spinal tumor	27.89	NA	16.42	6.80	NA	51.11	090
63282	.....	A	Biopsy/excise spinal tumor	26.24	NA	15.57	6.39	NA	48.20	090
63283	.....	A	Biopsy/excise spinal tumor	24.86	NA	14.89	6.14	NA	45.89	090
63285	.....	A	Biopsy/excise spinal tumor	35.79	NA	20.26	8.76	NA	64.81	090
63286	.....	A	Biopsy/excise spinal tumor	35.43	NA	20.21	8.47	NA	64.11	090
63287	.....	A	Biopsy/excise spinal tumor	36.49	NA	20.77	8.97	NA	66.23	090
63290	.....	A	Biopsy/excise spinal tumor	37.17	NA	20.91	9.17	NA	67.25	090
63300	.....	A	Removal of vertebral body	24.29	NA	14.51	5.73	NA	44.53	090
63301	.....	A	Removal of vertebral body	27.44	NA	15.71	6.03	NA	49.18	090
63302	.....	A	Removal of vertebral body	27.65	NA	16.03	6.29	NA	49.97	090
63303	.....	A	Removal of vertebral body	30.33	NA	17.11	6.24	NA	53.68	090
63304	.....	A	Removal of vertebral body	30.16	NA	17.54	5.66	NA	53.36	090
63305	.....	A	Removal of vertebral body	31.85	NA	18.18	6.46	NA	56.49	090
63306	.....	A	Removal of vertebral body	32.04	NA	18.00	2.86	NA	52.90	090
63307	.....	A	Removal of vertebral body	31.45	NA	17.00	5.07	NA	53.52	090
63308	.....	A	Remove vertebral body add-on	5.22	NA	2.64	1.21	NA	9.07	ZZZ
63600	.....	A	Remove spinal cord lesion	13.94	NA	5.54	1.46	NA	20.94	090
63610	.....	A	Stimulation of spinal cord	8.68	56.38	2.33	0.52	65.58	11.53	000
63615	.....	A	Remove lesion of spinal cord	16.19	NA	9.35	3.42	NA	28.96	090
63650	.....	A	Implant neuroelectrodes	6.70	NA	3.30	0.58	NA	10.58	090
63655	.....	A	Implant neuroelectrodes	10.23	NA	7.00	2.22	NA	19.45	090
63660	.....	A	Revise/remove neuroelectrode	6.12	NA	3.71	0.78	NA	10.61	090
63685	.....	A	Implant neuroreceiver	7.00	NA	4.25	1.15	NA	12.40	090
63688	.....	A	Revise/remove neuroreceiver	5.36	NA	3.64	0.84	NA	9.84	090
63700	.....	A	Repair of spinal herniation	16.44	NA	10.40	3.22	NA	30.06	090
63702	.....	A	Repair of spinal herniation	18.37	NA	10.94	1.63	NA	30.94	090
63704	.....	A	Repair of spinal herniation	21.06	NA	13.05	4.60	NA	38.71	090
63706	.....	A	Repair of spinal herniation	23.97	NA	13.83	5.67	NA	43.47	090
63707	.....	A	Repair spinal fluid leakage	11.20	NA	7.78	2.35	NA	21.33	090
63709	.....	A	Repair spinal fluid leakage	14.24	NA	9.48	2.98	NA	26.70	090
63710	.....	A	Graft repair of spine defect	13.99	NA	9.16	3.13	NA	26.28	090
63740	.....	A	Install spinal shunt	11.30	NA	7.48	2.58	NA	21.36	090
63741	.....	A	Install spinal shunt	8.20	NA	4.86	1.26	NA	14.32	090
63744	.....	A	Revision of spinal shunt	8.05	NA	5.36	1.81	NA	15.22	090
63746	.....	A	Removal of spinal shunt	6.39	NA	3.88	1.38	NA	11.65	090
64400	.....	A	N block inj, trigeminal	1.10	2.04	0.37	0.07	3.21	1.54	000
64402	.....	A	N block inj, facial	1.24	1.77	0.54	0.08	3.09	1.86	000
64405	.....	A	N block inj, occipital	1.31	1.55	0.40	0.10	2.96	1.81	000
64408	.....	A	N block inj, vagus	1.40	1.60	0.66	0.11	3.11	2.17	000
64410	.....	A	N block inj, phrenic	1.42	2.64	0.41	0.10	4.16	1.93	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
64412	.....	A	N block inj, spinal accessor	1.17	2.78	0.37	0.10	4.05	1.64	000
64413	.....	A	N block inj, cervical plexus	1.39	1.93	0.45	0.11	3.43	1.95	000
64415	.....	A	N block inj, brachial plexus	1.47	2.91	0.40	0.10	4.48	1.97	000
64416	.....	A	N block cont infuse, b plex	3.48	NA	0.72	0.10	NA	4.30	010
64417	.....	A	N block inj, axillary	1.43	3.16	0.44	0.11	4.70	1.98	000
64418	.....	A	N block inj, suprascapular	1.31	2.72	0.38	0.08	4.11	1.77	000
64420	.....	A	N block inj, intercost, sng	1.17	3.58	0.36	0.08	4.83	1.61	000
64421	.....	A	N block inj, intercost, mlt	1.67	5.45	0.47	0.12	7.24	2.26	000
64425	.....	A	N block inj ilio-ing/hypogi	1.74	1.74	0.49	0.13	3.61	2.36	000
64430	.....	A	N block inj, pudendal	1.45	2.63	0.51	0.13	4.21	2.09	000
64435	.....	A	N block inj, paracervical	1.44	2.64	0.64	0.18	4.26	2.26	000
64445	.....	A	N block inj, sciatic, sng	1.47	2.75	0.39	0.10	4.32	1.96	000
64446	.....	A	N blk inj, sciatic, cont inf	3.23	NA	1.20	0.10	NA	4.53	010
64447	.....	A	N block inj fem, single	1.49	NA	0.52	0.10	NA	2.11	000
64448	.....	A	N block inj fem, cont inf	2.98	NA	1.03	0.10	NA	4.11	010
64449	.....	A	N block inj, lumbar plexus	2.98	NA	0.98	0.10	NA	4.06	010
64450	.....	A	N block, other peripheral	1.26	1.29	0.42	0.10	2.65	1.78	000
64470	.....	A	Inj paravertebral c/t	1.84	4.92	0.58	0.14	6.90	2.56	000
64472	.....	A	Inj paravertebral c/t add-on	1.28	1.96	0.32	0.11	3.35	1.71	ZZZ
64475	.....	A	Inj paravertebral l/s	1.40	4.61	0.49	0.11	6.12	2.00	000
64476	.....	A	Inj paravertebral l/s add-on	0.97	1.84	0.25	0.07	2.88	1.29	ZZZ
64479	.....	A	Inj foramen epidural c/t	2.19	7.14	0.73	0.17	9.50	3.09	000
64480	.....	A	Inj foramen epidural add-on	1.53	2.43	0.48	0.11	4.07	2.12	ZZZ
64483	.....	A	Inj foramen epidural l/s	1.89	7.64	0.66	0.14	9.67	2.69	000
64484	.....	A	Inj foramen epidural add-on	1.32	2.84	0.38	0.10	4.26	1.80	ZZZ
64505	.....	A	N block, spenopalatine gangl	1.35	1.24	0.49	0.10	2.69	1.94	000
64508	.....	A	N block, carotid sinus s/p	1.11	3.01	0.52	0.07	4.19	1.70	000
64510	.....	A	N block, stellate ganglion	1.21	3.27	0.39	0.08	4.56	1.68	000
64517	.....	A	N block inj, hypogas plxs	2.19	2.76	0.89	0.13	5.08	3.21	000
64520	.....	A	N block, lumbar/thoracic	1.34	4.63	0.43	0.10	6.07	1.87	000
64530	.....	A	N block inj, celiac pelus	1.57	4.01	0.49	0.11	5.69	2.17	000
64550	.....	A	Apply neurostimulator	0.18	0.30	0.05	0.01	0.49	0.24	000
64553	.....	A	Implant neuroelectrodes	2.30	2.77	1.88	0.20	5.27	4.38	010
64555	.....	A	Implant neuroelectrodes	2.26	3.16	1.23	0.13	5.55	3.62	010
64560	.....	A	Implant neuroelectrodes	2.35	2.69	1.34	0.20	5.24	3.89	010
64561	.....	A	Implant neuroelectrodes	6.70	NA	3.20	0.13	NA	10.03	010
64565	.....	A	Implant neuroelectrodes	1.75	3.39	1.28	0.10	5.24	3.13	010
64573	.....	A	Implant neuroelectrodes	7.46	NA	5.30	1.77	NA	14.53	090
64575	.....	A	Implant neuroelectrodes	4.33	NA	2.75	0.44	NA	7.52	090
64577	.....	A	Implant neuroelectrodes	4.59	NA	3.31	0.60	NA	8.50	090
64580	.....	A	Implant neuroelectrodes	4.10	NA	3.60	0.25	NA	7.95	090
64581	.....	A	Implant neuroelectrodes	13.42	NA	5.47	0.44	NA	19.33	090
64585	.....	A	Revise/remove neuroelectrode	2.05	11.70	1.75	0.35	14.10	4.15	010
64590	.....	A	Implant neuroreceiver	2.39	7.41	1.93	0.48	10.28	4.80	010
64595	.....	A	Revise/remove neuroreceiver	1.72	10.90	1.53	0.26	12.88	3.51	010
64600	.....	A	Injection treatment of nerve	3.43	8.56	1.60	0.34	12.33	5.37	010
64605	.....	A	Injection treatment of nerve	5.58	8.74	2.09	0.64	14.96	8.31	010
64610	.....	A	Injection treatment of nerve	7.12	8.00	3.63	1.34	16.46	12.09	010
64612	.....	A	Destroy nerve, face muscle	1.95	2.66	1.08	0.11	4.72	3.14	010
64613	.....	A	Destroy nerve, spine muscle	1.95	3.01	1.00	0.12	5.08	3.07	010
64614	.....	A	Destroy nerve, extrem musc	2.19	3.28	1.13	0.11	5.58	3.43	010
64620	.....	A	Injection treatment of nerve	2.82	4.67	1.21	0.20	7.69	4.23	010
64622	.....	A	Destr paravertebrl nerve l/s	2.98	7.74	1.26	0.20	10.92	4.44	010
64623	.....	A	Destr paravertebral n add-on	0.98	2.46	0.23	0.07	3.51	1.28	ZZZ
64626	.....	A	Destr paravertebrl nerve c/t	3.26	6.79	1.90	0.26	10.31	5.42	010
64627	.....	A	Destr paravertebral n add-on	1.15	2.65	0.27	0.10	3.90	1.52	ZZZ
64630	.....	A	Injection treatment of nerve	2.98	2.78	1.31	0.19	5.95	4.48	010
64640	.....	A	Injection treatment of nerve	2.74	4.32	1.71	0.13	7.19	4.58	010
64680	.....	A	Injection treatment of nerve	2.61	6.08	1.31	0.18	8.87	4.10	010
64681	.....	A	Injection treatment of nerve	3.53	8.81	2.13	0.18	12.52	5.84	010
64702	.....	A	Revise finger/toe nerve	4.21	NA	3.86	0.61	NA	8.68	090
64704	.....	A	Revise hand/foot nerve	4.54	NA	3.31	0.71	NA	8.56	090
64708	.....	A	Revise arm/leg nerve	6.09	NA	4.87	0.98	NA	11.94	090
64712	.....	A	Revision of sciatic nerve	7.71	NA	5.09	0.65	NA	13.45	090
64713	.....	A	Revision of arm nerve(s)	10.94	NA	5.98	1.21	NA	18.13	090
64714	.....	A	Revise low back nerve(s)	10.27	NA	4.35	0.77	NA	15.39	090
64716	.....	A	Revision of cranial nerve	6.27	NA	5.32	0.71	NA	12.30	090
64718	.....	A	Revise ulnar nerve at elbow	5.96	NA	5.94	1.04	NA	12.94	090
64719	.....	A	Revise ulnar nerve at wrist	4.82	NA	4.51	0.76	NA	10.09	090
64721	.....	A	Carpal tunnel surgery	4.27	5.01	5.01	0.71	9.99	9.99	090
64722	.....	A	Relieve pressure on nerve(s)	4.67	NA	3.13	0.38	NA	8.18	090
64726	.....	A	Release foot/toe nerve	4.16	NA	2.80	0.68	NA	7.64	090
64727	.....	A	Internal nerve revision	3.08	NA	1.52	0.48	NA	5.08	ZZZ
64732	.....	A	Incision of brow nerve	4.38	NA	3.58	0.92	NA	8.88	090
64734	.....	A	Incision of cheek nerve	4.89	NA	4.12	0.99	NA	10.00	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
64736		A	Incision of chin nerve	4.57	NA	4.09	0.85	NA	9.51	090
64738		A	Incision of jaw nerve	5.70	NA	4.67	1.01	NA	11.38	090
64740		A	Incision of tongue nerve	5.56	NA	4.45	0.52	NA	10.53	090
64742		A	Incision of facial nerve	6.18	NA	4.79	0.83	NA	11.80	090
64744		A	Incise nerve, back of head	5.21	NA	3.85	1.17	NA	10.23	090
64746		A	Incise diaphragm nerve	5.90	NA	4.40	0.90	NA	11.20	090
64752		A	Incision of vagus nerve	7.02	NA	4.27	0.99	NA	12.28	090
64755		A	Incision of stomach nerves	13.44	NA	5.75	1.39	NA	20.58	090
64760		A	Incision of vagus nerve	6.92	NA	3.57	0.61	NA	11.10	090
64761		A	Incision of pelvis nerve	6.37	NA	3.62	0.31	NA	10.30	090
64763		A	Incise hip/thigh nerve	6.89	NA	5.30	0.92	NA	13.11	090
64766		A	Incise hip/thigh nerve	8.62	NA	5.34	1.19	NA	15.15	090
64771		A	Sever cranial nerve	7.31	NA	5.65	1.58	NA	14.54	090
64772		A	Incision of spinal nerve	7.17	NA	4.99	1.44	NA	13.60	090
64774		A	Remove skin nerve lesion	5.14	NA	3.85	0.72	NA	9.71	090
64776		A	Remove digit nerve lesion	5.09	NA	3.72	0.76	NA	9.57	090
64778		A	Digit nerve surgery add-on	3.09	NA	1.52	0.46	NA	5.07	ZZZ
64782		A	Remove limb nerve lesion	6.19	NA	3.79	0.95	NA	10.93	090
64783		A	Limb nerve surgery add-on	3.70	NA	1.87	0.58	NA	6.15	ZZZ
64784		A	Remove nerve lesion	9.76	NA	6.64	1.40	NA	17.80	090
64786		A	Remove sciatic nerve lesion	15.37	NA	9.94	2.66	NA	27.97	090
64787		A	Implant nerve end	4.28	NA	2.15	0.67	NA	7.10	ZZZ
64788		A	Remove skin nerve lesion	4.58	NA	3.51	0.65	NA	8.74	090
64790		A	Removal of nerve lesion	11.25	NA	7.28	2.01	NA	20.54	090
64792		A	Removal of nerve lesion	14.83	NA	8.93	2.25	NA	26.01	090
64795		A	Biopsy of nerve	2.99	NA	1.61	0.48	NA	5.08	000
64802		A	Remove sympathetic nerves	9.10	NA	5.18	1.04	NA	15.32	090
64804		A	Remove sympathetic nerves	14.56	NA	7.14	2.15	NA	23.85	090
64809		A	Remove sympathetic nerves	13.59	NA	5.82	1.15	NA	20.56	090
64818		A	Remove sympathetic nerves	10.24	NA	5.28	1.29	NA	16.81	090
64820		A	Remove sympathetic nerves	10.31	NA	7.20	1.40	NA	18.91	090
64821		A	Remove sympathetic nerves	8.70	NA	7.42	1.19	NA	17.31	090
64822		A	Remove sympathetic nerves	8.70	NA	7.35	1.19	NA	17.24	090
64823		A	Remove sympathetic nerves	10.31	NA	8.27	1.40	NA	19.98	090
64831		A	Repair of digit nerve	9.39	NA	7.12	1.37	NA	17.88	090
64832		A	Repair nerve add-on	5.63	NA	2.98	0.82	NA	9.43	ZZZ
64834		A	Repair of hand or foot nerve	10.13	NA	7.14	1.47	NA	18.74	090
64835		A	Repair of hand or foot nerve	10.88	NA	7.75	1.63	NA	20.26	090
64836		A	Repair of hand or foot nerve	10.88	NA	7.72	1.58	NA	20.18	090
64837		A	Repair nerve add-on	6.22	NA	3.27	0.96	NA	10.45	ZZZ
64840		A	Repair of leg nerve	12.95	NA	8.38	1.03	NA	22.36	090
64856		A	Repair/transpose nerve	13.72	NA	9.27	2.05	NA	25.04	090
64857		A	Repair arm/leg nerve	14.41	NA	9.72	2.11	NA	26.24	090
64858		A	Repair sciatic nerve	16.40	NA	10.86	3.33	NA	30.59	090
64859		A	Nerve surgery	4.24	NA	2.22	0.60	NA	7.06	ZZZ
64861		A	Repair of arm nerves	19.13	NA	11.93	2.94	NA	34.00	090
64862		A	Repair of low back nerves	19.33	NA	12.10	2.96	NA	34.39	090
64864		A	Repair of facial nerve	12.48	NA	8.19	1.35	NA	22.02	090
64865		A	Repair of facial nerve	15.15	NA	9.97	1.64	NA	26.76	090
64866		A	Fusion of facial/other nerve	15.65	NA	9.82	1.27	NA	26.74	090
64868		A	Fusion of facial/other nerve	13.96	NA	8.97	1.68	NA	24.61	090
64870		A	Fusion of facial/other nerve	15.90	NA	8.84	1.29	NA	26.03	090
64872		A	Subsequent repair of nerve	1.98	NA	1.09	0.29	NA	3.36	ZZZ
64874		A	Repair & revise nerve add-on	2.96	NA	1.55	0.41	NA	4.92	ZZZ
64876		A	Repair nerve/shorten bone	3.36	NA	1.30	0.47	NA	5.13	ZZZ
64885		A	Nerve graft, head or neck	17.43	NA	11.04	1.81	NA	30.28	090
64886		A	Nerve graft, head or neck	20.63	NA	12.89	2.07	NA	35.59	090
64890		A	Nerve graft, hand or foot	15.06	NA	10.09	2.09	NA	27.24	090
64891		A	Nerve graft, hand or foot	16.05	NA	7.74	1.65	NA	25.44	090
64892		A	Nerve graft, arm or leg	14.57	NA	8.97	1.98	NA	25.52	090
64893		A	Nerve graft, arm or leg	15.51	NA	9.99	2.12	NA	27.62	090
64895		A	Nerve graft, hand or foot	19.14	NA	9.76	2.45	NA	31.35	090
64896		A	Nerve graft, hand or foot	20.37	NA	11.15	2.22	NA	33.74	090
64897		A	Nerve graft, arm or leg	18.14	NA	10.82	3.16	NA	32.12	090
64898		A	Nerve graft, arm or leg	19.39	NA	11.95	3.25	NA	34.59	090
64901		A	Nerve graft add-on	10.16	NA	5.34	1.19	NA	16.69	ZZZ
64902		A	Nerve graft add-on	11.76	NA	6.05	1.32	NA	19.13	ZZZ
64905		A	Nerve pedicle transfer	13.94	NA	8.65	1.82	NA	24.41	090
64907		A	Nerve pedicle transfer	18.72	NA	12.62	2.15	NA	33.49	090
64999		C	Nervous system surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
65091		A	Revise eye	6.42	NA	9.83	0.31	NA	16.56	090
65093		A	Revise eye with implant	6.83	NA	10.19	0.34	NA	17.36	090
65101		A	Removal of eye	6.99	NA	10.77	0.34	NA	18.10	090
65103		A	Remove eye/insert implant	7.53	NA	10.98	0.36	NA	18.87	090
65105		A	Remove eye/attach implant	8.44	NA	11.64	0.41	NA	20.49	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
65110	.....	A	Removal of eye	13.87	NA	14.77	0.82	NA	29.46	090
65112	.....	A	Remove eye/revise socket	16.29	NA	17.06	1.15	NA	34.50	090
65114	.....	A	Remove eye/revise socket	17.43	NA	17.28	1.13	NA	35.84	090
65125	.....	A	Revise ocular implant	3.10	9.32	3.00	0.18	12.60	6.28	090
65130	.....	A	Insert ocular implant	7.11	NA	10.36	0.34	NA	17.81	090
65135	.....	A	Insert ocular implant	7.29	NA	10.53	0.35	NA	18.17	090
65140	.....	A	Attach ocular implant	7.97	NA	10.99	0.37	NA	19.33	090
65150	.....	A	Revise ocular implant	6.22	NA	9.38	0.30	NA	15.90	090
65155	.....	A	Reinsert ocular implant	8.61	NA	11.72	0.48	NA	20.81	090
65175	.....	A	Removal of ocular implant	6.24	NA	9.75	0.31	NA	16.30	090
65205	.....	A	Remove foreign body from eye	0.71	0.61	0.19	0.04	1.36	0.94	000
65210	.....	A	Remove foreign body from eye	0.84	0.74	0.30	0.04	1.62	1.18	000
65220	.....	A	Remove foreign body from eye	0.71	0.61	0.18	0.06	1.38	0.95	000
65222	.....	A	Remove foreign body from eye	0.92	0.76	0.27	0.05	1.73	1.24	000
65235	.....	A	Remove foreign body from eye	7.53	NA	7.34	0.36	NA	15.23	090
65260	.....	A	Remove foreign body from eye	10.90	NA	11.54	0.52	NA	22.96	090
65265	.....	A	Remove foreign body from eye	12.52	NA	12.78	0.60	NA	25.90	090
65270	.....	A	Repair of eye wound	1.89	3.86	2.27	0.10	5.85	4.26	010
65272	.....	A	Repair of eye wound	3.80	5.85	5.27	0.19	9.84	9.26	090
65273	.....	A	Repair of eye wound	4.34	NA	5.70	0.20	NA	10.24	090
65275	.....	A	Repair of eye wound	5.31	5.74	5.74	0.32	11.37	11.37	090
65280	.....	A	Repair of eye wound	7.62	NA	8.26	0.36	NA	16.24	090
65285	.....	A	Repair of eye wound	12.83	NA	12.51	0.61	NA	25.95	090
65286	.....	A	Repair of eye wound	5.48	8.51	7.60	0.25	14.24	13.33	090
65290	.....	A	Repair of eye socket wound	5.38	NA	6.55	0.31	NA	12.24	090
65400	.....	A	Removal of eye lesion	6.03	8.72	7.55	0.29	15.04	13.87	090
65410	.....	A	Biopsy of cornea	1.46	1.73	0.65	0.07	3.26	2.18	000
65420	.....	A	Removal of eye lesion	4.15	7.60	6.80	0.20	11.95	11.15	090
65426	.....	A	Removal of eye lesion	5.22	7.56	6.61	0.24	13.02	12.07	090
65430	.....	A	Corneal smear	1.46	5.00	0.66	0.07	6.53	2.19	000
65435	.....	A	Curette/treat cornea	0.91	1.34	0.40	0.05	2.30	1.36	000
65436	.....	A	Curette/treat cornea	4.17	5.91	5.28	0.20	10.28	9.65	090
65450	.....	A	Treatment of corneal lesion	3.25	7.27	6.39	0.16	10.68	9.80	090
65600	.....	A	Revision of cornea	3.38	5.70	3.15	0.17	9.25	6.70	090
65710	.....	A	Corneal transplant	12.28	NA	12.46	0.59	NA	25.33	090
65730	.....	A	Corneal transplant	14.17	NA	11.98	0.67	NA	26.82	090
65750	.....	A	Corneal transplant	14.91	NA	13.49	0.71	NA	29.11	090
65755	.....	A	Corneal transplant	14.81	NA	13.41	0.70	NA	28.92	090
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	17.46	NA	14.47	0.83	NA	32.76	090
65771	.....	N	Radial keratotomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65772	.....	A	Correction of astigmatism	4.27	7.23	6.53	0.20	11.70	11.00	090
65775	.....	A	Correction of astigmatism	5.76	NA	7.43	0.26	NA	13.45	090
65780	.....	A	Ocular reconst, transplant	10.19	NA	10.04	0.35	NA	20.58	090
65781	.....	A	Ocular reconst, transplant	17.57	NA	13.45	0.35	NA	31.37	090
65782	.....	A	Ocular reconst, transplant	14.91	NA	11.79	0.35	NA	27.05	090
65800	.....	A	Drainage of eye	1.90	2.29	1.19	0.10	4.29	3.19	000
65805	.....	A	Drainage of eye	1.90	2.29	1.19	0.10	4.29	3.19	000
65810	.....	A	Drainage of eye	4.84	NA	8.13	0.23	NA	13.20	090
65815	.....	A	Drainage of eye	5.02	8.46	7.56	0.24	13.72	12.82	090
65820	.....	A	Relieve inner eye pressure	8.08	NA	10.75	0.38	NA	19.21	090
65850	.....	A	Incision of eye	10.46	NA	9.49	0.49	NA	20.44	090
65855	.....	A	Laser surgery of eye	3.83	5.26	4.09	0.20	9.29	8.12	010
65860	.....	A	Incise inner eye adhesions	3.53	3.94	3.28	0.17	7.64	6.98	090
65865	.....	A	Incise inner eye adhesions	5.57	NA	6.56	0.26	NA	12.39	090
65870	.....	A	Incise inner eye adhesions	6.23	NA	7.21	0.29	NA	13.73	090
65875	.....	A	Incise inner eye adhesions	6.50	NA	7.52	0.30	NA	14.32	090
65880	.....	A	Incise inner eye adhesions	7.05	NA	7.76	0.34	NA	15.15	090
65900	.....	A	Remove eye lesion	10.87	NA	11.60	0.55	NA	23.02	090
65920	.....	A	Remove implant of eye	8.35	NA	8.80	0.40	NA	17.55	090
65930	.....	A	Remove blood clot from eye	7.40	NA	7.82	0.35	NA	15.57	090
66020	.....	A	Injection treatment of eye	1.58	2.40	1.60	0.08	4.06	3.26	010
66030	.....	A	Injection treatment of eye	1.24	2.23	1.44	0.06	3.53	2.74	010
66130	.....	A	Remove eye lesion	7.65	7.56	6.99	0.37	15.58	15.01	090
66150	.....	A	Glaucoma surgery	8.25	NA	9.94	0.40	NA	18.59	090
66155	.....	A	Glaucoma surgery	8.24	NA	9.91	0.38	NA	18.53	090
66160	.....	A	Glaucoma surgery	10.11	NA	10.77	0.49	NA	21.37	090
66165	.....	A	Glaucoma surgery	7.96	NA	9.79	0.37	NA	18.12	090
66170	.....	A	Glaucoma surgery	12.09	NA	12.56	0.58	NA	25.23	090
66172 ...	.....	A	Incision of eye	14.95	NA	15.26	0.71	NA	30.92	090
66180	.....	A	Implant eye shunt	14.47	NA	11.67	0.68	NA	26.82	090
66185	.....	A	Revise eye shunt	8.09	NA	8.28	0.38	NA	16.75	090
66220	.....	A	Repair eye lesion	7.73	NA	8.83	0.38	NA	16.94	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
66225	.....	A	Repair/graft eye lesion	10.99	NA	9.42	0.53	NA	20.94	090
66250	.....	A	Follow-up surgery of eye	5.95	7.74	6.57	0.28	13.97	12.80	090
66500	.....	A	Incision of iris	3.69	NA	5.15	0.18	NA	9.02	090
66505	.....	A	Incision of iris	4.06	NA	5.44	0.20	NA	9.70	090
66600	.....	A	Remove iris and lesion	8.63	NA	8.99	0.41	NA	18.03	090
66605	.....	A	Removal of iris	12.72	NA	11.37	0.73	NA	24.82	090
66625	.....	A	Removal of iris	5.10	7.09	6.35	0.24	12.43	11.69	090
66630	.....	A	Removal of iris	6.12	NA	7.50	0.29	NA	13.91	090
66635	.....	A	Removal of iris	6.21	NA	6.71	0.29	NA	13.21	090
66680	.....	A	Repair iris & ciliary body	5.41	NA	6.10	0.25	NA	11.76	090
66682	.....	A	Repair iris & ciliary body	6.17	NA	7.50	0.29	NA	13.96	090
66700	.....	A	Destruction, ciliary body	4.75	5.40	4.09	0.23	10.38	9.07	090
66710	.....	A	Destruction, ciliary body	4.75	5.27	3.88	0.22	10.24	8.85	090
66720	.....	A	Destruction, ciliary body	4.75	5.76	4.64	0.23	10.74	9.62	090
66740	.....	A	Destruction, ciliary body	4.75	5.43	4.26	0.22	10.40	9.23	090
66761	.....	A	Revision of iris	4.05	5.61	4.28	0.19	9.85	8.52	090
66762	.....	A	Revision of iris	4.55	5.69	4.27	0.22	10.46	9.04	090
66770	.....	A	Removal of inner eye lesion	5.15	6.11	4.77	0.24	11.50	10.16	090
66820	.....	A	Incision, secondary cataract	3.87	NA	7.18	0.19	NA	11.24	090
66821	.....	A	After cataract laser surgery	2.34	4.01	3.92	0.12	6.47	6.38	090
66825	.....	A	Reposition intraocular lens	8.18	NA	10.18	0.38	NA	18.74	090
66830	.....	A	Removal of lens lesion	8.15	NA	7.15	0.38	NA	15.68	090
66840	.....	A	Removal of lens material	7.86	NA	7.07	0.37	NA	15.30	090
66850	.....	A	Removal of lens material	9.06	NA	7.83	0.43	NA	17.32	090
66852	.....	A	Removal of lens material	9.91	NA	8.29	0.47	NA	18.67	090
66920	.....	A	Extraction of lens	8.81	NA	7.51	0.42	NA	16.74	090
66930	.....	A	Extraction of lens	10.12	NA	8.64	0.49	NA	19.25	090
66940	.....	A	Extraction of lens	8.88	NA	8.10	0.42	NA	17.40	090
66982	.....	A	Cataract surgery, complex	13.42	NA	10.02	0.67	NA	24.11	090
66983	.....	A	Cataract surg w/iol, 1 stage	8.94	NA	6.27	0.44	NA	15.65	090
66984	.....	A	Cataract surg w/iol, 1 stage	10.17	NA	7.70	0.49	NA	18.36	090
66985	.....	A	Insert lens prosthesis	8.34	NA	7.54	0.40	NA	16.28	090
66986	.....	A	Exchange lens prosthesis	12.21	NA	9.31	0.59	NA	22.11	090
66990	.....	A	Ophthalmic endoscope add-on	1.50	NA	0.69	0.07	NA	2.26	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	5.67	NA	4.43	0.26	NA	10.36	090
67010	.....	A	Partial removal of eye fluid	6.83	NA	4.98	0.32	NA	12.13	090
67015	.....	A	Release of eye fluid	6.88	NA	7.81	0.32	NA	15.01	090
67025	.....	A	Replace eye fluid	6.80	14.38	7.58	0.32	21.50	14.70	090
67027	.....	A	Implant eye drug system	10.79	12.91	8.89	0.55	24.25	20.23	090
67028	.....	A	Injection eye drug	2.51	6.57	1.15	0.13	9.21	3.79	000
67030	.....	A	Incise inner eye strands	4.81	NA	6.88	0.23	NA	11.92	090
67031	.....	A	Laser surgery, eye strands	3.65	4.78	4.13	0.18	8.61	7.96	090
67036	.....	A	Removal of inner eye fluid	11.82	NA	9.45	0.56	NA	21.83	090
67038	.....	A	Strip retinal membrane	21.12	NA	16.00	1.01	NA	38.13	090
67039	.....	A	Laser treatment of retina	14.44	NA	12.67	0.68	NA	27.79	090
67040	.....	A	Laser treatment of retina	17.13	NA	14.17	0.82	NA	32.12	090
67101	.....	A	Repair detached retina	7.49	9.95	8.20	0.35	17.79	16.04	090
67105	.....	A	Repair detached retina	7.37	8.08	6.30	0.35	15.80	14.02	090
67107	.....	A	Repair detached retina	14.76	NA	12.95	0.70	NA	28.41	090
67108	.....	A	Repair detached retina	20.70	NA	17.21	0.98	NA	38.89	090
67110	.....	A	Repair detached retina	8.76	15.54	9.33	0.42	24.72	18.51	090
67112	.....	A	Rerepair detached retina	16.76	NA	14.76	0.79	NA	32.31	090
67115	.....	A	Release encircling material	4.96	NA	7.16	0.23	NA	12.35	090
67120	.....	A	Remove eye implant material	5.95	12.43	7.01	0.28	18.66	13.24	090
67121	.....	A	Remove eye implant material	10.61	NA	11.28	0.50	NA	22.39	090
67141	.....	A	Treatment of retina	5.17	7.32	6.56	0.24	12.73	11.97	090
67145	.....	A	Treatment of retina	5.34	5.81	4.99	0.25	11.40	10.58	090
67208	.....	A	Treatment of retinal lesion	6.66	6.01	5.44	0.31	12.98	12.41	090
67210	.....	A	Treatment of retinal lesion	8.77	6.31	5.85	0.42	15.50	15.04	090
67218	.....	A	Treatment of retinal lesion	18.42	NA	14.28	0.64	NA	33.34	090
67220	.....	A	Treatment of choroid lesion	13.06	9.93	8.93	0.61	23.60	22.60	090
67221	.....	R	Ocular photodynamic ther	3.99	4.74	1.83	0.19	8.92	6.01	000
67225	.....	A	Eye photodynamic ther add-on	0.47	0.26	0.22	0.01	0.74	0.70	ZZZ
67227	.....	A	Treatment of retinal lesion	6.54	6.45	5.44	0.31	13.30	12.29	090
67228	.....	A	Treatment of retinal lesion	12.67	10.94	8.50	0.60	24.21	21.77	090
67250	.....	A	Reinforce eye wall	8.61	NA	10.48	0.43	NA	19.52	090
67255	.....	A	Reinforce/graft eye wall	8.85	NA	11.07	0.42	NA	20.34	090
67299	.....	C	Eye surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67311	.....	A	Revise eye muscle	6.61	NA	6.49	0.32	NA	13.42	090
67312	.....	A	Revise two eye muscles	8.49	NA	7.63	0.42	NA	16.54	090
67314	.....	A	Revise eye muscle	7.48	NA	7.34	0.36	NA	15.18	090
67316	.....	A	Revise two eye muscles	9.60	NA	8.31	0.48	NA	18.39	090
67318	.....	A	Revise eye muscle(s)	7.81	NA	7.72	0.37	NA	15.90	090
67320	.....	A	Revise eye muscle(s) add-on	4.31	NA	1.98	0.20	NA	6.49	ZZZ

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
67331		A	Eye surgery follow-up add-on	4.04	NA	1.93	0.20	NA	6.17	ZZZ
67332		A	Rerevise eye muscles add-on	4.46	NA	2.05	0.22	NA	6.73	ZZZ
67334		A	Revise eye muscle w/suture	3.96	NA	1.82	0.19	NA	5.97	ZZZ
67335		A	Eye suture during surgery	2.48	NA	1.14	0.12	NA	3.74	ZZZ
67340		A	Revise eye muscle add-on	4.90	NA	2.25	0.23	NA	7.38	ZZZ
67343		A	Release eye tissue	7.31	NA	7.41	0.36	NA	15.08	090
67345		A	Destroy nerve of eye muscle	2.94	4.42	1.39	0.16	7.52	4.49	010
67350		A	Biopsy eye muscle	2.85	NA	1.89	0.16	NA	4.90	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	9.70	NA	12.64	0.52	NA	22.86	090
67405		A	Explore/drain eye socket	7.88	NA	11.21	0.43	NA	19.52	090
67412		A	Explore/treat eye socket	9.45	NA	13.10	0.49	NA	23.04	090
67413		A	Explore/treat eye socket	9.94	NA	12.26	0.52	NA	22.72	090
67414		A	Explr/decompress eye socket	11.07	NA	14.17	0.58	NA	25.82	090
67415		A	Aspiration, orbital contents	1.75	NA	0.77	0.11	NA	2.63	000
67420		A	Explore/treat eye socket	19.95	NA	18.96	1.01	NA	39.92	090
67430		A	Explore/treat eye socket	13.31	NA	16.04	1.16	NA	30.51	090
67440		A	Explore/drain eye socket	13.02	NA	15.64	0.70	NA	29.36	090
67445		A	Explr/decompress eye socket	14.34	NA	15.84	0.76	NA	30.94	090
67450		A	Explore/biopsy eye socket	13.43	NA	15.99	0.67	NA	30.09	090
67500		A	Inject/treat eye socket	0.79	0.83	0.19	0.05	1.67	1.03	000
67505		A	Inject/treat eye socket	0.82	0.92	0.21	0.05	1.79	1.08	000
67515		A	Inject/treat eye socket	0.61	0.83	0.28	0.02	1.46	0.91	000
67550		A	Insert eye socket implant	10.13	NA	12.40	0.60	NA	23.13	090
67560		A	Revise eye socket implant	10.54	NA	12.43	0.56	NA	23.53	090
67570		A	Decompress optic nerve	13.50	NA	15.38	0.83	NA	29.71	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	1.34	4.88	0.64	0.07	6.29	2.05	010
67710		A	Incision of eyelid	1.01	5.04	0.54	0.05	6.10	1.60	010
67715		A	Incision of eyelid fold	1.21	4.62	0.63	0.06	5.89	1.90	010
67800		A	Remove eyelid lesion	1.37	2.52	0.69	0.07	3.96	2.13	010
67801		A	Remove eyelid lesions	1.87	5.40	0.93	0.10	7.37	2.90	010
67805		A	Remove eyelid lesions	2.21	5.55	1.08	0.11	7.87	3.40	010
67808		A	Remove eyelid lesion(s)	3.78	NA	5.29	0.20	NA	9.27	090
67810		A	Biopsy of eyelid	1.47	3.69	0.68	0.07	5.23	2.22	000
67820		A	Revise eyelashes	0.88	1.12	0.38	0.05	2.05	1.31	000
67825		A	Revise eyelashes	1.37	1.60	1.08	0.07	3.04	2.52	010
67830		A	Revise eyelashes	1.69	7.55	1.97	0.08	9.32	3.74	010
67835		A	Revise eyelashes	5.53	NA	5.05	0.26	NA	10.84	090
67840		A	Remove eyelid lesion	2.03	5.38	1.00	0.10	7.51	3.13	010
67850		A	Treat eyelid lesion	1.68	6.12	1.92	0.08	7.88	3.68	010
67875		A	Closure of eyelid by suture	1.34	7.11	0.63	0.07	8.52	2.04	000
67880		A	Revision of eyelid	3.78	9.75	4.35	0.19	13.72	8.32	090
67882		A	Revision of eyelid	5.04	11.13	5.56	0.25	16.42	10.85	090
67900		A	Repair brow defect	6.11	10.63	6.38	0.36	17.10	12.85	090
67901		A	Repair eyelid defect	6.93	NA	6.47	0.38	NA	13.78	090
67902		A	Repair eyelid defect	6.99	NA	6.54	0.41	NA	13.94	090
67903		A	Repair eyelid defect	6.33	11.39	6.76	0.47	18.19	13.56	090
67904		A	Repair eyelid defect	6.22	12.61	7.24	0.31	19.14	13.77	090
67906		A	Repair eyelid defect	6.75	9.20	6.07	0.50	16.45	13.32	090
67908		A	Repair eyelid defect	5.10	8.93	5.74	0.24	14.27	11.08	090
67909		A	Revise eyelid defect	5.37	9.47	6.14	0.30	15.14	11.81	090
67911		A	Revise eyelid defect	5.24	NA	6.10	0.28	NA	11.62	090
67912		A	Correction eyelid w/ implant	5.65	20.59	5.33	0.28	26.52	11.26	090
67914		A	Repair eyelid defect	3.66	9.40	3.99	0.19	13.25	7.84	090
67915		A	Repair eyelid defect	3.16	7.99	2.61	0.16	11.31	5.93	090
67916		A	Repair eyelid defect	5.28	11.90	5.75	0.26	17.44	11.29	090
67917		A	Repair eyelid defect	5.99	9.81	6.21	0.30	16.10	12.50	090
67921		A	Repair eyelid defect	3.38	9.20	3.79	0.17	12.75	7.34	090
67922		A	Repair eyelid defect	3.04	7.94	3.52	0.16	11.14	6.72	090
67923		A	Repair eyelid defect	5.85	11.47	5.96	0.29	17.61	12.10	090
67924		A	Repair eyelid defect	5.76	9.20	5.72	0.28	15.24	11.76	090
67930		A	Repair eyelid wound	3.59	8.48	2.98	0.20	12.27	6.77	010
67935		A	Repair eyelid wound	6.18	11.48	6.01	0.35	18.01	12.54	090
67938		A	Remove eyelid foreign body	1.32	5.87	0.57	0.07	7.26	1.96	010
67950		A	Revision of eyelid	5.79	8.34	6.64	0.36	14.49	12.79	090
67961		A	Revision of eyelid	5.66	10.27	5.76	0.31	16.24	11.73	090
67966		A	Revision of eyelid	6.53	8.42	5.73	0.40	15.35	12.66	090
67971		A	Reconstruction of eyelid	9.73	NA	7.34	0.50	NA	17.57	090
67973		A	Reconstruction of eyelid	12.80	NA	9.33	0.71	NA	22.84	090
67974		A	Reconstruction of eyelid	12.77	NA	9.24	0.65	NA	22.66	090
67975		A	Reconstruction of eyelid	9.08	NA	7.02	0.46	NA	16.56	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	1.36	5.75	0.68	0.07	7.18	2.11	010
68040		A	Treatment of eyelid lesions	0.85	4.86	0.39	0.04	5.75	1.28	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
68100	.....	A	Biopsy of eyelid lining	1.34	5.07	0.62	0.07	6.48	2.03	000
68110	.....	A	Remove eyelid lining lesion	1.76	6.12	1.42	0.08	7.96	3.26	010
68115	.....	A	Remove eyelid lining lesicn	2.35	5.62	1.14	0.12	8.09	3.61	010
68130	.....	A	Remove eyelid lining lesion	4.90	8.20	4.33	0.23	13.33	9.46	090
68135	.....	A	Remove eyelid lining lesion	1.83	5.38	0.91	0.08	7.29	2.82	010
68200	.....	A	Treat eyelid by injection	0.49	0.73	0.23	0.02	1.24	0.74	000
68320	.....	A	Revise/graft eyelid lining	5.34	6.63	5.47	0.25	12.22	11.06	090
68325	.....	A	Revise/graft eyelid lining	7.32	NA	6.46	0.36	NA	14.14	090
68326	.....	A	Revise/graft eyelid lining	7.11	NA	6.34	0.36	NA	13.81	090
68328	.....	A	Revise/graft eyelid lining	8.13	NA	7.08	0.48	NA	15.69	090
68330	.....	A	Revise eyelid lining	4.80	7.32	6.11	0.23	12.35	11.14	090
68335	.....	A	Revise/graft eyelid lining	7.15	NA	6.87	0.35	NA	14.37	090
68340	.....	A	Separate eyelid adhesions	4.15	10.91	4.79	0.20	15.26	9.14	090
68360	.....	A	Revise eyelid lining	4.35	6.68	5.64	0.20	11.23	10.19	090
68362	.....	A	Revise eyelid lining	7.30	NA	7.80	0.35	NA	15.45	090
68371	.....	A	Harvest eye tissue, alograft	4.87	NA	4.66	0.20	NA	9.73	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	1.68	7.69	2.06	0.08	9.45	3.82	010
68420	.....	A	Incise/drain tear sac	2.29	8.01	2.35	0.12	10.42	4.76	010
68440	.....	A	Incise tear duct opening	0.93	4.99	0.50	0.05	5.97	1.48	010
68500	.....	A	Removal of tear gland	10.96	NA	10.27	0.72	NA	21.95	090
68505	.....	A	Partial removal, tear gland	10.88	NA	11.28	0.68	NA	22.84	090
68510	.....	A	Biopsy of tear gland	4.58	8.50	2.11	0.23	13.31	6.92	000
68520	.....	A	Removal of tear sac	7.47	NA	7.85	0.40	NA	15.72	090
68525	.....	A	Biopsy of tear sac	4.40	NA	2.04	0.22	NA	6.66	000
68530	.....	A	Clearance of tear duct	3.64	9.55	2.88	0.19	13.38	6.71	010
68540	.....	A	Remove tear gland lesion	10.54	NA	9.88	0.55	NA	20.97	090
68550	.....	A	Remove tear gland lesion	13.18	NA	11.87	0.79	NA	25.84	090
68700	.....	A	Repair tear ducts	6.56	NA	7.36	0.32	NA	14.24	090
68705	.....	A	Revise tear duct opening	2.05	5.51	1.01	0.10	7.66	3.16	010
68720	.....	A	Create tear sac drain	8.91	NA	8.35	0.46	NA	17.72	090
68745	.....	A	Create tear duct drain	8.58	NA	8.32	0.46	NA	17.36	090
68750	.....	A	Create tear duct drain	8.61	NA	8.77	0.44	NA	17.82	090
68760	.....	A	Close tear duct opening	1.72	4.04	1.25	0.08	5.84	3.05	010
68761	.....	A	Close tear duct opening	1.35	3.46	0.99	0.07	4.88	2.41	010
68770	.....	A	Close tear system fistula	6.98	12.89	6.85	0.34	20.21	14.17	090
68801	.....	A	Dilate tear duct opening	0.93	0.94	0.61	0.05	1.92	1.59	010
68810	.....	A	Probe nasolacrimal duct	1.89	2.34	0.93	0.10	4.33	2.92	010
68811	.....	A	Probe nasolacrimal duct	2.34	NA	2.37	0.12	NA	4.83	010
68815	.....	A	Probe nasolacrimal duct	3.18	8.25	2.71	0.17	11.60	6.06	010
68840	.....	A	Explore/irrigate tear ducts	1.24	1.66	0.97	0.06	2.96	2.27	010
68850	.....	A	Injection for tear sac x-ray	0.80	16.48	0.30	0.04	17.32	1.14	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	1.44	3.01	1.43	0.12	4.57	2.99	010
69005	.....	A	Drain external ear lesion	2.10	3.00	1.87	0.19	5.29	4.16	010
69020	.....	A	Drain outer ear canal lesion	1.47	3.97	2.07	0.13	5.57	3.67	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	1.76	0.40	0.05	2.62	1.26	000
69105	.....	A	Biopsy of external ear canal	0.85	2.33	0.77	0.07	3.25	1.69	000
69110	.....	A	Remove external ear, partial	3.42	4.11	3.06	0.29	7.82	6.77	090
69120	.....	A	Removal of external ear	4.03	NA	4.01	0.37	NA	8.41	090
69140	.....	A	Remove ear canal lesion(s)	7.92	NA	6.76	0.67	NA	15.35	090
69145	.....	A	Remove ear canal lesion(s)	2.61	3.61	2.62	0.22	6.44	5.45	090
69150	.....	A	Extensive ear canal surgery	13.35	NA	10.00	1.28	NA	24.63	090
69155	.....	A	Extensive ear/neck surgery	20.68	NA	14.62	1.81	NA	37.11	090
69200	.....	A	Clear outer ear canal	0.77	2.36	0.60	0.06	3.19	1.43	000
69205	.....	A	Clear outer ear canal	1.19	NA	1.37	0.11	NA	2.67	010
69210	.....	A	Remove impacted ear wax	0.61	0.64	0.24	0.05	1.30	0.90	000
69220	.....	A	Clean out mastoid cavity	0.83	2.34	0.74	0.07	3.24	1.64	000
69222	.....	A	Clean out mastoid cavity	1.39	3.82	2.05	0.12	5.33	3.56	010
69300	.....	R	Revise external ear	6.32	NA	4.28	0.52	NA	11.12	YYY
69310	.....	A	Rebuild outer ear canal	10.73	NA	8.46	0.92	NA	20.11	090
69320	.....	A	Rebuild outer ear canal	16.86	NA	12.23	1.40	NA	30.49	090
69399	.....	C	Outer ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69400	.....	A	Inflate middle ear canal	0.83	2.36	0.68	0.07	3.26	1.58	000
69401	.....	A	Inflate middle ear canal	0.63	1.31	0.65	0.05	1.99	1.33	000
69405	.....	A	Catheterize middle ear canal	2.62	3.52	2.31	0.22	6.36	5.15	010
69410	.....	A	Inset middle ear (baffle)	0.33	2.06	0.50	0.02	2.41	0.85	000
69420	.....	A	Incision of eardrum	1.32	3.11	1.60	0.12	4.55	3.04	010
69421	.....	A	Incision of eardrum	1.72	NA	2.11	0.16	NA	3.99	010
69424	.....	A	Remove ventilating tube	0.85	2.16	0.69	0.07	3.08	1.61	000
69433	.....	A	Create eardrum opening	1.51	3.13	1.68	0.13	4.77	3.32	010
69436	.....	A	Create eardrum opening	1.95	NA	2.24	0.17	NA	4.36	010
69440	.....	A	Exploration of middle ear	7.53	NA	6.34	0.64	NA	14.51	090
69450	.....	A	Eardrum revision	5.54	NA	5.07	0.47	NA	11.08	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
69501		A	Mastoidectomy	9.02	NA	7.13	0.78	NA	16.93	090
69502		A	Mastoidectomy	12.31	NA	9.36	1.03	NA	22.70	090
69505		A	Remove mastoid structures	12.92	NA	9.62	1.10	NA	23.64	090
69511		A	Extensive mastoid surgery	13.44	NA	9.95	1.15	NA	24.54	090
69530		A	Extensive mastoid surgery	19.08	NA	13.14	1.58	NA	33.80	090
69535		A	Remove part of temporal bone	35.93	NA	22.59	3.10	NA	61.62	090
69540		A	Remove ear lesion	1.19	3.72	1.95	0.11	5.02	3.25	010
69550		A	Remove ear lesion	10.93	NA	8.39	0.96	NA	20.28	090
69552		A	Remove ear lesion	19.35	NA	13.06	1.63	NA	34.04	090
69554		A	Remove ear lesion	32.97	NA	21.10	2.78	NA	56.85	090
69601		A	Mastoid surgery revision	13.16	NA	10.11	1.10	NA	24.37	090
69602		A	Mastoid surgery revision	13.50	NA	10.05	1.13	NA	24.68	090
69603		A	Mastoid surgery revision	13.94	NA	10.28	1.20	NA	25.42	090
69604		A	Mastoid surgery revision	13.94	NA	10.26	1.17	NA	25.37	090
69605		A	Mastoid surgery revision	18.38	NA	12.94	1.55	NA	32.87	090
69610		A	Repair of eardrum	4.40	5.45	3.30	0.37	10.22	8.07	010
69620		A	Repair of eardrum	5.86	6.19	4.55	0.48	12.53	10.89	090
69631		A	Repair eardrum structures	9.80	NA	7.94	0.83	NA	18.57	090
69632		A	Rebuild eardrum structures	12.68	NA	9.83	1.07	NA	23.58	090
69633		A	Rebuild eardrum structures	12.03	NA	9.49	1.01	NA	22.53	090
69635		A	Repair eardrum structures	13.25	NA	9.50	1.04	NA	23.79	090
69636		A	Rebuild eardrum structures	15.13	NA	11.26	1.28	NA	27.67	090
69637		A	Rebuild eardrum structures	15.02	NA	11.20	1.27	NA	27.49	090
69641		A	Revise middle ear & mastoid	12.64	NA	9.58	1.07	NA	23.29	090
69642		A	Revise middle ear & mastoid	16.74	NA	12.24	1.41	NA	30.39	090
69643		A	Revise middle ear & mastoid	15.23	NA	11.27	1.29	NA	27.79	090
69644		A	Revise middle ear & mastoid	16.87	NA	12.19	1.43	NA	30.49	090
69645		A	Revise middle ear & mastoid	16.29	NA	11.83	1.39	NA	29.51	090
69646		A	Revise middle ear & mastoid	17.89	NA	12.76	1.51	NA	32.16	090
69650		A	Release middle ear bone	9.60	NA	7.48	0.82	NA	17.90	090
69660		A	Revise middle ear bone	11.83	NA	8.70	1.01	NA	21.54	090
69661		A	Revise middle ear bone	15.65	NA	11.19	1.32	NA	28.16	090
69662		A	Revise middle ear bone	15.35	NA	10.91	1.29	NA	27.55	090
69666		A	Repair middle ear structures	9.69	NA	7.55	0.82	NA	18.06	090
69667		A	Repair middle ear structures	9.70	NA	7.54	0.86	NA	18.10	090
69670		A	Remove mastoid air cells	11.44	NA	8.73	0.93	NA	21.10	090
69676		A	Remove middle ear nerve	9.47	NA	7.68	0.83	NA	17.98	090
69700		A	Close mastoid fistula	8.18	NA	5.93	0.66	NA	14.77	090
69710		N	Implant/replace hearing aid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
69711		A	Remove/repair hearing aid	10.38	NA	8.15	0.74	NA	19.27	090
69714		A	Implant temple bone w/stimul	13.92	NA	10.00	1.21	NA	25.13	090
69715		A	Temple bne implnt w/stimulat	18.15	NA	12.50	1.58	NA	32.23	090
69717		A	Temple bone implant revision	14.89	NA	9.67	1.29	NA	25.85	090
69718		A	Revise temple bone implant	18.39	NA	12.41	1.61	NA	32.41	090
69720		A	Release facial nerve	14.30	NA	10.86	1.23	NA	26.39	090
69725		A	Release facial nerve	25.24	NA	17.01	2.13	NA	44.38	090
69740		A	Repair facial nerve	15.87	NA	10.46	1.35	NA	27.68	090
69745		A	Repair facial nerve	16.59	NA	11.46	1.20	NA	29.25	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	8.51	NA	6.88	0.72	NA	16.11	090
69802		A	Incise inner ear	13.03	NA	9.69	1.09	NA	23.81	090
69805		A	Explore inner ear	13.74	NA	10.14	1.16	NA	25.04	090
69806		A	Explore inner ear	12.28	NA	9.26	1.03	NA	22.57	090
69820		A	Establish inner ear window	10.28	NA	7.91	0.79	NA	18.98	090
69840		A	Revise inner ear window	10.20	NA	6.98	0.77	NA	17.95	090
69905		A	Remove inner ear	11.04	NA	8.38	0.92	NA	20.34	090
69910		A	Remove inner ear & mastoid	13.55	NA	9.81	1.13	NA	24.49	090
69915		A	Incise inner ear nerve	21.11	NA	14.30	1.85	NA	37.26	090
69930		A	Implant cochlear device	16.71	NA	11.95	1.43	NA	30.09	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	25.49	NA	16.21	3.48	NA	45.18	090
69955		A	Release facial nerve	26.89	NA	17.76	2.27	NA	46.92	090
69960		A	Release inner ear canal	26.89	NA	17.24	2.91	NA	47.04	090
69970		A	Remove inner ear lesion	29.87	NA	18.53	2.80	NA	51.20	090
69979		C	Temporal bone surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69990		R	Microsurgery add-on	3.45	NA	1.82	0.67	NA	5.94	ZZZ
70010		A	Contrast x-ray of brain	1.18	4.70	NA	0.29	6.17	NA	XXX
70010	26	A	Contrast x-ray of brain	1.18	0.40	0.40	0.07	1.65	1.65	XXX
70010	TC	A	Contrast x-ray of brain	0.00	4.30	NA	0.22	4.52	NA	XXX
70015		A	Contrast x-ray of brain	1.18	1.74	NA	0.14	3.06	NA	XXX
70015	26	A	Contrast x-ray of brain	1.18	0.40	0.40	0.06	1.64	1.64	XXX
70015	TC	A	Contrast x-ray of brain	0.00	1.34	NA	0.08	1.42	NA	XXX
70030		A	X-ray eye for foreign body	0.17	0.48	NA	0.03	0.68	NA	XXX
70030	26	A	X-ray eye for foreign body	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70030	TC	A	X-ray eye for foreign body	0.00	0.42	NA	0.02	0.44	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
70100		A	X-ray exam of jaw	0.18	0.58	NA	0.03	0.79	NA	XXX
70100	26	A	X-ray exam of jaw	0.18	0.06	0.06	0.01	0.25	0.25	XXX
70100	TC	A	X-ray exam of jaw	0.00	0.52	NA	0.02	0.54	NA	XXX
70110		A	X-ray exam of jaw	0.25	0.70	NA	0.05	1.00	NA	XXX
70110	26	A	X-ray exam of jaw	0.25	0.08	0.08	0.01	0.34	0.34	XXX
70110	TC	A	X-ray exam of jaw	0.00	0.62	NA	0.04	0.66	NA	XXX
70120		A	X-ray exam of mastoids	0.18	0.68	NA	0.05	0.91	NA	XXX
70120	26	A	X-ray exam of mastoids	0.18	0.06	0.06	0.01	0.25	0.25	XXX
70120	TC	A	X-ray exam of mastoids	0.00	0.62	NA	0.04	0.66	NA	XXX
70130		A	X-ray exam of mastoids	0.34	0.88	NA	0.06	1.28	NA	XXX
70130	26	A	X-ray exam of mastoids	0.34	0.11	0.11	0.01	0.46	0.46	XXX
70130	TC	A	X-ray exam of mastoids	0.00	0.77	NA	0.05	0.82	NA	XXX
70134		A	X-ray exam of middle ear	0.34	0.83	NA	0.06	1.23	NA	XXX
70134	26	A	X-ray exam of middle ear	0.34	0.11	0.11	0.01	0.46	0.46	XXX
70134	TC	A	X-ray exam of middle ear	0.00	0.72	NA	0.05	0.77	NA	XXX
70140		A	X-ray exam of facial bones	0.19	0.68	NA	0.05	0.92	NA	XXX
70140	26	A	X-ray exam of facial bones	0.19	0.06	0.06	0.01	0.26	0.26	XXX
70140	TC	A	X-ray exam of facial bones	0.00	0.62	NA	0.04	0.66	NA	XXX
70150		A	X-ray exam of facial bones	0.26	0.86	NA	0.06	1.18	NA	XXX
70150	26	A	X-ray exam of facial bones	0.26	0.09	0.09	0.01	0.36	0.36	XXX
70150	TC	A	X-ray exam of facial bones	0.00	0.77	NA	0.05	0.82	NA	XXX
70160		A	X-ray exam of nasal bones	0.17	0.58	NA	0.03	0.78	NA	XXX
70160	26	A	X-ray exam of nasal bones	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70160	TC	A	X-ray exam of nasal bones	0.00	0.52	NA	0.02	0.54	NA	XXX
70170		A	X-ray exam of tear duct	0.30	1.04	NA	0.07	1.41	NA	XXX
70170	26	A	X-ray exam of tear duct	0.30	0.10	0.10	0.01	0.41	0.41	XXX
70170	TC	A	X-ray exam of tear duct	0.00	0.94	NA	0.06	1.00	NA	XXX
70190		A	X-ray exam of eye sockets	0.21	0.69	NA	0.05	0.95	NA	XXX
70190	26	A	X-ray exam of eye sockets	0.21	0.07	0.07	0.01	0.29	0.29	XXX
70190	TC	A	X-ray exam of eye sockets	0.00	0.62	NA	0.04	0.66	NA	XXX
70200		A	X-ray exam of eye sockets	0.28	0.86	NA	0.06	1.20	NA	XXX
70200	26	A	X-ray exam of eye sockets	0.28	0.09	0.09	0.01	0.38	0.38	XXX
70200	TC	A	X-ray exam of eye sockets	0.00	0.77	NA	0.05	0.82	NA	XXX
70210		A	X-ray exam of sinuses	0.17	0.68	NA	0.05	0.90	NA	XXX
70210	26	A	X-ray exam of sinuses	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70210	TC	A	X-ray exam of sinuses	0.00	0.62	NA	0.04	0.66	NA	XXX
70220		A	X-ray exam of sinuses	0.25	0.85	NA	0.06	1.16	NA	XXX
70220	26	A	X-ray exam of sinuses	0.25	0.08	0.08	0.01	0.34	0.34	XXX
70220	TC	A	X-ray exam of sinuses	0.00	0.77	NA	0.05	0.82	NA	XXX
70240		A	X-ray exam, pituitary saddle	0.19	0.48	NA	0.03	0.70	NA	XXX
70240	26	A	X-ray exam, pituitary saddle	0.19	0.06	0.06	0.01	0.26	0.26	XXX
70240	TC	A	X-ray exam, pituitary saddle	0.00	0.42	NA	0.02	0.44	NA	XXX
70250		A	X-ray exam of skull	0.24	0.70	NA	0.05	0.99	NA	XXX
70250	26	A	X-ray exam of skull	0.24	0.08	0.08	0.01	0.33	0.33	XXX
70250	TC	A	X-ray exam of skull	0.00	0.62	NA	0.04	0.66	NA	XXX
70260		A	X-ray exam of skull	0.34	0.99	NA	0.07	1.40	NA	XXX
70260	26	A	X-ray exam of skull	0.34	0.11	0.11	0.01	0.46	0.46	XXX
70260	TC	A	X-ray exam of skull	0.00	0.88	NA	0.06	0.94	NA	XXX
70300		A	X-ray exam of teeth	0.10	0.31	NA	0.03	0.44	NA	XXX
70300	26	A	X-ray exam of teeth	0.10	0.05	0.05	0.01	0.16	0.16	XXX
70300	TC	A	X-ray exam of teeth	0.00	0.26	NA	0.02	0.28	NA	XXX
70310		A	X-ray exam of teeth	0.16	0.50	NA	0.03	0.69	NA	XXX
70310	26	A	X-ray exam of teeth	0.16	0.08	0.08	0.01	0.25	0.25	XXX
70310	TC	A	X-ray exam of teeth	0.00	0.42	NA	0.02	0.44	NA	XXX
70320		A	Full mouth x-ray of teeth	0.22	0.85	NA	0.06	1.13	NA	XXX
70320	26	A	Full mouth x-ray of teeth	0.22	0.08	0.08	0.01	0.31	0.31	XXX
70320	TC	A	Full mouth x-ray of teeth	0.00	0.77	NA	0.05	0.82	NA	XXX
70328		A	X-ray exam of jaw joint	0.18	0.55	NA	0.03	0.76	NA	XXX
70328	26	A	X-ray exam of jaw joint	0.18	0.06	0.06	0.01	0.25	0.25	XXX
70328	TC	A	X-ray exam of jaw joint	0.00	0.49	NA	0.02	0.51	NA	XXX
70330		A	X-ray exam of jaw joints	0.24	0.91	NA	0.06	1.21	NA	XXX
70330	26	A	X-ray exam of jaw joints	0.24	0.08	0.08	0.01	0.33	0.33	XXX
70330	TC	A	X-ray exam of jaw joints	0.00	0.83	NA	0.05	0.88	NA	XXX
70332		A	X-ray exam of jaw joint	0.54	2.28	NA	0.14	2.96	NA	XXX
70332	26	A	X-ray exam of jaw joint	0.54	0.20	0.20	0.02	0.76	0.76	XXX
70332	TC	A	X-ray exam of jaw joint	0.00	2.08	NA	0.12	2.20	NA	XXX
70336		A	Magnetic image, jaw joint	1.47	11.61	NA	0.67	13.75	NA	XXX
70336	26	A	Magnetic image, jaw joint	1.47	0.50	0.50	0.08	2.05	2.05	XXX
70336	TC	A	Magnetic image, jaw joint	0.00	11.11	NA	0.59	11.70	NA	XXX
70350		A	X-ray head for orthodontia	0.17	0.45	NA	0.03	0.65	NA	XXX
70350	26	A	X-ray head for orthodontia	0.17	0.07	0.07	0.01	0.25	0.25	XXX
70350	TC	A	X-ray head for orthodontia	0.00	0.38	NA	0.02	0.40	NA	XXX
70355		A	Panoramic x-ray of jaws	0.20	0.65	NA	0.05	0.90	NA	XXX
70355	26	A	Panoramic x-ray of jaws	0.20	0.08	0.08	0.01	0.29	0.29	XXX
70355	TC	A	Panoramic x-ray of jaws	0.00	0.57	NA	0.04	0.61	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
70360		A	X-ray exam of neck	0.17	0.48	NA	0.03	0.68	NA	XXX
70360	26	A	X-ray exam of neck	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70360	TC	A	X-ray exam of neck	0.00	0.42	NA	0.02	0.44	NA	XXX
70370		A	Throat x-ray & fluoroscopy	0.32	1.40	NA	0.08	1.80	NA	XXX
70370	26	A	Throat x-ray & fluoroscopy	0.32	0.11	0.11	0.01	0.44	0.44	XXX
70370	TC	A	Throat x-ray & fluoroscopy	0.00	1.29	NA	0.07	1.36	NA	XXX
70371		A	Speech evaluation, complex	0.84	2.36	NA	0.17	3.37	NA	XXX
70371	26	A	Speech evaluation, complex	0.84	0.28	0.28	0.05	1.17	1.17	XXX
70371	TC	A	Speech evaluation, complex	0.00	2.08	NA	0.12	2.20	NA	XXX
70373		A	Contrast x-ray of larynx	0.44	1.92	NA	0.13	2.49	NA	XXX
70373	26	A	Contrast x-ray of larynx	0.44	0.15	0.15	0.02	0.61	0.61	XXX
70373	TC	A	Contrast x-ray of larynx	0.00	1.77	NA	0.11	1.88	NA	XXX
70380		A	X-ray exam of salivary gland	0.17	0.72	NA	0.05	0.94	NA	XXX
70380	26	A	X-ray exam of salivary gland	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70380	TC	A	X-ray exam of salivary gland	0.00	0.66	NA	0.04	0.70	NA	XXX
70390		A	X-ray exam of salivary duct	0.38	1.90	NA	0.13	2.41	NA	XXX
70390	26	A	X-ray exam of salivary duct	0.38	0.13	0.13	0.02	0.53	0.53	XXX
70390	TC	A	X-ray exam of salivary duct	0.00	1.77	NA	0.11	1.88	NA	XXX
70450		A	Ct head/brain w/o dye	0.85	4.95	NA	0.30	6.10	NA	XXX
70450	26	A	Ct head/brain w/o dye	0.85	0.28	0.28	0.05	1.18	1.18	XXX
70450	TC	A	Ct head/brain w/o dye	0.00	4.67	NA	0.25	4.92	NA	XXX
70460		A	Ct head/brain w/dye	1.12	5.99	NA	0.36	7.47	NA	XXX
70460	26	A	Ct head/brain w/dye	1.12	0.38	0.38	0.06	1.56	1.56	XXX
70460	TC	A	Ct head/brain w/dye	0.00	5.61	NA	0.30	5.91	NA	XXX
70470		A	Ct head/brain w/o & w/ dye	1.26	7.43	NA	0.44	9.13	NA	XXX
70470	26	A	Ct head/brain w/o & w/ dye	1.26	0.42	0.42	0.07	1.75	1.75	XXX
70470	TC	A	Ct head/brain w/o & w/ dye	0.00	7.01	NA	0.37	7.38	NA	XXX
70480		A	Ct orbit/ear/fossa w/o dye	1.27	5.10	NA	0.32	6.69	NA	XXX
70480	26	A	Ct orbit/ear/fossa w/o dye	1.27	0.43	0.43	0.07	1.77	1.77	XXX
70480	TC	A	Ct orbit/ear/fossa w/o dye	0.00	4.67	NA	0.25	4.92	NA	XXX
70481		A	Ct orbit/ear/fossa w/dye	1.37	6.07	NA	0.37	7.81	NA	XXX
70481	26	A	Ct orbit/ear/fossa w/dye	1.37	0.46	0.46	0.07	1.90	1.90	XXX
70481	TC	A	Ct orbit/ear/fossa w/dye	0.00	5.61	NA	0.30	5.91	NA	XXX
70482		A	Ct orbit/ear/fossa w/o&w dye	1.44	7.50	NA	0.44	9.38	NA	XXX
70482	26	A	Ct orbit/ear/fossa w/o&w dye	1.44	0.49	0.49	0.07	2.00	2.00	XXX
70482	TC	A	Ct orbit/ear/fossa w/o&w dye	0.00	7.01	NA	0.37	7.38	NA	XXX
70486		A	Ct maxillofacial w/o dye	1.13	5.05	NA	0.31	6.49	NA	XXX
70486	26	A	Ct maxillofacial w/o dye	1.13	0.38	0.38	0.06	1.57	1.57	XXX
70486	TC	A	Ct maxillofacial w/o dye	0.00	4.67	NA	0.25	4.92	NA	XXX
70487		A	Ct maxillofacial w/dye	1.29	6.05	NA	0.37	7.71	NA	XXX
70487	26	A	Ct maxillofacial w/dye	1.29	0.44	0.44	0.07	1.80	1.80	XXX
70487	TC	A	Ct maxillofacial w/dye	0.00	5.61	NA	0.30	5.91	NA	XXX
70488		A	Ct maxillofacial w/o & w dye	1.41	7.48	NA	0.44	9.33	NA	XXX
70488	26	A	Ct maxillofacial w/o & w dye	1.41	0.47	0.47	0.07	1.95	1.95	XXX
70488	TC	A	Ct maxillofacial w/o & w dye	0.00	7.01	NA	0.37	7.38	NA	XXX
70490		A	Ct soft tissue neck w/o dye	1.27	5.10	NA	0.32	6.69	NA	XXX
70490	26	A	Ct soft tissue neck w/o dye	1.27	0.43	0.43	0.07	1.77	1.77	XXX
70490	TC	A	Ct soft tissue neck w/o dye	0.00	4.67	NA	0.25	4.92	NA	XXX
70491		A	Ct soft tissue neck w/dye	1.37	6.07	NA	0.37	7.81	NA	XXX
70491	26	A	Ct soft tissue neck w/dye	1.37	0.46	0.46	0.07	1.90	1.90	XXX
70491	TC	A	Ct soft tissue neck w/dye	0.00	5.61	NA	0.30	5.91	NA	XXX
70492		A	Ct sft tsue nck w/o & w/dye	1.44	7.49	NA	0.44	9.37	NA	XXX
70492	26	A	Ct sft tsue nck w/o & w/dye	1.44	0.48	0.48	0.07	1.99	1.99	XXX
70492	TC	A	Ct sft tsue nck w/o & w/dye	0.00	7.01	NA	0.37	7.38	NA	XXX
70496		A	Ct angiography, head	1.74	11.10	NA	0.68	13.52	NA	XXX
70496	26	A	Ct angiography, head	1.74	0.58	0.58	0.10	2.42	2.42	XXX
70496	TC	A	Ct angiography, head	0.00	10.52	NA	0.58	11.10	NA	XXX
70498		A	Ct angiography, neck	1.74	11.11	NA	0.68	13.53	NA	XXX
70498	26	A	Ct angiography, neck	1.74	0.59	0.59	0.10	2.43	2.43	XXX
70498	TC	A	Ct angiography, neck	0.00	10.52	NA	0.58	11.10	NA	XXX
70540		A	Mri orbit/face/neck w/o dye	1.34	11.56	NA	0.43	13.33	NA	XXX
70540	26	A	Mri orbit/face/neck w/o dye	1.34	0.45	0.45	0.05	1.84	1.84	XXX
70540	TC	A	Mri orbit/face/neck w/o dye	0.00	11.11	NA	0.38	11.49	NA	XXX
70542		A	Mri orbit/face/neck w/dye	1.61	13.88	NA	0.53	16.02	NA	XXX
70542	26	A	Mri orbit/face/neck w/dye	1.61	0.55	0.55	0.06	2.22	2.22	XXX
70542	TC	A	Mri orbit/face/neck w/dye	0.00	13.33	NA	0.47	13.80	NA	XXX
70543		A	Mri orbt/fac/nck w/o & w dye	2.14	25.39	NA	0.92	28.45	NA	XXX
70543	26	A	Mri orbt/fac/nck w/o & w dye	2.14	0.71	0.71	0.08	2.93	2.93	XXX
70543	TC	A	Mri orbt/fac/nck w/o & w dye	0.00	24.68	NA	0.84	25.52	NA	XXX
70544		A	Mr angiography head w/o dye	1.19	11.51	NA	0.65	13.35	NA	XXX
70544	26	A	Mr angiography head w/o dye	1.19	0.40	0.40	0.06	1.65	1.65	XXX
70544	TC	A	Mr angiography head w/o dye	0.00	11.11	NA	0.59	11.70	NA	XXX
70545		A	Mr angiography head w/dye	1.19	11.51	NA	0.65	13.35	NA	XXX
70545	26	A	Mr angiography head w/dye	1.19	0.40	0.40	0.06	1.65	1.65	XXX
70545	TC	A	Mr angiography head w/dye	0.00	11.11	NA	0.59	11.70	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
70546	.....	A	Mr angiograph head w/o&w dye	1.79	22.83	NA	0.69	25.31	NA	XXX
70546	26	A	Mr angiograph head w/o&w dye	1.79	0.61	0.61	0.10	2.50	2.50	XXX
70546	TC	A	Mr angiograph head w/o&w dye	0.00	22.22	NA	0.59	22.81	NA	XXX
70547	.....	A	Mr angiography neck w/o dye	1.19	11.51	NA	0.65	13.35	NA	XXX
70547	26	A	Mr angiography neck w/o dye	1.19	0.40	0.40	0.06	1.65	1.65	XXX
70547	TC	A	Mr angiography neck w/o dye	0.00	11.11	NA	0.59	11.70	NA	XXX
70548	.....	A	Mr angiography neck w/dye	1.19	11.51	NA	0.65	13.35	NA	XXX
70548	26	A	Mr angiography neck w/dye	1.19	0.40	0.40	0.06	1.65	1.65	XXX
70548	TC	A	Mr angiography neck w/dye	0.00	11.11	NA	0.59	11.70	NA	XXX
70549	.....	A	Mr angiograph neck w/o&w dye	1.79	22.83	NA	0.69	25.31	NA	XXX
70549	26	A	Mr angiograph neck w/o&w dye	1.79	0.61	0.61	0.10	2.50	2.50	XXX
70549	TC	A	Mr angiograph neck w/o&w dye	0.00	22.22	NA	0.59	22.81	NA	XXX
70551	.....	A	Mri brain w/o dye	1.47	11.61	NA	0.67	13.75	NA	XXX
70551	26	A	Mri brain w/o dye	1.47	0.50	0.50	0.08	2.05	2.05	XXX
70551	TC	A	Mri brain w/o dye	0.00	11.11	NA	0.59	11.70	NA	XXX
70552	.....	A	Mri brain w/ dye	1.77	13.94	NA	0.80	16.51	NA	XXX
70552	26	A	Mri brain w/ dye	1.77	0.61	0.61	0.10	2.48	2.48	XXX
70552	TC	A	Mri brain w/ dye	0.00	13.33	NA	0.70	14.03	NA	XXX
70553	.....	A	Mri brain w/o & w/ dye	2.35	25.46	NA	1.43	29.24	NA	XXX
70553	26	A	Mri brain w/o & w/ dye	2.35	0.78	0.78	0.12	3.25	3.25	XXX
70553	TC	A	Mri brain w/o & w/ dye	0.00	24.68	NA	1.31	25.99	NA	XXX
70557	.....	C	Mri brain w/o dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX
70557	26	A	Mri brain w/o dye	2.88	0.99	0.99	0.08	3.95	3.95	XXX
70557	TC	C	Mri brain w/o dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX
70558	.....	C	Mri brain w/ dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX
70558	26	A	Mri brain w/ dye	3.18	1.09	1.09	0.10	4.37	4.37	XXX
70558	TC	C	Mri brain w/ dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX
70559	.....	C	Mri brain w/o & w/ dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX
70559	26	A	Mri brain w/o & w/ dye	3.18	1.09	1.09	0.12	4.39	4.39	XXX
70559	TC	C	Mri brain w/o & w/ dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX
71010	.....	A	Chest x-ray	0.18	0.53	NA	0.03	0.74	NA	XXX
71010	26	A	Chest x-ray	0.18	0.06	0.06	0.01	0.25	0.25	XXX
71010	TC	A	Chest x-ray	0.00	0.47	NA	0.02	0.49	NA	XXX
71015	.....	A	Chest x-ray	0.21	0.59	NA	0.03	0.83	NA	XXX
71015	26	A	Chest x-ray	0.21	0.07	0.07	0.01	0.29	0.29	XXX
71015	TC	A	Chest x-ray	0.00	0.52	NA	0.02	0.54	NA	XXX
71020	.....	A	Chest x-ray	0.22	0.69	NA	0.05	0.96	NA	XXX
71020	26	A	Chest x-ray	0.22	0.07	0.07	0.01	0.30	0.30	XXX
71020	TC	A	Chest x-ray	0.00	0.62	NA	0.04	0.66	NA	XXX
71021	.....	A	Chest x-ray	0.27	0.81	NA	0.06	1.14	NA	XXX
71021	26	A	Chest x-ray	0.27	0.09	0.09	0.01	0.37	0.37	XXX
71021	TC	A	Chest x-ray	0.00	0.72	NA	0.05	0.77	NA	XXX
71022	.....	A	Chest x-ray	0.31	0.82	NA	0.07	1.20	NA	XXX
71022	26	A	Chest x-ray	0.31	0.10	0.10	0.02	0.43	0.43	XXX
71022	TC	A	Chest x-ray	0.00	0.72	NA	0.05	0.77	NA	XXX
71023	.....	A	Chest x-ray and fluoroscopy	0.38	0.90	NA	0.07	1.35	NA	XXX
71023	26	A	Chest x-ray and fluoroscopy	0.38	0.13	0.13	0.02	0.53	0.53	XXX
71023	TC	A	Chest x-ray and fluoroscopy	0.00	0.77	NA	0.05	0.82	NA	XXX
71030	.....	A	Chest x-ray	0.31	0.87	NA	0.06	1.24	NA	XXX
71030	26	A	Chest x-ray	0.31	0.10	0.10	0.01	0.42	0.42	XXX
71030	TC	A	Chest x-ray	0.00	0.77	NA	0.05	0.82	NA	XXX
71034	.....	A	Chest x-ray and fluoroscopy	0.46	1.59	NA	0.10	2.15	NA	XXX
71034	26	A	Chest x-ray and fluoroscopy	0.46	0.16	0.16	0.02	0.64	0.64	XXX
71034	TC	A	Chest x-ray and fluoroscopy	0.00	1.43	NA	0.08	1.51	NA	XXX
71035	.....	A	Chest x-ray	0.18	0.58	NA	0.03	0.79	NA	XXX
71035	26	A	Chest x-ray	0.18	0.06	0.06	0.01	0.25	0.25	XXX
71035	TC	A	Chest x-ray	0.00	0.52	NA	0.02	0.54	NA	XXX
71040	.....	A	Contrast x-ray of bronchi	0.58	1.64	NA	0.12	2.34	NA	XXX
71040	26	A	Contrast x-ray of bronchi	0.58	0.19	0.19	0.04	0.81	0.81	XXX
71040	TC	A	Contrast x-ray of bronchi	0.00	1.45	NA	0.08	1.53	NA	XXX
71060	.....	A	Contrast x-ray of bronchi	0.74	2.43	NA	0.17	3.34	NA	XXX
71060	26	A	Contrast x-ray of bronchi	0.74	0.25	0.25	0.04	1.03	1.03	XXX
71060	TC	A	Contrast x-ray of bronchi	0.00	2.18	NA	0.13	2.31	NA	XXX
71090	.....	A	X-ray & pacemaker insertion	0.54	1.88	NA	0.13	2.55	NA	XXX
71090	26	A	X-ray & pacemaker insertion	0.54	0.21	0.21	0.02	0.77	0.77	XXX
71090	TC	A	X-ray & pacemaker insertion	0.00	1.67	NA	0.11	1.78	NA	XXX
71100	.....	A	X-ray exam of ribs	0.22	0.64	NA	0.05	0.91	NA	XXX
71100	26	A	X-ray exam of ribs	0.22	0.07	0.07	0.01	0.30	0.30	XXX
71100	TC	A	X-ray exam of ribs	0.00	0.57	NA	0.04	0.61	NA	XXX
71101	.....	A	X-ray exam of ribs/chest	0.27	0.75	NA	0.05	1.07	NA	XXX
71101	26	A	X-ray exam of ribs/chest	0.27	0.09	0.09	0.01	0.37	0.37	XXX
71101	TC	A	X-ray exam of ribs/chest	0.00	0.66	NA	0.04	0.70	NA	XXX
71110	.....	A	X-ray exam of ribs	0.27	0.86	NA	0.06	1.19	NA	XXX
71110	26	A	X-ray exam of ribs	0.27	0.09	0.09	0.01	0.37	0.37	XXX
71110	TC	A	X-ray exam of ribs	0.00	0.77	NA	0.05	0.82	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
71111	.....	A	X-ray exam of ribs/ chest	0.32	0.99	NA	0.07	1.38	NA	XXX
71111	26	A	X-ray exam of ribs/ chest	0.32	0.11	0.11	0.01	0.44	0.44	XXX
71111	TC	A	X-ray exam of ribs/ chest	0.00	0.88	NA	0.06	0.94	NA	XXX
71120	.....	A	X-ray exam of breastbone	0.20	0.71	NA	0.05	0.96	NA	XXX
71120	26	A	X-ray exam of breastbone	0.20	0.07	0.07	0.01	0.28	0.28	XXX
71120	TC	A	X-ray exam of breastbone	0.00	0.64	NA	0.04	0.68	NA	XXX
71130	.....	A	X-ray exam of breastbone	0.22	0.77	NA	0.05	1.04	NA	XXX
71130	26	A	X-ray exam of breastbone	0.22	0.07	0.07	0.01	0.30	0.30	XXX
71130	TC	A	X-ray exam of breastbone	0.00	0.70	NA	0.04	0.74	NA	XXX
71250	.....	A	Ct thorax w/o dye	1.15	6.24	NA	0.37	7.76	NA	XXX
71250	26	A	Ct thorax w/o dye	1.15	0.39	0.39	0.06	1.60	1.60	XXX
71250	TC	A	Ct thorax w/o dye	0.00	5.85	NA	0.31	6.16	NA	XXX
71260	.....	A	Ct thorax w/dye	1.23	7.42	NA	0.43	9.08	NA	XXX
71260	26	A	Ct thorax w/dye	1.23	0.41	0.41	0.06	1.70	1.70	XXX
71260	TC	A	Ct thorax w/dye	0.00	7.01	NA	0.37	7.38	NA	XXX
71270	.....	A	Ct thorax w/o & w/ dye	1.37	9.23	NA	0.53	11.13	NA	XXX
71270	26	A	Ct thorax w/o & w/ dye	1.37	0.46	0.46	0.07	1.90	1.90	XXX
71270	TC	A	Ct thorax w/o & w/ dye	0.00	8.77	NA	0.46	9.23	NA	XXX
71275	.....	A	Ct angiography, chest	1.91	12.92	NA	0.45	15.28	NA	XXX
71275	26	A	Ct angiography, chest	1.91	0.64	0.64	0.07	2.62	2.62	XXX
71275	TC	A	Ct angiography, chest	0.00	12.28	NA	0.38	12.66	NA	XXX
71550	.....	A	Mri chest w/o dye	1.45	11.60	NA	0.49	13.54	NA	XXX
71550	26	A	Mri chest w/o dye	1.45	0.49	0.49	0.05	1.99	1.99	XXX
71550	TC	A	Mri chest w/o dye	0.00	11.11	NA	0.44	11.55	NA	XXX
71551	.....	A	Mri chest w/dye	1.72	13.91	NA	0.59	16.22	NA	XXX
71551	26	A	Mri chest w/dye	1.72	0.58	0.58	0.07	2.37	2.37	XXX
71551	TC	A	Mri chest w/dye	0.00	13.33	NA	0.52	13.85	NA	XXX
71552	.....	A	Mri chest w/o & w/dye	2.25	25.43	NA	0.77	28.45	NA	XXX
71552	26	A	Mri chest w/o & w/dye	2.25	0.75	0.75	0.10	3.10	3.10	XXX
71552	TC	A	Mri chest w/o & w/dye	0.00	24.68	NA	0.67	25.35	NA	XXX
71555	.....	R	Mri angio chest w or w/o dye	1.80	11.72	NA	0.69	14.21	NA	XXX
71555	26	R	Mri angio chest w or w/o dye	1.80	0.61	0.61	0.10	2.51	2.51	XXX
71555	TC	R	Mri angio chest w or w/o dye	0.00	11.11	NA	0.59	11.70	NA	XXX
72010	.....	A	X-ray exam of spine	0.45	1.16	NA	0.10	1.71	NA	XXX
72010	26	A	X-ray exam of spine	0.45	0.15	0.15	0.04	0.64	0.64	XXX
72010	TC	A	X-ray exam of spine	0.00	1.01	NA	0.06	1.07	NA	XXX
72020	.....	A	X-ray exam of spine	0.15	0.47	NA	0.03	0.65	NA	XXX
72020	26	A	X-ray exam of spine	0.15	0.05	0.05	0.01	0.21	0.21	XXX
72020	TC	A	X-ray exam of spine	0.00	0.42	NA	0.02	0.44	NA	XXX
72040	.....	A	X-ray exam of neck spine	0.22	0.67	NA	0.05	0.94	NA	XXX
72040	26	A	X-ray exam of neck spine	0.22	0.07	0.07	0.01	0.30	0 30	XXX
72040	TC	A	X-ray exam of neck spine	0.00	0.60	NA	0.04	0.64	NA	XXX
72050	.....	A	X-ray exam of neck spine	0.31	0.98	NA	0.08	1.37	NA	XXX
72050	26	A	X-ray exam of neck spine	0.31	0.10	0.10	0.02	0.43	0.43	XXX
72050	TC	A	X-ray exam of neck spine	0.00	0.88	NA	0.06	0.94	NA	XXX
72052	.....	A	X-ray exam of neck spine	0.36	1.24	NA	0.08	1.68	NA	XXX
72052	26	A	X-ray exam of neck spine	0.36	0.12	0.12	0.02	0.50	0.50	XXX
72052	TC	A	X-ray exam of neck spine	0.00	1.12	NA	0.06	1.18	NA	XXX
72069	.....	A	X-ray exam of trunk spine	0.22	0.57	NA	0.04	0.83	NA	XXX
72069	26	A	X-ray exam of trunk spine	0.22	0.08	0.08	0.02	0.32	0.32	XXX
72069	TC	A	X-ray exam of trunk spine	0.00	0.49	NA	0.02	0.51	NA	XXX
72070	.....	A	X-ray exam of thoracic spine	0.22	0.71	NA	0.05	0.98	NA	XXX
72070	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72070	TC	A	X-ray exam of thoracic spine	0.00	0.64	NA	0.04	0.68	NA	XXX
72072	.....	A	X-ray exam of thoracic spine	0.22	0.79	NA	0.06	1.07	NA	XXX
72072	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72072	TC	A	X-ray exam of thoracic spine	0.00	0.72	NA	0.05	0.77	NA	XXX
72074	.....	A	X-ray exam of thoracic spine	0.22	0.97	NA	0.07	1.26	NA	XXX
72074	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72074	TC	A	X-ray exam of thoracic spine	0.00	0.90	NA	0.06	0.96	NA	XXX
72080	.....	A	X-ray exam of trunk spine	0.22	0.73	NA	0.06	1.01	NA	XXX
72080	26	A	X-ray exam of trunk spine	0.22	0.07	0.07	0.02	0.31	0.31	XXX
72080	TC	A	X-ray exam of trunk spine	0.00	0.66	NA	0.04	0.70	NA	XXX
72090	.....	A	X-ray exam of trunk spine	0.28	0.76	NA	0.06	1.10	NA	XXX
72090	26	A	X-ray exam of trunk spine	0.28	0.10	0.10	0.02	0.40	0.40	XXX
72090	TC	A	X-ray exam of trunk spine	0.00	0.66	NA	0.04	0.70	NA	XXX
72100	.....	A	X-ray exam of lower spine	0.22	0.73	NA	0.06	1.01	NA	XXX
72100	26	A	X-ray exam of lower spine	0.22	0.07	0.07	0.02	0.31	0.31	XXX
72100	TC	A	X-ray exam of lower spine	0.00	0.66	NA	0.04	0.70	NA	XXX
72110	.....	A	X-ray exam of lower spine	0.31	1.00	NA	0.08	1.39	NA	XXX
72110	26	A	X-ray exam of lower spine	0.31	0.10	0.10	0.02	0.43	0.43	XXX
72110	TC	A	X-ray exam of lower spine	0.00	0.90	NA	0.06	0.96	NA	XXX
72114	.....	A	X-ray exam of lower spine	0.36	1.30	NA	0.10	1.76	NA	XXX
72114	26	A	X-ray exam of lower spine	0.36	0.12	0.12	0.04	0.52	0.52	XXX
72114	TC	A	X-ray exam of lower spine	0.00	1.18	NA	0.06	1.24	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
72120		A	X-ray exam of lower spine	0.22	0.95	NA	0.08	1.25	NA	XXX
72120	26	A	X-ray exam of lower spine	0.22	0.07	0.07	0.02	0.31	0.31	XXX
72120	TC	A	X-ray exam of lower spine	0.00	0.88	NA	0.06	0.94	NA	XXX
72125		A	Ct neck spine w/o dye	1.15	6.24	NA	0.37	7.76	NA	XXX
72125	26	A	Ct neck spine w/o dye	1.15	0.39	0.39	0.06	1.60	1.60	XXX
72125	TC	A	Ct neck spine w/o dye	0.00	5.85	NA	0.31	6.16	NA	XXX
72126		A	Ct neck spine w/dye	1.21	7.42	NA	0.43	9.06	NA	XXX
72126	26	A	Ct neck spine w/dye	1.21	0.41	0.41	0.06	1.68	1.68	XXX
72126	TC	A	Ct neck spine w/dye	0.00	7.01	NA	0.37	7.38	NA	XXX
72127		A	Ct neck spine w/o & w/dye	1.26	9.20	NA	0.53	10.99	NA	XXX
72127	26	A	Ct neck spine w/o & w/dye	1.26	0.43	0.43	0.07	1.76	1.76	XXX
72127	TC	A	Ct neck spine w/o & w/dye	0.00	8.77	NA	0.46	9.23	NA	XXX
72128		A	Ct chest spine w/o dye	1.15	6.24	NA	0.37	7.76	NA	XXX
72128	26	A	Ct chest spine w/o dye	1.15	0.39	0.39	0.06	1.60	1.60	XXX
72128	TC	A	Ct chest spine w/o dye	0.00	5.85	NA	0.31	6.16	NA	XXX
72129		A	Ct chest spine w/dye	1.21	7.42	NA	0.43	9.06	NA	XXX
72129	26	A	Ct chest spine w/dye	1.21	0.41	0.41	0.06	1.68	1.68	XXX
72129	TC	A	Ct chest spine w/dye	0.00	7.01	NA	0.37	7.38	NA	XXX
72130		A	Ct chest spine w/o & w/dye	1.26	9.19	NA	0.53	10.98	NA	XXX
72130	26	A	Ct chest spine w/o & w/dye	1.26	0.42	0.42	0.07	1.75	1.75	XXX
72130	TC	A	Ct chest spine w/o & w/dye	0.00	8.77	NA	0.46	9.23	NA	XXX
72131		A	Ct lumbar spine w/o dye	1.15	6.24	NA	0.37	7.76	NA	XXX
72131	26	A	Ct lumbar spine w/o dye	1.15	0.39	0.39	0.06	1.60	1.60	XXX
72131	TC	A	Ct lumbar spine w/o dye	0.00	5.85	NA	0.31	6.16	NA	XXX
72132		A	Ct lumbar spine w/dye	1.21	7.42	NA	0.44	9.07	NA	XXX
72132	26	A	Ct lumbar spine w/dye	1.21	0.41	0.41	0.07	1.69	1.69	XXX
72132	TC	A	Ct lumbar spine w/dye	0.00	7.01	NA	0.37	7.38	NA	XXX
72133		A	Ct lumbar spine w/o & w/dye	1.26	9.20	NA	0.53	10.99	NA	XXX
72133	26	A	Ct lumbar spine w/o & w/dye	1.26	0.43	0.43	0.07	1.76	1.76	XXX
72133	TC	A	Ct lumbar spine w/o & w/dye	0.00	8.77	NA	0.46	9.23	NA	XXX
72141		A	Mri neck spine w/o dye	1.59	11.65	NA	0.67	13.91	NA	XXX
72141	26	A	Mri neck spine w/o dye	1.59	0.54	0.54	0.08	2.21	2.21	XXX
72141	TC	A	Mri neck spine w/o dye	0.00	11.11	NA	0.59	11.70	NA	XXX
72142		A	Mri neck spine w/dye	1.91	13.98	NA	0.81	16.70	NA	XXX
72142	26	A	Mri neck spine w/dye	1.91	0.65	0.65	0.11	2.67	2.67	XXX
72142	TC	A	Mri neck spine w/dye	0.00	13.33	NA	0.70	14.03	NA	XXX
72146		A	Mri chest spine w/o dye	1.59	12.87	NA	0.72	15.18	NA	XXX
72146	26	A	Mri chest spine w/o dye	1.59	0.54	0.54	0.08	2.21	2.21	XXX
72146	TC	A	Mri chest spine w/o dye	0.00	12.33	NA	0.64	12.97	NA	XXX
72147		A	Mri chest spine w/dye	1.91	13.97	NA	0.81	16.69	NA	XXX
72147	26	A	Mri chest spine w/dye	1.91	0.64	0.64	0.11	2.66	2.66	XXX
72147	TC	A	Mri chest spine w/dye	0.00	13.33	NA	0.70	14.03	NA	XXX
72148		A	Mri lumbar spine w/o dye	1.47	12.83	NA	0.72	15.02	NA	XXX
72148	26	A	Mri lumbar spine w/o dye	1.47	0.50	0.50	0.08	2.05	2.05	XXX
72148	TC	A	Mri lumbar spine w/o dye	0.00	12.33	NA	0.64	12.97	NA	XXX
72149		A	Mri lumbar spine w/dye	1.77	13.94	NA	0.81	16.52	NA	XXX
72149	26	A	Mri lumbar spine w/dye	1.77	0.61	0.61	0.11	2.49	2.49	XXX
72149	TC	A	Mri lumbar spine w/dye	0.00	13.33	NA	0.70	14.03	NA	XXX
72156		A	Mri neck spine w/o & w/dye	2.56	25.53	NA	1.44	29.53	NA	XXX
72156	26	A	Mri neck spine w/o & w/dye	2.56	0.85	0.85	0.13	3.54	3.54	XXX
72156	TC	A	Mri neck spine w/o & w/dye	0.00	24.68	NA	1.31	25.99	NA	XXX
72157		A	Mri chest spine w/o & w/dye	2.56	25.53	NA	1.44	29.53	NA	XXX
72157	26	A	Mri chest spine w/o & w/dye	2.56	0.85	0.85	0.13	3.54	3.54	XXX
72157	TC	A	Mri chest spine w/o & w/dye	0.00	24.68	NA	1.31	25.99	NA	XXX
72158		A	Mri lumbar spine w/o & w/dye	2.35	25.46	NA	1.44	29.25	NA	XXX
72158	26	A	Mri lumbar spine w/o & w/dye	2.35	0.78	0.78	0.13	3.26	3.26	XXX
72158	TC	A	Mri lumbar spine w/o & w/dye	0.00	24.68	NA	1.31	25.99	NA	XXX
72159		N	Mr angio spine w/o&w/dye	+1.79	12.98	12.98	0.74	15.51	15.51	XXX
72159	26	N	Mr angio spine w/o&w/dye	+1.79	0.69	0.69	0.10	2.58	2.58	XXX
72159	TC	N	Mr angio spine w/o&w/dye	+0.00	12.29	12.29	0.64	12.93	12.93	XXX
72170		A	X-ray exam of pelvis	0.17	0.58	NA	0.03	0.78	NA	XXX
72170	26	A	X-ray exam of pelvis	0.17	0.06	0.06	0.01	0.24	0.24	XXX
72170	TC	A	X-ray exam of pelvis	0.00	0.52	NA	0.02	0.54	NA	XXX
72190		A	X-ray exam of pelvis	0.21	0.73	NA	0.05	0.99	NA	XXX
72190	26	A	X-ray exam of pelvis	0.21	0.07	0.07	0.01	0.29	0.29	XXX
72190	TC	A	X-ray exam of pelvis	0.00	0.66	NA	0.04	0.70	NA	XXX
72191		A	Ct angiograph pelv w/o&w/dye	1.80	12.54	NA	0.45	14.79	NA	XXX
72191	26	A	Ct angiograph pelv w/o&w/dye	1.80	0.61	0.61	0.07	2.48	2.48	XXX
72191	TC	A	Ct angiograph pelv w/o&w/dye	0.00	11.93	NA	0.38	12.31	NA	XXX
72192		A	Ct pelvis w/o dye	1.08	6.21	NA	0.37	7.66	NA	XXX
72192	26	A	Ct pelvis w/o dye	1.08	0.36	0.36	0.06	1.50	1.50	XXX
72192	TC	A	Ct pelvis w/o dye	0.00	5.85	NA	0.31	6.16	NA	XXX
72193		A	Ct pelvis w/dye	1.15	7.18	NA	0.42	8.75	NA	XXX
72193	26	A	Ct pelvis w/dye	1.15	0.39	0.39	0.06	1.60	1.60	XXX
72193	TC	A	Ct pelvis w/dye	0.00	6.79	NA	0.36	7.15	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
72194	.....	A	Ct pelvis w/o & w/dye	1.21	8.82	NA	0.49	10.52	NA	XXX
72194	26	A	Ct pelvis w/o & w/dye	1.21	0.41	0.41	0.06	1.68	1.68	XXX
72194	TC	A	Ct pelvis w/o & w/dye	0.00	8.41	NA	0.43	8.84	NA	XXX
72195	.....	A	Mri pelvis w/o dye	1.45	11.60	NA	0.50	13.55	NA	XXX
72195	26	A	Mri pelvis w/o dye	1.45	0.49	0.49	0.06	2.00	2.00	XXX
72195	TC	A	Mri pelvis w/o dye	0.00	11.11	NA	0.44	11.55	NA	XXX
72196	.....	A	Mri pelvis w/dye	1.72	13.91	NA	0.58	16.21	NA	XXX
72196	26	A	Mri pelvis w/dye	1.72	0.58	0.58	0.06	2.36	2.36	XXX
72196	TC	A	Mri pelvis w/dye	0.00	13.33	NA	0.52	13.85	NA	XXX
72197	.....	A	Mri pelvis w/o & w/dye	2.25	25.43	NA	1.01	28.69	NA	XXX
72197	26	A	Mri pelvis w/o & w/dye	2.25	0.75	0.75	0.10	3.10	3.10	XXX
72197	TC	A	Mri pelvis w/o & w/dye	0.00	24.68	NA	0.91	25.59	NA	XXX
72198	.....	A	Mr angio pelvis w/o & w/dye	1.79	11.80	NA	0.69	14.28	NA	XXX
72198	26	A	Mr angio pelvis w/o & w/dye	1.79	0.69	0.69	0.10	2.58	2.58	XXX
72198	TC	A	Mr angio pelvis w/o & w/dye	0.00	11.11	NA	0.59	11.70	NA	XXX
72200	.....	A	X-ray exam sacroiliac joints	0.17	0.58	NA	0.03	0.78	NA	XXX
72200	26	A	X-ray exam sacroiliac joints	0.17	0.06	0.06	0.01	0.24	0.24	XXX
72200	TC	A	X-ray exam sacroiliac joints	0.00	0.52	NA	0.02	0.54	NA	XXX
72202	.....	A	X-ray exam sacroiliac joints	0.19	0.68	NA	0.05	0.92	NA	XXX
72202	26	A	X-ray exam sacroiliac joints	0.19	0.06	0.06	0.01	0.26	0.26	XXX
72202	TC	A	X-ray exam sacroiliac joints	0.00	0.62	NA	0.04	0.66	NA	XXX
72220	.....	A	X-ray exam of tailbone	0.17	0.63	NA	0.05	0.85	NA	XXX
72220	26	A	X-ray exam of tailbone	0.17	0.06	0.06	0.01	0.24	0.24	XXX
72220	TC	A	X-ray exam of tailbone	0.00	0.57	NA	0.04	0.61	NA	XXX
72240	.....	A	Contrast x-ray of neck spine	0.90	4.99	NA	0.30	6.19	NA	XXX
72240	26	A	Contrast x-ray of neck spine	0.90	0.29	0.29	0.05	1.24	1.24	XXX
72240	TC	A	Contrast x-ray of neck spine	0.00	4.70	NA	0.25	4.95	NA	XXX
72255	.....	A	Contrast x-ray, thorax spine	0.90	4.58	NA	0.27	5.75	NA	XXX
72255	26	A	Contrast x-ray, thorax spine	0.90	0.28	0.28	0.05	1.23	1.23	XXX
72255	TC	A	Contrast x-ray, thorax spine	0.00	4.30	NA	0.22	4.52	NA	XXX
72265	.....	A	Contrast x-ray, lower spine	0.83	4.30	NA	0.27	5.40	NA	XXX
72265	26	A	Contrast x-ray, lower spine	0.83	0.26	0.26	0.05	1.14	1.14	XXX
72265	TC	A	Contrast x-ray, lower spine	0.00	4.04	NA	0.22	4.26	NA	XXX
72270	.....	A	Contrast x-ray, spine	1.32	6.48	NA	0.40	8.20	NA	XXX
72270	26	A	Contrast x-ray, spine	1.32	0.43	0.43	0.08	1.83	1.83	XXX
72270	TC	A	Contrast x-ray, spine	0.00	6.05	NA	0.32	6.37	NA	XXX
72275	.....	A	Epidurography	0.76	2.28	NA	0.26	3.30	NA	XXX
72275	26	A	Epidurography	0.76	0.20	0.20	0.04	1.00	1.00	XXX
72275	TC	A	Epidurography	0.00	2.08	NA	0.22	2.30	NA	XXX
72285	.....	A	X-ray c/t spine disk	1.15	8.68	NA	0.50	10.33	NA	XXX
72285	26	A	X-ray c/t spine disk	1.15	0.36	0.36	0.07	1.58	1.58	XXX
72285	TC	A	X-ray c/t spine disk	0.00	8.32	NA	0.43	8.75	NA	XXX
72295	.....	A	X-ray of lower spine disk	0.83	8.06	NA	0.45	9.34	NA	XXX
72295	26	A	X-ray of lower spine disk	0.83	0.27	0.27	0.05	1.15	1.15	XXX
72295	TC	A	X-ray of lower spine disk	0.00	7.79	NA	0.40	8.19	NA	XXX
73000	.....	A	X-ray exam of collar bone	0.16	0.57	NA	0.03	0.76	NA	XXX
73000	26	A	X-ray exam of collar bone	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73000	TC	A	X-ray exam of collar bone	0.00	0.52	NA	0.02	0.54	NA	XXX
73010	.....	A	X-ray exam of shoulder blade	0.17	0.58	NA	0.03	0.78	NA	XXX
73010	26	A	X-ray exam of shoulder blade	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73010	TC	A	X-ray exam of shoulder blade	0.00	0.52	NA	0.02	0.54	NA	XXX
73020	.....	A	X-ray exam of shoulder	0.15	0.52	NA	0.03	0.70	NA	XXX
73020	26	A	X-ray exam of shoulder	0.15	0.05	0.05	0.01	0.21	0.21	XXX
73020	TC	A	X-ray exam of shoulder	0.00	0.47	NA	0.02	0.49	NA	XXX
73030	.....	A	X-ray exam of shoulder	0.18	0.63	NA	0.05	0.86	NA	XXX
73030	26	A	X-ray exam of shoulder	0.18	0.06	0.06	0.01	0.25	0.25	XXX
73030	TC	A	X-ray exam of shoulder	0.00	0.57	NA	0.04	0.61	NA	XXX
73040	.....	A	Contrast x-ray of shoulder	0.54	2.26	NA	0.16	2.96	NA	XXX
73040	26	A	Contrast x-ray of shoulder	0.54	0.18	0.18	0.04	0.76	0.76	XXX
73040	TC	A	Contrast x-ray of shoulder	0.00	2.08	NA	0.12	2.20	NA	XXX
73050	.....	A	X-ray exam of shoulders	0.20	0.73	NA	0.06	0.99	NA	XXX
73050	26	A	X-ray exam of shoulders	0.20	0.07	0.07	0.02	0.29	0.29	XXX
73050	TC	A	X-ray exam of shoulders	0.00	0.66	NA	0.04	0.70	NA	XXX
73060	.....	A	X-ray exam of humerus	0.17	0.63	NA	0.05	0.85	NA	XXX
73060	26	A	X-ray exam of humerus	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73060	TC	A	X-ray exam of humerus	0.00	0.57	NA	0.04	0.61	NA	XXX
73070	.....	A	X-ray exam of elbow	0.15	0.57	NA	0.03	0.75	NA	XXX
73070	26	A	X-ray exam of elbow	0.15	0.05	0.05	0.01	0.21	0.21	XXX
73070	TC	A	X-ray exam of elbow	0.00	0.52	NA	0.02	0.54	NA	XXX
73080	.....	A	X-ray exam of elbow	0.17	0.63	NA	0.05	0.85	NA	XXX
73080	26	A	X-ray exam of elbow	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73080	TC	A	X-ray exam of elbow	0.00	0.57	NA	0.04	0.61	NA	XXX
73085	.....	A	Contrast x-ray of elbow	0.54	2.27	NA	0.16	2.97	NA	XXX
73085	26	A	Contrast x-ray of elbow	0.54	0.19	0.19	0.04	0.77	0.77	XXX
73085	TC	A	Contrast x-ray of elbow	0.00	2.08	NA	0.12	2.20	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
73090		A	X-ray exam of forearm	0.16	0.57	NA	0.03	0.76	NA	XXX
73090	26	A	X-ray exam of forearm	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73090	TC	A	X-ray exam of forearm	0.00	0.52	NA	0.02	0.54	NA	XXX
73092		A	X-ray exam of arm, infant	0.16	0.54	NA	0.03	0.73	NA	XXX
73092	26	A	X-ray exam of arm, infant	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73092	TC	A	X-ray exam of arm, infant	0.00	0.49	NA	0.02	0.51	NA	XXX
73100		A	X-ray exam of wrist	0.16	0.55	NA	0.04	0.75	NA	XXX
73100	26	A	X-ray exam of wrist	0.16	0.06	0.06	0.02	0.24	0.24	XXX
73100	TC	A	X-ray exam of wrist	0.00	0.49	NA	0.02	0.51	NA	XXX
73110		A	X-ray exam of wrist	0.17	0.59	NA	0.03	0.79	NA	XXX
73110	26	A	X-ray exam of wrist	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73110	TC	A	X-ray exam of wrist	0.00	0.53	NA	0.02	0.55	NA	XXX
73115		A	Contrast x-ray of wrist	0.54	1.75	NA	0.14	2.43	NA	XXX
73115	26	A	Contrast x-ray of wrist	0.54	0.19	0.19	0.04	0.77	0.77	XXX
73115	TC	A	Contrast x-ray of wrist	0.00	1.56	NA	0.10	1.66	NA	XXX
73120		A	X-ray exam of hand	0.16	0.54	NA	0.03	0.73	NA	XXX
73120	26	A	X-ray exam of hand	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73120	TC	A	X-ray exam of hand	0.00	0.49	NA	0.02	0.51	NA	XXX
73130		A	X-ray exam of hand	0.17	0.59	NA	0.03	0.79	NA	XXX
73130	26	A	X-ray exam of hand	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73130	TC	A	X-ray exam of hand	0.00	0.53	NA	0.02	0.55	NA	XXX
73140		A	X-ray exam of finger(s)	0.13	0.46	NA	0.03	0.62	NA	XXX
73140	26	A	X-ray exam of finger(s)	0.13	0.04	0.04	0.01	0.18	0.18	XXX
73140	TC	A	X-ray exam of finger(s)	0.00	0.42	NA	0.02	0.44	NA	XXX
73200		A	Ct upper extremity w/o dye	1.08	5.28	NA	0.31	6.67	NA	XXX
73200	26	A	Ct upper extremity w/o dye	1.08	0.36	0.36	0.06	1.50	1.50	XXX
73200	TC	A	Ct upper extremity w/o dye	0.00	4.92	NA	0.25	5.17	NA	XXX
73201		A	Ct upper extremity w/dye	1.15	6.24	NA	0.37	7.76	NA	XXX
73201	26	A	Ct upper extremity w/dye	1.15	0.39	0.39	0.06	1.60	1.60	XXX
73201	TC	A	Ct upper extremity w/dye	0.00	5.85	NA	0.31	6.16	NA	XXX
73202		A	Ct uppr extremity w/o&w/dye	1.21	7.77	NA	0.45	9.43	NA	XXX
73202	26	A	Ct uppr extremity w/o&w/dye	1.21	0.41	0.41	0.07	1.69	1.69	XXX
73202	TC	A	Ct uppr extremity w/o&w/dye	0.00	7.36	NA	0.38	7.74	NA	XXX
73206		A	Ct angio upr extrm w/o&w/dye	1.80	11.47	NA	0.45	13.72	NA	XXX
73206	26	A	Ct angio upr extrm w/o&w/dye	1.80	0.60	0.60	0.07	2.47	2.47	XXX
73206	TC	A	Ct angio upr extrm w/o&w/dye	0.00	10.87	NA	0.38	11.25	NA	XXX
73218		A	Mri upper extremity w/o dye	1.34	11.56	NA	0.43	13.33	NA	XXX
73218	26	A	Mri upper extremity w/o dye	1.34	0.45	0.45	0.05	1.84	1.84	XXX
73218	TC	A	Mri upper extremity w/o dye	0.00	11.11	NA	0.38	11.49	NA	XXX
73219		A	Mri upper extremity w/dye	1.61	13.88	NA	0.53	16.02	NA	XXX
73219	26	A	Mri upper extremity w/dye	1.61	0.55	0.55	0.06	2.22	2.22	XXX
73219	TC	A	Mri upper extremity w/dye	0.00	13.33	NA	0.47	13.80	NA	XXX
73220		A	Mri uppr extremity w/o&w/dye	2.14	25.39	NA	0.94	28.47	NA	XXX
73220	26	A	Mri uppr extremity w/o&w/dye	2.14	0.71	0.71	0.10	2.95	2.95	XXX
73220	TC	A	Mri uppr extremity w/o&w/dye	0.00	24.68	NA	0.84	25.52	NA	XXX
73221		A	Mri joint upr extrem w/o dye	1.34	11.56	NA	0.43	13.33	NA	XXX
73221	26	A	Mri joint upr extrem w/o dye	1.34	0.45	0.45	0.05	1.84	1.84	XXX
73221	TC	A	Mri joint upr extrem w/o dye	0.00	11.11	NA	0.38	11.49	NA	XXX
73222		A	Mri joint upr extrem w/dye	1.61	13.87	NA	0.53	16.01	NA	XXX
73222	26	A	Mri joint upr extrem w/dye	1.61	0.54	0.54	0.06	2.21	2.21	XXX
73222	TC	A	Mri joint upr extrem w/dye	0.00	13.33	NA	0.47	13.80	NA	XXX
73223		A	Mri joint upr extr w/o&w/dye	2.14	25.39	NA	0.92	28.45	NA	XXX
73223	26	A	Mri joint upr extr w/o&w/dye	2.14	0.71	0.71	0.08	2.93	2.93	XXX
73223	TC	A	Mri joint upr extr w/o&w/dye	0.00	24.68	NA	0.84	25.52	NA	XXX
73225		N	Mr angio upr extr w/o&w/dye	+1.72	11.74	11.74	0.69	14.15	14.15	XXX
73225	26	N	Mr angio upr extr w/o&w/dye	+1.72	0.67	0.67	0.10	2.49	2.49	XXX
73225	TC	N	Mr angio upr extr w/o&w/dye	+0.00	11.07	11.07	0.59	11.66	11.66	XXX
73500		A	X-ray exam of hip	0.17	0.53	NA	0.03	0.73	NA	XXX
73500	26	A	X-ray exam of hip	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73500	TC	A	X-ray exam of hip	0.00	0.47	NA	0.02	0.49	NA	XXX
73510		A	X-ray exam of hip	0.21	0.64	NA	0.06	0.91	NA	XXX
73510	26	A	X-ray exam of hip	0.21	0.07	0.07	0.02	0.30	0.30	XXX
73510	TC	A	X-ray exam of hip	0.00	0.57	NA	0.04	0.61	NA	XXX
73520		A	X-ray exam of hips	0.26	0.75	NA	0.06	1.07	NA	XXX
73520	26	A	X-ray exam of hips	0.26	0.09	0.09	0.02	0.37	0.37	XXX
73520	TC	A	X-ray exam of hips	0.00	0.66	NA	0.04	0.70	NA	XXX
73525		A	Contrast x-ray of hip	0.54	2.26	NA	0.16	2.96	NA	XXX
73525	26	A	Contrast x-ray of hip	0.54	0.18	0.18	0.04	0.76	0.76	XXX
73525	TC	A	Contrast x-ray of hip	0.00	2.08	NA	0.12	2.20	NA	XXX
73530		A	X-ray exam of hip	0.29	0.62	NA	0.03	0.94	NA	XXX
73530	26	A	X-ray exam of hip	0.29	0.10	0.10	0.01	0.40	0.40	XXX
73530	TC	A	X-ray exam of hip	0.00	0.52	NA	0.02	0.54	NA	XXX
73540		A	X-ray exam of pelvis & hips	0.20	0.64	NA	0.06	0.90	NA	XXX
73540	26	A	X-ray exam of pelvis & hips	0.20	0.07	0.07	0.02	0.29	0.29	XXX
73540	TC	A	X-ray exam of pelvis & hips	0.00	0.57	NA	0.04	0.61	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
73542	.....	A	X-ray exam, sacroiliac joint	0.59	2.24	NA	0.16	2.99	NA	XXX
73542	26	A	X-ray exam, sacroiliac joint	0.59	0.16	0.16	0.04	0.79	0.79	XXX
73542	TC	A	X-ray exam, sacroiliac joint	0.00	2.08	NA	0.12	2.20	NA	XXX
73550	.....	A	X-ray exam of thigh	0.17	0.63	NA	0.05	0.85	NA	XXX
73550	26	A	X-ray exam of thigh	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73550	TC	A	X-ray exam of thigh	0.00	0.57	NA	0.04	0.61	NA	XXX
73560	.....	A	X-ray exam of knee, 1 or 2	0.17	0.58	NA	0.04	0.79	NA	XXX
73560	26	A	X-ray exam of knee, 1 or 2	0.17	0.06	0.06	0.02	0.25	0.25	XXX
73560	TC	A	X-ray exam of knee, 1 or 2	0.00	0.52	NA	0.02	0.54	NA	XXX
73562	.....	A	X-ray exam of knee, 3	0.18	0.63	NA	0.06	0.87	NA	XXX
73562	26	A	X-ray exam of knee, 3	0.18	0.06	0.06	0.02	0.26	0.26	XXX
73562	TC	A	X-ray exam of knee, 3	0.00	0.57	NA	0.04	0.61	NA	XXX
73564	.....	A	X-ray exam, knee, 4 or more	0.22	0.70	NA	0.06	0.98	NA	XXX
73564	26	A	X-ray exam, knee, 4 or more	0.22	0.08	0.08	0.02	0.32	0.32	XXX
73564	TC	A	X-ray exam, knee, 4 or more	0.00	0.62	NA	0.04	0.66	NA	XXX
73565	.....	A	X-ray exam of knees	0.17	0.55	NA	0.04	0.76	NA	XXX
73565	26	A	X-ray exam of knees	0.17	0.06	0.06	0.02	0.25	0.25	XXX
73565	TC	A	X-ray exam of knees	0.00	0.49	NA	0.02	0.51	NA	XXX
73580	.....	A	Contrast x-ray of knee joint	0.54	2.78	NA	0.18	3.50	NA	XXX
73580	26	A	Contrast x-ray of knee joint	0.54	0.18	0.18	0.04	0.76	0.76	XXX
73580	TC	A	Contrast x-ray of knee joint	0.00	2.60	NA	0.14	2.74	NA	XXX
73590	.....	A	X-ray exam of lower leg	0.17	0.58	NA	0.03	0.78	NA	XXX
73590	26	A	X-ray exam of lower leg	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73590	TC	A	X-ray exam of lower leg	0.00	0.52	NA	0.02	0.54	NA	XXX
73592	.....	A	X-ray exam of leg, infant	0.16	0.55	NA	0.03	0.74	NA	XXX
73592	26	A	X-ray exam of leg, infant	0.16	0.06	0.06	0.01	0.23	0.23	XXX
73592	TC	A	X-ray exam of leg, infant	0.00	0.49	NA	0.02	0.51	NA	XXX
73600	.....	A	X-ray exam of ankle	0.16	0.54	NA	0.03	0.73	NA	XXX
73600	26	A	X-ray exam of ankle	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73600	TC	A	X-ray exam of ankle	0.00	0.49	NA	0.02	0.51	NA	XXX
73610	.....	A	X-ray exam of ankle	0.17	0.59	NA	0.03	0.79	NA	XXX
73610	26	A	X-ray exam of ankle	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73610	TC	A	X-ray exam of ankle	0.00	0.53	NA	0.02	0.55	NA	XXX
73615	.....	A	Contrast x-ray of ankle	0.54	2.27	NA	0.16	2.97	NA	XXX
73615	26	A	Contrast x-ray of ankle	0.54	0.19	0.19	0.04	0.77	0.77	XXX
73615	TC	A	Contrast x-ray of ankle	0.00	2.08	NA	0.12	2.20	NA	XXX
73620	.....	A	X-ray exam of foot	0.16	0.54	NA	0.03	0.73	NA	XXX
73620	26	A	X-ray exam of foot	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73620	TC	A	X-ray exam of foot	0.00	0.49	NA	0.02	0.51	NA	XXX
73630	.....	A	X-ray exam of foot	0.17	0.59	NA	0.03	0.79	NA	XXX
73630	26	A	X-ray exam of foot	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73630	TC	A	X-ray exam of foot	0.00	0.53	NA	0.02	0.55	NA	XXX
73650	.....	A	X-ray exam of heel	0.16	0.52	NA	0.03	0.71	NA	XXX
73650	26	A	X-ray exam of heel	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73650	TC	A	X-ray exam of heel	0.00	0.47	NA	0.02	0.49	NA	XXX
73660	.....	A	X-ray exam of toe(s)	0.13	0.46	NA	0.03	0.62	NA	XXX
73660	26	A	X-ray exam of toe(s)	0.13	0.04	0.04	0.01	0.18	0.18	XXX
73660	TC	A	X-ray exam of toe(s)	0.00	0.42	NA	0.02	0.44	NA	XXX
73700	.....	A	Ct lower extremity w/o dye	1.08	5.28	NA	0.31	6.67	NA	XXX
73700	26	A	Ct lower extremity w/o dye	1.08	0.36	0.36	0.06	1.50	1.50	XXX
73700	TC	A	Ct lower extremity w/o dye	0.00	4.92	NA	0.25	5.17	NA	XXX
73701	.....	A	Ct lower extremity w/dye	1.15	6.24	NA	0.37	7.76	NA	XXX
73701	26	A	Ct lower extremity w/dye	1.15	0.39	0.39	0.06	1.60	1.60	XXX
73701	TC	A	Ct lower extremity w/dye	0.00	5.85	NA	0.31	6.16	NA	XXX
73702	.....	A	Ct lwr extremity w/o&w/dye	1.21	7.77	NA	0.44	9.42	NA	XXX
73702	26	A	Ct lwr extremity w/o&w/dye	1.21	0.41	0.41	0.06	1.68	1.68	XXX
73702	TC	A	Ct lwr extremity w/o&w/dye	0.00	7.36	NA	0.38	7.74	NA	XXX
73706	.....	A	Ct angio lwr extr w/o&w/dye	1.89	11.51	NA	0.45	13.85	NA	XXX
73706	26	A	Ct angio lwr extr w/o&w/dye	1.89	0.64	0.64	0.07	2.60	2.60	XXX
73706	TC	A	Ct angio lwr extr w/o&w/dye	0.00	10.87	NA	0.38	11.25	NA	XXX
73718	.....	A	Mri lower extremity w/o dye	1.34	11.56	NA	0.43	13.33	NA	XXX
73718	26	A	Mri lower extremity w/o dye	1.34	0.45	0.45	0.05	1.84	1.84	XXX
73718	TC	A	Mri lower extremity w/o dye	0.00	11.11	NA	0.38	11.49	NA	XXX
73719	.....	A	Mri lower extremity w/dye	1.61	13.87	NA	0.53	16.01	NA	XXX
73719	26	A	Mri lower extremity w/dye	1.61	0.54	0.54	0.06	2.21	2.21	XXX
73719	TC	A	Mri lower extremity w/dye	0.00	13.33	NA	0.47	13.80	NA	XXX
73720	.....	A	Mri lwr extremity w/o&w/dye	2.14	25.39	NA	0.94	28.47	NA	XXX
73720	26	A	Mri lwr extremity w/o&w/dye	2.14	0.71	0.71	0.10	2.95	2.95	XXX
73720	TC	A	Mri lwr extremity w/o&w/dye	0.00	24.68	NA	0.84	25.52	NA	XXX
73721	.....	A	Mri jnt of lwr extre w/o dye	1.34	11.56	NA	0.43	13.33	NA	XXX
73721	26	A	Mri jnt of lwr extre w/o dye	1.34	0.45	0.45	0.05	1.84	1.84	XXX
73721	TC	A	Mri jnt of lwr extre w/o dye	0.00	11.11	NA	0.38	11.49	NA	XXX
73722	.....	A	Mri joint of lwr extr w/dye	1.61	13.88	NA	0.54	16.03	NA	XXX
73722	26	A	Mri joint of lwr extr w/dye	1.61	0.55	0.55	0.07	2.23	2.23	XXX
73722	TC	A	Mri joint of lwr extr w/dye	0.00	13.33	NA	0.47	13.80	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
73723	.....	A	Mri joint lwr extr w/o&w/dye	2.14	25.39	NA	0.92	28.45	NA	XXX
73723	26	A	Mri joint lwr extr w/o&w/dye	2.14	0.71	0.71	0.08	2.93	2.93	XXX
73723	TC	A	Mri joint lwr extr w/o&w/dye	0.00	24.68	NA	0.84	25.52	NA	XXX
73725	.....	R	Mr ang lwr ext w or w/o dye	1.81	11.72	NA	0.69	14.22	NA	XXX
73725	26	R	Mr ang lwr ext w or w/o dye	1.81	0.61	0.61	0.10	2.52	2.52	XXX
73725	TC	R	Mr ang lwr ext w or w/o dye	0.00	11.11	NA	0.59	11.70	NA	XXX
74000	.....	A	X-ray exam of abdomen	0.18	0.58	NA	0.03	0.79	NA	XXX
74000	26	A	X-ray exam of abdomen	0.18	0.06	0.06	0.01	0.25	0.25	XXX
74000	TC	A	X-ray exam of abdomen	0.00	0.52	NA	0.02	0.54	NA	XXX
74010	.....	A	X-ray exam of abdomen	0.23	0.65	NA	0.05	0.93	NA	XXX
74010	26	A	X-ray exam of abdomen	0.23	0.08	0.08	0.01	0.32	0.32	XXX
74010	TC	A	X-ray exam of abdomen	0.00	0.57	NA	0.04	0.61	NA	XXX
74020	.....	A	X-ray exam of abdomen	0.27	0.71	NA	0.05	1.03	NA	XXX
74020	26	A	X-ray exam of abdomen	0.27	0.09	0.09	0.01	0.37	0.37	XXX
74020	TC	A	X-ray exam of abdomen	0.00	0.62	NA	0.04	0.66	NA	XXX
74022	.....	A	X-ray exam series, abdomen	0.32	0.83	NA	0.06	1.21	NA	XXX
74022	26	A	X-ray exam series, abdomen	0.32	0.11	0.11	0.01	0.44	0.44	XXX
74022	TC	A	X-ray exam series, abdomen	0.00	0.72	NA	0.05	0.77	NA	XXX
74150	.....	A	Ct abdomen w/o dye	1.18	6.01	NA	0.36	7.55	NA	XXX
74150	26	A	Ct abdomen w/o dye	1.18	0.40	0.40	0.06	1.64	1.64	XXX
74150	TC	A	Ct abdomen w/o dye	0.00	5.61	NA	0.30	5.91	NA	XXX
74160	.....	A	Ct abdomen w/dye	1.26	7.21	NA	0.43	8.90	NA	XXX
74160	26	A	Ct abdomen w/dye	1.26	0.42	0.42	0.07	1.75	1.75	XXX
74160	TC	A	Ct abdomen w/dye	0.00	6.79	NA	0.36	7.15	NA	XXX
74170	.....	A	Ct abdomen w/o &w /dye	1.39	8.88	NA	0.50	10.77	NA	XXX
74170	26	A	Ct abdomen w/o &w /dye	1.39	0.47	0.47	0.07	1.93	1.93	XXX
74170	TC	A	Ct abdomen w/o &w /dye	0.00	8.41	NA	0.43	8.84	NA	XXX
74175	.....	A	Ct angio abdom w/o & w/dye	1.89	12.57	NA	0.45	14.91	NA	XXX
74175	26	A	Ct angio abdom w/o & w/dye	1.89	0.64	0.64	0.07	2.60	2.60	XXX
74175	TC	A	Ct angio abdom w/o & w/dye	0.00	11.93	NA	0.38	12.31	NA	XXX
74181	.....	A	Mri abdomen w/o dye	1.45	11.60	NA	0.51	13.56	NA	XXX
74181	26	A	Mri abdomen w/o dye	1.45	0.49	0.49	0.07	2.01	2.01	XXX
74181	TC	A	Mri abdomen w/o dye	0.00	11.11	NA	0.44	11.55	NA	XXX
74182	.....	A	Mri abdomen w/dye	1.72	13.91	NA	0.59	16.22	NA	XXX
74182	26	A	Mri abdomen w/dye	1.72	0.58	0.58	0.07	2.37	2.37	XXX
74182	TC	A	Mri abdomen w/dye	0.00	13.33	NA	0.52	13.85	NA	XXX
74183	.....	A	Mri abdomen w/o & w/dye	2.25	25.43	NA	1.01	28.69	NA	XXX
74183	26	A	Mri abdomen w/o & w/dye	2.25	0.75	0.75	0.10	3.10	3.10	XXX
74183	TC	A	Mri abdomen w/o & w/dye	0.00	24.68	NA	0.91	25.59	NA	XXX
74185	.....	R	Mri angio, abdom w orw/o dye	1.79	11.71	NA	0.69	14.19	NA	XXX
74185	26	R	Mri angio, abdom w orw/o dye	1.79	0.60	0.60	0.10	2.49	2.49	XXX
74185	TC	R	Mri angio, abdom w orw/o dye	0.00	11.11	NA	0.59	11.70	NA	XXX
74190	.....	A	X-ray exam of peritoneum	0.48	1.45	NA	0.09	2.02	NA	XXX
74190	26	A	X-ray exam of peritoneum	0.48	0.16	0.16	0.02	0.66	0.66	XXX
74190	TC	A	X-ray exam of peritoneum	0.00	1.29	NA	0.07	1.36	NA	XXX
74210	.....	A	Contrst x-ray exam of throat	0.36	1.30	NA	0.08	1.74	NA	XXX
74210	26	A	Contrst x-ray exam of throat	0.36	0.12	0.12	0.02	0.50	0.50	XXX
74210	TC	A	Contrst x-ray exam of throat	0.00	1.18	NA	0.06	1.24	NA	XXX
74220	.....	A	Contrast x-ray, esophagus	0.46	1.33	NA	0.08	1.87	NA	XXX
74220	26	A	Contrast x-ray, esophagus	0.46	0.15	0.15	0.02	0.63	0.63	XXX
74220	TC	A	Contrast x-ray, esophagus	0.00	1.18	NA	0.06	1.24	NA	XXX
74230	.....	A	Cine/vid x-ray, throat/esoph	0.53	1.47	NA	0.09	2.09	NA	XXX
74230	26	A	Cine/vid x-ray, throat/esoph	0.53	0.18	0.18	0.02	0.73	0.73	XXX
74230	TC	A	Cine/vid x-ray, throat/esoph	0.00	1.29	NA	0.07	1.36	NA	XXX
74235	.....	A	Remove esophagus obstruction	1.18	3.00	NA	0.20	4.38	NA	XXX
74235	26	A	Remove esophagus obstruction	1.18	0.40	0.40	0.06	1.64	1.64	XXX
74235	TC	A	Remove esophagus obstruction	0.00	2.60	NA	0.14	2.74	NA	XXX
74240	.....	A	X-ray exam, upper gi tract	0.69	1.68	NA	0.12	2.49	NA	XXX
74240	26	A	X-ray exam, upper gi tract	0.69	0.23	0.23	0.04	0.96	0.96	XXX
74240	TC	A	X-ray exam, upper gi tract	0.00	1.45	NA	0.08	1.53	NA	XXX
74241	.....	A	X-ray exam, upper gi tract	0.69	1.71	NA	0.12	2.52	NA	XXX
74241	26	A	X-ray exam, upper gi tract	0.69	0.23	0.23	0.04	0.96	0.96	XXX
74241	TC	A	X-ray exam, upper gi tract	0.00	1.48	NA	0.08	1.56	NA	XXX
74245	.....	A	X-ray exam, upper gi tract	0.90	2.66	NA	0.18	3.74	NA	XXX
74245	26	A	X-ray exam, upper gi tract	0.90	0.30	0.30	0.05	1.25	1.25	XXX
74245	TC	A	X-ray exam, upper gi tract	0.00	2.36	NA	0.13	2.49	NA	XXX
74246	.....	A	Contrst x-ray uppr gi tract	0.69	1.86	NA	0.14	2.69	NA	XXX
74246	26	A	Contrst x-ray uppr gi tract	0.69	0.23	0.23	0.04	0.96	0.96	XXX
74246	TC	A	Contrst x-ray uppr gi tract	0.00	1.63	NA	0.10	1.73	NA	XXX
74247	.....	A	Contrst x-ray uppr gi tract	0.69	1.90	NA	0.15	2.74	NA	XXX
74247	26	A	Contrst x-ray uppr gi tract	0.69	0.23	0.23	0.04	0.96	0.96	XXX
74247	TC	A	Contrst x-ray uppr gi tract	0.00	1.67	NA	0.11	1.78	NA	XXX
74249	.....	A	Contrst x-ray uppr gi tract	0.90	2.85	NA	0.19	3.94	NA	XXX
74249	26	A	Contrst x-ray uppr gi tract	0.90	0.30	0.30	0.05	1.25	1.25	XXX
74249	TC	A	Contrst x-ray uppr gi tract	0.00	2.55	NA	0.14	2.69	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
74250	.....	A	X-ray exam of small bowel	0.47	1.45	NA	0.09	2.01	NA	XXX
74250	26	A	X-ray exam of small bowel	0.47	0.16	0.16	0.02	0.65	0.65	XXX
74250	TC	A	X-ray exam of small bowel	0.00	1.29	NA	0.07	1.36	NA	XXX
74251	.....	A	X-ray exam of small bowel	0.69	1.52	NA	0.11	2.32	NA	XXX
74251	26	A	X-ray exam of small bowel	0.69	0.23	0.23	0.04	0.96	0.96	XXX
74251	TC	A	X-ray exam of small bowel	0.00	1.29	NA	0.07	1.36	NA	XXX
74260	.....	A	X-ray exam of small bowel	0.50	1.65	NA	0.10	2.25	NA	XXX
74260	26	A	X-ray exam of small bowel	0.50	0.17	0.17	0.02	0.69	0.69	XXX
74260	TC	A	X-ray exam of small bowel	0.00	1.48	NA	0.08	1.56	NA	XXX
74270	.....	A	Contrast x-ray exam of colon	0.69	1.92	NA	0.15	2.76	NA	XXX
74270	26	A	Contrast x-ray exam of colon	0.69	0.23	0.23	0.04	0.96	0.96	XXX
74270	TC	A	Contrast x-ray exam of colon	0.00	1.69	NA	0.11	1.80	NA	XXX
74280	.....	A	Contrast x-ray exam of colon	0.98	2.54	NA	0.18	3.70	NA	XXX
74280	26	A	Contrast x-ray exam of colon	0.98	0.33	0.33	0.05	1.36	1.36	XXX
74280	TC	A	Contrast x-ray exam of colon	0.00	2.21	NA	0.13	2.34	NA	XXX
74283	.....	A	Contrast x-ray exam of colon	2.01	3.20	NA	0.25	5.46	NA	XXX
74283	26	A	Contrast x-ray exam of colon	2.01	0.66	0.66	0.11	2.78	2.78	XXX
74283	TC	A	Contrast x-ray exam of colon	0.00	2.54	NA	0.14	2.68	NA	XXX
74290	.....	A	Contrast x-ray, gallbladder	0.32	0.83	NA	0.06	1.21	NA	XXX
74290	26	A	Contrast x-ray, gallbladder	0.32	0.11	0.11	0.01	0.44	0.44	XXX
74290	TC	A	Contrast x-ray, gallbladder	0.00	0.72	NA	0.05	0.77	NA	XXX
74291	.....	A	Contrast x-rays, gallbladder	0.20	0.49	NA	0.03	0.72	NA	XXX
74291	26	A	Contrast x-rays, gallbladder	0.20	0.07	0.07	0.01	0.28	0.28	XXX
74291	TC	A	Contrast x-rays, gallbladder	0.00	0.42	NA	0.02	0.44	NA	XXX
74300	.....	C	X-ray bile ducts/pancreas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
74300	26	A	X-ray bile ducts/pancreas	0.36	0.12	0.12	0.02	0.50	0.50	XXX
74300	TC	C	X-ray bile ducts/pancreas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
74301	.....	C	X-rays at surgery add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
74301	26	A	X-rays at surgery add-on	0.21	0.07	0.07	0.01	0.29	0.29	ZZZ
74301	TC	C	X-rays at surgery add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
74305	.....	A	X-ray bile ducts/pancreas	0.42	0.91	NA	0.07	1.40	NA	XXX
74305	26	A	X-ray bile ducts/pancreas	0.42	0.14	0.14	0.02	0.58	0.58	XXX
74305	TC	A	X-ray bile ducts/pancreas	0.00	0.77	NA	0.05	0.82	NA	XXX
74320	.....	A	Contrast x-ray of bile ducts	0.54	3.31	NA	0.19	4.04	NA	XXX
74320	26	A	Contrast x-ray of bile ducts	0.54	0.18	0.18	0.02	0.74	0.74	XXX
74320	TC	A	Contrast x-ray of bile ducts	0.00	3.13	NA	0.17	3.30	NA	XXX
74327	.....	A	X-ray bile stone removal	0.70	1.98	NA	0.15	2.83	NA	XXX
74327	26	A	X-ray bile stone removal	0.70	0.23	0.23	0.04	0.97	0.97	XXX
74327	TC	A	X-ray bile stone removal	0.00	1.75	NA	0.11	1.86	NA	XXX
74328	.....	A	X-ray bile duct endoscopy	0.70	3.36	NA	0.21	4.27	NA	XXX
74328	26	A	X-ray bile duct endoscopy	0.70	0.23	0.23	0.04	0.97	0.97	XXX
74328	TC	A	X-ray bile duct endoscopy	0.00	3.13	NA	0.17	3.30	NA	XXX
74329	.....	A	X-ray for pancreas endoscopy	0.70	3.36	NA	0.21	4.27	NA	XXX
74329	26	A	X-ray for pancreas endoscopy	0.70	0.23	0.23	0.04	0.97	0.97	XXX
74329	TC	A	X-ray for pancreas endoscopy	0.00	3.13	NA	0.17	3.30	NA	XXX
74330	.....	A	X-ray bile/panc endoscopy	0.89	3.43	NA	0.22	4.54	NA	XXX
74330	26	A	X-ray bile/panc endoscopy	0.89	0.30	0.30	0.05	1.24	1.24	XXX
74330	TC	A	X-ray bile/panc endoscopy	0.00	3.13	NA	0.17	3.30	NA	XXX
74340	.....	A	X-ray guide for GI tube	0.54	2.78	NA	0.16	3.48	NA	XXX
74340	26	A	X-ray guide for GI tube	0.54	0.18	0.18	0.02	0.74	0.74	XXX
74340	TC	A	X-ray guide for GI tube	0.00	2.60	NA	0.14	2.74	NA	XXX
74350	.....	A	X-ray guide, stomach tube	0.76	3.38	NA	0.21	4.35	NA	XXX
74350	26	A	X-ray guide, stomach tube	0.76	0.25	0.25	0.04	1.05	1.05	XXX
74350	TC	A	X-ray guide, stomach tube	0.00	3.13	NA	0.17	3.30	NA	XXX
74355	.....	A	X-ray guide, intestinal tube	0.76	2.85	NA	0.18	3.79	NA	XXX
74355	26	A	X-ray guide, intestinal tube	0.76	0.25	0.25	0.04	1.05	1.05	XXX
74355	TC	A	X-ray guide, intestinal tube	0.00	2.60	NA	0.14	2.74	NA	XXX
74360	.....	A	X-ray guide, GI dilation	0.54	3.32	NA	0.19	4.05	NA	XXX
74360	26	A	X-ray guide, GI dilation	0.54	0.19	0.19	0.02	0.75	0.75	XXX
74360	TC	A	X-ray guide, GI dilation	0.00	3.13	NA	0.17	3.30	NA	XXX
74363	.....	A	X-ray, bile duct dilation	0.87	6.34	NA	0.37	7.58	NA	XXX
74363	26	A	X-ray, bile duct dilation	0.87	0.29	0.29	0.05	1.21	1.21	XXX
74363	TC	A	X-ray, bile duct dilation	0.00	6.05	NA	0.32	6.37	NA	XXX
74400	.....	A	Contrst x-ray, urinary tract	0.49	1.83	NA	0.13	2.45	NA	XXX
74400	26	A	Contrst x-ray, urinary tract	0.49	0.16	0.16	0.02	0.67	0.67	XXX
74400	TC	A	Contrst x-ray, urinary tract	0.00	1.67	NA	0.11	1.78	NA	XXX
74410	.....	A	Contrst x-ray, urinary tract	0.49	2.09	NA	0.13	2.71	NA	XXX
74410	26	A	Contrst x-ray, urinary tract	0.49	0.16	0.16	0.02	0.67	0.67	XXX
74410	TC	A	Contrst x-ray, urinary tract	0.00	1.93	NA	0.11	2.04	NA	XXX
74415	.....	A	Contrst x-ray, urinary tract	0.49	2.26	NA	0.14	2.89	NA	XXX
74415	26	A	Contrst x-ray, urinary tract	0.49	0.16	0.16	0.02	0.67	0.67	XXX
74415	TC	A	Contrst x-ray, urinary tract	0.00	2.10	NA	0.12	2.22	NA	XXX
74420	.....	A	Contrst x-ray, urinary tract	0.36	2.72	NA	0.16	3.24	NA	XXX
74420	26	A	Contrst x-ray, urinary tract	0.36	0.12	0.12	0.02	0.50	0.50	XXX
74420	TC	A	Contrst x-ray, urinary tract	0.00	2.60	NA	0.14	2.74	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
74425	.....	A	Contrst x-ray, urinary tract	0.36	1.41	NA	0.09	1.86	NA	XXX
74425	26	A	Contrst x-ray, urinary tract	0.36	0.12	0.12	0.02	0.50	0.50	XXX
74425	TC	A	Contrst x-ray, urinary tract	0.00	1.29	NA	0.07	1.36	NA	XXX
74430	.....	A	Contrast x-ray, bladder	0.32	1.15	NA	0.08	1.55	NA	XXX
74430	26	A	Contrast x-ray, bladder	0.32	0.11	0.11	0.02	0.45	0.45	XXX
74430	TC	A	Contrast x-ray, bladder	0.00	1.04	NA	0.06	1.10	NA	XXX
74440	.....	A	X-ray, male genital tract	0.38	1.24	NA	0.08	1.70	NA	XXX
74440	26	A	X-ray, male genital tract	0.38	0.12	0.12	0.02	0.52	0.52	XXX
74440	TC	A	X-ray, male genital tract	0.00	1.12	NA	0.06	1.18	NA	XXX
74445	.....	A	X-ray exam of penis	1.13	1.50	NA	0.12	2.75	NA	XXX
74445	26	A	X-ray exam of penis	1.13	0.38	0.38	0.06	1.57	1.57	XXX
74445	TC	A	X-ray exam of penis	0.00	1.12	NA	0.06	1.18	NA	XXX
74450	.....	A	X-ray, urethra/bladder	0.33	1.56	NA	0.10	1.99	NA	XXX
74450	26	A	X-ray, urethra/bladder	0.33	0.11	0.11	0.02	0.46	0.46	XXX
74450	TC	A	X-ray, urethra/bladder	0.00	1.45	NA	0.08	1.53	NA	XXX
74455	.....	A	X-ray, urethra/bladder	0.33	1.67	NA	0.12	2.12	NA	XXX
74455	26	A	X-ray, urethra/bladder	0.33	0.11	0.11	0.02	0.46	0.46	XXX
74455	TC	A	X-ray, urethra/bladder	0.00	1.56	NA	0.10	1.66	NA	XXX
74470	.....	A	X-ray exam of kidney lesion	0.54	1.42	NA	0.09	2.05	NA	XXX
74470	26	A	X-ray exam of kidney lesion	0.54	0.18	0.18	0.02	0.74	0.74	XXX
74470	TC	A	X-ray exam of kidney lesion	0.00	1.24	NA	0.07	1.31	NA	XXX
74475	.....	A	X-ray control, cath insert	0.54	4.22	NA	0.24	5.00	NA	XXX
74475	26	A	X-ray control, cath insert	0.54	0.18	0.18	0.02	0.74	0.74	XXX
74475	TC	A	X-ray control, cath insert	0.00	4.04	NA	0.22	4.26	NA	XXX
74480	.....	A	X-ray control, cath insert	0.54	4.22	NA	0.24	5.00	NA	XXX
74480	26	A	X-ray control, cath insert	0.54	0.18	0.18	0.02	0.74	0.74	XXX
74480	TC	A	X-ray control, cath insert	0.00	4.04	NA	0.22	4.26	NA	XXX
74485	.....	A	X-ray guide, GU dilation	0.54	3.31	NA	0.21	4.06	NA	XXX
74485	26	A	X-ray guide, GU dilation	0.54	0.18	0.18	0.04	0.76	0.76	XXX
74485	TC	A	X-ray guide, GU dilation	0.00	3.13	NA	0.17	3.30	NA	XXX
74710	.....	A	X-ray measurement of pelvis	0.34	1.15	NA	0.08	1.57	NA	XXX
74710	26	A	X-ray measurement of pelvis	0.34	0.11	0.11	0.02	0.47	0.47	XXX
74710	TC	A	X-ray measurement of pelvis	0.00	1.04	NA	0.06	1.10	NA	XXX
74740	.....	A	X-ray, female genital tract	0.38	1.42	NA	0.09	1.89	NA	XXX
74740	26	A	X-ray, female genital tract	0.38	0.13	0.13	0.02	0.53	0.53	XXX
74740	TC	A	X-ray, female genital tract	0.00	1.29	NA	0.07	1.36	NA	XXX
74742	.....	A	X-ray, fallopian tube	0.61	3.34	NA	0.19	4.14	NA	XXX
74742	26	A	X-ray, fallopian tube	0.61	0.21	0.21	0.02	0.84	0.84	XXX
74742	TC	A	X-ray, fallopian tube	0.00	3.13	NA	0.17	3.30	NA	XXX
74775	.....	A	X-ray exam of perineum	0.62	1.66	NA	0.12	2.40	NA	XXX
74775	26	A	X-ray exam of perineum	0.62	0.21	0.21	0.04	0.87	0.87	XXX
74775	TC	A	X-ray exam of perineum	0.00	1.45	NA	0.08	1.53	NA	XXX
75552	.....	A	Heart mri for morph w/o dye	1.59	11.65	NA	0.67	13.91	NA	XXX
75552	26	A	Heart mri for morph w/o dye	1.59	0.54	0.54	0.08	2.21	2.21	XXX
75552	TC	A	Heart mri for morph w/o dye	0.00	11.11	NA	0.59	11.70	NA	XXX
75553	.....	A	Heart mri for morph w/dye	1.99	11.77	NA	0.70	14.46	NA	XXX
75553	26	A	Heart mri for morph w/dye	1.99	0.66	0.66	0.11	2.76	2.76	XXX
75553	TC	A	Heart mri for morph w/dye	0.00	11.11	NA	0.59	11.70	NA	XXX
75554	.....	A	Cardiac MRI/function	1.82	11.76	NA	0.67	14.25	NA	XXX
75554	26	A	Cardiac MRI/function	1.82	0.65	0.65	0.08	2.55	2.55	XXX
75554	TC	A	Cardiac MRI/function	0.00	11.11	NA	0.59	11.70	NA	XXX
75555	.....	A	Cardiac MRI/limited study	1.73	11.75	NA	0.67	14.15	NA	XXX
75555	26	A	Cardiac MRI/limited study	1.73	0.64	0.64	0.08	2.45	2.45	XXX
75555	TC	A	Cardiac MRI/limited study	0.00	11.11	NA	0.59	11.70	NA	XXX
75556	.....	N	Cardiac MRI/flow mapping	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75600	.....	A	Contrast x-ray exam of aorta	0.49	12.68	NA	0.67	13.84	NA	XXX
75600	26	A	Contrast x-ray exam of aorta	0.49	0.19	0.19	0.02	0.70	0.70	XXX
75600	TC	A	Contrast x-ray exam of aorta	0.00	12.49	NA	0.65	13.14	NA	XXX
75605	.....	A	Contrast x-ray exam of aorta	1.13	12.90	NA	0.71	14.74	NA	XXX
75605	26	A	Contrast x-ray exam of aorta	1.13	0.41	0.41	0.06	1.60	1.60	XXX
75605	TC	A	Contrast x-ray exam of aorta	0.00	12.49	NA	0.65	13.14	NA	XXX
75625	.....	A	Contrast x-ray exam of aorta	1.13	12.88	NA	0.71	14.72	NA	XXX
75625	26	A	Contrast x-ray exam of aorta	1.13	0.39	0.39	0.06	1.58	1.58	XXX
75625	TC	A	Contrast x-ray exam of aorta	0.00	12.49	NA	0.65	13.14	NA	XXX
75630	.....	A	X-ray aorta, leg arteries	1.78	13.65	NA	0.78	16.21	NA	XXX
75630	26	A	X-ray aorta, leg arteries	1.78	0.63	0.63	0.10	2.51	2.51	XXX
75630	TC	A	X-ray aorta, leg arteries	0.00	13.02	NA	0.68	13.70	NA	XXX
75635	.....	A	Ct angio abdominal arteries	2.39	16.58	NA	0.49	19.46	NA	XXX
75635	26	A	Ct angio abdominal arteries	2.39	0.80	0.80	0.11	3.30	3.30	XXX
75635	TC	A	Ct angio abdominal arteries	0.00	15.78	NA	0.38	16.16	NA	XXX
75650	.....	A	Artery x-rays, head & neck	1.48	12.99	NA	0.73	15.20	NA	XXX
75650	26	A	Artery x-rays, head & neck	1.48	0.50	0.50	0.08	2.06	2.06	XXX
75650	TC	A	Artery x-rays, head & neck	0.00	12.49	NA	0.65	13.14	NA	XXX
75658	.....	A	Artery x-rays, arm	1.30	12.97	NA	0.72	14.99	NA	XXX
75658	26	A	Artery x-rays, arm	1.30	0.48	0.48	0.07	1.85	1.85	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
75658	TC	A	Artery x-rays, arm	0.00	12.49	NA	0.65	13.14	NA	XXX
75660		A	Artery x-rays, head & neck	1.30	12.94	NA	0.72	14.96	NA	XXX
75660	26	A	Artery x-rays, head & neck	1.30	0.45	0.45	0.07	1.82	1.82	XXX
75660	TC	A	Artery x-rays, head & neck	0.00	12.49	NA	0.65	13.14	NA	XXX
75662		A	Artery x-rays, head & neck	1.65	13.09	NA	0.75	15.49	NA	XXX
75662	26	A	Artery x-rays, head & neck	1.65	0.60	0.60	0.10	2.35	2.35	XXX
75662	TC	A	Artery x-rays, head & neck	0.00	12.49	NA	0.65	13.14	NA	XXX
75665		A	Artery x-rays, head & neck	1.30	12.94	NA	0.73	14.97	NA	XXX
75665	26	A	Artery x-rays, head & neck	1.30	0.45	0.45	0.08	1.83	1.83	XXX
75665	TC	A	Artery x-rays, head & neck	0.00	12.49	NA	0.65	13.14	NA	XXX
75671		A	Artery x-rays, head & neck	1.65	13.05	NA	0.75	15.45	NA	XXX
75671	26	A	Artery x-rays, head & neck	1.65	0.56	0.56	0.10	2.31	2.31	XXX
75671	TC	A	Artery x-rays, head & neck	0.00	12.49	NA	0.65	13.14	NA	XXX
75676		A	Artery x-rays, neck	1.30	12.94	NA	0.73	14.97	NA	XXX
75676	26	A	Artery x-rays, neck	1.30	0.45	0.45	0.08	1.83	1.83	XXX
75676	TC	A	Artery x-rays, neck	0.00	12.49	NA	0.65	13.14	NA	XXX
75680		A	Artery x-rays, neck	1.65	13.05	NA	0.75	15.45	NA	XXX
75680	26	A	Artery x-rays, neck	1.65	0.56	0.56	0.10	2.31	2.31	XXX
75680	TC	A	Artery x-rays, neck	0.00	12.49	NA	0.65	13.14	NA	XXX
75685		A	Artery x-rays, spine	1.30	12.93	NA	0.72	14.95	NA	XXX
75685	26	A	Artery x-rays, spine	1.30	0.44	0.44	0.07	1.81	1.81	XXX
75685	TC	A	Artery x-rays, spine	0.00	12.49	NA	0.65	13.14	NA	XXX
75705		A	Artery x-rays, spine	2.17	13.23	NA	0.78	16.18	NA	XXX
75705	26	A	Artery x-rays, spine	2.17	0.74	0.74	0.13	3.04	3.04	XXX
75705	TC	A	Artery x-rays, spine	0.00	12.49	NA	0.65	13.14	NA	XXX
75710		A	Artery x-rays, arm/leg	1.13	12.88	NA	0.72	14.73	NA	XXX
75710	26	A	Artery x-rays, arm/leg	1.13	0.39	0.39	0.07	1.59	1.59	XXX
75710	TC	A	Artery x-rays, arm/leg	0.00	12.49	NA	0.65	13.14	NA	XXX
75716		A	Artery x-rays, arms/legs	1.30	12.93	NA	0.72	14.95	NA	XXX
75716	26	A	Artery x-rays, arms/legs	1.30	0.44	0.44	0.07	1.81	1.81	XXX
75716	TC	A	Artery x-rays, arms/legs	0.00	12.49	NA	0.65	13.14	NA	XXX
75722		A	Artery x-rays, kidney	1.13	12.90	NA	0.71	14.74	NA	XXX
75722	26	A	Artery x-rays, kidney	1.13	0.41	0.41	0.06	1.60	1.60	XXX
75722	TC	A	Artery x-rays, kidney	0.00	12.49	NA	0.65	13.14	NA	XXX
75724		A	Artery x-rays, kidneys	1.48	13.06	NA	0.71	15.25	NA	XXX
75724	26	A	Artery x-rays, kidneys	1.48	0.57	0.57	0.06	2.11	2.11	XXX
75724	TC	A	Artery x-rays, kidneys	0.00	12.49	NA	0.65	13.14	NA	XXX
75726		A	Artery x-rays, abdomen	1.13	12.87	NA	0.71	14.71	NA	XXX
75726	26	A	Artery x-rays, abdomen	1.13	0.38	0.38	0.06	1.57	1.57	XXX
75726	TC	A	Artery x-rays, abdomen	0.00	12.49	NA	0.65	13.14	NA	XXX
75731		A	Artery x-rays, adrenal gland	1.13	12.87	NA	0.71	14.71	NA	XXX
75731	26	A	Artery x-rays, adrenal gland	1.13	0.38	0.38	0.06	1.57	1.57	XXX
75731	TC	A	Artery x-rays, adrenal gland	0.00	12.49	NA	0.65	13.14	NA	XXX
75733		A	Artery x-rays, adrenals	1.30	12.93	NA	0.72	14.95	NA	XXX
75733	26	A	Artery x-rays, adrenals	1.30	0.44	0.44	0.07	1.81	1.81	XXX
75733	TC	A	Artery x-rays, adrenals	0.00	12.49	NA	0.65	13.14	NA	XXX
75736		A	Artery x-rays, pelvis	1.13	12.87	NA	0.71	14.71	NA	XXX
75736	26	A	Artery x-rays, pelvis	1.13	0.38	0.38	0.06	1.57	1.57	XXX
75736	TC	A	Artery x-rays, pelvis	0.00	12.49	NA	0.65	13.14	NA	XXX
75741		A	Artery x-rays, lung	1.30	12.93	NA	0.72	14.95	NA	XXX
75741	26	A	Artery x-rays, lung	1.30	0.44	0.44	0.07	1.81	1.81	XXX
75741	TC	A	Artery x-rays, lung	0.00	12.49	NA	0.65	13.14	NA	XXX
75743		A	Artery x-rays, lungs	1.65	13.04	NA	0.73	15.42	NA	XXX
75743	26	A	Artery x-rays, lungs	1.65	0.55	0.55	0.08	2.28	2.28	XXX
75743	TC	A	Artery x-rays, lungs	0.00	12.49	NA	0.65	13.14	NA	XXX
75746		A	Artery x-rays, lung	1.13	12.87	NA	0.71	14.71	NA	XXX
75746	26	A	Artery x-rays, lung	1.13	0.38	0.38	0.06	1.57	1.57	XXX
75746	TC	A	Artery x-rays, lung	0.00	12.49	NA	0.65	13.14	NA	XXX
75756		A	Artery x-rays, chest	1.13	12.95	NA	0.70	14.78	NA	XXX
75756	26	A	Artery x-rays, chest	1.13	0.46	0.46	0.05	1.64	1.64	XXX
75756	TC	A	Artery x-rays, chest	0.00	12.49	NA	0.65	13.14	NA	XXX
75774		A	Artery x-ray, each vessel	0.36	12.62	NA	0.67	13.65	NA	ZZZ
75774	26	A	Artery x-ray, each vessel	0.36	0.13	0.13	0.02	0.51	0.51	ZZZ
75774	TC	A	Artery x-ray, each vessel	0.00	12.49	NA	0.65	13.14	NA	ZZZ
75790		A	Visualize A–V shunt	1.83	1.95	NA	0.19	3.97	NA	XXX
75790	26	A	Visualize A–V shunt	1.83	0.61	0.61	0.11	2.55	2.55	XXX
75790	TC	A	Visualize A–V shunt	0.00	1.34	NA	0.08	1.42	NA	XXX
75801		A	Lymph vessel x-ray, arm/leg	0.81	5.64	NA	0.35	6.80	NA	XXX
75801	26	A	Lymph vessel x-ray, arm/leg	0.81	0.27	0.27	0.06	1.14	1.14	XXX
75801	TC	A	Lymph vessel x-ray, arm/leg	0.00	5.37	NA	0.29	5.66	NA	XXX
75803		A	Lymph vessel x-ray,arms/legs	1.16	5.76	NA	0.35	7.27	NA	XXX
75803	26	A	Lymph vessel x-ray,arms/legs	1.16	0.39	0.39	0.06	1.61	1.61	XXX
75803	TC	A	Lymph vessel x-ray,arms/legs	0.00	5.37	NA	0.29	5.66	NA	XXX
75805		A	Lymph vessel x-ray, trunk	0.81	6.32	NA	0.37	7.50	NA	XXX
75805	26	A	Lymph vessel x-ray, trunk	0.81	0.27	0.27	0.05	1.13	1.13	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
75805	TC	A	Lymph vessel x-ray, trunk	0.00	6.05	NA	0.32	6.37	NA	XXX
75807		A	Lymph vessel x-ray, trunk	1.16	6.44	NA	0.38	7.98	NA	XXX
75807	26	A	Lymph vessel x-ray, trunk	1.16	0.39	0.39	0.06	1.61	1.61	XXX
75807	TC	A	Lymph vessel x-ray, trunk	0.00	6.05	NA	0.32	6.37	NA	XXX
75809		A	Nonvascular shunt, x-ray	0.47	0.93	NA	0.07	1.47	NA	XXX
75809	26	A	Nonvascular shunt, x-ray	0.47	0.16	0.16	0.02	0.65	0.65	XXX
75809	TC	A	Nonvascular shunt, x-ray	0.00	0.77	NA	0.05	0.82	NA	XXX
75810		A	Vein x-ray, spleen/liver	1.13	12.87	NA	0.72	14.72	NA	XXX
75810	26	A	Vein x-ray, spleen/liver	1.13	0.38	0.38	0.07	1.58	1.58	XXX
75810	TC	A	Vein x-ray, spleen/liver	0.00	12.49	NA	0.65	13.14	NA	XXX
75820		A	Vein x-ray, arm/leg	0.70	1.17	NA	0.10	1.97	NA	XXX
75820	26	A	Vein x-ray, arm/leg	0.70	0.23	0.23	0.04	0.97	0.97	XXX
75820	TC	A	Vein x-ray, arm/leg	0.00	0.94	NA	0.06	1.00	NA	XXX
75822		A	Vein x-ray, arms/legs	1.05	1.82	NA	0.14	3.01	NA	XXX
75822	26	A	Vein x-ray, arms/legs	1.05	0.35	0.35	0.06	1.46	1.46	XXX
75822	TC	A	Vein x-ray, arms/legs	0.00	1.47	NA	0.08	1.55	NA	XXX
75825		A	Vein x-ray, trunk	1.13	12.87	NA	0.72	14.72	NA	XXX
75825	26	A	Vein x-ray, trunk	1.13	0.38	0.38	0.07	1.58	1.58	XXX
75825	TC	A	Vein x-ray, trunk	0.00	12.49	NA	0.65	13.14	NA	XXX
75827		A	Vein x-ray, chest	1.13	12.87	NA	0.71	14.71	NA	XXX
75827	26	A	Vein x-ray, chest	1.13	0.38	0.38	0.06	1.57	1.57	XXX
75827	TC	A	Vein x-ray, chest	0.00	12.49	NA	0.65	13.14	NA	XXX
75831		A	Vein x-ray, kidney	1.13	12.87	NA	0.71	14.71	NA	XXX
75831	26	A	Vein x-ray, kidney	1.13	0.38	0.38	0.06	1.57	1.57	XXX
75831	TC	A	Vein x-ray, kidney	0.00	12.49	NA	0.65	13.14	NA	XXX
75833		A	Vein x-ray, kidneys	1.48	12.99	NA	0.73	15.20	NA	XXX
75833	26	A	Vein x-ray, kidneys	1.48	0.50	0.50	0.08	2.06	2.06	XXX
75833	TC	A	Vein x-ray, kidneys	0.00	12.49	NA	0.65	13.14	NA	XXX
75840		A	Vein x-ray, adrenal gland	1.13	12.88	NA	0.73	14.74	NA	XXX
75840	26	A	Vein x-ray, adrenal gland	1.13	0.39	0.39	0.08	1.60	1.60	XXX
75840	TC	A	Vein x-ray, adrenal gland	0.00	12.49	NA	0.65	13.14	NA	XXX
75842		A	Vein x-ray, adrenal glands	1.48	12.98	NA	0.73	15.19	NA	XXX
75842	26	A	Vein x-ray, adrenal glands	1.48	0.49	0.49	0.08	2.05	2.05	XXX
75842	TC	A	Vein x-ray, adrenal glands	0.00	12.49	NA	0.65	13.14	NA	XXX
75860		A	Vein x-ray, neck	1.13	12.89	NA	0.72	14.74	NA	XXX
75860	26	A	Vein x-ray, neck	1.13	0.40	0.40	0.07	1.60	1.60	XXX
75860	TC	A	Vein x-ray, neck	0.00	12.49	NA	0.65	13.14	NA	XXX
75870		A	Vein x-ray, skull	1.13	12.89	NA	0.72	14.74	NA	XXX
75870	26	A	Vein x-ray, skull	1.13	0.40	0.40	0.07	1.60	1.60	XXX
75870	TC	A	Vein x-ray, skull	0.00	12.49	NA	0.65	13.14	NA	XXX
75872		A	Vein x-ray, skull	1.13	12.87	NA	0.71	14.71	NA	XXX
75872	26	A	Vein x-ray, skull	1.13	0.38	0.38	0.06	1.57	1.57	XXX
75872	TC	A	Vein x-ray, skull	0.00	12.49	NA	0.65	13.14	NA	XXX
75880		A	Vein x-ray, eye socket	0.70	1.18	NA	0.10	1.98	NA	XXX
75880	26	A	Vein x-ray, eye socket	0.70	0.24	0.24	0.04	0.98	0.98	XXX
75880	TC	A	Vein x-ray, eye socket	0.00	0.94	NA	0.06	1.00	NA	XXX
75885		A	Vein x-ray, liver	1.43	12.97	NA	0.72	15.12	NA	XXX
75885	26	A	Vein x-ray, liver	1.43	0.48	0.48	0.07	1.98	1.98	XXX
75885	TC	A	Vein x-ray, liver	0.00	12.49	NA	0.65	13.14	NA	XXX
75887		A	Vein x-ray, liver	1.43	12.97	NA	0.72	15.12	NA	XXX
75887	26	A	Vein x-ray, liver	1.43	0.48	0.48	0.07	1.98	1.98	XXX
75887	TC	A	Vein x-ray, liver	0.00	12.49	NA	0.65	13.14	NA	XXX
75889		A	Vein x-ray, liver	1.13	12.87	NA	0.71	14.71	NA	XXX
75889	26	A	Vein x-ray, liver	1.13	0.38	0.38	0.06	1.57	1.57	XXX
75889	TC	A	Vein x-ray, liver	0.00	12.49	NA	0.65	13.14	NA	XXX
75891		A	Vein x-ray, liver	1.13	12.87	NA	0.71	14.71	NA	XXX
75891	26	A	Vein x-ray, liver	1.13	0.38	0.38	0.06	1.57	1.57	XXX
75891	TC	A	Vein x-ray, liver	0.00	12.49	NA	0.65	13.14	NA	XXX
75893		A	Venous sampling by catheter	0.54	12.67	NA	0.67	13.88	NA	XXX
75893	26	A	Venous sampling by catheter	0.54	0.18	0.18	0.02	0.74	0.74	XXX
75893	TC	A	Venous sampling by catheter	0.00	12.49	NA	0.65	13.14	NA	XXX
75894		A	X-rays, transcath therapy	1.30	24.36	NA	1.34	27.00	NA	XXX
75894	26	A	X-rays, transcath therapy	1.30	0.44	0.44	0.08	1.82	1.82	XXX
75894	TC	A	X-rays, transcath therapy	0.00	23.92	NA	1.26	25.18	NA	XXX
75896		A	X-rays, transcath therapy	1.30	21.27	NA	1.16	23.73	NA	XXX
75896	26	A	X-rays, transcath therapy	1.30	0.46	0.46	0.07	1.83	1.83	XXX
75896	TC	A	X-rays, transcath therapy	0.00	20.81	NA	1.09	21.90	NA	XXX
75898		A	Follow-up angiography	1.64	1.60	NA	0.14	3.38	NA	XXX
75898	26	A	Follow-up angiography	1.64	0.56	0.56	0.08	2.28	2.28	XXX
75898	TC	A	Follow-up angiography	0.00	1.04	NA	0.06	1.10	NA	XXX
75900		A	Arterial catheter exchange	0.49	20.95	NA	1.12	22.56	NA	XXX
75900	26	A	Arterial catheter exchange	0.49	0.16	0.16	0.02	0.67	0 67	XXX
75900	TC	A	Arterial catheter exchange	0.00	20.79	NA	1.10	21.89	NA	XXX
75901		A	Remove cva device obstruct	0.49	1.45	NA	0.85	2.79	NA	XXX
75901	26	A	Remove cva device obstruct	0.49	0.16	0.16	0.02	0.67	0.67	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
75901	TC	A	Remove cva device obstruct	0.00	1.29	NA	0.83	2.12	NA	XXX
75902	.....	A	Remove cva lumen obstruct	0.39	1.42	NA	0.85	2.66	NA	XXX
75902	26	A	Remove cva lumen obstruct	0.39	0.13	0.13	0.02	0.54	0.54	XXX
75902	TC	A	Remove cva lumen obstruct	0.00	1.29	NA	0.83	2.12	NA	XXX
75940	.....	A	X-ray placement, vein filter	0.54	12.67	NA	0.69	13.90	NA	XXX
75940	26	A	X-ray placement, vein filter	0.54	0.18	0.18	0.04	0.76	0.76	XXX
75940	TC	A	X-ray placement, vein filter	0.00	12.49	NA	0.65	13.14	NA	XXX
75945	.....	A	Intravascular us	0.40	4.66	NA	0.28	5.34	NA	XXX
75945	26	A	Intravascular us	0.40	0.14	0.14	0.04	0.58	0.58	XXX
75945	TC	A	Intravascular us	0.00	4.52	NA	0.24	4.76	NA	XXX
75946	.....	A	Intravascular us add-on	0.40	2.41	NA	0.17	2.98	NA	ZZZ
75946	26	A	Intravascular us add-on	0.40	0.14	0.14	0.04	0.58	0.58	ZZZ
75946	TC	A	Intravascular us add-on	0.00	2.27	NA	0.13	2.40	NA	ZZZ
75952	.....	C	Endovasc repair abdom aorta	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75952	26	A	Endovasc repair abdom aorta	4.47	1.51	1.51	0.92	6.80	6.80	XXX
75952	TC	C	Endovasc repair abdom aorta	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75953	.....	C	Abdom aneurysm endovas rpr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75953	26	A	Abdom aneurysm endovas rpr	1.35	0.46	0.46	0.82	2.63	2.63	XXX
75953	TC	C	Abdom aneurysm endovas rpr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75954	.....	C	Iliac aneurysm endovas rpr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75954	26	A	Iliac aneurysm endovas rpr	1.35	0.48	0.48	0.82	2.65	2.65	XXX
75954	TC	C	Iliac aneurysm endovas rpr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75960	.....	A	Transcatheter intro, stent	0.82	15.07	NA	0.82	16.71	NA	XXX
75960	26	A	Transcatheter intro, stent	0.82	0.29	0.29	0.05	1.16	1.16	XXX
75960	TC	A	Transcatheter intro, stent	0.00	14.78	NA	0.77	15.55	NA	XXX
75961	.....	A	Retneval, broken catheter	4.23	11.82	NA	0.77	16.82	NA	XXX
75961	26	A	Retrieval, broken catheter	4.23	1.41	1.41	0.22	5.86	5.86	XXX
75961	TC	A	Retrieval, broken catheter	0.00	10.41	NA	0.55	10.96	NA	XXX
75962	.....	A	Repair arterial blockage	0.54	15.80	NA	0.87	17.21	NA	XXX
75962	26	A	Repair arterial blockage	0.54	0.19	0.19	0.04	0.77	0.77	XXX
75962	TC	A	Repair arterial blockage	0.00	15.61	NA	0.83	16.44	NA	XXX
75964	.....	A	Repair artery blockage, each	0.36	8.45	NA	0.45	9.26	NA	ZZZ
75964	26	A	Repair artery blockage, each	0.36	0.12	0.12	0.02	0.50	0.50	ZZZ
75964	TC	A	Repair artery blockage, each	0.00	8.33	NA	0.43	8.76	NA	ZZZ
75966	.....	A	Repair arterial blockage	1.30	16.08	NA	0.90	18.28	NA	XXX
75966	26	A	Repair arterial blockage	1.30	0.47	0.47	0.07	1.84	1.84	XXX
75966	TC	A	Repair arterial blockage	0.00	15.61	NA	0.83	16.44	NA	XXX
75968	.....	A	Repair artery blockage, each	0.36	8.46	NA	0.44	9.26	NA	ZZZ
75968	26	A	Repair artery blockage, each	0.36	0.13	0.13	0.01	0.50	0.50	ZZZ
75968	TC	A	Repair artery blockage, each	0.00	8.33	NA	0.43	8.76	NA	ZZZ
75970	.....	A	Vascular biopsy	0.83	11.73	NA	0.65	13.21	NA	XXX
75970	26	A	Vascular biopsy	0.83	0.29	0.29	0.05	1.17	1.17	XXX
75970	TC	A	Vascular biopsy	0.00	11.44	NA	0.60	12.04	NA	XXX
75978	.....	A	Repair venous blockage	0.54	15.79	NA	0.85	17.18	NA	XXX
75978	26	A	Repair venous blockage	0.54	0.18	0.18	0.02	0.74	0.74	XXX
75978	TC	A	Repair venous blockage	0.00	15.61	NA	0.83	16.44	NA	XXX
75980	.....	A	Contrast xray exam bile duct	1.43	5.85	NA	0.36	7.64	NA	XXX
75980	26	A	Contrast xray exam bile duct	1.43	0.48	0.48	0.07	1.98	1.98	XXX
75980	TC	A	Contrast xray exam bile duct	0.00	5.37	NA	0.29	5.66	NA	XXX
75982	.....	A	Contrast xray exam bile duct	1.43	6.53	NA	0.39	8.35	NA	XXX
75982	26	A	Contrast xray exam bile duct	1.43	0.48	0.48	0.07	1.98	1.98	XXX
75982	TC	A	Contrast xray exam bile duct	0.00	6.05	NA	0.32	6.37	NA	XXX
75984	.....	A	Xray control catheter change	0.72	2.17	NA	0.15	3.04	NA	XXX
75984	26	A	Xray control catheter change	0.72	0.24	0.24	0.04	1.00	1.00	XXX
75984	TC	A	Xray control catheter change	0.00	1.93	NA	0.11	2.04	NA	XXX
75989	.....	A	Abscess drainage under x-ray	1.18	3.53	NA	0.23	4.94	NA	XXX
75989	26	A	Abscess drainage under x-ray	1.18	0.40	0.40	0.06	1.64	1.64	XXX
75989	TC	A	Abscess drainage under x-ray	0.00	3.13	NA	0.17	3.30	NA	XXX
75992	.....	A	Atherectomy, x-ray exam	0.54	15.80	NA	0.85	17.19	NA	XXX
75992	26	A	Atherectomy, x-ray exam	0.54	0.19	0.19	0.02	0.75	0.75	XXX
75992	TC	A	Atherectomy, x-ray exam	0.00	15.61	NA	0.83	16.44	NA	XXX
75993	.....	A	Atherectomy, x-ray exam	0.36	8.47	NA	0.44	9.27	NA	ZZZ
75993	26	A	Atherectomy, x-ray exam	0.36	0.14	0.14	0.01	0.51	0.51	ZZZ
75993	TC	A	Atherectomy, x-ray exam	0.00	8.33	NA	0.43	8.76	NA	ZZZ
75994	.....	A	Atherectomy, x-ray exam	1.30	16.08	NA	0.90	18.28	NA	XXX
75994	26	A	Atherectomy, x-ray exam	1.30	0.47	0.47	0.07	1.84	1.84	XXX
75994	TC	A	Atherectomy, x-ray exam	0.00	15.61	NA	0.83	16.44	NA	XXX
75995	.....	A	Atherectomy, x-ray exam	1.30	16.09	NA	0.90	18.29	NA	XXX
75995	26	A	Atherectomy, x-ray exam	1.30	0.48	0.48	0.07	1.85	1.85	XXX
75995	TC	A	Atherectomy, x-ray exam	0.00	15.61	NA	0.83	16.44	NA	XXX
75996	.....	A	Atherectomy, x-ray exam	0.36	8.45	NA	0.44	9.25	NA	ZZZ
75996	26	A	Atherectomy, x-ray exam	0.36	0.12	0.12	0.01	0.49	0.49	ZZZ
75996	TC	A	Atherectomy, x-ray exam	0.00	8.33	NA	0.43	8.76	NA	ZZZ
75998	.....	A	Fluoroguide for vein device	0.38	1.42	NA	0.15	1.95	NA	ZZZ
75998	26	A	Fluoroguide for vein device	0.38	0.13	0.13	0.05	0.56	0.56	ZZZ

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
75998	TC	A	Fluoroguide for vein device	0.00	1.29	NA	0.10	1.39	NA	ZZZ
76000		A	Fluoroscope examination	0.17	1.34	NA	0.08	1.59	NA	XXX
76000	26	A	Fluoroscope examination	0.17	0.05	0.05	0.01	0.23	0.23	XXX
76000	TC	A	Fluoroscope examination	0.00	1.29	NA	0.07	1.36	NA	XXX
76001		A	Fluoroscope exam, extensive	0.67	2.82	NA	0.18	3.67	NA	XXX
76001	26	A	Fluoroscope exam, extensive	0.67	0.22	0.22	0.04	0.93	0.93	XXX
76001	TC	A	Fluoroscope exam, extensive	0.00	2.60	NA	0.14	2.74	NA	XXX
76003		A	Needle localization by x-ray	0.54	1.46	NA	0.11	2.11	NA	XXX
76003	26	A	Needle localization by x-ray	0.54	0.17	0.17	0.04	0.75	0.75	XXX
76003	TC	A	Needle localization by x-ray	0.00	1.29	NA	0.07	1.36	NA	XXX
76005		A	Fluoroguide for spine inject	0.60	1.45	NA	0.11	2.16	NA	XXX
76005	26	A	Fluoroguide for spine inject	0.60	0.16	0.16	0.04	0.80	0.80	XXX
76005	TC	A	Fluoroguide for spine inject	0.00	1.29	NA	0.07	1.36	NA	XXX
76006		A	X-ray stress view	0.41	0.19	0.19	0.05	0.65	0.65	XXX
76010		A	X-ray, nose to rectum	0.18	0.58	NA	0.03	0.79	NA	XXX
76010	26	A	X-ray, nose to rectum	0.18	0.06	0.06	0.01	0.25	0.25	XXX
76010	TC	A	X-ray, nose to rectum	0.00	0.52	NA	0.02	0.54	NA	XXX
76012		C	Percut vertebroplasty fluor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76012	26	A	Percut vertebroplasty fluor	1.30	0.48	0.48	0.28	2.06	2.06	XXX
76012	TC	C	Percut vertebroplasty fluor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76013		C	Percut vertebroplasty, ct	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76013	26	A	Percut vertebroplasty, ct	1.37	0.49	0.49	0.58	2.44	2.44	XXX
76013	TC	C	Percut vertebroplasty, ct	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76020		A	X-rays for bone age	0.19	0.58	NA	0.03	0.80	NA	XXX
76020	26	A	X-rays for bone age	0.19	0.06	0.06	0.01	0.26	0.26	XXX
76020	TC	A	X-rays for bone age	0.00	0.52	NA	0.02	0.54	NA	XXX
76040		A	X-rays, bone evaluation	0.27	0.86	NA	0.09	1.22	NA	XXX
76040	26	A	X-rays, bone evaluation	0.27	0.09	0.09	0.04	0.40	0.40	XXX
76040	TC	A	X-rays, bone evaluation	0.00	0.77	NA	0.05	0.82	NA	XXX
76061		A	X-rays, bone survey	0.45	1.14	NA	0.08	1.67	NA	XXX
76061	26	A	X-rays, bone survey	0.45	0.15	0.15	0.02	0.62	0.62	XXX
76061	TC	A	X-rays, bone survey	0.00	0.99	NA	0.06	1.05	NA	XXX
76062		A	X-rays, bone survey	0.54	1.61	NA	0.10	2.25	NA	XXX
76062	26	A	X-rays, bone survey	0.54	0.18	0.18	0.02	0.74	0.74	XXX
76062	TC	A	X-rays, bone survey	0.00	1.43	NA	0.08	1.51	NA	XXX
76065		A	X-rays, bone evaluation	0.70	0.96	NA	0.06	1.72	NA	XXX
76065	26	A	X-rays, bone evaluation	0.70	0.24	0.24	0.01	0.95	0.95	XXX
76065	TC	A	X-rays, bone evaluation	0.00	0.72	NA	0.05	0.77	NA	XXX
76066		A	Joint survey, single view	0.31	1.21	NA	0.08	1.60	NA	XXX
76066	26	A	Joint survey, single view	0.31	0.11	0.11	0.02	0.44	0.44	XXX
76066	TC	A	Joint survey, single view	0.00	1.10	NA	0.06	1.16	NA	XXX
76070		A	Ct bone density, axial	0.25	3.01	NA	0.17	3.43	NA	XXX
76070	26	A	Ct bone density, axial	0.25	0.08	0.08	0.01	0.34	0.34	XXX
76070	TC	A	Ct bone density, axial	0.00	2.93	NA	0.16	3.09	NA	XXX
76071		A	Ct bone density, peripheral	0.22	3.00	NA	0.06	3.28	NA	XXX
76071	26	A	Ct bone density, peripheral	0.22	0.07	0.07	0.01	0.30	0.30	XXX
76071	TC	A	Ct bone density, peripheral	0.00	2.93	NA	0.05	2.98	NA	XXX
76075		A	Dexa, axial skeleton study	0.30	3.17	NA	0.18	3.65	NA	XXX
76075	26	A	Dexa, axial skeleton study	0.30	0.10	0.10	0.01	0.41	0.41	XXX
76075	TC	A	Dexa, axial skeleton study	0.00	3.07	NA	0.17	3.24	NA	XXX
76076		A	Dexa, peripheral study	0.22	0.82	NA	0.06	1.10	NA	XXX
76076	26	A	Dexa, peripheral study	0.22	0.08	0.08	0.01	0.31	0.31	XXX
76076	TC	A	Dexa, peripheral study	0.00	0.74	NA	0.05	0.79	NA	XXX
76078		A	Radiographic absorptiometry	0.20	0.81	NA	0.06	1.07	NA	XXX
76078	26	A	Radiographic absorptiometry	0.20	0.07	0.07	0.01	0.28	0.28	XXX
76078	TC	A	Radiographic absorptiometry	0.00	0.74	NA	0.05	0.79	NA	XXX
76080		A	X-ray exam of fistula	0.54	1.22	NA	0.08	1.84	NA	XXX
76080	26	A	X-ray exam of fistula	0.54	0.18	0.18	0.02	0.74	0.74	XXX
76080	TC	A	X-ray exam of fistula	0.00	1.04	NA	0.06	1.10	NA	XXX
76082		A	Computer mammogram add-on	0.06	0.44	NA	0.02	0.52	NA	ZZZ
76082	26	A	Computer mammogram add-on	0.06	0.02	0.02	0.01	0.09	0.09	ZZZ
76082	TC	A	Computer mammogram add-on	0.00	0.42	NA	0.01	0.43	NA	ZZZ
76083		A	Computer mammogram add-on	0.06	0.44	NA	0.02	0.52	NA	ZZZ
76083	26	A	Computer mammogram add-on	0.06	0.02	0.02	0.01	0.09	0.09	ZZZ
76083	TC	A	Computer mammogram add-on	0.00	0.42	NA	0.01	0.43	NA	ZZZ
76085		F	Computer mammogram add-on	+0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
76085	26	F	Computer mammogram add-on	+0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
76085	TC	F	Computer mammogram add-on	+0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
76086		A	X-ray of mammary duct	0.36	2.72	NA	0.16	3.24	NA	XXX
76086	26	A	X-ray of mammary duct	0.36	0.12	0.12	0.02	0.50	0.50	XXX
76086	TC	A	X-ray of mammary duct	0.00	2.60	NA	0.14	2.74	NA	XXX
76088		A	X-ray of mammary ducts	0.45	3.78	NA	0.21	4.44	NA	XXX
76088	26	A	X-ray of mammary ducts	0.45	0.15	0.15	0.02	0.62	0.62	XXX
76088	TC	A	X-ray of mammary ducts	0.00	3.63	NA	0.19	3.82	NA	XXX
76090		A	Mammogram, one breast	0.70	1.27	NA	0.10	2.07	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Descnption	Physician work RVUs[3]	Non-facil-ity PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facil-ity Total	Facility total	Global
76090	26	A	Mammogram, one breast	0.70	0.23	0.23	0.04	0.97	0.97	XXX
76090	TC	A	Mammogram, one breast	0.00	1.04	NA	0.06	1.10	NA	XXX
76091	.....	A	Mammogram, both breasts	0.87	1.58	NA	0.11	2.56	NA	XXX
76091	26	A	Mammogram, both breasts	0.87	0.29	0.29	0.04	1.20	1.20	XXX
76091	TC	A	Mammogram, both breasts	0.00	1.29	NA	0.07	1.36	NA	XXX
76092	.....	A	Mammogram, screening	0.70	1.45	NA	0.11	2.26	NA	XXX
76092	26	A	Mammogram, screening	0.70	0.23	0.23	0.04	0.97	0.97	XXX
76092	TC	A	Mammogram, screening	0.00	1.22	NA	0.07	1.29	NA	XXX
76093	.....	A	Magnetic image, breast	1.62	18.02	NA	0.99	20.63	NA	XXX
76093	26	A	Magnetic image, breast	1.62	0.55	0.55	0.08	2.25	2.25	XXX
76093	TC	A	Magnetic image, breast	0.00	17.47	NA	0.91	18.38	NA	XXX
76094	.....	A	Magnetic image, both breasts	1.62	24.25	NA	1.31	27.18	NA	XXX
76094	26	A	Magnetic image, both breasts	1.62	0.54	0.54	0.08	2.24	2.24	XXX
76094	TC	A	Magnetic image, both breasts	0.00	23.71	NA	1.23	24.94	NA	XXX
76095	.....	A	Stereotactic breast biopsy	1.58	7.63	NA	0.48	9.69	NA	XXX
76095	26	A	Stereotactic breast biopsy	1.58	0.53	0.53	0.11	2.22	2.22	XXX
76095	TC	A	Stereotactic breast biopsy	0.00	7.10	NA	0.37	7.47	NA	XXX
76096	.....	A	X-ray of needle wire, breast	0.56	1.48	NA	0.11	2.15	NA	XXX
76096	26	A	X-ray of needle wire, breast	0.56	0.19	0.19	0.04	0.79	0.79	XXX
76096	TC	A	X-ray of needle wire, breast	0.00	1.29	NA	0.07	1.36	NA	XXX
76098	.....	A	X-ray exam, breast specimen	0.16	0.47	NA	0.03	0.66	NA	XXX
76098	26	A	X-ray exam, breast specimen	0.16	0.05	0.05	0.01	0.22	0.22	XXX
76098	TC	A	X-ray exam, breast specimen	0.00	0.42	NA	0.02	0.44	NA	XXX
76100	.....	A	X-ray exam of body section	0.58	1.43	NA	0.11	2.12	NA	XXX
76100	26	A	X-ray exam of body section	0.58	0.19	0.19	0.04	0.81	0.81	XXX
76100	TC	A	X-ray exam of body section	0.00	1.24	NA	0.07	1.31	NA	XXX
76101	.....	A	Complex body section x-ray	0.58	1.60	NA	0.12	2.30	NA	XXX
76101	26	A	Complex body section x-ray	0.58	0.19	0.19	0.04	0.81	0.81	XXX
76101	TC	A	Complex body section x-ray	0.00	1.41	NA	0.08	1.49	NA	XXX
76102	.....	A	Complex body section x-rays	0.58	1.92	NA	0.15	2.65	NA	XXX
76102	26	A	Complex body section x-rays	0.58	0.20	0.20	0.04	0.82	0.82	XXX
76102	TC	A	Complex body section x-rays	0.00	1.72	NA	0.11	1.83	NA	XXX
76120	.....	A	Cine/video x-rays	0.38	1.17	NA	0.08	1.63	NA	XXX
76120	26	A	Cine/video x-rays	0.38	0.13	0.13	0.02	0.53	0.53	XXX
76120	TC	A	Cine/video x-rays	0.00	1.04	NA	0.06	1.10	NA	XXX
76125	.....	A	Cine/video x-rays add-on	0.27	0.86	NA	0.06	1.19	NA	ZZZ
76125	26	A	Cine/video x-rays add-on	0.27	0.09	0.09	0.01	0.37	0.37	ZZZ
76125	TC	A	Cine/video x-rays add-on	0.00	0.77	NA	0.05	0.82	NA	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	0.42	NA	0.02	0.44	NA	XXX
76350	.....	C	Special x-ray contrast study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76355	.....	A	Ct scan for localization	1.20	8.60	NA	0.49	10.29	NA	XXX
76355	26	A	Ct scan for localization	1.20	0.41	0.41	0.07	1.68	1.68	XXX
76355	TC	A	Ct scan for localization	0.00	8.19	NA	0.42	8.61	NA	XXX
76360	.....	A	Ct scan for needle biopsy	1.15	8.58	NA	0.48	10.21	NA	XXX
76360	26	A	Ct scan for needle biopsy	1.15	0.39	0.39	0.06	1.60	1.60	XXX
76360	TC	A	Ct scan for needle biopsy	0.00	8.19	NA	0.42	8.61	NA	XXX
76362	.....	A	Ct guide for tissue ablation	3.98	9.51	NA	1.67	15.16	NA	XXX
76362	26	A	Ct guide for tissue ablation	3.98	1.32	1.32	0.22	5.52	5.52	XXX
76362	TC	A	Ct guide for tissue ablation	0.00	8.19	NA	1.45	9.64	NA	XXX
76370	.....	A	Ct scan for therapy guide	0.85	3.21	NA	0.21	4.27	NA	XXX
76370	26	A	Ct scan for therapy guide	0.85	0.28	0.28	0.05	1.18	1.18	XXX
76370	TC	A	Ct scan for therapy guide	0.00	2.93	NA	0.16	3.09	NA	XXX
76375	.....	A	3d/holograph reconstr add-on	0.16	3.56	NA	0.19	3.91	NA	XXX
76375	26	A	3d/holograph reconstr add-on	0.16	0.05	0.05	0.01	0.22	0.22	XXX
76375	TC	A	3d/holograph reconstr add-on	0.00	3.51	NA	0.18	3.69	NA	XXX
76380	.....	A	CAT scan follow-up study	0.97	3.80	NA	0.23	5.00	NA	XXX
76380	26	A	CAT scan follow-up study	0.97	0.33	0.33	0.05	1.35	1.35	XXX
76380	TC	A	CAT scan follow-up study	0.00	3.47	NA	0.18	3.65	NA	XXX
76390	.....	N	Mr spectroscopy	+1.39	11.55	11.55	0.66	13.60	13.60	XXX
76390	26	N	Mr spectroscopy	+1.39	0.48	0.48	0.07	1.94	1.94	XXX
76390	TC	N	Mr spectroscopy	+0.00	11.07	11.07	0.59	11.66	11.66	XXX
76393	.....	A	Mr guidance for needle place	1.49	11.62	NA	0.63	13.74	NA	XXX
76393	26	A	Mr guidance for needle place	1.49	0.51	0.51	0.08	2.08	2.08	XXX
76393	TC	A	Mr guidance for needle place	0.00	11.11	NA	0.55	11.66	NA	XXX
76394	.....	A	Mri for tissue ablation	4.23	12.52	NA	1.78	18.53	NA	XXX
76394	26	A	Mri for tissue ablation	4.23	1.41	1.41	0.23	5.87	5.87	XXX
76394	TC	A	Mri for tissue ablation	0.00	11.11	NA	1.55	12.66	NA	XXX
76400	.....	A	Magnetic image, bone marrow	1.59	11.64	NA	0.67	13.90	NA	XXX
76400	26	A	Magnetic image, bone marrow	1.59	0.53	0.53	0.08	2.20	2.20	XXX
76400	TC	A	Magnetic image, bone marrow	0.00	11.11	NA	0.59	11.70	NA	XXX
76490	.....	D	Us for tissue ablation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76490	26	D	Us for tissue ablation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76490	TC	D	Us for tissue ablation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76496	.....	C	Fluoroscopic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
76496	26	C	Fluoroscopic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76496	TC	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	0.00	0.00	0.00	XXX
76497	26	C	Ct procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76497	TC	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	0.00	0.00	0.00	XXX
76498	26	C	Mri procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76498	TC	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	0.00	0.00	0.00	XXX
76499	26	C	Radiographic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76499	TC	C	Radiographic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76506	.....	A	Echo exam of head	0.63	1.66	NA	0.12	2.41	NA	XXX
76506	26	A	Echo exam of head	0.63	0.25	0.25	0.04	0.92	0.92	XXX
76506	TC	A	Echo exam of head	0.00	1.41	NA	0.08	1.49	NA	XXX
76511	.....	A	Echo exam of eye	0.93	1.10	NA	0.09	2.12	NA	XXX
76511	26	A	Echo exam of eye	0.93	0.41	0.41	0.02	1.36	1.36	XXX
76511	TC	A	Echo exam of eye	0.00	0.69	NA	0.07	0.76	NA	XXX
76512	.....	A	Echo exam of eye	0.66	1.03	NA	0.11	1.80	NA	XXX
76512	26	A	Echo exam of eye	0.66	0.30	0.30	0.01	0.97	0.97	XXX
76512	TC	A	Echo exam of eye	0.00	0.73	NA	0.10	0.83	NA	XXX
76513	.....	A	Echo exam of eye, water bath	0.66	1.11	NA	0.11	1.88	NA	XXX
76513	26	A	Echo exam of eye, water bath	0.66	0.30	0.30	0.01	0.97	0.97	XXX
76513	TC	A	Echo exam of eye, water bath	0.00	0.81	NA	0.10	0.91	NA	XXX
76514	.....	A	Echo exam of eye, thickness	0.17	0.14	NA	0.02	0.33	NA	XXX
76514	26	A	Echo exam of eye, thickness	0.17	0.08	0.08	0.01	0.26	0.26	XXX
76514	TC	A	Echo exam of eye, thickness	0.00	0.06	NA	0.01	0.07	NA	XXX
76516	.....	A	Echo exam of eye	0.54	0.74	NA	0.08	1.36	NA	XXX
76516	26	A	Echo exam of eye	0.54	0.25	0.25	0.01	0.80	0.80	XXX
76516	TC	A	Echo exam of eye	0.00	0.49	NA	0.07	0.56	NA	XXX
76519	.....	A	Echo exam of eye	0.54	0.83	NA	0.08	1.45	NA	XXX
76519	26	A	Echo exam of eye	0.54	0.25	0.25	0.01	0.80	0.80	XXX
76519	TC	A	Echo exam of eye	0.00	0.58	NA	0.07	0.65	NA	XXX
76529	.....	A	Echo exam of eye	0.57	0.78	NA	0.09	1.44	NA	XXX
76529	26	A	Echo exam of eye	0.57	0.25	0.25	0.01	0.83	0.83	XXX
76529	TC	A	Echo exam of eye	0.00	0.53	NA	0.08	0.61	NA	XXX
76536	.....	A	Us exam of head and neck	0.56	1.60	NA	0.10	2.26	NA	XXX
76536	26	A	Us exam of head and neck	0.56	0.19	0.19	0.02	0.77	0.77	XXX
76536	TC	A	Us exam of head and neck	0.00	1.41	NA	0.08	1.49	NA	XXX
76604	.....	A	Us exam, chest, b-scan	0.55	1.47	NA	0.09	2.11	NA	XXX
76604	26	A	Us exam, chest, b-scan	0.55	0.18	0.18	0.02	0.75	0.75	XXX
76604	TC	A	Us exam, chest, b-scan	0.00	1.29	NA	0.07	1.36	NA	XXX
76645	.....	A	Us exam, breast(s)	0.54	1.22	NA	0.10	1.86	NA	XXX
76645	26	A	Us exam, breast(s)	0.54	0.18	0.18	0.04	0.76	0.76	XXX
76645	TC	A	Us exam, breast(s)	0.00	1.04	NA	0.06	1.10	NA	XXX
76700	.....	A	Us exam, abdom, complete	0.81	2.22	NA	0.16	3.19	NA	XXX
76700	26	A	Us exam, abdom, complete	0.81	0.27	0.27	0.05	1.13	1.13	XXX
76700	TC	A	Us exam, abdom, complete	0.00	1.95	NA	0.11	2.06	NA	XXX
76705	.....	A	Echo exam of abdomen	0.59	1.61	NA	0.12	2.32	NA	XXX
76705	26	A	Echo exam of abdomen	0.59	0.20	0.20	0.04	0.83	0.83	XXX
76705	TC	A	Echo exam of abdomen	0.00	1.41	NA	0.08	1.49	NA	XXX
76770	.....	A	Us exam abdo back wall, comp	0.74	2.20	NA	0.15	3.09	NA	XXX
76770	26	A	Us exam abdo back wall, comp	0.74	0.25	0.25	0.04	1.03	1.03	XXX
76770	TC	A	Us exam abdo back wall, comp	0.00	1.95	NA	0.11	2.06	NA	XXX
76775	.....	A	Us exam abdo back wall, lim	0.58	1.60	NA	0.12	2.30	NA	XXX
76775	26	A	Us exam abdo back wall, lim	0.58	0.19	0.19	0.04	0.81	0.81	XXX
76775	TC	A	Us exam abdo back wall, lim	0.00	1.41	NA	0.08	1.49	NA	XXX
76778	.....	A	Us exam kidney transplant	0.74	2.20	NA	0.15	3.09	NA	XXX
76778	26	A	Us exam kidney transplant	0.74	0.25	0.25	0.04	1.03	1.03	XXX
76778	TC	A	Us exam kidney transplant	0.00	1.95	NA	0.11	2.06	NA	XXX
76800	.....	A	Us exam, spinal canal	1.12	1.76	NA	0.13	3.01	NA	XXX
76800	26	A	Us exam, spinal canal	1.12	0.35	0.35	0.05	1.52	1.52	XXX
76800	TC	A	Us exam, spinal canal	0.00	1.41	NA	0.08	1.49	NA	XXX
76801	.....	A	Ob us < 14 wks, single fetus	0.98	2.43	NA	0.17	3.58	NA	XXX
76801	26	A	Ob us < 14 wks, single fetus	0.98	0.35	0.35	0.05	1.38	1.38	XXX
76801	TC	A	Ob us < 14 wks, single fetus	0.00	2.08	NA	0.12	2.20	NA	XXX
76802	.....	A	Ob us < 14 wks, addl fetus	0.83	1.33	NA	0.17	2.33	NA	ZZZ
76802	26	A	Ob us < 14 wks, addl fetus	0.83	0.29	0.29	0.05	1.17	1.17	ZZZ
76802	TC	A	Ob us < 14 wks, addl fetus	0.00	1.04	NA	0.12	1.16	NA	ZZZ
76805	.....	A	Ob us >/= 14 wks, sngl fetus	0.98	2.43	NA	0.17	3.58	NA	XXX
76805	26	A	Ob us >/= 14 wks, sngl fetus	0.98	0.35	0.35	0.05	1.38	1.38	XXX
76805	TC	A	Ob us >/= 14 wks, sngl fetus	0.00	2.08	NA	0.12	2.20	NA	XXX
76810	.....	A	Ob us >/= 14 wks, addl fetus	0.97	1.39	NA	0.30	2.66	NA	ZZZ
76810	26	A	Ob us >/= 14 wks, addl fetus	0.97	0.35	0.35	0.08	1.40	1.40	ZZZ
76810	TC	A	Ob us >/= 14 wks, addl fetus	0.00	1.04	NA	0.22	1.26	NA	ZZZ
76811	.....	A	Ob us, detailed, sngl fetus	1.89	4.16	NA	0.61	6.66	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
76811	26	A	Ob us, detailed, sngl fetus	1.89	0.66	0.66	0.18	2.73	2.73	XXX
76811	TC	A	Ob us, detailed, sngl fetus	0.00	3.50	NA	0.43	3.93	NA	XXX
76812	.....	A	Ob us, detailed, addl fetus	1.77	1.68	NA	0.55	4.00	NA	ZZZ
76812	26	A	Ob us, detailed, addl fetus	1.77	0.64	0.64	0.14	2.55	2.55	ZZZ
76812	TC	A	Ob us, detailed, addl fetus	0.00	1.04	NA	0.41	1.45	NA	ZZZ
76815	.....	A	Ob us, limited, fetus(s)	0.65	1.64	NA	0.10	2.39	NA	XXX
76815	26	A	Ob us, limited, fetus(s)	0.65	0.23	0.23	0.02	0.90	0.90	XXX
76815	TC	A	Ob us, limited, fetus(s)	0.00	1.41	NA	0.08	1.49	NA	XXX
76816	.....	A	Ob us, follow-up, per fetus	0.85	1.42	NA	0.08	2.35	NA	XXX
76816	26	A	Ob us, follow-up, per fetus	0.85	0.32	0.32	0.02	1.19	1.19	XXX
76816	TC	A	Ob us, follow-up, per fetus	0.00	1.10	NA	0.06	1.16	NA	XXX
76817	.....	A	Transvaginal us, obstetric	0.75	1.79	NA	0.08	2.62	NA	XXX
76817	26	A	Transvaginal us, obstetric	0.75	0.28	0.28	0.02	1.05	1.05	XXX
76817	TC	A	Transvaginal us, obstetric	0.00	1.51	NA	0.06	1.57	NA	XXX
76818	.....	A	Fetal biophys profile w/nst	1.04	2.00	NA	0.15	3.19	NA	XXX
76818	26	A	Fetal biophys profile w/nst	1.04	0.40	0.40	0.05	1.49	1.49	XXX
76818	TC	A	Fetal biophys profile w/nst	0.00	1.60	NA	0.10	1.70	NA	XXX
76819	.....	A	Fetal biophys profil w/o nst	0.77	1.89	NA	0.12	2.78	NA	XXX
76819	26	A	Fetal biophys profil w/o nst	0.77	0.29	0.29	0.02	1.08	1.08	XXX
76819	TC	A	Fetal biophys profil w/o nst	0.00	1.60	NA	0.10	1.70	NA	XXX
76825	.....	A	Echo exam of fetal heart	1.66	2.57	NA	0.18	4.41	NA	XXX
76825	26	A	Echo exam of fetal heart	1.66	0.62	0.62	0.07	2.35	2.35	XXX
76825	TC	A	Echo exam of fetal heart	0.00	1.95	NA	0.11	2.06	NA	XXX
76826	.....	A	Echo exam of fetal heart	0.83	1.00	NA	0.09	1.92	NA	XXX
76826	26	A	Echo exam of fetal heart	0.83	0.30	0.30	0.04	1.17	1.17	XXX
76826	TC	A	Echo exam of fetal heart	0.00	0.70	NA	0.05	0.75	NA	XXX
76827	.....	A	Echo exam of fetal heart	0.58	1.93	NA	0.14	2.65	NA	XXX
76827	26	A	Echo exam of fetal heart	0.58	0.22	0.22	0.02	0.82	0.82	XXX
76827	TC	A	Echo exam of fetal heart	0.00	1.71	NA	0.12	1.83	NA	XXX
76828	.....	A	Echo exam of fetal heart	0.56	1.32	NA	0.10	1.98	NA	XXX
76828	26	A	Echo exam of fetal heart	0.56	0.22	0.22	0.02	0.80	0.80	XXX
76828	TC	A	Echo exam of fetal heart	0.00	1.10	NA	0.08	1.18	NA	XXX
76830	.....	A	Transvaginal us, non-ob	0.69	1.74	NA	0.14	2.57	NA	XXX
76830	26	A	Transvaginal us, non-ob	0.69	0.23	0.23	0.04	0.96	0.96	XXX
76830	TC	A	Transvaginal us, non-ob	0.00	1.51	NA	0.10	1.61	NA	XXX
76831	.....	A	Echo exam, uterus	0.72	1.77	NA	0.12	2.61	NA	XXX
76831	26	A	Echo exam, uterus	0.72	0.26	0.26	0.02	1.00	1.00	XXX
76831	TC	A	Echo exam, uterus	0.00	1.51	NA	0.10	1.61	NA	XXX
76856	.....	A	Us exam, pelvic, complete	0.69	1.74	NA	0.14	2.57	NA	XXX
76856	26	A	Us exam, pelvic, complete	0.69	0.23	0.23	0.04	0.96	0.96	XXX
76856	TC	A	Us exam, pelvic, complete	0.00	1.51	NA	0.10	1.61	NA	XXX
76857	.....	A	Us exam, pelvic, limited	0.38	1.71	NA	0.08	2.17	NA	XXX
76857	26	A	Us exam, pelvic, limited	0.38	0.13	0.13	0.02	0.53	0.53	XXX
76857	TC	A	Us exam, pelvic, limited	0.00	1.58	NA	0.06	1.64	NA	XXX
76870	.....	A	Us exam, scrotum	0.64	1.72	NA	0.14	2.50	NA	XXX
76870	26	A	Us exam, scrotum	0.64	0.21	0.21	0.04	0.89	0.89	XXX
76870	TC	A	Us exam, scrotum	0.00	1.51	NA	0.10	1.61	NA	XXX
76872	.....	A	Us, transrectal	0.69	2.10	NA	0.15	2.94	NA	XXX
76872	26	A	Us, transrectal	0.69	0.23	0.23	0.05	0.97	0.97	XXX
76872	TC	A	Us, transrectal	0.00	1.87	NA	0.10	1.97	NA	XXX
76873	.....	A	Echograp trans r, pros study	1.54	2.59	NA	0.26	4.39	NA	XXX
76873	26	A	Echograp trans r, pros study	1.54	0.51	0.51	0.10	2.15	2.15	XXX
76873	TC	A	Echograp trans r, pros study	0.00	2.08	NA	0.16	2.24	NA	XXX
76880	.....	A	Us exam, extremity	0.59	1.61	NA	0.12	2.32	NA	XXX
76880	26	A	Us exam, extremity	0.59	0.20	0.20	0.04	0.83	0.83	XXX
76880	TC	A	Us exam, extremity	0.00	1.41	NA	0.08	1.49	NA	XXX
76885	.....	A	Us exam infant hips, dynamic	0.74	1.76	NA	0.14	2.64	NA	XXX
76885	26	A	Us exam infant hips, dynamic	0.74	0.25	0.25	0.04	1.03	1.03	XXX
76885	TC	A	Us exam infant hips, dynamic	0.00	1.51	NA	0.10	1.61	NA	XXX
76886	.....	A	Us exam infant hips, static	0.62	1.62	NA	0.12	2.36	NA	XXX
76886	26	A	Us exam infant hips, static	0.62	0.21	0.21	0.04	0.87	0.87	XXX
76886	TC	A	Us exam infant hips, static	0.00	1.41	NA	0.08	1.49	NA	XXX
76930	.....	A	Echo guide, cardiocentesis	0.67	1.77	NA	0.12	2.56	NA	XXX
76930	26	A	Echo guide, cardiocentesis	0.67	0.26	0.26	0.02	0.95	0.95	XXX
76930	TC	A	Echo guide, cardiocentesis	0.00	1.51	NA	0.10	1.61	NA	XXX
76932	.....	A	Echo guide for heart biopsy	0.67	1.77	NA	0.12	2.56	NA	XXX
76932	26	A	Echo guide for heart biopsy	0.67	0.26	0.26	0.02	0.95	0.95	XXX
76932	TC	A	Echo guide for heart biopsy	0.00	1.51	NA	0.10	1.61	NA	XXX
76936	.....	A	Echo guide for artery repair	1.98	6.90	NA	0.47	9.35	NA	XXX
76936	26	A	Echo guide for artery repair	1.98	0.66	0.66	0.13	2.77	2.77	XXX
76936	TC	A	Echo guide for artery repair	0.00	6.24	NA	0.34	6.58	NA	XXX
76937	.....	A	Us guide, vascular access	0.30	0.48	NA	0.15	0.93	NA	ZZZ
76937	26	A	Us guide, vascular access	0.30	0.10	0.10	0.05	0.45	0.45	ZZZ
76937	TC	A	Us guide, vascular access	0.00	0.38	NA	0.10	0.48	NA	ZZZ
76940	.....	A	Us guide, tissue ablation	1.99	2.16	NA	0.42	4.57	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
76940	26	A	Us guide, tissue ablation	1.99	0.65	0.65	0.13	2.77	2.77	XXX
76940	TC	A	Us guide, tissue ablation	0.00	1.51	NA	0.29	1.80	NA	XXX
76941		A	Echo guide for transfusion	1.33	2.00	NA	0.15	3.48	NA	XXX
76941	26	A	Echo guide for transfusion	1.33	0.48	0.48	0.07	1.88	1.88	XXX
76941	TC	A	Echo guide for transfusion	0.00	1.52	NA	0.08	1.60	NA	XXX
76942		A	Echo guide for biopsy	0.67	2.77	NA	0.15	3.59	NA	XXX
76942	26	A	Echo guide for biopsy	0.67	0.22	0.22	0.05	0.94	0.94	XXX
76942	TC	A	Echo guide for biopsy	0.00	2.55	NA	0.10	2.65	NA	XXX
76945		A	Echo guide, villus sampling	0.67	1.75	NA	0.12	2.54	NA	XXX
76945	26	A	Echo guide, villus sampling	0.67	0.23	0.23	0.04	0.94	0.94	XXX
76945	TC	A	Echo guide, villus sampling	0.00	1.52	NA	0.08	1.60	NA	XXX
76946		A	Echo guide for amniocentesis	0.38	1.65	NA	0.11	2.14	NA	XXX
76946	26	A	Echo guide for amniocentesis	0.38	0.14	0.14	0.01	0.53	0.53	XXX
76946	TC	A	Echo guide for amniocentesis	0.00	1.51	NA	0.10	1.61	NA	XXX
76948		A	Echo guide, ova aspiration	0.38	1.64	NA	0.12	2.14	NA	XXX
76948	26	A	Echo guide, ova aspiration	0.38	0.13	0.13	0.02	0.53	0.53	XXX
76948	TC	A	Echo guide, ova aspiration	0.00	1.51	NA	0.10	1.61	NA	XXX
76950		A	Echo guidance radiotherapy	0.58	1.48	NA	0.11	2.17	NA	XXX
76950	26	A	Echo guidance radiotherapy	0.58	0.19	0.19	0.04	0.81	0.81	XXX
76950	TC	A	Echo guidance radiotherapy	0.00	1.29	NA	0.07	1.36	NA	XXX
76965		A	Echo guidance radiotherapy	1.33	5.96	NA	0.37	7.66	NA	XXX
76965	26	A	Echo guidance radiotherapy	1.33	0.44	0.44	0.08	1.85	1.85	XXX
76965	TC	A	Echo guidance radiotherapy	0.00	5.52	NA	0.29	5.81	NA	XXX
76970		A	Ultrasound exam follow-up	0.40	1.17	NA	0.08	1.65	NA	XXX
76970	26	A	Ultrasound exam follow-up	0.40	0.13	0.13	0.02	0.55	0.55	XXX
76970	TC	A	Ultrasound exam follow-up	0.00	1.04	NA	0.06	1.10	NA	XXX
76975		A	GI endoscopic ultrasound	0.81	1.79	NA	0.14	2.74	NA	XXX
76975	26	A	GI endoscopic ultrasound	0.81	0.28	0.28	0.04	1.13	1.13	XXX
76975	TC	A	GI endoscopic ultrasound	0.00	1.51	NA	0.10	1.61	NA	XXX
76977		A	Us bone density measure	0.05	0.83	NA	0.06	0.94	NA	XXX
76977	26	A	Us bone density measure	0.05	0.02	0.02	0.01	0.08	0.08	XXX
76977	TC	A	Us bone density measure	0.00	0.81	NA	0.05	0.86	NA	XXX
76986		A	Ultrasound guide intraoper	1.19	3.01	NA	0.22	4.42	NA	XXX
76986	26	A	Ultrasound guide intraoper	1.19	0.41	0.41	0.08	1.68	1.68	XXX
76986	TC	A	Ultrasound guide intraoper	0.00	2.60	NA	0.14	2.74	NA	XXX
76999		C	Echo examination procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76999	26	C	Echo examination procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76999	TC	C	Echo examination procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77261		A	Radiation therapy planning	1.38	0.52	0.52	0.07	1.97	1.97	XXX
77262		A	Radiation therapy planning	2.10	0.76	0.76	0.11	2.97	2.97	XXX
77263		A	Radiation therapy planning	3.12	1.12	1.12	0.16	4.40	4.40	XXX
77280		A	Set radiation therapy field	0.70	3.67	NA	0.22	4.59	NA	XXX
77280	26	A	Set radiation therapy field	0.70	0.23	0.23	0.04	0.97	0.97	XXX
77280	TC	A	Set radiation therapy field	0.00	3.44	NA	0.18	3.62	NA	XXX
77285		A	Set radiation therapy field	1.04	5.86	NA	0.35	7.25	NA	XXX
77285	26	A	Set radiation therapy field	1.04	0.34	0.34	0.05	1.43	1.43	XXX
77285	TC	A	Set radiation therapy field	0.00	5.52	NA	0.30	5.82	NA	XXX
77290		A	Set radiation therapy field	1.55	6.95	NA	0.42	8.92	NA	XXX
77290	26	A	Set radiation therapy field	1.55	0.50	0.50	0.07	2.12	2.12	XXX
77290	TC	A	Set radiation therapy field	0.00	6.45	NA	0.35	6.80	NA	XXX
77295		A	Set radiation therapy field	4.54	29.16	NA	1.69	35.39	NA	XXX
77295	26	A	Set radiation therapy field	4.54	1.46	1.46	0.22	6.22	6.22	XXX
77295	TC	A	Set radiation therapy field	0.00	27.70	NA	1.47	29.17	NA	XXX
77299		C	Radiation therapy planning	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77299	26	C	Radiation therapy planning	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77299	TC	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	1.53	NA	0.11	2.26	NA	XXX
77300	26	A	Radiation therapy dose plan	0.62	0.20	0.20	0.04	0.86	0.86	XXX
77300	TC	A	Radiation therapy dose plan	0.00	1.33	NA	0.07	1.40	NA	XXX
77301		A	Radiotherapy dose plan, imrt	7.95	30.26	NA	1.69	39.90	NA	XXX
77301	26	A	Radiotherapy dose plan, imrt	7.95	2.56	2.56	0.22	10.73	10.73	XXX
77301	TC	A	Radiotherapy dose plan, imrt	0.00	27.70	NA	1.47	29.17	NA	XXX
77305		A	Teletx isodose plan simple	0.70	2.07	NA	0.15	2.92	NA	XXX
77305	26	A	Teletx isodose plan simple	0.70	0.23	0.23	0.04	0.97	0.97	XXX
77305	TC	A	Teletx isodose plan simple	0.00	1.84	NA	0.11	1.95	NA	XXX
77310		A	Teletx isodose plan intermed	1.04	2.65	NA	0.18	3.87	NA	XXX
77310	26	A	Teletx isodose plan intermed	1.04	0.34	0.34	0.05	1.43	1.43	XXX
77310	TC	A	Teletx isodose plan intermed	0.00	2.31	NA	0.13	2.44	NA	XXX
77315		A	Teletx isodose plan complex	1.55	3.14	NA	0.21	4.90	NA	XXX
77315	26	A	Teletx isodose plan complex	1.55	0.50	0.50	0.07	2.12	2.12	XXX
77315	TC	A	Teletx isodose plan complex	0.00	2.64	NA	0.14	2.78	NA	XXX
77321		A	Special teletx port plan	0.94	4.32	NA	0.25	5.51	NA	XXX
77321	26	A	Special teletx port plan	0.94	0.31	0.31	0.05	1.30	1.30	XXX
77321	TC	A	Special teletx port plan	0.00	4.01	NA	0.20	4.21	NA	XXX
77326		A	Brachytx isodose calc simp	0.92	2.64	NA	0.18	3.74	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
77326	26	A	Brachytx isodose calc simp	0.92	0.30	0.30	0.05	1.27	1.27	XXX
77326	TC	A	Brachytx isodose calc simp	0.00	2.34	NA	0.13	2.47	NA	XXX
77327	.....	A	Brachytx isodose calc interm	1.38	3.89	NA	0.25	5.52	NA	XXX
77327	26	A	Brachytx isodose calc interm	1.38	0.45	0.45	0.07	1.90	1.90	XXX
77327	TC	A	Brachytx isodose calc interm	0.00	3.44	NA	0.18	3.62	NA	XXX
77328	.....	A	Brachytx isodose plan compl	2.08	5.58	NA	0.36	8.02	NA	XXX
77328	26	A	Brachytx isodose plan compl	2.08	0.66	0.66	0.11	2.85	2.85	XXX
77328	TC	A	Brachytx isodose plan compl	0.00	4.92	NA	0.25	5.17	NA	XXX
77331	.....	A	Special radiation dosimetry	0.87	0.78	NA	0.07	1.72	NA	XXX
77331	26	A	Special radiation dosimetry	0.87	0.28	0.28	0.05	1.20	1.20	XXX
77331	TC	A	Special radiation dosimetry	0.00	0.50	NA	0.02	0.52	NA	XXX
77332	.....	A	Radiation treatment aid(s)	0.54	1.50	NA	0.09	2.13	NA	XXX
77332	26	A	Radiation treatment aid(s)	0.54	0.17	0.17	0.02	0.73	0.73	XXX
77332	TC	A	Radiation treatment aid(s)	0.00	1.33	NA	0.07	1.40	NA	XXX
77333	.....	A	Radiation treatment aid(s)	0.84	2.15	NA	0.16	3.15	NA	XXX
77333	26	A	Radiation treatment aid(s)	0.84	0.27	0.27	0.05	1.16	1.16	XXX
77333	TC	A	Radiation treatment aid(s)	0.00	1.88	NA	0.11	1.99	NA	XXX
77334	.....	A	Radiation treatment aid(s)	1.23	3.62	NA	0.23	5.08	NA	XXX
77334	26	A	Radiation treatment aid(s)	1.23	0.40	0.40	0.06	1.69	1.69	XXX
77334	TC	A	Radiation treatment aid(s)	0.00	3.22	NA	0.17	3.39	NA	XXX
77336	.....	A	Radiation physics consult	0.00	2.96	NA	0.16	3.12	NA	XXX
77370	.....	A	Radiation physics consult	0.00	3.46	NA	0.18	3.64	NA	XXX
77399	.....	C	External radiation dosimetry	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77399	26	C	External radiation dosimetry	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77399	TC	C	External radiation dosimetry	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77401	.....	A	Radiation treatment delivery	0.00	1.76	NA	0.11	1.87	NA	XXX
77402	.....	A	Radiation treatment delivery	0.00	1.76	NA	0.11	1.87	NA	XXX
77403	.....	A	Radiation treatment delivery	0.00	1.76	NA	0.11	1.87	NA	XXX
77404	.....	A	Radiation treatment delivery	0.00	1.76	NA	0.11	1.87	NA	XXX
77406	.....	A	Radiation treatment delivery	0.00	1.76	NA	0.11	1.87	NA	XXX
77407	.....	A	Radiation treatment delivery	0.00	2.07	NA	0.12	2.19	NA	XXX
77408	.....	A	Radiation treatment delivery	0.00	2.07	NA	0.12	2.19	NA	XXX
77409	.....	A	Radiation treatment delivery	0.00	2.07	NA	0.12	2.19	NA	XXX
77411	.....	A	Radiation treatment delivery	0.00	2.07	NA	0.12	2.19	NA	XXX
77412	.....	A	Radiation treatment delivery	0.00	2.31	NA	0.13	2.44	NA	XXX
77413	.....	A	Radiation treatment delivery	0.00	2.31	NA	0.13	2.44	NA	XXX
77414	.....	A	Radiation treatment delivery	0.00	2.31	NA	0.13	2.44	NA	XXX
77416	.....	A	Radiation treatment delivery	0.00	2.31	NA	0.13	2.44	NA	XXX
77417	.....	A	Radiology port film(s)	0.00	0.59	NA	0.04	0.63	NA	XXX
77418	.....	A	Radiation tx delivery, imrt	0.00	17.83	NA	0.13	17.96	NA	XXX
77427	.....	A	Radiation tx management, x5	3.29	1.06	1.06	0.17	4.52	4.52	XXX
77431	.....	A	Radiation therapy management	1.80	0.68	0.68	0.08	2.56	2.56	XXX
77432	.....	A	Stereotactic radiation trmt	7.88	2.93	2.93	0.40	11.21	11.21	XXX
77470	.....	A	Special radiation treatment	2.08	11.71	NA	0.70	14.49	NA	XXX
77470	26	A	Special radiation treatment	2.08	0.66	0.66	0.11	2.85	2.85	XXX
77470	TC	A	Special radiation treatment	0.00	11.05	NA	0.59	11.64	NA	XXX
77499	.....	C	Radiation therapy management	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77499	26	C	Radiation therapy management	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77499	TC	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 trmt, complex	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77600	.....	R	Hyperthermia treatment	1.55	3.52	NA	0.26	5.33	NA	XXX
77600	26	R	Hyperthermia treatment	1.55	0.50	0.50	0.10	2.15	2.15	XXX
77600	TC	R	Hyperthermia treatment	0.00	3.02	NA	0.16	3.18	NA	XXX
77605	.....	R	Hyperthermia treatment	2.08	4.69	NA	0.38	7.15	NA	XXX
77605	26	R	Hyperthermia treatment	2.08	0.66	0.66	0.16	2.90	2.90	XXX
77605	TC	R	Hyperthermia treatment	0.00	4.03	NA	0.22	4.25	NA	XXX
77610	.....	R	Hyperthermia treatment	1.55	3.53	NA	0.24	5.32	NA	XXX
77610	26	R	Hyperthermia treatment	1.55	0.51	0.51	0.08	2.14	2.14	XXX
77610	TC	R	Hyperthermia treatment	0.00	3.02	NA	0.16	3.18	NA	XXX
77615	.....	R	Hyperthermia treatment	2.08	4.69	NA	0.33	7.10	NA	XXX
77615	26	R	Hyperthermia treatment	2.08	0.66	0.66	0.11	2.85	2.85	XXX
77615	TC	R	Hyperthermia treatment	0.00	4.03	NA	0.22	4.25	NA	XXX
77620	.....	R	Hyperthermia treatment	1.55	3.54	NA	0.23	5.32	NA	XXX
77620	26	R	Hyperthermia treatment	1.55	0.52	0.52	0.07	2.14	2.14	XXX
77620	TC	R	Hyperthermia treatment	0.00	3.02	NA	0.16	3.18	NA	XXX
77750	.....	A	Infuse radioactive materials	4.88	2.91	NA	0.27	8.06	NA	090
77750	26	A	Infuse radioactive materials	4.88	1.59	1.59	0.20	6.67	6.67	090
77750	TC	A	Infuse radioactive materials	0.00	1.32	NA	0.07	1.39	NA	090
77761	.....	A	Apply intrcav radiat simple	3.79	3.58	NA	0.33	7.70	NA	090
77761	26	A	Apply intrcav radiat simple	3.79	1.10	1.10	0.19	5.08	5.08	090
77761	TC	A	Apply intrcav radiat simple	0.00	2.48	NA	0.14	2.62	NA	090
77762	.....	A	Apply intrcav radiat interm	5.69	5.42	NA	0.45	11.56	NA	090

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CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
77762	26	A	Apply intrcav radiat interm	5.69	1.85	1.85	0.26	7.80	7.80	090
77762	TC	A	Apply intrcav radiat interm	0.00	3.57	NA	0.19	3.76	NA	090
77763	.....	A	Apply intrcav radiat compl	8.52	7.20	NA	0.64	16.36	NA	090
77763	26	A	Apply intrcav radiat compl	8.52	2.75	2.75	0.41	11.68	11.68	090
77763	TC	A	Apply intrcav radiat compl	0.00	4.45	NA	0.23	4.68	NA	090
77776	.....	A	Apply interstit radiat simpl	4.63	3.12	NA	0.42	8.17	NA	090
77776	26	A	Apply interstit radiat simpl	4.63	0.97	0.97	0.29	5.89	5.89	090
77776	TC	A	Apply interstit radiat simpl	0.00	2.15	NA	0.13	2.28	NA	090
77777	.....	A	Apply interstit radiat inter	7.44	6.57	NA	0.60	14.61	NA	090
77777	26	A	Apply interstit radiat inter	7.44	2.37	2.37	0.38	10.19	10.19	090
77777	TC	A	Apply interstit radiat inter	0.00	4.20	NA	0.22	4.42	NA	090
77778	.....	A	Apply interstit radiat compl	11.13	8.66	NA	0.82	20.61	NA	090
77778	26	A	Apply interstit radiat compl	11.13	3.57	3.57	0.56	15.26	15.26	090
77778	TC	A	Apply interstit radiat compl	0.00	5.09	NA	0.26	5.35	NA	090
77781	.....	A	High intensity brachytherapy	1.65	20.67	NA	1.13	23.45	NA	090
77781	26	A	High intensity brachytherapy	1.65	0.54	0.54	0.08	2.27	2.27	090
77781	TC	A	High intensity brachytherapy	0.00	20.13	NA	1.05	21.18	NA	090
77782	.....	A	High intensity brachytherapy	2.48	20.93	NA	1.17	24.58	NA	090
77782	26	A	High intensity brachytherapy	2.48	0.80	0.80	0.12	3.40	3.40	090
77782	TC	A	High intensity brachytherapy	0.00	20.13	NA	1.05	21.18	NA	090
77783	.....	A	High intensity brachytherapy	3.71	21.32	NA	1.23	26.26	NA	090
77783	26	A	High intensity brachytherapy	3.71	1.19	1.19	0.18	5.08	5.08	090
77783	TC	A	High intensity brachytherapy	0.00	20.13	NA	1.05	21.18	NA	090
77784	.....	A	High intensity brachytherapy	5.58	21.93	NA	1.31	28.82	NA	090
77784	26	A	High intensity brachytherapy	5.58	1.80	1.80	0.26	7.64	7.64	090
77784	TC	A	High intensity brachytherapy	0.00	20.13	NA	1.05	21.18	NA	090
77789	.....	A	Apply surface radiation	1.11	0.82	NA	0.06	1.99	NA	000
77789	26	A	Apply surface radiation	1.11	0.37	0.37	0.04	1.52	1.52	000
77789	TC	A	Apply surface radiation	0.00	0.45	NA	0.02	0.47	NA	000
77790	.....	A	Radiation handling	1.04	0.84	NA	0.07	1.95	NA	XXX
77790	26	A	Radiation handling	1.04	0.34	0.34	0.05	1.43	1.43	XXX
77790	TC	A	Radiation handling	0.00	0.50	NA	0.02	0.52	NA	XXX
77799	.....	C	Radium/radioisotope therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77799	26	C	Radium/radioisotope therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77799	TC	C	Radium/radioisotope therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78000	.....	A	Thyroid, single uptake	0.19	1.03	NA	0.07	1.29	NA	XXX
78000	26	A	Thyroid, single uptake	0.19	0.07	0.07	0.01	0.27	0.27	XXX
78000	TC	A	Thyroid, single uptake	0.00	0.96	NA	0.06	1.02	NA	XXX
78001	.....	A	Thyroid, multiple uptakes	0.26	1.38	NA	0.08	1.72	NA	XXX
78001	26	A	Thyroid, multiple uptakes	0.26	0.09	0.09	0.01	0.36	0.36	XXX
78001	TC	A	Thyroid, multiple uptakes	0.00	1.29	NA	0.07	1.36	NA	XXX
78003	.....	A	Thyroid suppress/stimul	0.33	1.07	NA	0.07	1.47	NA	XXX
78003	26	A	Thyroid suppress/stimul	0.33	0.11	0.11	0.01	0.45	0.45	XXX
78003	TC	A	Thyroid suppress/stimul	0.00	0.96	NA	0.06	1.02	NA	XXX
78006	.....	A	Thyroid imaging with uptake	0.49	2.53	NA	0.15	3.17	NA	XXX
78006	26	A	Thyroid imaging with uptake	0.49	0.17	0.17	0.02	0.68	0.68	XXX
78006	TC	A	Thyroid imaging with uptake	0.00	2.36	NA	0.13	2.49	NA	XXX
78007	.....	A	Thyroid image, mult uptakes	0.50	2.72	NA	0.16	3.38	NA	XXX
78007	26	A	Thyroid image, mult uptakes	0.50	0.17	0.17	0.02	0.69	0.69	XXX
78007	TC	A	Thyroid image, mult uptakes	0.00	2.55	NA	0.14	2.69	NA	XXX
78010	.....	A	Thyroid imaging	0.39	1.94	NA	0.13	2.46	NA	XXX
78010	26	A	Thyroid imaging	0.39	0.13	0.13	0.02	0.54	0.54	XXX
78010	TC	A	Thyroid imaging	0.00	1.81	NA	0.11	1.92	NA	XXX
78011	.....	A	Thyroid imaging with flow	0.45	2.55	NA	0.15	3.15	NA	XXX
78011	26	A	Thyroid imaging with flow	0.45	0.16	0.16	0.02	0.63	0.63	XXX
78011	TC	A	Thyroid imaging with flow	0.00	2.39	NA	0.13	2.52	NA	XXX
78015	.....	A	Thyroid met imaging	0.67	2.78	NA	0.18	3.63	NA	XXX
78015	26	A	Thyroid met imaging	0.67	0.23	0.23	0.04	0.94	0.94	XXX
78015	TC	A	Thyroid met imaging	0.00	2.55	NA	0.14	2.69	NA	XXX
78016	.....	A	Thyroid met imaging/studies	0.82	3.74	NA	0.22	4.78	NA	XXX
78016	26	A	Thyroid met imaging/studies	0.82	0.29	0.29	0.04	1.15	1.15	XXX
78016	TC	A	Thyroid met imaging/studies	0.00	3.45	NA	0.18	3.63	NA	XXX
78018	.....	A	Thyroid met imaging, body	0.86	5.68	NA	0.33	6.87	NA	XXX
78018	26	A	Thyroid met imaging, body	0.86	0.30	0.30	0.04	1.20	1.20	XXX
78018	TC	A	Thyroid met imaging, body	0.00	5.38	NA	0.29	5.67	NA	XXX
78020	.....	A	Thyroid met uptake	0.60	1.50	NA	0.16	2.26	NA	ZZZ
78020	26	A	Thyroid met uptake	0.60	0.21	0.21	0.02	0.83	0.83	ZZZ
78020	TC	A	Thyroid met uptake	0.00	1.29	NA	0.14	1.43	NA	ZZZ
78070	.....	A	Parathyroid nuclear imaging	0.82	2.09	NA	0.15	3.06	NA	XXX
78070	26	A	Parathyroid nuclear imaging	0.82	0.28	0.28	0.04	1.14	1.14	XXX
78070	TC	A	Parathyroid nuclear imaging	0.00	1.81	NA	0.11	1.92	NA	XXX
78075	.....	A	Adrenal nuclear imaging	0.74	5.65	NA	0.33	6.72	NA	XXX
78075	26	A	Adrenal nuclear imaging	0.74	0.27	0.27	0.04	1.05	1.05	XXX
78075	TC	A	Adrenal nuclear imaging	0.00	5.38	NA	0.29	5.67	NA	XXX
78099	.....	C	Endocrine nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
78099	26	C	Endocrine nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78099	TC	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	2.22	NA	0.14	2.91	NA	XXX
78102	26	A	Bone marrow imaging, ltd	0.55	0.20	0.20	0.02	0.77	0.77	XXX
78102	TC	A	Bone marrow imaging, ltd	0.00	2.02	NA	0.12	2.14	NA	XXX
78103		A	Bone marrow imaging, mult	0.75	3.41	NA	0.21	4.37	NA	XXX
78103	26	A	Bone marrow imaging, mult	0.75	0.26	0.26	0.04	1.05	1.05	XXX
78103	TC	A	Bone marrow imaging, mult	0.00	3.15	NA	0.17	3.32	NA	XXX
78104		A	Bone marrow imaging, body	0.80	4.32	NA	0.26	5.38	NA	XXX
78104	26	A	Bone marrow imaging, body	0.80	0.28	0.28	0.04	1.12	1.12	XXX
78104	TC	A	Bone marrow imaging, body	0.00	4.04	NA	0.22	4.26	NA	XXX
78110		A	Plasma volume, single	0.19	1.01	NA	0.07	1.27	NA	XXX
78110	26	A	Plasma volume, single	0.19	0.07	0.07	0.01	0.27	0.27	XXX
78110	TC	A	Plasma volume, single	0.00	0.94	NA	0.06	1.00	NA	XXX
78111		A	Plasma volume, multiple	0.22	2.63	NA	0.15	3.00	NA	XXX
78111	26	A	Plasma volume, multiple	0.22	0.08	0.08	0.01	0.31	0.31	XXX
78111	TC	A	Plasma volume, multiple	0.00	2.55	NA	0.14	2.69	NA	XXX
78120		A	Red cell mass, single	0.23	1.80	NA	0.12	2.15	NA	XXX
78120	26	A	Red cell mass, single	0.23	0.08	0.08	0.01	0.32	0.32	XXX
78120	TC	A	Red cell mass, single	0.00	1.72	NA	0.11	1.83	NA	XXX
78121		A	Red cell mass, multiple	0.32	3.00	NA	0.15	3.47	NA	XXX
78121	26	A	Red cell mass, multiple	0.32	0.11	0.11	0.01	0.44	0.44	XXX
78121	TC	A	Red cell mass, multiple	0.00	2.89	NA	0.14	3.03	NA	XXX
78122		A	Blood volume	0.45	4.72	NA	0.26	5.43	NA	XXX
78122	26	A	Blood volume	0.45	0.16	0.16	0.02	0.63	0.63	XXX
78122	TC	A	Blood volume	0.00	4.56	NA	0.24	4.80	NA	XXX
78130		A	Red cell survival study	0.61	3.04	NA	0.18	3.83	NA	XXX
78130	26	A	Red cell survival study	0.61	0.21	0.21	0.04	0.86	0.86	XXX
78130	TC	A	Red cell survival study	0.00	2.83	NA	0.14	2.97	NA	XXX
78135		A	Red cell survival kinetics	0.64	5.05	NA	0.29	5.98	NA	XXX
78135	26	A	Red cell survival kinetics	0.64	0.22	0.22	0.04	0.90	0.90	XXX
78135	TC	A	Red cell survival kinetics	0.00	4.83	NA	0.25	5.08	NA	XXX
78140		A	Red cell sequestration	0.61	4.10	NA	0.24	4.95	NA	XXX
78140	26	A	Red cell sequestration	0.61	0.20	0.20	0.04	0.85	0.85	XXX
78140	TC	A	Red cell sequestration	0.00	3.90	NA	0.20	4.10	NA	XXX
78160		A	Plasma iron turnover	0.33	3.75	NA	0.23	4.31	NA	XXX
78160	26	A	Plasma iron turnover	0.33	0.12	0.12	0.04	0.49	0.49	XXX
78160	TC	A	Plasma iron turnover	0.00	3.63	NA	0.19	3.82	NA	XXX
78162		A	Radioiron absorption exam	0.45	3.37	NA	0.18	4.00	NA	XXX
78162	26	A	Radioiron absorption exam	0.45	0.19	0.19	0.01	0.65	0.65	XXX
78162	TC	A	Radioiron absorption exam	0.00	3.18	NA	0.17	3.35	NA	XXX
78170		A	Red cell iron utilization	0.41	5.40	NA	0.33	6.14	NA	XXX
78170	26	A	Red cell iron utilization	0.41	0.14	0.14	0.05	0.60	0.60	XXX
78170	TC	A	Red cell iron utilization	0.00	5.26	NA	0.28	5.54	NA	XXX
78172		C	Total body iron estimation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78172	26	A	Total body iron estimation	0.53	0.18	0.18	0.02	0.73	0.73	XXX
78172	TC	C	Total body iron estimation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78185		A	Spleen imaging	0.40	2.48	NA	0.15	3.03	NA	XXX
78185	26	A	Spleen imaging	0.40	0.14	0.14	0.02	0.56	0.56	XXX
78185	TC	A	Spleen imaging	0.00	2.34	NA	0.13	2.47	NA	XXX
78190		A	Platelet survival, kinetics	1.08	6.06	NA	0.37	7.51	NA	XXX
78190	26	A	Platelet survival, kinetics	1.08	0.39	0.39	0.07	1.54	1.54	XXX
78190	TC	A	Platelet survival, kinetics	0.00	5.67	NA	0.30	5.97	NA	XXX
78191		A	Platelet survival	0.61	7.48	NA	0.41	8.50	NA	XXX
78191	26	A	Platelet survival	0.61	0.21	0.21	0.04	0.86	0.86	XXX
78191	TC	A	Platelet survival	0.00	7.27	NA	0.37	7.64	NA	XXX
78195		A	Lymph system imaging	1.19	4.46	NA	0.28	5.93	NA	XXX
78195	26	A	Lymph system imaging	1.19	0.42	0.42	0.06	1.67	1.67	XXX
78195	TC	A	Lymph system imaging	0.00	4.04	NA	0.22	4.26	NA	XXX
78199		C	Blood/lymph nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78199	26	C	Blood/lymph nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78199	TC	C	Blood/lymph nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78201		A	Liver imaging	0.44	2.49	NA	0.15	3.08	NA	XXX
78201	26	A	Liver imaging	0.44	0.15	0.15	0.02	0.61	0.61	XXX
78201	TC	A	Liver imaging	0.00	2.34	NA	0.13	2.47	NA	XXX
78202		A	Liver imaging with flow	0.51	3.04	NA	0.16	3.71	NA	XXX
78202	26	A	Liver imaging with flow	0.51	0.18	0.18	0.02	0.71	0.71	XXX
78202	TC	A	Liver imaging with flow	0.00	2.86	NA	0.14	3.00	NA	XXX
78205		A	Liver imaging (3D)	0.71	6.10	NA	0.35	7.16	NA	XXX
78205	26	A	Liver imaging (3D)	0.71	0.25	0.25	0.04	1.00	1.00	XXX
78205	TC	A	Liver imaging (3D)	0.00	5.85	NA	0.31	6.16	NA	XXX
78206		A	Liver image (3d) with flow	0.95	6.19	NA	0.16	7.30	NA	XXX
78206	26	A	Liver image (3d) with flow	0.95	0.34	0.34	0.05	1.34	1.34	XXX
78206	TC	A	Liver image (3d) with flow	0.00	5.85	NA	0.11	5.96	NA	XXX
78215		A	Liver and spleen imaging	0.49	3.09	NA	0.16	3.74	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
78215	26	A	Liver and spleen imaging	0.49	0.17	0.17	0.02	0.68	0.68	XXX
78215	TC	A	Liver and spleen imaging	0.00	2.92	NA	0.14	3.06	NA	XXX
78216		A	Liver & spleen image/flow	0.57	3.65	NA	0.20	4.42	NA	XXX
78216	26	A	Liver & spleen image/flow	0.57	0.20	0.20	0.02	0.79	0.79	XXX
78216	TC	A	Liver & spleen image/flow	0.00	3.45	NA	0.18	3.63	NA	XXX
78220		A	Liver function study	0.49	3.86	NA	0.21	4.56	NA	XXX
78220	26	A	Liver function study	0.49	0.17	0.17	0.02	0.68	0.68	XXX
78220	TC	A	Liver function study	0.00	3.69	NA	0.19	3.88	NA	XXX
78223		A	Hepatobiliary imaging	0.84	3.91	NA	0.24	4.99	NA	XXX
78223	26	A	Hepatobiliary imaging	0.84	0.28	0.28	0.05	1.17	1.17	XXX
78223	TC	A	Hepatobiliary imaging	0.00	3.63	NA	0.19	3.82	NA	XXX
78230		A	Salivary gland imaging	0.45	2.30	NA	0.15	2.90	NA	XXX
78230	26	A	Salivary gland imaging	0.45	0.15	0.15	0.02	0.62	0.62	XXX
78230	TC	A	Salivary gland imaging	0.00	2.15	NA	0.13	2.28	NA	XXX
78231		A	Serial salivary imaging	0.52	3.34	NA	0.19	4.05	NA	XXX
78231	26	A	Serial salivary imaging	0.52	0.19	0.19	0.02	0.73	0.73	XXX
78231	TC	A	Serial salivary imaging	0.00	3.15	NA	0.17	3.32	NA	XXX
78232		A	Salivary gland function exam	0.47	3.68	NA	0.19	4.34	NA	XXX
76232	26	A	Salivary gland function exam	0.47	0.17	0.17	0.01	0.65	0.65	XXX
78232	TC	A	Salivary gland function exam	0.00	3.51	NA	0.18	3.69	NA	XXX
78258		A	Esophageal motility study	0.74	3.11	NA	0.18	4.03	NA	XXX
78258	26	A	Esophageal motility study	0.74	0.25	0.25	0.04	1.03	1.03	XXX
78258	TC	A	Esophageal motility study	0.00	2.86	NA	0.14	3.00	NA	XXX
78261		A	Gastric mucosa imaging	0.69	4.32	NA	0.26	5.27	NA	XXX
78261	26	A	Gastric mucosa imaging	0.69	0.25	0.25	0.04	0.98	0.98	XXX
78261	TC	A	Gastric mucosa imaging	0.00	4.07	NA	0.22	4.29	NA	XXX
78262		A	Gastroesophageal reflux exam	0.68	4.46	NA	0.26	5.40	NA	XXX
78262	26	A	Gastroesophageal reflux exam	0.68	0.24	0.24	0.04	0.96	0.96	XXX
78262	TC	A	Gastroesophageal reflux exam	0.00	4.22	NA	0.22	4.44	NA	XXX
78264		A	Gastric emptying study	0.78	4.37	NA	0.26	5.41	NA	XXX
78264	26	A	Gastric emptying study	0.78	0.27	0.27	0.04	1.09	1.09	XXX
78264	TC	A	Gastric emptying study	0.00	4.10	NA	0.22	4.32	NA	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	1.61	NA	0.11	1.92	NA	XXX
78270	26	A	Vit B–12 absorption exam	0.20	0.07	0.07	0.01	0.28	0.28	XXX
78270	TC	A	Vit B–12 absorption exam	0.00	1.54	NA	0.10	1.64	NA	XXX
78271		A	Vit b-12 absrp exam, int fac	0.20	1.70	NA	0.11	2.01	NA	XXX
78271	26	A	Vit b-12 absrp exam, int fac	0.20	0.07	0.07	0.01	0.28	0.28	XXX
78271	TC	A	Vit b-12 absrp exam, int fac	0.00	1.63	NA	0.10	1.73	NA	XXX
78272		A	Vit B–12 absorp, combined	0.27	2.40	NA	0.14	2.81	NA	XXX
78272	26	A	Vit B–12 absorp, combined	0.27	0.10	0.10	0.01	0.38	0.38	XXX
78272	TC	A	Vit B–12 absorp, combined	0.00	2.30	NA	0.13	2.43	NA	XXX
78278		A	Acute GI blood loss imaging	0.98	5.17	NA	0.30	6.45	NA	XXX
78278	26	A	Acute GI blood loss imaging	0.98	0.34	0.34	0.05	1.37	1.37	XXX
78278	TC	A	Acute GI blood loss imaging	0.00	4.83	NA	0.25	5.08	NA	XXX
78282		C	GI protein loss exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78282	26	A	GI protein loss exam	0.38	0.13	0.13	0.02	0.53	0.53	XXX
78282	TC	C	GI protein loss exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78290		A	Meckel's divert exam	0.68	3.25	NA	0.20	4.13	NA	XXX
78290	26	A	Meckel's divert exam	0.68	0.23	0.23	0.04	0.95	0.95	XXX
78290	TC	A	Meckel's divert exam	0.00	3.02	NA	0.16	3.18	NA	XXX
78291		A	Leveen/shunt patency exam	0.87	3.35	NA	0.21	4.43	NA	XXX
78291	26	A	Leveen/shunt patency exam	0.87	0.31	0.31	0.05	1.23	1.23	XXX
78291	TC	A	Leveen/shunt patency exam	0.00	3.04	NA	0.16	3.20	NA	XXX
78299		C	GI nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78299	26	C	GI nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78299	TC	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	2.67	NA	0.18	3.47	NA	XXX
78300	26	A	Bone imaging, limited area	0.62	0.21	0.21	0.04	0.87	0.87	XXX
78300	TC	A	Bone imaging, limited area	0.00	2.46	NA	0.14	2.60	NA	XXX
78305		A	Bone imaging, multiple areas	0.83	3.91	NA	0.23	4.97	NA	XXX
78305	26	A	Bone imaging, multiple areas	0.83	0.28	0.28	0.04	1.15	1.15	XXX
78305	TC	A	Bone imaging, multiple areas	0.00	3.63	NA	0.19	3.82	NA	XXX
78306		A	Bone imaging, whole body	0.86	4.53	NA	0.27	5.66	NA	XXX
78306	26	A	Bone imaging, whole body	0.86	0.29	0.29	0.05	1.20	1.20	XXX
78306	TC	A	Bone imaging, whole body	0.00	4.24	NA	0.22	4.46	NA	XXX
78315		A	Bone imaging, 3 phase	1.01	5.08	NA	0.30	6.39	NA	XXX
78315	26	A	Bone imaging, 3 phase	1.01	0.35	0.35	0.05	1.41	1.41	XXX
78315	TC	A	Bone imaging, 3 phase	0.00	4.73	NA	0.25	4.98	NA	XXX
78320		A	Bone imaging (3D)	1.03	6.22	NA	0.36	7.61	NA	XXX
78320	26	A	Bone imaging (3D)	1.03	0.37	0.37	0.05	1.45	1.45	XXX
78320	TC	A	Bone imaging (3D)	0.00	5.85	NA	0.31	6.16	NA	XXX
78350		A	Bone mineral, single photon	0.22	0.81	NA	0.06	1.09	NA	XXX
78350	26	A	Bone mineral, single photon	0.22	0.07	0.07	0.01	0.30	0.30	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
78350	TC	A	Bone mineral, single photon	0.00	0.74	NA	0.05	0.79	NA	XXX
78351	.....	N	Bone mineral, dual photon	+0.30	1.73	0.12	0.01	2.04	0.43	XXX
78399	.....	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78399	26	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78399	TC	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	0.00	0.00	0.00	XXX
78414	26	A	Non-imaging heart function	0.45	0.16	0.16	0.02	0.63	0.63	XXX
78414	TC	C	Non-imaging heart function	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78428	.....	A	Cardiac shunt imaging	0.78	2.53	NA	0.17	3.48	NA	XXX
78428	26	A	Cardiac shunt imaging	0.78	0.30	0.30	0.04	1.12	1.12	XXX
78428	TC	A	Cardiac shunt imaging	0.00	2.23	NA	0.13	2.36	NA	XXX
78445	.....	A	Vascular flow imaging	0.49	2.01	NA	0.13	2.63	NA	XXX
78445	26	A	Vascular flow imaging	0.49	0.17	0.17	0.02	0.68	0.68	XXX
78445	TC	A	Vascular flow imaging	0.00	1.84	NA	0.11	1.95	NA	XXX
78455	.....	A	Venous thrombosis study	0.73	4.20	NA	0.24	5.17	NA	XXX
78455	26	A	Venous thrombosis study	0.73	0.25	0.25	0.04	1.02	1.02	XXX
78455	TC	A	Venous thrombosis study	0.00	3.95	NA	0.20	4.15	NA	XXX
78456	.....	A	Acute venous thrombus image	0.99	4.30	NA	0.34	5.63	NA	XXX
78456	26	A	Acute venous thrombus image	0.99	0.35	0.35	0.05	1.39	1.39	XXX
78456	TC	A	Acute venous thrombus image	0.00	3.95	NA	0.29	4.24	NA	XXX
78457	.....	A	Venous thrombosis imaging	0.77	2.91	NA	0.18	3.86	NA	XXX
78457	26	A	Venous thrombosis imaging	0.77	0.27	0.27	0.04	1.08	1.08	XXX
78457	TC	A	Venous thrombosis imaging	0.00	2.64	NA	0.14	2.78	NA	XXX
78458	.....	A	Ven thrombosis images, bilat	0.89	4.32	NA	0.24	5.45	NA	XXX
78458	26	A	Ven thrombosis images, bilat	0.89	0.33	0.33	0.04	1.26	1.26	XXX
78458	TC	A	Ven thrombosis images, bilat	0.00	3.99	NA	0.20	4.19	NA	XXX
78459	.....	C	Heart muscle imaging (PET)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78459	26	R	Heart muscle imaging (PET)	1.49	0.59	0.59	0.05	2.13	2.13	XXX
78459	TC	C	Heart muscle imaging (PET)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78460	.....	A	Heart muscle blood, single	0.86	2.64	NA	0.17	3.67	NA	XXX
78460	26	A	Heart muscle blood, single	0.86	0.30	0.30	0.04	1.20	1.20	XXX
78460	TC	A	Heart muscle blood, single	0.00	2.34	NA	0.13	2.47	NA	XXX
78461	.....	A	Heart muscle blood, multiple	1.22	5.11	NA	0.31	6.64	NA	XXX
78461	26	A	Heart muscle blood, multiple	1.22	0.44	0.44	0.06	1.72	1.72	XXX
78461	TC	A	Heart muscle blood, multiple	0.00	4.67	NA	0.25	4.92	NA	XXX
78464	.....	A	Heart image (3d), single	1.08	7.40	NA	0.42	8.90	NA	XXX
78464	26	A	Heart image (3d), single	1.08	0.39	0.39	0.05	1.52	1.52	XXX
78464	TC	A	Heart image (3d), single	0.00	7.01	NA	0.37	7.38	NA	XXX
78465	.....	A	Heart image (3d), multiple	1.45	12.23	NA	0.67	14.35	NA	XXX
78465	26	A	Heart image (3d), multiple	1.45	0.53	0.53	0.06	2.04	2.04	XXX
78465	TC	A	Heart image (3d), multiple	0.00	11.70	NA	0.61	12.31	NA	XXX
78466	.....	A	Heart infarct image	0.69	2.85	NA	0.18	3.72	NA	XXX
78466	26	A	Heart infarct image	0.69	0.25	0.25	0.04	0.98	0.98	XXX
78466	TC	A	Heart infarct image	0.00	2.60	NA	0.14	2.74	NA	XXX
78468	.....	A	Heart infarct image (ef)	0.80	3.91	NA	0.23	4.94	NA	XXX
78468	26	A	Heart infarct image (ef)	0.80	0.28	0.28	0.04	1.12	1.12	XXX
78468	TC	A	Heart infarct image (ef)	0.00	3.63	NA	0.19	3.82	NA	XXX
78469	.....	A	Heart infarct image (3D)	0.91	5.50	NA	0.32	6.73	NA	XXX
78469	26	A	Heart infarct image (3D)	0.91	0.32	0.32	0.04	1.27	1.27	XXX
78469	TC	A	Heart infarct image (3D)	0.00	5.18	NA	0.28	5.46	NA	XXX
78472	.....	A	Gated heart, planar, single	0.97	5.82	NA	0.35	7.14	NA	XXX
78472	26	A	Gated heart, planar, single	0.97	0.35	0.35	0.05	1.37	1.37	XXX
78472	TC	A	Gated heart, planar, single	0.00	5.47	NA	0.30	5.77	NA	XXX
78473	.....	A	Gated heart, multiple	1.46	8.71	NA	0.48	10.65	NA	XXX
78473	26	A	Gated heart, multiple	1.46	0.52	0.52	0.06	2.04	2.04	XXX
78473	TC	A	Gated heart, multiple	0.00	8.19	NA	0.42	8.61	NA	XXX
78478	.....	A	Heart wall motion add-on	0.62	1.78	NA	0.12	2.52	NA	XXX
78478	26	A	Heart wall motion add-on	0.62	0.23	0.23	0.02	0.87	0.87	XXX
78478	TC	A	Heart wall motion add-on	0.00	1.55	NA	0.10	1.65	NA	XXX
78480	.....	A	Heart function add-on	0.62	1.78	NA	0.12	2.52	NA	XXX
78480	26	A	Heart function add-on	0.62	0.23	0.23	0.02	0.87	0.87	XXX
78480	TC	A	Heart function add-on	0.00	1.55	NA	0.10	1.65	NA	XXX
78481	.....	A	Heart first pass, single	0.97	5.55	NA	0.32	6.84	NA	XXX
78481	26	A	Heart first pass, single	0.97	0.37	0.37	0.04	1.38	1.38	XXX
78481	TC	A	Heart first pass, single	0.00	5.18	NA	0.28	5.46	NA	XXX
78483	.....	A	Heart first pass, multiple	1.46	8.35	NA	0.47	10.28	NA	XXX
78483	26	A	Heart first pass, multiple	1.46	0.55	0.55	0.06	2.07	2.07	XXX
78483	TC	A	Heart first pass, multiple	0.00	7.80	NA	0.41	8.21	NA	XXX
78491	.....	I	Heart image (pet), single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78491	26	I	Heart image (pet), single	+1.49	0.60	0.60	0.06	2.15	2.15	XXX
78491	TC	I	Heart image (pet), single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78492	.....	I	Heart image (pet), multiple	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78492	26	I	Heart image (pet), multiple	+1.86	0.74	0.74	0.07	2.67	2.67	XXX
78492	TC	I	Heart image (pet), multiple	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78494	.....	A	Heart image, spect	1.18	7.43	NA	0.35	8.96	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
78494	26	A	Heart image, spect	1.18	0.42	0.42	0.05	1.65	1.65	XXX
78494	TC	A	Heart image, spect	0.00	7.01	NA	0.30	7.31	NA	XXX
78496		A	Heart first pass add-on	0.50	7.20	NA	0.32	8.02	NA	ZZZ
78496	26	A	Heart first pass add-on	0.50	0.19	0.19	0.02	0.71	0.71	ZZZ
78496	TC	A	Heart first pass add-on	0.00	7.01	NA	0.30	7.31	NA	ZZZ
78499		C	Cardiovascular nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78499	26	C	Cardiovascular nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78499	TC	C	Cardiovascular nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78580		A	Lung perfusion imaging	0.74	3.65	NA	0.22	4.61	NA	XXX
78580	26	A	Lung perfusion imaging	0.74	0.25	0.25	0.04	1.03	1.03	XXX
78580	TC	A	Lung perfusion imaging	0.00	3.40	NA	0.18	3.58	NA	XXX
78584		A	Lung V/Q image single breath	0.98	3.51	NA	0.22	4.71	NA	XXX
78584	26	A	Lung V/Q image single breath	0.98	0.33	0.33	0.05	1.36	1.36	XXX
78584	TC	A	Lung V/Q image single breath	0.00	3.18	NA	0.17	3.35	NA	XXX
78585		A	Lung V/Q imaging	1.08	5.96	NA	0.36	7.40	NA	XXX
78585	26	A	Lung V/Q imaging	1.08	0.37	0.37	0.06	1.51	1.51	XXX
78585	TC	A	Lung V/Q imaging	0.00	5.59	NA	0.30	5.89	NA	XXX
78586		A	Aerosol lung image, single	0.40	2.70	NA	0.16	3.26	NA	XXX
78586	26	A	Aerosol lung image, single	0.40	0.13	0.13	0.02	0.55	0.55	XXX
78586	TC	A	Aerosol lung image, single	0.00	2.57	NA	0.14	2.71	NA	XXX
78587		A	Aerosol lung image, multiple	0.49	2.95	NA	0.16	3.60	NA	XXX
78587	26	A	Aerosol lung image, multiple	0.49	0.17	0.17	0.02	0.68	0.68	XXX
78587	TC	A	Aerosol lung image, multiple	0.00	2.78	NA	0.14	2.92	NA	XXX
78588		A	Perfusion lung image	1.08	3.55	NA	0.24	4.87	NA	XXX
78588	26	A	Perfusion lung image	1.08	0.37	0.37	0.06	1.51	1.51	XXX
78588	TC	A	Perfusion lung image	0.00	3.18	NA	0.18	3.36	NA	XXX
78591		A	Vent image, 1 breath, 1 proj	0.40	2.97	NA	0.16	3.53	NA	XXX
78591	26	A	Vent image, 1 breath, 1 proj	0.40	0.14	0.14	0.02	0.56	0.56	XXX
78591	TC	A	Vent image, 1 breath, 1 proj	0.00	2.83	NA	0.14	2.97	NA	XXX
78593		A	Vent image, 1 proj, gas	0.49	3.59	NA	0.20	4.28	NA	XXX
78593	26	A	Vent image, 1 proj, gas	0.49	0.17	0.17	0.02	0.68	0.68	XXX
78593	TC	A	Vent image, 1 proj, gas	0.00	3.42	NA	0.18	3.60	NA	XXX
78594		A	Vent image, mult proj, gas	0.53	5.12	NA	0.27	5.92	NA	XXX
78594	26	A	Vent image, mult proj, gas	0.53	0.18	0.18	0.02	0.73	0.73	XXX
78594	TC	A	Vent image, mult proj, gas	0.00	4.94	NA	0.25	5.19	NA	XXX
78596		A	Lung differential function	1.26	7.44	NA	0.43	9.13	NA	XXX
78596	26	A	Lung differential function	1.26	0.43	0.43	0.06	1.75	1.75	XXX
78596	TC	A	Lung differential function	0.00	7.01	NA	0.37	7.38	NA	XXX
78599		C	Respiratory nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78599	26	C	Respiratory nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78599	TC	C	Respiratory nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78600		A	Brain imaging, ltd static	0.44	3.01	NA	0.16	3.61	NA	XXX
78600	26	A	Brain imaging, ltd static	0.44	0.15	0.15	0.02	0.61	0.61	XXX
78600	TC	A	Brain imaging, ltd static	0.00	2.86	NA	0.14	3.00	NA	XXX
78601		A	Brain imaging, ltd w/flow	0.51	3.55	NA	0.20	4.26	NA	XXX
78601	26	A	Brain imaging, ltd w/flow	0.51	0.18	0.18	0.02	0.71	0.71	XXX
78601	TC	A	Brain imaging, ltd w/flow	0.00	3.37	NA	0.18	3.55	NA	XXX
78605		A	Brain imaging, complete	0.53	3.56	NA	0.20	4.29	NA	XXX
78605	26	A	Brain imaging, complete	0.53	0.19	0.19	0.02	0.74	0.74	XXX
78605	TC	A	Brain imaging, complete	0.00	3.37	NA	0.18	3.55	NA	XXX
78606		A	Brain imaging, compl w/flow	0.64	4.05	NA	0.24	4.93	NA	XXX
78606	26	A	Brain imaging, compl w/flow	0.64	0.22	0.22	0.04	0.90	0.90	XXX
78606	TC	A	Brain imaging, compl w/flow	0.00	3.83	NA	0.20	4.03	NA	XXX
78607		A	Brain imaging (3D)	1.22	6.94	NA	0.41	8.57	NA	XXX
78607	26	A	Brain imaging (3D)	1.22	0.44	0.44	0.06	1.72	1.72	XXX
78607	TC	A	Brain imaging (3D)	0.00	6.50	NA	0.35	6.85	NA	XXX
78608		N	Brain imaging (PET)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78609		N	Brain imaging (PET)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78610		A	Brain flow imaging only	0.30	1.67	NA	0.11	2.08	NA	XXX
78610	26	A	Brain flow imaging only	0.30	0.11	0.11	0.01	0.42	0.42	XXX
78610	TC	A	Brain flow imaging only	0.00	1.56	NA	0.10	1.66	NA	XXX
78615		A	Cerebral vascular flow image	0.42	3.97	NA	0.22	4.61	NA	XXX
78615	26	A	Cerebral vascular flow image	0.42	0.16	0.16	0.02	0.60	0.60	XXX
78615	TC	A	Cerebral vascular flow image	0.00	3.81	NA	0.20	4.01	NA	XXX
78630		A	Cerebrospinal fluid scan	0.68	5.22	NA	0.30	6.20	NA	XXX
78630	26	A	Cerebrospinal fluid scan	0.68	0.23	0.23	0.04	0.95	0.95	XXX
78630	TC	A	Cerebrospinal fluid scan	0.00	4.99	NA	0.26	5.25	NA	XXX
78635		A	CSF ventriculography	0.61	2.76	NA	0.16	3.53	NA	XXX
78635	26	A	CSF ventriculography	0.61	0.24	0.24	0.02	0.87	0.87	XXX
78635	TC	A	CSF ventriculography	0.00	2.52	NA	0.14	2.66	NA	XXX
78645		A	CSF shunt evaluation	0.57	3.60	NA	0.20	4.37	NA	XXX
78645	26	A	CSF shunt evaluation	0.57	0.20	0.20	0.02	0.79	0.79	XXX
78645	TC	A	CSF shunt evaluation	0.00	3.40	NA	0.18	3.58	NA	XXX
78647		A	Cerebrospinal fluid scan	0.89	6.17	NA	0.35	7.41	NA	XXX
78647	26	A	Cerebrospinal fluid scan	0.89	0.32	0.32	0.04	1.25	1.25	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
78647	TC	A	Cerebrospinal fluid scan	0.00	5.85	NA	0.31	6.16	NA	XXX
78650	.....	A	CSF leakage imaging	0.61	4.81	NA	0.26	5.68	NA	XXX
78650	26	A	CSF leakage imaging	0.61	0.21	0.21	0.02	0.84	0.84	XXX
78650	TC	A	CSF leakage imaging	0.00	4.60	NA	0.24	4.84	NA	XXX
78660	.....	A	Nuclear exam of tear flow	0.53	2.28	NA	0.14	2.95	NA	XXX
78660	26	A	Nuclear exam of tear flow	0.53	0.18	0.18	0.02	0.73	0.73	XXX
78660	TC	A	Nuclear exam of tear flow	0.00	2.10	NA	0.12	2.22	NA	XXX
78699	.....	C	Nervous system nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78699	26	C	Nervous system nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78699	TC	C	Nervous system nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78700	.....	A	Kidney imaging, static	0.45	3.17	NA	0.18	3.80	NA	XXX
78700	26	A	Kidney imaging, static	0.45	0.15	0.15	0.02	0.62	0.62	XXX
78700	TC	A	Kidney imaging, static	0.00	3.02	NA	0.16	3.18	NA	XXX
78701	.....	A	Kidney imaging with flow	0.49	3.70	NA	0.20	4.39	NA	XXX
78701	26	A	Kidney imaging with flow	0.49	0.17	0.17	0.02	0.68	0.68	XXX
78701	TC	A	Kidney imaging with flow	0.00	3.53	NA	0.18	3.71	NA	XXX
78704	.....	A	Imaging renogram	0.74	4.17	NA	0.24	5.15	NA	XXX
78704	26	A	Imaging renogram	0.74	0.25	0.25	0.04	1.03	1.03	XXX
78704	TC	A	Imaging renogram	0.00	3.92	NA	0.20	4.12	NA	XXX
78707	.....	A	Kidney flow/function image	0.95	4.76	NA	0.28	5.99	NA	XXX
78707	26	A	Kidney flow/function image	0.95	0.33	0.33	0.05	1.33	1.33	XXX
78707	TC	A	Kidney flow/function image	0.00	4.43	NA	0.23	4.66	NA	XXX
78708	.....	A	Kidney flow/function image	1.20	4.85	NA	0.29	6.34	NA	XXX
78708	26	A	Kidney flow/function image	1.20	0.42	0.42	0.06	1.68	1.68	XXX
78708	TC	A	Kidney flow/function image	0.00	4.43	NA	0.23	4.66	NA	XXX
78709	.....	A	Kidney flow/function image	1.40	4.91	NA	0.30	6.61	NA	XXX
78709	26	A	Kidney flow/function image	1.40	0.48	0.48	0.07	1.95	1.95	XXX
78709	TC	A	Kidney flow/function image	0.00	4.43	NA	0.23	4.66	NA	XXX
78710	.....	A	Kidney imaging (3D)	0.66	6.08	NA	0.35	7.09	NA	XXX
78710	26	A	Kidney imaging (3D)	0.66	0.23	0.23	0.04	0.93	0.93	XXX
78710	TC	A	Kidney imaging (3D)	0.00	5.85	NA	0.31	6.16	NA	XXX
78715	.....	A	Renal vascular flow exam	0.30	1.67	NA	0.11	2.08	NA	XXX
78715	26	A	Renal vascular flow exam	0.30	0.11	0.11	0.01	0.42	0.42	XXX
78715	TC	A	Renal vascular flow exam	0.00	1.56	NA	0.10	1.66	NA	XXX
78725	.....	A	Kidney function study	0.38	1.90	NA	0.12	2.40	NA	XXX
78725	26	A	Kidney function study	0.38	0.13	0.13	0.01	0.52	0.52	XXX
78725	TC	A	Kidney function study	0.00	1.77	NA	0.11	1.88	NA	XXX
78730	.....	A	Urinary bladder retention	0.36	1.58	NA	0.10	2.04	NA	XXX
78730	26	A	Urinary bladder retention	0.36	0.13	0.13	0.02	0.51	0.51	XXX
78730	TC	A	Urinary bladder retention	0.00	1.45	NA	0.08	1.53	NA	XXX
78740	.....	A	Ureteral reflux study	0.57	2.29	NA	0.14	3.00	NA	XXX
78740	26	A	Ureteral reflux study	0.57	0.19	0.19	0.02	0.78	0.78	XXX
78740	TC	A	Ureteral reflux study	0.00	2.10	NA	0.12	2.22	NA	XXX
78760	.....	A	Testicular imaging	0.66	2.88	NA	0.18	3.72	NA	XXX
78760	26	A	Testicular imaging	0.66	0.22	0.22	0.04	0.92	0.92	XXX
78760	TC	A	Testicular imaging	0.00	2.66	NA	0.14	2.80	NA	XXX
78761	.....	A	Testicular imaging/flow	0.71	3.42	NA	0.21	4.34	NA	XXX
78761	26	A	Testicular imaging/flow	0.71	0.24	0.24	0.04	0.99	0.99	XXX
78761	TC	A	Testicular imaging/flow	0.00	3.18	NA	0.17	3.35	NA	XXX
78799	.....	C	Genitourinary nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78799	26	C	Genitourinary nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78799	TC	C	Genitourinary nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78800	.....	A	Tumor imaging, limited area	0.66	3.59	NA	0.22	4.47	NA	XXX
78800	26	A	Tumor imaging, limited area	0.66	0.22	0.22	0.04	0.92	0.92	XXX
78800	TC	A	Tumor imaging, limited area	0.00	3.37	NA	0.18	3.55	NA	XXX
78801	.....	A	Tumor imaging, mult areas	0.79	4.46	NA	0.26	5.51	NA	XXX
78801	26	A	Tumor imaging, mult areas	0.79	0.27	0.27	0.04	1.10	1.10	XXX
78801	TC	A	Tumor imaging, mult areas	0.00	4.19	NA	0.22	4.41	NA	XXX
78802	.....	A	Tumor imaging, whole body	0.86	5.79	NA	0.34	6.99	NA	XXX
78802	26	A	Tumor imaging, whole body	0.86	0.30	0.30	0.04	1.20	1.20	XXX
78802	TC	A	Tumor imaging, whole body	0.00	5.49	NA	0.30	5.79	NA	XXX
78803	.....	A	Tumor imaging (3D)	1.08	6.89	NA	0.40	8.37	NA	XXX
78803	26	A	Tumor imaging (3D)	1.08	0.39	0.39	0.05	1.52	1.52	XXX
78803	TC	A	Tumor imaging (3D)	0.00	6.50	NA	0.35	6.85	NA	XXX
78804	.....	A	Tumor imaging, whole body	1.06	4.62	NA	0.34	6.02	NA	XXX
78804	26	A	Tumor imaging, whole body	1.06	0.38	0.38	0.04	1.48	1.48	XXX
78804	TC	A	Tumor imaging, whole body	0.00	4.24	NA	0.30	4.54	NA	XXX
78805	.....	A	Abscess imaging, ltd area	0.73	3.62	NA	0.22	4.57	NA	XXX
78805	26	A	Abscess imaging, ltd area	0.73	0.25	0.25	0.04	1.02	1.02	XXX
78805	TC	A	Abscess imaging, ltd area	0.00	3.37	NA	0.18	3.55	NA	XXX
78806	.....	A	Abscess imaging, whole body	0.86	6.67	NA	0.39	7.92	NA	XXX
78806	26	A	Abscess imaging, whole body	0.86	0.30	0.30	0.04	1.20	1.20	XXX
78806	TC	A	Abscess imaging, whole body	0.00	6.37	NA	0.35	6.72	NA	XXX
78807	.....	A	Nuclear localization/abscess	1.08	6.90	NA	0.40	8.38	NA	XXX
78807	26	A	Nuclear localization/abscess	1.08	0.40	0.40	0.05	1.53	1.53	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
78807	TC	A	Nuclear localization/abscess	0.00	6.50	NA	0.35	6.85	NA	XXX
78810	.....	N	Tumor imaging (PET)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78810	26	N	Tumor imaging (PET)	+1.92	0.74	0.74	0.11	2.77	2.77	XXX
78810	TC	N	Tumor imaging (PET)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78890	.....	B	Nuclear medicine data proc	+0.05	1.31	NA	0.07	1.43	NA	XXX
78890	26	B	Nuclear medicine data proc	+0.05	0.02	0.02	0.01	0.08	0.08	XXX
78890	TC	B	Nuclear medicine data proc	+0.00	1.29	NA	0.06	1.35	NA	XXX
78891	.....	B	Nuclear med data proc	+0.10	2.64	NA	0.14	2.88	NA	XXX
78891	26	B	Nuclear med data proc	+0.10	0.04	0.04	0.01	0.15	0.15	XXX
78891	TC	B	Nuclear med data proc	+0.00	2.60	NA	0.13	2.73	NA	XXX
78990	.....	I	Provide diag radionuclide(s)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78999	.....	C	Nuclear diagnostic exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78999	26	C	Nuclear diagnostic exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78999	TC	C	Nuclear diagnostic exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79000	.....	A	Init hyperthyroid therapy	1.79	3.22	NA	0.22	5.23	NA	XXX
79000	26	A	Init hyperthyroid therapy	1.79	0.62	0.62	0.08	2.49	2.49	XXX
79000	TC	A	Init hyperthyroid therapy	0.00	2.60	NA	0.14	2.74	NA	XXX
79001	.....	A	Repeat hyperthyroid therapy	1.04	1.65	NA	0.12	2.81	NA	XXX
79001	26	A	Repeat hyperthyroid therapy	1.04	0.36	0.36	0.05	1.45	1.45	XXX
79001	TC	A	Repeat hyperthyroid therapy	0.00	1.29	NA	0.07	1.36	NA	XXX
79020	.....	A	Thyroid ablation	1.80	3.21	NA	0.22	5.23	NA	XXX
79020	26	A	Thyroid ablation ..	1.80	0.61	0.61	0.08	2.49	2.49	XXX
79020	TC	A	Thyroid ablation	0.00	2.60	NA	0.14	2.74	NA	XXX
79030	.....	A	Thyroid ablation, carcinoma	2.09	3.31	NA	0.24	5.64	NA	XXX
79030	26	A	Thyroid ablation, carcinoma	2.09	0.71	0.71	0.10	2.90	2.90	XXX
79030	TC	A	Thyroid ablation, carcinoma	0.00	2.60	NA	0.14	2.74	NA	XXX
79035	.....	A	Thyroid metastatic therapy	2.51	3.48	NA	0.25	6.24	NA	XXX
79035	26	A	Thyroid metastatic therapy	2.51	0.88	0.88	0.11	3.50	3.50	XXX
79035	TC	A	Thyroid metastatic therapy	0.00	2.60	NA	0.14	2.74	NA	XXX
79100	.....	A	Hematopoetic nuclear therapy	1.31	3.07	NA	0.20	4.58	NA	XXX
79100	26	A	Hematopoetic nuclear therapy	1.31	0.47	0.47	0.06	1.84	1.84	XXX
79100	TC	A	Hematopoetic nuclear therapy	0.00	2.60	NA	0.14	2.74	NA	XXX
79200	.....	A	Intracavitary nuclear trmt	1.98	3.29	NA	0.22	5.49	NA	XXX
79200	26	A	Intracavitary nuclear trmt	1.98	0.69	0.69	0.08	2.75	2.75	XXX
79200	TC	A	Intracavitary nuclear trmt	0.00	2.60	NA	0.14	2.74	NA	XXX
79300	.....	C	Interstitial nuclear therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79300	26	A	Interstitial nuclear therapy	1.59	0.57	0.57	0.08	2.24	2.24	XXX
79300	TC	C	Interstitial nuclear therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79400	.....	A	Nonhemato nuclear therapy	1.95	3.27	NA	0.24	5.46	NA	XXX
79400	26	A	Nonhemato nuclear therapy	1.95	0.67	0.67	0.10	2.72	2.72	XXX
79400	TC	A	Nonhemato nuclear therapy	0.00	2.60	NA	0.14	2.74	NA	XXX
79403	.....	A	Hematopoetic nuclear therapy	2.24	5.15	NA	0.24	7.63	NA	XXX
79403	26	A	Hematopoetic nuclear therapy	2.24	0.91	0.91	0.10	3.25	3.25	XXX
79403	TC	A	Hematopoetic nuclear therapy	0.00	4.24	NA	0.14	4.38	NA	XXX
79420	.....	C	Intravascular nuclear ther	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79420	26	A	Intravascular nuclear ther	1.50	0.50	0.50	0.07	2.07	2.07	XXX
79420	TC	C	Intravascular nuclear ther	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79440	.....	A	Nuclear joint therapy	1.98	3.33	NA	0.24	5.55	NA	XXX
79440	26	A	Nuclear joint therapy	1.98	0.73	0.73	0.10	2.81	2.81	XXX
79440	TC	A	Nuclear joint therapy	0.00	2.60	NA	0.14	2.74	NA	XXX
79900	.....	C	Provide ther radiopharm(s)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79999	.....	C	Nuclear medicine therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79999	26	C	Nuclear medicine therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79999	TC	C	Nuclear medicine therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
80500	.....	A	Lab pathology consultation	0.37	0.21	0.16	0.01	0.59	0.54	XXX
80502	.....	A	Lab pathology consultation	1.32	0.64	0.59	0.06	2.02	1.97	XXX
83020	26	A	Hemoglobin electrophoresis	0.37	0.16	0.16	0.01	0.54	0.54	XXX
83912	26	A	Genetic examination	0.37	0.15	0.15	0.01	0.53	0.53	XXX
84165	26	A	Electrophoreisis of proteins	0.37	0.16	0.16	0.01	0.54	0.54	XXX
84181	26	A	Western blot test	0.37	0.14	0.14	0.01	0.52	0.52	XXX
84182	26	A	Protein, western blot test	0.37	0.17	0.17	0.01	0.55	0.55	XXX
85060	.....	A	Blood smear interpretation	0.45	0.19	0.19	0.02	0.66	0.66	XXX
85097	.....	A	Bone marrow interpretation	0.93	1.64	0.41	0.04	2.61	1.38	XXX
85390	26	A	Fibrinolysins screen	0.37	0.12	0.12	0.01	0.50	0.50	XXX
85396	.....	A	Clotting assay, whole blood	0.37	NA	0.17	0.04	NA	0.58	XXX
85576	26	A	Blood platelet aggregation	0.37	0.16	0.16	0.01	0.54	0.54	XXX
86077	.....	A	Physician blood bank service	0.93	0.47	0.41	0.04	1.44	1.38	XXX
86078	.....	A	Physician blood bank service	0.93	0.50	0.41	0.04	1.47	1.38	XXX
86079	.....	A	Physician blood bank service	0.93	0.50	0.42	0.04	1.47	1.39	XXX
86255	26	A	Fluorescent antibody, screen	0.37	0.17	0.16	0.01	0.55	0.54	XXX
86256	26	A	Fluorescent antibody, titer	0.37	0.16	0.16	0.01	0.54	0.54	XXX
86320	26	A	Serum immunoelectrophoresis	0.37	0.16	0.16	0.01	0.54	0.54	XXX
86325	26	A	Other immunoelectrophoresis	0.37	0.16	0.16	0.01	0.54	0.54	XXX
86327	26	A	Immunoelectrophoresis assay	0.42	0.19	0.19	0.01	0.62	0.62	XXX
86334	26	A	Immunofixation procedure	0.37	0.16	0.16	0.01	0.54	0.54	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
86485		C	Skin test, candida	0.00	0.00	0.00	0.00	0.00	0.00	XXX
86490		A	Coccidioidomycosis skin test	0.00	0.29	NA	0.02	0.31	NA	XXX
86510		A	Histoplasmosis skin test	0.00	0.32	NA	0.02	0.34	NA	XXX
86580		A	TB intradermal test	0.00	0.25	NA	0.02	0.27	NA	XXX
86585		A	TB tine test	0.00	0.20	NA	0.01	0.21	NA	XXX
86586		C	Skin test, unlisted	0.00	0.00	0.00	0.00	0.00	0.00	XXX
87164	26	A	Dark field examination	0.37	0.12	0.12	0.01	0.50	0.50	XXX
87207	26	A	Smear, special stain	0.37	0.17	0.16	0.01	0.55	0.54	XXX
88104		A	Cytopathology, fluids	0.56	0.76	NA	0.04	1.36	NA	XXX
88104	26	A	Cytopathology, fluids	0.56	0.25	0.25	0.02	0.83	0.83	XXX
88104	TC	A	Cytopathology, fluids	0.00	0.51	NA	0.02	0.53	NA	XXX
88106		A	Cytopathology, fluids	0.56	0.62	NA	0.04	1.22	NA	XXX
88106	26	A	Cytopathology, fluids	0.56	0.25	0.25	0.02	0.83	0.83	XXX
88106	TC	A	Cytopathology, fluids	0.00	0.37	NA	0.02	0.39	NA	XXX
88107		A	Cytopathology, fluids	0.76	0.98	NA	0.06	1.80	NA	XXX
88107	26	A	Cytopathology, fluids	0.76	0.34	0.34	0.04	1.14	1.14	XXX
88107	TC	A	Cytopathology, fluids	0.00	0.64	NA	0.02	0.66	NA	XXX
88108		A	Cytopath, concentrate tech	0.56	0.82	NA	0.04	1.42	NA	XXX
88108	26	A	Cytopath, concentrate tech	0.56	0.25	0.25	0.02	0.83	0.83	XXX
88108	TC	A	Cytopath, concentrate tech	0.00	0.57	NA	0.02	0.59	NA	XXX
88112		A	Cytopath, cell enhance tech	1.17	2.02	NA	0.08	3.27	NA	XXX
88112	26	A	Cytopath, cell enhance tech	1.17	0.53	0.53	0.06	1.76	1.76	XXX
88112	TC	A	Cytopath, cell enhance tech	0.00	1.49	NA	0.02	1.51	NA	XXX
88125		A	Forensic cytopathology	0.26	0.27	NA	0.02	0.55	NA	XXX
88125	26	A	Forensic cytopathology	0.26	0.12	0.12	0.01	0.39	0.39	XXX
88125	TC	A	Forensic cytopathology	0.00	0.15	NA	0.01	0.16	NA	XXX
88141		A	Cytopath, c/v, interpret	0.42	0.18	0.18	0.01	0.61	0.61	XXX
88160		A	Cytopath smear, other source	0.50	0.93	NA	0.04	1.47	NA	XXX
88160	26	A	Cytopath smear, other source	0.50	0.22	0.22	0.02	0.74	0.74	XXX
88160	TC	A	Cytopath smear, other source	0.00	0.71	NA	0.02	0.73	NA	XXX
88161		A	Cytopath smear, other source	0.50	0.88	NA	0.04	1.42	NA	XXX
88161	26	A	Cytopath smear, other source	0.50	0.22	0.22	0.02	0.74	0.74	XXX
88161	TC	A	Cytopath smear, other source	0.00	0.66	NA	0.02	0.68	NA	XXX
88162		A	Cytopath smear, other source	0.76	0.68	NA	0.06	1.50	NA	XXX
88162	26	A	Cytopath smear, other source	0.76	0.34	0.34	0.04	1.14	1.14	XXX
88162	TC	A	Cytopath smear, other source	0.00	0.34	NA	0.02	0.36	NA	XXX
88172		A	Cytopathology eval of fna	0.60	0.67	NA	0.04	1.31	NA	XXX
88172	26	A	Cytopathology eval of fna	0.60	0.27	0.27	0.02	0.89	0.89	XXX
88172	TC	A	Cytopathology eval of fna	0.00	0.40	NA	0.02	0.42	NA	XXX
88173		A	Cytopath eval, fna, report	1.38	1.78	NA	0.08	3.24	NA	XXX
88173	26	A	Cytopath eval, fna, report	1.38	0.62	0.62	0.06	2.06	2.06	XXX
88173	TC	A	Cytopath eval, fna, report	0.00	1.16	NA	0.02	1.18	NA	XXX
88180		A	Cell marker study	0.36	1.45	NA	0.03	1.84	NA	XXX
88180	26	A	Cell marker study	0.36	0.16	0.16	0.01	0.53	0.53	XXX
88180	TC	A	Cell marker study	0.00	1.29	NA	0.02	1.31	NA	XXX
88182		A	Cell marker study	0.77	1.61	NA	0.08	2.46	NA	XXX
88182	26	A	Cell marker study	0.77	0.34	0.34	0.04	1.15	1.15	XXX
88182	TC	A	Cell marker study	0.00	1.27	NA	0.04	1.31	NA	XXX
88199		C	Cytopathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88199	26	C	Cytopathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88199	TC	C	Cytopathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88291		A	Cyto/molecular report	0.52	0.28	0.28	0.02	0.82	0.82	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	0.28	NA	0.02	0.38	NA	XXX
88300	26	A	Surgical path, gross	0.08	0.04	0.04	0.01	0.13	0.13	XXX
88300	TC	A	Surgical path, gross	0.00	0.24	NA	0.01	0.25	NA	XXX
88302		A	Tissue exam by pathologist	0.13	0.70	NA	0.03	0.86	NA	XXX
88302	26	A	Tissue exam by pathologist	0.13	0.06	0.06	0.01	0.20	0.20	XXX
88302	TC	A	Tissue exam by pathologist	0.00	0.64	NA	0.02	0.66	NA	XXX
88304		A	Tissue exam by pathologist	0.22	0.88	NA	0.03	1.13	NA	XXX
88304	26	A	Tissue exam by pathologist	0.22	0.10	0.10	0.01	0.33	0.33	XXX
88304	TC	A	Tissue exam by pathologist	0.00	0.78	NA	0.02	0.80	NA	XXX
88305		A	Tissue exam by pathologist	0.75	1.75	NA	0.06	2.56	NA	XXX
88305	26	A	Tissue exam by pathologist	0.75	0.34	0.34	0.02	1.11	1.11	XXX
88305	TC	A	Tissue exam by pathologist	0.00	1.41	NA	0.04	1.45	NA	XXX
88307		A	Tissue exam by pathologist	1.58	2.67	NA	0.13	4.38	NA	XXX
88307	26	A	Tissue exam by pathologist	1.58	0.70	0.70	0.07	2.35	2.35	XXX
88307	TC	A	Tissue exam by pathologist	0.00	1.97	NA	0.06	2.03	NA	XXX
88309		A	Tissue exam by pathologist	2.27	3.27	NA	0.16	5.70	NA	XXX
88309	26	A	Tissue exam by pathologist	2.27	1.00	1.00	0.10	3.37	3.37	XXX
88309	TC	A	Tissue exam by pathologist	0.00	2.27	NA	0.06	2.33	NA	XXX
88311		A	Decalcify tissue	0.24	0.20	NA	0.02	0.46	NA	XXX
88311	26	A	Decalcify tissue	0.24	0.11	0.11	0.01	0.36	0.36	XXX
88311	TC	A	Decalcify tissue	0.00	0.09	NA	0.01	0.10	NA	XXX
88312		A	Special stains	0.54	1.36	NA	0.03	1.93	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
88312	26	A	Special stains	0.54	0.24	0.24	0.02	0.80	0.80	XXX
88312	TC	A	Special stains	0.00	1.12	NA	0.01	1.13	NA	XXX
88313	.....	A	Special stains	0.24	1.10	NA	0.02	1.36	NA	XXX
88313	26	A	Special stains	0.24	0.11	0.11	0.01	0.36	0.36	XXX
88313	TC	A	Special stains	0.00	0.99	NA	0.01	1.00	NA	XXX
88314	.....	A	Histochemical stain	0.45	0.89	NA	0.04	1.38	NA	XXX
88314	26	A	Histochemical stain	0.45	0.20	0.20	0.02	0.67	0.67	XXX
88314	TC	A	Histochemical stain	0.00	0.69	NA	0.02	0.71	NA	XXX
88318	.....	A	Chemical histochemistry	0.42	0.81	NA	0.02	1.25	NA	XXX
88318	26	A	Chemical histochemistry	0.42	0.19	0.19	0.01	0.62	0.62	XXX
88318	TC	A	Chemical histochemistry	0.00	0.62	NA	0.01	0.63	NA	XXX
88319	.....	A	Enzyme histochemistry	0.53	1.90	NA	0.04	2.47	NA	XXX
88319	26	A	Enzyme histochemistry	0.53	0.23	0.23	0.02	0.78	0.78	XXX
88319	TC	A	Enzyme histochemistry	0.00	1.67	NA	0.02	1.69	NA	XXX
88321	.....	A	Microslide consultation	1.29	0.81	0.57	0.05	2.15	1.91	XXX
88323	.....	A	Microslide consultation	1.34	1.45	NA	0.08	2.87	NA	XXX
88323	26	A	Microslide consultation	1.34	0.60	0.60	0.06	2.00	2.00	XXX
88323	TC	A	Microslide consultation	0.00	0.85	NA	0.02	0.87	NA	XXX
88325	.....	A	Comprehensive review of data	2.21	2.98	0.97	0.10	5.29	3.28	XXX
88329	.....	A	Path consult introp	0.67	0.64	0.30	0.02	1.33	0.99	XXX
88331	.....	A	Path consult intraop, 1 bloc	1.18	1.00	NA	0.09	2.27	NA	XXX
88331	26	A	Path consult intraop, 1 bloc	1.18	0.53	0.53	0.05	1.76	1.76	XXX
88331	TC	A	Path consult intraop, 1 bloc	0.00	0.47	NA	0.04	0.51	NA	XXX
88332	.....	A	Path consult intraop, addl	0.59	0.50	NA	0.04	1.13	NA	XXX
88332	26	A	Path consult intraop, addl	0.59	0.26	0.26	0.02	0.87	0.87	XXX
88332	TC	A	Path consult intraop, addl	0.00	0.24	NA	0.02	0.26	NA	XXX
88342	.....	A	Immunohistochemistry	0.85	1.36	NA	0.06	2.27	NA	XXX
88342	26	A	Immunohistochemistry	0.85	0.38	0.38	0.04	1.27	1.27	XXX
88342	TC	A	Immunohistochemistry	0.00	0.98	NA	0.02	1.00	NA	XXX
88346	.....	A	Immunofluorescent study	0.86	1.46	NA	0.06	2.38	NA	XXX
88346	26	A	Immunofluorescent study	0.86	0.38	0.38	0.04	1.28	1.28	XXX
88346	TC	A	Immunofluorescent study	0.00	1.08	NA	0.02	1.10	NA	XXX
88347	.....	A	Immunofluorescent study	0.86	1.78	NA	0.06	2.70	NA	XXX
88347	26	A	Immunofluorescent study	0.86	0.36	0.36	0.04	1.26	1.26	XXX
88347	TC	A	Immunofluorescent study	0.00	1.42	NA	0.02	1.44	NA	XXX
88348	.....	A	Electron microscopy	1.50	8.57	NA	0.13	10.20	NA	XXX
88348	26	A	Electron microscopy	1.50	0.65	0.65	0.06	2.21	2.21	XXX
88348	TC	A	Electron microscopy	0.00	7.92	NA	0.07	7.99	NA	XXX
88349	.....	A	Scanning electron microscopy	0.76	10.00	NA	0.10	10.86	NA	XXX
88349	26	A	Scanning electron microscopy	0.76	0.34	0.34	0.04	1.14	1.14	XXX
88349	TC	A	Scanning electron microscopy	0.00	9.66	NA	0.06	9.72	NA	XXX
88355	.....	A	Analysis, skeletal muscle	1.84	2.63	NA	0.14	4.61	NA	XXX
88355	26	A	Analysis, skeletal muscle	1.84	0.81	0.81	0.08	2.73	2.73	XXX
88355	TC	A	Analysis, skeletal muscle	0.00	1.82	NA	0.06	1.88	NA	XXX
88356	.....	A	Analysis, nerve	3.00	2.91	NA	0.19	6.10	NA	XXX
88356	26	A	Analysis, nerve	3.00	1.29	1.29	0.12	4.41	4.41	XXX
88356	TC	A	Analysis, nerve	0.00	1.62	NA	0.07	1.69	NA	XXX
88358	.....	A	Analysis, tumor	2.80	1.39	NA	0.19	4.38	NA	XXX
88358	26	A	Analysis, tumor	2.80	1.24	1.24	0.12	4.16	4.16	XXX
88358	TC	A	Analysis, tumor	0.00	0.15	NA	0.07	0.22	NA	XXX
88361	.....	A	Immunohistochemistry, tumor	0.93	2.62	NA	0.19	3.74	NA	XXX
88361	26	A	Immunohistochemistry, tumor	0.93	0.42	0.42	0.12	1.47	1.47	XXX
88361	TC	A	Immunohistochemistry, tumor	0.00	2.20	NA	0.07	2.27	NA	XXX
88362	.....	A	Nerve teasing preparations	2.16	4.44	NA	0.14	6.74	NA	XXX
88362	26	A	Nerve teasing preparations	2.16	0.93	0.93	0.08	3.17	3.17	XXX
88362	TC	A	Nerve teasing preparations	0.00	3.51	NA	0.06	3.57	NA	XXX
88365	.....	A	Tissue hybridization	0.92	2.23	NA	0.06	3.21	NA	XXX
88365	26	A	Tissue hybridization	0.92	0.41	0.41	0.04	1.37	1.37	XXX
88365	TC	A	Tissue hybridization	0.00	1.82	NA	0.02	1.84	NA	XXX
88371	26	A	Protein, western blot tissue	0.37	0.13	0.13	0.01	0.51	0.51	XXX
88372	26	A	Protein analysis w/probe	0.37	0.17	0.17	0.01	0.55	0.55	XXX
88380	.....	C	Microdissection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88380	26	C	Microdissection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88380	TC	C	Microdissection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88399	.....	C	Surgical pathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88399	26	C	Surgical pathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88399	TC	C	Surgical pathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
89060	26	A	Exam,synovial fluid crystals	0.37	0.17	0.16	0.01	0.55	0.54	XXX
89100	.....	A	Sample intestinal contents	0.60	1.62	0.22	0.02	2.24	0.84	XXX
89105	.....	A	Sample intestinal contents	0.50	2.26	0.17	0.02	2.78	0.69	XXX
89130	.....	A	Sample stomach contents	0.45	1.76	0.13	0.02	2.23	0.60	XXX
89132	.....	A	Sample stomach contents	0.19	1.51	0.06	0.01	1.71	0.26	XXX
89135	.....	A	Sample stomach contents	0.79	1.61	0.25	0.04	2.44	1.08	XXX
89136	.....	A	Sample stomach contents	0.21	1.66	0.09	0.01	1.88	0.31	XXX
89140	.....	A	Sample stomach contents	0.93	2.09	0.28	0.04	3.06	1.25	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
89141	.....	A	Sample stomach contents	0.85	2.75	0.34	0.04	3.64	1.23	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
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 ig, im, 50mg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90379	.....	I	Rsv ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90384	.....	i	Rh ig, full-dose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90385	.....	E	Rh ig, minidose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90386	.....	I	Rh ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90389	.....	I	Tetanus ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90393	.....	E	Vaccina ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90396	.....	E	Varicella-zoster ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90399	.....	I	Immune globulin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90471	.....	A	Immunization admin	0.00	0.20	NA	0.01	0.21	NA	XXX
90472	.....	A	Immunization admin, each add	0.00	0.14	NA	0.01	0.15	NA	ZZZ
90473	.....	N	Immune admin oral/nasal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90474	.....	N	Immune admin oral/nasal addl	0.00	0.00	0.00	0.00	0.00	0.00	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
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
90655	.....	X	Flu vaccine, 6–35 mo, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90657	.....	X	Flu vaccine, 6–35 mo, 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
90659	.....	D	Flu vaccine, whole, 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
90665	.....	E	Lyme disease vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90669	.....	N	Pneumococcal vacc, ped <5	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 vaccine, 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
90698	.....	E	Dtap-hib-ip vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90700	.....	E	Dtap vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90701	.....	E	Dtp vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90702	.....	E	Dt vaccine < 7, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90703	.....	E	Tetanus vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90704	.....	E	Mumps vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90705	.....	E	Measles vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90706	.....	E	Rubella vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90707	.....	E	Mmr vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90708	.....	E	Measles-rubella vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90710	.....	E	Mmrv vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90712	.....	E	Oral poliovirus vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90713	.....	E	Poliovirus, ipv, sc	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

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
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
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
90780		A	IV infusion therapy, 1 hour	0.00	1.10	NA	0.07	1.17	NA	XXX
90781		A	IV infusion, additional hour	0.00	0.56	NA	0.04	0.60	NA	ZZZ
90782		T	Injection, sc/im	0.00	0.11	NA	0.01	0.12	NA	XXX
90783		T	Injection, ia	0.00	0.41	NA	0.02	0.43	NA	XXX
90784		T	Injection, iv	0.00	0.47	NA	0.04	0.51	NA	XXX
90788		T	Injection of antibiotic	0.00	0.12	NA	0.01	0.13	NA	XXX
90799		C	Ther/prophylactic/dx inject	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90801		A	Psy dx interview	2.78	1.19	0.94	0.07	4.04	3.79	XXX
90802		A	Intac psy dx interview	2.99	1.22	0.99	0.08	4.29	4.06	XXX
90804		A	Psytx, office, 20–30 min	1.20	0.50	0.39	0.04	1.74	1.63	XXX
90805		A	Psytx, off, 20–30 min w/e&m	1.36	0.51	0.43	0.04	1.91	1.83	XXX
90806		A	Psytx, off, 45–50 min	1.85	0.71	0.62	0.05	2.61	2.52	XXX
90807		A	Psytx, off, 45–50 min w/e&m	2.01	0.70	0.64	0.06	2.77	2.71	XXX
90808		A	Psytx, office, 75–80 min	2.77	1.04	0.91	0.08	3.89	3.76	XXX
90809		A	Psytx, off, 75–80, w/e&m	2.93	1.01	0.93	0.08	4.02	3.94	XXX
90810		A	Intac psytx, off, 20–30 min	1.31	0.52	0.43	0.04	1.87	1.78	XXX
90811		A	Intac psytx, 20–30, w/e&m	1.47	0.58	0.47	0.04	2.09	1.98	XXX
90812		A	Intac psytx, off, 45–50 min	1.96	0.79	0.65	0.06	2.81	2.67	XXX
90813		A	Intac psytx, 45–50 min w/e&m	2.12	0.77	0.67	0.06	2.95	2.85	XXX
90814		A	Intac psytx, off, 75–80 min	2.88	1.11	0.99	0.08	4.07	3.95	XXX
90815		A	Intac psytx, 75–80 w/e&m	3.04	1.06	0.96	0.08	4.18	4.08	XXX
90816		A	Psytx, hosp, 20–30 min	1.24	NA	0.47	0.04	NA	1.75	XXX
90817		A	Psytx, hosp, 20–30 min w/e&m	1.40	NA	0.47	0.04	NA	1.91	XXX
90818		A	Psytx, hosp, 45–50 min	1.88	NA	0.69	0.05	NA	2.62	XXX
90819		A	Psytx, hosp, 45–50 min w/e&m	2.04	NA	0.66	0.06	NA	2.76	XXX
90821		A	Psytx, hosp, 75–80 min	2.81	NA	1.02	0.07	NA	3.90	XXX
90822		A	Psytx, hosp, 75–80 min w/e&m	2.97	NA	0.96	0.08	NA	4.01	XXX
90823		A	Intac psytx, hosp, 20–30 min	1.35	NA	0.49	0.04	NA	1.88	XXX
90824		A	Intac psytx, hsp 20–30 w/e&m	1.51	NA	0.50	0.04	NA	2.05	XXX
90826		A	Intac psytx, hosp, 45–50 min	2.00	NA	0.73	0.05	NA	2.78	XXX
90827		A	Intac psytx, hsp 45–50 w/e&m	2.15	NA	0.69	0.06	NA	2.90	XXX
90828		A	Intac psytx, hosp, 75–80 min	2.92	NA	1.08	0.08	NA	4.08	XXX
90829		A	Intac psytx, hsp 75–80 w/e&m	3.08	NA	0.99	0.08	NA	4.15	XXX
90845		A	Psychoanalysis	1.78	0.59	0.57	0.05	2.42	2.40	XXX
90846		R	Family psytx w/o patient	1.82	0.66	0.65	0.05	2.53	2.52	XXX
90847		R	Family psytx w/patient	2.20	0.82	0.77	0.06	3.08	3.03	XXX
90849		R	Multiple family group psytx	0.59	0.28	0.24	0.01	0.88	0.84	XXX
90853		A	Group psychotherapy	0.59	0.25	0.23	0.01	0.85	0.83	XXX
90857		A	Intac group psytx	0.63	0.30	0.26	0.02	0.95	0.91	XXX
90862		A	Medication management	0.94	0.41	0.33	0.02	1.37	1.29	XXX
90865		A	Narcosynthesis	2.82	1.62	0.90	0.08	4.52	3.80	XXX
90870		A	Electroconvulsive therapy	1.87	0.80	0.80	0.05	2.72	2.72	000
90871		N	Electroconvulsive therapy	+2.70	1.07	1.07	0.07	3.84	3.84	000
90875		N	Psychophysiological therapy	+1.19	0.90	0.47	0.04	2.13	1.70	XXX
90876		N	Psychophysiological therapy	+1.89	1.17	0.73	0.05	3.11	2.67	XXX
90880		A	Hypnotherapy	2.18	1.05	0.69	0.06	3.29	2.93	XXX
90882		N	Environmental manipulation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90885		B	Psy evaluation of records	+0.96	0.38	0.38	0.02	1.36	1.36	XXX
90887		B	Consultation with family	+1.47	0.83	0.57	0.04	2.34	2.08	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	0.67	0.14	0.02	1.10	0.57	000
90911		A	Biofeedback peri/uro/rectal	0.88	1.64	0.32	0.05	2.57	1.25	000
90918		I	ESRD related services, month	+11.12	7.50	7.50	0.36	18.98	18.98	XXX
90919		I	ESRD related services, month	+8.49	4.15	4.15	0.29	12.93	12.93	XXX
90920		I	ESRD related services, month	+7.23	3.89	3.89	0.23	11.35	11.35	XXX
90921		I	ESRD related services, month	+4.44	2.52	2.52	0.14	7.10	7.10	XXX
90922		A	ESRD related services, day	0.37	0.22	0.22	0.01	0.60	0.60	XXX
90923		A	Esrd related services, day	0.28	0.13	0.13	0.01	0.42	0.42	XXX
90924		A	Esrd related services, day	0.24	0.12	0.12	0.01	0.37	0.37	XXX
90925		A	Esrd related services, day	0.15	0.08	0.08	0.01	0.24	0.24	XXX
90935		A	Hemodialysis, one evaluation	1.21	NA	0.68	0.04	NA	1.93	000
90937		A	Hemodialysis, repeated eval	2.10	NA	0.99	0.07	NA	3.16	000
90939		X	Hemodialysis study, transcut	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90940		X	Hemodialysis access study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90945		A	Dialysis, one evaluation	1.27	NA	0.70	0.05	NA	2.02	000

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CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
90947	.....	A	Dialysis, repeated eval	2.15	NA	1.01	0.07	NA	3.23	000
90989	.....	X	Dialysis training, complete	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90993	.....	X	Dialysis training, incompl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90997	.....	A	Hemoperfusion	1.83	NA	1.43	0.06	NA	3.32	000
90999	.....	C	Dialysis procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91000	.....	A	Esophageal intubation	0.73	0.33	NA	0.05	1.11	NA	000
91000	26	A	Esophageal intubation	0.73	0.25	0.25	0.04	1.02	1.02	000
91000	TC	A	Esophageal intubation	0.00	0.08	NA	0.01	0.09	NA	000
91010	.....	A	Esophagus motility study	1.24	2.76	NA	0.12	4.12	NA	000
91010	26	A	Esophagus motility study	1.24	0.45	0.45	0.06	1.75	1.75	000
91010	TC	A	Esophagus motility study	0.00	2.31	NA	0.06	2.37	NA	000
91011	.....	A	Esophagus motility study	1.49	3.25	NA	0.12	4.86	NA	000
91011	26	A	Esophagus motility study	1.49	0.54	0.54	0.06	2.09	2.09	000
91011	TC	A	Esophagus motility study	0.00	2.71	NA	0.06	2.77	NA	000
91012	.....	A	Esophagus motility study	1.45	3.40	NA	0.14	4.99	NA	000
91012	26	A	Esophagus motility study	1.45	0.52	0.52	0.07	2.04	2.04	000
91012	TC	A	Esophagus motility study	0.00	2.88	NA	0.07	2.95	NA	000
91020	.....	A	Gastric motility	1.43	2.99	NA	0.13	4.55	NA	000
91020	26	A	Gastric motility	1.43	0.50	0.50	0.07	2.00	2.00	000
91020	TC	A	Gastric motility	0.00	2.49	NA	0.06	2.55	NA	000
91030	.....	A	Acid perfusion of esophagus	0.90	2.43	NA	0.06	3.39	NA	000
91030	26	A	Acid perfusion of esophagus	0.90	0.33	0.33	0.04	1.27	1.27	000
91030	TC	A	Acid perfusion of esophagus	0.00	2.10	NA	0.02	2.12	NA	000
91032	.....	A	Esophagus, acid reflux test	1.20	4.20	NA	0.12	5.52	NA	000
91032	26	A	Esophagus, acid reflux test	1.20	0.43	0.43	0.06	1.69	1.69	000
91032	TC	A	Esophagus, acid reflux test	0.00	3.77	NA	0.06	3.83	NA	000
91033	.....	A	Prolonged acid reflux test	1.29	4.23	NA	0.17	5.69	NA	000
91033	26	A	Prolonged acid reflux test	1.29	0.46	0.46	0.06	1.81	1.81	000
91033	TC	A	Prolonged acid reflux test	0.00	3.77	NA	0.11	3.88	NA	000
91052	.....	A	Gastric analysis test	0.79	2.22	NA	0.06	3.07	NA	000
91052	26	A	Gastric analysis test	0.79	0.28	0.28	0.04	1.11	1.11	000
91052	TC	A	Gastric analysis test	0.00	1.94	NA	0.02	1.96	NA	000
91055	.....	A	Gastric intubation for smear	0.93	2.39	NA	0.07	3.39	NA	000
91055	26	A	Gastric intubation for smear	0.93	0.27	0.27	0.05	1.25	1.25	000
91055	TC	A	Gastric intubation for smear	0.00	2.12	NA	0.02	2.14	NA	000
91060	.....	A	Gastric saline load test	0.45	0.30	NA	0.04	0.79	NA	000
91060	26	A	Gastric saline load test	0.45	0.14	0.14	0.02	0.61	0.61	000
91060	TC	A	Gastric saline load test	0.00	0.16	NA	0.02	0.18	NA	000
91065	.....	A	Breath hydrogen test	0.20	2.00	NA	0.03	2.23	NA	000
91065	26	A	Breath hydrogen test	0.20	0.07	0.07	0.01	0.28	0.28	000
91065	TC	A	Breath hydrogen test	0.00	1.93	NA	0.02	1.95	NA	000
91100	.....	A	Pass intestine bleeding tube	1.07	NA	0.29	0.07	NA	1.43	000
91105	.....	A	Gastric intubation treatment	0.37	NA	0.09	0.02	NA	0.48	000
91110	.....	A	Gi tract capsule endoscopy	3.63	21.39	NA	0.09	25.11	NA	XXX
91110	26	A	Gi tract capsule endoscopy	3.63	1.31	1.31	0.02	4.96	4.96	XXX
91110	TC	A	Gi tract capsule endoscopy	0.00	20.08	NA	0.07	20.15	NA	XXX
91122	.....	A	Anal pressure record	1.76	6.14	NA	0.20	8.10	NA	000
91122	26	A	Anal pressure record	1.76	0.62	0.62	0.12	2.50	2.50	000
91122	TC	A	Anal pressure record	0.00	5.52	NA	0.08	5.60	NA	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	0.00	0.00	0.00	XXX
91132	26	A	Electrogastrography	0.52	0.19	0.19	0.04	0.75	0.75	XXX
91132	TC	C	Electrogastrography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91133	.....	C	Electrogastrography w/test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91133	26	A	Electrogastrography w/test	0.66	0.24	0.24	0.04	0.94	0.94	XXX
91133	TC	C	Electrogastrography w/test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91299	.....	C	Gastroenterology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91299	26	C	Gastroenterology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91299	TC	C	Gastroenterology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92002	.....	A	Eye exam, new patient	0.87	0.97	0.35	0.02	1.86	1.24	XXX
92004	.....	A	Eye exam, new patient	1.66	1.70	0.68	0.04	3.40	2.38	XXX
92012	.....	A	Eye exam established pat	0.67	1.03	0.29	0.01	1.71	0.97	XXX
92014	.....	A	Eye exam & treatment	1.09	1.40	0.48	0.02	2.51	1.59	XXX
92015	.....	N	Refraction	+0.38	1.50	0.15	0.01	1.89	0.54	XXX
92018	.....	A	New eye exam & treatment	2.49	NA	1.09	0.04	NA	3.62	XXX
92019	.....	A	Eye exam & treatment	1.30	NA	0.57	0.04	NA	1.91	XXX
92020	.....	A	Special eye evaluation	0.37	0.34	0.16	0.01	0.72	0.54	XXX
92060	.....	A	Special eye evaluation	0.69	0.73	NA	0.02	1.44	NA	XXX
92060	26	A	Special eye evaluation	0.69	0.29	0.29	0.01	0.99	0.99	XXX
92060	TC	A	Special eye evaluation	0.00	0.44	NA	0.01	0.45	NA	XXX
92065	.....	A	Orthoptic/pleoptic training	0.37	0.55	NA	0.02	0.94	NA	XXX
92065	26	A	Orthoptic/pleoptic training	0.37	0.15	0.15	0.01	0.53	0.53	XXX
92065	TC	A	Orthoptic/pleoptic training	0.00	0.40	NA	0.01	0.41	NA	XXX
92070	.....	A	Fitting of contact lens	0.70	1.08	0.32	0.01	1.79	1.03	XXX
92081	.....	A	Visual field examination(s)	0.36	0.87	NA	0.02	1.25	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
92081	26	A	Visual field examination(s)	0.36	0.16	0.16	0.01	0.53	0.53	XXX
92081	TC	A	Visual field examination(s)	0.00	0.71	NA	0.01	0.72	NA	XXX
92082		A	Visual field examination(s)	0.44	1.15	NA	0.02	1.61	NA	XXX
92082	26	A	Visual field examination(s)	0.44	0.19	0.19	0.01	0.64	0.64	XXX
92082	TC	A	Visual field examination(s)	0.00	0.96	NA	0.01	0.97	NA	XXX
92083		A	Visual field examination(s)	0.50	1.34	NA	0.02	1.86	NA	XXX
92083	26	A	Visual field examination(s)	0.50	0.22	0.22	0.01	0.73	0.73	XXX
92083	TC	A	Visual field examination(s)	0.00	1.12	NA	0.01	1.13	NA	XXX
92100		A	Serial tonometry exam(s)	0.91	1.27	0.37	0.02	2.20	1.30	XXX
92120		A	Tonography & eye evaluation	0.81	1.05	0.32	0.02	1.88	1.15	XXX
92130		A	Water provocation tonography	0.81	1.25	0.38	0.02	2.08	1.21	XXX
92135		A	Opthalmic dx imaging	0.35	0.80	NA	0.02	1.17	NA	XXX
92135	26	A	Opthalmic dx imaging	0.35	0.16	0.16	0.01	0.52	0.52	XXX
92135	TC	A	Opthalmic dx imaging	0.00	0.64	NA	0.01	0.65	NA	XXX
92136		A	Ophthalmic biometry	0.54	1.77	NA	0.08	2.39	NA	XXX
92136	26	A	Ophthalmic biometry	0.54	0.25	0.25	0.01	0.80	0.80	XXX
92136	TC	A	Ophthalmic biometry	0.00	1.52	NA	0.07	1.59	NA	XXX
92140		A	Glaucoma provocative tests	0.50	0.94	0.22	0.01	1.45	0.73	XXX
92225		A	Special eye exam, initial	0.38	0.22	0.16	0.01	0.61	0.55	XXX
92226		A	Special eye exam, subsequent	0.33	0.21	0.15	0.01	0.55	0.49	XXX
92230		A	Eye exam with photos	0.60	1.69	0.20	0.02	2.31	0.82	XXX
92235		A	Eye exam with photos	0.81	2.95	NA	0.08	3.84	NA	XXX
92235	26	A	Eye exam with photos	0.81	0.37	0.37	0.02	1.20	1.20	XXX
92235	TC	A	Eye exam with photos	0.00	2.58	NA	0.06	2.64	NA	XXX
92240		A	Icg angiography	1.09	7.12	NA	0.08	8.29	NA	XXX
92240	26	A	Icg angiography	1.09	0.51	0.51	0.02	1.62	1.62	XXX
92240	TC	A	Icg angiography	0.00	6.61	NA	0.06	6.67	NA	XXX
92250		A	Eye exam with photos	0.44	1.75	NA	0.02	2.21	NA	XXX
92250	26	A	Eye exam with photos	0.44	0.20	0.20	0.01	0.65	0.65	XXX
92250	TC	A	Eye exam with photos	0.00	1.55	NA	0.01	1.56	NA	XXX
92260		A	Ophthalmoscopy/dynamometry	0.20	0.29	0.09	0.01	0.50	0.30	XXX
92265		A	Eye muscle evaluation	0.81	1.90	NA	0.04	2.75	NA	XXX
92265	26	A	Eye muscle evaluation	0.81	0.29	0.29	0.02	1.12	1.12	XXX
92265	TC	A	Eye muscle evaluation	0.00	1.61	NA	0.02	1.63	NA	XXX
92270		A	Electro-oculography	0.81	1.57	NA	0.06	2.44	NA	XXX
92270	26	A	Electro-oculography	0.81	0.34	0.34	0.04	1.19	1.19	XXX
92270	TC	A	Electro-oculography	0.00	1.23	NA	0.02	1.25	NA	XXX
92275		A	Electroretinography	1.00	1.97	NA	0.04	3.01	NA	XXX
92275	26	A	Electroretinography	1.00	0.44	0.44	0.02	1.46	1.46	XXX
92275	TC	A	Electroretinography	0.00	1.53	NA	0.02	1.55	NA	XXX
92283		A	Color vision examination	0.17	0.84	NA	0.02	1.03	NA	XXX
92283	26	A	Color vision examination	0.17	0.07	0.07	0.01	0.25	0.25	XXX
92283	TC	A	Color vision examination	0.00	0.77	NA	0.01	0.78	NA	XXX
92284		A	Dark adaptation eye exam	0.24	2.33	NA	0.02	2.59	NA	XXX
92284	26	A	Dark adaptation eye exam	0.24	0.09	0.09	0.01	0.34	0.34	XXX
92284	TC	A	Dark adaptation eye exam	0.00	2.24	NA	0.01	2.25	NA	XXX
92285		A	Eye photography	0.20	1.07	NA	0.02	1.29	NA	XXX
92285	26	A	Eye photography	0.20	0.09	0.09	0.01	0.30	0.30	XXX
92285	TC	A	Eye photography	0.00	0.98	NA	0.01	0.99	NA	XXX
92286		A	Internal eye photography	0.66	3.40	NA	0.03	4.09	NA	XXX
92286	26	A	Internal eye photography	0.66	0.30	0.30	0.01	0.97	0.97	XXX
92286	TC	A	Internal eye photography	0.00	3.10	NA	0.02	3.12	NA	XXX
92287		A	Internal eye photography	0.81	2.73	0.31	0.02	3.56	1.14	XXX
92310		N	Contact lens fitting	+1.16	1.12	0.46	0.04	2.32	1.66	XXX
92311		A	Contact lens fitting	1.07	1.20	0.35	0.04	2.31	1.46	XXX
92312		A	Contact lens fitting	1.25	1.17	0.50	0.04	2.46	1.79	XXX
92313		A	Contact lens fitting	0.91	1.17	0.29	0.02	2.10	1.22	XXX
92314		N	Prescription of contact lens	+0.69	0.94	0.27	0.01	1.64	0.97	XXX
92315		A	Prescription of contact lens	0.45	0.96	0.16	0.01	1.42	0.62	XXX
92316		A	Prescription of contact lens	0.68	1.00	0.30	0.01	1.69	0.99	XXX
92317		A	Prescription of contact lens	0.45	1.06	0.14	0.01	1.52	0.60	XXX
92325		A	Modification of contact lens	0.00	0.40	NA	0.01	0.41	NA	XXX
92326		A	Replacement of contact lens	0.00	1.62	NA	0.06	1.68	NA	XXX
92330		A	Fitting of artificial eye	1.07	1.08	0.33	0.05	2.20	1.45	XXX
92335		A	Fitting of artificial eye	0.45	1.01	0.17	0.01	1.47	0.63	XXX
92340		N	Fitting of spectacles	+0.37	0.70	0.14	0.01	1.08	0.52	XXX
92341		N	Fitting of spectacles	+0.47	0.74	0.18	0.01	1.22	0.66	XXX
92342		N	Fitting of spectacles	+0.53	0.76	0.21	0.01	1.30	0.75	XXX
92352		B	Special spectacles fitting	+0.37	0.73	0.14	0.01	1.11	0.52	XXX
92353		B	Special spectacles fitting	+0.50	0.78	0.19	0.02	1.30	0.71	XXX
92354		B	Special spectacles fitting	+0.00	8.78	NA	0.10	8.88	NA	XXX
92355		B	Special spectacles fitting	+0.00	4.30	NA	0.01	4.31	NA	XXX
92358		B	Eye prosthesis service	+0.00	0.96	NA	0.05	1.01	NA	XXX
92370		N	Repair & adjust spectacles	+0.32	0.56	0.13	0.02	0.90	0.47	XXX
92371		B	Repair & adjust spectacles	+0.00	0.62	NA	0.02	0.64	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
92390	.....	N	Supply of spectacles	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92391	.....	N	Supply of contact lenses	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92392	.....	I	Supply of low vision aids	+0.00	3.81	3.81	0.02	3.83	3.83	XXX
92393	.....	I	Supply of artificial eye	+0.00	11.83	11.83	0.56	12.39	12.39	XXX
92395	.....	I	Supply of spectacles	+0.00	1.29	1.29	0.10	1.39	1.39	XXX
92396	.....	I	Supply of contact lenses	+0.00	2.17	2.17	0.07	2.24	2.24	XXX
92499	.....	C	Eye service or procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92499	26	C	Eye service or procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92499	TC	C	Eye service or procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92502	.....	A	Ear and throat examination	1.50	NA	1.15	0.07	NA	2.72	000
92504	.....	A	Ear microscopy examination	0.18	0.51	0.09	0.01	0.70	0.28	XXX
92506	.....	A	Speech/hearing evaluation	0.86	2.65	0.41	0.05	3.56	1.32	XXX
92507	.....	A	Speech/hearing therapy	0.52	1.15	0.24	0.02	1.69	0.78	XXX
92508	.....	A	Speech/hearing therapy	0.26	0.53	0.12	0.01	0.80	0.39	XXX
92510	.....	I	Rehab for ear implant	+1.49	2.09	0.82	0.07	3.65	2.38	XXX
92511	.....	A	Nasopharyngoscopy	0.84	3.18	0.80	0.04	4.06	1.68	000
92512	.....	A	Nasal function studies	0.55	1.09	0.18	0.02	1.66	0.75	XXX
92516	.....	A	Facial nerve function test	0.43	0.90	0.22	0.02	1.35	0.67	XXX
92520	.....	A	Laryngeal function studies	0.76	0.51	0.39	0.04	1.31	1.19	XXX
92526	.....	A	Oral function therapy	0.55	1.68	0.20	0.02	2.25	0.77	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
92541	.....	A	Spontaneous nystagmus test	0.40	0.97	NA	0.04	1.41	NA	XXX
92541	26	A	Spontaneous nystagmus test	0.40	0.19	0.19	0.02	0.61	0.61	XXX
92541	TC	A	Spontaneous nystagmus test	0.00	0.78	NA	0.02	0.80	NA	XXX
92542	.....	A	Positional nystagmus test	0.33	1.07	NA	0.03	1.43	NA	XXX
92542	26	A	Positional nystagmus test	0.33	0.16	0.16	0.01	0.50	0.50	XXX
92542	TC	A	Positional nystagmus test	0.00	0.91	NA	0.02	0.93	NA	XXX
92543	.....	A	Caloric vestibular test	0.10	0.55	NA	0.02	0.67	NA	XXX
92543	26	A	Caloric vestibular test	0.10	0.05	0.05	0.01	0.16	0.16	XXX
92543	TC	A	Caloric vestibular test	0.00	0.50	NA	0.01	0.51	NA	XXX
92544	.....	A	Optokinetic nystagmus test	0.26	0.85	NA	0.03	1.14	NA	XXX
92544	26	A	Optokinetic nystagmus test	0.26	0.13	0.13	0.01	0.40	0.40	XXX
92544	TC	A	Optokinetic nystagmus test	0.00	0.72	NA	0.02	0.74	NA	XXX
92545	.....	A	Oscillating tracking test	0.23	0.80	NA	0.03	1.06	NA	XXX
92545	26	A	Oscillating tracking test	0.23	0.11	0.11	0.01	0.35	0.35	XXX
92545	TC	A	Oscillating tracking test	0.00	0.69	NA	0.02	0.71	NA	XXX
92546	.....	A	Sinusoidal rotational test	0.29	1.82	NA	0.03	2.14	NA	XXX
92546	26	A	Sinusoidal rotational test	0.29	0.13	0.13	0.01	0.43	0.43	XXX
92546	TC	A	Sinusoidal rotational test	0.00	1.69	NA	0.02	1.71	NA	XXX
92547	.....	A	Supplemental electrical test	0.00	1.17	NA	0.06	1.23	NA	ZZZ
92548	.....	A	Posturography	0.50	3.23	NA	0.15	3.88	NA	XXX
92548	26	A	Posturography	0.50	0.26	0.26	0.02	0.78	0.78	XXX
92548	TC	A	Posturography	0.00	2.97	NA	0.13	3.10	NA	XXX
92551	.....	N	Pure tone hearing test, air	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92552	.....	A	Pure tone audiometry, air	0.00	0.44	NA	0.04	0.48	NA	XXX
92553	.....	A	Audiometry, air & bone	0.00	0.65	NA	0.06	0.71	NA	XXX
92555	.....	A	Speech threshold audiometry	0.00	0.38	NA	0.04	0.42	NA	XXX
92556	.....	A	Speech audiometry, complete	0.00	0.57	NA	0.06	0.63	NA	XXX
92557	.....	A	Comprehensive hearing test	0.00	1.18	NA	0.12	1.30	NA	XXX
92559	.....	N	Group audiometric testing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92560	.....	N	Bekesy audiometry, screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92561	.....	A	Bekesy audiometry, diagnosis	0.00	0.70	NA	0.06	0.76	NA	XXX
92562	.....	A	Loudness balance test	0.00	0.41	NA	0.04	0.45	NA	XXX
92563	.....	A	Tone decay hearing test	0.00	0.38	NA	0.04	0.42	NA	XXX
92564	.....	A	Sisi hearing test	0.00	0.47	NA	0.05	0.52	NA	XXX
92565	.....	A	Stenger test, pure tone	0.00	0.40	NA	0.04	0.44	NA	XXX
92567	.....	A	Tympanometry	0.00	0.52	NA	0.06	0.58	NA	XXX
92568	.....	A	Acoustic reflex testing	0.00	0.38	NA	0.04	0.42	NA	XXX
92569	.....	A	Acoustic reflex decay test	0.00	0.41	NA	0.04	0.45	NA	XXX
92571	.....	A	Filtered speech hearing test	0.00	0.39	NA	0.04	0.43	NA	XXX
92572	.....	A	Staggered spondaic word test	0.00	0.09	NA	0.01	0.10	NA	XXX
92573	.....	A	Lombard test	0.00	0.35	NA	0.04	0.39	NA	XXX
92575	.....	A	Sensorineural acuity test	0.00	0.30	NA	0.02	0.32	NA	XXX
92576	.....	A	Synthetic sentence test	0.00	0.44	NA	0.05	0.49	NA	XXX
92577	.....	A	Stenger test, speech	0.00	0.70	NA	0.07	0.77	NA	XXX
92579	.....	A	Visual audiometry (vra)	0.00	0.71	NA	0.06	0.77	NA	XXX
92582	.....	A	Conditioning play audiometry	0.00	0.71	NA	0.06	0.77	NA	XXX
92583	.....	A	Select picture audiometry	0.00	0.88	NA	0.08	0.96	NA	XXX
92584	.....	A	Electrocochleography	0.00	2.45	NA	0.20	2.65	NA	XXX
92585	.....	A	Auditor evoke potent, compre	0.50	2.06	NA	0.16	2.72	NA	XXX
92585	26	A	Auditor evoke potent, compre	0.50	0.22	0.22	0.02	0.74	0.74	XXX
92585	TC	A	Auditor evoke potent, compre	0.00	1.84	NA	0.14	1.98	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
92586		A	Auditor evoke potent, limit	0.00	1.84	NA	0.14	1.98	NA	XXX
92587		A	Evoked auditory test	0.13	1.36	NA	0.12	1.61	NA	XXX
92587	26	A	Evoked auditory test	0.13	0.07	0.07	0.01	0.21	0.21	XXX
92587	TC	A	Evoked auditory test	0.00	1.29	NA	0.11	1.40	NA	XXX
92588		A	Evoked auditory test	0.36	1.63	NA	0.14	2.13	NA	XXX
92588	26	A	Evoked auditory test	0.36	0.17	0.17	0.01	0.54	0.54	XXX
92588	TC	A	Evoked auditory test	0.00	1.46	NA	0.13	1.59	NA	XXX
92589		A	Auditory function test(s)	0.00	0.53	NA	0.06	0.59	NA	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	0.59	NA	0.06	0.65	NA	XXX
92597		A	Oral speech device eval	0.86	1.71	0.46	0.05	2.62	1.37	XXX
92601		A	Cochlear implt f/up exam < 7	0.00	3.46	NA	0.07	3.53	NA	XXX
92602		A	Reprogram cochlear implt < 7	0.00	2.39	NA	0.07	2.46	NA	XXX
92603		A	Cochlear implt f/up exam 7 >	0.00	2.26	NA	0.07	2.33	NA	XXX
92604		A	Reprogram cochlear implt 7 >	0.00	1.49	NA	0.07	1.56	NA	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	3.25	NA	0.05	3.30	NA	XXX
92608		A	Ex for speech device rx addl	0.00	0.67	NA	0.05	0.72	NA	XXX
92609		A	Use of speech device service	0.00	1.62	NA	0.04	1.66	NA	XXX
92610		A	Evaluate swallowing function	0.00	3.40	NA	0.08	3.48	NA	XXX
92611		A	Motion fluoroscopy/swallow	0.00	3.40	NA	0.08	3.48	NA	XXX
92612		A	Endoscopy swallow tst (fees)	1.26	2.74	0.67	0.08	4.08	2.01	XXX
92613		B	Endoscopy swallow tst (fees)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92614		A	Laryngoscopic sensory test	1.26	2.43	0.63	0.08	3.77	1.97	XXX
92615		B	Eval laryngoscopy sense tst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92616		A	Fees w/laryngeal sense test	1.87	3.31	0.97	0.08	5.26	2.92	XXX
92617		B	Interprt fees/laryngeal test	0.00	0.00	0.00	0.00	0.00	0.00	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	3.78	NA	0.99	0.25	NA	5.02	000
92953		A	Temporary extemal pacing	0.23	NA	0.23	0.01	NA	0.47	000
92960		A	Cardioversion electric, ext	2.24	6.76	1.19	0.10	9.10	3.53	000
92961		A	Cardioversion, electric, int	4.57	NA	2.10	0.20	NA	6.87	000
92970		A	Cardioassist, internal	3.50	NA	1.07	0.20	NA	4.77	000
92971		A	Cardioassist, external	1.76	NA	0.86	0.07	NA	2.69	000
92973		A	Percut coronary thrombectomy	3.26	NA	1.31	0.14	NA	4.71	ZZZ
92974		A	Cath place, cardio brachytx	2.98	NA	1.20	0.17	NA	4.35	ZZZ
92975		A	Dissolve clot, heart vessel	7.21	NA	2.85	0.26	NA	10.32	000
92977		A	Dissolve clot, heart vessel	0.00	7.99	NA	0.46	8.45	NA	XXX
92978		A	Intravasc us, heart add-on	1.79	5.23	NA	0.31	7.33	NA	ZZZ
92978	26	A	Intravasc us, heart add-on	1.79	0.71	0.71	0.07	2.57	2.57	ZZZ
92978	TC	A	Intravasc us, heart add-on	0.00	4.52	NA	0.24	4.76	NA	ZZZ
92979		A	Intravasc us, heart add-on	1.43	2.84	NA	0.18	4.45	NA	ZZZ
92979	26	A	Intravasc us, heart add-on	1.43	0.57	0.57	0.05	2.05	2.05	ZZZ
92979	TC	A	Intravasc us, heart add-on	0.00	2.27	NA	0.13	2.40	NA	ZZZ
92980		A	Insert intracoronary stent	14.76	NA	6.13	0.85	NA	21.74	000
92981		A	Insert intracoronary stent	4.15	NA	1.66	0.24	NA	6.05	ZZZ
92982		A	Coronary artery dilation	10.92	NA	4.59	0.62	NA	16.13	000
92984		A	Coronary artery dilation	2.95	NA	1.18	0.17	NA	4.30	ZZZ
92986		A	Revision of aortic valve	21.68	NA	11.78	1.37	NA	34.83	090
92987		A	Revision of mitral valve	22.57	NA	12.17	1.41	NA	36.15	090
92990		A	Revision of pulmonary valve	17.24	NA	9.76	1.08	NA	28.08	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	12.02	NA	5.04	0.70	NA	17.76	000
92996		A	Coronary atherectomy add-on	3.24	NA	1.29	0.19	NA	4.72	ZZZ
92997		A	Pul art balloon repr, percut	11.93	NA	4.89	0.76	NA	17.58	000
92998		A	Pul art balloon repr, percut	5.97	NA	2.23	0.37	NA	8.57	ZZZ
93000		A	Electrocardiogram, complete	0.17	0.51	NA	0.03	0.71	NA	XXX
93005		A	Electrocardiogram, tracing	0.00	0.45	NA	0.02	0.47	NA	XXX
93010		A	Electrocardiogram report	0.17	0.06	0.06	0.01	0.24	0.24	XXX
93012		A	Transmission of ecg	0.00	5.96	NA	0.18	6.14	NA	XXX
93014		A	Report on transmitted ecg	0.52	0.19	0.19	0.02	0.73	0.73	XXX
93015		A	Cardiovascular stress test	0.75	1.96	NA	0.13	2.84	NA	XXX
93016		A	Cardiovascular stress test	0.45	0.17	0.17	0.01	0.63	0.63	XXX
93017		A	Cardiovascular stress test	0.00	1.67	NA	0.11	1.78	NA	XXX
93018		A	Cardiovascular stress test	0.30	0.12	0.12	0.01	0.43	0.43	XXX
93024		A	Cardiac drug stress test	1.16	1.57	NA	0.13	2.86	NA	XXX
93024	26	A	Cardiac drug stress test	1.16	0.46	0.46	0.05	1.67	1.67	XXX
93024	TC	A	Cardiac drug stress test	0.00	1.11	NA	0.08	1.19	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
93025		A	Microvolt t-wave assess	0.75	8.30	NA	0.13	9.18	NA	XXX
93025	26	A	Microvolt t-wave assess	0.75	0.30	0.30	0.02	1.07	1.07	XXX
93025	TC	A	Microvolt t-wave assess	0.00	8.00	NA	0.11	8.11	NA	XXX
93040		A	Rhythm ECG with report	0.16	0.19	NA	0.02	0.37	NA	XXX
93041		A	Rhythm ECG, tracing	0.00	0.14	NA	0.01	0.15	NA	XXX
93042		A	Rhythm ECG, report	0.16	0.05	0.05	0.01	0.22	0.22	XXX
93224		A	ECG monitor/report, 24 hrs	0.52	3.59	NA	0.24	4.35	NA	XXX
93225		A	ECG monitor/record, 24 hrs	0.00	1.23	NA	0.08	1.31	NA	XXX
93226		A	ECG monitor/report, 24 hrs	0.00	2.16	NA	0.14	2.30	NA	XXX
93227		A	ECG monitor/review, 24 hrs	0.52	0.20	0.20	0.02	0.74	0.74	XXX
93230		A	ECG monitor/report, 24 hrs	0.52	3.86	NA	0.26	4.64	NA	XXX
93231		A	Ecg monitor/record, 24 hrs	0.00	1.51	NA	0.11	1.62	NA	XXX
93232		A	ECG monitor/report, 24 hrs	0.00	2.15	NA	0.13	2.28	NA	XXX
93233		A	ECG monitor/review, 24 hrs	0.52	0.20	0.20	0.02	0.74	0.74	XXX
93235		A	ECG monitor/report, 24 hrs	0.45	2.77	NA	0.15	3.37	NA	XXX
93236		A	ECG monitor/report, 24 hrs	0.00	2.60	NA	0.14	2.74	NA	XXX
93237		A	ECG monitor/review, 24 hrs	0.45	0.17	0.17	0.01	0.63	0.63	XXX
93268		A	ECG record/review	0.52	7.38	NA	0.28	8.18	NA	XXX
93270		A	ECG recording	0.00	1.23	NA	0.08	1.31	NA	XXX
93271		A	Ecg/monitoring and analysis	0.00	5.96	NA	0.18	6.14	NA	XXX
93272		A	Ecg/review, interpret only	0.52	0.19	0.19	0.02	0.73	0.73	XXX
93278		A	ECG/signal-averaged	0.25	1.24	NA	0.12	1.61	NA	XXX
93278	26	A	ECG/signal-averaged	0.25	0.10	0.10	0.01	0.36	0.36	XXX
93278	TC	A	ECG/signal-averaged	0.00	1.14	NA	0.11	1.25	NA	XXX
93303		A	Echo transthoracic	1.29	4.31	NA	0.28	5.88	NA	XXX
93303	26	A	Echo transthoracic	1.29	0.49	0.49	0.05	1.83	1.83	XXX
93303	TC	A	Echo transthoracic	0.00	3.82	NA	0.23	4.05	NA	XXX
93304		A	Echo transthoracic	0.75	2.22	NA	0.15	3.12	NA	XXX
93304	26	A	Echo transthoracic	0.75	0.29	0.29	0.02	1.06	1.06	XXX
93304	TC	A	Echo transthoracic	0.00	1.93	NA	0.13	2.06	NA	XXX
93307		A	Echo exam of heart	0.91	4.18	NA	0.27	5.36	NA	XXX
93307	26	A	Echo exam of heart	0.91	0.36	0.36	0.04	1.31	1.31	XXX
93307	TC	A	Echo exam of heart	0.00	3.82	NA	0.23	4.05	NA	XXX
93308		A	Echo exam of heart	0.53	2.14	NA	0.15	2.82	NA	XXX
93308	26	A	Echo exam of heart	0.53	0.21	0.21	0.02	0.76	0.76	XXX
93308	TC	A	Echo exam of heart	0.00	1.93	NA	0.13	2.06	NA	XXX
93312		A	Echo transesophageal	2.19	4.54	NA	0.39	7.12	NA	XXX
93312	26	A	Echo transesophageal	2.19	0.79	0.79	0.10	3.08	3.08	XXX
93312	TC	A	Echo transesophageal	0.00	3.75	NA	0.29	4.04	NA	XXX
93313		A	Echo transesophageal	0.94	NA	0.21	0.06	NA	1.21	XXX
93314		A	Echo transesophageal	1.24	4.23	NA	0.34	5.81	NA	XXX
93314	26	A	Echo transesophageal	1.24	0.48	0.48	0.05	1.77	1.77	XXX
93314	TC	A	Echo transesophageal	0.00	3.75	NA	0.29	4.04	NA	XXX
93315		C	Echo transesophageal	0.00	0.00	NA	0.00	0.00	NA	XXX
93315	26	A	Echo transesophageal	2.76	1.02	1.02	0.12	3.90	3.90	XXX
93315	TC	C	Echo transesophageal	0.00	0.00	NA	0.00	0.00	NA	XXX
93316		A	Echo transesophageal	0.94	NA	0.24	0.06	NA	1.24	XXX
93317		C	Echo transesophageal	0.00	0.00	NA	0.00	0.00	NA	XXX
93317	26	A	Echo transesophageal	1.82	0.67	0.67	0.07	2.56	2.56	XXX
93317	TC	C	Echo transesophageal	0.00	0.00	NA	0.00	0.00	NA	XXX
93318		C	Echo transesophageal intraop	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93318	26	A	Echo transesophageal intraop	2.19	0.49	0.49	0.07	2.75	2.75	XXX
93318	TC	C	Echo transesophageal intraop	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93320		A	Doppler echo exam, heart	0.38	1.85	NA	0.13	2.36	NA	ZZZ
93320	26	A	Doppler echo exam, heart	0.38	0.15	0.15	0.01	0.54	0.54	ZZZ
93320	TC	A	Doppler echo exam, heart	0.00	1.70	NA	0.12	1.82	NA	ZZZ
93321		A	Doppler echo exam, heart	0.15	1.16	NA	0.09	1.40	NA	ZZZ
93321	26	A	Doppler echo exam, heart	0.15	0.06	0.06	0.01	0.22	0.22	ZZZ
93321	TC	A	Doppler echo exam, heart	0.00	1.10	NA	0.08	1.18	NA	ZZZ
93325		A	Doppler color flow add-on	0.07	2.91	NA	0.21	3.19	NA	ZZZ
93325	26	A	Doppler color flow add-on	0.07	0.03	0.03	0.01	0.11	0.11	ZZZ
93325	TC	A	Doppler color flow add-on	0.00	2.88	NA	0.20	3.08	NA	ZZZ
93350		A	Echo transthoracic	1.47	2.33	NA	0.15	3.95	NA	XXX
93350	26	A	Echo transthoracic	1.47	0.58	0.58	0.02	2.07	2.07	XXX
93350	TC	A	Echo transthoracic	0.00	1.75	NA	0.13	1.88	NA	XXX
93501		A	Right heart catheterization	3.00	17.93	NA	1.23	22.16	NA	000
93501	26	A	Right heart catheterization	3.00	1.17	1.17	0.19	4.36	4.36	000
93501	TC	A	Right heart catheterization	0.00	16.76	NA	1.04	17.80	NA	000
93503		A	Insert/place heart catheter	2.89	NA	0.68	0.19	NA	3.76	000
93505		A	Biopsy of heart lining	4.36	3.67	NA	0.44	8.47	NA	000
93505	26	A	Biopsy of heart lining	4.36	1.71	1.71	0.28	6.35	6.35	000
93505	TC	A	Biopsy of heart lining	0.00	1.96	NA	0.16	2.12	NA	000
93508		A	Cath placement, angiography	4.08	14.60	NA	0.90	19.58	NA	000
93508	26	A	Cath placement, angiography	4.08	2.11	2.11	0.25	6.44	6.44	000
93508	TC	A	Cath placement, angiography	0.00	12.49	NA	0.65	13.14	NA	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
93510	.....	A	Left heart catheterization	4.31	38.84	NA	2.55	45.70	NA	000
93510	26	A	Left heart catheterization	4.31	2.20	2.20	0.26	6.77	6.77	000
93510	TC	A	Left heart catheterization	0.00	36.64	NA	2.29	38.93	NA	000
93511	.....	A	Left heart catheterization	5.00	38.15	NA	2.53	45.68	NA	000
93511	26	A	Left heart catheterization	5.00	2.48	2.48	0.31	7.79	7.79	000
93511	TC	A	Left heart catheterization	0.00	35.67	NA	2.22	37.89	NA	000
93514	.....	A	Left heart catheterization	7.01	38.85	NA	2.66	48.52	NA	000
93514	26	A	Left heart catheterization	7.01	3.18	3.18	0.44	10.63	10.63	000
93514	TC	A	Left heart catheterization	0.00	35.67	NA	2.22	37.89	NA	000
93524	.....	A	Left heart catheterization	6.91	49.83	NA	3.34	60.08	NA	000
93524	26	A	Left heart catheterization	6.91	3.22	3.22	0.43	10.56	10.56	000
93524	TC	A	Left heart catheterization	0.00	46.61	NA	2.91	49.52	NA	000
93526	.....	A	Rt & Lt heart catheters	5.96	50.74	NA	3.37	60.07	NA	000
93526	26	A	Rt & Lt heart catheters	5.96	2.86	2.86	0.37	9.19	9.19	000
93526	TC	A	Rt & Lt heart catheters	0.00	47.88	NA	3.00	50.88	NA	000
93527	.....	A	Rt & Lt heart catheters	7.24	49.97	NA	3.37	60.58	NA	000
93527	26	A	Rt & Lt heart catheters	7.24	3.36	3.36	0.46	11.06	11.06	000
93527	TC	A	Rt & Lt heart catheters	0.00	46.61	NA	2.91	49.52	NA	000
93528	.....	A	Rt & Lt heart catheters	8.95	50.70	NA	3.47	63.12	NA	000
93528	26	A	Rt & Lt heart catheters	8.95	4.09	4.09	0.56	13.60	13.60	000
93528	TC	A	Rt & Lt heart catheters	0.00	46.61	NA	2.91	49.52	NA	000
93529	.....	A	Rt, lt heart catheterization	4.77	48.92	NA	3.21	56.90	NA	000
93529	26	A	Rt, lt heart catheterization	4.77	2.31	2.31	0.30	7.38	7.38	000
93529	TC	A	Rt, lt heart catheterization	0.00	46.61	NA	2.91	49.52	NA	000
93530	.....	A	Rt heart cath, congenital	4.21	18.73	NA	1.33	24.27	NA	000
93530	26	A	Rt heart cath, congenital	4.21	1.97	1.97	0.29	6.47	6.47	000
93530	TC	A	Rt heart cath, congenital	0.00	16.76	NA	1.04	17.80	NA	000
93531	.....	A	R & l heart cath, congenital	8.30	51.52	NA	3.55	63.37	NA	000
93531	26	A	R & l heart cath, congenital	8.30	3.64	3.64	0.55	12.49	12.49	000
93531	TC	A	R & l heart cath, congenital	0.00	47.88	NA	3.00	50.88	NA	000
93532	.....	A	R & l heart cath, congenital	9.94	50.93	NA	3.53	64.40	NA	000
93532	26	A	R & l heart cath, congenital	9.94	4.32	4.32	0.62	14.88	14.88	000
93532	TC	A	R & l heart cath, congenital	0.00	46.61	NA	2.91	49.52	NA	000
93533	.....	A	R & l heart cath, congenital	6.66	49.46	NA	3.43	59.55	NA	000
93533	26	A	R & l heart cath, congenital	6.66	2.85	2.85	0.52	10.03	10.03	000
93533	TC	A	R & l heart cath, congenital	0.00	46.61	NA	2.91	49.52	NA	000
93539	.....	A	Injection, cardiac cath	0.40	NA	0.16	0.01	NA	0.57	000
93540	.....	A	Injection, cardiac cath	0.43	NA	0.17	0.01	NA	0.61	000
93541	.....	A	Injection for lung angiogram	0.29	NA	0.11	0.01	NA	0.41	000
93542	.....	A	Injection for heart x-rays	0.29	NA	0.11	0.01	NA	0.41	000
93543	.....	A	Injection for heart x-rays	0.29	NA	0.12	0.01	NA	0.42	000
93544	.....	A	Injection for aortography	0.25	NA	0.10	0.01	NA	0.36	000
93545	.....	A	Inject for coronary x-rays	0.40	NA	0.16	0.01	NA	0.57	000
93555	.....	A	Imaging, cardiac cath	0.81	6.54	NA	0.38	7.73	NA	XXX
93555	26	A	Imaging, cardiac cath	0.81	0.32	0.32	0.04	1.17	1.17	XXX
93555	TC	A	Imaging, cardiac cath	0.00	6.22	NA	0.34	6.56	NA	XXX
93556	.....	A	Imaging, cardiac cath	0.83	10.13	NA	0.54	11.50	NA	XXX
93556	26	A	Imaging, cardiac cath	0.83	0.33	0.33	0.04	1.20	1.20	XXX
93556	TC	A	Imaging, cardiac cath	0.00	9.80	NA	0.50	10.30	NA	XXX
93561	.....	A	Cardiac output measurement	0.50	0.68	NA	0.08	1.26	NA	000
93561	26	A	Cardiac output measurement	0.50	0.16	0.16	0.02	0.68	0.68	000
93561	TC	A	Cardiac output measurement	0.00	0.52	NA	0.06	0.58	NA	000
93562	.....	A	Cardiac output measurement	0.16	0.37	NA	0.05	0.58	NA	000
93562	26	A	Cardiac output measurement	0.16	0.05	0.05	0.01	0.22	0.22	000
93562	TC	A	Cardiac output measurement	0.00	0.32	NA	0.04	0.36	NA	000
93571	.....	A	Heart flow reserve measure	1.79	5.20	NA	0.37	7.36	NA	ZZZ
93571	26	A	Heart flow reserve measure	1.79	0.68	0.68	0.13	2.60	2.60	ZZZ
93571	TC	A	Heart flow reserve measure	0.00	4.52	NA	0.24	4.76	NA	ZZZ
93572	.....	A	Heart flow reserve measure	1.43	2.77	NA	0.33	4.53	NA	ZZZ
93572	26	A	Heart flow reserve measure	1.43	0.50	0.50	0.20	2.13	2.13	ZZZ
93572	TC	A	Heart flow reserve measure	0.00	2.27	NA	0.13	2.40	NA	ZZZ
93580	.....	A	Transcath closure of asd	17.90	NA	7.27	1.37	NA	26.54	000
93581	.....	A	Transcath closure of vsd	24.29	NA	9.74	1.37	NA	35.40	000
93600	.....	A	Bundle of His recording	2.11	2.77	NA	0.26	5.14	NA	000
93600	26	A	Bundle of His recording	2.11	0.84	0.84	0.13	3.08	3.08	000
93600	TC	A	Bundle of His recording	0.00	1.93	NA	0.13	2.06	NA	000
93602	.....	A	Intra-atrial recording	2.11	1.93	NA	0.21	4.25	NA	000
93602	26	A	Intra-atrial recording	2.11	0.83	0.83	0.14	3.08	3.08	000
93602	TC	A	Intra-atrial recording	0.00	1.10	NA	0.07	1.17	NA	000
93603	.....	A	Right ventricular recording	2.11	2.49	NA	0.24	4.84	NA	000
93603	26	A	Right ventricular recording	2.11	0.82	0.82	0.13	3.06	3.06	000
93603	TC	A	Right ventricular recording	0.00	1.67	NA	0.11	1.78	NA	000
93609	.....	A	Map tachycardia, add-on	4.97	4.66	NA	0.79	10.42	NA	ZZZ
93609	26	A	Map tachycardia, add-on	4.97	1.97	1.97	0.62	7.56	7.56	ZZZ
93609	TC	A	Map tachycardia, add-on	0.00	2.69	NA	0.17	2.86	NA	ZZZ

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
93610		A	Intra-atrial pacing	3.00	2.51	NA	0.30	5.81	NA	000
93610	26	A	Intra-atrial pacing	3.00	1.17	1.17	0.20	4.37	4.37	000
93610	TC	A	Intra-atrial pacing	0.00	1.34	NA	0.10	1.44	NA	000
93612		A	Intraventricular pacing	3.00	2.77	NA	0.31	6.08	NA	000
93612	26	A	Intraventricular pacing	3.00	1.17	1.17	0.20	4.37	4.37	000
93612	TC	A	Intraventricular pacing	0.00	1.60	NA	0.11	1.71	NA	000
93613		A	Electrophys map 3d, add-on	6.96	NA	2.80	0.62	NA	10.38	ZZZ
93615		A	Esophageal recording	0.98	0.59	NA	0.06	1.63	NA	000
93615	26	A	Esophageal recording	0.98	0.27	0.27	0.04	1.29	1.29	000
93615	TC	A	Esophageal recording	0.00	0.32	NA	0.02	0.34	NA	000
93616		A	Esophageal recording	1.48	0.76	NA	0.09	2.33	NA	000
93616	26	A	Esophageal recording	1.48	0.44	0.44	0.07	1.99	1.99	000
93616	TC	A	Esophageal recording	0.00	0.32	NA	0.02	0.34	NA	000
93618		A	Heart rhythm pacing	4.24	5.62	NA	0.50	10.36	NA	000
93618	26	A	Heart rhythm pacing	4.24	1.69	1.69	0.26	6.19	6.19	000
93618	TC	A	Heart rhythm pacing	0.00	3.93	NA	0.24	4.17	NA	000
93619		A	Electrophysiology evaluation	7.28	10.86	NA	0.93	19.07	NA	000
93619	26	A	Electrophysiology evaluation	7.28	3.22	3.22	0.46	10.96	10.96	000
93619	TC	A	Electrophysiology evaluation	0.00	7.64	NA	0.47	8.11	NA	000
93620		C	Electrophysiology evaluation	0.00	0.00	NA	0.00	0.00	NA	000
93620	26	A	Electrophysiology evaluation	11.52	4.91	4.91	0.72	17.15	17.15	000
93620	TC	C	Electrophysiology evaluation	0.00	0.00	NA	0.00	0.00	NA	000
93621		C	Electrophysiology evaluation	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93621	26	A	Electrophysiology evaluation	2.09	0.83	0.83	0.18	3.10	3.10	ZZZ
93621	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93622		C	Electrophysiology evaluation	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93622	26	A	Electrophysiology evaluation	3.08	1.22	1.22	0.80	5.10	5.10	ZZZ
93622	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93623		C	Stimulation, pacing heart	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93623	26	A	Stimulation, pacing heart	2.83	1.12	1.12	0.18	4.13	4.13	ZZZ
93623	TC	C	Stimulation, pacing heart	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93624		A	Electrophysiologic study	4.78	4.19	NA	0.43	9.40	NA	000
93624	26	A	Electrophysiologic study	4.78	2.23	2.23	0.30	7.31	7.31	000
93624	TC	A	Electrophysiologic study	0.00	1.96	NA	0.13	2.09	NA	000
93631		A	Heart pacing, mapping	7.56	8.87	NA	1.40	17.83	NA	000
93631	26	A	Heart pacing, mapping	7.56	2.78	2.78	0.79	11.13	11.13	000
93631	TC	A	Heart pacing, mapping	0.00	6.09	NA	0.61	6.70	NA	000
93640		A	Evaluation heart device	3.50	8.49	NA	0.64	12.63	NA	000
93640	26	A	Evaluation heart device	3.50	1.38	1.38	0.22	5.10	5.10	000
93640	TC	A	Evaluation heart device	0.00	7.11	NA	0.42	7.53	NA	000
93641		A	Electrophysiology evaluation	5.90	9.45	NA	0.79	16.14	NA	000
93641	26	A	Electrophysiology evaluation	5.90	2.34	2.34	0.37	8.61	8.61	000
93641	TC	A	Electrophysiology evaluation	0.00	7.11	NA	0.42	7.53	NA	000
93642		A	Electrophysiology evaluation	4.86	9.36	NA	0.61	14.83	NA	000
93642	26	A	Electrophysiology evaluation	4.86	2.25	2.25	0.19	7.30	7.30	000
93642	TC	A	Electrophysiology evaluation	0.00	7.11	NA	0.42	7.53	NA	000
93650		A	Ablate heart dysrhythm focus	10.45	NA	4.50	0.66	NA	15.61	000
93651		A	Ablate heart dysrhythm focus	16.16	NA	6.41	1.02	NA	23.59	000
93652		A	Ablate heart dysrhythm focus	17.58	NA	6.98	1.10	NA	25.66	000
93660		A	Tilt table evaluation	1.88	2.42	NA	0.09	4.39	NA	000
93660	26	A	Tilt table evaluation	1.88	0.75	0.75	0.07	2.70	2.70	000
93660	TC	A	Tilt table evaluation	0.00	1.67	NA	0.02	1.69	NA	000
93662		C	Intracardiac ecg (ice)	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93662	26	A	Intracardiac ecg (ice)	2.78	1.12	1.12	0.49	4.39	4.39	ZZZ
93662	TC	C	Intracardiac ecg (ice)	0.00	0.00	NA	0.00	0.00	NA	ZZZ
93668		N	Peripheral vascular rehab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93701		A	Bioimpedance, thoracic	0.17	1.03	NA	0.02	1.22	NA	XXX
93701	26	A	Bioimpedance, thoracic	0.17	0.07	0.07	0.01	0.25	0.25	XXX
93701	TC	A	Bioimpedance, thoracic	0.00	0.96	NA	0.01	0.97	NA	XXX
93720		A	Total body plethysmography	0.17	0.75	NA	0.07	0.99	NA	XXX
93721		A	Plethysmography tracing	0.00	0.70	NA	0.06	0.76	NA	XXX
93722		A	Plethysmography report	0.17	0.05	0.05	0.01	0.23	0.23	XXX
93724		A	Analyze pacemaker system	4.86	5.86	NA	0.46	11.18	NA	000
93724	26	A	Analyze pacemaker system	4.86	1.93	1.93	0.22	7.01	7.01	000
93724	TC	A	Analyze pacemaker system	0.00	3.93	NA	0.24	4.17	NA	000
93727		A	Analyze ilr system	0.52	0.20	0.20	0.06	0.78	0.78	XXX
93731		A	Analyze pacemaker system	0.45	0.67	NA	0.06	1.18	NA	XXX
93731	26	A	Analyze pacemaker system	0.45	0.18	0.18	0.02	0.65	0.65	XXX
93731	TC	A	Analyze pacemaker system	0.00	0.49	NA	0.04	0.53	NA	XXX
93732		A	Analyze pacemaker system	0.91	0.87	NA	0.08	1.86	NA	XXX
93732	26	A	Analyze pacemaker system	0.91	0.36	0.36	0.04	1.31	1.31	XXX
93732	TC	A	Analyze pacemaker system	0.00	0.51	NA	0.04	0.55	NA	XXX
93733		A	Telephone analy, pacemaker	0.17	0.78	NA	0.07	1.02	NA	XXX
93733	26	A	Telephone analy, pacemaker	0.17	0.07	0.07	0.01	0.25	0.25	XXX
93733	TC	A	Telephone analy, pacemaker	0.00	0.71	NA	0.06	0.77	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
93734	.....	A	Analyze pacemaker system	0.38	0.50	NA	0.03	0.91	NA	XXX
93734	26	A	Analyze pacemaker system	0.38	0.15	0.15	0.01	0.54	0.54	XXX
93734	TC	A	Analyze pacemaker system	0.00	0.35	NA	0.02	0.37	NA	XXX
93735	.....	A	Analyze pacemaker system	0.74	0.73	NA	0.08	1.55	NA	XXX
93735	26	A	Analyze pacemaker system	0.74	0.29	0.29	0.04	1.07	1.07	XXX
93735	TC	A	Analyze pacemaker system	0.00	0.44	NA	0.04	0.48	NA	XXX
93736	.....	A	Telephonic analy, pacemaker	0.15	0.69	NA	0.07	0.91	NA	XXX
93736	26	A	Telephonic analy, pacemaker	0.15	0.06	0.06	0.01	0.22	0.22	XXX
93736	TC	A	Telephonic analy, pacemaker	0.00	0.63	NA	0.06	0.69	NA	XXX
93740	.....	B	Temperature gradient studies	+0.16	0.19	NA	0.02	0.37	NA	XXX
93740	26	B	Temperature gradient studies	+0.16	0.04	0.04	0.01	0.21	0.21	XXX
93740	TC	B	Temperature gradient studies	+0.00	0.15	NA	0.01	0.16	NA	XXX
93741	.....	A	Analyze ht pace device sngl	0.80	0.98	NA	0.06	1.84	NA	XXX
93741	26	A	Analyze ht pace device sngl	0.80	0.32	0.32	0.02	1.14	1.14	XXX
93741	TC	A	Analyze ht pace device sngl	0.00	0.66	NA	0.04	0.70	NA	XXX
93742	.....	A	Analyze ht pace device sngl	0.90	1.02	NA	0.06	1.98	NA	XXX
93742	26	A	Analyze ht pace device sngl	0.90	0.36	0.36	0.02	1.28	1.28	XXX
93742	TC	A	Analyze ht pace device sngl	0.00	0.66	NA	0.04	0.70	NA	XXX
93743	.....	A	Analyze ht pace device dual	1.02	1.13	NA	0.08	2.23	NA	XXX
93743	26	A	Analyze ht pace device dual	1.02	0.41	0.41	0.04	1.47	1.47	XXX
93743	TC	A	Analyze ht pace device dual	0.00	0.72	NA	0.04	0.76	NA	XXX
93744	.....	A	Analyze ht pace device dual	1.17	1.13	NA	0.08	2.38	NA	XXX
93744	26	A	Analyze ht pace device dual	1.17	0.47	0.47	0.04	1.68	1.68	XXX
93744	TC	A	Analyze ht pace device dual	0.00	0.66	NA	0.04	0.70	NA	XXX
93760	.....	N	Cephalic thermogram	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93762	.....	N	Peripheral thermogram	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93770	.....	B	Measure venous pressure	+0.16	0.08	NA	0.02	0.26	NA	XXX
93770	26	B	Measure venous pressure	+0.16	0.05	0.05	0.01	0.22	0.22	XXX
93770	TC	B	Measure venous pressure	+0.00	0.03	NA	0.01	0.04	NA	XXX
93784	.....	A	Ambulatory BP monitoring	0.17	0.97	0.97	0.02	1.16	1.16	XXX
93786	.....	A	Ambulatory BP recording	0.00	0.90	NA	0.01	0.91	NA	XXX
93788	.....	A	Ambulatory BP analysis	0.00	0.51	NA	0.01	0.52	NA	XXX
93790	.....	A	Review/report BP recording	0.17	0.06	0.06	0.01	0.24	0.24	XXX
93797	.....	A	Cardiac rehab	0.18	0.39	0.07	0.01	0.58	0.26	000
93798	.....	A	Cardiac rehab/monitor	0.28	0.51	0.11	0.01	0.80	0.40	000
93799	.....	C	Cardiovascular procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93799	26	C	Cardiovascular procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93799	TC	C	Cardiovascular procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93875	.....	A	Extracranial study	0.22	1.67	NA	0.12	2.01	NA	XXX
93875	26	A	Extracranial study	0.22	0.08	0.08	0.01	0.31	0.31	XXX
93875	TC	A	Extracranial study	0.00	1.59	NA	0.11	1.70	NA	XXX
93880	.....	A	Extracranial study	0.60	4.20	NA	0.40	5.20	NA	XXX
93880	26	A	Extracranial study	0.60	0.21	0.21	0.05	0.86	0.86	XXX
93880	TC	A	Extracranial study	0.00	3.99	NA	0.35	4.34	NA	XXX
93882	.....	A	Extracranial study	0.40	3.02	NA	0.27	3.69	NA	XXX
93882	26	A	Extracranial study	0.40	0.14	0.14	0.05	0.59	0.59	XXX
93882	TC	A	Extracranial study	0.00	2.88	NA	0.22	3.10	NA	XXX
93886	.....	A	Intracranial study	0.93	4.51	NA	0.44	5.88	NA	XXX
93886	26	A	Intracranial study	0.93	0.38	0.38	0.06	1.37	1.37	XXX
93886	TC	A	Intracranial study	0.00	4.13	NA	0.38	4.51	NA	XXX
93888	.....	A	Intracranial study	0.62	3.06	NA	0.31	3.99	NA	XXX
93888	26	A	Intracranial study	0.62	0.23	0.23	0.05	0.90	0.90	XXX
93888	TC	A	Intracranial study	0.00	2.83	NA	0.26	3.09	NA	XXX
93922	.....	A	Extremity study	0.25	1.94	NA	0.15	2.34	NA	XXX
93922	26	A	Extremity study	0.25	0.09	0.09	0.02	0.36	0.36	XXX
93922	TC	A	Extremity study	0.00	1.85	NA	0.13	1.98	NA	XXX
93923	.....	A	Extremity study	0.45	3.03	NA	0.27	3.75	NA	XXX
93923	26	A	Extremity study	0.45	0.16	0.16	0.05	0.66	0.66	XXX
93923	TC	A	Extremity study	0.00	2.87	NA	0.22	3.09	NA	XXX
93924	.....	A	Extremity study	0.50	3.78	NA	0.31	4.59	NA	XXX
93924	26	A	Extremity study	0.50	0.17	0.17	0.06	0.73	0.73	XXX
93924	TC	A	Extremity study	0.00	3.61	NA	0.25	3.86	NA	XXX
93925	.....	A	Lower extremity study	0.58	4.90	NA	0.40	5.88	NA	XXX
93925	26	A	Lower extremity study	0.58	0.20	0.20	0.05	0.83	0.83	XXX
93925	TC	A	Lower extremity study	0.00	4.70	NA	0.35	5.05	NA	XXX
93926	.....	A	Lower extremity study	0.39	3.49	NA	0.27	4.15	NA	XXX
93926	26	A	Lower extremity study	0.39	0.13	0.13	0.04	0.56	0.56	XXX
93926	TC	A	Lower extremity study	0.00	3.36	NA	0.23	3.59	NA	XXX
93930	.....	A	Upper extremity study	0.46	3.89	NA	0.41	4.76	NA	XXX
93930	26	A	Upper extremity study	0.46	0.16	0.16	0.04	0.66	0.66	XXX
93930	TC	A	Upper extremity study	0.00	3.73	NA	0.37	4.10	NA	XXX
93931	.....	A	Upper extremity study	0.31	2.84	NA	0.26	3.41	NA	XXX
93931	26	A	Upper extremity study	0.31	0.11	0.11	0.02	0.44	0.44	XXX
93931	TC	A	Upper extremity study	0.00	2.73	NA	0.24	2.97	NA	XXX
93965	.....	A	Extremity study	0.35	1.87	NA	0.14	2.36	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
93965	26	A	Extremity study	0.35	0.12	0.12	0.02	0.49	0.49	XXX
93965	TC	A	Extremity study	0.00	1.75	NA	0.12	1.87	NA	XXX
93970		A	Extremity study	0.68	3.98	NA	0.46	5.12	NA	XXX
93970	26	A	Extremity study	0.68	0.23	0.23	0.06	0.97	0.97	XXX
93970	TC	A	Extremity study	0.00	3.75	NA	0.40	4.15	NA	XXX
93971		A	Extremity study	0.45	2.87	NA	0.30	3.62	NA	XXX
93971	26	A	Extremity study	0.45	0.15	0.15	0.04	0.64	0.64	XXX
93971	TC	A	Extremity study	0.00	2.72	NA	0.26	2.98	NA	XXX
93975		A	Vascular study	1.79	5.86	NA	0.56	8.21	NA	XXX
93975	26	A	Vascular study	1.79	0.61	0.61	0.13	2.53	2.53	XXX
93975	TC	A	Vascular study	0.00	5.25	NA	0.43	5.68	NA	XXX
93976		A	Vascular study	1.20	3.48	NA	0.37	5.05	NA	XXX
93976	26	A	Vascular study	1.20	0.41	0.41	0.07	1.68	1.68	XXX
93976	TC	A	Vascular study	0.00	3.07	NA	0.30	3.37	NA	XXX
93978		A	Vascular study	0.65	3.60	NA	0.43	4.68	NA	XXX
93978	26	A	Vascular study	0.65	0.22	0.22	0.06	0.93	0.93	XXX
93978	TC	A	Vascular study	0.00	3.38	NA	0.37	3.75	NA	XXX
93979		A	Vascular study	0.44	2.67	NA	0.29	3.40	NA	XXX
93979	26	A	Vascular study	0.44	0.16	0.16	0.05	0.65	0.65	XXX
93979	TC	A	Vascular study	0.00	2.51	NA	0.24	2.75	NA	XXX
93980		A	Penile vascular study	1.24	4.84	NA	0.42	6.50	NA	XXX
93980	26	A	Penile vascular study	1.24	0.42	0.42	0.08	1.74	1.74	XXX
93980	TC	A	Penile vascular study	0.00	4.42	NA	0.34	4.76	NA	XXX
93981		A	Penile vascular study	0.44	4.66	NA	0.33	5.43	NA	XXX
93981	26	A	Penile vascular study	0.44	0.15	0.15	0.02	0.61	0.61	XXX
93981	TC	A	Penile vascular study	0.00	4.51	NA	0.31	4.82	NA	XXX
93990		A	Doppler flow testing	0.25	3.41	NA	0.25	3.91	NA	XXX
93990	26	A	Doppler flow testing	0.25	0.09	0.09	0.02	0.36	0.36	XXX
93990	TC	A	Doppler flow testing	0.00	3.32	NA	0.23	3.55	NA	XXX
94010		A	Breathing capacity test	0.17	0.69	NA	0.03	0.89	NA	XXX
94010	26	A	Breathing capacity test	0.17	0.05	0.05	0.01	0.23	0.23	XXX
94010	TC	A	Breathing capacity test	0.00	0.64	NA	0.02	0.66	NA	XXX
94014		A	Patient recorded spirometry	0.52	0.78	NA	0.03	1.33	NA	XXX
94015		A	Patient recorded spirometry	0.00	0.61	NA	0.01	0.62	NA	XXX
94016		A	Review patient spirometry	0.52	0.17	0.17	0.02	0.71	0.71	XXX
94060		A	Evaluation of wheezing	0.31	1.14	NA	0.07	1.52	NA	XXX
94060	26	A	Evaluation of wheezing	0.31	0.10	0.10	0.01	0.42	0.42	XXX
94060	TC	A	Evaluation of wheezing	0.00	1.04	NA	0.06	1.10	NA	XXX
94070		A	Evaluation of wheezing	0.60	3.05	NA	0.12	3.77	NA	XXX
94070	26	A	Evaluation of wheezing	0.60	0.19	0.19	0.02	0.81	0.81	XXX
94070	TC	A	Evaluation of wheezing	0.00	2.86	NA	0.10	2.96	NA	XXX
94150		B	Vital capacity test	+0.07	0.49	NA	0.02	0.58	NA	XXX
94150	26	B	Vital capacity test	+0.07	0.03	0.03	0.01	0.11	0.11	XXX
94150	TC	B	Vital capacity test	+0.00	0.46	NA	0.01	0.47	NA	XXX
94200		A	Lung function test (MBC/MVV)	0.11	0.45	NA	0.03	0.59	NA	XXX
94200	26	A	Lung function test (MBC/MVV)	0.11	0.03	0.03	0.01	0.15	0.15	XXX
94200	TC	A	Lung function test (MBC/MVV)	0.00	0.42	NA	0.02	0.44	NA	XXX
94240		A	Residual lung capacity	0.26	0.67	NA	0.06	0.99	NA	XXX
94240	26	A	Residual lung capacity	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94240	TC	A	Residual lung capacity	0.00	0.59	NA	0.05	0.64	NA	XXX
94250		A	Expired gas collection	0.11	0.67	NA	0.02	0.80	NA	XXX
94250	26	A	Expired gas collection	0.11	0.03	0.03	0.01	0.15	0.15	XXX
94250	TC	A	Expired gas collection	0.00	0.64	NA	0.01	0.65	NA	XXX
94260		A	Thoracic gas volume	0.13	0.59	NA	0.05	0.77	NA	XXX
94260	26	A	Thoracic gas volume	0.13	0.04	0.04	0.01	0.18	0.18	XXX
94260	TC	A	Thoracic gas volume	0.00	0.55	NA	0.04	0.59	NA	XXX
94350		A	Lung nitrogen washout curve	0.26	0.76	NA	0.05	1.07	NA	XXX
94350	26	A	Lung nitrogen washout curve	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94350	TC	A	Lung nitrogen washout curve	0.00	0.68	NA	0.04	0.72	NA	XXX
94360		A	Measure airflow resistance	0.26	0.71	NA	0.07	1.04	NA	XXX
94360	26	A	Measure airflow resistance	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94360	TC	A	Measure airflow resistance	0.00	0.63	NA	0.06	0.69	NA	XXX
94370		A	Breath airway closing volume	0.26	0.73	NA	0.03	1.02	NA	XXX
94370	26	A	Breath airway closing volume	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94370	TC	A	Breath airway closing volume	0.00	0.65	NA	0.02	0.67	NA	XXX
94375		A	Respiratory flow volume loop	0.31	0.63	NA	0.03	0.97	NA	XXX
94375	26	A	Respiratory flow volume loop	0.31	0.10	0.10	0.01	0.42	0.42	XXX
94375	TC	A	Respiratory flow volume loop	0.00	0.53	NA	0.02	0.55	NA	XXX
94400		A	CO2 breathing response curve	0.40	0.85	NA	0.07	1.32	NA	XXX
94400	26	A	CO2 breathing response curve	0.40	0.13	0.13	0.01	0.54	0.54	XXX
94400	TC	A	CO2 breathing response curve	0.00	0.72	NA	0.06	0.78	NA	XXX
94450		A	Hypoxia response curve	0.40	0.69	NA	0.04	1.13	NA	XXX
94450	26	A	Hypoxia response curve	0.40	0.12	0.12	0.02	0.54	0.54	XXX
94450	TC	A	Hypoxia response curve	0.00	0.57	NA	0.02	0.59	NA	XXX
94620		A	Pulmonary stress test/simple	0.64	2.45	NA	0.12	3.21	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
94620	26	A	Pulmonary stress test/simple	0.64	0.20	0.20	0.02	0.86	0.86	XXX
94620	TC	A	Pulmonary stress test/simple	0.00	2.25	NA	0.10	2.35	NA	XXX
94621		A	Pulm stress test/complex	1.41	2.10	NA	0.16	3.67	NA	XXX
94621	26	A	Pulm stress test/complex	1.41	0.44	0.44	0.06	1.91	1.91	XXX
94621	TC	A	Pulm stress test/complex	0.00	1.66	NA	0.10	1.76	NA	XXX
94640		A	Airway inhalation treatment	0.00	0.32	NA	0.02	0.34	NA	XXX
94642		C	Aerosol inhalation treatment	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94656		A	Initial ventilator mgmt	1.21	1.21	0.32	0.07	2.49	1.60	XXX
94657		A	Continued ventilator mgmt	0.83	1.02	0.25	0.04	1.89	1.12	XXX
94660		A	Pos airway pressure, CPAP	0.76	0.67	0.24	0.04	1.47	1.04	XXX
94662		A	Neg press ventilation, cnp	0.76	NA	0.24	0.02	NA	1.02	XXX
94664		A	Evaluate pt use of inhaler	0.00	0.33	NA	0.04	0.37	NA	XXX
94667		A	Chest wall manipulation	0.00	0.57	NA	0.05	0.62	NA	XXX
94668		A	Chest wall manipulation	0.00	0.48	NA	0.02	0.50	NA	XXX
94680		A	Exhaled air analysis, o2	0.26	1.93	NA	0.07	2.26	NA	XXX
94680	26	A	Exhaled air analysis, o2	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94680	TC	A	Exhaled air analysis, o2	0.00	1.85	NA	0.06	1.91	NA	XXX
94681		A	Exhaled air analysis, o2/co2	0.20	2.66	NA	0.13	2.99	NA	XXX
94681	26	A	Exhaled air analysis, o2/co2	0.20	0.07	0.07	0.01	0.28	0.28	XXX
94681	TC	A	Exhaled air analysis, o2/co2	0.00	2.59	NA	0.12	2.71	NA	XXX
94690		A	Exhaled air analysis	0.07	2.01	NA	0.05	2.13	NA	XXX
94690	26	A	Exhaled air analysis	0.07	0.02	0.02	0.01	0.10	0.10	XXX
94690	TC	A	Exhaled air analysis	0.00	1.99	NA	0.04	2.03	NA	XXX
94720		A	Monoxide diffusing capacity	0.26	1.01	NA	0.07	1.34	NA	XXX
94720	26	A	Monoxide diffusing capacity	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94720	TC	A	Monoxide diffusing capacity	0.00	0.93	NA	0.06	0.99	NA	XXX
94725		A	Membrane diffusion capacity	0.26	3.00	NA	0.13	3.39	NA	XXX
94725	26	A	Membrane diffusion capacity	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94725	TC	A	Membrane diffusion capacity	0.00	2.92	NA	0.12	3.04	NA	XXX
94750		A	Pulmonary compliance study	0.23	1.38	NA	0.05	1.66	NA	XXX
94750	26	A	Pulmonary compliance study	0.23	0.07	0.07	0.01	0.31	0.31	XXX
94750	TC	A	Pulmonary compliance study	0.00	1.31	NA	0.04	1.35	NA	XXX
94760		T	Measure blood oxygen level	0.00	0.04	NA	0.02	0.06	NA	XXX
94761		T	Measure blood oxygen level	0.00	0.07	NA	0.06	0.13	NA	XXX
94762		A	Measure blood oxygen level	0.00	0.41	NA	0.10	0.51	NA	XXX
94770		A	Exhaled carbon dioxide test	0.15	1.70	NA	0.08	1.93	NA	XXX
94770	26	A	Exhaled carbon dioxide test	0.15	0.04	0.04	0.01	0.20	0.20	XXX
94770	TC	A	Exhaled carbon dioxide test	0.00	1.66	NA	0.07	1.73	NA	XXX
94772		C	Breath recording, infant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94772	26	C	Breath recording, infant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94772	TC	C	Breath recording, infant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94799		C	Pulmonary service/procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94799	26	C	Pulmonary service/procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94799	TC	C	Pulmonary service/procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95004		A	Percut allergy skin tests	0.00	0.11	NA	0.01	0.11	NA	XXX
95010		A	Percut allergy titrate test	0.15	0.33	0.06	0.01	0.49	0.22	XXX
95015		A	Id allergy titrate-drug/bug	0.15	0.15	0.06	0.01	0.31	0.22	XXX
95024		A	Id allergy test, drug/bug	0.00	0.14	NA	0.01	0.15	NA	XXX
95027		A	Id allergy titrate-airborne	0.00	0.14	NA	0.01	0.15	NA	XXX
95028		A	Id allergy test-delayed type	0.00	0.23	NA	0.01	0.24	NA	XXX
95044		A	Allergy patch tests	0.00	0.20	NA	0.01	0.21	NA	XXX
95052		A	Photo patch test	0.00	0.25	NA	0.01	0.26	NA	XXX
95056		A	Photosensitivity tests	0.00	0.17	NA	0.01	0.18	NA	XXX
95060		A	Eye allergy tests	0.00	0.35	NA	0.02	0.37	NA	XXX
95065		A	Nose allergy test	0.00	0.20	NA	0.01	0.21	NA	XXX
95070		A	Bronchial allergy tests	0.00	2.26	NA	0.02	2.28	NA	XXX
95071		A	Bronchial allergy tests	0.00	2.90	NA	0.02	2.92	NA	XXX
95075		A	Ingestion challenge test	0.94	0.83	0.39	0.04	1.81	1.37	XXX
95078		A	Provocative testing	0.00	0.25	NA	0.02	0.27	NA	XXX
95115		A	Immunotherapy, one injection	0.00	0.39	NA	0.02	0.41	NA	000
95117		A	Immunotherapy injections	0.00	0.50	NA	0.02	0.52	NA	000
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	0.15	0.02	0.01	0.22	0.09	000
95145		A	Antigen therapy services	0.06	0.33	0.02	0.01	0.40	0.09	000
95146		A	Antigen therapy services	0.06	0.46	0.03	0.01	0.53	0.10	000
95147		A	Antigen therapy services	0.06	0.43	0.02	0.01	0.50	0.09	000
95148		A	Antigen therapy services	0.06	0.60	0.03	0.01	0.67	0.10	000
95149		A	Antigen therapy services	0.06	0.82	0.03	0.01	0.89	0.10	000
95165		A	Antigen therapy services	0.06	0.20	0.02	0.01	0.27	0.09	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
95170	.....	A	Antigen therapy services	0.06	0.14	0.02	0.01	0.21	0.09	000
95180	.....	A	Rapid desensitization	2.00	1.54	0.83	0.05	3.59	2.88	000
95199	.....	C	Allergy immunology services	0.00	0.00	0.00	0.00	0.00	0.00	000
95250	.....	A	Glucose monitoring, cont	0.00	3.89	NA	0.01	3.90	NA	XXX
95805	.....	A	Multiple sleep latency test	1.87	16.50	NA	0.41	18.78	NA	XXX
95805	26	A	Multiple sleep latency test	1.87	0.66	0.66	0.07	2.60	2.60	XXX
95805	TC	A	Multiple sleep latency test	0.00	15.84	NA	0.34	16.18	NA	XXX
95806	.....	A	Sleep study, unattended	1.65	3.88	NA	0.38	5.91	NA	XXX
95806	26	A	Sleep study, unattended	1.65	0.55	0.55	0.07	2.27	2.27	XXX
95806	TC	A	Sleep study, unattended	0.00	3.33	NA	0.31	3.64	NA	XXX
95807	.....	A	Sleep study, attended	1.65	11.91	NA	0.48	14.04	NA	XXX
95807	26	A	Sleep study, attended	1.65	0.54	0.54	0.06	2.25	2.25	XXX
95807	TC	A	Sleep study, attended	0.00	11.37	NA	0.42	11.79	NA	XXX
95808	.....	A	Polysomnography, 1–3	2.63	13.20	NA	0.53	16.36	NA	XXX
95808	26	A	Polysomnography, 1–3	2.63	0.93	0.93	0.11	3.67	3.67	XXX
95808	TC	A	Polysomnography, 1–3	0.00	12.27	NA	0.42	12.69	NA	XXX
95810	.....	A	Polysomnography, 4 or more	3.51	17.30	NA	0.56	21.37	NA	XXX
95810	26	A	Polysomnography, 4 or more	3.51	1.20	1.20	0.14	4.85	4.85	XXX
95810	TC	A	Polysomnography, 4 or more	0.00	16.10	NA	0.42	16.52	NA	XXX
95811	.....	A	Polysomnography w/cpap	3.78	18.74	NA	0.59	23.11	NA	XXX
95811	26	A	Polysomnography w/cpap	3.78	1.29	1.29	0.16	5.23	5.23	XXX
95811	TC	A	Polysomnography w/cpap	0.00	17.45	NA	0.43	17.88	NA	XXX
95812	.....	A	Eeg, 41–60 minutes	1.07	3.98	NA	0.16	5.21	NA	XXX
95812	26	A	Eeg, 41–60 minutes	1.07	0.46	0.46	0.05	1.58	1.58	XXX
95812	TC	A	Eeg, 41–60 minutes	0.00	3.52	NA	0.11	3.63	NA	XXX
95813	.....	A	Eeg, over 1 hour	1.72	5.00	NA	0.18	6.90	NA	XXX
95813	26	A	Eeg, over 1 hour	1.72	0.70	0.70	0.07	2.49	2.49	XXX
95813	TC	A	Eeg, over 1 hour	0.00	4.30	NA	0.11	4.41	NA	XXX
95816	.....	A	Eeg, awake and drowsy	1.07	3.20	NA	0.15	4.42	NA	XXX
95816	26	A	Eeg, awake and drowsy	1.07	0.47	0.47	0.05	1.59	1.59	XXX
95816	TC	A	Eeg, awake and drowsy	0.00	2.73	NA	0.10	2.83	NA	XXX
95819	.....	A	Eeg, awake and asleep	1.07	3.74	NA	0.15	4.96	NA	XXX
95819	26	A	Eeg, awake and asleep	1.07	0.47	0.47	0.05	1.59	1.59	XXX
95819	TC	A	Eeg, awake and asleep	0.00	3.27	NA	0.10	3.37	NA	XXX
95822	.....	A	Eeg, coma or sleep only	1.07	4.43	NA	0.18	5.68	NA	XXX
95822	26	A	Eeg, coma or sleep only	1.07	0.47	0.47	0.05	1.59	1.59	XXX
95822	TC	A	Eeg, coma or sleep only	0.00	3.96	NA	0.13	4.09	NA	XXX
95824	.....	C	Eeg, cerebral death only	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95824	26	A	Eeg, cerebral death only	0.74	0.32	0.32	0.06	1.12	1.12	XXX
95824	TC	C	Eeg, cerebral death only	0.00	0.00	NA	0.00	0.00	NA	XXX
95827	.....	A	Eeg, all night recording	1.07	2.68	NA	0.18	3.93	NA	XXX
95827	26	A	Eeg, all night recording	1.07	0.41	0.41	0.04	1.52	1.52	XXX
95827	TC	A	Eeg, all night recording	0.00	2.27	NA	0.14	2.41	NA	XXX
95829	.....	A	Surgery electrocorticogram	6.17	32.01	NA	0.39	38.57	NA	XXX
95829	26	A	Surgery electrocorticogram	6.17	2.35	2.35	0.37	8.89	8.89	XXX
95829	TC	A	Surgery electrocorticogram	0.00	29.66	NA	0.02	29.68	NA	XXX
95830	.....	A	Insert electrodes for EEG	1.69	3.42	0.73	0.08	5.19	2.50	XXX
95831	.....	A	Limb muscle testing, manual	0.28	0.35	0.13	0.01	0.64	0.42	XXX
95832	.....	A	Hand muscle testing, manual	0.29	0.26	0.12	0.01	0.56	0.42	XXX
95833	.....	A	Body muscle testing, manual	0.47	0.46	0.23	0.01	0.94	0.71	XXX
95834	.....	A	Body muscle testing, manual	0.60	0.51	0.28	0.02	1.13	0.90	XXX
95851	.....	A	Range of motion measurements	0.16	0.37	0.08	0.01	0.54	0.25	XXX
95852	.....	A	Range of motion measurements	0.11	0.26	0.05	0.01	0.38	0.17	XXX
95857	.....	A	Tensilon test	0.53	0.62	0.23	0.02	1.17	0.78	XXX
95858	.....	A	Tensilon test & myogram	1.55	1.07	NA	0.09	2.71	NA	XXX
95858	26	A	Tensilon test & myogram	1.55	0.67	0.67	0.05	2.27	2.27	XXX
95858	TC	A	Tensilon test & myogram	0.00	0.40	NA	0.04	0.44	NA	XXX
95860	.....	A	Muscle test, one limb	0.95	1.47	NA	0.06	2.48	NA	XXX
95860	26	A	Muscle test, one limb	0.95	0.43	0.43	0.04	1.42	1.42	XXX
95860	TC	A	Muscle test, one limb	0.00	1.04	NA	0.02	1.06	NA	XXX
95861	.....	A	Muscle test, 2 limbs	1.53	1.40	NA	0.12	3.05	NA	XXX
95861	26	A	Muscle test, 2 limbs	1.53	0.68	0.68	0.06	2.27	2.27	XXX
95861	TC	A	Muscle test, 2 limbs	0.00	0.72	NA	0.06	0.78	NA	XXX
95863	.....	A	Muscle test, 3 limbs	1.86	1.74	NA	0.13	3.73	NA	XXX
95863	26	A	Muscle test, 3 limbs	1.86	0.81	0.81	0.07	2.74	2.74	XXX
95863	TC	A	Muscle test, 3 limbs	0.00	0.93	NA	0.06	0.99	NA	XXX
95864	.....	A	Muscle test, 4 limbs	1.98	2.65	NA	0.19	4.82	NA	XXX
95864	26	A	Muscle test, 4 limbs	1.98	0.88	0.88	0.07	2.93	2.93	XXX
95864	TC	A	Muscle test, 4 limbs	0.00	1.77	NA	0.12	1.89	NA	XXX
95867	.....	A	Muscle test cran nerv unilat	0.79	0.93	NA	0.08	1.80	NA	XXX
95867	26	A	Muscle test cran nerv unilat	0.79	0.35	0.35	0.04	1.18	1.18	XXX
95867	TC	A	Muscle test cran nerv unilat	0.00	0.58	NA	0.04	0.62	NA	XXX
95868	.....	A	Muscle test cran nerve bilat	1.17	1.21	NA	0.10	2.48	NA	XXX
95868	26	A	Muscle test cran nerve bilat	1.17	0.52	0.52	0.05	1.74	1.74	XXX
95868	TC	A	Muscle test cran nerve bilat	0.00	0.69	NA	0.05	0.74	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
95869	.....	A	Muscle test, thor paraspinal	0.37	0.38	NA	0.03	0.78	NA	XXX
95869	26	A	Muscle test, thor paraspinal	0.37	0.17	0.17	0.01	0.55	0.55	XXX
95869	TC	A	Muscle test, thor paraspinal	0.00	0.21	NA	0.02	0.23	NA	XXX
95870	.....	A	Muscle test, nonparaspinal	0.37	0.37	NA	0.03	0.77	NA	XXX
95870	26	A	Muscle test, nonparaspinal	0.37	0.16	0.16	0.01	0.54	0.54	XXX
95870	TC	A	Muscle test, nonparaspinal	0.00	0.21	NA	0.02	0.23	NA	XXX
95872	.....	A	Muscle test, one fiber	1.49	1.24	NA	0.10	2.83	NA	XXX
95872	26	A	Muscle test, one fiber	1.49	0.64	0.64	0.05	2.18	2.18	XXX
95872	TC	A	Muscle test, one fiber	0.00	0.60	NA	0.05	0.65	NA	XXX
95875	.....	A	Limb exercise test	1.09	1.49	NA	0.11	2.69	NA	XXX
95875	26	A	Limb exercise test	1.09	0.48	0.48	0.05	1.62	1.62	XXX
95875	TC	A	Limb exercise test	0.00	1.01	NA	0.06	1.07	NA	XXX
95900	.....	A	Motor nerve conduction test	0.42	1.30	NA	0.03	1.75	NA	XXX
95900	26	A	Motor nerve conduction test	0.42	0.19	0.19	0.01	0.62	0.62	XXX
95900	TC	A	Motor nerve conduction test	0.00	1.11	NA	0.02	1.13	NA	XXX
95903	.....	A	Motor nerve conduction test	0.60	1.22	NA	0.04	1.86	NA	XXX
95903	26	A	Motor nerve conduction test	0.60	0.26	0.26	0.02	0.88	0.88	XXX
95903	TC	A	Motor nerve conduction test	0.00	0.96	NA	0.02	0.98	NA	XXX
95904	.....	A	Sense nerve conduction test	0.34	1.12	NA	0.03	1.49	NA	XXX
95904	26	A	Sense nerve conduction test	0.34	0.15	0.15	0.01	0.50	0.50	XXX
95904	TC	A	Sense nerve conduction test	0.00	0.97	NA	0.02	0.99	NA	XXX
95920	.....	A	Intraop nerve test add-on	2.10	2.23	NA	0.24	4.57	NA	ZZZ
95920	26	A	Intraop nerve test add-on	2.10	0.94	0.94	0.17	3.21	3.21	ZZZ
95920	TC	A	Intraop nerve test add-on	0.00	1.29	NA	0.07	1.36	NA	ZZZ
95921	.....	A	Autonomic nerv function test	0.89	0.71	NA	0.06	1.66	NA	XXX
95921	26	A	Autonomic nerv function test	0.89	0.33	0.33	0.04	1.26	1.26	XXX
95921	TC	A	Autonomic nerv function test	0.00	0.38	NA	0.02	0.40	NA	XXX
95922	.....	A	Autonomic nerv function test	0.95	0.79	NA	0.06	1.80	NA	XXX
95922	26	A	Autonomic nerv function test	0.95	0.41	0.41	0.04	1.40	1.40	XXX
95922	TC	A	Autonomic nerv function test	0.00	0.38	NA	0.02	0.40	NA	XXX
95923	.....	A	Autonomic nerv function test	0.89	2.13	NA	0.06	3.08	NA	XXX
95923	26	A	Autonomic nerv function test	0.89	0.38	0.38	0.04	1.31	1.31	XXX
95923	TC	A	Autonomic nerv function test	0.00	1.75	NA	0.02	1.77	NA	XXX
95925	.....	A	Somatosensory testing	0.54	1.13	NA	0.08	1.75	NA	XXX
95925	26	A	Somatosensory testing	0.54	0.23	0.23	0.02	0.79	0.79	XXX
95925	TC	A	Somatosensory testing	0.00	0.90	NA	0.06	0.96	NA	XXX
95926	.....	A	Somatosensory testing	0.54	1.14	NA	0.08	1.76	NA	XXX
95926	26	A	Somatosensory testing	0.54	0.24	0.24	0.02	0.80	0.80	XXX
95926	TC	A	Somatosensory testing	0.00	0.90	NA	0.06	0.96	NA	XXX
95927	.....	A	Somatosensory testing	0.54	1.15	NA	0.10	1.79	NA	XXX
95927	26	A	Somatosensory testing	0.54	0.25	0.25	0.04	0.83	0.83	XXX
95927	TC	A	Somatosensory testing	0.00	0.90	NA	0.06	0.96	NA	XXX
95930	.....	A	Visual evoked potential test	0.35	1.45	NA	0.02	1.82	NA	XXX
95930	26	A	Visual evoked potential test	0.35	0.15	0.15	0.01	0.51	0.51	XXX
95930	TC	A	Visual evoked potential test	0.00	1.30	NA	0.01	1.31	NA	XXX
95933	.....	A	Blink reflex test	0.59	1.02	NA	0.08	1.69	NA	XXX
95933	26	A	Blink reflex test	0.59	0.25	0.25	0.02	0.86	0.86	XXX
95933	TC	A	Blink reflex test	0.00	0.77	NA	0.06	0.83	NA	XXX
95934	.....	A	H-reflex test	0.51	0.44	NA	0.04	0.99	NA	XXX
95934	26	A	H-reflex test	0.51	0.23	0.23	0.02	0.76	0.76	XXX
95934	TC	A	H-reflex test	0.00	0.21	NA	0.02	0.23	NA	XXX
95936	.....	A	H-reflex test	0.55	0.45	NA	0.04	1.04	NA	XXX
95936	26	A	H-reflex test	0.55	0.24	0.24	0.02	0.81	0.81	XXX
95936	TC	A	H-reflex test	0.00	0.21	NA	0.02	0.23	NA	XXX
95937	.....	A	Neuromuscular junction test	0.65	0.61	NA	0.04	1.30	NA	XXX
95937	26	A	Neuromuscular junction test	0.65	0.27	0.27	0.02	0.94	0.94	XXX
95937	TC	A	Neuromuscular junction test	0.00	0.34	NA	0.02	0.36	NA	XXX
95950	.....	A	Ambulatory eeg monitoring	1.50	4.53	NA	0.53	6.56	NA	XXX
95950	26	A	Ambulatory eeg monitoring	1.50	0.64	0.64	0.10	2.24	2.24	XXX
95950	TC	A	Ambulatory eeg monitoring	0.00	3.89	NA	0.43	4.32	NA	XXX
95951	.....	C	EEG monitoring/videorecord	0.00	0.00	NA	0.00	0.00	NA	XXX
95951	26	A	EEG monitoring/videorecord	5.97	2.59	2.59	0.24	8.80	8.80	XXX
95951	TC	C	EEG monitoring/videorecord	0.00	0.00	NA	0.00	0.00	NA	XXX
95953	.....	A	EEG monitoring/computer	3.06	7.59	NA	0.55	11.20	NA	XXX
95953	26	A	EEG monitoring/computer	3.06	1.31	1.31	0.12	4.49	4.49	XXX
95953	TC	A	EEG monitoring/computer	0.00	6.28	NA	0.43	6.71	NA	XXX
95954	.....	A	EEG monitoring/giving drugs	2.44	4.33	NA	0.18	6.95	NA	XXX
95954	26	A	EEG monitoring/giving drugs	2.44	1.05	1.05	0.12	3.61	3.61	XXX
95954	TC	A	EEG monitoring/giving drugs	0.00	3.28	NA	0.06	3.34	NA	XXX
95955	.....	A	EEG during surgery	1.00	2.31	NA	0.23	3.54	NA	XXX
95955	26	A	EEG during surgery	1.00	0.37	0.37	0.06	1.43	1.43	XXX
95955	TC	A	EEG during surgery	0.00	1.94	NA	0.17	2.11	NA	XXX
95956	.....	A	Eeg monitoring, cable/radio	3.06	14.32	NA	0.56	17.94	NA	XXX
95956	26	A	Eeg monitoring, cable/radio	3.06	1.32	1.32	0.13	4.51	4.51	XXX
95956	TC	A	Eeg monitoring, cable/radio	0.00	13.00	NA	0.43	13.43	NA	XXX

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[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
95957	.....	A	EEG digital analysis	1.97	2.55	NA	0.20	4.72	NA	XXX
95957	26	A	EEG digital analysis	1.97	0.86	0.86	0.08	2.91	2.91	XXX
95957	TC	A	EEG digital analysis	0.00	1.69	NA	0.12	1.81	NA	XXX
95958	.....	A	EEG monitoring/function test	4.23	3.50	NA	0.35	8.08	NA	XXX
95958	26	A	EEG monitoring/function test	4.23	1.77	1.77	0.22	6.22	6.22	XXX
95958	TC	A	EEG monitoring/function test	0.00	1.73	NA	0.13	1.86	NA	XXX
95961	.....	A	Electrode stimulation, brain	2.95	2.63	NA	0.29	5.87	NA	XXX
95961	26	A	Electrode stimulation, brain	2.95	1.34	1.34	0.22	4.51	4.51	XXX
95961	TC	A	Electrode stimulation, brain	0.00	1.29	NA	0.07	1.36	NA	XXX
95962	.....	A	Electrode stim, brain add-on	3.19	2.70	NA	0.27	6.16	NA	ZZZ
95962	26	A	Electrode stim, brain add-on	3.19	1.41	1.41	0.20	4.80	4.80	ZZZ
95962	TC	A	Electrode stim, brain add-on	0.00	1.29	NA	0.07	1.36	NA	ZZZ
95965	.....	C	Meg, spontaneous	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95965	26	A	Meg, spontaneous	7.95	3.46	3.46	0.37	11.78	11.78	XXX
95965	TC	C	Meg, spontaneous	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95966	.....	C	Meg, evoked, single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95966	26	A	Meg, evoked, single	3.98	1.74	1.74	0.18	5.90	5.90	XXX
95966	TC	C	Meg, evoked, single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95967	.....	C	Meg, evoked, each addl	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
95967	26	A	Meg, evoked, each addl	3.48	1.35	1.35	0.16	4.99	4.99	ZZZ
95967	TC	C	Meg, evoked, each addl	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
95970	.....	A	Analyze neurostim, no prog	0.45	0.17	0.15	0.04	0.66	0.64	XXX
95971	.....	A	Analyze neurostim, simple	0.78	0.28	0.23	0.07	1.13	1.08	XXX
95972	.....	A	Analyze neurostim, complex	1.49	0.60	0.50	0.20	2.29	2.19	XXX
95973	.....	A	Analyze neurostim, complex	0.91	0.40	0.35	0.08	1.39	1.34	ZZZ
95974	.....	A	Cranial neurostim, complex	2.98	1.31	1.31	0.18	4.47	4.47	XXX
95975	.....	A	Cranial neurostim, complex	1.69	0.73	0.73	0.08	2.50	2.50	ZZZ
95990	.....	A	Spin/brain pump refil & main	0.00	1.49	NA	0.06	1.55	NA	XXX
95991	.....	A	Spin/brain pump refil & main	0.77	1.49	0.19	0.06	2.32	1.02	XXX
95999	.....	C	Neurological procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96000	.....	A	Motion analysis, video/3d	1.79	NA	0.57	0.02	NA	2.38	XXX
96001	.....	A	Motion test w/ft press meas	2.14	NA	0.67	0.02	NA	2.83	XXX
96002	.....	A	Dynamic surface emg	0.41	NA	0.15	0.02	NA	0.58	XXX
96003	.....	A	Dynamic fine wire emg	0.37	NA	0.14	0.04	NA	0.55	XXX
96004	.....	A	Phys review of motion tests	2.13	0.96	0.96	0.10	3.19	3.19	XXX
96100	.....	A	Psychological testing	0.00	1.75	NA	0.18	1.93	NA	XXX
96105	.....	A	Assessment of aphasia	0.00	1.75	NA	0.18	1.93	NA	XXX
96110	.....	A	Developmental test, lim	0.00	0.18	NA	0.18	0.36	NA	XXX
96111	.....	A	Developmental test, extend	2.59	1.07	NA	0.18	3.84	NA	XXX
96115	.....	A	Neurobehavior status exam	0.00	1.75	NA	0.18	1.93	NA	XXX
96117	.....	A	Neuropsych test battery	0.00	1.75	NA	0.18	1.93	NA	XXX
96150	.....	A	Assess lth/behave, init	0.50	0.19	0.18	0.02	0.71	0.70	XXX
96151	.....	A	Assess hlth/behave, subseq	0.48	0.18	0.17	0.02	0.68	0.67	XXX
96152	.....	A	Intervene hlth/behave, indiv	0.46	0.18	0.16	0.02	0.66	0.64	XXX
96153	.....	A	Intervene hlth/behave, group	0.10	0.04	0.04	0.01	0.15	0.15	XXX
96154	.....	A	Interv hlth/behav, fam w/pt	0.45	0.17	0.16	0.02	0.64	0.63	XXX
96155	.....	N	Interv hlth/behav fam no pt	+0.44	0.18	0.17	0.02	0.64	0.63	XXX
96400	.....	A	Chemotherapy, sc/im	0.00	0.88	NA	0.01	0.89	NA	XXX
96405	.....	A	Intralesional chemo admin	0.52	1.94	0.23	0.02	2.48	0.77	000
96406	.....	A	Intralesional chemo admin	0.80	2.58	0.30	0.02	3.40	1.12	000
96408	.....	A	Chemotherapy, push technique	0.00	0.96	NA	0.06	1.02	NA	XXX
96410	.....	A	Chemotherapy,infusion method	0.00	1.54	NA	0.08	1.62	NA	XXX
96412	.....	A	Chemo, infuse method add-on	0.00	1.14	NA	0.07	1.21	NA	ZZZ
96414	.....	A	Chemo, infuse method add-on	0.00	1.32	NA	0.08	1.40	NA	XXX
96420	.....	A	Chemotherapy, push technique	0.00	1.24	NA	0.08	1.32	NA	XXX
96422	.....	A	Chemotherapy,infusion method	0.00	1.22	NA	0.08	1.30	NA	XXX
96423	.....	A	Chemo, infuse method add-on	0.00	0.48	NA	0.02	0.50	NA	ZZZ
96425	.....	A	Chemotherapy,infusion method	0.00	1.42	NA	0.08	1.50	NA	XXX
96440	.....	A	Chemotherapy, intracavitary	2.36	7.40	1.04	0.14	9.90	3.54	000
96445	.....	A	Chemotherapy, intracavitary	2.19	7.38	1.03	0.08	9.65	3.30	000
96450	.....	A	Chemotherapy, into CNS	1.88	6.26	0.91	0.07	8.21	2.86	000
96520	.....	A	Port pump refill & main	0.00	0.88	NA	0.06	0.94	NA	XXX
96530	.....	A	Syst pump refill & main	0.00	1.05	NA	0.06	1.11	NA	XXX
96542	.....	A	Chemotherapy injection	1.41	3.80	0.55	0.06	5.27	2.02	XXX
96545	.....	B	Provide chemotherapy agent	0.00	0.00	0.00	0.00	0.00	0.00	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	0.99	NA	0.04	1.03	NA	XXX
96570	.....	A	Photodynamic tx, 30 min	1.09	NA	0.37	0.05	NA	1.51	ZZZ
96571	.....	A	Photodynamic tx, addl 15 min	0.55	NA	0.20	0.02	NA	0.77	ZZZ
96900	.....	A	Ultraviolet light therapy	0.00	0.49	NA	0.02	0.51	NA	XXX
96902	.....	B	Trichogram	+0.41	0.25	0.16	0.01	0.67	0.58	XXX
96910	.....	A	Photochemotherapy with UV–B	0.00	1.08	NA	0.04	1.12	NA	XXX
96912	.....	A	Photochemotherapy with UV–A	0.00	1.36	NA	0.05	1.41	NA	XXX
96913	.....	A	Photochemotherapy, UV–A or B	0.00	1.80	NA	0.10	1.90	NA	XXX
96920	.....	A	Laser tx, skin < 250 sq cm	1.14	7.74	0.58	0.11	8.99	1.83	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
96921		A	Laser tx, skin 250–500 sq cm	1.16	7.81	0.59	0.11	9.08	1.86	000
96922		A	Laser tx, skin > 500 sq cm	2.09	8.56	1.04	0.19	10.84	3.32	000
96999		C	Dermatological procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97001		A	Pt evaluation	1.19	0.74	0.46	0.06	1.99	1.71	XXX
97002		A	Pt re-evaluation	0.60	0.45	0.24	0.02	1.07	0.86	XXX
97003		A	Ot evaluation	1.19	0.87	0.41	0.06	2.12	1.66	XXX
97004		A	Ot re-evaluation	0.60	0.62	0.20	0.02	1.24	0.82	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	0.05	NA	0.01	0.12	NA	XXX
97012		A	Mechanical traction therapy	0.25	0.14	NA	0.01	0.40	NA	XXX
97014		I	Electric stimulation therapy	+0.18	0.19	0.19	0.01	0.38	0.38	XXX
97016		A	Vasopneumatic device therapy	0.18	0.19	NA	0.01	0.38	NA	XXX
97018		A	Paraffin bath therapy	0.06	0.11	NA	0.01	0.18	NA	XXX
97020		A	Microwave therapy	0.06	0.06	NA	0.01	0.13	NA	XXX
97022		A	Whirlpool therapy	0.17	0.22	NA	0.01	0.40	NA	XXX
97024		A	Diathermy treatment	0.06	0.09	NA	0.01	0.16	NA	XXX
97026		A	Infrared therapy	0.06	0.06	NA	0.01	0.13	NA	XXX
97028		A	Ultraviolet therapy	0.08	0.07	NA	0.01	0.16	NA	XXX
97032		A	Electrical stimulation	0.25	0.16	NA	0.01	0.42	NA	XXX
97033		A	Electric current therapy	0.26	0.28	NA	0.02	0.56	NA	XXX
97034		A	Contrast bath therapy	0.21	0.16	NA	0.01	0.38	NA	XXX
97035		A	Ultrasound therapy	0.21	0.11	NA	0.01	0.33	NA	XXX
97036		A	Hydrotherapy	0.28	0.33	NA	0.01	0.62	NA	XXX
97039		A	Physical therapy treatment	0.20	0.10	NA	0.01	0.31	NA	XXX
97110		A	Therapeutic exercises	0.45	0.28	NA	0.04	0.77	NA	XXX
97112		A	Neuromuscular reeducation	0.45	0.31	NA	0.02	0.78	NA	XXX
97113		A	Aquatic therapy/exercises	0.44	0.41	NA	0.04	0.89	NA	XXX
97116		A	Gait training therapy	0.40	0.24	NA	0.02	0.66	NA	XXX
97124		A	Massage therapy	0.35	0.23	NA	0.01	0.59	NA	XXX
97139		A	Physical medicine procedure	0.21	0.21	NA	0.01	0.43	NA	XXX
97140		A	Manual therapy	0.43	0.26	NA	0.02	0.71	NA	XXX
97150		A	Group therapeutic procedures	0.27	0.18	NA	0.02	0.47	NA	XXX
97504		A	Orthotic training	0.45	0.33	NA	0.04	0.82	NA	XXX
97520		A	Prosthetic training	0.45	0.28	NA	0.02	0.75	NA	XXX
97530		A	Therapeutic activities	0.44	0.32	NA	0.02	0.78	NA	XXX
97532		A	Cognitive skills development	0.44	0.21	NA	0.01	0.66	NA	XXX
97533		A	Sensory integration	0.44	0.24	NA	0.01	0.69	NA	XXX
97535		A	Self care mngment training	0.45	0.34	NA	0.02	0.81	NA	XXX
97537		A	Community/work reintegration	0.45	0.27	NA	0.01	0.73	NA	XXX
97542		A	Wheelchair mngment training	0.45	0.28	NA	0.01	0.74	NA	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
97601		A	Wound(s) care, selective	0.50	0.50	NA	0.05	1.05	NA	XXX
97602		B	Wound(s) care non-selective	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97703		A	Prosthetic checkout	0.25	0.42	NA	0.02	0.69	NA	XXX
97750		A	Physical performance test	0.45	0.30	NA	0.02	0.77	NA	XXX
97755		A	Assistive technology assess	0.62	0.29	NA	0.02	0.93	NA	XXX
97780		N	Acupuncture w/o stimul	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97781		N	Acupuncture w/stimul	0.00	0.00	0.00	0.00	0.00	0.00	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	0.00	0.47	NA	0.01	0.48	NA	XXX
97803		A	Med nutrition, indiv, subseq	0.00	0.47	NA	0.01	0.48	NA	XXX
97804		A	Medical nutrition, group	0.00	0.18	NA	0.01	0.19	NA	XXX
98925		A	Osteopathic manipulation	0.45	0.33	0.14	0.01	0.79	0.60	000
98926		A	Osteopathic manipulation	0.65	0.43	0.25	0.02	1.10	0.92	000
98927		A	Osteopathic manipulation	0.87	0.52	0.30	0.04	1.43	1.21	000
98928		A	Osteopathic manipulation	1.02	0.61	0.35	0.04	1.67	1.41	000
98929		A	Osteopathic manipulation	1.18	0.69	0.37	0.05	1.92	1.60	000
98940		A	Chiropractic manipulation	0.45	0.24	0.12	0.01	0.70	0.58	000
98941		A	Chiropractic manipulation	0.65	0.30	0.18	0.02	0.97	0.85	000
98942		A	Chiropractic manipulation	0.87	0.37	0.24	0.04	1.28	1.15	000
98943		N	Chiropractic manipulation	+0.40	0.24	0.16	0.01	0.65	0.57	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
99025		F	Initial surgical evaluation	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
99052		B	Medical services at night	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99054		B	Medical servcs, unusual hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99056		B	Non-office medical services	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

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
99070		B	Special supplies	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99071		B	Patient education materials	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99075		N	Medical testimony	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99078		B	Group health education	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99080		B	Special reports or forms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99082		C	Unusual physician travel	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99090		B	Computer data analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99091		B	Collect/review data from pt	0.00	0.00	0.00	0.00	0.00	0.00	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
99141		B	Sedation, iv/im or inhalant	+0.80	1.95	0.39	0.05	2.80	1.24	XXX
99142		B	Sedation, oral/rectal/nasal	+0.60	1.00	0.31	0.04	1.64	0.95	XXX
99170		A	Anogenital exam, child	1.74	1.72	0.53	0.08	3.54	2.35	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	0.00	0.00	0.00	0.00	0.00	XXX
99175		A	Induction of vomiting	0.00	1.38	NA	0.10	1.48	NA	XXX
99183		A	Hyperbaric oxygen therapy	2.33	4.86	0.73	0.14	7.33	3.20	XXX
99185		A	Regional hypothermia	0.00	0.64	NA	0.04	0.68	NA	XXX
99186		A	Total body hypothermia	0.00	1.77	NA	0.44	2.21	NA	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	0.44	NA	0.02	0.46	NA	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	0.45	0.51	0.16	0.02	0.98	0.63	XXX
99202		A	Office/outpatient visit, new	0.87	0.79	0.32	0.06	1.72	1.25	XXX
99203		A	Office/outpatient visit, new	1.33	1.15	0.49	0.10	2.58	1.92	XXX
99204		A	Office/outpatient visit, new	1.99	1.54	0.71	0.12	3.65	2.82	XXX
99205		A	Office/outpatient visit, new	2.65	1.82	0.93	0.14	4.61	3.72	XXX
99211		A	Office/outpatient visit, est	0.17	0.41	0.06	0.01	0.59	0.24	XXX
99212		A	Office/outpatient visit, est	0.45	0.56	0.16	0.02	1.03	0.63	XXX
99213		A	Office/outpatient visit, est	0.67	0.71	0.23	0.04	1.42	0.94	XXX
99214		A	Office/outpatient visit, est	1.09	1.06	0.39	0.05	2.20	1.53	XXX
99215		A	Office/outpatient visit, est	1.76	1.36	0.63	0.08	3.20	2.47	XXX
99217		A	Observation care discharge	1.27	NA	0.54	0.06	NA	1.87	XXX
99218		A	Observation care	1.27	NA	0.44	0.06	NA	1.77	XXX
99219		A	Observation care	2.13	NA	0.71	0.10	NA	2.94	XXX
99220		A	Observation care	2.97	NA	1.02	0.13	NA	4.12	XXX
99221		A	Initial hospital care	1.27	NA	0.45	0.06	NA	1.78	XXX
99222		A	Initial hospital care	2.13	NA	0.73	0.10	NA	2.96	XXX
99223		A	Initial hospital care	2.97	NA	1.03	0.12	NA	4.12	XXX
99231		A	Subsequent hospital care	0.64	NA	0.23	0.02	NA	0.89	XXX
99232		A	Subsequent hospital care	1.05	NA	0.37	0.04	NA	1.46	XXX
99233		A	Subsequent hospital care	1.50	NA	0.53	0.06	NA	2.09	XXX
99234		A	Observ/hosp same date	2.55	NA	0.99	0.13	NA	3.67	XXX
99235		A	Observ/hosp same date	3.40	NA	1.29	0.16	NA	4.85	XXX
99236		A	Observ/hosp same date	4.25	NA	1.58	0.20	NA	6.03	XXX
99238		A	Hospital discharge day	1.27	NA	0.55	0.05	NA	1.87	XXX
99239		A	Hospital discharge day	1.74	NA	0.74	0.06	NA	2.54	XXX
99241		A	Office consultation	0.64	0.65	0.22	0.05	1.34	0.91	XXX
99242		A	Office consultation	1.28	1.06	0.47	0.11	2.45	1.86	XXX
99243		A	Office consultation	1.71	1.41	0.63	0.12	3.24	2.46	XXX
99244		A	Office consultation	2.57	1.85	0.91	0.16	4.58	3.64	XXX
99245		A	Office consultation	3.41	2.29	1.22	0.19	5.89	4.82	XXX
99251		A	Initial inpatient consult	0.66	NA	0.25	0.05	NA	0.96	XXX
99252		A	Initial inpatient consult	1.31	NA	0.51	0.10	NA	1.92	XXX
99253		A	Initial inpatient consult	1.81	NA	0.68	0.11	NA	2.60	XXX
99254		A	Initial inpatient consult	2.62	NA	0.98	0.13	NA	3.73	XXX
99255		A	Initial inpatient consult	3.63	NA	1.34	0.18	NA	5.15	XXX
99261		A	Follow-up inpatient consult	0.42	NA	0.15	0.02	NA	0.59	XXX
99262		A	Follow-up inpatient consult	0.85	NA	0.31	0.04	NA	1.20	XXX
99263		A	Follow-up inpatient consult	1.26	NA	0.46	0.05	NA	1.77	XXX
99271		A	Confirmatory consultation	0.45	0.56	0.16	0.04	1.05	0.65	XXX
99272		A	Confirmatory consultation	0.84	0.83	0.31	0.07	1.74	1.22	XXX
99273		A	Confirmatory consultation	1.18	1.11	0.45	0.08	2.37	1.71	XXX
99274		A	Confirmatory consultation	1.72	1.37	0.64	0.11	3.20	2.47	XXX
99275		A	Confirmatory consultation	2.30	1.64	0.82	0.12	4.06	3.24	XXX
99281		A	Emergency dept visit	0.33	NA	0.09	0.02	NA	0.44	XXX
99282		A	Emergency dept visit	0.55	NA	0.15	0.04	NA	0.74	XXX
99283		A	Emergency dept visit	1.23	NA	0.31	0.10	NA	1.64	XXX
99284		A	Emergency dept visit	1.94	NA	0.48	0.14	NA	2.56	XXX
99285		A	Emergency dept visit	3.04	NA	0.72	0.23	NA	3.99	XXX
99288		B	Direct advanced life support	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
99289	.....	A	Ped crit care transport	4.77	NA	1.68	0.17	NA	6.62	XXX
99290	.....	A	Ped crit care transport addl	2.39	NA	0.83	0.08	NA	3.30	ZZZ
99291	.....	A	Critical care, first hour	3.98	2.37	1.29	0.17	6.52	5.44	XXX
99292	.....	A	Critical care, addl 30 min	1.99	0.81	0.64	0.08	2.88	2.71	ZZZ
99293	.....	A	Ped critical care, initial	15.91	NA	5.00	0.84	NA	21.75	XXX
99294	.....	A	Ped critical care, subseq	7.95	NA	2.50	0.28	NA	10.73	XXX
99295	.....	A	Neonate crit care, initial	18.38	NA	5.43	0.84	NA	24.65	XXX
99296	.....	A	Neonate critical care subseq	7.95	NA	2.57	0.28	NA	10.80	XXX
99298	.....	A	Ic for lbw infant < 1500 gm	2.73	NA	0.94	0.12	NA	3.79	XXX
99299	.....	A	Ic, lbw infant 1500–2500 gm	2.49	NA	0.96	0.12	NA	3.57	XXX
99301	.....	A	Nursing facility care	1.19	0.68	0.41	0.05	1.92	1.65	XXX
99302	.....	A	Nursing facility care	1.60	0.96	0.55	0.06	2.62	2.21	XXX
99303	.....	A	Nursing facility care	2.00	1.18	0.67	0.07	3.25	2.74	XXX
99311	.....	A	Nursing fac care, subseq	0.60	0.49	0.20	0.02	1.11	0.82	XXX
99312	.....	A	Nursing fac care, subseq	0.99	0.66	0.34	0.04	1.69	1.37	XXX
99313	.....	A	Nursing fac care, subseq	1.41	0.85	0.48	0.05	2.31	1.94	XXX
99315	.....	A	Nursing fac discharge day	1.12	0.47	0.38	0.05	1.64	1.55	XXX
99316	.....	A	Nursing fac discharge day	1.49	0.63	0.52	0.06	2.18	2.07	XXX
99321	.....	A	Rest home visit, new patient	0.71	0.35	NA	0.02	1.08	NA	XXX
99322	.....	A	Rest home visit, new patient	1.00	0.47	NA	0.04	1.51	NA	XXX
99323	.....	A	Rest home visit, new patient	1.27	0.56	NA	0.05	1.88	NA	XXX
99331	.....	A	Rest home visit, est pat	0.60	0.32	NA	0.02	0.94	NA	XXX
99332	.....	A	Rest home visit, est pat	0.80	0.39	NA	0.04	1.23	NA	XXX
99333	.....	A	Rest home visit, est pat	0.99	0.47	NA	0.04	1.50	NA	XXX
99341	.....	A	Home visit, new patient	1.00	0.49	NA	0.06	1.55	NA	XXX
99342	.....	A	Home visit, new patient	1.51	0.68	NA	0.06	2.25	NA	XXX
99343	.....	A	Home visit, new patient	2.26	0.95	NA	0.08	3.29	NA	XXX
99344	.....	A	Home visit, new patient	3.01	1.20	NA	0.12	4.33	NA	XXX
99345	.....	A	Home visit, new patient	3.77	1.45	NA	0.14	5.36	NA	XXX
99347	.....	A	Home visit, est patient	0.76	0.41	NA	0.04	1.21	NA	XXX
99348	.....	A	Home visit, est patient	1.25	0.71	NA	0.05	2.01	NA	XXX
99349	.....	A	Home visit, est patient	2.01	1.05	NA	0.07	3.13	NA	XXX
99350	.....	A	Home visit, est patient	3.01	1.43	NA	0.12	4.56	NA	XXX
99354	.....	A	Prolonged service, office	1.76	0.74	0.61	0.07	2.57	2.44	ZZZ
99355	.....	A	Prolonged service, office	1.76	0.72	0.58	0.07	2.55	2.41	ZZZ
99356	.....	A	Prolonged service, inpatient	1.70	NA	0.62	0.07	NA	2.39	ZZZ
99357	.....	A	Prolonged service, inpatient	1.70	NA	0.64	0.07	NA	2.41	ZZZ
99358	.....	B	Prolonged serv, w/o contact	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99359	.....	B	Prolonged serv, w/o contact	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99360	.....	X	Physician standby services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99361	.....	B	Physician/team conference	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99362	.....	B	Physician/team conference	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99371	.....	B	Physician phone consultation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99372	.....	B	Physician phone consultation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99373	.....	B	Physician phone consultation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99374	.....	B	Home health care supervision	+1.09	0.70	0.43	0.05	1.84	1.57	XXX
99375	.....	I	Home health care supervision	+1.72	1.56	1.56	0.07	3.35	3.35	XXX
99377	.....	B	Hospice care supervision	+1.09	0.70	0.43	0.05	1.84	1.57	XXX
99378	.....	I	Hospice care supervision	+1.72	1.95	1.95	0.07	3.74	3.74	XXX
99379	.....	B	Nursing fac care supervision	+1.09	0.70	0.70	0.04	1.83	1.83	XXX
99380	.....	B	Nursing fac care supervision	+1.72	1.00	1.00	0.06	2.78	2.78	XXX
99381	.....	N	Prev visit, new, infant	+1.18	1.51	0.46	0.05	2.74	1.69	XXX
99382	.....	N	Prev visit, new, age 1–4	+1.35	1.55	0.53	0.05	2.95	1.93	XXX
99383	.....	N	Prev visit, new, age 5–11	+1.35	1.49	0.53	0.05	2.89	1.93	XXX
99384	.....	N	Prev visit, new, age 12–17	+1.52	1.56	0.60	0.06	3.14	2.18	XXX
99385	.....	N	Prev visit, new, age 18–39	+1.52	1.56	0.60	0.06	3.14	2.18	XXX
99386	.....	N	Prev visit, new, age 40–64	+1.87	1.75	0.72	0.07	3.69	2.66	XXX
99387	.....	N	Prev visit, new, 65 & over	+2.05	1.88	0.79	0.07	4.00	2.91	XXX
99391	.....	N	Prev visit, est, infant	+1.01	1.02	0.40	0.04	2.07	1.45	XXX
99392	.....	N	Prev visit, est, age 1–4	+1.18	1.09	0.46	0.05	2.32	1.69	XXX
99393	.....	N	Prev visit, est, age 5–11	+1.18	1.06	0.46	0.05	2.29	1.69	XXX
99394	.....	N	Prev visit, est, age 12–17	+1.35	1.14	0.53	0.05	2.54	1.93	XXX
99395	.....	N	Prev visit, est, age 18–39	+1.35	1.17	0.53	0.05	2.57	1.93	XXX
99396	.....	N	Prev visit, est, age 40–64	+1.52	1.26	0.60	0.06	2.84	2.18	XXX
99397	.....	N	Prev visit, est, 65 & over	+1.70	1.37	0.66	0.06	3.13	2.42	XXX
99401	.....	N	Preventive counseling, indiv	+0.48	0.63	0.19	0.01	1.12	0.68	XXX
99402	.....	N	Preventive counseling, indiv	+0.97	0.87	0.38	0.02	1.86	1.37	XXX
99403	.....	N	Preventive counseling, indiv	+1.45	1.09	0.57	0.04	2.58	2.06	XXX
99404	.....	N	Preventive counseling, indiv	+1.94	1.33	0.75	0.05	3.32	2.74	XXX
99411	.....	N	Preventive counseling, group	+0.15	0.18	0.06	0.01	0.34	0.22	XXX
99412	.....	N	Preventive counseling, group	+0.25	0.25	0.10	0.01	0.51	0.36	XXX
99420	.....	N	Health risk assessment test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99429	.....	N	Unlisted preventive service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99431	.....	A	Initial care, normal newborn	1.16	NA	0.39	0.05	NA	1.60	XXX
99432	.....	A	Newborn care, not in hosp	1.25	0.91	0.41	0.07	2.23	1.73	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
99433	.....	A	Normal newborn care/hospital	0.62	NA	0.20	0.02	NA	0.84	XXX
99435	.....	A	Newborn discharge day hosp	1.49	NA	0.51	0.06	NA	2.06	XXX
99436	.....	A	Attendance, birth	1.49	NA	0.48	0.06	NA	2.03	XXX
99440	.....	A	Newborn resuscitation	2.91	NA	0.93	0.13	NA	3.97	XXX
99450	.....	N	Life/disability evaluation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99455	.....	R	Disability examination	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
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
99551	.....	F	Home infus, pain mgmt, iv/sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99552	.....	F	Hm infus pain mgmt, epid/ith	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99553	.....	F	Home infuse, tocolytic tx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99554	.....	F	Home infus, hormone/platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99555	.....	F	Home infuse, chemotheraphy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99556	.....	F	Home infus, antibio/fung/vir	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99557	.....	F	Home infuse, anticoagulant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99558	.....	F	Home infuse, immunotherapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99559	.....	F	Home infus, penton dialysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99560	.....	F	Home infus, entero nutrition	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99561	.....	F	Home infuse, hydration tx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99562	.....	F	Home infus, parent nutrition	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99563	.....	F	Home admin, pentamidine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99564	.....	F	Hme infus, antihemophil agnt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99565	.....	F	Home infus, proteinase inhib	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99566	.....	F	Home infuse, iv therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99567	.....	F	Home infuse, sympath agent	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99568	.....	F	Home infus, misc drug, daily	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99569	.....	F	Home infuse, each addl tx	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 addl hr	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
D0150	.....	R	Comprehensve oral evaluation	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0240	.....	R	Intraoral occlusal film	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0250	.....	R	Extraoral first film	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0260	.....	R	Extraoral ea additional film	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0270	.....	R	Dental bitewing single film	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0272	.....	R	Dental bitewings two films	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0274	.....	R	Dental bitewings four films	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0277	.....	R	Vert bitewings-sev to eight	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0460	.....	R	Pulp vitality test	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0472	.....	R	Gross exam, prep & report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0473	.....	R	Micro exam, prep & report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0474	.....	R	Micro w exam of surg margins	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0480	.....	R	Cytopath smear prep & report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0502	.....	R	Other oral pathology procedu	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0999	.....	R	Unspecified diagnostic proce	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D1510	.....	R	Space maintainer fxd unilat	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D1515	.....	R	Fixed bilat space maintainer	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D1520	.....	R	Remove unilat space maintain	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D1525	.....	R	Remove bilat space maintain	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D1550	.....	R	Recement space maintainer	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D2970	.....	R	Temporary- fractured tooth	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D2999	.....	R	Dental unspec restorative pr	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D3460	.....	R	Endodontic endosseous implan	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D3999	.....	R	Endodontic procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4260	.....	R	Osseous surgery per quadrant	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4263	.....	R	Bone replce graft first site	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4264	.....	R	Bone replce graft each add	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4268	.....	R	Surgical revision procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D4270	.....	R	Pedicle soft tissue graft pr	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4271	.....	R	Free soft tissue graft proc	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4273	.....	R	Subepithelial tissue graft	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4355	.....	R	Full mouth debridement	0.00	0.00	0.00	0.00	0.00	0.00	YYY

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
D4381		R	Localized chemo delivery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5911		R	Facial moulage sectional	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5912		R	Facial moulage complete	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5951		R	Feeding aid	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5983		R	Radiation applicator	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5984		R	Radiation shield	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5985		R	Radiation cone locator	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5987		R	Commissure splint	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D6920		R	Dental connector bar	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7111		R	Coronal remnants deciduous t	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7140		R	Extraction erupted tooth/exr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7210		R	Rem imp tooth w mucoper flp	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7220		R	Impact tooth remov soft tiss	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7230		R	Impact tooth remov part bony	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7240		R	Impact tooth remov comp bony	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7241		R	Impact tooth rem bony w/comp	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7250		R	Tooth root removal	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7260		R	Oral antral fistula closure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7261		R	Primary closure sinus perf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7291		R	Transseptal fiberotomy	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7940		R	Reshaping bone orthognathic	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9110		R	Tx dental pain minor proc	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9230		R	Analgesia	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9248		R	Sedation (non-iv)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D9630		R	Other drugs/medicaments	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9930		R	Treatment of complications	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9940		R	Dental occlusal guard	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9950		R	Occlusion analysis	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9951		R	Limited occlusal adjustment	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9952		R	Complete occlusal adjustment	0.00	0.00	0.00	0.00	0.00	0.00	YYY
G0001		X	Drawing blood for specimen	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
G0030		C	PET imaging prev PET single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0030	26	A	PET imaging prev PET single	1.49	0.60	0.60	0.05	2.14	2.14	XXX
G0030	TC	C	PET imaging prev PET single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0031		C	PET imaging prev PET multple	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0031	26	A	PET imaging prev PET multple	1.86	0.72	0.72	0.07	2.65	2.65	XXX
G0031	TC	C	PET imaging prev PET multple	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0032		C	PET follow SPECT 78464 singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0032	26	A	PET follow SPECT 78464 singl	1.49	0.55	0.55	0.06	2.10	2.10	XXX
G0032	TC	C	PET follow SPECT 78464 singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0033		C	PET follow SPECT 78464 mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0033	26	A	PET follow SPECT 78464 mult	1.86	0.74	0.74	0.07	2.67	2.67	XXX
G0033	TC	C	PET follow SPECT 78464 mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0034		C	PET follow SPECT 76865 singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0034	26	A	PET follow SPECT 76865 singl	1.49	0.58	0.58	0.06	2.13	2.13	XXX
G0034	TC	C	PET follow SPECT 76865 singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0035		C	PET follow SPECT 78465 mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0035	26	A	PET follow SPECT 78465 mult	1.86	0.73	0.73	0.07	2.66	2.66	XXX
G0035	TC	C	PET follow SPECT 78465 mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0036		C	PET follow comry angio sing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0036	26	A	PET follow comry angio sing	1.49	0.57	0.57	0.05	2.11	2.11	XXX
G0036	TC	C	PET follow comry angio sing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0037		C	PET follow comry angio mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0037	26	A	PET follow comry angio mult	1.86	0.71	0.71	0.07	2.64	2.64	XXX
G0037	TC	C	PET follow comry angio mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0038		C	PET follow myocard perf sing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0038	26	A	PET follow myocard perf sing	1.49	0.53	0.53	0.05	2.07	2.07	XXX
G0038	TC	C	PET follow myocard perf sing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0039		C	PET follow myocard perf mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0039	26	A	PET follow myocard perf mult	1.86	0.72	0.72	0.08	2.66	2.66	XXX
G0039	TC	C	PET follow myocard perf mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0040		C	PET follow stress echo singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0040	26	A	PET follow stress echo singl	1.49	0.61	0.61	0.05	2.15	2.15	XXX
G0040	TC	C	PET follow stress echo singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0041		C	PET follow stress echo mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0041	26	A	PET follow stress echo mult	1.86	0.74	0.74	0.06	2.66	2.66	XXX
G0041	TC	C	PET follow stress echo mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0042		C	PET follow ventriculogm sing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0042	26	A	PET follow ventriculogm sing	1.49	0.62	0.62	0.05	2.16	2.16	XXX
G0042	TC	C	PET follow ventriculogm sing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0043		C	PET follow ventriculogm mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
G0043	26	A	PET follow ventriculogm mult	1.86	0.75	0.75	0.07	2.68	2.68	XXX
G0043	TC	C	PET follow ventriculogm mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0044		C	PET following rest ECG singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0044	26	A	PET following rest ECG singl	1.49	0.60	0.60	0.05	2.14	2.14	XXX
G0044	TC	C	PET following rest ECG singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0045		C	PET following rest ECG mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0045	26	A	PET following rest ECG mult	1.86	0.73	0.73	0.07	2.66	2.66	XXX
G0045	TC	C	PET following rest ECG mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0046		C	PET follow stress ECG singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0046	26	A	PET follow stress ECG singl	1.49	0.60	0.60	0.05	2.14	2.14	XXX
G0046	TC	C	PET follow stress ECG singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0047		C	PET follow stress ECG mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0047	26	A	PET follow stress ECG mult	1.86	0.74	0.74	0.07	2.67	2.67	XXX
G0047	TC	C	PET follow stress ECG mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0101		A	CA screen;pelvic/breast exam	0.45	0.54	0.17	0.01	1.00	0.63	XXX
G0102		A	Prostate ca screening; dre	0.17	0.41	0.06	0.01	0.59	0.24	XXX
G0103		X	Psa, total screening	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0104		A	CA screen;flexi sigmoidscope	0.95	2.24	0.53	0.06	3.25	1.54	000
G0105		A	Colorectal scrn; hi risk ind	3.68	6.13	1.60	0.24	10.05	5.52	000
G0105	53	A	Colorectal scrn; hi risk ind	0.95	2.24	0.53	0.06	3.25	1.54	000
G0106		A	Colon CA screen;barium enema	0.98	2.54	NA	0.18	3.70	NA	XXX
G0106	26	A	Colon CA screen;barium enema	0.98	0.33	0.33	0.05	1.36	1.36	XXX
G0106	TC	A	Colon CA screen;barium enema	0.00	2.21	NA	0.13	2.34	NA	XXX
G0107		X	CA screen; fecal blood test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0108		A	Diab manage trn per indiv	0.00	0.82	NA	0.01	0.83	NA	XXX
G0109		A	Diab manage trn ind/group	0.00	0.48	NA	0.01	0.49	NA	XXX
G0110		D	Nett pulm-rehab educ; ind	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0111		D	Nett pulm-rehab educ; group	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0112		D	Nett;nutrition guid, initial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0113		D	Nett;nutrition guid,subseqnt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0114		D	Nett; psychosocial consult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0115		D	Nett; psychological testing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0116		D	Nett; psychosocial counsel	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0117		T	Glaucoma scrn hgh risk direc	0.45	0.71	0.19	0.02	1.18	0.66	XXX
G0118		T	Glaucoma scrn hgh risk direc	0.17	0.53	0.07	0.01	0.71	0.25	XXX
G0120		A	Colon ca scrn; barium enema	0.98	2.54	NA	0.18	3.70	NA	XXX
G0120	26	A	Colon ca scrn; barium enema	0.98	0.33	0.33	0.05	1.36	1.36	XXX
G0120	TC	A	Colon ca scrn; barium enema	0.00	2.21	NA	0.13	2.34	NA	XXX
G0121		A	Colon ca scrn not hi rsk ind	3.68	6.13	1.60	0.24	10.05	5.52	000
G0121	53	A	Colon ca scrn not hi rsk ind	0.95	2.24	0.53	0.06	3.25	1.54	000
G0122		N	Colon ca scrn; barium enema	+0.98	2.59	2.59	0.18	3.75	3.75	XXX
G0122	26	N	Colon ca scrn; barium enema	+0.98	0.39	0.39	0.05	1.42	1.42	XXX
G0122	TC	N	Colon ca scrn; barium enema	+0.00	2.20	2.20	0.13	2.33	2.33	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	0.18	0.18	0.01	0.61	0.61	XXX
G0125		C	PET image pulmonary nodule	0.00	0.00	NA	0.00	0.00	NA	XXX
G0125	26	A	PET image pulmonary nodule	1.49	0.54	0.54	0.06	2.09	2.09	XXX
G0125	TC	C	PET image pulmonary nodule	0.00	0.00	NA	0.00	0.00	NA	XXX
G0127		R	Trim nail(s)	0.17	0.26	0.07	0.01	0.44	0.25	000
G0128		R	CORF skilled nursing service	0.08	0.03	0.03	0.01	0.12	0.12	XXX
G0130		A	Single energy x-ray study	0.22	0.86	NA	0.06	1.14	NA	XXX
G0130	26	A	Single energy x-ray study	0.22	0.07	0.07	0.01	0.30	0.30	XXX
G0130	TC	A	Single energy x-ray study	0.00	0.79	NA	0.05	0.84	NA	XXX
G0141		A	Scr c/v cyto,autosys and md	0.42	0.18	0.18	0.01	0.61	0.61	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	3.67	0.03	0.01	3.75	0.11	XXX
G0167		D	Hyperbaric oz tx;no md reqrd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0168		A	Wound closure by adhesive	0.45	1.96	0.16	0.01	2.42	0.62	000
G0173		X	Stereo radiosurgery,complete	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	1.09	NA	0.01	1.55	NA	XXX
G0180		A	MD certification HHA patient	0.67	1.33	NA	0.02	2.02	NA	XXX
G0181		A	Home health care supervision	1.72	1.56	NA	0.07	3.35	NA	XXX
G0182		A	Hospice care supervision	1.72	1.76	NA	0.07	3.55	NA	XXX
G0186		C	Dstry eye lesn,fdr vssl tech	0.00	0.00	0.00	0.00	0.00	0.00	YYY
G0202		A	Screeningmammographydigital	0.70	2.75	NA	0.11	3.56	NA	XXX
G0202	26	A	Screeningmammographydigital	0.70	0.23	0.23	0.04	0.97	0.97	XXX
G0202	TC	A	Screeningmammographydigital	0.00	2.52	NA	0.07	2.59	NA	XXX
G0204		A	Diagnosticmammographydigital	0.87	2.77	NA	0.12	3.76	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
G0204	26	A	Diagnosticmammographydigital	0.87	0.29	0.29	0.05	1.21	1.21	XXX
G0204	TC	A	Diagnosticmammographydigital	0.00	2.48	NA	0.07	2.55	NA	XXX
G0206		A	Diagnosticmammographydigital	0.70	2.23	NA	0.11	3.04	NA	XXX
G0206	26	A	Diagnosticmammographydigital	0.70	0.23	0.23	0.05	0.98	0.98	XXX
G0206	TC	A	Diagnosticmammographydigital	0.00	2.00	NA	0.06	2.06	NA	XXX
G0210		C	PET img wholebody dxlung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0210	26	A	PET img wholebody dxlung	1.49	0.52	0.52	0.05	2.06	2.06	XXX
G0210	TC	C	PET img wholebody dxlung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0211		C	PET img wholbody init lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0211	26	A	PET img wholbody init lung	1.49	0.52	0.52	0.05	2.06	2.06	XXX
G0211	TC	C	PET img wholbody init lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0212		C	PET img wholebod restag lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0212	26	A	PET img wholebod restag lung	1.49	0.52	0.52	0.05	2.06	2.06	XXX
G0212	TC	C	PET img wholebod restag lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0213		C	PET img wholbody dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0213	26	A	PET img wholbody dx	1.49	0.52	0.52	0.05	2.06	2.06	XXX
G0213	TC	C	PET img wholbody dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0214		C	PET img wholebod init	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0214	26	A	PET img wholebod init	1.49	0.52	0.52	0.05	2.06	2.06	XXX
G0214	TC	C	PET img wholebod init	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0215		C	PETimg wholebod restag	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0215	26	A	PETimg wholebod restag	1.49	0.53	0.53	0.05	2.07	2.07	XXX
G0215	TC	C	PETimg wholebod restag	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0216		C	PET img wholebod dx melanoma	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0216	26	A	PET img wholebod dx melanoma	1.49	0.52	0.52	0.05	2.06	2.06	XXX
G0216	TC	C	PET img wholebod dx melanoma	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0217		C	PET img wholebod init melan	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0217	26	A	PET img wholebod init melan	1.49	0.53	0.53	0.05	2.07	2.07	XXX
G0217	TC	C	PET img wholebod init melan	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0218		C	PET img wholebod restag mela	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0218	26	A	PET img wholebod restag mela	1.49	0.53	0.53	0.05	2.07	2.07	XXX
G0218	TC	C	PET img wholebod restag mela	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0219		N	PET img wholbod melano nonco	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0219	26	N	PET img wholbod melano nonco	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0219	TC	N	PET img wholbod melano nonco	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0220		C	PET img wholebod dx lymphoma	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0220	26	A	PET img wholebod dx lymphoma	1.49	0.52	0.52	0.05	2.06	2.06	XXX
G0220	TC	C	PET img wholebod dx lymphoma	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0221		C	PET imag wholbod init lympho	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0221	26	A	PET imag wholbod init lympho	1.49	0.52	0.52	0.05	2.06	2.06	XXX
G0221	TC	C	PET imag wholbod init lympho	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0222		C	PET imag wholbod resta lymph	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0222	26	A	PET imag wholbod resta lymph	1.49	0.53	0.53	0.05	2.07	2.07	XXX
G0222	TC	C	PET imag wholbod resta lymph	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0223		C	PET imag wholbod reg dx head	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0223	26	A	PET imag wholbod reg dx head	1.49	0.52	0.52	0.05	2.06	2.06	XXX
G0223	TC	C	PET imag wholbod reg dx head	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0224		C	PET imag wholbod reg ini hea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0224	26	A	PET imag wholbod reg ini hea	1.49	0.52	0.52	0.05	2.06	2.06	XXX
G0224	TC	C	PET imag wholbod reg ini hea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0225		C	PET whol restag headneckonly	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0225	26	A	PET whol restag headneckonly	1.49	0.53	0.53	0.05	2.07	2.07	XXX
G0225	TC	C	PET whol restag headneckonly	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0226		C	PET img wholbody dx esophagl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0226	26	A	PET img wholbody dx esophagl	1.49	0.54	0.54	0.05	2.08	2.08	XXX
G0226	TC	C	PET img wholbody dx esophagl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0227		C	PET img wholbod ini esophage	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0227	26	A	PET img wholbod ini esophage	1.49	0.54	0.54	0.05	2.08	2.08	XXX
G0227	TC	C	PET img wholbod ini esophage	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0228		C	PET img wholbod restg esopha	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0228	26	A	PET img wholbod restg esopha	1.49	0.52	0.52	0.05	2.06	2.06	XXX
G0228	TC	C	PET img wholbod restg esopha	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0229		C	PET img metaboloc brain pres	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0229	26	A	PET img metaboloc brain pres	1.49	0.53	0.53	0.05	2.07	2.07	XXX
G0229	TC	C	PET img metaboloc brain pres	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0230		C	PET myocard viability post	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0230	26	A	PET myocard viability post	1.49	0.55	0.55	0.05	2.09	2.09	XXX
G0230	TC	C	PET myocard viability post	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0231		C	PET WhBD colorec; gamma cam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0231	26	A	PET WhBD colorec; gamma cam	1.49	0.52	0.52	0.05	2.06	2.06	XXX
G0231	TC	C	PET WhBD colorec; gamma cam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0232		C	PET whbd lymphoma; gamma cam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0232	26	A	PET whbd lymphoma; gamma cam	1.49	0.53	0.53	0.05	2.07	2.07	XXX
G0232	TC	C	PET whbd lymphoma; gamma cam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0233		C	PET whbd melanoma; gamma cam	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
G0233	26	A	PET whbd melanoma; gamma cam	1.49	0.53	0.53	0.05	2.07	2.07	XXX
G0233	TC	C	PET whbd melanoma; gamma cam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0234		C	PET WhBD pulm nod; gamma cam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0234	26	A	PET WhBD pulm nod; gamma cam	1.49	0.53	0.53	0.05	2.07	2.07	XXX
G0234	TC	C	PET WhBD pulm nod; gamma cam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0236		F	Digital film convert diag ma	+0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
G0236	26	F	Digital film convert diag ma	+0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
G0236	TC	F	Digital film convert diag ma	+0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
G0237		A	Therapeutic procd strg endur	0.00	0.47	NA	0.02	0.49	NA	XXX
G0238		C	Oth resp proc, indiv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0239		C	Oth resp proc, group	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0242		X	Multisource photon ster plan	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0243		X	Multisour photon stero treat	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0244		E	Observ care by facility topt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0245		R	Initial foot exam pt lops	0.87	0.79	0.32	0.06	1.72	1.25	XXX
G0246		R	Followup eval of foot pt lop	0.45	0.56	0.16	0.02	1.03	0.63	XXX
G0247		R	Routine footcare pt w lops	0.50	0.52	0.21	0.06	1.08	0.77	ZZZ
G0248		R	Demonstrate use home inr mon	0.00	6.84	NA	0.01	6.85	NA	XXX
G0249		R	Provide test material,equipm	0.00	3.97	NA	0.01	3.98	NA	XXX
G0250		R	MD review interpret of test	0.18	0.06	0.06	0.01	0.25	0.25	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	0.00	0.00	0.00	XXX
G0252	26	N	PET imaging initial dx	+1.50	0.60	0.60	0.04	2.14	2.14	XXX
G0252	TC	N	PET imaging initial dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0253		C	PET image brst dection recur	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0253	26	A	PET image brst dection recur	1.86	0.71	0.71	0.08	2.65	2.65	XXX
G0253	TC	C	PET image brst dection recur	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0254		C	PET image brst eval to tx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0254	26	A	PET image brst eval to tx	1.86	0.71	0.71	0.08	2.65	2.65	XXX
G0254	TC	C	PET image brst eval to tx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0255		N	Current percep threshold tst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0255	26	N	Current percep threshold tst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0255	TC	N	Current percep threshold tst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0256		E	Prostate brachy w palladium	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
G0258		E	IV infusion during obs stay	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
G0261		E	Prostate brachy w iodine see	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0262		D	Sm intestinal image capsule	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0262	26	D	Sm intestinal image capsule	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0262	TC	D	Sm intestinal image capsule	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0263		E	Adm with CHF, CP, asthma	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0264		E	Assmt otr CHF, CP, asthma	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0265		X	Cryopresevation Freeze+stora	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0266		X	Thawing + expansion froz cel	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0267		X	Bone marrow or psc harvest	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0268		A	Removal of impacted wax md	0.61	0.64	0.25	0.05	1.30	0.91	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	0.00	0.47	NA	0.01	0.48	NA	XXX
G0271		A	Group MNT 2 or more 30 mins	0.00	0.18	NA	0.01	0.19	NA	XXX
G0272		D	Naso/oro gastric tube pl MD	0.00	0.00	0.00	0.00	0.00	0.00	000
G0273		D	Pretx planning, non-Hodgkins	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0273	26	D	Pretx planning, non-Hodgkins	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0273	TC	D	Pretx planning, non-Hodgkins	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0274		D	Radiopharm tx, non-Hodgkins	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0274	26	D	Radiopharm tx, non-Hodgkins	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0274	TC	D	Radiopharm tx, non-Hodgkins	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0275		A	Renal angio, cardiac cath	0.25	NA	0.10	0.01	NA	0.36	ZZZ
G0278		A	Iliac art angio,cardiac cath	0.25	NA	0.10	0.01	NA	0.36	ZZZ
G0279		C	Excorp shock tx, elbow epi	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0280		C	Excorp shock tx other than	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0281		A	Elec stim unattend for press	0.18	0.11	NA	0.01	0.30	NA	XXX
G0282		N	Elect stim,wound care not pd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0283		A	Elec stim other than wound	0.18	0.11	NA	0.01	0.30	NA	XXX
G0288		A	Recon, CTA for surg plan	0.00	10.53	NA	0.18	10.71	NA	XXX
G0289		A	Arthro, loose body + chondro	1.47	NA	0.57	0.32	NA	2.36	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
G0292		E	Adm exp drugs,clinical trial	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
G0296		C	PET imge restag thyrod cance	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0296	26	A	PET imge restag thyrod cance	1.86	0.71	0.71	0.08	2.65	2.65	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility Total	Facility total	Global
G0296	TC	C	PET imge restag thyrod cance	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0297		X	Insert single chamber/cd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0298		X	Insert dual chamber/cd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0299		X	Inser/repos single icd+leads	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0300		X	Insert reposit lead dual+gen	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
G0308		A	ESRD related svc 4+mo<2yrs	12.69	8.58	8.58	0.42	21.69	21.69	XXX
G0309		A	ESRD related svc 2–3mo<2yrs	10.57	7.13	7.13	0.36	18.06	18.06	XXX
G0310		A	ESRD related svc 1 visit<2yr	8.45	5.72	5.72	0.28	14.45	14.45	XXX
G0311		A	ESRD related svs 4+mo 2–11yr	9.68	4.74	4.74	0.34	14.76	14.76	XXX
G0312		A	ESRD relate svs 2–3 mo 2–11y	8.07	3.94	3.94	0.29	12.30	12.30	XXX
G0313		A	ESRD related svs 1 mon 2–11y	6.46	3.16	3.16	0.22	9.84	9.84	XXX
G0314		A	ESRD related svs 4+ mo 12–19	8.24	4.45	4.45	0.26	12.95	12.95	XXX
G0315		A	ESRD related svs 2–3mo 12–19	6.87	3.69	3.69	0.23	10.79	10.79	XXX
G0316		A	ESRD relate svs 1 vist 12–19	5.50	2.96	2.96	0.17	8.63	8.63	XXX
G0317		A	ESRD related svs 4+mo 20+yrs	5.07	2.88	2.88	0.17	8.12	8.12	XXX
G0318		A	ESRD related svs 2–3 mo 20+y	4.23	2.39	2.39	0.14	6.76	6.76	XXX
G0319		A	ESRD related svs 1 visit 20+	3.38	1.92	1.92	0.11	5.41	5.41	XXX
G0320		A	ESRD related svs home under2	10.57	7.13	7.13	0.36	18.06	18.06	XXX
G0321		A	ESRD related svs home mo<2ys	6.87	3.69	3.69	0.23	10.79	10.79	XXX
G0322		A	ESRD relate svs home mo12–19	8.07	3.94	3.94	0.29	12.30	12.30	XXX
G0323		A	ESRD related svs home mo 20+	4.23	2.39	2.39	0.14	6.76	6.76	XXX
G0324		A	ESRD related svs home/dy<2y	0.35	0.24	0.24	0.01	0.60	0.60	XXX
G0325		A	ESRD relate home/dy 2–11 yr	0.23	0.12	0.12	0.01	0.36	0.36	XXX
G0326		A	ESRD relate home/dy 12–19y	0.27	0.13	0.13	0.01	0.41	0.41	XXX
G0327		A	ESRD relate home/dy 20+yrs	0.14	0.08	0.08	0.01	0.23	0.23	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
G9016		N	Demo-smoking cessation coun	0.00	0.00	0.00	0.00	0.00	0.00	XXX
M0064		A	Visit for drug monitoring	0.37	0.35	0.12	0.01	0.73	0.50	XXX
P3001		A	Screening pap smear by phys	0.42	0.18	0.18	0.01	0.61	0.61	XXX
Q0035		A	Cardiokymography	0.17	0.46	NA	0.03	0.66	NA	XXX
Q0035	26	A	Cardiokymography	0.17	0.07	0.07	0.01	0.25	0.25	XXX
Q0035	TC	A	Cardiokymography	0.00	0.39	NA	0.02	0.41	NA	XXX
Q0091		A	Obtaining screen pap smear	0.37	0.67	0.14	0.01	1.05	0.52	XXX
Q0092		A	Set up port xray equipment	0.00	0.32	NA	0.01	0.33	NA	XXX
Q3014		X	Telehealth facility fee	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0070		C	Transport portable x-ray	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0075		C	Transport port x-ray multipl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0076		B	Transport portable EKG	0.00	0.00	0.00	0.00	0.00	0.00	XXX
V5299		R	Hearing service	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM C.—CODES WITH INTERIM RVUS

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility total	Facility total	Global
11400		A	Exc tr-ext b9+marg 0.5 < cm	0.85	2.04	0.90	0.07	2.96	1.82	010
11401		A	Exc tr-ext b9+marg 0.6–1 cm	1.22	2.10	1.04	0.11	3.43	2.37	010
11402		A	Exc tr-ext b9+marg 1.1–2 cm	1.50	2.27	1.10	0.14	3.91	2.74	010
11403		A	Exc tr-ext b9+marg 2.1–3 cm	1.78	2.45	1.35	0.19	4.42	3.32	010
11404		A	Exc tr-ext b9+marg 3.1–4 cm	2.05	2.77	1.43	0.22	5.04	3.70	010
11406		A	Exc tr-ext b9+marg > 4.0 cm	2.74	3.14	1.69	0.30	6.18	4.73	010

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ADDENDUM C.—CODES WITH INTERIM RVUs—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility total	Facility total	Global
11420		A	Exc h-f-nk-sp b9+marg 0.5 <	0.97	1.80	0.94	0.10	2.87	2.01	010
11421		A	Exc h-f-nk-sp b9+marg 0.6–1	1.41	2.10	1.13	0.13	3.64	2.67	010
11422		A	Exc h-f-nk-sp b9+marg 1.1–2	1.62	2.30	1.36	0.17	4.09	3.15	010
11423		A	Exc h-f-nk-sp b9+marg 2.1–3	2.00	2.64	1.48	0.20	4.84	3.68	010
11424		A	Exc h-f-nk-sp b9+marg 3.1–4	2.42	2.86	1.63	0.25	5.53	4.30	010
11426		A	Exc h-f-nk-sp b9+marg > 4 cm	3.76	3.57	2.13	0.41	7.74	6.30	010
11440		A	Exc face-mm b9+marg 0.5 < cm	1.05	2.31	1.35	0.10	3.46	2.50	010
11441		A	Exc face-mm b9+marg 0.6–1 cm	1.47	2.42	1.53	0.13	4.02	3.13	010
11442		A	Exc face-mm b9+marg 1.1–2 cm	1.71	2.62	1.60	0.17	4.50	3.48	010
11443		A	Exc face-mm b9+marg 2.1–3 cm	2.28	3.01	1.85	0.22	5.51	4.35	010
11444		A	Exc face-mm b9+marg 3.1–4 cm	3.12	3.58	2.21	0.30	7.00	5.63	010
11446		A	Exc face-mm b9+marg > 4 cm	4.46	4.16	2.82	0.36	8.98	7.64	010
11600		A	Exc tr-ext mlg+marg 0.5 < cm	1.30	2.70	0.99	0.11	4.11	2.40	010
11601		A	Exc tr-ext mlg+marg 0.6–1 cm	1.79	2.76	1.24	0.14	4.69	3.17	010
11602		A	Exc tr-ext mlg+marg 1.1–2 cm	1.94	2.90	1.29	0.16	5.00	3.39	010
11603		A	Exc tr-ext mlg+marg 2.1–3 cm	2.18	3.15	1.35	0.19	5.52	3.72	010
11604		A	Exc tr-ext mlg+marg 3.1–4 cm	2.39	3.46	1.42	0.22	6.07	4.03	010
11606		A	Exc tr-ext mlg+marg > 4 cm	3.41	4.16	1.77	0.34	7.91	5.52	010
11620		A	Exc h-f-nk-sp mlg+marg 0.5 <	1.18	2.66	0.97	0.11	3.95	2.26	010
11621		A	Exc h-f-nk-sp mlg+marg 0.6–1	1.75	2.77	1.26	0.14	4.66	3.15	010
11622		A	Exc h-f-nk-sp mlg+marg 1.1–2	2.08	3.04	1.41	0.18	5.30	3.67	010
11623		A	Exc h-f-nk-sp mlg+marg 2.1–3	2.60	3.41	1.61	0.24	6.25	4.45	010
11624		A	Exc h-f-nk-sp mlg+marg 3.1–4	3.04	3.83	1.80	0.30	7.17	5.14	010
11626		A	Exc h-f-nk-sp mlg+mar > 4 cm	4.28	4.74	2.43	0.42	9.44	7.13	010
11640		A	Exc face-mm malig+marg 0.5 <	1.34	2.73	1.13	0.12	4.19	2.59	010
11641		A	Exc face-mm malig+marg 0.6–1	2.15	3.10	1.55	0.18	5.43	3.88	010
11642		A	Exc face-mm malig+marg 1.1–2	2.58	3.48	1.75	0.22	6.28	4.55	010
11643		A	Exc face-mm malig+marg 2.1–3	3.08	3.89	1.98	0.29	7.26	5.35	010
11644		A	Exc face-mm malig+marg 3.1–4	4.01	4.79	2.49	0.40	9.20	6.90	010
11646		A	Exc face-mm mlg+marg > 4 cm	5.92	5.87	3.53	0.55	12.34	10.00	010
20982		A	Ablate, bone tumor(s) perq	7.24	106.25	3.02	0.68	114.17	10.94	000
21030		A	Excise max/zygoma b9 tumor	3.87	6.57	4.05	0.72	11.16	8.64	090
21040		A	Excise mandible lesion	3.87	6.61	3.88	0.23	10.71	7.98	090
21685		A	Hyoid myotomy & suspension	12.93	NA	10.21	1.51	NA	24.65	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
22532		A	Lat thorax spine fusion	23.86	NA	14.92	4.53	NA	43.31	090
22533		A	Lat lumbar spine fusion	22.99	NA	13.60	3.81	NA	40.40	090
22534		A	Lat thor/lumb, addl seg	5.97	NA	3.08	1.17	NA	10.22	ZZZ
31622		A	Dx bronchoscope/wash	2.76	4.20	0.89	0.17	7.13	3.82	000
31623		A	Dx bronchoscope/brush	2.86	5.09	0.90	0.17	8.12	3.93	000
31624		A	Dx bronchoscope/lavage	2.86	4.32	0.90	0.16	7.34	3.92	000
31625		A	Bronchoscopy w/biopsy(s)	3.35	5.41	1.27	0.19	8.95	4.81	000
31628		A	Bronchoscopy/lung bx, each	3.79	5.62	1.36	0.17	9.58	5.32	000
31629		A	Bronchoscopy/needle bx, each	3.35	NA	1.24	0.16	NA	4.75	000
31630		A	Bronchoscopy dilate/fx repr	3.80	NA	1.98	0.36	NA	6.14	000
31631		A	Bronchoscopy, dilate w/stent	4.35	NA	2.01	0.37	NA	6.73	000
31632		A	Bronchoscopy/lung bx, addl	1.02	0.76	0.32	0.17	1.95	1.51	ZZZ
31633		A	Bronchoscopy/needle bx addl	1.31	0.92	0.41	0.17	2.40	1.89	ZZZ
31635		A	Bronchoscopy w/fb removal	3.66	NA	1.68	0.25	NA	5.59	000
31640		A	Bronchoscopy w/tumor excise	4.91	NA	2.33	0.44	NA	7.68	000
33310		A	Exploratory heart surgery	18.40	NA	9.27	2.71	NA	30.38	090
33315		A	Exploratory heart surgery	22.24	NA	10.53	3.48	NA	36.25	090
34805		A	Endovasc abdo repair w/pros	21.76	NA	9.51	1.98	NA	33.25	090
35510		A	Artery bypass graft	22.87	NA	10.22	2.09	NA	35.18	090
35512		A	Artery bypass graft	22.37	NA	10.05	2.09	NA	34.51	090
35522		A	Artery bypass graft	21.64	NA	9.79	2.09	NA	33.52	090
35525		A	Artery bypass graft	20.51	NA	9.41	2.09	NA	32.01	090
35697		A	Reimplant artery each	2.98	NA	1.03	0.41	NA	4.42	ZZZ
36511		A	Apheresis wbc	1.73	NA	0.69	0.07	NA	2.49	000
36512		A	Apheresis rbc	1.73	NA	0.69	0.07	NA	2.49	000
36513		A	Apheresis platelets	1.73	NA	0.69	0.07	NA	2.49	000
36514		A	Apheresis plasma	1.73	NA	0.69	0.07	NA	2.49	000
36515		A	Apheresis, adsorp/reinfuse	1.73	NA	0.73	0.07	NA	2.53	000
36516		A	Apheresis, selective	1.73	NA	0.73	0.07	NA	2.53	000
36555		A	Insert non-tunnel cv cath	2.66	6.06	0.82	0.20	8.92	3.68	000
36556		A	Insert non-tunnel cv cath	2.49	5.06	0.75	0.10	7.65	3.34	000
36557		A	Insert tunneled cv cath	5.07	13.64	2.59	0.59	19.30	8.25	010
36558		A	Insert tunneled cv cath	4.77	13.54	2.48	0.59	18.90	7.84	010
36560		A	Insert tunneled cv cath	6.21	29.38	2.98	0.59	36.18	9.78	010
36561		A	Insert tunneled cv cath	5.97	29.29	2.89	0.59	35.85	9.45	010
36563		A	Insert tunneled cv cath	6.16	26.75	2.99	0.67	33.58	9.82	010
36565		A	Insert tunneled cv cath	5.97	22.30	2.89	0.59	28.86	9.45	010
36566		A	Insert tunneled cv cath	6.46	23.11	3.06	0.59	30.16	10.11	010
36568		A	Insert tunneled cv cath	1.91	8.29	0.60	0.20	10.40	2.71	000

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ADDENDUM C.—CODES WITH INTERIM RVUS—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility total	Facility total	Global
36569	.....	A	Insert tunneled cv cath	1.81	6.77	0.58	0.16	8.74	2.55	000
36570	.....	A	Insert tunneled cv cath	5.29	40.53	2.66	0.59	46.41	8.54	010
36571	.....	A	Insert tunneled cv cath	5.27	35.86	2.65	0.59	41.72	8.51	010
36575	.....	A	Repair tunneled cv cath	0.67	3.35	0.26	0.59	4.61	1.52	000
36576	.....	A	Repair tunneled cv cath	3.17	7.73	1.77	0.59	11.49	5.53	010
36578	.....	A	Replace tunneled cv cath	3.48	10.57	2.21	0.59	14.64	6.28	010
36580	.....	A	Replace tunneled cv cath	1.30	5.88	0.42	0.16	7.34	1.88	000
36581	.....	A	Replace tunneled cv cath	3.42	13.30	1.85	0.59	17.31	5.86	010
36582	.....	A	Replace tunneled cv cath	5.17	26.69	2.78	0.59	32.45	8.54	010
36583	.....	A	Replace tunneled cv cath	5.22	13.17	2.80	0.59	18.98	8.61	010
36584	.....	A	Replace tunneled cv cath	1.19	6.33	0.56	0.16	7.68	1.91	000
36585	.....	A	Replace tunneled cv cath	4.77	35.52	2.65	0.59	40.88	8.01	010
36589	.....	A	Removal tunneled cv cath	2.26	2.13	1.42	0.25	4.64	3.93	010
36590	.....	A	Removal tunneled cv cath	3.28	6.34	1.64	0.41	10.03	5.33	010
36595	.....	A	Mech remov tunneled cv cath	3.58	18.94	1.47	0.28	22.80	5.33	000
36596	.....	A	Mech remov tunneled cv cath	0.75	4.43	0.50	0.05	5.23	1.30	000
36597	.....	A	Reposition venous catheter	1.20	3.18	0.44	0.07	4.45	1.71	000
36838	.....	A	Dist revas ligation, hemo	20.51	NA	9.41	2.97	NA	32.89	090
37765	.....	A	Phleb veins—extrem—to 20	7.31	NA	4.56	0.48	NA	12.35	090
37766	.....	A	Phleb veins—extrem 20+	9.25	NA	5.28	0.48	NA	15.01	090
37785	.....	A	Ligate/divide/excise vein	3.82	5.16	2.66	0.49	9.47	6.97	090
38207	.....	I	Cryopreserve stem cells	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38208	.....	I	Thaw preserved stem cells	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38209	.....	I	Wash harvest stem cells	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38210	.....	I	T-cell depletion of harvest	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38211	.....	I	Tumor cell deplete of harvst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38212	.....	I	Rbc depletion of harvest	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38213	.....	I	Platelet deplete of harvest	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38214	.....	I	Volume deplete of harvest	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38215	.....	I	Harvest stem cell concentrte	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43235	.....	A	Uppr gi endoscopy, diagnosis	2.38	5.12	1.08	0.16	7.66	3.62	000
43237	.....	A	Endoscopic us exam, esoph	3.97	NA	1.63	0.26	NA	5.86	000
43238	.....	A	Uppr gi endoscopy w/us fn bx	5.00	NA	1.99	0.26	NA	7.25	000
43242	.....	A	Uppr gi endoscopy w/us fn bx	7.27	NA	2.82	0.35	NA	10.44	000
43259	.....	A	Endoscopic ultrasound exam	5.17	NA	2.06	0.26	NA	7.49	000
43752	.....	A	Nasal/orogastric w/stent	0.68	0.26	0.26	0.02	0.96	0.96	000
47133	.....	X	Removal of donor liver	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47140	.....	A	Partial removal, donor liver	54.69	NA	22.98	4.77	NA	82.44	090
47141	.....	A	Partial removal, donor liver	67.12	NA	27.70	4.77	NA	99.59	090
47142	.....	A	Partial removal, donor liver	74.57	NA	30.29	4.77	NA	109.63	090
53500	.....	A	Urethrlys, transvag w/ scope	12.14	NA	6.27	0.89	NA	19.30	090
57425	.....	A	Laparoscopy, surg, colpopexy	15.66	NA	6.76	1.73	NA	24.15	090
58545	.....	A	Laparoscopic myomectomy	14.52	NA	7.31	1.74	NA	23.57	090
58546	.....	A	Laparo-myomectomy, complex	18.89	NA	9.12	1.74	NA	29.75	090
58550	.....	A	Laparo-asst vag hysterectomy	14.11	NA	7.44	1.73	NA	23.28	090
58552	.....	A	Laparo-vag hyst incl t/o	14.11	NA	7.42	1.73	NA	23.26	090
58553	.....	A	Laparo-vag hyst, complex	18.89	NA	9.08	1.47	NA	29.44	090
58554	.....	A	Laparo-vag hyst w/t/o, compl	18.89	NA	9.38	1.47	NA	29.74	090
59070	.....	A	Transabdom amnioinfus w/ us	5.22	5.19	2.43	0.28	10.69	7.93	000
59072	.....	A	Umbilical cord occlud w/ us	8.95	NA	3.17	0.67	NA	12.79	000
59074	.....	A	Fetal fluid drainage w/ us	5.22	4.66	2.43	0.28	10.16	7.93	000
59076	.....	A	Fetal shunt placement, w/ us	8.95	NA	3.17	0.67	NA	12.79	000
59897	.....	C	Fetal invas px w/ us	0.00	0.00	0.00	0.00	0.00	0.00	YYY
61537	.....	A	Removal of brain tissue	24.86	NA	14.63	6.45	NA	45.94	090
61538	.....	A	Removal of brain tissue	26.66	NA	15.58	6.45	NA	48.69	090
61539	.....	A	Removal of brain tissue	31.90	NA	18.07	7.93	NA	57.90	090
61540	.....	A	Removal of brain tissue	29.83	NA	17.69	7.93	NA	55.45	090
61543	.....	A	Removal of brain tissue	29.05	NA	16.65	7.32	NA	53.02	090
61566	.....	A	Removal of brain tissue	30.82	NA	17.62	6.45	NA	54.89	090
61567	.....	A	Incision of brain tissue	35.30	NA	20.98	6.45	NA	62.73	090
61863	.....	A	Implant neuroelectrode	13.84	NA	9.34	4.76	NA	27.94	090
61864	.....	A	Implant neuroelectrde, addl	4.47	NA	2.31	1.13	NA	7.91	ZZZ
61867	.....	A	Implant neuroelectrode	22.83	NA	13.98	4.76	NA	41.57	090
61868	.....	A	Implant neuroelectrde, addl	7.87	NA	4.07	1.20	NA	13.14	ZZZ
63101	.....	A	Removal of vertebral body	31.82	NA	19.57	5.66	NA	57.05	090
63102	.....	A	Removal of vertebral body	31.82	NA	19.57	5.66	NA	57.05	090
63103	.....	A	Remove vertebral body add-on	3.88	NA	2.03	0.76	NA	6.67	ZZZ
64449	.....	A	N block inj, lumbar plexus	2.98	NA	0.98	0.10	NA	4.06	010
64517	.....	A	N block inj, hypogas plxs	2.19	2.76	0.89	0.13	5.08	3.21	000
64680	.....	A	Injection treatment of nerve	2.61	6.08	1.31	0.18	8.87	4.10	010
64681	.....	A	Injection treatment of nerve	3.53	8.81	2.13	0.18	12.52	5.84	010
65780	.....	A	Ocular reconst, transplant	10.19	NA	10.04	0.35	NA	20.58	090
65781	.....	A	Ocular reconst, transplant	17.57	NA	13.45	0.35	NA	31.37	090
65782	.....	A	Ocular reconst, transplant	14.91	NA	11.79	0.35	NA	27.05	090
67912	.....	A	Correction eyelid w/ implant	5.65	20.59	5.33	0.28	26.52	11.26	090

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[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM C.—CODES WITH INTERIM RVUS—Continued

CPT[1]/ HCPCS[2]	MOD	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Non-facility total	Facility total	Global
68371		A	Harvest eye tissue, alograft	4.87	NA	4.66	0.20	NA	9.73	010
70557	26	A	Mri brain w/o dye	2.88	0.99	0.99	0.08	3.95	3.95	XXX
70558	26	A	Mri brain w/ dye	3.18	1.09	1.09	0.10	4.37	4.37	XXX
70559	26	A	Mri brain w/o & w/ dye	3.18	1.09	1.09	0.12	4.39	4.39	XXX
75901	26	A	Remove cva device obstruct	0.49	0.16	0.16	0.02	0.67	0.67	XXX
75902	26	A	Remove cva lumen obstruct	0.39	0.13	0.13	0.02	0.54	0.54	XXX
75998	26	A	Fluoroguide for vein device	0.38	0.13	0.13	0.05	0.56	0.56	ZZZ
76082	26	A	Computer mammogram add-on	0.06	0.02	0.02	0.01	0.09	0.09	ZZZ
76083	26	A	Computer mammogram add-on	0.06	0.02	0.02	0.01	0.09	0.09	ZZZ
76514	26	A	Echo exam of eye, thickness	0.17	0.08	0.08	0.01	0.26	0.26	XXX
76937	26	A	Us guide, vascular access	0.30	0.10	0.10	0.05	0.45	0.45	ZZZ
78800	26	A	Tumor imaging, limited area	0.66	0.22	0.22	0.04	0.92	0.92	XXX
78801	26	A	Tumor imaging, mult areas	0.79	0.27	0.27	0.04	1.10	1.10	XXX
78802	26	A	Tumor imaging, whole body	0.86	0.30	0.30	0.04	1.20	1.20	XXX
78803	26	A	Tumor imaging (3D)	1.08	0.39	0.39	0.05	1.52	1.52	XXX
78804	26	A	Tumor imaging, whole body	1.06	0.38	0.38	0.04	1.48	1.48	XXX
79100	26	A	Hematopoetic nuclear therapy	1.31	0.47	0.47	0.06	1.84	1.84	XXX
79400	26	A	Nonhemato nuclear therapy	1.95	0.67	0.67	0.10	2.72	2.72	XXX
79403	26	A	Hematopoetic nuclear therapy	2.24	0.91	0.91	0.10	3.25	3.25	XXX
85396		A	Clotting assay, whole blood	0.37	NA	0.17	0.04	NA	0.58	XXX
88112	26	A	Cytopath, cell enhance tech	1.17	0.53	0.53	0.06	1.76	1.76	XXX
88342	26	A	Immunohistochemistry	0.85	0.38	0.38	0.04	1.27	1.27	XXX
88358	26	A	Analysis, tumor	2.80	1.24	1.24	0.12	4.16	4.16	XXX
88361	26	A	Immunohistochemistry, tumor	0.93	0.42	0.42	0.12	1.47	1.47	XXX
91110	26	A	Gi tract capsule endoscopy	3.63	1.31	1.31	0.02	4.96	4.96	XXX
93784		A	Ambulatory BP monitoring	0.17	0.97	0.97	0.02	1.16	1.16	XXX
93786		A	Ambulatory BP recording	0.00	0.90	NA	0.01	0.91	NA	XXX
93788		A	Ambulatory BP analysis	0.00	0.51	NA	0.01	0.52	NA	XXX
93790		A	Review/report BP recording	0.17	0.06	0.06	0.01	0.24	0.24	XXX
95990		A	Spin/brain pump refil & main	0.00	1.49	NA	0.06	1.55	NA	XXX
95991		A	Spin/brain pump refil & main	0.77	1.49	0.19	0.06	2.32	1.02	XXX
96110		A	Developmental test, lim	0.00	0.18	NA	0.18	0.36	NA	XXX
96111		A	Developmental test, extend	2.59	1.07	NA	0.18	3.84	NA	XXX
97537		A	Community/work reintegration	0.45	0.27	NA	0.01	0.73	NA	XXX
97755		A	Assistive technology assess	0.62	0.29	NA	0.02	0.93	NA	XXX
G0308		A	ESRD related svc 4+mo<2yrs	12.69	8.58	8.58	0.42	21.69	21.69	XXX
G0309		A	ESRD related svc 2–3mo<2yrs	10.57	7.13	7.13	0.36	18.06	18.06	XXX
G0310		A	ESRD related svc 1 visit<2yr	8.45	5.72	5.72	0.28	14.45	14.45	XXX
G0311		A	ESRD related svs 4+mo 2–11yr	9.68	4.74	4.74	0.34	14.76	14.76	XXX
G0312		A	ESRD relate svs 2–3 mo 2–11y	8.07	3.94	3.94	0.29	12.30	12.30	XXX
G0313		A	ESRD related svs 1 mon 2–11y	6.46	3.16	3.16	0.22	9.84	9.84	XXX
G0314		A	ESRD related svs 4+ mo 12–19	8.24	4.45	4.45	0.26	12.95	12.95	XXX
G0315		A	ESRD related svs 2–3mo 12–19	6.87	3.69	3.69	0.23	10.79	10.79	XXX
G0316		A	ESRD relate svs 1 vist 12–19	5.50	2.96	2.96	0.17	8.63	8.63	XXX
G0317		A	ESRD related svs 4+mo 20+yrs	5.07	2.88	2.88	0.17	8.12	8.12	XXX
G0318		A	ESRD related svs 2–3 mo 20+y	4.23	2.39	2.39	0.14	6.76	6.76	XXX
G0319		A	ESRD related svs 1 visit 20+	3.38	1.92	1.92	0.11	5.41	5.41	XXX
G0320		A	ESRD related svs home under2	10.57	7.13	7.13	0.36	18.06	18.06	XXX
G0321		A	ESRD related svs home mo<2ys	6.87	3.69	3.69	0.23	10.79	10.79	XXX
G0322		A	ESRD relate svs home mo12–19	8.07	3.94	3.94	0.29	12.30	12.30	XXX
G0323		A	ESRD related svs home mo 20+	4.23	2.39	2.39	0.14	6.76	6.76	XXX
G0324		A	ESRD related svs home/dy<2y	0.35	0.24	0.24	0.01	0.60	0.60	XXX
G0325		A	ESRD relate home/dy 2–11 yr	0.23	0.12	0.12	0.01	0.36	0.36	XXX
G0326		A	ESRD relate home/dy 12–19y	0.27	0.13	0.13	0.01	0.41	0.41	XXX
G0327		A	ESRD relate home/dy 20+yrs	0.14	0.08	0.08	0.01	0.23	0.23	XXX

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ADDENDUM D.—2004 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY

Carrier No.	Locality No.	Locality name	Work	Practice expense	Malpractice
00510	00	Alabama	0.978	0.870	0.779
00831	01	Alaska	1.064	1.172	1.126
00832	00	Arizona	0.994	0.978	1.090
00520	13	Arkansas	0.953	0.847	0.389
31146	26	Anaheim/Santa Ana, CA	1.037	1.184	0.955
31146	18	Los Angeles, CA	1.056	1.139	0.955
31140	03	Marin/Napa/Solano, CA	1.015	1.248	0.669
31140	07	Oakland/Berkeley, CA	1.041	1.235	0.669

Payment locality serviced by two carriers.

Note: Only malpractice GPCI has been updated. The work and practice expense GPCIs will be updated as part of a mid-year, 2004 regulation. Malpractice GPCI scaled by 1.0021 to retain budget neutrality.

ADDENDUM D.—2004 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY—Continued

Carrier No.	Locality No.	Locality name	Work	Practice expense	Mal-practice
31140	05	San Francisco, CA	1.068	1.458	0.669
31140	06	San Mateo, CA	1.048	1.432	.663
31140	09	Santa Clara, CA	1.063	1.380	0.622
31146	17	Ventura, CA	1.028	1.125	0.763
31146	99	Rest of California*	1.007	1.034	0.740
31140	99	Rest of California*	1.007	1.034	0.740
00824	01	Colorado	0.985	0.992	0.821
00591	00	Connecticut	1.050	1.156	0.933
00902	01	Delaware	1.019	1.035	0.802
00903	01	DC + MD/VA Suburbs	1.050	1.166	0.917
00590	03	Fort Lauderdale, FL	0.996	1.018	1.790
00590	04	Miami, FL	1.015	1.052	2.399
00590	99	Rest of Florida	0.975	0.946	1.268
00511	01	Atlanta, GA	1.006	1.059	0.951
00511	99	Rest of Georgia	0.970	0.892	0.951
00833	01	Hawaii/Guam	0.997	1.124	0.817
05130	00	Idaho	0.960	0.881	0.478
00952	16	Chicago, IL	1.028	1.092	1.832
00952	12	East St. Louis, IL	0.988	0.924	1.720
00952	15	Suburban Chicago, IL	1.006	1.071	1.648
00952	99	Rest of Illinois	0.964	0.889	1.175
00630	00	Indiana	0.981	0.922	0.459
00826	00	Iowa	0.959	0.876	0.593
00650	00	Kansas*	0.963	0.895	0.738
00740	04	Kansas*	0.963	0.895	0.738
00660	00	Kentucky	0.970	0.866	0.875
00528	01	New Orleans, LA	0.998	0.945	1.240
00528	99	Rest of Louisiana	0.968	0.870	1.066
31142	03	Southern Maine	0.979	0.999	0.652
31142	99	Rest of Maine	0.961	0.910	0.652
00901	01	Baltimore/Surr. Cntys, MD	1.021	1.038	0.931
00901	99	Rest of Maryland	0.984	0.972	0.767
31143	01	Metropolitan Boston	1.041	1.239	0.803
31143	99	Rest of Massachusetts	1.010	1.129	0.803
00953	01	Detroit, MI	1.043	1.038	2.741
00953	99	Rest of Michigan	0.997	0.938	1.545
00954	00	Minnesota	0.990	0.974	0.431
00512	00	Mississippi	0.957	0.837	0.750
00740	02	Metropolitan Kansas City, MO	0.988	0.967	0.896
00523	01	Metropolitan St. Louis, MO	0.994	0.938	0.893
00740	99	Rest of Missouri*	0.946	0.825	0.842
00523	99	Rest of Missouri*	0.946	0.825	0.842
00751	01	Montana	0.950	0.876	0.815
00655	00	Nebraska	0.948	0.877	0.442
00834	00	Nevada	1.005	1.039	1.138
31144	40	New Hampshire	0.986	1.030	0.883
00805	01	Northern NJ	1.058	1.193	0.916
00805	99	Rest of New Jersey	1.029	1.110	0.916
00521	05	New Mexico	0.973	0.900	0.898
00803	01	Manhattan, NY	1.094	1.351	1.586
00803	02	Nyc Suburbs/Long I., NY	1.068	1.251	1.869
00803	03	Poughkpsie/N Nyc Suburbs, NY	1.011	1.075	1.221
14330	04	Queens, NY	1.058	1.228	1.791
00801	99	Rest of New York	0.998	0.944	0.720
05535	00	North Carolina	0.970	0.931	0.618
00820	01	North Dakota	0.950	0.880	0.630
00883	00	Ohio	0.988	0.944	0.967
00522	00	Oklahoma	0.968	0.876	0.413
00835	01	Portland, OR	0.996	1.049	0.438
00835	99	Rest of Oregon	0.961	0.933	0.438
00865	01	Metropolitan Philadelphia, PA	1.023	1.092	1.400
00865	99	Rest of Pennsylvania	0.989	0.929	0.790
00973	20	Puerto Rico	0.881	0.712	0.268
00870	01	Rhode Island	1.017	1.065	0.896
00880	01	South Carolina	0.974	0.904	0.336
00820	02	South Dakota	0.935	0.878	0.385
05440	35	Tennessee	0.975	0.900	0.612

Payment locality serviced by two carriers.

Note: Only malpractice GPCI has been updated. The work and practice expense GPCIs will be updated as part of a mid-year, 2004 regulation. Malpractice GPCI scaled by 1.0021 to retain budget neutrality

ADDENDUM D.—2004 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY—Continued

Carrier No.	Locality No.	Locality name	Work	Practice expense	Mal-practice
00900	31	Austin, TX	0.986	0.996	0.922
00900	20	Beaumont, TX	0.992	0.890	1.318
00900	09	Brazoria, TX	0.992	0.978	1.318
00900	11	Dallas, TX	1.010	1.065	0.996
00900	28	Fort Worth, TX	0.987	0.981	0.996
00900	15	Galveston, TX	0.988	0.969	1.318
00900	18	Houston, TX	1.020	1.007	1.316
00900	99	Rest of Texas	0.966	0.880	1.047
00910	09	Utah	0.976	0.941	0.653
31145	50	Vermont	0.973	0.986	0.527
00973	50	Virgin Islands	0.965	1.023	1.003
00904	00	Virginia	0.984	0.938	0.540
00836	02	Seattle (King Cnty), WA	1.005	1.100	0.803
00836	99	Rest of Washington	0.981	0.972	0.803
00884	16	West Virginia	0.963	0.850	1.462
00951	00	Wisconsin	0.981	0.929	0.865
00825	21	Wyoming	0.967	0.895	0.970

Payment locality serviced by two carriers.
Note: Only malpractice GPCI has been updated. The work and practice expense GPCIs will be updated as part of a mid-year, 2004 regulation. Malpractice GPCI scaled by 1.0021 to retain budget neutrality.

ADDENDUM E.—2005 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY

Carrier No.	Locality No.	Locality name	Work	Practice expense	Mal-practice
00510	00	Alabama	0.978	0.870	0.752
00831	01	Alaska	1.064	1.172	1.029
00832	00	Arizona	0.994	0.978	1.069
00520	13	Arkansas	0.953	0.847	0.438
31146	26	Anaheim/Santa Ana, CA	1.037	1.184	0.954
31146	18	Los Angeles, CA	1.056	1.139	0.954
31140	03	Marin/Napa/Solano, CA	1.015	1.248	0.651
31140	07	Oakland/Berkeley, CA	1.041	1.235	0.651
31140	05	San Francisco, CA	1.068	1.458	0.651
31140	06	San Mateo, CA	1.048	1.432	0.639
31140	09	Santa Clara, CA	1.063	1.380	0.604
31146	17	Ventura, CA	1.028	1.125	0.744
31146	99	Rest of California*	1.007	1.034	0.733
31140	99	Rest of California*	1.007	1.034	0.733
00824	01	Colorado	0.985	0.992	0.803
00591	00	Connecticut	1.050	1.156	0.900
00902	01	Delaware	1.019	1.035	0.892
00903	01	DC + MD/VA Suburbs	1.050	1.166	0.926
00590	03	Fort Lauderdale, FL	0.996	1.018	1.703
00590	04	Miami, FL	1.015	1.052	2.269
00590	99	Rest of Florida	0.975	0.946	1.272
00511	01	Atlanta, GA	1.006	1.059	0.966
00511	99	Rest of Georgia	0.970	0.892	0.966
00833	01	Hawaii/Guam	0.997	1.124	0.800
05130	00	Idaho	0.960	0.881	0.459
00952	16	Chicago, IL	1.028	1.092	1.867
00952	12	East St. Louis, IL	0.988	0.924	1.750
00952	15	Suburban Chicago, IL	1.006	1.071	1.652
00952	99	Rest of Illinois	0.964	0.889	1.193
00630	00	Indiana	0.981	0.922	0.436
00826	00	Iowa	0.959	0.876	0.589
00650	00	Kansas*	0.963	0.895	0.721
00740	04	Kansas*	0.963	0.895	0.721
00660	00	Kentucky	0.970	0.866	0.873
00528	01	New Orleans, LA	0.998	0.945	1.197
00528	99	Rest of Louisiana	0.968	0.870	1.058
31142	03	Southern Maine	0.979	0.999	0.637
31142	99	Rest of Maine	0.961	0.910	0.637
00901	01	Baltimore/Surr. Cntys, MD	1.021	1.038	0.947
00901	99	Rest of Maryland	0.984	0.972	0.760
31143	01	Metropolitan Boston	1.041	1.239	0.823

Payment locality serviced by two carriers.
Note: Only malpractice GPCI has been updated. The work and practice expense GPCIs will be updated as part of a mid-year, 2004 regulation. Malpractice GPCI scaled by 1.0021 to retain budget neutrality.

ADDENDUM E.—2005 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY—Continued

Carrier No.	Locality No.	Locality name	Work	Practice expense	Malpractice
31143	99	Rest of Massachusetts	1.010	1.129	0.823
00953	01	Detroit, MI	1.043	1.038	2.744
00953	99	Rest of Michigan	0.997	0.938	1.518
00954	00	Minnesota	0.990	0.974	0.410
00512	00	Mississippi	0.957	0.837	0.722
00740	02	Metropolitan Kansas City, MO	0.988	0.967	0.946
00523	01	Metropolitan St. Louis, MO	0.994	0.938	0.941
00740	99	Rest of Missouri*	0.946	0.825	0.892
00523	99	Rest of Missouri*	0.946	0.825	0.892
00751	01	Montana	0.950	0.876	0.904
00655	00	Nebraska	0.948	0.877	0.454
00834	00	Nevada	1.005	1.039	1.068
31144	40	New Hampshire	0.986	1.030	0.942
00805	01	Northern NJ	1.058	1.193	0.973
00805	99	Rest of New Jersey	1.029	1.110	0.973
00521	05	New Mexico	0.973	0.900	0.895
00803	01	Manhattan, NY	1.094	1.351	1.504
00803	02	Nyc Suburbs/Long I., NY	1.068	1.251	1.785
00803	03	Poughkpsie/N Nyc Suburbs, NY	1.011	1.075	1.167
14330	04	Queens, NY	1.058	1.228	1.710
00801	99	Rest of New York	0.998	0.944	0.677
05535	00	North Carolina	0.970	0.931	0.640
00820	01	North Dakota	0.950	0.880	0.602
00883	00	Ohio	0.988	0.944	0.976
00522	00	Oklahoma	0.968	0.876	0.382
00835	01	Portland, OR	0.996	1.049	0.441
00835	99	Rest of Oregon	0.961	0.933	0.441
00865	01	Metropolitan Philadelphia, PA	1.023	1.092	1.386
00865	99	Rest of Pennsylvania	0.989	0.929	0.806
00973	20	Puerto Rico	0.881	0.712	0.261
00870	01	Rhode Island	1.017	1.065	0.909
00880	01	South Carolina	0.974	0.904	0.394
00820	02	South Dakota	0.935	0.878	0.365
05440	35	Tennessee	0.975	0.900	0.631
00900	31	Austin, TX	0.986	0.996	0.986
00900	20	Beaumont, TX	0.992	0.890	1.298
00900	09	Brazoria, TX	0.992	0.978	1.298
00900	11	Dallas, TX	1.010	1.065	1.061
00900	28	Fort Worth, TX	0.987	0.981	1.061
00900	15	Galveston, TX	0.988	0.969	1.298
00900	18	Houston, TX	1.020	1.007	1.297
00900	99	Rest of Texas	0.966	0.880	1.138
00910	09	Utah	0.976	0.941	0.662
31145	50	Vermont	0.973	0.986	0.514
00973	50	Virgin Islands	0.965	1.023	1.003
00904	00	Virginia	0.984	0.938	0.579
00836	02	Seattle (King Cnty), WA	1.005	1.100	0.819
00836	99	Rest of Washington	0.981	0.972	0.819
00884	16	West Virginia	0.963	0.850	1.547
00951	00	Wisconsin	0.981	0.929	0.790
00825	21	Wyoming	0.967	0.895	0.935

Payment locality serviced by two carriers.
Note: Only malpractice GPCI has been updated. The work and practice expense GPCIs will be updated as part of a mid-year, 2004 regulation. Malpractice GPCI scaled by 1.0021 to retain budget neutrality.

ADDENDUM F.—UPDATED LIST OF CPT [1]/HCPCS CODES USED TO DESCRIBE CERTAIN DESIGNATED HEALTH SERVICES UNDER THE PHYSICIAN SELF-REFERRAL PROVISIONS (SECTION 1877 OF THE SOCIAL SECURITY ACT)

CLINICAL LABORATORY SERVICES

INCLUDE CPT codes for all clinical laboratory services in the 80000 series, except EXCLUDE CPT codes for the following blood component collection services:

86890	Autologous blood process

ADDENDUM F.—UPDATED LIST OF CPT [1]/HCPCS CODES USED TO DESCRIBE CERTAIN DESIGNATED HEALTH SERVICES UNDER THE PHYSICIAN SELF-REFERRAL PROVISIONS (SECTION 1877 OF THE SOCIAL SECURITY ACT)—Continued

86891	Autologous blood, op salvage
86927	Plasma, fresh frozen
86930	Frozen blood prep
86931	Frozen blood thaw
86932	Frozen blood freeze/thaw
86945	Blood product/irradiation
86950	Leukacyte transfusion

ADDENDUM F.—UPDATED LIST OF CPT [1]/HCPCS CODES USED TO DESCRIBE CERTAIN DESIGNATED HEALTH SERVICES UNDER THE PHYSICIAN SELF-REFERRAL PROVISIONS (SECTION 1877 OF THE SOCIAL SECURITY ACT)—Continued

86965	Pooling blood platelets
86985	Split blood or products

INCLUDE the following CPT and HCPCS level 2 codes for other clinical laboratory services:

0010T	TB test, gamma interferon
0023T	Phenotype drug test, hiv 1
0026T	Measure remnant lipoproteins
0030T	Antiprothrombin antibody
0041T	Detect ur infect agnt w/cpas
0043T	Co expired gas analysis
0058T	Cryopreservation, ovary tiss
0059T	Cryopreservation, oocyte
G0001	Drawing blood for specimen
G0027	Semen analysis
G0103	Psa, total screening
G0107	CA screen; fecal blood test
G0123	Screen cerv/vag thin layer
G0124	Screen c/v thin layer by MD
G0141	Scr c/v cyto,autosys and md
G0143	Scr c/v cyto,thinlayer,rescr
G0144	Scr c/v cyto,thinlayer,rescr
G0145	Scr c/v cyto,thinlayer,rescr
G0147	Scr c/v cyto, automated sys
G0148	Scr c/v cyto, autosys, rescr
G0306	CBC/diffwbc w/o platelet
G0307	CBC without platelet
P2028	Cephalin floculation test
P2029	Congo red blood test
P2033	Blood thymol turbidity
P2038	Blood mucoprotein
P3000	Screen pap by tech w md supv
P3001	Screening pap smear by phys
P9612	Catheterize for urine spec
P9615	Urine specimen collect mult
Q0111	Wet mounts/ w preparations
Q0112	Potassium hydroxide preps
Q0113	Pinworm examinations
Q0114	Fern test
Q0115	Post-coital mucous exam

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH-LANGUAGE PATHOLOGY SERVICES

INCLUDE the following CPT codes for the physical therapy/occupational therapy/speech-language pathology services in the 97000 series:

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
97020	Microwave therapy
97022	Whirlpool therapy
97024	Diathermy treatment
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation
97033	Electric current therapy
97034	Contrast bath therapy
97035	Ultrasound therapy
97036	Hydrotherapy
97039	Physical therapy treatment
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97113	Aquatic therapy/exercises
97116	Gait training therapy
97124	Massage therapy
97139	Physical medicine procedure
97140	Manual therapy
97150	Group therapeutic procedures
97504	Orthotic training
97520	Prosthetic training
97530	Therapeutic activities
97532	Cognitive skills development
97533	Sensory integration
97535	Self care mngment training
97537	Community/work reintegration
97542	Wheelchair mngment training
97545	Work hardening
97546	Work hardening add-on
97703	Prosthetic checkout
97750	Physical performance test
97755	Assistive technology assess
97799	Physical medicine procedure

INCLUDE CPT codes for physical therapy/occupational therapy/speech-language pathology services not in the 97000 series:

64550	Apply neurostimulator
90901	Biofeedback train, any meth
90911	Biofeedback peri/uro/rectal
92506	Speech/hearing evaluation
92507	Speech/hearing therapy
92508	Speech/hearing therapy
92526	Oral function therapy
92597	Oral speech device eval
92601	Cochlear implt f/up exam < 7
92602	Reprogram cochlear implt < 7
92603	Cochlear implt f/up exam 7 >
92604	Reprogram cochlear implt 7 >
92607	Ex for speech device rx, 1hr
92608	Ex for speech device rx addl
92609	Use of speech device service
92610	Evaluate swallowing function
92611	Motion fluoroscopy/swallow
92612	Endoscopy swallow tst (fees)
92614	Laryngoscopic sensory test
92616	Fees w/laryngeal sense test
93797	Cardiac rehab
93798	Cardiac rehab/monitor
94667	Chest wall manipulation
94668	Chest wall manipulation
94762	Measure blood oxygen level
95831	Limb muscle testing, manual
95832	Hand muscle testing, manual
95833	Body muscle testing, manual
95834	Body muscle testing, manual
95851	Range of motion measurements
95852	Range of motion measurements
96000	Motion analysis, video/3d
96001	Motion test w/ft press meas
96002	Dynamic surface emg
96003	Dynamic fine wire emg
96105	Assessment of aphasia
96110	Developmental test, lim
96111	Developmental test, extend
96115	Neurobehavior status exam
0029T	Magnetic tx for incontinence

INCLUDE HCPCS level 2 codes for the following physical therapy/occupational therapy/speech-language pathology services:

G0279	Excorp shock tx, elbow epi
G0280	Excorp shock tx other than
G0281	Elec stim unattend for press
G0283	Elec stim other than wound

RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES

INCLUDE the following codes in the CPT 70000 series:

70100	X-ray exam of jaw
70110	X-ray exam of jaw
70120	X-ray exam of mastoids
70130	X-ray exam of mastoids
70134	X-ray exam of middle ear
70140	X-ray exam of facial bones
70150	X-ray exam of facial bones
70160	X-ray exam of nasal bones
70190	X-ray exam of eye sockets
70200	X-ray exam of eye sockets
70210	X-ray exam of sinuses
70220	X-ray exam of sinuses
70240	X-ray exam, pituitary saddle
70250	X-ray exam of skull
70260	X-ray exam of skull
70300	X-ray exam of teeth
70310	X-ray exam of teeth
70320	Full mouth x-ray of teeth
70328	X-ray exam of jaw joint
70330	X-ray exam of jaw joints
70336	Magnetic image, jaw joint
70350	X-ray head for orthodontia
70355	Panoramic x-ray of jaws
70360	X-ray exam of neck
70370	Throat x-ray & fluoroscopy
70371	Speech evaluation, complex
70380	X-ray exam of salivary gland
70450	Ct head/brain w/o dye
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/ dye
70480	Ct orbit/ear/fossa w/o dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o&w dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/dye
70488	Ct maxillofacial w/o & w dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w dye
70544	Mr angiography head w/o dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o&w dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiograph neck w/o&w dye
70551	Mri brain w/o dye
70552	Mri brain w/ dye
70553	Mri brain w/o & w/ dye
71010	Chest x-ray
71015	Chest x-ray
71020	Chest x-ray
71021	Chest x-ray
71022	Chest x-ray
71023	Chest x-ray and fluoroscopy
71030	Chest x-ray
71034	Chest x-ray and fluoroscopy
71035	Chest x-ray
71100	X-ray exam of ribs
71101	X-ray exam of ribs/chest
71110	X-ray exam of ribs
71111	X-ray exam of ribs/ chest
71120	X-ray exam of breastbone
71130	X-ray exam of breastbone
71250	Ct thorax w/o dye
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/ dye
71275	Ct angiography, chest
71550	Mri chest w/o dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
71555	Mri angio chest w or w/o dye
72010	X-ray exam of spine
72020	X-ray exam of spine
72040	X-ray exam of neck spine
72050	X-ray exam of neck spine
72052	X-ray exam of neck spine
72069	X-ray exam of trunk spine

ADDENDUM F.—UPDATED LIST OF CPT [1]/HCPCS CODES USED TO DESCRIBE CERTAIN DESIGNATED HEALTH SERVICES UNDER THE PHYSICIAN SELF-REFERRAL PROVISIONS (SECTION 1877 OF THE SOCIAL SECURITY ACT)—Continued

72070	X-ray exam of thoracic spine
72072	X-ray exam of thoracic spine
72074	X-ray exam of thoracic spine
72080	X-ray exam of trunk spine
72090	X-ray exam of trunk spine
72100	X-ray exam of lower spine
72110	X-ray exam of lower spine
72114	X-ray exam of lower spine
72120	X-ray exam of lower spine
72125	Ct neck spine w/o dye
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72131	Ct lumbar spine w/o dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72141	Mri neck spine w/o dye
72142	Mri neck spine w/dye
72146	Mri chest spine w/o dye
72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72170	X-ray exam of pelvis
72190	X-ray exam of pelvis
72191	Ct angiograph pelv w/o&w/dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w dye
72198	Mr angio pelvis w/o & w/dye
72200	X-ray exam sacroiliac joints
72202	X-ray exam sacroiliac joints
72220	X-ray exam of tailbone
73000	X-ray exam of collar bone
73010	X-ray exam of shoulder blade
73020	X-ray exam of shoulder
73030	X-ray exam of shoulder
73050	X-ray exam of shoulders
73060	X-ray exam of humerus
73070	X-ray exam of elbow
73080	X-ray exam of elbow
73090	X-ray exam of forearm
73092	X-ray exam of arm, infant
73100	X-ray exam of wrist
73110	X-ray exam of wrist
73120	X-ray exam of hand
73130	X-ray exam of hand
73140	X-ray exam of finger(s)
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o&w/dye
73206	Ct angio upr extrm w/o&w/dye
73218	Mri upper extremity w/o dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o&w/dye
73221	Mri joint upr extrem w/o dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o&w/dye
73500	X-ray exam of hip
73510	X-ray exam of hip
73520	X-ray exam of hips
73540	X-ray exam of pelvis & hips
73550	X-ray exam of thigh
73560	X-ray exam of knee, 1 or 2
73562	X-ray exam of knee, 3
73564	X-ray exam, knee, 4 or more
73565	X-ray exam of knees
73590	X-ray exam of lower leg

ADDENDUM F.—UPDATED LIST OF CPT [1]/HCPCS CODES USED TO DESCRIBE CERTAIN DESIGNATED HEALTH SERVICES UNDER THE PHYSICIAN SELF-REFERRAL PROVISIONS (SECTION 1877 OF THE SOCIAL SECURITY ACT)—Continued

73592	X-ray exam of leg, infant
73600	X-ray exam of ankle
73610	X-ray exam of ankle
73620	X-ray exam of foot
73630	X-ray exam of foot
73650	X-ray exam of heel
73660	X-ray exam of toe(s)
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o&w/dye
73706	Ct angio lwr extr w/o&w/dye
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o&w/dye
73721	Mri jnt of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o&w/dye
73725	Mr ang lwr ext w or w/o dye
74000	X-ray exam of abdomen
74010	X-ray exam of abdomen
74020	X-ray exam of abdomen
74022	X-ray exam series, abdomen
74150	Ct abdomen w/o dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o &w /dye
74175	Ct angio abdom w/o & w/dye
74181	Mri abdomen w/o dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
74185	Mri angio, abdom w orw/o dye
74210	Contrst x-ray exam of throat
74220	Contrast x-ray, esophagus
74230	Cine/vid x-ray, throat/esoph
74240	X-ray exam, upper gi tract
74241	X-ray exam, upper gi tract
74245	X-ray exam, upper gi tract
74246	Contrst x-ray uppr gi tract
74247	Contrst x-ray uppr gi tract
74249	Contrst x-ray uppr gi tract
74250	X-ray exam of small bowel
74290	Contrast x-ray, gallbladder
74291	Contrast x-rays, gallbladder
74710	X-ray measurement of pelvis
75552	Heart mri for morph w/o dye
75553	Heart mri for morph w/dye
75554	Cardiac MRI/function
75555	Cardiac MRI/limited study
75635	Ct angio abdominal arteries
76000	Fluoroscope examination
76006	X-ray stress view
76010	X-ray, nose to rectum
76020	X-rays for bone age
76040	X-rays, bone evaluation
76061	X-rays, bone survey
76062	X-rays, bone survey
76065	X-rays, bone evaluation
76066	Joint survey, single view
76070	Ct bone density, axial
76071	Ct bone density, peripheral
76082	Computer mammogram add-on
76083	Computer mammogram add-on
76090	Mammogram, one breast
76091	Mammogram, both breasts
76092	Mammogram, screening
76093	Magnetic image, breast
76094	Magnetic image, both breasts
76100	X-ray exam of body section
76101	Complex body section x-ray
76102	Complex body section x-rays
76120	Cine/video x-rays
76125	Cine/video x-rays add-on
76150	X-ray exam, dry process
76370	Ct scan for therapy guide
76375	3d/holograph reconstr add-on
76380	CAT scan follow-up study

ADDENDUM F.—UPDATED LIST OF CPT [1]/HCPCS CODES USED TO DESCRIBE CERTAIN DESIGNATED HEALTH SERVICES UNDER THE PHYSICIAN SELF-REFERRAL PROVISIONS (SECTION 1877 OF THE SOCIAL SECURITY ACT)—Continued

76400	Magnetic image, bone marrow
76499	Radiographic procedure
76506	Echo exam of head
76511	Echo exam of eye
76512	Echo exam of eye
76513	Echo exam of eye, water bath
76514	Echo exam of eye, thickness
76516	Echo exam of eye
76519	Echo exam of eye
76536	Us exam of head and neck
76604	Us exam, chest, 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
76818	Fetal biophys profile w/nst
76819	Fetal biophys profil w/o nst
76825	Echo exam of fetal heart
76826	Echo exam of fetal heart
76827	Echo exam of fetal heart
76828	Echo exam of fetal heart
76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited
76870	Us exam, scrotum
76880	Us exam, extremity
76885	Us exam infant hips, dynamic
76886	Us exam infant hips, static
76970	Ultrasound exam follow-up
76977	Us bone density measure
76999	Echo examination procedure
	INCLUDE the following CPT codes for echocardiography and vascular ultrasound:
93303	Echo transthoracic
93304	Echo transthoracic
93307	Echo exam of heart
93308	Echo exam of heart
93320	Doppler echo exam, heart [if used in conjunction with 93303-93308]
93321	Doppler echo exam, heart [if used in conjunction with 93303-93308]
93325	Doppler color flow add-on [if used in conjunction with 93303-93308]
93875	Extracranial study
93880	Extracranial study
93882	Extracranial study
93886	Intracranial study
93888	Intracranial study
93922	Extremity study
93923	Extremity study
93924	Extremity study
93925	Lower extremity study
93926	Lower extremity study
93930	Upper extremity study
93931	Upper extremity study
93965	Extremity study
93970	Extremity study
93971	Extremity study
93975	Vascular study
93976	Vascular study
93978	Vascular study
93979	Vascular study

ADDENDUM F.—UPDATED LIST OF CPT [1]/HCPCS CODES USED TO DESCRIBE CERTAIN DESIGNATED HEALTH SERVICES UNDER THE PHYSICIAN SELF-REFERRAL PROVISIONS (SECTION 1877 OF THE SOCIAL SECURITY ACT)—Continued

93980	Penile vascular study
93981	Penile vascular study
93990	Doppler flow testing

INCLUDE the following CPT and HCPCS level 2 codes:

51798	Us urine capacity measure
91110	Gi tract capsule endoscopy
0028T	Dexa body composition study
0042T	Ct perfusion w/contrast, cbf
G0202	Screeningmammographydigital
G0204	Diagnosticmammographydigital
G0206	Diagnosticmammographydigital
G0288	Recon, CTA for surg plan
R0070	Transport portable x-ray
R0075	Transport port x-ray multipl

RADIATION THERAPY SERVICES AND SUPPLIES

INCLUDE the following codes in the CPT 70000 series:

77261	Radiation therapy planning
77262	Radiation therapy planning
77263	Radiation therapy planning
77280	Set radiation therapy field
77285	Set radiation therapy field
77290	Set radiation therapy field
77295	Set radiation therapy field
77299	Radiation therapy planning
77300	Radiation therapy dose plan
77301	Radiotherapy dose plan, imrt
77305	Teletx isodose plan simple
77310	Teletx isodose plan intermed
77315	Teletx isodose plan complex
77321	Special teletx port plan
77326	Brachytx isodose calc simp
77327	Brachytx isodose calc interm
77328	Brachytx isodose plan compl
77331	Special radiation dosimetry
77332	Radiation treatment aid(s)
77333	Radiation treatment aid(s)
77334	Radiation treatment aid(s)
77336	Radiation physics consult
77370	Radiation physics consult
77399	External radiation dosimetry
77401	Radiation treatment delivery
77402	Radiation treatment delivery
77403	Radiation treatment delivery
77404	Radiation treatment delivery
77406	Radiation treatment delivery
77407	Radiation treatment delivery
77408	Radiation treatment delivery
77409	Radiation treatment delivery
77411	Radiation treatment delivery
77412	Radiation treatment delivery
77413	Radiation treatment delivery

ADDENDUM F.—UPDATED LIST OF CPT [1]/HCPCS CODES USED TO DESCRIBE CERTAIN DESIGNATED HEALTH SERVICES UNDER THE PHYSICIAN SELF-REFERRAL PROVISIONS (SECTION 1877 OF THE SOCIAL SECURITY ACT)—Continued

77414	Radiation treatment delivery
77416	Radiation treatment delivery
77417	Radiology port film(s)
77418	Radiation tx delivery, imrt
77427	Radiation tx management, x5
77431	Radiation therapy management
77432	Stereotactic radiation trmt
77470	Special radiation treatment
77499	Radiation therapy management
77520	Proton trmt, simple w/o comp
77522	Proton trmt, simple w/comp
77523	Proton trmt, intermediate
77525	Proton treatment, complex
77600	Hyperthermia treatment
77605	Hyperthermia treatment
77610	Hyperthermia treatment
77615	Hyperthermia treatment
77620	Hyperthermia treatment
77750	Infuse radioactive materials
77761	Apply intrcav radiat simple
77762	Apply intrcav radiat interm
77763	Apply intrcav radiat compl
77776	Apply interstit radiat simpl
77777	Apply interstit radiat inter
77778	Apply interstit radiat compl
77781	High intensity brachytherapy
77782	High intensity brachytherapy
77783	High intensity brachytherapy
77784	High intensity brachytherapy
77789	Apply surface radiation
77790	Radiation handling
77799	Radium/radioisotope therapy

INCLUDE the following CPT and HCPCS level 2 codes classified elsewhere:

31643	Diag bronchoscope/catheter
50559	Renal endoscopy/radiotracer
55859	Percut/needle insert, pros
61770	Incise skull for treatment
61793	Focus radiation beam
92974	Cath place, cardio brachytx
G0173	Stereo radiosurgery,complete
G0242	Multisource photon ster plan
G0243	Multisour photon stero treat
G0251	Linear acc based stero radio
G0256	Prostate brachy w palladium
G0261	Prostate brachytherapy w/rad
G0338	Linear accelerator stero pln
G0339	Robot lin-radsurg com, first
G0340	Robt lin-radsurg fractx 2-5

DRUGS USED BY PATIENTS UNDERGOING DIALYSIS

The physician self-referral prohibition does not apply to the following dialysis-related outpatient prescription drugs furnished in or by an ESRD facility if the conditions in § 411.355(g) are satisfied:

ADDENDUM F.—UPDATED LIST OF CPT [1]/HCPCS CODES USED TO DESCRIBE CERTAIN DESIGNATED HEALTH SERVICES UNDER THE PHYSICIAN SELF-REFERRAL PROVISIONS (SECTION 1877 OF THE SOCIAL SECURITY ACT)—Continued

J0636	Inj calcitriol per 0.1 mcg
J0895	Deferoxamine mesylate inj
J1270	Injection, doxercalciferol
J1750	Iron dextran
J1756	Iron sucrose injection
J2501	Paricalcitol
J2916	Na ferric gluconate complex
J2997	Alteplase recombinant
Q4054	Darbepoetin alfa, esrd use
Q4055	Epoetin alfa, esrd use

PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES

The physician self-referral prohibition does not apply to the following tests if they are performed for screening purposes and satisfy the conditions in § 411.355(h):

76083	Computer mammogram add-on
76092	Mammogram, screening
76977	Us bone density measure
G0103	Psa, total screening
G0107	CA screen; fecal blood test
G0123	Screen cerv/vag thin layer
G0124	Screen c/v thin layer by MD
G0141	Scr c/v cyto,autosys and md
G0143	Scr c/v cyto,thinlayer,rescr
G0144	Scr c/v cyto,thinlayer,rescr
G0145	Scr c/v cyto,thinlayer,rescr
G0147	Scr c/v cyto, automated sys
G0148	Scr c/v cyto, autosys, rescr
G0202	Screeningmammographydigital
P3000	Screen pap by tech w md supv
P3001	Screening pap smear by phys

The physician self-referral prohibition does not apply to the following immunization and vaccine codes if they satisfy the conditions in § 411.355(h):

90655	Flu vaccine, 6-35 mo, im
90657	Flu vaccine, 6-35 mo, im
90658	Flu vaccine, 3 yrs, im
90732	Pneumococcal vaccine
90740	Hepb vacc, ill pat dose im
90743	Hep b vacc, adol, 2 dose im
90744	Hepb vacc ped/adol 3 dose im
90746	Hepb vaccine, adult, im
90747	Hepb vacc, ill pat 4 dose im

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Friday,
November 7, 2003

Part III

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 410 and 419

Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2004 Payment Rates; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410 and 419

[CMS–1471–FC]

RIN 0938–AL19

Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2004 Payment Rates

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

ACTION: Final rule with comment period.

SUMMARY: This final rule with comment period revises the Medicare hospital outpatient prospective payment system to implement applicable statutory requirements and changes arising from our continuing experience with this system. In addition, it describes changes to the amounts and factors used to determine the payment rates for Medicare hospital outpatient services paid under the prospective payment system. These changes are applicable to services furnished on or after January 1, 2004. Finally, this rule responds to public comments received on the August 12, 2003 proposed rule for revisions to the hospital outpatient prospective payment system and payment rates (68 FR 47966).

DATES: *Effective date:* This final rule is effective January 1, 2004.

Comment date: We will consider comments on the ambulatory payment classification assignments of Healthcare Common Procedure Coding System codes identified in Addendum B with new interim (NI) condition codes, if we receive them at the appropriate address, as provided below, no later than 5 p.m. on January 6, 2004.

ADDRESSES: In commenting, please refer to file code CMS–1471–FC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission or e-mail.

Mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1471–FC, P.O. Box 8018, Baltimore, MD 21244–8018.

Please allow sufficient time for mailed comments to be timely received in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) to one of the following addresses: Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH 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.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Dana Burley, (410) 786–0378—outpatient prospective payment issues; Suzanne Asplen, (410) 786–4558 or Jana Petze, (410) 786–9374—partial hospitalization and community mental health centers issues.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, 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, call (410) 786–7195.

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

Outline of Contents

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

ACEP American College of Emergency Physicians
AHA American Hospital Association
AHIMA American Health Information Management Association
AMA American Medical Association
APC Ambulatory payment classification
ASC Ambulatory surgical center
AWP Average wholesale price
BBA Balanced Budget Act of 1997
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
BBRA Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999
CAH Critical access hospital
CCR Cost center specific cost-to-charge ratio
CMHC Community mental health center
CMS Centers for Medicare & Medicaid Services (Formerly known as the Health Care Financing Administration)
CPT [Physicians'] Current Procedural Terminology, Fourth Edition, 2002, copyrighted by the American Medical Association
CY Calendar year
DMEPOS Durable medical equipment, prosthetics, orthotics, and supplies
DRG Diagnosis-related group
DSH Disproportionate Share Hospital
EACH Essential Access Community Hospital
E/M Evaluation and management
ESRD End-stage renal disease
FACA Federal Advisory Committee Act
FDA Food and Drug Administration
FI Fiscal intermediary
FSS Federal Supply Schedule
FY Federal fiscal year
HCPCS Healthcare Common Procedure Coding System
HCRIS Hospital Cost Report Information System
HHA Home health agency
HIPAA Health Insurance Portability and Accountability Act of 1996
ICD–9–CM International Classification of Diseases, Ninth Edition, Clinical Modification
IME Indirect Medical Education
IPPS (Hospital) inpatient prospective payment system
IVIG Intravenous Immune Globulin
LTC Long Term Care
MedPAC Medicare Payment Advisory Commission
MDH Medicare Dependent Hospital
MSA Metropolitan statistical area
NECMA New England County Metropolitan Area
OCE Outpatient code editor
OMB Office of Management and Budget
OPD (Hospital) outpatient department
OPPS (Hospital) outpatient prospective payment system
PHP Partial hospitalization program
PM Program memorandum
PPS Prospective payment system
PPV Pneumococcal pneumonia (virus)
PRA Paperwork Reduction Act
RFA Regulatory Flexibility Act
RRC Rural Referral Center
SBA Small Business Administration
SCH Sole Community Hospital
SDP Single drug pricer
SI Status Indicator
TEFRA Tax Equity and Fiscal Responsibility Act
TOPS Transitional outpatient payments
USPDI United States Pharmacopoeia Drug Information

I. Background

A. Authority for the Outpatient Prospective Payment System

When the Medicare statute was originally enacted, Medicare payment for hospital outpatient services was based on hospital-specific costs. In an effort to ensure that Medicare and its beneficiaries pay appropriately for services and to encourage more efficient delivery of care, the Congress mandated replacement of the cost-based payment methodology with a prospective payment system (PPS). The Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), enacted on August 5, 1997, added section 1833(t) to the Social Security Act (the Act) authorizing implementation of a PPS for hospital outpatient services. The Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113), enacted on November 29, 1999, made major changes that affected the hospital outpatient PPS (OPPS). The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554), enacted on December 21, 2000, made further changes in the OPPS. The OPPS was first implemented for services furnished on or after August 1, 2000.

B. Summary of Rulemaking for the Outpatient Prospective Payment System

- On September 8, 1998, we published a proposed rule (63 FR 47552) to establish in regulations a PPS for hospital outpatient services, to eliminate the formula-driven overpayment for certain hospital outpatient services, and to extend reductions in payment for costs of hospital outpatient services.
- On April 7, 2000, we published a final rule with comment period (65 FR

18434) that addressed the provisions of the PPS for hospital outpatient services scheduled to be effective for services furnished on or after July 1, 2000. Under this system, Medicare payment for hospital outpatient services included in the PPS is made at a predetermined, specific rate. These outpatient services are classified according to a list of ambulatory payment classifications (APCs). The April 7, 2000 final rule with comment period also established requirements for provider departments and provider-based entities and prohibited Medicare payment for nonphysician services furnished to a hospital outpatient by a provider or supplier other than a hospital unless the services are furnished under arrangement. In addition, this rule extended reductions in payment for costs of hospital outpatient services as required by the BBA and amended by the BBRA. Medicare regulations governing the hospital OPPS are set forth at 42 CFR part 419. Subsequently, we announced a delay in implementation of the OPPS from July 1, 2000 to August 1, 2000.

- On August 3, 2000, we published an interim final rule with comment period (65 FR 47670) that modified criteria that we use to determine which medical devices are eligible for transitional pass-through payments. The rule also corrected and clarified certain provider-based provisions included in the April 7, 2000 rule.
- On November 13, 2000, we published an interim final rule with comment period (65 FR 67798) to provide the annual update to the amounts and factors for OPPS payment rates effective for services furnished on or after January 1, 2001. We implemented the 2001 OPPS on January 1, 2001. We also responded to public comments on those portions of the April 7, 2000 final rule that implemented related provisions of the BBRA and public comments on the August 3, 2000 rule.
- On November 2, 2001, we published a final rule (66 FR 55857) that announced the Medicare OPPS conversion factor for calendar year (CY) 2002. It also described the Secretary s estimate of the total amount of the transitional pass-through payments for CY 2002 and the implementation of a uniform reduction in each of the pass-through payments for that year.
- On November 2, 2001, we also published an interim final rule with comment period (66 FR 55850) that set forth the criteria the Secretary will use to establish new categories of medical devices eligible for transitional pass-through payments under Medicare's OPPS.
- On November 30, 2001, we published a final rule (66 FR 59856) that revised the Medicare OPPS to implement applicable statutory requirements, including relevant provisions of BIPA, and changes resulting from continuing experience with this system. In addition, it described the CY 2002 payment rates for Medicare hospital outpatient services paid under the PPS. This final rule also announced a uniform reduction of 68.9 percent to be applied to each of the transitional pass-through payments for certain categories of medical devices and drugs and biologicals.
- On December 31, 2001, we published a final rule (66 FR 67494) that delayed, until no later than April 1, 2002, the effective date of CY 2002 payment rates and the uniform reduction of transitional pass-through payments that were announced in the November 30, 2001 final rule. In addition, this final rule indefinitely delayed certain related regulatory provisions.
- On March 1, 2002, we published a final rule (67 FR 9556) that corrected technical errors that affected the amounts and factors used to determine the payment rates for services paid under the Medicare OPPS and corrected the uniform reduction to be applied to transitional pass-through payments for CY 2002 as published in the November 30, 2001 final rule. These corrections and the regulatory provisions that had been delayed became effective on April 1, 2002.
- On November 1, 2002, we published a final rule (67 FR 66718) that revised the Medicare OPPS to update the payment weights and conversion factor for services payable under the 2003 OPPS on the basis of data from claims for services furnished from April 1, 2001 through March 31, 2002. The rule also removed from pass-through status most drugs and devices that had been paid under pass-through provisions in 2002 as required by the applicable provisions of law governing the duration of pass-through payment.
- On August 12, 2003, we published a proposed rule (68 FR 47966) that proposed the Medicare OPPS conversion factor for CY 2004. In addition, it described proposed changes to the amounts and factors used to determine the payment rates for Medicare hospital outpatient services paid under the prospective payment system.

C. Summary of Changes in the August 12, 2003 Proposed Rule

On August 12, 2003, we published a proposed rule (68 FR 47966) that proposed changes to the Medicare hospital OPPS and CY 2004 payment rates including proposed changes used to determine these payment rates. The following is a summary of the major changes that we proposed and the issues we addressed in the August 12, 2003 proposed rule.

1. Changes Required by Statute

We proposed the following changes to implement statutory requirements:

- Add APCs, delete APCs, and modify the composition of some existing APCs.
- Recalibrate the relative payment weights of the APCs.
- Update the conversion factor and the wage index.
- Revise the APC payment amounts to reflect the APC reclassifications, the recalibration of payment weights, and the other required updates and adjustments.
- Cease transitional pass-through payments for drugs and biologicals and devices that will have been paid under the transitional pass-through methodology for at least 2 years by January 1, 2004.
- Cease transitional outpatient payments (TOPS payments) for all hospitals paid under OPPS except for cancer hospitals and children s hospitals.

2. Additional Changes to OPPS

We proposed the following additional changes to the OPPS:

- Adjust payment to moderate the effects of decreased median costs for non-pass-through drugs, biologicals, and radiopharmaceuticals.
- Implement a new method for paying for drug administration.
- Create new evaluation and management service codes for outpatient clinic and emergency department encounters.
- Change status indicators for Healthcare Common Procedure Coding System (HCPCS) codes.
- List midyear and proposed HCPCS codes that are paid under OPPS.
- Allocate a portion of the outlier percentage target amount to community mental health centers (CMHCs) and create a separate threshold for outlier payments for partial hospitalization services.
- Create methodology and payment rates for separately payable drugs and radiopharmaceuticals for 2004.
- Make several changes in our current payment policy with regard to payment

for Q0081, Q0083, Q0084, and Q0085 to facilitate accurate payments for drugs and drug administration.

• Change the status indicator and payment amount for P9010 by assigning it to APC 0957 (Platelet concentrate) with a payment rate of $37.30.

• Establish new payment bands for new technology APCs.

D. Public Comments and Responses to the August 12, 2003 Proposed Rule

We received approximately 876 timely items of correspondence containing multiple comments on the August 12, 2003 proposed rule. Summaries of the public comments and our responses to those comments are set forth below under the appropriate section heading of this final rule with comment period.

We received comments from various sources including but not limited to health care facilities, physicians, drug and device manufacturers, and beneficiaries. Hospital associations and the Medicare Payment Advisory Commission (MedPAC) generally supported our proposed approach to revising the relative weights for APCs. Pharmaceutical and medical device manufacturers and some individual hospitals that furnish particular devices or drugs were concerned with the proposed reductions in payment for medical devices and drugs. We received many thoughtful comments from a wide range of commenters with regard to methodological issues in OPPS. In addition, several comments provided external data to support their assertions. The following are the major issues addressed by the commenters:

• The proposal to use $150 as the packaging threshold for separate payment of drugs.

• The proposal to pay for orphan drugs within the OPPS, basing payment on claims data.

• The proposal to pay for generic drugs at 43 percent of average wholesale prices (AWP) beginning with the time of the generic drug's Food and Drug Administration (FDA) approval.

• The proposed payments for blood and blood products under OPPS.

• The proposal to establish a separate outlier pool for community mental health centers(CMHCs).The proposal to apply an adjustment to increase payment to small rural hospitals' clinic and emergency room (ER) visit rates to ameliorate the effect of the sunsetting of the transitional corridor payments.

• The proposal to reinstitute drug and device coding requirements.

• Propose APC assignments and status indicators for numerous services.

In addition to comments regarding the policy proposals in the August 12, 2003 proposed rule, we received comments about the publication date of the proposed rule and the comment period.

Comment: Some commenters objected to the use of the date on which the August 12, 2003 proposed rule was made public by web posting and by public display at the Office of the Federal Register as the beginning of the comment period. They indicated that we should start the comment period only on the publication of the proposed rule in the **Federal Register** because that is where subscribers look for it. They objected to what they view as a 55-day comment period if it were to start on the date of **Federal Register** publication (August 12, 2003). Some commenters objected to the publication of the proposed rule so late in the year. They indicated that our publication on August 9 resulted in the comment period ending so close to the publication deadline for the final rule that they believed that their comments could not be fully analyzed and used and would not be as effective as if the proposed rule were published in June or early July. They urged us to publish the proposed rule in late spring. Some commenters objected to the scheduling of the APC Panel meeting so soon after the issuance of the proposed rule because they felt that it gave them inadequate time to prepare their presentations for the Panel.

Response: The comment period on a proposed rule begins on the day that the proposed rule is available for public comment. We believe that putting the document on display at the Office of the Federal Register and also making it available on the CMS Web site meets the test of being publicly available and that, therefore, is the start of the comment period. The publication of the proposed rule on the internet makes it available to many more people than routinely access the **Federal Register** or can visit the Office of the Federal Register where the display copy is located. The public had 60 days to comment on the proposed rule. This is the standard amount of time generally allowed for comment on notices of proposed rulemaking. Therefore, we do not believe the public was at a disadvantage or limited in the amount of time available to make public comments.

Our review of the public comments is extensive, with the comments being read and considered carefully, often by many staff. We agree that it is preferable, when possible, to issue the proposed rule as early as possible. However, the important issue is whether we have sufficient time to carefully and thoughtfully consider all comments in development of the final rule, rather than the amount of time between the end of the comment period and the publication of the final rule.

II. Changes to the Ambulatory Payment Classification (APC) Groups and Relative Weights

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

Section 1833(t)(9)(A) of the Act requires the Secretary to review the components of the OPPS not less often than annually and to revise the groups, relative payment weights, and other adjustments to take into account changes in medical practice, changes in technology, and the addition of new services, new cost data, and other relevant information and factors. Section 1833(t)(9)(A) of the Act requires the Secretary, beginning in 2001, to consult with an outside panel of experts to review the APC groups and the relative payment weights.

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

We use the median cost of the item or service in implementing this provision. The statute authorizes the Secretary to make exceptions to the 2 times rule "in unusual cases, such as low volume items and services."

For purposes of the proposed rule and this final rule we analyzed the APC groups within this statutory framework.

A. Recommendations of the Advisory Panel on APC Groups

1. Establishment of the Advisory Panel on APC Groups

Section 1833(t)(9)(A) of the Social Security Act (the Act) requires that we consult with an outside panel of experts, the Panel, to review the clinical integrity of the APC groups and their

weights. The Act specifies that the Panel will act in an advisory capacity. This expert panel, which is to be composed of representatives of providers subject to the OPPS (currently employed full-time, in their respective areas of expertise), reviews and advises us about the clinical integrity of the APC groups and their weights. The Panel is not restricted to using our data and may use data collected or developed by organizations outside the Department in conducting its review.

On November 21, 2000, the Secretary signed the charter establishing an "Advisory Panel on APC Groups." The Panel is technical in nature and is governed by the provisions of the Federal Advisory Committee Act (FACA) as amended (Pub. L. 92–463).

On November 1, 2002, the Secretary renewed the charter. The new charter indicates that the Panel continues to be technical in nature, is governed by the provisions of the FACA, may convene "up to three meetings per year," and is chaired by a Federal official.

To establish the Panel, we solicited members in a notice published in the **Federal Register** on December 5, 2000 (65 FR 75943). We received applications from more than 115 individuals nominating either a colleague or themselves. After carefully reviewing the applications, we chose 15 highly qualified individuals to serve on the Panel.

Because of the loss of 6 Panel members in March 2003 due to the expiration of terms of office, retirement, and a career change, a **Federal Register** notice was published on February 28, 2003 (68 FR 9671), requesting nominations of Panel members. From the 40 nominations we received, 6 new members have been chosen and have been identified on the CMS web site.

We received one comment regarding our selection of Panel members.

Comment: One commenter stated that Community Mental Health Centers (CMHCs) have not been represented on the APC Panel even though the names of qualified nominees have been submitted. The commenter went on to say that the **Federal Register** (February 28, 2003, at 68 FR 9671 through 9672) specifically states, "Qualified nominees will meet those requirements necessary to be a Panel member. Panel members must be representatives of Medicare providers (including Community Mental Health Centers) subject to the OPPS * * * [therefore,] I feel that it is imperative to have a freestanding CMHC representative on the Panel."

Response: The **Federal Register** notice on the APC Panel to which the commenter referred, states in section II, Criteria for Nominees, the following: "The Panel shall consist of up to 15 members selected by the Secretary, or designee, from among representatives of Medicare providers (including Community Mental Health Centers) subject to the OPPS." The language does not mandate that a CMHC representative will be on the Panel. In the regulation, we simply identified representatives from CMHCs—or any other organizations—as possible nominees.

This year, when we requested nominations for the APC Panel, the list of nominees was long, prestigious, and included representatives from all aspects of the health care industry: Doctors, nurses, hospital administrators, coders, etc. Therefore, our choices were difficult; however, since there are definite Federal guidelines governing our selections, and specific Panel and Agency needs to address, given the clinical range of services paid under the OPPS, we were able to identify the most qualified individuals. Since the needs of the Agency and the Panel change due to members leaving, we invite all concerned Medicare providers to continue to nominate qualified individuals when the need arises.

The Panel's biannual meetings are forums to discuss APCs and representatives from the CMCHs—and other organizations—are invited to attend Panel meetings and to make presentations to the Panel on relevant agenda items.

Comment: The commenter also stated that the APC Panel sets the payment rates for the outpatient services.

Response: While the Panel is an advisory committee mandated by law to review the APC groups, and their associated weights, and to advise the Secretary of Health and Human Services and the Administrator of the Centers for Medicare & Medicaid Services concerning the clinical integrity of the APC groups and their weights, the APC Panel does not set payment rates for outpatient services. The advice provided by the Panel is considered by us in our development of the annual rulemaking to update the hospital OPPS. The APC Panel's activities most often address whether or not the HCPCS codes within the APCs are comparable clinically and with respect to resource use, assigning new codes to new or existing APCs, reassigning codes to different APCs, and the configuring of existing APCs into new APCs.

2. August 2003 Meeting

The APC Panel met on August 22, 2003 to discuss issues presented in the proposed rule of August 12. We announced the meeting in the **Federal Register** on July 25 and invited the public to make presentations to the Panel on issues discussed in the proposed rule. In this section, we summarize the issues discussed by the Panel, their recommendations on those issues, and our decisions with respect to their recommendations.

a. Blood and Blood Products

The Panel heard testimony by suppliers of blood and blood products and their representatives who expressed significant concerns about the proposed payment rates, particularly in light of new safety and testing requirements. These presenters to the Panel recommended that we exclude blood and blood products from the OPPS and pay for them at reasonable cost. After listening to the testimony, reviewing the median costs and proposed payments rate from our hospital claims data, and deliberating the issue, the Panel recommended that we continue to pay for blood and blood products within the OPPS. However, the Panel further recommended that we freeze the payment rates for blood and blood products at 2003 levels for 2004 and 2005 while we undertake further analysis of the cost data. The Panel also recommended that hospitals be educated on the proper billing for blood and blood products.

As discussed elsewhere in this final rule, we will accept the Panel's recommendation with respect to 2004. We will freeze the payment rates for blood and blood products at the 2003 payment levels. However, we are not making a decision with respect to 2005 at this time. Any proposals regarding our 2005 payment rates or policies for these items will be discussed in our proposed rule for the CY 2005 update. The Panel also recommended that the APCs for blood and blood products be on the agenda for the winter 2004 meeting in time for consideration of the 2005 payment rates. We agree to place this item on the agenda for the next APC Panel meeting.

b. Nuclear Medicine, Brachytherapy, and Radiosurgery Services

(1) Nuclear Medicine APCs and Radiopharmaceuticals

The Panel heard testimony on and considered the proposed restructuring of the nuclear medicine APCs discussed in the August 12, 2003 proposed rule. The Panel recommended that we move forward with the categorization system in the proposed OPPS 2004 rule absent strong, reasoned opposition from provider groups. If strong opposition was revealed in the public comments,

the Panel recommended that we maintain the classification system that is in place for 2003. The Panel also recommended that we change the HCPCS code descriptors for radiopharmaceuticals to be on a "per-dose" basis—not on a "per-unit" basis.

We have accepted the Panel's recommendation that we move forward with the proposed restructuring, after considering public comments on this issue. As discussed in section II.A.3 of this final rule, we will implement the restructuring with certain changes to the proposed reclassification based on our review of the public comments. For reasons discussed in section VI.B.3 of this final rule, we are not accepting the Panel's recommendation to change the HCPCS code descriptors at this time.

The Panel further recommended that APCs for radiopharmaceuticals be on the agenda for the January 2004 meeting. In preparation for that meeting, the Panel recommended that our staff analyze the claims for the nuclear medicine APCs and do the following: Itemize the costs, determine what proportion of the median cost can be attributed to radiopharmaceuticals, and present the data at the Panel's January 2004 meeting. The Panel recommended that the issue of packaging the costs of radiopharmaceuticals under the 2003 threshold of $150 be placed on the agenda for the Panel's winter 2004 meeting.

We will consider this topic for placement on the agenda for the Panel's 2004 meeting. As discussed in section VI.B.3 of this rule, however, we are revising our threshold for packaging radiopharmaceuticals from $150 to $50.

(2) Brachytherapy Services

The Panel recommended that we review whether the codes for needles and catheters were included in the payment rate proposed for APC 0313. The Panel also recommended that we consider outside data presented by commenters in establishing payment rates for APCs 312 and 651 to arrive at an appropriate payment rate. See our discussion, below, regarding APCs 312, 313, and 651 and our considerations concerning the claims used to set the relative weights for these APCs.

The Panel further recommended that we discontinue use of G codes for prostate brachytherapy and use appropriate Current Procedural Terminology (CPT) codes paid in clinical APCs when making payment for these services. The Panel recommended we pay separately for brachytherapy sources for the treatment of prostate cancer in the same manner by which we are paying separately for the brachytherapy sources for the treatment of other types of cancer. We have accepted the Panel's recommendation. As discussed in section II.B.4 of this final rule, we will discontinue use of the special G codes for prostate brachytherapy and allow separate payment for the sources used in these treatments.

(3) Radiation Therapy and Radiosurgery APC Issues

The APC Panel heard testimony concerning radiation treatment delivery codes CPT 77412 through 77416, which we proposed to assign to APC 0301 and CPT 77417, assigned to APC 0260. The presenter stated that many hospital billing departments had not updated their charge masters since the inception of OPPS to reflect the costs of newer technology, specifically with respect to the use of x-ray guidance during external beam radiation treatment delivery. The APC Panel recommended that we review whether the use of x-ray guidance (as opposed to CT or ultrasound guidance) for radiation therapy is being properly reported and included in the payment rates for the radiation treatment delivery codes. We agree that we should review these issues further and will do so in preparation for the 2005 update. However, we did not receive sufficient or convincing information upon which to base a change for 2004. Therefore, we encourage interested parties to submit any additional information on the use of these codes and cost of providing these services in the outpatient hospital setting in response to this final rule with comment period.

The APC Panel also heard testimony concerning the proposed payment rate for CPT 77418, assigned to APC 0412 (IMRT treatment delivery). The presenter stated that the proposed amount was too low. However, the APC Panel supported the proposal in the absence of compelling evidence that the rate derived from the claims data is wrong. We concur with the APC Panel's recommendation and will retain CPT 77418 in APC 0412. We used approximately 113,000 claims to set the weight for this procedure, which we believe is a sufficiently robust set of data.

During this section of the APC Panel's August 22 meeting, the Panel members also heard testimony concerning HCPCS codes G0251 and G0173 used to report stereotactic radiosurgery. The APC Panel supported the proposed payment rates for these codes until more data become available. The APC Panel also asked to review this issue further at its winter 2004 meeting. We discuss stereotactic radiosurgery in further detail below. We have decided to make certain changes to the payment for these procedures. However, the APC assignment for these codes for 2004 is interim final. We solicit comments on the 2004 assignments, and we will also include this on the APC Panel's agenda for its winter 2004 meeting.

The final topic in this section of the APC Panel's August 22 meeting pertained to HCPCS codes G0242 and G0243 (multi source photon stereotactic planning). The APC Panel was requested to recommend that we combine the coding for these procedures under one code, with the payment for the new code derived by adding the payment for G0242 and G0243 together. The information presented to the APC Panel stated that the services represented by the two G codes represent one continuous procedure, that it is a surgical procedure, and the cost center mapping should be to a surgical cost center. The APC Panel will review this request at its winter 2004 meeting. The APC Panel is interested in receiving comments on this topic from professional societies representing neurosurgeons, radiation oncologists and others concerning this proposal.

c. Payment and Coding for Drug Administration and for Certain Drugs, Biologicals, and Radiopharmaceuticals

The APC Panel heard testimony and discussed the proposals described in the August 12, 2003 proposed rule on payment for drug administration and the packaging of the costs of drugs, biologicals, and radiopharmaceuticals. The APC Panel recommended that:

- We continue to use the current "Q" codes for drug administration and not institute new "G" codes to represent the administration of either packaged or separately paid drugs.
- We allow billing of Q0081 on a per-visit basis, rather than on a per-day basis as proposed.
- We delete Q0085 and allow hospitals to use both Q0083 and Q0084 when billing for chemotherapy administered by both infusion and other techniques in a given visit.
- That we consider adopting the final option among the three new methods of paying for drug administration that we proposed, as options to the current policy, in the August 12, 2003 proposed rule.
- That we look further at hospital pharmacies' costs for preparing drugs and radiopharmaceuticals and this issue be examined more closely by the Panel during its winter 2004 meeting.

The APC Panel also expressed serious concern about the dollar threshold for

the packaging of drugs and the adequacy of payment for separately paid drugs. However, in the absence of alternative proposals by us, the APC Panel did not make further recommendations on that issue. The APC Panel requested that we present alternative options during the winter 2004 meeting, including a new APC structure for drugs and radiopharmaceuticals. As for specific drug issues, after hearing testimony concerning the codes for Baclofin refill kits, the APC Panel recommended that we delete code C9010 and retain the other codes for this product used in the treatment of Parkinson's disease and spasticity.

We have carefully considered each of the APC Panel's recommendations along with comments on the subject of drug administration and payment for drugs, biologicals, and radiopharmaceuticals. For the reasons discussed more fully elsewhere in this final rule, we have decided to accept the APC Panel's recommendations that we continue using Q0081 through Q0084 in 2004; that we continue to define these codes on a per-visit, rather than per-day basis; that we delete code Q0085; and that we delete code C9010. We have decided to continue paying for the drug administration "Q" codes according to our current rules and discuss that decision further in section VI.B.4 of this final rule. We will consider the Panel's recommendation that we investigate other approaches for paying for drugs and radiopharmaceuticals. However, for 2004, we have determined that we will pay separately under their own APCs for drugs, biologicals and radiopharmaceuticals for which the median per day costs are in excess of $50.

(4) Device-Related Procedures

The APC Panel heard testimony from the device manufacturing community and others concerning payment for procedures that involve the implantation of devices. The presenters discussed concerns that affected such procedures in general, such as the absence of a proposal to limit payment reductions for such procedures between 2003 and 2004 and issues related to the hospital claims for these procedures. Presentations to the APC Panel also discussed inadequacies in the claims data or our methodology for using the claims data to set relative weights for specific device-related APCs (APCs 0046, 0107, 0108, 0222, 0225, 0385, and 0386. Presenters urged that the APC Panel advise us to use the best external data possible, including proprietary data that would be held confidential. Presentations to the APC Panel also addressed the multiple surgical reduction with respect to device-related APCs.

The APC Panel recommended:

- That we use credible external data that can be made publicly available for establishing the median costs for APCs 0107 and 0386.
- That we change the status indicator for CPT 61885 so that it is not subject to the multiple procedure discounting.
- That we assign the new CPT codes for central venous access devices into appropriate APCs, either clinical APCs or new technology APCs.
- That the APC assignments of the new central venous access devices be reviewed by the APC Panel at its next meeting.
- That we provide the APC Panel with median cost data for all APCs in spreadsheet format for its consideration in advance of and during its next meeting.
- That we review the presenter's suggestions with respect to APC 0046 and make recommendations for any changes to this APC to the APC Panel at its next meeting.
- That we change the status indicator for CPT 93571 and 93572 from "N" (packaged status) to an appropriate indicator that allows separate payment under the APC.

We considered the final set of recommendations from the APC Panel's August 2003 meeting and have accepted several of them. Specifically, we decided to use external data in setting the median cost for 2004 for APC 0107. We have not used external data for APC 0386. Each of these decisions is discussed in greater detail elsewhere in this final rule. We accepted the Panel's recommendation to change the status indicator for CPT 61885. In order to do so, we moved this code into its own APC, 0039, Implant neurostim, one array. We have assigned the new CPT codes for central venous access devices to New Technology APCs as displayed in Addendum B. The range of new CPT codes is 36555 through 36597, and the new APC assignments include APCs 0032, 0115, 0109, 0187, and 1541.

The assignment of these codes is subject to public comment and will be placed on the APC Panel's agenda for its next meeting. During that meeting, we will also provide the APC Panel with spreadsheet data on the median costs of all APCs. With respect to APC 0046, we are sympathetic to the presenter's concerns. However, we were not provided with data that we considered sufficient to assess whether a new coding structure with increased payment rates is warranted for the treatment of bone fractures with external fixation devices. However, we would support the specialty societies' efforts to request changes to the existing CPT coding structure. For reasons discussed elsewhere, we have not accepted the Panel's recommendation with respect to CPT codes 93571 and 93572.

Comment: An association voiced concern that the Panel meeting on August 22, 2003 came too soon after the publication of the August 12, 2003 proposed rule for its members to prepare adequately for presentation to the Panel.

Response: The agency must schedule the Panel meetings sufficiently in advance of the meeting in order to provide ample notice to the public of the meeting and to allow sufficient time for the Panel members to arrange their schedules. We attempted to balance those needs with the goal of conducting the first mid-year meeting of the Panel during the comment period so that issues discussed in the August 12, 2003 proposed rule could be topics for the Panel's consideration and interested parties' testimony before the Panel. The July 25, 2003 **Federal Register** notice (68 FR 44089) announced the second 2003 meeting of the APC Panel, which we believe provided sufficient advance notice of the meeting.

While it is true that the proposed rule was placed on display on August 6, published on August 12, and the meeting was held on August 22, 2003, many interested parties attended the meeting and presented thoughtful comments on most issues discussed in the proposed rule. Nevertheless, we will take this comment into consideration for future planning of APC Panel meetings.

Comment: Several commenters expressed concern about the length of the meeting and time allotted on the agenda to particular issues. One commenter stated that scheduling only [1] day for Panel deliberations was inadequate. A commenter was concerned that device-related issues were relegated to the last hour, that presenters were given only 2 minutes, and that there was little time for Panel discussion and consideration of the issues presented.

Response: We appreciate the commenter's interest in ensuring that adequate time be allowed for the public to present issues for the Panel's consideration and for the Panel to have sufficient time for their discussion and deliberation.

Although the device issues were scheduled for the last hour of the meeting, the Panel members received the written presentations beforehand, and had an opportunity to review them

before the meeting. Placing a limit on presentations is a prerogative of the Panel Chair and must at times be done in order to allow all interested parties to make presentations on agenda items. However, we will take all of the concerns into consideration when scheduling future meetings.

3. Recommendations of the Advisory Panel and Our Responses

January 2003 Meeting

In this section, we consider the Panel's recommendations affecting specific APCs. The Panel based its recommendations on claims data for the period April 1, 2002 through September 30, 2002. This data set comprises a portion of the data that will be used to set 2004 payment rates. APC titles in this discussion are those that existed when the APC Panel met in January 2003. In a few cases, APC titles have been changed for this final rule, and, therefore, some APCs do not have the same title in Addendum A as they have in this section.

The Panel's agenda included APCs that our staff believed violated the 2 times rule as well as APCs for which comments were submitted. As discussed below, the Panel sometimes declined to recommend a change in an APC even though the APC appeared to violate the 2 times rule. In section II.B of the August 12, 2003 proposed rule, we discuss our proposals regarding the 2 times rule based on the April 1 through December 31, 2002 data that we used to determine the final 2004 APC relative weights. Section II.B (68 FR 47977) of the August 12, 2003 proposed rule also details the criteria we used when deciding to propose exceptions to the 2 times rule.

Unless otherwise specified in each of the following discussions of the APC Panel's recommendations, our proposed actions are finalized in this final rule.

a. Debridement and Destruction

APC 0012: Level I Debridement & Destruction

APC 0013: Level II Debridement & Destruction

We expressed concern to the Panel that APCs 0012 and 0013 appear to violate the 2 times rule. In order to remedy these violations, we asked the Panel to consider the following changes:

(1) Move the following codes from APC 0013 to APC 0012:

HCPCS	Description
11001	Debride infected skin add-on.
11302	Shave skin lesion.
15786	Abrasion, lesion, single.
15793	Chemical peel, nonfacial.
15851	Removal of sutures.
16000	Initial treatment of burn(s).
16025	Treatment of burn(s).

(2) Move code 11057 (Trim skin lesions, over 4) from APC 0012 to APC 0013.

The Panel agreed with our staff and recommended that we make these changes. We proposed to accept the Panel's recommendation.

However, we received comments from a group of hospitals concerning the proposed change for CPT code 15851, removal of sutures under anesthesia (other than local), same surgeon. In their comments, the hospitals noted that the descriptor for CPT codes 15851 and 15850 (removal of sutures under anesthesia (other than local), other surgeon, were virtually identical with the exception of which surgeon performs the suture removal. The commenters did not believe that the identity of the surgeon could result in a significant difference in resource costs to the hospital. Our clinical staff agree and believe that the difference in hospital median costs derived from our claims data may be due to a misunderstanding about the coding. For 2004, we have decided that we will place both CPT codes for suture remove under anesthesia in APC 0016.

b. Excision/Biopsy

APC 0019: Level I Excision/Biopsy

APC 0020: Level II Excision/Biopsy

APC 0021: Level III Excision/Biopsy

We expressed concern to the Panel that APCs 0019 and 0020 appear to violate the 2 times rule. In order to remedy these violations, we asked the Panel to consider the following changes:

(1) Move the following HCPCS codes from APC 0019 to a new APC:

HCPCS	Description
11755	Biopsy, nail unit.
11976	Removal of contraceptive cap.
24200	Removal of arm foreign body.
28190	Removal of foot foreign body.
56605	Biopsy of vulva/perineum.
56606	Biopsy of vulva/perineum.
69100	Biopsy of external ear.

The APC Panel recommended that we make these changes, and we proposed to do so in our August 12, 2003 proposed rule.

(2) Move the following HCPCS codes from APC 0020 to APC 0021:

HCPCS	Description
11404	Removal of skin lesion.
11423	Removal of skin lesion.
11604	Removal of skin lesion.
11623	Removal of skin lesion.

The Panel recommended that we not change the structure of APCs 0019, 0020, and 0021 at this time in the interest of preserving clinical homogeneity. In August, we proposed to accept the Panel's recommendation that we make no changes to the structure of these APCs for 2004. However, following our review of the median costs developed for the final rule, using a more complete set of claims for services from April through December 2002, we determined that CPT codes 11404 and 11623 should be moved to APC 0021. We plan to place these APCs on the Panel's agenda for the 2005 update.

c. Thoracentesis/Lavage Procedures and Endoscopies

APC 0071: Level I Endoscopy Upper Airway

APC 0072: Level II Endoscopy Upper Airway

APC 0073: Level III Endoscopy Upper Airway

We expressed concern to the Panel that APCs 0071 and 0072 appear to violate the 2 times rule. In order to remedy these violations, we asked the Panel to consider the changes below.

Move the following HCPCS codes as described below:

TABLE 1.—HCPCS CODES FINAL TO BE REDISTRIBUTED FROM APCS 0071 AND 0072 TO APCS 0071, 0072, AND 0073

HCPCS	Description	2003 APC	2004 APC
31505	Diagnostic laryngoscopy.	0072	0071
31575	Diagnostic laryngoscopy.	0071	0072
31720	Clearance of airways.	0072	0073

The Panel recommended that we make the above changes. We proposed to accept the Panel's recommendation, with the exception of CPT code 31720. After reviewing an additional quarter of claims data that were not available at the time the Panel convened, placement of CPT code 31720 into APC 0072 better reflects its resource consumption. Therefore, we proposed to keep CPT code 31720 in APC 0072.

d. Cardiac and Ambulatory Blood Pressure Monitoring

APC 0097: Cardiac and Ambulatory Blood Pressure Monitoring

We expressed concern to the Panel that APC 0097 appears to violate the 2 times rule. We asked the Panel to recommend options for resolving this violation and suggested splitting APC 0097 into two APCs. The Panel recommended that the structure of APC 0097 should not be changed at this time based on clinical homogeneity considerations. We proposed to accept the Panel's recommendation that we make no changes to APC 0097 for 2004. We received no comments disagreeing with this proposal, and we will adopt it for 2004. We also plan to place this APC on the Panel's agenda for the 2005 update.

e. Electrocardiograms

APC 0099: Electrocardiograms

APC 0340: Minor Ancillary Procedures

We expressed concern to the Panel that APC 0099 appears to violate the 2 times rule. We asked the Panel to recommend options for resolving this violation, and suggested moving CPT code 93701 (Bioimpedance, thoracic) from APC 0099 to APC 0340. The Panel believed, however, that the structure of APC 0099 should not be changed at this time based on clinical homogeneity considerations. We proposed to accept the Panel's recommendation that we make no changes to APC 0099 for 2004. We plan to place this APC on the Panel's agenda for the 2005 update.

f. Cardiac Stress Tests

APC 0100: Cardiac Stress Tests

A presenter to the Panel, who represented a device manufacturer, requested that we move CPT code 93025 (Microvolt t-wave assessment) out of APC 0100. The presenter believes that the actual cost for this procedure is significantly higher than for other procedures in the same APC. Since this technology is often billed in conjunction with other procedures (for example, stress tests, CPT code 93017), few single-APC claims were available to evaluate the presenter's contention.

The Panel believed the data presented are insufficient to merit moving the code and recommended that CPT code 93025 remain in APC 0100 until more data are available for review. We proposed to accept the Panel's recommendation that CPT code 93025 remain in APC 0100 until more claims data become available for review. We will adopt this proposal for 2004.

g. Revision/Removal of Pacemakers or Automatic Implantable Cardioverter Defibrillators

APC 0105: Revision/Removal of Pacemakers, AICD, or Vascular

We asked the Panel to review the codes within APC 0105 for an apparent violation of the 2 times rule, stating that we believe the apparent violation is a result of incorrectly coded claims. The Panel agreed and recommended no changes to APC 0105 at this time. We proposed to accept the Panel's recommendation that we make no changes to APC 0105 until more accurate claims data become available and support the need for a change. We will adopt this proposal for 2004.

h. Sigmoidoscopy

APC 0146: Level I Sigmoidoscopy

APC 0147: Level II Sigmoidoscopy

We expressed concern to the Panel that relatively simple procedures such as anoscopy and rigid sigmoidoscopy have higher median costs than more complex procedures such as flexible sigmoidoscopy. Panel members suggested the high costs may be due to the need to perform an otherwise minor office procedure in a hospital setting (for example, due to the clinical condition of the patient). Panel members also suggested that claims may be incorrectly coded because coding instructions do not clearly state how to code when the procedure performed is not as extensive as the procedure planned (for example, when a colonoscopy is planned but only a sigmoidoscopy is performed). In these cases, coding instructions are unclear as to whether the planned procedure should be reported with a modifier for reduced services or with the code for the actual procedure performed.

The Panel recommended that we make no changes to APCs 0146 and 0147 at this time. We proposed to accept the Panel's recommendation that we make no changes to APCs 0146 and 0147. We will adopt this proposal for 2004. However, we plan to place this APC on the Panel's agenda for the 2005 update.

i. Anal/Rectal Procedures

APC 0148: Level I Anal/Rectal Procedure

APC 0149: Level III Anal/Rectal Procedure

APC 0155: Level II Anal/Rectal Procedure

We expressed concern to the Panel that APCs 0148 and 0149 appear to violate the 2 times rule. We asked the Panel to recommend options for resolving these violations, and suggested rearranging some of the CPT codes within APCs 0148, 0149, and 0155. The Panel recommended that we move CPT code 46040 (Incision of rectal abscess) from APC 0155 to APC 0149. We proposed to accept the Panel's recommendation, and we will adopt it for 2004.

j. Insertion of Penile Prosthesis

APC 0179: Urinary Incontinence Procedures

APC 0182: Insertion of Penile Prosthesis

A presenter to the Panel representing manufacturers and providers requested that APC 0182 be split into two APCs, based on whether the procedure used inflatable or non-inflatable penile prostheses. The presenter stated that the complexity of the procedure, the cost of the devices, and related resources were all significantly higher with inflatable prostheses.

The Panel recommended that we eliminate APCs 0179 and 0182 and create two new APCs, 0385 and 0386, that contain the following CPT codes:

APC 0385

HCPCS	Description
52282	Cystoscopy, implant stent.
53440	Correct bladder function.
53444	Insert tandem cuff.
54400	Insert semi-rigid prosthesis.
54416	Remv/repl penis contain prosthesis.

APC 0386

HCPCS	Description
53445	Insert uro/ves nck sphincter.
53447	Remove/replace ur sphincter.
54401	Insert self-contained prosthesis.
54405	Insert multi-comp penis prosthesis.
54410	Remove/replace penis prosthesis.

We proposed to accept the Panel's recommendation to eliminate APCs 0179 and 0182 and create two new APCs, 0385 and 0386, containing the above CPT code configurations.

k. Surgical Hysteroscopy

APC 0190: Surgical Hysteroscopy

A presenter to the Panel, who represented a device manufacturer, requested that we move CPT code 58563 (Hysteroscopy, ablation) from APC 0190 to a higher paying APC. The presenter noted that endometrial cryoablation is included in a new technology APC, while a thermal ablation system is included with older, less costly

techniques. The presenter expressed concern that cryoablation may be reimbursed at a higher rate than the thermal ablation system, giving its manufacturers an unfair competitive advantage.

Panel members agreed that new, more expensive technologies that prove to be more effective merit review for a higher payment rate. Without substantial evidence of greater effectiveness, however, the Panel was reluctant to create APCs that provide an incentive to use a more expensive device. In its discussion of whether or not to recommend moving CPT code 58563 to a higher paying APC, the Panel recommended that we take into account different methods of endometrial ablation associated with hysteroscopy, adequately reflect the resources used for the various procedures, avoid creating a competitive advantage or disadvantage, and collect data needed to track costs on the type of technologies used for this procedure.

After consulting with experts in the field, we proposed to split APC 0190 (Surgical Hysteroscopy) into two APCs that are more clinically homogeneous. We proposed to change the description for APC 0190 from "Surgical Hysteroscopy" to "Level I Hysteroscopy" and keep the following HCPCS codes in APC 0190:

HCPCS	Description
58558	Hysteroscopy, biopsy.
58559	Hysteroscopy, lysis.
58562	Hysteroscopy, remove fb.
58579	Hysteroscope procedure.

We also proposed to move the following HCPCS codes from APC 0190 to newly created APC 0387 titled "Level II Hysteroscopy":

HCPCS	Description
58560	Hysteroscopy, resect septum.
58561	Hysteroscopy, remove myoma.
58563	Hysteroscopy, ablation.

In addition, we proposed to move the following HCPCS codes as described below:

TABLE 2.—HCPCS CODES TO BE REDISTRIBUTED TO APCS 0130, 0195, AND 0190

HCPCS	Description	2003 APC	2004 APC
58578	Laparoscopic procedure, uterus.	0190	0130
58353	Endometrial ablate, thermal.	0193	0195
58555	Hysteroscopy, diagnostic, sep. procedure.	0194	0190

We believe these final changes take into account the different technologies used to perform these procedures while maintaining the clinical comparability of these APCs as well as improving their homogeneity in terms of resource consumption.

1. Female Reproductive Procedures

APC 0195: Level VII Female Reproductive Proc

APC 0202: Level VIII Female Reproductive Proc

A commenter requested that we place CPT code 57288 (Repair bladder defect) in its own APC because it requires the use of a device. Our staff suggested that CPT codes 57288 and 57287 remain in APC 0202, while the remaining codes in APC 0202 be moved to APC 0195:

HCPCS	Description
57109	Vaginectomy partial w/ nodes.
58920	Partial removal of ovary(s).
58925	Removal of ovarian cyst(s).

The Panel agreed with our staff, and we proposed to accept the Panel's recommendation to move CPT codes 57109, 58920, and 58925 from APC 0202 to APC 0195. We will adopt the Panel's recommendation for 2004.

m. Nerve Injections

APC 0203: Level IV Nerve Injections
APC 0204: Level I Nerve Injections
APC 0206: Level II Nerve Injections
APC 0207: Level III Nerve Injections

Several commenters suggested changes in the configuration of APCs 0203, 0204, 0206, and 0207 because of concerns that the current classifications result in payment rates that are too low relative to the resource costs associated with certain procedures in these APCs. Several of these APCs include procedures associated with drugs or devices for which pass-through payments are scheduled to expire in 2003.

We requested the Panel's input regarding whether or not these APCs should be restructured. The Panel stated that the current configuration of APCs 0203, 0204, 0206, and 0207 is more clinically cohesive than the previous year's configuration and that more data should be collected before making any changes. We proposed to accept the Panel's recommendation that we make no changes to the structure of these APCs until more data become available for review. We will adopt the Panel's recommendation for 2004.

n. Laminotomies and Laminectomies; Implantation of Pain Management Device

APC 0208: Laminotomies and Laminectomies

APC 0223: Implantation of Pain Management Device

A presenter to the Panel, who represented a device manufacturer, requested that we move CPT code 62351 (Implant spinal canal catheter) from APC 0208 to APC 0223 to better capture the device cost that may be involved with the procedure. The Panel believed the data were insufficient to merit moving the code and recommended that CPT code 62351 remain in APC 0208 until more data are available for review. We proposed to accept the Panel's recommendation that CPT code 62351 remain in APC 0208 until more claims data become available for review. We will adopt the Panel's recommendation for 2004.

o. Extended EEG Studies and Sleep Studies; Electroencephalogram

APC 0209: Extended EEG Studies and Sleep Studies, Level II

APC 0213: Extended EEG Studies and Sleep Studies, Level I

APC 0214: Electroencephalogram

We expressed concern to the Panel that APC 0213 appears to minimally violate the 2 times rule. In order to remedy this violation, we asked the Panel to consider a commenter's suggestion that we move CPT code 95955 (EEG during surgery) from APC 0214 to APC 0213. The Panel agreed with the commenter's suggestion. We proposed to accept the Panel's recommendation to move CPT code 95955 from APC 0214 to APC 0213.

p. Nerve and Muscle Tests

APC 0215: Level I Nerve and Muscle Tests

APC 0216: Level III Nerve and Muscle Tests APC 0218:

Level II Nerve and Muscle Tests

We expressed concern to the Panel that APC 0218 appears to violate the 2 times rule. In order to remedy this violation, one commenter requested that we move CPT codes 95921 (Autonomic nerve function test) and 95922 (Autonomic nerve function test) from APC 0218 to APC 0216, while another

commenter requested that we move CPT code 95904 (Sensory nerve conduction test) from APC 0215 to APC 0218. Alternatively, our staff suggested to the Panel that the following CPT codes be moved from APC 0218 to APC 0215.

HCPCS	Description
95858	Tensilon test & myogram.
95870	Muscle test, nonparaspinal.
95900	Motor nerve conduction test.
95903	Motor nerve conduction test.

After considering all of the above proposals, the Panel recommended that we move CPT codes 95858, 95870, 95900, and 95903 from APC 0218 to APC 0215. We proposed to accept the Panel's recommendation.

q. Implantation of Drug Infusion Device

APC 0227: Implantation of Drug Infusion Device

APC 0227 contains only two CPT codes: Implantation of programmable spine infusion pumps, 62362, and Implantation of non-programmable spine infusion pumps, 62361. A commenter requested that we split APC 0227 into two APCs to recognize the cost difference between CPT code 62361 and CPT code 62362. However, since our cost data do not show a significant cost difference between the two devices and APC 0227 does not violate the 2 times rule, the Panel recommended that CPT codes 62361 and 62362 remain in APC 0227. We proposed to accept the Panel's recommendation, which we will adopt for 2004.

r. Ophthalmologic APCs

APC 0230: Level I Eye Tests & Treatments

APC 0235: Level I Posterior Segment Eye Procedures

APC 0236: Level II Posterior Segment Eye Procedures

APC 0698: Level II Eye Tests & Treatments

We advised the Panel that APCs 0230 and 0235 violate the 2 times rule but that the current configuration of these APCs reflects the Panel's previous recommendations. A presenter to the Panel, who represented a device manufacturer, expressed concern that the pass-through device category "New Technology: Intraocular Lens" was discontinued and these devices are now packaged. The presenter asked the Panel to recommend that future new intraocular lens devices be considered for a new pass-through category.

To remedy the violations to the 2 times rule, we asked the Panel to consider moving CPT code 67820 (Revise eyelashes) from APC 0230 to APC 0698 and CPT code 67110 (Repair detached retina) from APC 0235 to APC 0236. The Panel recommended that we make these changes. We proposed to accept the Panel's recommendation and monitor the data for APC 0235 for possible review next year. We will adopt this recommendation for 2004. The Panel also acknowledged that making recommendations concerning pass-through categories is beyond their purview.

s. Skin Tests and Miscellaneous Red Blood Cell Tests; Transfusion Laboratory Procedures

APC 0341: Skin Tests and Miscellaneous Red Blood Cell Tests

APC 0345: Level I Transfusion Laboratory Procedures We advised the Panel that APCs 0341 and 0345 minimally violate the 2 times rule and suggested moving several CPT codes within these APCs into a new APC because a commenter expressed concern over the combination of skin tests and miscellaneous red blood cell tests in APC 0341, asserting that services within this APC cannot be considered comparable with respect to resource usage.

In order to remedy these violations to the 2 times rule, we suggested moving CPT code 86901 (Blood typing, Rh (D)) from APC 0345 to a new APC along with the following CPT codes from APC 0341:

HCPCS	Description
86880	Coombs test, direct.
86885	Coombs test, indirect, qualitative.
86886	Coombs test, indirect, titer.
86900	Blood typing, ABO.

The Panel recommended that we make the above changes. We proposed to accept the Panel's recommendation to move HCPCS codes 86880, 86885, 86886, and 86900 from APC 0341 to new APC 0409 and to move CPT code 86901 (Blood typing, Rh (D)) from APC 0345 to new APC 0409. We will adopt the Panel's recommendation for 2004.

t. Otorhinolaryngologic Function Tests

APC 0363: Level I Otorhinolaryngologic Function Tests

APC 0660: Level II Otorhinolaryngologic Function Tests

We expressed concern to the Panel that APC 0660 appears to violate the 2 times rule and suggested moving CPT codes 92543 (Caloric vestibular test) and 92588 (Evoked auditory test) from APC 0660 to APC 0363. The Panel recommended that we make these CPT code changes. We proposed to accept the Panel's recommendation to move CPT codes 92543 and 92588 from APC 0660 to APC 0363, and we will adopt the proposal for 2004.

u. Tube Changes and Repositioning

APC 0121: Level I Tube changes and Repositioning

APC 0122: Level II Tube changes and Repositioning

We expressed concern to the Panel that APC 0121 appears to violate the 2 times rule. In order to remedy this violation, we suggested moving the following CPT codes from APC 0121 to APC 0122:

HCPCS	Description
47530	Revise/reinsert bile tube.
50688	Change of ureter tube.
51710	Change of bladder tube.
62225	Replace/irrigate catheter.

The Panel recommended that we make these CPT code changes. We proposed to accept the Panel's recommendation to move CPT codes 47530, 50688, 51710, and 62225 from APC 0121 to APC 0122. We will adopt the proposal for 2004.

v. Myelography

APC 0274: Myelography

We advised the Panel that APC 0274 minimally violates the 2 times rule and suggested moving CPT codes 72285 (X-ray c/t spine disk) and 72295 (X-ray c/t spine disk) from APC 0274 to a new APC. A presenter, from an organization representing radiologists, agreed with our proposal. The Panel recommended that we make these CPT code changes. We proposed to accept the Panel's recommendation to move CPT codes 72285 and 72295 from APC 0274 to new APC 0388. We will adopt the recommendation for 2004.

w. Therapeutic Radiologic Procedures

APC 0296: Level I Therapeutic Radiologic Procedures

APC 0297: Level II Therapeutic Radiologic Procedures

We advised the Panel that APCs 0296 and 0297 appear to minimally violate the 2 times rule as a result of changes recommended by the Panel and adopted by us last year. The Panel recommended that no changes be made to APCs 0296 and 0297 in the interest of preserving the clinical homogeneity of these APCs. We proposed to accept the Panel's recommendation that we make no CPT code changes to APCs 0296 and 0297, and we are adopting the proposal for 2004.

x. Vascular Procedures; Cannula/Access Device Procedures

APC 0103: Miscellaneous Vascular Procedures

APC 0115: Cannula/Access Device Procedures

A commenter requested that we move CPT code 36860 (External cannula declotting) from APC 0103 to APC 0115, asserting that this procedure is more similar to other procedures in APC 0115 and does not fit well in its current miscellaneous APC. The Panel found that the claims data were insufficient to support moving CPT code 36860 from APC 0103 to the higher paying APC 0115 and recommended that CPT code 36860 remain in APC 0103 until more data are available for review. We proposed to accept the Panel's recommendation that CPT code 36860 remain in APC 0103 until more claims data become available for review. We will adopt this proposal for 2004.

y. Angiography and Venography Except Extremity

APC 0279: Level II Angiography and Venography except Extremity

APC 0280: Level III Angiography and Venography except Extremity

APC 0668: Level I Angiography and Venography except Extremity

A commenter requested that we move CPT code 75978 (Repair venous blockage) from APC 0668 to APC 0280 and that we move CPT code 75774 (Artery x-ray, each vessel) from APC 0668 to APC 0279. A presenter to the Panel testified that CPT code 75978 is commonly used for dialysis patients and often requires multiple intraoperative attempts to succeed; thus, it should be paid under APC 0280. The Panel believed that APCs 0279, 0280, and 0668 were clinically homogenous and recommended that we only make changes after consulting with experts in the field. We proposed to accept the Panel's recommendation to make no changes to APCs 0279, 0280, and 0668 until we have consulted with experts in the field. We plan to place these APCs on the Panel's agenda for the 2005 update.

z. Computed Tomography (CT), Magnetic Resonance (MR), and Ultrasound Guidance Procedures Currently Packaged

APC 0332: Computerized Axial Tomography and Computerized Angiography without Contrast Material

APC 0335: Magnetic Resonance Imaging, Miscellaneous

APC 0268: Ultrasound Guidance Procedures

A presenter to the Panel expressed concern that the packaging of guidance procedures for tissue ablation does not recognize the significant difference in cost and time required to perform each procedure (for example, MRI vs. CT). This presenter believed that hospitals needed more education on the appropriate application of these codes. Another commenter requested that CPT codes 76362, 76394, and 76490 be changed from a status indicator of N to a status indicator of S and be included in an appropriate clinical or new technology APC.

The Panel agreed with the above comments and stated that the packaging of these three procedures made it difficult for hospitals to track their use for the purpose of allocating funds. The Panel recommended changing the following CPT codes from a packaged status (N status indicator) to a separately payable status (S status indicator) within the indicated APCs:

TABLE 3.—HCPCS CODES TO BE DESIGNATED AS SEPARATELY PAYABLE

HCPCS	Description	2003 SI	2004 SI	2004 APC
76362	CT scan for tissue ablation	N	S	0332
76394	MRI for tissue ablation	N	S	0335
76490	US for tissue ablation	N	S	0268

We proposed to accept the Panel's recommendation to change HCPCS codes 76362, 76394, and 76490 from a packaged status to a separately payable status as indicated above. HCPCS 76490 has been deleted for 2004. However, we will pay for it under APC 0268 during the grace period from January through March 2004.

aa. Magnetic Resonance Imaging and Magnetic Resonance Angiography Without Contrast

APC 0336: Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast

A commenter requested that we change CPT code 76393 (MR guidance for needle placement) from a packaged status to a separately payable status within APC 0336. Based on clinical homogeneity considerations, the Panel agreed with the commenter and recommended that CPT code 76393 be changed from a status indicator of N to a status indicator of S and placed in APC 0335. We proposed to accept the Panel's recommendation.

bb. Plain Film Except Teeth; Plain Film Except Teeth Including Bone Density Measurement

APC 0260: Level I Plain Film Except Teeth

APC 0261: Level II Plain Film Except Teeth Including Bone Density Measurement

APC 0272: Level I Fluoroscopy

A commenter requested that we move CPT codes 76120 (Cine/video x-rays) and 76125 (Cine/video x-rays add-on) from APC 0260 to APC 0261. However, a presenter to the Panel argued that these CPT codes are fluoroscopic procedures that should not be grouped with Level I radiography procedures. The Panel recommended that we move CPT code 76120 from APC 0260 to APC 0272 and that CPT code 76125 remain in APC 0260. This change makes the APCs more clinically coherent. We proposed to accept the Panel's recommendation, and we will adopt the proposal for 2004.

cc. Chemotherapy Administration by Other Technique Except Infusion

APC 0116: Chemotherapy Administration by Other Technique Except Infusion

A presenter to the Panel requested that we split APC 0116 into three APCs according to the method of administration: (a) Subcutaneous or intramuscular administration (CPT code 96400); (b) "push" administration (CPT code 96408); and (c) central nervous system administration (CPT code 96450). The presenter also requested that existing CPT codes should replace the more nonspecific Q codes for administration of chemotherapy because the CPT codes will provide more detailed data on methods of chemotherapy administration, which could be used for future payment policy decisions. Another presenter agreed with this request and stated that CPT codes are preferable to Q codes because other payers require CPT codes.

The Panel agreed with the above suggestions to split APC 0116 into 3 APCs according to the method of

administration. The Panel recommended that we require hospitals to use the existing CPT codes (for example, 96400, 96408, and 96450) for administration of chemotherapy and map them to APCs 0116, 0117, and 0118, as appropriate. The Panel also recommended that payment rates be based on current Q code cost data until cost data for the CPT codes are available. These cost data will be used to determine whether to change the APC structure for chemotherapy administration

We proposed not to accept the Panel's recommendations to split APC 0116 into three APCs and to use CPT codes for administration of chemotherapy. We will consider such a split in the future but would like to first address the administration of drugs issue. Based on the comments we received on our proposed drug administration coding, we believe that making a change in APC 0116 will be too complicated and burdensome for hospitals at this time. (See a full discussion of this in section VI.B.4 of this final rule.)

We will consider such a split for APC 0116 for CY 2005. We also believe the use of CPT codes will be burdensome to hospitals, will require extensive education, and will result in a significant amount of miscoding. The CPT codes for infusion therapy are based on the service furnished per hour. We do not believe that all hospitals routinely record the start and stop time for infusion therapy and that doing so in order to be able to bill the proper number of hours of infusion therapy could be very burdensome for them. Moreover, the historic cost data on which we base the payment for the service are reported on a per visit basis (much easier to cull from the record than the number of hours of service) and if we changed to CPT codes for these services, we will be unable to convert the charge/cost data now on a per visit basis to a per hour basis (as required by the CPT code) for budget neutrality purposes. *See* section VI of this final rule for further discussion on payments for drugs and drug administration.

dd. Capturing the Costs of Drugs, Biologicals and Radiopharmaceuticals Packaged Into APCs

APC 0290: Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans
APC 0291: Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans
APC 0292: Level III Diagnostic Nuclear Medicine Excluding Myocardial Scans
APC 0294: Level II Therapeutic Nuclear Medicine
APC 0666: Myocardial Add-on Scans

At the January 2003 meeting, we told the Panel that APCs 0290 and 0291 appear to violate the 2 times rule. Several presenters to the Panel expressed concern that our cost data are inadequate because of confusion over coding due to changes in codes and coding instructions for these procedures, poor hospital reporting of radiopharmaceutical use, and the use of single (not multiple) claims in determining costs. One presenter claimed that the current cost data used for CPT code 78122 (Whole blood volume determination) underestimated real costs because of confusion about whether to code radiopharmaceuticals on a "per dose" basis or "per millicurie" basis. This presenter requested that we move CPT code 78122 from APC 0290 to the higher paying APC 0292.

Other presenters agreed with these concerns and stated they were applicable to payments for all drugs, not just radiopharmaceuticals. These commenters were also concerned about the loss of drug-specific data due to packaging because hospitals will have no incentive to code, and thereby identify, packaged drugs.

Pass-through payments for 236 drugs, biologicals, and radiopharmaceuticals expired as of 2003, were then paid either separately or packaged with the procedures with which they are associated. Drugs and radiopharmaceuticals with median costs for administration of $150 or less were packaged. Beginning in 2003, claims data do not provide specific cost information for packaged items. We requested input from the Panel on methods for determining drug costs in the future.

Panel members were concerned that packaging the costs of radiopharmaceuticals into procedures would result in underpayments for the service because we lack adequate data on the cost of radiopharmaceuticals. They were also concerned about creating incentives to use radiopharmaceuticals based on cost rather than clinical efficacy. The Panel recommended that we consider grouping drugs and radiopharmaceuticals into new APCs taking into account both their cost and clinical use. The Panel further recommended that, if new APCs for radionuclides are created, the descriptors should be as simple as possible and use of confusing units of measure should be limited.

Due to the packaging of radiopharmaceuticals into the APC payments for nuclear medicine procedures, we, along with commenters have expressed concern to the Panel regarding whether the current nuclear medicine APC structure is homogeneous in terms of resource consumption. We have reviewed information about the use and cost of various radiopharmaceuticals and believe that restructuring the APCs for nuclear medicine will result in greater clinical and resource homogeneity. Therefore, we proposed to eliminate APCs 0286, 0290, 0291, 0292, 0294, and 0666 and create 20 new APCs for nuclear medicine.

Comment: We received many comments about the proposed nuclear medicine APCs. Generally, commenters supported our proposal for the new APCs but had suggestions for modifications to improve clinical and resource use homogeneity. The suggested modifications are:

- Split APC 0398 into three levels to account for differences in the number of sessions provided and type and amount of radiopharmaceutical used with these procedures.
- Split APC 0401 into two levels to account for the different number of sessions, type and amount of radiopharmaceuticals used, and whether or not ventilation imaging and perfusion imaging are part of the procedure.
- Delete codes G0273 and G0274 and use the newly created CPT codes 78804 and 79403. They recommended that we assign 78804 to a new APC 0406T, Tumor/Infection Imaging Level II and that we assign 79403 to the new APC for Radionucliide Therapy APC, created by combining proposed APCs 0407 and 0408.
- Move codes 78015, 78016, and 78018 from APC 0390 to APC 0406 because they are for metastatic tumor imaging rather than for one organ system.
- Move all of the nuclear medicine "add-on" codes into one APC to be named "Nuclear Medicine Add-On Imaging." Three of the codes, 78478, Heart wall motion add-on, 78480 Heart function add-on, and 78496, Heart function first pass add-on, are assigned to proposed APC 0399. They recommended moving the remaining add-on code, 78020, Thyroid carcinoma metastases uptake, to proposed APC 0399 with the other three add-on codes, to create an APC comprised of add-on codes with a status indicator "X."
- Move each of the codes in the series of codes, 78X99 into the appropriate APCs based on the organ system to be consistent with the proposed APC structure.
- Reassign codes 78270, 78271, and 78272 to APC 0389 because they are

non-imaging nuclear medicine procedures with resource use more similar to the procedures in APC 0389.

• Combine APCs 0390, 0391, and 0392 to create two new APCs composed of thyroid, parathyroid, and adrenal systems. They suggest that the codes should be reassigned to two levels of endocrine imaging based on the number of sessions and radiopharmaceuticals used in the procedure. The titles suggested for the new APCs are "Endocrine Level I" and "Endocrine Level II."

• Combine proposed APCs 0407 and 0408 into one APC because hospital claims data do not reflect any logical division between the two proposed APCs. Further, they request that all of the nuclear medicine therapy codes in the new APC should be paid separately since they know of no nuclear medicine therapeutic radiopharmaceutical that has costs below the proposed $150 threshold for packaging.

• Collapse and redistribute code assignments in APCs 0404 and 0405 to create two new APCs for Level I and Level II Renal and Genitourinary Studies. They recommended assigning only one code, 78709, Kidney imaging, multiple studies, with and without pharmaceutical intervention, to the Level II APC.

Response: After careful review of the recommendations, with one exception, we concur with the commenters that their recommended modifications to the proposed APC classifications improve clinical homogeneity and payment equity. The shifts in median cost that result from the adjustments are minor in most cases and overall, the increased cost is not significant.

The one exception to our agreement with the commenters' recommendation is regarding the assignment of 78708, Kidney imaging with vascular flow and function, single study. Commenters recommended that it be assigned to APC 0404. We believe that it is more appropriately assigned to APC 0405 based on both clinical and resource use considerations.

Although we do not disagree with the commenters' suggestions, we also will not assign the new code 78804, pre-treatment planning, non-Hodgkins to the APC suggested by the commenters. Instead, we will assign it to new technology APC 1508. A detailed discussion of this assignment and other issues related to Zevalin is below in section VI.B.

Thus, we will finalize the nuclear medicine APCs as shown below.

APC 0376: CARDIAC IMAGING LEVEL II

HCPCS	Description
78473	Gated heart, multiple.
78483	Heart first pass, multiple.

APC 0377: CARDIAC IMAGING LEVEL III

HCPCS	Description
78461	Heart muscle blood, multiple.
78465	Heart image (3D), multiple.

APC 0378: PULMONARY IMAGING LEVEL II

HCPCS	Description
78584	Lung V/Q image gas, single breath.
78585	Lung V/Q imaging gas.
78588	Lung V/Q imaging aerosol.
78596	Lung differential function.

APC 0389: NON-IMAGING NUCLEAR MEDICINE

HCPCS	Description
78000	Thyroid, single uptake.
78001	Thyroid, multiple uptakes.
78003	Thyroid suppress/stimuli.
78190	Platelet survival, kinetics.
78191	Platelet survival.
78270	Vitamin B–12 absorption exam.
78271	Vitamin B–12 absorp. exam, intrin. Fac.
78272	Vitamin B–12 absorp, combined.
78725	Kidney function study.

APC 0390: ENDOCRINE LEVEL I

HCPCS	Description
78006	Thyroid imaging with uptake.
78010	Thyroid imaging.
78011	Thyroid imaging with flow.
78099	Endocrine nuclear procedure.

APC 0391: ENDOCRINE LEVEL II

HCPCS	Description
78007	Thyroid image, mult uptakes.
78070	Parathyroid nuclear imaging.
78075	Adrenal nuclear imaging.

APC 0393: RED CELL/PLASMA STUDIES

HCPCS	Description
78110	Plasma volume, single.
78111	Plasma volume, multiple.
78120	Red cell mass, single.
78121	Red cell mass, multiple.
78122	Blood volume.
78130	Red cell survival study.
78135	Red cell survival kinetics.
78140	Red cell sequestration.
78160	Plasma iron turnover.
78162	Radioiron absorption exam.
78170	Red cell iron utilization.
78172	Total body iron estimation.

APC 0394: HEPATOBILIARY IMAGING

HCPCS	Description
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.

APC 0395: GASTROINTESTINAL IMAGING

HCPCS	Description
78230	Salivary gland imaging.
78231	Serial salivary imaging.
78232	Salivary gland function exam.
78258	Esophageal motility study.
78261	Gastric mucosa imaging.
78262	Gastroesophageal reflux exam.
78264	Gastric emptying study.
78278	Acute GI blood loss imaging.
78282	GI protein loss exam.
78290	Meckel's divert exam.
78291	Leveen/shunt patency exam.
78299	GI nuclear procedure.

APC 0396: BONE IMAGING

HCPCS	Description
78300	Bone imaging, limited area.
78305	Bone imaging, multiple areas.
78306	Bone imaging, whole body.
78315	Bone imaging, 3 phase.
78320	Bone imaging (3D).
78399	Musculoskeletal nuclear exam.

APC 0397: VASCULAR IMAGING

HCPCS	Description
78445	Venous thrombosis study.
78455	Venous thrombosis study.

APC 0397: VASCULAR IMAGING—Continued

HCPCS	Description
78456	Acute venous thrombus image.
78457	Venous thrombosis imaging.
78458	Ven thrombosis images, bilat.

APC 0398: CARDIAC IMAGING LEVEL I

HCPCS	Description
78414	Non-imaging heart function.
78428	Cardiac shunt imaging.
78460	Heart muscle blood, single.
78464	Heart image (3D), single.
78466	Heart infarct image.
78468	Heart infarct image (ef).
78469	Heart infarct image (3D).
78472	Gated heart, planar, single.
78481	Heart first pass, single.
78494	Heart image, spect.
78499	Unlisted cardiovascular.

APC 0399: NUCLEAR MEDICINE ADD-ON IMAGING

HCPCS	Description
78020	Thyroid met uptake.
78478	Heart wall motion add-on.
78480	Heart function add-on.
78496	Heart first pass add-on.

APC 0400: HEMATOPOIETIC IMAGING

HCPCS	Description
78102	Bone marrow imaging, ltd.
78103	Bone marrow imaging, mult.
78104	Bone marrow imaging, body.
78185	Spleen imaging.
78195	Lymph system imaging.
78199	Blood/lymph nuclear exam.

APC 0401: PULMONARY IMAGING, LEVEL 1

HCPCS	Description
78580	Lung perfusion imaging.
78586	Aerosol lung image, single.
78587	Aerosol lung image, multiple.
78591	Vent image, 1 breath, 1 proj.
78593	Vent image, 1 proj, gas.
78594	Vent image, mult proj, gas.
78599	Respiratory Nuclear Exam.

APC 0402: BRAIN IMAGING

HCPCS	Description
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).

APC 0402: BRAIN IMAGING—Continued

HCPCS	Description
78610	Brain flow imaging only.
78615	Cerebral vascular flow image.
78699	Nervous system nuclear exam.

APC 0403: CSF IMAGING

HCPCS	Description
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.

APC 0404: RENAL & GENITOURINARY STUDIES LEVEL I

HCPCS	Description
78700	Kidney imaging, static.
78701	Kidney imaging with flow.
78704	Imaging renogram.
78707	Kidney flow/function image.
78710	Kidney imaging (3D).
78715	Renal vascular flow exam.

APC 0405: RENAL & GENITOURINARY STUDIES LEVEL II

HCPCS	Description
78708	Kidney flow/function image.
78709	Kidney flow/function image.

APC 0406: TUMOR/INFECTION IMAGING

HCPCS	Description
78015	Thyroid metastases imaging.
78016	Thyroid metastases imaging/studies.
78018	Thyroid metastases imaging/body.
78800	Tumor imaging, limited area.
78801	Tumor imaging, mult areas.
78802	Tumor imaging, whole body.
78803	Tumor imaging, whole body.
78805	Abscess imaging, ltd area.
78806	Abscess imaging, whole body.
78807	Nuclear localization/abscess.

APC 0407: RADIONUCLIIDE THERAPY

HCPCS	Description
79000	Init hyperthyroid therapy.
79001	Repeat hyperthyroid therapy.
79020	Thyroid ablation.
79030	Thyroid ablation, carcinoma.
79035	Thyroid metastatic therapy.

APC 0407: RADIONUCLIIDE THERAPY—Continued

HCPCS	Description
79100	Hematopoetic nuclear therapy.
79200	Intracavitary nuclear treatment.
79300	Interstitial nuclear therapy.
79400	Nonhemato nuclear therapy.
79420	Intravascular nuclear therapy.
79440	Nuclear joint therapy.
79999	Nuclear medicine therapy.

APC 1507: NEW TECHNOLOGY LEVEL VII ($500–$600)

79403	Hematopoetic nuclear therapy.

APC 1508: TUMOR/INFECTION IMAGING LEVEL II

HCPCS	Description
78804	Pre-tx planning, non-Hodgkins.

We believe that the final APC structure, which takes into account the organ(s) being examined (or treated) as well as the type and complexity of the procedure, is more homogeneous both clinically and in terms of resource consumption than the current APC structure.

ee. Endoscopy Lower Airway

APC 0076: Endoscopy Lower Airway

A presenter to the Panel expressed concern that APC 0076 apparently violates the 2 times rule and requested that we move CPT code 31631 (bronchoscopy with tracheal stent placement) from APC 0076 and into a new APC.

The Panel suggested that a new APC comprised of the four most costly procedures in APC 0076 will result in a more homogenous grouping, and recommended that we move the following CPT codes from APC 0076 and into newly created APC 0415.

HCPCS	Description
31630	Bronchoscopy dilate/fracture reduction.
31631	Bronchoscopy, dilate w/stent.
31640	Bronchoscopy w/tumor excise.
31641	Bronchoscopy, treat blockage.

We proposed to accept the Panel's recommendation that we move CPT codes 31630, 31631, 31640, and 31641 from APC 0076 to new APC 0415. We

received no comments disagreeing with this proposal and will adopt this recommendation for 2004.

ff. Gastrointestinal Endoscopic Stenting Procedures

APC 0141: Upper GI Procedures
APC 0142: Small Intestine Endoscopy
APC 0143: Lower GI Endoscopy
APC 0147: Level II Sigmoidoscopy

A commenter requested that we create a new APC that will be comprised of all the gastrointestinal endoscopic stent codes. The Panel agreed with the commenter's suggestion because the resource requirements for all gastrointestinal endoscopic stents appear to be similar. The Panel recommended that we move the following CPT codes from their 2003 APCs to newly created APC 0384 for 2004:

TABLE 4.—HCPCS CODES TO BE MOVED INTO NEW APC 0384

HCPCS	Description	2003 APC	2004 APC
43219	Esophagus endoscopy	0141	0384
43256	Upper GI endoscopy w/stent	0141	0384
44370	Small bowel endoscopy w/stent	0142	0384
44379	Small bowel endoscopy w/stent	0142	0384
44383	Small bowel endoscopy	0142	0384
44397	Colonoscopy w/stent	0143	0384
45387	Colonoscopy w/stent	0143	0384
45327	Proctosigmoidoscopy w/stent	0147	0384
45345	Sigmoidoscopy w/stent	0147	0384

We proposed to accept the Panel's recommendation to move the following gastrointestinal endoscopic stent CPT codes into newly created APC 0384: 43219, 43256 (from APC 0141); 44370, 44379, 44383 (from APC 0142); 44397, 45387 (from APC 0143); 45327, 45345 (from APC 0147). We received no comments disagreeing with this proposal, and we will adopt it for 2004.

gg. Capturing the Costs of Devices That Are Packaged Into APCs

APC 0081: Non-Coronary Angioplasty or Atherectomy
APC 0083: Coronary Angioplasty and Percutaneous Valvuloplasty
APC 0104: Transcatheter Placement of Intracoronary Stents
APC 0222: Implantation of Neurological Device
APC 0223: Implantation of Pain Management Device
APC 0227: Implantation of Drug Infusion Device
APC 0229: Transcatheter Placement of Intravascular Shunts

Several commenters requested that the status indicators for the above APCs (all of which include high-cost devices) be changed from T (multiple-procedure discount applies) to S (multiple-procedure discount does not apply). Two presenters to the Panel stated that hospitals do not pay less for devices when they are used in the context of a multiple-procedure claim and suggested that we apply the multiple-procedure reduction to the non-device portion of the claim only. Alternatively, these presenters recommended that we apply the discount policy only when the device cost is below a predetermined proportion of the APC cost. Another presenter to the Panel requested that APCs 0222, 0223, and 0227 be exempt from the multiple-procedure discount policy because the cost of the devices used in these procedures makes up more than 50 percent of the APC cost.

We sought the Panel's input as to whether there are situations in which we should not apply our multiple procedure discount policy. The Panel recommended no changes to the status indicators for any of the device-related APCs discussed because they were concerned that exemptions from the discount policy could result in incentives to use more devices than necessary. However, the Panel asked that we analyze our data to determine if we may be underpaying for devices when the multiple procedure discounting policy is applied and recommended that we develop some methodology to track device costs. In section II.B of this preamble, we discuss the issue of device costs and multiple procedure reductions and our progress to date in developing "combination APCs" to address the Panel's concern.

hh. Discussion of Ways To Increase the Use of Multiple Claims To Set APC Payment Rates

A presenter to the Panel suggested that we use dates of service on multiple procedure claims to increase the number of claims we use to set payment rates. Another presenter suggested that we could further increase the number of multiple procedure claims that could be used to set payment rates by ignoring codes with status indicator K. Other suggestions were to exclude from consideration those APCs with small dollar values and to create a new code or APC specifically for the insertion and removal of devices.

The Panel recommended that our staff explore ways to increase the number of claims used to set payment rates, including the following methodologies: sort multiple claims by date of service; exclude codes with K status indicator from evaluation; exclude those APCs with nominal costs (the definition of "nominal" can be determined by modeling a variety of possible dollar amounts). In addition, the Panel recommended that we not create G codes as part of the effort to use multiple procedure claims for developing relative weights. If new codes are needed, the Panel suggested that our staff work with the American Medical Association's CPT Board to identify possible new codes.

B. Other Changes Affecting the APCs

1. Limit on Variation of Costs of Services Classified Within an APC Group

Section 1833(t)(2) of the Act provides that the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest cost item or service within an APC group is more than 2 times greater than the lowest cost item or service within the same group. However, the statute authorizes the Secretary to make exceptions to this limit on the variation of costs within each APC group in unusual cases such as low volume items and services. No exception may be made in the case of a drug or biological that has been designated as an orphan drug under section 526 of the Federal Food, Drug, and Cosmetic Act.

Taking into account the proposed APC changes discussed in relation to the APC Panel recommendations in section II.A.4 of this preamble and the use of 2002 claims data to calculate the

median cost of procedures classified to APCs, we reviewed all the APCs to determine which of them would not meet the 2 times limit. We use the following criteria when deciding whether to make exceptions to the 2 times rule for affected APCs:

- Resource homogeneity.
- Clinical homogeneity.
- Hospital concentration.
- Frequency of service (volume).
- Opportunity for upcoding and code fragmentation. For a detailed discussion of these criteria, refer to the April 7, 2000 final rule (65 FR 18457).

The following table contains the final list of APCs that we exempt from the 2 times rule based on the criteria cited above. In cases in which a recommendation of the APC Panel appeared to result in or allow a violation of the 2 times rule, we generally accepted the Panel recommendation because Panel recommendations were based on explicit consideration of resource use, clinical homogeneity, hospital specialization, and the quality of the data used to determine payment rates.

The median cost for hospital outpatient services for these and all other APCs can be found at Web site: *http://www.cms.hhs.gov*.

TABLE 5.—APCS EXEMPTED FROM 2 TIMES RULE

Final Rule APC	Description
0006	Level I Incision & Drainage.
0012	Level I Debridement & Destruction.
0018	Biopsy of Skin/Puncture of Lesion.
0019	Level I Excision/Biopsy.
0020	Level II Excision/Biopsy.
0043	Closed Treatment Fracture Finger/Toe/Trunk.
0046	Open/Percutaneous Treatment Fracture or Dislocation.
0058	Level I Strapping and Cast Application.
0060	Manipulation Therapy.
0071	Level I Endoscopy Upper Airway.
0074	Level IV Endoscopy Upper Airway.
0084	Level I Electrophysiologic Evaluation.
0093	Vascular Reconstruction/Fistula Repair without Device.
0097	Cardiac and Ambulatory Blood Pressure Monitoring.
0099	Electrocardiograms.
0103	Miscellaneous Vascular Procedures.
0105	Revision/Removal of Pacemakers, AICD, or Vascular.
0109	Removal of Implanted Devices.
0130	Level I Laparoscopy.
0147	Level II Sigmoidoscopy.
0148	Level I Anal/Rectal Procedure.
0155	Level II Anal/Rectal Procedure.
0165	Level III Urinary and Anal Procedures.
0192	Level IV Female Reproductive Proc.
0203	Level IV Nerve Injections.
0204	Level I Nerve Injections.
0207	Level III Nerve Injections.
0213	Extended EEG Studies and Sleep Studies, Level I.
0214	Electroencephalogram.
0218	Level II Nerve and Muscle Tests.
0231	Level III Eye Tests & Treatments.
0233	Level II Anterior Segment Eye Procedures.
0235	Level I Posterior Segment Eye Procedures.
0239	Level II Repair and Plastic Eye Procedures.
0245	Level I Cataract Procedures without IOL Insert.
0252	Level II ENT Procedures.
0262	Plain Film of Teeth.
0266	Level II Diagnostic Ultrasound Except Vascular.
0274	Myelography.
0279	Level II Angiography and Venography except Extremity.
0297	Level II Therapeutic Radiologic Procedures.
0303	Treatment Device Construction.
0314	Hyperthermic Therapies.
0323	Extended Individual Psychotherapy.
0340	Minor Ancillary Procedures.
0341	Skin Tests.
0344	Level III Pathology.
0355	Level III Immunizations.
0356	Level IV Immunizations.
0363	Level I Otorhinolaryngologic Function Tests.
0364	Level I Audiometry.
0367	Level I Pulmonary Test.
0368	Level II Pulmonary Tests.
0370	Allergy Tests.
0373	Neuropsychological Testing.
0397	Vascular Imaging.
0398	Level I Cardiac Imaging.
0402	Brain Imaging.
0404	Renal and Genitourinary Studies Level I.

TABLE 5.—APCS EXEMPTED FROM 2 TIMES RULE—Continued

Final Rule APC	Description
0407	Radionuclide Therapy.
0409	Red Blood Cell Tests.
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver.
0692	Electronic Analysis of Neurostimulator Pulse Generators.
0698	Level II Eye Tests & Treatments.
0699	Level IV Eye Tests & Treatments.
1528	New Technology—Level XXVIII ($5000-$5500).

2. Procedures Moved From New Technology APCs to Clinically Appropriate APCs

In the November 30, 2001 final rule (66 FR 59903), we made final our proposal to change the period of time during which a service may be paid under a new technology APC. Beginning in 2002, the policy is to retain a service within a new technology APC group until we have acquired adequate data that allow us to assign the service to a clinically appropriate APC. This policy allows us to move a service from a new technology APC in less than 2 years if sufficient data are available, and it also allows us to retain a service in a new technology APC for more than 3 years if sufficient data upon which to base a decision for reassignment have not been collected.

In the context of new technology procedures, we create HCPCS codes for services only. We do not create HCPCS codes for equipment that is used in the course of providing an item or service (except in the case of "C" codes for devices that meet the criteria for transitional pass-through payments). Equipment that is used to provide an item or service is not separately coded because it is a resource required to furnish the service. Like other resources that are required to furnish a service (for example, cost of a room, cost of staff, cost of supplies), the hospital should show charges either as part of its charge for the procedure or with a revenue code.

As described below, we proposed to delete four HCPCS codes that are currently paid in new technology APCs. We believed that these four HCPCS codes do not conform to our current policy to not create HCPCS codes for equipment used to provide a service. In addition, we stated that there soon would exist, CPT codes to describe all of the services being furnished, including any equipment that is needed to perform them, so we believe it is appropriate at this time to delete the HCPCS codes. The HCPCS codes which we proposed to delete effective January 1, 2004 were:

C1088; Laser Optic Treatment System, Indigo Laseroptic Treatment System
C9701; Stretta System
C9703; Bard Endoscopic Suturing System, and C9711; H.E.L.P. Apheresis System.

A full description of these HCPCS is available in the proposed rule (67 FR 47978).

We received no comments in response to this proposal. However, we have determined that our proposal to delete codes C9701 and C9703 was in error. Upon further review of this issue, we have determined that these codes were in fact established to represent complete procedures. Therefore, we will retain codes C9701 and C9703.

Comment: A provider of treatment planning software submitted several comments regarding this service. In their first set of comments on the 2003 OPPS final rule with comment, the commenter agreed with our decision to create a new G-code, G0288, for their product, Preview, and other similar treatment planning software and to assign this service to new technology APC 0975. G0288 was created and assigned to new technology APC 0975 for the 2003 final rule and was subject to comment after its publication. In their comments in response to the 2003 final rule with comment, they indicated that the $625 payment rate associated with new technology APC 0975 appropriately reflected the costs of Preview to providers. However, this party recommended that we pay for G0288 under certain circumstances. These included payment only for treatment planning imaging services that are FDA approved; that is, to follow FDA's determinations concerning which imaging software programs are sufficiently comprehensive and accurate. Further, the commenter recommended that we pay for both pre-surgical and post-surgical imaging, claiming optimum effectiveness of the related endovascular repair procedures only occurs when imaging studies are performed both before and after surgery. Third, this party recommended that we use G0288 in the OPPS but not in other Medicare payment systems until cost data were more complete. The commenter believed that we should encourage use of the CPT process to develop codes that describe a wide range of applications for the treatment planning imaging that may develop.

The commenter also commented on our August 12, 2003 proposed rule, in which we proposed assigning G0288 to new APC 0414, with a payment rate of $260.65. This commenter stated that the proposed payment is inadequate and based on flawed, imputed cost data. It also asserted that the descriptors for APC 0414 and G0288 do not restrict the use of this code to services that meet the "recognized standards and specifications" for three-dimensional computer-aided measurement planning simulation ("3D–CAMPS") services and recommended that we revise the proposed payment for APC 0414 based on hospital acquisition cost data that they provided. The commenter also recommended that we create a revenue code specifically for APC 0414 to enable more rational charge determination for the service and that we revise the descriptors for APC 0414 and G0288 to ensure that the codes only are used for the 3D–CAMPS systems, and to clarify that the service may be applied pre- or post-surgically. The recommended descriptor is: "Three-dimensional computer-aided measurement simulation (3D–CAMPS) services for pre-surgical and post-surgical imaging."

Response: We proposed to move G0288 from new technology APC 0975 to APC 0414 because we believe that we had sufficient 2002 claims data for our analysis. The predecessor C-code for Preview, C9708, was reported approximately 1,300 times in 2002, with a median cost of $272.48. However, we have reviewed the hospital cost data that the commenting party provided, and believe that there may be some claims in our data that understate the cost of the treatment planning software. We have decided to give equal weight to the median cost based on our claims data and the median cost of $625 provided by the commenter, based on its analysis. Therefore, we are establishing the appropriate cost

amount as $448.74. As a result, we are assigning G0288 to new technology service APC 1506, for a payment rate of $450.00. We are continuing the assignment of G0288 to a new technology APC because this is still a relatively new procedure and we still have concerns regarding our cost data.

We agree that this can be used for treatment planning prior to surgery and for post-surgical monitoring and have revised the code descriptor to clarify this point. The descriptor for this code is revised as follows: G0288 Reconstruction, computed tomographic angiography of aorta for preoperative planning and evaluation post vascular surgery. We assume that hospitals providing this service will abide by the FDA labeling requirements for equipment used in providing this service.

3. Revision of Cost Bands and Payment Amounts for New Technology APCs

We proposed to implement a comprehensive restructuring of all the new technology APCs. First, the cost intervals in the current new technology APCs are inconsistent, ranging from $50 to $1,500. Secondly, as the number of procedures assigned to new technology APCs increases, we believe that narrower cost bands are required to avoid inaccurate payment for new technology services. The increased number of new technology APCs that would result from narrowing the cost bands cannot be accommodated within the current sequence of available APC numbers. Therefore, we proposed to dedicate two new series of APC numbers to the restructured new technology APCs, which would allow us to narrow the cost bands and also afford us flexibility in creating additional bands as future needs may dictate.

We proposed to establish cost bands from $0 to $100 in increments of $50, from $100 through $2,000 in intervals of $100, and from $2,000 through $6,000 in intervals of $500. We believe that these intervals would allow us to price new technology services more appropriately and consistently. We also propose to retain two parallel sets of new technology APCs, one with status indicator "S" and the other with status indicator "T." We solicited comments on the hierarchy of cost levels of the restructured new technology APCs.

The final list of restructured new technology APCs is in Addendum A.

We received a number of comments in support of this proposal to restructure the new technology APC bands. Therefore, we will finalize our proposal.

4. Creation of APCs for Combinations of Device Procedures

In the August 12, 2003 proposed rule, we discussed data development that we had undertaken to create median costs for combinations of HCPCS codes in different APCs that we believed were frequently performed on the same day. We focused our work on pairs of APCs, one of which contained a service that required an expensive device. See 68 FR 47979 for a complete description of the data development. We undertook this activity to see if creating larger classification groups of this type might increase the number of multiple procedure claims that we could use to set payment rates for these services. We also thought that the analysis might yield useful information regarding the appropriateness of the multiple procedure reduction for combinations of services that include at least one APC with an expensive device, that are commonly performed on the same date. In many cases, we found that the combination APC medians closely approximated the median that results under the current policy (that is, the sum of single medians for each APC, reducing the median for the lower cost procedure by 50 percent). In other cases, the data revealed combination APC median costs that were considerably higher or lower than under our current policy.

We concluded in the proposed rule that the results of the study provided no compelling reason to change our payment policy. We asked for comment on all aspects of the methodology, analysis, and payment options. We also asked for discussion of how we could use more multiple procedure claims were we not to create combination APCs and for an explanation of why external data should be used in lieu of our single or multiple procedure claims data to set median costs for APCs with large device costs. However, we did not propose to create combination APCs or to make payment based on the combination APC medians for 2004.

We received only a few comments on the combination APC methodology and these were in the context of why we should not apply multiple procedure reductions to specific combinations of APCs. See the discussion of multiple procedure reduction in V.D.2 for a summary of these comments and our responses.

III. Recalibration of APC Weights for CY 2004

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

To recalibrate the relative APC weights for services furnished on or after January 1, 2004 and before January 1, 2005, we used the same basic methodology that we described in the April 7, 2000 final rule. That is, we recalibrated the weights based on claims and cost report data for outpatient services. We used the most recent available data to construct the database for calculating APC group weights. For the purpose of recalibrating APC relative weights for CY 2004, the most recent available claims data are the approximately 127 million final action claims for hospital outpatient department services furnished on or after April 1, 2002 and before January 1, 2003. We eliminated 2.6 million claims for bill types other than OPPS bill types and claims for services furnished in Maryland, Guam, and the Virgin Islands. We matched the remaining claims that were paid under the OPPS to the most recent cost report filed by the individual hospitals represented in our claims data. We were left with about 75 million claims for which we could identify cost report data. The APC relative weights continue to be based on the median hospital costs for services in the APC groups.

A. Data Issues

1. Period of Claims Data Used

We used claims for the period beginning April 1, 2002 through and including December 31, 2002 as the basis for the CY 2004 OPPS. The statute requires that we take into account new cost data and other relevant information and factors in reviewing and revising the weights, and we believe that this period will give us the most recent costs. We chose not to include the claims for the period beginning on January 1, 2002 through March 31, 2002 because they were used to set the payment rates for the 2003 OPPS and we believe that the most recent 9 months of claims data will result in payment rates that are most representative of the current relative costs of hospital outpatient services.

Comment: Some commenters supported our use of claims for this 9-month period for setting the weights for

the 2004 OPPS. Other commenters wanted us to use external data in lieu of claims data for specified APCs because they believed that the payments that result from the median costs developed using claims data were inadequate. Other commenters objected to the use of 2002 claims data because they stated that 2002 costs would not be an appropriate proxy for the relative costs of drugs, biologicals, and radiopharmaceuticals in 2004 and they urged us to use hospital acquisition costs instead of claims data.

Response: We used 2002 claims data for services furnished from April 1, 2002 through December 31, 2002 as the basis for the relative weights used to create payment amounts for the 2004 OPPS. Our established policy is to use the most recent claims data available. For the August 12, 2003 proposed rule and this final rule, those data are for services in the last 3 quarters of 2002. These data are used to calculate median costs upon which to base our relative weights. The OPPS seeks and uses relative costs to create weights that are used to distribute a fixed amount of Medicare payment for OPPS services appropriately among hospitals. Therefore, the accuracy of the relativity is more important than whether the median costs derived from the claims data accurately reflect the costs of the services. *See* section III.B for our discussion of the use of external data.

2. Treatment of "Multiple Procedure" Claims

Since the inception of the OPPS, we have received many requests asking that we ensure that the data from claims that contain charges for multiple procedures are included in the data from which we calculate the OPPS relative payment weights. Those making the requests believe that relying solely on single-procedure claims to recalibrate APC weights fails to take into account data for many frequently performed and complex procedures, particularly those commonly performed in combination with other procedures.

We agree that it is desirable to use the data from as many claims as possible to recalibrate the relative payment weights, including those with multiple procedures. For CY 2003, we identified a number of multiple-procedure claims that could be treated as single-procedure claims, enabling us to greatly increase the number of claims used to develop the APC payment weights. However, there remain several inherent features of multiple procedure claims that prevent us from using all of them to recalibrate the payment weights. We discussed these obstacles in detail in the August 9, 2002 proposed rule (67 FR 52092, 52108 through 52111), and the November 1, 2002 final rule (67 FR 66718, 66743 through 66746).

To enable us to use more claims in the creation of median costs upon which our payment weights and rates are based, we proposed several changes to how we use claims data for the CY 2004 OPPS. Specifically, we proposed to expand the number of HCPCS codes that we "ignore" for the purpose of creating pseudo single claims from claims that contain other separately payable HCPCS codes. We also looked at dates of service on packaged HCPCS codes and packaged revenue centers, and proposed where possible, to attribute the charges to major, separately payable HCPCS codes based on the codes' dates of service. We also considered creating combination APCs for procedures that have a significant device component. Our complete discussion of the use of data to set the weights for CY 2004 OPPS follows in section III.B of this preamble.

Expansion of the List of Codes To Be Ignored in Creation of Single Claims

For CY 2003 OPPS, we ignored the presence of HCPCS codes 93005, 71010, and 71020 to create pseudo-single claims where there was only one remaining separately paid, major HCPCS code on the claim. Ignoring these codes enabled us to attribute the costs of packaged HCPCS codes and packaged revenue centers to the remaining separately paid, major HCPCS codes and, thereby, create a useable psuedo single claim. We did this because we believed that the charges found in the packaged HCPCS or packaged revenue centers would be appropriately associated with the only other separately payable HCPCS that remained on the claim once the ignored codes were bypassed.

For CY 2004 OPPS, we proposed to expand the list of HCPCS codes to be ignored for purposes of creating pseudo-single claims. On claims that contain other separately payable HCPCS, we proposed to bypass the HCPCS codes in the APCs identified in Table 6. As with the previously ignored HCPCS codes 93005, 71010, and 71020, we believe that there are additional codes that are highly unlikely to have charges that are found in packaged HCPCS or in packaged revenue centers. Therefore, we believe that they also can be ignored for the purpose of creating pseudo-single claims from the remaining charges on the claim. We solicited comments on the proposed methodology to create pseudo-single claims, on the list of codes that we proposed to ignore (Table 6), and whether there are other low-cost services that we could ignore using this methodology. We also requested comments on whether we should use the charges for the codes in the APCs in Table 6 to create pseudo singles for these codes from these claims.

Use of Dates of Service To Create Single Claims

For CY 2004, we used dates of service on HCPCS codes and on packaged revenue centers to attribute charges to a major payable HCPCS code where the dates of service match. We could only use this approach where there are different dates of service for the separately payable major HCPCS codes. Where there are multiple major payable HCPCS codes on a claim with the same date, we could not use this approach because there was no way to tell to which major payable HCPCS code the charges from the packaged HCPCS or packaged revenue center belonged. Moreover, where the hospital did not provide dates for all packaged revenue centers, we could not attribute charges based on the date of service.

Use of Single Procedure Claims

Comment: Some commenters objected to the use of single procedure claims as the basis for setting weights for all APCs. The commenters are concerned that even with the changes we made to use more claims for 2004 OPPS, some of the APCs had medians based on less than 10 percent of their true claims volume. They believe that this methodology results in the use of claims only for simple, low-cost cases from small, relatively non-busy centers with low levels of technological complexity and inappropriately low costs and charges. They urged us to use external data, whether proprietary or not, in place of the claims-derived medians when the medians would otherwise be based on a small number of claims.

Some commenters urged us to ignore codes for procedures performed on the same day as procedures of interest to them and to package all revenue center charges and charges for packaged HCPCS codes into the code for which they were seeking a median. Some commenters gave us relatively elaborate strategies for creating pseduo-single claims out of multiple procedure claims for particular services or groups of services that were of interest to them. Some of these related to special packaging for chemotherapy services and nuclear medicine services. The commenters urged us to model our data for the 2005 OPPS according to the specifications they provided.

Response: We would certainly prefer to use all claims in the setting of weights for APCs, if it were possible to do so validly. However, we continue to be plagued by our inability to allocate revenue center charges when there are multiple major procedure codes for services performed on the same day. We are unable to determine how to accurately split some costs (for example, recovery room time) among the major procedures. We have received no comments that offer alternatives that would enable us to do so with confidence.

We did not accept the service-specific strategies for acquiring more single claims that were submitted in comments because none of them could be generalized to the entire claims population in such a way that we could be sure that they would not distort the relativity of all services. We set weights for hundreds of APCs in this system and we think it is important that the same rules governing creation of pseudo single claims from multiple procedure claims be applied across all services so that packaging occurs uniformly and the relativity of services is maintained. It is a practical impossibility to have different strategies for creating pseudo singles for each category of services.

We did not use the line items that were ignored in the calculation of medians for the APC into which they would fall because we lacked confidence that they would accurately represent the full cost of the service. We asked for comments on this in the proposed rule. Based on the comments that indicate that the data for these line items should be used in median setting, we expect to use these line items for median setting for the 2005 proposed rule.

APCs to be Ignored To Create More Single Claims

Comment: Commenters supported the expansion of the list of APCs that we ignored to create single procedure claims from multiple procedure claims to enable us to use more claims data in weight setting. A commenter asked that we confirm that the line items that were ignored to create pseudo-single claims (See Table 6) are used in the weight setting process. A commenter asked that we implement the combination APC approach as a way of using more claims data for multiple procedure claims. One commenter asked that we add evaluation and management codes to the list of codes ignored for purposes of creating pseudo-singles. Other commenters provided lists of additional codes that could be ignored to create more pseudo-single claims.

Commenters also supported the use of dates of service on lines with revenue code charges where they could be used to attribute charges to HCPCS codes for weight setting. Some commenters advised that we should use the date of service aggregation at the beginning of the pseudo-single claim creation to achieve the best effects. Some commenters asked that we require all hospitals to use dates of service on all lines (but not before July 1, 2004), even where only revenue codes are on the lines, so that more claims could be used in future years.

Several commenters asked that we eliminate the requirement for series bills for certain services if we require a date of service for each line because the claim will grow in size as charges for multiple dates of service that are now combined on a single line with no date of service will now have to be split into multiple lines to show the date of service. The commenters fear that the increase in the lines on the claim may result in errors on the claim and there may be cashflow problems if more claims are returned to the provider. The commenters indicated that delays in payment for series bills covering 30 days of service are significant.

Response: For the 2004 OPPS, we did make progress in using more claims by looking to the dates on revenue center charges, where they exist, to assign them to a single major procedure on the same date. We applied the date of service criteria before we ignored APCs to create single claims. Moreover, we were able to create more single procedure claims by ignoring procedures for which we thought no revenue center charges or packaged HCPCS charges would be appropriately assigned. We appreciate the information provided in comments and hope that the public will continue to furnish us with an expanded list of codes that they believe can be considered "stand alone" codes, which we could properly ignore in creating pseudo single claims from claims containing multiple major procedures. We did not add evaluation and management service codes to the list because we believe that drugs and supplies are often used during such services and that it would not be correct to assume that all of the supply and drug charges on the claim were for items and services used with the procedure that also is billed also on the same claim. We would like to further explore the issue of which claims to ignore for pseudo single creation with the APC Panel in its winter meeting and to seek the Panel's views on the specific code to be added to the list of codes to be ignored for this purpose.

While we did not apply the combination APC approach, we expect to continue to explore whether this would, upon further refinement, have value in establishing correct weights for procedures performed in combination with one another. We hope to improve both of these processes next year and to develop other methods of using multiple procedure claims.

We did not use the line items for the HCPCS codes we ignored in the calculation of medians for those HCPCS codes. We asked for public comment on the issue. In view of the public comments supporting the concept of ignoring certain codes for creation of pseudo singles and supporting the validity of using these line items in the median setting for these codes, we will propose to use them for median setting for the 2005 proposed rule.

Our requirement for series bills creates efficiencies in claims processing that enable us to provide better provider service. In view of the decision to not implement the drug administration option, which would have required coding of all drugs, and seemed to be the impetus for the comment, we do not expect to revise our series bill policy.

B. Description of Our Calculation of Weights for CY 2004

The methodology we followed to calculate the APC relative payment weights proposed for CY 2004 is as follows:

- We excluded from the data claims for those bill and claim types that would not be paid under the OPPS (for example, bill type 72X for dialysis services for patients with end-stage renal disease (ESRD)).
- We eliminated claims from hospitals located in Maryland, Guam, and the U.S. Virgin Islands.
- Using the most recent available cost report from each hospital, we converted billed charges to costs and aggregated them to the procedure or visit level first by identifying the cost-to-charge ratio specific to each hospital's cost centers ("cost center specific cost-to-charge ratios" or CCRs) and then by matching the CCRs to revenue centers used on the hospital's CY 2001 outpatient bills. The CCRs include operating and capital costs but exclude items paid on a reasonable cost basis.
- We eliminated from the hospital CCR data 287 hospitals that we identified as having reported charges on their cost reports that were not actual charges (for example, a uniform charge applied to all services). Of these, 206 hospitals had claims data.
- We eliminated from our data claims for critical access hospitals that are not

paid under OPPS and whose claims are therefore not suitable for use in setting weights for services paid under OPPS.

- We calculated the geometric mean of the total operating CCRs of hospitals remaining in the CCR data. We removed from the CCR data 56 hospitals whose total operating CCR deviated from the geometric mean by more than three standard deviations.
- We excluded from our data approximately 3.11 million claims submitted by the hospitals that we removed or trimmed from the hospital CCR data.
- We matched revenue centers from the remaining universe of claims to hospital CCRs.
- We separated the remaining claims that we had matched with a cost report into the following three distinct groups: (1) Single-procedure claims; (2) multiple-procedure claims; and (3) claims on which we could not identify at least one OPPS covered service. Single-procedure claims are those that include only one HCPCS code (other than laboratory and incidentals such as packaged drugs and venipuncture) that could be grouped to an APC. Multiple-procedure claims include more than one HCPCS code that could be mapped to an APC. Dividing the claims yielded approximately 24.43 million single-procedure claims and 16.86 million multiple-procedure claims.

We converted 9.833 million multiple-procedure claims to single-procedure claims using the following criteria: (1) If a multiple-procedure claim contained lines with a HCPCS code in the pathology series (that is, CPT 80000 series of codes), we treated each of those lines as a single claim. (2) For multiple-procedure claims with a packaged HCPCS code (status indicator "N") on the claim, we ignored line items for preoperative procedures and for those services in the APCs identified in Table 6. These are services with payment amounts below $50 (under the CY 2003 OPPS) for which we believe the charge represents the totality of the charges associated with the service (that is, that there are no packaged HCPCS or packaged revenue centers attributable to the service). If only one procedure (other than HCPCS codes in Table 6) existed on the claim, we treated it as a single-procedure claim. (3) If the claim had no packaged HCPCS codes and if there were no packaged revenue centers on the claim, we treated each line with a procedure as a single-procedure claim if billed with single units. (4) If the claim had no packaged HCPCS codes but had packaged revenue centers for the procedure, we ignored the line item for codes in the APCs identified in Table 6. If only one HCPCS code remained, we treated the claim as a single-procedure claim.

TABLE 6.—APCS THAT WERE IGNORED TO CREATE PSEUDO SINGLE PROCEDURE CLAIMS

APC	APC Description	Status indicator
0001	Level I Photochemotherapy	S
0060	Manipulation Therapy	S
0077	Level I Pulmonary Treatment	S
0099	Electrocardiograms	S
0215	Level I Nerve and Muscle Tests	S
0215	Level I Nerve and Muscle Tests	S
0230	Level I Eye Tests & Treatments	S
0260	Level I Plain Film Except Teeth	X
0262	Plain Film of Teeth	X
0271	Mammography	S
0341	Skin Tests and Miscellaneous Red Blood Cell Tests	X
0342	Level I Pathology	X
0343	Level II Pathology	X
0344	Level III Pathology	X
0345	Level I Transfusion Laboratory Procedures	X
0364	Level I Audiometry	X
0367	Level I Pulmonary Test	X
0669	Digital Mammography	S
0690	Electronic Analysis of Pacemakers and other Cardiac Devices.	S
0706	New Technology—Level I ($0–$50)	S

In addition, we assessed the dates of service for HCPCS codes and packaged revenue centers on each claim that contained more than one major code. Where it was possible to attribute charges for packaged HCPCS and packaged revenue centers to HCPCS codes for major procedures by matching unique dates of service, we did this and created single claims by packaging charges into the charge for the major service on the same date. We were only able to do this if the multiple major procedures had different dates of service and if there were dates of service on all of the packaged revenue centers. Dates of service on revenue centers are not required and, therefore, only claims from hospitals that submitted dates of service on revenue centers in CY 2002 could be used in this process for maximizing the number of single-procedure claims to be used for weight setting.

- To calculate median costs for services within an APC, we used only single-procedure bills and those multiple-procedure bills that we converted into single claims. If a claim had a single code with a zero charge (that would have been considered a single-procedure claim), we did not use it. As we discussed in section III.A.2 of this final rule, we did not use multiple-procedure claims that billed more than one separately payable HCPCS code with charges for packaged items and services such as anesthesia, recovery room, or supplies that could not be reliably allocated or apportioned among the primary HCPCS codes on the claim. We have not yet developed what we regard as an acceptable method of using multiple procedure bills to recalibrate APC weights that minimizes the risk of improperly assigning charges to the wrong procedure or visit.

For APCs in Table 7, we required that there be a C code on the claim for the claim to be used. These APCs require the use of a device in the provision of the service. Moreover, in 2002, hospitals were required to bill the C code in order for the device to receive pass-through

payment for the device. Therefore, if no C code was billed on the claim, we presumed that the claim was incorrectly coded, and we did not use it. For some of these APCs, we further required that specific devices be on the claim.

TABLE 7.—APCS FOR WHICH A HCPCS FOR A DEVICE WAS REQUIRED TO BE ON A CLAIM USED FOR WEIGHT SETTING

APC	APC Description	Status
0032	Insertion of Central Venous/Arterial Catheter	T
0039	Implant Neurostim, One Array	S
0048	Arthroplasty with Prosthesis	T
0080	Diagnostic Cardiac Catheterization	T
0081	Non-Coronary Angioplasty or Atherectomy	T
0082	Coronary Atherectomy	T
0083	Coronary Angioplasty and Percutaneous Valvuloplasty	T
0085	Level II Electrophysiologic Evaluation	T
0086	Ablate Heart Dysrhythm Focus	T
0087	Cardiac Electrophysiologic Recording/Mapping	T
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	T
0090	Insertion/Replacement of Pacemaker Pulse Generator	T
0104	Transcatheter Placement of Intracoronary Stents	T
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	T
0107	Insertion of Cardioverter-Defibrillator	T
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T
0115	Cannula/Access Device Procedures	T
0119	Implantation of Devices	T
0122	Level II Tube Changes and Repositioning	T
0167	Level III Urethral Procedures	T
0202	Level VIII Female Reproductive Proc	T
0222	Implantation of Neurological Device	T
0225	Implantation of Neurostimulator Electrodes	S
0226	Implantation of Drug Infusion Reservoir	T
0227	Implantation of Drug Infusion Device	T
0229	Transcatheter Placement of Intravascular Shunts	T
0259	Level VI ENT Procedures	T
0313	Brachytherapy	S
0384	GI Procedures with Stents	T
0385	Level I Prosthetic Urological Procedures	T
0386	Level II Prosthetic Urological Procedures	T
0648	Breast Reconstruction with Prosthesis	T
0652	Insertion of Intraperitoneal Catheters	T
0653	Vascular Reconstruction/Fistula Repair with Device	T
0654	Insertion/Replacement of a Permanent Dual Chamber Pacemaker	T
0655	Insertion/Replacement/Conversion of a Permanent Dual Chamber Pacemaker	T
0670	Intravenous and Intracardiac Ultrasound	S
0674	Prostate Cryoablation	T
0680	Insertion of Patient Activated Event Recorders	S
0681	Knee Arthroplasty	T

• For each single-procedure claim, we calculated a cost for every billed line item charge by multiplying each revenue center charge by the appropriate hospital-specific CCR. We used the most recent settled or submitted cost reports. Using the most recent "submitted to settled ratio," we adjusted CCRs for the submitted cost reports but not the settled ones. If an appropriate cost center did not exist for a given hospital, we crosswalked the revenue center to a secondary cost center when possible, or used the hospital's overall CCR for outpatient department services. We excluded from this calculation all charges associated with HCPCS codes previously defined as not paid under the OPPS (for example, laboratory, ambulance, and therapy services). We included all charges associated with HCPCS codes that are designated as packaged services (that is, HCPCS codes with the status indicator of "N").

• To calculate per-service costs, we used the charges shown in revenue centers that contained items integral to performing services. Table 8 contains a list of the revenue centers that we packaged into major HCPCS codes when they appeared on the same claim. This is a change to the packaging of revenue centers by category of service that had been done since the inception of the OPPS in the April 7, 2000 final rule (65 FR 18457). In all prior years of the OPPS, we had specific subsets of revenue centers that we packaged into major HCPCS codes based on the type of service we assigned to the HCPCS code for this purpose. For example, we had a set of revenue centers that could be packaged into visit codes and a different, but overlapping, set of revenue centers that could be packaged into surgery codes. For 2004 OPPS, we converted these categories to a single set of revenue codes (see Table 8) that would be packaged into the major HCPCS code with which it appears on a claim. We believe that this will increase the likelihood that the total charge for the major HCPCS code will capture all of the costs attributed to the services furnished. Table 8 lists packaged services by revenue center that we are proposing to use to calculate per-service costs for outpatient services furnished in CY 2004.

TABLE 8.—PACKAGED SERVICES BY REVENUE CODE

Revenue code	Description
250	Pharmacy.
251	Generic.
252	Nongeneric.

TABLE 8.—PACKAGED SERVICES BY REVENUE CODE—Continued

Revenue code	Description
254	Pharmacy Incident to Other Diagnostic.
255	Pharmacy Incident to Radiology.
257	Nonprescription Drugs.
258	IV Solutions.
259	Other Pharmacy.
260	IV Therapy, General Class.
262	IV Therapy/Pharmacy Services.
263	Supply/Delivery.
264	IV Therapy/Supplies.
269	Other IV Therapy.
270	M&S Supplies.
271	Nonsterile Supplies.
272	Sterile Supplies.
274	Prosthetic/Orthotic Devices.
275	Pacemaker Drug.
276	Intraocular Lens Source Drug.
278	Other Implants.
279	Other M&S Supplies.
280	Oncology.
289	Other Oncology.
290	Durable Medical Equipment.
370	Anesthesia.
371	Anesthesia Incident to Radiology.
372	Anesthesia Incident to Other Diagnostic.
379	Other Anesthesia.
390	Blood Storage and Processing.
399	Other Blood Storage and Processing.
560	Medical Social Services.
569	Other Medical Social Services.
621	Supplies Incident to Radiology.
622	Supplies Incident to Other Diagnostic.
624	Investigational Device (IDE).
630	Drugs Requiring Specific Identification, General Class.
631	Single Source.
632	Multiple.
633	Restrictive Prescription.
637	Self-Administered Drug (Insulin Admin. in Emergency Diabetic. COMA) .
700	Cast Room.
709	Other Cast Room.
710	Recovery Room.
719	Other Recovery Room.
720	Labor Room.
721	Labor.
762	Observation Room.
810	Organ Acquisition.

TABLE 8.—PACKAGED SERVICES BY REVENUE CODE—Continued

Revenue code	Description
819	Other Organ Acquisition.
942	Education/Training.

- We standardized costs for geographic wage variation by dividing the labor-related portion of the operating and capital costs for each billed item by the proposed FY 2004 hospital inpatient prospective payment system (IPPS) wage index published in the **Federal Register** on May 9, 2002 (67 FR 31602). We used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. We have used this estimate since the inception of the OPPS and continue to believe that it is appropriate. (*See* the April 7, 2000 final rule (65 FR 18496) for a complete description of how we derived this percentage).
- We summed the standardized labor-related cost and the nonlabor-related cost component for each billed item to derive the total standardized cost for each procedure or medical visit.
- We removed extremely unusual costs that appeared to be errors in the data using a trimming methodology analogous to what we use in calculating the diagnosis-related group (DRG) weights for the hospital IPPS. That is, we eliminated any bills with costs outside of three standard deviations from the geometric mean.
- After trimming the procedure and visit level costs, we mapped each procedure or visit cost to its assigned APC, including, to the extent possible, the proposed APC changes.
- We calculated the median cost for each APC.

To develop the median cost for observation (APC 339, HCPCS code G0244), we selected claims containing HCPCS code G0244 (Observation care provided by a facility to a patient with CHF, chest pain, or asthma, minimum eight hours, maximum forty-eight hours) that also showed one or more of the ICD–9 (International Classification of Diseases, Ninth Edition) diagnosis codes required for payment of APC 339. We ignored other separately payable codes so that the claims with G0244 would not be excluded for having multiple major procedures on a single claim. We packaged the costs of allowable revenue centers and HCPCS codes with status indicator "N" into the cost of G0244, and trimmed as was done for the calculation of the median costs for other APCs.

- Using the median APC costs, we calculated the relative payment weights for each APC. As in prior years, we scaled all the relative payment weights to APC 0601, Mid-level clinic visit, because it is one of the most frequently performed services in the hospital outpatient setting. We assigned APC 0601 a relative payment weight of 1.00 and divided the median cost for each APC by the median cost for APC 0601 to derive the relative payment weight for each APC. Using 2002 data, the median cost for APC 0601 is $58.78.

Section 1833(t)(9)(B) of the Act requires that APC revisions, relative payment weight revisions, and wage index and other adjustments be made in a manner that ensures that estimated aggregate payments under the OPPS for 2004 are neither greater than nor less than the estimated aggregate payments that would have been made without the changes. To comply with this requirement concerning the APC changes, we compared aggregate payments using the CY 2003 relative weights to aggregate payments using the CY 2004 proposed weights. Based on this comparison, we made an adjustment of 0.981635942 to the weights. The weights that we developed for 2004 OPPS, which incorporate the recalibration adjustments explained in this section, are listed in Addendum A and Addendum B.

Impact of Allocation of Equipment and Capital Costs

Comment: Several commenters indicated that the weight setting methodology may have a disproportionately adverse effect on procedures performed in departments with higher medical equipment and capital costs such as radiology and nuclear medicine. The commenters indicated that the capital costs incurred by these departments are generally spread among all hospital departments on a square foot or other basis, rather than being specifically allocated to the departments that incur the costs involved. This would distort the cost to charge ratios for these departments, resulting in under-weighting of the APCs for the services they furnish. Commenters indicated that we recognized this in the preamble to the 2000 OPPS rule (65 FR 18485, April 7, 2002) but indicated that it did not have the data necessary to make the appropriate adjustment due to hospital reporting processes. The commenter indicated that it would be appropriate for us to re-evaluate mechanisms that could be used to ameliorate the distortion.

Response: We recognize that the allocation of capital and equipment costs to revenue centers that do not use the equipment could distort cost to charge ratios for the revenue centers that use the equipment (and presumably whose charges reflect those costs). It is not clear how cost to charge ratios could be adjusted for such allocations. However, for the 2005 OPPS, we hope to explore the effect and impact of basing relative weights on relative hospital charges, rather than costs. If weights are based on relative charges, then presumably, the charges for services with high cost equipment and capital expenses would reflect those costs relative to other services without such costs.

Dates of Service on Revenue Code Lines

Comment: Commenters supported requiring dates of service on lines with revenue code charges but asked that the requirement not be enforced until June 2004 to enable hospitals to have sufficient time to adjust their systems to provide this information.

Response: Subsequent to the proposed rule, we learned that the X 12N 837 standard transaction with which covered entities had to be in compliance on October 16, 2003, requires a date of service on each line item containing a charge.

Single Revenue Code List for Packaging

Comment: One commenter supported the use of a single revenue code list for packaging costs into separately paid HCPCS codes. The commenter indicated that this change would result in more accurately attributing costs to services. Another commenter objected to our proposed changes for packaging revenue centers. This commenter is concerned that the use of a single set of revenue codes for packaging into the major procedure on a claim may inappropriately allocate charges not associated with the major service on the claim. For example, the commenter stated that revenue code 254 and revenue code 255 should continue to map to a radiological APC, and charges in these revenue centers should not be assigned to a major non-radiological procedure.

Response: We proposed to combine the multiple lists of revenue codes into one because there was significant overlap in them and our physicians believed that the risk of not picking up appropriate charges was greater than the risk of picking up charges that were not appropriate. In the case cited by the commenter, we are depending on hospital billing and our reliance on single procedure claims to preclude us from packaging a charge for a radiological service into a HCPCS code for a non-radiological service. We have never had a complaint that we have packaged more costs than were appropriate into a HCPCS code, although we frequently are told that we neglected to pick up all related charges. For the final rule, we retained the single set of revenue codes for packaging into separately payable major HCPCS codes.

Need for Stability in Relative Weights

Comment: Commenters stated that significant changes in weights for services from year to year are difficult for hospitals because not all hospitals provide all services and if the APC rates fall for the particular service mix the hospital furnishes, this can mean significant shifts in total payment for outpatient services from Medicare from year to year. Commenters indicated that we should adjust medians derived from claims data to limit the amount of change that occurs from year to year. Commenters indicated that hospitals are limiting availability of services based on declining Medicare OPPS revenues and that once a service is curtailed or eliminated, it is not likely to be reintroduced again because the hospital will cease monitoring the costs of the device and equipment needed to offer the service once it is no longer provided in the hospital and, therefore, even if it would be cost effective to reintroduce the service, it is not likely to occur. Commenters indicated that the pattern of revenue changes is a factor in hospital decisions regarding whether to acquire state-of-the-art equipment. Therefore, reductions in payments for equipment-intense services discourage hospitals from acquiring the equipment necessary to provide state-of-the-art services to Medicare beneficiaries. Commenters also indicated that the cumulative effects of the reductions from 2002 payment rates, particularly for procedures to implant medical devices, have resulted in significant payment cuts for many of these procedures and will discourage acquisition of the items necessary to provide the highest quality care.

A commenter stated that we should stabilize the APC rate when a device comes off of pass-through status. Several commenters stated that the proposed rates reverse the progress that was made in 2002 by using the manufacturer prices in the setting of medians for 2002. Commenters indicated that we should adjust the medians from claims data to ensure that no APC's median falls more than 5 percent compared to the medians used for payment in 2003. A commenter suggested that we adjust the medians whenever there is more than a 20 percent reduction from one year to the next. Another commenter indicated that all APCs that decline more than 10 percent compared to 2003 adjusted medians should be adjusted in the same way that we proposed to adjust medians for drugs, biologicals and radiopharmaceuticals and that these adjustments also should apply to brachytherapy sources.

Another commenter asked that we let no median cost used in weight setting fall more than half the difference between the loss and 15 percent because this methodology offers a buffer for hospitals to minimize annual changes. Another commenter indicated that we should freeze the 2003 payment rates, particularly for brachytherapy services and should educate providers to show all of the charges for all of the ancillary services on the claim so that they will be included in the development of relative weights for future years.

Response: We are sympathetic with the concerns of hospitals that the OPPS should be sufficiently stable that hospitals would have the capacity to plan and budget for future years. We recognize that the early years of a payment system may result in shifts in payment across services. However, a prospective payment system is a system of averaging in which the payment to the hospital becomes an overall amount that the hospital has at its disposal to use in the way it finds to be most efficient and effective. The payments for individual services are the means by which the amount of money to be spent on OPPS is distributed among hospitals but the hospitals have the right to use that payment as they choose across all services they choose to furnish. The OPPS is a system that attempts to calibrate payments for a service or procedure to best approximate the costs that an efficient provider would incur in providing the service or procedure in order to give providers incentives for efficient procurement and service delivery.

As we indicated in the proposed rule, for 2004, some of the same services had significant declines in median costs compared to the 2003 adjusted median but not compared to the 2003 median before adjustment. We did not propose to adjust the 2004 medians for procedural APCs compared to the 2003 adjusted median. Instead, we indicated that we would consider using external data that could be made publicly available if we were convinced that the medians for 2004 would result in payment rates that were grossly aberrant in the context of the service.

After reviewing the comments, and our final claims data for 2004, we decided that we would not adjust the medians for procedural APCs but that we would adjust medians for certain APCs for which we were given external data that could be made public because we were convinced that the medians from our claims data resulted in median costs that were grossly variant. We adjusted the medians for the following APCs using external data: APC 0107 (insertion of cardioverter-defibrilator), APC 0108 (Insertion/replacement/repair of cardioverter defibrillator leads and insertion of pulse generator), APC 0222 (implantation of neurostimulator), APC 0039 (which was broken out of APC 0222) and APC 0674 (prostate cryoablation). For each of these APCs we calculated an adjusted device portion of the median by taking one part of the device cost from our data and one part of the device cost supplied by external data. We added the adjusted device median to the nondevice median from our data to acquire the adjusted median. In the case of APC 0108, we used the external device cost data that was used to set the median for the 2003 OPPS because we received no outside data for the 2004 OPPS for this APC and because the proposed median of $28,685.30 set forth in the proposed rule was considerably higher than the final rule data median of $23,944.80, which resulted when additional claims were used to calculate the median cost. In other cases, we found that corrections in the APC assignment or splitting an APC into two APCs resulted in more accurate median costs.

For 2004, we will adjust median costs for drugs, biologicals and radiopharmaceuticals as proposed for reasons discussed in section VI.B.3. We will freeze payments for blood and blood products at the 2003 rates for reasons discussed in section VI.B.8. We will pay single indication orphan drugs at 88 percent AWP for reasons discussed in section VI.B.6.

Comparison of Procedural APC Medians for the 2004 OPPS to Adjusted Medians for 2003 OPPS

Using the data available to us at the time we developed the proposed rule, we identified APCs that showed decreases in median cost of more than 10 percent compared to the adjusted medians on which their payments were based for 2003. We discussed specific APC medians to the extent that we understood the reason for the decreases or were particularly puzzled by the change. We requested comments on the medians and provided a set of criteria for external data that could be used to supplement the median costs derived from our claims data. The criteria we provided regarding the use of external data included a stipulation that the data must not be confidential because any data we use must be available to the public. We also provided a list of preferred (but not required) criteria that addressed our preferences for characteristics of the data. We indicated that to be of optimal use, the external data should represent a divergent group of hospitals by location and type, identify the number of devices billed to Medicare as well as rebates or reductions for bulk purchases, identify the HCPCS codes with which the devices would be used, identify the source of the data and include both charges and costs for each hospital by quarter for the last 3 quarters of 2002 (68 FR 47987). We did not propose to adjust the medians for procedural APCs in the manner that they were adjusted for the 2003 OPPS. For 2004 we did not apply a systematic adjustment to all medians that declined more than a specified percentage in comparison with the medians for 2003. Instead, as discussed previously, we adjusted the medians of 5 APCs based on external data where we thought it was necessary and we have split some APCs where we thought doing so would result in more accurate relative weights.

Use of External Data

Comment: Some commenters opposed the use of external data on the basis that they believe that they will result in unfair imbalances in payment. They recognized that the application of cost-to-charge ratios will not result in amounts that are equal to full acquisition costs but they believe that as long as the same standard methodology is used across all services, the relative payments will be correct. They indicated that in a system of averaging, it is not necessary or even expected that each item and service will be paid at acquisition cost. They encouraged us to remain faithful to the averaging process inherent in a prospective payment system and not to rely on external data. Some commenters opposed use of external data and supported the requirement that they be publicly disclosable. Other commenters stated that we should use our claims data to set weights because they accurately reflect the relative hospital costs of providing outpatient services. However, these commenters were concerned with how different rates for some services in the 2004 proposed rule are from the rates for the same services in 2003.

Some commenters said that we should use external data that are proprietary and maintain the confidentiality of such data. Several commenters indicated that the prices for medical devices are often covered by agreements that preclude the parties from disclosing the price of the device and that we should use the data to set prices, notwithstanding that they cannot be made available for inspection by the parties whose payments may be reduced by their use. Several commenters stated that we used external data that were proprietary for setting of 2002 weights, and for some 2003 weights and that we should do so again because data from manufacturer price lists and invoices more accurately reflect the costs attained by applying the cost-to-charge ratios for hospital departments to the charges for the devices to get costs to package into the APC medians. These commenters stated that external data should be used more widely than data based on the criteria that were used for the 2003 OPPS for the use of external data (that is, that the device-cost portion of the APC exceeded 80 percent of the total APC cost for external data to be used). These commenters stated that external data should be used for all APCs that show significant reductions since the 2002 OPPS. In particular, they cited the APC Panel recommendation that outside data be used to set the median cost for APC 107.

Some commenters had specific comments on the criteria we provided for use of external data. One commenter stated that its members did not have and could not easily acquire the data that would ensure that the data represent a diverse group of hospitals by location and type nor could they identify specific hospitals that used their devices. The commenter also stated that its members could not provide the information on discounts and rebates against their price lists that we requested. The commenter indicated that its members did not want to provide the HCPCS codes in which their products were used but instead, wanted us to require the typical applications that they feel are most appropriate. The commenters agreed that they could provide the source of the data. The commenters stated that its members could not provide data that corresponded with the same period of time being used to set the relative weights for all APCs.

Response: In the proposed rule, we indicated that external data should cover services furnished during the last 3 quarters of 2002 (68 FR 47987). We appreciate that manufacturers and wholesalers would not want to disclose negotiated prices for 2003 or 2004 for competitive reasons. However, we fail to

understand how they could be harmed by publicly disclosing prices that were applicable in 2002 but have now been obsolete for a year. Moreover, since upward adjustment of any median cost results in reduction of payments for all other items and services, we believe that, in a governmental payment program, the parties whose payments are reduced by the use of external data should be able to examine all elements of the payment system.

We do not believe that widespread use of external data to set median costs for selected APCs is appropriate in a system that relies on relativity to establish payment amounts. We are sympathetic with the concerns of some commenters that widespread use of external data will result in payment inequities rather than appropriate payments to hospitals based on the relative weights of the services they furnish. However, we are also concerned about circumstances in which we are convinced that the payment amounts that would result from the medians from our data will discourage hospitals to provide access to needed care. Therefore, in the case of several APCs as discussed elsewhere, we used external data to adjust the medians. In general, however, we continue to have confidence in the integrity of our claims data with respect to the procedural APCs. For the future, we prefer to seek ways to refine the methodologies that we apply to our own data, such as the use of a greater percentage of claims to set the weights for certain APCs.

Comment: Several commenters stated that we should work with them to set the methodology for the 2005 medians in view of the absence of device codes in the 2003 data and should pursue a study of the acquisition costs of devices in particular, so that there will be valid device related data for setting the 2005 OPPS.

Response: We are always interested in hearing the proposals of outside parties with regard to our methodology for setting OPPS weights. We recognize the concern that the absence of device codes for 2003 claims may lead to median costs that fail to fully incorporate the costs of the devices used in the applicable APCs and we are interested in all ideas for preventing this problem. Our proposed methodology will be presented in the proposed rule for the 2005 OPPS and will be open to public comment.

General Comments About Payment

Comment: A commenter asked that we base the relative weights on the geometric mean that we use for trimming the data. The commenter indicated that the use of the geometric mean is the industry standard for both trimming aberrant data, as we use it, and also for calculating relative weights when costs are not distributed symmetrically. The commenter stated that the use of the geometric mean is particularly useful in circumstances that mirror those of OPPS: the first years of a new system and with low-volume high-cost services. The commenter noted that we agreed to move forward with analyses to look at the use of a mean versus median cost for weight setting in the November 1, 2002 final rule published in the **Federal Register**, but believes that not much analysis is needed since the use of the geometric mean is an industry standard for setting relative weights.

Response: We appreciate the thoughtful comments on this issue and other suggestions on how we might improve our rate setting methodology. We will continue to explore these options in 2004. Our efforts in 2003 were limited to creating unscaled weights from the means used for the 2003 OPPS and comparing them to the unscaled weights for medians for 2003 OPPS. Our preliminary comparison revealed that there would be many swings in payments. Hence, for the 2004 OPPS, we continued our use of the median cost.

In preparation for 2005 OPPS, we hope to calculate OPPS amounts using the mean costs, and also mean and median charges (to circumvent the effects of cost-to-charge ratios), and the 2004 OPPS conversion factor. This should give us a more complete view of the impact of revising our methodology in this way.

Charge Compression and Cost Finding

Comment: A commenter indicated that the use of cost to charge ratios is consistent with the concept of averaging that underpins a prospective payment system and that the system should not seek to micro-cost individual items or services but rather should rely upon the hospital charging patterns irrespective of Medicare policy to base relativity. The commenter indicated that while some items have different markups than others, the use of a standardized methodology to establish relative weights for all services should result in appropriate relative payments. The commenter strongly objected to any additional burdens that would be imposed in order to fine tune the pass-through payment system or weights at the expense of all other APC payments. The commenter specifically objected to CMS overriding the claims data to alter the ratio for new technology devices because the commenter believes that such adjustments will make the OPPS unduly administratively complex and create unfair imbalances in payment.

Other commenters opposed the use of cost-to-charge ratios applied to charges to acquire cost data. They indicated that in many cases, we had to use overall hospital cost-to-charge ratios that had no relevance to the costs of the services being determined and therefore resulted in invalid representations of median costs. They also indicated that both the departmental and the hospital specific cost-to-charge ratios were derived in part from costs that are commingled between inpatient and outpatient services and therefore are not necessarily representative of a ratio that could be applied to outpatient services alone, as we do. Some commenters indicated that we ignore studies that demonstrate that charges are compressed, with low-cost services being marked up more than high-cost services, thus resulting in systematic underpayment of high-cost items and diminishing beneficiary access to high-cost services. A commenter suggested that, for drugs, biologicals and radiopharmaceuticals, we set a minimum payment based on the Federal Supply Schedule price plus a percentage markup to ensure that payment for drugs, biologicals, and radiopharmaceuticals was sufficient to make them available to Medicare beneficiaries who need them.

Several commenters indicated that the application of hospital specific cost-to-charge ratios at the department level where available, otherwise at the hospital level will always result in incorrect costs because hospitals do not have a consistent markup for all items and services within a department. They indicated that hospitals markup low-cost items more than high-cost items and that therefore, the application of a cost-to-charge ratio, even at the department level, will never result in the hospital acquisition cost for an item. They indicated that there is no easy adjustment to correct for charge compression and they urge us to explore using external data, developing surveys or doing studies to acquire hospital cost data that can be used in place of the median costs acquired from claims data.

Response: We recognize that the application of cost-to-charge ratios to charges for individual items as needed to develop median costs for APCs is imperfect. However, the only means at our disposal for determining costs from the charges on the claims was to calculate a cost-to-charge ratio using the cost report data that we believe is

applicable to the OPD (for example, excluding room and board). We acknowledge that this system for determining relative values is imperfect, but we believe that it continues to be preferable to total reliance for particular items on external data which could inappropriately inflate Medicare payments for those items to the detriment of general hospital services. As indicated above, we hope to explore use of mean costs, and mean and median charges in preparation for the 2005 OPPS to determine if such a change would result in better relative weights and less instability in OPPS payments for particular services from year to year. However for 2004, we based relative weights on median costs derived through the application of a cost-to-charge ratio to the charges for the services.

General Concerns About Decreases

Comment: We received many comments objecting to proposed decreases in the proposed payment rates for specific services. These commenters indicated that the service has become more expensive rather than less expensive over the year, or indicated that the payment for the service declined for 2003 and should not decline for 2004. In some cases, the comments indicated that the payment should remain at the 2003 rate so that hospitals will not consider discontinuing the service.

Response: The OPPS is a relative payment system based upon the relative median costs of services. We calculate the costs of services by applying a cost to charge ratio to the charges for the services and then packaging the costs together for major HCPCS codes. We then calculate the median of the array of costs across all claims for HCPCS codes in an APC. There are many factors that can affect whether the cost of services rises or falls from one year to the next. In general, for the 2004 OPPS, about half the APC median costs increased and about half decreased compared to the 2003 median costs. In most cases, the changes were modest and such changes from year to year are to be expected as hospitals find ways to reduce costs for some services and incur higher costs for others. Because we do not expect the mix of services furnished in hospitals to vary hugely from year to year across the universe of hospitals, we do not expect that the changes in relative costs to create enormous impacts either.

Disparity in Payments for Overhead Costs for the Same Service

Comment: A commenter indicated that OPPS provides disparate payment for the overhead costs associated with services that are furnished both in physician offices and in hospital outpatient departments. As an example, the commenter indicated that CMS attributes $25.36 in physician practice expense to CPT code 99213 (office or outpatient mid level evaluation and management service for an established patient) but pays a hospital $54.46 (the amount set forth in the proposed rule) for the overhead for the same service and indicated that for other services the OPPS payment is as much as 4 times the amount paid to physicians for practice expense for the same service. The commenter asked that CMS establish payment equity for the same service furnished in these respective settings.

Response: The method for calculating payment for physicians' practice expenses under the Medicare physician fee schedule is established by law, as is the method we use for the outpatient setting. The application of the different methodologies results in different payment amounts in the two settings.

Comments and responses on payment amounts for specific APCs are included in section II.B.

Source of Data for Weight Setting

Comment: One commenter stated that we should conduct a study to establish a source for cost data other than claims data on which to base APC weights. Another commenter strongly objected to use of survey data because the commenter did not believe that it could ever fully capture all hospital costs for services and that therefore, the survey data would be used only for items and would have to be integrated with claims data for services. The commenter did not believe that the two could be integrated in a way that would properly reflect the relative costs.

Response: We believe that relative weights should generally be based on claims data because, notwithstanding the weaknesses, claims data are the most complete and accurate source of information about all services furnished by all providers paid under OPPS. We believe that it would be unreasonably expensive to acquire survey data that would be representative of the entire population of Medicare hospitals and all OPPS services furnished in them. We do not support the idea of using only selected hospitals and/or selected services because we think data from a limited survey would not be representative of the whole population of Medicare hospitals and services and would not be accurate to reflect relative costs of all services.

Incomplete Hospital Bills

Comment: Commenters indicated that when OPPS was implemented, hospitals no longer had a payment incentive to ensure that all charges were shown on the claim because there was no longer a direct relationship between the amount of charges on the claim and the interim payment they would receive for services. Therefore they ceased to complete the claim as fully as when the charges were directly related to the Medicare interim payment. Several commenters indicated that in some cases, hospitals went as far as to remove items from the chargemaster so that a charge was no longer created when an item or service was used, particularly if the item or service were from a department other than the department billing the CPT code. A commenter said that in many cases, hospitals ceased to bill all charges for services if the completion of the claim with all charges would delay the submission of the claim to Medicare and therefore delay the Medicare payment to the hospital. Commenters indicated that hospitals did this particularly for services like brachytherapy in which the services were furnished from multiple departments of the hospital and the claim could be delayed significantly to accumulate all charges. Commenters indicated that the absence of all charges for services could result in poor data and instability in median costs from year to year, particularly when we use only single procedure claims.

Response: We encourage hospitals to report all charges for all services on claims for Medicare payment so that the data on which relative weights are set will fully reflect the relative costs of all services. However, where all charges are not included on the claim but the costs exist in the cost centers, the cost-to-charge ratios would increase and, to some extent, offset the effect of the absence of charges. Hence, while we would prefer that hospitals bill all charges for the services they furnish, where they do not do so, it does not necessarily mean that the costs derived from applying the hospital's cost-to-charge ratio to charges would result in improper relative weights for the services.

C. Discussion of Relative Weights for Specific Procedural APCs

New APC for Antepartum Care

We proposed rule to split APC 0199, Obstetrical Care Service, into two APCs.

For this final rule, new APC 0700, Antepartum Care Service, was created and 59412 (external cephalic version) was assigned to it. The two remaining HCPCS code 59409 (vaginal delivery only) and 59612 (vaginal delivery only, after previous cesarean delivery) will remain in APC 0199, Obstetrical Care Service. We received no comments about this APC and will finalize our proposal.

Implantation of Neurostimulators and Implantation of Neurostimulator Leads (APCs 0222 and 225)

Comment: Commenters encouraged us to use a "dampening" approach to increase the median costs for these APCs and to use external data to set the payment weights for APCs 0222 and 0225. Commenters indicated that the proposed payment amounts do not cover the cost of the device, much less the hospital services to furnish it. Commenters indicated that our policy of calculating median weights based on single claims or pseudo single claims disadvantages these services by resulting in the use of only the simplest and lowest cost services. A commenter indicated that these services have had relative weights that were too low since the inception of OPPS and that the cumulative effect of multiple years of payment reductions will cause hospitals to cease to provide these services to Medicare beneficiaries. A commenter suggested that we split these APCs to reflect the different resources used in implanting one device versus another device in the same APC. A commenter also asked that we establish a separate APC for the NeuroCybernetic Prosthesis System.

Response: We also are concerned that the median costs for these APCs appear to be so low relative to other OPPS median costs. Both of these APCs are ones for which we require that selected C codes be on the claims that are used in calculation of the median to increase the likelihood that we are using correctly coded claims for these services. We recognize that the need to use single procedure claims and the need to further select claims that appear to be correctly coded reduce the number of claims used in median calculation. However, if we did not require that selected C codes were on the claims used, the median costs would be even lower than those calculated. Hence, using more single procedure claims would, in this case, result in even lower median costs.

For 2004, we have made changes to both of these APCs. In the case of APC 0222, we removed HCPCS code 61885 from APC 0222 and we placed it in its own APC 0039 because the APC Panel recommended that its status indicator be changed from a "T" to an "S" in order to not apply the multiple procedure reduction when two devices are implanted, as is often the case. Moreover, for both APC 0222 and APC 0039, we accepted external data for the device cost and used one part external data and one part claims data for the device portion of the APC's median cost to which we added the nondevice portion of the median cost. This increased the median cost for APC 0222 from a final data median of $11,050.90 to an adjusted median cost of $13,383.79. This increased the median cost for APC 0039 from a final data median cost of $10,741.66 to an adjusted median cost of $13,555.80. We believe that this more accurately reflects the relative cost of these services to other OPPS services.

In the case of APC 0225, we split the APC into two APCs, (APC 0225) and (APC 0040). APC 0225 contains CPT codes 63655, 64553, 64573, 64580 and 64577 and for this final rule, has a median cost of $11,873.72. APC 0040 contains CPT codes 64560, 64555, 63650, 64561, 64575, 64581, and 64565 and, for this final rule, has a median cost of $3,002.98. Both APCs have a status indicator "S" (to which multiple procedure discounts do not apply).

We believe that these changes will result in more appropriate relative weights for these services in relation to other OPPS services.

Brachytherapy Issues

High Dose Rate Brachytherapy (APC 0313)

Comment: Commenters objected to the proposed payment amounts for this APC and indicated that the costs of the procedure could not be fully included in it. Commenters indicated that they did not believe that hospitals were billing for both the needles and the catheters. These commenters recommended that we use only claims that contain the primary procedure code, the HDR Iridium source code, and codes for catheters and needles. A commenter indicated that the direct costs for the practice expense in physician offices for the codes in this APC average $1,130.16 and that it is inconceivable to the commenter that hospital costs could be any less. The commenter believes that the faulty data are attributable to hospital billing errors and urged us to educate hospitals regarding how to bill the service properly. A commenter asked us to issue a program instruction requiring hospitals to report both the cost of the HDR source and the needles or catheters needed to administer the treatment by date of service to facilitate setting of a correct median cost. The commenter is concerned that the actual cost of brachytherapy needles and catheters has not been captured and is not incorporated into any of the related APCs. Commenters also indicated that the discussion of the APC in the August 12, 2003 proposed rule was confusing and did not fit the services furnished in this APC.

Response: Upon receipt of comments and after listening to the concerns of outside groups during the comment period, we explored the circumstances surrounding the development of the median cost for the APC that resulted in the weights and payments in the August 12, 2003 proposed rule. We found that, while the APC was on the list of APCs for which claims were required to contain C codes and although the criteria required that there be both a brachytherapy source (C1717) and either needles (C1715) or catheters (C1728), no claims that met all of those criteria were found among the single procedure claims for that APC. Therefore, the system defaulted to using all single procedure claims, for which there were no sources or needles/catheters on the claim. Hence, APC 0313 was erroneously included in Table 7 as an APC for which C codes were required. Moreover, our discussion of the median for the APC was in error to say that there had been sources packaged into the payment for 2002 and that this accounted for the reduction in proposed payment for 2003.

For the final rule, we acquired more single procedure claims but again, none of the single procedure claims contained both sources and needles or catheters. We then revised our criteria to require only that the claims must contain sources (C1717). This gave us 27 single procedure claims that we used to acquire a median cost of $936.52, a significant increase over the median for all claims of $795.83.

In the course of discussions regarding this APC, some parties suggested that we ignore other procedure codes, such as dosimetry codes, that are typically found on claims for these services because the commenters believe that no charges billed under packaged revenue codes or packaged HCPCS should be allocated to those other procedures. We plan to explore the expansion of the codes we ignore for selection of single procedure claims for the 2005 OPPS. However, we did not believe we had sufficient information or data to make such a change for the final rule for 2004. We again note that it is important for

hospitals to include charges for all services they furnish on the claim so that we can better ensure that the relative weights are based on the most accurate data possible.

Low Dose Rate Brachytherapy (APCs 312 and 651)

Comment: We received several comments regarding payment for low dose, non-prostate brachytherapy (APCs 312 and 651). Commenters cited the proposed reduction in payment for APC 0312 and expressed concern that our methodology that excludes a number of multiple procedure bills results in our use of data from atypical encounters such as those in small centers with minimal technological complexity and inappropriate costs and charges. Commenters indicated that typically other services would be furnished on the same day and that the presence of these services on the claim would likely result in the claim not being used. Commenters indicated that the resources used for the services in these APCs are highly variable depending on the part of the body being treated and the nature of the equipment involved. They indicated that some hospitals ceased billing charges for all of the services furnished when OPPS was implemented because showing the charges on the claim would no longer result in more payment but showing all charges on the claim was costly, burdensome, and slowed billing. Commenters indicated that we should educate providers in the correct way to bill for the catheters, needles, and sources used for this service and that in the absence of acceptable median costs, we should adjust the medians to result in reasonable payments for the service. Commenters indicated that we should select only claims that contain device costs and ignore claims that do not contain such costs, setting the median cost on the subset of selected claims.

Response: We used the medians from our final data to set the relative weights on which the payments will be based for 2004. We were not convinced by comments that the data did not reflect a median cost that was appropriate relative to the costs of other OPPS services. We recognize that our methodology excludes a large number of claims because there were multiple procedures on the claim and as we indicated in the discussion of multiple procedure claims, we are continuing to work on ways to use more claims data. We will closely examine expanding the list of CPT and HCPCS codes that could be ignored to create pseudo single claims for use in calculating median costs to set relative weights. For future years, we will consider whether to impose criteria for correctly coded claims, such as requiring that the claims contain either any C code or specified C codes for brachytherapy sources and needles or catheters that are necessary to insert the sources. We were not able to do this for the 2004 OPPS. For the 2005 OPPS, we will use the claims data from 2003, for which there is no coding of brachytherapy needles or catheters, although there is coding of sources that can be used to select correctly coded claims.

As we previously indicated, for the 2004 OPPS, we will pay for prostate brachytherapy using the CPT codes and the HCPCS codes for brachytherapy sources used. We expect that the majority of the CPT codes billed will be 77778 (APC 0651) and 55859 (APC 0163) and that the HCPCS codes billed will be C1718 (brachytherapy source, iodine 125) or C1720 (brachy source, palladium 103). When we calculate the total median cost on which the payment to the hospital for the services involved in prostate brachytherapy will be based, we determine that paying under APC 0651 and APC 0163 with separate payment for the sources (APC 1718 or APC 1720) will result in more payment than would be the case under the packaged payment we proposed. For example, if we assume that 100 sources are implanted during a prostate brachytherapy procedure, we would expect the hospital to bill 77778, 55859, and 100 units of either C1718 or C1720. The sum of the applicable medians will be $6,486.54 if using iodine sources and $7,261.54 if using palladium sources. This is a considerable increase over the payments in 2003, which were $5,154.34 with iodine sources and $5,998.24 with palladium sources. We believe that this circumstance will be the predominant use of APC 0651 and that the total median for the service will result in appropriate relative weights on which to set the payments.

APC 0312 was billed just over 850 times for the 9 months of data used in the final rule. Of the five CPT codes in this APC, four have median costs for the CPT code of less than $400 and one code, 77776, Interstitial radiation source application, simple has a median of $2,218.18. However, that code does not meet the test of being significant, which we define as having a frequency greater than 1,000 or a frequency lower than 99 and a percentage of larger than or equal to 2 percent. Therefore, we have not moved it from the APC.

Separate Payment for All Brachytherapy Sources

Comment: Commenters indicated that we should provide separate payment for all brachytherapy sources but that the current payment structure and amounts are inadequate. Commenters indicated that we should create two new permanent separate brachytherapy source APCs for high activity iodine 125 and high activity palladium 103 sources that should be paid on a per source, per patient basis in addition to the procedure code. Commenters indicated that the proposed rates for iodine 125 and palladium 103 sources do not capture the costs of loose low dose seeds, much less the costs of high activity sources, which typically cost in excess of $150 per source.

Response: For 2004, we will pay separately for implantable brachytherapy sources based on the median costs from our claims data. We were not convinced by comments that the relative weights that will result from these median costs are inappropriate.

Prostate Brachytherapy

Comment: Commenters indicated that the creation of the new G codes (G0256 and G0261) for prostate brachytherapy imposes an unneeded burden on hospitals and that it conflict with the reporting of the service by other payers. Additionally, commenters stated that the use of the codes will preclude us from capturing the costs of the service in the future. The commenters encouraged us to eliminate the G codes and pay using the CPT codes for the procedures and the HCPCS codes for the sources on a per source, per case basis. They indicated that this would allow us to capture the true costs of the procedures to set rates in the future and that this approach is consistent with the APC Panel recommendation to us. A commenter requested that we eliminate APC 0649 (Prostate Brachytherapy Palladium Seeds) and APC 0684 (Prostate Brachytherapy Iodine Seeds) and reinstate the previous policy that allowed hospitals to bill the prostate brachytherapy procedures with two separate APCs; one for urology CPT code 55859 and one for the radiation oncology CPT code 77778. The commenter stated that this elimination would be consistent with our decision to pay for the sources on an individual basis. The commenter believed that creation of the G codes has caused unnecessary confusion for hospitals. The procedure is now described with a single G code; however, only one revenue center can be selected, causing confusion since these APCs have both a

urology CPT code as well as a radiation oncology CPT code. The commenter requested that we eliminate these two APC groups and institute a system that would allow the two procedures to be reported in separate APC groups.

Response: We agree and have deleted the alphanumeric HCPCS codes for packaged prostate brachytherapy and will pay using CPT codes for the procedures and the HCPCS codes for the sources. We have deleted the G codes (G0256 and G0261) and APCs 0649 and 0684; and for 2004, we will pay prostate brachytherapy procedures under APCs 0163 and 0651. Brachytherapy sources used for prostate brachytherapy will be paid on a per source basis using APCs 1718 (iodine) and 1720 (palladium).

Cryoablation of the Prostate (APC 0674)

Comment: Commenters indicated that the proposed payment was too low to pay for both the hospital services and the cost of the probes used in the procedure. They indicated that 92 percent of the procedures use 6 or more probes (64 percent use 6 probes and 28 percent use more than 6 probes). They indicated that a kit of 6 probes costs $5,000 and asked that we set a payment amount no less than the minimum cost a hospital incurs to provide the service, which they stated is $6,750. Commenters indicated that charges for this new technology were not properly reported by hospitals and that therefore the data do not properly reflect the costs of the service.

Response: We recognize that with the device being paid as a pass-through for the first time effective April 1, 2001, it is likely that there are irregularities in the claims data regarding the number of units of the device that have probably led to a median cost that is not representative of the relative cost of the procedure with the device packaged. Therefore, for 2004, we used one part of the acquisition cost of 6 probes ($5,000 for 6 probes which are used in 64 percent of the procedures) and one part of the device cost from our claims data to create an adjusted device cost median to which we added the nondevice cost from our claims data to acquire an adjusted median of $6,915.08 on which we based the relative weight for the 2004 OPPS. This compares favorably to the median of $5,925.41 on which the August 12, 2003 proposed rule was based and also compares favorably to the final rule data median of $6,283.49 on which the payment weights would have been based had we not used external data to adjust the device portion of the median.

Payment for Cesium-131

A new brachytherapy source, Cesium-131, came to our attention during the latter part of this year, through the pass-through device application process. We reached a decision on this application after publication of the August 12, 2003 proposed rule. We determined that this source did not meet our criteria for creation of a new pass-through category for devices. However, we believe that separate payment for a substantially equivalent new brachytherapy source is warranted, since we pay separately for other sources. The indications presented to us for Cesium-131 were substantially the same as those for Palladium-103 and Iodine-125. As such, the reasons for separate payment of brachytherapy sources, for example, variation in the number of seeds or other source forms make packaging into a clinical APC an undesirable option. Therefore, we have decided to create a separate APC so that the costs of this new source may be tracked like those of other brachytherapy sources. The payment rate for this source is $44.67 per seed. This payment rate is close to the reported price of the Cesium-131 seed and equal to our payment rate based on claims for Palladium-103, a source that is used for similar clinical indications.

Cardiopulmonary Resuscitation

Comment: A commenter indicated that a 28 percent drop in payment for this service is unwarranted because of the number of people and the level of training needed when this service is furnished.

Response: We were not convinced that the relative weight that would result from the use of the median cost for this APC would be inappropriate in relation to other OPPS services. Therefore, we will use the median cost from the final rule data to set the weight for this APC.

Computer Aided Detection for Diagnostic Mammography

Comment: A commenter expressed concern about our proposal to reassign Computer-Aided Detection for Diagnostic Mammography from a New Technology APC to APC 0410. The commenter stated that the proposed reassignment is premature and would result in a reduced payment rate that would be approximately half of the payment rate for the technical component of procedures performed in other settings. The commenter recommended that we retain this procedure in New Technology APC 1501 until we have greater claims experience.

Response: The alphanumeric HCPCS code for this service (G0236) is being replaced by a CPT code for the same service for 2004 (CPT code 76082). We found over 43,000 claims for this service in the 2002 data on which we are basing the 2004 relative weights. We believe that this volume of services is sufficient to justify setting a relative weight based on cost information rather than keeping the service in a new technology APC. Moreover, the practice expense portion of payment for this service is not relevant to the setting of relative weights for OPPS services, in which the relativity is established within the context of services paid under OPPS and not with regard to the practice expense for services under the Medicare physician fee schedule.

Orthopedic Fracture Fixation Procedures

Comment: Commenters stated that APCs 0043, 0046, 0047, 0048, 0049, and 0050 are not clinically similar and they violate the 2 times rule. They asked that we separate out the more costly procedures that involve fracture fixation devices because they involve additional time, resources, and significant costs of fixation devices. They recommended that we either create two new APCs with corresponding HCPCS codes for upper (at a payment of approximately $2,000) and lower fracture fixation devices (at a payment of approximately $3,000) or create two code modifiers (for upper and lower fixation devices) and multiple new APCs.

Response: For the 2004 OPPS, services that require an external fixation device will continue to be paid in APCs that also provide payment for fractures that do not require external fixation devices. While we are sympathetic to the commenters' concerns, we are not able to identify CPT codes that always require use of an external fixation device or the extent to which such devices are required for other codes. Nor did the information we received from the commenters provide a convincing breakdown of the differences in costs for procedures using external fixation devices. To create new APCs or new APC relative weights to provide additional payment for external fixation devices where such APCs would also contain procedures that do not routinely require use of an external fixation device, would result in overpayment of those procedures. Moreover, since most services in these APCs do not require an external fixation device, it may be appropriate to continue to pay for them in these APCs to encourage hospitals to use them only when required. Furthermore, we would be reluctant to

impose an additional burden on hospitals by establishing "G" codes or modifiers to use in reporting procedures with or without external fixation devices. However, as we state elsewhere, we would support interested specialty societies' decisions to request the CPT to consider this coding issue.

APC 0680 Reveal ILR

Comment: A commenter indicated that the proposed payment rate is about 95 percent of the hospital acquisition cost of the device, leaving the hospital at an immediate loss if it implants this device. The commenter indicated that it is the only manufacturer of the device and therefore the only source of acquisition cost for the device. They indicated that in 2002, the cost was $3,495 and recommended that we re-evaluate and re-price the APC to provide sufficient payment that beneficiaries will have access to the device when needed. They indicated that the predominant site of service is in the hospital outpatient department and that if payment is below hospital cost, beneficiary access will eventually be limited.

Response: The final rule data for APC 0680 reveals a median cost of $3,691.15 for this APC, on which the relative weights for 2004 are based. We were not convinced by comments that this median cost would result in a relative weight that would be inappropriate relative to the payments for other services under OPPS.

Fractional Flow Reserve (FFR)

Comment: A commenter indicated that fractional flow reserve (CPT codes 93571, Intravascular doppler velocity and/or pressure derived coronary flow reserve measurement * * * during coronary angiography, initial vessel and 93572, each additional vessel) should be paid separately in addition to the procedure with which they are performed, rather than being packaged into the payment for the primary procedure. The commenter indicated that FFR should be paid separately because it is an expensive service with higher device and equipment costs and takes more time and staff than if it is not used. They also indicated that we pay separately for Intravascular ultrasound (IVUS) which is also deployed via guidewires. They stated that the principal difference is that IVUS describes the anatomy of the vessels while FFR describes the blood flow through the vessels. They indicated that it is inequitable to treat them differently. Payment for IVUS but not FFR creates inappropriate financial incentives for hospitals in determining which procedures to provide.

Response: Currently, where FFR is provided, the costs for it are packaged with the principal service to which FFR is an addition, which we expect to be coronary angiography. If we were to pay separately for this service, we would need to remove the costs for this service from the cost for services with which it was packaged (that is, coronary arteriography), which would reduce the medians on which the payments for those services are based. This would reduce the median and therefore the payment for coronary angiography. We are concerned with the circumstances under which this service would be appropriately paid under Medicare and will consider development of a national coverage decision regarding when it is medically necessary to treat illness or injury. After such a coverage decision is made, we will reconsider whether it is appropriate to pay separately for the service.

Cataract Surgery With IOL Implantation (APC 0246)

Comment: A manufacturer of intraocular lenses was concerned that on claims for the procedures in APC 246, the median charge of claims for which no charge is reported using revenue code 276 (Intraocular lens) is one-third lower than the median charge of claims where a charge is reported using revenue code 276. The commenter believes that when charges are not listed in revenue center 0276, they are omitted from the claim altogether, rather than being placed in a different revenue center. The commenter recommended that we adopt a policy of using only claims for APC 0246 that report charges for revenue code 276, which would be consistent with our proposal to calculate relative weights for certain device-related APCs using only claims that included a separate and correctly coded charge for a device.

Response: For the 2004 OPPS, payment for cataract surgery with IOL insertion is based on the median cost for the procedure from the final data. A review of the 2002 claims for procedures in APC 246, which includes CPT code 66984, one of the highest volume outpatient surgical procedures paid under the OPPS, indicates that the vast majority are billed with revenue code 276. Long-standing instructions require hospitals to report the IOL charge under revenue code 276 when billing for a procedure in APC 246.

In our implementing instructions for the 2004 OPPS update, we will remind hospitals and the contractors who process OPPS claims that, in order to receive payment for a procedure in APC 246, hospitals are required to report the associated IOL charge under revenue code 276. We will also consider for the 2005 OPPS update the commenter's recommendation that we use only claims with revenue code 276 to recalibrate the relative payment weight for APC 246. Our data are extremely robust for this APC (with a frequency of nearly 520,000), and they indicate that the preponderance of the claims used to establish the 2004 median does include revenue code 276.

Transcatheter Placement of Intracoronary Drug-Eluting Stent Procedures (APC 0656)

Comment: One commenter supported our recognition of the new drug-eluting stent technology through the creation of two "G" codes (G0290 and G0291) and their placement in new APC 0656. However, the commenter questioned how we calculated the proposed payment rate for 2004. The commenter stated that some patients classically considered at higher risk for percutaneous interventions, including diabetics and patients with multi-vessel disease, are being referred for drug-eluting stent procedures. The commenter stated that the clinical disposition of these patients makes them more complex and more resource-intensive than the average patient. The commenter further noted that, while the reporting of a second main coronary vessel procedure would result in a second, reduced APC payment, that our payment for the single vessel should be based on an average of 1.7 stents per vessel. Finally, the commenter recommended that we add APC 0656 to the list of APCs for which a device was required to be on the claim for weight setting.

Response: For the 2004 OPPS, we will continue to base the payment for transcatheter placement of intracoronary drug eluting stents on the median for APC 0104, transcatheter placement of intracoronary stents. We increased the median for APC 0104 ($4,765.05) by $1,200 to acquire the median we used for APC 0656. We are using the same adjustment amount used for a single stent in the inpatient prospective payment system. We received no comments that are sufficiently compelling to convince us that more than one stent per vessel typically will be used when this service is furnished in the outpatient department or that the adjustment amount of $1,200 per stent is inappropriate. We will consider including this on the agenda for the next APC Panel meeting.

With respect to the comment that we should add APC 0656 to the list of APCs for which a device was required to be on the claim for weight setting, we believe it would be inappropriate to do so for the 2004 OPPS. This is because the drug-eluting stent was not approved by the FDA until 2003, and, therefore, it did not appear in the 2002 data. Moreover, since there are no device codes for coronary stents for use on claims in 2003, the 2003 data will not contain the device codes that would be needed to create a subset of stent device claims to use for the 2005 OPPS. However, in view of the reinstitution of device coding for 2004, we will consider this comment in our work to develop the 2006 OPPS. Moreover, as we indicated above, we based the payment for APC 0656 on the median for APC 0104, which was calculated from claims that contained C codes for stents.

Cardioverter Defibrillator (APC 0107)

Comment: Commenters indicated that the proposed payment for this APC was too low to pay for the device, much less the cost of the services to implant it. They indicated that the cost of the device in 2002 varied between $19,160 and $21,410 among major group purchasers, considerably more than the proposed payment of $15,773.28. They asked that we use the external data to set the device portion of the hospital cost.

Response: We reviewed the data for this APC and considered the comments of the APC Panel at its August 2003 meeting on the August 12, 2003 proposed rule. We were convinced that the median for this device is too low to be appropriate relative to other median costs. We used external data that had been presented to the APC Panel to calculate a mean external acquisition cost and used one part external cost to one part median cost from our claims data to acquire an adjusted cost for the device. We then added the nondevice median from our claims data to the adjusted device acquisition cost to acquire an adjusted median that we used to set the relative weight for this APC. Effective for October 1, 2003, we established codes to be used for reporting the services assigned to APCs 107 and 108. Specifically, CPT code 33240 (Insertion of cardioverter defibrillator) is no longer recognized as a valid code for OPPS. Instead, hospitals now report either G0297 (Insertion of single chamber pacing cardioverter defibrillator pulse generator) or G0298 (Insertion of dual chamber pacing cardioverter defibrillator pulse generator). Also effective for October 1, 2003, CPT code 33249 (Insertion/replacement/repair of cardioverter defibrillator and insertion of pulse generator) is no longer recognized as a valid code for OPPS. Instead, hospitals will report either G0299 (Insertion or repositioning of electrode lead for single chamber pacing cardioverter defibrillator and insertion of pulse generator) or G0300 (Insertion or repositioning of electrode lead for dual chamber pacing cardioverter defibrillator and insertion of pulse generator). These codes were created to capture differential costs related to single and dual chamber cardioverter defibrillators. Claims containing the CPT codes we no longer recognize for OPPS (CPT codes 33240 and 33249) are being returned to providers to be coded correctly and resubmitted.

Insertion of Pacemaker Dual Chamber (APC 0655) and Insertion of Pacemaker Single Chamber (APC 0089)

Comment: A commenter indicated that the proposed payment rates for these APCs are only slightly more than the lowest median hospital acquisition cost of the device leaving a hospital little or no payment for the services to implant it. They asked that we re-evaluate and price these APCs at a level that pays the full cost of the device and services.

Response: We carefully reviewed the data for these APCs. We were not convinced that there was a need to adjust the median for either of these APCs. The median cost for APC 0655 is about 12 percent higher than the adjusted median on which the 2003 payment weights were based (2003 adjusted median of $7,298.52 versus the final rule median of $8,225.23). The median cost for APC 0089 is slightly higher than the adjusted median on which the 2003 weights were based (2003 adjusted median of $6,686.16 versus the final rule median of $6,754.63). The comment was not convincing that these median costs were inappropriate in relation to the other median costs that will be used to set the relative weights. Moreover, since median costs for both APCs rose above the amounts achieved by upward adjustments for these APCs in 2003, we believe that the medians are appropriately relative to the costs for other services that will be used to set the relative weights.

Insertion of Pacemaker, Dual Chamber Generator Only (APC 0654)

Comment: A commenter indicated that the proposed payment rate is about 95 percent of the hospital acquisition cost of the device, leaving the hospital at an immediate loss if it implants this device. They asked that we re-evaluate and price these APCs at a level that pays the full cost of the device and services.

Response: The median cost for this APC is about 19 percent higher than the adjusted median on which the 2003 payment weight was based (2003 adjusted median of $5,456.63 versus the final rule median of $6,495.61). We saw no reason to further adjust the median on which the relative weights for 2004 are based. The comment was not convincing that these median costs were inappropriate in relation to the other median costs that will be used to set the relative weights. Moreover, since the median cost for the APC rose above the amounts achieved by upward adjustments for the APC in 2003, we believe that the median is appropriately relative to the costs for other services that will be used to set the relative weights.

INTEGRA Wound Products and Other Wound Products

Comment: We received a comment concerning INTEGRA Dermal Regeneration Template and INTEGRA Bilayer Wound Matrix in which the commenter stated that there is a payment disparity between the INTEGRA products and APLIGRAF, DERMAGRAFT and TRANSCYTE, which are eligible for separate payment as biologicals. The commenter noted that hospitals that use APLIGRAF, DERMAGRAFT, and TRANSCYTE receive an extra payment in the form of a pass-through or other separately paid APC payment in addition to the APC payment for the skin repair procedures (APC 0025), while users of the aforementioned INTEGRA products receive only the regular payment associated with skin repair CPT codes. The commenter stated that this payment differentiation provides a financial incentive to hospitals to use the other skin replacement products, and places INTEGRA at a competitive disadvantage. The commenter recommended that we create a product-specific APC for INTEGRA to provide comparable payment for "this class of products." Alternatively, the commenter recommended that we establish a single APC that includes the cost of all or most skin replacement technologies. The manufacturer noted that hospitals using INTEGRA would receive only $340.41 under our proposed rate for APC 0025, while total payments for APC 0025 plus the product-specific codes for APLIGRAF, DERMAGRAFT, and TRANSCYTE would be between $770.86 and $1,072.86.

Response: TRANSCYTE was approved for transitional pass-through

payment as a biological as of July 1, 2003; DERMAGRAFT continues in pass-through status through 2004; and APLIGRAF is a former pass-through biological proposed to be paid separately as non-pass-through biological, that is, status indicator "K." Since no party has yet applied for transitional pass-through payment for INTEGRA along with relevant documentation in order to evaluate Integra as a biological for pass-through payment, we have not been able to evaluate pass-through payment status as a biological for this product. We are sympathetic to the commenter's concern, and we find merit in the recommendation to group a class of skin replacement products into the same APC. However, we do not believe that we have sufficient information at present upon which to determine the appropriate payment rate for such an APC. Furthermore, we would want to allow the public an opportunity to provide input on such a proposal. Therefore, we will consider the recommendation of a common APC for skin repair using new skin replacement technologies for 2005. We will also consider referring this issue for consideration by the APC Panel at its next meeting. Meanwhile, we invite public comment on the concept of grouping payment for skin repair procedures using new skin repair technologies such as INTEGRA, DERMAGRAFT, and APLIGRAF into a common APC.

Stereotactic Radiosurgery

Comment: A commenter urged that we continue to consider stereotactic radiosurgery (SRS) to be a radiation procedure and that we not reopen the revenue code of surgery for SRS, stating that a radiation oncologist is a critical component to the delivery of SRS. The commenter expressed concern for unintended consequences that may result from unbundling of services associated with this procedure.

Response: We appreciate the commenter's concern for accurately capturing the costs of stereotactic radiosurgery. As a matter of policy, however, we do not generally mandate the reporting of services under specific revenue centers but leave that decision up to the hospitals.

Comment: We received several comments regarding stereotactic radiosurgery (SRS). Commenters were concerned that the current G code descriptors do not appropriately recognize the differences among the various forms of SRS. Commenters explained that there are two basic methods in which SRS can be delivered to patients, linear accelerator-based treatment (often referred to as "Linac") and multi-source photon-based treatment (often referred to as Cobalt 60). Advances in technology have further distinguished these treatment modalities. Linear accelerator-based treatment can be performed using various types of SRS systems, two of which include gantry-based systems and image-guided robotic SRS systems. Commenters stated that the existing G codes do not accurately describe the unique differences among these services and therefore do not accurately capture the costs involved in providing these services.

For example, several commenters expressed concern regarding the limitation imposed by the code descriptor for HCPCS code G0242, which restricts its use to planning for Cobalt 60-based treatment. While some commenters stated that planning costs for linear accelerator-based treatment and Cobalt 60-based treatment are identical, other commenters asserted that planning costs for these services differ significantly.

Commenters recommended the following options to resolve the issue:

(1) Create another G code to distinguish between linear accelerator-based SRS and Cobalt 60-based SRS, which would be consistent with the two G codes (G0173 for linear accelerator-based and G0243 for Cobalt 60-based) for SRS treatment delivery; or

(2) Modify the descriptor for HCPCS code G0242 to describe treatment planning for both linear accelerator-based and Cobalt 60-based SRS treatments. For clarification purposes, the current G codes for SRS treatment delivery services are as follows:

G codes for linear accelerator-based SRS treatment delivery:

HCPCS code G0173—Stereotactic radiosurgery, complete course of therapy in one session.

HCPCS code G0251—Linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum 5 sessions per course of treatment.

G code for Cobalt 60-based SRS treatment delivery:

HCPCS code G0243—Multi-source photon stereotactic radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment, all lesions. The current G code for Cobalt 60-based SRS treatment planning is as follows:

HCPCS code G0242—Multi-source photon stereotactic radiosurgery (Cobalt 60 multi-source converging beams) plan, including dose volume histograms for target and critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment.

Response: We agree with commenters that the current description for HCPCS code G0242 is limited to the planning of Cobalt 60-based SRS treatment and does not account for the planning of linear accelerator-based SRS treatment. To be consistent with the two G codes we created for treatment delivery, we will create a new G code (G0338) to distinguish linear accelerator-based SRS treatment planning from Cobalt 60-based SRS treatment planning. We will place G0338 in APC 1516 at a payment rate of $1,450. The new G code for linear accelerator-based SRS treatment planning will be as follows:

HCPCS code G0338—Linear-accelerator-based stereotactic radiosurgery plan, including dose volume histograms for target and critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment.

Comment: Several commenters expressed concern that our current code descriptors for HCPCS codes G0173 and G0251 do not distinguish between the various types of linear accelerator-based SRS treatment. Currently, image-guided robotic linear accelerator-based SRS systems are grouped with other forms of linear accelerator-based SRS systems using HCPCS codes G0173 and G0251. Commenters requested that we modify the code descriptors to distinguish image-guided robotic systems from other forms of linear accelerator-based SRS systems to account for the wide cost variation in delivering these services.

Response: We agree with commenters that the descriptors for HCPCS codes G0173 and G0251 do not distinguish image-guided robotic SRS systems from other forms of linear accelerator-based SRS systems to account for the cost variation of delivering these services. To more accurately capture the true costs of these services, we will create two new G codes (G0339 and G0340) to describe complete and fractionated image-guided robotic linear accelerator-based SRS treatment. Please see response to below comment for code descriptors.

Comment: Commenters urged that we modify the code descriptor for the delivery of image-guided robotic SRS to include both complete and fractionated courses of therapy in one code, resulting in the same payment amount for both types of therapy. Commenters explained

that the per-session costs of delivering image-guided robotic linear accelerator-based SRS are the same, regardless of whether the patient's disease requires one treatment or multiple treatments.

Response: Our claims data do not support the assertion that the per-session costs of delivering image-guided robotic linear accelerator-based SRS is equal to the costs of delivering a complete course of image-guided robotic linear accelerator-based SRS treatment. However, we acknowledge the possibility that claims data for G0173 and G0251 may include both image-guided robotic linear accelerator-based SRS treatments as well as other forms of linear accelerator-based SRS treatments and, as a result, the median cost may not accurately reflect the true costs of delivering image-guided robotic linear accelerator-based SRS therapy. As stated in our response to the above comment, we will create two new G codes (G0339 and G0340) to distinguish complete and fractionated image-guided robotic linear accelerator-based SRS treatment from other forms of complete and fractionated linear accelerator-based SRS treatment. We will place HCPCS code G0339 (complete session) in APC 1528 at a payment rate of $5250. The APC placement of HCPCS code G0340 is discussed below.

While we recognize the costs to provide multi-session image-guided robotic SRS therapy may be greater than the current payment rate for HCPCS code G0251, we received no convincing cost data supporting commenters' claims that the costs of performing each additional session subsequent to the first session of a fractionated treatment is equivalent to the costs of performing a complete session. Rather, we believe that certain economies of scale are realized when performing each additional session subsequent to the first session of a fractionated treatment. That is, based on our understanding of the therapy, we do not believe that the same exact amount of hospital resources would be utilized for each subsequent session.

Statements provided by various interested parties indicate that the costs of providing each session of a fractionated treatment range from $2700 to $9000. However, we received no convincing data to substantiate these statements. We have estimated that approximately 75 percent of the costs of a complete session would be required to provide each additional session subsequent to the first session of a fractionated treatment. Therefore, we will place HCPCS code G0340 in new technology APC 1525, which covers procedures ranging from $3500 to $4000 in payment and which pays $3750. This new technology APC range pays approximately seventy-five percent of the payment for HCPCS code G0339. We will modify the descriptor for HCPCS code 0340 to describe additional sessions (second through fifth sessions) subsequent to the first session of a fractionated treatment. In addition, we will expand the descriptor for a complete session (HCPCS code G0339) to include the first session of a multi-session treatment. To further clarify, when providers perform multi-session image-guided robotic SRS therapy, they should bill using HCPCS code G0339 for the first session. For each additional session subsequent to the first session, providers should bill using only HCPCS code G0340 up to a maximum of five sessions.

Although we received no clinical data to substantiate the use of a single session versus multiple fractionations up to five sessions, a few commenters stated that a maximum of five sessions may be utilized to treat certain conditions; therefore, we will continue to pay for the delivery of multi-session therapy (HCPCS code G0340) up to a maximum of five sessions per course of treatment. When additional data is submitted, we may reconsider this payment decision.

As described above, we will create the following new G codes to identify image-guided robotic linear accelerator-based SRS treatment delivery:

HCPCS code G0339—Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session, or first session of fractionated treatment.

HCPCS code G0340—Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment.

SIRTeX Medical (RE: SIR-Spheres Brachytherapy Source)

Comment: The manufacturer of a brachytherapy source to treat liver cancer commented that our proposed payment of $8,870.88 for APC 2616 was inadequate to pay for its product, which it reported costs $14,000 per treatment dose. This commenter stated that there are only two products that would fit this APC, which is for Yttrium-90 brachytherapy source. Moreover, this party claimed that there were significant clinical differences between its product and another Yttrium-90 source, and that these differences necessitated the price differential between the two products. The commenter requested establishment of a separate alpha-numeric HCPCS code for its product, in order to account for the cost differences between the two Yttrium-90 products and to set more equitable payment rates for the two products.

Response: We appreciate the concerns of the commenter. We would first note that payment to APC 2616 has increased to $9,615.50 per dose compared to the 2003 payment of $6,485.37. The information provided in the comment did not convince us that the payment rate resulting from the 2002 claims data is inadequate to pay hospitals for the Yttrium-90 products. We are uncertain whether or not there are other Yttrium-90 sources in addition to the two discussed in this comment that would need to be considered in any analysis of the relative costs of the products. Therefore, until we have additional data, we believe that code C2616 and APC 2616 adequately describes and pays for Yttrium-90 brachytherapy sources.

Low Osmolar Contrast Media

Comment: A radiology specialty society expressed disappointment because we did not address payment for low osmolar contrast media (LOCM) in the proposed rule. The commenter believes that the variability in usage and Medicare's restricted coverage of LOCM warrant payment in a separate APC in the 2004 final rule. The commenter recommends that we increase the relative weights of APCs that include codes that involve the use of LOCM agents to reflect the additional costs of these agents if we do not establish a separate APC to pay for LOCM.

Response: We issued a program memorandum on November 22, 2002 (Transmittal A–02–120, Change Request 2185) in which we removed all requirements differentiating payment between high osmolar contrast material and LOCM as well as restrictions that would limit payment for LOCM only to patients with specific diagnoses. In that program memorandum, we instructed our contractors to discontinue any edits that would prohibit payment for LOCM if specific diagnoses were not reflected on the claim, effective for services furnished on or after January 1, 2003. We further directed contractors to instruct hospitals to include charges for LOCM in the charge for the diagnostic procedure or, if LOCM is billed as a separate charge, to use revenue code 254 or 255 as appropriate. These instructions applied only to hospitals subject to the OPPS.

We disagree with the commenter's recommendation that a separate APC

should be established to bill for LOCM for several reasons. Prior to issuance of Transmittal A–02–120, covered LOCM costs would have been reflected either in an appropriate revenue code or within the hospital's charge for a diagnostic procedure or in a charge with an appropriate HCPCS code (A4644, A4645, or A4646). To the extent that hospitals submitted covered charges for LOCM in 2002, those costs are packaged into the cost of the procedure with which the LOCM was used. We expect that claims for services involving the use of LOCM furnished during CY 2003 will reflect even more fully costs associated with LOCM in light of the instructions that were issued in Transmittal A–02–120. These costs will be reflected in the 2005 update of the OPPS. Finally, without verifiable information that demonstrates the actual market-based price that a broadly based national sample of hospitals are routinely required to pay in order to procure LOCM, we have no data upon which to base a determination that a separate APC for LOCM would be appropriate.

Prosthetic Urology

Comment: Several commenters supported the proposed restructuring of the prosthetic urology procedures into APCs 385 and 386. However, the commenters urged us to consider further refinements to increase the payment rates for these APCs. The commenters expressed concern about the use of a single departmental cost-to-charge ratio for devices and recommended for calendar year 2005 that we implement edits in our development of median costs to benchmark cost data for device procedures so that charges for expensive devices are not reduced below a designated point. The commenters also stated that hospitals charged for only one component of a prosthetic urology device for multi-component prosthetic urology devices. The commenters believe this resulted in under-reporting of charges for the entire procedure. The commenters recommended that we use external data to adjust the level of payment for multi-component devices and exclude claims with device costs less than $5,000 from the rate-setting database. Commenters stated that hospitals in the States of California, Colorado, Florida, Illinois, North Dakota, New York, and Oklahoma have closed their prosthetic urology programs because Medicare OPPS payments are too low.

Response: APCs 385 and 386 were created by splitting APC 0182 into two APCs for higher cost and lower cost devices (penile prostheses and urinary sphincters). The payment for these procedures in 2003 is $4,975.96. As a result of splitting former APC 0182 into two APCs, the payment amount for 2004 is $3,663.93 for APC 0385 and $6,342.07 for APC 0386. This is a relatively small reduction for APC 0385 with the lower cost devices and a very significant increase for APC 0386, with the higher cost devices. Moreover, as discussed in more detail elsewhere, we decided to change the status indicator for these APCs from "T" to an "S" so that the multiple procedure reduction will not apply to them (or other procedures with a "T" status indicator) on the same day. These changes together result in significantly more payment for these services in 2004 than in 2003. Therefore, we did not use external data to further adjust the median cost on which the payment was based.

Intensity Modulation Radiation Therapy

Comment: Commenters urged that we withdraw our proposal to move intensity modulation radiation therapy (IMRT) treatment planning (CPT code 77301) from new technology APC 1510 (previously APC 0712 in 2003) to APC 0413 and IMRT treatment delivery (CPT code 77418) from new technology APC 1506 (previously APC 0710 in 2003) to APC 0412. Commenters indicated that the payments proposed for APCs 0412 and 0413 are too low to adequately compensate hospitals for the costs of the services. One commenter further explained that part of the problem behind the low median cost may be that, according to CMS PM A–02–26, hospitals are precluded from billing for all of the services involved in this treatment. The commenter indicated that hospitals should be able to bill and be paid for the simulations (CPT codes 77280–77295), dosimetry calculations (CPT code 77300). an isodose plan (CPT codes 77305–77315), special teletherapy port plan (CPT code 77321), continuing medical physics (CPT code 77336) and special medical physics (CPT code 77370). Commenters requested that CPT codes 77301 and 77418 be retained in their current new technology APCs (APCs 1510 and 1506, respectively) for another year to provide additional time for provider education about the proper coding of these services and to enable the data to mature.

Response: We agree with commenters that the payment rate for APC 0413 does not adequately cover the costs of providing IMRT treatment planning (CPT code 77301). As noted by one commenter, PM A–02–26 instructs that services identified by CPT codes 77280 through 77295, 77300, and 77305 through 77321, 77336, and 77370 are included in the APC payment for IMRT and SR planning. The low median for CPT code 77301 appears to be a result of miscoding. Therefore, we will retain CPT code 77301 in new technology APC 1510 to allow additional time for provider education and to enable the data to mature. We believe, however, that the significant volume of single claims (93 percent of total claims) used to set the payment rate for IMRT treatment delivery (CPT code 77418) accurately reflects the costs hospitals are reporting for this service. Based on this robust claims data, we will move CPT 77418 from new technology APC 1506 (previously APC 0710 in 2003) to APC 0412 (IMRT Treatment Delivery).

Comment: One commenter requested that we allow the use of existing IMRT CPT codes 77301 and 77418 for compensator-based IMRT technology in the hospital outpatient setting. The commenter states that Medicare beneficiaries may be denied access to compensator-based IMRT as a result of inadequate payment for this service.

Response: We do not prohibit the use of existing IMRT CPT codes 77301 and 77418 to be billed for compensator-based IMRT technology in the hospital outpatient setting. Rather, we believe the confusion may pertain to billing instructions for CPT codes 77301 and 77334 billed on the same day. CMS PM A–02–26 instructs that "payment for IMRT and SR planning does not include payment for services described by CPT codes 77332 through 77334. When provided, these services should be billed in addition to the IMRT and SR planning codes 77301 and G0242." Providers billing for both CPT codes 77301 (IMRT treatment planning) and 77334 (design and construction of complex treatment devices) on the same day should append a 59 modifier to receive accurate payment.

Proton Beam Therapy

Comment: Several commenters indicated that proton beam therapy, intermediate and complex should be moved from APC 0650 to a new technology APC (as it appears in Addendum B). However, commenters stated that these two codes should not be placed in the same APC due to a significant difference in resource utilization. We received several other comments supporting our proposal to maintain simple proton beam therapy (CPT codes 77520 and 77522) in APC 0664 and intermediate and complex proton beam therapies (CPT codes 77523 and 77525, respectively) in APC 1511 (previously APC 0712 in 2003).

Response: We agree with commenters that codes for simple proton beam

radiation therapy (CPT codes 77520 and 77522) should be placed in a different APC than codes for intermediary (CPT code 77523) and complex (CPT code 77525) radiation therapy. As we stated in the correction notice of February 10, 2003 (68 FR 6636), we also agree with commenters that it would be inappropriate to return codes for simple proton beam therapy to a new technology APC due to having sufficient claims data to integrate these codes into the OPPS. We continue to believe that the placement of these codes in APC 0664 is appropriate based on having used 98 percent of total claims for simple proton beam therapy to set the 2004 median for APC 0664. Therefore, CPT codes 77520 and 77522 will remain in APC 0664.

The placement of intermediate (CPT code 77523) and complex (CPT code 77525) proton beam therapies in APC 650 in the November 1, 2002 final rule (67 FR 66718) for the 2003 OPPS was an error that was corrected in the correction notice of February 10, 2003 (68 FR 6636). We clarified in the correction notice that these CPT codes were placed in new technology APC 0712 for CY 2003 because they lacked sufficient cost data to confidently move these codes out of a new technology APC. We continue to lack sufficient cost data to move these codes into a clinical APC; therefore, we will crosswalk CPT codes 77523 and 77525 from new technology APC 0712 to the corresponding new technology APC 1511 for CY 2004. Once sufficient data is available, we will be able to determine whether intermediate and complex proton beam therapies should be placed in the same APC.

FDG PET Procedures

Comment: Several commenters commended us for our proposed rates for FDG PET procedures. They were pleased that the proposed 2004 rates for the FDG PET procedure and the radiopharmaceutical when combined are nearly identical to the rates for the combined procedure and radiopharmaceutical for 2003. Commenters stated that the retention of FDG PET procedures in a new technology APC will allow providers an additional year to improve their reporting practices, while providing us with another year of more accurate claims data.

Response: We agree with commenters that the retention of FDG PET procedures in a new technology APC for an additional year will allow providers a reasonable amount of time to improve their reporting practices, while providing us with another year of claims experience. Therefore, we will retain FDG PET procedures in new technology APC 1516.

Comment: One commenter expressed concern that HCPCS code G0296 did not appear in Addendum B of the August 12, 2003 proposed rule. The commenter urged us to place this new code in APC 1516 with other FDG PET procedures.

Response: We thank the commenter for bringing to our attention the absence of HCPCS code G0296 from addendum B of the proposed rule. We agree with the commenter's recommendation to place this code in the same APC as other FDG PET procedures. Therefore, we will place HCPCS code G0296 in new technology APC 1516.

Comment: One commenter recommended the establishment of a revenue code dedicated solely to PET procedures.

Response: Revenue codes exist for hospital accounting purposes and, in general we do not require that particular services be billed with particular revenue codes. We are not convinced that adding specific requirements for revenue coding or expanding the revenue codes to acquire more specific information will result in better data or that the end result would be cost effective in terms of its potential effect on hospital operations.

IV. Transitional Pass-Through and Related Payment Issues

A. Background

Section 1833(t)(6) of the Act provides for temporary additional payments or "transitional pass-through payments" for certain medical devices, drugs, and biological agents. As originally enacted by the BBRA, this provision required the Secretary to make additional payments to hospitals for current orphan drugs, as designated under section 526 of the Federal Food, Drug, and Cosmetic Act, Pub. L. 107–186; current drugs, biological agents, and brachytherapy devices used for the treatment of cancer; and current drugs and biological products.

For those drugs, biological agents, and devices referred to as "current," the transitional pass-through payment began on the first date the hospital OPPS was implemented (before enactment of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA), Pub. L. 106–554, enacted December 21, 2000).

Transitional pass-through payments are also required for certain "new" medical devices, drugs, and biological agents that were not being paid for as a hospital outpatient service as of December 31, 1996 and whose cost is "not insignificant" in relation to the OPPS payment for the procedures or services associated with the new device, drug, or biological. Under the statute, transitional pass-through payments can be made for at least 2 years but not more than 3 years.

Section 1833(t)(6)(B)(i) of the Act required that we establish by April 1, 2001, initial categories to be used for purposes of determining which medical devices are eligible for transitional pass-through payments. Section 1833(t)(6)(B)(i)(II) of the Act explicitly authorized us to establish initial categories by program memorandum (PM). On March 22, 2001, we issued two PMs, Transmittals A–01–40 and A–01–41 that established the initial categories. We posted them on our Web site at: *http://www.hcfa.gov/pubforms/transmit/A0140.pdf* and *http://www.hcfa.gov/pubforms/transmit/A0141.pdf*, respectively.

Transmittal A–01–41 includes a list of the initial device categories, a crosswalk of all the item-specific codes for individual devices that were approved for transitional pass-through payments, and the initial category code by which the cross-walked individual device was to be billed beginning April 1, 2001. Items eligible for transitional pass-through payments are generally coded using a Level II HCPCS code with an alpha prefix of "C." Pass-through device categories are identified by status indicator "H" and pass-through drugs and biological agents are identified by status indicator "G." Subsequently, we added a number of additional categories, retired 95 categories effective January 1, 2003, and made clarifications to some of the categories' long descriptors found in various program transmittals. A list of current device category codes can be found below, in Table 10.

Section 1833(t)(6)(B)(ii) of the Act also requires us to establish, through rulemaking, criteria that will be used to create additional device categories for transitional pass-through payment. The criteria for new categories were the subject of a separate interim final rule with comment period published in the **Federal Register** on November 2, 2001 (66 FR 55850) and made final in the November 1, 2002 **Federal Register** (67 FR 66781) announcing the 2003 update to the OPPS.

Transitional pass-through categories are for devices only; they do not apply to drugs or biological agents. The regulations at § 419.64 governing transitional pass-through payments for eligible drugs and biological agents are unaffected by the creation of categories.

The process to apply for transitional pass-through payment for eligible drugs and biological agents or for additional device categories can be found on respective pages on our Web site at *http://www.cms.gov.* If we revise the application instructions in any way, we will post the revisions on our Web site and submit the changes for approval by the Office of Management and Budget (OMB) as required under the Paperwork Reduction Act (PRA). Notification of new drug, biological, or device category application processes is generally posted on the OPPS Web site at *http://www.cms.gov.*

B. Discussion of Pro Rata Reduction

Section 1833(t)(6)(E) of the Act limits the total projected amount of transitional pass-through payments for a given year to an "applicable percentage" of projected total Medicare and beneficiary payments under the hospital OPPS. For a year before 2004, the applicable percentage is 2.5 percent; for 2004 and subsequent years, we specify the applicable percentage up to 2.0 percent. We proposed to set the percentage at 2.0 percent for the 2004 OPPS.

If we estimate before the beginning of the calendar year that the total amount of pass-through payments in that year would exceed the applicable percentage, section 1833(t)(6)(E)(iii) of the Act requires a prospective uniform reduction in the amount of each of the transitional pass-through payments made in that year to ensure that the limit is not exceeded. We make an estimate of pass-through spending to determine not only whether payment exceeds the applicable percentage but also to determine the appropriate reduction to the conversion factor.

In the August 12, 2003 proposed rule, we described in the detail the methodology we used to make an estimate of pass-through spending in 2004 (68 FR 47992). In general, we specified that after using the respective methodologies described in the proposed rule, to determine projected 2004 pass-through spending for the groups of devices, drugs, and biological agents, we would calculate total projected 2004 pass-through spending as a percentage of the total projected payments (Medicare and beneficiary payments) under OPPS to determine if the pro rata reduction would be required.

Table 9 shows our current estimate of 2004 pass-through spending for known pass-through drugs, biologicals, and devices based on information available at the time this table was developed. We specified in the proposed rule that we were uncertain whether estimated pass-through spending in 2004 would exceed $456 million (2.0 percent of total estimated OPPS spending) because we had not yet completed the estimate of pass-through spending for a number of drugs and devices. In particular, we did not have estimates for those drugs still under agency review for additional pass-through payments beginning October 2003 or the changes in pass-through spending that could result from quarterly rather than annual updates of AWP for pass-through drugs. Finally, we would incorporate an estimate of pass-through spending for items for which pass-through payment becomes effective later in 2004 (that is, April 1, 2004; July 1, 2004; and October 1, 2004) based on estimates of items that become eligible for pass-through payment on October 1, 2003 and January 1, 2004. Specifically, we would assume a proportionate amount of spending for items that become eligible later in the year while making an adjustment to account for the fact that items made eligible later in the year will not receive pass-through payments for the entire year. We invited comments on the methodology we proposed and the estimates for utilization that appeared in Table 12 of the August 12, 2003 proposed rule. We received several comments on this proposal, which are summarized below along with our responses.

TABLE 9.—ESTIMATE OF PASS-THROUGH SPENDING IN 2004

HCPC	APC	Drug biological	2004 pass-through payment portion	2004 estimated utilization	2004 anticipated pass-through payments
		Existing Pass-through Drugs/biologicals			
J0583	9111	Injectin Bivalrudin, per 1 mg	$0.40	$5,278,000	$2,111,200
C9112	9112	Injection, Perflutren lipid microsphere, per 2 ml	37.44	67,000	2,508,480
C9113	9113	Injection, Pantoprazole sodium, per vial	6.34	20,000	126,800
J1335	9116	Injection, Ertapenum sodium, per 500 mg	6.00	14,400	86,400
J2505	9119	Injection, Pegfilgrastim, per 6 mg single dose vial	708.00	110,344	78,123,329
J9395	9120	Injection, Fluvestrant, per 25 mg	22.13	274,156	6,067,072
C9121	9121	Injection, Argatroban, per 5 mg	4.13	50,000	206,500
C9200	9200	Orcel, per 36 cm2	286.80	1,000	286,800
C9123	9123	Transcyte, per 247 sq cm	194.76	100	19,476
C9203	9203	Injection Perflexane lipid microspheres, per 10 ml vial	36.00	82,400	2,966,400
J2324	9114	Injection, Nesiritide, per 0.5 mg vial	38.30	60,000	2,298,000
J3315	9122	Injection, Triptorelin pamoate, per 3.75 mg	100.70	307,440	30,959,208
J3487	9115	Injection, Zoledronic acid, per 1 mg	54.93	539,000	29,607,270
J3486	9204	Injectionm Ziprasidone mesylate, per 10 mg	5.25	234,286	1,230,000
C9205	9205	Injection, Oxaliplatin, per 5 mg	23.86	280,756	6,698,845
C9208	9208	Injection, IV, Agalsidase beta, per 1 mg	31.27	194,533	6,083,040
C9201	9201	Dermagraft, per 37.5 square centimeters	145.92	9,264	1,351,803
C9209	9209	Injection, IV, Laronidase, per 2.9 mg	162.72	2,612	425,092
		Pass-through Drugs/Biologicals Effective January 2004			
C9207	9207	Injection, IV, Bortezomib, per 3.5 mg	262.66	102,680	26,970,000
C9210	9210	Injection, IV, Palonosetron HCl, per 0.25 mg (250 micrograms)	77.76	37,500	2,916,000
C9211	9211	Injection, alefacept, for intravenous use, per 7.5 mg	168.00	13,775	2,314,200
C9212	9212	Injection, alefacept, for intramuscular use, per 7.5 mg	119.40	27,550	3,289,470
		Existing Pass-through Devices			
C1783	1783	Ocular implant, aqueous drainage assist device		324	160,250
C1814	1814	Retinal tamponade device, silicone oil		35,173	13,675,262
C1884	1884	Embolization Protective System		25,000	38,601,544
C1888	1888	Catheter, ablation, non-cardiac, endovascular (implantable)		215	129,731

TABLE 9.—ESTIMATE OF PASS-THROUGH SPENDING IN 2004—Continued

HCPC	APC	Drug biological	2004 pass-through payment portion	2004 estimated utilization	2004 anticipated pass-through payments
C1900	1900	Lead, left ventricular coronary venous system		2,095	2,819,912
C2614	2614	Probe, percutaneous lumbar discectomy		901	1,752,445
C2632	2632	Brachytherapy solution, iodine—125, per mCi		225	1,890,000
C1818	1818	Integrated keratoprosthesis		4	27,800
		Pass-through Devices Effective January 2004			
C1819	1819	Tissue localization-excision dev		9,858	1,823,730
		Other Items Expected To Be Determined Eligible for 2004			
		Spending for future approved drugs			22,466,959
		Spending for future approved devices			12,791,197
		Total Spending for Pass-through Drugs/biologicals, and devices 2004.			302,784,216

Comment: Several commenters objected to the methods used to project pass-through drug spending, especially those techniques used to estimate future products that are first eligible for pass-through payments beginning in April 2004 or later in the year. They are concerned that pass-through expenditures in 2004 will exceed the statutory cap and cause us to impose a pro rata reduction. Several hospital associations propose that we limit the funds allocated for the pass-through pool to one percent and use the remaining 1.0 percent to fund all other APCs. They suggest that we over-estimate pass-through spending, which results in the reduction of payment rates for other critical care services.

Response: Section 1833(t)(6)(E)(i) of the Act requires that the Secretary estimate the total pass-through payments to be made for the forthcoming year (which allows us to determine the amount of the conversion factor for the forthcoming year) and to the extent the estimate exceeds the statutory limit, reduce the amount of each pass-through payment. For 2004, the statutory limit is 2.0 percent of total estimated program payments. In the August 12, 2003 proposed rule, we provided our best estimate at that time of pass-through payments for the drugs and devices for which we expected to make pass-through payments in 2004, and we explained our methodology for determining the estimate for the final rule. We provided a list of the devices and drugs we either knew would be paid under pass-through next year or which we believed may be paid as pass-through items in 2004.

We finalized our estimate of 2004 pass-through spending and, for the reasons discussed below, we have determined that no pro rata reduction will be required in 2004. As discussed below the estimate falls under the statutory limit of 2.0 percent. Therefore, the conversion factor has been increased correspondingly from the proposed rule by 0.7 percent.

Pass-Through Devices Effective January 2004

Comment: One commenter recommended that we not impose a pro rata reduction on pass-through devices if the estimated pass-through expenditures increase appreciably. A device manufacturers' association was concerned that new drugs will take an increasing share of the pass-through pool. They suggested that the shift to more pass-through spending on drugs will increase under the easier qualifications for drug pass-through payments and encouraged us to reconsider the issue to determine how to ensure that devices maintain an "adequate" share of the pass-through pool.

Response: Section 1833(t)(6)(E)(iii) of the Act requires a prospective uniform reduction (pro rata) of the amount of each of the transitional pass-through payments made in that year, if it is expected that pass-through payments will exceed the cap set for OPPS pass-through expenditures. Therefore, if any pro rata reduction applies, we are required to apply it to pass-through devices as well as drugs and biological agents. For 2004, we do not expect the total payments for pass-through drugs and devices to exceed the statutory limit. Therefore, as discussed elsewhere, we will not impose a pro rata adjustment on any pass-through items in 2004.

V. Payment for Devices

A. Pass-Through Devices

Section 1833(t)(6)(B)(iii) of the Act requires that a category of devices be eligible for transitional pass-through payments for at least 2, but not more than 3, years. This period begins with the first date on which a transitional pass-through payment is made for any medical device that is described by the category. We proposed that two device categories currently in effect would expire effective January 1, 2004. Our proposed payment methodology for devices that have been paid by means of pass-through categories, and for which pass-through status would expire effective January 1, 2004, is discussed in the section below.

Although the device category codes became effective April 1, 2001, most of the item-specific "C" codes for pass-through devices that were crosswalked to the new category codes were approved for pass-through payment in CY 2000 and as of January 1, 2001. (The crosswalk for item-specific "C" codes to category codes was issued in Transmittals A–01–41 and A–01–97). We based the expiration dates for the category codes listed in Table 10, on when a category was first created, or when the item-specific devices that are described by, and included in, the initial categories were first paid as pass-through devices, before the implementation of device categories. The device category expiration dates are listed in Table 10. We proposed to base the expiration date for a device category on the earliest effective date of pass-through payment status of the devices that populate that category. There are two categories for devices that will have been eligible for pass-through payments for more than 2½ years as of December 31, 2003, and we proposed that they would not be eligible for pass-through payments effective January 1, 2004. The two categories we proposed for expiration are C1765 and C2618, as indicated in Table 10. Each category includes devices for which pass-through payment was first made under OPPS in 2000 or 2001.

A comprehensive list of all currently effective pass-through device categories is displayed in Table 10. Also displayed

are the dates the devices described by the category were populated and their respective expiration dates. For devices continuing on pass-through status after 2003, expiration dates were set forth in the August 12, proposed rule and are finalized here. Newly added code C1819 is first announced in this final rule and is given a December 31, 2005 expiration date.

The methodology used to base expiration of a device category is the same as that used to determine the 95 initial categories that expired as of January 1, 2003. A list including those 95 categories that expired as of January 1, 2003 (as well as 5 categories that continued to be paid in 2003) is found in the November 1, 2002 final rule (67 FR 66761 through 66763).

TABLE 10.—LIST OF CURRENT PASS—THROUGH DEVICE CATEGORIES WITH EXPIRATION DATES

HCPCS codes	Category long descriptor	Date(s) populated	Expiration date
C1765	Adhesion Barrier	10/1/00–3/31/01; 7/1/01.	12/31/03
C2618	Probe, cryoblation	4/1/01	12/31/03
C1888	Catheter, ablation, non-cardiac, endovascular (implantable)	7/1/02	12/31/04
C1900	Lead, left ventricular coronary venous system	7/1/02	12/31/04
C1783	Ocular implant, aqueous drainage assist device	7/1/02	12/31/04
C1884	Embolization protective system	1/1/03	12/31/04
C2614	Probe, percutaneous lumbar discectomy	1/1/03	12/31/04
C2632	Brachytherapy solution, iodine-125, per mCi	1/1/03	12/31/04
C1814	Retinal tamponade device, silicone oil	4/1/03	12/31/05
C1818	Integrated keratoprosthesis	7/1/03	12/31/05
C1819	Tissue localization excision device	1/1/04	12/31/05

We received several comments on this proposal, which are summarized below along with our responses.

Comment: A few parties provided comments on our criteria for eligibility for a new device category for pass-through payment as published in the November 1, 2002 **Federal Register** (67 FR 66781).

Response: We made no proposal to modify our criteria for establishment of a new category for transitional pass-through payment, so the criteria were not subject to comment in this rulemaking period. However, we will take note of these comments as considerations in our ongoing evaluation of the new device category process.

New Technology Treatment for New Devices for Brachytherapy Catheters and Needles

Comment: A commenter asked that we consider pass-through payment or new technology payment for new devices of brachytherapy catheters and needles when they are approved by FDA for new indications and treatment protocols.

Response: We have a process for applying for pass-through new technology APC status. See *http://www.cms.hhs.gov* for instructions. If a provider or other party believes that an item or service meets the criteria for pass-through or new technology status, the interested party should submit an application, and we will then make a judgement based on the individual circumstances described in the application.

B. Expiration of Transitional Pass-Through Payments in CY 2004

In the November 1, 2002 final rule, we established a policy for payment of devices included in pass-through categories that are due to expire (67 FR 66763). We stated that we would package the costs of the devices no longer eligible for pass-through payments in 2003 into the costs of the clinical APCs with which the devices were billed in 2001. There were very few exceptions to the policy (for example, brachytherapy sources for other than prostate brachytherapy), and we proposed to make no changes. Therefore, we proposed that payment for the devices that populate C1765 and C2618, which we proposed would cease to be eligible for pass-through payment on January 1, 2004, would be made as part of the payment for the APCs with which they are billed.

The methodology that we proposed to use to package expiring pass-through device costs is consistent with the packaging methodology that we describe in section II.B.5. For the codes in APCs displayed in Table 10 of the proposed rule, we proposed to use only those claims on which the hospital included the "C" code and to discard the claims on which no "C" code is billed. We proposed to limit our analysis to the claims with "C" codes because we are not confident that the claims for the relevant APCs include the charges for the devices unless the "C" codes are specifically billed.

To calculate the total cost for a service on a per-service basis, we included all charges billed with the service in a revenue center in addition to packaged HCPCS codes with status indicator "N." We also packaged the costs of devices that we proposed would no longer be eligible for pass-through payment in 2004 into the HCPCS codes with which the devices were billed.

We received several comments on this proposal, which are summarized below along with our responses.

Comment: A commenter supported packaging the cost of expiring pass-through codes C2618 and CC1765 into the payment for the procedure in which they are used because they believe that packaging minimizes payment incentive to use these devices over other appropriate devices. The commenter urged CMS to release the crosswalk it will use to assign pass-through device costs to specific APCs so that they can confirm the appropriateness of the assignment.

Response: There is no such crosswalk. Devices and packaged drugs (that is, those with a per day median cost of $50 or less) are packaged into the HCPCS code on the single procedure claim (natural single or pseudo single) with which they are billed. The packaging is controlled solely by what the hospital bills on the claim. To determine what drugs and devices were packaged into an APC, one would need to undertake an extensive analysis of all single and pseudo single claims used in weight setting. The only time that judgment was used to attribute a device to an APC was not for purposes of packaging charges into APCs but rather was in the setting of median costs for 5 APCs in which external data on acquisition costs was used in a one to one proportion

with claims data to set the device cost for an APC as discussed above.

C. Reinstitution of C Codes for Expired Device Categories

Comment: Some commenters strongly objected to reinstatement of the C codes for devices because of the burden that it would impose on hospitals without a corresponding benefit in immediate payment. They indicated that charges for devices are included in the revenue code charges for the services furnished and that using C codes will increase administrative costs significantly without any benefit to patient care or hospital revenues. They indicated that hospital staffs would not be able to differentiate between devices that should be reported and those that should not. One commenter said that widespread confusion over what device to code and what device to not code is the reason that the claims for services that require pass-through devices often do not show codes for the devices. The commenter indicates that most hospitals could not comply with this requirement by January 1, 2004 in any case because of extensive changes to chargemasters that would be needed. Moreover, given that many hospitals did not comply even when the use of the code would have resulted in separate payment is a strong indication that they would be unlikely to comply when no additional payment will result from coding devices. Commenters indicated that reintroducing C codes for devices will result in continuation of improper coding and will lead to a false sense of confidence in the data for procedures that require devices. A commenter said that if CMS decided to reintroduce C codes for devices, CMS should reinstate the same C codes that were used for device coding in 2002 because it would minimize confusion.

Other commenters said that CMS should reinstate the C codes for reporting of devices so that CMS and others can ensure that only correctly coded claims are used to set medians for APCs into which device costs are packaged. They said that coding for devices is needed so that CMS can be assured that the costs of the devices are packaged into the costs for the procedure when the medians for the procedure are set. They urged us to continue to use the presence of an appropriate device code as a criterion for claims used to set medians for devices.

Response: For 2004, we are reactivating the C codes for device categories as they existed on December 31, 2002. The use of the code is not required and will not be enforced. However, hospitals should understand that providing complete and accurate information on the claims about the services that were furnished and the charges for those services is fundamental to our establishment of relative weights on which the payment for their services is based.

Comment: Commenters that supported the reinstitution of C codes for devices said that CMS should continue to restrict the claims used for APCs with a device to claims that contain the charges for the devices used in the APC. In particular, a commenter said that the median for APC 0246 (Cataract removal with intraocular lens) should be based only on claims that contain charges under revenue center 0276 and that claims for APC 0246 that do not contain charges in revenue center 0276 should not be used to set the median. In the case of this APC, the commenter asked that we adopt the 2004 proposed payment at a minimum. Other commenters opposed the reinstitution of C codes for devices, which would preclude us from restricting claims used to set weights for device APCs to claims containing such codes.

Response: We restricted the claims used to set the medians for the APCs contained in Table 7 to claims for which there was a line item containing a device category code that was in use for services furnished on April 1, 2002 through and including December 31, 2002. We believed that restricting the claims used to set median costs to those that met this criterion resulted in median costs that more accurately reflected relative costs of these services. Moreover, for the APCs in Table 7 we required that the claim not only contain a device code that was valid during the period specified but we also required that the claim must have a particular device code or combination of device codes.

For APC 0313 (high dose rate brachytherapy), we attempted to require both brachytherapy sources HDR Iridium 192 (C1717) and either a catheter (C1728) or needle (C1715) but we found that no single procedure claims met those criteria. Hence, the median for APC 0313 that appeared in the 2003 OPPS final rule was the median for claims that did not meet the specified criteria and it was mistakenly included in Table 10 in the NPRM. For this final rule, we again began by applying the criteria including source and needle or catheter codes, but still no claims met the criteria. Therefore, we sought only single procedure claims that contained brachytherapy sources. We found 27 single procedure claims that met the revised criteria and we used the median cost of $936.52 that resulted from those claims.

D. Other Policy Issues Relating to Pass-Through Device Categories

1. Reducing Transitional Pass-Through Payments To Offset Costs Packaged Into APC Groups

In the November 30, 2001 final rule, we explained the methodology we used to estimate the portion of each APC rate that could reasonably be attributed to the cost of associated devices that are eligible for pass-through payments (66 FR 59904). Beginning with the implementation of the 2002 OPPS update (April 1, 2002), we deduct from the pass-through payments for the identified devices an amount that offsets the portion of the APC payment amount that we determine is associated with the device, as required by section 1833(t)(6)(D)(ii) of the Act. In the November 1, 2002 final rule, we published the applicable offset amounts for 2003 (67 FR 66801).

For the 2002 and 2003 OPPS updates, we estimated the portion of each APC rate that could reasonably be attributed to the cost of an associated pass-through device that is eligible for pass-through payment using claims data from the period used for recalibration of the APC rates. Using these claims, we calculated a median cost for every APC without packaging the costs of associated C codes for device categories that were billed with the APC. We then calculated a median cost for every APC with the costs of associated device category C codes that were billed with the APC packaged into the median. Comparing the median APC cost minus device packaging to the median APC cost including device packaging enables us to determine the percentage of the median APC cost that is attributable to associated pass-through devices. By applying these percentages to final APC rates, we determined the applicable offset amount. We included any APC on the offset list for which the device cost was at least 1 percent of the APC's cost.

As we discussed in our November 1, 2002 final rule (67 FR 66801), the listed offsets are those that may potentially be used because we do not know which procedures would be billed with newly created categories.

After publication of the November 1, 2002 final rule, we received a comment indicating that in some cases it may be inappropriate to apply an offset to a new device category because the device category is not replacing any device whose costs have been packaged into the APC. We agree with this comment

and proposed to modify our policy for applying offsets. Specifically, we proposed to apply an offset to a new device category only when we can determine that an APC contains costs associated with the device. We specified in the proposed rule that we would continue our existing methodology for determining the offset amount, described above. However, we solicited comments for alternative methodologies for determining the offset amounts that potentially could be applied to the payment amounts for new device categories.

We added that we could use this methodology to establish the device offset amounts for the 2004 OPPS because we are using 2002 claims on which device codes are reported. However, for the 2005 update to OPPS, we proposed to use 2003 claims that would not include device coding. Thus, for 2005, we are considering whether or not to use the charges from lines on the claim having no HCPCS code but have charges under revenue codes 272, 275, 276, 278, 279, 280, 289, and 624 as proxies for the device charges that would have been billed with HCPCS codes for these devices in previous years. We are also considering the reinstitution of the C codes for expired device categories and requiring hospitals to use one or more newly created C codes for identification of devices and costs on claims. *See* section VI.B of this final rule for further discussion.

We proposed to review each new device category on a case-by-case basis to determine whether device costs associated with the new category are packaged into the existing APC structure.

We reviewed the device categories eligible for continuing pass-through payment in 2004 to determine whether the costs associated with the device categories are packaged into the existing APCs. For the categories existing as of publication of the proposed rule, we determined that there are no close or identifiable costs associated with the devices in our data related to the respective APCs that are normally billed with those devices. Therefore, for these categories we proposed to set the offset to $0 for 2004.

If we create a new device category and determine that our data contain identifiable costs associated with the devices in any APC, we would apply an offset. We proposed, if any offsets apply, for new categories, to announce the offsets in a transmittal that announces the information regarding the new category.

We received several comments on the proposal, which are summarized below along with our responses.

Comment: Device manufacturers and associations generally supported our proposal to modify our policy in applying offsets to only those device categories where we can determine that an APC contains costs associated with the device category. One commenter also recommended that we not apply offsets to those categories that do not replace current devices found in the APC costs.

Response: We will apply an offset to a new device category only when we are able to determine that an APC contains costs associated with the new device. We will also continue our existing methodology for determining any offset amount, if we find that device costs associated with a new device category are packaged into the APCs. We will include information about any applicable offset in the transmittal we issue to announce information regarding the new category.

We also will publish the device percentages related to APCs on our web site. We believe this information is useful to the public even if we do not use the information to apply any particular offset to new device categories, because we use this information to apply the tests of "not insignificant cost" to a proposed new device category application. A transitional pass-through device category must have an average cost that is not insignificant in relation to the OPD fee schedule amount, according to section 1833(t)(6)(A)(iv)(II) of the Act.

2. Multiple Procedure Reduction for Devices

In our discussion in the proposed rule of recommendations of the Advisory Panel, we noted that the Panel asked us to analyze our data to determine if we may be underpaying for devices when the multiple procedure policy is applied (68 FR 47976). We made no proposal to change our policy regarding the multiple procedure reduction for device-related APCs, but we did receive a number of comments on the topic.

Comment: Commenters stated that we should change the status indicator (SI) from "T" to "S" for APCs with packaged device costs so that the multiple procedure discount will not adversely affect the payment for APCs that contain high cost devices. One commenter indicated that no APC for which the device percentage is 50 percent or more should be subjected to a multiple procedure reduction because any such reduction would reduce the Medicare payment below the hospital's cost for the device. The commenter offered to work with us to develop a list of device percentages of APC payments that would not be subject to the multiple procedure reduction. Another commenter suggested that we create a modifier that could be used to override the multiple procedure reduction for certain codes with SI "T". Some commenters said that any code that is not subject to the multiple procedure modifier under the Medicare physician fee schedule should be subjected to a multiple procedure modifier under OPPS.

Response: We are concerned that the application of the multiple procedure reduction has been a recurring theme among commenters with regard to APCs that contain significant device costs. We continue to believe that for most cases, including many cases with devices, the payment reductions for the second and subsequent payments are appropriate. This is particularly true given that there must be two procedures with SI=T for the reduction to occur. Hence, if a device procedure is performed with a non-device procedure, the non-device procedure will not be reduced if the device procedure has an SI=S, even if the non-device procedure is less costly because it was done at the same time as the device intense procedure. We are reluctant to change the SIs for device procedures because of the increase that will occur for non-device procedures. The shift in median costs will be picked up in the scaling of relative weights for budget neutrality and will result in some reduction for all services, shifting payment to procedures and away from other services types (for example, E&M, diagnostic tests).

Decisions regarding the application of the multiple procedure SIs are made independently for the Medicare physician fee schedule and the OPPS. The physician fee schedule decision is heavily dependent upon the work performed by the physician and the OPPS decision is made only with regard to the resources the hospital supplies for the service to be performed. There is no reason to believe that a decision to reduce or not reduce for multiple procedures in one system would necessarily justify that same decision in the other system.

For 2004 OPPS we have not changed the policy. However, as we did for 2003 OPPS, we have changed the SI for certain APCs for which we were convinced that the application of the multiple procedure reduction would result in inappropriate payment. For 2005, we hope to analyze the effects of a more systematic approach to determining when we should apply the

multiple procedure reduction to APCs with high device costs. We hope to develop these possible approaches and discuss them with the APC Panel at its winter meeting.

Prosthetic Urology (APCs 0385 and 0386)

Comment: Commenters said that APCs 0385 and 0386 should be changed from SI=S to SI=T and that the APC Panel agreed and recommended these changes in its August 22, 2003 meeting. The commenters indicated that when a penile prosthesis and a urinary sphincter are both implanted at the same time, while there is some cost efficiency (for example, OR time, recovery room time, drugs, supplies), the cost of the prostheses are such a large part of the cost of the APC that the reduction of the second APC by 50 percent results in less than cost being paid.

Response: For the 2004 OPPS, we have changed the SI for these APCs from T to S, so that when both the prosthesis and sphincter are implanted on the same date, the multiple procedure reduction will not apply to the second device. These APCs each contain a combination of penile prostheses and sphincters. Our data analysis shows that it is not a rare occurrence for both to be implanted on the same day and that each APC has a device percentage in excess of 60 percent. For these reasons, we have changed the SI for these APCs to "S" for 2004.

Electrophysiology APCs (APCs 0085, 0086 and 0087)

Comment: Commenters said that APCs 0085, 0086, and 0087 should not be subject to the multiple procedure reduction because the devices used in these procedures are not less costly when the second procedure is done on the same day. Commenters said that these procedures have become so advanced that they now are commonly done on the same day and that the multiple procedure reduction significantly reduces the payments below what they were paid when they were done on subsequent days. A commenter suggested that we should create a combination APC for APCs 0085, 0086 and 0087 or for APCs 0085 and 0086 since these are often performed on the same day and the commenter believes that the multiple procedure reduction improperly reduces payment for them.

Response: We have not changed the SI for these APCs because we do not believe that such a change is warranted. Although devices are integral to these APCs, the device portion of the median is not very significant. Each has a device percent lower than 35 percent (APC 0085 = 25.61 percent, APC 0086=34.77 percent, APC 0087= 30 percent). Moreover, we believe that there is efficiency in performing these procedures on the same day in the outpatient setting, which is why hospital practice has changed. Therefore, we are retaining these procedures as SI=T for 2004.

Implantation or Revision of Pain Management Catheter; Implantation of Drug Infusion Device (APCs 0223 and 0227)

Comment: A commenter indicated that the same rationale that applies to implantation of neurostimulators (discussed immediately preceding) applies to APCs 0223 and 0227 and that therefore, the multiple procedure reduction should not apply.

Response: We are not convinced by the comment that it would be appropriate to change the SI for APCs 0223 and 0227 from "T" to "S". We believe that there are economies of scale that cause these procedures to allow for appropriate payment when they are performed with other procedures.

Left Ventricular Leads (APCs 0105, 1547 and 1550)

Comment: A commenter indicated that placement of a Left ventricular lead (CPT code 33224, 33225, and 33226, APCs 0105, 1547 and 1550 respectively) should not be subjected to the multiple procedure reduction.

Response: We have reviewed the codes contained in these APCs and we are not convinced that it would be appropriate to change the SI for these APCs.

VI. Payment for Drugs, Biologicals, Radiopharmaceutical Agents, Blood, and Blood Products

A. Pass-Through Drugs and Biologicals

In the proposed rule, we expressed concern about the extent to which Medicare pays more for pass-through drugs than other payers and more than the market-based price of drugs. To address this problem of how to pay appropriately for drugs that are priced using the AWP, we are developing regulations that would revise the current payment methodology for Part B covered drugs paid under section 1842(o) of the Act. We proposed to adopt and apply the provisions of the final AWP rule to establish the AWP of pass-through drugs payable under the OPPS. If implementation of the AWP final rule necessitates mid-year changes in the 2004 OPPS payment rates for pass-through drugs, we proposed to make those changes on a prospective payment basis through our regular OPPS Transmittal process and PRICER quarterly updates. We further proposed to issue instructions by program memorandum regarding implementation of the provisions of the AWP final rule to set payment rates for pass-through drugs under the OPPS.

We stated that if the AWP final rule is not issued in time to permit us to apply its provisions to price pass-through drugs furnished on or after January 1, 2004, we proposed to use 95 percent of the AWP listed in the most recent quarterly update of the Single Drug Pricer (SDP). If a drug with pass-through status is not included in the SDP, we proposed to forward to the SDP contractor the AWP information submitted as part of the pass-through application for calculation of an allowed payment amount.

Because the January SDP would not be available in time, we proposed to announce the January 1, 2004 prices for pass-through drugs in our January 2004 OPPS implementing instructions to fiscal intermediaries and in the January 2004 OPPS PRICER rather than in the 2004 final rule, which is to be published in the **Federal Register** by November 1, 2003. We further proposed to update the AWP for pass-through drugs paid under the OPPS on a quarterly basis in accordance with the quarterly updates of the SDP. The updated rates for pass-through drugs and biologicals would also be issued through our quarterly OPPS program memoranda and PRICER updates.

Comment: A national hospital association supported our proposal to use the SDP to determine the payment amount for pass-through drugs and biologicals. However, the same commenter expressed concern about not having accurate 2004 information on AWP until after the 2004 OPPS is implemented, which would make it impossible to predict pass-through spending and not give hospitals enough time to update their billing systems. The commenter also opposed our proposal to update the AWP for pass-through drugs on a quarterly basis because it would result in increased confusion and burden on hospitals to make quarterly price changes and could result in CMS having to make quarterly adjustments to the pass-through pool to recalculate the relative payment weights for all APCs.

A provider expressed reservations about the impact of the AWP rule, which could precipitate a shift in care from physicians' offices to hospitals. This commenter recommended that we determine pass-through payment

amounts using market applications by drug manufacturers and acquisition data solicited from the hospital industry through group purchasing organizations and individual hospitals and systems. The same commenter encouraged us to delay changes in pass-through payments pending an assessment of the impact of the AWP rule on physician practices.

Response: We wish to clarify how our use of the SDP to price pass-through drugs will affect the OPPS in 2004. The payment rates for pass-through drugs and biologicals that are shown in Addendum B are based on the April 1, 2003 SDP, which was the update that was available when we recalibrated the relative payment weights for this final rule. We also used these payment rates as the basis for estimating pass-through spending in 2004, which is discussed in section IV of this preamble.

We have carefully considered the commenter's concern about the confusion that could result if we were to revise the payment amounts for pass-through drugs and biologicals by installing prices from the January 2004 update of the SDP in the OPPS PRICER for implementation beginning January 1, 2004. We agree with the commenter that, because of the timing, this proposal could create operational problems both for providers and for our claims processing systems. Therefore, we will retain the payment amounts published in this final rule as the payment amounts for pass-through drugs effective January 1, 2004.

Further, to keep quarterly changes to a minimum, we have decided not to implement at this time our proposal to update the AWP for pass-through drugs paid under the OPPS on a quarterly basis in accordance with quarterly SDP updates.

At this time, we are not implementing the AWP rule. Therefore, we are not making final the OPPS changes we proposed that would have resulted from the AWP rule.

Comment: Several commenters were concerned about the delay in processing pass-through applications and assigning c-codes for new drugs and biologicals. Commenters believed that the lack of immediate payment under OPPS for new FDA-approved drugs and biologicals may drive hospitals to discontinue providing innovative life-saving therapies to Medicare beneficiaries until pass-through payments are established. Another commenter suggested that CMS create and regularly update a central on-line listing of all current codes for pass-through drugs, biologicals, and devices. The Web site should also list all pass-through drug and device applications under review, and their status in the review process.

Response: We understand the concerns expressed by commenters about the impact of the time gap from FDA approval to our c-code assignment and payment for new pass-through items; however, our position on this issue remains the same as that described in the November 1, 2002 final rule (67 FR 66780–81).

B. Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status

1. Background

Under the OPPS, we currently pay for radiopharmaceuticals, drugs, and biologicals including blood, and blood products, which do not have pass-through status, in one of three ways: packaged payment, separate payment (individual APCs), and reasonable cost. As we explained in the April 7, 2000 final rule (65 FR 18450), we generally package the cost of drugs and radiopharmaceuticals into the APC payment rate for the procedure or treatment with which the products are usually furnished. Hospitals do not receive separate payment from Medicare for packaged items and supplies, and hospitals may not bill beneficiaries separately for any such packaged items and supplies whose costs are recognized and paid for within the national OPPS payment rate for the associated procedure or service. (Transmittal A–01–133, a Program Memorandum issued to Intermediaries on November 20, 2001, explains in greater detail the rules regarding separate payment for packaged services). As we explained in the November 1, 2002 final rule (67 FR 66757), we do not classify diagnostic and therapeutic radiopharmaceutical agents as drugs or biologicals as described in section 1861(t) of the Act.

Comment: Several trade associations and manufacturers urged CMS to revise its policy that radiopharmaceuticals are not drugs. They emphasized that radiopharmaceuticals go through the same FDA approval process as drugs, are approved for inclusion in the United States Pharmacopoeia Drug Indication, and have historically been considered drugs under OPPS. They indicated that Congress is considering a legislative clarification that under OPPS radiopharmaceuticals will continue to be treated and paid as drugs.

Response: We appreciate the comments on this issue. We do not intend, by our designation of radiopharmaceuticals for purposes of determining which items are eligible for pass-through status, to imply that radiopharmaceuticals are not considered drugs under the Food, Drug, and Cosmetic Act or that they are not subject to the same FDA approval process as those items that we have designated as drugs. However, we will continue to consider radiopharmaceuticals as neither a drug nor biological. Our reasons were set forth in the November 1, 2002 final rule (67 FR 66757). In that rule, we stated that a careful reading of the statutory language in section 1861(t)(1) convinces us that inclusion of an item in, for example, the USPDI, does not necessarily mean that the item is a drug or biological. Inclusion in such a reference (or approval by a hospital committee) is a necessary condition for us to call a product a drug or biological, but it is not enough. CMS must make its own determination that a product is a drug or biological for OPPS purposes under its governing statutes, and this determination is different from and does not affect FDA's determination that a product is a drug or biological under the Food, Drug, and Cosmetic Act.

While we have determined that radiopharmaceuticals are not drugs under the OPPS, we have chosen to establish separate payment for radiopharmaceuticals under the same packaging threshold policy that we apply to drugs and biologicals. We have also determined that we will apply the same adjustments to the median costs for radiopharmaceuticals that will apply to non-pass-through, separately paid drugs and biologicals.

Payment for New Radionucliide Therapy for Certain Forms of Non-Hodgkins Lymphoma

Currently, payment for the radiopharmaceutical Zevalin (Ibritumomab Tiuxetan) is packaged into the payment for HCPCS codes G0273 (Pretx planning, non-Hodgkins) and G0274 (Radiopharm tx, non-Hodgkins). To ensure consistency with our payment policy for other radiopharmaceuticals (that is, making separate payment for radiopharmaceuticals whose costs are greater than $150 per episode of care), we proposed to make payment for Zevalin (ibritumomab tiuxetan) separately from payment for the procedures with which Zevalin (ibritumomab tiuxetan) is used.

We proposed to use HCPCS A9522 (Indium 111 ibritumomab tiuxetan) to report the use of In-111 Zevalin (In-111 Ibritumomab Tiuxetan) and HCPCS A9523 (Yttrium 90 ibritumomab tiuxetan) to report the use of Y90 Zevalin (Y90 Ibritumomab Tiuxetan). We proposed to place HCPCS A9522 in

APC 9118 with a payment amount of $2,084.55 and HCPCS A9523 in APC 9117 with a payment amount of $18,066.09. We note that payment rates for radiopharmaceuticals are not subject to wage index adjustments because no portion of the payment is attributed to labor-related costs.

Because we proposed that payment for G0273 and G0274 no longer include payment for Zevalin, we also proposed to place G0273 into newly created APC 0406 and G0274 into newly created APC 0408. These APCs include procedures that are similar clinically and in terms of resource consumption to G0274 and G0273, respectively.

Zevalin (ibritumomab tiuxetan) is a radioimmunotherapy that is used to treat patients with certain forms of non-Hodgkin's lymphoma (NHL). Medicare began payment under the OPPS for Zevalin services furnished on or after October 1, 2002.

On June 27, 2003, the FDA approved the manufacture and sale of Bexxar (tositumomab and Iodine I 131 tositumomab), which is another radioimmunotherapy used to treat patients with certain forms of non-Hodgkin's lymphoma. Both Zevalin and Bexxar are therapeutic regimens administered in two separate steps: The first step is diagnostic to determine radiopharmaceutical biodistribution of radiolabeled antibodies; the second step is the therapeutic administration of targeted radiolabeled antibodies.

On September 8, 2003, we issued a One Time Notification (Transmittal 1, Change Request 2914) to implement payment for Bexxar effective for services furnished on or after July 1, 2003. We instructed hospitals to bill for Bexxar using HCPCS codes G0273 (Pretx planning, non-Hodgkins), G0274 (Radiopharm tx, non-Hodgkins), and G3001 (Administration and supply of tositumomab, 450mg). Publication deadlines precluded our being able to address payment for Bexxar in the August 12, 2003 proposed rule.

Comment: A major hospital association, a nuclear medicine specialty organization, several providers that treat cancer patients, and two radiopharmaceutical manufacturers submitted comments regarding the changes we proposed to the coding and payment for Zevalin (ibritumomab tiuxetan) under the 2004 OPPS. The commenters agree with our proposal to separate payment for Zevalin from the payment for the procedure and to pay for Zevalin using HCPCS codes A9522 and A9523, which would not be subject to a wage index adjustment. One commenter noted that the HCPCS descriptors for A9522 and A9523 define the unit of service as "per millicurie," but that the payment we proposed for these two codes appeared to be a total payment amount rather than a per millicurie rate. Several commenters recommended that the code descriptors for A9522 and A9523 be revised to read "per dose" rather than "per millicurie."

Response: We appreciate the commenters" support of our proposal to pay for Zevalin separately from its administration. We also agree with the commenter who suggested that the payment rate proposed for A9522 and A9523 was incorrectly shown as a total payment amount rather than a per millicure rate, and we have made certain that the final payment amounts implemented in the 2004 update are consistent with the code descriptor for the service. We further agree with the recommendation of commenters that the HCPCS descriptors for Indium 111 ibritumomab tiuxetan and Yttrium 90 ibritumomab tiuxetan would be less confusing if expressed in terms of dose rather than millicuries. However, the descriptors for A9522 and A9523 were established by the HCPCS National Panel through the process described on our Web site at *http://www.cms.hhs.gov/medicare/hcpcs/*, and such a descriptor change could not be applied for in time for January 1, 2004 implementation of the OPPS. Therefore, we are establishing two temporary C-codes for hospitals to use to bill under the OPPS for Indium 111 ibritumomab tiuxetan and Yttrium 90 ibritumomab tiuxetan, for services furnished beginning January 1, 2004, as follows:

C1082, Supply of radiopharmaceutical diagnostic imaging agent, indium-111 ibritumomab tiuxetan, per dose

C1083, Supply of radiopharmaceutical therapeutic imaging agent, Yttrium 90 ibritumomab tiuxetan, per dose

Comment: One commenter recommended that we create separate codes that parallel A9522 and A9523 to bill for Bexxar (tositumomab and I–131 tositumomab).

Response: We are establishing two temporary C-codes for hospitals to use to bill under the OPPS for I–131 tositumomab for services furnished beginning January 1, 2004, as follows:

C1080, Supply of radiopharmaceutical diagnostic imaging agent, I–131 tositumomab, per dose

C1081, Supply of radiopharmaceutical therapeutic imaging agent, I–131 tositumomab, per dose

Comment: Several commenters recommended that we discontinue use of HCPCS codes G0273 and G0274 to describe the administration of Zevalin and that, instead, we instruct hospitals to report new CPT code 78804, Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging, and new CPT code 79403, Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion. One commenter expressed concern about our proposal to assign G0273 for pre-treatment planning and administration of the diagnostic dose to APC 0406, Tumor/Infection Imaging because the payment rate proposed for APC 0406 ($258.10) is inadequate to pay for the cost of the scans required to measure the distribution of the radiopharmaceutical agent. The same commenter agreed with our proposal to assign G0274 for administration of the therapeutic dose to APC 0408, with a proposed payment rate of $217.16.

Response: We agree with the commenters' recommendations that we replace HCPCS codes G0273 and G0274 with CPT codes 78804 and 79403, respectively. We will direct our contractors to instruct hospitals to use CPT code 78804 to report administration of the diagnostic dose of ibritumomab tiuxetan and I–131 tositumomab and to report CPT code 79403 to report administration of the therapeutic dose of ibritumomab tiuxetan and I–131 tositumomab. We also agree with the concern of commenters that the payment amount for APC 0406 in the final rule is insufficient for administration of the diagnostic radiolabeled antibodies plus the imaging required to determine radiopharmaceutical localization of tumor(s) and distribution of the radiopharmaceutical agent. Therefore, we are assigning CPT code 78804 to New Technology APC 1508, which has a payment rate of $650. After we have had an opportunity to collect claims data that indicate hospital costs for this procedure, we will re-evaluate its APC assignment. Further, there are several additional expenses associated with these innovative radioimmunotherapies used to treat patients with certain forms of non-Hodgkin's lymphoma, which we discuss below. We are therefore assigning CPT code 70403 to New Technology APC 1507, until we have collected sufficient data to confirm the appropriate clinical APC for this service.

Comment: Several commenters expressed concern that our proposed payment for Zevalin ($2,084.55 for the diagnostic dose of indium and $18,066.09 for the therapeutic dose of

yttrium) would be approximately $2,000 less than what it costs a hospital to purchase Zevalin from a nuclear pharmacy, thereby jeopardizing beneficiary access to this therapy. One commenter submitted information from a nuclear pharmacy attesting that it has dispensed 2,068 patient-specific doses of Zevalin nationwide (1,071 Indium doses and 997 Yttrium doses) and that its current charges are $2,260 per dose of Indium-111 Zevalin and $19,565 per dose of Yttrium-90 Zevalin. The commenter stated that this represents nearly 80 percent of all Zevalin doses dispensed between product launch in April 2002 through June 30, 2003.

Another commenter expressed concern about the adverse impact that the proposed reduction in payments for Zevalin could have on payment for Bexxar in 2004. The commenter urged us not to base payment for Bexxar on what we proposed for Zevalin but, rather, on hospital acquisition costs for Bexxar, which approximate the wholesale acquisition cost (WAC) of $2,250 for the diagnostic dose and $19,500 for the therapeutic dose.

Response: Although we established a code to enable hospitals to bill for and receive separate payment for Zevalin effective October 1, 2002, hospitals could only report this code through December 31, 2002. (Effective January 1, 2003, we combined payment for Zevalin with its administration, using HCPCS codes G0273 and G0274.) Our 2002 claims data are insufficient to allow us to calculate a median cost for Zevalin. Because Bexxar was approved by the FDA in June 2003, it was not billed at all in 2002. Therefore, we cannot determine payment rates for either radiopharmaceutical based on the standard methodology that we use to calculate the other APC relative payment weights and rates. In instances where we lack adequate data upon which to base a payment rate, we have relied wholly or in part on external data as the basis for rate setting. For example, in the absence of claims data, we use data submitted in applications for new technology status to enable us to assign a service to an appropriate new technology APC. Elsewhere in this final rule, we discuss how we are using external data to set 2004 payment rates for certain other services and procedures.

We received information consistent with our request for verifiable data (68 FR 47998) that indicates the payment amounts we proposed for A9522 and A9523 in the proposed rule do not reflect the price for Zevalin that is widely available to the hospital market.

Therefore, we are making final the following payments, effective for services furnished on or after January 1, 2004:

For HCPCS code C1080 (APC 1080) the payment is $2,260;

For HCPCS code C1081 (APC 1081) the payment is $19,565; For HCPCS code C1082 (APC 9118) the payment is $2,260;

For HCPCS code C1083 (APC 9117) the payment is $19,565.

Comment: One commenter expressed concern about the inadequacy of the 2003 payment rate ($2,159) that we established for HCPCS code G3001, Administration and supply of tositumomab, 450mg. The commenter noted that the WAC for unlabeled tositumomab is $2,125, and that a payment amount of $2,159 is not sufficient to pay hospitals for both the acquisition of unlabeled tositumomab and its administration. The commenter was also concerned that packaging the unlabeled antibody tositumomab with its administration and assigning it to an APC that is subject to wage adjustment would result in large payment differences across the country. The commenter noted that the unlabeled antibody rituximab, which is used with Zevalin therapy, is a separately payable drug and therefore not subject to wage index adjustments. The commenter recommended that we either increase the payment rate for G3001 and exempt it from wage adjustment or that we create a new code for unlabeled tositumomab, assign a payment rate that reflects its acquisition cost, and pay separately for its administration using HCPCS code Q0084.

Response: After carefully reviewing the commenter's concerns, we have assigned HCPCS code G3001 to New Technology APC 1522, which has a payment rate of $2,250. Unlabeled tositumomab is not approved as either a drug or a radiopharmaceutical, but is a supply that is required as part of the Bexxar treatment regimen. Therefore, we do not agree with the commenter's recommendation that we assign a separate new code to unlabeled tositumomab. Moreover, administration of unlabeled tositumomab is a complete service that qualifies it for assignment to a New Technology APC. We believe that the increased payment resulting from assignment of G3001 to New Technology APC 1522 will be sufficient to enable hospitals to acquire and administer unlabeled tositumomab, notwithstanding application of a wage adjustment.

Comment: One commenter recommended that we modify the payment amounts for the existing codes used to bill for Bexxar or that we establish new codes to recognize the costs of patient evaluation, education, and clearance for radiation safety purposes as well as the costs of compounding Bexxar by radiopharmacies. The same commenter suggested that, as an alternative to establishing a new code for the costs associated with the procedures required for patient safety and education when Bexxar is used, we allow hospitals to report an appropriate Evaluation and Management code for patient evaluation, education, and clearance when receiving diagnostic or therapeutic services involving radioisotopes.

Response: We disagree with the commenter's recommendation that an additional code is needed to pay for radiopharmacy compounding costs or that an allowance of $1,000 should be added to the payment for the both diagnostic and therapeutic doses of Bexxar to offset these costs. We believe that the rates we are implementing in this final rule, as discussed above, provide sufficient payment for radiopharmacy compounding or delivery costs that hospitals may incur when using Bexxar or Zevalin. We have carefully considered the commenter's recommendation that hospitals be allowed to bill an appropriate evaluation and management code for patient evaluation, education, and clearance following procedures involving radioisotopes. We recognize that special requirements may have to be met before releasing a patient following exposure to a high dose of radiation. We would expect the patient's physician to provide, and bill for separately with appropriate documentation, a significant portion of the preparation and education needed by a patient being treated with Zevalin or Bexxar. However, to the extent that qualified hospital staff are required to provide additional face-to-face patient education and instructions before the patient's release following radioimmunotherapy, the hospital may bill an appropriate evaluation and management code as long as the medical record documents that the services are medically necessary and that they constitute a distinct, separately identifiable evaluation and management service that is consistent with the hospital's criteria for that service.

Drugs and Biologicals for Which Pass-Through Status Will Expire in 2004

Section 1833(t)(6)(C)(i) of the Act specifies that the duration of transitional pass-through payments for drugs and biologicals must be no less

than 2 years nor any longer than 3 years. The drugs and biologicals that are due to expire on December 31, 2003 meet that criterion. Table 11 lists the drugs and biologicals for which pass-through status will expire on December 31, 2003.

TABLE 11.—LIST OF DRUGS AND BIOLOGICALS FOR WHICH PASS-THROUGH STATUS EXPIRES CY 2004

HCPCS	APC	Long descriptor	Trade name	Pass-through expiration date
C9202	9202	Injection, suspension of microspheres of human serum albumin with octafluoropropane, per 3ml.	Optison (single source)	12–31–03
J0587	9018	Injection, Botulinum toxin, type B, per 100 units	Myobloc (single source)	12–31–03
J0637	9019	Injection, Caspofungin acetate, 5 mg	Cancidas (single source)	12–31–03
J7517	9015	Mycophenolate mofetil, oral per 250 mg	CellCept (single source)	12–31–03
J9010	9110	Injection, Alemtuzumab, per 10 mg	Campath (single source)	12–31–03
J9017	9012	Injection, Arsenic trioxide, per 1 mg	Trisenox (single source)	12–31–03
J9219	7051	Implant, Leuprolide acetate, per 65 mg implant	Viadur (single source)	12–31–03

Comment: A commenter requested that we maintain transitional pass-through status for this biological through calendar year 2004. The commenter indicated that Dermagraft was approved as a pass-through device effective October 1, 2000 through March 31, 2001, by which time CMS had concluded that Dermagraft should be classified as a biological for payment purposes. Dermagraft later re-qualified for pass-through status as a biological effective April 1, 2002. The commenter stated that CMS should not count the time Dermagraft was on the pass-through list as a device to determine whether this product received a minimum of 2 years under pass-through status.

Response: We agree with the commenter and will retain Dermagraft in pass-through status through December 2004.

Comment: The manufacturer of an ultrasound contrast agent, Optison (APC 9202, C9202), expressed concern about our decision to retire their product from pass-through status on December 31, 2003. The manufacturer indicated that two of Optison's competitors, Definity (C9112) and Imagent (C9203) will remain pass-throughs in 2004 and receive higher payments, while payment for Optison will be based on median cost calculated from hospital claims data. The commenter was concerned about differential OPPS payments to hospitals for clinically similar products and recommended that we should either allow all of these agents to remain on pass-through status until December 31, 2004, or remove them and use claims data to establish a uniform payment rate for 2004.

Response: As stated above, section 1833(t)(6)(C)(i) of the Act specifies that transitional pass-through payments for drugs and biologicals must be made for at least for 2 years but not more than 3 years. Pass-through payment for Optison was established on April 1, 2001, while Definity and Imagent received pass-through status on April 1, 2002 and April 1, 2003, respectively. Since hospitals have been billing for and receiving pass-through payments for Optison for at least 2 years, we have the statutory authority to remove this item from pass-through status. Since pass-through payments for Definity and Imagent have not exceeded the minimum 2-year period yet, these products will retain their special status in 2004. In the absence of verifiable external data, the 2004 payment rate for Optison was calculated using hospital claims data from April through December 2002 and was eligible for dampening.

2. Criteria for Packaging Payment for Drugs, Biologicals, and Radiopharmaceuticals

To the maximum extent possible, our intention is to package into the APC payment the costs of any items and supplies that are furnished with an outpatient procedure. For 2004, we proposed to continue with our policy of paying separately for drugs and radiopharmaceuticals whose median cost per day exceeds $150 and packaging the cost of drugs and radiopharmaceuticals with median cost per day of less than $150 into the procedures with which they are billed. In the proposed rule, we set forth the methodology we used to calculate the median cost per day for drugs, biologicals, and radiopharmaceuticals (68 FR 47996–47997).

We proposed to provide an exception in 2004 to the packaging rule for drugs and radiopharmaceuticals whose payment status would change as a result of using newer data. For 2004, we proposed that:

- Currently packaged drugs and radiopharmaceuticals with median costs per day at or above $150 would receive separate payment in 2004.
- Currently separately payable drugs and radiopharmaceuticals with median costs per day under $150 would continue to receive separate payment in CY 2004.
- Drugs whose pass-through status would expire on December 31, 2003, and whose median costs per day are under $150 would receive separate payment in 2004.
- Currently packaged drugs and radiopharmaceuticals with median costs per day below $150 would remain packaged in 2004.

We requested comments on the methodology we used to determine the median cost per day, on the threshold we proposed to use for packaging drugs and radiopharmaceuticals, and on the proposal to pay separately for drugs and radiopharmaceuticals whose payment status would change based on use of recent claims data and our proposed methodology. We also requested comments on alternatives to packaging.

We received many comments on our proposals, which are summarized below along with our responses.

Comment: We received many comments from patient advocates, individual clinicians, physician and nursing professional associations, individual hospitals, and manufacturers and their representatives that expressed significant concerns over our proposal to continue the 2003 policy under which we package the cost of most drugs, biologicals and radiopharmaceuticals that cost $150 or less. We also received several comments from major provider groups in support of the packaging proposal and recommending a higher threshold. One such organization recommends that we study this issue further to develop a more appropriate long-term solution.

Commenters who disagreed with the proposal to package drugs, biologicals and radiopharmaceuticals costing $150 or less believe that the proposed rates for the drug administration codes do not adequately address the costs of hospitals to administer these drugs. Several commenters conducted their own analyses of this issue in conjunction

with the proposals for drug administration discussed elsewhere in this final rule. For many of these commenters, the issues of packaging, drug payment rates and our discussion of drug administration in the proposed rule were intertwined. Some commenters that disagreed with our $150 packaging threshold asserted that most visits involve delivery of drugs that had been designated as packaged and that overpayment for visits with no packaged drugs is small compared to the overall underpayment of both packaged and separately payable drugs. Particular concern was expressed about the packaging of cancer chemotherapy drugs. One commenter stated that the dosages may vary significantly, and where given in high doses the cost for a single drug alone may exceed the total packaged payment. Also, commenters stated that several packaged drugs are often administered during a single infusion, and where the cost of a single packaged drug may be less than $150 the cost of multiple packaged drugs is often greater than $150.

Several commenters indicated that the methodology and cost data we used to calculate the median cost per day for drugs and radiopharmaceuticals were based on incorrectly coded claims where the wrong number of units were reported and a very limited number of single claims were captured which failed to portray the hospitals' charges appropriately. Therefore, certain high cost items fell below the $150 threshold.

Commenters expressed concern about patient access to effective but lower cost drugs and the disincentive we may create by paying separately for those over $150 per day. One organization stated that cancer centers have reported that they have taken or are considering steps to restrict patient access to those drugs that we have packaged. One hospital estimated that it would lose approximately $490 per visit for a patient receiving chemotherapy due to the $150 packaging rule and the proposed reductions in payments for certain drugs. While some commenters expressed general concerns about packaging the costs of any drugs, biologicals or radiopharmaceuticals, other commenters recommended that we apply a $50 threshold in lieu of the proposed $150 threshold in determining which items to pay for separately. Some of the commenters recommending a $50 threshold cited statutory changes under consideration by Congress that would mandate a $50 threshold.

Response: For 2004, we have established a $50 median cost per day threshold in determining whether drugs, biologicals and radiopharmaceuticals will be packaged. Those items that fall below the threshold will be packaged into the costs of the service or procedure with which they are billed; those items with median costs above the threshold will be paid for separately in 2004.

We analyzed our data in determining our final drug administration coding and payment policy, as discussed elsewhere in this final rule, and reviewed the median costs of all APCs under both a $150 and a $50 packaging rule. We concluded that there was not a sufficient difference in the median costs under those two scenarios, resulting in inadequate payment when drugs, biologicals and radiopharmaceuticals costing between $50 and $150 would be used by the hospital. Therefore, we agree with the majority of commenters that, for 2004, the appropriate threshold should be $50.

We also recognize, as several commenters did, that packaging creates incentives for hospital efficiencies and will continue to apply that concept to devices, most supplies and equipment associated with a procedural APC, and low cost drugs. However, we are convinced that under our current methodology for establishing relative weights, that packaging drugs, biologicals and radiopharmaceuticals costing in excess of the $50 threshold per patient per day would not provide adequate payment in 2004 and could adversely affect beneficiary access to important therapies. Nevertheless, our final decision for 2004 does not mean that a change in our methodology for establishing relative weights in the future could not cause us to revisit our packaging policy in the future. Since we have lowered the packaging threshold from $150 to $50, we will not adopt the proposal to provide an exception to the packaging rule for drugs and radiopharmaceuticals whose payment status would change from 2003 to 2004 as a result of using newer 2002 data.

However, we note several exceptions to our policy of packaging drugs, biologicals and radiopharmaceuticals for which the median per day cost is less than the $50 threshold. As discussed elsewhere in this final rule, we will allow separate payment under the OPPS for all blood and blood products and for single indication orphan drugs. We will also allow separate payment for hepatitis B vaccine under the OPPS. While the median per day costs for several hepatitis B vaccine codes fell below the $50 threshold using the final rule data, we believe that continued separate payment for these codes is warranted given the special, separate benefit category established by Congress. Separate payment for influenza and pneumococcal vaccines will continue to be made outside of the OPPS on a reasonable cost basis.

3. Payment for Drugs, Biologicals, and Radiopharmaceuticals That Are Not Packaged

In order to establish payment rates for separately payable drugs and radiopharmaceuticals for the 2004 OPPS, we first determined median cost for each drug and radiopharmaceutical per unit. When we compared the median cost per unit used for determining the 2003 payment rate (for example, the true or dampened median cost) for separately payable drugs and radiopharmaceuticals with their 2004 median cost per unit, we found fluctuations in costs from 2003 to 2004.

We solicited comments concerning the reasons for the fluctuations in median costs from 2003 to 2004. We stated our interest in determining whether these fluctuations reflect changes in the market prices of these drugs and radiopharmaceuticals or problems in the hospital claims data (for example, inaccurate coding, improper charges) that we use for setting payment rates.

In the proposed rule, we discussed in detail several options we considered to address the fluctuations in median costs for separately payable drugs and radiopharmaceuticals (68 FR 47997–47998). The option that we proposed for 2004 was a variation of the methodology used for the 2003 OPPS. For separately payable drugs and radiopharmaceuticals whose 2004 median costs decreased by more than 15 percent from the applicable 2003 median cost, we proposed to limit the reduction in median costs to one fourth of the difference between the value derived from claims data and a 15 percent reduction (for example, for a drug whose cost decreased by 35 percent from the applicable 2003 median cost, the allowed reduction from 2003 to 2004 would be 15 percent + (¼ times 35 − 15) percent = 20 percent). For separately payable drugs and radiopharmaceuticals whose median costs decreased by less than 15 percent from 2003 to 2004, we proposed to establish their payment rates using the median costs derived from the 2002 claims data. We stated that, based on more complete claims data we expected to have for the final rule and on the comments from the public, we would re-evaluate the appropriateness of adjusting median costs for drugs for which median costs would decline in 2004.

We also proposed a separate payment policy for drugs, biologicals, and radiopharmaceuticals for which generic alternatives have been approved by the Food and Drug Administration (FDA) between October 2001 and December 2002.

We solicited comment on both our proposed methodology and payment rates for separately payable drugs and radiopharmaceuticals for 2004. We requested that commenters who disagree with the proposed rate for a drug or radiopharmaceutical submit verifiable information to support their opinions that the proposed rate is inaccurate and does not reflect the price that is widely available to the hospital market.

We received a number of comments on our payment methodology options for separately payable drugs, biologicals, and radiopharmaceuticals. Those comments are summarized below along with our responses.

Comment: We received a number of comments noting disagreement with the proposed payment rates for separately paid drugs, biologicals and radiopharmaceuticals overall. Many of these comments were included in the comments on our packaging proposal, summarized above, and expressed some of the same concerns, such as restrictions to patient access, particularly to cancer chemotherapy drugs. One hospital commenting on the proposed rates stated that, as with most hospitals, they continually attempt to leverage buying power to reduce the costs of drugs but, like most hospitals, have been unable to do so for certain drugs. Commenters asked that we critically review the data used to establish the payment rates including consideration of the charge compression issue. Commenters stated that the proposed payments would not cover the direct acquisition costs of certain items.

A number of commenters objecting to our proposed payment rates stated that the hospital data that we use to calculate those rates are flawed and that the methodology we employ to convert hospital claims data to relative weights is problematic. Commenters attributed these concerns to issues such as hospital billing practices that result in inaccurate reporting of units or charges, HCPCS coding changes, and the use of cost-to-charge ratios across all products regardless of whether an item is high or low cost.

We received numerous comments on alternatives to our proposed policies for separately payable drugs and radiopharmaceuticals. One commenter suggested that we pay the amount of the hospital's acquisition cost plus an additional 25 percent to pay for costs of receiving, processing and storing the items. Other comments suggested that we limit the decreases for all separately paid drugs to a reduction of 10 percent in the payment rates, as we proposed for blood and blood products, instead of our proposed policy of limiting reductions in median costs for those separately paid items with median costs with reductions greater than 15 percent. Another suggestion was that we establish a payment rate floor for a product that could be raised if a manufacturer submitted information demonstrating that the rate should be higher than the floor.

Several commenters indicated that we should use only claims that have the appropriate administration or procedure code and the HCPCS code for a particular drug or radiopharmaceutical when determining the median cost for that drug or radiopharmaceutical. One commenter recommended that we pay for drugs and biologicals at 95% AWP to standardize payments for drugs and biologicals across different practice settings. Another commenter requested that we establish payment floors that are equal to those in the pending Congressional Medicare legislation (for example, certain sole source drugs would be paid at least 88 percent of AWP in 2004); whereas another drug manufacturer recommended that we use the Federal Supply Schedule price plus a certain percentage (for example, 12.5 percent) as an absolute minimum payment amount for drugs and radiopharmaceuticals.

In addition to the comments regarding our proposed payment rates for drugs, biologicals and radiopharmaceuticals overall, we received comments concerning the proposed rate for specific items. For a few of those items, we received external cost data that met the preferred criteria we set forth in our proposed rule (for example, non-proprietary data that demonstrates actual, market-based prices at which a broadly-based national sample of hospitals were able to procure the item). Several commenters suggested that we substitute external data on hospital acquisition cost for median costs calculated from our claims data when determining the payment rate for drugs and radiopharmaceuticals for which we have received such data. Others recommended that we use external data to benchmark payment for drugs and radiopharmaceuticals and make appropriate adjustments to the proposed 2004 payment levels. Even though most commenters supported the use of external data in place of hospital claims data, a national hospital association expressed concern about the use of external data in OPPS. The commenter indicated that if external data is used for rate setting in 2004, then we may have to continue to collect data on acquisition cost for future years to be able to continue to adjust the weights. Instead, the commenter was supportive of using claims data to set payment rates without the use of external data and urged us to remain committed to the averaging process inherent in the prospective payment system.

Response: We have decided to adopt the general principle proposed in our August 12, 2003 proposed rule limiting the reduction in median costs to one-fourth of the difference between the value derived from our claims data and a 15 percent reduction. For example, a drug whose median cost decreased by 35 percent from the median cost used to establish the separate payment rate for 2003 would be 15 percent + (¼ times 35–15) percent, or 20 percent. However, we will not apply this methodology to the medians of those drugs, biologicals and radiopharmaceuticals that are packaged in 2003 but for which we will allow separate payment in 2004. Payment for drugs, biologicals and radiopharmaceuticals that emerge from packaged status in 2004 because their median per day costs are greater than $50 per day will be based on the unadjusted median cost derived from our April–December 2002 claims data. Since these items are packaged in 2003, we did not calculate any adjusted medians on which to base their payments on for 2003. Thus, we are unable to determine the extent to which their median costs fluctuate from 2003 to 2004.

As discussed in our proposed rule and elsewhere in this final rule, we used a more complete set of claims for the April–December 2002 claims period and the most recently submitted cost report data to calculate median costs for all currently separately paid drugs, biologicals and radiopharmaceuticals. Our analysis of the later and more complete data revealed that a number of these items continued to experience a decline of more than 15% in median cost. We again considered several options to address the fluctuations in medians, which for some items would result in wide fluctuations in payments to hospitals. One option was to do nothing to adjust for the fluctuations; another option was to apply a more modest give-back (for example, 50 percent instead of 75 percent, after allowing for the 15 percent reduction.) We also considered the comments we received on drug payments in general and for specific items.

We did not adopt the options that would allow no adjustments for items separately paid in 2003 where the costs declined because we were convinced by the many commenters on this topic that such fluctuations create problems for the hospitals. We were also convinced by the commenters that a less generous give-back, such as 50 percent, would not adequately address the very real concerns about patient access to some of these drugs, particularly for cancer chemotherapy. We believe that, for the majority of items paid separately in 2003 for which the more recent hospital data indicates a reduction in excess of 15 percent, the adjustment methodology we proposed and that we are adopting for this final rule provides an adequate buffer for the hospitals against dramatic fluctuations in payment amounts while at the same time not significantly affecting the budget neutrality scalar applied to the relative weights for all services.

We believe that either the use of our unadjusted medians or, where applicable, a median adjusted to limit reductions greater than 15 percent methodology, will not adversely impact beneficiary access. However, we were convinced by the external data meeting our preferred criteria and the related comments that we received for several items, the payment rates resulting from our data alone could provide a disincentive for hospitals to provide these particular therapies. Therefore, we have determined that we will use this credible and relevant external data to establish a median cost for the following items listed in table 15. For these items, as with the few device-related APCs for which we are considering external data, we have calculated an adjusted median cost by blending the median cost derived from our dampening methodology with the cost data from the external sources on a one-to-one ratio.

TABLE 12.—LIST OF DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS FOR WHICH BLENDED DATA WERE USED TO DETERMINE 2004 PAYMENT RATES

APC	HCPCS	Short descriptor	2004 adjusted median cost	External acquisition cost	2004 1:1 Blended median cost
0909	J1825	Interferon beta-1a	$159.16	$231.25	$195.21
9022	Q3025	IM inj interferon beta-1a	53.05	77.08	65.07
0902	J0585	Botulinum toxin a	2.86	3.92	3.39
7000	J0207	Amifostine	241.95	369.49	305.72
1624	Q3007	Sodium phosphate p32	49.18	100.00	74.59
1625	Q3008	Indium 111-in pentetreotide	400.41	550.00	475.21
1305	C1305	Apligraf	659.55	1,077.57	868.56

We note that we also received external data for other items, which we did not use for rate setting. In those cases, we determined the data was not reliable because the data did not meet the preferred criteria set forth in the August 12, 2003 proposed rule.

Comment: One commenter raised a concern about our proposal to limit reductions in the median costs of non-pass-through drugs and biologicals to one-fourth of the difference between the actual decline and 15% less than the 2003 adjusted median. While expressing support for an initiative that reduces significant fluctuation in APC payment rates from one year to the next, the commenter expressed uncertainty about the size of the reduction limitation and suggested that CMS consider a less generous dampening approach since the budget-neutral dampening would negatively affect other APCs.

Response: While we believe that a general limitation on reductions in payments for certain drugs and biologicals is warranted for reasons discussed elsewhere in this final rule, we also recognize the commenter's concerns about the effect that such a policy would have on other APCs. We have decided to address the commenter's concern by placing an upper limit on adjustments to the median costs used to calculate the 2004 payment rates. We believe that it is reasonable to place such an upper limit on the dampening so that the resulting adjusted median is no greater than 95 percent of AWP or the 2004 unadjusted median. We reviewed the drugs, biologicals, and radiopharmaceuticals whose median costs decreased by more than 15 percent from 2003 to 2004. We then compared the adjusted median (after dampening) to 95 percent of AWP for each of the items. In cases where 95 percent of AWP was higher than the adjusted median, we capped the adjusted median at a value that was the higher of 95 percent of AWP or the 2004 unadjusted median. The 95 percent of AWPs for these drugs and radiopharmaceuticals were calculated using AWP values from the Redbook that were effective as of April 1, 2003. We reviewed the drugs, biologicals, and radiopharmaceuticals whose median costs decreased by more than 15 percent from 2003 to 2004. We then compared the adjusted median (after dampening) to 95 percent of AWP for each of the items. In cases where 95 percent of AWP was higher than the adjusted median, we capped the adjusted median at a value that was the higher of 95 percent of the AWP or the 2004 unadjusted median. The drugs, biologicals, and radiopharmaceuticals affected by this policy are listed in the table below.

TABLE 13.—ITEMS WHOSE 2004 ADJUSTED MEDIANS ARE CAPPED AT THE HIGHER OF 95 PERCENT OF AWP OR THEIR 2004 UNADJUSTED MEDIAN

APC	Description	2004 adjusted median	95% AWP	2004 unadjusted median
1095	Technetium TC 99m depreotide	$216.26	$40.00	$17.18
0820	Daunorubicin	89.80	78.14	65.81
0961	Albumin (human), 5%, 50 ml	41.86	15.31	16.15
0963	Albumin (human), 5%, 250 ml	204.03	58.00	62.83
0964	Albumin (human), 25%, 20 ml	46.10	15.31	21.86
0965	Albumin (human), 25%, 50 ml	114.36	30.63	51.12

4. Payment for Drug Administration

In order to facilitate accurate payments for drugs and drug administration, we considered whether to make several changes in our current payment policy with regard to payment for Q0081, Q0083, Q0084, and Q0085.

We proposed to continue our current policy of packaging drugs and radiopharmaceuticals that cost less than $150 per episode of care into the APC with which they are associated (for example, nuclear medicine scans, drug administration).

In the proposed rule, we presented data that showed that paying based on a median cost for the APC for each of the four current codes generally results in underpayment when packaged drugs are billed on the claim and overpayment when separately paid drugs are billed on the claim. In the proposed rule we discussed our data analysis in detail. We also discussed four alternatives to the current codes and APC payments in detail (68 FR 47999–48003). In summary, the 4 alternatives presented were:

1. Maintain the current codes and APCs with payments based on the median costs of all claims in the APC.

2. Eliminate the four current codes and create eight new codes to enable hospitals to report that they administered a packaged drug or a separately paid drug. We would pay a different APC amount for each of the eight new codes. The new code descriptors would parallel those of the current codes. This would retain the concept of using one code rather than two when both "infusion" and administration of chemotherapy by "other than infusion" occurred (as exists under the current codes). Coders would have to look up the drugs administered to know which code to bill.

3. Eliminate the four current codes and create six new codes to enable hospitals to report that they administered a packaged drug or separately paid drug and pay a different APC amount for each of the six new codes. In this option, no code equivalent to Q0085 would exist. Therefore, when administering chemotherapy by "infusion" or "other than infusion," hospitals would report two codes, one for administration by "infusion" and one for administration by "other than infusion." This would eliminate the need to use one code when both infusion and another method of administration of chemotherapy occurred. Coders would have to look up the drugs administered to know which code to bill.

4. Retain three of the current codes (Q0081, Q0083, and Q0084) but delete Q0085 (infusion and other administration of chemotherapy) and modify the OCE to use the drugs billed on the claim to assign an APC for packaged drugs or an APC for separately paid drugs. No drug administration code could be paid without a drug also being reported on the claim. We solicited comments on each of the options in the proposed rule.

For 2004 OPPS we will continue the use of Q0081, Q0083 and Q0084 to pay for drug administration, for both packaged drugs and separately paid drugs. These drug administration codes will continue to describe the administration of drugs per visit. As recommended by the APC Panel, we will cease to make payment under OPPS for Q0085 and will instead permit the services described by Q0085 to be billed using both Q0083 and Q0084. We believe that this will result in appropriate payment for drug administration because for 2004 OPPS we will pay separately for drugs for which the per day median cost is in excess of $50 per day.

Comment: Commenters stated that appropriate payment for drug administration is very important but the options provided for making changes would be extremely burdensome and cannot be done for 2004, if ever. They indicated that the risk of incorrect coding and the adverse consequences of incorrect coding for options 2, 3 or 4 are severe and that the payment changes do not justify the change in codes or policy. Commenters indicated that options 2–4 would increase operational costs that would eliminate any benefit from higher payments; decrease accuracy of coding for drug administration; increase improper payments due to decreased accuracy of coding; increase inaccuracies in claims data due to decreased accuracy of coding. The commenters indicated that they believe that there were many errors in the addenda (Addenda L, M, N, O, P, and Q) in the proposed rule that would be used for option 4 and that it would be virtually impossible to create mutually exclusive lists of drugs as would be required to implement option 4.

Commenters indicated that they believed the options as presented in the NPRM would violate the HIPAA requirements that the same service be coded the same way for all payers. They urged CMS to eliminate the Q codes for drug administration and in favor of use of the CPT codes to code drugs administration. Commenters asked that CMS engage the APC Panel in a discussion of the best way to code drug administration.

One of the commenters indicated that its analysis showed that options 2, 3 or 4 have considerable financial risk for Medicare. Specifically, the commenter indicated that its analysis revealed that option 2 would result in additional payments of $107.1 million for 2004. A commenter asked that CMS create a task force to study the most appropriate methodology for payment for drug administration and for setting payment rates. A commenter supported option 4, which would continue the current coding and map the combination of a drug administration code and drug codes to the appropriate APC. One commenter suggested that we continue the current coding for drug administration, set payment rates at the packaged drug rate for the APC but offset the payment by the difference if no appropriate drug is billed for the same date of service. The commenter indicated that this would simplify the coding and the payment for drug administration and should result in greater accuracy of payment. A commenter supported options 2 or 3 as the most accurate for payment of drugs furnished in the emergency department.

Response: For the reasons discussed earlier in this section, for 2004, CMS will continue use of Q0081, Q0083 and Q0084. Q0085 will not be recognized as a valid OPPS code for 2004. Instead, when a hospital furnishes chemotherapy infusion and chemotherapy via another route, the hospital will bill and be paid for both Q0083 and Q0084. Coding for drug administration is discussed in greater detail below in the context of other comments.

As discussed in elsewhere in this final rule, for 2004, CMS will pay separately for all drugs, biologicals and radiopharmaceuticals that have a per day median cost in excess of $50. Therefore, only drugs, biologicals and radiopharmaceuticals that have a per day median cost of $50 or less will be packaged into the payment for the services. Therefore, the payment for drug administration codes Q0081, Q0083 and Q0084 will be based on the median costs for drug administration with only drugs having a median per day cost of $50 or less packaged into the cost of the administration code. We believe that separate payment for drugs with a median cost in excess of $50 will result in the drug administration codes being paid more accurately and will result in more equitable payment for both the drugs and their administration.

Edits To Ensure Correct Billing for Drugs

Comment: A commenter asked that CMS create a series of edits in the OCE that would facilitate the collection of better data on drug costs and drug administration. Specifically, the commenter wants the OCE to edit out claims where a drug administration code is billed with no drug code on the claim; where a chemotherapy drug administration code is billed with a revenue code 25X and no specific HCPS code; and where multiple units of a drug administration code are billed on the same line.

Response: We will consider what edits may be appropriate for inclusion in the OCE with regard to drug administration to facilitate collection of better data. However, we are concerned that edits of the type requested by the commenter may both impose greater billing burden on hospitals and create complexities that could delay claims processing.

Discounting of Non-Chemotherapy Administration

Comment: Commenters indicated that no multiple procedure reduction should be applied to Q0081 (infusion of drugs other than chemotherapy) or its successor codes under any of the options. They indicated that payment is already too low to cover the cost of the infusion and that reducing it further when there are more costly procedures on the claim will only further under pay the service.

Response: We have retained the status indicator of "T" for Q0081. This status indicator means that the code will be reduced by 50 percent if it is the lower priced service on the same claim with another procedure with the status indicator "T". In most cases, we expect that this reduction would occur when there is a separate procedure performed on the same day as the infusion and that there will be significant efficiencies in administering an infusion. If the infusion is performed by itself or with a visit, or with a service with status code "S", the multiple procedure reduction will not apply.

Payment for Drug Administration on a Per Day Versus a Per Visit Basis

Comment: Commenters indicated that it would be incorrect to revise the definition of the drug administration codes to be per day instead of per visit, as they are currently defined. They referred to many cases in which it is necessary for a patient to have more than one administration of non-chemotherapy drugs in a day and that hospitals should be able to bill multiple units of the applicable code when that occurs. They noted that the APC Panel supported this view with regard to Q0081, infusion of non-chemotherapy drugs. They asked that CMS provide explicit instructions regarding billing for drug administration and ensure that fiscal intermediaries are bound to comply with the national instructions. One commenter asked that CMS create modifiers or specific HCPCS codes to reflect administration of multiple chemotherapy agents during a single session and that CMS permit payment for more than one chemotherapy administration on the same day of service, with a new modifier to reflect truly separate administrations.

Response: We acknowledge the commenters' concerns about our proposal to change the drug administration codes from a per visit basis to a per day basis and have not revised the definition of the drug administration codes from per day to per visit.

CPT Codes for Drug Administration

Comment: Many commenters suggested that CMS should delete the HCPCS alphanumeric codes for drug administration and should use existing CPT codes. They indicated that the APC Panel supports this change and that it would be less burdensome for providers than using the HCPCS alphanumeric codes. One commenter presented a crosswalk that could be used to pay under the current drug administration APCs while permitting hospitals to bill using CPT codes. A commenter indicated that hospitals already maintain start and stop times for infusion therapies and that, therefore, the use of CPT codes for infusion would not be more burdensome than the current HCPCS codes.

Response: For the reasons discussed earlier in this section, for 2004 OPPS, administration of infusion of non-chemotherapy drugs, infusion of chemotherapy drugs and administration of chemotherapy by other than infusion, will continue to be billed and paid based on Q0081, Q0083 and Q0084. However, we take seriously the requests of the commenters and the APC Panel that we should use the CPT codes to pay for drug administration. We will seriously consider the crosswalk submitted and will discuss it with the APC Panel at its winter meeting. We also will pursue a means by which the existing data from 2003 hospital claims, which exist only for the Q codes, which are per visit, can be used to pay for services billed under the CPT infusion codes, which are on a per hour basis.

Elimination of Q0085 Chemotherapy Administration by Both Infusion and Other Technique

Comment: Several commenters supported elimination of Q0085 and the continued use of Q0083 and Q0084 in place of Q0085.

Response: As indicated above, we will no longer recognize Q0085 for payment of drug administration services for 2004. The code could not be deleted from HCPCS because the 2004 HCPCS was complete before the NPRM comment period closed. Instead, hospitals will bill and be paid for both Q0083 and Q0084 when they furnish chemotherapy by both infusion and another route.

Charge Compression Reduction Through Revenue Code Requirements and Expansion of Revenue Codes

Comment: A commenter indicated that CMS could reduce charge compression effects by requiring hospitals to do detailed coding of drugs using the most specific categories of revenue codes. The commenter indicated that CMS would also need to create additional revenue codes to collect more specific information. The commenter indicated that collection of drug charge information at such detailed levels would both reduce charge compression and give CMS more information when determining which drugs to package to specific drug administration services.

Response: CMS will not require that specific revenue codes be used for drugs and will not ask the National Uniform Billing Committee to create additional revenue codes to collect more specific information. Revenue codes exist for hospital accounting purposes and, in general CMS does not require that particular services be billed with particular revenue codes. We are not convinced that adding specific requirements for revenue coding or expanding the revenue codes to acquire more specific information will result in better data or that the end result would be cost effective in terms of its potential effect on hospital operations. We believe that such requests to the NUBC should be generated by the provider community if it believes such changes would be in their overall best interest.

Request for Clarification of Instructions

Comment: Commenters said that CMS needs to develop and issue clear national instructions on how drug administration in the OPD should be billed and to ensure that fiscal intermediaries all comply uniformly with the instructions. They said that in the absence of national instructions,

fiscal intermediary medical directors have developed and enforced local medical review policies that vary considerably from one another, resulting in very different interpretations of how services should be billed and of the amount of payment for the same set of circumstances. They specifically recommend that we address issues including how often drug administration codes can be billed in a day, billing for piggyback infusions, how to bill units of service, billing for pain control pump services, double infusions, and use of chemotherapy administration codes for patients with non-cancer diagnoses. The commenter also asked for clarification of the use of 90782 (IM injection) and 90784 (IVP injection) when used for sedation before surgery, Q0081 when used to keep a vein open, and Q0083 with regard to whether it should be billed each time a chemotherapy drug is administered. A commenter also asked that CMS clarify whether HCCPS codes Q0081, Q0083, Q0084 and Q0085, CPT codes 90783, 90784 and 90788 may be billed more than once per visit. The commenter indicated that CMS previously said that CPT codes 90782–90788 may be billed separately for each injection and asked if this is a change to CMS policy in this regard.

Response: CMS will develop program instructions regarding how the drug administration codes should be used. We will attempt to address the specific questions identified in the comments in the course of developing those instructions. When the instructions are issued, they will be binding on all Medicare fiscal intermediaries under their contract with CMS. In the absence of national instructions, Medicare fiscal intermediaries have authority to develop local medical review policies governing billing, coverage and payment.

With regard to the issue of how often in a day Q0081, Q0083 and Q0084 may be billed, each of these codes is to be used to report all services in a single visit, regardless of the number of drugs administered during that visit. Therefore, if two chemotherapy drugs are administered by intravenous injection and 3 chemotherapy drugs are administered by infusion, the hospital would bill 1 unit of Q0083 and 1 unit of Q0084. A second unit of either code would only be billed if the patient left the OPD after completion of the first administration and then returned later for a separate encounter for administration of another chemotherapy drug. If the patient leaves the OPD and returns later in the day suffering from dehydration and requires infusion of fluids and infusion of antiemetics, the hospital would bill Q0081 for those services. If the patient returns later in the same day for another infusion of one or more chemotherapy drugs that could not be administered at the earlier infusion for medical reasons, the hospital may bill 2 units of Q0084.

CPT codes 90782–90788 each represent an injection and as such, one unit of the code may be billed each time there is a separate injection that meets the definition of the code.

As indicated above, drugs for which the median cost per day is greater than $50 are paid separately and are not packaged into the payment for the drug administration codes with which they are billed. *See* Addendum B for the 2004 OPPS payment amount for separately paid drugs, which are indicated with both payment amounts and status indicator "K."

Proposed Payment Rates for Drug Administration

Comment: Commenters indicated that the proposed payment rates for drug administration are too low to adequately compensate hospitals for the costs of packaged drugs. They indicated that there is some confusion over the resultant decrease in drug administration medians after low cost drugs ($50–$150) were packaged into the drug administration codes. The expectation was that the addition of the drug costs would result in increases. Moreover, they stated that the payment rates for drug administration services that include drugs that cost $50 to $150 per day, are so low that none of the rates are adequate to cover cases for which multiple drugs of $100 each are administered.

A commenter who is particularly concerned with immunosuppressive drugs that are needed by beneficiaries following organ transplants, indicated that in 2000, Congress directed the Secretary of HHS to prepare a report to Congress containing recommendations regarding a cost effective way of providing coverage for immunosuppressive drugs to promote the objectives of improving health outcomes by decreasing transplant rejection rates attributable to failure to comply with immunosuppressive drug therapy and to achieve Medicare cost savings by preventing the need for secondary transplants and other care related to post transplant complications (Pub. L. 106–113). The commenter believes that packaging transplant drugs into the payment for drug administration and the proposal of such a low amount of payment defeats Congress's stated intention in this case and will decrease beneficiary access to immunosuppressive drug therapy following transplant surgery.

Response: We believe that making separate payment for both the procedure and drugs for which there is a median per day cost in excess of $50, will result in appropriate payment for the procedure with which the drug is billed. In the case of the HCPCS codes for administration of drugs per visit (Q0081, Q0083 and Q0084), compared to the proposed payments published in the NPRM, payments for the procedures do not decline by much when calculated without packaged drugs that have medians of $50 to $150. Therefore, we believe that total payments will be more appropriate for these drugs in 2004.

With respect to post-transplant immunosuppressive drugs, we would note that take-home supplies of such drugs are billed to the Durable Medical Equipment Regional Carriers and paid for separately outside of the OPPS. To the extent that such drugs fall below the $50 median cost per day, we expect the frequency of administration in the hospital outpatient setting to be low.

Coding for Drugs

Comment: A trade association representing drug manufacturers supported our proposal to require hospitals to report individual codes for all drugs, including those that are packaged, on the grounds that it would improve the quality of our data. Most commenters representing hospitals and hospital associations opposed the proposal. They indicated that the operational impact on hospitals would be significant, if we were to implement such a requirement. It would take a year or more to update chargemasters and train staff, and many more codes would have to be established for drugs that are administered but not identified in the current HCPCS. Hospitals and hospital groups did not support detailed reporting of routine, low cost drugs and supplies that are currently reported only using a packaged revenue code. A commenter stated that if CMS were to choose to require drug and/or device coding, CMS should give hospitals at least a year to prepare to implement the requirement and work with hospitals to identify all drugs and devices that would require codes, develop HCPCS codes with dosage descriptions that match the administered or purchased dose, assign HCPS to all administered drugs, clarify reporting of self-administered drugs and drugs considered integral to a procedure under OPPS, and identify applicable drugs and devices in hospital

chargemasters. Commenters indicated that the use of "unclassified drugs" and "unclassified biologicals" would increase if hospitals are required to bill all drugs and that such a requirement would result in less reliable data for CMS at great cost to hospitals, with no measurable benefit. Some commenters indicated that the use of unclassified codes would create significantly more work for hospital staff and Medicare contractors. One commenter was concerned that this requirement would force hospitals to contort internal ordering and billing systems in order to match HCPCS codes to unrelated packaged dosage amounts, thereby significantly increasing the potential for error in the administration of drugs and putting patient safety at risk.

Response: Because we are not implementing any of the new drug administration coding requirements that we proposed, the need for more detailed drug coding is removed. Therefore, we are not requiring hospitals to report with a HCPCS code every drug that is administered to a patient. However, in order to receive payment for a drug for which a separate payment is provided, hospitals will have to continue to bill for the drug using revenue code 636, "Drugs requiring detail coding," and report the appropriate HCPCS code for the drug. Drugs for which separate payment is allowed are designated by status indicator "K" in Addendum B. Hospitals should continue to bill for packaged drugs, which are assigned status indicator "N," using any of the drug revenue codes that are packaged revenue codes under the OPPS: 250, 251, 252, 254, 255, 257, 258, 259, 631, 632, or 633. Hospitals are not required to use HCPCS codes when billing for packaged drugs, unless revenue code 636 is used. Although we are not requiring hospitals to report HCPCS codes for packaged drugs, it is essential that hospitals continue to bill charges for packaged drugs by including the charge for packaged drugs in the charge for the procedure or service with which the drug is used, or as a separate drug charge (whether or not it is separately payable). Reporting charges for packaged drugs is critical because packaged drug costs are used for calculating outlier payments and are also identified when we calculate hospital costs for the procedures and services with which the drugs are used in the course of the annual OPPS updates.

Comment: Several commenters recommended that CMS establish a unique revenue code for radiopharmaceuticals that hospitals would be required to use when reporting all radiopharmaceuticals, whether packaged or separately payable. They indicated that establishing a unique revenue code would assist CMS in tracking costs for the radiopharmaceuticals and contribute to more accurate cost data collection.

Response: We do not establish revenue codes. Rather, the National Uniform Billing Committee (NUBC) receives and considers such requests from multiple sources, including providers and other members of the public. While we continue to examine cost-to-charge and cost compression issues, we will consider whether such an approach would assist CMS in refining our methods of establishing relative weights. We would also note that the commenters and other interested parties may also request that the NUBC consider the creation of new revenue codes.

Comment: Several commenters expressed concern about the frequent coding changes implemented for radiopharmaceuticals over the past two years. They recommended that CMS revise the HCPCS coding descriptors for products that do not currently have "per dose" or "per study" descriptors to reflect the products as they are administered to the patient. They emphasized that creating these new descriptors and corresponding payment rates will improve data collection and help to ensure equitable payment to hospitals.

Response: We recognize the concerns expressed by these commenters. However, we are striving to achieve stability in descriptor changes, and we believe that in changing descriptors to "per dose", we will lose specificity with respect to the data we will receive from hospitals. We are not convinced that there is a programmatic need to change the radiopharmaceutical code descriptors to "per dose" and that our claims data are problematic for setting payment rates for these products; however, we will continue to work with industry representatives to ensure that the current HCPCS descriptors are appropriate and review this issue in the future, if needed. Furthermore, we stress the importance of proper coding by providers so that we can get accurate data for future rate setting.

Comment: One drug manufacturer urged CMS to advise hospitals that it is appropriate for them to set charges for drugs submitted to Medicare for OPPS services so that the charges reflect actual product costs when charges are multiplied by hospital and cost-center-specific ratios of cost-to-charges. The commenter also requested CMS to not rely on data obtained in the absence of such advice. A comment from a national hospital organization, however, advised CMS to permit hospitals to continue to establish their charge structures and mark-up policies separate and apart from CMS's payment policies. The commenter indicated that only in this manner would prospective payments appropriately reflect general trends in charges and mark-ups across all hospitals.

Response: We do not regulate what hospitals charge for hospital services and will not advise hospitals regarding how to determine the charge for an item or service. Hospital charges have fundamental uses and the use of charges to determine relative costs for OPPS should not be the determining factor in how a hospital sets its charge for any item or service. The OPPS is a system based upon the relative costs of services and these costs are developed by applying the hospital's most recent cost to charge ratio to the charges of the hospital for the item. While we recognize that the system is imperfect, we believe that on average, it results in appropriate relative weights. However we recognize that on occasion, this is not true and therefore, as discussed elsewhere, we have used external data where we believe that the median derived from claims data does not appropriately reflect the relative cost of the item or service.

Comment: One commenter requested that we change the status indicator for HCPCS code J7599 (Immunosuppressive drug, not otherwise classified) from "E" to "N" so that new immunosuppresives can be identified on claims forms as a separate line item until a unique pass-through "C" code can be assigned to the product.

Response: We agree that the status indicator for J7599 should be "N" and have made that change for CY 2004. As for other new drugs and biologicals, interested parties may submit an application for pass-through status for new immunosuppressives.

Coding for Drugs Billed as Supplies

Comment: Commenters said that CMS significantly complicated the issue of billing for drugs when it indicated that drugs that are an integral part of the procedure should be billed as supplies (revenue code 270) rather than as pharmaceuticals (revenue code 250).

Response: We did not issue instructions to require that drugs that are an integral part of a surgical procedure be billed using revenue code 270 (supplies) rather than revenue code 250 (pharmaceuticals). Rather, we instructed hospitals to report drugs that are treated as supplies because they are

an integral part of a procedure or treatment under the revenue code associated with the cost center under which the hospital accumulates the costs for the drugs. (See section XXIV.D of Transmittal A–02–129, issued on January 3, 2003.)

In general, supplies that are an integral component of a procedure or treatment are not reported with a HCPCS code. The charges for such supplies are typically reflected either in the charges on the line for the HCPCS for the procedure or on another line with a revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report.

Correct Coding Initiative Edits

5. Generic Drugs, and Radiopharmaceuticals

In general, hospital acquisition costs for drugs, biologicals, and radiopharmaceutical agents with generic competitors are lower than the acquisition costs for sole source or multi-source drugs. In order to ensure that Medicare recognizes these lower costs in a timely manner, we proposed a new method of calculating payment amounts for drugs, biologicals, and radiopharmaceuticals that are separately paid under the OPPS and for which the Food and Drug Administration (FDA) has recently approved generic alternatives.

Because many hospitals have long term purchasing arrangements for drugs and radiopharmaceuticals, we believe that there is generally a 12-month lag between the time that generic items are made available and when our claims data will accurately reflect the costs associated with the availability of the generic alternative. Therefore, during the interval between FDA approval of a generic item and the time when we would reasonably expect claims data to reflect the cost of generic alternatives, we proposed to adopt the following methodology to price the affected drugs, biologicals, and radiopharmaceuticals under the OPPS.

We proposed to identify items approved for generic availability by the FDA during the 6 months before the first day of the claims period we use as the basis for an annual OPPS update. Where we determine that our claims data do not reflect the costs of generic alternatives for a separately payable drug, biological, or radiopharmaceutical, we proposed to base our payment rate on 43 percent of the AWP for the drug, biological, or radiopharmaceutical.

To apply this payment methodology to the 2004 OPPS update, we reviewed FDA approvals for generic drugs, biologicals, and radiopharmaceuticals issued between October 2001 and December 2002. We found six drugs, which we proposed to be separately paid under the 2004 OPPS that had generic alternatives approved during that time. These drugs are: Daunorubicin, Bleomycin, Pamidronate, Paclitaxel, Ifosfomide, and Idarubicin. Table 21 shows the dates when the FDA approved generic alternatives for these drugs.

We solicited comments on this proposed method of calculating payment for drugs, biologicals, and radiopharmaceuticals for which generic alternatives have recently been approved. Specifically, we were interested in comments concerning our proposed methodology for identifying these items, whether we properly identified all the items, and whether our proposed payment policy for these generic alternatives is appropriate.

We received many comments on our proposal regarding generic drugs and radiopharmaceuticals, which are summarized below along with our responses.

Comment: One commenter applauded CMS's efforts to lower payment for generic products to an amount more closely aligned with hospital acquisition cost. However, the commenter indicated that payment for generic cancer products would continue to be excessive and contribute to an environment where hospitals may offer treatments using less effective chemotherapy products. Alternatively, comments from a national hospital association and numerous manufacturers stated that the presence of generic alternatives in the market does not necessarily result in cost savings for hospitals. They indicated that established multi-year contracts may prevent providers from switching immediately to generic alternatives. As a result, providers would not realize any cost savings from buying the generic products until the conclusion of their existing contract, which in some cases may be a few years after the generics are available in the market. Commenters also indicated that it is quite common for shortages of generic equivalents to occur when they first appear in the market. Thus, there is no guarantee that sufficient quantities of generic alternatives will be available in the marketplace for all providers to purchase them. Furthermore, adoption of generic drugs by hospitals is also affected by whether the providers determine they are safe to use in comparison to the brand name products. One commenter recommended that CMS continue to use its 2002 claims data to set the payment rated for these drugs.

Response: We appreciate these insightful comments and agree with the commenters that the time it takes for hospitals to realize cost savings (or price decreases) from purchasing generic products is longer than we initially expected because of the various reasons described by the commenters. Further research on this issue also shows that cost savings due to competition between generic and name brand drugs can vary. One reason is that in some cases regulations allow the first generic marketed to compete with a name brand drug to have a period of exclusivity during which time no other generics may come on the market. This period of exclusivity may mean that cost savings during this period of exclusivity are less than cost savings that occur once more than one generic is put on the market. For 2004, we believe that calculating payment rates for generics according to the methodology discussed above would not sufficiently take into consideration the true costs incurred by hospitals for purchasing generic products. Therefore, we believe that it is appropriate to calculate the payment rates for generics according to the same methodology used for other separately payable drugs and radiopharmaceuticals.

6. Orphan Drugs

In the proposed rule we stated that we no longer believe that paying for orphan drugs at reasonable cost, outside of OPPS is appropriate, and we proposed the following payment policy:

- We proposed to continue using the same criteria to identify single indication orphan drugs (67 FR 66772).
- We proposed to discontinue retrospective cost payments and to make prospective payments under the OPPS for those identified single indication orphan drugs.
- We proposed to base payments on the same methodology we use to pay for other drugs including any limitation on payment reductions (as described above).
- We proposed to make separate payment for the single indication orphan drugs and place them in APCs.

The 11 single indication orphan drugs that would be affected by our proposal are: (J0205 Injection, alglucerase, per 10 units; J0256 Injection, alpha 1-proteinase inhibitor, 10 mg; J9300 Gemtuzumab ozogamicin, 5 mg; and J1785 Injection, imiglucerase, per unit); J2355 Injection, oprelvekin, 5 mg; J3240 Injection, thyrotropin alpha, 0.9 mg;

J7513 Daclizumab parenteral, 25 mg; J9015 Aldesleukin, per vial; J9160 Denileukin diftitox, 300 mcg; J9216 Interferon, gamma 1–b, 3 million units; and Q2019 Injection, basiliximab, 20 mg.

We solicited comments on these proposals and requested that commenters submit information meeting the same criteria as comments for other drugs (as discussed above). We received numerous comments, all of which were in opposition to our proposals regarding payment for orphan drugs.

Comment: Every commenter who commented on the changes we proposed regarding payments for single indication orphan drugs opposed our proposal to discontinue payment for orphan drugs on a reasonable cost basis and to instead use the same methodology to set payment amounts for the single indication orphan drugs that we use to set rates for other drugs. Commenters stated that doing so would create serious access problems for patients who rely on an orphan drug for treatment of a rare disease because hospitals would no longer be able to afford to treat them. A number of commenters were particularly concerned by the decreased payment rate proposed for alpha-1-proteinase inhibitor. Some pointed out that the data we used to calculate payments for orphan drugs are especially flawed because of the low volume, high cost characteristics of orphan drugs, complicated by errors in the way hospitals bill for drugs generally. Recommendations from commenters included: applying the dampening rule to limit decreases to 10% of reasonable cost payments in 2003; establishing a payment floor; and, continuing to pay for orphan drugs on a reasonable cost basis.

Response: We carefully reviewed commenters' concerns about the impact our proposal would have on patient access to orphan drugs. We do not dispute that orphan drugs used solely to treat an orphan condition are generally expensive and, by definition, are rarely used. We also recognize that coding changes may have resulted in questionable billing data. However, we believe that it is important to balance these concerns with maintaining a consistent payment system for hospital outpatient department services overall, and to limit to the maximum possible extent payment for services or items outside the OPPS. We also discussed in the August 12 proposed rule our concerns about the increased number of drugs that meet our criteria for special payment status as single indication orphan drugs and the resulting increase in the number of hospital outpatient services that would be paid outside the OPPS were we to continue to pay for these drugs on a reasonable cost basis. It was in light of these factors that we proposed to discontinue payment for single indication orphan drugs on a reasonable cost basis outside the OPPS and to use our claims data as the basis for setting payment rates for those drugs that we have identified as meeting our criteria for special payment status as single indication orphan drugs. We also proposed to pay separately for the single indication orphan drugs and to assign each of them to an APC.

Having weighed the concerns raised by commenters and our concerns about the increasing number of outpatient services that would be paid outside the OPPS were we to continue the current policy of paying for single indication orphan drugs on a reasonable cost basis, we have decided that beneficiaries, hospitals, and the Medicare program will be best served over the long term by our making payment for the single indication orphan drugs under the OPPS at 88 percent of the AWP. We arrived at 88 percent based on our analysis of claims data, and our intent that payment be sufficient to ensure that all beneficiaries have access to needed drugs. Among the 11 orphan drugs, the highest median cost in the claims data was approximately 78 percent of the AWP. After considering comments we received on the proposed rule, we were concerned that merely adopting the existing highest percentage of the AWP may not ensure that a sufficient payment amount is established in all cases prospectively. We therefore have provided for an additional margin of ten percentage points to account for possible future increases, and ensure sufficient payment. This results in the percentage of 88 percent that we have adopted in this final rule.

However, we received information consistent with our request for verifiable data (68 FR 47998) that indicates the payment amounts we proposed for alpha-1 proteinase inhibitor, for imiglucerase, and for alglucerase do not reflect the price at which these drugs are widely available to the hospital market. This information, combined with the concerns expressed by commenters generally that the payment amounts we proposed for the 11 drugs that meet our criteria for special payment as single indication orphan drugs are too low and may threaten beneficiary access to the drugs, have persuaded us to make final one modification to the method we proposed for setting payment rates for drugs that are paid as single indication orphan drugs under the OPPS. That is, rather than using claims data to calculate payment rates for single indication orphan drugs that meet our criteria for special payment under the OPPS, we are setting payment for all but two of these drugs at 88 percent of their AWP as established in the April 1, 2003 single drug pricer (SDP). As discussed above, we received information about the widely available market price for imiglucerase and alglucerase, and, based on that information, we have priced these two drugs at 94 percent of their AWP.

We believe that this policy is a reasonable compromise. It enables us to set a prospective payment amount under the OPPS for qualified single indication orphan drugs. But, by increasing payment levels for these low volume drugs, we minimize the risk of compromising beneficiary access to treatment for life-threatening, rare diseases.

Therefore, we have set payment rates for single indication orphan drugs in accordance with the following policy, effective January 1, 2004:

- We are using the same criteria that we implemented in CY 2003 to identify single indication orphan drugs used solely for an orphan condition for special payment under the OPPS;
- We are discontinuing payment on a reasonable cost basis for single indication orphan drugs furnished in the outpatient department of hospital that is subject to the OPPS;
- We are making separate payment for single indication orphan drugs and assigning them to APCs;
- We are setting payment under the 2004 OPPS for single indication orphan drugs at 88 percent of the AWP listed for these drugs in the April 1, 2003 single drug pricer unless we are presented with verifiable information that shows that our payment rate does not reflect the price that is widely available to the hospital market.

Comment: Several commenters objected to our special treatment for only 11 orphan drugs, rather than including all of the drugs that the FDA designates as having orphan status. A few commenters recommended that we set the criteria for special treatment based on claims volume instead of our current criteria. That is, CMS would set a criterion for "high volume" drugs based on a threshold of 30,000 or more claims per year. Then, any FDA-designated orphan drug with less than the threshold volume of claims would be subject to special payment under the OPPS as an orphan drug.

Response: Using the statutory authority at section 1833(t)(1)(B)(i) of

the Act, which gives the Secretary broad authority to designate covered OPD services under the OPPS, we have established criteria which distinguish these 11 drugs from other drugs designated as orphan drugs by the FDA under the Orphan Drug Act. Our determination under this authority to provide special payment for a subset of FDA-designated orphan drugs does not affect FDA's classification of drugs under the Orphan Drug Act. Because these 11 drugs have a low volume of patient use, lack other indications, and have no other source of payment, we allow special treatment of them so beneficiaries can continue to have access to them. Because these 11 drugs are used solely to treat an orphan condition that affects a relatively low number of beneficiaries, hospitals receive payment for a low volume of cases by definition, and the cost of the drug is not spread across other uses. We are concerned that if we were to adopt the commenter's recommendation that we qualify all FDA-designated orphan drugs under a particular volume threshold for special payment under the OPPS, we could be expanding this special payment provision, which is meant to target the small number of orphan drugs that are used solely to treat rare diseases, to drugs that are used for other conditions and indications, for which hospitals would also be receiving payment. Therefore, we are not adding a volume threshold to our criteria for identifying orphan drugs that receive special payment under the OPPS in 2004.

7. Vaccines

Outpatient hospital departments administer large amounts of the vaccines for influenza (flu) and pneumococcal pneumonia (PPV), typically by participating in immunization programs. In recent years, the availability and cost of some vaccines (particularly the flu vaccine) have fluctuated considerably. As discussed in the November 1, 2002 final rule (67 FR 66718), we were advised by providers that OPPS payment was insufficient to cover the costs of the flu vaccine and that access of Medicare beneficiaries to flu vaccines might be limited. They cited the timing of updates to OPPS rates as a major concern. They said that our update methodology, which uses 2-year-old claims data to recalibrate payment rates would never be able to take into account yearly fluctuations in the cost of the flu vaccine. We agreed and decided to pay hospitals for influenza and pneumococcal pneumonia vaccines based on a reasonable cost methodology. As a result of this change, hospitals, home health agencies (HHAs), and hospices were paid at reasonable cost for these vaccines in 2003. We are aware that access concerns continue to exist for these vaccines; therefore, we proposed to continue paying for influenza and pneumococcal pneumonia vaccines under reasonable cost methodology.

We received no comments regarding our payment proposal for vaccines, and finalize our proposal in this rule.

8. Blood and Blood Products

Since the OPPS was first implemented in August 2000, separate payment has been made for blood and blood products in APCs rather than packaging them into payment for the procedures with which they were administered. We proposed to continue to pay separately for blood and blood products.

The list of APCs containing blood and blood products can be found in the November 1, 2002 final rule (67 FR 66750). We note that the APCs for these products are intended to make payment for the costs of the products. Costs for storage and other administrative expenses are packaged into the APCs for the procedures with which the products are used.

As described in the November 1, 2002 final rule (67 FR 66773), we applied a special dampening option to blood and blood products that had significant reductions in payment rates from 2002 to 2003. For 2003, we limited the decrease in payment rates for blood and blood products to approximately 15 percent.

After careful comparison of the 2003 dampened medians with the 2004 medians from our claims data, we determined that establishing payment rates based on the 2004 median costs would, for many blood and blood products, result in payments that are significantly lower than hospital acquisition costs. In order to mitigate any significant payment reductions and to minimize any compromise in access of beneficiaries to these products, we proposed a 10 percent limit to decreases in payment rates for blood and blood products from 2003 to 2004.

We solicited comment on this proposal, especially from hospitals. Specifically, we solicited comments that include verifiable information about the widely available acquisition cost of commonly used blood and blood products.

We received several comments on this proposal, which are summarized below along with our responses.

Comment: Several hospital groups supported the recommendation made by the APC Panel at its August 22, 2003 meeting and urged us to consider freezing 2004 payment rates for blood and blood products at the 2003 levels. A few commenters recommended that CMS use data provided by suppliers of blood and blood products to help set payment rates for 2004. Two commenters stated that major blood organizations are prepared to share the data for verification with CMS. Another commenter recommended that CMS base payments on either reasonable cost or external data.

Response: After carefully reviewing the concerns expressed by commenters and analyzing the further reductions in payment that would result from using our 2002 claims data, even with the 10 percent limit on payment decreases that we proposed, we are convinced that our payments would be considerably lower than what it costs hospitals to acquire blood and blood products. Further, we are mindful of the increasing number of tests required to ensure the safety of the nation's blood supply, which is adding to the cost of processing blood and blood products. Therefore, in order to ensure that our beneficiaries have uninterrupted access to safe blood and blood products, we agree with the recommendation of commenters and the APC Panel that we freeze payments for blood and blood products in 2004 at 2003 payment levels rather than implement our proposal to limit payment decreases to 10 percent. This will enable us to undertake further study of the issues raised by commenters and by presenters at the August APC Panel meeting, without putting beneficiary access to blood and blood products at risk. Therefore, effective for services furnished on or after January 1, 2004, the payment rates for blood and blood products will not change from their 2003 levels.

Comment: One commenter was concerned that while autologous blood and directed donor blood do not have separate CPT codes, hospitals' costs to obtain them are different. Hospitals can only report charges for the autologous blood unit if the patient receives it; otherwise, hospitals must absorb the cost of the autologous donation. The same commenter also suggested that CMS research the issue of whether providing blood to patients with special needs would increase hospital costs. The commenter stated that hospitals do not receive additional payment when conducting national searches to meet special blood needs. Another commenter was concerned that drugs and biologicals were dampened to a

lesser extent than blood and blood products. The commenter requested that CMS discontinue the differential dampening and apply the dampening rule equally.

Response: The commenter's concerns about rules governing payment for autologous blood and the costs associated with procuring blood for patients with special needs fall outside the scope of our proposed rule. These questions require further analysis and study, which we cannot undertake in time for implementation of the 2004 update of the OPPS. However, as we examine the current policies that affect payment for blood and blood products under the OPPS, we will consider both of the commenter's concerns.

As for the comment regarding adoption of a uniform dampening policy for both separately payable drugs as well as blood and blood products, this concern is no longer an issue because of our decision to freeze payment rates for blood and blood products at their 2003 levels for 2004.

Comment: Several commenters requested that CMS provide and promote guidance on correct coding and billing for blood and blood products to hospitals and other providers.

Response: We acknowledge the need for comprehensive billing and coding guidelines for hospitals and other providers. This is an area we expect to address in the near future.

9. Intravenous Immune Globulin

In the proposed rule, we discussed public comments suggesting that we reclassify intravenous immune globulin (IVIG) as a blood and blood product. We stated that after a review of claims data, we believe that payment for these products is appropriate using the methodology we proposed to implement for other drugs and biologicals. Therefore, we proposed to continue to classify IVIG as a biologic. We solicited comments on this proposal.

We received several comments on this proposal, which are summarized below along with our responses.

Comment: Several trade associations, manufacturers, patient organizations and individual commenters urged CMS to classify intravenous immune globulin (IVIG) under the "blood and blood product category." They indicated that IVIG is derived from plasma fractionation similar to other products categorized as a blood and blood product by CMS; and, furthermore, IVIG falls within the FDA's definition of "blood and blood product." Some of the commenters expressed concern about the potential negative impact on patient access as a result of our proposed payment policy. Another commenter requested that we consider all plasma-derived products and their recombinant analogs as blood products.

Response: We appreciate these comments. However, we continue to believe that IVIG and other plasma-derived therapies and their recombinant analogs are comparable to other drugs and biologicals, and they do not have the same access concerns as other blood and blood products. Our policy regarding IVIG and plasma therapies were described in the November 1, 2002 final rule (67 FR 66774). For 2004, IVIG will be a separately payable item, and its payment rate will be based on approximately 26,500 claims for approximately 1.5 million services. As mentioned in the August 12, 2003 proposed rule (68 FR 48005), analysis of the claims data indicated that hospital costs and billing practices for IVIG have been consistent over the past two years. Therefore, we believe that the 2002 claims data contain a sufficiently robust set of claims for IVIG on which to base the payment rate for this item using the methodology that will be used for other separately payable non-pass-through drugs, biologicals, and radiopharmaceuticals.

10. Payment for Split Unit of Blood

Since implementation of the OPPS, we have assigned status indicator "E" to HCPCS code P9011, blood (split unit). Status indicator "E" designates services for which payment is not allowed under the OPPS or services that are not covered by Medicare. P9011 was created to identify situations where one unit of red blood cells or whole blood, for example, is split and half of the unit is transfused to one patient and the other half to another patient. Because use of split units is not uncommon, we proposed to change the status indicator for P9011 from "E" to "K" and assign it to a blood and blood product APC that pays approximately 50 percent of the payment for the whole unit of blood. We proposed to assign P9011 to APC 0957 (Platelet concentrate) with a payment rate of $37.30. We invited comments on this proposed change in the status indicator and payment amount for P9011.

We received a few comments on this proposal, which are summarized below along with our responses.

Comment: Commenters pointed out that there was a typographical error in the proposed rule in which we referred to the split unit of blood as P9010 rather than P9011.

Response: We agree this was an error and have corrected it in this preamble and are making final our proposal to assign P9011 to APC 0957 (platelet concentrate).

11. Other Issues

We proposed to continue our payment policy for Procrit and Aranesp for calendar year 2004. As explained in detail in the November 1, 2002 final rule (67 FR 66758), Aranesp and Procrit are in separate APCs, and are paid at equivalent rates with the application of a ratio to convert the dosage units of Aranesp into units of Procrit. We indicated that we might refine the conversion ratio as soon as feasible based on information not available at the time we established the current conversion ratio.

We have continued to gather information regarding an appropriate conversion ratio by reviewing recent published studies and data from alternative sources. In the proposed rule, we stated that we remain open to establishing a different conversion ratio in the final rule if we conclude that a change is warranted based on public comments and information submitted during the public comment period and/or any other information we consider in developing the final rule. Therefore, we proposed to continue with the current policy regarding payment for Procrit and Aranesp, including the current conversion ratio. We solicited comments on this issue and we stated that we would base any changes to our current payment policy for these two drugs only on data that we could make available to the public.

We received several comments on this proposal, which are summarized below along with our responses.

Comment: We received several comments concerning payment under the OPPS for erythropoietin and an erythropoietin-like product. Specifically, the comments pertained to payment for Aranesp™ (marketed by Amgen) and Procrit™ (marketed by Ortho Biotech) under the OPPS and the decision we made for 2003 with respect to an appropriate conversion ratio to ensure that these products, which use the same biological mechanism to produce the same results, are paid at the same rate .

Response: Erythropoietin, a protein produced by the kidney, stimulates the bone marrow to produce red blood cells. In severe kidney disease, the kidney is not able to produce normal amounts of erythropoietin and this leads to the anemia. Additionally, certain chemotherapeutic agents used in the treatment of some cancers suppress the bone marrow and cause anemia. Treatment with exogenous erythropoietin can increase red blood

cell production in these patients and thus treat their anemia.

In the late 1980's, scientists used recombinant DNA technology to produce an erythropoietin-like protein called epoetin alfa. Epoetin alfa has exactly the same amino acid structure as the erythropoietin humans produce naturally and, when given to patients with anemia, stimulates red blood cell production.

Two commercial epoetin-alfa products are currently marketed in the United States: Epogen™ (marketed by Amgen) and Procrit™ (marketed by Ortho Biotech). These products are exactly the same but are marketed under two different trade names. Both Epogen™ and Procrit™ are approved by the FDA for marketing for the following conditions: (1) Treatment of anemia related to chronic renal failure (including patients on and not on dialysis), (2) treatment of Zidovudine-related anemia in HIV patients, (3) treatment of anemia in cancer patients on chemotherapy, and (4) treatment of anemia related to allogenic blood transfusions in surgery patients. Both products are given either intravenously or subcutaneously up to three times a week.

Amgen developed a new erythropoietin-like product, darbepoetin alfa, which it markets as Aranesp™. Also produced by recombinant DNA technology, darbepoetin alfa differs from epoetin alfa by the addition of two carbohydrate chains. The addition of these two carbohydrate chains affects the biologic half-life of the compound. This change, in turn, affects how often the biological can be administered, which yields a decreased dosing schedule for darbepoetin alfa by comparison to epoetin alfa. Amgen has received FDA approval to market Aranesp™ for treatment of anemia related to chronic renal failure (including patients on and not on dialysis) and for treatment of chemotherapy-related anemia in cancer patients.

Because darbepoetin alfa has two additional carbohydrate side-chains, it is not structurally identical to epoetin alfa. However, the two products use the same biological mechanism to produce the same clinical results—stimulation of the bone marrow to produce red blood cells.

These biologicals are dosed in different units. Epoetin alfa is dosed in Units per kilogram (U/kg) of patient weight and darbepoetin alfa in micrograms per kilogram (mcg/kg). The difference in dosing metric is due to changes in the accepted convention at the time of each product's development. At the time epoetin alfa was developed, biologicals (such as those developed through recombinant DNA) were typically dosed in International Units (IU or Units for short), a measure of the product's biologic activity. They were not dosed by weight (for example, micrograms) because of a concern that weight might not accurately reflect their standard biologic activity. The biologic activity of such products can now be accurately predicted by weight, however, and manufacturers have begun specifying the doses of such biologicals by weight. No standard formula exists for converting amounts of a biologic dosed in Units to amounts of a drug dosed by weight.

In the clinical management of individual patients, CMS recognizes that no precise method of converting an epoetin alfa dose to a darbepoetin alfa dose has yet been established for any of the approved clinical uses. There are general guidelines for conversion and clinicians modify the dose based on the patient's hematopoietic response after the start of treatment with the new biological. For the purpose of developing a payment policy, however, it is feasible to establish a method of converting the dose of each of these drugs to the other. This payment methodology is intended to reflect average dosing requirements for the entire Medicare target population, and is not intended to serve as a guide for dosing individual patients.

As part of the process to define and further refine a payment conversion ratio between these biologicals, CMS held a series of meetings with representatives from both Amgen and Ortho Biotech. Both companies provided substantial new data, both published and unpublished. We also reviewed the Food and Drug Administration labeling for each product (EpogenTM, ProcritTM, and AranespTM), hired an independent contractor to review the available clinical evidence, and performed an internal review of this evidence as well. CMS took into consideration both published and unpublished studies as well as abstracts, conference reports, clinical guidelines, marketing material, and other reports and materials provided by Amgen and Ortho Biotech.

As noted in the OPPS final rule for 2003, CMS was interested in having a "head-to-head" comparison of epoetin alfa to darbepoetin alfa either in patients with chronic kidney disease or in cancer patients with chemotherapy-induced anemia, and in which appropriate outcome measures were used. Because no head-to-head study has yet been completed, CMS also considered clinical studies that either compared both products to each other or that linked the dose of a particular product with an appropriate health outcome measure. For the 2003 OPPS, we held a series of meetings with both Amgen and Ortho Biotech. We examined the written and published information provided by both companies, reviewed the FDA labeling for each product, hired an independent contractor to review available clinical evidence and performed an internal review of the evidence as well. In our review, we placed the greatest emphasis on published, high quality clinical studies and looked for the best possible estimates based on an evaluation of the dosing of each product that, on average, produced the same clinical response. Based on our own review of the evidence, our consultation with the independent contractor who also reviewed the evidence, and our discussions with each company, we established a conversion ratio for purposes of payment in 2003 of 260 International Units of epoetin alfa to one microgram of darbepoetin alfa (260:1).

Since publication of the OPPS final rule for 2003, we have continued to review and refine our analysis of the appropriate conversion ratio between these biologicals. In order to facilitate analysis of the non-peer reviewed materials submitted by Amgen and Ortho Biotech, we initiated a process in July 2003, in which each company shared with CMS, our contractor, and each other, a detailed description of the methods used in each of their unpublished clinical studies. Each company was then asked to submit to us their comments as well as the responses to questions raised by the other company's review. Finally, based on our analysis of this information, CMS submitted questions to each company to clarify their views. The final payment conversion ratio is based on our analysis of the information submitted during the process described above, as well as claims analysis, and other publicly available information.

Chemotherapy-induced anemia: The articles submitted by the manufacturers regarding treatment of chemotherapy-induced anemia (CIA) were all observational, retrospective, cohort studies. Several of these studies were conducted with a high degree of attention to minimizing avoidable bias and maximizing data integrity. Observational studies are, however, unavoidably subject to patient selection bias since study subjects are not randomly assigned to the groups being compared. It is not possible to eliminate the possibility that the choice of

erythropoetic agent was somehow systematically linked to characteristics of the patients treated. Similarities or differences in clinical response may reflect either baseline patient characteristics or the effects of the therapy being studied.

Another major limitation of observational studies is that the researcher typically has no control over the manner in which the intervention under study has been delivered. In this instance, an additional difficulty with using observational studies to assess the equivalence of dosages of epoetin alfa and darbepoetin alfa in chemotherapy-induced anemia in cancer patients is that the response to these drugs may be disease-driven, dosage-driven, or both (depending for example, among other factors, on the individual cancer patient's level of endogenous erythropoietin). A large range of dosages of both epoetin alfa and darbepoetin alfa may show similar effects in any given patient and higher than necessary dosages may not be reflected in greater elevations of hemoglobin. More generally, the populations in the reported studies may show different results due to differences in demographics, health status, types of cancer, and cancer treatments.

Beyond these methodological concerns, the question of what constitutes the best indicator of drug effect remains unsettled. Studies in the literature have used one or more of the following end-points to analyze the effects of erythropoietic drugs:

1. Hemoglobin response—an increase from baseline of >2 g/dL (usually in the absence of transfusion in the preceding 28 days)
2. Hematopoietic response—Hemoglobin increase of >2g/dL from baseline or a hemoglobin >12g/dL
3. Mean change in hemoglobin "the mean increase in hemoglobin from baseline (usually in the absence of transfusion in the preceding 28 days)
4. Transfusions of red blood cells "the number (percent) of patients requiring transfusion measured at various time intervals.

Studies submitted by one of the manufacturers proposed additional measures such as "early hemoglobin response" (the hemoglobin rise from baseline at 4 or 5 weeks) and the "area under the curve" defined by hemoglobin increases from baseline. The FDA has not used these measures as criteria for registration (i.e., market approval) and they do not appear to be regularly used in the peer reviewed literature of erythropoietic drugs and their use either in kidney disease or in oncology. Therefore, their clinical significance is unclear at this time. They do, however, raise the question of how hemoglobin response patterns affect symptoms that matter most to patients. Both companies are conducting additional clinical studies to address further the potential importance of front-loaded regimens that provide high initial doses of erythropoietic drugs in order to stimulate a more rapid clinical response.

During the process of exchanging and critiquing study methods, Amgen and Ortho-Biotech each raised significant methodological concerns about the study designs used to obtain new data. In addition to the overall concern about the observational methodology and selection of the outcome chosen for purposes of comparison, the following concerns were raised:

—the use of survival curves to analyze clinical data in this context
—the possible effect of patient functional status on erythropoietic response
—the technique for calculating mean values for drug dosages (arithmetic vs geometric means)
—the strategy for deciding how to handle data from patients who received transfusions
—the significance of an early rise in hemoglobin, and/or the significance of measures of hemoglobin response over the entire 12–16 week treatment interval

Each company provided extensive and compelling discussions of these and other issues, highlighting the fact that conclusions regarding the relative potency of these products are inherently limited by the nature and quality of the clinical data that currently exist. Despite the limitations of the available studies, CMS believes that it has sufficient data to establish a reasonable conversion ratio for payment purposes.

Amgen submitted several observational studies, including one community-based study and three medication use evaluations (MUE). While interim results from two of these studies have been published in peer-reviewed journals, final results have not yet been subjected to full peer review. In one study (Vadhan-Raj, 2003), patients were started on darbepoetin at 3 mcg/kg every other week (QOW). The patients received up to 8 doses (16 weeks). The patients had hemoglobin (Hgb) responses comparable to that seen with epoetin 40,000–60,000 IU per week. The protocol allowed a dose increase and 43 percent of participants had their darbepoetin dose increased to 5 mcg/kg/QOW per the protocol. Virtually all of the Amgen studies produced results that suggested a conversion ratio of 400:1.

Ortho Biotech submitted early unpublished results from a multicenter head-to-head trial of 40,000 IU of epoetin weekly compared to 200 mcg of darbepoetin every other week. The primary end-point is the change in Hgb from baseline at week 5, and initial results show significantly greater increase in Hgb for patients treated with epoetin. Ortho Biotech also submitted data from several retrospective analyses of medical charts and electronic medial records, totaling several thousand patients. None of these studies have yet been peer-reviewed or published. All of the Ortho-sponsored studies provide results suggesting that the appropriate conversion ratio is 260:1 or less.

In the observational studies that directly compare Aranesp and Procrit for the treatment of CIA, and report total dose per patient per episode of both epoetin and darbepoetin, the ratio of mean total doses is 341:1 and the ratio of median total doses is 352:1. However, selection bias may affect the validity of these studies. CMS therefore believes that the above-mentioned ratios may still overestimate, at least modestly, the potency of darbepoetin alfa relative to epoetin alfa. An analysis of Medicare claims data from 2002 and 2003 determined that the ratio of utilization of Procrit to Aranesp in Medicare patients was 330:1 (units:mcg).

As noted above, a conversion ratio between the dosages of these two products is not meant to guide what should be done for individual patients in clinical practice. In addition, by using a conversion ratio CMS is not attempting to establish a lower or upper limit on the amount of either biological a physician can prescribe to a patient. CMS expects that physicians will continue to prescribe these biologicals based on their own clinical judgment of the needs of individual patients.

Based on our own review of the evidence, our consultation with the independent contactor who also reviewed the evidence, and our discussions with Amgen and Ortho Biotech, CMS concludes that an appropriate conversion ratio for the purposes of a payment policy is 330 International Units of epoetin alfa to one microgram of darbepoetin alfa (330:1) for the purpose of treating chemotherapy-induced anemia.

Chronic Kidney Disease without dialysis: It is well established that as a patient progresses through the stages of chronic kidney disease (CKD), erythropoietin levels decline and anemia tends to develop. Furthermore,

CKD patients are a very heterogeneous population, and it is likely that they will need varying doses of erythropoietic drugs as their CKD progresses to ESRD. At the present time there are no head-to-head randomized controlled clinical trials that look at erythropoietic drug needs across the spectrum of CKD.

Amgen presented studies that examined the effect of darbepoetin on hemoglobin in this population. Two studies showed a dose conversion ratio (DCR) range between 215–330. These were observational studies similarly affected by the methodological weaknesses of this study design previously discussed for chemotherapy-induced anemia. A third study submitted by Amgen showed a DCR of 168:1 and is the only study that prospectively looked at darbepoetin and epoetin.

We estimate that no more than 10 percent of the Medicare patients who receive darbepoetin in the hospital outpatient setting receive it solely because of CKD. As a result, at this time, we believe that it could be confusing and burdensome for hospitals as well as the Medicare claims processing systems to use different HCPCS codes assigned to different APCs in order to distinguish and pay different amounts for darbepoetin used by patients with CIA from darbepoetin used by patients with CKD. Therefore, given the heterogeneity of the population, the general paucity of scientific evidence on CKD, the estimated low incidence of CKD-only indications in the OPPS population, and the potential burden on providers of requiring different codes for different indications, we are not establishing a different payment rate for darbepoetin for CKD at this time. However, CMS invites the submission of peer reviewed clinical data to further illuminate the issue. Therefore, we are going to use a 330:1 conversion ratio for CKD also and, therefore, a single APC payment rate for darbepoetin alfa, in 2004.

VII. Wage Index Changes for CY 2004

Section 1833(t)(2)(D) of the Act requires that we determine a wage adjustment factor to adjust for geographic wage differences, in a budget neutral manner, that portion of the OPPS payment rate and copayment amount that is attributable to labor and labor-related costs.

We used the proposed Federal fiscal year (FY) 2004 hospital inpatient PPS wage index to make wage adjustments in determining the proposed payment rates set forth in the proposed rule. We also proposed to use the final FY 2004 hospital inpatient wage index to calculate the final CY 2004 payment rates and coinsurance amounts for OPPS. Therefore, we have used the corrected final FY 2004 hospital inpatient wage index to make wage adjustments in determining the final payments rates set forth in this final rule. The corrected final FY 2004 hospital inpatient wage index published as Tables 4A, 4B, and 4C in the October 6, 2003 **Federal Register** (68 FR 57732 through 57758) is reprinted in this final rule as Addendum H—Wage Index for Urban Areas; Addendum I—Wage Index for Rural Areas; and Addendum J—Wage Index for Hospitals That Are Reclassified. We used the corrected final FY 2004 hospital inpatient wage index to calculate the payment rates and coinsurance amounts published in this final rule to implement the OPPS for CY 2004. We note however, that from time to time, there are mid-year corrections to these wage indices and that our contractors will adopt and implement the mid-year changes for OPPS in the same manner that they make mid-year changes for inpatient hospital prospective payment.

We received several comments on how we apply the wage index in setting rates.

Comment: Commenters stated that we should exempt the device portion of the median cost from wage adjustment. They indicated that the wage index reflects the variation in wages and that applying it to 60 percent of an APC payment where part of that payment is for devices, to which the wage index is not applicable, results in inappropriately low payments in rural areas and discourages the expansion of state of the art technologies to rural hospitals. A commenter indicated that we should work with the commenter to calculate and publish a list of the device percentages for each APC and that the wage index adjustment should not be applied to that portion of the APC.

Response: To apply the wage index only to the non-device portion of the APC payment will mean a significant revision to the methodology used to calculate the relative weights and the conversion factor as well as changes to the system that applies the wage index on individual claims. When we calculate median costs, we divide 60 percent of the cost by the wage index for the hospital to neutralize the cost for the effects of the wage index. In addition, when we determine the conversion factor, we calculate a wage adjustment scalar to adjust for any increase or decrease that may occur to total payments from changes in the wage index. Moreover, it cannot be assumed that not applying the wage index to the device portion of the APC payment will result in increased payment for APCs that require devices. In localities that have high wage indices, this change could result in reductions in payments for device APCs. For example, if the wage index is 1.5 and the national APC payment is $10,000, the wage index applied to 60 percent of the APC increases the payment to the high wage index hospital to $13,000. If the wage index is 0.9, the wage index applied to 60 percent of the APC decreases the payment to the hospital to $9,400. However, if the wage index is applied only to 20 percent of the APC payment because 80 percent of the cost of the APC is for the device, the hospital in the high wage index area will now get $11,000 (a $2,000 loss) and the hospital in the low wage index area will now get $9,800 (a $400 gain).

Also, because the wage index is used to neutralize costs derived from charges and is a factor in the conversion factor, the $10,000 payment in the example may change. To gauge the full impact of such a change, we would have to undertake significant statistical analysis. We will continue to apply the wage index to 60 percent of the APC for 2004. However, we recognize the need to reassess whether this percentage is correct in view of the packaging of high cost devices into APCs and will make every effort to do a reassessment for 2005 OPPS proposed rule. If we determine that a change to the percentage might be appropriate, we will propose it in the 2005 OPPS NPRM.

VIII. Copayment for CY 2004

In the November 30, 2001 final rule (66 FR 59887), we adopted a methodology that applied five rules for calculating APC copayment amounts when payments for APC groups change because the APCs' relative weights are recalibrated or when individual services are reclassified from one APC group to another. In calculating the unadjusted copayment amounts for 2004, we encountered circumstances that the methodology in the November 30, 2001 final rule either did not address or whose applicability was ambiguous. Therefore, we proposed to revise and clarify the methodology we would follow to calculate unadjusted copayment amounts, including situations in which recalibration of the relative payment weight of an existing APC results in a change in the APC payment; situations in which reclassification of HCPCS codes from an existing APC to another APC results in a change in the APC payment; and situations in which newly created APCs are comprised of HCPCS codes from existing APCs.

As we stated in the August 12, 2003 proposed rule, as a general rule, we would seek to lower the coinsurance rate for the services in an APC from the prior year. This principle is consistent with section 1833(t)(8)(C)(ii) of the Act, which accelerates the reduction in the national unadjusted coinsurance rate so that beneficiary liability will eventually equal 20 percent of the OPPS payment rate for all OPPS services and with section 1833(t)(3)(B), which indicates the congressional goal of achieving 20 percent coinsurance when fully phased in and gives the Secretary the authority to set rules for determining copayment amounts to new services. However, in no event is the proposed 2004 unadjusted coinsurance amount for an APC group lower than 20 percent or greater than 50 percent of the payment rate.

We proposed to determine copayment amounts in 2004 and subsequent years in accordance with the following rules.

1. When an APC group consists solely of HCPCS codes that were not paid under the OPPS the prior year because they were packaged or excluded or are new codes, the unadjusted copayment amount would be 20 percent of the APC payment rate.

2. If a new APC that did not exist during the prior year is created and consists of HCPCS codes previously assigned to other APCs, the copayment amount is calculated as the product of the APC payment rate and the lowest coinsurance percentage of the codes comprising the new APC.

3. If no codes are added to or removed from an APC and, after recalibration of its relative payment weight, the new payment rate is equal to or *greater than* the prior year's rate, the copayment amount remains constant (unless the resulting coinsurance percentage is less than 20 percent).

4. If no codes are added to or removed from an APC and, after recalibration of its relative payment weight, the new payment rate is *less than* the prior year's rate, the copayment amount is calculated as the product of the new payment rate and the prior year's coinsurance percentage.

5. If HCPCS codes are added to or deleted from an APC, and, after recalibrating its relative payment weight, holding its unadjusted copayment amount constant results in a decrease in the coinsurance percentage for the reconfigured APC, the copayment amount would not change (unless retaining the copayment amount would result in a coinsurance rate less than 20 percent).

6. If HCPCS codes are added to an APC, and, after recalibrating its relative payment weight, holding its unadjusted copayment amount constant results in an increase in the coinsurance percentage for the reconfigured APC, the copayment amount would be calculated as the product of the payment rate of the reconfigured APC and the lowest coinsurance percentage of the codes being added to the reconfigured APC.

We stated in the proposed rule that this methodology would, in general, reduce the beneficiary coinsurance rate and copayment amount for APCs for which the payment rate changes as the result of the reconfiguration of APCs and/or the recalibration of relative payment weights. We received no comments from the public on our proposal for the calculation of beneficiary copayment amounts.

The unadjusted copayment amounts for services payable under the OPPS effective January 1, 2004 are shown in Addendum A and Addendum B.

IX. Conversion Factor Update for CY 2004

Section 1833(t)(3)(C)(ii) of the Act requires us to update the conversion factor used to determine payment rates under the OPPS on an annual basis.

Section 1833(t)(3)(C)(iv) of the Act provides that for 2004, the update is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act.

The forecast of the hospital market basket increase for FY 2004 published in the inpatient PPS proposed rule on May 19, 2003 was 3.5 percent. To set the proposed OPPS conversion factor for 2004, we increased the 2003 conversion factor of $52.151 (the figure from the November 1, 2002 final rule (67 FR 66788) by 3.5 percent.

In accordance with section 1833(t)(9)(B) of the Act, we further adjusted the proposed conversion factor for 2004 to ensure that the revisions we proposed to update by means of the wage index are made on a budget-neutral basis. We calculated a budget neutrality factor of 1.003 for wage index changes by comparing total payments from our simulation model using the proposed FY 2004 hospital inpatient PPS wage index values to those payments using the current (FY 2003) wage index values. In addition, for CY 2004, allowed pass-through payments have decreased to 2 percent of total OPPS payments, down from 2.3 percent in CY 2003. The 0.3 percent was also used to adjust the conversion factor.

The proposed market basket increase factor of 3.5 percent for 2004, the required wage index budget neutrality adjustment of approximately 1.003, and the 0.3 percent adjustment to the pass-through estimate, resulted in a proposed conversion factor for 2004 of $54.289.

For purposes of updating the CY 2003 conversion factor to determine a final conversion factor for CY 2004 we applied an update factor based on the final hospital inpatient market basket increase for FY 2004 of 3.4 percent, as published in the final rule for IPPS on August 1, 2003. We further adjusted the conversion factor by applying a budget neutrality factor of 1.001 for wage index changes based on final FY 2004 hospital inpatient PPS wage index values as published in a correction notice to the IPPS final rule on October 6, 2003. In addition, for CY 2004, estimated pass-through payments have decreased to 1.3 percent of total OPPS payments, down from 2.3 percent in CY 2003. The conversion factor was further adjusted by the difference in estimated pass-through payments of 1.0 percent.

The increase factor of 3.4 percent for 2004, the required wage index budget neutrality adjustment of slightly more than 1.001 and the 1.0 percent adjustment to the pass-through estimate, result in a final conversion factor for 2004 of $54.561.

We received several comments concerning the conversion factor update for 2004, which are summarized below.

Comment: Several commenters stated that the OPPS has been underfunded since its inception. One commenter stated that the OPPS conversion factor has increased by less than the full market basket increase and urged that we work with Congress to enact an annual outpatient update for 2005 that corrects for the funding gap. Other commenters, noting the preliminary estimate of pass-through spending in our proposed rule of August 12 of 1.0 percent of total OPPS payments, strongly urged us to return the remaining 1.0 percent to the conversion factor to help fund all other APCs.

Response: As described elsewhere in this final rule, we have completed our estimate of pass-through spending for 2004. By statute, we are authorized to spend only 2.0 percent of total estimated OPPS payments on pass-through spending for 2004. According to the best information available to us at this time, we estimate the total pass-through spending to be 1.3 percent of total OPPS spending for 2004. For 2003, we estimated the total pass-through spending to be 2.3 percent of total. Thus, we have returned the additional 1.0 percent to the conversion factor.

X. Outlier Policy and Elimination of Transitional Corridor Payments for CY 2004

A. Outlier Policy for CY 2004

For OPPS services furnished between August 1, 2000 and April 1, 2002, we calculated outlier payments in the aggregate for all OPPS services that appear on a bill in accordance with section 1833(t)(5)(D) of the Act. In the November 30, 2001 final rule (66 FR 59856, 59888), we specified that beginning with 2002, we would calculate outlier payments based on each individual OPPS service. We revised the aggregate method that we had used to calculate outlier payments and began to determine outliers on a service-by-service basis.

As explained in the April 7, 2000 final rule (65 FR 18498), we set a target for outlier payments at 2.0 percent of total payments. For purposes of simulating payments to calculate outlier thresholds, we proposed to continue to set the target for outlier payments at 2.0 percent. For 2003, the outlier threshold is met when costs of furnishing a service or procedure exceed 2.75 times the APC payment amount, and the current outlier payment percentage is 45 percent of the amount of costs in excess of the threshold.

For the reasons discussed in detail in section XI.E of this preamble, we proposed to establish two separate outlier thresholds, one for community mental health centers (CMHCs) and one for hospitals. For CY 2004, we proposed to continue to set the target for outlier payments at 2.0 percent of total OPPS payments (a portion of that 2.0 percent, 0.36 percent, would be allocated to CMHCs for PHP services). Based on our simulations for 2004, we proposed to set the hospital threshold for 2004 at 2.75 times the APC payment amount, and the proposed 2004 payment percentage applicable to costs over the threshold at 50 percent. We proposed to set the threshold for CMHCs for 2004 at 11.75 times the APC payment amount and the 2004 outlier payment percentage applicable to costs over the threshold at 50 percent. In this final rule, we are setting the target amount for outlier payments at 2.6 times the APC payment for hospitals and 3.65 times the APC payment for CMHCs. For 2004, the hospital outlier threshold is met when costs of furnishing a service or procedure exceed 2.6 times the APC payment amount and the outlier payment percentage is 50 percent of the amount of costs in excess of the threshold. Similarly, for CMHCs the threshold is met when costs of furnishing a service or procedure exceed 3.65 times the APC payment amount and the outlier payment percentage is 50 percent of the amount of costs in excess of the threshold.

We received several comments concerning our proposal to establish two separate outlier pools, one for hospitals and another for CMHCs, and to determine eligibility for outlier payments by applying an outlier threshold of 2.75 times the APC payment for hospitals and 11.75 times the APC payment for CMHCs. The comments we received concerning that proposal are summarized in section XI E.3 along with our responses. Comments we received pertaining to other aspects of our proposal for outlier payments are summarized below:

Comment: One hospital association contended that outpatient services that qualify for outlier payments should receive 80 percent of their costs above the threshold, rather than the proposed level of 50 percent. The association stated that an increased payment level would help to ameliorate the level of losses incurred by hospitals, such as teaching hospitals, that provide complex outpatient services and would make OPPS policy consistent with the policy under the IPPS. The association also pointed out that because we apply an outlier threshold that is a multiple of the APC payment, rather than a fixed dollar amount, hospitals that provide certain costlier services must absorb significantly more costs before even qualifying for outlier payments, making it even more important to increase the outlier payment percentage. The association recognized that increasing the payment percentage would require additional funds and recommended that we seriously consider increasing the outlier payment pool from its current level of 2.0 percent of total OPPS payments to 3.0 percent, the maximum allowed by law for 2004 and beyond.

Response: Although we acknowledge the importance of outlier payments to providers, those payments are intended to ensure that the Medicare program shares, to some extent, in the extraordinarily high costs a provider may incur in caring for specific patients in unusual circumstances. Outlier payments are not intended to be paid on a routine or regular basis for treating the majority of Medicare beneficiaries. The APC payments are developed to be reasonable and adequate payment for all but the most extraordinary cases. At this time, we do not believe that it would be appropriate to shift additional funds from APC payments in order to increase the outlier payment percentage. Increasing the outlier pool would result in reduced payments for the majority of services providers furnish in order to make increased payments for the rare, extraordinarily high cost cases a provider may treat.

Comment: A hospital association commented that we have furnished very little data on actual outlier payments under the OPPS, so hospitals have no way of knowing whether actual payments were higher or lower than estimated outlier payments and are unable to comment on the proper outlier threshold for OPPS. The association pointed out that we have historically furnished data on actual outlier payments in the IPPS rule and recommended that we furnish data on OPPS outlier payments so that hospitals may be able to make informed comments on the proper threshold.

Response: Based on hospital and CMHC claims submitted for the period April 1, 2002 through December 31, 2002, outlier payments for that period amounted to 1.78 percent of total OPPS payments. The outlier target we were trying to achieve for that period was 1.5 percent of total OPPS payments. Outlier payments to hospitals alone amounted to 1.54 percent of total OPPS payments to hospitals, while outlier payments to CMHCs amounted to 49.8 percent of their total OPPS payments.

B. Elimination of Transitional Corridor Payments for CY 2004

Since the inception of the OPPS, providers have been eligible to receive additional transitional payments if the payments they received under the OPPS were less than the payments they would have received for the same services under the payment system in effect before the OPPS. Under 1833(t)(7) of the Act, most hospitals that realize lower payments under the OPPS received transitional corridor payments based on a percent of the decrease in payments. However, rural hospitals having 100 or fewer beds, as well as cancer hospitals and children's hospitals described in section 1886(d)(1)(B)(iii) and (v) of the Act, were held harmless under this provision and paid the full amount of the decrease in payments under the OPPS.

Transitional corridor payments were intended to be temporary payments to ease providers' transition from the prior cost-based payment system to the prospective payment system. Beginning January 1, 2004, in accordance with section 1833(t)(7) of the Act, transitional corridor payments will no longer be paid to providers other than cancer hospitals and children's hospitals. Cancer hospitals and children's hospitals are held harmless permanently

under the transitional corridor provisions of the statute.

Since small rural hospitals may not be able to achieve the same level of operating efficiencies as larger rural hospitals and urban hospitals, we were concerned that the possible decrease in payments to these hospitals resulting from the elimination of the transitional corridor payments could result in these hospitals having to decrease or altogether cease to provide certain outpatient services. A reduction of services could have consequences for Medicare beneficiaries and their continued access to care in rural areas. In light of these concerns, we stated in the August 12, 2003 proposed rule that one thing we could do is to provide increased APC payments for clinic and emergency room visits furnished by rural hospitals having 100 or fewer beds. Any adjustment to payments for these hospitals would be made under the authority granted to the Secretary under section 1833(t)(2)(E) of the Act, to establish in a budget neutral manner adjustments as determined to be necessary to ensure equitable payments, such as adjustments for certain classes of hospitals. In the August 12, 2003 proposed rule, we invited comments on whether we should provide an adjustment, such as the one described above, for small rural hospitals.

We received a few comments regarding the elimination of transitional corridor payments, which are summarized below along with our responses.

Comment: Two commenters stated that the loss of transitional corridor payments would dramatically affect revenues for rural hospitals; therefore, they supported increased payments to rural hospitals for clinic and emergency room visits. One hospital association recommended that we provide appropriate payment protections for small rural hospitals that provide emergency services to safeguard them from any adverse consequences stemming from the elimination of transitional corridor payments and to avoid life-threatening consequences by protecting beneficiaries' timely access to emergency services. Two additional commenters contended that our proposal would be inadequate and that to avoid curtailing services to Medicare beneficiaries relief is needed for small rural hospitals, sole community hospitals, and rural referral centers. They recommended that we continue transitional corridor payments using the authority we have to make adjustments under section 1833(t)(2)(E) of the Act. One commenter stated that our proposal failed to address other outpatient services that will be underpaid and suggested that transitional corridor payments be continued for a year while a more broad based payment methodology is developed for small rural hospitals. Another commenter recommended a rural APC add-on adjustment for all APCs paid to rural hospitals to acknowledge that these hospitals cannot achieve the same level of operating efficiencies as larger rural and urban hospitals. Another commenter argued that termination of transitional corridor payments was detrimental to all hospitals and recommended retaining transitional corridor payments for all hospitals.

One commenter opposed shifting payments from larger hospitals in order to increase payments to small rural hospitals. The commenter stated that all hospitals, regardless of size and location, struggle with gaining operating efficiencies under the OPPS. One hospital association indicated that transitional corridor payments have been a critical source of financial support for many teaching hospitals and payments to these hospitals deserve further analyses by us, which would likely result in the conclusion that a teaching hospital adjustment is warranted. Several hospital associations expressed concern about our proposal to create differential payment rates between urban and rural hospitals for clinic and emergency room visits, and one questioned our legal authority to pay differently for the same service. One of the associations added that as a preferred alternative, it is urging the Congress to allocate additional resources to extend the transitional corridor and hold harmless provisions to all providers as well as urging the Congress to increase payments for clinic and emergency room visits for all hospitals. Another of the hospital associations stated that it does not support a budget neutral, redistributive adjustment through regulation, but is instead urging the Congress to allocate additional resources to assist rural hospitals by increasing payment rates for clinic and emergency room visits for all hospitals.

The Medicare Payment Advisory Commission (MedPAC) commented that the August 12, 2003 proposed rule failed to provide a rationale for proposing increased payments for emergency room and clinic visits as a means of supporting small rural hospitals and recognized that only limited cost report data are available to assess the performance of small rural hospitals under the OPPS. MedPAC stated that we should consider other regulatory options to ensure access to care for rural beneficiaries, such as a low-volume adjustment and pointed out that any payment adjustment should be accompanied by an analysis of how small rural hospitals have fared under the OPPS, the impact of any payment adjustment, and the impact of other policies that affect rural hospitals such as conversion to critical access status. MedPAC also stated that legislative remedies could include extending the hold harmless policy or providing a transition from hold harmless status.

Response: Although we expressed concerns in the August 12, 2003 proposed rule that the sunsetting of transitional corridor payments might significantly impact small rural hospitals and we invited comments about whether we should provide for some type of adjustment to payments for these hospitals, we did not receive a large number of comments and the comments we did receive are mixed on the issue. Although some commenters called for an extension of hold harmless transitional corridor payments for small rural hospitals, we do not believe that is a viable option because any adjustment we would make under the authority of section 1833(t) of the Act would have to be made on a budget neutral basis and would result in decreased APC payments for all providers. Because we did not receive a strong response in favor of increased visit payments to small rural hospitals or compelling evidence that clearly supported the position that an adjustment for small rural hospitals is necessary to ensure access to hospital outpatient services in areas served by small rural hospitals, we will not adopt a payment adjustment for small rural hospitals. We will continue to seek information related to specific situations that demonstrate that access to care is a problem for Medicare beneficiaries.

XI. Other Policy Decisions and Changes

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

Facilities code clinic and emergency department visits using the same [Physicians'] Current Procedural Terminology (CPT) codes as physicians. For both clinic and emergency department visits, there are currently five levels of care. Because these codes were defined to reflect only the activities of physicians, they are inadequate to describe the range and mix of services provided to patients in the clinic and emergency department settings (for example, ongoing nursing care, preparation for diagnostic tests, and patient education).

In the April 7, 2000 final rule (65 FR 18434), we stated that in order to ensure proper payment to hospitals, it was important that emergency and clinic visits be coded properly. To facilitate proper coding, we required each hospital to create an internal set of guidelines to determine what level of visit to report for each patient. In the August 24, 2001 proposed rule (66 FR 44672), we asked for public comments regarding national guidelines for hospital coding of emergency and clinic visits. Commenters recommended that we keep the current E/M coding system until facility-specific E/M codes for emergency department and clinic visits, along with national coding guidelines, were established. Commenters also recommended that we convene a panel of experts to develop codes and guidelines that are simple to understand, implement, and that are compliant with the Health Insurance Portability and Accountability Act (HIPAA) requirements.

Outcome of January 2002 APC Panel Meeting

During its January 2002 meeting, the APC Panel made several recommendations regarding coding for evaluation and management services. After careful review and consideration of written comments, oral testimony, and the APC Panel's recommendations, we proposed the following in the August 9, 2002 proposed rule (for implementation no earlier than January 2004):

1. To develop five G codes to describe emergency department services:
GXXX1—Level 1 Facility Emergency Services;
GXXX2—Level 2 Facility Emergency Services;
GXXX3—Level 3 Facility Emergency Services;
GXXX4—Level 4 Facility Emergency Services; and
GXXX5—Level 5 Facility Emergency Services.
2. To develop five G codes to describe clinic services:
GXXX6—Level 1 Facility Clinic Services;
GXXX7—Level 2 Facility Clinic Services;
GXXX8—Level 3 Facility Clinic Services;
GXXX9—Level 4 Facility Clinic Services; and
GXXX10—Level 5 Facility Clinic Services.
3. To replace CPT Visit Codes with the 10 new G codes for OPPS payment purposes.
4. To establish separate documentation guidelines for emergency visits and clinic visits.

In our November 1, 2002 final rule (67 FR 66792), we stated that the most appropriate forum for development of new code definitions and guidelines would be an independent expert panel that would make recommendations to us. In light of the expertise of organizations such as the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA), we felt that these organizations were particularly well equipped to make recommendations to us and to provide ongoing education to providers.

On their own initiative, the AHA and the AHIMA convened an independent expert panel of individuals from various organizations to develop code descriptions and guidelines for hospital emergency department and clinic visits and to make recommendations to us.

The panel recommended the following to us.

1. We should make payment for emergency and clinic visits based on four levels of care.

2. We should create HCPCS codes to describe these levels of care as follows:
GXXX1—Level 1 Emergency Visit.
GXXX2—Level 2 Emergency Visit.
GXXX3—Level 3 Emergency Visit.
GXXX4—Critical Care provided in the emergency department.
GXXX5—Level 1 Clinic Visit.
GXXX6—Level 2 Clinic Visit.
GXXX7—Level 3 Clinic Visit.
GXXX8—Critical Care provided in the clinic.

3. We should replace all the HCPCS currently in APCs 600, 601, 602, 610, 611, 612, and 620 with GXXX1 through GXXX8.

4. Based on the above recommendations, we would crosswalk payments as follows: GXXX1 to APC 610, GXXX2 to APC 611, GXXX3 to APC 612, GXXX4 to APC 620, GXXX5 to APC600, GXXX6 to APC 601, GXXX7 to APC 602, and GXXX8 to APC 620. These crosswalks and code descriptions are listed in Table 14 below.

TABLE 14.—CROSSWALKS OF 2003 HCPCS CODES TO THE PROPOSED G CODES

2003 HCPCS description	2004 G code description	2003 HCPCS	2004 Proposed G codes	APC	Payment amount
Emergency department visit	Level 1 Emergency Visit	99281 99282	GXXX1	0610	$74.70
Emergency department visit	Level 2 Emergency Visit	99283	GXXX2	0611	130.77
Emergency department visit	Level 3 Emergency Visit	99284 99285	GXXX3	0612	226.30
Critical care	Level 4 Critical Care provided in the emergency department.	99291 99292	GXXX4	0620	491.01
Office/outpatient visit, new	Level 1 Clinic Visit	99201 99202	GXXX5	0600	50.62
Office/outpatient visit, new	Level 2 Clinic Visit	99203	GXXX6	0601	53.56
Office/outpatient visit, new	Level 3 Clinic Visit	99204 99205	GXXX7	0602	82.07
Office/outpatient visit, established	Level 1 Clinic Visit	99211 99212	GXXX5	0600	50.62
Office/outpatient visit, established	Level 2 Clinic Visit	99213	GXXX6	0601	53.56
Office/outpatient visit, established	Level 3 Clinic Visit	99214 99215	GXXX7	0602	82.07
Office consultation	Level 1 Clinic Visit	99241 99242	GXXX5	0600	50.62
Office consultation	Level 2 Clinic Visit	99243	GXXX6	0601	53.56
Office consultation	Level 3 Clinic Visit	99244 99245	GXXX7	0602	82.07

TABLE 14.—CROSSWALKS OF 2003 HCPCS CODES TO THE PROPOSED G CODES—Continued

2003 HCPCS description	2004 G code description	2003 HCPCS	2004 Proposed G codes	APC	Payment amount
Critical care	Level 4 Critical Care provided in the clinic.	99291 99292	GXXX8	0620	491.01

The independent panel convened by the AHA and AHIMA recommended these levels in anticipation of the development of national coding guidelines for emergency and clinic visits that meet the following criteria we announced in the August 9, 2002 proposed rule (67 FR 52131):

1. Coding guidelines for emergency and clinic visits should be based on emergency department or clinic facility resource use, rather than physician resource use.

2. Coding guidelines should be clear, facilitate accurate payment, be usable for compliance purposes and audits, and comply with HIPAA.

3. Coding guidelines should only require documentation that is clinically necessary for patient care. Preferably, coding guidelines should be based on current hospital documentation requirements.

4. Coding guidelines should not create incentives for inappropriate coding (for example, up-coding).

We have received recommendations for a set of coding guidelines from the independent E/M panel comprised of members of the AHA and AHIMA. We proposed to implement new evaluation and management codes only when we are also ready to implement guidelines for their use, after allowing ample opportunity for public comment, systems change, and provider education. We also proposed to use cost data from the current HCPCS codes in these APCs to determine the relative weights of these APCs until cost data from GXXX1 through GXXX8 are available to set relative weights. We note that this proposal requires discontinuing the use of all HCPCS codes in these APCs and would not allow us to collect cost data for the five levels of emergency and clinic visits that are currently described by CPT codes. We further note that we would no longer be able to distinguish among the costs for visits by new patients, established patients, consultation patients, or patients being seen for more specialized care (for example, pelvic screening exams and glaucoma screening exams).

We would be using claims data from current HCPCS codes and crosswalking those data to the new codes in the same APCs; therefore, there would be no change in payment for any of these services as a result of these coding changes. Once cost data become available from the new HCPCS codes, we would use those data to set the relative weights, and, therefore, there should be no budgetary impact.

We are currently considering the set of proposed national coding guidelines for emergency and clinic visits recommended by the independent panel. We plan to make any proposed guidelines available to the public for comment on the OPPS web site as soon as they are complete. We will notify the public through our listserve when these proposed guidelines become available. To subscribe to this listserve, please go to the following Web site: *http://www.cms.hhs.gov/medlearn/listserv.asp* and follow the directions to the OPPS listserve. With regard to the development of these guidelines, our primary concerns are—

1. To make appropriate payment for medically necessary care;

2. To minimize the information collection and reporting burden on facilities;

3. To minimize any incentives to provide unnecessary or low quality care;

4. To minimize the extent to which separately billable services are counted as E/M services;

5. To develop coding guidelines that are consistent with facility resource use; and

6. To develop coding guidelines that are clear, facilitate accurate payment, are useful for compliance purposes and audits, and comply with HIPAA. Before adoption and implementation of any coding changes or coding guidelines, ample time will be provided for the public to comment on our proposal and, following announcement of any final decisions, for the education of clinicians and coders and for hospitals to make the necessary changes in their systems to accommodate the codes and guidelines. In the proposed rule, we requested comments on the amount of time hospitals believe would be adequate to implement these new codes and guidelines. We stated that we remain committed to working with appropriate organizations and stakeholders in our continuing development of a standard set of codes and national guidelines for facility coding of emergency and clinic visits.

We received comments on our proposal, which are summarized below with our responses.

Comment: Several physician societies objected to the creation of new G codes to replace existing CPT codes for facility coding of emergency and clinic visits. These commenters stated that new G codes for these services would add an unnecessary layer of complexity and confusion to the system, and that the existing CPT codes adequately and appropriately describe the services provided in the emergency and clinic settings. One physician society supported the creation of new G codes for facility coding of emergency and clinic visits, agreeing that CPT codes fail to accurately describe facility resources used to provide E/M services, but expressed concern that payers or auditors might refer to crosswalks made in establishing facility E/M code levels to determine appropriate level of coding for physician E/M services. This commenter urged CMS to clarify that the levels of visits for facility E/M services should not be used by payers or auditors to verify that physicians have billed for the appropriate level of visit.

Several commenters, including a hospital association and federation, commended CMS for proposing new G codes for facility coding of emergency and clinic visits, stating that existing CPT codes for E/M services correspond to different levels of physician effort and fail to adequately describe non-physician resources. These commenters stated that the proposed new G codes would appropriately capture facility resources, minimize confusion relative to physician versus facility E/M services, and adequately meet hospitals' need to comply with HIPAA regulations.

Response: We agree with those commenters who believe that CPT codes for E/M services describe different levels of physician effort, and therefore, fail to accurately describe facility resources used to provide E/M services. In the November 1, 2002 final rule (67 FR 66718), we explained that the development of new HCPCS codes for facility visits was necessary to address potential HIPAA compliance issues. We also agree with comments that the

proposed new G codes would appropriately capture facility resources and minimize confusion relative to physician versus facility E/M services. Therefore, we will continue to develop coding guidelines for facility E/M codes that are clear, facilitate accurate payment, are useful for compliance purposes and audits, and comply with HIPAA. For clarification purposes, levels of visits for facility E/M services. should not be used by payers or auditors to verify that physicians have billed for the appropriate level of visit.

Comment: We received a number of comments regarding our proposal of three levels of care (plus critical care) for clinic and emergency department visits. Several commenters stated that variation in cost per visit warrants five levels of service mapping to five separate APCs to maintain reasonable steps in payment as treatment costs increase. These commenters expressed concern that the agency will no longer have the ability to collect cost data for the five levels of emergency and clinic visits currently described by CPT codes, and that an averaging of charges over only three levels of service will result in adverse effects (that is, overpayments and underpayments) at the low and high end of visit codes. Furthermore, these commenters stated that private payers require a five tiered system and may not recognize the new G codes for payment. In contrast, we received several comments supporting our proposal of three levels of care (plus critical care) for clinic and emergency department visits. These commenters stated that three levels would help reduce the coding complexity and would be a more appropriate and accurate mechanism for reporting emergency and clinic visits.

Response: We appreciate the commenters' concerns while at the same time recognizing merits in the independent expert panel's recommendation to create three levels of care (plus critical care) for clinic and emergency visits. Given the level of interest in this issue and the importance to Medicare and to hospitals of establishing the appropriate codes and payment levels for these services, we will continue to study the issue. Prior to implementation of new facility E/M codes we will carefully consider all commenters' concerns related to variation in visit costs and recognition of a three tiered system by private payers. We will also consider placing this issue on the agenda for the 2004 APC Panel meeting.

Comment: Several physician societies expressed concern about potential discrepancies in payment for the same services furnished in clinic and emergency departments versus physician offices. One commenter stated that the proposal lacked physician input. While acknowledging statutory requirements that dictate the structure of the payment system for non-physician resources required to support physician services and the payment system for outpatient facility resources, commenters stated that we should avoid adopting policies that further increase the inequity in Medicare's payment systems. These commenters urged us to establish payment equity for the same services furnished in these respective settings.

Response: As stated elsewhere, the statute contains different provisions for how payments are established under the physician fee schedule and how payments are established under the OPPS. With respect to the absence of physician input on the proposal, we welcome comments from all interested parties as we continue to develop our policy.

Comment: We received numerous and detailed comments in reference to the model guidelines proposed by the independent expert panel convened by the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA).

Response: We are appreciative of the detailed comments we received in reference to the model guidelines proposed by the independent expert panel convened by the AHA and AHIMA. While we will carefully consider these comments in our continued review of the independent panel's proposed guidelines, we will not be responding to such comments in this rule since CMS did not propose these coding guidelines in the August 12, 2003 proposed rule.

Comment: Several commenters supported our decision to delay implementation of new E/M codes for clinic and emergency department visits until we have established defined and uniform coding guidelines.

Response: To minimize confusion, we continue to believe that a national set of defined coding guidelines must be established and implemented in conjunction with any new E/M codes for clinic and emergency department visits.

Comment: Several commenters encouraged CMS to make any proposed guidelines for billing hospital emergency room and clinic visits publicly available with opportunity to comment as soon as they are complete.

Response: We plan to make any coding guidelines that we are considering available to the public for comment on the OPPS Web site as soon as they are complete. We will notify the public through our listserve when these proposed guidelines become available. To subscribe to this listserve, please go to the following Web site: *http://www.cms.hhs.gov/medlearn/listserv.asp* and follow the directions to the OPPS listserve. As stated elsewhere, we will provide ample opportunity for the public to comment on the proposal.

Comment: Several commenters requested that CMS provide adequate time for the education of clinicians and coders and for hospitals to make the necessary changes in their systems to accommodate new evaluation and management (E/M) codes and guidelines. While two commenters requested a minimum notice of three months prior to implementation, the majority of commenters requested a minimum notice of between six and twelve months prior to implementation of facility evaluation and management codes and guidelines.

Response: We will continue to be considerate of the time necessary to educate clinicians and coders and for hospitals to modify their systems to accommodate new codes and guidelines. Based on comments received, we will provide a minimum notice of between six and twelve months prior to implementation of facility evaluation and management codes and guidelines. We do not expect to implement these new codes and guidelines any earlier than January 2005.

B. Status Indicators and Issues Related to OCE Editing

The status indicators we assign to HCPCS codes and APCs under the OPPS have an important role in payment for services under the OPPS because they indicate whether a service represented by an HCPCS code is payable under the OPPS or another payment system and also whether particular OPPS policies apply to the code. We are providing our status indicator (SI) assignments for APCs in Addendum A, HCPCS codes in Addendum B, definitions of the status indicators in Addendum D1, and definitions of code condition indicators in Addendum D2.

The OPPS is based on HCPCS codes for medical and other health services. These codes are used for a wide variety of payment systems under Medicare, including, but not limited to, the Medicare fee schedule for physician services, the Medicare fee schedule for durable medical equipment and prosthetic devices, and the Medicare clinical laboratory fee schedule. For purposes of making payment under the

OPPS, we must be able to signal the claims processing system which HCPCS codes are paid under the OPPS and those codes to which particular OPPS payment policies apply. We accomplish this identification in the OPPS through a system of payment status indicators with specific meanings.

We assign one and only one status indicator to each APC and to each HCPCS code. Each HCPCS code that is assigned to an APC has the same status indicator as the APC to which it is assigned.

The software that controls Medicare payment looks to the status indicators attached to the HCPCS codes and APCs for direction in the processing of the claim. Therefore, the assignment of the status indicators has significance for the payment of services.

In the August 12, 2003 proposed rule, we listed the OPPS status indicators and described how we proposed to use them in the 2004 OPPS. We also solicited comments on the appropriateness of the status indicator that we proposed to assign to each APC in Addendum A and each HCPCS code in Addendum B. Because the assignment of a status indicator designates how a particular outpatient service will be paid, either under the OPPS or under another payment system, or why payment is not made for a code, the comments that we received regarding the status indicator assigned to a particular APC or HCPCS code are discussed elsewhere in this final rule, within the context of the payment policy or rule that affect how payment is determined for the APC or HCPCS code.

Since publication of the August 12 proposed rule, we have been preparing specifications for the January 1, 2004 outpatient code editor (OCE) and PRICER, which are pivotal in determining how hospital claims for outpatient services are processed and paid. In the course of discussions with the contractors and systems maintainers with whom we work to ensure that claims are processed appropriately and in accordance with the policies and changes that we are implementing in this final OPPS rule for 2004, several issues related to status indicator definitions and claims processing edits and dispositions have arisen. As a result of these discussions, we have determined that claims would be processed more accurately if we established two additional payment status indicators to designate with greater specificity the appropriate disposition of certain codes for which payment is not made under the OPPS. Therefore, we are adding two status indicators, status indicator "B" and status indicator "Y," to Addendum D1, which lists all of the status indicators established as part of the OPPS and describes what they signify. We have also revised and refined the status indicator definitions and clarified the explanation of what each status indicator means. None of these changes affect how services are paid under the OPPS. Rather, the changes are intended to clarify how the status indicators relate to existing payment policy and rules and to assist hospitals and our contractors in determining the disposition of individual HCPCS codes when they are billed to Medicare.

In 2004, we are adding a new Status Indicator "Y" to designate codes for non-implantable Durable Medical Equipment (DME) to assist hospitals in identifying codes that they must bill directly to the Durable Medical Equipment Regional Carrier (DMERC) rather than to the fiscal intermediary. Codes assigned Status Indicator "Y" are listed in Addendum B.

Historically, we have used Status Indicator "E" to identify certain HCPCS codes that are recognized by Medicare but that are not payable under the OPPS when they are submitted on an outpatient hospital Part B bill type (bill type 12x, 13x, or 14x). Beginning with implementation of the 2004 final rule, we are assigning Status Indicator "B" to HCPCS codes that are not payable under OPPS when submitted on an outpatient hospital Part B bill type (12x, 13x, and 14x), but that may be payable by intermediaries to other provider types when submitted on an appropriate bill type, such as bill type 75x submitted by a CORF. In some cases, another code may be submitted by hospitals on an outpatient hospital Part B bill type (12x, 13x, and 14x) to receive payment for a service or code that is assigned status indicator "B" in Addendum B. Because we did not include these status indicator changes in the August 12, 2003 proposed rule, we invite comments on their addition to Addendum D1, and on the revised definitions and explanations that we included in Addendum D1.

Addendum D2 shows the indicators that we use to designate codes that are new in 2004 for which comments may be submitted as well as codes that are deleted in 2004 either with or without a grace period.

C. Observation Services

In the November 1, 2002 update to the OPPS (67 FR 66794), we summarized and clarified previously published guidance (Transmittal A–02–026) regarding payment requirements for HCPCS code G0244, Observation care provided by a facility to a patient with congestive heart failure, chest pain or asthma, minimum of 8 hours, maximum 48 hours. We also implemented HCPCS codes G0263 and G0264 to identify patients directly admitted to observation. In January 2003, we published Transmittal A–02–129, which provides further instructions regarding billing for observation services. In the proposed rule, we did not propose anything new with regard to observation services, nor did we seek public comment on observation issues. We stated that we would update by Program Memorandum any changes in the list of ICD–9–CM codes required for payment of HCPCS code G0244 resulting from the October 1 annual update of ICD–9–CM. We also stated in the proposed rule that we would include any changes in the 2004 final OPPS rule and allow the public an opportunity to comment.

We have had an opportunity to review the October 1, 2003 update of the ICD–9–CM and we have determined that there are not changes that affect the list of diagnosis codes required for payment of HCPCS code G0244. Therefore, we are not implementing any changes in the way we pay for observation services under the 2004 OPPS.

D. Procedures That Will Be Paid Only as Inpatient Procedures

Before implementation of the OPPS, Medicare paid reasonable costs for services provided in the outpatient department. The claims submitted were subject to medical review by the fiscal intermediaries to determine the appropriateness of providing certain services in the outpatient setting. We did not specify in regulations those services that were appropriate to be provided only in the inpatient setting and that, therefore, should be payable only when provided in that setting.

Section 1833(t)(1)(B)(i) of the Act gives the Secretary broad authority to determine the services to be covered and paid for under the OPPS. In the April 7, 2000 final rule, we identified procedures that are typically provided only in an inpatient setting and, therefore, would not be paid by Medicare under the OPPS (65 FR 18455). These procedures comprise what is referred to as the "inpatient list." The inpatient list specifies those services that are only paid when provided in an inpatient setting. These are services that require inpatient care because of the nature of the procedure, the need for at least 24 hours of post-operative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient. As we

discussed in the April 7, 2000 and the November 30, 2001 final rules, we use the following criteria when reviewing procedures to determine whether or not they should be moved from the inpatient list and assigned to an APC group for payment under the OPPS:

- Most outpatient departments are equipped to provide the services to the Medicare population.
- The simplest procedure described by the code may be performed in most outpatient departments.
- The procedure is related to codes that we have already removed from the inpatient list.

In the November 1, 2002 final rule, we added the following criteria for use in reviewing procedures to determine whether they should be removed from the inpatient list and assigned to an APC group for payment under the OPPS:

- We have determined that the procedure is being performed in multiple hospitals on an outpatient basis; or
- We have determined that the procedure can be appropriately and safely performed in an ASC and is on the list of approved ambulatory surgical center (ASC) procedures or proposed by us for addition to the ASC list.

At its January 2003 meeting, the APC Panel did not make recommendations regarding procedures on the inpatient list, and in the proposed rule, we did not propose to make any of the procedures that are currently on the inpatient list in Addendum E payable under the OPPS in 2004. We solicited comments on whether any procedures in Addendum E should be paid under the OPPS. We asked commenters recommending reclassification of a procedure to an APC to include evidence (preferably from peer-reviewed medical literature) that the procedure is being performed on an outpatient basis in a safe and effective manner. We also solicited comments on the appropriate APC assignment for the procedure in the event that we determine in the final rule, based on comments, that the procedure would be payable under the OPPS in 2004.

Following our review of any comments that we receive about the procedures in Addendum E, we indicated in the proposed rule that we would propose either to assign a CPT code to an APC for payment under the OPPS or, if the comments did not provide sufficient information and data to enable us to make a decision, to present the comments to the APC Panel at its 2004 meeting.

Procedures on the inpatient list can be found in Addendum E. CPT codes that are new in 2004 and that we believe are appropriately assigned status indicator "C" to designate that they are on the inpatient list can be found in Addendum B with condition code "NI". We invite comment on assignment of these codes to the inpatient list.

We received a few comments regarding the inpatient list, which are summarized below with our responses.

Comment: A group of providers representing 18 health care systems around the country requested that CMS clarify the intent of the inpatient list. The commenter expressed concern that some independent medical review criteria appear to equate codes with APC payments as procedures that CMS has determined must be outpatient services both because they are payable under the OPPS and because they are not included on the inpatient list. The commenter is concerned that hospitals will interpret these criteria to mean that any procedure or service not on the inpatient list must be furnished on an outpatient basis, regardless of the needs of the patient.

Response: We wish to clarify that assignment of an APC payment to a service or procedure does not mean that Medicare covers the service or procedure or that it may only be payable when furnished in an outpatient setting. In the November 1, 2002 final rule (67 FR 66739) as well as the April 7, 2000 and the November 30, 2001 final rules, we explain in detail our rationale for the inpatient list. Assignment of an APC payment to a service or procedure does not prohibit hospitals from providing these services on an inpatient basis when it is reasonable and necessary to admit the patient based on the patient's medical condition.

Comment: The same commenter repeated objections that have been submitted in comments to OPPS rules in prior years, that it is unfair to deny payment to hospitals for procedures on the inpatient list, but to pay physicians when they perform procedures on the inpatient list in a hospital outpatient setting. The commenter asserts that physicians are not responsive to hospital efforts to educate them regarding Medicare payment for procedures on the inpatient list performed on a patient who has not been admitted as an inpatient because the location that the physician chooses to perform a procedure has no impact on Medicare payment for the physician's professional services. Moreover, the commenter asserts that physicians disagree with assignment of procedures to the inpatient list because new technology or surgical advances allow the procedure to be appropriately performed on an outpatient basis. The commenter urged us to release the inpatient list as part of the physician's fee schedule in order to align hospital and physician incentives.

Response: In the November 1, 2002 final rule (67 FR 66740) we responded to similar comments regarding hospitals' concerns about physicians being paid for procedures on the inpatient list that are performed on an outpatient basis even though payment is denied to hospitals for those procedures. As we state above, the basis for the inpatient list is rooted in section 1833(t)(1)(B)(i) of the Act, which gives the Secretary broad authority to determine the services to be covered and paid for under the OPPS. The authority in this section of the Act does not extend to services that are covered and paid for under the Medicare physician fee schedule, which is a separate benefit and payment system. However, we believe that as hospitals and physicians continue to gain experience and become more knowledgeable about how Medicare pays for services under the OPPS, problems associated with the existence of the inpatient list will continue to diminish.

Moreover, we welcome at any time recommendations from hospitals and/or physicians regarding procedures currently on the inpatient list that are being safely and appropriately performed on an outpatient basis. Requests for review of a code or group of codes on the inpatient list should be sent to the Director, Division of Outpatient Care, Centers for Medicare & Medicaid Services, Mailstop C4–05–17, 7500 Security Boulevard, Baltimore, MD 21244–1850. Such requests should include supporting information and data to demonstrate that the code meets the five criteria for payment under the OPPS that are listed above, and that are also discussed in the November 1, 2002 final rule (67 FR 66739). In addition, we ask that evidence be submitted, including operative reports of actual cases and peer-reviewed medical literature, to demonstrate that the procedure is being performed on an outpatient basis in a safe and appropriate manner in a variety of different types of hospitals.

Comment: The same commenter recommended that we change our policy for OPPS payment of inpatient services when the patient is transferred to another hospital. They state that the current requirement creates unnecessary administrative burden when a hospital, in order to receive payment, must admit a patient simply to stabilize them prior to transfer. The commenter

recommended that, when procedures on the inpatient list are provided to patients in order to stabilize the patient immediately prior to transfer, we ignore the payment status indicator of "C" assigned to the procedure on a claim and allow the claim to be paid under the OPPS.

Response: Procedures on the inpatient list performed on patients whose status is that of outpatient are not payable under the OPPS. However, we recognize that there are occasions when a procedure on the inpatient list may have to be performed to resuscitate or stabilize a patient with an emergent, life-threatening condition whose status is that of an outpatient. We also recognize that, once stabilized, such a patient may subsequently require transfer to another facility in order to receive appropriate care. As we explain in the November 1, 2002 final rule (67 FR 66798), when a physician performs a procedure on the inpatient list to resuscitate or stabilize a patient with an emergent, life-threatening condition whose status is that of an outpatient, we expect the physician to order that the patient be admitted following the procedure for the purpose of receiving inpatient hospital services and occupying an inpatient hospital bed. Or, the physician may order that the patient be admitted and then determine that the patient should be transferred to another provider. In the latter instance, Medicare allows payment for services furnished to a patient who is transferred to another provider. However, in order for the discharging hospital to receive payment in cases where it is determined that appropriate care for the patient necessitates transfer to another provider, long-standing Medicare rules provide that the patient has to have been admitted to the discharging hospital. Further, as we discuss in the November 1, 2002 final rule, it is important that the particular circumstances necessitating performance of a procedure on the inpatient list when the patient's status is that of an outpatient be thoroughly documented in the medical record. For these reasons, we disagree with and are not implementing the commenter's recommendation that we modify the outpatient code editor (OCE) to allow payment under the OPPS for services furnished to resuscitate or stabilize an outpatient with an emergent, life-threatening condition who is transferred to another facility following a procedure on the inpatient list.

Comment: One hospital requested that we remove CPT 37182, Insertion of transvenous intrahepatic protosystemic shunts(s) (TIPS), from the inpatient list. One health system requested that we remove CPT 20660, Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure) and CPT 49061, Drainage of retroperitoneal abscess; percutaneous, from the inpatient list.

Response: Our medical officers reviewed these recommendations and determined that these codes do not meet the criteria for removing a procedure from the inpatient list and assignment to an APC. We would expect patients whose medical condition requires these procedures to be admitted as inpatients in order to have these procedures performed. Our data indicate that these procedures are performed predominantly in the inpatient setting. Therefore, in the absence of evidence demonstrating that these procedures are being performed on an outpatient basis in a safe and appropriate manner in a variety of different types of hospitals and that the criteria for removing a procedure from the inpatient list are met, we are retaining these codes on the inpatient list.

Comment: A provider group requested that we change the status indicator of the following codes from "N" to "C," because these are add-on codes for procedures already on the inpatient list: CPT 61316, Incision and subcutaneous placement of cranial bone graft; CPT 61517, Implantation of brain intracavitary chemotherapy agent; CPT 62148, Incision and retrieval of subcutaneous cranial bone graft for cranioplasty; and, CPT 62160, Neuroendoscopy, intracranial, for placement or replacement of ventricular catheter and attachment to shunt system or external drainage.

Response: We thank the commenter for bringing these codes to our attention and we agree that the status indicator for these codes should be changed from "N" to "C."

New APC To Pay for Services Furnished on Same Date as Service With Modifier -CA:

In the 2003 update of the OPPS, we implemented a new modifier -CA, Procedure payable only in the inpatient setting when performed emergently on an outpatient who dies before admission. In section VI of Transmittal A–02–129, issued on January 3, 2003, we instructed hospitals on the use of modifier -CA when submitting a claim on bill type 13x for a procedure that is on the inpatient list and that is assigned payment SI "C." (Transmittal A–02–129 can be found on our web site at *cms.hhs.gov.*) We also implemented in the November 1, 2002 final rule (67 FR 66799) a new payment policy to allow payment, under certain conditions, for outpatient services on a claim that have the same date of service as the HCPCS code billed with modifier -CA. A single payment for outpatient services on the claim, other than those coded with SI "C" and modifier -CA, is currently made under APC 0977.

We reviewed this policy and determined that assigning payment for these services to APC 0977, which is a New Technology APC, is problematic because payment under New Technology APCs is a fixed amount that does not have a relative payment weight and is, therefore, not subject to recalibration based on hospital costs. We proposed to establish a new APC for which payment would be made under certain conditions for otherwise payable outpatient services furnished on the same date of service that a procedure with SI "C" is performed emergently on an outpatient who dies before admission to the hospital as an inpatient. Beginning in 2004, hospitals would be paid under APC 0375 instead of APC 0977 for services furnished on the same date of service that a procedure with SI "C" and modifier -CA is billed. We proposed at the outset to set the payment rate for APC 0375 in the amount of $1,150, which is the payment amount for the newly structured New Technology APC that would replace APC 0977. When the APC weights are recalibrated in 2005, we would use charge data from CY 2003 claims for line items that have the same date of service as the line with modifier -CA and that show a HCPCS code with status indicator "V," "S," "T," "X," "N," or "K" to calculate a median cost and relative payment weight for APC 375. Once we have claims data, we would be able to determine whether it is appropriate to calculate a relative payment weight based on median costs from our claims data or to continue a fixed payment rate for these special cases. In the proposed rule, we invited comments on these proposed changes.

Comment: One commenter was concerned with the methodology for calculation of APC 375, Ancillary Outpatient Services when Patient Expires. The commenter stated that items such as pass-through devices and drugs and packaged items reported without HCPCS should be included in the calculation.

Response: It is conceivable that a pass-through drug or device could be furnished to a patient during the same encounter when a procedure billed with modifier -CA is performed. If that were the case, we would expect the hospital to include these services on the claim submitted for the encounter. Although

we would not pay separately for the pass-through items, we agree with the commenter that we should consider taking these costs into account when evaluating how best to establish the payment rate for APC 375 in future updates of the OPPS. We also agree that charges reported with a revenue code but without a HCPCS code should be considered as well.

E. Partial Hospitalization Payment Methodology

1. Background

As we discussed in the April 7, 2000 OPPS final rule (65 FR 18452), partial hospitalization is an intensive outpatient program of psychiatric services provided to patients in place of inpatient psychiatric care. A partial hospitalization program (PHP) may be provided by a hospital to its outpatients or by a Medicare-certified community mental health center (CMHC). Payment to providers under the OPPS for PHPs represents the provider's overhead costs associated with the program. Because a day of care is the unit that defines the structure and scheduling of partial hospitalization services, we established a per diem payment methodology for the PHP APC, effective for services furnished on or after August 1, 2000.

The analysis of hospital partial hospitalization claims resulted in a per diem payment of $202.19, effective August 1, 2000. This amount was updated effective January 1, 2001 and April 1, 2002 to $206.82 and $212.27, respectively.

Effective January 1, 2003, the PHP APC amount was $240.03, of which $48.17 is the beneficiary's coinsurance. In the proposed rule, we described the methodology we followed in developing the 2003 PHP payment rate.

2. PHP APC Update for CY 2004

For CY 2004, we analyzed hospital and CMHC PHP claims for services furnished between April 1, 2002 and December 31, 2002. We intended to propose to use the same methodology for computing median costs per day for CY 2004 that was used to compute the CY 2003 PHP median cost per day. However, when we applied the methodology to the CMHC claims, the CMHC median cost per day was determined to be significantly higher than the median cost per day for hospital outpatient departments to provide the same benefit. In addition, the difference in median costs per day was significantly larger than last year.

As a result, we proposed a per diem rate for PHP services furnished during CY 2004 based solely on hospital PHP data. The proposed PHP APC 0033 amount, after scaling, was determined to be $208.95, of which $41.69 is the beneficiary's coinsurance.

However, a Program Memorandum issued on January 17, 2003, directed the FIs to recalculate hospital and CMHC cost-to-charge ratios. We anticipated receipt of the updated ratios this summer, and indicated that if the updated cost-to-charge ratios resulted in a more reasonable median per diem rate, we would use the CMHC data in developing the final rate for CY 2004.

We received 42 public comments in response to this proposal. A summary of the comments is provided below along with our responses.

Comment: In general, the commenters expressed concern that a reduction in the PHP rate of this magnitude would lead to the closure of many PHPs and that limited access to this crucial service would result in more costly inpatient hospital care as the ony alternative. A hospital association commented that basing the rate on only hospital data is inconsistent with other prospective payment systems and recommended that we find an alternative method to secure reliable CMHC data. CMHCs commented that their costs are higher than hospitals', with most in the $300 to $400 range. One commenter provided summary information on the average per day costs for seven CMHCs. Although the average per day cost for these seven providers was $390, the costs for individual providers ranged from $216 to $725. Unfortunately, the commenter did not provide a breakdown of these costs. Another commenter indicated that a per day rate of $300 to $350 was more appropriate than our proposed amount.

Another commenter stated that our inability to process the data timely does not constitute an appropriate basis for excluding all CMHC data from the per diem calculations. The commenters suggested alternatives such as including prior years' CMHC data trended forward based on medical inflation or maintaining the CY 2003 payment rate for PHP services furnished in CY 2004. One commenter questioned why the median cost per day for hospitals was reported as $225 but the proposed rate was reduced to $208.95.

Response: As we stated in the August 12, 2003 proposed rule, we intended to review the PHP data using the updated cost-to-charge ratios to compute the final CY 2004 PHP APC. As expected, the updated ratios reduced the median cost per day for CMHCs. The revised medians are $440 for CMHCs and $206 for hospitals. Combining these files results in a median per diem PHP cost of $303. As with all APCs in the OPPS, the median cost for each APC is scaled to be relative to a mid-level office visit and the conversion factor is applied. The resulting APC amount for CY 2004 is $286.82 of which $57.36 is the beneficiary's coinsurance.

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

Response: We used the best available data in computing the APCs. The January 17, 2003 Program Memorandum directed FIs to update the cost-to-charge ratios on an ongoing basis whenever a more recent full year cost report is available. In this way, we hope to minimize the time lag between the cost-to-charge ratios and claims data.

Comment: One commenter provided links to certain data files that were used to establish the APC rates. Since APC 0033 and certain HCPCS codes that are only paid under OPPS when they are furnished as part of a PHP were not included in these data files, the commenter believed that the data used to establish the PHP APC amount is incomplete.

Response: These data files are provided so that interested parties can study the costs associated with the HCPCS codes that comprise each APC and other analyses. We are required to include the HCPCS codes within each APC that are similar in resource use. This is not the case with the PHP APC (0033) in which the day of care is the unit that defines the structure and scheduling of PHPs and the composition of the PHP APC consists of the cost of all services provided each day. Although we require that each PHP day include a psychotherapy service, we do not specify the specific mix of other services provided and have focused our analysis on the cost per day rather than the cost of each service furnished within the day. As a result, we will add APC 0033 to the file that displays the APC median costs, but not the PHP data that show medians by HCPCS codes. We will continue to analyze the PHP data and will reconsider this position in the future.

Comment: One commenter related that administrative costs for CMHCs continue to be a major impediment to operating PHPs for Medicare beneficiaries. Medicare does not cover transportation to and from programs and does not cover meals. Almost all programs offer transportation because in

most cases Medicare beneficiaries with serious mental illnesses would not be able to access these programs without the transportation. They also commented about the current Medicare bad debt policy, which is beyond the scope of the August 12, 2003 proposed rule.

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

Comment: Several commenters summed the median cost figures for various combinations of HCPCS codes 90853 (group psychotherapy), 90818 (individual psychotherapy, 45–50 minutes), and 90847 (family psychotherapy, with patient present) and concluded that the per diem amount is considerably less than the combined cost of these services.

Response: We believe that the figures cited by the commenters were taken from a file that shows the median cost for single bills, for example, where group psychotherapy was the only service furnished. We do not believe that this is an appropriate comparison. These amounts are provided to enable the public to identify the median cost of services before scaling. It is important to note that these services are not PHP services, but rather single outpatient therapeutic sessions. As stated earlier, we used data from PHP programs (both hospitals and CMHCs) to determine the median cost of a day of PHP. PHP is a program of services where savings can be realized by hospitals and CMHCs over delivering individual psychotherapy services.

Comment: Several commenters compared the proposed per diem amount to the cost of the minimum services mandated by us or by the local medical review policies (LMRP) used by their FIs.

Response: We have not specified the specific daily components of a PHP. However, there is an edit in our claims processing system to identify claims that do not have at least three services, with at least one psychotherapy service (individual, group, or family therapy) for each day of PHP care. We have implemented this edit to ensure that PHPs meet the statutory requirement that they be intensive treatment programs provided in lieu of inpatient psychiatric hospital services. Claims with fewer than three services per day undergo medical review by the FIs to ensure that the patient is receiving intensive treatment. There may be legitimate reasons for a day on a claim to have fewer services, for example, where the patient leaves the program early to receive medical care. Medical review of these claims verifies that the patient requires and is receiving a PHP level of care.

Comment: The commenters also questioned our requirement that psychotherapy services be conducted by a Master's level practitioner. One commenter questioned how a hospital could comply with the three services per day requirement when licensed clinical social worker (CSW) services are bundled into the per diem payment.

Response: We do not require that a Master's prepared practitioner furnish psychotherapy services in a PHP. However, in accordance with section 1861(ff)(2)(A) of the Act, we require that practitioners who furnish psychotherapy services are authorized to do so by their States, through licensure, certification, or other official State processes. When a service is furnished by a practitioner who is not authorized by the State to furnish psychotherapy services, the service would not be recognized as a PHP service.

With respect to billing by CSWs, the professional component of services furnished by CSWs to PHP patients is bundled into the per diem payment amount and no billing to the Part B carrier is permitted. The rationale for this policy was explained in the interim final regulation with comment period we published on February 11, 1994 (59 FR 6570).

The OPPS is intended to pay PHP providers for the resources associated with sponsoring a PHP, for example, building maintenance, utilities, and support staff, including the cost of CSWs. Thus, where a PHP provider utilizes CSWs for psychotherapy services to PHP patients, payment for the professional costs of the CSW is made through the OPPS per diem payment. However, if a PHP utilizes psychiatrists, clinical psychologists, nurse practitioners, physician assistants, or clinical nurse specialists to furnish therapeutic services to PHP patients, the physician or practitioner may bill the Part B carrier for payment under the physician fee schedule for their professional services. When this occurs, the PHP provider may bill the FI under the OPPS for the facility resources associated with the psychotherapy service.

We note that a physician or any of the practitioners specified in 42 CFR 410.43(b) (including CSWs) may bill the Part B carrier for their professional services furnished to hospital outpatients who are *not* in a PHP. In this case, the hospital would bill the FI under the OPPS for the facility resources associated with the service furnished.

Comment: Several commenters suggested alternative methodologies for paying PHP providers, such as linking per diem and outlier payments to the units of service furnished each day or paying providers the average of all PHP costs plus 40 percent, subject to final settlement based on the provider's cost.

Response: We plan further analysis of the PHP data and may propose changes to the payment methodology for CY 2005. We note that OPPS is a prospective system and a methodology with interim payments subject to cost settlement would not be allowable under the statute.

Comment: One commenter believes the sample used to determine the rates is skewed and represents a subset of the provider community that provides PHP services.

Response: We do not agree that the sample is skewed. All facilities that submit claims for PHP services have been included in the development of the final rate.

3. Outlier Payments for PHPs

In a related matter, the use of historical cost-to-charge ratios applied to current charges has resulted in an excessive amount of outlier payments being made to CMHCs. As a result of more in-depth analysis of the 2001 data files that were used to compute the CY 2003 PHP per diem amount, we discovered a significant difference in the amount of outlier payments made to hospitals and CMHCs for PHP.

In the August 12, 2003 proposed rule, we stated that given the difference in PHP charges between hospitals and CMHCs, we did not believe it was appropriate to make outlier payments to CMHCs using the outlier percentage target amount and threshold established for hospitals. Therefore, we proposed to designate a portion of the estimated 2.0 percent outlier target amount specifically for CMHCs, consistent with the percentage of projected payments to CMHCs under the OPPS in CY 2004, excluding outlier payments. Since CMHCs were projected to receive 0.36 percent of total OPPS payments in CY 2004, excluding outlier payments, we proposed to designate 0.36 percent of the estimated 2.0 percent outlier target amount for CMHCs and establish a threshold to achieve that level of outlier payments. Based on our simulations of CMHC payments in 2004, we proposed to set the threshold for CY 2004 at 11.75 times the PHP APC payment amount. We proposed to apply the same outlier payment percentage that applies to hospitals. Therefore, for CY 2004, we

proposed to pay 50 percent of CMHC and hospital per diem costs over the threshold.

Comment: Several commenters representing CMHCs suggested that in developing our proposed outlier policy, we made generalizations and overreacted to a few aberrant providers. Also, these commenters believe the per diem amount is insufficient and that outlier payments would provide the additional amounts they needed to stay in business until more representative data could be obtained and analyzed.

Response: Based on our analysis of PHP claims data, nearly half of the CMHCs billing for PHP services in 2002 received outlier payments. The total dollar amount of outlier payments received by these CMHCs was nearly equal to the total amount all CMHCs received in per diem payments. Of those CMHCs that received outlier payments, 56 percent received an average of more than $200 per day in outlier payments, 30 percent received more than $300 per day in outlier payments, 21 percent received more than $400 per day in outlier payments, and 11 percent received more than $500 per day in outlier payments.

The outlier policy is intended to compensate providers for treating exceptionally resource-intensive patients. Outlier payments were never intended to be made for all patients and used as a supplement to the per diem payment amount. Our analysis showed that the CMHC average charge per day increased by 31 percent from CY 2001 to CY 2002. We do not believe this increase in charges correlates to an equivalent increase in CMHC costs. Rather, our analysis indicates that the increase in charges was made in order to qualify for outlier payments to cover CMHC operating expenses, not for patients who are exceptionally resource-intensive. We are concerned that if CMHCs continue this pattern of escalating charges, CMHCs will receive a disproportionate share of outlier payments compared to non-CMHCs that do not artificially inflate their charges, thereby limiting outlier money for truly deserving cases.

Comment: Although one commenter supported our proposed outlier policy, most commenters, including major hospital associations, did not believe it was sound policy to create separate outlier thresholds based on site of service.

Response: Applying the updated cost-to-charge ratios reduced the CMHC charges to better reflect their costs. We are concerned, however, that the impact of updated cost-to-charge ratios may be mitigated by future increases in charges. We proposed an outlier policy in consideration of the charges on the claims, the cost report data available, and the payments made to CMHCs. Our analysis indicates that CMHCs have dramatically increased their charges between CY 2001 and CY 2002. Between CYs 2001 to 2002, CMHC average per diem charges increased by 31 percent. We believe that in most cases, these increases in charges were not related to a corresponding increase in costs, but rather were designed to enhance outlier payments. We believe the data may indicate a pattern of artificially inflated charges by CMHCs that needs to be addressed. Although we agree that establishing site of service differences is not generally the preferred approach, we continue to believe that establishing two separate outlier percentages is the most appropriate way to address the problem to account for the disparity between hospital and CMHC PHP per diem charges.

For these reasons, for CY 2004, we are establishing a separate CMHC threshold. The threshold is based on the proportion of total OPPS payments CMHCs are estimated to receive in CY 2004. As stated earlier in this section, our analysis indicated that CMHCs were projected to receive 0.36 percent of total OPPS payments in CY 2004, excluding outlier payments. Therefore, we proposed to designate 0.36 percent of the estimated 2.0 percent outlier target amount for CMHCs and establish a threshold to achieve that level of outlier payments. Based on our simulations of CMHC payments in 2004, we proposed to set the threshold for CY 2004 at 11.75 times the PHP APC payment amount. We have updated our simulations using the final CY 2004 PHP per diem rate. CMHCs are now projected to receive approximately 0.5 percent of estimated total OPPS payments in CY 2004, excluding outlier payments. We have calculated the CMHC outlier threshold to achieve that level of payment. The resulting threshold for CY 2004 is 3.65 percent times the APC 0033 payment amount. We will apply the same outlier payment percentage that applies to hospitals. Therefore, for CY 2004, we will pay 50 percent of the difference between CMHC per diem costs and the CMHC outlier threshold amount. We intend to analyze whether a separate CMHC outlier threshold will continue to be appropriate in future updates.

XII. General Data, Billing, and Coding Issues

We received a number of general comments about OPPS data and related issues to which we respond below. Not all coding questions are addressed, however. We do not believe that the final rule is the appropriate venue in which to address specific inquiries about billing.

OPPS Data

Comment: A commenter indicated that it was difficult to model the August 12, 2003 proposed rule after its release and urged us to provide timely responses to questions about data, data files, and the specifics of the methodology used to generate relative weights, either by having data meetings or by clarifying the language in the final rule and median cost files. The commenter asked that we create a web-site to post responses to questions on data so that the information will be available for all to use. The commenter also asked that a number of data elements be added to the median cost file and the limited data set of claims that is available for public purchase.

Response: We have tried to respond to questions on data related issues on a flow basis. However, staff limitations and the need to develop the final rule greatly restrict the amount of time that our staff can devote to replying to these questions. Moreover, creation and maintenance of a web-site to post answers to questions from a few people with special interests is not a good use of our limited staff resources. We would encourage interested parties who have suggestions for improving our data file clarity to contact us with those specifics.

Creation of a National Outpatient Coding Governing Body

Comment: A commenter indicated that we should create an outpatient coding governing body that would educate providers regarding the correct use of codes, maintain a web-site on which all guidance on coding would be maintained, and oversee the Medicare fiscal intermediary interpretation of codes to ensure national uniformity across fiscal intermediaries.

Response: The HCPCS codes most often used for payment under OPPS are CPT codes, which are created and owned by the American Medical Association (AMA). Providers should look to the many resources available from the AMA for education regarding the correct use of CPT codes. The alphanumeric HCPCS codes are created and owned by us but they form a very limited portion of the services payable under OPPS and, as providers have frequently asked, we attempt to eliminate alphanumeric codes whenever possible and to work with the AMA to create CPT codes for use in both the physician fee schedule and the OPPS.

We attempt to provide coding guidance on alphanumeric codes, which are usually created only when there is a coverage or payment decision and when there is no CPT code that describes the service being covered or paid. However, providers must look to the AMA for education and support in the use of the CPT codes that form the bulk of OPPS.

Comment: We received one comment requesting that we publish updated addenda each quarter.

Response: The addenda that are published annually online are an official public record that cannot be changed without going through the **Federal Register**. We provide the Addenda in Excel format for the convenience of users since it is difficult to manipulate data in pdf format.

We also received a number of comments that were not relevant to the proposals made in the August 12, 2003 proposed rule. The commenters requested specific coding changes and requested clarification or guidance regarding certain billing requirements. Although we will provide answers to the questions raised, the final rule is not the appropriate venue for that guidance. We will consider the requests and suggestions provided, and will continue our ongoing efforts to formulate and publish billing instructions. Similarly, we will consult with our clinical experts regarding the suggestions made regarding coding of outpatient department procedures and other services.

Revenue Code Edits

Comment: A commenter asked whether we permit fiscal intermediaries to impose CPT to revenue code edits. The commenter believes that CMS has said that providers may choose the revenue code that applies to the item or service being billed but that some fiscal intermediaries have imposed revenue code to CPT edits that prevent hospitals from billing the service under the revenue code that they believe is appropriate and that cause unnecessary and unfair payment denials.

Response: We have issued some instructions that require that specific revenue codes be billed with certain HCPCS codes, such as specific revenues codes that must be used when billing for devices that qualify for pass-through payments. Where explicit instructions have not been issued, we instructed intermediaries to advise hospitals to report charges under the revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report. However, we have not explicitly prohibited intermediaries from installing the revenue code to HCPCS code edits, so it is possible that certain edits are applied by some intermediaries and not others. The commenter did not provide examples of the edits that are causing what the commenter considers to be unnecessary and unfair payment denials.

New CPT Venous Access Codes

Comment: A commenter indicated that CPT had revised its venous access codes and encouraged us to use external information to determine hospital acquisition costs for devices used in these procedures.

Response: We carefully reviewed the new CPT codes for insertion of venous access devices and we assigned the new CPT codes to APCs based on our clinicians' view of the relative amount of hospital resources that the services, as described by the new codes, would use. We note that the new CPT codes represent longstanding services, albeit with new code descriptions and code numbers. Since these are new CPT codes (albeit for existing services), the APC and status indicator assignments are interim and subject to comment.

New "NI" Drug Codes

There are several new HCPCS codes for drugs, biologicals, and radiopharmaceuticals that are new for 2004. Since these codes were not subject to public comment in the August 12, 2003 proposed rule, they have been assigned to code condition "NI" and are subject to public comments following the publication of this rule. Some of these new codes for drugs and radiopharmaceuticals are replacements for codes for which we have hospital cost data. In these cases, we cross-walked the data for the expired codes to the new codes to determine their packaging status and payment rates. For codes that did not have a predecessor, we had no means to determine associated hospital costs; therefore, we assigned the codes to packaged status for 2004. We reinforce the importance of billing for packaged codes with appropriate charges so that we can collect cost data on these codes to use for future rate setting. We invite comments on the status indicators that have been assigned to these codes. Commenters who would like us to consider their cost data for these codes may submit verifiable external information according to the criteria set forth in the August 12, 2003 proposed rule.

Status Indicator Changes for Services Currently Packaged

Comment: A commenter asked us to pay separately for the following services for which payment is currently packaged into payment for other services. Commenters asked that we change the SI for CPT code 36540, collection of blood from an implanted access device, to a payable SI because otherwise hospitals would be forced to bill an E&M code when this is the only service provided. Commenters asked that we change the SI for 36600, withdrawal of arterial blood, from an "N" to a "T" since it requires more effort and risk than a simple venipuncture (which is paid separately under the clinical laboratory fee schedule) Commenters asked that we change the SI for 90471 and 90472, vaccine administration and each subsequent administration, from N to X since patients may present only to receive the vaccine because otherwise hospitals must bill an E&M to receive any payment. Commenters asked that we change the SI for CPT codes 94760, 94761, and 94762, Pulse oximetry, multiple and continuous, from "N" to "X" because these may be the only services the patient receives and, in the case of CPT code 94762, the service continues for a long period of time. Commenters also asked that we change the SI for the following services from "N" to "C" since they are add-ons to services that are inpatient only: 61316, 61517, 62148, and 62160.

Response: We will carefully consider the status indicator changes for the currently packaged services for which the commenter wants separate payment for 2005 OPPS. The commenters did not provide enough information or empirical evidence to convince us of the need for these changes and so we would like to have the opportunity to receive input about this from the APC Panel. We have revised the SI for the following codes from "N" to a "C" in recognition that if there are charges for these codes which are add-ons to inpatient only procedures, they are billing errors and should not be packaged into the median costs for other procedures on the claim that can be paid in the outpatient department: 61316, 61517, 62148, and 62160.

XIII. Provisions of the Final Rule With Comment Period for 2004

A. Changes Required By Statute

We made the following changes to implement statutory requirements:

- Added APCs, deleted APCs, and modified the composition of some existing APCs.

- Recalibrated the relative payment weights of the APCs.
- Updated the conversion factor and the wage index.
- Revised the APC payment amounts to reflect the APC reclassifications, the recalibration of payment weights, and the other required updates and adjustments.
- Ceased transitional pass-through payments for drugs and biologicals and devices that will have been paid under the transitional pass-through methodology for at least 2 years by January 1, 2004.
- Ceased transitional outpatient payments (TOPS payments) for all hospitals paid under OPPS except for cancer hospitals and children's hospitals.

B. Additional Changes

We made the following additional changes to the OPPS:

- Adjusted payment to moderate the effects of decreased median costs for non-pass-through drugs, biologicals, and radiopharmaceuticals.
- Changed status indicators for HCPCS codes.
- Listed midyear and proposed HCPCS codes that are paid under OPPS.
- Allocated a portion of the outlier percentage target amount to CMHCs and created a separate threshold for outlier payments for partial hospitalization services.
- Created methodology and payment rates for separately payable drugs and radiopharmaceuticals for 2004.
- Changed the status indicator and payment amount for P901 by assigning it to APC 0957 (Platelet concentrate) with a payment rate of $37.30.

C. Major Changes From the Proposed Rule

- We will apply a $50 threshold in lieu of the proposed $150 threshold in determining which drugs to pay for separately.
- We will set payment for all except two orphan drugs that meet our criteria for special payment under the OPPS at 88 percent of their AWP as established in the April 2003 single drug pricer (SDP). Based on widely available market prices for two orphan drugs, we will set the payment for these two orphan drugs at 94 percent of their AWP.
- We will set payment rates for 2004 for blood and blood products at 2003 payment rates.

XIV. 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.

The OPPS provisions set forth in this final rule do not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

XV. Response to Public Comments

Because of the large number of items of correspondence 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, if we proceed with a subsequent document, we will respond to comments in the preamble to that document.

XVI. Regulatory Impact Analysis

A. General

We have examined the impacts of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We estimate the effects of the provisions that will be implemented by this final rule will result in expenditures exceeding $100 million in any 1 year. We estimate the total increase (from changes in the final rule as well as enrollment, utilization, and case mix changes) in expenditures under the OPPS for CY 2004 compared to CY 2003 to be approximately $0.607 billion. Therefore, this final rule is an economically significant rule under Executive Order 12866, and a major rule under 5 U.S.C. 804(2).

The RFA requires agencies to determine whether a rule will have a significant economic impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year (*see* 65 FR 69432).

For purposes of the RFA, we have determined that approximately 37 percent of hospitals will be considered small entities according to the Small Business Administration (SBA) size standards. We do not have data available to calculate the percentages of entities in the pharmaceutical preparation manufacturing, biological products, or medical instrument industries that will be considered to be small entities according to the SBA size standards. For the pharmaceutical preparation manufacturing industry (NAICS 325412), the size standard is 750 or fewer employees and $67.6 billion in annual sales (1997 business census). For biological products (except diagnostic) (NAICS 325414), with $5.7 billion in annual sales, and medical instruments (NAICS 339112), with $18.5 billion in annual sales, the standard is 50 or fewer employees (*see* the standards Web site at *http://www.sba.gov/regulations/siccodes/*). Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area (MSA) and has fewer than 100

beds (or New England County Metropolitan Area (NECMA)). Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the OPPS, we classify these hospitals as urban hospitals. We believe that the changes in this final rule will affect both a substantial number of rural hospitals as well as other classes of hospitals and that the effects on some may be significant. Therefore, we conclude that this final rule will have a significant impact on a substantial number of small entities.

Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This final rule will not mandate any requirements for State, local, or tribal governments. This final rule will not impose unfunded mandates on the private sector of more than $110 million dollars.

Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes a final rule that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications.

We have examined this final rule in accordance with Executive Order 13132, Federalism, and have determined that it will not have an impact on the rights, roles, and responsibilities of State, local or tribal governments. The impact analysis (*see* Table 15) shows that payments to governmental hospitals (including State, local, and tribal governmental hospitals) will increase by 4.9 percent under the final rule.

B. Changes in This Final Rule

We are making several changes to the OPPS that are required by the statute. We are required under section 1833(t)(3)(C)(ii) of the Act to update annually the conversion factor used to determine the APC payment rates. We are also required under section 1833(t)(9)(A) of the Act to revise, not less often than annually, the wage index and other adjustments. In addition, we must review the clinical integrity of payment groups and weights at least annually. Accordingly, in this final rule, we are updating the conversion factor and the wage index adjustment for hospital outpatient services furnished beginning January 1, 2004 as we discuss in sections IX and VII, respectively, of this final rule. We are also revising the relative APC payment weights based on claims data from April 1, 2002 through December 31, 2002. Finally, we are removing two devices and eight drugs and biological agents from pass-through payment status. Alternatives to the changes we proposed and why we did not accept them are discussed throughout this final rule. In particular, see section V.B with regard to the expiration of pass-through payment for devices; see section VI.B with regard to the expiration of pass-through payment for drugs and biological agents.

Under this final rule, the change to the conversion factor as provided by statute will increase total OPPS payments by 4.5 percent in 2004. The changes to the wage index and to the APC weights (which incorporate the cessation of pass-through payments for many drugs and devices) will not increase OPPS payments because the OPPS is budget neutral. However, the wage index and APC weight changes will change the distribution of payments within the budget neutral system as shown in Table 15 and described in more detail in this section. The overall 4.5 percent increase does not take into account the expiration of transitional corridor payments or the end of the hold harmless provisions for small rural hospitals.

A. Alternatives Considered

Alternatives to the changes we are making and the reasons that we have chosen the options we have are discussed throughout this final rule. Some of the major issues discussed in this rule and the sections in which they are discussed follow:

Issue	Preamble section
Drug packaging threshold	VI.B.2.
Drug administration	VI.B.4.
Adjustment of median costs	II.B.
Outlier policy	X.A.
Device coding	V.C.
Payment adjustment for small rural hospitals.	X.B.
Payment for orphan drugs, generic drugs and blood.	VI.B.
APC changes	II.A and III.C.

Conclusion

It is clear that the changes in this final rule will affect both a substantial number of rural hospitals as well as other classes of hospitals, and the effects on some may be significant. Therefore, the discussion below, in combination with the rest of this final rule, constitutes a regulatory impact analysis.

The OPPS rates for CY 2004 will have, overall, a positive effect for every category of hospital. These changes in the OPPS for 2004 will result in an overall 4.5 percent increase in Medicare payments to hospitals, exclusive of outlier and transitional pass-through payments. We also noted that both the overall 4.5 percent increase and the percent changes to individual classes of hospitals depicted in Table 15 are exclusive of any impacts to those hospitals that would result from the expiration of the transitional corridor payments or the end of the hold harmless provision for small rural hospitals. As described in the preamble, budget neutrality adjustments are made to the conversion factor and the relative weights to ensure that the revisions in the wage index, APC groups, and relative weights do not affect aggregate payments. We also note that both the overall 4.5 percent increase and the percent changes to individual classes of hospitals depicted in Table 15 are exclusive of any impacts to those hospitals that would result from the expiration of the transitional corridor payments or the end of the hold harmless provision for small rural hospitals. The impact of the wage and recalibration changes does vary somewhat by hospital group. Estimates of these impacts are displayed on Table 15.

The overall projected increase in payments for urban hospitals is slightly lower (4.3 percent) than the average increase for all hospitals (4.5 percent) while the increase for rural hospitals is slightly greater (4.9 percent) than the average increase. Again, as noted above, these numbers do not include the effect of the expiration of the transitional hold harmless payments to small rural hospitals. The introduction of a new wage index combined with changes to the APC structure will result in small distributional changes for all categories of hospitals. Rural hospitals will gain 0.2 percent from the wage index change and another 0.2 percent as a result of APC changes. Large urban hospitals will lose 0.2 percent from the APC change, whereas "other" urban hospitals show an increase of 0.1 percent from the APC changes. A discussion of the distribution of outlier payments that we project under this final rule can be found under section XV.E below. Table 16 presents the outlier distribution that we expect to see under this final rule.

C. Limitations of Our Analysis

The distributional impacts represent the projected effects of the policy changes, as well as statutory changes effective for 2004, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per service while holding all other payment policies constant. We use the best data available but do not attempt to predict behavioral responses to our policy changes. In addition, we do not make adjustments for future changes in variables such as service volume, service mix, or number of encounters.

D. Estimated Impacts of This Final Rule on Hospitals

The OPPS is a budget neutral payment system under which the increase to the total payments made under OPPS is limited by the increase to the conversion factor set under the methodology in the statute. The impact tables show the redistribution of hospital payments among providers as a result of a new wage index and APC structure. In some cases, under this final rule, hospitals will receive more total payment than in 2003 while in other cases they will receive less total payment than they received in 2003. The impact of this final rule will depend on a number of factors, most significant of which are the mix of services furnished by a hospital (for example, how the APCs for the hospital's most frequently furnished services will change) and the impact of the wage index changes on the hospital.

Column 4 in Table 15 represents the full impact on each hospital group of all the changes for 2004. Columns 2 and 3 in the table reflect the independent effects of the final change in the wage index and the APC reclassification and recalibration changes, respectively. We excluded critical access hospitals (CAHs) from the analysis of the impact of the final 2004 OPPS rates that is summarized in Table 15. For that reason, the total number of hospitals included in Table 15 (4,378) is lower than in previous years. CAHs are excluded from the OPPS.

To a very limited extent, wage index changes favor rural hospital categories. Large urban hospitals with greater than 500 beds show the largest percent decrease (−3.0) attributable to wage index changes. Rural hospitals show modest increases of 0.2 percent for most bed sizes but show the largest gains for categories with fewer than 50 beds or 150 to 199 beds where the wage index change results in a 0.4 percent increase. Rural hospitals located in Puerto Rico show the largest negative impact (−2.5 percent) due to changes in the wage index. Hospitals located in the Middle Atlantic region also experience a large negative impact −0.6 percent due to wage index changes regardless of urban or rural designation. However, this effect is somewhat lessened by the distribution of outlier payments as discussed in more detail below.

The APC reclassification and recalibration changes also favor rural hospitals with the exception of rural hospitals with 200 or more beds that show a negative effect (−0.8 percent). Conversely, urban hospitals with greater than 199 beds show a decrease attributed to APC recalibration. Urban hospitals in excess of 500 beds show a 0.5 percent decrease as a result of APC recalibration. In general, APC changes are small and result in very few distributional changes among hospital categories.

In both urban and rural areas, hospitals that provide a lower volume of outpatient services are projected to receive a larger increase in payments than higher volume hospitals. In rural areas, hospitals with volumes between 5,000 and 20,999 are projected to experience increases larger than 5.0 percent. Urban hospitals that provide low-volume services show similar rates of increases (5.0 percent). Conversely, urban and rural hospitals providing more than 21,000 services are projected to experience a rate of increase in the 4.0 to 4.7 percent range.

Major teaching hospitals are projected to experience a smaller increase in payments (3.7 percent) than the aggregate for all hospitals (4.5 percent) due to negative impacts from both the wage index (−0.4 percent) and APC recalibration (−0.4 percent). Hospitals with less intensive teaching programs are projected to experience an overall increase (4.5 percent) that is equal to the average for all hospitals. There is little difference in impact among hospitals that serve low-income patients where increases in payments range from 4.3 to 4.7 percent higher than in 2003.

Psychiatric hospitals and long term care facilities show the largest increase in payment rates among all categories of hospital providers. Psychiatric hospitals show an increase of 18.2 percent as a result of an increase in payment rates for partial hospitalization programs and for other services such as psychotherapy. Also, payments made to psychiatric facilities represent a small portion of total spending for OPPS, approximately 60.6 million dollars for 2004. Long-term care facilities show a growth rate of 7.5 percent over payments made in 2003. We believe this is the result of a policy change that removes payments made for therapy services from the physician fee schedule to the hospital outpatient prospective payment system. Payments made for long-term care account for a small amount of OPPS payments, approximately 14.5 million for 2004.

TABLE 15.—IMPACT OF CHANGE FOR CY 2004 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

[Percent change in total payments to hospital (program and beneficiary); does not include hold harmless, corridor, outlier or transitional pass-through payments]

	Number of hospitals (1)	New Wage index (2)	APC changes (3)	All CY 2004 changes (4)
ALL HOSPITALS	4,378	0	0	4.5
NON-TEFRA HOSPITALS	3,854	0	−0.1	4.4
URBAN HOSPS	2,383	−0.1	−0.1	4.3
LARGE URBAN (GT 1 MILL.)	1,377	0	−0.2	4.2
OTHER URBAN (LE 1 MILL.)	1,006	−0.1	0.1	4.4
RURAL HOSPS	1,471	0.2	0.2	4.9
BEDS (URBAN)				
0–99 BEDS	538	0.1	0.6	5.2
100–199 BEDS	878	−0.1	0.3	4.8
200–299 BEDS	454	−0.1	−0.1	4.3
300–499 BEDS	363	0.1	−0.4	4.2
500 + BEDS	150	−0.3	−0.5	3.7
BEDS (RURAL)				
0–49 BEDS	699	0.4	0.6	5.6

TABLE 15.—IMPACT OF CHANGE FOR CY 2004 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent change in total payments to hospital (program and beneficiary); does not include hold harmless, corridor, outlier or transitional pass-through payments]

	Number of hospitals (1)	New Wage index (2)	APC changes (3)	All CY 2004 changes (4)
50–99 BEDS	454	0.2	0.6	5.3
100–149 BEDS	190	0.2	0	4.7
150–199 BEDS	66	0.4	0.1	4.9
200 + BEDS	62	0.1	−0.8	3.7
VOLUME (URBAN)				
LT 5,000 Lines	186	0.1	1	5.6
5,000–10,999 Lines	350	0	0.9	5.4
11,000–20,999 Lines	499	−0.1	0.7	5.1
21,000–42,999 Lines	720	0.1	0.1	4.6
GT 42,999 Lines	628	−0.1	−0.4	4
VOLUME (RURAL)				
LT 5,000 Lines	364	0.3	0	4.8
5,000–10,999 Lines	466	0.3	0.5	5.3
11,000–20,999 Lines	346	0.2	0.7	5.4
21,000–42,999 Lines	234	0.3	0	4.7
GT 42,999 Lines	61	0.1	−0.4	4.2
REGION (URBAN)				
NEW ENGLAND	128	−0.3	−0.3	3.9
MIDDLE ATLANTIC	369	−0.6	−0.5	3.4
SOUTH ATLANTIC	353	0	0	4.5
EAST NORTH CENT.	400	−0.2	−0.2	4
EAST SOUTH CENT.	149	0.3	0.2	5
WEST NORTH CENT.	163	0.2	0.5	5.1
WEST SOUTH CENT.	295	0.1	0.1	4.7
MOUNTAIN	122	0.8	0	5.3
PACIFIC	364	0.3	−0.2	4.6
PUERTO RICO	40	0	4.8	9.5
REGION (RURAL)				
NEW ENGLAND	36	0.4	1.7	6.7
MIDDLE ATLANTIC	65	−0.6	0.9	4.9
SOUTH ATLANTIC	216	0.1	0	4.6
EAST NORTH CENT.	193	0.2	0	4.7
EAST SOUTH CENT.	227	0.2	−0.2	4.5
WEST NORTH CENT.	247	0.8	0.5	5.8
WEST SOUTH CENT.	269	0.4	0.2	5.2
MOUNTAIN	123	0.2	−0.1	4.6
PACIFIC	90	0.4	−0.9	3.9
PUERTO RICO	5	−2.5	0.3	2.2
TEACHING STATUS				
NON-TEACHING	2,805	0.1	0.1	4.7
MINOR	761	0.1	−0.1	4.5
MAJOR	288	−0.4	−0.4	3.7
DSH PATIENT (PERCENT)				
0	10	3	3.8	11.6
GT 0–0.10	897	0	−0.2	4.3
0.10–0.16	837	−0.1	0	4.4
0.16–0.23	787	0.1	−0.2	4.3
0.23–0.35	744	0	0.1	4.5
GE 0.35	579	−0.1	0.2	4.7
URBAN IME/DSH				
IME & DSH	965	−0.1	−0.2	4.1
IME/NO DSH	1	−0.1	8.5	13.3
NO IME/DSH	1,409	0	0.1	4.6
NO IME/NO DSH	8	3	3.7	11.6
RURAL HOSP. TYPES				
NO SPECIAL STATUS	469	0.1	0.2	4.9
RRC	161	0.3	−0.5	4.3
SCH/EACH	489	0.3	0.5	5.4
MDH	250	0.3	1.6	6.5
SCH AND RRC	75	0.1	−0.3	4.3
TYPE OF OWNERSHIP				
VOLUNTARY	2,370	−0.1	−0.2	4.2
PROPRIETARY	696	0.2	0.5	5.2
GOVERNMENT	788	0.2	0.3	4.9
SPECIALTY HOSPITALS				
EYE AND EAR	13	−0.6	1.8	5.7
CANCER	11	0	−1.2	3.2
TEFRA HOSPITALS (NOT INCLUDED ON OTHER LINES)				
REHAB	155	0.5	−1.1	3.9

TABLE 15.—IMPACT OF CHANGE FOR CY 2004 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent change in total payments to hospital (program and beneficiary); does not include hold harmless, corridor, outlier or transitional pass-through payments]

	Number of hospitals (1)	New Wage index (2)	APC changes (3)	All CY 2004 changes (4)
PSYCH	175	0.8	12.2	18.2
LTC	150	1.6	1.2	7.5
CHILDREN	44	0	0.5	4.9

1. Some data necessary to classify hospitals by category were missing; thus, the total number of hospitals in each category may not equal the national total.
2. This column shows the impact of updating the wage index used to calculate payment by applying the FY 2004 hospital inpatient wage index after geographic reclassification by the Medicare Geographic Classification Review Board. The appropriate hospital inpatient wage index appears in a correction notice published in the FEDERAL REGISTER on October 6, 2003 68FR 57732.
3. This column shows the impact of changes resulting from the reclassification of HCPCS codes among APC groups and the recalibration of APC weights based on 2002 hospital claims data.
4. This column shows changes in total payment from CY 2003 to CY 2004, excluding outlier and pass-through payments. It incorporates all of the changes reflected in columns 2 and 3. In addition, it shows the impact of the FY 2004 payment update. The sum of the columns may be different from the percentage changes shown here due to rounding.
5. Volume is expressed in terms of the number of lines that appear on a claim.

E. Projected Distribution of Outlier Payments

As stated elsewhere in this preamble, we have allocated 2 percent of the estimated 2004 expenditures to outlier payments. Table 16 below illustrates the percentage of outlier payments relative to the total projected payments for the categories of hospitals that we show in the impact table.

We project, based on the mix of services for the hospitals that will be paid under the OPPS in 2004, that approximately 95 percent of hospitals will receive outlier payments. For the majority of provider groups, the table shows outlier payments as a percent of total payments in the 1.5 to 3.5 percent range. Two categories, Rehabilitation and Children's hospitals are the exception with outlier to total payment ratios of 6.7 and 11.9 percent respectively. We would point out that these hospital types represent a small number of providers with a low volume of services. The anticipated outlier payments for urban hospitals can be expected to ameliorate the impact of the wage index and APC changes on payments to urban hospitals.

TABLE 16.—DISTRIBUTION OF OUTLIER PAYMENTS FOR CY 2004 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT

	Number of hospitals	Percent of total hospitals	Number of hospitals with outliers	Outlier payments as a percent of total payments (percent)
ALL HOSPITALS	4,378	100	4,144	2.0
NON-TEFRA HOSPITALS	3,854	88	3,841	2.0
URBAN HOSPS	2,383	54.4	2,372	2.1
LARGE URBAN (GT 1 MILL.)	1,377	31.4	1,371	2.3
OTHER URBAN (LE 1 MILL.)	1,006	23	1,001	1.8
RURAL HOSPS	1,471	33.6	1,469	1.7
BEDS (URBAN)				
0–99 BEDS	538	12.2	529	2.5
100–199 BEDS	878	20	877	1.8
200–299 BEDS	454	10.4	453	1.9
300–499 BEDS	363	8.2	363	2.1
500 + BEDS	150	3.4	150	2.6
BEDS (RURAL)				
0–49 BEDS	699	16	698	2.3
50–99 BEDS	454	10.4	453	1.9
100–149 BEDS	190	4.4	190	1.4
150–199 BEDS	66	1.6	66	1.7
200 + BEDS	62	1.4	62	1.4
VOLUME (URBAN)				
LT 5,000	186	4.2	175	3.2
5,000–10,999	350	8	350	3.0
11,000–20,999	499	11.4	499	2.1
21,000–42,999	720	16.4	720	2.0
GT 42,999	628	14.4	628	2.1
VOLUME (RURAL)				
LT 5,000	364	8.4	362	3.1
5,000–10,999	466	10.6	466	2.2
11,000–20,999	346	8	346	1.8
21,000–42,999	234	5.4	234	1.5
GT 42,999	61	1.4	61	1.5
REGION (URBAN)				
NEW ENGLAND	128	3	127	1.8

TABLE 16.—DISTRIBUTION OF OUTLIER PAYMENTS FOR CY 2004 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT—Continued

	Number of hospitals	Percent of total hospitals	Number of hospitals with outliers	Outlier payments as a percent of total payments (percent)
MIDDLE ATLANTIC	369	8.4	369	3.1
SOUTH ATLANTIC	353	8	353	1.9
EAST NORTH CENT.	400	9.2	396	1.9
EAST SOUTH CENT.	149	3.4	148	1.4
WEST NORTH CENT.	163	3.8	163	1.6
WEST SOUTH CENT.	295	6.8	295	2.4
MOUNTAIN	122	2.8	120	1.9
PACIFIC	364	8.4	361	2.0
PUERTO RICO	40	1	40	0.6
REGION (RURAL)				
NEW ENGLAND	36	0.8	36	2.2
MIDDLE ATLANTIC	65	1.4	65	1.6
SOUTH ATLANTIC	216	5	215	1.6
EAST NORTH CENT.	193	4.4	193	1.6
EAST SOUTH CENT.	227	5.2	227	1.2
WEST NORTH CENT.	247	5.6	246	1.8
WEST SOUTH CENT.	269	6.2	269	1.8
MOUNTAIN	123	2.8	123	2.8
PACIFIC	90	2	90	2.4
PUERTO RICO	5	0.2	5	1.0
TEACHING STATUS				
NON-TEACHING	2,805	64	2,793	1.8
MINOR	761	17.4	760	1.7
MAJOR	288	6.6	288	3.0
DSH PATIENT (PERCENT)				
0	10	0.2	8	3.5
GT 0–0.10	897	20.4	892	1.9
0.10–0.16	837	19.2	837	1.8
0.16–0.23	787	18	787	1.7
0.23–0.35	744	17	741	2.3
GE 0.35	579	13.2	576	2.9
URBAN IME/DSH				
IME & DSH	965	22	965	2.3
IME/NO DSH	1	0	0	0.0
NO IME/DSH	1,409	32.2	1,400	1.8
NO IME/NO DSH	8	0.2	7	3.5
RURAL HOSP. TYPES				
NO SPECIAL STATUS	469	10.8	467	1.8
RRC	161	3.6	161	1.4
SCH/EACH	489	11.2	489	2.1
MDH	250	5.8	250	2.0
SCH AND RRC	75	1.8	75	1.5
TYPE OF OWNERSHIP				
VOLUNTARY	2,370	54.2	2,366	1.9
PROPRIETARY	696	15.8	689	2.0
GOVERNMENT	788	18	786	2.5
SPECIALTY HOSPITALS				
EYE AND EAR	13	0.2	13	2.7
CANCER	11	0.2	11	3.9
TEFRA HOSPITALS (NOT INCLUDED ON OTHER LINES)				
REHAB	155	3.6	103	6.7
PSYCH	175	4	59	0.5
LTC	150	3.4	98	2.5
CHILDREN	44	1	43	11.9

F. Estimated Impacts of This Final Rule on Beneficiaries

For services for which the beneficiary pays a coinsurance of 20 percent of the payment rate, the beneficiary share of payment will increase for services for which OPPS payments will rise and will decrease for services for which OPPS payments will fall. For example, for a mid-level office visit (APC 0601), the minimum unadjusted co-payment in 2003 was $10.11; under this final rule, the minimum unadjusted co-payment for APC 601 will be $10.71 because the OPPS payment for the service will increase under this final rule. For some services (those services for which a national unadjusted co-payment amount is shown in Addendum B) the beneficiary co-payment is frozen based on historic data and will not change, and will therefore present no potential impact on beneficiaries.

However, in all cases, the statute limits beneficiary liability for co-payment for a service to the inpatient hospital deductible for the applicable year. This amount is $876 for 2004. In general, the impact of this final rule on beneficiaries will vary based on the service the beneficiary receives and whether the co-payment for the service is one that is frozen under the OPPS.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: October 27, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: October 29, 2003.

Tommy G. Thompson,

Secretary.

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0001	Level I Photochemotherapy	S	0.4237	$23.12	$7.09	$4.62
0002	Level I Fine Needle Biopsy/Aspiration	T	0.8083	$44.10	.....	$8.82
0003	Bone Marrow Biopsy/Aspiration	T	2.3229	$126.74	.....	$25.35
0004	Level I Needle Biopsy/ Aspiration Except Bone Marrow	T	1.5882	$86.65	$22.36	$17.33
0005	Level II Needle Biopsy/Aspiration Except Bone Marrow	T	3.2698	$178.40	$71.59	$35.68
0006	Level I Incision & Drainage	T	1.6527	$90.17	$23.26	$18.03
0007	Level II Incision & Drainage	T	11.8633	$647.27	.....	$129.45
0008	Level III Incision and Drainage	T	19.4831	$1,063.02	.....	$212.60
0009	Nail Procedures	T	0.6652	$36.29	$8.34	$7.26
0010	Level I Destruction of Lesion	T	0.6480	$35.36	$10.08	$7.07
0011	Level II Destruction of Lesion	T	2.2217	$121.22	$27.88	$24.24
0012	Level I Debridement & Destruction	T	0.7694	$41.98	$11.18	$8.40
0013	Level II Debridement & Destruction	T	1.1272	$61.50	$14.20	$12.30
0015	Level III Debridement & Destruction	T	1.5968	$87.12	$20.35	$17.42
0016	Level IV Debridement & Destruction	T	2.5724	$140.35	$57.31	$28.07
0017	Level VI Debridement & Destruction	T	16.3697	$893.15	$227.84	$178.63
0018	Biopsy of Skin/Puncture of Lesion	T	0.9178	$50.08	$16.04	$10.02
0019	Level I Excision/ Biopsy	T	3.9493	$215.48	$71.87	$43.10
0020	Level II Excision/ Biopsy	T	7.0842	$386.52	$113.25	$77.30
0021	Level III Excision/ Biopsy	T	14.3594	$783.46	$219.48	$156.69
0022	Level IV Excision/ Biopsy	T	18.7932	$1,025.38	$354.45	$205.08
0023	Exploration Penetrating Wound	T	2.8141	$153.54	$40.37	$30.71
0024	Level I Skin Repair	T	1.6850	$91.94	$33.10	$18.39
0025	Level II Skin Repair	T	5.1912	$283.24	$107.00	$56.65
0027	Level IV Skin Repair	T	15.8990	$867.47	$329.72	$173.49
0028	Level I Breast Surgery	T	17.6584	$963.46	$303.74	$192.69
0029	Level II Breast Surgery	T	30.1167	$1,643.20	$632.64	$328.64
0030	Level III Breast Surgery	T	37.3083	$2,035.58	$763.55	$407.12
0032	Insertion of Central Venous/Arterial Catheter	T	11.4907	$626.94	.....	$125.39
0033	Partial Hospitalization	P	5.2569	$286.82	.....	$57.36
0035	Placement of Arterial or Central Venous Catheter	T	0.1691	$9.23	$2.79	$1.85
0036	Level II Fine Needle Biopsy/Aspiration	T	1.5170	$82.77	.....	$16.55
0037	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	9.8921	$539.72	$237.45	$107.94
0039	Implantation of Neurostimulator	S	235.1866	$12,832.02	.....	$2,566.40
0040	Level II Implantation of Neurostimulator Electrodes	S	52.1002	$2,842.64	.....	$568.53
0041	Level I Arthroscopy	T	27.3819	$1,493.98	.....	$298.80
0042	Level II Arthroscopy	T	43.0808	$2,350.53	$804.74	$470.11
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	1.9074	$104.07	.....	$20.81
0045	Bone/Joint Manipulation Under Anesthesia	T	13.5889	$741.42	$268.47	$148.28
0046	Open/Percutaneous Treatment Fracture or Dislocation	T	32.5581	$1,776.40	$535.76	$355.28
0047	Arthroplasty without Prosthesis	T	29.9582	$1,634.55	$537.03	$326.91
0048	Arthroplasty with Prosthesis	T	51.4609	$2,807.76	$695.60	$561.55
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	19.6046	$1,069.65	.....	$213.93
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	24.8651	$1,356.66	.....	$271.33
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	34.5144	$1,883.14	.....	$376.63
0052	Level IV Musculoskeletal Procedures Except Hand and Foot.	T	42.7126	$2,330.44	.....	$466.09
0053	Level I Hand Musculoskeletal Procedures	T	14.8831	$812.04	$253.49	$162.41
0054	Level II Hand Musculoskeletal Procedures	T	24.2456	$1,322.86	.....	$264.57
0055	Level I Foot Musculoskeletal Procedures	T	18.7205	$1,021.41	$355.34	$204.28
0056	Level II Foot Musculoskeletal Procedures	T	25.3930	$1,385.47	$405.81	$277.09
0057	Bunion Procedures	T	25.5035	$1,391.50	$475.91	$278.30
0058	Level I Strapping and Cast Application	S	1.0931	$59.64	.....	$11.93
0060	Manipulation Therapy	S	0.2788	$15.21	.....	$3.04
0068	CPAP Initiation	S	1.0807	$58.96	$29.48	$11.79
0069	Thoracoscopy	T	28.9392	$1,578.95	$591.64	$315.79
0070	Thoracentesis/Lavage Procedures	T	3.0717	$167.60	.....	$33.52
0071	Level I Endoscopy Upper Airway	T	0.8799	$48.01	$12.89	$9.60

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCs) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0072	Level II Endoscopy Upper Airway	T	1.7613	$96.10	$26.68	$19.22
0073	Level III Endoscopy Upper Airway	T	3.4541	$188.46	$73.38	$37.69
0074	Level IV Endoscopy Upper Airway	T	13.9480	$761.02	$295.70	$152.20
0075	Level V Endoscopy Upper Airway	T	20.3815	$1,112.04	$445.92	$222.41
0076	Level I Endoscopy Lower Airway	T	9.2346	$503.85	$189.82	$100.77
0077	Level I Pulmonary Treatment	S	0.2837	$15.48	$7.74	$3.10
0078	Level II Pulmonary Treatment	S	0.7917	$43.20	$14.55	$8.64
0079	Ventilation Initiation and Management	S	2.1494	$117.27	.....	$23.45
0080	Diagnostic Cardiac Catheterization	T	36.0160	$1,965.07	$838.92	$393.01
0081	Non-Coronary Angioplasty or Atherectomy	T	35.0285	$1,911.19	.....	$382.24
0082	Coronary Atherectomy	T	110.2196	$6,013.69	$1,293.59	$1,202.74
0083	Coronary Angioplasty and Percutaneous Valvuloplasty	T	59.2047	$3,230.27	.....	$646.05
0084	Level I Electrophysiologic Evaluation	S	10.5226	$574.12	.....	$114.82
0085	Level II Electrophysiologic Evaluation	T	35.4126	$1,932.15	$426.25	$386.43
0086	Ablate Heart Dysrhythm Focus	T	44.9389	$2,451.91	$833.33	$490.38
0087	Cardiac Electrophysiologic Recording/Mapping	T	39.8161	$2,172.41	.....	$434.48
0088	Thrombectomy	T	34.6942	$1,892.95	$655.22	$378.59
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes.	T	117.1896	$6,393.98	$1,722.59	$1,278.80
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	96.8284	$5,283.05	$1,651.45	$1,056.61
0091	Level II Vascular Ligation	T	28.8326	$1,573.14	$348.23	$314.63
0092	Level I Vascular Ligation	T	25.0959	$1,369.26	$505.37	$273.85
0093	Vascular Reconstruction/Fistula Repair without Device	T	21.3104	$1,162.72	$277.34	$232.54
0094	Level I Resuscitation and Cardioversion	S	2.6345	$143.74	$48.58	$28.75
0095	Cardiac Rehabilitation	S	0.5994	$32.70	$16.35	$6.54
0096	Non-Invasive Vascular Studies	S	1.7176	$93.71	$46.85	$18.74
0097	Cardiac and Ambulatory Blood Pressure Monitoring	X	1.0635	$58.03	$23.80	$11.61
0098	Injection of Sclerosing Solution	T	1.0729	$58.54	$14.06	$11.71
0099	Electrocardiograms	S	0.3703	$20.20	.....	$4.04
0100	Cardiac Stress Tests	X	1.5862	$86.54	$41.44	$17.31
0101	Tilt Table Evaluation	S	4.4040	$240.29	$105.27	$48.06
0103	Miscellaneous Vascular Procedures	T	11.6202	$634.01	$223.63	$126.80
0104	Transcatheter Placement of Intracoronary Stents	T	82.6713	$4,510.63	.....	$902.13
0105	Revision/Removal of Pacemakers, AICD, or Vascular	T	19.1898	$1,047.01	$370.40	$209.40
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes.	T	58.9719	$3,217.57	.....	$643.51
0107	Insertion of Cardioverter-Defibrillator	T	337.1304	$18,394.17	$3,699.14	$3,678.83
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.	T	433.2998	$23,641.27	.....	$4,728.25
0109	Removal of Implanted Devices	T	7.4705	$407.60	$131.49	$81.52
0110	Transfusion	S	3.6718	$200.34	.....	$40.07
0111	Blood Product Exchange	S	13.1719	$718.67	$200.18	$143.73
0112	Apheresis, Photopheresis, and Plasmapheresis	S	37.5832	$2,050.58	$612.47	$410.12
0113	Excision Lymphatic System	T	19.9322	$1,087.52	.....	$217.50
0114	Thyroid/Lymphadenectomy Procedures	T	37.5963	$2,051.29	$485.91	$410.26
0115	Cannula/Access Device Procedures	T	25.6437	$1,399.15	$459.35	$279.83
0116	Chemotherapy Administration by Other Technique Except Infusion.	S	0.7996	$43.63	.....	$8.73
0117	Chemotherapy Administration by Infusion Only	S	3.0360	$165.65	$42.54	$33.13
0119	Implantation of Infusion Pump	T	134.7194	$7,350.43	.....	$1,470.09
0120	Infusion Therapy Except Chemotherapy	T	1.9114	$104.29	$28.21	$20.86
0121	Level I Tube changes and Repositioning	T	2.1189	$115.61	$43.80	$23.12
0122	Level II Tube changes and Repositioning	T	8.8621	$483.53	$99.16	$96.71
0123	Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant.	S	5.2882	$288.53	.....	$57.71
0124	Revision of Implanted Infusion Pump	T	23.8050	$1,298.82	.....	$259.76
0125	Refilling of Infusion Pump	T	2.1606	$117.88	.....	$23.58
0130	Level I Laparoscopy	T	32.7724	$1,788.09	$659.53	$357.62
0131	Level II Laparoscopy	T	40.8064	$2,226.44	$1,001.89	$445.29
0132	Level III Laparoscopy	T	57.2045	$3,121.13	$1,239.22	$624.23
0140	Esophageal Dilation without Endoscopy	T	6.4525	$352.05	$107.24	$70.41
0141	Upper GI Procedures	T	7.8206	$426.70	$143.38	$85.34
0142	Small Intestine Endoscopy	T	8.7959	$479.91	$152.78	$95.98
0143	Lower GI Endoscopy	T	8.2957	$452.62	$186.06	$90.52
0146	Level I Sigmoidoscopy	T	3.9826	$217.29	$64.40	$43.46
0147	Level II Sigmoidoscopy	T	7.6808	$419.07	.....	$83.81
0148	Level I Anal/Rectal Procedure	T	3.8320	$209.08	$63.38	$41.82
0149	Level III Anal/Rectal Procedure	T	17.1425	$935.31	$293.06	$187.06
0150	Level IV Anal/Rectal Procedure	T	22.1919	$1,210.81	$437.12	$242.16

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP).	T	17.9462	$979.16	$245.46	$195.83
0152	Percutaneous Abdominal and Biliary Procedures	T	9.1474	$499.09	$125.28	$99.82
0153	Peritoneal and Abdominal Procedures	T	20.8723	$1,138.81	$410.87	$227.76
0154	Hernia/Hydrocele Procedures	T	26.9636	$1,471.16	$464.85	$294.23
0155	Level II Anal/Rectal Procedure	T	10.0809	$550.02	$188.89	$110.00
0156	Level II Urinary and Anal Procedures	T	2.4747	$135.02	$40.52	$27.00
0157	Colorectal Cancer Screening: Barium Enema	S	2.5693	$140.18	.....	$28.04
0158	Colorectal Cancer Screening: Colonoscopy	T	7.4244	$405.08	.....	$101.27
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	2.7823	$151.81	.....	$37.95
0160	Level I Cystourethroscopy and other Genitourinary Procedures.	T	6.8801	$375.39	$105.06	$75.08
0161	Level II Cystourethroscopy and other Genitourinary Procedures.	T	16.8407	$918.85	$249.36	$183.77
0162	Level III Cystourethroscopy and other Genitourinary Procedures.	T	21.9098	$1,195.42	.....	$239.08
0163	Level IV Cystourethroscopy and other Genitourinary Procedures.	T	33.8805	$1,848.55	.....	$369.71
0164	Level I Urinary and Anal Procedures	T	1.2021	$65.59	$17.59	$13.12
0165	Level III Urinary and Anal Procedures	T	14.6838	$801.16	.....	$160.23
0166	Level I Urethral Procedures	T	16.7918	$916.18	$218.73	$183.24
0167	Level III Urethral Procedures	T	30.0186	$1,637.84	$555.84	$327.57
0168	Level II Urethral Procedures	T	30.0147	$1,637.63	$405.60	$327.53
0169	Lithotripsy	T	45.1150	$2,461.52	$1,115.69	$492.30
0170	Dialysis	S	5.9678	$325.61	.....	$65.12
0180	Circumcision	T	18.6176	$1,015.79	$304.87	$203.16
0181	Penile Procedures	T	29.4217	$1,605.28	$621.82	$321.06
0183	Testes/Epididymis Procedures	T	21.6724	$1,182.47	.....	$236.49
0184	Prostate Biopsy	T	3.8995	$212.76	$96.27	$42.55
0187	Miscellaneous Placement/Repositioning	X	4.4288	$241.64	$90.71	$48.33
0188	Level II Female Reproductive Proc	T	1.1365	$62.01	.....	$12.40
0189	Level III Female Reproductive Proc	T	1.4232	$77.65	$18.09	$15.53
0190	Level I Hysteroscopy	T	19.6922	$1,074.43	$424.28	$214.89
0191	Level I Female Reproductive Proc	T	0.1853	$10.11	$2.93	$2.02
0192	Level IV Female Reproductive Proc	T	2.7121	$147.97	$39.11	$29.59
0193	Level V Female Reproductive Proc	T	15.0453	$820.89	$171.13	$164.18
0194	Level VIII Female Reproductive Proc	T	18.4286	$1,005.48	$397.84	$201.10
0195	Level IX Female Reproductive Proc	T	25.6950	$1,401.94	$483.80	$280.39
0196	Dilation and Curettage	T	16.1219	$879.63	$338.23	$175.93
0197	Infertility Procedures	T	4.8280	$263.42	.....	$52.68
0198	Pregnancy and Neonatal Care Procedures	T	1.3578	$74.08	$32.19	$14.82
0199	Obstetrical Care Service	T	17.2831	$942.98	.....	$188.60
0200	Level VII Female Reproductive Proc	T	17.9920	$981.66	$307.83	$196.33
0201	Level VI Female Reproductive Proc	T	16.8660	$920.23	$329.65	$184.05
0202	Level X Female Reproductive Proc	T	38.9821	$2,126.90	$1,042.18	$425.38
0203	Level IV Nerve Injections	T	11.5969	$632.74	$276.76	$126.55
0204	Level I Nerve Injections	T	2.1711	$118.46	$40.13	$23.69
0206	Level II Nerve Injections	T	5.2875	$288.49	$75.55	$57.70
0207	Level III Nerve Injections	T	6.4554	$352.21	$123.69	$70.44
0208	Laminotomies and Laminectomies	T	40.2830	$2,197.88	.....	$439.58
0209	Extended EEG Studies and Sleep Studies, Level II	S	11.5435	$629.82	$280.58	$125.96
0212	Nervous System Injections	T	2.9739	$162.26	$74.67	$32.45
0213	Extended EEG Studies and Sleep Studies, Level I	S	2.9055	$158.53	$65.74	$31.71
0214	Electroencephalogram	S	2.2176	$120.99	$58.12	$24.20
0215	Level I Nerve and Muscle Tests	S	0.6457	$35.23	$15.76	$7.05
0216	Level III Nerve and Muscle Tests	S	2.8535	$155.69	$67.98	$31.14
0218	Level II Nerve and Muscle Tests	S	1.1404	$62.22	.....	$12.44
0220	Level I Nerve Procedures	T	16.5554	$903.28	.....	$180.66
0221	Level II Nerve Procedures	T	24.8875	$1,357.89	$463.62	$271.58
0222	Implantation of Neurological Device	T	232.2024	$12,669.20	.....	$2,533.84
0223	Implantation or Revision of Pain Management Catheter	T	26.7610	$1,460.11	.....	$292.02
0224	Implantation of Reservoir/Pump/Shunt	T	34.1770	$1,864.73	$453.41	$372.95
0225	Level I Implementation of Neurostimulator Electrodes	S	206.0034	$11,239.75	.....	$2,247.95
0226	Implantation of Drug Infusion Reservoir	T	136.2989	$7,436.60	.....	$1,487.32
0227	Implantation of Drug Infusion Device	T	160.8363	$8,775.39	.....	$1,755.08
0228	Creation of Lumbar Subarachnoid Shunt	T	52.2880	$2,852.89	$639.03	$570.58
0229	Transcatherter Placement of Intravascular Shunts	T	61.9895	$3,382.21	$771.23	$676.44
0230	Level I Eye Tests & Treatments	S	0.7619	$41.57	$14.97	$8.31
0231	Level III Eye Tests & Treatments	S	2.1883	$119.40	$50.94	$23.88

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCs) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0232	Level I Anterior Segment Eye Procedures	T	4.9206	$268.47	$103.17	$53.69
0233	Level II Anterior Segment Eye Procedures	T	14.4205	$786.80	$266.33	$157.36
0234	Level III Anterior Segment Eye Procedures	T	21.4631	$1,171.05	$511.31	$234.21
0235	Level I Posterior Segment Eye Procedures	T	5.0749	$276.89	$72.04	$55.38
0236	Level II Posterior Segment Eye Procedures	T	18.6701	$1,018.66	.....	$203.73
0237	Level III Posterior Segment Eye Procedures	T	34.1784	$1,864.81	$818.54	$372.96
0238	Level I Repair and Plastic Eye Procedures	T	3.1954	$174.34	$58.96	$34.87
0239	Level II Repair and Plastic Eye Procedures	T	6.1331	$334.63	.....	$66.93
0240	Level III Repair and Plastic Eye Procedures	T	17.4535	$952.28	$315.31	$190.46
0241	Level IV Repair and Plastic Eye Procedures	T	22.1969	$1,211.09	$384.47	$242.22
0242	Level V Repair and Plastic Eye Procedures	T	29.4294	$1,605.70	$597.36	$321.14
0243	Strabismus/Muscle Procedures	T	21.7323	$1,185.74	$431.39	$237.15
0244	Corneal Transplant	T	37.6284	$2,053.04	$803.26	$410.61
0245	Level I Cataract Procedures without IOL Insert	T	12.2973	$670.95	$222.22	$134.19
0246	Cataract Procedures with IOL Insert	T	22.9755	$1,253.57	$495.96	$250.71
0247	Laser Eye Procedures Except Retinal	T	4.9482	$269.98	$104.31	$54.00
0248	Laser Retinal Procedures	T	4.8223	$263.11	$95.08	$52.62
0249	Level II Cataract Procedures without IOL Insert	T	27.7406	$1,513.55	$524.67	$302.71
0250	Nasal Cauterization/Packing	T	1.4697	$80.19	$28.07	$16.04
0251	Level I ENT Procedures	T	1.7880	$97.56	.....	$19.51
0252	Level II ENT Procedures	T	6.4469	$351.75	$113.41	$70.35
0253	Level III ENT Procedures	T	15.2249	$830.69	$282.29	$166.14
0254	Level IV ENT Procedures	T	21.8901	$1,194.35	$321.35	$238.87
0256	Level V ENT Procedures	T	35.1548	$1,918.08	.....	$383.62
0258	Tonsil and Adenoid Procedures	T	20.6265	$1,125.40	$437.25	$225.08
0259	Level VI ENT Procedures	T	392.8622	$21,434.95	$9,394.83	$4,286.99
0260	Level I Plain Film Except Teeth	X	0.7802	$42.57	$21.28	$8.51
0261	Level II Plain Film Except Teeth Including Bone Density Measurement.	X	1.3176	$71.89	.....	$14.38
0262	Plain Film of Teeth	X	0.7540	$41.14	$9.82	$8.23
0263	Level I Miscellaneous Radiology Procedures	X	2.1883	$119.40	$43.58	$23.88
0264	Level II Miscellaneous Radiology Procedures	X	3.0287	$165.25	$79.41	$33.05
0265	Level I Diagnostic Ultrasound Except Vascular	S	1.0289	$56.14	$28.07	$11.23
0266	Level II Diagnostic Ultrasound Except Vascular	S	1.6117	$87.94	$43.97	$17.59
0267	Level III Diagnostic Ultrasound Except Vascular	S	2.4586	$134.14	$65.52	$26.83
0268	Ultrasound Guidance Procedures	S	1.3081	$71.37	.....	$14.27
0269	Level III Echocardiogram Except Transesophageal	S	3.2309	$176.28	$87.24	$35.26
0270	Transesophageal Echocardiogram	S	5.8546	$319.43	$146.79	$63.89
0271	Mammography	S	0.6499	$35.46	$16.80	$7.09
0272	Level I Fluoroscopy	X	1.4166	$77.29	$38.36	$15.46
0274	Myelography	S	3.5931	$196.04	$93.63	$39.21
0275	Arthrography	S	3.2775	$178.82	$69.09	$35.76
0276	Level I Digestive Radiology	S	1.5906	$86.78	$41.72	$17.36
0277	Level II Digestive Radiology	S	2.4444	$133.37	$60.47	$26.67
0278	Diagnostic Urography	S	2.7012	$147.38	$66.07	$29.48
0279	Level II Angiography and Venography except Extremity	S	10.7073	$584.20	$174.57	$116.84
0280	Level III Angiography and Venography except Extremity	S	19.1015	$1,042.20	$353.85	$208.44
0281	Venography of Extremity	S	6.6031	$360.27	$115.16	$72.05
0282	Miscellaneous Computerized Axial Tomography	S	1.6834	$91.85	$44.51	$18.37
0283	Computerized Axial Tomography with Contrast Material	S	4.6543	$253.94	$126.27	$50.79
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contras.	S	7.1165	$388.28	$194.13	$77.66
0285	Myocardial Positron Emission Tomography (PET)	S	14.1508	$772.08	$334.45	$154.42
0287	Complex Venography	S	6.4923	$354.23	$111.33	$70.85
0288	Bone Density:Axial Skeleton	S	1.2726	$69.43	.....	$13.89
0289	Needle Localization for Breast Biopsy	X	3.4900	$190.42	$44.80	$38.08
0296	Level I Therapeutic Radiologic Procedures	S	2.8635	$156.24	$69.20	$31.25
0297	Level II Therapeutic Radiologic Procedures	S	7.7145	$420.91	$172.51	$84.18
0299	Miscellaneous Radiation Treatment	S	5.7618	$314.37	.....	$62.87
0300	Level I Radiation Therapy	S	1.4912	$81.36	.....	$16.27
0301	Level II Radiation Therapy	S	2.1340	$116.43	.....	$23.29
0302	Level III Radiation Therapy	S	6.3268	$345.20	$130.77	$69.04
0303	Treatment Device Construction	X	2.8835	$157.33	$66.95	$31.47
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.6742	$91.35	$41.52	$18.27
0305	Level II Therapeutic Radiation Treatment Preparation	X	3.6767	$200.60	$91.38	$40.12
0310	Level III Therapeutic Radiation Treatment Preparation	X	13.7165	$748.39	$325.27	$149.68
0312	Radioelement Applications	S	3.6637	$199.90	.....	$39.98
0313	Brachytherapy	S	16.2481	$886.51	.....	$177.30
0314	Hyperthermic Therapies	S	4.6041	$251.20	$101.77	$50.24

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCs) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0320	Electroconvulsive Therapy	S	5.3785	$293.46	$80.06	$58.69
0321	Biofeedback and Other Training	S	1.2387	$67.58	$21.78	$13.52
0322	Brief Individual Psychotherapy	S	1.2802	$69.85		$13.97
0323	Extended Individual Psychotherapy	S	1.8689	$101.97	$21.26	$20.39
0324	Family Psychotherapy	S	2.4473	$133.53		$26.71
0325	Group Psychotherapy	S	1.4865	$81.10	$18.27	$16.22
0330	Dental Procedures	S	0.5745	$31.35		$6.27
0332	Computerized Axial Tomography and Computerized Angiography without Contras.	S	3.3936	$185.16	$91.27	$37.03
0333	Computerized Axial Tomography and Computerized Angio w/o Contrast Material.	S	5.4241	$295.94	$146.98	$59.19
0335	Magnetic Resonance Imaging, Miscellaneous	S	6.3499	$346.46	$151.46	$69.29
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Cont.	S	6.3897	$348.63	$174.31	$69.73
0337	MRI and Magnetic Resonance Angiography without Contrast Material followed.	S	9.2075	$502.37	$240.77	$100.47
0339	Observation	S	3.8356	$209.27		$41.85
0340	Minor Ancillary Procedures	X	0.6314	$34.45		$6.89
0341	Skin Tests	X	0.1365	$7.45	$3.03	$1.49
0342	Level I Pathology	X	0.2162	$11.80	$5.88	$2.36
0343	Level II Pathology	X	0.4617	$25.19	$12.55	$5.04
0344	Level III Pathology	X	0.6291	$34.32	$17.16	$6.86
0345	Level I Transfusion Laboratory Procedures	X	0.2550	$13.91	$3.10	$2.78
0346	Level II Transfusion Laboratory Procedures	X	0.3866	$21.09	$5.32	$4.22
0347	Level III Transfusion Laboratory Procedures	X	0.9610	$52.43	$13.20	$10.49
0348	Fertility Laboratory Procedures	X	0.8194	$44.71		$8.94
0352	Level I Injections	X	0.1230	$6.71		$1.34
0353	Level II Allergy Injections	X	0.3982	$21.73		$4.35
0355	Level III Immunizations	K	0.2749	$15.00		$3.00
0356	Level IV Immunizations	K	0.7698	$42.00		$8.40
0359	Level II Injections	X	0.8000	$43.65		$8.73
0360	Level I Alimentary Tests	X	1.7313	$94.46	$42.45	$18.89
0361	Level II Alimentary Tests	X	3.5510	$193.75	$83.23	$38.75
0362	Level III Otorhinolaryngologic Function Tests	X	2.6984	$147.23		$29.45
0363	Level I Otorhinolaryngologic Function Tests	X	0.8641	$47.15	$17.44	$9.43
0364	Level I Audiometry	X	0.4459	$24.33	$9.06	$4.87
0365	Level II Audiometry	X	1.2132	$66.19	$18.95	$13.24
0367	Level I Pulmonary Test	X	0.5887	$32.12	$15.16	$6.42
0368	Level II Pulmonary Tests	X	0.9319	$50.85	$25.42	$10.17
0369	Level III Pulmonary Tests	X	2.4984	$136.32	$44.18	$27.26
0370	Allergy Tests	X	0.9185	$50.11	$11.58	$10.02
0371	Level I Allergy Injections	X	0.4105	$22.40		$4.48
0372	Therapeutic Phlebotomy	X	0.5607	$30.59	$10.09	$6.12
0373	Neuropsychological Testing	X	2.0899	$114.03		$22.81
0374	Monitoring Psychiatric Drugs	X	1.1252	$61.39		$12.28
0375	Ancillary Outpatient Services When Patient Expires	T		$1,150.00		$230.00
0376	Level II Cardiac Imaging	S	4.4510	$242.85	$121.42	$48.57
0377	Level III Cardiac Imaging	S	6.8830	$375.54	$187.76	$75.11
0378	Level II Pulmonary Imaging	S	5.4852	$299.28	$149.63	$59.86
0379	Injection adenosine 6 MG	K	0.2078	$11.34		$2.27
0380	Dipyridamole injection	K	0.2525	$13.78		$2.76
0384	GI Procedures with Stents	T	20.6602	$1,127.24	$244.83	$225.45
0385	Level I Prosthetic Urological Procedures	S	67.1530	$3,663.93		$732.79
0386	Level II Prosthetic Urological Procedures	S	116.2382	$6,342.07		$1,268.41
0387	Level II Hysteroscopy	T	28.1480	$1,535.78	$655.55	$307.16
0388	Discography	S	11.6347	$634.80	$303.19	$126.96
0389	Non-imaging Nuclear Medicine	S	1.6328	$89.09	$44.54	$17.82
0390	Level I Endocrine Imaging	S	2.7907	$152.26	$76.13	$30.45
0391	Level II Endocrine Imaging	S	3.1956	$174.36	$87.18	$34.87
0393	Red Cell/Plasma Studies	S	4.4354	$242.00	$121.00	$48.40
0394	Hepatobiliary Imaging	S	4.3714	$238.51	$119.25	$47.70
0395	GI Tract Imaging	S	3.9536	$215.71	$107.85	$43.14
0396	Bone Imaging	S	4.1883	$228.52	$114.26	$45.70
0397	Vascular Imaging	S	2.2183	$121.03	$60.51	$24.21
0398	Level I Cardiac Imaging	S	4.5091	$246.02	$123.01	$49.20
0399	Nuclear Medicine Add-on Imaging	S	1.5273	$83.33	$41.66	$16.67
0400	Hematopoietic Imaging	S	3.8242	$208.65	$104.32	$41.73
0401	Level I Pulmonary Imaging	S	3.3736	$184.07	$92.03	$36.81
0402	Brain Imaging	S	5.4063	$294.97	$147.48	$58.99

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCs) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0403	CSF Imaging	S	3.8402	$209.53	$104.76	$41.91
0404	Renal and Genitourinary Studies Level I	S	3.7303	$203.53	$101.76	$40.71
0405	Renal and Genitourinary Studies Level II	S	4.3432	$236.97	$118.48	$47.39
0406	Tumor/Infection Imaging	S	4.3955	$239.82	$119.91	$47.96 W≤
0407	Radionuclide Therapy	S	3.5841	$195.55	$97.77	$39.11
0409	Red Blood Cell Tests	X	0.1390	$7.58	$2.32	$1.52
0410	Mammogram Add On	S	0.1523	$8.31		$1.66
0411	Respiratory Procedures	S	0.4367	$23.83		$4.77
0412	IMRT Treatment Delivery	S	5.3904	$294.11		$58.82
0413	IMRT Treatment Plan	S	7.4469	$406.31		$81.26
0415	Level II Endoscopy Lower Airway	T	20.7348	$1,131.31	$459.92	$226.26
0600	Low Level Clinic Visits	V	0.9278	$50.62		$10.12
0601	Mid Level Clinic Visits	V	0.9816	$53.56		$10.71
0602	High Level Clinic Visits	V	1.5041	$82.07		$16.41
0610	Low Level Emergency Visits	V	1.3691	$74.70	$19.57	$14.94
0611	Mid Level Emergency Visits	V	2.3967	$130.77	$36.16	$26.15
0612	High Level Emergency Visits	V	4.1476	$226.30	$54.12	$45.26
0620	Critical Care	S	8.9992	$491.01	$142.30	$98.20
0648	Breast Reconstruction with Prosthesis	T	54.0165	$2,947.19		$589.44
0651	Complex Interstitial Radiation Source Application	S	10.2314	$558.24		$111.65
0652	Insertion of Intraperitoneal Catheters	T	27.0364	$1,475.13		$295.03
0653	Vascular Reconstruction/Fistula Repair with Device	T	30.0334	$1,638.65		$327.73
0654	Insertion/Replacement of a permanent dual chamber pacemaker.	T	112.6957	$6,148.79		$1,229.76
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	T	142.7039	$7,786.07		$1,557.21
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents.	T	103.4907	$5,646.56		$1,129.31
0657	Placement of Tissue Clips	S	1.5102	$82.40		$16.48
0658	Percutaneous Breast Biopsies	T	5.5779	$304.34		$60.87
0659	Hyperbaric Oxygen	S	3.0228	$164.93		$32.99
0660	Level II Otorhinolaryngologic Function Tests	X	1.7353	$94.68	$30.66	$18.94
0661	Level IV Pathology	X	3.2576	$177.74	$88.87	$35.55
0662	CT Angiography	S	5.8775	$320.68	$156.47	$64.14
0664	Proton Beam Radiation Therapy	S	9.7295	$530.85		$106.17
0665	Bone Density:AppendicularSkeleton	S	0.7257	$39.59		$7.92
0668	Level I Angiography and Venography except Extremity	S	10.2660	$560.12	$237.76	$112.02
0669	Digital Mammography	S	0.9009	$49.15		$9.83
0670	Intravenous and Intracardiac Ultrasound	S	27.4483	$1,497.61	$542.37	$299.52
0671	Level II Echocardiogram Except Transesophageal	S	1.6384	$89.39	$44.69	$17.88
0672	Level IV Posterior Segment Procedures	T	38.9476	$2,125.02	$988.43	$425.00
0673	Level IV Anterior Segment Eye Procedures	T	26.8390	$1,464.36	$649.56	$292.87
0674	Prostate Cryoablation	T	119.9733	$6,545.86		$1,309.17
0675	Prostatic Thermotherapy	T	49.3452	$2,692.32		$538.46
0676	Level II Transcatheter Thrombolysis	T	2.7315	$149.03	$40.30	$29.81
0677	Level I Transcatheter Thrombolysis	T	2.1805	$118.97		$23.79
0678	External Counterpulsation	T	2.0659	$112.72		$22.54
0679	Level II Resuscitation and Cardioversion	S	5.4887	$299.47	$95.30	$59.89
0680	Insertion of Patient Activated Event Recorders	S	62.8252	$3,427.81		$685.56
0681	Knee Arthroplasty	T	98.1613	$5,355.78	$2,131.36	$1,071.16
0682	Level V Debridement & Destruction	T	8.0790	$440.80	$174.57	$88.16
0683	Level II Photochemotherapy	S	1.5489	$84.51	$30.42	$16.90
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	4.8100	$262.44	$115.47	$52.49
0686	Level III Skin Repair	T	7.9247	$432.38	$198.89	$86.48
0687	Revision/Removal of Neurostimulator Electrodes	T	20.4416	$1,115.31	$513.05	$223.06
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver.	T	46.7347	$2,549.89	$1,249.45	$509.98
0689	Electronic Analysis of Cardioverter-defibrillators	S	0.5533	$30.19		$6.04
0690	Electronic Analysis of Pacemakers and other Cardiac Devices.	S	0.4074	$22.23	$10.63	$4.45
0691	Electronic Analysis of Programmable Shunts/Pumps	S	2.8066	$153.13	$76.56	$30.63
0692	Electronic Analysis of Neurostimulator Pulse Generators	S	1.1057	$60.33	$30.16	$12.07
0693	Level II Breast Reconstruction	T	39.0111	$2,128.48	$798.17	$425.70
0694	Mohs Surgery	T	2.9752	$162.33	$64.93	$32.47
0695	Level VII Debridement & Destruction	T	19.1849	$1,046.75	$266.59	$209.35
0697	Level I Echocardiogram Except Transesophageal	S	1.4415	$78.65	$39.32	$15.73
0698	Level II Eye Tests & Treatments	S	0.9599	$52.37	$18.72	$10.47
0699	Level IV Eye Tests & Treatments	T	2.2303	$121.69	$47.46	$24.34
0700	Antepartum Manipulation	T	2.4306	$132.62	$37.13	$26.52

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCs) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0701	SR 89 chloride, per mCi	K	7.3835	$402.85		$80.57
0702	SM 153 lexidronam, 50 mCi	K	16.0268	$874.44		$174.89
0704	IN 111 Satumomab pendetide per dose	K	2.2811	$124.46		$24.89
0705	Technetium TC99M tetrofosmin	K	1.0642	$58.06		$11.61
0726	Dexrazoxane hcl injection, 250 mg	K	2.0616	$112.48		$22.50
0728	Filgrastim 300 mcg injection	K	2.2631	$123.48		$24.70
0730	Pamidronate disodium , 30 mg	K	3.1949	$174.32		$34.86
0731	Sargramostim injection	K	0.2991	$16.32		$3.26
0732	Mesna injection 200 mg	K	0.5211	$28.43		$5.69
0733	Non esrd epoetin alpha inj, 1000 u	K	0.1802	$9.83		$1.97
0734	Injection, darbepoetin alfa (for non-ESRD), per 1 mcg	K		$3.24		$0.65
0763	Dolasetron mesylate oral	K	0.7514	$41.00		$8.20
0764	Granisetron HCl injection	K	0.1044	$5.70		$1.14
0765	Granisetron HCl 1 mg oral	K	0.6322	$34.49		$6.90
0800	Leuprolide acetate, 3.75 mg	K	3.3525	$182.92		$36.58
0802	Etoposide oral 50 mg	K	0.5016	$27.37		$5.47
0807	Aldesleukin/single use vial	K		$680.35		$136.07
0809	Bcg live intravesical vac	K	1.9015	$103.75		$20.75
0810	Goserelin acetate implant 3.6 mg	K	5.2265	$285.16		$57.03
0811	Carboplatin injection 50 mg	K	1.5849	$86.47		$17.29
0813	Cisplatin 10 mg injection	K	0.3985	$21.74		$4.35
0814	Asparaginase injection	K	0.2957	$16.13		$3.23
0815	Cyclophosphamide 100 MG inj	K	0.0868	$4.74		$0.95
0816	Cyclophosphamide lyophilized	K	0.0825	$4.50		$0.90
0817	Cytarabine hcl 100 MG inj	K	0.0930	$5.07		$1.01
0819	Dacarbazine 100 mg inj	K	0.0974	$5.31		$1.06
0820	Daunorubicin 10 mg	K	1.3557	$73.97		$14.79
0821	Daunorubicin citrate liposom 10 mg	K	2.9976	$163.55		$32.71
0823	Docetaxel, 20 mg	K	4.0499	$220.97		$44.19
0824	Etoposide 10 MG inj	K	0.0836	$4.56		$0.91
0827	Floxuridine injection 500 mg	K	2.0928	$114.19		$22.84
0828	Gemcitabine HCL 200 mg	K	1.4742	$80.43		$16.09
0830	Irinotecan injection 20 mg	K	1.8428	$100.55		$20.11
0831	Ifosfomide injection 1 gm	K	1.9435	$106.04		$21.21
0832	Idarubicin hcl injection 5 mg	K	3.2663	$178.21		$35.64
0834	Interferon alfa-2a inj	K	0.3777	$20.61		$4.12
0836	Interferon alfa-2b inj recombinant, 1 million	K	0.2003	$10.93		$2.19
0838	Interferon gamma 1-b inj, 3 million u	K		$180.15		$36.03
0840	Melphalan hydrochl 50 mg	K	4.6719	$254.90		$50.98
0842	Fludarabine phosphate inj 50 mg	K	3.7708	$205.74		$41.15
0844	Pentostatin injection, 10 mg	K	17.7045	$965.98		$193.20
0847	Doxorubic hcl 10 MG vl chemo	K	0.1212	$6.61		$1.32
0849	Rituximab, 100 mg	K	5.6158	$306.40		$61.28
0850	Streptozocin injection, 1 gm	K	1.1948	$65.19		$13.04
0851	Thiotepa injection	K	1.0984	$59.93		$11.99
0852	Topotecan, 4 mg	K	7.9435	$433.41		$86.68
0855	Vinorelbine tartrate, 10 mg	K	1.1874	$64.79		$12.96
0856	Porfimer sodium, 75 mg	K	29.2205	$1,594.30		$318.86
0857	Bleomycin sulfate injection 15 u	K	2.9427	$160.56		$32.11
0858	Cladribine, 1mg	K	0.6931	$37.82		$7.56
0860	Plicamycin (mithramycin) inj	K	0.2826	$15.42		$3.08
0861	Leuprolide acetate injection 1 mg	K	0.7991	$43.60		$8.72
0862	Mitomycin 5 mg inj	K	0.9719	$53.03		$10.61
0863	Paclitaxel injection, 30 mg	K	2.0553	$112.14		$22.43
0864	Mitoxantrone hcl, 5 mg	K	3.1832	$173.68		$34.74
0865	Interferon alfa-n3 inj, human leukocyte derived, 2	K	1.4598	$79.65		$15.93
0884	Rho d immune globulin inj, 1 dose pkg	K	0.1863	$10.16		$2.03
0888	Cyclosporine oral 100 mg	K	0.0470	$2.56		$0.51
0890	Lymphocyte immune globulin 250 mg	K	2.3439	$127.89		$25.58
0891	Tacrolimus oral per 1 mg	K	0.0246	$1.34		$0.27
0900	Alglucerase injection, per 10 u	K		$37.13		$7.43
0901	Alpha 1 proteinase inhibitor, 10 mg	K		$3.43		$0.69
0902	Botulinum toxin a, per unit	K	0.0588	$3.21		$0.64
0903	Cytomegalovirus imm IV/vial	K	5.3368	$291.18		$58.24
0905	Immune globulin, 1g	K	0.8057	$43.96		$8.79
0906	RSV-ivig, 50 mg	K	0.8910	$48.61		$9.72
0907	Ganciclovir sodium injection	K	0.5918	$32.29		$6.46
0909	Interferon beta-1a, 33 mcg	K	3.3868	$184.79		$36.96
0910	Interferon beta-1b /0.25 mg	K	1.8421	$100.51		$20.10

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0911	Streptokinase per 250,000 iu	K	1.5733	$85.84		$17.17
0913	Ganciclovir long act implant	K	1.5861	$86.54		$17.31
0916	Imiglucerase injection/unit	K		$3.71		$0.74
0917	Adenosine injection	K	1.0393	$56.71		$11.34
0925	Factor viii per iu	K		$0.51		$0.10
0926	Factor VIII (porcine) per iu	K		$1.52		$0.30
0927	Factor viii recombinant per iu	K		$1.01		$0.20
0928	Factor ix complex per iu	K		$0.51		$0.10
0929	Anti-inhibitor per iu	K		$1.01		$0.20
0931	Factor IX non-recombinant, per iu	K		$0.51		$0.10
0932	Factor IX recombinant, per iu	K		$1.01		$0.20
0949	Plasma, Pooled Multiple Donor, Solvent/Detergent T	K		$124.31		$24.86
0950	Blood (Whole) For Transfusion	K		$87.93		$17.59
0952	Cryoprecipitate	K		$29.31		$5.86
0954	RBC leukocytes reduced	K		$119.26		$23.85
0955	Plasma, Fresh Frozen	K		$95.00		$19.00
0956	Plasma Protein Fraction	K		$92.98		$18.60
0957	Platelet Concentrate	K		$41.44		$8.29
0958	Platelet Rich Plasma	K		$53.56		$10.71
0959	Red Blood Cells	K		$86.41		$17.28
0960	Washed Red Blood Cells	K		$160.69		$32.14
0961	Infusion, Albumin (Human) 5%, 50 ml	K	0.2802	$15.29		$3.06
0963	Albumin (human), 5%, 250 ml	K	1.0901	$59.48		$11.90
0964	Albumin (human), 25%, 20 ml	K	0.3741	$20.41		$4.08
0965	Albumin (human), 25%, 50ml	K	0.8869	$48.39		$9.68
0966	Plasmaprotein fract,5%,250ml	K		$464.90		$92.98
1009	Cryoprecip reduced plasma	K		$37.39		$7.48
1010	Blood, L/R, CMV-neg	K		$121.78		$24.36
1011	Platelets, HLA-m, L/R, unit	K		$499.77		$99.95
1013	Platelet concentrate, L/R, unit	K		$49.52		$9.90
1016	Blood, L/R, froz/deglycerol/washed	K		$301.68		$60.34
1017	Platelets, aph/pher, L/R, CMV-neg, unit	K		$393.15		$78.63
1018	Blood, L/R, irradiated	K		$132.40		$26.48
1019	Platelets, aph/pher, L/R, irradiated, unit	K		$406.28		$81.26
1020	Pit, pher,L/R,CMV,irrad	K		$495.22		$99.04
1021	RBC, frz/deg/wsh, L/R, irrad	K		$336.04		$67.21
1022	RBC, L/R, CMV neg, irrad	K		$201.12		$40.22
1045	Iobenguane sulfate I-131per 0.5 mCi	K	3.0392	$165.82		$33.16
1064	I-131 sodium iodide capsule	K	0.1004	$5.48		$1.10
1065	I-131 sodium iodide solution	K	0.1189	$6.49		$1.30
1079	CO 57/58 per 0.5 uCi	K	1.2556	$68.51		$13.70
1080	I-131 tositumomab, dx	K		$2,260.00		$452.00
1081	I-131 tositumomab, tx	K		$19,565.00		$3,913.00
1084	Denileukin diftitox, 300 MCG	K		$1,232.88		$246.58
1086	Temozolomide,oral 5 mg	K	0.0690	$3.76		$0.75
1089	Cyanocobalamin cobalt co57	K	1.0460	$57.07		$11.41
1091	IN 111 Oxyquinoline, per .5 mCi	K	4.1151	$224.52		$44.90
1092	IN 111 Pentetate, per.0.5 mCi	K	3.9855	$217.45		$43.49
1095	Technetium TC 99M Depreotide	K	0.6940	$37.87		$7.57
1096	TC 99M Exametazime, per dose	K	3.8609	$210.65		$42.13
1122	TC 99M arcitumomab, per vial	K	9.8014	$534.77		$106.95
1166	Cytarabine liposome	K	5.1134	$278.99		$55.80
1167	Epirubicin hcl, 2 mg	K	0.3744	$20.43		$4.09
1178	Busulfan IV, 6 mg	K	5.4930	$299.70		$59.94
1200	TC 99M Sodium Glucoheptonat	K	0.5550	$30.28		$6.06
1201	TC 99M SUCCIMER, PER Vial	K	1.4706	$80.24		$16.05
1203	Verteporfin for injection	K	16.4439	$897.20		$179.44
1207	Octreotide injection, depot	K	1.2049	$65.74		$13.15
1305	Apligraf	K	15.0691	$822.19		$164.44
1409	Factor viia recombinant, per 1.2 mg	K		$1,083.93		$216.79
1501	New Technology—Level I ($0–$50)	S		$25.00		$5.00
1502	New Technology—Level II ($50–$100)	S		$75.00		$15.00
1503	New Technology—Level III ($100–$200)	S		$150.00		$30.00
1504	New Technology—Level IV ($200–$300)	S		$250.00		$50.00
1505	New Technology—Level V ($300–$400)	S		$350.00		$70.00
1506	New Technology—Level VI ($400–$500)	S		$450.00		$90.00
1507	New Technology—Level VII ($500–$600)	S		$550.00		$110.00
1508	New Technology—Level VIII ($600–$700)	S		$650.00		$130.00
1509	New Technology—Level IX ($700–$800)	S		$750.00		$150.00

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCs) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
1510	New Technology—Level X ($800–$900)	S		$850.00		$170.00
1511	New Technology—Level XI ($900–$1000)	S		$950.00		$190.00
1512	New Technology—Level XII ($1000–$1100)	S		$1,050.00		$210.00
1513	New Technology—Level XIII ($1100–$1200)	S		$1,150.00		$230.00
1514	New Technology-Level XIV ($1200- $1300)	S		$1,250.00		$250.00
1515	New Technology—Level XV ($1300–$1400)	S		$1,350.00		$270.00
1516	New Technology—Level XVI ($1400–$1500)	S		$1,450.00		$290.00
1517	New Technology—Level XVII ($1500-$1600)	S		$1,550.00		$310.00
1518	New Technology—Level XVIII ($1600-$1700)	S		$1,650.00		$330.00
1519	New Technology—Level IXX ($1700-$1800)	S		$1,750.00		$350.00
1520	New Technology—Level XX ($1800-$1900)	S		$1,850.00		$370.00
1521	New Technology—Level XXI ($1900-$2000)	S		$1,950.00		$390.00
1522	New Technology—Level XXII ($2000-$2500)	S		$2,250.00		$450.00
1523	New Technology—Level XXIII ($2500-$3000)	S		$2,750.00		$550.00
1524	New Technology—Level XIV ($3000-$3500)	S		$3,250.00		$650.00
1525	New Technology—Level XXV ($3500-$4000)	S		$3,750.00		$750.00
1526	New Technology—Level XXVI ($4000-$4500)	S		$4,250.00		$850.00
1527	New Technology—Level XXVII ($4500-$5000)	S		$4,750.00		$950.00
1528	New Technology—Level XXVIII ($5000-$5500)	S		$5,250.00		$1,050.00
1529	New Technology—Level XXIX ($5500-$6000)	S		$5,750.00		$1,150.00
1530	New Technology—Level XXX ($6000-$6500)	S		$6,250.00		$1,250.00
1531	New Technology—Level XXXI ($6500-$7000)	S		$6,750.00		$1,350.00
1532	New Technology—Level XXXII ($7000-$7500)	S		$7,250.00		$1,450.00
1533	New Technology—Level XXXIII ($7500-$8000)	S		$7,750.00		$1,550.00
1534	New Technology—Level XXXIV ($8000-$8500)	S		$8,250.00		$1,650.00
1535	New Technology—Level XXXV ($8500-$9000)	S		$8,750.00		$1,750.00
1536	New Technology—Level XXXVI ($9000-$9500)	S		$9,250.00		$1,850.00
1537	New Technology—Level XXXVII ($9500-$10000)	S		$9,750.00		$1,950.00
1538	New Technology—Level I ($0–$50)	T		$25.00		$5.00
1539	New Technology—Level II ($50–$100)	T		$75.00		$15.00
1540	New Technology—Level III ($100–$200)	T		$150.00		$30.00
1541	New Technology—Level IV ($200–$300)	T		$250.00		$50.00
1542	New Technology—Level V ($300–$400)	T		$350.00		$70.00
1543	New Technology—Level VI ($400–$500)	T		$450.00		$90.00
1544	New Technology—Level VII ($500–$600)	T		$550.00		$110.00
1545	New Technology—Level VIII ($600–$700)	T		$650.00		$130.00
1546	New Technology—Level IX ($700–$800)	T		$750.00		$150.00
1547	New Technology—Level X ($800–$900)	T		$850.00		$170.00
1548	New Technology—Level XI ($900–$1000)	T		$950.00		$190.00
1549	New Technology—Level XII ($1000–$1100)	T		$1,050.00		$210.00
1550	New Technology—Level XIII ($1100–$1200)	T		$1,150.00		$230.00
1551	New Technology-Level XIV ($1200- $1300)	T		$1,250.00		$250.00
1552	New Technology—Level XV ($1300–$1400)	T		$1,350.00		$270.00
1553	New Technology—Level XVI ($1400–$1500)	T		$1,450.00		$290.00
1554	New Technology—Level XVII ($1500-$1600)	T		$1,550.00		$310.00
1555	New Technology—Level XVIII ($1600-$1700)	T		$1,650.00		$330.00
1556	New Technology—Level XIX ($1700-$1800)	T		$1,750.00		$350.00
1557	New Technology—Level XX ($1800-$1900)	T		$1,850.00		$370.00
1558	New Technology—Level XXI ($1900-$2000)	T		$1,950.00		$390.00
1559	New Technology—Level XXII ($2000-$2500)	T		$2,250.00		$450.00
1560	New Technology—Level XXIII ($2500-$3000)	T		$2,750.00		$550.00
1561	New Technology—Level XXIV ($3000-$3500)	T		$3,250.00		$650.00
1562	New Technology—Level XXV ($3500-$4000)	T		$3,750.00		$750.00
1563	New Technology—Level XXVI ($4000-$4500)	T		$4,250.00		$850.00
1564	New Technology—Level XXVII ($4500-$5000)	T		$4,750.00		$950.00
1565	New Technology—Level XXVIII ($5000-$5500)	T		$5,250.00		$1,050.00
1566	New Technology—Level XXIX ($5500-$6000)	T		$5,750.00		$1,150.00
1567	New Technology—Level XXX ($6000-$6500)	T		$6,250.00		$1,250.00
1568	New Technology—Level XXXI ($6500-$7000)	T		$6,750.00		$1,350.00
1569	New Technology—Level XXXII ($7000-$7500)	T		$7,250.00		$1,450.00
1570	New Technology—Level XXXIII ($7500-$8000)	T		$7,750.00		$1,550.00
1571	New Technology—Level XXXIV ($8000-$8500)	T		$8,250.00		$1,650.00
1572	New Technology—Level XXXV ($8500-$9000)	T		$8,750.00		$1,750.00
1573	New Technology—Level XXXVI ($9000-$9500)	T		$9,250.00		$1,850.00
1574	New Technology—Level XXXVII ($9500-$10000)	T		$9,750.00		$1,950.00
1600	Technetium TC 99m sestamibi	K	1.1782	$64.28		$12.86
1603	Thallous chloride TL 201/mci	K	0.3645	$19.89		$3.98
1604	IN 111 capromab pendetide, per dose	K	12.6045	$687.71		$137.54
1605	Abciximab injection, 10 mg	K	5.3048	$289.44		$57.89

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCs) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
1606	Anistreplase, 30 u	K	27.7939	$1,516.46		$303.29
1607	Eptifibatide injection, 5mg	K	0.1465	$7.99		$1.60
1608	Etanercept injection	K	1.8762	$102.37		$20.47
1609	Rho(D) immune globulin h, sd, 100 iu	K	0.1789	$9.76		$1.95
1611	Hylan G-F 20 injection, 16 mg	K	2.2628	$123.46		$24.69
1612	Daclizumab, parenteral, 25 mg	K		$393.78		$78.76
1613	Trastuzumab, 10 mg	K	0.7434	$40.56		$8.11
1614	Valrubicin, 200 mg	K	8.4635	$461.78		$92.36
1615	Basiliximab, 20 mg	K		$1,425.06		$285.01
1618	Vonwillebrandfactrcmplx, per iu	K		$1.01		$0.20
1619	Gallium ga 67	K	0.2056	$11.22		$2.24
1620	Technetium tc99m bicisate	K	3.3666	$183.69		$36.74
1622	Technetium tc99m mertiatide	K	0.3782	$20.63		$4.13
1624	Sodium phosphate p32	K	1.2941	$70.61		$14.12
1625	Indium 111-in pentetreotide	K	8.2447	$449.84		$89.97
1628	Chromic phosphate p32	K	1.8057	$98.52		$19.70
1716	Brachytx source, Gold 198	K	1.3811	$75.35		$15.07
1718	Brachytx source, Iodine 125	K	0.6843	$37.34		$7.47
1719	Brachytx source,Non-HDR Ir-192	K	0.3187	$17.39		$3.48
1720	Brachytx source, Palladium 103	K	0.8187	$44.67		$8.93
1775	FDG, per dose (4-40 mCi/ml)	K	5.9471	$324.48		$64.90
1783	Ocular implant, aqueous drain device	H				$0.00
1814	Retinal Tamp, silicone oil	H				$-.00
1818	Integrated keratoprosthesis	H				$0.00
1819	Tissue localization-excision dev	H				$0.00
1884	Embolization Protect syst	H				$0.00
1888	Catheter, ablation, non-cardiac, endovascular (implantable)	H				$0.00
1900	Lead coronary venous	H				$0.00
2614	Probe, percutaneous lumbar disc	H				$0.00
2616	Brachytx source, Yttrium-90	K	176.2339	$9,615.50		$1,923.10
2632	Brachytx sol, I-125, per mCi	H				$0.00
2633	Brachytx source, Cesium-131	K	0.8187	$44.67		$8.93
7000	Amifostine, 500 mg	K	5.3041	$289.40		$57.88
7007	Inj milrinone lactate, per 5 mg	K	0.2129	$11.62		$2.32
7011	Oprelvekin injection, 5 mg	K		$248.16		$49.63
7015	Busulfan, oral, 2 mg	K	0.0288	$1.57		$0.31
7019	Aprotinin, 10,000 kiu	K	0.0215	$1.17		$0.23
7024	Corticorelin ovine triflutat	K	4.1221	$224.91		$44.98
7025	Digoxin immune FAB (ovine)	K	4.9694	$271.14		$54.23
7026	Ethanolamine oleate 100 mg	K	0.5099	$27.82		$5.56
7027	Fomepizole, 15mg	K	0.1325	$7.23		$1.45
7028	Fosphenytoin, 50 mg	K	0.0895	$4.88		$0.98
7030	Hemin, per 1 mg	K	0.0118	$0.64		$0.13
7031	Octreotide acetate injection	K	0.0264	$1.44		$0.29
7034	Somatropin injection	K	0.7547	$41.18		$8.24
7035	Teniposide, 50 mg	K	2.5185	$137.41		$27.48
7036	Urokinase 250,000 iu inj	K	3.7855	$206.54		$41.31
7037	Urofollitropin, 75 iu	K	1.1634	$63.48		$12.70
7038	Muromonab-CD3, 5 mg	K	5.8803	$320.84		$64.17
7040	Pentastarch 10% solution	K	0.4838	$26.40		$5.28
7041	Tirofiban hydrochloride 12.5 mg	K	4.176	$227.85		$45.57
7042	Capecitabine, oral, 150 mg	K	0.0302	$1.65		$0.33
7043	Infliximab injection 10 mg	K	0.7122	$38.86		$7.77
7045	Trimetrexate glucoronate	K	1.1246	$61.36		$12.27
7046	Doxorubicin hcl liposome inj 10 mg	K	4.6982	$256.34		$51.27
7048	Alteplase recombinant	K	0.2856	$15.58		$3.12
7049	Filgrastim 480 mcg injection	K	3.2251	$175.96		$35.19
7051	Leuprolide acetate implant, 65 mg	K	67.2039	$3,666.71		$733.34
7316	Sodium hyaluronate injection	K	2.5436	$138.78		$27.76
9001	Linezolid injection	K	0.2771	$15.12		$3.02
9002	Tenecteplase, 50mg/vial	K	23.7669	$1,296.75		$259.35
9003	Palivizumab, per 50mg	K	6.3077	$344.15		$68.83
9004	Gemtuzumab ozogamicin inj,5mg	K		$2,022.90		$404.58
9005	Reteplase injection	K	10.4165	$568.33		$113.67
9006	Tacrolimus injection	K	0.1048	$5.72		$1.14
9008	Baclofen Refill Kit-500mcg	K	0.1264	$6.90		$1.38
9009	Baclofen refill kit—per 2000 mcg	K	0.7499	$40.92		$8.18
9010	Baclofen refill kit—per 4000 mcg	K	0.7739	$42.22		$8.44
9012	Arsenic Trioxide	K	0.4933	$26.91		$5.38

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
9013	Co 57 cobaltous chloride	K	1.0386	$56.67		$11.33
9015	Mycophenolate mofetil oral 250 mg	K	0.0374	$2.04		$0.41
9018	Botulinum toxin B, per 100 u	K	0.1279	$6.98		$1.40
9019	Caspofungin acetate, 5 mg	K	0.5432	$29.64		$5.93
9020	Sirolimus tablet, 1 mg	K	0.0529	$2.89		$0.58
9021	Immune globulin 10 mg	K	0.0080	$0.44		$0.09
9022	IM inj interferon beta 1-a	K	1.1290	$61.60		$12.32
9023	Rho d immune globulin 50 mcg	K	0.0310	$1.69		$0.34
9024	Amphotericin B, lipid formulation	K	0.3823	$20.86		$4.17
9025	Radiopharms Used to Image Perfusion of Heart	K	2.6372	$143.89		$28.78
9100	Iodinated I-131albumin, per 5 uci	K	0.0066	$0.36		$0.07
9104	Anti-thymocycte globulin rabbit	K	2.9978	$163.56		$32.71
9105	Hep B imm glob, per 1 ml	K	1.3074	$71.33		$14.27
9108	Thyrotropin alfa, per 1.1 mg	K		$572.00		$114.40
9109	Tirofliban hcl, per 6.25 mg	K	2.1737	$118.60		$23.72
9110	Alemtuzumab, per 10 mg	K	7.7873	$424.88		$84.98
9111	Inj, bivalirudin, per 250 mg vial	G		$1.60		$0.24
9112	Perflutren lipid micro, per 2ml	G		$148.20		$22.15
9113	Inj, pantoprazole sodium, vial	G		$25.08		$3.75
9114	Nesiritide, per 0.5 mg vial	G		$151.62		$22.66
9115	Inj, zoledronic acid, per 1 mg	G		$217.43		$32.50
9116	Inj, Ertapenem sodium, per 1 gm vial	G		$23.74		$3.55
9117	Yttrium 90 ibritumomab tiuxetan	K		$19,565.00		$3,913.00
9118	In-111 ibritumomab tiuxetan	K		$2,260.00		$452.00
9119	Pegfilgrastim, per 1 mg	G		$2,802.50		$418.90
9120	Inj, Fulvestrant, per 50 mg	G		$87.58		$13.09
9121	Inj, Argatroban, per 5 mg	G		$16.35		$2.44
9122	Inj, Triptorelin pamoate, per 3.75 mg	G		$398.62		$59.58
9123	Transcyte, per 247 sq cm	G		$770.93		$115.23
9200	Orcel, per 36 cm2	G		$1,135.25		$169.69
9201	Dermagraft, per 37.5 sq cm	G		$577.60		$86.34
9202	Octafluoropropane	K	2.1737	$118.60		$23.72
9203	Perflexane lipid micro	G		$142.50		$21.30
9204	Ziprasidone mesylate	G		$20.79		$3.11
9205	Oxaliplatin	G		$94.46		$14.12
9207	Injection, bortezomib	G		$1,039.68		$155.40
9208	Injection, agalsidase beta	G		$123.78		$18.50
9209	Injection, laronidase	G		$644.10		$96.28
9210	Injection, palonosetron HCL	G		$307.80		$46.01
9211	Inj, alefacept, IV	G		$665.00		$99.40
9212	Inj, alefacept, IM	G		$472.63		$70.65
9217	Leuprolide acetate suspnsion, 7.5 mg	K	5.7252	$312.37		$62.47
9500	Platelets, irradiated	K		$74.79		$14.96
9501	Platelets, pheresis	K		$408.81		$81.76
9502	Platelet pheresis irradiated	K		$443.68		$88.74
9503	Fresh frozen plasma, ea unit	K		$69.74		$13.95
9504	RBC deglycerolized	K		$183.44		$36.69
9505	RBC irradiated	K		$108.65		$21.73
9506	Granulocytes, pheresis	K		$1,248.66		$249.73

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0001F	E	NI	Blood pressure, measured					
0001T	C		Endovas repr abdo ao aneurys					
0002F	E	NI	Tobacco use, smoking, assess					
0002T	C	DG	Endovas repr abdo ao aneurys					
0003F	E	NI	Tobacco use, non-smoking					
0003T	S		Cervicography	1501		$25.00		$5.00
0004F	E	NI	Tobacco use txmnt counseling					
0005F	E	NI	Tobacco use txmnt, pharmacol					
0005T	C		Perc cath stent/brain cv art					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0006F	E	NI	Statin therapy, prescribed					
0006T	C		Perc cath stent/brain cv art					
0007F	E	NI	Beta-blocker thx prescribed					
0007T	C		Perc cath stent/brain cv art					
0008F	E	NI	Ace inhibitor thx prescribed					
0008T	E		Upper gi endoscopy w/suture					
0009F	E	NI	Assess anginal symptom/level					
0009T	T		Endometrial cryoablation	1557		$1,850.00		$370.00
00100	N		Anesth, salivary gland					
00102	N		Anesth, repair of cleft lip					
00103	N		Anesth, blepharoplasty					
00104	N		Anesth, electroshock					
0010F	E	NI	Assess anginal symptom/level					
0010T	A		Tb test, gamma interferon					
0011F	E	NI	Oral antiplat thx prescribed					
00120	N		Anesth, ear surgery					
00124	N		Anesth, ear exam					
00126	N		Anesth, tympanotomy					
0012T	T		Osteochondral knee autograft	0041	27.3819	$1,493.98		$298.80
0013T	T		Osteochondral knee allograft	0041	27.3819	$1,493.98		$298.80
00140	N		Anesth, procedures on eye					
00142	N		Anesth, lens surgery					
00144	N		Anesth, corneal transplant					
00145	N		Anesth, vitreoretinal surg					
00147	N		Anesth, iridectomy					
00148	N		Anesth, eye exam					
0014T	T		Meniscal transplant, knee	0041	27.3819	$1,493.98		$298.80
00160	N		Anesth, nose/sinus surgery					
00162	N		Anesth, nose/sinus surgery					
00164	N		Anesth, biopsy of nose					
0016T	T		Thermotx choroid vasc lesion	0235	5.0749	$276.89	$72.04	$55.38
00170	N		Anesth, procedure on mouth					
00172	N		Anesth, cleft palate repair					
00174	C		Anesth, pharyngeal surgery					
00176	C		Anesth, pharyngeal surgery					
0017T	E		Photocoagulat macular drusen					
0018T	S		Transcranial magnetic stimul	0215	0.6457	$35.23	$15.76	$7.05
00190	N		Anesth, face/skull bone surg					
00192	C		Anesth, facial bone surgery					
0019T	E		Extracorp shock wave tx, ms					
0020T	A		Extracorp shock wave tx, ft					
00210	N		Anesth, open head surgery					
00212	N		Anesth, skull drainage					
00214	C		Anesth, skull drainage					
00215	C		Anesth, skull repair/fract					
00216	N		Anesth, head vessel surgery					
00218	N		Anesth, special head surgery					
0021T	C		Fetal oximetry, tmsvag/cerv					
00220	N		Anesth, intrcm nerve					
00222	N		Anesth, head nerve surgery					
0023T	A		Phenotype drug test, hiv 1					
0024T	C		Transcath cardiac reduction					
0025T	S	DG	Ultrasonic pachymetry	0230	0.7619	$41.57	$14.97	$8.31
0026T	A		Measure remnant lipoproteins					
0027T	T		Endoscopic epidural lysis	1547		$850.00		$170.00
0028T	N		Dexa body composition study					
0029T	A		Magnetic tx for incontinence					
00300	N		Anesth, head/neck/ptrunk					
0030T	A		Antiprothrombin antibody					
0031T	N		Speculoscopy					
00320	N		Anesth, neck organ, 1 & over					
00322	N		Anesth, biopsy of thyroid					
00326	N		Anesth, larynx/trach, < 1 yr					
0032T	N		Speculoscopy w/direct sample					
0033T	C		Endovasc taa repr incl subcl					
0034T	C		Endovasc taa repr w/o subcl					
00350	N		Anesth, neck vessel surgery					
00352	N		Anesth, neck vessel surgery					
0035T	C		Insert endovasc prosth, taa					
0036T	C		Endovasc prosth, taa, add-on					
0037T	C		Artery transpose/endovas taa					
0038T	C		Rad endovasc taa rpr w/cover					
0039T	C		Rad s/i, endovasc taa repair					
00400	N		Anesth, skin, ext/per/atrunk					
00402	N		Anesth, surgery of breast					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
00404	C		Anesth, surgery of breast					
00406	C		Anesth, surgery of breast					
0040T	C		Rad s/i, endovasc taa prosth					
00410	N		Anesth, correct heart rhythm					
0041T	A		Detect ur infect agnt w/cpas					
0042T	N		Ct perfusion w/contrast, cbf					
0043T	A		Co expired gas analysis					
0044T	N		Whole body photography					
00450	N		Anesth, surgery of shoulder					
00452	C		Anesth, surgery of shoulder					
00454	N		Anesth, collar bone biopsy					
0045T	N	NI	Whole body photography					
0046T	T	NI	Cath lavage, mammary duct(s)	0018	0.9178	$50.08	$16.04	$10.02
00470	N		Anesth, removal of rib					
00472	N		Anesth, chest wall repair					
00474	C		Anesth, surgery of rib(s)					
0047T	T	NI	Cath lavage, mammary duct(s)	0018	0.9178	$50.08	$16.04	$10.02
0048T	C	NI	Implant ventricular device					
0049T	C	NI	External circulation assist					
00500	N		Anesth, esophageal surgery					
0050T	C	NI	Removal circulation assist					
0051T	C	NI	Implant total heart system					
00520	N		Anesth, chest procedure					
00522	N		Anesth, chest lining biopsy					
00524	C		Anesth, chest drainage					
00528	N		Anesth, chest partition view					
00529	N	NI	Anesth, chest partition view					
0052T	C	NI	Replace component heart syst					
00530	N		Anesth, pacemaker insertion					
00532	N		Anesth, vascular access					
00534	N		Anesth, cardioverter/defib					
00537	N		Anesth, cardiac electrophys					
00539	N		Anesth, trach-bronch reconst					
0053T	C	NI	Replace component heart syst					
00540	C		Anesth, chest surgery					
00541	N		Anesth, one lung ventilation					
00542	C		Anesth, release of lung					
00544	C	DG	Anesth, chest lining removal					
00546	C	DG	Anesth, lung,chest wall surg					
00548	N	DG	Anesth, trachea,bronchi surg					
0054T	E	NI	Bone surgery using computer					
00550	N	DG	Anesth, sternal debridement					
0055T	E	NI	Bone surgery using computer					
00560	C	DG	Anesth, open heart surgery					
00562	C	DG	Anesth, open heart surgery					
00563	N	DG	Anesth, heart proc w/pump					
00566	N	DG	Anesth, cabg w/o pump					
0056T	E	NI	Bone surgery using computer					
0057T	E	NI	Uppr gi scope w/ thrml txmnt					
00580	C		Anesth, heart/lung transplnt					
0058T	X	NI	Cryopreservation, ovary tiss	0348	0.8194	$44.71		$8.94
0059T	X	NI	Cryopreservation, oocyte	0348	0.8194	$44.71		$8.94
00600	N		Anesth, spine, cord surgery					
00604	C		Anesth, sitting procedure					
0060T	E	NI	Electrical impedance scan					
0061T	E	NI	Destruction of tumor, breast					
00620	N		Anesth, spine, cord surgery					
00622	C		Anesth, removal of nerves					
00630	N		Anesth, spine, cord surgery					
00632	C		Anesth, removal of nerves					
00634	C		Anesth for chemonucleolysis					
00635	N		Anesth, lumbar puncture					
00640	N		Anesth, spine manipulation					
00670	C		Anesth, spine, cord surgery					
00700	N		Anesth, abdominal wall surg					
00702	N		Anesth, for liver biopsy					
00730	N		Anesth, abdominal wall surg					
00740	N		Anesth, upper gi visualize					
00750	N		Anesth, repair of hernia					
00752	N		Anesth, repair of hernia					
00754	N		Anesth, repair of hernia					
00756	N		Anesth, repair of hernia					
00770	N		Anesth, blood vessel repair					
00790	N		Anesth, surg upper abdomen					
00792	C		Anesth, hemorr/excise liver					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
00794	C		Anesth, pancreas removal					
00796	C		Anesth, for liver transplant					
00797	N		Anesth, surgery for obesity					
00800	N		Anesth, abdominal wall surg					
00802	C		Anesth, fat layer removal					
00810	N		Anesth, low intestine scope					
00820	N		Anesth, abdominal wall surg					
00830	N		Anesth, repair of hernia					
00832	N		Anesth, repair of hernia					
00834	N		Anesth, hernia repair< 1 yr					
00836	N		Anesth hernia repair preemie					
00840	N		Anesth, surg lower abdomen					
00842	N		Anesth, amniocentesis					
00844	C		Anesth, pelvis surgery					
00846	C		Anesth, hysterectomy					
00848	C		Anesth, pelvic organ surg					
00851	N		Anesth, tubal ligation					
00860	N		Anesth, surgery of abdomen					
00862	N		Anesth, kidney/ureter surg					
00864	C		Anesth, removal of bladder					
00865	C		Anesth, removal of prostate					
00866	C		Anesth, removal of adrenal					
00868	C		Anesth, kidney transplant					
00870	N		Anesth, bladder stone surg					
00872	N		Anesth kidney stone destruct					
00873	N		Anesth kidney stone destruct					
00880	N		Anesth, abdomen vessel surg					
00882	C		Anesth, major vein ligation					
00902	N		Anesth, anorectal surgery					
00904	C		Anesth, perineal surgery					
00906	N		Anesth, removal of vulva					
00908	C		Anesth, removal of prostate					
00910	N		Anesth, bladder surgery					
00912	N		Anesth, bladder tumor surg					
00914	N		Anesth, removal of prostate					
00916	N		Anesth, bleeding control					
00918	N		Anesth, stone removal					
00920	N		Anesth, genitalia surgery					
00921	N		Anesth, vasectomy					
00922	N		Anesth, sperm duct surgery					
00924	N		Anesth, testis exploration					
00926	N		Anesth, removal of testis					
00928	C		Anesth, removal of testis					
00930	N		Anesth, testis suspension					
00932	C		Anesth, amputation of penis					
00934	C		Anesth, penis, nodes removal					
00936	C		Anesth, penis, nodes removal					
00938	N		Anesth, insert penis device					
00940	N		Anesth, vaginal procedures					
00942	N		Anesth, surg on vag/urethral					
00944	C		Anesth, vaginal hysterectomy					
00948	N		Anesth, repair of cervix					
00950	N		Anesth, vaginal endoscopy					
00952	N		Anesth, hysteroscope/graph					
01112	N		Anesth, bone aspirate/bx					
01120	N		Anesth, pelvis surgery					
01130	N		Anesth, body cast procedure					
01140	C		Anesth, amputation at pelvis					
01150	C		Anesth, pelvic tumor surgery					
01160	N		Anesth, pelvis procedure					
01170	N		Anesth, pelvis surgery					
01173	N	NI	Anesth, fx repair, pelvis					
01180	N		Anesth, pelvis nerve removal					
01190	C		Anesth, pelvis nerve removal					
01200	N		Anesth, hip joint procedure					
01202	N		Anesth, arthroscopy of hip					
01210	N		Anesth, hip joint surgery					
01212	C		Anesth, hip disarticulation					
01214	C		Anesth, hip arthroplasty					
01215	N		Anesth, revise hip repair					
01220	N		Anesth, procedure on femur					
01230	N		Anesth, surgery of femur					
01232	C		Anesth, amputation of femur					
01234	C		Anesth, radical femur surg					
01250	N		Anesth, upper leg surgery					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
01260	N		Anesth, upper leg veins surg					
01270	N		Anesth, thigh arteries surg					
01272	C		Anesth, femoral artery surg					
01274	C		Anesth, femoral embolectomy					
01320	N		Anesth, knee area surgery					
01340	N		Anesth, knee area procedure					
01360	N		Anesth, knee area surgery					
01380	N		Anesth, knee joint procedure					
01382	N		Anesth, dx knee arthroscopy					
01390	N		Anesth, knee area procedure					
01392	N		Anesth, knee area surgery					
01400	N		Anesth, knee joint surgery					
01402	C		Anesth, knee arthroplasty					
01404	C		Anesth, amputation at knee					
01420	N		Anesth, knee joint casting					
01430	N		Anesth, knee veins surgery					
01432	N		Anesth, knee vessel surg					
01440	N		Anesth, knee arteries surg					
01442	C		Anesth, knee artery surg					
01444	C		Anesth, knee artery repair					
01462	N		Anesth, lower leg procedure					
01464	N		Anesth, ankle/ft arthroscopy					
01470	N		Anesth, lower leg surgery					
01472	N		Anesth, achilles tendon surg					
01474	N		Anesth, lower leg surgery					
01480	N		Anesth, lower leg bone surg					
01482	N		Anesth, radical leg surgery					
01484	N		Anesth, lower leg revision					
01486	C		Anesth, ankle replacement					
01490	N		Anesth, lower leg casting					
01500	N		Anesth, leg arteries surg					
01502	C		Anesth, lwr leg embolectomy					
01520	N		Anesth, lower leg vein surg					
01522	N		Anesth, lower leg vein surg					
01610	N		Anesth, surgery of shoulder					
01620	N		Anesth, shoulder procedure					
01622	N		Anes dx shoulder arthroscopy					
01630	N		Anesth, surgery of shoulder					
01632	C		Anesth, surgery of shoulder					
01634	C		Anesth, shoulder joint amput					
01636	C		Anesth, forequarter amput					
01638	C		Anesth, shoulder replacement					
01650	N		Anesth, shoulder artery surg					
01652	C		Anesth, shoulder vessel surg					
01654	C		Anesth, shoulder vessel surg					
01656	C		Anesth, arm-leg vessel surg					
01670	N		Anesth, shoulder vein surg					
01680	N		Anesth, shoulder casting					
01682	N		Anesth, airplane cast					
01710	N		Anesth, elbow area surgery					
01712	N		Anesth, uppr arm tendon surg					
01714	N		Anesth, uppr arm tendon surg					
01716	N		Anesth, biceps tendon repair					
01730	N		Anesth, uppr arm procedure					
01732	N		Anesth, dx elbow arthroscopy					
01740	N		Anesth, upper arm surgery					
01742	N		Anesth, humerus surgery					
01744	N		Anesth, humerus repair					
01756	C		Anesth, radical humerus surg					
01758	N		Anesth, humeral lesion surg					
01760	N		Anesth, elbow replacement					
01770	N		Anesth, uppr arm artery surg					
01772	N		Anesth, uppr arm embolectomy					
01780	N		Anesth, upper arm vein surg					
01782	N		Anesth, uppr arm vein repair					
01810	N		Anesth, lower arm surgery					
01820	N		Anesth, lower arm procedure					
01829	N		Anesth, dx wrist arthroscopy					
01830	N		Anesth, lower arm surgery					
01832	N		Anesth, wrist replacement					
01840	N		Anesth, lwr arm artery surg					
01842	N		Anesth, lwr arm embolectomy					
01844	N		Anesth, vascular shunt surg					
01850	N		Anesth, lower arm vein surg					
01852	N		Anesth, lwr arm vein repair					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
01860	N		Anesth, lower arm casting					
01905	N		Anes, spine inject, x-ray/re					
01916	N		Anesth, dx arteriography					
01920	N		Anesth, catheterize heart					
01922	N		Anesth, cat or MRI scan					
01924	N		Anes, ther interven rad, art					
01925	N		Anes, ther interven rad, car					
01926	N		Anes, tx interv rad hrt/cran					
01930	N		Anes, ther interven rad, vei					
01931	N		Anes, ther interven rad, tip					
01932	N		Anes, tx interv rad, th vein					
01933	N		Anes, tx interv rad, cran v					
01951	N		Anesth, burn, less 4 percent					
01952	N		Anesth, burn, 4-9 percent					
01953	N		Anesth, burn, each 9 percent					
01958	N	NI	Anesth, antepartum manipul					
01960	N		Anesth, vaginal delivery					
01961	N		Anesth, cs delivery					
01962	N		Anesth, emer hysterectomy					
01963	N		Anesth, cs hysterectomy					
01964	N		Anesth, abortion procedures					
01967	N		Anesth/analg, vag delivery					
01968	N		Anes/analg cs deliver add-on					
01969	N		Anesth/analg cs hyst add-on					
01990	C		Support for organ donor					
01991	N		Anesth, nerve block/inj					
01992	N		Anesth, n block/inj, prone					
01995	N		Regional anesthesia limb					
01996	N		Hosp manage cont drug admin					
01999	N		Unlisted anesth procedure					
10021	T		Fna w/o image	0002	0.8083	$44.10		$8.82
10022	T		Fna w/image	0036	1.5170	$82.77		$16.55
10040	T		Acne surgery	0010	0.6480	$35.36	$10.08	$7.07
10060	T		Drainage of skin abscess	0006	1.6527	$90.17	$23.26	$18.03
10061	T		Drainage of skin abscess	0006	1.6527	$90.17	$23.26	$18.03
10080	T		Drainage of pilonidal cyst	0006	1.6527	$90.17	$23.26	$18.03
10081	T		Drainage of pilonidal cyst	0007	11.8633	$647.27		$129.45
10120	T		Remove foreign body	0006	1.6527	$90.17	$23.26	$18.03
10121	T		Remove foreign body	0021	14.3594	$783.46	$219.48	$156.69
10140	T		Drainage of hematoma/fluid	0007	11.8633	$647.27		$129.45
10160	T		Puncture drainage of lesion	0018	0.9178	$50.08	$16.04	$10.02
10180	T		Complex drainage, wound	0007	11.8633	$647.27		$129.45
11000	T		Debride infected skin	0015	1.5968	$87.12	$20.35	$17.42
11001	T		Debride infected skin add-on	0012	0.7694	$41.98	$11.18	$8.40
11010	T		Debride skin, fx	0019	3.9493	$215.48	$71.87	$43.10
11011	T		Debride skin/muscle, fx	0019	3.9493	$215.48	$71.87	$43.10
11012	T		Debride skin/muscle/bone, fx	0019	3.9493	$215.48	$71.87	$43.10
11040	T		Debride skin, partial	0015	1.5968	$87.12	$20.35	$17.42
11041	T		Debride skin, full	0015	1.5968	$87.12	$20.35	$17.42
11042	T		Debride skin/tissue	0016	2.5724	$140.35	$57.31	$28.07
11043	T		Debride tissue/muscle	0016	2.5724	$140.35	$57.31	$28.07
11044	T		Debride tissue/muscle/bone	0682	8.0790	$440.80	$174.57	$88.16
11055	T		Trim skin lesion	0012	0.7694	$41.98	$11.18	$8.40
11056	T		Trim skin lesions, 2 to 4	0012	0.7694	$41.98	$11.18	$8.40
11057	T		Trim skin lesions, over 4	0013	1.1272	$61.50	$14.20	$12.30
11100	T		Biopsy, skin lesion	0018	0.9178	$50.08	$16.04	$10.02
11101	T		Biopsy, skin add-on	0018	0.9178	$50.08	$16.04	$10.02
11200	T		Removal of skin tags	0013	1.1272	$61.50	$14.20	$12.30
11201	T		Remove skin tags add-on	0015	1.5968	$87.12	$20.35	$17.42
11300	T		Shave skin lesion	0012	0.7694	$41.98	$11.18	$8.40
11301	T		Shave skin lesion	0012	0.7694	$41.98	$11.18	$8.40
11302	T		Shave skin lesion	0012	0.7694	$41.98	$11.18	$8.40
11303	T		Shave skin lesion	0015	1.5968	$87.12	$20.35	$17.42
11305	T		Shave skin lesion	0013	1.1272	$61.50	$14.20	$12.30
11306	T		Shave skin lesion	0013	1.1272	$61.50	$14.20	$12.30
11307	T		Shave skin lesion	0013	1.1272	$61.50	$14.20	$12.30
11308	T		Shave skin lesion	0013	1.1272	$61.50	$14.20	$12.30
11310	T		Shave skin lesion	0013	1.1272	$61.50	$14.20	$12.30
11311	T		Shave skin lesion	0013	1.1272	$61.50	$14.20	$12.30
11312	T		Shave skin lesion	0013	1.1272	$61.50	$14.20	$12.30
11313	T		Shave skin lesion	0016	2.5724	$140.35	$57.31	$28.07
11400	T		Removal of skin lesion	0019	3.9493	$215.48	$71.87	$43.10
11401	T		Removal of skin lesion	0019	3.9493	$215.48	$71.87	$43.10
11402	T		Removal of skin lesion	0019	3.9493	$215.48	$71.87	$43.10
11403	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
11404	T		Removal of skin lesion	0021	14.3594	$783.46	$219.48	$156.69
11406	T		Removal of skin lesion	0021	14.3594	$783.46	$219.48	$156.69
11420	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11421	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11422	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11423	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11424	T		Removal of skin lesion	0021	14.3594	$783.46	$219.48	$156.69
11426	T		Removal of skin lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11440	T		Removal of skin lesion	0019	3.9493	$215.48	$71.87	$43.10
11441	T		Removal of skin lesion	0019	3.9493	$215.48	$71.87	$43.10
11442	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11443	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11444	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11446	T		Removal of skin lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11450	T		Removal, sweat gland lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11451	T		Removal, sweat gland lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11462	T		Removal, sweat gland lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11463	T		Removal, sweat gland lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11470	T		Removal, sweat gland lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11471	T		Removal, sweat gland lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11600	T		Removal of skin lesion	0019	3.9493	$215.48	$71.87	$43.10
11601	T		Removal of skin lesion	0019	3.9493	$215.48	$71.87	$43.10
11602	T		Removal of skin lesion	0019	3.9493	$215.48	$71.87	$43.10
11603	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11604	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11606	T		Removal of skin lesion	0021	14.3594	$783.46	$219.48	$156.69
11620	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11621	T		Removal of skin lesion	0019	3.9493	$215.48	$71.87	$43.10
11622	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11623	T		Removal of skin lesion	0021	14.3594	$783.46	$219.48	$156.69
11624	T		Removal of skin lesion	0021	14.3594	$783.46	$219.48	$156.69
11626	T		Removal of skin lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11640	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11641	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11642	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11643	T		Removal of skin lesion	0020	7.0842	$386.52	$113.25	$77.30
11644	T		Removal of skin lesion	0021	14.3594	$783.46	$219.48	$156.69
11646	T		Removal of skin lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11719	T		Trim nail(s)	0009	0.6652	$36.29	$8.34	$7.26
11720	T		Debride nail, 1-5	0009	0.6652	$36.29	$8.34	$7.26
11721	T		Debride nail, 6 or more	0009	0.6652	$36.29	$8.34	$7.26
11730	T		Removal of nail plate	0013	1.1272	$61.50	$14.20	$12.30
11732	T		Remove nail plate, add-on	0012	0.7694	$41.98	$11.18	$8.40
11740	T		Drain blood from under nail	0009	0.6652	$36.29	$8.34	$7.26
11750	T		Removal of nail bed	0019	3.9493	$215.48	$71.87	$43.10
11752	T		Remove nail bed/finger tip	0022	18.7932	$1,025.38	$354.45	$205.08
11755	T		Biopsy, nail unit	0019	3.9493	$215.48	$71.87	$43.10
11760	T		Repair of nail bed	0024	1.6850	$91.94	$33.10	$18.39
11762	T		Reconstruction of nail bed	0024	1.6850	$91.94	$33.10	$18.39
11765	T		Excision of nail fold, toe	0015	1.5968	$87.12	$20.35	$17.42
11770	T		Removal of pilonidal lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11771	T		Removal of pilonidal lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11772	T		Removal of pilonidal lesion	0022	18.7932	$1,025.38	$354.45	$205.08
11900	T		Injection into skin lesions	0012	0.7694	$41.98	$11.18	$8.40
11901	T		Added skin lesions injection	0012	0.7694	$41.98	$11.18	$8.40
11920	T		Correct skin color defects	0024	1.6850	$91.94	$33.10	$18.39
11921	T		Correct skin color defects	0024	1.6850	$91.94	$33.10	$18.39
11922	T		Correct skin color defects	0024	1.6850	$91.94	$33.10	$18.39
11950	T		Therapy for contour defects	0024	1.6850	$91.94	$33.10	$18.39
11951	T		Therapy for contour defects	0024	1.6850	$91.94	$33.10	$18.39
11952	T		Therapy for contour defects	0024	1.6850	$91.94	$33.10	$18.39
11954	T		Therapy for contour defects	0024	1.6850	$91.94	$33.10	$18.39
11960	T		Insert tissue expander(s)	0027	15.8990	$867.47	$329.72	$173.49
11970	T		Replace tissue expander	0027	15.8990	$867.47	$329.72	$173.49
11971	T		Remove tissue expander(s)	0022	18.7932	$1,025.38	$354.45	$205.08
11975	E		Insert contraceptive cap					
11976	T		Removal of contraceptive cap	0019	3.9493	$215.48	$71.87	$43.10
11977	E		Removal/reinsert contra cap					
11980	X		Implant hormone pellet(s)	0340	0.6314	$34.45		$6.89
11981	X		Insert drug implant device	0340	0.6314	$34.45		$6.89
11982	X		Remove drug implant device	0340	0.6314	$34.45		$6.89
11983	X		Remove/insert drug implant	0340	0.6314	$34.45		$6.89
12001	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12002	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12004	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
12005	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12006	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12007	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12011	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12013	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12014	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12015	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12016	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12017	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12018	T		Repair superficial wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12020	T		Closure of split wound	0024	1.6850	$91.94	$33.10	$18.39
12021	T		Closure of split wound	0024	1.6850	$91.94	$33.10	$18.39
12031	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12032	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12034	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12035	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12036	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12037	T		Layer closure of wound(s)	0025	5.1912	$283.24	$107.00	$56.65
12041	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12042	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12044	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12045	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12046	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12047	T		Layer closure of wound(s)	0025	5.1912	$283.24	$107.00	$56.65
12051	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12052	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12053	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12054	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12055	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12056	T		Layer closure of wound(s)	0024	1.6850	$91.94	$33.10	$18.39
12057	T		Layer closure of wound(s)	0025	5.1912	$283.24	$107.00	$56.65
13100	T		Repair of wound or lesion	0025	5.1912	$283.24	$107.00	$56.65
13101	T		Repair of wound or lesion	0025	5.1912	$283.24	$107.00	$56.65
13102	T		Repair wound/lesion add-on	0024	1.6850	$91.94	$33.10	$18.39
13120	T		Repair of wound or lesion	0024	1.6850	$91.94	$33.10	$18.39
13121	T		Repair of wound or lesion	0024	1.6850	$91.94	$33.10	$18.39
13122	T		Repair wound/lesion add-on	0024	1.6850	$91.94	$33.10	$18.39
13131	T		Repair of wound or lesion	0024	1.6850	$91.94	$33.10	$18.39
13132	T		Repair of wound or lesion	0024	1.6850	$91.94	$33.10	$18.39
13133	T		Repair wound/lesion add-on	0024	1.6850	$91.94	$33.10	$18.39
13150	T		Repair of wound or lesion	0025	5.1912	$283.24	$107.00	$56.65
13151	T		Repair of wound or lesion	0024	1.6850	$91.94	$33.10	$18.39
13152	T		Repair of wound or lesion	0025	5.1912	$283.24	$107.00	$56.65
13153	T		Repair wound/lesion add-on	0024	1.6850	$91.94	$33.10	$18.39
13160	T		Late closure of wound	0027	15.8990	$867.47	$329.72	$173.49
14000	T		Skin tissue rearrangement	0027	15.8990	$867.47	$329.72	$173.49
14001	T		Skin tissue rearrangement	0027	15.8990	$867.47	$329.72	$173.49
14020	T		Skin tissue rearrangement	0027	15.8990	$867.47	$329.72	$173.49
14021	T		Skin tissue rearrangement	0027	15.8990	$867.47	$329.72	$173.49
14040	T		Skin tissue rearrangement	0027	15.8990	$867.47	$329.72	$173.49
14041	T		Skin tissue rearrangement	0027	15.8990	$867.47	$329.72	$173.49
14060	T		Skin tissue rearrangement	0027	15.8990	$867.47	$329.72	$173.49
14061	T		Skin tissue rearrangement	0027	15.8990	$867.47	$329.72	$173.49
14300	T		Skin tissue rearrangement	0027	15.8990	$867.47	$329.72	$173.49
14350	T		Skin tissue rearrangement	0027	15.8990	$867.47	$329.72	$173.49
15000	T		Skin graft	0025	5.1912	$283.24	$107.00	$56.65
15001	T		Skin graft add-on	0025	5.1912	$283.24	$107.00	$56.65
15050	T		Skin pinch graft	0025	5.1912	$283.24	$107.00	$56.65
15100	T		Skin split graft	0027	15.8990	$867.47	$329.72	$173.49
15101	T		Skin split graft add-on	0027	15.8990	$867.47	$329.72	$173.49
15120	T		Skin split graft	0027	15.8990	$867.47	$329.72	$173.49
15121	T		Skin split graft add-on	0027	15.8990	$867.47	$329.72	$173.49
15200	T		Skin full graft	0027	15.8990	$867.47	$329.72	$173.49
15201	T		Skin full graft add-on	0025	5.1912	$283.24	$107.00	$56.65
15220	T		Skin full graft	0027	15.8990	$867.47	$329.72	$173.49
15221	T		Skin full graft add-on	0025	5.1912	$283.24	$107.00	$56.65
15240	T		Skin full graft	0027	15.8990	$867.47	$329.72	$173.49
15241	T		Skin full graft add-on	0025	5.1912	$283.24	$107.00	$56.65
15260	T		Skin full graft	0027	15.8990	$867.47	$329.72	$173.49
15261	T		Skin full graft add-on	0025	5.1912	$283.24	$107.00	$56.65
15342	T		Cultured skin graft, 25 cm	0024	1.6850	$91.94	$33.10	$18.39
15343	T		Culture skn graft addl 25 cm	0024	1.6850	$91.94	$33.10	$18.39
15350	T		Skin homograft	0686	7.9247	$432.38	$198.89	$86.48
15351	T		Skin homograft add-on	0027	15.8990	$867.47	$329.72	$173.49
15400	T		Skin heterograft	0025	5.1912	$283.24	$107.00	$56.65

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
15401	T		Skin heterograft add-on	0025	5.1912	$283.24	$107.00	$56.65
15570	T		Form skin pedicle flap	0027	15.8990	$867.47	$329.72	$173.49
15572	T		Form skin pedicle flap	0027	15.8990	$867.47	$329.72	$173.49
15574	T		Form skin pedicle flap	0027	15.8990	$867.47	$329.72	$173.49
15576	T		Form skin pedicle flap	0027	15.8990	$867.47	$329.72	$173.49
15600	T		Skin graft	0027	15.8990	$867.47	$329.72	$173.49
15610	T		Skin graft	0027	15.8990	$867.47	$329.72	$173.49
15620	T		Skin graft	0027	15.8990	$867.47	$329.72	$173.49
15630	T		Skin graft	0027	15.8990	$867.47	$329.72	$173.49
15650	T		Transfer skin pedicle flap	0027	15.8990	$867.47	$329.72	$173.49
15732	T		Muscle-skin graft, head/neck	0027	15.8990	$867.47	$329.72	$173.49
15734	T		Muscle-skin graft, trunk	0027	15.8990	$867.47	$329.72	$173.49
15736	T		Muscle-skin graft, arm	0027	15.8990	$867.47	$329.72	$173.49
15738	T		Muscle-skin graft, leg	0027	15.8990	$867.47	$329.72	$173.49
15740	T		Island pedicle flap graft	0027	15.8990	$867.47	$329.72	$173.49
15750	T		Neurovascular pedicle graft	0027	15.8990	$867.47	$329.72	$173.49
15756	C		Free muscle flap, microvasc					
15757	C		Free skin flap, microvasc					
15758	C		Free fascial flap, microvasc					
15760	T		Composite skin graft	0027	15.8990	$867.47	$329.72	$173.49
15770	T		Derma-fat-fascia graft	0027	15.8990	$867.47	$329.72	$173.49
15775	T		Hair transplant punch grafts	0025	5.1912	$283.24	$107.00	$56.65
15776	T		Hair transplant punch grafts	0025	5.1912	$283.24	$107.00	$56.65
15780	T		Abrasion treatment of skin	0022	18.7932	$1,025.38	$354.45	$205.08
15781	T		Abrasion treatment of skin	0019	3.9493	$215.48	$71.87	$43.10
15782	T		Dressing change not for burn	0019	3.9493	$215.48	$71.87	$43.10
15783	T		Abrasion treatment of skin	0016	2.5724	$140.35	$57.31	$28.07
15786	T		Abrasion, lesion, single	0012	0.7694	$41.98	$11.18	$8.40
15787	T		Abrasion, lesions, add-on	0013	1.1272	$61.50	$14.20	$12.30
15788	T		Chemical peel, face, epiderm	0012	0.7694	$41.98	$11.18	$8.40
15789	T		Chemical peel, face, dermal	0015	1.5968	$87.12	$20.35	$17.42
15792	T		Chemical peel, nonfacial	0012	0.7694	$41.98	$11.18	$8.40
15793	T		Chemical peel, nonfacial	0012	0.7694	$41.98	$11.18	$8.40
15810	T		Salabrasion	0016	2.5724	$140.35	$57.31	$28.07
15811	T		Salabrasion	0016	2.5724	$140.35	$57.31	$28.07
15819	T		Plastic surgery, neck	0025	5.1912	$283.24	$107.00	$56.65
15820	T		Revision of lower eyelid	0027	15.8990	$867.47	$329.72	$173.49
15821	T		Revision of lower eyelid	0027	15.8990	$867.47	$329.72	$173.49
15822	T		Revision of upper eyelid	0027	15.8990	$867.47	$329.72	$173.49
15823	T		Revision of upper eyelid	0027	15.8990	$867.47	$329.72	$173.49
15824	T		Removal of forehead wrinkles	0027	15.8990	$867.47	$329.72	$173.49
15825	T		Removal of neck wrinkles	0027	15.8990	$867.47	$329.72	$173.49
15826	T		Removal of brow wrinkles	0027	15.8990	$867.47	$329.72	$173.49
15828	T		Removal of face wrinkles	0027	15.8990	$867.47	$329.72	$173.49
15829	T		Removal of skin wrinkles	0027	15.8990	$867.47	$329.72	$173.49
15831	T		Excise excessive skin tissue	0022	18.7932	$1,025.38	$354.45	$205.08
15832	T		Excise excessive skin tissue	0022	18.7932	$1,025.38	$354.45	$205.08
15833	T		Excise excessive skin tissue	0022	18.7932	$1,025.38	$354.45	$205.08
15834	T		Excise excessive skin tissue	0022	18.7932	$1,025.38	$354.45	$205.08
15835	T		Excise excessive skin tissue	0025	5.1912	$283.24	$107.00	$56.65
15836	T		Excise excessive skin tissue	0021	14.3594	$783.46	$219.48	$156.69
15837	T		Excise excessive skin tissue	0021	14.3594	$783.46	$219.48	$156.69
15838	T		Excise excessive skin tissue	0021	14.3594	$783.46	$219.48	$156.69
15839	T		Excise excessive skin tissue	0021	14.3594	$783.46	$219.48	$156.69
15840	T		Graft for face nerve palsy	0027	15.8990	$867.47	$329.72	$173.49
15841	T		Graft for face nerve palsy	0027	15.8990	$867.47	$329.72	$173.49
15842	T		Flap for face nerve palsy	0027	15.8990	$867.47	$329.72	$173.49
15845	T		Skin and muscle repair, face	0027	15.8990	$867.47	$329.72	$173.49
15850	T		Removal of sutures	0016	2.5724	$140.35	$57.31	$28.07
15851	T		Removal of sutures	0016	2.5724	$140.35	$57.31	$28.07
15852	X		Dressing change,not for bum	0340	0.6314	$34.45		$6.89
15860	S		Test for blood flow in graft	1501		$25.00		$5.00
15876	T		Suction assisted lipectomy	0027	15.8990	$867.47	$329.72	$173.49
15877	T		Suction assisted lipectomy	0027	15.8990	$867.47	$329.72	$173.49
15878	T		Suction assisted lipectomy	0027	15.8990	$867.47	$329.72	$173.49
15879	T		Suction assisted lipectomy	0027	15.8990	$867.47	$329.72	$173.49
15920	T		Removal of tail bone ulcer	0019	3.9493	$215.48	$71.87	$43.10
15922	T		Removal of tail bone ulcer	0027	15.8990	$867.47	$329.72	$173.49
15931	T		Remove sacrum pressure sore	0022	18.7932	$1,025.38	$354.45	$205.08
15933	T		Remove sacrum pressure sore	0022	18.7932	$1,025.38	$354.45	$205.08
15934	T		Remove sacrum pressure sore	0027	15.8990	$867.47	$329.72	$173.49
15935	T		Remove sacrum pressure sore	0027	15.8990	$867.47	$329.72	$173.49
15936	T		Remove sacrum pressure sore	0027	15.8990	$867.47	$329.72	$173.49
15937	T		Remove sacrum pressure sore	0027	15.8990	$867.47	$329.72	$173.49
15940	T		Remove hip pressure sore	0022	18.7932	$1,025.38	$354.45	$205.08

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
15941	T		Remove hip pressure sore	0022	18.7932	$1,025.38	$354.45	$205.08
15944	T		Remove hip pressure sore	0027	15.8990	$867.47	$329.72	$173.49
15945	T		Remove hip pressure sore	0027	15.8990	$867.47	$329.72	$173.49
15946	T		Remove hip pressure sore	0027	15.8990	$867.47	$329.72	$173.49
15950	T		Remove thigh pressure sore	0022	18.7932	$1,025.38	$354.45	$205.08
15951	T		Remove thigh pressure sore	0022	18.7932	$1,025.38	$354.45	$205.08
15952	T		Remove thigh pressure sore	0027	15.8990	$867.47	$329.72	$173.49
15953	T		Remove thigh pressure sore	0027	15.8990	$867.47	$329.72	$173.49
15956	T		Remove thigh pressure sore	0027	15.8990	$867.47	$329.72	$173.49
15958	T		Remove thigh pressure sore	0027	15.8990	$867.47	$329.72	$173.49
15999	T		Removal of pressure sore	0022	18.7932	$1,025.38	$354.45	$205.08
16000	T		Initial treatment of bum(s)	0012	0.7694	$41.98	$11.18	$8.40
16010	T		Treatment of bum(s)	0016	2.5724	$140.35	$57.31	$28.07
16015	T		Treatment of bum(s)	0017	16.3697	$893.15	$227.84	$178.63
16020	T		Treatment of bum(s)	0013	1.1272	$61.50	$14.20	$12.30
16025	T		Treatment of bum(s)	0012	0.7694	$41.98	$11.18	$8.40
16030	T		Treatment of bum(s)	0015	1.5968	$87.12	$20.35	$17.42
16035	C		Incision of bum scab, initi					
16036	C		Escharotomy; add'l incision					
17000	T		Destroy benign/premlg lesion	0010	0.6480	$35.36	$10.08	$7.07
17003	T		Destroy lesions, 2-14	0010	0.6480	$35.36	$10.08	$7.07
17004	T		Destroy lesions, 15 or more	0011	2.2217	$121.22	$27.88	$24.24
17106	T		Destruction of skin lesions	0011	2.2217	$121.22	$27.88	$24.24
17107	T		Destruction of skin lesions	0011	2.2217	$121.22	$27.88	$24.24
17108	T		Destruction of skin lesions	0011	2.2217	$121.22	$27.88	$24.24
17110	T		Destruct lesion, 1-14	0010	0.6480	$35.36	$10.08	$7.07
17111	T		Destruct lesion, 15 or more	0010	0.6480	$35.36	$10.08	$7.07
17250	T		Chemical cautery, tissue	0013	1.1272	$61.50	$14.20	$12.30
17260	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17261	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17262	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17263	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17264	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17266	T		Destruction of skin lesions	0016	2.5724	$140.35	$57.31	$28.07
17270	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17271	T		Destruction of skin lesions	0013	1.1272	$61.50	$14.20	$12.30
17272	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17273	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17274	T		Destruction of skin lesions	0016	2.5724	$140.35	$57.31	$28.07
17276	T		Destruction of skin lesions	0016	2.5724	$140.35	$57.31	$28.07
17280	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17281	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17282	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17283	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17284	T		Destruction of skin lesions	0016	2.5724	$140.35	$57.31	$28.07
17286	T		Destruction of skin lesions	0015	1.5968	$87.12	$20.35	$17.42
17304	T		Chemosurgery of skin lesion	0694	2.9752	$162.33	$64.93	$32.47
17305	T		2 stage mohs, up to 5 spec	0694	2.9752	$162.33	$64.93	$32.47
17306	T		3 stage mohs, up to 5 spec	0694	2.9752	$162.33	$64.93	$32.47
17307	T		Mohs addl stage up to 5 spec	0694	2.9752	$162.33	$64.93	$32.47
17310	T		Extensive skin chemosurgery	0694	2.9752	$162.33	$64.93	$32.47
17340	T		Cryotherapy of skin	0012	0.7694	$41.98	$11.18	$8.40
17360	T		Skin peel therapy	0012	0.7694	$41.98	$11.18	$8.40
17380	T		Hair removal by electrolysis	0012	0.7694	$41.98	$11.18	$8.40
17999	T		Skin tissue procedure	0006	1.6527	$90.17	$23.26	$18.03
19000	T		Drainage of breast lesion	0004	1.5882	$86.65	$22.36	$17.33
19001	T		Drain breast lesion add-on	0004	1.5882	$86.65	$22.36	$17.33
19020	T		Incision of breast lesion	0007	11.8633	$647.27		$129.45
19030	N		Injection for breast x-ray					
19100	T		Bx breast percut w/o image	0005	3.2698	$178.40	$71.59	$35.68
19101	T		Biopsy of breast, open	0028	17.6584	$963.46	$303.74	$192.69
19102	T		Bx breast percut w/image	0005	3.2698	$178.40	$71.59	$35.68
19103	T		Bx breast percut w/device	0658	5.5779	$304.34		$60.87
19110	T		nipple exploration	0028	17.6584	$963.46	$303.74	$192.69
19112	T		Excise breast duct fistula	0028	17.6584	$963.46	$303.74	$192.69
19120	T		Removal of breast lesion	0028	17.6584	$963.46	$303.74	$192.69
19125	T		Excision, breast lesion	0028	17.6584	$963.46	$303.74	$192.69
19126	T		Excision, addl breast lesion	0028	17.6584	$963.46	$303.74	$192.69
19140	T		Removal of breast tissue	0028	17.6584	$963.46	$303.74	$192.69
19160	T		Removal of breast tissue	0028	17.6584	$963.46	$303.74	$192.69
19162	T		Remove breast tissue, nodes	0693	39.0111	$2,128.48	$798.17	$425.70
19180	T		Removal of breast	0029	30.1167	$1,643.20	$632.64	$328.64
19182	T		Removal of breast	0029	30.1167	$1,643.20	$632.64	$328.64
19200	C		Removal of breast					
19220	C		Removal of breast					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
19240	T		Removal of breast	0030	37.3083	$2,035.58	$763.55	$407.12
19260	T		Removal of chest wall lesion	0021	14.3594	$783.46	$219.48	$156.69
19271	C		Revision of chest wall					
19272	C		Extensive chest wall surgery					
19290	N		Place needle wire, breast					
19291	N		Place needle wire, breast					
19295	S		Place breast clip, percut	0657	1.5102	$82.40		$16.48
19316	T		Suspension of breast	0029	30.1167	$1,643.20	$632.64	$328.64
19318	T		Reduction of large breast	0693	39.0111	$2,128.48	$798.17	$425.70
19324	T		Enlarge breast	0693	39.0111	$2,128.48	$798.17	$425.70
19325	T		Enlarge breast with implant	0648	54.0165	$2,947.19		$589.44
19328	T		Removal of breast implant	0029	30.1167	$1,643.20	$632.64	$328.64
19330	T		Removal of implant material	0029	30.1167	$1,643.20	$632.64	$328.64
19340	T		Immediate breast prosthesis	0030	37.3083	$2,035.58	$763.55	$407.12
19342	T		Delayed breast prosthesis	0648	54.0165	$2,947.19		$589.44
19350	T		Breast reconstruction	0028	17.6584	$963.46	$303.74	$192.69
19355	T		Correct inverted nipple(s)	0029	30.1167	$1,643.20	$632.64	$328.64
19357	T		Breast reconstruction	0648	54.0165	$2,947.19		$589.44
19361	C		Breast reconstruction					
19364	C		Breast reconstruction					
19366	T		Breast reconstruction	0029	30.1167	$1,643.20	$632.64	$328.64
19367	C		Breast reconstruction					
19368	C		Breast reconstruction					
19369	C		Breast reconstruction					
19370	T		Surgery of breast capsule	0029	30.1167	$1,643.20	$632.64	$328.64
19371	T		Removal of breast capsule	0029	30.1167	$1,643.20	$632.64	$328.64
19380	T		Revise breast reconstruction	0030	37.3083	$2,035.58	$763.55	$407.12
19396	T		Design custom breast implant	0029	30.1167	$1,643.20	$632.64	$328.64
19499	T		Breast surgery procedure	0028	17.6584	$963.46	$303.74	$192.69
20000	T		Incision of abscess	0006	1.6527	$90.17	$23.26	$18.03
20005	T		Incision of deep abscess	0049	19.6046	$1,069.65		$213.93
20100	T		Explore wound, neck	0023	2.8141	$153.54	$40.37	$30.71
20101	T		Explore wound, chest	0027	15.8990	$867.47	$329.72	$173.49
20102	T		Explore wound, abdomen	0027	15.8990	$867.47	$329.72	$173.49
20103	T		Explore wound, extremity	0023	2.8141	$153.54	$40.37	$30.71
20150	T		Excise epiphyseal bar	0051	34.5144	$1,883.14		$376.63
20200	T		Muscle biopsy	0021	14.3594	$783.46	$219.48	$156.69
20205	T		Deep muscle biopsy	0021	14.3594	$783.46	$219.48	$156.69
20206	T		Needle biopsy, muscle	0005	3.2698	$178.40	$71.59	$35.68
20220	T		Bone biopsy, trocar/needle	0019	3.9493	$215.48	$71.87	$43.10
20225	T		Bone biopsy, trocar/needle	0020	7.0842	$386.52	$113.25	$77.30
20240	T		Bone biopsy, excisional	0022	18.7932	$1,025.38	$354.45	$205.08
20245	T		Bone biopsy, excisional	0022	18.7932	$1,025.38	$354.45	$205.08
20250	T		Open bone biopsy	0049	19.6046	$1,069.65		$213.93
20251	T		Open bone biopsy	0049	19.6046	$1,069.65		$213.93
20500	T		Injection of sinus tract	0251	1.7880	$97.56		$19.51
20501	N		Inject sinus tract for x-ray					
20520	T		Removal of foreign body	0019	3.9493	$215.48	$71.87	$43.10
20525	T		Removal of foreign body	0022	18.7932	$1,025.38	$354.45	$205.08
20526	T		Ther injection, carp tunnel	0204	2.1711	$118.46	$40.13	$23.69
20550	T		Inject tendon/ligament/cyst	0204	2.1711	$118.46	$40.13	$23.69
20551	T		Inj tendon origin/insertion	0204	2.1711	$118.46	$40.13	$23.69
20552	T		Inj trigger point, 1/2 muscl	0204	2.1711	$118.46	$40.13	$23.69
20553	T		Inject trigger points, > 3	0204	2.1711	$118.46	$40.13	$23.69
20600	T		Drain/inject, joint/bursa	0204	2.1711	$118.46	$40.13	$23.69
20605	T		Drain/inject, joint/bursa	0204	2.1711	$118.46	$40.13	$23.69
20610	T		Drain/inject, joint/bursa	0204	2.1711	$118.46	$40.13	$23.69
20612	T		Aspirate/inj ganglion cyst	0204	2.1711	$118.46	$40.13	$23.69
20615	T		Treatment of bone cyst	0004	1.5882	$86.65	$22.36	$17.33
20650	T		Insert and remove bone pin	0049	19.6046	$1,069.65		$213.93
20660	C		Apply, rem fixation device					
20661	C		Application of head brace					
20662	C		Application of pelvis brace					
20663	C		Application of thigh brace					
20664	C		Halo brace application					
20665	X		Removal of fixation device	0340	0.6314	$34.45		$6.89
20670	T		Removal of support implant	0021	14.3594	$783.46	$219.48	$156.69
20680	T		Removal of support implant	0022	18.7932	$1,025.38	$354.45	$205.08
20690	T		Apply bone fixation device	0050	24.8651	$1,356.66		$271.33
20692	T		Apply bone fixation device	0050	24.8651	$1,356.66		$271.33
20693	T		Adjust bone fixation device	0049	19.6046	$1,069.65		$213.93
20694	T		Remove bone fixation device	0049	19.6046	$1,069.65		$213.93
20802	C		Replantation, arm, complete					
20805	C		Replant forearm, complete					
20808	C		Replantation hand, complete					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
20816	C		Replantation digit, complete					
20822	C		Replantation digit, complete					
20824	C		Replantation thumb, complete					
20827	C		Replantation thumb, complete					
20838	C		Replantation foot, complete					
20900	T		Removal of bone for graft	0050	24.8651	$1,356.66		$271.33
20902	T		Removal of bone for graft	0050	24.8651	$1,356.66		$271.33
20910	T		Remove cartilage for graft	0027	15.8990	$867.47	$329.72	$173.49
20912	T		Remove cartilage for graft	0027	15.8990	$867.47	$329.72	$173.49
20920	T		Removal of fascia for graft	0027	15.8990	$867.47	$329.72	$173.49
20922	T		Removal of fascia for graft	0027	15.8990	$867.47	$329.72	$173.49
20924	T		Removal of tendon for graft	0050	24.8651	$1,356.66		$271.33
20926	T		Removal of tissue for graft	0027	15.8990	$867.47	$329.72	$173.49
20930	C		Spinal bone allograft					
20931	C		Spinal bone allograft					
20936	C		Spinal bone autograft					
20937	C		Spinal bone autograft					
20938	C		Spinal bone autograft					
20950	T		Fluid pressure, muscle	0006	1.6527	$90.17	$23.26	$18.03
20955	C		Fibula bone graft, microvasc					
20956	C		Iliac bone graft, microvasc					
20957	C		Mt bone graft, microvasc					
20962	C		Other bone graft, microvasc					
20969	C		Bone/skin graft, microvasc					
20970	C		Bone/skin graft, iliac crest					
20972	C		Bone/skin graft, metatarsal					
20973	C		Bone/skin graft, great toe					
20974	A		Electrical bone stimulation					
20975	T		Electrical bone stimulation	0049	19.6046	$1,069.65		$213.93
20979	A		Us bone stimulation					
20982	T	NI	Ablate, bone tumor(s) perq	1557		$1,850.00		$370.00
20999	T		Musculoskeletal surgery	0049	19.6046	$1,069.65		$213.93
21010	T		Incision of jaw joint	0254	21.8901	$1,194.35	$321.35	$238.87
21015	T		Resection of facial tumor	0253	15.2249	$830.69	$282.29	$166.14
21025	T		Excision of bone, lower jaw	0256	35.1548	$1,918.08		$383.62
21026	T		Excision of facial bone(s)	0256	35.1548	$1,918.08		$383.62
21029	T		Contour of face bone lesion	0256	35.1548	$1,918.08		$383.62
21030	T		Removal of face bone lesion	0254	21.8901	$1,194.35	$321.35	$238.87
21031	T		Remove exostosis, mandible	0254	21.8901	$1,194.35	$321.35	$238.87
21032	T		Remove exostosis, maxilla	0254	21.8901	$1,194.35	$321.35	$238.87
21034	T		Removal of face bone lesion	0256	35.1548	$1,918.08		$383.62
21040	T		Removal of jaw bone lesion	0254	21.8901	$1,194.35	$321.35	$238.87
21044	T		Removal of jaw bone lesion	0256	35.1548	$1,918.08		$383.62
21045	C		Extensive jaw surgery					
21046	T		Remove mandible cyst complex	0256	35.1548	$1,918.08		$383.62
21047	T		Excise lwr jaw cyst w/repair	0256	35.1548	$1,918.08		$383.62
21048	T		Remove maxilla cyst complex	0256	35.1548	$1,918.08		$383.62
21049	T		Excis uppr jaw cyst w/repair	0256	35.1548	$1,918.08		$383.62
21050	T		Removal of jaw joint	0256	35.1548	$1,918.08		$383.62
21060	T		Remove jaw joint cartilage	0256	35.1548	$1,918.08		$383.62
21070	T		Remove coronoid process	0256	35.1548	$1,918.08		$383.62
21076	T		Prepare face/oral prosthesis	0254	21.8901	$1,194.35	$321.35	$238.87
21077	T		Prepare face/oral prosthesis	0256	35.1548	$1,918.08		$383.62
21079	T		Prepare face/oral prosthesis	0256	35.1548	$1,918.08		$383.62
21080	T		Prepare face/oral prosthesis	0256	35.1548	$1,918.08		$383.62
21081	T		Prepare face/oral prosthesis	0256	35.1548	$1,918.08		$383.62
21082	T		Prepare face/oral prosthesis	0256	35.1548	$1,918.08		$383.62
21083	T		Prepare face/oral prosthesis	0256	35.1548	$1,918.08		$383.62
21084	T		Prepare face/oral prosthesis	0256	35.1548	$1,918.08		$383.62
21085	T		Prepare face/oral prosthesis	0253	15.2249	$830.69	$282.29	$166.14
21086	T		Prepare face/oral prosthesis	0256	35.1548	$1,918.08		$383.62
21087	T		Prepare face/oral prosthesis	0256	35.1548	$1,918.08		$383.62
21088	T		Prepare face/oral prosthesis	0256	35.1548	$1,918.08		$383.62
21089	T		Prepare face/oral prosthesis	0253	15.2249	$830.69	$282.29	$166.14
21100	T		Maxillofacial fixation	0256	35.1548	$1,918.08		$383.62
21110	T		Interdental fixation	0252	6.4469	$351.75	$113.41	$70.35
21116	N		Injection, jaw joint x-ray					
21120	T		Reconstruction of chin	0254	21.8901	$1,194.35	$321.35	$238.87
21121	T		Reconstruction of chin	0254	21.8901	$1,194.35	$321.35	$238.87
21122	T		Reconstruction of chin	0254	21.8901	$1,194.35	$321.35	$238.87
21123	T		Reconstruction of chin	0254	21.8901	$1,194.35	$321.35	$238.87
21125	T		Augmentation, lower jaw bone	0254	21.8901	$1,194.35	$321.35	$238.87
21127	T		Augmentation, lower jaw bone	0256	35.1548	$1,918.08		$383.62
21137	T		Reduction of forehead	0254	21.8901	$1,194.35	$321.35	$238.87
21138	T		Reduction of forehead	0256	35.1548	$1,918.08		$383.62

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21139	T		Reduction of forehead	0256	35.1548	$1,918.08		$383.62
21141	C		Reconstruct midface, lefort					
21142	C		Reconstruct midface, lefort					
21143	C		Reconstruct midface, lefort					
21145	C		Reconstruct midface, lefort					
21146	C		Reconstruct midface, lefort					
21147	C		Reconstruct midface, lefort					
21150	C		Reconstruct midface, lefort					
21151	C		Reconstruct midface, lefort					
21154	C		Reconstruct midface, lefort					
21155	C		Reconstruct midface, lefort					
21159	C		Reconstruct midface, lefort					
21160	C		Reconstruct midface, lefort					
21172	C		Reconstruct orbit/forehead					
21175	C		Reconstruct orbit/forehead					
21179	C		Reconstruct entire forehead					
21180	C		Reconstruct entire forehead					
21181	T		Contour cranial bone lesion	0254	21.8901	$1,194.35	$321.35	$238.87
21182	C		Reconstruct cranial bone					
21183	C		Reconstruct cranial bone					
21184	C		Reconstruct cranial bone					
21188	C		Reconstruction of midface					
21193	C		Reconst lwr jaw w/o graft					
21194	C		Reconst lwr jaw w/graft					
21195	C		Reconst lwr jaw w/o fixation					
21196	C		Reconst lwr jaw w/fixation					
21198	T		Reconstr lwr jaw segment	0256	35.1548	$1,918.08		$383.62
21199	T		Reconstr lwr jaw w/advance	0256	35.1548	$1,918.08		$383.62
21206	T		Reconstruct upper jaw bone	0256	35.1548	$1,918.08		$383.62
21208	T		Augmentation of facial bones	0256	35.1548	$1,918.08		$383.62
21209	T		Reduction of facial bones	0256	35.1548	$1,918.08		$383.62
21210	T		Face bone graft	0256	35.1548	$1,918.08		$383.62
21215	T		Lower jaw bone graft	0256	35.1548	$1,918.08		$383.62
21230	T		Rib cartilage graft	0256	35.1548	$1,918.08		$383.62
21235	T		Ear cartilage graft	0254	21.8901	$1,194.35	$321.35	$238.87
21240	T		Reconstruction of jaw joint	0256	35.1548	$1,918.08		$383.62
21242	T		Reconstruction of jaw joint	0256	35.1548	$1,918.08		$383.62
21243	T		Reconstruction of jaw joint	0256	35.1548	$1,918.08		$383.62
21244	T		Reconstruction of lower jaw	0256	35.1548	$1,918.08		$383.62
21245	T		Reconstruction of jaw	0256	35.1548	$1,918.08		$383.62
21246	T		Reconstruction of jaw	0256	35.1548	$1,918.08		$383.62
21247	C		Reconstruct lower jaw bone					
21248	T		Reconstruction of jaw	0256	35.1548	$1,918.08		$383.62
21249	T		Reconstruction of jaw	0256	35.1548	$1,918.08		$383.62
21255	C		Reconstruct lower jaw bone					
21256	C		Reconstruction of orbit					
21260	T		Revise eye sockets	0256	35.1548	$1,918.08		$383.62
21261	T		Revise eye sockets	0256	35.1548	$1,918.08		$383.62
21263	T		Revise eye sockets	0256	35.1548	$1,918.08		$383.62
21267	T		Revise eye sockets	0256	35.1548	$1,918.08		$383.62
21268	C		Revise eye sockets					
21270	T		Augmentation, cheek bone	0256	35.1548	$1,918.08		$383.62
21275	T		Revision, orbitofacial bones	0256	35.1548	$1,918.08		$383.62
21280	T		Revision of eyelid	0256	35.1548	$1,918.08		$383.62
21282	T		Revision of eyelid	0253	15.2249	$830.69	$282.29	$166.14
21295	T		Revision of jaw muscle/bone	0252	6.4469	$351.75	$113.41	$70.35
21296	T		Revision of jaw muscle/bone	0254	21.8901	$1,194.35	$321.35	$238.87
21299	T		Cranio/maxillofacial surgery	0253	15.2249	$830.69	$282.29	$166.14
21300	T		Treatment of skull fracture	0253	15.2249	$830.69	$282.29	$166.14
21310	X		Treatment of nose fracture	0340	0.6314	$34.45		$6.89
21315	X		Treatment of nose fracture	0340	0.6314	$34.45		$6.89
21320	X		Treatment of nose fracture	0340	0.6314	$34.45		$6.89
21325	T		Treatment of nose fracture	0254	21.8901	$1,194.35	$321.35	$238.87
21330	T		Treatment of nose fracture	0254	21.8901	$1,194.35	$321.35	$238.87
21335	T		Treatment of nose fracture	0254	21.8901	$1,194.35	$321.35	$238.87
21336	T		Treat nasal septal fracture	0046	32.5581	$1,776.40	$535.76	$355.28
21337	T		Treat nasal septal fracture	0253	15.2249	$830.69	$282.29	$166.14
21338	T		Treat nasoethmoid fracture	0254	21.8901	$1,194.35	$321.35	$238.87
21339	T		Treat nasoethmoid fracture	0254	21.8901	$1,194.35	$321.35	$238.87
21340	T		Treatment of nose fracture	0256	35.1548	$1,918.08		$383.62
21343	C		Treatment of sinus fracture					
21344	C		Treatment of sinus fracture					
21345	T		Treat nose/jaw fracture	0254	21.8901	$1,194.35	$321.35	$238.87
21346	C		Treat nose/jaw fracture					
21347	C		Treat nose/jaw fracture					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21348	C		Treat nose/jaw fracture					
21355	T		Treat cheek bone fracture	0256	35.1548	$1,918.08		$383.62
21356	C		Treat cheek bone fracture					
21360	C		Treat cheek bone fracture					
21365	C		Treat cheek bone fracture					
21366	C		Treat cheek bone fracture					
21385	C		Treat eye socket fracture					
21386	C		Treat eye socket fracture					
21387	C		Treat eye socket fracture					
21390	T		Treat eye socket fracture	0256	35.1548	$1,918.08		$383.62
21395	C		Treat eye socket fracture					
21400	T		Treat eye socket fracture	0252	6.4469	$351.75	$113.41	$70.35
21401	T		Treat eye socket fracture	0253	15.2249	$830.69	$282.29	$166.14
21406	T		Treat eye socket fracture	0256	35.1548	$1,918.08		$383.62
21407	T		Treat eye socket fracture	0256	35.1548	$1,918.08		$383.62
21408	C		Treat eye socket fracture					
21421	T		Treat mouth roof fracture	0254	21.8901	$1,194.35	$321.35	$238.87
21422	C		Treat mouth roof fracture					
21423	C		Treat mouth roof fracture					
21431	C		Treat craniofacial fracture					
21432	C		Treat craniofacial fracture					
21433	C		Treat craniofacial fracture					
21435	C		Treat craniofacial fracture					
21436	C		Treat craniofacial fracture					
21440	T		Treat dental ridge fracture	0254	21.8901	$1,194.35	$321.35	$238.87
21445	T		Treat dental ridge fracture	0254	21.8901	$1,194.35	$321.35	$238.87
21450	T		Treat lower jaw fracture	0251	1.7880	$97.56		$19.51
21451	T		Treat lower jaw fracture	0252	6.4469	$351.75	$113.41	$70.35
21452	T		Treat lower jaw fracture	0253	15.2249	$830.69	$282.29	$166.14
21453	T		Treat lower jaw fracture	0256	35.1548	$1,918.08		$383.62
21454	T		Treat lower jaw fracture	0254	21.8901	$1,194.35	$321.35	$238.87
21461	T		Treat lower jaw fracture	0256	35.1548	$1,918.08		$383.62
21462	T		Treat lower jaw fracture	0256	35.1548	$1,918.08		$383.62
21465	T		Treat lower jaw fracture	0256	35.1548	$1,918.08		$383.62
21470	T		Treat lower jaw fracture	0256	35.1548	$1,918.08		$383.62
21480	T		Reset dislocated jaw	0251	1.7880	$97.56		$19.51
21485	T		Reset dislocated jaw	0253	15.2249	$830.69	$282.29	$166.14
21490	T		Repair dislocated jaw	0256	35.1548	$1,918.08		$383.62
21493	T		Treat hyoid bone fracture	0252	6.4469	$351.75	$113.41	$70.35
21494	T		Treat hyoid bone fracture	0252	6.4469	$351.75	$113.41	$70.35
21495	C		Treat hyoid bone fracture					
21497	T		Interdental wiring	0253	15.2249	$830.69	$282.29	$166.14
21499	T		Head surgery procedure	0253	15.2249	$830.69	$282.29	$166.14
21501	T		Drain neck/chest lesion	0008	19.4831	$1,063.02		$212.60
21502	T		Drain chest lesion	0049	19.6046	$1,069.65		$213.93
21510	C		Drainage of bone lesion					
21550	T		Biopsy of neck/chest	0021	14.3594	$783.46	$219.48	$156.69
21555	T		Remove lesion, neck/chest	0022	18.7932	$1,025.38	$354.45	$205.08
21556	T		Remove lesion, neck/chest	0022	18.7932	$1,025.38	$354.45	$205.08
21557	C		Remove tumor, neck/chest					
21600	T		Partial removal of rib	0050	24.8651	$1,356.66		$271.33
21610	T		Partial removal of rib	0050	24.8651	$1,356.66		$271.33
21615	C		Removal of rib					
21616	C		Removal of rib and nerves					
21620	C		Partial removal of sternum					
21627	C		Sternal debridement					
21630	C		Extensive sternum surgery					
21632	C		Extensive sternum surgery					
21685	T	NI	Hyoid myotomy & suspension	0252	6.4469	$351.75	$113.41	$70.35
21700	T		Revision of neck muscle	0049	19.6046	$1,069.65		$213.93
21705	C		Revision of neck muscle/rib					
21720	T		Revision of neck muscle	0049	19.6046	$1,069.65		$213.93
21725	T		Revision of neck muscle	0006	1.6527	$90.17	$23.26	$18.03
21740	C		Reconstruction of sternum					
21742	T		Repair stern/nuss w/o scope	0051	34.5144	$1,883.14		$376.63
21743	T		Repair sternum/nuss w/scope	0051	34.5144	$1,883.14		$376.63
21750	C		Repair of sternum separation					
21800	T		Treatment of rib fracture	0043	1.9074	$104.07		$20.81
21805	T		Treatment of rib fracture	0046	32.5581	$1,776.40	$535.76	$355.28
21810	C		Treatment of rib fracture(s)					
21820	T		Treat sternum fracture	0043	1.9074	$104.07		$20.81
21825	C		Treat sternum fracture					
21899	T		Neck/chest surgery procedure	0252	6.4469	$351.75	$113.41	$70.35
21920	T		Biopsy soft tissue of back	0020	7.0842	$386.52	$113.25	$77.30
21925	T		Biopsy soft tissue of back	0022	18.7932	$1,025.38	$354.45	$205.08

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21930	T		Remove lesion, back or flank	0022	18.7932	$1,025.38	$354.45	$205.08
21935	T		Remove tumor, back	0022	18.7932	$1,025.38	$354.45	$205.08
22100	T		Remove part of neck vertebra	0208	40.2830	$2,197.88		$439.58
22101	T		Remove part, thorax vertebra	0208	40.2830	$2,197.88		$439.58
22102	T		Remove part, lumbar vertebra	0208	40.2830	$2,197.88		$439.58
22103	T		Remove extra spine segment	0208	40.2830	$2,197.88		$439.58
22110	C		Remove part of neck vertebra					
22112	C		Remove part, thorax vertebra					
22114	C		Remove part, lumbar vertebra					
22116	C		Remove extra spine segment					
22210	C		Revision of neck spine					
22212	C		Revision of thorax spine					
22214	C		Revision of lumbar spine					
22216	C		Revise, extra spine segment					
22220	C		Revision of neck spine					
22222	C		Revision of thorax spine					
22224	C		Revision of lumbar spine					
22226	C		Revise, extra spine segment					
22305	T		Treat spine process fracture	0043	1.9074	$104.07		$20.81
22310	T		Treat spine fracture	0043	1.9074	$104.07		$20.81
22315	T		Treat spine fracture	0043	1.9074	$104.07		$20.81
22318	C		Treat odontoid fx w/o graft					
22319	C		Treat odontoid fx w/graft					
22325	C		Treat spine fracture					
22326	C		Treat neck spine fracture					
22327	C		Treat thorax spine fracture					
22328	C		Treat each add spine fx					
22505	T		Manipulation of spine	0045	13.5889	$741.42	$268.47	$148.28
22520	T		Percut vertebroplasty thor	0050	24.8651	$1,356.66		$271.33
22521	T		Percut vertebroplasty lumb	0050	24.8651	$1,356.66		$271.33
22522	T		Percut vertebroplasty add'l	0050	24.8651	$1,356.66		$271.33
22532	C	NI	Lat thorax spine fusion					
22533	C	NI	Lat lumbar spine fusion					
22534	C	NI	Lat thor/lumb, add'l seg					
22548	C		Neck spine fusion					
22554	C		Neck spine fusion					
22556	C		Thorax spine fusion					
22558	C		Lumbar spine fusion					
22585	C		Additional spinal fusion					
22590	C		Spine & skull spinal fusion					
22595	C		Neck spinal fusion					
22600	C		Neck spine fusion					
22610	C		Thorax spine fusion					
22612	T		Lumbar spine fusion	0208	40.2830	$2,197.88		$439.58
22614	T		Spine fusion, extra segment	0208	40.2830	$2,197.88		$439.58
22630	C		Lumbar spine fusion					
22632	C		Spine fusion, extra segment					
22800	C		Fusion of spine					
22802	C		Fusion of spine					
22804	C		Fusion of spine					
22808	C		Fusion of spine					
22810	C		Fusion of spine					
22812	C		Fusion of spine					
22818	C		Kyphectomy, 1-2 segments					
22819	C		Kyphectomy, 3 or more					
22830	C		Exploration of spinal fusion					
22840	C		Insert spine fixation device					
22841	C		Insert spine fixation device					
22842	C		Insert spine fixation device					
22843	C		Insert spine fixation device					
22844	C		Insert spine fixation device					
22845	C		Insert spine fixation device					
22846	C		Insert spine fixation device					
22847	C		Insert spine fixation device					
22848	C		Insert pelv fixation device					
22849	C		Reinsert spinal fixation					
22850	C		Remove spine fixation device					
22851	C		Apply spine prosth device					
22852	C		Remove spine fixation device					
22855	C		Remove spine fixation device					
22899	T		Spine surgery procedure	0043	1.9074	$104.07		$20.81
22900	T		Remove abdominal wall lesion	0022	18.7932	$1,025.38	$354.45	$205.08
22999	T		Abdomen surgery procedure	0022	18.7932	$1,025.38	$354.45	$205.08
23000	T		Removal of calcium deposits	0021	14.3594	$783.46	$219.48	$156.69
23020	T		Release shoulder joint	0051	34.5144	$1,883.14		$376.63

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
23030	T		Drain shoulder lesion	0008	19.4831	$1,063.02		$212.60
23031	T		Drain shoulder bursa	0008	19.4831	$1,063.02		$212.60
23035	T		Drain shoulder bone lesion	0049	19.6046	$1,069.65		$213.93
23040	T		Exploratory shoulder surgery	0050	24.8651	$1,356.66		$271.33
23044	T		Exploratory shoulder surgery	0050	24.8651	$1,356.66		$271.33
23065	T		Biopsy shoulder tissues	0021	14.3594	$783.46	$219.48	$156.69
23066	T		Biopsy shoulder tissues	0022	18.7932	$1,025.38	$354.45	$205.08
23075	T		Removal of shoulder lesion	0021	14.3594	$783.46	$219.48	$156.69
23076	T		Removal of shoulder lesion	0022	18.7932	$1,025.38	$354.45	$205.08
23077	T		Remove tumor of shoulder	0022	18.7932	$1,025.38	$354.45	$205.08
23100	T		Biopsy of shoulder joint	0049	19.6046	$1,069.65		$213.93
23101	T		Shoulder joint surgery	0050	24.8651	$1,356.66		$271.33
23105	T		Remove shoulder joint lining	0050	24.8651	$1,356.66		$271.33
23106	T		Incision of collarbone joint	0050	24.8651	$1,356.66		$271.33
23107	T		Explore treat shoulder joint	0050	24.8651	$1,356.66		$271.33
23120	T		Partial removal, collar bone	0051	34.5144	$1,883.14		$376.63
23125	T		Removal of collar bone	0051	34.5144	$1,883.14		$376.63
23130	T		Remove shoulder bone, part	0051	34.5144	$1,883.14		$376.63
23140	T		Removal of bone lesion	0049	19.6046	$1,069.65		$213.93
23145	T		Removal of bone lesion	0050	24.8651	$1,356.66		$271.33
23146	T		Removal of bone lesion	0050	24.8651	$1,356.66		$271.33
23150	T		Removal of humerus lesion	0050	24.8651	$1,356.66		$271.33
23155	T		Removal of humerus lesion	0050	24.8651	$1,356.66		$271.33
23156	T		Removal of humerus lesion	0050	24.8651	$1,356.66		$271.33
23170	T		Remove collar bone lesion	0050	24.8651	$1,356.66		$271.33
23172	T		Remove shoulder blade lesion	0050	24.8651	$1,356.66		$271.33
23174	T		Remove humerus lesion	0050	24.8651	$1,356.66		$271.33
23180	T		Remove collar bone lesion	0050	24.8651	$1,356.66		$271.33
23182	T		Remove shoulder blade lesion	0050	24.8651	$1,356.66		$271.33
23184	T		Remove humerus lesion	0050	24.8651	$1,356.66		$271.33
23190	T		Partial removal of scapula	0050	24.8651	$1,356.66		$271.33
23195	T		Removal of head of humerus	0050	24.8651	$1,356.66		$271.33
23200	C		Removal of collar bone					
23210	C		Removal of shoulder blade					
23220	C		Partial removal of humerus					
23221	C		Partial removal of humerus					
23222	C		Partial removal of humerus					
23330	T		Remove shoulder foreign body	0020	7.0842	$386.52	$113.25	$77.30
23331	T		Remove shoulder foreign body	0022	18.7932	$1,025.38	$354.45	$205.08
23332	C		Remove shoulder foreign body					
23350	N		Injection for shoulder x-ray					
23395	T		Muscle transfer,shoulder/arm	0051	34.5144	$1,883.14		$376.63
23397	T		Muscle transfers	0052	42.7126	$2,330.44		$466.09
23400	T		Fixation of shoulder blade	0050	24.8651	$1,356.66		$271.33
23405	T		Incision of tendon & muscle	0050	24.8651	$1,356.66		$271.33
23406	T		Incise tendon(s) & muscle(s)	0050	24.8651	$1,356.66		$271.33
23410	T		Repair of tendon(s)	0052	42.7126	$2,330.44		$466.09
23412	T		Repair rotator cuff, chronic	0052	42.7126	$2,330.44		$466.09
23415	T		Release of shoulder ligament	0051	34.5144	$1,883.14		$376.63
23420	T		Repair of shoulder	0052	42.7126	$2,330.44		$466.09
23430	T		Repair biceps tendon	0052	42.7126	$2,330.44		$466.09
23440	T		Remove/transplant tendon	0052	42.7126	$2,330.44		$466.09
23450	T		Repair shoulder capsule	0052	42.7126	$2,330.44		$466.09
23455	T		Repair shoulder capsule	0052	42.7126	$2,330.44		$466.09
23460	T		Repair shoulder capsule	0052	42.7126	$2,330.44		$466.09
23462	T		Repair shoulder capsule	0052	42.7126	$2,330.44		$466.09
23465	T		Repair shoulder capsule	0052	42.7126	$2,330.44		$466.09
23466	T		Repair shoulder capsule	0052	42.7126	$2,330.44		$466.09
23470	T		Reconstruct shoulder joint	0048	51.4609	$2,807.76	$695.60	$561.55
23472	C		Reconstruct shoulder joint					
23480	T		Revision of collar bone	0051	34.5144	$1,883.14		$376.63
23485	T		Revision of collar bone	0051	34.5144	$1,883.14		$376.63
23490	T		Reinforce clavicle	0051	34.5144	$1,883.14		$376.63
23491	T		Reinforce shoulder bones	0051	34.5144	$1,883.14		$376.63
23500	T		Treat clavicle fracture	0043	1.9074	$104.07		$20.81
23505	T		Treat clavicle fracture	0043	1.9074	$104.07		$20.81
23515	T		Treat clavicle fracture	0046	32.5581	$1,776.40	$535.76	$355.28
23520	T		Treat clavicle dislocation	0043	1.9074	$104.07		$20.81
23525	T		Treat clavicle dislocation	0043	1.9074	$104.07		$20.81
23530	T		Treat clavicle dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
23532	T		Treat clavicle dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
23540	T		Treat clavicle dislocation	0043	1.9074	$104.07		$20.81
23545	T		Treat clavicle dislocation	0043	1.9074	$104.07		$20.81
23550	T		Treat clavicle dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
23552	T		Treat clavicle dislocation	0046	32.5581	$1,776.40	$535.76	$355.28

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
23570	T		Treat shoulder blade fx	0043	1.9074	$104.07		$20.81
23575	T		Treat shoulder blade fx	0043	1.9074	$104.07		$20.81
23585	T		Treat scapula fracture	0046	32.5581	$1,776.40	$535.76	$355.28
23600	T		Treat humerus fracture	0043	1.9074	$104.07		$20.81
23605	T		Treat humerus fracture	0043	1.9074	$104.07		$20.81
23615	T		Treat humerus fracture	0046	32.5581	$1,776.40	$535.76	$355.28
23616	T		Treat humerus fracture	0046	32.5581	$1,776.40	$535.76	$355.28
23620	T		Treat humerus fracture	0043	1.9074	$104.07		$20.81
23625	T		Treat humerus fracture	0043	1.9074	$104.07		$20.81
23630	T		Treat humerus fracture	0046	32.5581	$1,776.40	$535.76	$355.28
23650	T		Treat shoulder dislocation	0043	1.9074	$104.07		$20.81
23655	T		Treat shoulder dislocation	0045	13.5889	$741.42	$268.47	$148.28
23660	T		Treat shoulder dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
23665	T		Treat dislocation/fracture	0043	1.9074	$104.07		$20.81
23670	T		Treat dislocation/fracture	0046	32.5581	$1,776.40	$535.76	$355.28
23675	T		Treat dislocation/fracture	0043	1.9074	$104.07		$20.81
23680	T		Treat dislocation/fracture	0046	32.5581	$1,776.40	$535.76	$355.28
23700	T		Fixation of shoulder	0045	13.5889	$741.42	$268.47	$148.28
23800	T		Fusion of shoulder joint	0051	34.5144	$1,883.14		$376.63
23802	T		Fusion of shoulder joint	0051	34.5144	$1,883.14		$376.63
23900	C		Amputation of arm & girdle					
23920	C		Amputation at shoulder joint					
23921	T		Amputation follow-up surgery	0025	5.1912	$283.24	$107.00	$56.65
23929	T		Shoulder surgery procedure	0043	1.9074	$104.07		$20.81
23930	T		Drainage of arm lesion	0008	19.4831	$1,063.02		$212.60
23931	T		Drainage of arm bursa	0007	11.8633	$647.27		$129.45
23935	T		Drain arm/elbow bone lesion	0049	19.6046	$1,069.65		$213.93
24000	T		Exploratory elbow surgery	0050	24.8651	$1,356.66		$271.33
24006	T		Release elbow joint	0050	24.8651	$1,356.66		$271.33
24065	T		Biopsy arm/elbow soft tissue	0021	14.3594	$783.46	$219.48	$156.69
24066	T		Biopsy arm/elbow soft tissue	0021	14.3594	$783.46	$219.48	$156.69
24075	T		Remove arm/elbow lesion	0021	14.3594	$783.46	$219.48	$156.69
24076	T		Remove arm/elbow lesion	0022	18.7932	$1,025.38	$354.45	$205.08
24077	T		Remove tumor of arm/elbow	0022	18.7932	$1,025.38	$354.45	$205.08
24100	T		Biopsy elbow joint lining	0049	19.6046	$1,069.65		$213.93
24101	T		Explore/treat elbow joint	0050	24.8651	$1,356.66		$271.33
24102	T		Remove elbow joint lining	0050	24.8651	$1,356.66		$271.33
24105	T		Removal of elbow bursa	0049	19.6046	$1,069.65		$213.93
24110	T		Remove humerus lesion	0049	19.6046	$1,069.65		$213.93
24115	T		Remove/graft bone lesion	0050	24.8651	$1,356.66		$271.33
24116	T		Remove/graft bone lesion	0050	24.8651	$1,356.66		$271.33
24120	T		Remove elbow lesion	0049	19.6046	$1,069.65		$213.93
24125	T		Remove/graft bone lesion	0050	24.8651	$1,356.66		$271.33
24126	T		Remove/graft bone lesion	0050	24.8651	$1,356.66		$271.33
24130	T		Removal of head of radius	0050	24.8651	$1,356.66		$271.33
24134	T		Removal of arm bone lesion	0050	24.8651	$1,356.66		$271.33
24136	T		Remove radius bone lesion	0050	24.8651	$1,356.66		$271.33
24138	T		Remove elbow bone lesion	0050	24.8651	$1,356.66		$271.33
24140	T		Partial removal of arm bone	0050	24.8651	$1,356.66		$271.33
24145	T		Partial removal of radius	0050	24.8651	$1,356.66		$271.33
24147	T		Partial removal of elbow	0050	24.8651	$1,356.66		$271.33
24149	C		Radical resection of elbow					
24150	T		Extensive humerus surgery	0052	42.7126	$2,330.44		$466.09
24151	T		Extensive humerus surgery	0052	42.7126	$2,330.44		$466.09
24152	T		Extensive radius surgery	0052	42.7126	$2,330.44		$466.09
24153	T		Extensive radius surgery	0052	42.7126	$2,330.44		$466.09
24155	T		Removal of elbow joint	0051	34.5144	$1,883.14		$376.63
24160	T		Remove elbow joint implant	0050	24.8651	$1,356.66		$271.33
24164	T		Remove radius head implant	0050	24.8651	$1,356.66		$271.33
24200	T		Removal of arm foreign body	0019	3.9493	$215.48	$71.87	$43.10
24201	T		Removal of arm foreign body	0021	14.3594	$783.46	$219.48	$156.69
24220	N		Injection for elbow x-ray					
24300	T		Manipulate elbow w/anesth	0045	13.5889	$741.42	$268.47	$148.28
24301	T		Muscle/tendon transfer	0050	24.8651	$1,356.66		$271.33
24305	T		Arm tendon lengthening	0050	24.8651	$1,356.66		$271.33
24310	T		Revision of arm tendon	0049	19.6046	$1,069.65		$213.93
24320	T		Repair of arm tendon	0051	34.5144	$1,883.14		$376.63
24330	T		Revision of arm muscles	0051	34.5144	$1,883.14		$376.63
24331	T		Revision of arm muscles	0051	34.5144	$1,883.14		$376.63
24332	T		Tenolysis, triceps	0049	19.6046	$1,069.65		$213.93
24340	T		Repair of biceps tendon	0051	34.5144	$1,883.14		$376.63
24341	T		Repair arm tendon/muscle	0051	34.5144	$1,883.14		$376.63
24342	T		Repair of ruptured tendon	0051	34.5144	$1,883.14		$376.63
24343	T		Repr elbow lat ligmnt w/tiss	0050	24.8651	$1,356.66		$271.33
24344	T		Reconstruct elbow lat ligmnt	0051	34.5144	$1,883.14		$376.63

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
24345	T		Repr elbw med ligmnt w/tissu	0050	24.8651	$1,356.66		$271.33
24346	T		Reconstruct elbow med ligmnt	0051	34.5144	$1,883.14		$376.63
24350	T		Repair of tennis elbow	0050	24.8651	$1,356.66		$271.33
24351	T		Repair of tennis elbow	0050	24.8651	$1,356.66		$271.33
24352	T		Repair of tennis elbow	0050	24.8651	$1,356.66		$271.33
24354	T		Repair of tennis elbow	0050	24.8651	$1,356.66		$271.33
24356	T		Revision of tennis elbow	0050	24.8651	$1,356.66		$271.33
24360	T		Reconstruct elbow joint	0047	29.9582	$1,634.55	$537.03	$326.91
24361	T		Reconstruct elbow joint	0048	51.4609	$2,807.76	$695.60	$561.55
24362	T		Reconstruct elbow joint	0048	51.4609	$2,807.76	$695.60	$561.55
24363	T		Replace elbow joint	0048	51.4609	$2,807.76	$695.60	$561.55
24365	T		Reconstruct head of radius	0047	29.9582	$1,634.55	$537.03	$326.91
24366	T		Reconstruct head of radius	0048	51.4609	$2,807.76	$695.60	$561.55
24400	T		Revision of humerus	0050	24.8651	$1,356.66		$271.33
24410	T		Revision of humerus	0050	24.8651	$1,356.66		$271.33
24420	T		Revision of humerus	0051	34.5144	$1,883.14		$376.63
24430	T		Repair of humerus	0051	34.5144	$1,883.14		$376.63
24435	T		Repair humerus with graft	0051	34.5144	$1,883.14		$376.63
24470	T		Revision of elbow joint	0051	34.5144	$1,883.14		$376.63
24495	T		Decompression of forearm	0050	24.8651	$1,356.66		$271.33
24498	T		Reinforce humerus	0051	34.5144	$1,883.14		$376.63
24500	T		Treat humerus fracture	0043	1.9074	$104.07		$20.81
24505	T		Treat humerus fracture	0043	1.9074	$104.07		$20.81
24515	T		Treat humerus fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24516	T		Treat humerus fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24530	T		Treat humerus fracture	0043	1.9074	$104.07		$20.81
24535	T		Treat humerus fracture	0043	1.9074	$104.07		$20.81
24538	T		Treat humerus fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24545	T		Treat humerus fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24546	T		Treat humerus fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24560	T		Treat humerus fracture	0043	1.9074	$104.07		$20.81
24565	T		Treat humerus fracture	0043	1.9074	$104.07		$20.81
24566	T		Treat humerus fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24575	T		Treat humerus fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24576	T		Treat humerus fracture	0043	1.9074	$104.07		$20.81
24577	T		Treat humerus fracture	0043	1.9074	$104.07		$20.81
24579	T		Treat humerus fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24582	T		Treat humerus fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24586	T		Treat elbow fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24587	T		Treat elbow fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24600	T		Treat elbow dislocation	0043	1.9074	$104.07		$20.81
24605	T		Treat elbow dislocation	0045	13.5889	$741.42	$268.47	$148.28
24615	T		Treat elbow dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
24620	T		Treat elbow fracture	0043	1.9074	$104.07		$20.81
24635	T		Treat elbow fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24640	T		Treat elbow dislocation	0043	1.9074	$104.07		$20.81
24650	T		Treat radius fracture	0043	1.9074	$104.07		$20.81
24655	T		Treat radius fracture	0043	1.9074	$104.07		$20.81
24665	T		Treat radius fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24666	T		Treat radius fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24670	T		Treat ulnar fracture	0043	1.9074	$104.07		$20.81
24675	T		Treat ulnar fracture	0043	1.9074	$104.07		$20.81
24685	T		Treat ulnar fracture	0046	32.5581	$1,776.40	$535.76	$355.28
24800	T		Fusion of elbow joint	0051	34.5144	$1,883.14		$376.63
24802	T		Fusion/graft of elbow joint	0051	34.5144	$1,883.14		$376.63
24900	C		Amputation of upper arm					
24920	C		Amputation of upper arm					
24925	T		Amputation follow-up surgery	0049	19.6046	$1,069.65		$213.93
24930	C		Amputation follow-up surgery					
24931	C		Amputate upper arm & implant					
24935	T		Revision of amputation	0052	42.7126	$2,330.44		$466.09
24940	C		Revision of upper arm					
24999	T		Upper arm/elbow surgery	0043	1.9074	$104.07		$20.81
25000	T		Incision of tendon sheath	0049	19.6046	$1,069.65		$213.93
25001	T		Incise flexor carpi radialis	0049	19.6046	$1,069.65		$213.93
25020	T		Decompress forearm 1 space	0049	19.6046	$1,069.65		$213.93
25023	T		Decompress forearm 1 space	0050	24.8651	$1,356.66		$271.33
25024	T		Decompress forearm 2 spaces	0050	24.8651	$1,356.66		$271.33
25025	T		Decompress forearm 2 spaces	0050	24.8651	$1,356.66		$271.33
25028	T		Drainage of forearm lesion	0049	19.6046	$1,069.65		$213.93
25031	T		Drainage of forearm bursa	0049	19.6046	$1,069.65		$213.93
25035	T		Treat forearm bone lesion	0049	19.6046	$1,069.65		$213.93
25040	T		Explore/treat wrist joint	0050	24.8651	$1,356.66		$271.33
25065	T		Biopsy forearm soft tissues	0021	14.3594	$783.46	$219.48	$156.69
25066	T		Biopsy forearm soft tissues	0022	18.7932	$1,025.38	$354.45	$205.08

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25075	T		Removel forearm lesion subcu	0021	14.3594	$783.46	$219.48	$156.69
25076	T		Removel forearm lesion deep	0022	18.7932	$1,025.38	$354.45	$205.08
25077	T		Remove tumor, forearm/wrist	0022	18.7932	$1,025.38	$354.45	$205.08
25085	T		Incision of wrist capsule	0049	19.6046	$1,069.65		$213.93
25100	T		Biopsy of wrist joint	0049	19.6046	$1,069.65		$213.93
25101	T		Explore/treat wrist joint	0050	24.8651	$1,356.66		$271.33
25105	T		Remove wrist joint lining	0050	24.8651	$1,356.66		$271.33
25107	T		Remove wrist joint cartilage	0050	24.8651	$1,356.66		$271.33
25110	T		Remove wrist tendon lesion	0049	19.6046	$1,069.65		$213.93
25111	T		Remove wrist tendon lesion	0053	14.8831	$812.04	$253.49	$162.41
25112	T		Reremove wrist tendon lesion	0053	14.8831	$812.04	$253.49	$162.41
25115	T		Remove wrist/forearm lesion	0049	19.6046	$1,069.65		$213.93
25116	T		Remove wrist/forearm lesion	0049	19.6046	$1,069.65		$213.93
25118	T		Excise wrist tendon sheath	0050	24.8651	$1,356.66		$271.33
25119	T		Partial removal of ulna	0050	24.8651	$1,356.66		$271.33
25120	T		Removal of forearm lesion	0050	24.8651	$1,356.66		$271.33
25125	T		Remove/graft forearm lesion	0050	24.8651	$1,356.66		$271.33
25126	T		Remove/graft forearm lesion	0050	24.8651	$1,356.66		$271.33
25130	T		Removal of wrist lesion	0050	24.8651	$1,356.66		$271.33
25135	T		Remove & graft wrist lesion	0050	24.8651	$1,356.66		$271.33
25136	T		Remove & graft wrist lesion	0050	24.8651	$1,356.66		$271.33
25145	T		Remove forearm bone lesion	0050	24.8651	$1,356.66		$271.33
25150	T		Partial removal of ulna	0050	24.8651	$1,356.66		$271.33
25151	T		Partial removal of radius	0050	24.8651	$1,356.66		$271.33
25170	T		Extensive forearm surgery	0052	42.7126	$2,330.44		$466.09
25210	T		Removal of wrist bone	0054	24.2456	$1,322.86		$264.57
25215	T		Removal of wrist bones	0054	24.2456	$1,322.86		$264.57
25230	T		Partial removal of radius	0050	24.8651	$1,356.66		$271.33
25240	T		Partial removal of ulna	0050	24.8651	$1,356.66		$271.33
25246	N		Injection for wrist x-ray					
25248	T		Remove forearm foreign body	0049	19.6046	$1,069.65		$213.93
25250	T		Removal of wrist prosthesis	0050	24.8651	$1,356.66		$271.33
25251	T		Removal of wrist prosthesis	0050	24.8651	$1,356.66		$271.33
25259	T		Manipulate wrist w/anesthes	0043	1.9074	$104.07		$20.81
25260	T		Repair forearm tendon/muscle	0050	24.8651	$1,356.66		$271.33
25263	T		Repair forearm tendon/muscle	0050	24.8651	$1,356.66		$271.33
25265	T		Repair forearm tendon/muscle	0050	24.8651	$1,356.66		$271.33
25270	T		Repair forearm tendon/muscle	0050	24.8651	$1,356.66		$271.33
25272	T		Repair forearm tendon/muscle	0050	24.8651	$1,356.66		$271.33
25274	T		Repair forearm tendon/muscle	0050	24.8651	$1,356.66		$271.33
25275	T		Repair forearm tendon sheath	0050	24.8651	$1,356.66		$271.33
25280	T		Revise wrist/forearm tendon	0050	24.8651	$1,356.66		$271.33
25290	T		Incise wrist/forearm tendon	0050	24.8651	$1,356.66		$271.33
25295	T		Release wrist/forearm tendon	0049	19.6046	$1,069.65		$213.93
25300	T		Fusion of tendons at wrist	0050	24.8651	$1,356.66		$271.33
25301	T		Fusion of tendons at wrist	0050	24.8651	$1,356.66		$271.33
25310	T		Transplant forearm tendon	0051	34.5144	$1,883.14		$376.63
25312	T		Transplant forearm tendon	0051	34.5144	$1,883.14		$376.63
25315	T		Revise palsy hand tendon(s)	0051	34.5144	$1,883.14		$376.63
25316	T		Revise palsy hand tendon(s)	0051	34.5144	$1,883.14		$376.63
25320	T		Repair/revise wrist joint	0051	34.5144	$1,883.14		$376.63
25332	T		Revise wrist joint	0047	29.9582	$1,634.55	$537.03	$326.91
25335	T		Realignment of hand	0051	34.5144	$1,883.14		$376.63
25337	T		Reconstruct ulna/radioulnar	0051	34.5144	$1,883.14		$376.63
25350	T		Revision of radius	0051	34.5144	$1,883.14		$376.63
25355	T		Revision of radius	0051	34.5144	$1,883.14		$376.63
25360	T		Revision of ulna	0050	24.8651	$1,356.66		$271.33
25365	T		Revise radius & ulna	0050	24.8651	$1,356.66		$271.33
25370	T		Revise radius or ulna	0051	34.5144	$1,883.14		$376.63
25375	T		Revise radius & ulna	0051	34.5144	$1,883.14		$376.63
25390	T		Shorten radius or ulna	0050	24.8651	$1,356.66		$271.33
25391	T		Lengthen radius or ulna	0051	34.5144	$1,883.14		$376.63
25392	T		Shorten radius & ulna	0050	24.8651	$1,356.66		$271.33
25393	T		Lengthen radius & ulna	0051	34.5144	$1,883.14		$376.63
25394	T		Repair carpal bone, shorten	0053	14.8831	$812.04	$253.49	$162.41
25400	T		Repair radius or ulna	0050	24.8651	$1,356.66		$271.33
25405	T		Repair/graft radius or ulna	0050	24.8651	$1,356.66		$271.33
25415	T		Repair radius & ulna	0050	24.8651	$1,356.66		$271.33
25420	T		Repair/graft radius & ulna	0051	34.5144	$1,883.14		$376.63
25425	T		Repair/graft radius or ulna	0051	34.5144	$1,883.14		$376.63
25426	T		Repair/graft radius & ulna	0051	34.5144	$1,883.14		$376.63
25430	T		Vasc graft into carpal bone	0054	24.2456	$1,322.86		$264.57
25431	T		Repair nonunion carpal bone	0054	24.2456	$1,322.86		$264.57
25440	T		Repair/graft wrist bone	0051	34.5144	$1,883.14		$376.63
25441	T		Reconstruct wrist joint	0048	51.4609	$2,807.76	$695.60	$561.55

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25442	T		Reconstruct wrist joint	0048	51.4609	$2,807.76	$695.60	$561.55
25443	T		Reconstruct wrist joint	0048	51.4609	$2,807.76	$695.60	$561.55
25444	T		Reconstruct wrist joint	0048	51.4609	$2,807.76	$695.60	$561.55
25445	T		Reconstruct wrist joint	0048	51.4609	$2,807.76	$695.60	$561.55
25446	T		Wrist replacement	0048	51.4609	$2,807.76	$695.60	$561.55
25447	T		Repair wrist joint(s)	0047	29.9582	$1,634.55	$537.03	$326.91
25449	T		Remove wrist joint implant	0047	29.9582	$1,634.55	$537.03	$326.91
25450	T		Revision of wrist joint	0051	34.5144	$1,883.14		$376.63
25455	T		Revision of wrist joint	0051	34.5144	$1,883.14		$376.63
25490	T		Reinforce radius	0051	34.5144	$1,883.14		$376.63
25491	T		Reinforce ulna	0051	34.5144	$1,883.14		$376.63
25492	T		Reinforce radius and ulna	0051	34.5144	$1,883.14		$376.63
25500	T		Treat fracture of radius	0043	1.9074	$104.07		$20.81
25505	T		Treat fracture of radius	0043	1.9074	$104.07		$20.81
25515	T		Treat fracture of radius	0046	32.5581	$1,776.40	$535.76	$355.28
25520	T		Treat fracture of radius	0043	1.9074	$104.07		$20.81
25525	T		Treat fracture of radius	0046	32.5581	$1,776.40	$535.76	$355.28
25526	T		Treat fracture of radius	0046	32.5581	$1,776.40	$535.76	$355.28
25530	T		Treat fracture of ulna	0043	1.9074	$104.07		$20.81
25535	T		Treat fracture of ulna	0043	1.9074	$104.07		$20.81
25545	T		Treat fracture of ulna	0046	32.5581	$1,776.40	$535.76	$355.28
25560	T		Treat fracture radius & ulna	0043	1.9074	$104.07		$20.81
25565	T		Treat fracture radius & ulna	0043	1.9074	$104.07		$20.81
25574	T		Treat fracture radius & ulna	0046	32.5581	$1,776.40	$535.76	$355.28
25575	T		Treat fracture radius/ulna	0046	32.5581	$1,776.40	$535.76	$355.28
25600	T		Treat fracture radius/ulna	0043	1.9074	$104.07		$20.81
25605	T		Treat fracture radius/ulna	0043	1.9074	$104.07		$20.81
25611	T		Treat fracture radius/ulna	0046	32.5581	$1,776.40	$535.76	$355.28
25620	T		Treat fracture radius/ulna	0046	32.5581	$1,776.40	$535.76	$355.28
25622	T		Treat wrist bone fracture	0043	1.9074	$104.07		$20.81
25624	T		Treat wrist bone fracture	0043	1.9074	$104.07		$20.81
25628	T		Treat wrist bone fracture	0046	32.5581	$1,776.40	$535.76	$355.28
25630	T		Treat wrist bone fracture	0043	1.9074	$104.07		$20.81
25635	T		Treat wrist bone fracture	0043	1.9074	$104.07		$20.81
25645	T		Treat wrist bone fracture	0046	32.5581	$1,776.40	$535.76	$355.28
25650	T		Treat wrist bone fracture	0043	1.9074	$104.07		$20.81
25651	T		Pin ulnar styloid fracture	0046	32.5581	$1,776.40	$535.76	$355.28
25652	T		Treat fracture ulnar styloid	0046	32.5581	$1,776.40	$535.76	$355.28
25660	T		Treat wrist dislocation	0043	1.9074	$104.07		$20.81
25670	T		Treat wrist dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
25671	T		Pin radioulnar dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
25675	T		Treat wrist dislocation	0043	1.9074	$104.07		$20.81
25676	T		Treat wrist dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
25680	T		Treat wrist fracture	0043	1.9074	$104.07		$20.81
25685	T		Treat wrist fracture	0046	32.5581	$1,776.40	$535.76	$355.28
25690	T		Treat wrist dislocation	0043	1.9074	$104.07		$20.81
25695	T		Treat wrist dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
25800	T		Fusion of wrist joint	0051	34.5144	$1,883.14		$376.63
25805	T		Fusion/graft of wrist joint	0051	34.5144	$1,883.14		$376.63
25810	T		Fusion/graft of wrist joint	0051	34.5144	$1,883.14		$376.63
25820	T		Fusion of hand bones	0053	14.8831	$812.04	$253.49	$162.41
25825	T		Fuse hand bones with graft	0054	24.2456	$1,322.86		$264.57
25830	T		Fusion, radioulnar jnt/ulna	0051	34.5144	$1,883.14		$376.63
25900	C		Amputation of forearm					
25905	C		Amputation of forearm					
25907	T		Amputation follow-up surgery	0049	19.6046	$1,069.65		$213.93
25909	C		Amputation follow-up surgery					
25915	C		Amputation of forearm					
25920	C		Amputate hand at wrist					
25922	T		Amputate hand at wrist	0049	19.6046	$1,069.65		$213.93
25924	C		Amputation follow-up surgery					
25927	C		Amputation of hand					
25929	T		Amputation follow-up surgery	0027	15.8990	$867.47	$329.72	$173.49
25931	C		Amputation follow-up surgery					
25999	T		Forearm or wrist surgery	0043	1.9074	$104.07		$20.81
26010	T		Drainage of finger abscess	0006	1.6527	$90.17	$23.26	$18.03
26011	T		Drainage of finger abscess	0007	11.8633	$647.27		$129.45
26020	T		Drain hand tendon sheath	0053	14.8831	$812.04	$253.49	$162.41
26025	T		Drainage of palm bursa	0053	14.8831	$812.04	$253.49	$162.41
26030	T		Drainage of palm bursa(s)	0053	14.8831	$812.04	$253.49	$162.41
26034	T		Treat hand bone lesion	0053	14.8831	$812.04	$253.49	$162.41
26035	T		Decompress fingers/hand	0053	14.8831	$812.04	$253.49	$162.41
26037	T		Decompress fingers/hand	0053	14.8831	$812.04	$253.49	$162.41
26040	T		Release palm contracture	0054	24.2456	$1,322.86		$264.57
26045	T		Release palm contracture	0054	24.2456	$1,322.86		$264.57

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment[1]
26055	T		Incise finger tendon sheath	0053	14.8831	$812.04	$253.49	$162.41
26060	T		Incision of finger tendon	0053	14.8831	$812.04	$253.49	$162.41
26070	T		Explore/treat hand joint	0053	14.8831	$812.04	$253.49	$162.41
26075	T		Explore/treat finger joint	0053	14.8831	$812.04	$253.49	$162.41
26080	T		Explore/treat finger joint	0053	14.8831	$812.04	$253.49	$162.41
26100	T		Biopsy hand joint lining	0053	14.8831	$812.04	$253.49	$162.41
26105	T		Biopsy finger joint lining	0053	14.8831	$812.04	$253.49	$162.41
26110	T		Biopsy finger joint lining	0053	14.8831	$812.04	$253.49	$162.41
26115	T		Removel hand lesion subcut	0022	18.7932	$1,025.38	$354.45	$205.08
26116	T		Removel hand lesion, deep	0022	18.7932	$1,025.38	$354.45	$205.08
26117	T		Remove tumor, hand/finger	0022	18.7932	$1,025.38	$354.45	$205.08
26121	T		Release palm contracture	0054	24.2456	$1,322.86		$264.57
26123	T		Release palm contracture	0054	24.2456	$1,322.86		$264.57
26125	T		Release palm contracture	0054	24.2456	$1,322.86		$264.57
26130	T		Remove wrist joint lining	0053	14.8831	$812.04	$253.49	$162.41
26135	T		Revise finger joint, each	0054	24.2456	$1,322.86		$264.57
26140	T		Revise finger joint, each	0053	14.8831	$812.04	$253.49	$162.41
26145	T		Tendon excision, palm/finger	0053	14.8831	$812.04	$253.49	$162.41
26160	T		Remove tendon sheath lesion	0053	14.8831	$812.04	$253.49	$162.41
26170	T		Removal of palm tendon, each	0053	14.8831	$812.04	$253.49	$162.41
26180	T		Removal of finger tendon	0053	14.8831	$812.04	$253.49	$162.41
26185	T		Remove finger bone	0053	14.8831	$812.04	$253.49	$162.41
26200	T		Remove hand bone lesion	0053	14.8831	$812.04	$253.49	$162.41
26205	T		Remove/graft bone lesion	0054	24.2456	$1,322.86		$264.57
26210	T		Removal of finger lesion	0053	14.8831	$812.04	$253.49	$162.41
26215	T		Remove/graft finger lesion	0053	14.8831	$812.04	$253.49	$162.41
26230	T		Partial removal of hand bone	0053	14.8831	$812.04	$253.49	$162.41
26235	T		Partial removal, finger bone	0053	14.8831	$812.04	$253.49	$162.41
26236	T		Partial removal, finger bone	0053	14.8831	$812.04	$253.49	$162.41
26250	T		Extensive hand surgery	0053	14.8831	$812.04	$253.49	$162.41
26255	T		Extensive hand surgery	0054	24.2456	$1,322.86		$264.57
26260	T		Extensive finger surgery	0053	14.8831	$812.04	$253.49	$162.41
26261	T		Extensive finger surgery	0053	14.8831	$812.04	$253.49	$162.41
26262	T		Partial removal of finger	0053	14.8831	$812.04	$253.49	$162.41
26320	T		Removal of implant from hand	0021	14.3594	$783.46	$219.48	$156.69
26340	T		Manipulate finger w/anesth	0043	1.9074	$104.07		$20.81
26350	T		Repair finger/hand tendon	0054	24.2456	$1,322.86		$264.57
26352	T		Repair/graft hand tendon	0054	24.2456	$1,322.86		$264.57
26356	T		Repair finger/hand tendon	0054	24.2456	$1,322.86		$264.57
26357	T		Repair finger/hand tendon	0054	24.2456	$1,322.86		$264.57
26358	T		Repair/graft hand tendon	0054	24.2456	$1,322.86		$264.57
26370	T		Repair finger/hand tendon	0054	24.2456	$1,322.86		$264.57
26372	T		Repair/graft hand tendon	0054	24.2456	$1,322.86		$264.57
26373	T		Repair finger/hand tendon	0054	24.2456	$1,322.86		$264.57
26390	T		Revise hand/finger tendon	0054	24.2456	$1,322.86		$264.57
26392	T		Repair/graft hand tendon	0054	24.2456	$1,322.86		$264.57
26410	T		Repair hand tendon	0053	14.8831	$812.04	$253.49	$162.41
26412	T		Repair/graft hand tendon	0054	24.2456	$1,322.86		$264.57
26415	T		Excision, hand/finger tendon	0054	24.2456	$1,322.86		$264.57
26416	T		Graft hand or finger tendon	0054	24.2456	$1,322.86		$264.57
26418	T		Repair finger tendon	0053	14.8831	$812.04	$253.49	$162.41
26420	T		Repair/graft finger tendon	0054	24.2456	$1,322.86		$264.57
26426	T		Repair finger/hand tendon	0054	24.2456	$1,322.86		$264.57
26428	T		Repair/graft finger tendon	0054	24.2456	$1,322.86		$264.57
26432	T		Repair finger tendon	0053	14.8831	$812.04	$253.49	$162.41
26433	T		Repair finger tendon	0053	14.8831	$812.04	$253.49	$162.41
26434	T		Repair/graft finger tendon	0054	24.2456	$1,322.86		$264.57
26437	T		Realignment of tendons	0053	14.8831	$812.04	$253.49	$162.41
26440	T		Release palm/finger tendon	0053	14.8831	$812.04	$253.49	$162.41
26442	T		Release palm & finger tendon	0054	24.2456	$1,322.86		$264.57
26445	T		Release hand/finger tendon	0053	14.8831	$812.04	$253.49	$162.41
26449	T		Release forearm/hand tendon	0054	24.2456	$1,322.86		$264.57
26450	T		Incision of palm tendon	0053	14.8831	$812.04	$253.49	$162.41
26455	T		Incision of finger tendon	0053	14.8831	$812.04	$253.49	$162.41
26460	T		Incise hand/finger tendon	0053	14.8831	$812.04	$253.49	$162.41
26471	T		Fusion of finger tendons	0053	14.8831	$812.04	$253.49	$162.41
26474	T		Fusion of finger tendons	0053	14.8831	$812.04	$253.49	$162.41
26476	T		Tendon lengthening	0053	14.8831	$812.04	$253.49	$162.41
26477	T		Tendon shortening	0053	14.8831	$812.04	$253.49	$162.41
26478	T		Lengthening of hand tendon	0053	14.8831	$812.04	$253.49	$162.41
26479	T		Shortening of hand tendon	0053	14.8831	$812.04	$253.49	$162.41
26480	T		Transplant hand tendon	0054	24.2456	$1,322.86		$264.57
26483	T		Transplant/graft hand tendon	0054	24.2456	$1,322.86		$264.57
26485	T		Transplant palm tendon	0054	24.2456	$1,322.86		$264.57
26489	T		Transplant/graft palm tendon	0054	24.2456	$1,322.86		$264.57

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Descnption	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26490	T		Revise thumb tendon	0054	24.2456	$1,322.86		$264.57
26492	T		Tendon transfer with graft	0054	24.2456	$1,322.86		$264.57
26494	T		Hand tendon/muscle transfer	0054	24.2456	$1,322.86		$264.57
26496	T		Revise thumb tendon	0054	24.2456	$1,322.86		$264.57
26497	T		Finger tendon transfer	0054	24.2456	$1,322.86		$264.57
26498	T		Finger tendon transfer	0054	24.2456	$1,322.86		$264.57
26499	T		Revision of finger	0054	24.2456	$1,322.86		$264.57
26500	T		Hand tendon reconstruction	0053	14.8831	$812.04	$253.49	$162.41
26502	T		Hand tendon reconstruction	0054	24.2456	$1,322.86		$264.57
26504	T		Hand tendon reconstruction	0054	24.2456	$1,322.86		$264.57
26508	T		Release thumb contracture	0053	14.8831	$812.04	$253.49	$162.41
26510	T		Thumb tendon transfer	0054	24.2456	$1,322.86		$264.57
26516	T		Fusion of knuckle joint	0054	24.2456	$1,322.86		$264.57
26517	T		Fusion of knuckle joints	0054	24.2456	$1,322.86		$264.57
26518	T		Fusion of knuckle joints	0054	24.2456	$1,322.86		$264.57
26520	T		Release knuckle contracture	0053	14.8831	$812.04	$253.49	$162.41
26525	T		Release finger contracture	0053	14.8831	$812.04	$253.49	$162.41
26530	T		Revise knuckle joint	0047	29.9582	$1,634.55	$537.03	$326.91
26531	T		Revise knuckle with implant	0048	51.4609	$2,807.76	$695.60	$561.55
26535	T		Revise finger joint	0047	29.9582	$1,634.55	$537.03	$326.91
26536	T		Revise/implant finger joint	0048	51.4609	$2,807.76	$695.60	$561.55
26540	T		Repair hand joint	0053	14.8831	$812.04	$253.49	$162.41
26541	T		Repair hand joint with graft	0054	24.2456	$1,322.86		$264.57
26542	T		Repair hand joint with graft	0053	14.8831	$812.04	$253.49	$162.41
26545	T		Reconstruct finger joint	0054	24.2456	$1,322.86		$264.57
26546	T		Repair nonunion hand	0054	24.2456	$1,322.86		$264.57
26548	T		Reconstruct finger joint	0054	24.2456	$1,322.86		$264.57
26550	T		Construct thumb replacement	0054	24.2456	$1,322.86		$264.57
26551	C		Great toe-hand transfer					
26553	C		Single transfer, toe-hand					
26554	C		Double transfer, toe-hand					
26555	T		Positional change of finger	0054	24.2456	$1,322.86		$264.57
26556	C		Toe joint transfer					
26560	T		Repair of web finger	0053	14.8831	$812.04	$253.49	$162.41
26561	T		Repair of web finger	0054	24.2456	$1,322.86		$264.57
26562	T		Repair of web finger	0054	24.2456	$1,322.86		$264.57
26565	T		Correct metacarpal flaw	0054	24.2456	$1,322.86		$264.57
26567	T		Correct finger deformity	0054	24.2456	$1,322.86		$264.57
26568	T		Lengthen metacarpal/finger	0054	24.2456	$1,322.86		$264.57
26580	T		Repair hand deformity	0054	24.2456	$1,322.86		$264.57
26587	T		Reconstruct extra finger	0053	14.8831	$812.04	$253.49	$162.41
26590	T		Repair finger deformity	0054	24.2456	$1,322.86		$264.57
26591	T		Repair muscles of hand	0054	24.2456	$1,322.86		$264.57
26593	T		Release muscles of hand	0053	14.8831	$812.04	$253.49	$162.41
26596	T		Excision constricting tissue	0054	24.2456	$1,322.86		$264.57
26600	T		Treat metacarpal fracture	0043	1.9074	$104.07		$20.81
26605	T		Treat metacarpal fracture	0043	1.9074	$104.07		$20.81
26607	T		Treat metacarpal fracture	0043	1.9074	$104.07		$20.81
26608	T		Treat metacarpal fracture	0046	32.5581	$1,776.40	$535.76	$355.28
26615	T		Treat metacarpal fracture	0046	32.5581	$1,776.40	$535.76	$355.28
26641	T		Treat thumb dislocation	0043	1.9074	$104.07		$20.81
26645	T		Treat thumb fracture	0043	1.9074	$104.07		$20.81
26650	T		Treat thumb fracture	0046	32.5581	$1,776.40	$535.76	$355.28
26665	T		Treat thumb fracture	0046	32.5581	$1,776.40	$535.76	$355.28
26670	T		Treat hand dislocation	0043	1.9074	$104.07		$20.81
26675	T		Treat hand dislocation	0043	1.9074	$104.07		$20.81
26676	T		Pin hand dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
26685	T		Treat hand dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
26686	T		Treat hand dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
26700	T		Treat knuckle dislocation	0043	1.9074	$104.07		$20.81
26705	T		Treat knuckle dislocation	0043	1.9074	$104.07		$20.81
26706	T		Pin knuckle dislocation	0043	1.9074	$104.07		$20.81
26715	T		Treat knuckle dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
26720	T		Treat finger fracture, each	0043	1.9074	$104.07		$20.81
26725	T		Treat finger fracture, each	0043	1.9074	$104.07		$20.81
26727	T		Treat finger fracture, each	0046	32.5581	$1,776.40	$535.76	$355.28
26735	T		Treat finger fracture, each	0046	32.5581	$1,776.40	$535.76	$355.28
26740	T		Treat finger fracture, each	0043	1.9074	$104.07		$20.81
26742	T		Treat finger fracture, each	0043	1.9074	$104.07		$20.81
26746	T		Treat finger fracture, each	0046	32.5581	$1,776.40	$535.76	$355.28
26750	T		Treat finger fracture, each	0043	1.9074	$104.07		$20.81
26755	T		Treat finger fracture, each	0043	1.9074	$104.07		$20.81
26756	T		Pin finger fracture, each	0046	32.5581	$1,776.40	$535.76	$355.28
26765	T		Treat finger fracture, each	0046	32.5581	$1,776.40	$535.76	$355.28
26770	T		Treat finger dislocation	0043	1.9074	$104.07		$20.81

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26775	T		Treat finger dislocation	0045	13.5889	$741.42	$268.47	$148.28
26776	T		Pin finger dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
26785	T		Treat finger dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
26820	T		Thumb fusion with graft	0054	24.2456	$1,322.86		$264.57
26841	T		Fusion of thumb	0054	24.2456	$1,322.86		$264.57
26842	T		Thumb fusion with graft	0054	24.2456	$1,322.86		$264.57
26843	T		Fusion of hand joint	0054	24.2456	$1,322.86		$264.57
26844	T		Fusion/graft of hand joint	0054	24.2456	$1,322.86		$264.57
26850	T		Fusion of knuckle	0054	24.2456	$1,322.86		$264.57
26852	T		Fusion of knuckle with graft	0054	24.2456	$1,322.86		$264.57
26860	T		Fusion of finger joint	0054	24.2456	$1,322.86		$264.57
26861	T		Fusion of finger jnt, add-on	0054	24.2456	$1,322.86		$264.57
26862	T		Fusion/graft of finger joint	0054	24.2456	$1,322.86		$264.57
26863	T		Fuse/graft added joint	0054	24.2456	$1,322.86		$264.57
26910	T		Amputate metacarpal bone	0054	24.2456	$1,322.86		$264.57
26951	T		Amputation of finger/thumb	0053	14.8831	$812.04	$253.49	$162.41
26952	T		Amputation of finger/thumb	0053	14.8831	$812.04	$253.49	$162.41
26989	T		Hand/finger surgery	0043	1.9074	$104.07		$20.81
26990	T		Drainage of pelvis lesion	0049	19.6046	$1,069.65		$213.93
26991	T		Drainage of pelvis bursa	0049	19.6046	$1,069.65		$213.93
26992	C		Drainage of bone lesion					
27000	T		Incision of hip tendon	0049	19.6046	$1,069.65		$213.93
27001	T		Incision of hip tendon	0050	24.8651	$1,356.66		$271.33
27003	T		Incision of hip tendon	0050	24.8651	$1,356.66		$271.33
27005	C		Incision of hip tendon					
27006	C		Incision of hip tendons					
27025	C		Incision of hip/thigh fascia					
27030	C		Drainage of hip joint					
27033	T		Exploration of hip joint	0051	34.5144	$1,883.14		$376.63
27035	T		Denervation of hip joint	0052	42.7126	$2,330.44		$466.09
27036	C		Excision of hip joint/muscle					
27040	T		Biopsy of soft tissues	0020	7.0842	$386.52	$113.25	$77.30
27041	T		Biopsy of soft tissues	0019	3.9493	$215.48	$71.87	$43.10
27047	T		Remove hip/pelvis lesion	0022	18.7932	$1,025.38	$354.45	$205.08
27048	T		Remove hip/pelvis lesion	0022	18.7932	$1,025.38	$354.45	$205.08
27049	T		Remove tumor, hip/pelvis	0022	18.7932	$1,025.38	$354.45	$205.08
27050	T		Biopsy of sacroiliac joint	0049	19.6046	$1,069.65		$213.93
27052	T		Biopsy of hip joint	0049	19.6046	$1,069.65		$213.93
27054	C		Removal of hip joint lining					
27060	T		Removal of ischial bursa	0049	19.6046	$1,069.65		$213.93
27062	T		Remove femur lesion/bursa	0049	19.6046	$1,069.65		$213.93
27065	T		Removal of hip bone lesion	0049	19.6046	$1,069.65		$213.93
27066	T		Removal of hip bone lesion	0050	24.8651	$1,356.66		$271.33
27067	T		Remove/graft hip bone lesion	0050	24.8651	$1,356.66		$271.33
27070	C		Partial removal of hip bone					
27071	C		Partial removal of hip bone					
27075	C		Extensive hip surgery					
27076	C		Extensive hip surgery					
27077	C		Extensive hip surgery					
27078	C		Extensive hip surgery					
27079	C		Extensive hip surgery					
27080	T		Removal of tail bone	0050	24.8651	$1,356.66		$271.33
27086	T		Remove hip foreign body	0020	7.0842	$386.52	$113.25	$77.30
27087	T		Remove hip foreign body	0049	19.6046	$1,069.65		$213.93
27090	C		Removal of hip prosthesis					
27091	C		Removal of hip prosthesis					
27093	N		Injection for hip x-ray					
27095	N		Injection for hip x-ray					
27096	B		Inject sacroiliac joint					
27097	T		Revision of hip tendon	0050	24.8651	$1,356.66		$271.33
27098	T		Transfer tendon to pelvis	0050	24.8651	$1,356.66		$271.33
27100	T		Transfer of abdominal muscle	0051	34.5144	$1,883.14		$376.63
27105	T		Transfer of spinal muscle	0051	34.5144	$1,883.14		$376.63
27110	T		Transfer of iliopsoas muscle	0051	34.5144	$1,883.14		$376.63
27111	T		Transfer of iliopsoas muscle	0051	34.5144	$1,883.14		$376.63
27120	C		Reconstruction of hip socket					
27122	C		Reconstruction of hip socket					
27125	C		Partial hip replacement					
27130	C		Total hip arthroplasty					
27132	C		Total hip arthroplasty					
27134	C		Revise hip joint replacement					
27137	C		Revise hip joint replacement					
27138	C		Revise hip joint replacement					
27140	C		Transplant femur ridge					
27146	C		Incision of hip bone					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27147	C		Revision of hip bone					
27151	C		Incision of hip bones					
27156	C		Revision of hip bones					
27158	C		Revision of pelvis					
27161	C		Incision of neck of femur					
27165	C		Incision/fixation of femur					
27170	C		Repair/graft femur head/neck					
27175	C		Treat slipped epiphysis					
27176	C		Treat slipped epiphysis					
27177	C		Treat slipped epiphysis					
27178	C		Treat slipped epiphysis					
27179	C		Revise head/neck of femur					
27181	C		Treat slipped epiphysis					
27185	C		Revision of femur epiphysis					
27187	C		Reinforce hip bones					
27193	T		Treat pelvic ring fracture	0043	1.9074	$104.07		$20.81
27194	T		Treat pelvic ring fracture	0045	13.5889	$741.42	$268.47	$148.28
27200	T		Treat tail bone fracture	0043	1.9074	$104.07		$20.81
27202	T		Treat tail bone fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27215	C		Treat pelvic fracture(s)					
27216	T		Treat pelvic ring fracture	0050	24.8651	$1,356.66		$271.33
27217	C		Treat pelvic ring fracture					
27218	C		Treat pelvic ring fracture					
27220	T		Treat hip socket fracture	0043	1.9074	$104.07		$20.81
27222	C		Treat hip socket fracture					
27226	C		Treat hip wall fracture					
27227	C		Treat hip fracture(s)					
27228	C		Treat hip fracture(s)					
27230	T		Treat thigh fracture	0043	1.9074	$104.07		$20.81
27232	C		Treat thigh fracture					
27235	T		Treat thigh fracture	0050	24.8651	$1,356.66		$271.33
27236	C		Treat thigh fracture					
27238	T		Treat thigh fracture	0043	1.9074	$104.07		$20.81
27240	C		Treat thigh fracture					
27244	C		Treat thigh fracture					
27245	C		Treat thigh fracture					
27246	T		Treat thigh fracture	0043	1.9074	$104.07		$20.81
27248	C		Treat thigh fracture					
27250	T		Treat hip dislocation	0043	1.9074	$104.07		$20.81
27252	T		Treat hip dislocation	0045	13.5889	$741.42	$268.47	$148.28
27253	C		Treat hip dislocation					
27254	C		Treat hip dislocation					
27256	T		Treat hip dislocation	0043	1.9074	$104.07		$20.81
27257	T		Treat hip dislocation	0045	13.5889	$741.42	$268.47	$148.28
27258	C		Treat hip dislocation					
27259	C		Treat hip dislocation					
27265	T		Treat hip dislocation	0043	1.9074	$104.07		$20.81
27266	T		Treat hip dislocation	0045	13.5889	$741.42	$268.47	$148.28
27275	T		Manipulation of hip joint	0045	13.5889	$741.42	$268.47	$148.28
27280	C		Fusion of sacroiliac joint					
27282	C		Fusion of pubic bones					
27284	C		Fusion of hip joint					
27286	C		Fusion of hip joint					
27290	C		Amputation of leg at hip					
27295	C		Amputation of leg at hip					
27299	T		Pelvis/hip joint surgery	0043	1.9074	$104.07		$20.81
27301	T		Drain thigh/knee lesion	0008	19.4831	$1,063.02		$212.60
27303	C		Drainage of bone lesion					
27305	T		Incise thigh tendon & fascia	0049	19.6046	$1,069.65		$213.93
27306	T		Incision of thigh tendon	0049	19.6046	$1,069.65		$213.93
27307	T		Incision of thigh tendons	0049	19.6046	$1,069.65		$213.93
27310	T		Exploration of knee joint	0050	24.8651	$1,356.66		$271.33
27315	T		Partial removal, thigh nerve	0220	16.5554	$903.28		$180.66
27320	T		Partial removal, thigh nerve	0220	16.5554	$903.28		$180.66
27323	T		Biopsy, thigh soft tissues	0021	14.3594	$783.46	$219.48	$156.69
27324	T		Biopsy, thigh soft tissues	0022	18.7932	$1,025.38	$354.45	$205.08
27327	T		Removal of thigh lesion	0022	18.7932	$1,025.38	$354.45	$205.08
27328	T		Removal of thigh lesion	0022	18.7932	$1,025.38	$354.45	$205.08
27329	T		Remove tumor, thigh/knee	0022	18.7932	$1,025.38	$354.45	$205.08
27330	T		Biopsy, knee joint lining	0050	24.8651	$1,356.66		$271.33
27331	T		Explore/treat knee joint	0050	24.8651	$1,356.66		$271.33
27332	T		Removal of knee cartilage	0050	24.8651	$1,356.66		$271.33
27333	T		Removal of knee cartilage	0050	24.8651	$1,356.66		$271.33
27334	T		Remove knee joint lining	0050	24.8651	$1,356.66		$271.33
27335	T		Remove knee joint lining	0050	24.8651	$1,356.66		$271.33

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27340	T		Removal of kneecap bursa	0049	19.6046	$1,069.65		$213.93
27345	T		Removal of knee cyst	0049	19.6046	$1,069.65		$213.93
27347	T		Remove knee cyst	0049	19.6046	$1,069.65		$213.93
27350	T		Removal of kneecap	0050	24.8651	$1,356.66		$271.33
27355	T		Remove femur lesion	0050	24.8651	$1,356.66		$271.33
27356	T		Remove femur lesion/graft	0050	24.8651	$1,356.66		$271.33
27357	T		Remove femur lesion/graft	0050	24.8651	$1,356.66		$271.33
27358	T		Remove femur lesion/fixation	0050	24.8651	$1,356.66		$271.33
27360	T		Partial removal, leg bone(s)	0050	24.8651	$1,356.66		$271.33
27365	C		Extensive leg surgery					
27370	N		Injection for knee x-ray					
27372	T		Removal of foreign body	0022	18.7932	$1,025.38	$354.45	$205.08
27380	T		Repair of kneecap tendon	0049	19.6046	$1,069.65		$213.93
27381	T		Repair/graft kneecap tendon	0049	19.6046	$1,069.65		$213.93
27385	T		Repair of thigh muscle	0049	19.6046	$1,069.65		$213.93
27386	T		Repair/graft of thigh muscle	0049	19.6046	$1,069.65		$213.93
27390	T		Incision of thigh tendon	0049	19.6046	$1,069.65		$213.93
27391	T		Incision of thigh tendons	0049	19.6046	$1,069.65		$213.93
27392	T		Incision of thigh tendons	0049	19.6046	$1,069.65		$213.93
27393	T		Lengthening of thigh tendon	0050	24.8651	$1,356.66		$271.33
27394	T		Lengthening of thigh tendons	0050	24.8651	$1,356.66		$271.33
27395	T		Lengthening of thigh tendons	0051	34.5144	$1,883.14		$376.63
27396	T		Transplant of thigh tendon	0050	24.8651	$1,356.66		$271.33
27397	T		Transplants of thigh tendons	0051	34.5144	$1,883.14		$376.63
27400	T		Revise thigh muscles/tendons	0051	34.5144	$1,883.14		$376.63
27403	T		Repair of knee cartilage	0050	24.8651	$1,356.66		$271.33
27405	T		Repair of knee ligament	0051	34.5144	$1,883.14		$376.63
27407	T		Repair of knee ligament	0051	34.5144	$1,883.14		$376.63
27409	T		Repair of knee ligaments	0051	34.5144	$1,883.14		$376.63
27418	T		Repair degenerated kneecap	0051	34.5144	$1,883.14		$376.63
27420	T		Revision of unstable kneecap	0051	34.5144	$1,883.14		$376.63
27422	T		Revision of unstable kneecap	0051	34.5144	$1,883.14		$376.63
27424	T		Revision/removal of kneecap	0051	34.5144	$1,883.14		$376.63
27425	T		Lateral retinacular release	0050	24.8651	$1,356.66		$271.33
27427	T		Reconstruction, knee	0052	42.7126	$2,330.44		$466.09
27428	T		Reconstruction, knee	0052	42.7126	$2,330.44		$466.09
27429	T		Reconstruction, knee	0052	42.7126	$2,330.44		$466.09
27430	T		Revision of thigh muscles	0051	34.5144	$1,883.14		$376.63
27435	T		Incision of knee joint	0051	34.5144	$1,883.14		$376.63
27437	T		Revise kneecap	0047	29.9582	$1,634.55	$537.03	$326.91
27438	T		Revise kneecap with implant	0048	51.4609	$2,807.76	$695.60	$561.55
27440	T		Revision of knee joint	0047	29.9582	$1,634.55	$537.03	$326.91
27441	T		Revision of knee joint	0047	29.9582	$1,634.55	$537.03	$326.91
27442	T		Revision of knee joint	0047	29.9582	$1,634.55	$537.03	$326.91
27443	T		Revision of knee joint	0047	29.9582	$1,634.55	$537.03	$326.91
27445	C		Revision of knee joint					
27446	T		Revision of knee joint	0681	98.1613	$5,355.78	$2,131.36	$1,071.16
27447	C		Total knee arthroplasty					
27448	C		Incision of thigh					
27450	C		Incision of thigh					
27454	C		Realignment of thigh bone					
27455	C		Realignment of knee					
27457	C		Realignment of knee					
27465	C		Shortening of thigh bone					
27466	C		Lengthening of thigh bone					
27468	C		Shorten/lengthen thighs					
27470	C		Repair of thigh					
27472	C		Repair/graft of thigh					
27475	C		Surgery to stop leg growth					
27477	C		Surgery to stop leg growth					
27479	C		Surgery to stop leg growth					
27485	C		Surgery to stop leg growth					
27486	C		Revise/replace knee joint					
27487	C		Revise/replace knee joint					
27488	C		Removal of knee prosthesis					
27495	C		Reinforce thigh					
27496	T		Decompression of thigh/knee	0049	19.6046	$1,069.65		$213.93
27497	T		Decompression of thigh/knee	0049	19.6046	$1,069.65		$213.93
27498	T		Decompression of thigh/knee	0049	19.6046	$1,069.65		$213.93
27499	T		Decompression of thigh/knee	0049	19.6046	$1,069.65		$213.93
27500	T		Treatment of thigh fracture	0043	1.9074	$104.07		$20.81
27501	T		Treatment of thigh fracture	0043	1.9074	$104.07		$20.81
27502	T		Treatment of thigh fracture	0043	1.9074	$104.07		$20.81
27503	T		Treatment of thigh fracture	0043	1.9074	$104.07		$20.81
27506	C		Treatment of thigh fracture					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27507	C		Treatment of thigh fracture					
27508	T		Treatment of thigh fracture	0043	1.9074	$104.07		$20.81
27509	T		Treatment of thigh fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27510	T		Treatment of thigh fracture	0043	1.9074	$104.07		$20.81
27511	C		Treatment of thigh fracture					
27513	C		Treatment of thigh fracture					
27514	C		Treatment of thigh fracture					
27516	T		Treat thigh fx growth plate	0043	1.9074	$104.07		$20.81
27517	T		Treat thigh fx growth plate	0043	1.9074	$104.07		$20.81
27519	C		Treat thigh fx growth plate					
27520	T		Treat kneecap fracture	0043	1.9074	$104.07		$20.81
27524	T		Treat kneecap fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27530	T		Treat knee fracture	0043	1.9074	$104.07		$20.81
27532	T		Treat knee fracture	0043	1.9074	$104.07		$20.81
27535	C		Treat knee fracture					
27536	C		Treat knee fracture					
27538	T		Treat knee fracture(s)	0043	1.9074	$104.07		$20.81
27540	C		Treat knee fracture					
27550	T		Treat knee dislocation	0043	1.9074	$104.07		$20.81
27552	T		Treat knee dislocation	0045	13.5889	$741.42	$268.47	$148.28
27556	C		Treat knee dislocation					
27557	C		Treat knee dislocation					
27558	C		Treat knee dislocation					
27560	T		Treat kneecap dislocation	0043	1.9074	$104.07		$20.81
27562	T		Treat kneecap dislocation	0045	13.5889	$741.42	$268.47	$148.28
27566	T		Treat kneecap dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
27570	T		Fixation of knee joint	0045	13.5889	$741.42	$268.47	$148.28
27580	C		Fusion of knee					
27590	C		Amputate leg at thigh					
27591	C		Amputate leg at thigh					
27592	C		Amputate leg at thigh					
27594	T		Amputation follow-up surgery	0049	19.6046	$1,069.65		$213.93
27596	C		Amputation follow-up surgery					
27598	C		Amputate lower leg at knee					
27599	T		Leg surgery procedure	0043	1.9074	$104.07		$20.81
27600	T		Decompression of lower leg	0049	19.6046	$1,069.65		$213.93
27601	T		Decompression of lower leg	0049	19.6046	$1,069.65		$213.93
27602	T		Decompression of lower leg	0049	19.6046	$1,069.65		$213.93
27603	T		Drain lower leg lesion	0007	11.8633	$647.27		$129.45
27604	T		Drain lower leg bursa	0049	19.6046	$1,069.65		$213.93
27605	T		Incision of achilles tendon	0055	18.7205	$1,021.41	$355.34	$204.28
27606	T		Incision of achilles tendon	0049	19.6046	$1,069.65		$213.93
27607	T		Treat lower leg bone lesion	0049	19.6046	$1,069.65		$213.93
27610	T		Explore/treat ankle joint	0050	24.8651	$1,356.66		$271.33
27612	T		Exploration of ankle joint	0050	24.8651	$1,356.66		$271.33
27613	T		Biopsy lower leg soft tissue	0020	7.0842	$386.52	$113.25	$77.30
27614	T		Biopsy lower leg soft tissue	0022	18.7932	$1,025.38	$354.45	$205.08
27615	T		Remove tumor, lower leg	0046	32.5581	$1,776.40	$535.76	$355.28
27618	T		Remove lower leg lesion	0021	14.3594	$783.46	$219.48	$156.69
27619	T		Remove lower leg lesion	0022	18.7932	$1,025.38	$354.45	$205.08
27620	T		Explore/treat ankle joint	0050	24.8651	$1,356.66		$271.33
27625	T		Remove ankle joint lining	0050	24.8651	$1,356.66		$271.33
27626	T		Remove ankle joint lining	0050	24.8651	$1,356.66		$271.33
27630	T		Removal of tendon lesion	0049	19.6046	$1,069.65		$213.93
27635	T		Remove lower leg bone lesion	0050	24.8651	$1,356.66		$271.33
27637	T		Remove/graft leg bone lesion	0050	24.8651	$1,356.66		$271.33
27638	T		Remove/graft leg bone lesion	0050	24.8651	$1,356.66		$271.33
27640	T		Partial removal of tibia	0051	34.5144	$1,883.14		$376.63
27641	T		Partial removal of fibula	0050	24.8651	$1,356.66		$271.33
27645	C		Extensive lower leg surgery					
27646	C		Extensive lower leg surgery					
27647	T		Extensive ankle/heel surgery	0051	34.5144	$1,883.14		$376.63
27648	N		Injection for ankle x-ray					
27650	T		Repair achilles tendon	0051	34.5144	$1,883.14		$376.63
27652	T		Repair/graft achilles tendon	0051	34.5144	$1,883.14		$376.63
27654	T		Repair of achilles tendon	0051	34.5144	$1,883.14		$376.63
27656	T		Repair leg fascia defect	0049	19.6046	$1,069.65		$213.93
27658	T		Repair of leg tendon, each	0049	19.6046	$1,069.65		$213.93
27659	T		Repair of leg tendon, each	0049	19.6046	$1,069.65		$213.93
27664	T		Repair of leg tendon, each	0049	19.6046	$1,069.65		$213.93
27665	T		Repair of leg tendon, each	0050	24.8651	$1,356.66		$271.33
27675	T		Repair lower leg tendons	0049	19.6046	$1,069.65		$213.93
27676	T		Repair lower leg tendons	0050	24.8651	$1,356.66		$271.33
27680	T		Release of lower leg tendon	0050	24.8651	$1,356.66		$271.33
27681	T		Release of lower leg tendons	0050	24.8651	$1,356.66		$271.33

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27685	T		Revision of lower leg tendon	0050	24.8651	$1,356.66		$271.33
27686	T		Revise lower leg tendons	0050	24.8651	$1,356.66		$271.33
27687	T		Revision of calf tendon	0050	24.8651	$1,356.66		$271.33
27690	T		Revise lower leg tendon	0051	34.5144	$1,883.14		$376.63
27691	T		Revise lower leg tendon	0051	34.5144	$1,883.14		$376.63
27692	T		Revise additional leg tendon	0051	34.5144	$1,883.14		$376.63
27695	T		Repair of ankle ligament	0050	24.8651	$1,356.66		$271.33
27696	T		Repair of ankle ligaments	0050	24.8651	$1,356.66		$271.33
27698	T		Repair of ankle ligament	0050	24.8651	$1,356.66		$271.33
27700	T		Revision of ankle joint	0047	29.9582	$1,634.55	$537.03	$326.91
27702	C		Reconstruct ankle joint					
27703	C		Reconstruction, ankle joint					
27704	T		Removal of ankle implant	0049	19.6046	$1,069.65		$213.93
27705	T		Incision of tibia	0051	34.5144	$1,883.14		$376.63
27707	T		Incision of fibula	0049	19.6046	$1,069.65		$213.93
27709	T		Incision of tibia & fibula	0050	24.8651	$1,356.66		$271.33
27712	C		Realignment of lower leg					
27715	C		Revision of lower leg					
27720	C		Repair of tibia					
27722	C		Repair/graft of tibia					
27724	C		Repair/graft of tibia					
27725	C		Repair of lower leg					
27727	C		Repair of lower leg					
27730	T		Repair of tibia epiphysis	0050	24.8651	$1,356.66		$271.33
27732	T		Repair of fibula epiphysis	0050	24.8651	$1,356.66		$271.33
27734	T		Repair lower leg epiphyses	0050	24.8651	$1,356.66		$271.33
27740	T		Repair of leg epiphyses	0050	24.8651	$1,356.66		$271.33
27742	T		Repair of leg epiphyses	0051	34.5144	$1,883.14		$376.63
27745	T		Reinforce tibia	0051	34.5144	$1,883.14		$376.63
27750	T		Treatment of tibia fracture	0043	1.9074	$104.07		$20.81
27752	T		Treatment of tibia fracture	0043	1.9074	$104.07		$20.81
27756	T		Treatment of tibia fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27758	T		Treatment of tibia fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27759	T		Treatment of tibia fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27760	T		Treatment of ankle fracture	0043	1.9074	$104.07		$20.81
27762	T		Treatment of ankle fracture	0043	1.9074	$104.07		$20.81
27766	T		Treatment of ankle fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27780	T		Treatment of fibula fracture	0043	1.9074	$104.07		$20.81
27781	T		Treatment of fibula fracture	0043	1.9074	$104.07		$20.81
27784	T		Treatment of fibula fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27786	T		Treatment of ankle fracture	0043	1.9074	$104.07		$20.81
27788	T		Treatment of ankle fracture	0043	1.9074	$104.07		$20.81
27792	T		Treatment of ankle fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27808	T		Treatment of ankle fracture	0043	1.9074	$104.07		$20.81
27810	T		Treatment of ankle fracture	0043	1.9074	$104.07		$20.81
27814	T		Treatment of ankle fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27816	T		Treatment of ankle fracture	0043	1.9074	$104.07		$20.81
27818	T		Treatment of ankle fracture	0043	1.9074	$104.07		$20.81
27822	T		Treatment of ankle fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27823	T		Treatment of ankle fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27824	T		Treat lower leg fracture	0043	1.9074	$104.07		$20.81
27825	T		Treat lower leg fracture	0043	1.9074	$104.07		$20.81
27826	T		Treat lower leg fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27827	T		Treat lower leg fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27828	T		Treat lower leg fracture	0046	32.5581	$1,776.40	$535.76	$355.28
27829	T		Treat lower leg joint	0046	32.5581	$1,776.40	$535.76	$355.28
27830	T		Treat lower leg dislocation	0043	1.9074	$104.07		$20.81
27831	T		Treat lower leg dislocation	0043	1.9074	$104.07		$20.81
27832	T		Treat lower leg dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
27840	T		Treat ankle dislocation	0043	1.9074	$104.07		$20.81
27842	T		Treat ankle dislocation	0045	13.5889	$741.42	$268.47	$148.28
27846	T		Treat ankle dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
27848	T		Treat ankle dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
27860	T		Fixation of ankle joint	0045	13.5889	$741.42	$268.47	$148.28
27870	T		Fusion of ankle joint	0051	34.5144	$1,883.14		$376.63
27871	T		Fusion of tibiofibular joint	0051	34.5144	$1,883.14		$376.63
27880	C		Amputation of lower leg					
27881	C		Amputation of lower leg					
27882	C		Amputation of lower leg					
27884	T		Amputation follow-up surgery	0049	19.6046	$1,069.65		$213.93
27886	C		Amputation follow-up surgery					
27888	C		Amputation of foot at ankle					
27889	T		Amputation of foot at ankle	0050	24.8651	$1,356.66		$271.33
27892	T		Decompression of leg	0049	19.6046	$1,069.65		$213.93
27893	T		Decompression of leg	0049	19.6046	$1,069.65		$213.93

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27894	T		Decompression of leg	0049	19.6046	$1,069.65		$213.93
27899	T		Leg/ankle surgery procedure	0043	1.9074	$104.07		$20.81
28001	T		Drainage of bursa of foot	0007	11.8633	$647.27		$129.45
28002	T		Treatment of foot infection	0049	19.6046	$1,069.65		$213.93
28003	T		Treatment of foot infection	0049	19.6046	$1,069.65		$213.93
28005	T		Treat foot bone lesion	0055	18.7205	$1,021.41	$355.34	$204.28
28008	T		Incision of foot fascia	0055	18.7205	$1,021.41	$355.34	$204.28
28010	T		Incision of toe tendon	0055	18.7205	$1,021.41	$355.34	$204.28
28011	T		Incision of toe tendons	0055	18.7205	$1,021.41	$355.34	$204.28
28020	T		Exploration of foot joint	0055	18.7205	$1,021.41	$355.34	$204.28
28022	T		Exploration of foot joint	0055	18.7205	$1,021.41	$355.34	$204.28
28024	T		Exploration of toe joint	0055	18.7205	$1,021.41	$355.34	$204.28
28030	T		Removal of foot nerve	0220	16.5554	$903.28		$180.66
28035	T		Decompression of tibia nerve	0220	16.5554	$903.28		$180.66
28043	T		Excision of foot lesion	0021	14.3594	$783.46	$219.48	$156.69
28045	T		Excision of foot lesion	0055	18.7205	$1,021.41	$355.34	$204.28
28046	T		Resection of tumor, foot	0055	18.7205	$1,021.41	$355.34	$204.28
28050	T		Biopsy of foot joint lining	0055	18.7205	$1,021.41	$355.34	$204.28
28052	T		Biopsy of foot joint lining	0055	18.7205	$1,021.41	$355.34	$204.28
28054	T		Biopsy of toe joint lining	0055	18.7205	$1,021.41	$355.34	$204.28
28060	T		Partial removal, foot fascia	0056	25.3930	$1,385.47	$405.81	$277.09
28062	T		Removal of foot fascia	0056	25.3930	$1,385.47	$405.81	$277.09
28070	T		Removal of foot joint lining	0056	25.3930	$1,385.47	$405.81	$277.09
28072	T		Removal of foot joint lining	0056	25.3930	$1,385.47	$405.81	$277.09
28080	T		Removal of foot lesion	0055	18.7205	$1,021.41	$355.34	$204.28
28086	T		Excise foot tendon sheath	0055	18.7205	$1,021.41	$355.34	$204.28
28088	T		Excise foot tendon sheath	0055	18.7205	$1,021.41	$355.34	$204.28
28090	T		Removal of foot lesion	0055	18.7205	$1,021.41	$355.34	$204.28
28092	T		Removal of toe lesions	0055	18.7205	$1,021.41	$355.34	$204.28
28100	T		Removal of ankle/heel lesion	0055	18.7205	$1,021.41	$355.34	$204.28
28102	T		Remove/graft foot lesion	0056	25.3930	$1,385.47	$405.81	$277.09
28103	T		Remove/graft foot lesion	0056	25.3930	$1,385.47	$405.81	$277.09
28104	T		Removal of foot lesion	0055	18.7205	$1,021.41	$355.34	$204.28
28106	T		Remove/graft foot lesion	0056	25.3930	$1,385.47	$405.81	$277.09
28107	T		Remove/graft foot lesion	0056	25.3930	$1,385.47	$405.81	$277.09
28108	T		Removal of toe lesions	0055	18.7205	$1,021.41	$355.34	$204.28
28110	T		Part removal of metatarsal	0056	25.3930	$1,385.47	$405.81	$277.09
28111	T		Part removal of metatarsal	0055	18.7205	$1,021.41	$355.34	$204.28
28112	T		Part removal of metatarsal	0055	18.7205	$1,021.41	$355.34	$204.28
28113	T		Part removal of metatarsal	0055	18.7205	$1,021.41	$355.34	$204.28
28114	T		Removal of metatarsal heads	0055	18.7205	$1,021.41	$355.34	$204.28
28116	T		Revision of foot	0055	18.7205	$1,021.41	$355.34	$204.28
28118	T		Removal of heel bone	0055	18.7205	$1,021.41	$355.34	$204.28
28119	T		Removal of heel spur	0055	18.7205	$1,021.41	$355.34	$204.28
28120	T		Part removal of ankle/heel	0055	18.7205	$1,021.41	$355.34	$204.28
28122	T		Partial removal of foot bone	0055	18.7205	$1,021.41	$355.34	$204.28
28124	T		Partial removal of toe	0055	18.7205	$1,021.41	$355.34	$204.28
28126	T		Partial removal of toe	0055	18.7205	$1,021.41	$355.34	$204.28
28130	T		Removal of ankle bone	0055	18.7205	$1,021.41	$355.34	$204.28
28140	T		Removal of metatarsal	0055	18.7205	$1,021.41	$355.34	$204.28
28150	T		Removal of toe	0055	18.7205	$1,021.41	$355.34	$204.28
28153	T		Partial removal of toe	0055	18.7205	$1,021.41	$355.34	$204.28
28160	T		Partial removal of toe	0055	18.7205	$1,021.41	$355.34	$204.28
28171	T		Extensive foot surgery	0055	18.7205	$1,021.41	$355.34	$204.28
28173	T		Extensive foot surgery	0055	18.7205	$1,021.41	$355.34	$204.28
28175	T		Extensive foot surgery	0055	18.7205	$1,021.41	$355.34	$204.28
28190	T		Removal of foot foreign body	0019	3.9493	$215.48	$71.87	$43.10
28192	T		Removal of foot foreign body	0021	14.3594	$783.46	$219.48	$156.69
28193	T		Removal of foot foreign body	0020	7.0842	$386.52	$113.25	$77.30
28200	T		Repair of foot tendon	0055	18.7205	$1,021.41	$355.34	$204.28
28202	T		Repair/graft of foot tendon	0056	25.3930	$1,385.47	$405.81	$277.09
28208	T		Repair of foot tendon	0055	18.7205	$1,021.41	$355.34	$204.28
28210	T		Repair/graft of foot tendon	0056	25.3930	$1,385.47	$405.81	$277.09
28220	T		Release of foot tendon	0055	18.7205	$1,021.41	$355.34	$204.28
28222	T		Release of foot tendons	0055	18.7205	$1,021.41	$355.34	$204.28
28225	T		Release of foot tendon	0055	18.7205	$1,021.41	$355.34	$204.28
28226	T		Release of foot tendons	0055	18.7205	$1,021.41	$355.34	$204.28
28230	T		Incision of foot tendon(s)	0055	18.7205	$1,021.41	$355.34	$204.28
28232	T		Incision of toe tendon	0055	18.7205	$1,021.41	$355.34	$204.28
28234	T		Incision of foot tendon	0055	18.7205	$1,021.41	$355.34	$204.28
28238	T		Revision of foot tendon	0056	25.3930	$1,385.47	$405.81	$277.09
28240	T		Release of big toe	0055	18.7205	$1,021.41	$355.34	$204.28
28250	T		Revision of foot fascia	0056	25.3930	$1,385.47	$405.81	$277.09
28260	T		Release of midfoot joint	0056	25.3930	$1,385.47	$405.81	$277.09
28261	T		Revision of foot tendon	0056	25.3930	$1,385.47	$405.81	$277.09

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28262	T		Revision of foot and ankle	0056	25.3930	$1,385.47	$405.81	$277.09
28264	T		Release of midfoot joint	0056	25.3930	$1,385.47	$405.81	$277.09
28270	T		Release of foot contracture	0055	18.7205	$1,021.41	$355.34	$204.28
28272	T		Release of toe joint, each	0055	18.7205	$1,021.41	$355.34	$204.28
28280	T		Fusion of toes	0055	18.7205	$1,021.41	$355.34	$204.28
28285	T		Repair of hammertoe	0055	18.7205	$1,021.41	$355.34	$204.28
28286	T		Repair of hammertoe	0055	18.7205	$1,021.41	$355.34	$204.28
28288	T		Partial removal of foot bone	0056	25.3930	$1,385.47	$405.81	$277.09
28289	T		Repair hallux rigidus	0056	25.3930	$1,385.47	$405.81	$277.09
28290	T		Correction of bunion	0056	25.3930	$1,385.47	$405.81	$277.09
28292	T		Correction of bunion	0057	25.5035	$1,391.50	$475.91	$278.30
28293	T		Correction of bunion	0057	25.5035	$1,391.50	$475.91	$278.30
28294	T		Correction of bunion	0056	25.3930	$1,385.47	$405.81	$277.09
28296	T		Correction of bunion	0056	25.3930	$1,385.47	$405.81	$277.09
28297	T		Correction of bunion	0057	25.5035	$1,391.50	$475.91	$278.30
28298	T		Correction of bunion	0056	25.3930	$1,385.47	$405.81	$277.09
28299	T		Correction of bunion	0057	25.5035	$1,391.50	$475.91	$278.30
28300	T		Incision of heel bone	0056	25.3930	$1,385.47	$405.81	$277.09
28302	T		Incision of ankle bone	0056	25.3930	$1,385.47	$405.81	$277.09
28304	T		Incision of midfoot bones	0056	25.3930	$1,385.47	$405.81	$277.09
28305	T		Incise/graft midfoot bones	0056	25.3930	$1,385.47	$405.81	$277.09
28306	T		Incision of metatarsal	0056	25.3930	$1,385.47	$405.81	$277.09
28307	T		Incision of metatarsal	0056	25.3930	$1,385.47	$405.81	$277.09
28308	T		Incision of metatarsal	0056	25.3930	$1,385.47	$405.81	$277.09
28309	T		Incision of metatarsals	0056	25.3930	$1,385.47	$405.81	$277.09
28310	T		Revision of big toe	0055	18.7205	$1,021.41	$355.34	$204.28
28312	T		Revision of toe	0055	18.7205	$1,021.41	$355.34	$204.28
28313	T		Repair deformity of toe	0055	18.7205	$1,021.41	$355.34	$204.28
28315	T		Removal of sesamoid bone	0055	18.7205	$1,021.41	$355.34	$204.28
28320	T		Repair of foot bones	0056	25.3930	$1,385.47	$405.81	$277.09
28322	T		Repair of metatarsals	0056	25.3930	$1,385.47	$405.81	$277.09
28340	T		Resect enlarged toe tissue	0055	18.7205	$1,021.41	$355.34	$204.28
28341	T		Resect enlarged toe	0055	18.7205	$1,021.41	$355.34	$204.28
28344	T		Repair extra toe(s)	0056	25.3930	$1,385.47	$405.81	$277.09
28345	T		Repair webbed toe(s)	0056	25.3930	$1,385.47	$405.81	$277.09
28360	T		Reconstruct cleft foot	0056	25.3930	$1,385.47	$405.81	$277.09
28400	T		Treatment of heel fracture	0043	1.9074	$104.07		$20.81
28405	T		Treatment of heel fracture	0043	1.9074	$104.07		$20.81
28406	T		Treatment of heel fracture	0046	32.5581	$1,776.40	$535.76	$355.28
28415	T		Treat heel fracture	0046	32.5581	$1,776.40	$535.76	$355.28
28420	T		Treat/graft heel fracture	0046	32.5581	$1,776.40	$535.76	$355.28
28430	T		Treatment of ankle fracture	0043	1.9074	$104.07		$20.81
28435	T		Treatment of ankle fracture	0043	1.9074	$104.07		$20.81
28436	T		Treatment of ankle fracture	0046	32.5581	$1,776.40	$535.76	$355.28
28445	T		Treat ankle fracture	0046	32.5581	$1,776.40	$535.76	$355.28
28450	T		Treat midfoot fracture, each	0043	1.9074	$104.07		$20.81
28455	T		Treat midfoot fracture, each	0043	1.9074	$104.07		$20.81
28456	T		Treat midfoot fracture	0046	32.5581	$1,776.40	$535.76	$355.28
28465	T		Treat midfoot fracture, each	0046	32.5581	$1,776.40	$535.76	$355.28
28470	T		Treat metatarsal fracture	0043	1.9074	$104.07		$20.81
28475	T		Treat metatarsal fracture	0043	1.9074	$104.07		$20.81
28476	T		Treat metatarsal fracture	0046	32.5581	$1,776.40	$535.76	$355.28
28485	T		Treat metatarsal fracture	0046	32.5581	$1,776.40	$535.76	$355.28
28490	T		Treat big toe fracture	0043	1.9074	$104.07		$20.81
28495	T		Treat big toe fracture	0043	1.9074	$104.07		$20.81
28496	T		Treat big toe fracture	0046	32.5581	$1,776.40	$535.76	$355.28
28505	T		Treat big toe fracture	0046	32.5581	$1,776.40	$535.76	$355.28
28510	T		Treatment of toe fracture	0043	1.9074	$104.07		$20.81
28515	T		Treatment of toe fracture	0043	1.9074	$104.07		$20.81
28525	T		Treat toe fracture	0046	32.5581	$1,776.40	$535.76	$355.28
28530	T		Treat sesamoid bone fracture	0043	1.9074	$104.07		$20.81
28531	T		Treat sesamoid bone fracture	0046	32.5581	$1,776.40	$535.76	$355.28
28540	T		Treat foot dislocation	0043	1.9074	$104.07		$20.81
28545	T		Treat foot dislocation	0045	13.5889	$741.42	$268.47	$148.28
28546	T		Treat foot dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
28555	T		Repair foot dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
28570	T		Treat foot dislocation	0043	1.9074	$104.07		$20.81
28575	T		Treat foot dislocation	0043	1.9074	$104.07		$20.81
28576	T		Treat foot dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
28585	T		Repair foot dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
28600	T		Treat foot dislocation	0043	1.9074	$104.07		$20.81
28605	T		Treat foot dislocation	0043	1.9074	$104.07		$20.81
28606	T		Treat foot dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
28615	T		Repair foot dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
28630	T		Treat toe dislocation	0043	1.9074	$104.07		$20.81

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28635	T		Treat toe dislocation	0045	13.5889	$741.42	$268.47	$148.28
28636	T		Treat toe dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
28645	T		Repair toe dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
28660	T		Treat toe dislocation	0043	1.9074	$104.07		$20.81
28665	T		Treat toe dislocation	0045	13.5889	$741.42	$268.47	$148.28
28666	T		Treat toe dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
28675	T		Repair of toe dislocation	0046	32.5581	$1,776.40	$535.76	$355.28
28705	T		Fusion of foot bones	0056	25.3930	$1,385.47	$405.81	$277.09
28715	T		Fusion of foot bones	0056	25.3930	$1,385.47	$405.81	$277.09
28725	T		Fusion of foot bones	0056	25.3930	$1,385.47	$405.81	$277.09
28730	T		Fusion of foot bones	0056	25.3930	$1,385.47	$405.81	$277.09
28735	T		Fusion of foot bones	0056	25.3930	$1,385.47	$405.81	$277.09
28737	T		Revision of foot bones	0056	25.3930	$1,385.47	$405.81	$277.09
28740	T		Fusion of foot bones	0056	25.3930	$1,385.47	$405.81	$277.09
28750	T		Fusion of big toe joint	0056	25.3930	$1,385.47	$405.81	$277.09
28755	T		Fusion of big toe joint	0055	18.7205	$1,021.41	$355.34	$204.28
28760	T		Fusion of big toe joint	0056	25.3930	$1,385.47	$405.81	$277.09
28800	C		Amputation of midfoot					
28805	C		Amputation thru metatarsal					
28810	T		Amputation toe & metatarsal	0055	18.7205	$1,021.41	$355.34	$204.28
28820	T		Amputation of toe	0055	18.7205	$1,021.41	$355.34	$204.28
28825	T		Partial amputation of toe	0055	18.7205	$1,021.41	$355.34	$204.28
28899	T		Foot/toes surgery procedure	0043	1.9074	$104.07		$20.81
29000	S		Application of body cast	0058	1.0931	$59.64		$11.93
29010	S		Application of body cast	0058	1.0931	$59.64		$11.93
29015	S		Application of body cast	0058	1.0931	$59.64		$11.93
29020	S		Application of body cast	0058	1.0931	$59.64		$11.93
29025	S		Application of body cast	0058	1.0931	$59.64		$11.93
29035	S		Application of body cast	0058	1.0931	$59.64		$11.93
29040	S		Application of body cast	0058	1.0931	$59.64		$11.93
29044	S		Application of body cast	0058	1.0931	$59.64		$11.93
29046	S		Application of body cast	0058	1.0931	$59.64		$11.93
29049	S		Application of figure eight	0058	1.0931	$59.64		$11.93
29055	S		Application of shoulder cast	0058	1.0931	$59.64		$11.93
29058	S		Application of shoulder cast	0058	1.0931	$59.64		$11.93
29065	S		Application of long arm cast	0058	1.0931	$59.64		$11.93
29075	S		Application of forearm cast	0058	1.0931	$59.64		$11.93
29085	S		Apply hand/wrist cast	0058	1.0931	$59.64		$11.93
29086	S		Apply finger cast	0058	1.0931	$59.64		$11.93
29105	S		Apply long arm splint	0058	1.0931	$59.64		$11.93
29125	S		Apply forearm splint	0058	1.0931	$59.64		$11.93
29126	S		Apply forearm splint	0058	1.0931	$59.64		$11.93
29130	S		Application of finger splint	0058	1.0931	$59.64		$11.93
29131	S		Application of finger splint	0058	1.0931	$59.64		$11.93
29200	S		Strapping of chest	0058	1.0931	$59.64		$11.93
29220	S		Strapping of low back	0058	1.0931	$59.64		$11.93
29240	S		Strapping of shoulder	0058	1.0931	$59.64		$11.93
29260	S		Strapping of elbow or wrist	0058	1.0931	$59.64		$11.93
29280	S		Strapping of hand or finger	0058	1.0931	$59.64		$11.93
29305	S		Application of hip cast	0058	1.0931	$59.64		$11.93
29325	S		Application of hip casts	0058	1.0931	$59.64		$11.93
29345	S		Application of long leg cast	0058	1.0931	$59.64		$11.93
29355	S		Application of long leg cast	0058	1.0931	$59.64		$11.93
29358	S		Apply long leg cast brace	0058	1.0931	$59.64		$11.93
29365	S		Application of long leg cast	0058	1.0931	$59.64		$11.93
29405	S		Apply short leg cast	0058	1.0931	$59.64		$11.93
29425	S		Apply short leg cast	0058	1.0931	$59.64		$11.93
29435	S		Apply short leg cast	0058	1.0931	$59.64		$11.93
29440	S		Addition of walker to cast	0058	1.0931	$59.64		$11.93
29445	S		Apply rigid leg cast	0058	1.0931	$59.64		$11.93
29450	S		Application of leg cast	0058	1.0931	$59.64		$11.93
29505	S		Application, long leg splint	0058	1.0931	$59.64		$11.93
29515	S		Application lower leg splint	0058	1.0931	$59.64		$11.93
29520	S		Strapping of hip	0058	1.0931	$59.64		$11.93
29530	S		Strapping of knee	0058	1.0931	$59.64		$11.93
29540	S		Strapping of ankle	0058	1.0931	$59.64		$11.93
29550	S		Strapping of toes	0058	1.0931	$59.64		$11.93
29580	S		Application of paste boot	0058	1.0931	$59.64		$11.93
29590	S		Application of foot splint	0058	1.0931	$59.64		$11.93
29700	S		Removal/revision of cast	0058	1.0931	$59.64		$11.93
29705	S		Removal/revision of cast	0058	1.0931	$59.64		$11.93
29710	S		Removal/revision of cast	0058	1.0931	$59.64		$11.93
29715	S		Removal/revision of cast	0058	1.0931	$59.64		$11.93
29720	S		Repair of body cast	0058	1.0931	$59.64		$11.93
29730	S		Windowing of cast	0058	1.0931	$59.64		$11.93

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
29740	S		Wedging of cast	0058	1.0931	$59.64		$11.93
29750	S		Wedging of clubfoot cast	0058	1.0931	$59.64		$11.93
29799	S		Casting/strapping procedure	0058	1.0931	$59.64		$11.93
29800	T		Jaw arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29804	T		Jaw arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29805	T		Shoulder arthroscopy, dx	0041	27.3819	$1,493.98		$298.80
29806	T		Shoulder arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29807	T		Shoulder arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29819	T		Shoulder arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29820	T		Shoulder arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29821	T		Shoulder arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29822	T		Shoulder arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29823	T		Shoulder arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29824	T		Shoulder arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29825	T		Shoulder arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29826	T		Shoulder arthroscopy/surgery	0042	43.0808	$2,350.53	$804.74	$470.11
29827	T		Arthroscop rotator cuff repr	0041	27.3819	$1,493.98		$298.80
29830	T		Elbow arthroscopy	0041	27.3819	$1,493.98		$298.80
29834	T		Elbow arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29835	T		Elbow arthroscopy/surgery	0042	43.0808	$2,350.53	$804.74	$470.11
29836	T		Elbow arthroscopy/surgery	0042	43.0808	$2,350.53	$804.74	$470.11
29837	T		Elbow arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29838	T		Elbow arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29840	T		Wrist arthroscopy	0041	27.3819	$1,493.98		$298.80
29843	T		Wrist arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29844	T		Wrist arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29845	T		Wrist arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29846	T		Wrist arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29847	T		Wrist arthroscopy/surgery	0041	27.3819	$1.493.98		$298.80
29848	T		Wrist endoscopy/surgery	0041	27.3819	$1,493.98		$298.80
29850	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29851	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29855	T		Tibial arthroscopy/surgery	0042	43.0808	$2,350.53	$804.74	$470.11
29856	T		Tibial arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29860	T		Hip arthroscopy, dx	0041	27.3819	$1,493.98		$298.80
29861	T		Hip arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29862	T		Hip arthroscopy/surgery	0042	43.0808	$2,350.53	$804.74	$470.11
29863	T		Hip arthroscopy/surgery	0042	43.0808	$2,350.53	$804.74	$470.11
29870	T		Knee arthroscopy, dx	0041	27.3819	$1,493.98		$298.80
29871	T		Knee arthroscopy/drainage	0041	27.3819	$1,493.98		$298.80
29873	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29874	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29875	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29876	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29877	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29879	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29880	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29881	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29882	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29883	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29884	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29885	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29886	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29887	T		Knee arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29888	T		Knee arthroscopy/surgery	0042	43.0808	$2,350.53	$804.74	$470.11
29889	T		Knee arthroscopy/surgery	0042	43.0808	$2,350.53	$804.74	$470.11
29891	T		Ankle arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29892	T		Ankle arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29893	T		Scope, plantar fasciotomy	0055	18.7205	$1,021.41	$355.34	$204.28
29894	T		Ankle arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29895	T		Ankle arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29897	T		Ankle arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29898	T		Ankle arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29899	T		Ankle arthroscopy/surgery	0041	27.3819	$1,493.98		$298.80
29900	T		Mcp joint arthroscopy, dx	0053	14.8831	$812.04	$253.49	$162.41
29901	T		Mcp joint arthroscopy, surg	0053	14.8831	$812.04	$253.49	$162.41
29902	T		Mcp joint arthroscopy, surg	0053	14.8831	$812.04	$253.49	$162.41
29999	T		Arthroscopy of joint	0041	27.3819	$1,493.98		$298.80
30000	T		Drainage of nose lesion	0251	1.7880	$97.56		$19.51
30020	T		Drainage of nose lesion	0251	1.7880	$97.56		$19.51
30100	T		Intranasal biopsy	0252	6.4469	$351.75	$113.41	$70.35
30110	T		Removal of nose polyp(s)	0253	15.2249	$830.69	$282.29	$166.14
30115	T		Removal of nose polyp(s)	0253	15.2249	$830.69	$282.29	$166.14
30117	T		Removal of intranasal lesion	0253	15.2249	$830.69	$282.29	$166.14
30118	T		Removal of intranasal lesion	0254	21.8901	$1,194.35	$321.35	$238.87

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
30120	T		Revision of nose	0253	15.2249	$830.69	$282.29	$166.14
30124	T		Removal of nose lesion	0252	6.4469	$351.75	$113.41	$70.35
30125	T		Removal of nose lesion	0256	35.1548	$1,918.08		$383.62
30130	T		Removal of turbinate bones	0253	15.2249	$830.69	$282.29	$166.14
30140	T		Removal of turbinate bones	0254	21.8901	$1,194.35	$321.35	$238.87
30150	T		Partial removal of nose	0256	35.1548	$1,918.08		$383.62
30160	T		Removal of nose	0256	35.1548	$1,918.08		$383.62
30200	T		Injection treatment of nose	0253	15.2249	$830.69	$282.29	$166.14
30210	T		Nasal sinus therapy	0252	6.4469	$351.75	$113.41	$70.35
30220	T		Insert nasal septal button	0252	6.4469	$351.75	$113.41	$70.35
30300	X		Remove nasal foreign body	0340	0.6314	$34.45		$6.89
30310	T		Remove nasal foreign body	0253	15.2249	$830.69	$282.29	$166.14
30320	T		Remove nasal foreign body	0253	15.2249	$830.69	$282.29	$166.14
30400	T		Reconstruction of nose	0256	35.1548	$1,918.08		$383.62
30410	T		Reconstruction of nose	0256	35.1548	$1,918.08		$383.62
30420	T		Reconstruction of nose	0256	35.1548	$1,918.08		$383.62
30430	T		Revision of nose	0254	21.8901	$1,194.35	$321.35	$238.87
30435	T		Revision of nose	0256	35.1548	$1,918.08		$383.62
30450	T		Revision of nose	0256	35.1548	$1,918.08		$383.62
30460	T		Revision of nose	0256	35.1548	$1,918.08		$383.62
30462	T		Revision of nose	0256	35.1548	$1,918.08		$383.62
30465	T		Repair nasal stenosis	0256	35.1548	$1,918.08		$383.62
30520	T		Repair of nasal septum	0254	21.8901	$1,194.35	$321.35	$238.87
30540	T		Repair nasal defect	0256	35.1548	$1,918.08		$383.62
30545	T		Repair nasal defect	0256	35.1548	$1,918.08		$383.62
30560	T		Release of nasal adhesions	0251	1.7880	$97.56		$19.51
30580	T		Repair upper jaw fistula	0256	35.1548	$1,918.08		$383.62
30600	T		Repair mouth/nose fistula	0256	35.1548	$1,918.08		$383.62
30620	T		Intranasal reconstruction	0256	35.1548	$1,918.08		$383.62
30630	T		Repair nasal septum defect	0254	21.8901	$1,194.35	$321.35	$238.87
30801	T		Cauterization, inner nose	0252	6.4469	$351.75	$113.41	$70.35
30802	T		Cauterization, inner nose	0253	15.2249	$830.69	$282.29	$166.14
30901	T		Control of nosebleed	0250	1.4697	$80.19	$28.07	$16.04
30903	T		Control of nosebleed	0250	1.4697	$80.19	$28.07	$16.04
30905	T		Control of nosebleed	0250	1.4697	$80.19	$28.07	$16.04
30906	T		Repeat control of nosebleed	0250	1.4697	$80.19	$28.07	$16.04
30915	T		Ligation, nasal sinus artery	0091	28.8326	$1,573.14	$348.23	$314.63
30920	T		Ligation, upper jaw artery	0092	25.0959	$1,369.26	$505.37	$273.85
30930	T		Therapy, fracture of nose	0253	15.2249	$830.69	$282.29	$166.14
30999	T		Nasal surgery procedure	0251	1.7880	$97.56		$19.51
31000	T		Irrigation, maxillary sinus	0251	1.7880	$97.56		$19.51
31002	T		Irrigation, sphenoid sinus	0252	6.4469	$351.75	$113.41	$70.35
31020	T		Exploration, maxillary sinus	0254	21.8901	$1,194.35	$321.35	$238.87
31030	T		Exploration, maxillary sinus	0256	35.1548	$1,918.08		$383.62
31032	T		Explore sinus, remove polyps	0256	35.1548	$1,918.08		$383.62
31040	T		Exploration behind upper jaw	0254	21.8901	$1,194.35	$321.35	$238.87
31050	T		Exploration, sphenoid sinus	0256	35.1548	$1,918.08		$383.62
31051	T		Sphenoid sinus surgery	0256	35.1548	$1,918.08		$383.62
31070	T		Exploration of frontal sinus	0254	21.8901	$1,194.35	$321.35	$238.87
31075	T		Exploration of frontal sinus	0256	35.1548	$1,918.08		$383.62
31080	T		Removal of frontal sinus	0256	35.1548	$1,918.08		$383.62
31081	T		Removal of frontal sinus	0256	35.1548	$1,918.08		$383.62
31084	T		Removal of frontal sinus	0256	35.1548	$1,918.08		$383.62
31085	T		Removal of frontal sinus	0256	35.1548	$1,918.08		$383.62
31086	T		Removal of frontal sinus	0256	35.1548	$1,918.08		$383.62
31087	T		Removal of frontal sinus	0256	35.1548	$1,918.08		$383.62
31090	T		Exploration of sinuses	0256	35.1548	$1,918.08		$383.62
31200	T		Removal of ethmoid sinus	0256	35.1548	$1,918.08		$383.62
31201	T		Removal of ethmoid sinus	0256	35.1548	$1,918.08		$383.62
31205	T		Removal of ethmoid sinus	0256	35.1548	$1,918.08		$383.62
31225	C		Removal of upper jaw					
31230	C		Removal of upper jaw					
31231	T		Nasal endoscopy, dx	0071	0.8799	$48.01	$12.89	$9.60
31233	T		Nasal/sinus endoscopy, dx	0072	1.7613	$96.10	$26.68	$19.22
31235	T		Nasal/sinus endoscopy, dx	0074	13.9480	$761.02	$295.70	$152.20
31237	T		Nasal/sinus endoscopy, surg	0075	20.3815	$1,112.04	$445.92	$222.41
31238	T		Nasal/sinus endoscopy, surg	0074	13.9480	$761.02	$295.70	$152.20
31239	T		Nasal/sinus endoscopy, surg	0075	20.3815	$1,112.04	$445.92	$222.41
31240	T		Nasal/sinus endoscopy, surg	0074	13.9480	$761.02	$295.70	$152.20
31254	T		Revision of ethmoid sinus	0075	20.3815	$1,112.04	$445.92	$222.41
31255	T		Removal of ethmoid sinus	0075	20.3815	$1,112.04	$445.92	$222.41
31256	T		Exploration maxillary sinus	0075	20.3815	$1,112.04	$445.92	$222.41
31267	T		Endoscopy, maxillary sinus	0075	20.3815	$1,112.04	$445.92	$222.41
31276	T		Sinus endoscopy, surgical	0075	20.3815	$1,112.04	$445.92	$222.41
31287	T		Nasal/sinus endoscopy, surg	0075	20.3815	$1,112.04	$445.92	$222.41

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31288	T		Nasal/sinus endoscopy, surg	0075	20.3815	$1,112.04	$445.92	$222.41
31290	C		Nasal/sinus endoscopy, surg					
31291	C		Nasal/sinus endoscopy, surg					
31292	C		Nasal/sinus endoscopy, surg					
31293	C		Nasal/sinus endoscopy, surg					
31294	C		Nasal/sinus endoscopy, surg					
31299	T		Sinus surgery procedure	0252	6.4469	$351.75	$113.41	$70.35
31300	T		Removal of larynx lesion	0254	21.8901	$1,194.35	$321.35	$238.87
31320	T		Diagnostic incision, larynx	0256	35.1548	$1,918.08		$383.62
31360	C		Removal of larynx					
31365	C		Removal of larynx					
31367	C		Partial removal of larynx					
31368	C		Partial removal of larynx					
31370	C		Partial removal of larynx					
31375	C		Partial removal of larynx					
31380	C		Partial removal of larynx					
31382	C		Partial removal of larynx					
31390	C		Removal of larynx & pharynx					
31395	C		Reconstruct larynx & pharynx					
31400	T		Revision of larynx	0256	35.1548	$1,918.08		$383.62
31420	T		Removal of epiglottis	0256	35.1548	$1,918.08		$383.62
31500	S		Insert emergency airway	0094	2.6345	$143.74	$48.58	$28.75
31502	T		Change of windpipe airway	0121	2.1189	$115.61	$43.80	$23.12
31505	T		Diagnostic laryngoscopy	0071	0.8799	$48.01	$12.89	$9.60
31510	T		Laryngoscopy with biopsy	0074	13.9480	$761.02	$295.70	$152.20
31511	T		Remove foreign body, larynx	0072	1.7613	$96.10	$26.68	$19.22
31512	T		Removal of larynx lesion	0074	13.9480	$761.02	$295.70	$152.20
31513	T		Injection into vocal cord	0072	1.7613	$96.10	$26.68	$19.22
31515	T		Laryngoscopy for aspiration	0074	13.9480	$761.02	$295.70	$152.20
31520	T		Diagnostic laryngoscopy	0072	1.7613	$96.10	$26.68	$19.22
31525	T		Diagnostic laryngoscopy	0074	13.9480	$761.02	$295.70	$152.20
31526	T		Diagnostic laryngoscopy	0075	20.3815	$1,112.04	$445.92	$222.41
31527	T		Laryngoscopy for treatment	0075	20.3815	$1,112.04	$445.92	$222.41
31528	T		Laryngoscopy and dilation	0074	13.9480	$761.02	$295.70	$152.20
31529	T		Laryngoscopy and dilation	0074	13.9480	$761.02	$295.70	$152.20
31530	T		Operative laryngoscopy	0075	20.3815	$1,112.04	$445.92	$222.41
31531	T		Operative laryngoscopy	0075	20.3815	$1,112.04	$445.92	$222.41
31535	T		Operative laryngoscopy	0075	20.3815	$1,112.04	$445.92	$222.41
31536	T		Operative laryngoscopy	0075	20.3815	$1,112.04	$445.92	$222.41
31540	T		Operative laryngoscopy	0075	20.3815	$1,112.04	$445.92	$222.41
31541	T		Operative laryngoscopy	0075	20.3815	$1,112.04	$445.92	$222.41
31560	T		Operative laryngoscopy	0075	20.3815	$1,112.04	$445.92	$222.41
31561	T		Operative laryngoscopy	0075	20.3815	$1,112.04	$445.92	$222.41
31570	T		Laryngoscopy with injection	0074	13.9480	$761.02	$295.70	$152.20
31571	T		Laryngoscopy with injection	0075	20.3815	$1,112.04	$445.92	$222.41
31575	T		Diagnostic laryngoscopy	0072	1.7613	$96.10	$26.68	$19.22
31576	T		Laryngoscopy with biopsy	0075	20.3815	$1,112.04	$445.92	$222.41
31577	T		Remove foreign body, larynx	0073	3.4541	$188.46	$73.38	$37.69
31578	T		Removal of larynx lesion	0075	20.3815	$1,112.04	$445.92	$222.41
31579	T		Diagnostic laryngoscopy	0073	3.4541	$188.46	$73.38	$37.69
31580	T		Revision of larynx	0256	35.1548	$1,918.08		$383.62
31582	T		Revision of larynx	0256	35.1548	$1,918.08		$383.62
31584	C		Treat larynx fracture					
31585	T		Treat larynx fracture	0253	15.2249	$830.69	$282.29	$166.14
31586	T		Treat larynx fracture	0256	35.1548	$1,918.08		$383.62
31587	C		Revision of larynx					
31588	T		Revision of larynx	0256	35.1548	$1,918.08		$383.62
31590	T		Reinnervate larynx	0256	35.1548	$1,918.08		$383.62
31595	T		Larynx nerve surgery	0256	35.1548	$1,918.08		$383.62
31599	T		Larynx surgery procedure	0254	21.8901	$1,194.35	$321.35	$238.87
31600	T		Incision of windpipe	0254	21.8901	$1,194.35	$321.35	$238.87
31601	T		Incision of windpipe	0254	21.8901	$1,194.35	$321.35	$238.87
31603	T		Incision of windpipe	0252	6.4469	$351.75	$113.41	$70.35
31605	T		Incision of windpipe	0253	15.2249	$830.69	$282.29	$166.14
31610	T		Incision of windpipe	0254	21.8901	$1,194.35	$321.35	$238.87
31611	T		Surgery/speech prosthesis	0254	21.8901	$1,194.35	$321.35	$238.87
31612	T		Puncture/clear windpipe	0254	21.8901	$1,194.35	$321.35	$238.87
31613	T		Repair windpipe opening	0254	21.8901	$1,194.35	$321.35	$238.87
31614	T		Repair windpipe opening	0256	35.1548	$1,918.08		$383.62
31615	T		Visualization of windpipe	0076	9.2346	$503.85	$189.82	$100.77
31622	T		Dx bronchoscope/wash	0076	9.2346	$503.85	$189.82	$100.77
31623	T		Dx bronchoscope/brush	0076	9.2346	$503.85	$189.82	$100.77
31624	T		Dx bronchoscope/lavage	0076	9.2346	$503.85	$189.82	$100.77
31625	T		Bronchoscopy w/biopsy(s)	0076	9.2346	$503.85	$189.82	$100.77
31628	T		Bronchoscopy/lung bx, each	0076	9.2346	$503.85	$189.82	$100.77

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31629	T		Bronchoscopy/needle bx, each	0076	9.2346	$503.85	$189.82	$100.77
31630	T		Bronchoscopy dilate/fx repr	0415	20.7348	$1,131.31	$459.92	$226.26
31631	T		Bronchoscopy, dilate w/stent	0415	20.7348	$1,131.31	$459.92	$226.26
31632	T	NI	Bronchoscopy/lung bx, add'l	0076	9.2346	$503.85	$189.82	$100.77
31633	T	NI	Bronchoscopy/needle bx add'l	0076	9.2346	$503.85	$189.82	$100.77
31635	T		Bronchoscopy w/fb removal	0076	9.2346	$503.85	$189.82	$100.77
31640	T		Bronchoscopy w/tumor excise	0415	20.7348	$1,131.31	$459.92	$226.26
31641	T		Bronchoscopy, treat blockage	0415	20.7348	$1,131.31	$459.92	$226.26
31643	T		Diag bronchoscope/catheter	0076	9.2346	$503.85	$189.82	$100.77
31645	T		Bronchoscopy, clear airways	0076	9.2346	$503.85	$189.82	$100.77
31646	T		Bronchoscopy, reclear airway	0076	9.2346	$503.85	$189.82	$100.77
31656	T		Bronchoscopy, inj for x-ray	0076	9.2346	$503.85	$189.82	$100.77
31700	T		Insertion of airway catheter	0072	1.7613	$96.10	$26.68	$19.22
31708	N		Instill airway contrast dye					
31710	N		Insertion of airway catheter					
31715	N		Injection for bronchus x-ray					
31717	T		Bronchial brush biopsy	0073	3.4541	$188.46	$73.38	$37.69
31720	T		Clearance of airways	0071	0.8799	$48.01	$12.89	$9.60
31725	C		Clearance of airways					
31730	T		Intro, windpipe wire/tube	0073	3.4541	$188.46	$73.38	$37.69
31750	T		Repair of windpipe	0256	35.1548	$1,918.08		$383.62
31755	T		Repair of windpipe	0256	35.1548	$1,918.08		$383.62
31760	C		Repair of windpipe					
31766	C		Reconstruction of windpipe					
31770	C		Repair/graft of bronchus					
31775	C		Reconstruct bronchus					
31780	C		Reconstruct windpipe					
31781	C		Reconstruct windpipe					
31785	T		Remove windpipe lesion	0254	21.8901	$1,194.35	$321.35	$238.87
31786	C		Remove windpipe lesion					
31800	C		Repair of windpipe injury					
31805	C		Repair of windpipe injury					
31820	T		Closure of windpipe lesion	0253	15.2249	$830.69	$282.29	$166.14
31825	T		Repair of windpipe defect	0254	21.8901	$1,194.35	$321.35	$238.87
31830	T		Revise windpipe scar	0254	21.8901	$1,194.35	$321.35	$238.87
31899	T		Airways surgical procedure	0076	9.2346	$503.85	$189.82	$100.77
32000	T		Drainage of chest	0070	3.0717	$167.60		$33.52
32002	T		Treatment of collapsed lung	0070	3.0717	$167.60		$33.52
32005	T		Treat lung lining chemically	0070	3.0717	$167.60		$33.52
32020	T		Insertion of chest tube	0070	3.0717	$167.60		$33.52
32035	C		Exploration of chest					
32036	C		Exploration of chest					
32095	C		Biopsy through chest wall					
32100	C		Exploration/biopsy of chest					
32110	C		Explore/repair chest					
32120	C		Re-exploration of chest					
32124	C		Explore chest free adhesions					
32140	C		Removal of lung lesion(s)					
32141	C		Remove/treat lung lesions					
32150	C		Removal of lung lesion(s)					
32151	C		Remove lung foreign body					
32160	C		Open chest heart massage					
32200	C		Drain, open, lung lesion					
32201	T		Drain, percut, lung lesion	0070	3.0717	$167.60		$33.52
32215	C		Treat chest lining					
32220	C		Release of lung					
32225	C		Partial release of lung					
32310	C		Removal of chest lining					
32320	C		Free/remove chest lining					
32400	T		Needle biopsy chest lining	0005	3.2698	$178.40	$71.59	$35.68
32402	C		Open biopsy chest lining					
32405	T		Biopsy, lung or mediastinum	0685	4.8100	$262.44	$115.47	$52.49
32420	T		Puncture/clear lung	0070	3.0717	$167.60		$33.52
32440	C		Removal of lung					
32442	C		Sleeve pneumonectomy					
32445	C		Removal of lung					
32480	C		Partial removal of lung					
32482	C		Bilobectomy					
32484	C		Segmentectomy					
32486	C		Sleeve lobectomy					
32488	C		Completion pneumonectomy					
32491	C		Lung volume reduction					
32500	C		Partial removal of lung					
32501	C		Repair bronchus add-on					
32520	C		Remove lung & revise chest					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
32522	C		Remove lung & revise chest					
32525	C		Remove lung & revise chest					
32540	C		Removal of lung lesion					
32601	T		Thoracoscopy, diagnostic	0069	28.9392	$1,578.95	$591.64	$315.79
32602	T		Thoracoscopy, diagnostic	0069	28.9392	$1,578.95	$591.64	$315.79
32603	T		Thoracoscopy, diagnostic	0069	28.9392	$1,578.95	$591.64	$315.79
32604	T		Thoracoscopy, diagnostic	0069	28.9392	$1,578.95	$591.64	$315.79
32605	T		Thoracoscopy, diagnostic	0069	28.9392	$1,578.95	$591.64	$315.79
32606	T		Thoracoscopy, diagnostic	0069	28.9392	$1,578.95	$591.64	$315.79
32650	C		Thoracoscopy, surgical					
32651	C		Thoracoscopy, surgical					
32652	C		Thoracoscopy, surgical					
32653	C		Thoracoscopy, surgical					
32654	C		Thoracoscopy, surgical					
32655	C		Thoracoscopy, surgical					
32656	C		Thoracoscopy, surgical					
32657	C		Thoracoscopy, surgical					
32658	C		Thoracoscopy, surgical					
32659	C		Thoracoscopy, surgical					
32660	C		Thoracoscopy, surgical					
32661	C		Thoracoscopy, surgical					
32662	C		Thoracoscopy, surgical					
32663	C		Thoracoscopy, surgical					
32664	C		Thoracoscopy, surgical					
32665	C		Thoracoscopy, surgical					
32800	C		Repair lung hernia					
32810	C		Close chest after drainage					
32815	C		Close bronchial fistula					
32820	C		Reconstruct injured chest					
32850	C		Donor pneumonectomy					
32851	C		Lung transplant, single					
32852	C		Lung transplant with bypass					
32853	C		Lung transplant, double					
32854	C		Lung transplant with bypass					
32900	C		Removal of rib(s)					
32905	C		Revise & repair chest wall					
32906	C		Revise & repair chest wall					
32940	C		Revision of lung					
32960	T		Therapeutic pneumothorax	0070	3.0717	$167.60		$33.52
32997	C		Total lung lavage					
32999	T		Chest surgery procedure	0070	3.0717	$167.60		$33.52
33010	T		Drainage of heart sac	0070	3.0717	$167.60		$33.52
33011	T		Repeat drainage of heart sac	0070	3.0717	$167.60		$33.52
33015	C		Incision of heart sac					
33020	C		Incision of heart sac					
33025	C		Incision of heart sac					
33030	C		Partial removal of heart sac					
33031	C		Partial removal of heart sac					
33050	C		Removal of heart sac lesion					
33120	C		Removal of heart lesion					
33130	C		Removal of heart lesion					
33140	C		Heart revascularize (tmr)					
33141	C		Heart tmr w/other procedure					
33200	C		Insertion of heart pacemaker					
33201	C		Insertion of heart pacemaker					
33206	T		Insertion of heart pacemaker	0089	117.1896	$6,393.98	$1,722.59	$1,278.80
33207	T		Insertion of heart pacemaker	0089	117.1896	$6,393.98	$1,722.59	$1,278.80
33208	T		Insertion of heart pacemaker	0655	142.7039	$7,786.07		$1,557.21
33210	T		Insertion of heart electrode	0106	58.9719	$3,217.57		$643.51
33211	T		Insertion of heart electrode	0106	58.9719	$3,217.57		$643.51
33212	T		Insertion of pulse generator	0090	96.8284	$5,283.05	$1,651.45	$1,056.61
33213	T		Insertion of pulse generator	0654	112.6957	$6,148.79		$1,229.76
33214	T		Upgrade of pacemaker system	0655	142.7039	$7,786.07		$1,557.21
33215	T		Reposition pacing-defib lead	0105	19.1898	$1,047.01	$370.40	$209.40
33216	T		Revise eltrd pacing-defib	0106	58.9719	$3,217.57		$643.51
33217	T		Insert lead pace-defib, dual	0106	58.9719	$3,217.57		$643.51
33218	T		Repair lead pace-defib, one	0106	58.9719	$3,217.57		$643.51
33220	T		Repair lead pace-defib, dual	0106	58.9719	$3,217.57		$643.51
33222	T		Revise pocket, pacemaker	0027	15.8990	$867.47	$329.72	$173.49
33223	T		Revise pocket, pacing-defib	0027	15.8990	$867.47	$329.72	$173.49
33224	T		Insert pacing lead & connect	1547		$850.00		$170.00
33225	T		L ventric pacing lead add-on	1550		$1,150.00		$230.00
33226	T		Reposition l ventric lead	0105	19.1898	$1,047.01	$370.40	$209.40
33233	T		Removal of pacemaker system	0105	19.1898	$1,047.01	$370.40	$209.40
33234	T		Removal of pacemaker system	0105	19.1898	$1,047.01	$370.40	$209.40

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33235	T		Removal pacemaker electrode	0105	19.1898	$1,047.01	$370.40	$209.40
33236	C		Remove electrode/thoracotomy					
33237	C		Remove electrode/thoracotomy					
33238	C		Remove electrode/thoracotomy					
33240	B		Insert pulse generator					
33241	T		Remove pulse generator	0105	19.1898	$1,047.01	$370.40	$209.40
33243	C		Remove eltrd/thoracotomy					
33244	T		Remove eltrd, transven	0105	19.1898	$1,047.01	$370.40	$209.40
33245	C		Insert epic eltrd pace-defib					
33246	C		Insert epic eltrd/generator					
33249	B		Eltrd/insert pace-defib					
33250	C		Ablate heart dysrhythm focus					
33251	C		Ablate heart dysrhythm focus					
33253	C		Reconstruct atria					
33261	C		Ablate heart dysrhythm focus					
33282	S		Implant pat-active ht record	0680	62.8252	$3,427.81		$685.56
33284	T		Remove pat-active ht record	0109	7.4705	$407.60	$131.49	$81.52
33300	C		Repair of heart wound					
33305	C		Repair of heart wound					
33310	C		Exploratory heart surgery					
33315	C		Exploratory heart surgery					
33320	C		Repair major blood vessel(s)					
33321	C		Repair major vessel					
33322	C		Repair major blood vessel(s)					
33330	C		Insert major vessel graft					
33332	C		Insert major vessel graft					
33335	C		Insert major vessel graft					
33400	C		Repair of aortic valve					
33401	C		Valvuloplasty, open					
33403	C		Valvuloplasty, w/cp bypass					
33404	C		Prepare heart-aorta conduit					
33405	C		Replacement of aortic valve					
33406	C		Replacement of aortic valve					
33410	C		Replacement of aortic valve					
33411	C		Replacement of aortic valve					
33412	C		Replacement of aortic valve					
33413	C		Replacement of aortic valve					
33414	C		Repair of aortic valve					
33415	C		Revision, subvalvular tissue					
33416	C		Revise ventricle muscle					
33417	C		Repair of aortic valve					
33420	C		Revision of mitral valve					
33422	C		Revision of mitral valve					
33425	C		Repair of mitral valve					
33426	C		Repair of mitral valve					
33427	C		Repair of mitral valve					
33430	C		Replacement of mitral valve					
33460	C		Revision of tricuspid valve					
33463	C		Valvuloplasty, tricuspid					
33464	C		Valvuloplasty, tricuspid					
33465	C		Replace tricuspid valve					
33468	C		Revision of tricuspid valve					
33470	C		Revision of pulmonary valve					
33471	C		Valvotomy, pulmonary valve					
33472	C		Revision of pulmonary valve					
33474	C		Revision of pulmonary valve					
33475	C		Replacement, pulmonary valve					
33476	C		Revision of heart chamber					
33478	C		Revision of heart chamber					
33496	C		Repair, prosth valve clot					
33500	C		Repair heart vessel fistula					
33501	C		Repair heart vessel fistula					
33502	C		Coronary artery correction					
33503	C		Coronary artery graft					
33504	C		Coronary artery graft					
33505	C		Repair artery w/tunnel					
33506	C		Repair artery, translocation					
33508	N		Endoscopic vein harvest					
33510	C		CABG, vein, single					
33511	C		CABG, vein, two					
33512	C		CABG, vein, three					
33513	C		CABG, vein, four					
33514	C		CABG, vein, five					
33516	C		Cabg, vein, six or more					
33517	C		CABG, artery-vein, single					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33518	C		CABG, artery-vein, two					
33519	C		CABG, artery-vein, three					
33521	C		CABG, artery-vein, four					
33522	C		CABG, artery-vein, five					
33523	C		Cabg, art-vein, six or more					
33530	C		Coronary artery, bypass/reop					
33533	C		CABG, arterial, single					
33534	C		CABG, arterial, two					
33535	C		CABG, arterial, three					
33536	C		Cabg, arterial, four or more					
33542	C		Removal of heart lesion					
33545	C		Repair of heart damage					
33572	C		Open coronary endarterectomy					
33600	C		Closure of valve					
33602	C		Closure of valve					
33606	C		Anastomosis/artery-aorta					
33608	C		Repair anomaly w/conduit					
33610	C		Repair by enlargement					
33611	C		Repair double ventricle					
33612	C		Repair double ventricle					
33615	C		Repair, modified fontan					
33617	C		Repair single ventricle					
33619	C		Repair single ventricle					
33641	C		Repair heart septum defect					
33645	C		Revision of heart veins					
33647	C		Repair heart septum defects					
33660	C		Repair of heart defects					
33665	C		Repair of heart defects					
33670	C		Repair of heart chambers					
33681	C		Repair heart septum defect					
33684	C		Repair heart septum defect					
33688	C		Repair heart septum defect					
33690	C		Reinforce pulmonary artery					
33692	C		Repair of heart defects					
33694	C		Repair of heart defects					
33697	C		Repair of heart defects					
33702	C		Repair of heart defects					
33710	C		Repair of heart defects					
33720	C		Repair of heart defect					
33722	C		Repair of heart defect					
33730	C		Repair heart-vein defect(s)					
33732	C		Repair heart-vein defect					
33735	C		Revision of heart chamber					
33736	C		Revision of heart chamber					
33737	C		Revision of heart chamber					
33750	C		Major vessel shunt					
33755	C		Major vessel shunt					
33762	C		Major vessel shunt					
33764	C		Major vessel shunt & graft					
33766	C		Major vessel shunt					
33767	C		Major vessel shunt					
33770	C		Repair great vessels defect					
33771	C		Repair great vessels defect					
33774	C		Repair great vessels defect					
33775	C		Repair great vessels defect					
33776	C		Repair great vessels defect					
33777	C		Repair great vessels defect					
33778	C		Repair great vessels defect					
33779	C		Repair great vessels defect					
33780	C		Repair great vessels defect					
33781	C		Repair great vessels defect					
33786	C		Repair arterial trunk					
33788	C		Revision of pulmonary artery					
33800	C		Aortic suspension					
33802	C		Repair vessel defect					
33803	C		Repair vessel defect					
33813	C		Repair septal defect					
33814	C		Repair septal defect					
33820	C		Revise major vessel					
33822	C		Revise major vessel					
33824	C		Revise major vessel					
33840	C		Remove aorta constriction					
33845	C		Remove aorta constriction					
33851	C		Remove aorta constriction					
33852	C		Repair septal defect					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33853	C		Repair septal defect					
33860	C		Ascending aortic graft					
33861	C		Ascending aortic graft					
33863	C		Ascending aortic graft					
33870	C		Transverse aortic arch graft					
33875	C		Thoracic aortic graft					
33877	C		Thoracoabdominal graft					
33910	C		Remove lung artery emboli					
33915	C		Remove lung artery emboli					
33916	C		Surgery of great vessel					
33917	C		Repair pulmonary artery					
33918	C		Repair pulmonary atresia					
33919	C		Repair pulmonary atresia					
33920	C		Repair pulmonary atresia					
33922	C		Transect pulmonary artery					
33924	C		Remove pulmonary shunt					
33930	C		Removal of donor heart/lung					
33935	C		Transplantation, heart/lung					
33940	C		Removal of donor heart					
33945	C		Transplantation of heart					
33960	C		External circulation assist					
33961	C		External circulation assist					
33967	C		Insert ia percut device					
33968	C		Remove aortic assist device					
33970	C		Aortic circulation assist					
33971	C		Aortic circulation assist					
33973	C		Insert balloon device					
33974	C		Remove intra-aortic balloon					
33975	C		Implant ventricular device					
33976	C		Implant ventricular device					
33977	C		Remove ventricular device					
33978	C		Remove ventricular device					
33979	C		Insert intracorporeal device					
33980	C		Remove intracorporeal device					
33999	T		Cardiac surgery procedure	0070	3.0717	$167.60		$33.52
34001	C		Removal of artery clot					
34051	C		Removal of artery clot					
34101	T		Removal of artery clot	0088	34.6942	$1,892.95	$655.22	$378.59
34111	T		Removal of arm artery clot	0088	34.6942	$1,892.95	$655.22	$378.59
34151	C		Removal of artery clot					
34201	T		Removal of artery clot	0088	34.6942	$1,892.95	$655.22	$378.59
34203	T		Removal of leg artery clot	0088	34.6942	$1,892.95	$655.22	$378.59
34401	C		Removal of vein clot					
34421	T		Removal of vein clot	0088	34.6942	$1,892.95	$655.22	$378.59
34451	C		Removal of vein clot					
34471	T		Removal of vein clot	0088	34.6942	$1,892.95	$655.22	$378.59
34490	T		Removal of vein clot	0088	34.6942	$1,892.95	$655.22	$378.59
34501	T		Repair valve, femoral vein	0088	34.6942	$1,892.95	$655.22	$378.59
34502	C		Reconstruct vena cava					
34510	T		Transposition of vein valve	0088	34.6942	$1,892.95	$655.22	$378.59
34520	T		Cross-over vein graft	0088	34.6942	$1,892.95	$655.22	$378.59
34530	T		Leg vein fusion	0088	34.6942	$1,892.95	$655.22	$378.59
34800	C		Endovasc abdo repair w/tube					
34802	C		Endovasc abdo repr w/device					
34804	C		Endovasc abdo repr w/device					
34805	C	NI	Endovasc abdo repair w/pros					
34808	C		Endovasc abdo occlud device					
34812	C		Xpose for endoprosth, aortic					
34813	C		Femoral endovas graft add-on					
34820	C		Xpose for endoprosth, iliac					
34825	C		Endovasc extend prosth, init					
34826	C		Endovasc exten prosth, add'l					
34830	C		Open aortic tube prosth repr					
34831	C		Open aortoiliac prosth repr					
34832	C		Open aortofemor prosth repr					
34833	C		Xpose for endoprosth, iliac					
34834	C		Xpose, endoprosth, brachial					
34900	C		Endovasc iliac repr w/graft					
35001	C		Repair defect of artery					
35002	C		Repair artery rupture, neck					
35005	C		Repair defect of artery					
35011	T		Repair defect of artery	0653	30.0334	$1,638.65		$327.73
35013	C		Repair artery rupture, arm					
35021	C		Repair defect of artery					
35022	C		Repair artery rupture, chest					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35045	C		Repair defect of arm artery					
35081	C		Repair defect of artery					
35082	C		Repair artery rupture, aorta					
35091	C		Repair defect of artery					
35092	C		Repair artery rupture, aorta					
35102	C		Repair defect of artery					
35103	C		Repair artery rupture, groin					
35111	C		Repair defect of artery					
35112	C		Repair artery rupture,spleen					
35121	C		Repair defect of artery					
35122	C		Repair artery rupture, belly					
35131	C		Repair defect of artery					
35132	C		Repair artery rupture, groin					
35141	C		Repair defect of artery					
35142	C		Repair artery rupture, thigh					
35151	C		Repair defect of artery					
35152	C		Repair artery rupture, knee					
35161	C		Repair defect of artery					
35162	C		Repair artery rupture					
35180	T		Repair blood vessel lesion	0093	21.3104	$1,162.72	$277.34	$232.54
35182	C		Repair blood vessel lesion					
35184	T		Repair blood vessel lesion	0093	21.3104	$1,162.72	$277.34	$232.54
35188	T		Repair blood vessel lesion	0088	34.6942	$1,892.95	$655.22	$378.59
35189	C		Repair blood vessel lesion					
35190	T		Repair blood vessel lesion	0093	21.3104	$1,162.72	$277.34	$232.54
35201	T		Repair blood vessel lesion	0093	21.3104	$1,162.72	$277.34	$232.54
35206	T		Repair blood vessel lesion	0093	21.3104	$1,162.72	$277.34	$232.54
35207	T		Repair blood vessel lesion	0088	34.6942	$1,892.95	$655.22	$378.59
35211	C		Repair blood vessel lesion					
35216	C		Repair blood vessel lesion					
35221	C		Repair blood vessel lesion					
35226	T		Repair blood vessel lesion	0093	21.3104	$1,162.72	$277.34	$232.54
35231	T		Repair blood vessel lesion	0093	21.3104	$1,162.72	$277.34	$232.54
35236	T		Repair blood vessel lesion	0093	21.3104	$1,162.72	$277.34	$232.54
35241	C		Repair blood vessel lesion					
35246	C		Repair blood vessel lesion					
35251	C		Repair blood vessel lesion					
35256	T		Repair blood vessel lesion	0093	21.3104	$1,162.72	$277.34	$232.54
35261	T		Repair blood vessel lesion	0653	30.0334	$1,638.65		$327.73
35266	T		Repair blood vessel lesion	0653	30.0334	$1,638.65		$327.73
35271	C		Repair blood vessel lesion					
35276	C		Repair blood vessel lesion					
35281	C		Repair blood vessel lesion					
35286	T		Repair blood vessel lesion	0653	30.0334	$1,638.65		$327.73
35301	C		Rechanneling of artery					
35311	C		Rechanneling of artery					
35321	T		Rechanneling of artery	0093	21.3104	$1,162.72	$277.34	$232.54
35331	C		Rechanneling of artery					
35341	C		Rechanneling of artery					
35351	C		Rechanneling of artery					
35355	C		Rechanneling of artery					
35361	C		Rechanneling of artery					
35363	C		Rechanneling of artery					
35371	C		Rechanneling of artery					
35372	C		Rechanneling of artery					
35381	C		Rechanneling of artery					
35390	C		Reoperation, carotid add-on					
35400	C		Angioscopy					
35450	C		Repair arterial blockage					
35452	C		Repair arterial blockage					
35454	C		Repair arterial blockage					
35456	C		Repair arterial blockage					
35458	T		Repair arterial blockage	0081	35.0285	$1,911.19		$382.24
35459	T		Repair arterial blockage	0081	35.0285	$1,911.19		$382.24
35460	T		Repair venous blockage	0081	35.0285	$1,911.19		$382.24
35470	T		Repair arterial blockage	0081	35.0285	$1,911.19		$382.24
35471	T		Repair arterial blockage	0081	35.0285	$1,911.19		$382.24
35472	T		Repair arterial blockage	0081	35.0285	$1,911.19		$382.24
35473	T		Repair arterial blockage	0081	35.0285	$1,911.19		$382.24
35474	T		Repair arterial blockage	0081	35.0285	$1,911.19		$382.24
35475	T		Repair arterial blockage	0081	35.0285	$1,911.19		$382.24
35476	T		Repair venous blockage	0081	35.0285	$1,911.19		$382.24
35480	C		Atherectomy, open					
35481	C		Atherectomy, open					
35482	C		Atherectomy, open					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35483	C		Atherectomy, open					
35484	T		Atherectomy, open	0081	35.0285	$1,911.19		$382.24
35485	T		Atherectomy, open	0081	35.0285	$1,911.19		$382.24
35490	T		Atherectomy, percutaneous	0081	35.0285	$1,911.19		$382.24
35491	T		Atherectomy, percutaneous	0081	35.0285	$1,911.19		$382.24
35492	T		Atherectomy, percutaneous	0081	35.0285	$1,911.19		$382.24
35493	T		Atherectomy, percutaneous	0081	35.0285	$1,911.19		$382.24
35494	T		Atherectomy, percutaneous	0081	35.0285	$1,911.19		$382.24
35495	T		Atherectomy, percutaneous	0081	35.0285	$1,911.19		$382.24
35500	T		Harvest vein for bypass	0081	35.0285	$1,911.19		$382.24
35501	C		Artery bypass graft					
35506	C		Artery bypass graft					
35507	C		Artery bypass graft					
35508	C		Artery bypass graft					
35509	C		Artery bypass graft					
35510	C	NI	Artery bypass graft					
35511	C		Artery bypass graft					
35512	C	NI	Artery bypass graft					
35515	C		Artery bypass graft					
35516	C		Artery bypass graft					
35518	C		Artery bypass graft					
35521	C		Artery bypass graft					
35522	C	NI	Artery bypass graft					
35525	C	NI	Artery bypass graft					
35526	C		Artery bypass graft					
35531	C		Artery bypass graft					
35533	C		Artery bypass graft					
35536	C		Artery bypass graft					
35541	C		Artery bypass graft					
35546	C		Artery bypass graft					
35548	C		Artery bypass graft					
35549	C		Artery bypass graft					
35551	C		Artery bypass graft					
35556	C		Artery bypass graft					
35558	C		Artery bypass graft					
35560	C		Artery bypass graft					
35563	C		Artery bypass graft					
35565	C		Artery bypass graft					
35566	C		Artery bypass graft					
35571	C		Artery bypass graft					
35572	N		Harvest femoropopliteal vein					
35582	C		Vein bypass graft					
35583	C		Vein bypass graft					
35585	C		Vein bypass graft					
35587	C		Vein bypass graft					
35600	C		Harvest artery for cabg					
35601	C		Artery bypass graft					
35606	C		Artery bypass graft					
35612	C		Artery bypass graft					
35616	C		Artery bypass graft					
35621	C		Artery bypass graft					
35623	C		Bypass graft, not vein					
35626	C		Artery bypass graft					
35631	C		Artery bypass graft					
35636	C		Artery bypass graft					
35641	C		Artery bypass graft					
35642	C		Artery bypass graft					
35645	C		Artery bypass graft					
35646	C		Artery bypass graft					
35647	C		Artery bypass graft					
35650	C		Artery bypass graft					
35651	C		Artery bypass graft					
35654	C		Artery bypass graft					
35656	C		Artery bypass graft					
35661	C		Artery bypass graft					
35663	C		Artery bypass graft					
35665	C		Artery bypass graft					
35666	C		Artery bypass graft					
35671	C		Artery bypass graft					
35681	C		Composite bypass graft					
35682	C		Composite bypass graft					
35683	C		Composite bypass graft					
35685	T		Bypass graft patency/patch	0093	21.3104	$1,162.72	$277.34	$232.54
35686	T		Bypass graft/av fist patency	0093	21.3104	$1,162.72	$277.34	$232.54
35691	C		Arterial transposition					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35693	C		Arterial transposition					
35694	C		Arterial transposition					
35695	C		Arterial transposition					
35697	C	NI	Reimplant artery each					
35700	C		Reoperation, bypass graft					
35701	C		Exploration, carotid artery					
35721	C		Exploration, femoral artery					
35741	C		Exploration popliteal artery					
35761	T		Exploration of artery/vein	0115	25.6437	$1,399.15	$459.35	$279.83
35800	C		Explore neck vessels					
35820	C		Explore chest vessels					
35840	C		Explore abdominal vessels					
35860	T		Explore limb vessels	0093	21.3104	$1,162.72	$277.34	$232.54
35870	C		Repair vessel graft defect					
35875	T		Removal of clot in graft	0088	34.6942	$1,892.95	$655.22	$378.59
35876	T		Removal of clot in graft	0088	34.6942	$1,892.95	$655.22	$378.59
35879	T		Revise graft w/vein	0088	34.6942	$1,892.95	$655.22	$378.59
35881	T		Revise graft w/vein	0088	34.6942	$1,892.95	$655.22	$378.59
35901	C		Excision, graft, neck					
35903	T		Excision, graft, extremity	0115	25.6437	$1,399.15	$459.35	$279.83
35905	C		Excision, graft, thorax					
35907	C		Excision, graft, abdomen					
36000	N		Place needle in vein					
36002	S		Pseudoaneurysm injection trt	0267	2.4586	$134.14	$65.52	$26.83
36005	N		Injection ext venography					
36010	N		Place catheter in vein					
36011	N		Place catheter in vein					
36012	N		Place catheter in vein					
36013	N		Place catheter in artery					
36014	N		Place catheter in artery					
36015	N		Place catheter in artery					
36100	N		Establish access to artery					
36120	N		Establish access to artery					
36140	N		Establish access to artery					
36145	N		Artery to vein shunt					
36160	N		Establish access to aorta					
36200	N		Place catheter in aorta					
36215	N		Place catheter in artery					
36216	N		Place catheter in artery					
36217	N		Place catheter in artery					
36218	N		Place catheter in artery					
36245	N		Place catheter in artery					
36246	N		Place catheter in artery					
36247	N		Place catheter in artery					
36248	N		Place catheter in artery					
36260	T		Insertion of infusion pump	0119	134.7194	$7,350.43		$1,470.09
36261	T		Revision of infusion pump	0124	23.8050	$1,298.82		$259.76
36262	T		Removal of infusion pump	0124	23.8050	$1,298.82		$259.76
36299	N		Vessel injection procedure					
36400	N		Bl draw < 3 yrs fem/jugular					
36405	N		Bl draw < 3 yrs scalp vein					
36406	N		Bl draw < 3 yrs other vein					
36410	N		Non-routine bl draw > 3 yrs					
36415	E		Drawing blood					
36416	E		Capillary blood draw					
36420	T		Vein access cutdown < 1 yr	0035	0.1691	$9.23	$2.79	$1.85
36425	T		Vein access cutdown > 1 yr	0035	0.1691	$9.23	$2.79	$1.85
36430	S		Blood transfusion service	0110	3.6718	$200.34		$40.07
36440	S		Bl push transfuse, 2 yr or <	0110	3.6718	$200.34		$40.07
36450	S		Bl exchange/transfuse, nb	0110	3.6718	$200.34		$40.07
36455	S		Bl exchange/transfuse non-nb	0110	3.6718	$200.34		$40.07
36460	S		Transfusion service, fetal	0110	3.6718	$200.34		$40.07
36468	T		Injection(s), spider veins	0098	1.0729	$58.54	$14.06	$11.71
36469	T		Injection(s), spider veins	0098	1.0729	$58.54	$14.06	$11.71
36470	T		Injection therapy of vein	0098	1.0729	$58.54	$14.06	$11.71
36471	T		Injection therapy of veins	0098	1.0729	$58.54	$14.06	$11.71
36481	N		Insertion of catheter, vein					
36488	T	DG	Insertion of catheter, vein	0032	11.4907	$626.94		$125.39
36489	T	DG	Insertion of catheter, vein	0032	11.4907	$626.94		$125.39
36490	T	DG	Insertion of catheter, vein	0032	11.4907	$626.94		$125.39
36491	T	DG	Insertion of catheter, vein	0032	11.4907	$626.94		$125.39
36493	X	DG	Repositioning of cvc	0187	4.4288	$241.64	$90.71	$48.33
36500	N		Insertion of catheter, vein					
36510	C		Insertion of catheter, vein					
36511	S		Apheresis wbc	0111	13.1719	$718.67	$200.18	$143.73

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
36512	S		Apheresis rbc	0111	13.1719	$718.67	$200.18	$143.73
36513	S		Apheresis platelets	0111	13.1719	$718.67	$200.18	$143.73
36514	S		Apheresis plasma	0111	13.1719	$718.67	$200.18	$143.73
36515	S		Apheresis, adsorp/reinfuse	0112	37.5832	$2,050.58	$612.47	$410.12
36516	S		Apheresis, selective	0112	37.5832	$2,050.58	$612.47	$410.12
36522	S		Photopheresis	0112	37.5832	$2,050.58	$612.47	$410.12
36530	T	DG	Insertion of infusion pump	0119	134.7194	$7,350.43		$1,470.09
36531	T	DG	Revision of infusion pump	0124	23.8050	$1,298.82		$259.76
36532	T	DG	Removal of infusion pump	0109	7.4705	$407.60	$131.49	$81.52
36533	T	DG	Insertion of access device	0115	25.6437	$1,399.15	$459.35	$279.83
36534	T	DG	Revision of access device	0109	7.4705	$407.60	$131.49	$81.52
36535	T	DG	Removal of access device	0109	7.4705	$407.60	$131.49	$81.52
36536	T	DG	Remove cva device obstruct	1541		$250.00		$50.00
36537	T	DG	Remove cva lumen obstruct	1541		$250.00		$50.00
36540	N		Collect blood venous device					
36550	T		Declot vascular device	0677	2.1805	$118.97		$23.79
36555	T	NI	Insert non-tunnel cv cath	0032	11.4907	$626.94		$125.39
36556	T	NI	Insert non-tunnel cv cath	0032	11.4907	$626.94		$125.39
36557	T	NI	insert tunneled cv cath	0032	11.4907	$626.94		$125.39
36558	T	NI	Insert tunneled cv cath	0032	11.4907	$626.94		$125.39
36560	T	NI	Insert tunneled cv cath	0115	25.6437	$1,399.15	$459.35	$279.83
36561	T	NI	Insert tunneled cv cath	0115	25.6437	$1,399.15	$459.35	$279.83
36563	T	NI	Insert tunneled cv cath	0115	25.6437	$1,399.15	$459.35	$279.83
36565	T	NI	Insert tunneled cv cath	0115	25.6437	$1,399.15	$459.35	$279.83
36566	T	NI	Insert tunneled cv cath	1564		$4,750.00		$950.00
36568	T	NI	Insert tunneled cv cath	0032	11.4907	$626.94		$125.39
36569	T	NI	Insert tunneled cv cath	0032	11.4907	$626.94		$125.39
36570	T	NI	Insert tunneled cv cath	0032	11.4907	$626.94		$125.39
36571	T	NI	Insert tunneled cv cath	0032	11.4907	$626.94		$125.39
36575	X	NI	Repair tunneled cv cath	0187	4.4288	$241.64	$90.71	$48.33
36576	X	NI	Repair tunneled cv cath	0187	4.4288	$241.64	$90.71	$48.33
36578	X	NI	Replace tunneled cv cath	0187	4.4288	$241.64	$90.71	$48.33
36580	T	NI	Replace tunneled cv cath	0032	11.4907	$626.94		$125.39
36581	T	NI	Replace tunneled cv cath	0032	11.4907	$626.94		$125.39
36582	T	NI	Replace tunneled cv cath	0115	25.6437	$1,399.15	$459.35	$279.83
36583	T	NI	Replace tunneled cv cath	0115	25.6437	$1,399.15	$459.35	$279.83
36584	T	NI	Replace tunneled cv cath	0032	11.4907	$626.94		$125.39
36585	T	NI	Replace tunneled cv cath	0032	11.4907	$626.94		$125.39
36589	X	NI	Removal tunneled cv cath	0187	4.4288	$241.64	$90.71	$48.33
36590	T	NI	Removal tunneled cv cath	0109	7.4705	$407.60	$131.49	$81.52
36595	T	NI	Mech remov tunneled cv cath	1541		$250.00		$50.00
36596	T	NI	Mech remov tunneled cv cath	1541		$250.00		$50.00
36597	X	NI	Reposition venous catheter	0187	4.4288	$241.64	$90.71	$48.33
36600	N		Withdrawal of arterial blood					
36620	N		Insertion catheter, artery					
36625	N		Insertion catheter, artery					
36640	T		Insertion catheter, artery	0032	11.4907	$626.94		$125.39
36660	C		Insertion catheter, artery					
36680	T		Insert needle, bone cavity	0120	1.9114	$104.29	$28.21	$20.86
36800	T		Insertion of cannula	0115	25.6437	$1,399.15	$459.35	$279.83
36810	T		Insertion of cannula	0115	25.6437	$1,399.15	$459.35	$279.83
36815	T		Insertion of cannula	0115	25.6437	$1,399.15	$459.35	$279.83
36819	T		Av fusion/uppr arm vein	0088	34.6942	$1,892.95	$655.22	$378.59
36820	T		Av fusion/forearm vein	0088	34.6942	$1,892.95	$655.22	$378.59
36821	T		Av fusion direct any site	0088	34.6942	$1,892.95	$655.22	$378.59
36822	C		Insertion of cannula(s)					
36823	C		Insertion of cannula(s)					
36825	T		Artery-vein autograft	0088	34.6942	$1,892.95	$655.22	$378.59
36830	T		Artery-vein graft	0088	34.6942	$1,892.95	$655.22	$378.59
36831	T		Open thrombect av fistula	0088	34.6942	$1,892.95	$655.22	$378.59
36832	T		Av fistula revision, open	0088	34.6942	$1,892.95	$655.22	$378.59
36833	T		Av fistula revision	0088	34.6942	$1,892.95	$655.22	$378.59
36834	T		Repair A-V aneurysm	0088	34.6942	$1,892.95	$655.22	$378.59
36835	T		Artery to vein shunt	0115	25.6437	$1,399.15	$459.35	$279.83
36838	T	NI	Dist revas ligation, hemo	0088	34.6942	$1,892.95	$655.22	$378.59
36860	T		External cannula declotting	0103	11.6202	$634.01	$223.63	$126.80
36861	T		Cannula declotting	0115	25.6437	$1,399.15	$459.35	$279.83
36870	T		Percut thrombect av fistula	0653	30.0334	$1,638.65		$327.73
37140	C		Revision of circulation					
37145	C		Revision of circulation					
37160	C		Revision of circulation					
37180	C		Revision of circulation					
37181	C		Splice spleen/kidney veins					
37182	C		Insert hepatic shunt (tips)					
37183	C		Remove hepatic shunt (tips)					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
37195	C		Thrombolytic therapy, stroke					
37200	T		Transcatheter biopsy	0685	4.8100	$262.44	$115.47	$52.49
37201	T		Transcatheter therapy infuse	0676	2.7315	$149.03	$40.30	$29.81
37202	T		Transcatheter therapy infuse	0677	2.1805	$118.97		$23.79
37203	T		Transcatheter retrieval	0103	11.6202	$634.01	$223.63	$126.80
37204	T		Transcatheter occlusion	0115	25.6437	$1,399.15	$459.35	$279.83
37205	T		Transcatheter stent	0229	61.9895	$3,382.21	$771.23	$676.44
37206	T		Transcatheter stent add-on	0229	61.9895	$3,382.21	$771.23	$676.44
37207	T		Transcatheter stent	0229	61.9895	$3,382.21	$771.23	$676.44
37208	T		Transcatheter stent add-on	0229	61.9895	$3,382.21	$771.23	$676.44
37209	T		Exchange arterial catheter	0103	11.6202	$634.01	$223.63	$126.80
37250	S		Iv us first vessel add-on	0670	27.4483	$1,497.61	$542.37	$299.52
37251	S		Iv us each add vessel add-on	0670	27.4483	$1,497.61	$542.37	$299.52
37500	T		Endoscopy ligate perf veins	0092	25.0959	$1,369.26	$505.37	$273.85
37501	T		Vascular endoscopy procedure	0092	25.0959	$1,369.26	$505.37	$273.85
37565	T		Ligation of neck vein	0093	21.3104	$1,162.72	$277.34	$232.54
37600	T		Ligation of neck artery	0093	21.3104	$1,162.72	$277.34	$232.54
37605	T		Ligation of neck artery	0091	28.8326	$1,573.14	$348.23	$314.63
37606	T		Ligation of neck artery	0091	28.8326	$1,573.14	$348.23	$314.63
37607	T		Ligation of a-v fistula	0092	25.0959	$1,369.26	$505.37	$273.85
37609	T		Temporal artery procedure	0021	14.3594	$783.46	$219.48	$156.69
37615	T		Ligation of neck artery	0091	28.8326	$1,573.14	$348.23	$314.63
37616	C		Ligation of chest artery					
37617	C		Ligation of abdomen artery					
37618	C		Ligation of extremity artery					
37620	T		Revision of major vein	0091	28.8326	$1,573.14	$348.23	$314.63
37650	T		Revision of major vein	0091	28.8326	$1,573.14	$348.23	$314.63
37660	C		Revision of major vein					
37700	T		Revise leg vein	0091	28.8326	$1,573.14	$348.23	$314.63
37720	T		Removal of leg vein	0092	25.0959	$1,369.26	$505.37	$273.85
37730	T		Removal of leg veins	0092	25.0959	$1,369.26	$505.37	$273.85
37735	T		Removal of leg veins/lesion	0092	25.0959	$1,369.26	$505.37	$273.85
37760	T		Revision of leg veins	0091	28.8326	$1,573.14	$348.23	$314.63
37765	T	NI	Phleb veins - extrem - to 20	0091	28.8326	$1,573.14	$348.23	$314.63
37766	T	NI	Phleb veins - extrem 20+	0091	28.8326	$1,573.14	$348.23	$314.63
37780	T		Revision of leg vein	0091	28.8326	$1,573.14	$348.23	$314.63
37785	T		Ligate/divide/excise vein	0091	28.8326	$1,573.14	$348.23	$314.63
37788	C		Revascularization, penis					
37790	T		Penile venous occlusion	0181	29.4217	$1,605.28	$621.82	$321.06
37799	T		Vascular surgery procedure	0035	0.1691	$9.23	$2.79	$1.85
38100	C		Removal of spleen, total					
38101	C		Removal of spleen, partial					
38102	C		Removal of spleen, total					
38115	C		Repair of ruptured spleen					
38120	T		Laparoscopy, splenectomy	0131	40.8064	$2,226.44	$1,001.89	$445.29
38129	T		Laparoscope proc, spleen	0130	32.7724	$1,788.09	$659.53	$357.62
38200	N		Injection for spleen x-ray					
38204	E		Bl donor search management					
38205	S		Harvest allogenic stem cells	0111	13.1719	$718.67	$200.18	$143.73
38206	S		Harvest auto stem cells	0111	13.1719	$718.67	$200.18	$143.73
38207	E		Cryopreserve stem cells					
38208	E		Thaw preserved stem cells					
38209	E		Wash harvest stem cells					
38210	E		T-cell depletion of harvest					
38211	E		Tumor cell deplete of harvst					
38212	E		Rbc depletion of harvest					
38213	E		Platelet deplete of harvest					
38214	E		Volume deplete of harvest					
38215	E		Harvest stem cell concentrte					
38220	T		Bone marrow aspiration	0003	2.3229	$126.74		$25.35
38221	T		Bone marrow biopsy	0003	2.3229	$126.74		$25.35
38230	S		Bone marrow collection	0123	5.2882	$288.53		$57.71
38240	S		Bone marrow/stem transplant	0123	5.2882	$288.53		$57.71
38241	S		Bone marrow/stem transplant	0123	5.2882	$288.53		$57.71
38242	S		Lymphocyte infuse transplant	0111	13.1719	$718.67	$200.18	$143.73
38300	T		Drainage, lymph node lesion	0008	19.4831	$1,063.02		$212.60
38305	T		Drainage, lymph node lesion	0008	19.4831	$1,063.02		$212.60
38308	T		Incision of lymph channels	0113	19.9322	$1,087.52		$217.50
38380	C		Thoracic duct procedure					
38381	C		Thoracic duct procedure					
38382	C		Thoracic duct procedure					
38500	T		Biopsy/removal, lymph nodes	0113	19.9322	$1,087.52		$217.50
38505	T		Needle biopsy, lymph nodes	0005	3.2698	$178.40	$71.59	$35.68
38510	T		Biopsy/removal, lymph nodes	0113	19.9322	$1,087.52		$217.50
38520	T		Biopsy/removal, lymph nodes	0113	19.9322	$1,087.52		$217.50

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
38525	T		Biopsy/removal, lymph nodes	0113	19.9322	$1,087.52		$217.50
38530	T		Biopsy/removal, lymph nodes	0113	19.9322	$1,087.52		$217.50
38542	T		Explore deep node(s), neck	0114	37.5963	$2,051.29	$485.91	$410.26
38550	T		Removal, neck/armpit lesion	0113	19.9322	$1,087.52		$217.50
38555	T		Removal, neck/armpit lesion	0113	19.9322	$1,087.52		$217.50
38562	C		Removal, pelvic lymph nodes					
38564	C		Removal, abdomen lymph nodes					
38570	T		Laparoscopy, lymph node biop	0131	40.8064	$2,226.44	$1,001.89	$445.29
38571	T		Laparoscopy, lymphadenectomy	0132	57.2045	$3,121.13	$1,239.22	$624.23
38572	T		Laparoscopy, lymphadenectomy	0131	40.8064	$2,226.44	$1,001.89	$445.29
38589	T		Laparoscope proc, lymphatic	0130	32.7724	$1,788.09	$659.53	$357.62
38700	T		Removal of lymph nodes, neck	0113	19.9322	$1,087.52		$217.50
38720	T		Removal of lymph nodes, neck	0113	19.9322	$1,087.52		$217.50
38724	C		Removal of lymph nodes, neck					
38740	T		Remove armpit lymph nodes	0114	37.5963	$2,051.29	$485.91	$410.26
38745	T		Remove armpit lymph nodes	0114	37.5963	$2,051.29	$485.91	$410.26
38746	C		Remove thoracic lymph nodes					
38747	C		Remove abdominal lymph nodes					
38760	T		Remove groin lymph nodes	0113	19.9322	$1,087.52		$217.50
38765	C		Remove groin lymph nodes					
38770	C		Remove pelvis lymph nodes					
38780	C		Remove abdomen lymph nodes					
38790	N		Inject for lymphatic x-ray					
38792	N		Identify sentinel node					
38794	N		Access thoracic lymph duct					
38999	S		Blood/lymph system procedure	0110	3.6718	$200.34		$40.07
39000	C		Exploration of chest					
39010	C		Exploration of chest					
39200	C		Removal chest lesion					
39220	C		Removal chest lesion					
39400	T		Visualization of chest	0069	28.9392	$1,578.95	$591.64	$315.79
39499	C		Chest procedure					
39501	C		Repair diaphragm laceration					
39502	C		Repair paraesophageal hernia					
39503	C		Repair of diaphragm hernia					
39520	C		Repair of diaphragm hernia					
39530	C		Repair of diaphragm hernia					
39531	C		Repair of diaphragm hernia					
39540	C		Repair of diaphragm hernia					
39541	C		Repair of diaphragm hernia					
39545	C		Revision of diaphragm					
39560	C		Resect diaphragm, simple					
39561	C		Resect diaphragm, complex					
39599	C		Diaphragm surgery procedure					
40490	T		Biopsy of lip	0251	1.7880	$97.56		$19.51
40500	T		Partial excision of lip	0253	15.2249	$830.69	$282.29	$166.14
40510	T		Partial excision of lip	0254	21.8901	$1,194.35	$321.35	$238.87
40520	T		Partial excision of lip	0253	15.2249	$830.69	$282.29	$166.14
40525	T		Reconstruct lip with flap	0254	21.8901	$1,194.35	$321.35	$238.87
40527	T		Reconstruct lip with flap	0254	21.8901	$1,194.35	$321.35	$238.87
40530	T		Partial removal of lip	0254	21.8901	$1,194.35	$321.35	$238.87
40650	T		Repair lip	0252	6.4469	$351.75	$113.41	$70.35
40652	T		Repair lip	0252	6.4469	$351.75	$113.41	$70.35
40654	T		Repair lip	0252	6.4469	$351.75	$113.41	$70.35
40700	T		Repair cleft lip/nasal	0256	35.1548	$1,918.08		$383.62
40701	T		Repair cleft lip/nasal	0256	35.1548	$1,918.08		$383.62
40702	T		Repair cleft lip/nasal	0256	35.1548	$1,918.08		$383.62
40720	T		Repair cleft lip/nasal	0256	35.1548	$1,918.08		$383.62
40761	T		Repair cleft lip/nasal	0256	35.1548	$1,918.08		$383.62
40799	T		Lip surgery procedure	0253	15.2249	$830.69	$282.29	$166.14
40800	T		Drainage of mouth lesion	0251	1.7880	$97.56		$19.51
40801	T		Drainage of mouth lesion	0252	6.4469	$351.75	$113.41	$70.35
40804	X		Removal, foreign body, mouth	0340	0.6314	$34.45		$6.89
40805	T		Removal, foreign body, mouth	0252	6.4469	$351.75	$113.41	$70.35
40806	T		Incision of lip fold	0251	1.7880	$97.56		$19.51
40808	T		Biopsy of mouth lesion	0251	1.7880	$97.56		$19.51
40810	T		Excision of mouth lesion	0253	15.2249	$830.69	$282.29	$166.14
40812	T		Excise/repair mouth lesion	0253	15.2249	$830.69	$282.29	$166.14
40814	T		Excise/repair mouth lesion	0253	15.2249	$830.69	$282.29	$166.14
40816	T		Excision of mouth lesion	0254	21.8901	$1,194.35	$321.35	$238.87
40818	T		Excise oral mucosa for graft	0251	1.7880	$97.56		$19.51
40819	T		Excise lip or cheek fold	0252	6.4469	$351.75	$113.41	$70.35
40820	T		Treatment of mouth lesion	0253	15.2249	$830.69	$282.29	$166.14
40830	T		Repair mouth laceration	0251	1.7880	$97.56		$19.51
40831	T		Repair mouth laceration	0252	6.4469	$351.75	$113.41	$70.35

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
40840	T		Reconstruction of mouth	0254	21.8901	$1,194.35	$321.35	$238.87
40842	T		Reconstruction of mouth	0254	21.8901	$1,194.35	$321.35	$238.87
40843	T		Reconstruction of mouth	0254	21.8901	$1,194.35	$321.35	$238.87
40844	T		Reconstruction of mouth	0256	35.1548	$1,918.08		$383.62
40845	T		Reconstruction of mouth	0256	35.1548	$1,918.08		$383.62
40899	T		Mouth surgery procedure	0252	6.4469	$351.75	$113.41	$70.35
41000	T		Drainage of mouth lesion	0253	15.2249	$830.69	$282.29	$166.14
41005	T		Drainage of mouth lesion	0251	1.7880	$97.56		$19.51
41006	T		Drainage of mouth lesion	0254	21.8901	$1,194.35	$321.35	$238.87
41007	T		Drainage of mouth lesion	0253	15.2249	$830.69	$282.29	$166.14
41008	T		Drainage of mouth lesion	0253	15.2249	$830.69	$282.29	$166.14
41009	T		Drainage of mouth lesion	0251	1.7880	$97.56		$19.51
41010	T		Incision of tongue fold	0253	15.2249	$830.69	$282.29	$166.14
41015	T		Drainage of mouth lesion	0251	1.7880	$97.56		$19.51
41016	T		Drainage of mouth lesion	0252	6.4469	$351.75	$113.41	$70.35
41017	T		Drainage of mouth lesion	0252	6.4469	$351.75	$113.41	$70.35
41018	T		Drainage of mouth lesion	0252	6.4469	$351.75	$113.41	$70.35
41100	T		Biopsy of tongue	0252	6.4469	$351.75	$113.41	$70.35
41105	T		Biopsy of tongue	0253	15.2249	$830.69	$282.29	$166.14
41108	T		Biopsy of floor of mouth	0252	6.4469	$351.75	$113.41	$70.35
41110	T		Excision of tongue lesion	0253	15.2249	$830.69	$282.29	$166.14
41112	T		Excision of tongue lesion	0253	15.2249	$830.69	$282.29	$166.14
41113	T		Excision of tongue lesion	0253	15.2249	$830.69	$282.29	$166.14
41114	T		Excision of tongue lesion	0254	21.8901	$1,194.35	$321.35	$238.87
41115	T		Excision of tongue fold	0252	6.4469	$351.75	$113.41	$70.35
41116	T		Excision of mouth lesion	0253	15.2249	$830.69	$282.29	$166.14
41120	T		Partial removal of tongue	0254	21.8901	$1,194.35	$321.35	$238.87
41130	C		Partial removal of tongue					
41135	C		Tongue and neck surgery					
41140	C		Removal of tongue					
41145	C		Tongue removal, neck surgery					
41150	C		Tongue, mouth, jaw surgery					
41153	C		Tongue, mouth, neck surgery					
41155	C		Tongue, jaw, & neck surgery					
41250	T		Repair tongue laceration	0251	1.7880	$97.56		$19.51
41251	T		Repair tongue laceration	0251	1.7880	$97.56		$19.51
41252	T		Repair tongue laceration	0252	6.4469	$351.75	$113.41	$70.35
41500	T		Fixation of tongue	0254	21.8901	$1,194.35	$321.35	$238.87
41510	T		Tongue to lip surgery	0253	15.2249	$830.69	$282.29	$166.14
41520	T		Reconstruction, tongue fold	0252	6.4469	$351.75	$113.41	$70.35
41599	T		Tongue and mouth surgery	0251	1.7880	$97.56		$19.51
41800	T		Drainage of gum lesion	0251	1.7880	$97.56		$19.51
41805	T		Removal foreign body, gum	0254	21.8901	$1,194.35	$321.35	$238.87
41806	T		Removal foreign body,jawbone	0253	15.2249	$830.69	$282.29	$166.14
41820	T		Excision, gum, each quadrant	0252	6.4469	$351.75	$113.41	$70.35
41821	T		Excision of gum flap	0252	6.4469	$351.75	$113.41	$70.35
41822	T		Excision of gum lesion	0253	15.2249	$830.69	$282.29	$166.14
41823	T		Excision of gum lesion	0254	21.8901	$1,194.35	$321.35	$238.87
41825	T		Excision of gum lesion	0253	15.2249	$830.69	$282.29	$166.14
41826	T		Excision of gum lesion	0253	15.2249	$830.69	$282.29	$166.14
41827	T		Excision of gum lesion	0254	21.8901	$1,194.35	$321.35	$238.87
41828	T		Excision of gum lesion	0253	15.2249	$830.69	$282.29	$166.14
41830	T		Removal of gum tissue	0253	15.2249	$830.69	$282.29	$166.14
41850	T		Treatment of gum lesion	0253	15.2249	$830.69	$282.29	$166.14
41870	T		Gum graft	0254	21.8901	$1,194.35	$321.35	$238.87
41872	T		Repair gum	0253	15.2249	$830.69	$282.29	$166.14
41874	T		Repair tooth socket	0254	21.8901	$1,194.35	$321.35	$238.87
41899	T		Dental surgery procedure	0253	15.2249	$830.69	$282.29	$166.14
42000	T		Drainage mouth roof lesion	0251	1.7880	$97.56		$19.51
42100	T		Biopsy roof of mouth	0252	6.4469	$351.75	$113.41	$70.35
42104	T		Excision lesion, mouth roof	0253	15.2249	$830.69	$282.29	$166.14
42106	T		Excision lesion, mouth roof	0253	15.2249	$830.69	$282.29	$166.14
42107	T		Excision lesion, mouth roof	0254	21.8901	$1,194.35	$321.35	$238.87
42120	T		Remove palate/lesion	0256	35.1548	$1,918.08		$383.62
42140	T		Excision of uvula	0252	6.4469	$351.75	$113.41	$70.35
42145	T		Repair palate, pharynx/uvula	0254	21.8901	$1,194.35	$321.35	$238.87
42160	T		Treatment mouth roof lesion	0253	15.2249	$830.69	$282.29	$166.14
42180	T		Repair palate	0251	1.7880	$97.56		$19.51
42182	T		Repair palate	0256	35.1548	$1,918.08		$383.62
42200	T		Reconstruct cleft palate	0256	35.1548	$1,918.08		$383.62
42205	T		Reconstruct cleft palate	0256	35.1548	$1,918.08		$383.62
42210	T		Reconstruct cleft palate	0256	35.1548	$1,918.08		$383.62
42215	T		Reconstruct cleft palate	0256	35.1548	$1,918.08		$383.62
42220	T		Reconstruct cleft palate	0256	35.1548	$1,918.08		$383.62
42225	T		Reconstruct cleft palate	0256	35.1548	$1,918.08		$383.62

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
42226	T		Lengthening of palate	0256	35.1548	$1,918.08		$383.62
42227	T		Lengthening of palate	0256	35.1548	$1,918.08		$383.62
42235	T		Repair palate	0253	15.2249	$830.69	$282.29	$166.14
42260	T		Repair nose to lip fistula	0254	21.8901	$1,194.35	$321.35	$238.87
42280	T		Preparation, palate mold	0251	1.7880	$97.56		$19.51
42281	T		Insertion, palate prosthesis	0253	15.2249	$830.69	$282.29	$166.14
42299	T		Palate/uvula surgery	0251	1.7880	$97.56		$19.51
42300	T		Drainage of salivary gland	0253	15.2249	$830.69	$282.29	$166.14
42305	T		Drainage of salivary gland	0253	15.2249	$830.69	$282.29	$166.14
42310	T		Drainage of salivary gland	0251	1.7880	$97.56		$19.51
42320	T		Drainage of salivary gland	0251	1.7880	$97.56		$19.51
42325	T		Create salivary cyst drain	0251	1.7880	$97.56		$19.51
42326	T		Create salivary cyst drain	0252	6.4469	$351.75	$113.41	$70.35
42330	T		Removal of salivary stone	0253	15.2249	$830.69	$282.29	$166.14
42335	T		Removal of salivary stone	0253	15.2249	$830.69	$282.29	$166.14
42340	T		Removal of salivary stone	0253	15.2249	$830.69	$282.29	$166.14
42400	T		Biopsy of salivary gland	0005	3.2698	$178.40	$71.59	$35.68
42405	T		Biopsy of salivary gland	0253	15.2249	$830.69	$282.29	$166.14
42408	T		Excision of salivary cyst	0253	15.2249	$830.69	$282.29	$166.14
42409	T		Drainage of salivary cyst	0253	15.2249	$830.69	$282.29	$166.14
42410	T		Excise parotid gland/lesion	0256	35.1548	$1,918.08		$383.62
42415	T		Excise parotid gland/lesion	0256	35.1548	$1,918.08		$383.62
42420	T		Excise parotid gland/lesion	0256	35.1548	$1,918.08		$383.62
42425	T		Excise parotid gland/lesion	0256	35.1548	$1,918.08		$383.62
42426	C		Excise parotid gland/lesion					
42440	T		Excise submaxillary gland	0256	35.1548	$1,918.08		$383.62
42450	T		Excise sublingual gland	0254	21.8901	$1,194.35	$321.35	$238.87
42500	T		Repair salivary duct	0254	21.8901	$1,194.35	$321.35	$238.87
42505	T		Repair salivary duct	0256	35.1548	$1,918.08		$383.62
42507	T		Parotid duct diversion	0256	35.1548	$1,918.08		$383.62
42508	T		Parotid duct diversion	0256	35.1548	$1,918.08		$383.62
42509	T		Parotid duct diversion	0256	35.1548	$1,918.08		$383.62
42510	T		Parotid duct diversion	0256	35.1548	$1,918.08		$383.62
42550	N		Injection for salivary x-ray					
42600	T		Closure of salivary fistula	0253	15.2249	$830.69	$282.29	$166.14
42650	T		Dilation of salivary duct	0252	6.4469	$351.75	$113.41	$70.35
42660	T		Dilation of salivary duct	0251	1.7880	$97.56		$19.51
42665	T		Ligation of salivary duct	0254	21.8901	$1,194.35	$321.35	$238.87
42699	T		Salivary surgery procedure	0253	15.2249	$830.69	$282.29	$166.14
42700	T		Drainage of tonsil abscess	0251	1.7880	$97.56		$19.51
42720	T		Drainage of throat abscess	0253	15.2249	$830.69	$282.29	$166.14
42725	T		Drainage of throat abscess	0256	35.1548	$1,918.08		$383.62
42800	T		Biopsy of throat	0253	15.2249	$830.69	$282.29	$166.14
42802	T		Biopsy of throat	0253	15.2249	$830.69	$282.29	$166.14
42804	T		Biopsy of upper nose/throat	0253	15.2249	$830.69	$282.29	$166.14
42806	T		Biopsy of upper nose/throat	0254	21.8901	$1,194.35	$321.35	$238.87
42808	T		Excise pharynx lesion	0253	15.2249	$830.69	$282.29	$166.14
42809	X		Remove pharynx foreign body	0340	0.6314	$34.45		$6.89
42810	T		Excision of neck cyst	0254	21.8901	$1,194.35	$321.35	$238.87
42815	T		Excision of neck cyst	0256	35.1548	$1,918.08		$383.62
42820	T		Remove tonsils and adenoids	0258	20.6265	$1,125.40	$437.25	$225.08
42821	T		Remove tonsils and adenoids	0258	20.6265	$1,125.40	$437.25	$225.08
42825	T		Removal of tonsils	0258	20.6265	$1,125.40	$437.25	$225.08
42826	T		Removal of tonsils	0258	20.6265	$1,125.40	$437.25	$225.08
42830	T		Removal of adenoids	0258	20.6265	$1,125.40	$437.25	$225.08
42831	T		Removal of adenoids	0258	20.6265	$1,125.40	$437.25	$225.08
42835	T		Removal of adenoids	0258	20.6265	$1,125.40	$437.25	$225.08
42836	T		Removal of adenoids	0258	20.6265	$1,125.40	$437.25	$225.08
42842	T		Extensive surgery of throat	0254	21.8901	$1,194.35	$321.35	$238.87
42844	T		Extensive surgery of throat	0256	35.1548	$1,918.08		$383.62
42845	C		Extensive surgery of throat					
42860	T		Excision of tonsil tags	0258	20.6265	$1,125.40	$437.25	$225.08
42870	T		Excision of lingual tonsil	0258	20.6265	$1,125.40	$437.25	$225.08
42890	T		Partial removal of pharynx	0256	35.1548	$1,918.08		$383.62
42892	T		Revision of pharyngeal walls	0256	35.1548	$1,918.08		$383.62
42894	C		Revision of pharyngeal walls					
42900	T		Repair throat wound	0252	6.4469	$351.75	$113.41	$70.35
42950	T		Reconstruction of throat	0254	21.8901	$1,194.35	$321.35	$238.87
42953	C		Repair throat, esophagus					
42955	T		Surgical opening of throat	0254	21.8901	$1,194.35	$321.35	$238.87
42960	T		Control throat bleeding	0250	1.4697	$80.19	$28.07	$16.04
42961	C		Control throat bleeding					
42962	T		Control throat bleeding	0256	35.1548	$1,918.08		$383.62
42970	T		Control nose/throat bleeding	0250	1.4697	$80.19	$28.07	$16.04
42971	C		Control nose/throat bleeding					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
42972	T		Control nose/throat bleeding	0253	15.2249	$830.69	$282.29	$166.14
42999	T		Throat surgery procedure	0252	6.4469	$351.75	$113.41	$70.35
43020	T		Incision of esophagus	0252	6.4469	$351.75	$113.41	$70.35
43030	T		Throat muscle surgery	0253	15.2249	$830.69	$282.29	$166.14
43045	C		Incision of esophagus					
43100	C		Excision of esophagus lesion					
43101	C		Excision of esophagus lesion					
43107	C		Removal of esophagus					
43108	C		Removal of esophagus					
43112	C		Removal of esophagus					
43113	C		Removal of esophagus					
43116	C		Partial removal of esophagus					
43117	C		Partial removal of esophagus					
43118	C		Partial removal of esophagus					
43121	C		Partial removal of esophagus					
43122	C		Partial removal of esophagus					
43123	C		Partial removal of esophagus					
43124	C		Removal of esophagus					
43130	T		Removal of esophagus pouch	0254	21.8901	$1,194.35	$321.35	$238.87
43135	C		Removal of esophagus pouch					
43200	T		Esophagus endoscopy	0141	7.8206	$426.70	$143.38	$85.34
43201	T		Esoph scope w/submucous inj	0141	7.8206	$426.70	$143.38	$85.34
43202	T		Esophagus endoscopy, biopsy	0141	7.8206	$426.70	$143.38	$85.34
43204	T		Esoph scope w/sclerosis inj	0141	7.8206	$426.70	$143.38	$85.34
43205	T		Esophagus endoscopy/ligation	0141	7.8206	$426.70	$143.38	$85.34
43215	T		Esophagus endoscopy	0141	7.8206	$426.70	$143.38	$85.34
43216	T		Esophagus endoscopy/lesion	0141	7.8206	$426.70	$143.38	$85.34
43217	T		Esophagus endoscopy	0141	7.8206	$426.70	$143.38	$85.34
43219	T		Esophagus endoscopy	0384	20.6602	$1,127.24	$244.83	$225.45
43220	T		Esoph endoscopy, dilation	0141	7.8206	$426.70	$143.38	$85.34
43226	T		Esoph endoscopy, dilation	0141	7.8206	$426.70	$143.38	$85.34
43227	T		Esoph endoscopy, repair	0141	7.8206	$426.70	$143.38	$85.34
43228	T		Esoph endoscopy, ablation	0141	7.8206	$426.70	$143.38	$85.34
43231	T		Esoph endoscopy w/us exam	0141	7.8206	$426.70	$143.38	$85.34
43232	T		Esoph endoscopy w/us fn bx	0141	7.8206	$426.70	$143.38	$85.34
43234	T		Upper GI endoscopy, exam	0141	7.8206	$426.70	$143.38	$85.34
43235	T		Uppr gi endoscopy, diagnosis	0141	7.8206	$426.70	$143.38	$85.34
43236	T		Uppr gi scope w/submuc inj	0141	7.8206	$426.70	$143.38	$85.34
43237	T	NI	Endoscopic us exam, esoph	0141	7.8206	$426.70	$143.38	$85.34
43238	T	NI	Uppr gi endoscopy w/us fn bx	0141	7.8206	$426.70	$143.38	$85.34
43239	T		Upper GI endoscopy, biopsy	0141	7.8206	$426.70	$143.38	$85.34
43240	T		Esoph endoscope w/drain cyst	0141	7.8206	$426.70	$143.38	$85.34
43241	T		Upper GI endoscopy with tube	0141	7.8206	$426.70	$143.38	$85.34
43242	T		Uppr gi endoscopy w/us fn bx	0141	7.8206	$426.70	$143.38	$85.34
43243	T		Upper gi endoscopy & inject	0141	7.8206	$426.70	$143.38	$85.34
43244	T		Upper GI endoscopy/ligation	0141	7.8206	$426.70	$143.38	$85.34
43245	T		Uppr gi scope dilate strictr	0141	7.8206	$426.70	$143.38	$85.34
43246	T		Place gastrostomy tube	0141	7.8206	$426.70	$143.38	$85.34
43247	T		Operative upper GI endoscopy	0141	7.8206	$426.70	$143.38	$85.34
43248	T		Uppr gi endoscopy/guide wire	0141	7.8206	$426.70	$143.38	$85.34
43249	T		Esoph endoscopy, dilation	0141	7.8206	$426.70	$143.38	$85.34
43250	T		Upper GI endoscopy/tumor	0141	7.8206	$426.70	$143.38	$85.34
43251	T		Operative upper GI endoscopy	0141	7.8206	$426.70	$143.38	$85.34
43255	T		Operative upper GI endoscopy	0141	7.8206	$426.70	$143.38	$85.34
43256	T		Uppr gi endoscopy w stent	0384	20.6602	$1,127.24	$244.83	$225.45
43258	T		Operative upper GI endoscopy	0141	7.8206	$426.70	$143.38	$85.34
43259	T		Endoscopic ultrasound exam	0141	7.8206	$426.70	$143.38	$85.34
43260	T		Endo cholangiopancreatograph	0151	17.9462	$979.16	$245.46	$195.83
43261	T		Endo cholangiopancreatograph	0151	17.9462	$979.16	$245.46	$195.83
43262	T		Endo cholangiopancreatograph	0151	17.9462	$979.16	$245.46	$195.83
43263	T		Endo cholangiopancreatograph	0151	17.9462	$979.16	$245.46	$195.83
43264	T		Endo cholangiopancreatograph	0151	17.9462	$979.16	$245.46	$195.83
43265	T		Endo cholangiopancreatograph	0151	17.9462	$979.16	$245.46	$195.83
43267	T		Endo cholangiopancreatograph	0151	17.9462	$979.16	$245.46	$195.83
43268	T		Endo cholangiopancreatograph	0384	20.6602	$1,127.24	$244.83	$225.45
43269	T		Endo cholangiopancreatograph	0384	20.6602	$1,127.24	$244.83	$225.45
43271	T		Endo cholangiopancreatograph	0151	17.9462	$979.16	$245.46	$195.83
43272	T		Endo cholangiopancreatograph	0151	17.9462	$979.16	$245.46	$195.83
43280	T		Laparoscopy, fundoplasty	0132	57.2045	$3,121.13	$1,239.22	$624.23
43289	T		Laparoscope proc, esoph	0130	32.7724	$1,788.09	$659.53	$357.62
43300	C		Repair of esophagus					
43305	C		Repair esophagus and fistula					
43310	C		Repair of esophagus					
43312	C		Repair esophagus and fistula					
43313	C		Esophagoplasty congenital					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
43314	C		Tracheo-esophagoplasty cong					
43320	C		Fuse esophagus & stomach					
43324	C		Revise esophagus & stomach					
43325	C		Revise esophagus & stomach					
43326	C		Revise esophagus & stomach					
43330	C		Repair of esophagus					
43331	C		Repair of esophagus					
43340	C		Fuse esophagus & intestine					
43341	C		Fuse esophagus & intestine					
43350	C		Surgical opening, esophagus					
43351	C		Surgical opening, esophagus					
43352	C		Surgical opening, esophagus					
43360	C		Gastrointestinal repair					
43361	C		Gastrointestinal repair					
43400	C		Ligate esophagus veins					
43401	C		Esophagus surgery for veins					
43405	C		Ligate/staple esophagus					
43410	C		Repair esophagus wound					
43415	C		Repair esophagus wound					
43420	C		Repair esophagus opening					
43425	C		Repair esophagus opening					
43450	T		Dilate esophagus	0140	6.4525	$352.05	$107.24	$70.41
43453	T		Dilate esophagus	0140	6.4525	$352.05	$107.24	$70.41
43456	T		Dilate esophagus	0140	6.4525	$352.05	$107.24	$70.41
43458	T		Dilate esophagus	0140	6.4525	$352.05	$107.24	$70.41
43460	C		Pressure treatment esophagus					
43496	C		Free jejunum flap, microvasc					
43499	T		Esophagus surgery procedure	0141	7.8206	$426.70	$143.38	$85.34
43500	C		Surgical opening of stomach					
43501	C		Surgical repair of stomach					
43502	C		Surgical repair of stomach					
43510	C		Surgical opening of stomach					
43520	C		Incision of pyloric muscle					
43600	T		Biopsy of stomach	0141	7.8206	$426.70	$143.38	$85.34
43605	C		Biopsy of stomach					
43610	C		Excision of stomach lesion					
43611	C		Excision of stomach lesion					
43620	C		Removal of stomach					
43621	C		Removal of stomach					
43622	C		Removal of stomach					
43631	C		Removal of stomach, partial					
43632	C		Removal of stomach, partial					
43633	C		Removal of stomach, partial					
43634	C		Removal of stomach, partial					
43635	C		Removal of stomach, partial					
43638	C		Removal of stomach, partial					
43639	C		Removal of stomach, partial					
43640	C		Vagotomy & pylorus repair					
43641	C		Vagotomy & pylorus repair					
43651	T		Laparoscopy, vagus nerve	0132	57.2045	$3,121.13	$1,239.22	$624.23
43652	T		Laparoscopy, vagus nerve	0132	57.2045	$3,121.13	$1,239.22	$624.23
43653	T		Laparoscopy, gastrostomy	0131	40.8064	$2,226.44	$1,001.89	$445.29
43659	T		Laparoscope proc, stom	0130	32.7724	$1,788.09	$659.53	$357.62
43750	T		Place gastrostomy tube	0141	7.8206	$426.70	$143.38	$85.34
43752	T		Nasal/orogastric w/stent	0121	2.1189	$115.61	$43.80	$23.12
43760	T		Change gastrostomy tube	0121	2.1189	$115.61	$43.80	$23.12
43761	T		Reposition gastrostomy tube	0121	2.1189	$115.61	$43.80	$23.12
43800	C		Reconstruction of pylorus					
43810	C		Fusion of stomach and bowel					
43820	C		Fusion of stomach and bowel					
43825	C		Fusion of stomach and bowel					
43830	T		Place gastrostomy tube	0141	7.8206	$426.70	$143.38	$85.34
43831	T		Place gastrostomy tube	0141	7.8206	$426.70	$143.38	$85.34
43832	C		Place gastrostomy tube					
43840	C		Repair of stomach lesion					
43842	C		Gastroplasty for obesity					
43843	C		Gastroplasty for obesity					
43846	C		Gastric bypass for obesity					
43847	C		Gastric bypass for obesity					
43848	C		Revision gastroplasty					
43850	C		Revise stomach-bowel fusion					
43855	C		Revise stomach-bowel fusion					
43860	C		Revise stomach-bowel fusion					
43865	C		Revise stomach-bowel fusion					
43870	T		Repair stomach opening	0141	7.8206	$426.70	$143.38	$85.34

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
43880	C		Repair stomach-bowel fistula					
43999	T		Stomach surgery procedure	0141	7.8206	$426.70	$143.38	$85.34
44005	C		Freeing of bowel adhesion					
44010	C		Incision of small bowel					
44015	C		Insert needle cath bowel					
44020	C		Explore small intestine					
44021	C		Decompress small bowel					
44025	C		Incision of large bowel					
44050	C		Reduce bowel obstruction					
44055	C		Correct malrotation of bowel					
44100	T		Biopsy of bowel	0141	7.8206	$426.70	$143.38	$85.34
44110	C		Excise intestine lesion(s)					
44111	C		Excision of bowel lesion(s)					
44120	C		Removal of small intestine					
44121	C		Removal of small intestine					
44125	C		Removal of small intestine					
44126	C		Enterectomy w/o taper, cong					
44127	C		Enterectomy w/taper, cong					
44128	C		Enterectomy cong, add-on					
44130	C		Bowel to bowel fusion					
44132	C		Enterectomy, cadaver donor					
44133	C		Enterectomy, live donor					
44135	C		Intestine transplnt, cadaver					
44136	C		Intestine transplant, live					
44139	C		Mobilization of colon					
44140	C		Partial removal of colon					
44141	C		Partial removal of colon					
44143	C		Partial removal of colon					
44144	C		Partial removal of colon					
44145	C		Partial removal of colon					
44146	C		Partial removal of colon					
44147	C		Partial removal of colon					
44150	C		Removal of colon					
44151	C		Removal of colon/ileostomy					
44152	C		Removal of colon/ileostomy					
44153	C		Removal of colon/ileostomy					
44155	C		Removal of colon/ileostomy					
44156	C		Removal of colon/ileostomy					
44160	C		Removal of colon					
44200	T		Laparoscopy, enterolysis	0131	40.8064	$2,226.44	$1,001.89	$445.29
44201	T		Laparoscopy, jejunostomy	0131	40.8064	$2,226.44	$1,001.89	$445.29
44202	C		Lap resect s/intestine singl					
44203	C		Lap resect s/intestine, addl					
44204	C		Laparo partial colectomy					
44205	C		Lap colectomy part w/ileum					
44206	T		Lap part colectomy w/stoma	0132	57.2045	$3,121.13	$1,239.22	$624.23
44207	T		L colectomy/coloproctostomy	0132	57.2045	$3,121.13	$1,239.22	$624.23
44208	T		L colectomy/coloproctostomy	0132	57.2045	$3,121.13	$1,239.22	$624.23
44210	C		Laparo total proctocolectomy					
44211	C		Laparo total proctocolectomy					
44212	C		Laparo total proctocolectomy					
44238	T		Laparoscope proc, intestine	0130	32.7724	$1,788.09	$659.53	$357.62
44239	T		Laparoscope proc, rectum	0130	32.7724	$1,788.09	$659.53	$357.62
44300	C		Open bowel to skin					
44310	C		Ileostomy/jejunostomy					
44312	T		Revision of ileostomy	0027	15.8990	$867.47	$329.72	$173.49
44314	C		Revision of ileostomy					
44316	C		Devise bowel pouch					
44320	C		Colostomy					
44322	C		Colostomy with biopsies					
44340	T		Revision of colostomy	0027	15.8990	$867.47	$329.72	$173.49
44345	C		Revision of colostomy					
44346	C		Revision of colostomy					
44360	T		Small bowel endoscopy	0142	8.7959	$479.91	$152.78	$95.98
44361	T		Small bowel endoscopy/biopsy	0142	8.7959	$479.91	$152.78	$95.98
44363	T		Small bowel endoscopy	0142	8.7959	$479.91	$152.78	$95.98
44364	T		Small bowel endoscopy	0142	8.7959	$479.91	$152.78	$95.98
44365	T		Small bowel endoscopy	0142	8.7959	$479.91	$152.78	$95.98
44366	T		Small bowel endoscopy	0142	8.7959	$479.91	$152.78	$95.98
44369	T		Small bowel endoscopy	0142	8.7959	$479.91	$152.78	$95.98
44370	T		Small bowel endoscopy/stent	0384	20.6602	$1,127.24	$244.83	$225.45
44372	T		Small bowel endoscopy	0142	8.7959	$479.91	$152.78	$95.98
44373	T		Small bowel endoscopy	0142	8.7959	$479.91	$152.78	$95.98
44376	T		Small bowel endoscopy	0142	8.7959	$479.91	$152.78	$95.98
44377	T		Small bowel endoscopy/biopsy	0142	8.7959	$479.91	$152.78	$95.98

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
44378	T		Small bowel endoscopy	0142	8.7959	$479.91	$152.78	$95.98
44379	T		S bowel endoscope w/stent	0384	20.6602	$1,127.24	$244.83	$225.45
44380	T		Small bowel endoscopy	0142	8.7959	$479.91	$152.78	$95.98
44382	T		Small bowel endoscopy	0142	8.7959	$479.91	$152.78	$95.98
44383	T		Ileoscopy w/stent	0384	20.6602	$1,127.24	$244.83	$225.45
44385	T		Endoscopy of bowel pouch	0143	8.2957	$452.62	$186.06	$90.52
44386	T		Endoscopy, bowel pouch/biop	0143	8.2957	$452.62	$186.06	$90.52
44388	T		Colonoscopy	0143	8.2957	$452.62	$186.06	$90.52
44389	T		Colonoscopy with biopsy	0143	8.2957	$452.62	$186.06	$90.52
44390	T		Colonoscopy for foreign body	0143	8.2957	$452.62	$186.06	$90.52
44391	T		Colonoscopy for bleeding	0143	8.2957	$452.62	$186.06	$90.52
44392	T		Colonoscopy & polypectomy	0143	8.2957	$452.62	$186.06	$90.52
44393	T		Colonoscopy, lesion removal	0143	8.2957	$452.62	$186.06	$90.52
44394	T		Colonoscopy w/snare	0143	8.2957	$452.62	$186.06	$90.52
44397	T		Colonoscopy w/stent	0384	20.6602	$1,127.24	$244.83	$225.45
44500	T		Intro, gastrointestinal tube	0121	2.1189	$115.61	$43.80	$23.12
44602	C		Suture, small intestine					
44603	C		Suture, small intestine					
44604	C		Suture, large intestine					
44605	C		Repair of bowel lesion					
44615	C		Intestinal stricturoplasty					
44620	C		Repair bowel opening					
44625	C		Repair bowel opening					
44626	C		Repair bowel opening					
44640	C		Repair bowel-skin fistula					
44650	C		Repair bowel fistula					
44660	C		Repair bowel-bladder fistula					
44661	C		Repair bowel-bladder fistula					
44680	C		Surgical revision, intestine					
44700	C		Suspend bowel w/prosthesis					
44701	N		Intraop colon lavage add-on					
44799	T		Unlisted procedure intestine	0142	8.7959	$479.91	$152.78	$95.98
44800	C		Excision of bowel pouch					
44820	C		Excision of mesentery lesion					
44850	C		Repair of mesentery					
44899	C		Bowel surgery procedure					
44900	C		Drain app abscess, open					
44901	C		Drain app abscess, percut					
44950	C		Appendectomy					
44955	C		Appendectomy add-on					
44960	C		Appendectomy					
44970	T		Laparoscopy, appendectomy	0130	32.7724	$1,788.09	$659.53	$357.62
44979	T		Laparoscope proc, app	0130	32.7724	$1,788.09	$659.53	$357.62
45000	T		Drainage of pelvic abscess	0148	3.8320	$209.08	$63.38	$41.82
45005	T		Drainage of rectal abscess	0148	3.8320	$209.08	$63.38	$41.82
45020	T		Drainage of rectal abscess	0148	3.8320	$209.08	$63.38	$41.82
45100	T		Biopsy of rectum	0149	17.1425	$935.31	$293.06	$187.06
45108	T		Removal of anorectal lesion	0150	22.1919	$1,210.81	$437.12	$242.16
45110	C		Removal of rectum					
45111	C		Partial removal of rectum					
45112	C		Removal of rectum					
45113	C		Partial proctectomy					
45114	C		Partial removal of rectum					
45116	C		Partial removal of rectum					
45119	C		Remove rectum w/reservoir					
45120	C		Removal of rectum					
45121	C		Removal of rectum and colon					
45123	C		Partial proctectomy					
45126	C		Pelvic exenteration					
45130	C		Excision of rectal prolapse					
45135	C		Excision of rectal prolapse					
45136	C		Excise ileoanal reservior					
45150	T		Excision of rectal stricture	0149	17.1425	$935.31	$293.06	$187.06
45160	T		Excision of rectal lesion	0150	22.1919	$1,210.81	$437.12	$242.16
45170	T		Excision of rectal lesion	0150	22.1919	$1,210.81	$437.12	$242.16
45190	T		Destruction, rectal tumor	0150	22.1919	$1,210.81	$437.12	$242.16
45300	T		Proctosigmoidoscopy dx	0146	3.9826	$217.29	$64.40	$43.46
45303	T		Proctosigmoidoscopy dilate	0146	3.9826	$217.29	$64.40	$43.46
45305	T		Proctosigmoidoscopy w/bx	0146	3.9826	$217.29	$64.40	$43.46
45307	T		Proctosigmoidoscopy fb	0146	3.9826	$217.29	$64.40	$43.46
45308	T		Proctosigmoidoscopy removal	0147	7.6808	$419.07		$83.81
45309	T		Proctosigmoidoscopy removal	0147	7.6808	$419.07		$83.81
45315	T		Proctosigmoidoscopy removal	0147	7.6808	$419.07		$83.81
45317	T		Proctosigmoidoscopy bleed	0147	7.6808	$419.07		$83.81
45320	T		Proctosigmoidoscopy ablate	0147	7.6808	$419.07		$83.81

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
45321	T		Proctosigmoidoscopy volvul	0147	7.6808	$419.07		$83.81
45327	T		Proctosigmoidoscopy w/stent	0384	20.6602	$1,127.24	$244.83	$225.45
45330	T		Diagnostic sigmoidoscopy	0146	3.9826	$217.29	$64.40	$43.46
45331	T		Sigmoidoscopy and biopsy	0146	3.9826	$217.29	$64.40	$43.46
45332	T		Sigmoidoscopy w/fb removal	0146	3.9826	$217.29	$64.40	$43.46
45333	T		Sigmoidoscopy & polypectomy	0147	7.6808	$419.07		$83.81
45334	T		Sigmoidoscopy for bleeding	0147	7.6808	$419.07		$83.81
45335	T		Sigmoidoscopy w/submuc inj	0147	7.6808	$419.07		$83.81
45337	T		Sigmoidoscopy & decompress	0147	7.6808	$419.07		$83.81
45338	T		Sigmoidoscopy w/tumr remove	0147	7.6808	$419.07		$83.81
45339	T		Sigmoidoscopy w/ablate tumr	0147	7.6808	$419.07		$83.81
45340	T		Sig w/balloon dilation	0147	7.6808	$419.07		$83.81
45341	T		Sigmoidoscopy w/ultrasound	0147	7.6808	$419.07		$83.81
45342	T		Sigmoidoscopy w/us guide bx	0147	7.6808	$419.07		$83.81
45345	T		Sigmoidoscopy w/stent	0384	20.6602	$1,127.24	$244.83	$225.45
45355	T		Surgical colonoscopy	0143	8.2957	$452.62	$186.06	$90.52
45378	T		Diagnostic colonoscopy	0143	8.2957	$452.62	$186.06	$90.52
45379	T		Colonoscopy w/fb removal	0143	8.2957	$452.62	$186.06	$90.52
45380	T		Colonoscopy and biopsy	0143	8.2957	$452.62	$186.06	$90.52
45381	T		Colonoscopy, submucous inj	0143	8.2957	$452.62	$186.06	$90.52
45382	T		Colonoscopy/control bleeding	0143	8.2957	$452.62	$186.06	$90.52
45383	T		Lesion removal colonoscopy	0143	8.2957	$452.62	$186.06	$90.52
45384	T		Lesion remove colonoscopy	0143	8.2957	$452.62	$186.06	$90.52
45385	T		Lesion removal colonoscopy	0143	8.2957	$452.62	$186.06	$90.52
45386	T		Colonoscopy dilate stricture	0143	8.2957	$452.62	$186.06	$90.52
45387	T		Colonoscopy w/stent	0384	20.6602	$1,127.24	$244.83	$225.45
45500	T		Repair of rectum	0149	17.1425	$935.31	$293.06	$187.06
45505	T		Repair of rectum	0150	22.1919	$1,210.81	$437.12	$242.16
45520	T		Treatment of rectal prolapse	0098	1.0729	$58.54	$14.06	$11.71
45540	C		Correct rectal prolapse					
45541	C		Correct rectal prolapse					
45550	C		Repair rectum/remove sigmoid					
45560	T		Repair of rectocele	0150	22.1919	$1,210.81	$437.12	$242.16
45562	C		Exploration/repair of rectum					
45563	C		Exploration/repair of rectum					
45800	C		Repair rect/bladder fistula					
45805	C		Repair fistula w/colostomy					
45820	C		Repair rectourethral fistula					
45825	C		Repair fistula w/colostomy					
45900	T		Reduction of rectal prolapse	0148	3.8320	$209.08	$63.38	$41.82
45905	T		Dilation of anal sphincter	0149	17.1425	$935.31	$293.06	$187.06
45910	T		Dilation of rectal narrowing	0149	17.1425	$935.31	$293.06	$187.06
45915	T		Remove rectal obstruction	0148	3.8320	$209.08	$63.38	$41.82
45999	T		Rectum surgery procedure	0148	3.8320	$209.08	$63.38	$41.82
46020	T		Placement of seton	0148	3.8320	$209.08	$63.38	$41.82
46030	T		Removal of rectal marker	0148	3.8320	$209.08	$63.38	$41.82
46040	T		Incision of rectal abscess	0149	17.1425	$935.31	$293.06	$187.06
46045	T		Incision of rectal abscess	0150	22.1919	$1,210.81	$437.12	$242.16
46050	T		Incision of anal abscess	0148	3.8320	$209.08	$63.38	$41.82
46060	T		Incision of rectal abscess	0150	22.1919	$1,210.81	$437.12	$242.16
46070	T		Incision of anal septum	0155	10.0809	$550.02	$188.89	$110.00
46080	T		Incision of anal sphincter	0149	17.1425	$935.31	$293.06	$187.06
46083	T		Incise external hemorrhoid	0148	3.8320	$209.08	$63.38	$41.82
46200	T		Removal of anal fissure	0150	22.1919	$1,210.81	$437.12	$242.16
46210	T		Removal of anal crypt	0149	17.1425	$935.31	$293.06	$187.06
46211	T		Removal of anal crypts	0150	22.1919	$1,210.81	$437.12	$242.16
46220	T		Removal of anal tag	0149	17.1425	$935.31	$293.06	$187.06
46221	T		Ligation of hemorrhoid(s)	0148	3.8320	$209.08	$63.38	$41.82
46230	T		Removal of anal tags	0149	17.1425	$935.31	$293.06	$187.06
46250	T		Hemorrhoidectomy	0150	22.1919	$1,210.81	$437.12	$242.16
46255	T		Hemorrhoidectomy	0150	22.1919	$1,210.81	$437.12	$242.16
46257	T		Remove hemorrhoids & fissure	0150	22.1919	$1,210.81	$437.12	$242.16
46258	T		Remove hemorrhoids & fistula	0150	22.1919	$1,210.81	$437.12	$242.16
46260	T		Hemorrhoidectomy	0150	22.1919	$1,210.81	$437.12	$242.16
46261	T		Remove hemorrhoids & fissure	0150	22.1919	$1,210.81	$437.12	$242.16
46262	T		Remove hemorrhoids & fistula	0150	22.1919	$1,210.81	$437.12	$242.16
46270	T		Removal of anal fistula	0150	22.1919	$1,210.81	$437.12	$242.16
46275	T		Removal of anal fistula	0150	22.1919	$1,210.81	$437.12	$242.16
46280	T		Removal of anal fistula	0150	22.1919	$1,210.81	$437.12	$242.16
46285	T		Removal of anal fistula	0150	22.1919	$1,210.81	$437.12	$242.16
46288	T		Repair anal fistula	0150	22.1919	$1,210.81	$437.12	$242.16
46320	T		Removal of hemorrhoid clot	0148	3.8320	$209.08	$63.38	$41.82
46500	T		Injection into hemorrhoid(s)	0155	10.0809	$550.02	$188.89	$110.00
46600	X		Diagnostic anoscopy	0340	0.6314	$34.45		$6.89
46604	T		Anoscopy and dilation	0147	7.6808	$419.07		$83.81

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
46606	T		Anoscopy and biopsy	0147	7.6808	$419.07		$83.81
46608	T		Anoscopy, remove for body	0147	7.6808	$419.07		$83.81
46610	T		Anoscopy, remove lesion	0147	7.6808	$419.07		$83.81
46611	T		Anoscopy	0147	7.6808	$419.07		$83.81
46612	T		Anoscopy, remove lesions	0147	7.6808	$419.07		$83.81
46614	T		Anoscopy, control bleeding	0147	7.6808	$419.07		$83.81
46615	T		Anoscopy	0147	7.6808	$419.07		$83.81
46700	T		Repair of anal stricture	0150	22.1919	$1,210.81	$437.12	$242.16
46705	C		Repair of anal stricture					
46706	T		Repr of anal fistula w/glue	0148	3.8320	$209.08	$63.38	$41.82
46715	C		Repair of anovaginal fistula					
46716	C		Repair of anovaginal fistula					
46730	C		Construction of absent anus					
46735	C		Construction of absent anus					
46740	C		Construction of absent anus					
46742	C		Repair of imperforated anus					
46744	C		Repair of cloacal anomaly					
46746	C		Repair of cloacal anomaly					
46748	C		Repair of cloacal anomaly					
46750	T		Repair of anal sphincter	0150	22.1919	$1,210.81	$437.12	$242.16
46751	C		Repair of anal sphincter					
46753	T		Reconstruction of anus	0150	22.1919	$1,210.81	$437.12	$242.16
46754	T		Removal of suture from anus	0149	17.1425	$935.31	$293.06	$187.06
46760	T		Repair of anal sphincter	0150	22.1919	$1,210.81	$437.12	$242.16
46761	T		Repair of anal sphincter	0150	22.1919	$1,210.81	$437.12	$242.16
46762	T		Implant artificial sphincter	0150	22.1919	$1,210.81	$437.12	$242.16
46900	T		Destruction, anal lesion(s)	0016	2.5724	$140.35	$57.31	$28.07
46910	T		Destruction, anal lesion(s)	0017	16.3697	$893.15	$227.84	$178.63
46916	T		Cryosurgery, anal lesion(s)	0013	1.1272	$61.50	$14.20	$12.30
46917	T		Laser surgery, anal lesions	0695	19.1849	$1,046.75	$266.59	$209.35
46922	T		Excision of anal lesion(s)	0695	19.1849	$1,046.75	$266.59	$209.35
46924	T		Destruction, anal lesion(s)	0695	19.1849	$1,046.75	$266.59	$209.35
46934	T		Destruction of hemorrhoids	0155	10.0809	$550.02	$188.89	$110.00
46935	T		Destruction of hemorrhoids	0155	10.0809	$550.02	$188.89	$110.00
46936	T		Destruction of hemorrhoids	0149	17.1425	$935.31	$293.06	$187.06
46937	T		Cryotherapy of rectal lesion	0149	17.1425	$935.31	$293.06	$187.06
46938	T		Cryotherapy of rectal lesion	0150	22.1919	$1,210.81	$437.12	$242.16
46940	T		Treatment of anal fissure	0149	17.1425	$935.31	$293.06	$187.06
46942	T		Treatment of anal fissure	0148	3.8320	$209.08	$63.38	$41.82
46945	T		Ligation of hemorrhoids	0155	10.0809	$550.02	$188.89	$110.00
46946	T		Ligation of hemorrhoids	0155	10.0809	$550.02	$188.89	$110.00
46999	T		Anus surgery procedure	0148	3.8320	$209.08	$63.38	$41.82
47000	T		Needle biopsy of liver	0685	4.8100	$262.44	$115.47	$52.49
47001	N		Needle biopsy, liver add-on					
47010	C		Open drainage, liver lesion					
47011	T		Percut drain, liver lesion	0037	9.8921	$539.72	$237.45	$107.94
47015	C		Inject/aspirate liver cyst					
47100	C		Wedge biopsy of liver					
47120	C		Partial removal of liver					
47122	C		Extensive removal of liver					
47125	C		Partial removal of liver					
47130	C		Partial removal of liver					
47133	C		Removal of donor liver					
47134	C	DG	Partial removal, donor liver					
47135	C	DG	Transplantation of liver					
47136	C	DG	Transplantation of liver					
47140	C	NI	Partial removal, donor liver					
47141	C	NI	Partial removal, donor liver					
47142	C	NI	Partial removal, donor liver					
47300	C	DG	Surgery for liver lesion					
47350	C	DG	Repair liver wound					
47360	C		Repair liver wound					
47361	C		Repair liver wound					
47362	C		Repair liver wound					
47370	T		Laparo ablate liver tumor rf	0131	40.8064	$2,226.44	$1,001.89	$445.29
47371	T		Laparo ablate liver cryosurg	0131	40.8064	$2,226.44	$1,001.89	$445.29
47379	T		Laparoscope procedure, liver	0130	32.7724	$1,788.09	$659.53	$357.62
47380	C		Open ablate liver tumor rf					
47381	C		Open ablate liver tumor cryo					
47382	T		Percut ablate liver rf	1557		$1,850.00		$370.00
47399	T		Liver surgery procedure	0037	9.8921	$539.72	$237.45	$107.94
47400	C		Incision of liver duct					
47420	C		Incision of bile duct					
47425	C		Incision of bile duct					
47460	C		Incise bile duct sphincter					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
47480	C		Incision of gallbladder					
47490	T		Incision of gallbladder	0152	9.1474	$499.09	$125.28	$99.82
47500	N		Injection for liver x-rays					
47505	N		Injection for liver x-rays					
47510	T		Insert catheter, bile duct	0152	9.1474	$499.09	$125.28	$99.82
47511	T		Insert bile duct drain	0152	9.1474	$499.09	$125.28	$99.82
47525	T		Change bile duct catheter	0122	8.8621	$483.53	$99.16	$96.71
47530	T		Revise/reinsert bile tube	0122	8.8621	$483.53	$99.16	$96.71
47550	C		Bile duct endoscopy add-on					
47552	T		Biliary endoscopy thru skin	0152	9.1474	$499.09	$125.28	$99.82
47553	T		Biliary endoscopy thru skin	0152	9.1474	$499.09	$125.28	$99.82
47554	T		Biliary endoscopy thru skin	0152	9.1474	$499.09	$125.28	$99.82
47555	T		Biliary endoscopy thru skin	0152	9.1474	$499.09	$125.28	$99.82
47556	T		Biliary endoscopy thru skin	0152	9.1474	$499.09	$125.28	$99.82
47560	T		Laparoscopy w/cholangio	0130	32.7724	$1,788.09	$659.53	$357.62
47561	T		Laparo w/cholangio/biopsy	0130	32.7724	$1,788.09	$659.53	$357.62
47562	T		Laparoscopic cholecystectomy	0131	40.8064	$2,226.44	$1,001.89	$445.29
47563	T		Laparo cholecystectomy/graph	0131	40.8064	$2,226.44	$1,001.89	$445.29
47564	T		Laparo cholecystectomy/explr	0131	40.8064	$2,226.44	$1,001.89	$445.29
47570	C		Laparo cholecystoenterostomy					
47579	T		Laparoscope proc, biliary	0130	32.7724	$1,788.09	$659.53	$357.62
47600	C		Removal of gallbladder					
47605	C		Removal of gallbladder					
47610	C		Removal of gallbladder					
47612	C		Removal of gallbladder					
47620	C		Removal of gallbladder					
47630	T		Remove bile duct stone	0152	9.1474	$499.09	$125.28	$99.82
47700	C		Exploration of bile ducts					
47701	C		Bile duct revision					
47711	C		Excision of bile duct tumor					
47712	C		Excision of bile duct tumor					
47715	C		Excision of bile duct cyst					
47716	C		Fusion of bile duct cyst					
47720	C		Fuse gallbladder & bowel					
47721	C		Fuse upper gi structures					
47740	C		Fuse gallbladder & bowel					
47741	C		Fuse gallbladder & bowel					
47760	C		Fuse bile ducts and bowel					
47765	C		Fuse liver ducts & bowel					
47780	C		Fuse bile ducts and bowel					
47785	C		Fuse bile ducts and bowel					
47800	C		Reconstruction of bile ducts					
47801	C		Placement, bile duct support					
47802	C		Fuse liver duct & intestine					
47900	C		Suture bile duct injury					
47999	T		Bile tract surgery procedure	0152	9.1474	$499.09	$125.28	$99.82
48000	C		Drainage of abdomen					
48001	C		Placement of drain, pancreas					
48005	C		Resect/debride pancreas					
48020	C		Removal of pancreatic stone					
48100	C		Biopsy of pancreas, open					
48102	T		Needle biopsy, pancreas	0685	4.8100	$262.44	$115.47	$52.49
48120	C		Removal of pancreas lesion					
48140	C		Partial removal of pancreas					
48145	C		Partial removal of pancreas					
48146	C		Pancreatectomy					
48148	C		Removal of pancreatic duct					
48150	C		Partial removal of pancreas					
48152	C		Pancreatectomy					
48153	C		Pancreatectomy					
48154	C		Pancreatectomy					
48155	C		Removal of pancreas					
48160	E		Pancreas removal/transplant					
48180	C		Fuse pancreas and bowel					
48400	C		Injection, intraop add-on					
48500	C		Surgery of pancreatic cyst					
48510	C		Drain pancreatic pseudocyst					
48511	T		Drain pancreatic pseudocyst	0037	9.8921	$539.72	$237.45	$107.94
48520	C		Fuse pancreas cyst and bowel					
48540	C		Fuse pancreas cyst and bowel					
48545	C		Pancreatorrhaphy					
48547	C		Duodenal exclusion					
48550	E		Donor pancreatectomy					
48554	E		Transpl allograft pancreas					
48556	C		Removal, allograft pancreas					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
48999	T		Pancreas surgery procedure	0005	3.2698	$178.40	$71.59	$35.68
49000	C		Exploration of abdomen					
49002	C		Reopening of abdomen					
49010	C		Exploration behind abdomen					
49020	C		Drain abdominal abscess					
49021	C		Drain abdominal abscess					
49040	C		Drain, open, abdom abscess					
49041	C		Drain, percut, abdom abscess					
49060	C		Drain, open, retrop abscess					
49061	C		Drain, percut, retroper absc					
49062	C		Drain to peritoneal cavity					
49080	T		Puncture, peritoneal cavity	0070	3.0717	$167.60		$33.52
49081	T		Removal of abdominal fluid	0070	3.0717	$167.60		$33.52
49085	T		Remove abdomen foreign body	0153	20.8723	$1,138.81	$410.87	$227.76
49180	T		Biopsy, abdominal mass	0685	4.8100	$262.44	$115.47	$52.49
49200	T		Removal of abdominal lesion	0130	32.7724	$1,788.09	$659.53	$357.62
49201	C		Remove abdom lesion, complex					
49215	C		Excise sacral spine tumor					
49220	C		Multiple surgery, abdomen					
49250	T		Excision of umbilicus	0153	20.8723	$1,138.81	$410.87	$227.76
49255	C		Removal of omentum					
49320	T		Diag laparo separate proc	0130	32.7724	$1,788.09	$659.53	$357.62
49321	T		Laparoscopy, biopsy	0130	32.7724	$1,788.09	$659.53	$357.62
49322	T		Laparoscopy, aspiration	0130	32.7724	$1,788.09	$659.53	$357.62
49323	T		Laparo drain lymphocele	0130	32.7724	$1,788.09	$659.53	$357.62
49329	T		Laparo proc, abdm/per/oment	0130	32.7724	$1,788.09	$659.53	$357.62
49400	N		Air injection into abdomen					
49419	T		Insrt abdom cath for chemotx	0119	134.7194	$7,350.43		$1,470.09
49420	T		Insert abdom drain, temp	0652	27.0364	$1,475.13		$295.03
49421	T		Insert abdom drain, perm	0652	27.0364	$1,475.13		$295.03
49422	T		Remove perm cannula/catheter	0105	19.1898	$1,047.01	$370.40	$209.40
49423	T		Exchange drainage catheter	0152	9.1474	$499.09	$125.28	$99.82
49424	N		Assess cyst, contrast inject					
49425	C		Insert abdomen-venous drain					
49426	T		Revise abdomen-venous shunt	0153	20.8723	$1,138.81	$410.87	$227.76
49427	N		Injection, abdominal shunt					
49428	C		Ligation of shunt					
49429	T		Removal of shunt	0105	19.1898	$1,047.01	$370.40	$209.40
49491	T		Rpr hem preemie reduc	0154	26.9636	$1,471.16	$464.85	$294.23
49492	T		Rpr ing hem premie, blocked	0154	26.9636	$1,471.16	$464.85	$294.23
49495	T		Rpr ing hernia baby, reduc	0154	26.9636	$1,471.16	$464.85	$294.23
49496	T		Rpr ing hernia baby, blocked	0154	26.9636	$1,471.16	$464.85	$294.23
49500	T		Rpr ing hernia, init, reduce	0154	26.9636	$1,471.16	$464.85	$294.23
49501	T		Rpr ing hernia, init blocked	0154	26.9636	$1,471.16	$464.85	$294.23
49505	T		Prp i/hem init reduc>5 yr	0154	26.9636	$1,471.16	$464.85	$294.23
49507	T		Prp i/hem init block>5 yr	0154	26.9636	$1,471.16	$464.85	$294.23
49520	T		Rerepair ing hernia, reduce	0154	26.9636	$1,471.16	$464.85	$294.23
49521	T		Rerepair ing hernia, blocked	0154	26.9636	$1,471.16	$464.85	$294.23
49525	T		Repair ing hernia, sliding	0154	26.9636	$1,471.16	$464.85	$294.23
49540	T		Repair lumbar hernia	0154	26.9636	$1,471.16	$464.85	$294.23
49550	T		Rpr rem hernia, init, reduce	0154	26.9636	$1,471.16	$464.85	$294.23
49553	T		Rpr fem hernia, init blocked	0154	26.9636	$1,471.16	$464.85	$294.23
49555	T		Rerepair fem hernia, reduce	0154	26.9636	$1,471.16	$464.85	$294.23
49557	T		Rerepair fem hernia, blocked	0154	26.9636	$1,471.16	$464.85	$294.23
49560	T		Rpr ventral hern init, reduc	0154	26.9636	$1,471.16	$464.85	$294.23
49561	T		Rpr ventral hern init, block	0154	26.9636	$1,471.16	$464.85	$294.23
49565	T		Rerepair ventrl hern, reduce	0154	26.9636	$1,471.16	$464.85	$294.23
49566	T		Rerepair ventrl hern, block	0154	26.9636	$1,471.16	$464.85	$294.23
49568	T		Hernia repair w/mesh	0154	26.9636	$1,471.16	$464.85	$294.23
49570	T		Rpr epigastric hern, reduce	0154	26.9636	$1,471.16	$464.85	$294.23
49572	T		Rpr epigastric hern, blocked	0154	26.9636	$1,471.16	$464.85	$294.23
49580	T		Rpr umbil hern, reduc < 5 yr	0154	26.9636	$1,471.16	$464.85	$294.23
49582	T		Rpr umbil hern, block < 5 yr	0154	26.9636	$1,471.16	$464.85	$294.23
49585	T		Rpr umbil hern, reduc > 5 yr	0154	26.9636	$1,471.16	$464.85	$294.23
49587	T		Rpr umbil hern, block > 5 yr	0154	26.9636	$1,471.16	$464.85	$294.23
49590	T		Repair spigilian hernia	0154	26.9636	$1,471.16	$464.85	$294.23
49600	T		Repair umbilical lesion	0154	26.9636	$1,471.16	$464.85	$294.23
49605	C		Repair umbilical lesion					
49606	C		Repair umbilical lesion					
49610	C		Repair umbilical lesion					
49611	C		Repair umbilical lesion					
49650	T		Laparo hernia repair initial	0131	40.8064	$2,226.44	$1,001.89	$445.29
49651	T		Laparo hernia repair recur	0131	40.8064	$2,226.44	$1,001.89	$445.29
49659	T		Laparo proc, hernia repair	0131	40.8064	$2,226.44	$1,001.89	$445.29
49900	C		Repair of abdominal wall					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
49904	C		Omental flap, extra-abdom					
49905	C		Omental flap					
49906	C		Free omental flap, microvasc					
49999	T		Abdomen surgery procedure	0153	20.8723	$1,138.81	$410.87	$227.76
50010	C		Exploration of kidney					
50020	C		Renal abscess, open drain					
50021	T		Renal abscess, percut drain	0037	9.8921	$539.72	$237.45	$107.94
50040	C		Drainage of kidney					
50045	C		Exploration of kidney					
50060	C		Removal of kidney stone					
50065	C		Incision of kidney					
50070	C		Incision of kidney					
50075	C		Removal of kidney stone					
50080	T		Removal of kidney stone	0163	33.8805	$1,848.55		$369.71
50081	T		Removal of kidney stone	0163	33.8805	$1,848.55		$369.71
50100	C		Revise kidney blood vessels					
50120	C		Exploration of kidney					
50125	C		Explore and drain kidney					
50130	C		Removal of kidney stone					
50135	C		Exploration of kidney					
50200	T		Biopsy of kidney	0685	4.8100	$262.44	$115.47	$52.49
50205	C		Biopsy of kidney					
50220	C		Remove kidney, open					
50225	C		Removal kidney open, complex					
50230	C		Removal kidney open, radical					
50234	C		Removal of kidney & ureter					
50236	C		Removal of kidney & ureter					
50240	C		Partial removal of kidney					
50280	C		Removal of kidney lesion					
50290	C		Removal of kidney lesion					
50300	C		Removal of donor kidney					
50320	C		Removal of donor kidney					
50340	C		Removal of kidney					
50360	C		Transplantation of kidney					
50365	C		Transplantation of kidney					
50370	C		Remove transplanted kidney					
50380	C		Reimplantation of kidney					
50390	T		Drainage of kidney lesion	0685	4.8100	$262.44	$115.47	$52.49
50392	T		Insert kidney drain	0161	16.8407	$918.85	$249.36	$183.77
50393	T		Insert ureteral tube	0161	16.8407	$918.85	$249.36	$183.77
50394	N		Injection for kidney x-ray					
50395	T		Create passage to kidney	0161	16.8407	$918.85	$249.36	$183.77
50396	T		Measure kidney pressure	0164	1.2021	$65.59	$17.59	$13.12
50398	T		Change kidney tube	0122	8.8621	$483.53	$99.16	$96.71
50400	C		Revision of kidney/ureter					
50405	C		Revision of kidney/ureter					
50500	C		Repair of kidney wound					
50520	C		Close kidney-skin fistula					
50525	C		Repair renal-abdomen fistula					
50526	C		Repair renal-abdomen fistula					
50540	C		Revision of horseshoe kidney					
50541	T		Laparo ablate renal cyst	0130	32.7724	$1,788.09	$659.53	$357.62
50542	T		Laparo ablate renal mass	0131	40.8064	$2,226.44	$1,001.89	$445.29
50543	T		Laparo partial nephrectomy	0131	40.8064	$2,226.44	$1,001.89	$445.29
50544	T		Laparoscopy, pyeloplasty	0130	32.7724	$1,788.09	$659.53	$357.62
50545	C		Laparo radical nephrectomy					
50546	C		Laparoscopic nephrectomy					
50547	C		Laparo removal donor kidney					
50548	C		Laparo remove w/ ureter					
50549	T		Laparoscope proc, renal	0130	32.7724	$1,788.09	$659.53	$357.62
50551	T		Kidney endoscopy	0160	6.8801	$375.39	$105.06	$75.08
50553	T		Kidney endoscopy	0161	16.8407	$918.85	$249.36	$183.77
50555	T		Kidney endoscopy & biopsy	0160	6.8801	$375.39	$105.06	$75.08
50557	T		Kidney endoscopy & treatment	0162	21.9098	$1,195.42		$239.08
50559	T		Renal endoscopy/radiotracer	0160	6.8801	$375.39	$105.06	$75.08
50561	T		Kidney endoscopy & treatment	0161	16.8407	$918.85	$249.36	$183.77
50562	T		Renal scope w/tumor resect	0160	6.8801	$375.39	$105.06	$75.08
50570	C		Kidney endoscopy					
50572	C		Kidney endoscopy					
50574	C		Kidney endoscopy & biopsy					
50575	C		Kidney endoscopy					
50576	C		Kidney endoscopy & treatment					
50578	C		Renal endoscopy/radiotracer					
50580	C		Kidney endoscopy & treatment					
50590	T		Fragmenting of kidney stone	0169	45.1150	$2,461.52	$1,115.69	$492.30

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
50600	C		Exploration of ureter					
50605	C		Insert ureteral support					
50610	C		Removal of ureter stone					
50620	C		Removal of ureter stone					
50630	C		Removal of ureter stone					
50650	C		Removal of ureter					
50660	C		Removal of ureter					
50684	N		Injection for ureter x-ray					
50686	T		Measure ureter pressure	0164	1.2021	$65.59	$17.59	$13.12
50688	T		Change of ureter tube	0122	8.8621	$483.53	$99.16	$96.71
50690	N		Injection for ureter x-ray					
50700	C		Revision of ureter					
50715	C		Release of ureter					
50722	C		Release of ureter					
50725	C		Release/revise ureter					
50727	C		Revise ureter					
50728	C		Revise ureter					
50740	C		Fusion of ureter & kidney					
50750	C		Fusion of ureter & kidney					
50760	C		Fusion of ureters					
50770	C		Splicing of ureters					
50780	C		Reimplant ureter in bladder					
50782	C		Reimplant ureter in bladder					
50783	C		Reimplant ureter in bladder					
50785	C		Reimplant ureter in bladder					
50800	C		Implant ureter in bowel					
50810	C		Fusion of ureter & bowel					
50815	C		Urine shunt to intestine					
50820	C		Construct bowel bladder					
50825	C		Construct bowel bladder					
50830	C		Revise urine flow					
50840	C		Replace ureter by bowel					
50845	C		Appendico-vesicostomy					
50860	C		Transplant ureter to skin					
50900	C		Repair of ureter					
50920	C		Closure ureter/skin fistula					
50930	C		Closure ureter/bowel fistula					
50940	C		Release of ureter					
50945	T		Laparoscopy ureterolithotomy	0131	40.8064	$2,226.44	$1,001.89	$445.29
50947	T		Laparo new ureter/bladder	0131	40.8064	$2,226.44	$1,001.89	$445.29
50948	T		Laparo new ureter/bladder	0131	40.8064	$2,226.44	$1,001.89	$445.29
50949	T		Laparoscope proc, ureter	0130	32.7724	$1,788.09	$659.53	$357.62
50951	T		Endoscopy of ureter	0160	6.8801	$375.39	$105.06	$75.08
50953	T		Endoscopy of ureter	0160	6.8801	$375.39	$105.06	$75.08
50955	T		Ureter endoscopy & biopsy	0161	16.8407	$918.85	$249.36	$183.77
50957	T		Ureter endoscopy & treatment	0161	16.8407	$918.85	$249.36	$183.77
50959	T		Ureter endoscopy & tracer	0161	16.8407	$918.85	$249.36	$183.77
50961	T		Ureter endoscopy & treatment	0161	16.8407	$918.85	$249.36	$183.77
50970	T		Ureter endoscopy	0160	6.8801	$375.39	$105.06	$75.08
50972	T		Ureter endoscopy & catheter	0160	6.8801	$375.39	$105.06	$75.08
50974	T		Ureter endoscopy & biopsy	0161	16.8407	$918.85	$249.36	$183.77
50976	T		Ureter endoscopy & treatment	0161	16.8407	$918.85	$249.36	$183.77
50978	T		Ureter endoscopy & tracer	0161	16.8407	$918.85	$249.36	$183.77
50980	T		Ureter endoscopy & treatment	0161	16.8407	$918.85	$249.36	$183.77
51000	T		Drainage of bladder	0164	1.2021	$65.59	$17.59	$13.12
51005	T		Drainage of bladder	0164	1.2021	$65.59	$17.59	$13.12
51010	T		Drainage of bladder	0165	14.6838	$801.16		$160.23
51020	T		Incise & treat bladder	0162	21.9098	$1,195.42		$239.08
51030	T		Incise & treat bladder	0162	21.9098	$1,195.42		$239.08
51040	T		Incise & drain bladder	0162	21.9098	$1,195.42		$239.08
51045	T		Incise bladder/drain ureter	0160	6.8801	$375.39	$105.06	$75.08
51050	T		Removal of bladder stone	0162	21.9098	$1,195.42		$239.08
51060	C		Removal of ureter stone					
51065	T		Remove ureter calculus	0162	21.9098	$1,195.42		$239.08
51080	T		Drainage of bladder abscess	0007	11.8633	$647.27		$129.45
51500	T		Removal of bladder cyst	0154	26.9636	$1,471.16	$464.85	$294.23
51520	T		Removal of bladder lesion	0162	21.9098	$1,195.42		$239.08
51525	C		Removal of bladder lesion					
51530	C		Removal of bladder lesion					
51535	C		Repair of ureter lesion					
51550	C		Partial removal of bladder					
51555	C		Partial removal of bladder					
51565	C		Revise bladder & ureter(s)					
51570	C		Removal of bladder					
51575	C		Removal of bladder & nodes					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
51580	C		Remove bladder/revise tract					
51585	C		Removal of bladder & nodes					
51590	C		Remove bladder/revise tract					
51595	C		Remove bladder/revise tract					
51596	C		Remove bladder/create pouch					
51597	C		Removal of pelvic structures					
51600	N		Injection for bladder x-ray					
51605	N		Preparation for bladder xray					
51610	N		Injection for bladder x-ray					
51700	T		Irrigation of bladder	0164	1.2021	$65.59	$17.59	$13.12
51701	N		Insert bladder catheter					
51702	N		Insert temp bladder cath					
51703	N		Insert bladder cath, complex					
51705	T		Change of bladder tube	0121	2.1189	$115.61	$43.80	$23.12
51710	T		Change of bladder tube	0122	8.8621	$483.53	$99.16	$96.71
51715	T		Endoscopic injection/implant	0167	30.0186	$1,637.84	$555.84	$327.57
51720	T		Treatment of bladder lesion	0156	2.4747	$135.02	$40.52	$27.00
51725	T		Simple cystometrogram	0156	2.4747	$135.02	$40.52	$27.00
51726	T		Complex cystometrogram	0156	2.4747	$135.02	$40.52	$27.00
51736	T		Urine flow measurement	0164	1.2021	$65.59	$17.59	$13.12
51741	T		Electro-uroflowmetry, first	0164	1.2021	$65.59	$17.59	$13.12
51772	T		Urethra pressure profile	0164	1.2021	$65.59	$17.59	$13.12
51784	T		Anal/urinary muscle study	0164	1.2021	$65.59	$17.59	$13.12
51785	T		Anal/urinary muscle study	0164	1.2021	$65.59	$17.59	$13.12
51792	T		Urinary reflex study	0164	1.2021	$65.59	$17.59	$13.12
51795	T		Urine voiding pressure study	0164	1.2021	$65.59	$17.59	$13.12
51797	T		Intraabdominal pressure test	0164	1.2021	$65.59	$17.59	$13.12
51798	X		Us urine capacity measure	0340	0.6314	$34.45		$6.89
51800	C		Revision of bladder/urethra					
51820	C		Revision of urinary tract					
51840	C		Attach bladder/urethra					
51841	C		Attach bladder/urethra					
51845	C		Repair bladder neck					
51860	C		Repair of bladder wound					
51865	C		Repair of bladder wound					
51880	T		Repair of bladder opening	0162	21.9098	$1,195.42		$239.08
51900	C		Repair bladder/vagina lesion					
51920	C		Close bladder-uterus fistula					
51925	C		Hysterectomy/bladder repair					
51940	C		Correction of bladder defect					
51960	C		Revision of bladder & bowel					
51980	C		Construct bladder opening					
51990	T		Laparo urethral suspension	0131	40.8064	$2,226.44	$1,001.89	$445.29
51992	T		Laparo sling operation	0132	57.2045	$3,121.13	$1,239.22	$624.23
52000	T		Cystoscopy	0160	6.8801	$375.39	$105.06	$75.08
52001	T		Cystoscopy, removal of clots	0160	6.8801	$375.39	$105.06	$75.08
52005	T		Cystoscopy & ureter catheter	0161	16.8407	$918.85	$249.36	$183.77
52007	T		Cystoscopy and biopsy	0161	16.8407	$918.85	$249.36	$183.77
52010	T		Cystoscopy & duct catheter	0160	6.8801	$375.39	$105.06	$75.08
52204	T		Cystoscopy	0161	16.8407	$918.85	$249.36	$183.77
52214	T		Cystoscopy and treatment	0162	21.9098	$1,195.42		$239.08
52224	T		Cystoscopy and treatment	0162	21.9098	$1,195.42		$239.08
52234	T		Cystoscopy and treatment	0162	21.9098	$1,195.42		$239.08
52235	T		Cystoscopy and treatment	0162	21.9098	$1,195.42		$239.08
52240	T		Cystoscopy and treatment	0162	21.9098	$1,195.42		$239.08
52250	T		Cystoscopy and radiotracer	0162	21.9098	$1,195.42		$239.08
52260	T		Cystoscopy and treatment	0161	16.8407	$918.85	$249.36	$183.77
52265	T		Cystoscopy and treatment	0160	6.8801	$375.39	$105.06	$75.08
52270	T		Cystoscopy & revise urethra	0161	16.8407	$918.85	$249.36	$183.77
52275	T		Cystoscopy & revise urethra	0161	16.8407	$918.85	$249.36	$183.77
52276	T		Cystoscopy and treatment	0161	16.8407	$918.85	$249.36	$183.77
52277	T		Cystoscopy and treatment	0162	21.9098	$1,195.42		$239.08
52281	T		Cystoscopy and treatment	0161	16.8407	$918.85	$249.36	$183.77
52282	S		Cystoscopy, implant stent	0385	67.1530	$3,663.93		$732.79
52283	T		Cystoscopy and treatment	0161	16.8407	$918.85	$249.36	$183.77
52285	T		Cystoscopy and treatment	0161	16.8407	$918.85	$249.36	$183.77
52290	T		Cystoscopy and treatment	0161	16.8407	$918.85	$249.36	$183.77
52300	T		Cystoscopy and treatment	0161	16.8407	$918.85	$249.36	$183.77
52301	T		Cystoscopy and treatment	0161	16.8407	$918.85	$249.36	$183.77
52305	T		Cystoscopy and treatment	0161	16.8407	$918.85	$249.36	$183.77
52310	T		Cystoscopy and treatment	0160	6.8801	$375.39	$105.06	$75.08
52315	T		Cystoscopy and treatment	0161	16.8407	$918.85	$249.36	$183.77
52317	T		Remove bladder stone	0162	21.9098	$1,195.42		$239.08
52318	T		Remove bladder stone	0162	21.9098	$1,195.42		$239.08
52320	T		Cystoscopy and treatment	0162	21.9098	$1,195.42		$239.08

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
52325	T		Cystoscopy, stone removal	0162	21.9098	$1,195.42		$239.08
52327	T		Cystoscopy, inject material	0162	21.9098	$1,195.42		$239.08
52330	T		Cystoscopy and treatment	0162	21.9098	$1,195.42		$239.08
52332	T		Cystoscopy and treatment	0162	21.9098	$1,195.42		$239.08
52334	T		Create passage to kidney	0162	21.9098	$1,195.42		$239.08
52341	T		Cysto w/ureter stricture tx	0162	21.9098	$1,195.42		$239.08
52342	T		Cysto w/up stricture tx	0162	21.9098	$1,195.42		$239.08
52343	T		Cysto w/renal stricture tx	0162	21.9098	$1,195.42		$239.08
52344	T		Cysto/uretero, stone remove	0162	21.9098	$1,195.42		$239.08
52345	T		Cysto/uretero w/up stricture	0162	21.9098	$1,195.42		$239.08
52346	T		Cystouretero w/renal strict	0162	21.9098	$1,195.42		$239.08
52347	T		Cystoscopy, resect ducts	0161	16.8407	$918.85	$249.36	$183.77
52351	T		Cystouretero & or pyeloscope	0161	16.8407	$918.85	$249.36	$183.77
52352	T		Cystouretero w/stone remove	0162	21.9098	$1,195.42		$239.08
52353	T		Cystouretero w/lithotripsy	0163	33.8805	$1,848.55		$369.71
52354	T		Cystouretero w/biopsy	0162	21.9098	$1,195.42		$239.08
52355	T		Cystouretero w/excise tumor	0162	21.9098	$1,195.42		$239.08
52400	T		Cystouretero w/congen repr	0162	21.9098	$1,195.42		$239.08
52450	T		Incision of prostate	0162	21.9098	$1,195.42		$239.08
52500	T		Revision of bladder neck	0162	21.9098	$1,195.42		$239.08
52510	T		Dilation prostatic urethra	0161	16.8407	$918.85	$249.36	$183.77
52601	T		Prostatectomy (TURP)	0163	33.8805	$1,848.55		$369.71
52606	T		Control postop bleeding	0162	21.9098	$1,195.42		$239.08
52612	T		Prostatectomy, first stage	0163	33.8805	$1,848.55		$369.71
52614	T		Prostatectomy, second stage	0163	33.8805	$1,848.55		$369.71
52620	T		Remove residual prostate	0163	33.8805	$1,848.55		$369.71
52630	T		Remove prostate regrowth	0163	33.8805	$1,848.55		$369.71
52640	T		Relieve bladder contracture	0162	21.9098	$1,195.42		$239.08
52647	T		Laser surgery of prostate	0163	33.8805	$1,848.55		$369.71
52648	T		Laser surgery of prostate	0163	33.8805	$1,848.55		$369.71
52700	T		Drainage of prostate abscess	0162	21.9098	$1,195.42		$239.08
53000	T		Incision of urethra	0166	16.7918	$916.18	$218.73	$183.24
53010	T		Incision of urethra	0166	16.7918	$916.18	$218.73	$183.24
53020	T		Incision of urethra	0166	16.7918	$916.18	$218.73	$183.24
53025	T		Incision of urethra	0166	16.7918	$916.18	$218.73	$183.24
53040	T		Drainage of urethra abscess	0167	30.0186	$1,637.84	$555.84	$327.57
53060	T		Drainage of urethra abscess	0166	16.7918	$916.18	$218.73	$183.24
53080	T		Drainage of urinary leakage	0166	16.7918	$916.18	$218.73	$183.24
53085	C		Drainage of urinary leakage					
53200	T		Biopsy of urethra	0166	16.7918	$916.18	$218.73	$183.24
53210	T		Removal of urethra	0168	30.0147	$1,637.63	$405.60	$327.53
53215	T		Removal of urethra	0166	16.7918	$916.18	$218.73	$183.24
53220	T		Treatment of urethra lesion	0168	30.0147	$1,637.63	$405.60	$327.53
53230	T		Removal of urethra lesion	0168	30.0147	$1,637.63	$405.60	$327.53
53235	T		Removal of urethra lesion	0166	16.7918	$916.18	$218.73	$183.24
53240	T		Surgery for urethra pouch	0168	30.0147	$1,637.63	$405.60	$327.53
53250	T		Removal of urethra gland	0166	16.7918	$916.18	$218.73	$183.24
53260	T		Treatment of urethra lesion	0166	16.7918	$916.18	$218.73	$183.24
53265	T		Treatment of urethra lesion	0166	16.7918	$916.18	$218.73	$183.24
53270	T		Removal of urethra gland	0167	30.0186	$1,637.84	$555.84	$327.57
53275	T		Repair of urethra defect	0166	16.7918	$916.18	$218.73	$183.24
53400	T		Revise urethra, stage 1	0168	30.0147	$1,637.63	$405.60	$327.53
53405	T		Revise urethra, stage 2	0168	30.0147	$1,637.63	$405.60	$327.53
53410	T		Reconstruction of urethra	0168	30.0147	$1,637.63	$405.60	$327.53
53415	C		Reconstruction of urethra					
53420	T		Reconstruct urethra, stage 1	0168	30.0147	$1,637.63	$405.60	$327.53
53425	T		Reconstruct urethra, stage 2	0168	30.0147	$1,637.63	$405.60	$327.53
53430	T		Reconstruction of urethra	0168	30.0147	$1,637.63	$405.60	$327.53
53431	T		Reconstruct urethra/bladder	0168	30.0147	$1,637.63	$405.60	$327.53
53440	S		Correct bladder function	0385	67.1530	$3,663.93		$732.79
53442	T		Remove perineal prosthesis	0167	30.0186	$1,637.84	$555.84	$327.57
53444	S		Insert tandem cuff	0385	67.1530	$3,663.93		$732.79
53445	S		Insert uro/ves nck sphincter	0386	116.2382	$6,342.07		$1,268.41
53446	T		Remove uro sphincter	0168	30.0147	$1,637.63	$405.60	$327.53
53447	S		Remove/replace ur sphincter	0386	116.2382	$6,342.07		$1,268.41
53448	C		Remov/replc ur sphinctr comp					
53449	T		Repair uro sphincter	0168	30.0147	$1,637.63	$405.60	$327.53
53450	T		Revision of urethra	0168	30.0147	$1,637.63	$405.60	$327.53
53460	T		Revision of urethra	0166	16.7918	$916.18	$218.73	$183.24
53500	T	NI	Urethrlys, transvag w/ scope	0168	30.0147	$1,637.63	$405.60	$327.53
53502	T		Repair of urethra injury	0166	16.7918	$916.18	$218.73	$183.24
53505	T		Repair of urethra injury	0167	30.0186	$1,637.84	$555.84	$327.57
53510	T		Repair of urethra injury	0166	16.7918	$916.18	$218.73	$183.24
53515	T		Repair of urethra injury	0168	30.0147	$1,637.63	$405.60	$327.53
53520	T		Repair of urethra defect	0168	30.0147	$1,637.63	$405.60	$327.53

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
53600	T		Dilate urethra stricture	0156	2.4747	$135.02	$40.52	$27.00
53601	T		Dilate urethra stricture	0164	1.2021	$65.59	$17.59	$13.12
53605	T		Dilate urethra stricture	0161	16.8407	$918.85	$249.36	$183.77
53620	T		Dilate urethra stricture	0165	14.6838	$801.16		$160.23
53621	T		Dilate urethra stricture	0164	1.2021	$65.59	$17.59	$13.12
53660	T		Dilation of urethra	0164	1.2021	$65.59	$17.59	$13.12
53661	T		Dilation of urethra	0164	1.2021	$65.59	$17.59	$13.12
53665	T		Dilation of urethra	0166	16.7918	$916.18	$218.73	$183.24
53850	T		Prostatic microwave thermotx	0675	49.3452	$2,692.32		$538.46
53852	T		Prostatic rf thermotx	0675	49.3452	$2,692.32		$538.46
53853	T		Prostatic water thermother	1550		$1,150.00		$230.00
53899	T		Urology surgery procedure	0164	1.2021	$65.59	$17.59	$13.12
54000	T		Slitting of prepuce	0166	16.7918	$916.18	$218.73	$183.24
54001	T		Slitting of prepuce	0166	16.7918	$916.18	$218.73	$183.24
54015	T		Drain penis lesion	0007	11.8633	$647.27		$129.45
54050	T		Destruction, penis lesion(s)	0013	1.1272	$61.50	$14.20	$12.30
54055	T		Destruction, penis lesion(s)	0017	16.3697	$893.15	$227.84	$178.63
54056	T		Cryosurgery, penis lesion(s)	0012	0.7694	$41.98	$11.18	$8.40
54057	T		Laser surg, penis lesion(s)	0017	16.3697	$893.15	$227.84	$178.63
54060	T		Excision of penis lesion(s)	0017	16.3697	$893.15	$227.84	$178.63
54065	T		Destruction, penis lesion(s)	0695	19.1849	$1,046.75	$266.59	$209.35
54100	T		Biopsy of penis	0021	14.3594	$783.46	$219.48	$156.69
54105	T		Biopsy of penis	0022	18.7932	$1,025.38	$354.45	$205.08
54110	T		Treatment of penis lesion	0181	29.4217	$1,605.28	$621.82	$321.06
54111	T		Treat penis lesion, graft	0181	29.4217	$1,605.28	$621.82	$321.06
54112	T		Treat penis lesion, graft	0181	29.4217	$1,605.28	$621.82	$321.06
54115	T		Treatment of penis lesion	0008	19.4831	$1,063.02		$212.60
54120	T		Partial removal of penis	0181	29.4217	$1,605.28	$621.82	$321.06
54125	C		Removal of penis					
54130	C		Remove penis & nodes					
54135	C		Remove penis & nodes					
54150	T		Circumcision	0180	18.6176	$1,015.79	$304.87	$203.16
54152	T		Circumcision	0180	18.6176	$1,015.79	$304.87	$203.16
54160	T		Circumcision	0180	18.6176	$1,015.79	$304.87	$203.16
54161	T		Circumcision	0180	18.6176	$1,015.79	$304.87	$203.16
54162	T		Lysis penil circumic lesion	0180	18.6176	$1,015.79	$304.87	$203.16
54163	T		Repair of circumcision	0180	18.6176	$1,015.79	$304.87	$203.16
54164	T		Frenulotomy of penis	0180	18.6176	$1,015.79	$304.87	$203.16
54200	T		Treatment of penis lesion	0156	2.4747	$135.02	$40.52	$27.00
54205	T		Treatment of penis lesion	0181	29.4217	$1,605.28	$621.82	$321.06
54220	T		Treatment of penis lesion	0156	2.4747	$135.02	$40.52	$27.00
54230	N		Prepare penis study					
54231	T		Dynamic cavernosometry	0165	14.6838	$801.16		$160.23
54235	T		Penile injection	0164	1.2021	$65.59	$17.59	$13.12
54240	T		Penis study	0164	1.2021	$65.59	$17.59	$13.12
54250	T		Penis study	0164	1.2021	$65.59	$17.59	$13.12
54300	T		Revision of penis	0181	29.4217	$1,605.28	$621.82	$321.06
54304	T		Revision of penis	0181	29.4217	$1,605.28	$621.82	$321.06
54308	T		Reconstruction of urethra	0181	29.4217	$1,605.28	$621.82	$321.06
54312	T		Reconstruction of urethra	0181	29.4217	$1,605.28	$621.82	$321.06
54316	T		Reconstruction of urethra	0181	29.4217	$1,605.28	$621.82	$321.06
54318	T		Reconstruction of urethra	0181	29.4217	$1,605.28	$621.82	$321.06
54322	T		Reconstruction of urethra	0181	29.4217	$1,605.28	$621.82	$321.06
54324	T		Reconstruction of urethra	0181	29.4217	$1,605.28	$621.82	$321.06
54326	T		Reconstruction of urethra	0181	29.4217	$1,605.28	$621.82	$321.06
54328	T		Revise penis/urethra	0181	29.4217	$1,605.28	$621.82	$321.06
54332	C		Revise penis/urethra					
54336	C		Revise penis/urethra					
54340	T		Secondary urethral surgery	0181	29.4217	$1,605.28	$621.82	$321.06
54344	T		Secondary urethral surgery	0181	29.4217	$1,605.28	$621.82	$321.06
54348	T		Secondary urethral surgery	0181	29.4217	$1,605.28	$621.82	$321.06
54352	T		Reconstruct urethra/penis	0181	29.4217	$1,605.28	$621.82	$321.06
54360	T		Penis plastic surgery	0181	29.4217	$1,605.28	$621.82	$321.06
54380	T		Repair penis	0181	29.4217	$1,605.28	$621.82	$321.06
54385	T		Repair penis	0181	29.4217	$1,605.28	$621.82	$321.06
54390	C		Repair penis and bladder					
54400	S		Insert semi-rigid prosthesis	0385	67.1530	$3,663.93		$732.79
54401	S		Insert self-contd prosthesis	0386	116.2382	$6,342.07		$1,268.41
54405	S		Insert multi-comp penis pros	0386	116.2382	$6,342.07		$1,268.41
54406	T		Remove muti-comp penis pros	0181	29.4217	$1,605.28	$621.82	$321.06
54408	T		Repair multi-comp penis pros	0181	29.4217	$1,605.28	$621.82	$321.06
54410	S		Remove/replace penis prosth	0386	116.2382	$6,342.07		$1,268.41
54411	C		Remov/replc penis pros, comp					
54415	T		Remove self-contd penis pros	0181	29.4217	$1,605.28	$621.82	$321.06
54416	S		Remv/repl penis contain pros	0385	67.1530	$3,663.93		$732.79

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
54417	C		Remv/replc penis pros, compl					
54420	T		Revision of penis	0181	29.4217	$1,605.28	$621.82	$321.06
54430	C		Revision of penis					
54435	T		Revision of penis	0181	29.4217	$1,605.28	$621.82	$321.06
54440	T		Repair of penis	0181	29.4217	$1,605.28	$621.82	$321.06
54450	T		Preputial stretching	0156	2.4747	$135.02	$40.52	$27.00
54500	T		Biopsy of testis	0037	9.8921	$539.72	$237.45	$107.94
54505	T		Biopsy of testis	0183	21.6724	$1,182.47		$236.49
54512	T		Excise lesion testis	0183	21.6724	$1,182.47		$236.49
54520	T		Removal of testis	0183	21.6724	$1,182.47		$236.49
54522	T		Orchiectomy, partial	0183	21.6724	$1,182.47		$236.49
54530	T		Removal of testis	0154	26.9636	$1,471.16	$464.85	$294.23
54535	C		Extensive testis surgery					
54550	T		Exploration for testis	0154	26.9636	$1,471.16	$464.85	$294.23
54560	C		Exploration for testis					
54600	T		Reduce testis torsion	0183	21.6724	$1,182.47		$236.49
54620	T		Suspension of testis	0183	21.6724	$1,182.47		$236.49
54640	T		Suspension of testis	0154	26.9636	$1,471.16	$464.85	$294.23
54650	C		Orchiopexy (Fowler-Stephens)					
54660	T		Revision of testis	0183	21.6724	$1,182.47		$236.49
54670	T		Repair testis injury	0183	21.6724	$1,182.47		$236.49
54680	T		Relocation of testis(es)	0183	21.6724	$1,182.47		$236.49
54690	T		Laparoscopy, orchiectomy	0131	40.8064	$2,226.44	$1,001.89	$445.29
54692	T		Laparoscopy, orchiopexy	0132	57.2045	$3,121.13	$1,239.22	$624.23
54699	T		Laparoscope proc, testis	0130	32.7724	$1,788.09	$659.53	$357.62
54700	T		Drainage of scrotum	0183	21.6724	$1,182.47		$236.49
54800	T		Biopsy of epididymis	0004	1.5882	$86.65	$22.36	$17.33
54820	T		Exploration of epididymis	0183	21.6724	$1,182.47		$236.49
54830	T		Remove epididymis lesion	0183	21.6724	$1,182.47		$236.49
54840	T		Remove epididymis lesion	0183	21.6724	$1,182.47		$236.49
54860	T		Removal of epididymis	0183	21.6724	$1,182.47		$236.49
54861	T		Removal of epididymis	0183	21.6724	$1,182.47		$236.49
54900	T		Fusion of spermatic ducts	0183	21.6724	$1,182.47		$236.49
54901	T		Fusion of spermatic ducts	0183	21.6724	$1,182.47		$236.49
55000	T		Drainage of hydrocele	0004	1.5882	$86.65	$22.36	$17.33
55040	T		Removal of hydrocele	0154	26.9636	$1,471.16	$464.85	$294.23
55041	T		Removal of hydroceles	0154	26.9636	$1,471.16	$464.85	$294.23
55060	T		Repair of hydrocele	0183	21.6724	$1,182.47		$236.49
55100	T		Drainage of scrotum abscess	0007	11.8633	$647.27		$129.45
55110	T		Explore scrotum	0183	21.6724	$1,182.47		$236.49
55120	T		Removal of scrotum lesion	0183	21.6724	$1,182.47		$236.49
55150	T		Removal of scrotum	0183	21.6724	$1,182.47		$236.49
55175	T		Revision of scrotum	0183	21.6724	$1,182.47		$236.49
55180	T		Revision of scrotum	0183	21.6724	$1,182.47		$236.49
55200	T		Incision of sperm duct	0183	21.6724	$1,182.47		$236.49
55250	T		Removal of sperm duct(s)	0183	21.6724	$1,182.47		$236.49 W≤
55300	N		Prepare, sperm duct x-ray					
55400	T		Repair of sperm duct	0183	21.6724	$1,182.47		$236.49
55450	T		Ligation of sperm duct	0183	21.6724	$1,182.47		$236.49
55500	T		Removal of hydrocele	0183	21.6724	$1,182.47		$236.49
55520	T		Removal of sperm cord lesion	0183	21.6724	$1,182.47		$236.49
55530	T		Revise spermatic cord veins	0183	21.6724	$1,182.47		$236.49
55535	T		Revise spermatic cord veins	0154	26.9636	$1,471.16	$464.85	$294.23
55540	T		Revise hernia & sperm veins	0154	26.9636	$1,471.16	$464.85	$294.23
55550	T		Laparo ligate spermatic vein	0131	40.8064	$2,226.44	$1,001.89	$445.29
55559	T		Laparo proc, spermatic cord	0130	32.7724	$1,788.09	$659.53	$357.62
55600	C		Incise sperm duct pouch					
55605	C		Incise sperm duct pouch					
55650	C		Remove sperm duct pouch					
55680	T		Remove sperm pouch lesion	0183	21.6724	$1,182.47		$236.49
55700	T		Biopsy of prostate	0184	3.8995	$212.76	$96.27	$42.55
55705	T		Biopsy of prostate	0184	3.8995	$212.76	$96.27	$42.55
55720	T		Drainage of prostate abscess	0162	21.9098	$1,195.42		$239.08
55725	T		Drainage of prostate abscess	0162	21.9098	$1,195.42		$239.08
55801	C		Removal of prostate					
55810	C		Extensive prostate surgery					
55812	C		Extensive prostate surgery					
55815	C		Extensive prostate surgery					
55821	C		Removal of prostate					
55831	C		Removal of prostate					
55840	C		Extensive prostate surgery					
55842	C		Extensive prostate surgery					
55845	C		Extensive prostate surgery					
55859	T		Percut/needle insert, pros	0163	33.8805	$1,848.55		$369.71
55860	T		Surgical exposure, prostate	0165	14.6838	$801.16		$160.23

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
55862	C		Extensive prostate surgery					
55865	C		Extensive prostate surgery					
55866	C		Laparo radical prostatectomy					
55870	T		Vag hyst w/enterocele repair	0197	4.8280	$263.42		$52.68
55873	T		Cryoablate prostate	0674	119.9733	$6,545.86		$1,309.17
55899	T		Genital surgery procedure	0164	1.2021	$65.59	$17.59	$13.12
55970	E		Sex transformation, M to F					
55980	E		Sex transformation, F to M					
56405	T		I & D of vulva/perineum	0192	2.7121	$147.97	$39.11	$29.59
56420	T		Drainage of gland abscess	0192	2.7121	$147.97	$39.11	$29.59
56440	T		Surgery for vulva lesion	0194	18.4286	$1,005.48	$397.84	$201.10
56441	T		Lysis of labial lesion(s)	0193	15.0453	$820.89	$171.13	$164.18
56501	T		Destroy, vulva lesions, sim	0017	16.3697	$893.15	$227.84	$178.63
56515	T		Destroy vulva lesion/s compl	0695	19.1849	$1,046.75	$266.59	$209.35
56605	T		Biopsy of vulva/perineum	0019	3.9493	$215.48	$71.87	$43.10
56606	T		Biopsy of vulva/perineum	0019	3.9493	$215.48	$71.87	$43.10
56620	T		Partial removal of vulva	0195	25.6950	$1,401.94	$483.80	$280.39
56625	T		Complete removal of vulva	0195	25.6950	$1,401.94	$483.80	$280.39
56630	C		Extensive vulva surgery					
56631	C		Extensive vulva surgery					
56632	C		Extensive vulva surgery					
56633	C		Extensive vulva surgery					
56634	C		Extensive vulva surgery					
56637	C		Extensive vulva surgery					
56640	C		Extensive vulva surgery					
56700	T		Partial removal of hymen	0194	18.4286	$1,005.48	$397.84	$201.10
56720	T		Incision of hymen	0193	15.0453	$820.89	$171.13	$164.18
56740	T		Remove vagina gland lesion	0194	18.4286	$1,005.48	$397.84	$201.10
56800	T		Repair of vagina	0194	18.4286	$1,005.48	$397.84	$201.10
56805	T		Repair clitoris	0194	18.4286	$1,005.48	$397.84	$201.10
56810	T		Repair of perineum	0194	18.4286	$1,005.48	$397.84	$201.10
56820	T		Exam of vulva w/scope	0188	1.1365	$62.01		$12.40
56821	T		Exam/biopsy of vulva w/scope	0189	1.4232	$77.65	$18.09	$15.53
57000	T		Exploration of vagina	0194	18.4286	$1,005.48	$397.84	$201.10
57010	T		Drainage of pelvic abscess	0194	18.4286	$1,005.48	$397.84	$201.10
57020	T		Drainage of pelvic fluid	0192	2.7121	$147.97	$39.11	$29.59
57022	T		I & d vaginal hematoma, pp	0007	11.8633	$647.27		$129.45
57023	T		I & d vag hematoma, non-ob	0007	11.8633	$647.27		$129.45
57061	T		Destroy vag lesions, simple	0194	18.4286	$1,005.48	$397.84	$201.10
57065	T		Destroy vag lesions, complex	0194	18.4286	$1,005.48	$397.84	$201.10
57100	T		Biopsy of vagina	0192	2.7121	$147.97	$39.11	$29.59
57105	T		Biopsy of vagina	0194	18.4286	$1,005.48	$397.84	$201.10
57106	T		Remove vagina wall, partial	0194	18.4286	$1,005.48	$397.84	$201.10
57107	T		Remove vagina tissue, part	0195	25.6950	$1,401.94	$483.80	$280.39
57109	T		Vaginectomy partial w/nodes	0195	25.6950	$1,401.94	$483.80	$280.39
57110	C		Remove vagina wall, complete					
57111	C		Remove vagina tissue, compl					
57112	C		Vaginectomy w/nodes, compl					
57120	T		Closure of vagina	0195	25.6950	$1,401.94	$483.80	$280.39
57130	T		Remove vagina lesion	0194	18.4286	$1,005.48	$397.84	$201.10
57135	T		Remove vagina lesion	0194	18.4286	$1,005.48	$397.84	$201.10
57150	T		Treat vagina infection	0191	0.1853	$10.11	$2.93	$2.02
57155	T		Insert uteri tandems/ovoids	0193	15.0453	$820.89	$171.13	$164.18
57160	T		Insert pessary/other device	0188	1.1365	$62.01		$12.40
57170	T		Fitting of diaphragm/cap	0191	0.1853	$10.11	$2.93	$2.02
57180	T		Treat vaginal bleeding	0192	2.7121	$147.97	$39.11	$29.59
57200	T		Repair of vagina	0194	18.4286	$1,005.48	$397.84	$201.10
57210	T		Repair vagina/perineum	0194	18.4286	$1,005.48	$397.84	$201.10
57220	T		Revision of urethra	0195	25.6950	$1,401.94	$483.80	$280.39
57230	T		Repair of urethral lesion	0195	25.6950	$1,401.94	$483.80	$280.39
57240	T		Repair bladder & vagina	0195	25.6950	$1,401.94	$483.80	$280.39
57250	T		Repair rectum & vagina	0195	25.6950	$1,401.94	$483.80	$280.39
57260	T		Repair of vagina	0195	25.6950	$1,401.94	$483.80	$280.39
57265	T		Extensive repair of vagina	0195	25.6950	$1,401.94	$483.80	$280.39
57268	T		Repair of bowel bulge	0195	25.6950	$1,401.94	$483.80	$280.39
57270	C		Repair of bowel pouch					
57280	C		Suspension of vagina					
57282	C		Repair of vaginal prolapse					
57284	T		Repair paravaginal defect	0195	25.6950	$1,401.94	$483.80	$280.39
57287	T		Revise/remove sling repair	0202	38.9821	$2,126.90	$1,042.18	$425.38
57288	T		Repair bladder defect	0202	38.9821	$2,126.90	$1,042.18	$425.38
57289	T		Repair bladder & vagina	0195	25.6950	$1,401.94	$483.80	$280.39
57291	T		Construction of vagina	0195	25.6950	$1,401.94	$483.80	$280.39
57292	C		Construct vagina with graft					
57300	T		Repair rectum-vagina fistula	0195	25.6950	$1,401.94	$483.80	$280.39

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
57305	C		Repair rectum-vagina fistula					
57307	C		Fistula repair & colostomy					
57308	C		Fistula repair, transperine					
57310	T		Repair urethrovaginal lesion	0195	25.6950	$1,401.94	$483.80	$280.39
57311	C		Repair urethrovaginal lesion					
57320	T		Repair bladder-vagina lesion	0195	25.6950	$1,401.94	$483.80	$280.39
57330	T		Repair bladder-vagina lesion	0195	25.6950	$1,401.94	$483.80	$280.39
57335	C		Repair vagina					
57400	T		Dilation of vagina	0194	18.4286	$1,005.48	$397.84	$201.10
57410	T		Pelvic examination	0194	18.4286	$1,005.48	$397.84	$201.10
57415	T		Remove vaginal foreign body	0194	18.4286	$1,005.48	$397.84	$201.10
57420	T		Exam of vagina w/scope	0192	2.7121	$147.97	$39.11	$29.59
57421	T		Exam/biopsy of vag w/scope	0192	2.7121	$147.97	$39.11	$29.59
57425	T	NI	Laparoscopy, surg, colpopexy	0130	32.7724	$1,788.09	$659.53	$357.62
57452	T		Examination of vagina	0189	1.4232	$77.65	$18.09	$15.53
57454	T		Vagina examination & biopsy	0192	2.7121	$147.97	$39.11	$29.59
57455	T		Biopsy of cervix w/scope	0192	2.7121	$147.97	$39.11	$29.59
57456	T		Endocerv curettage w/scope	0192	2.7121	$147.97	$39.11	$29.59
57460	T		Cervix excision	0193	15.0453	$820.89	$171.13	$164.18
57461	T		Conz of cervix w/scope, leep	0194	18.4286	$1,005.48	$397.84	$201.10
57500	T		Biopsy of cervix	0192	2.7121	$147.97	$39.11	$29.59
57505	T		Endocervical curettage	0192	2.7121	$147.97	$39.11	$29.59
57510	T		Cauterization of cervix	0193	15.0453	$820.89	$171.13	$164.18
57511	T		Cryocautery of cervix	0189	1.4232	$77.65	$18.09	$15.53
57513	T		Laser surgery of cervix	0193	15.0453	$820.89	$171.13	$164.18
57520	T		Conization of cervix	0194	18.4286	$1,005.48	$397.84	$201.10
57522	T		Conization of cervix	0195	25.6950	$1,401.94	$483.80	$280.39
57530	T		Removal of cervix	0195	25.6950	$1,401.94	$483.80	$280.39
57531	C		Removal of cervix, radical					
57540	C		Removal of residual cervix					
57545	C		Remove cervix/repair pelvis					
57550	T		Removal of residual cervix	0195	25.6950	$1,401.94	$483.80	$280.39
57555	T		Remove cervix/repair vagina	0195	25.6950	$1,401.94	$483.80	$280.39
57556	T		Remove cervix, repair bowel	0195	25.6950	$1,401.94	$483.80	$280.39
57700	T		Revision of cervix	0194	18.4286	$1,005.48	$397.84	$201.10
57720	T		Revision of cervix	0194	18.4286	$1,005.48	$397.84	$201.10
57800	T		Dilation of cervical canal	0193	15.0453	$820.89	$171.13	$164.18
57820	T		D & c of residual cervix	0196	16.1219	$879.63	$338.23	$175.93
58100	T		Biopsy of uterus lining	0188	1.1365	$62.01		$12.40
58120	T		Dilation and curettage	0196	16.1219	$879.63	$338.23	$175.93
58140	C		Removal of uterus lesion					
58145	T		Myomectomy vag method	0195	25.6950	$1,401.94	$483.80	$280.39
58146	C		Myomectomy abdom complex					
58150	C		Total hysterectomy					
58152	C		Total hysterectomy					
58180	C		Partial hysterectomy					
58200	C		Extensive hysterectomy					
58210	C		Extensive hysterectomy					
58240	C		Removal of pelvis contents					
58260	C		Vaginal hysterectomy					
58262	C		Vag hyst including t/o					
58263	C		Vag hyst w/t/o & vag repair					
58267	C		Vag hyst w/urinary repair					
58270	C		Vag hyst w/enterocele repair					
58275	C		Hysterectomy/revise vagina					
58280	C		Hysterectomy/revise vagina					
58285	C		Extensive hysterectomy					
58290	C		Vag hyst complex					
58291	C		Vag hyst incl t/o, complex					
58292	C		Vag hyst t/o & repair, compl					
58293	C		Vag hyst w/uro repair, compl					
58294	C		Vag hyst w/enterocele, compl					
58300	E		Insert intrauterine device					
58301	T		Remove intrauterine device	0189	1.4232	$77.65	$18.09	$15.53
58321	T		Artificial insemination	0197	4.8280	$263.42		$52.68
58322	T		Artificial insemination	0197	4.8280	$263.42		$52.68
58323	T		Sperm washing	0197	4.8280	$263.42		$52.68
58340	N		Catheter for hysterography					
58345	T		Reopen fallopian tube	0194	18.4286	$1,005.48	$397.84	$201.10
58346	T		Insert heyman uteri capsule	0193	15.0453	$820.89	$171.13	$164.18
58350	T		Reopen fallopian tube	0194	18.4286	$1,005.48	$397.84	$201.10
58353	T		Endometr ablate, thermal	0195	25.6950	$1,401.94	$483.80	$280.39
58400	C		Suspension of uterus					
58410	C		Suspension of uterus					
58520	C		Repair of ruptured uterus					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
58540	C		Revision of uterus					
58545	T		Laparoscopic myomectomy	0130	32.7724	$1,788.09	$659.53	$357.62
58546	T		Laparo-myomectomy, complex	0131	40.8064	$2,226.44	$1,001.89	$445.29
58550	T		Laparo-asst vag hysterectomy	0132	57.2045	$3,121.13	$1,239.22	$624.23
58552	T		Laparo-vag hyst incl t/o	0131	40.8064	$2,226.44	$1,001.89	$445.29
58553	T		Laparo-vag hyst, complex	0131	40.8064	$2,226.44	$1,001.89	$445.29
58554	T		Laparo-vag hyst w/t/o, compl	0131	40.8064	$2,226.44	$1,001.89	$445.29
58555	T		Hysteroscopy, dx, sep proc	0190	19.6922	$1,074.43	$424.28	$214.89
58558	T		Hysteroscopy, biopsy	0190	19.6922	$1,074.43	$424.28	$214.89
58559	T		Hysteroscopy, lysis	0190	19.6922	$1,074.43	$424.28	$214.89
58560	T		Hysteroscopy, resect septum	0387	28.1480	$1,535.78	$655.55	$307.16
58561	T		Hysteroscopy, remove myoma	0387	28.1480	$1,535.78	$655.55	$307.16
58562	T		Hysteroscopy, remove fb	0190	19.6922	$1,074.43	$424.28	$214.89
58563	T		Hysteroscopy, ablation	0387	28.1480	$1,535.78	$655.55	$307.16
58578	T		Laparo proc, uterus	0130	32.7724	$1,788.09	$659.53	$357.62
58579	T		Hysteroscope procedure	0190	19.6922	$1,074.43	$424.28	$214.89
58600	T		Division of fallopian tube	0195	25.6950	$1,401.94	$483.80	$280.39
58605	C		Division of fallopian tube					
58611	C		Ligate oviduct(s) add-on					
58615	T		Occlude fallopian tube(s)	0194	18.4286	$1,005.48	$397.84	$201.10
58660	T		Laparoscopy, lysis	0131	40.8064	$2,226.44	$1,001.89	$445.29
58661	T		Laparoscopy, remove adnexa	0131	40.8064	$2,226.44	$1,001.89	$445.29
58662	T		Laparoscopy, excise lesions	0131	40.8064	$2,226.44	$1,001.89	$445.29
58670	T		Laparoscopy, tubal cautery	0131	40.8064	$2,226.44	$1,001.89	$445.29
58671	T		Laparoscopy, tubal block	0131	40.8064	$2,226.44	$1,001.89	$445.29
58672	T		Laparoscopy, fimbrioplasty	0131	40.8064	$2,226.44	$1,001.89	$445.29
58673	T		Laparoscopy, salpingostomy	0131	40.8064	$2,226.44	$1,001.89	$445.29
58679	T		Laparo proc, oviduct-ovary	0130	32.7724	$1,788.09	$659.53	$357.62
58700	C		Removal of fallopian tube					
58720	C		Removal of ovary/tube(s)					
58740	C		Revise fallopian tube(s)					
58750	C		Repair oviduct					
58752	C		Revise ovarian tube(s)					
58760	C		Remove tubal obstruction					
58770	C		Create new tubal opening					
58800	T		Drainage of ovarian cyst(s)	0193	15.0453	$820.89	$171.13	$164.18
58805	C		Drainage of ovarian cyst(s)					
58820	T		Drain ovary abscess, open	0195	25.6950	$1,401.94	$483.80	$280.39
58822	C		Drain ovary abscess, percut					
58823	T		Drain pelvic abscess, percut	0193	15.0453	$820.89	$171.13	$164.18
58825	C		Transposition, ovary(s)					
58900	T		Biopsy of ovary(s)	0193	15.0453	$820.89	$171.13	$164.18
58920	T		Partial removal of ovary(s)	0195	25.6950	$1,401.94	$483.80	$280.39
58925	T		Removal of ovarian cyst(s)	0195	25.6950	$1,401.94	$483.80	$280.39
58940	C		Removal of ovary(s)					
58943	C		Removal of ovary(s)					
58950	C		Resect ovarian malignancy					
58951	C		Resect ovarian malignancy					
58952	C		Resect ovarian malignancy					
58953	C		Tah, rad dissect for debulk					
58954	C		Tah rad debulk/lymph remove					
58960	C		Exploration of abdomen					
58970	T		Retrieval of oocyte	0194	18.4286	$1,005.48	$397.84	$201.10
58974	T		Transfer of embryo	0197	4.8280	$263.42		$52.68
58976	T		Transfer of embryo	0197	4.8280	$263.42		$52.68
58999	T		Genital surgery procedure	0191	0.1853	$10.11	$2.93	$2.02
59000	T		Amniocentesis, diagnostic	0198	1.3578	$74.08	$32.19	$14.82
59001	T		Amniocentesis, therapeutic	0198	1.3578	$74.08	$32.19	$14.82
59012	T		Fetal cord puncture,prenatal	0198	1.3578	$74.08	$32.19	$14.82
59015	T		Chorion biopsy	0198	1.3578	$74.08	$32.19	$14.82
59020	T		Fetal contract stress test	0198	1.3578	$74.08	$32.19	$14.82
59025	T		Fetal non-stress test	0198	1.3578	$74.08	$32.19	$14.82
59030	T		Fetal scalp blood sample	0198	1.3578	$74.08	$32.19	$14.82
59050	E		Fetal monitor w/report					
59051	B		Fetal monitor/interpret only					
59070	T	NI	Transabdom amnioinfus w/ us	0198	1.3578	$74.08	$32.19	$14.82
59072	T	NI	Umbilical cord occlud w/ us	0198	1.3578	$74.08	$32.19	$14.82
59074	T	NI	Fetal fluid drainage w/ us	0198	1.3578	$74.08	$32.19	$14.82
59076	T	NI	Fetal shunt placement, w/ us	0198	1.3578	$74.08	$32.19	$14.82
59100	C		Remove uterus lesion					
59120	C		Treat ectopic pregnancy					
59121	C		Treat ectopic pregnancy					
59130	C		Treat ectopic pregnancy					
59135	C		Treat ectopic pregnancy					
59136	C		Treat ectopic pregnancy					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
59140	C		Treat ectopic pregnancy					
59150	T		Treat ectopic pregnancy	0131	40.8064	$2,226.44	$1,001.89	$445.29
59151	T		Treat ectopic pregnancy	0131	40.8064	$2,226.44	$1,001.89	$445.29
59160	T		D & c after delivery	0196	16.1219	$879.63	$338.23	$175.93
59200	T		Insert cervical dilator	0189	1.4232	$77.65	$18.09	$15.53
59300	T		Episiotomy or vaginal repair	0193	15.0453	$820.89	$171.13	$164.18
59320	T		Revision of cervix	0194	18.4286	$1,005.48	$397.84	$201.10
59325	C		Revision of cervix					
59350	C		Repair of uterus					
59400	B		Obstetrical care					
59409	T		Obstetrical care	0199	17.2831	$942.98		$188.60
59410	B		Obstetrical care					
59412	T		Antepartum manipulation	0700	2.4306	$132.62	$37.13	$26.52
59414	T		Deliver placenta	0199	17.2831	$942.98		$188.60
59425	B		Antepartum care only					
59426	B		Antepartum care only					
59430	B		Care after delivery					
59510	E		Cesarean delivery					
59514	C		Cesarean delivery only					
59515	E		Cesarean delivery					
59525	C		Remove uterus after cesarean					
59610	E		Vbac delivery					
59612	T		Vbac delivery only	0199	17.2831	$942.98		$188.60
59614	E		Vbac care after delivery					
59618	E		Attempted vbac delivery					
59620	C		Attempted vbac delivery only					
59622	E		Attempted vbac after care					
59812	T		Treatment of miscarriage	0201	16.8660	$920.23	$329.65	$184.05
59820	T		Care of miscarriage	0201	16.8660	$920.23	$329.65	$184.05
59821	T		Treatment of miscarriage	0201	16.8660	$920.23	$329.65	$184.05
59830	C		Treat uterus infection					
59840	T		Abortion	0200	17.9920	$981.66	$307.83	$196.33
59841	T		Abortion	0200	17.9920	$981.66	$307.83	$196.33
59850	C		Abortion					
59851	C		Abortion					
59852	C		Abortion					
59855	C		Abortion					
59856	C		Abortion					
59857	C		Abortion					
59866	T		Abortion (mpr)	0198	1.3578	$74.08	$32.19	$14.82
59870	T		Evacuate mole of uterus	0201	16.8660	$920.23	$329.65	$184.05
59871	T		Remove cerclage suture	0194	18.4286	$1,005.48	$397.84	$201.10
59897	T	NI	Fetal invas px w/ us	0198	1.3578	$74.08	$32.19	$14.82
59898	T		Laparo proc, ob care/deliver	0130	32.7724	$1,788.09	$659.53	$357.62
59899	T		Maternity care procedure	0198	1.3578	$74.08	$32.19	$14.82
60000	T		Drain thyroid/tongue cyst	0252	6.4469	$351.75	$113.41	$70.35
60001	T		Aspirate/inject thyriod cyst	0004	1.5882	$86.65	$22.36	$17.33
60100	T		Biopsy of thyroid	0004	1.5882	$86.65	$22.36	$17.33
60200	T		Remove thyroid lesion	0114	37.5963	$2,051.29	$485.91	$410.26
60210	T		Partial thyroid excision	0114	37.5963	$2,051.29	$485.91	$410.26
60212	T		Partial thyroid excision	0114	37.5963	$2,051.29	$485.91	$410.26
60220	T		Partial removal of thyroid	0114	37.5963	$2,051.29	$485.91	$410.26
60225	T		Partial removal of thyroid	0114	37.5963	$2,051.29	$485.91	$410.26
60240	T		Removal of thyroid	0114	37.5963	$2,051.29	$485.91	$410.26
60252	T		Removal of thyroid	0256	35.1548	$1,918.08		$383.62
60254	C		Extensive thyroid surgery					
60260	T		Repeat thyroid surgery	0256	35.1548	$1,918.08		$383.62
60270	C		Removal of thyroid					
60271	C		Removal of thyroid					
60280	T		Remove thyroid duct lesion	0114	37.5963	$2,051.29	$485.91	$410.26
60281	T		Remove thyroid duct lesion	0114	37.5963	$2,051.29	$485.91	$410.26
60500	T		Explore parathyroid glands	0256	35.1548	$1,918.08		$383.62
60502	C		Re-explore parathyroids					
60505	C		Explore parathyroid glands					
60512	T		Autotransplant parathyroid	0022	18.7932	$1,025.38	$354.45	$205.08
60520	C		Removal of thymus gland					
60521	C		Removal of thymus gland					
60522	C		Removal of thymus gland					
60540	C		Explore adrenal gland					
60545	C		Explore adrenal gland					
60600	C		Remove carotid body lesion					
60605	C		Remove carotid body lesion					
60650	C		Laparoscopy adrenalectomy					
60659	T		Laparo proc, endocrine	0130	32.7724	$1,788.09	$659.53	$357.62
60699	T		Endocrine surgery procedure	0114	37.5963	$2,051.29	$485.91	$410.26

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
61000	T		Remove cranial cavity fluid	0212	2.9739	$162.26	$74.67	$32.45
61001	T		Remove cranial cavity fluid	0212	2.9739	$162.26	$74.67	$32.45
61020	T		Remove brain cavity fluid	0212	2.9739	$162.26	$74.67	$32.45
61026	T		Injection into brain canal	0212	2.9739	$162.26	$74.67	$32.45
61050	T		Remove brain canal fluid	0212	2.9739	$162.26	$74.67	$32.45
61055	T		Injection into brain canal	0212	2.9739	$162.26	$74.67	$32.45
61070	T		Brain canal shunt procedure	0212	2.9739	$162.26	$74.67	$32.45
61105	C		Twist drill hole					
61107	C		Drill skull for implantation					
61108	C		Drill skull for drainage					
61120	C		Burr hole for puncture					
61140	C		Pierce skull for biopsy					
61150	C		Pierce skull for drainage					
61151	C		Pierce skull for drainage					
61154	C		Pierce skull & remove clot					
61156	C		Pierce skull for drainage					
61210	C		Pierce skull, implant device					
61215	T		Insert brain-fluid device	0224	34.1770	$1,864.73	$453.41	$372.95
61250	C		Pierce skull & explore					
61253	C		Pierce skull & explore					
61304	C		Open skull for exploration					
61305	C		Open skull for exploration					
61312	C		Open skull for drainage					
61313	C		Open skull for drainage					
61314	C		Open skull for drainage					
61315	C		Open skull for drainage					
61316	C		Implt cran bone flap to abdo					
61320	C		Open skull for drainage					
61321	C		Open skull for drainage					
61322	C		Decompressive craniotomy					
61323	C		Decompressive lobectomy					
61330	T		Decompress eye socket	0256	35.1548	$1,918.08		$383.62
61332	C		Explore/biopsy eye socket					
61333	C		Explore orbit/remove lesion					
61334	C		Explore orbit/remove object					
61340	C		Relieve cranial pressure					
61343	C		Incise skull (press relief)					
61345	C		Relieve cranial pressure					
61440	C		Incise skull for surgery					
61450	C		Incise skull for surgery					
61458	C		Incise skull for brain wound					
61460	C		Incise skull for surgery					
61470	C		Incise skull for surgery					
61480	C		Incise skull for surgery					
61490	C		Incise skull for surgery					
61500	C		Removal of skull lesion					
61501	C		Remove infected skull bone					
61510	C		Removal of brain lesion					
61512	C		Remove brain lining lesion					
61514	C		Removal of brain abscess					
61516	C		Removal of brain lesion					
61517	C		Implt brain chemotx add-on					
61518	C		Removal of brain lesion					
61519	C		Remove brain lining lesion					
61520	C		Removal of brain lesion					
61521	C		Removal of brain lesion					
61522	C		Removal of brain abscess					
61524	C		Removal of brain lesion					
61526	C		Removal of brain lesion					
61530	C		Removal of brain lesion					
61531	C		Implant brain electrodes					
61533	C		Implant brain electrodes					
61534	C		Removal of brain lesion					
61535	C		Remove brain electrodes					
61536	C		Removal of brain lesion					
61537	C	NI	Removal of brain tissue					
61538	C		Removal of brain tissue					
61539	C		Removal of brain tissue					
61540	C	NI	Removal of brain tissue					
61541	C		Incision of brain tissue					
61542	C		Removal of brain tissue					
61543	C		Removal of brain tissue					
61544	C		Remove & treat brain lesion					
61545	C		Excision of brain tumor					
61546	C		Removal of pituitary gland					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
61548	C		Removal of pituitary gland					
61550	C		Release of skull seams					
61552	C		Release of skull seams					
61556	C		Incise skull/sutures					
61557	C		Incise skull/sutures					
61558	C		Excision of skull/sutures					
61559	C		Excision of skull/sutures					
61563	C		Excision of skull tumor					
61564	C		Excision of skull tumor					
61566	C	NI	Removal of brain tissue					
61567	C	NI	Incision of brain tissue					
61570	C		Remove foreign body, brain					
61571	C		Incise skull for brain wound					
61575	C		Skull base/brainstem surgery					
61576	C		Skull base/brainstem surgery					
61580	C		Craniofacial approach, skull					
61581	C		Craniofacial approach, skull					
61582	C		Craniofacial approach, skull					
61583	C		Craniofacial approach, skull					
61584	C		Orbitocranial approach/skull					
61585	C		Orbitocranial approach/skull					
61586	C		Resect nasopharynx, skull					
61590	C		Infratemporal approach/skull					
61591	C		Infratemporal approach/skull					
61592	C		Orbitocranial approach/skull					
61595	C		Transtemporal approach/skull					
61596	C		Transcochlear approach/skull					
61597	C		Transcondylar approach/skull					
61598	C		Transpetrosal approach/skull					
61600	C		Resect/excise cranial lesion					
61601	C		Resect/excise cranial lesion					
61605	C		Resect/excise cranial lesion					
61606	C		Resect/excise cranial lesion					
61607	C		Resect/excise cranial lesion					
61608	C		Resect/excise cranial lesion					
61609	C		Transect artery, sinus					
61610	C		Transect artery, sinus					
61611	C		Transect artery, sinus					
61612	C		Transect artery, sinus					
61613	C		Remove aneurysm, sinus					
61615	C		Resect/excise lesion, skull					
61616	C		Resect/excise lesion, skull					
61618	C		Repair dura					
61619	C		Repair dura					
61623	T		Endovasc tempory vessel occl	1555		$1,650.00		$330.00
61624	C		Occlusion/embolization cath					
61626	T		Transcath occlusion, non-cns	0081	35.0285	$1,911.19		$382.24
61680	C		Intracranial vessel surgery					
61682	C		Intracranial vessel surgery					
61684	C		Intracranial vessel surgery					
61686	C		Intracranial vessel surgery					
61690	C		Intracranial vessel surgery					
61692	C		Intracranial vessel surgery					
61697	C		Brain aneurysm repr, complx					
61698	C		Brain aneurysm repr, complx					
61700	C		Brain aneurysm repr, simple					
61702	C		Inner skull vessel surgery					
61703	C		Clamp neck artery					
61705	G		Revise circulation to head					
61708	C		Revise circulation to head					
61710	C		Revise circulation to head					
61711	C		Fusion of skull arteries					
61720	C		Incise skull/brain surgery					
61735	C		Incise skull/brain surgery					
61750	C		Incise skull/brain biopsy					
61751	C		Brain biopsy w/ ct/mr guide					
61760	C		Implant brain electrodes					
61770	C		Incise skull for treatment					
61790	T		Treat trigeminal nerve	0220	16.5554	$903.28		$180.66
61791	T		Treat trigeminal tract	0204	2.1711	$118.46	$40.13	$23.69
61793	E		Focus radiation beam					
61795	S		Brain surgery using computer	0302	6.3268	$345.20	$130.77	$69.04
61850	C		Implant neuroelectrodes					
61860	C		Implant neuroelectrodes					
61862	C	DG	Implant neurostimul, subcort					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
61863	C	NI	Implant neuroelectrode					
61864	C	NI	Implant neuroelectrde, add'l					
61867	C	NI	Implant neuroelectrode					
61868	C	NI	Implant neuroelectrde, add'l					
61870	C		Implant neuroelectrodes					
61875	C		Implant neuroelectrodes					
61880	T		Revise/remove neuroelectrode	0687	20.4416	$1,115.31	$513.05	$223.06
61885	S		Implant neurostim one array	0039	235.1866	$12,832.02		$2,566.40
61886	T		Implant neurostim arrays	0222	232.2024	$12,669.20		$2,533.84
61888	T		Revise/remove neuroreceiver	0688	46.7347	$2,549.89	$1,249.45	$509.98
62000	C		Treat skull fracture					
62005	C		Treat skull fracture					
62010	C		Treatment of head injury					
62100	C		Repair brain fluid leakage					
62115	C		Reduction of skull defect					
62116	C		Reduction of skull defect					
62117	C		Reduction of skull defect					
62120	C		Repair skull cavity lesion					
62121	C		Incise skull repair					
62140	C		Repair of skull defect					
62141	C		Repair of skull defect					
62142	C		Remove skull plate/flap					
62143	C		Replace skull plate/flap					
62145	C		Repair of skull & brain					
62146	C		Repair of skull with graft					
62147	C		Repair of skull with graft					
62148	C		Retr bone flap to fix skull					
62160	C		Neuroendoscopy add-on					
62161	C		Dissect brain w/scope					
62162	C		Remove colloid cyst w/scope					
62163	C		Neuroendoscopy w/fb removal					
62164	C		Remove brain tumor w/scope					
62165	C		Remove pituit tumor w/scope					
62180	C		Establish brain cavity shunt					
62190	C		Establish brain cavity shunt					
62192	C		Establish brain cavity shunt					
62194	T		Replace/irrigate catheter	0121	2.1189	$115.61	$43.80	$23.12
62200	C		Establish brain cavity shunt					
62201	C		Establish brain cavity shunt					
62220	C		Establish brain cavity shunt					
62223	C		Establish brain cavity shunt					
62225	T		Replace/irrigate catheter	0122	8.8621	$483.53	$99.16	$96.71
62230	T		Replace/revise brain shunt	0224	34.1770	$1,864.73	$453.41	$372.95
62252	S		Csf shunt reprogram	0691	2.8066	$153.13	$76.56	$30.63
62256	C		Remove brain cavity shunt					
62258	C		Replace brain cavity shunt					
62263	T		Lysis epidural adhesions	0203	11.5969	$632.74	$276.76	$126.55
62264	T		Epidural lysis on single day	0203	11.5969	$632.74	$276.76	$126.55
62268	T		Drain spinal cord cyst	0212	2.9739	$162.26	$74.67	$32.45
62269	T		Needle biopsy, spinal cord	0005	3.2698	$178.40	$71.59	$35.68
62270	T		Spinal fluid tap, diagnostic	0206	5.2875	$288.49	$75.55	$57.70
62272	T		Drain cerebro spinal fluid	0206	5.2875	$288.49	$75.55	$57.70
62273	T		Treat epidural spine lesion	0206	5.2875	$288.49	$75.55	$57.70
62280	T		Treat spinal cord lesion	0207	6.4554	$352.21	$123.69	$70.44
62281	T		Treat spinal cord lesion	0207	6.4554	$352.21	$123.69	$70.44
62282	T		Treat spinal canal lesion	0207	6.4554	$352.21	$123.69	$70.44
62284	N		Injection for myelogram					
62287	T		Percutaneous diskectomy	0220	16.5554	$903.28		$180.66
62290	N		Inject for spine disk x-ray					
62291	N		Inject for spine disk x-ray					
62292	T		Injection into disk lesion	0212	2.9739	$162.26	$74.67	$32.45
62294	T		Injection into spinal artery	0212	2.9739	$162.26	$74.67	$32.45
62310	T		Inject spine c/t	0206	5.2875	$288.49	$75.55	$57.70
62311	T		Inject spine l/s (cd)	0206	5.2875	$288.49	$75.55	$57.70
62318	T		Inject spine w/cath, c/t	0206	5.2875	$288.49	$75.55	$57.70
62319	T		Inject spine w/cath l/s (cd)	0206	5.2875	$288.49	$75.55	$57.70
62350	T		Implant spinal canal cath	0223	26.7610	$1,460.11		$292.02
62351	T		Implant spinal canal cath	0208	40.2830	$2,197.88		$439.58
62355	T		Remove spinal canal catheter	0203	11.5969	$632.74	$276.76	$126.55
62360	T		Insert spine infusion device	0226	136.2989	$7,436.60		$1,487.32
62361	T		Implant spine infusion pump	0227	160.8363	$8,775.39		$1,755.08
62362	T		Implant spine infusion pump	0227	160.8363	$8,775.39		$1,755.08
62365	T		Remove spine infusion device	0203	11.5969	$632.74	$276.76	$126.55
62367	S		Analyze spine infusion pump	0691	2.8066	$153.13	$76.56	$30.63
62368	S		Analyze spine infusion pump	0691	2.8066	$153.13	$76.56	$30.63

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
63001	T		Removal of spinal lamina	0208	40.2830	$2,197.88		$439.58
63003	T		Removal of spinal lamina	0208	40.2830	$2,197.88		$439.58
63005	T		Removal of spinal lamina	0208	40.2830	$2,197.88		$439.58
63011	T		Removal of spinal lamina	0208	40.2830	$2,197.88		$439.58
63012	T		Removal of spinal lamina	0208	40.2830	$2,197.88		$439.58
63015	T		Removal of spinal lamina	0208	40.2830	$2,197.88		$439.58
63016	T		Removal of spinal lamina	0208	40.2830	$2,197.88		$439.58
63017	T		Removal of spinal lamina	0208	40.2830	$2,197.88		$439.58
63020	T		Neck spine disk surgery	0208	40.2830	$2,197.88		$439.58
63030	T		Low back disk surgery	0208	40.2830	$2,197.88		$439.58
63035	T		Spinal disk surgery add-on	0208	40.2830	$2,197.88		$439.58
63040	T		Laminotomy, single cervical	0208	40.2830	$2,197.88		$439.58
63042	T		Laminotomy, single lumbar	0208	40.2830	$2,197.88		$439.58
63043	C		Laminotomy, add'l cervical					
63044	C		Laminotomy, add'l lumbar					
63045	T		Removal of spinal lamina	0208	40.2830	$2,197.88		$439.58
63046	T		Removal of spinal lamina	0208	40.2830	$2,197.88		$439.58
63047	T		Removal of spinal lamina	0208	40.2830	$2,197.88		$439.58
63048	T		Remove spinal lamina add-on	0208	40.2830	$2,197.88		$439.58
63055	T		Decompress spinal cord	0208	40.2830	$2,197.88		$439.58
63056	T		Decompress spinal cord	0208	40.2830	$2,197.88		$439.58
63057	T		Decompress spine cord add-on	0208	40.2830	$2,197.88		$439.58
63064	T		Decompress spinal cord	0208	40.2830	$2,197.88		$439.58
63066	T		Decompress spine cord add-on	0208	40.2830	$2,197.88		$439.58
63075	C		Neck spine disk surgery					
63076	C		Neck spine disk surgery					
63077	C		Spine disk surgery, thorax					
63078	C		Spine disk surgery, thorax					
63081	C		Removal of vertebral body					
63082	C		Remove vertebral body add-on					
63085	C		Removal of vertebral body					
63086	C		Remove vertebral body add-on					
63087	C		Removal of vertebral body					
63088	C		Remove vertebral body add-on					
63090	C		Removal of vertebral body					
63091	C		Remove vertebral body add-on					
63101	C	NI	Removal of vertebral body					
63102	C	NI	Removal of vertebral body					
63103	C	NI	Remove vertebral body add-on					
63170	C		Incise spinal cord tract(s)					
63172	C		Drainage of spinal cyst					
63173	C		Drainage of spinal cyst					
63180	C		Revise spinal cord ligaments					
63182	C		Revise spinal cord ligaments					
63185	C		Incise spinal column/nerves					
63190	C		Incise spinal column/nerves					
63191	C		Incise spinal column/nerves					
63194	C		Incise spinal column & cord					
63195	C		Incise spinal column & cord					
63196	C		Incise spinal column & cord					
63197	C		Incise spinal column & cord					
63198	C		Incise spinal column & cord					
63199	C		Incise spinal column & cord					
63200	C		Release of spinal cord					
63250	C		Revise spinal cord vessels					
63251	C		Revise spinal cord vessels					
63252	C		Revise spinal cord vessels					
63265	C		Excise intraspinal lesion					
63266	C		Excise intraspinal lesion					
63267	C		Excise intraspinal lesion					
63268	C		Excise intraspinal lesion					
63270	C		Excise intraspinal lesion					
63271	C		Excise intraspinal lesion					
63272	C		Excise intraspinal lesion					
63273	C		Excise intraspinal lesion					
63275	C		Biopsy/excise spinal tumor					
63276	C		Biopsy/excise spinal tumor					
63277	C		Biopsy/excise spinal tumor					
63278	C		Biopsy/excise spinal tumor					
63280	C		Biopsy/excise spinal tumor					
63281	C		Biopsy/excise spinal tumor					
63282	C		Biopsy/excise spinal tumor					
63283	C		Biopsy/excise spinal tumor					
63285	C		Biopsy/excise spinal tumor					
63286	C		Biopsy/excise spinal tumor					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
63287	C		Biopsy/excise spinal tumor					
63290	C		Biopsy/excise spinal tumor					
63300	C		Removal of vertebral body					
63301	C		Removal of vertebral body					
63302	C		Removal of vertebral body					
63303	C		Removal of vertebral body					
63304	C		Removal of vertebral body					
63305	C		Removal of vertebral body					
63306	C		Removal of vertebral body					
63307	C		Removal of vertebral body					
63308	C		Remove vertebral body add-on					
63600	T		Remove spinal cord lesion	0220	16.5554	$903.28		$180.66
63610	T		Stimulation of spinal cord	0220	16.5554	$903.28		$180.66
63615	T		Remove lesion of spinal cord	0220	16.5554	$903.28		$180.66
63650	S		Implant neuroelectrodes	0040	52.1002	$2,842.64		$568.53
63655	S		Implant neuroelectrodes	0225	206.0034	$11,239.75		$2,247.95
63660	T		Revise/remove neuroelectrode	0687	20.4416	$1,115.31	$513.05	$223.06
63685	T		Implant neuroreceiver	0222	232.2024	$12,669.20		$2,533.84
63688	T		Revise/remove neuroreceiver	0688	46.7347	$2,549.89	$1,249.45	$509.98
63700	C		Repair of spinal herniation					
63702	C		Repair of spinal herniation					
63704	C		Repair of spinal herniation					
63706	C		Repair of spinal herniation					
63707	C		Repair spinal fluid leakage					
63709	C		Repair spinal fluid leakage					
63710	C		Graft repair of spine defect					
63740	C		Install spinal shunt					
63741	T		Install spinal shunt	0228	52.2880	$2,852.89	$639.03	$570.58
63744	T		Revision of spinal shunt	0228	52.2880	$2,852.89	$639.03	$570.58
63746	T		Removal of spinal shunt	0109	7.4705	$407.60	$131.49	$81.52
64400	T		N block inj, trigeminal	0204	2.1711	$118.46	$40.13	$23.69
64402	T		N block inj, facial	0204	2.1711	$118.46	$40.13	$23.69
64405	T		N block inj, occipital	0204	2.1711	$118.46	$40.13	$23.69
64408	T		N block inj, vagus	0204	2.1711	$118.46	$40.13	$23.69
64410	T		N block inj, phrenic	0204	2.1711	$118.46	$40.13	$23.69
64412	T		N block inj, spinal accessor	0204	2.1711	$118.46	$40.13	$23.69
64413	T		N block inj, cervical plexus	0204	2.1711	$118.46	$40.13	$23.69
64415	T		Injection for nerve block	0204	2.1711	$118.46	$40.13	$23.69
64416	T		N block cont infuse, b plex	0204	2.1711	$118.46	$40.13	$23.69
64417	T		N block inj, axillary	0204	2.1711	$118.46	$40.13	$23.69
64418	T		N block inj, suprascapular	0204	2.1711	$118.46	$40.13	$23.69
64420	T		N block inj, intercost, sng	0207	6.4554	$352.21	$123.69	$70.44
64421	T		N block inj, intercost, mlt	0207	6.4554	$352.21	$123.69	$70.44
64425	T		N block inj ilio-ing/hypogi	0204	2.1711	$118.46	$40.13	$23.69
64430	T		N block inj, pudendal	0204	2.1711	$118.46	$40.13	$23.69
64435	T		N block inj, paracervical	0204	2.1711	$118.46	$40.13	$23.69
64445	T		Injection for nerve block	0204	2.1711	$118.46	$40.13	$23.69
64446	T		N blk inj, sciatic, cont inf	0204	2.1711	$118.46	$40.13	$23.69
64447	T		N block inj fem, single	0204	2.1711	$118.46	$40.13	$23.69
64448	T		N block inj fem, cont inf	0204	2.1711	$118.46	$40.13	$23.69
64449	T	NI	N block inj, lumbar plexus	0204	2.1711	$118.46	$40.13	$23.69
64450	T		N block, other peripheral	0204	2.1711	$118.46	$40.13	$23.69
64470	T		Inj paravertebral c/t	0207	6.4554	$352.21	$123.69	$70.44
64472	T		Inj paravertebral c/t add-on	0207	6.4554	$352.21	$123.69	$70.44
64475	T		Inj paravertebral l/s	0207	6.4554	$352.21	$123.69	$70.44
64476	T		Inj paravertebral l/s add-on	0207	6.4554	$352.21	$123.69	$70.44
64479	T		Inj foramen epidural c/t	0207	6.4554	$352.21	$123.69	$70.44
64480	T		Inj foramen epidural add-on	0207	6.4554	$352.21	$123.69	$70.44
64483	T		Inj foramen epidural l/s	0207	6.4554	$352.21	$123.69	$70.44
64484	T		Inj foramen epidural add-on	0207	6.4554	$352.21	$123.69	$70.44
64505	T		N block, spenopalatine gangl	0204	2.1711	$118.46	$40.13	$23.69
64508	T		N block, carotid sinus s/p	0204	2.1711	$118.46	$40.13	$23.69
64510	T		N block, stellate ganglion	0207	6.4554	$352.21	$123.69	$70.44
64517	T	NI	N block inj, hypogas plxs	0204	2.1711	$118.46	$40.13	$23.69
64520	T		N block, lumbar/thoracic	0207	6.4554	$352.21	$123.69	$70.44
64530	T		N block inj, celiac pelus	0207	6.4554	$352.21	$123.69	$70.44
64550	A		Apply neurostimulator					
64553	S		Implant neuroelectrodes	0225	206.0034	$11,239.75		$2,247.95
64555	S		Implant neuroelectrodes	0040	52.1002	$2,842.64		$568.53
64560	S		Implant neuroelectrodes	0040	52.1002	$2,842.64		$568.53
64561	S		Implant neuroelectrodes	0040	52.1002	$2,842.64		$568.53
64565	S		Implant neuroelectrodes	0040	52.1002	$2,842.64		$568.53
64573	S		Implant neuroelectrodes	0225	206.0034	$11,239.75		$2,247.95
64575	S		Implant neuroelectrodes	0040	52.1002	$2,842.64		$568.53
64577	S		Implant neuroelectrodes	0225	206.0034	$11,239.75		$2,247.95

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64580	S		Implant neuroelectrodes	0225	206.0034	$11,239.75		$2,247.95
64581	S		Implant neuroelectrodes	0040	52.1002	$2,842.64		$568.53
64585	T		Revise/remove neuroelectrode	0687	20.4416	$1,115.31	$513.05	$223.06
64590	T		Implant neuroreceiver	0222	232.2024	$12,669.20		$2,533.84
64595	T		Revise/remove neuroreceiver	0688	46.7347	$2,549.89	$1,249.45	$509.98
64600	T		Injection treatment of nerve	0203	11.5969	$632.74	$276.76	$126.55
64605	T		Injection treatment of nerve	0203	11.5969	$632.74	$276.76	$126.55
64610	T		Injection treatment of nerve	0203	11.5969	$632.74	$276.76	$126.55
64612	T		Destroy nerve, face muscle	0204	2.1711	$118.46	$40.13	$23.69
64613	T		Destroy nerve, spine muscle	0204	2.1711	$118.46	$40.13	$23.69
64614	T		Destroy nerve, extrem musc	0204	2.1711	$118.46	$40.13	$23.69
64620	T		Injection treatment of nerve	0203	11.5969	$632.74	$276.76	$126.55
64622	T		Destr paravertebrl nerve l/s	0203	11.5969	$632.74	$276.76	$126.55
64623	T		Destr paravertebral n add-on	0203	11.5969	$632.74	$276.76	$126.55
64626	T		Destr paravertebrl nerve c/t	0203	11.5969	$632.74	$276.76	$126.55
64627	T		Destr paravertebral n add-on	0203	11.5969	$632.74	$276.76	$126.55
64630	T		Injection treatment of nerve	0207	6.4554	$352.21	$123.69	$70.44
64640	T		Injection treatment of nerve	0207	6.4554	$352.21	$123.69	$70.44
64680	T		Injection treatment of nerve	0203	11.5969	$632.74	$276.76	$126.55
64681	T	NI	Injection treatment of nerve	0203	11.5969	$632.74	$276.76	$126.55
64702	T		Revise finger/toe nerve	0220	16.5554	$903.28		$180.66
64704	T		Revise hand/foot nerve	0220	16.5554	$903.28		$180.66
64708	T		Revise arm/leg nerve	0220	16.5554	$903.28		$180.66
64712	T		Revision of sciatic nerve	0220	16.5554	$903.28		$180.66
64713	T		Revision of arm nerve(s)	0220	16.5554	$903.28		$180.66
64714	T		Revise low back nerve(s)	0220	16.5554	$903.28		$180.66
64716	T		Revision of cranial nerve	0220	16.5554	$903.28		$180.66
64718	T		Revise ulnar nerve at elbow	0220	16.5554	$903.28		$180.66
64719	T		Revise ulnar nerve at wrist	0220	16.5554	$903.28		$180.66
64721	T		Carpal tunnel surgery	0220	16.5554	$903.28		$180.66
64722	T		Relieve pressure on nerve(s)	0220	16.5554	$903.28		$180.66
64726	T		Release foot/toe nerve	0220	16.5554	$903.28		$180.66
64727	T		Internal nerve revision	0220	16.5554	$903.28		$180.66
64732	T		Incision of brow nerve	0220	16.5554	$903.28		$180.66
64734	T		Incision of cheek nerve	0220	16.5554	$903.28		$180.66
64736	T		Incision of chin nerve	0220	16.5554	$903.28		$180.66
64738	T		Incision of jaw nerve	0220	16.5554	$903.28		$180.66
64740	T		Incision of tongue nerve	0220	16.5554	$903.28		$180.66
64742	T		Incision of facial nerve	0220	16.5554	$903.28		$180.66
64744	T		Incise nerve, back of head	0220	16.5554	$903.28		$180.66
64746	T		Incise diaphragm nerve	0220	16.5554	$903.28		$180.66
64752	C		Incision of vagus nerve					
64755	C		Incision of stomach nerves					
64760	C		Incision of vagus nerve					
64761	T		Incision of pelvis nerve	0220	16.5554	$903.28		$180.66
64763	C		Incise hip/thigh nerve					
64766	C		Incise hip/thigh nerve					
64771	T		Sever cranial nerve	0220	16.5554	$903.28		$180.66
64772	T		Incision of spinal nerve	0220	16.5554	$903.28		$180.66
64774	T		Remove skin nerve lesion	0220	16.5554	$903.28		$180.66
64776	T		Remove digit nerve lesion	0220	16.5554	$903.28		$180.66
64778	T		Digit nerve surgery add-on	0220	16.5554	$903.28		$180.66
64782	T		Remove limb nerve lesion	0220	16.5554	$903.28		$180.66
64783	T		Limb nerve surgery add-on	0220	16.5554	$903.28		$180.66
64784	T		Remove nerve lesion	0220	16.5554	$903.28		$180.66
64786	T		Remove sciatic nerve lesion	0221	24.8875	$1,357.89	$463.62	$271.58
64787	T		Implant nerve end	0220	16.5554	$903.28		$180.66
64788	T		Remove skin nerve lesion	0220	16.5554	$903.28		$180.66
64790	T		Removal of nerve lesion	0220	16.5554	$903.28		$180.66
64792	T		Removal of nerve lesion	0221	24.8875	$1,357.89	$463.62	$271.58
64795	T		Biopsy of nerve	0220	16.5554	$903.28		$180.66
64802	T		Remove sympathetic nerves	0220	16.5554	$903.28		$180.66
64804	C		Remove sympathetic nerves					
64809	C		Remove sympathetic nerves					
64818	C		Remove sympathetic nerves					
64820	T		Remove sympathetic nerves	0220	16.5554	$903.28		$180.66
64821	T		Remove sympathetic nerves	0054	24.2456	$1,322.86		$264.57
64822	T		Remove sympathetic nerves	0054	24.2456	$1,322.86		$264.57
64823	T		Remove sympathetic nerves	0054	24.2456	$1,322.86		$264.57
64831	T		Repair of digit nerve	0221	24.8875	$1,357.89	$463.62	$271.58
64832	T		Repair nerve add-on	0221	24.8875	$1,357.89	$463.62	$271.58
64834	T		Repair of hand or foot nerve	0221	24.8875	$1,357.89	$463.62	$271.58
64835	T		Repair of hand or foot nerve	0221	24.8875	$1,357.89	$463.62	$271.58
64836	T		Repair of hand or foot nerve	0221	24.8875	$1,357.89	$463.62	$271.58
64837	T		Repair nerve add-on	0221	24.8875	$1,357.89	$463.62	$271.58

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64840	T		Repair of leg nerve	0221	24.8875	$1,357.89	$463.62	$271.58
64856	T		Repair/transpose nerve	0221	24.8875	$1,357.89	$463.62	$271.58
64857	T		Repair arm/leg nerve	0221	24.8875	$1,357.89	$463.62	$271.58
64858	T		Repair sciatic nerve	0221	24.8875	$1,357.89	$463.62	$271.58
64859	T		Nerve surgery	0221	24.8875	$1,357.89	$463.62	$271.58
64861	T		Repair of arm nerves	0221	24.8875	$1,357.89	$463.62	$271.58
64862	T		Repair of low back nerves	0221	24.8875	$1,357.89	$463.62	$271.58
64864	T		Repair of facial nerve	0221	24.8875	$1,357.89	$463.62	$271.58
64865	T		Repair of facial nerve	0221	24.8875	$1,357.89	$463.62	$271.58
64866	C		Fusion of facial/other nerve					
64868	C		Fusion of facial/other nerve					
64870	T		Fusion of facial/other nerve	0221	24.8875	$1,357.89	$463.62	$271.58
64872	T		Subsequent repair of nerve	0221	24.8875	$1,357.89	$463.62	$271.58
64874	T		Repair & revise nerve add-on	0221	24.8875	$1,357.89	$463.62	$271.58
64876	T		Repair nerve/shorten bone	0221	24.8875	$1,357.89	$463.62	$271.58
64885	T		Nerve graft, head or neck	0221	24.8875	$1,357.89	$463.62	$271.58
64886	T		Nerve graft, head or neck	0221	24.8875	$1,357.89	$463.62	$271.58
64890	T		Nerve graft, hand or foot	0221	24.8875	$1,357.89	$463.62	$271.58
64891	T		Nerve graft, hand or foot	0221	24.8875	$1,357.89	$463.62	$271.58
64892	T		Nerve graft, arm or leg	0221	24.8875	$1,357.89	$463.62	$271.58
64893	T		Nerve graft, arm or leg	0221	24.8875	$1,357.89	$463.62	$271.58
64895	T		Nerve graft, hand or foot	0221	24.8875	$1,357.89	$463.62	$271.58
64896	T		Nerve graft, hand or foot	0221	24.8875	$1,357.89	$463.62	$271.58
64897	T		Nerve graft, arm or leg	0221	24.8875	$1,357.89	$463.62	$271.58
64898	T		Nerve graft, arm or leg	0221	24.8875	$1,357.89	$463.62	$271.58
64901	T		Nerve graft add-on	0221	24.8875	$1,357.89	$463.62	$271.58
64902	T		Nerve graft add-on	0221	24.8875	$1,357.89	$463.62	$271.58
64905	T		Nerve pedicle transfer	0221	24.8875	$1,357.89	$463.62	$271.58
64907	T		Nerve pedicle transfer	0221	24.8875	$1,357.89	$463.62	$271.58
64999	T		Nervous system surgery	0204	2.1711	$118.46	$40.13	$23.69
65091	T		Revise eye	0242	29.4294	$1,605.70	$597.36	$321.14
65093	T		Revise eye with implant	0241	22.1969	$1,211.09	$384.47	$242.22
65101	T		Removal of eye	0242	29.4294	$1,605.70	$597.36	$321.14
65103	T		Remove eye/insert implant	0242	29.4294	$1,605.70	$597.36	$321.14
65105	T		Remove eye/attach implant	0242	29.4294	$1,605.70	$597.36	$321.14
65110	T		Removal of eye	0242	29.4294	$1,605.70	$597.36	$321.14
65112	T		Remove eye/revise socket	0242	29.4294	$1,605.70	$597.36	$321.14
65114	T		Remove eye/revise socket	0242	29.4294	$1,605.70	$597.36	$321.14
65125	T		Revise ocular implant	0240	17.4535	$952.28	$315.31	$190.46
65130	T		Insert ocular implant	0241	22.1969	$1,211.09	$384.47	$242.22
65135	T		Insert ocular implant	0241	22.1969	$1,211.09	$384.47	$242.22
65140	T		Attach ocular implant	0242	29.4294	$1,605.70	$597.36	$321.14
65150	T		Revise ocular implant	0241	22.1969	$1,211.09	$384.47	$242.22
65155	T		Reinsert ocular implant	0242	29.4294	$1,605.70	$597.36	$321.14
65175	T		Removal of ocular implant	0240	17.4535	$952.28	$315.31	$190.46
65205	S		Remove foreign body from eye	0698	0.9599	$52.37	$18.72	$10.47
65210	S		Remove foreign body from eye	0231	2.1883	$119.40	$50.94	$23.88
65220	S		Remove foreign body from eye	0231	2.1883	$119.40	$50.94	$23.88
65222	S		Remove foreign body from eye	0231	2.1883	$119.40	$50.94	$23.88
65235	T		Remove foreign body from eye	0233	14.4205	$786.80	$266.33	$157.36
65260	T		Remove foreign body from eye	0236	18.6701	$1,018.66		$203.73
65265	T		Remove foreign body from eye	0236	18.6701	$1,018.66		$203.73
65270	T		Repair of eye wound	0240	17.4535	$952.28	$315.31	$190.46
65272	T		Repair of eye wound	0233	14.4205	$786.80	$266.33	$157.36
65273	C		Repair of eye wound					
65275	T		Repair of eye wound	0233	14.4205	$786.80	$266.33	$157.36
65280	T		Repair of eye wound	0234	21.4631	$1,171.05	$511.31	$234.21
65285	T		Repair of eye wound	0234	21.4631	$1,171.05	$511.31	$234.21
65286	T		Repair of eye wound	0233	14.4205	$786.80	$266.33	$157.36
65290	T		Repair of eye socket wound	0243	21.7323	$1,185.74	$431.39	$237.15
65400	T		Removal of eye lesion	0233	14.4205	$786.80	$266.33	$157.36
65410	T		Biopsy of cornea	0233	14.4205	$786.80	$266.33	$157.36
65420	T		Removal of eye lesion	0233	14.4205	$786.80	$266.33	$157.36
65426	T		Removal of eye lesion	0234	21.4631	$1,171.05	$511.31	$234.21
65430	S		Corneal smear	0230	0.7619	$41.57	$14.97	$8.31
65435	T		Curette/treat cornea	0239	6.1331	$334.63		$66.93
65436	T		Curette/treat cornea	0233	14.4205	$786.80	$266.33	$157.36
65450	S		Treatment of corneal lesion	0231	2.1883	$119.40	$50.94	$23.88
65600	T		Revision of cornea	0240	17.4535	$952.28	$315.31	$190.46
65710	T		Corneal transplant	0244	37.6284	$2,053.04	$803.26	$410.61
65730	T		Corneal transplant	0244	37.6284	$2,053.04	$803.26	$410.61
65750	T		Corneal transplant	0244	37.6284	$2,053.04	$803.26	$410.61
65755	T		Corneal transplant	0244	37.6284	$2,053.04	$803.26	$410.61
65760	E		Revision of cornea					
65765	E		Revision of cornea					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
65767	E		Corneal tissue transplant					
65770	T		Revise cornea with implant	0244	37.6284	$2,053.04	$803.26	$410.61
65771	E		Radial keratotomy					
65772	T		Correction of astigmatism	0233	14.4205	$786.80	$266.33	$157.36
65775	T		Correction of astigmatism	0233	14.4205	$786.80	$266.33	$157.36
65780	T	NI	Ocular reconst, transplant	0244	37.6284	$2,053.04	$803.26	$410.61
65781	T	NI	Ocular reconst, transplant	0244	37.6284	$2,053.04	$803.26	$410.61
65782	T	NI	Ocular reconst, transplant	0244	37.6284	$2,053.04	$803.26	$410.61
65800	T		Drainage of eye	0233	14.4205	$786.80	$266.33	$157.36
65805	T		Drainage of eye	0233	14.4205	$786.80	$266.33	$157.36
65810	T		Drainage of eye	0234	21.4631	$1,171.05	$511.31	$234.21
65815	T		Drainage of eye	0234	21.4631	$1,171.05	$511.31	$234.21
65820	T		Relieve inner eye pressure	0232	4.9206	$268.47	$103.17	$53.69
65850	T		Incision of eye	0234	21.4631	$1,171.05	$511.31	$234.21
65855	T		Laser surgery of eye	0247	4.9482	$269.98	$104.31	$54.00
65860	T		Incise inner eye adhesions	0247	4.9482	$269.98	$104.31	$54.00
65865	T		Incise inner eye adhesions	0233	14.4205	$786.80	$266.33	$157.36
65870	T		Incise inner eye adhesions	0234	21.4631	$1,171.05	$511.31	$234.21
65875	T		Incise inner eye adhesions	0234	21.4631	$1,171.05	$511.31	$234.21
65880	T		Incise inner eye adhesions	0233	14.4205	$786.80	$266.33	$157.36
65900	T		Remove eye lesion	0233	14.4205	$786.80	$266.33	$157.36
65920	T		Remove implant of eye	0233	14.4205	$786.80	$266.33	$157.36
65930	T		Remove blood clot from eye	0234	21.4631	$1,171.05	$511.31	$234.21
66020	T		Injection treatment of eye	0233	14.4205	$786.80	$266.33	$157.36
66030	T		Injection treatment of eye	0233	14.4205	$786.80	$266.33	$157.36
66130	T		Remove eye lesion	0234	21.4631	$1,171.05	$511.31	$234.21
66150	T		Glaucoma surgery	0233	14.4205	$786.80	$266.33	$157.36
66155	T		Glaucoma surgery	0234	21.4631	$1,171.05	$511.31	$234.21
66160	T		Glaucoma surgery	0234	21.4631	$1,171.05	$511.31	$234.21
66165	T		Glaucoma surgery	0234	21.4631	$1,171.05	$511.31	$234.21
66170	T		Glaucoma surgery	0234	21.4631	$1,171.05	$511.31	$234.21
66172	T		Incision of eye	0673	26.8390	$1,464.36	$649.56	$292.87
66180	T		Implant eye shunt	0673	26.8390	$1,464.36	$649.56	$292.87
66185	T		Revise eye shunt	0673	26.8390	$1,464.36	$649.56	$292.87
66220	T		Repair eye lesion	0236	18.6701	$1,018.66		$203.73
66225	T		Repair/graft eye lesion	0673	26.8390	$1,464.36	$649.56	$292.87
66250	T		Follow-up surgery of eye	0233	14.4205	$786.80	$266.33	$157.36
66500	T		Incision of iris	0232	4.9206	$268.47	$103.17	$53.69
66505	T		Incision of iris	0232	4.9206	$268.47	$103.17	$53.69
66600	T		Remove iris and lesion	0233	14.4205	$786.80	$266.33	$157.36
66605	T		Removal of iris	0234	21.4631	$1,171.05	$511.31	$234.21
66625	T		Removal of iris	0233	14.4205	$786.80	$266.33	$157.36
66630	T		Removal of iris	0233	14.4205	$786.80	$266.33	$157.36
66635	T		Removal of iris	0234	21.4631	$1,171.05	$511.31	$234.21
66680	T		Repair iris & ciliary body	0234	21.4631	$1,171.05	$511.31	$234.21
66682	T		Repair iris & ciliary body	0234	21.4631	$1,171.05	$511.31	$234.21
66700	T		Destruction, ciliary body	0233	14.4205	$786.80	$266.33	$157.36
66710	T		Destruction, ciliary body	0233	14.4205	$786.80	$266.33	$157.36
66720	T		Destruction, ciliary body	0233	14.4205	$786.80	$266.33	$157.36
66740	T		Destruction, ciliary body	0233	14.4205	$786.80	$266.33	$157.36
66761	T		Revision of iris	0247	4.9482	$269.98	$104.31	$54.00
66762	T		Revision of iris	0247	4.9482	$269.98	$104.31	$54.00
66770	T		Removal of inner eye lesion	0247	4.9482	$269.98	$104.31	$54.00
66820	T		Incision, secondary cataract	0232	4.9206	$268.47	$103.17	$53.69
66821	T		After cataract laser surgery	0247	4.9482	$269.98	$104.31	$54.00
66825	T		Reposition intraocular lens	0234	21.4631	$1,171.05	$511.31	$234.21
66830	T		Removal of lens lesion	0232	4.9206	$268.47	$103.17	$53.69
66840	T		Removal of lens material	0245	12.2973	$670.95	$222.22	$134.19
66850	T		Removal of lens material	0249	27.7406	$1,513.55	$524.67	$302.71
66852	T		Removal of lens material	0249	27.7406	$1,513.55	$524.67	$302.71
66920	T		Extraction of lens	0249	27.7406	$1,513.55	$524.67	$302.71
66930	T		Extraction of lens	0249	27.7406	$1,513.55	$524.67	$302.71
66940	T		Extraction of lens	0245	12.2973	$670.95	$222.22	$134.19
66982	T		Cataract surgery, complex	0246	22.9755	$1,253.57	$495.96	$250.71
66983	T		Cataract surg w/iol, 1 stage	0246	22.9755	$1,253.57	$495.96	$250.71
66984	T		Cataract surg w/iol, 1 stage	0246	22.9755	$1,253.57	$495.96	$250.71
66985	T		Insert lens prosthesis	0246	22.9755	$1,253.57	$495.96	$250.71
66986	T		Exchange lens prosthesis	0246	22.9755	$1,253.57	$495.96	$250.71
66990	N		Ophthalmic endoscope add-on					
66999	T		Eye surgery procedure	0232	4.9206	$268.47	$103.17	$53.69
67005	T		Partial removal of eye fluid	0237	34.1784	$1,864.81	$818.54	$372.96
67010	T		Partial removal of eye fluid	0237	34.1784	$1,864.81	$818.54	$372.96
67015	T		Release of eye fluid	0237	34.1784	$1,864.81	$818.54	$372.96
67025	T		Replace eye fluid	0236	18.6701	$1,018.66		$203.73
67027	T		Implant eye drug system	0237	34.1784	$1,864.81	$818.54	$372.96

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
67028	T		Injection eye drug	0235	5.0749	$276.89	$72.04	$55.38
67030	T		Incise inner eye strands	0236	18.6701	$1,018.66	.....	$203.73
67031	T		Laser surgery, eye strands	0247	4.9482	$269.98	$104.31	$54.00
67036	T		Removal of inner eye fluid	0237	34.1784	$1,864.81	$818.54	$372.96
67038	T		Strip retinal membrane	0237	34.1784	$1,864.81	$818.54	$372.96
67039	T		Laser treatment of retina	0237	34.1784	$1,864.81	$818.54	$372.96
67040	T		Laser treatment of retina	0672	38.9476	$2,125.02	$988.43	$425.00
67101	T		Repair detached retina	0235	5.0749	$276.89	$72.04	$55.38
67105	T		Repair detached retina	0248	4.8223	$263.11	$95.08	$52.62
67107	T		Repair detached retina	0672	38.9476	$2,125.02	$988.43	$425.00
67108	T		Repair detached retina	0672	38.9476	$2,125.02	$988.43	$425.00
67110	T		Repair detached retina	0236	18.6701	$1,018.66	.....	$203.73
67112	T		Rerepair detached retina	0672	38.9476	$2,125.02	$988.43	$425.00
67115	T		Release encircling material	0236	18.6701	$1,018.66	.....	$203.73
67120	T		Remove eye implant material	0236	18.6701	$1,018.66	.....	$203.73
67121	T		Remove eye implant material	0237	34.1784	$1,864.81	$818.54	$372.96
67141	T		Treatment of retina	0235	5.0749	$276.89	$72.04	$55.38
67145	T		Treatment of retina	0248	4.8223	$263.11	$95.08	$52.62
67208	T		Treatment of retinal lesion	0235	5.0749	$276.89	$72.04	$55.38
67210	T		Treatment of retinal lesion	0248	4.8223	$263.11	$95.08	$52.62
67218	T		Treatment of retinal lesion	0236	18.6701	$1,018.66	.....	$203.73
67220	T		Treatment of choroid lesion	0235	5.0749	$276.89	$72.04	$55.38
67221	T		Ocular photodynamic ther	0235	5.0749	$276.89	$72.04	$55.38
67225	T		Eye photodynamic ther add-on	0235	5.0749	$276.89	$72.04	$55.38
67227	T		Treatment of retinal lesion	0235	5.0749	$276.89	$72.04	$55.38
67228	T		Treatment of retinal lesion	0248	4.8223	$263.11	$95.08	$52.62
67250	T		Reinforce eye wall	0240	17.4535	$952.28	$315.31	$190.46
67255	T		Reinforce/graft eye wall	0237	34.1784	$1,864.81	$818.54	$372.96
67299	T		Eye surgery procedure	0235	5.0749	$276.89	$72.04	$55.38
67311	T		Revise eye muscle	0243	21.7323	$1,185.74	$431.39	$237.15
67312	T		Revise two eye muscles	0243	21.7323	$1,185.74	$431.39	$237.15
67314	T		Revise eye muscle	0243	21.7323	$1,185.74	$431.39	$237.15
67316	T		Revise two eye muscles	0243	21.7323	$1,185.74	$431.39	$237.15
67318	T		Revise eye muscle(s)	0243	21.7323	$1,185.74	$431.39	$237.15
67320	T		Revise eye muscle(s) add-on	0243	21.7323	$1,185.74	$431.39	$237.15
67331	T		Eye surgery follow-up add-on	0243	21.7323	$1,185.74	$431.39	$237.15
67332	T		Rerevise eye muscles add-on	0243	21.7323	$1,185.74	$431.39	$237.15
67334	T		Revise eye muscle w/suture	0243	21.7323	$1,185.74	$431.39	$237.15
67335	T		Eye suture during surgery	0243	21.7323	$1,185.74	$431.39	$237.15
67340	T		Revise eye muscle add-on	0243	21.7323	$1,185.74	$431.39	$237.15
67343	T		Release eye tissue	0243	21.7323	$1,185.74	$431.39	$237.15
67345	T		Destroy nerve of eye muscle	0238	3.1954	$174.34	$58.96	$34.87
67350	T		Biopsy eye muscle	0699	2.2303	$121.69	$47.46	$24.34
67399	T		Eye muscle surgery procedure	0243	21.7323	$1,185.74	$431.39	$237.15
67400	T		Explore/biopsy eye socket	0241	22.1969	$1,211.09	$384.47	$242.22
67405	T		Explore/drain eye socket	0241	22.1969	$1,211.09	$384.47	$242.22
67412	T		Explore/treat eye socket	0241	22.1969	$1,211.09	$384.47	$242.22
67413	T		Explore/treat eye socket	0241	22.1969	$1,211.09	$384.47	$242.22
67414	T		Explr/decompress eye socket	0242	29.4294	$1,605.70	$597.36	$321.14
67415	T		Aspiration, orbital contents	0239	6.1331	$334.63	.....	$66.93
67420	T		Explore/treat eye socket	0242	29.4294	$1,605.70	$597.36	$321.14
67430	T		Explore/treat eye socket	0242	29.4294	$1,605.70	$597.36	$321.14
67440	T		Explore/drain eye socket	0242	29.4294	$1,605.70	$597.36	$321.14
67445	T		Explr/decompress eye socket	0242	29.4294	$1,605.70	$597.36	$321.14
67450	T		Explore/biopsy eye socket	0242	29.4294	$1,605.70	$597.36	$321.14
67500	S		Inject/treat eye socket	0231	2.1883	$119.40	$50.94	$23.88
67505	T		Inject/treat eye socket	0238	3.1954	$174.34	$58.96	$34.87
67515	T		Inject/treat eye socket	0239	6.1331	$334.63	.....	$66.93
67550	T		Insert eye socket implant	0242	29.4294	$1,605.70	$597.36	$321.14
67560	T		Revise eye socket implant	0241	22.1969	$1,211.09	$384.47	$242.22
67570	T		Decompress optic nerve	0242	29.4294	$1,605.70	$597.36	$321.14
67599	T		Orbit surgery procedure	0239	6.1331	$334.63	.....	$66.93
67700	T		Drainage of eyelid abscess	0238	3.1954	$174.34	$58.96	$34.87
67710	T		Incision of eyelid	0239	6.1331	$334.63	.....	$66.93
67715	T		Incision of eyelid fold	0240	17.4535	$952.28	$315.31	$190.46
67800	T		Remove eyelid lesion	0238	3.1954	$174.34	$58.96	$34.87
67801	T		Remove eyelid lesions	0239	6.1331	$334.63	.....	$66.93
67805	T		Remove eyelid lesions	0238	3.1954	$174.34	$58.96	$34.87
67808	T		Remove eyelid lesion(s)	0240	17.4535	$952.28	$315.31	$190.46
67810	T		Biopsy of eyelid	0238	3.1954	$174.34	$58.96	$34.87
67820	S		Revise eyelashes	0698	0.9599	$52.37	$18.72	$10.47
67825	T		Revise eyelashes	0238	3.1954	$174.34	$58.96	$34.87
67830	T		Revise eyelashes	0239	6.1331	$334.63	.....	$66.93
67835	T		Revise eyelashes	0240	17.4535	$952.28	$315.31	$190.46
67840	T		Remove eyelid lesion	0239	6.1331	$334.63	.....	$66.93

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
67850	T		Treat eyelid lesion	0239	6.1331	$334.63		$66.93
67875	T		Closure of eyelid by suture	0239	6.1331	$334.63		$66.93
67880	T		Revision of eyelid	0233	14.4205	$786.80	$266.33	$157.36
67882	T		Revision of eyelid	0240	17.4535	$952.28	$315.31	$190.46
67900	T		Repair brow defect	0240	17.4535	$952.28	$315.31	$190.46
67901	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67902	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67903	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67904	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67906	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67908	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67909	T		Revise eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67911	T		Revise eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67912	T	NI	Correction eyelid w/ implant	0239	6.1331	$334.63		$66.93
67914	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67915	T		Repair eyelid defect	0239	6.1331	$334.63		$66.93
67916	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67917	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67921	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67922	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67923	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67924	T		Repair eyelid defect	0240	17.4535	$952.28	$315.31	$190.46
67930	T		Repair eyelid wound	0240	17.4535	$952.28	$315.31	$190.46
67935	T		Repair eyelid wound	0240	17.4535	$952.28	$315.31	$190.46
67938	S		Remove eyelid foreign body	0698	0.9599	$52.37	$18.72	$10.47
67950	T		Revision of eyelid	0240	17.4535	$952.28	$315.31	$190.46
67961	T		Revision of eyelid	0240	17.4535	$952.28	$315.31	$190.46
67966	T		Revision of eyelid	0240	17.4535	$952.28	$315.31	$190.46
67971	T		Reconstruction of eyelid	0241	22.1969	$1,211.09	$384.47	$242.22
67973	T		Reconstruction of eyelid	0241	22.1969	$1,211.09	$384.47	$242.22
67974	T		Reconstruction of eyelid	0241	22.1969	$1,211.09	$384.47	$242.22
67975	T		Reconstruction of eyelid	0240	17.4535	$952.28	$315.31	$190.46
67999	T		Revision of eyelid	0240	17.4535	$952.28	$315.31	$190.46
68020	T		Incise/drain eyelid lining	0240	17.4535	$952.28	$315.31	$190.46
68040	S		Treatment of eyelid lesions	0698	0.9599	$52.37	$18.72	$10.47
68100	T		Biopsy of eyelid lining	0232	4.9206	$268.47	$103.17	$53.69
68110	T		Remove eyelid lining lesion	0699	2.2303	$121.69	$47.46	$24.34
68115	T		Remove eyelid lining lesion	0239	6.1331	$334.63		$66.93
68130	T		Remove eyelid lining lesion	0233	14.4205	$786.80	$266.33	$157.36
68135	T		Remove eyelid lining lesion	0239	6.1331	$334.63		$66.93
68200	S		Treat eyelid by injection	0698	0.9599	$52.37	$18.72	$10.47
68320	T		Revise/graft eyelid lining	0240	17.4535	$952.28	$315.31	$190.46
68325	T		Revise/graft eyelid lining	0242	29.4294	$1,605.70	$597.36	$321.14
68326	T		Revise/graft eyelid lining	0241	22.1969	$1,211.09	$384.47	$242.22
68328	T		Revise/graft eyelid lining	0241	22.1969	$1,211.09	$384.47	$242.22
68330	T		Revise eyelid lining	0233	14.4205	$786.80	$266.33	$157.36
68335	T		Revise/graft eyelid lining	0241	22.1969	$1,211.09	$384.47	$242.22
68340	T		Separate eyelid adhesions	0240	17.4535	$952.28	$315.31	$190.46
68360	T		Revise eyelid lining	0234	21.4631	$1,171.05	$511.31	$234.21
68362	T		Revise eyelid lining	0234	21.4631	$1,171.05	$511.31	$234.21
68371	T	NI	Harvest eye tissue, alograft	0233	14.4205	$786.80	$266.33	$157.36
68399	T		Eyelid lining surgery	0239	6.1331	$334.63		$66.93
68400	T		Incise/drain tear gland	0238	3.1954	$174.34	$58.96	$34.87
68420	T		Incise/drain tear sac	0240	17.4535	$952.28	$315.31	$190.46
68440	T		Incise tear duct opening	0238	3.1954	$174.34	$58.96	$34.87
68500	T		Removal of tear gland	0241	22.1969	$1,211.09	$384.47	$242.22
68505	T		Partial removal, tear gland	0241	22.1969	$1,211.09	$384.47	$242.22
68510	T		Biopsy of tear gland	0240	17.4535	$952.28	$315.31	$190.46
68520	T		Removal of tear sac	0241	22.1969	$1,211.09	$384.47	$242.22
68525	T		Biopsy of tear sac	0240	17.4535	$952.28	$315.31	$190.46
68530	T		Clearance of tear duct	0240	17.4535	$952.28	$315.31	$190.46
68540	T		Remove tear gland lesion	0241	22.1969	$1,211.09	$384.47	$242.22
68550	T		Remove tear gland lesion	0242	29.4294	$1,605.70	$597.36	$321.14
68700	T		Repair tear ducts	0241	22.1969	$1,211.09	$384.47	$242.22
68705	T		Revise tear duct opening	0238	3.1954	$174.34	$58.96	$34.87
68720	T		Create tear sac drain	0242	29.4294	$1,605.70	$597.36	$321.14
68745	T		Create tear duct drain	0241	22.1969	$1,211.09	$384.47	$242.22
68750	T		Create tear duct drain	0242	29.4294	$1,605.70	$597.36	$321.14
68760	S		Close tear duct opening	0698	0.9599	$52.37	$18.72	$10.47
68761	S		Close tear duct opening	0231	2.1883	$119.40	$50.94	$23.88
68770	T		Close tear system fistula	0240	17.4535	$952.28	$315.31	$190.46
68801	S		Dilate tear duct opening	0231	2.1883	$119.40	$50.94	$23.88
68810	T		Probe nasolacrimal duct	0699	2.2303	$121.69	$47.46	$24.34
68811	T		Probe nasolacrimal duct	0240	17.4535	$952.28	$315.31	$190.46
68815	T		Probe nasolacrimal duct	0240	17.4535	$952.28	$315.31	$190.46

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
68840	T		Explore/irrigate tear ducts	0699	2.2303	$121.69	$47.46	$24.34
68850	N		Injection for tear sac x-ray					
68899	T		Tear duct system surgery	0699	2.2303	$121.69	$47.46	$24.34
69000	T		Drain external ear lesion	0006	1.6527	$90.17	$23.26	$18.03
69005	T		Drain external ear lesion	0007	11.8633	$647.27		$129.45
69020	T		Drain outer ear canal lesion	0006	1.6527	$90.17	$23.26	$18.03
69090	E		Pierce earlobes					
69100	T		Biopsy of external ear	0019	3.9493	$215.48	$71.87	$43.10
69105	T		Biopsy of external ear canal	0253	15.2249	$830.69	$282.29	$166.14
69110	T		Remove external ear, partial	0021	14.3594	$783.46	$219.48	$156.69
69120	T		Removal of external ear	0254	21.8901	$1,194.35	$321.35	$238.87
69140	T		Remove ear canal lesion(s)	0254	21.8901	$1,194.35	$321.35	$238.87
69145	T		Remove ear canal lesion(s)	0021	14.3594	$783.46	$219.48	$156.69
69150	T		Extensive ear canal surgery	0252	6.4469	$351.75	$113.41	$70.35
69155	C		Extensive ear/neck surgery					
69200	X		Clear outer ear canal	0340	0.6314	$34.45		$6.89
69205	T		Clear outer ear canal	0022	18.7932	$1,025.38	$354.45	$205.08
69210	X		Remove impacted ear wax	0340	0.6314	$34.45		$6.89
69220	T		Clean out mastoid cavity	0012	0.7694	$41.98	$11.18	$8.40
69222	T		Clean out mastoid cavity	0253	15.2249	$830.69	$282.29	$166.14
69300	T		Revise external ear	0254	21.8901	$1,194.35	$321.35	$238.87
69310	T		Rebuild outer ear canal	0256	35.1548	$1,918.08		$383.62
69320	T		Rebuild outer ear canal	0256	35.1548	$1,918.08		$383.62
69399	T		Outer ear surgery procedure	0251	1.7880	$97.56		$19.51
69400	T		Inflate middle ear canal	0251	1.7880	$97.56		$19.51
69401	T		Inflate middle ear canal	0251	1.7880	$97.56		$19.51
69405	T		Catheterize middle ear canal	0252	6.4469	$351.75	$113.41	$70.35
69410	T		Inset middle ear (baffle)	0251	1.7880	$97.56		$19.51
69420	T		Incision of eardrum	0252	6.4469	$351.75	$113.41	$70.35
69421	T		Incision of eardrum	0253	15.2249	$830.69	$282.29	$166.14
69424	T		Remove ventilating tube	0252	6.4469	$351.75	$113.41	$70.35
69433	T		Create eardrum opening	0252	6.4469	$351.75	$113.41	$70.35
69436	T		Create eardrum opening	0253	15.2249	$830.69	$282.29	$166.14
69440	T		Exploration of middle ear	0254	21.8901	$1,194.35	$321.35	$238.87
69450	T		Eardrum revision	0256	35.1548	$1,918.08		$383.62
69501	T		Mastoidectomy	0256	35.1548	$1,918.08		$383.62
69502	T		Mastoidectomy	0254	21.8901	$1,194.35	$321.35	$238.87
69505	T		Remove mastoid structures	0256	35.1548	$1,918.08		$383.62
69511	T		Extensive mastoid surgery	0256	35.1548	$1,918.08		$383.62
69530	T		Extensive mastoid surgery	0256	35.1548	$1,918.08		$383.62
69535	C		Remove part of temporal bone					
69540	T		Remove ear lesion	0253	15.2249	$830.69	$282.29	$166.14
69550	T		Remove ear lesion	0256	35.1548	$1,918.08		$383.62
69552	T		Remove ear lesion	0256	35.1548	$1,918.08		$383.62
69554	C		Remove ear lesion					
69601	T		Mastoid surgery revision	0256	35.1548	$1,918.08		$383.62
69602	T		Mastoid surgery revision	0256	35.1548	$1,918.08		$383.62
69603	T		Mastoid surgery revision	0256	35.1548	$1,918.08		$383.62
69604	T		Mastoid surgery revision	0256	35.1548	$1,918.08		$383.62
69605	T		Mastoid surgery revision	0256	35.1548	$1,918.08		$383.62
69610	T		Repair of eardrum	0254	21.8901	$1,194.35	$321.35	$238.87
69620	T		Repair of eardrum	0254	21.8901	$1,194.35	$321.35	$238.87
69631	T		Repair eardrum structures	0256	35.1548	$1,918.08		$383.62
69632	T		Rebuild eardrum structures	0256	35.1548	$1,918.08		$383.62
69633	T		Rebuild eardrum structures	0256	35.1548	$1,918.08		$383.62
69635	T		Repair eardrum structures	0256	35.1548	$1,918.08		$383.62
69636	T		Rebuild eardrum structures	0256	35.1548	$1,918.08		$383.62
69637	T		Rebuild eardrum structures	0256	35.1548	$1,918.08		$383.62
69641	T		Revise middle ear & mastoid	0256	35.1548	$1,918.08		$383.62
69642	T		Revise middle ear & mastoid	0256	35.1548	$1,918.08		$383.62
69643	T		Revise middle ear & mastoid	0256	35.1548	$1,918.08		$383.62
69644	T		Revise middle ear & mastoid	0256	35.1548	$1,918.08		$383.62
69645	T		Revise middle ear & mastoid	0256	35.1548	$1,918.08		$383.62
69646	T		Revise middle ear & mastoid	0256	35.1548	$1,918.08		$383.62
69650	T		Release middle ear bone	0254	21.8901	$1,194.35	$321.35	$238.87
69660	T		Revise middle ear bone	0256	35.1548	$1,918.08		$383.62
69661	T		Revise middle ear bone	0256	35.1548	$1,918.08		$383.62
69662	T		Revise middle ear bone	0256	35.1548	$1,918.08		$383.62
69666	T		Repair middle ear structures	0256	35.1548	$1,918.08		$383.62
69667	T		Repair middle ear structures	0256	35.1548	$1,918.08		$383.62
69670	T		Remove mastoid air cells	0256	35.1548	$1,918.08		$383.62
69676	T		Remove middle ear nerve	0256	35.1548	$1,918.08		$383.62
69700	T		Close mastoid fistula	0256	35.1548	$1,918.08		$383.62
69710	E		Implant/replace hearing aid					
69711	T		Remove/repair hearing aid	0256	35.1548	$1,918.08		$383.62

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
69714	T		Implant temple bone w/stimul	0256	35.1548	$1,918.08		$383.62
69715	T		Temple bne implnt w/stimulat	0256	35.1548	$1,918.08		$383.62
69717	T		Temple bone implant revision	0256	35.1548	$1,918.08		$383.62
69718	T		Revise temple bone implant	0256	35.1548	$1,918.08		$383.62
69720	T		Release facial nerve	0256	35.1548	$1,918.08		$383.62
69725	T		Release facial nerve	0256	35.1548	$1,918.08		$383.62
69740	T		Repair facial nerve	0256	35.1548	$1,918.08		$383.62
69745	T		Repair facial nerve	0256	35.1548	$1,918.08		$383.62
69799	T		Middle ear surgery procedure	0253	15.2249	$830.69	$282.29	$166.14
69801	T		Incise inner ear	0256	35.1548	$1,918.08		$383.62
69802	T		Incise inner ear	0256	35.1548	$1,918.08		$383.62
69805	T		Explore inner ear	0256	35.1548	$1,918.08		$383.62
69806	T		Explore inner ear	0256	35.1548	$1,918.08		$383.62
69820	T		Establish inner ear window	0256	35.1548	$1,918.08		$383.62
69840	T		Revise inner ear window	0256	35.1548	$1,918.08		$383.62
69905	T		Remove inner ear	0256	35.1548	$1,918.08		$383.62
69910	T		Remove inner ear & mastoid	0256	35.1548	$1,918.08		$383.62
69915	T		Incise inner ear nerve	0256	35.1548	$1,918.08		$383.62
69930	T		Implant cochlear device	0259	392.8622	$21,434.95	$9,394.83	$4,286.99
69949	T		Inner ear surgery procedure	0253	15.2249	$830.69	$282.29	$166.14
69950	C		Incise inner ear nerve					
69955	T		Release facial nerve	0256	35.1548	$1,918.08		$383.62
69960	T		Release inner ear canal	0256	35.1548	$1,918.08		$383.62
69970	C		Remove inner ear lesion					
69979	T		Temporal bone surgery	0251	1.7880	$97.56		$19.51
69990	N		Microsurgery add-on					
70010	S		Contrast x-ray of brain	0274	3.5931	$196.04	$93.63	$39.21
70015	S		Contrast x-ray of brain	0274	3.5931	$196.04	$93.63	$39.21
70030	X		X-ray eye for foreign body	0260	0.7802	$42.57	$21.28	$8.51
70100	X		X-ray exam of jaw	0260	0.7802	$42.57	$21.28	$8.51
70110	X		X-ray exam of jaw	0260	0.7802	$42.57	$21.28	$8.51
70120	X		X-ray exam of mastoids	0260	0.7802	$42.57	$21.28	$8.51
70130	X		X-ray exam of mastoids	0260	0.7802	$42.57	$21.28	$8.51
70134	X		X-ray exam of middle ear	0261	1.3176	$71.89		$14.38
70140	X		X-ray exam of facial bones	0260	0.7802	$42.57	$21.28	$8.51
70150	X		X-ray exam of facial bones	0260	0.7802	$42.57	$21.28	$8.51
70160	X		X-ray exam of nasal bones	0260	0.7802	$42.57	$21.28	$8.51
70170	X		X-ray exam of tear duct	0263	2.1883	$119.40	$43.58	$23.88
70190	X		X-ray exam of eye sockets	0260	0.7802	$42.57	$21.28	$8.51
70200	X		X-ray exam of eye sockets	0260	0.7802	$42.57	$21.28	$8.51
70210	X		X-ray exam of sinuses	0260	0.7802	$42.57	$21.28	$8.51
70220	X		X-ray exam of sinuses	0260	0.7802	$42.57	$21.28	$8.51
70240	X		X-ray exam, pituitary saddle	0260	0.7802	$42.57	$21.28	$8.51
70250	X		X-ray exam of skull	0260	0.7802	$42.57	$21.28	$8.51
70260	X		X-ray exam of skull	0261	1.3176	$71.89		$14.38
70300	X		X-ray exam of teeth	0262	0.7540	$41.14	$9.82	$8.23
70310	X		X-ray exam of teeth	0262	0.7540	$41.14	$9.82	$8.23
70320	X		Full mouth x-ray of teeth	0262	0.7540	$41.14	$9.82	$8.23
70328	X		X-ray exam of jaw joint	0260	0.7802	$42.57	$21.28	$8.51
70330	X		X-ray exam of jaw joints	0260	0.7802	$42.57	$21.28	$8.51
70332	S		X-ray exam of jaw joint	0275	3.2775	$178.82	$69.09	$35.76
70336	S		Magnetic image, jaw joint	0335	6.3499	$346.46	$151.46	$69.29
70350	X		X-ray head for orthodontia	0260	0.7802	$42.57	$21.28	$8.51
70355	X		Panoramic x-ray of jaws	0260	0.7802	$42.57	$21.28	$8.51
70360	X		X-ray exam of neck	0260	0.7802	$42.57	$21.28	$8.51
70370	X		Throat x-ray & fluoroscopy	0272	1.4166	$77.29	$38.36	$15.46
70371	X		Speech evaluation, complex	0272	1.4166	$77.29	$38.36	$15.46
70373	X		Contrast x-ray of larynx	0263	2.1883	$119.40	$43.58	$23.88
70380	X		X-ray exam of salivary gland	0260	0.7802	$42.57	$21.28	$8.51
70390	X		X-ray exam of salivary duct	0264	3.0287	$165.25	$79.41	$33.05
70450	S		Ct head/brain w/o dye	0332	3.3936	$185.16	$91.27	$37.03
70460	S		Ct head/brain w/dye	0283	4.6543	$253.94	$126.27	$50.79
70470	S		Ct head/brain w/o & w/ dye	0333	5.4241	$295.94	$146.98	$59.19
70480	S		Ct orbit/ear/fossa w/o dye	0332	3.3936	$185.16	$91.27	$37.03
70481	S		Ct orbit/ear/fossa w/dye	0283	4.6543	$253.94	$126.27	$50.79
70482	S		Ct orbit/ear/fossa w/o&w dye	0333	5.4241	$295.94	$146.98	$59.19
70486	S		Ct maxillofacial w/o dye	0332	3.3936	$185.16	$91.27	$37.03
70487	S		Ct maxillofacial w/dye	0283	4.6543	$253.94	$126.27	$50.79
70488	S		Ct maxillofacial w/o & w dye	0333	5.4241	$295.94	$146.98	$59.19
70490	S		Ct soft tissue neck w/o dye	0332	3.3936	$185.16	$91.27	$37.03
70491	S		Ct soft tissue neck w/dye	0283	4.6543	$253.94	$126.27	$50.79
70492	S		Ct sft tsue nck w/o & w/dye	0333	5.4241	$295.94	$146.98	$59.19
70496	S		Ct angiography, head	0662	5.8775	$320.68	$156.47	$64.14
70498	S		Ct angiography, neck	0662	5.8775	$320.68	$156.47	$64.14
70540	S		Mri orbit/face/neck w/o dye	0336	6.3897	$348.63	$174.31	$69.73

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
70542	S		Mri orbit/face/neck w/dye	0284	7.1165	$388.28	$194.13	$77.66
70543	S		Mri orbt/fac/nck w/o & w dye	0337	9.2075	$502.37	$240.77	$100.47
70544	S		Mr angiography head w/o dye	0336	6.3897	$348.63	$174.31	$69.73
70545	S		Mr angiography head w/dye	0284	7.1165	$388.28	$194.13	$77.66
70546	S		Mr angiograph head w/o&w dye	0337	9.2075	$502.37	$240.77	$100.47
70547	S		Mr angiography neck w/o dye	0336	6.3897	$348.63	$174.31	$69.73
70548	S		Mr angiography neck w/dye	0284	7.1165	$388.28	$194.13	$77.66
70549	S		Mr angiograph neck w/o&w dye	0337	9.2075	$502.37	$240.77	$100.47
70551	S		Mri brain w/o dye	0336	6.3897	$348.63	$174.31	$69.73
70552	S		Mri brain w/ dye	0284	7.1165	$388.28	$194.13	$77.66
70553	S		Mri brain w/o & w/ dye	0337	9.2075	$502.37	$240.77	$100.47
70557	S	NI	Mri brain w/o dye	0336	6.3897	$348.63	$174.31	$69.73
70558	S	NI	Mri brain w/ dye	0284	7.1165	$388.28	$194.13	$77.66
70559	S	NI	Mri brain w/o & w/ dye	0337	9.2075	$502.37	$240.77	$100.47
71010	X		Chest x-ray	0260	0.7802	$42.57	$21.28	$8.51
71015	X		Chest x-ray	0260	0.7802	$42.57	$21.28	$8.51
71020	X		Chest x-ray	0260	0.7802	$42.57	$21.28	$8.51
71021	X		Chest x-ray	0260	0.7802	$42.57	$21.28	$8.51
71022	X		Chest x-ray	0260	0.7802	$42.57	$21.28	$8.51
71023	X		Chest x-ray and fluoroscopy	0272	1.4166	$77.29	$38.36	$15.46
71030	X		Chest x-ray	0260	0.7802	$42.57	$21.28	$8.51
71034	X		Chest x-ray and fluoroscopy	0272	1.4166	$77.29	$38.36	$15.46
71035	X		Chest x-ray	0260	0.7802	$42.57	$21.28	$8.51
71040	X		Contrast x-ray of bronchi	0263	2.1883	$119.40	$43.58	$23.88
71060	X		Contrast x-ray of bronchi	0264	3.0287	$165.25	$79.41	$33.05
71090	X		X-ray & pacemaker insertion	0272	1.4166	$77.29	$38.36	$15.46
71100	X		X-ray exam of ribs	0260	0.7802	$42.57	$21.28	$8.51
71101	X		X-ray exam of ribs/chest	0260	0.7802	$42.57	$21.28	$8.51
71110	X		X-ray exam of ribs	0260	0.7802	$42.57	$21.28	$8.51
71111	X		X-ray exam of ribs/ chest	0261	1.3176	$71.89		$14.38
71120	X		X-ray exam of breastbone	0260	0.7802	$42.57	$21.28	$8.51
71130	X		X-ray exam of breastbone	0260	0.7802	$42.57	$21.28	$8.51
71250	S		Ct thorax w/o dye	0332	3.3936	$185.16	$91.27	$37.03
71260	S		Ct thorax w/dye	0283	4.6543	$253.94	$126.27	$50.79
71270	S		Ct thorax w/o & w/ dye	0333	5.4241	$295.94	$146.98	$59.19
71275	S		Ct angiography, chest	0662	5.8775	$320.68	$156.47	$64.14
71550	S		Mri chest w/o dye	0336	6.3897	$348.63	$174.31	$69.73
71551	S		Mri chest w/dye	0284	7.1165	$388.28	$194.13	$77.66
71552	S		Mri chest w/o & w/dye	0337	9.2075	$502.37	$240.77	$100.47
71555	B		Mri angio chest w or w/o dye					
72010	X		X-ray exam of spine	0261	1.3176	$71.89		$14.38
72020	X		X-ray exam of spine	0260	0.7802	$42.57	$21.28	$8.51
72040	X		X-ray exam of neck spine	0260	0.7802	$42.57	$21.28	$8.51
72050	X		X-ray exam of neck spine	0261	1.3176	$71.89		$14.38
72052	X		X-ray exam of neck spine	0261	1.3176	$71.89		$14.38
72069	X		X-ray exam of trunk spine	0260	0.7802	$42.57	$21.28	$8.51
72070	X		X-ray exam of thoracic spine	0260	0.7802	$42.57	$21.28	$8.51
72072	X		X-ray exam of thoracic spine	0260	0.7802	$42.57	$21.28	$8.51
72074	X		X-ray exam of thoracic spine	0260	0.7802	$42.57	$21.28	$8.51
72080	X		X-ray exam of trunk spine	0260	0.7802	$42.57	$21.28	$8.51
72090	X		X-ray exam of trunk spine	0261	1.3176	$71.89		$14.38
72100	X		X-ray exam of lower spine	0260	0.7802	$42.57	$21.28	$8.51
72110	X		X-ray exam of lower spine	0261	1.3176	$71.89		$14.38
72114	X		X-ray exam of lower spine	0261	1.3176	$71.89		$14.38
72120	X		X-ray exam of lower spine	0260	0.7802	$42.57	$21.28	$8.51
72125	S		Ct neck spine w/o dye	0332	3.3936	$185.16	$91.27	$37.03
72126	S		Ct neck spine w/dye	0283	4.6543	$253.94	$126.27	$50.79
72127	S		Ct neck spine w/o & w/dye	0333	5.4241	$295.94	$146.98	$59.19
72128	S		Ct chest spine w/o dye	0332	3.3936	$185.16	$91.27	$37.03
72129	S		Ct chest spine w/dye	0283	4.6543	$253.94	$126.27	$50.79
72130	S		Ct chest spine w/o & w/dye	0333	5.4241	$295.94	$146.98	$59.19
72131	S		Ct lumbar spine w/o dye	0332	3.3936	$185.16	$91.27	$37.03
72132	S		Ct lumbar spine w/dye	0283	4.6543	$253.94	$126.27	$50.79
72133	S		Ct lumbar spine w/o & w/dye	0333	5.4241	$295.94	$146.98	$59.19
72141	S		Mri neck spine w/o dye	0336	6.3897	$348.63	$174.31	$69.73
72142	S		Mri neck spine w/dye	0284	7.1165	$388.28	$194.13	$77.66
72146	S		Mri chest spine w/o dye	0336	6.3897	$348.63	$174.31	$69.73
72147	S		Mri chest spine w/dye	0284	7.1165	$388.28	$194.13	$77.66
72148	S		Mri lumbar spine w/o dye	0336	6.3897	$348.63	$174.31	$69.73
72149	S		Mri lumbar spine w/dye	0284	7.1165	$388.28	$194.13	$77.66
72156	S		Mri neck spine w/o & w/dye	0337	9.2075	$502.37	$240.77	$100.47
72157	S		Mri chest spine w/o & w/dye	0337	9.2075	$502.37	$240.77	$100.47
72158	S		Mri lumbar spine w/o & w/dye	0337	9.2075	$502.37	$240.77	$100.47
72159	E		Mr angio spine w/o&w/dye					
72170	X		X-ray exam of pelvis	0260	0.7802	$42.57	$21.28	$8.51

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
72190	X		X-ray exam of pelvis	0260	0.7802	$42.57	$21.28	$8.51
72191	S		Ct angiograph pelv w/o&w/dye	0662	5.8775	$320.68	$156.47	$64.14
72192	S		Ct pelvis w/o dye	0332	3.3936	$185.16	$91.27	$37.03
72193	S		Ct pelvis w/dye	0283	4.6543	$253.94	$126.27	$50.79
72194	S		Ct pelvis w/o & w/dye	0333	5.4241	$295.94	$146.98	$59.19
72195	S		Mri pelvis w/o dye	0336	6.3897	$348.63	$174.31	$69.73
72196	S		Mri pelvis w/dye	0284	7.1165	$388.28	$194.13	$77.66
72197	S		Mri pelvis w/o & w/dye	0337	9.2075	$502.37	$240.77	$100.47
72198	E		Mr angio pelvis w/o & w/dye					
72200	X		X-ray exam sacroiliac joints	0260	0.7802	$42.57	$21.28	$8.51
72202	X		X-ray exam sacroiliac joints	0260	0.7802	$42.57	$21.28	$8.51
72220	X		X-ray exam of tailbone	0260	0.7802	$42.57	$21.28	$8.51
72240	S		Contrast x-ray of neck spine	0274	3.5931	$196.04	$93.63	$39.21
72255	S		Contrast x-ray, thorax spine	0274	3.5931	$196.04	$93.63	$39.21
72265	S		Contrast x-ray, lower spine	0274	3.5931	$196.04	$93.63	$39.21
72270	S		Contrast x-ray, spine	0274	3.5931	$196.04	$93.63	$39.21
72275	S		Epidurography	0274	3.5931	$196.04	$93.63	$39.21
72285	S		X-ray c/t spine disk	0388	11.6347	$634.80	$303.19	$126.96
72295	S		X-ray of lower spine disk	0388	11.6347	$634.80	$303.19	$126.96
73000	X		X-ray exam of collar bone	0260	0.7802	$42.57	$21.28	$8.51
73010	X		X-ray exam of shoulder blade	0260	0.7802	$42.57	$21.28	$8.51
73020	X		X-ray exam of shoulder	0260	0.7802	$42.57	$21.28	$8.51
73030	X		X-ray exam of shoulder	0260	0.7802	$42.57	$21.28	$8.51
73040	S		Contrast x-ray of shoulder	0275	3.2775	$178.82	$69.09	$35.76
73050	X		X-ray exam of shoulders	0260	0.7802	$42.57	$21.28	$8.51
73060	X		X-ray exam of humerus	0260	0.7802	$42.57	$21.28	$8.51
73070	X		X-ray exam of elbow	0260	0.7802	$42.57	$21.28	$8.51
73080	X		X-ray exam of elbow	0260	0.7802	$42.57	$21.28	$8.51
73085	S		Contrast x-ray of elbow	0275	3.2775	$178.82	$69.09	$35.76
73090	X		X-ray exam of forearm	0260	0.7802	$42.57	$21.28	$8.51
73092	X		X-ray exam of arm, infant	0260	0.7802	$42.57	$21.28	$8.51
73100	X		X-ray exam of wrist	0260	0.7802	$42.57	$21.28	$8.51
73110	X		X-ray exam of wrist	0260	0.7802	$42.57	$21.28	$8.51
73115	S		Contrast x-ray of wrist	0275	3.2775	$178.82	$69.09	$35.76
73120	X		X-ray exam of hand	0260	0.7802	$42.57	$21.28	$8.51
73130	X		X-ray exam of hand	0260	0.7802	$42.57	$21.28	$8.51
73140	X		X-ray exam of finger(s)	0260	0.7802	$42.57	$21.28	$8.51
73200	S		Ct upper extremity w/o dye	0332	3.3936	$185.16	$91.27	$37.03
73201	S		Ct upper extremity w/dye	0283	4.6543	$253.94	$126.27	$50.79
73202	S		Ct uppr extremity w/o&w/dye	0333	5.4241	$295.94	$146.98	$59.19
73206	S		Ct angio upr extrm w/o&w/dye	0662	5.8775	$320.68	$156.47	$64.14
73218	S		Mri upper extremity w/o dye	0336	6.3897	$348.63	$174.31	$69.73
73219	S		Mri upper extremity w/dye	0284	7.1165	$388.28	$194.13	$77.66
73220	S		Mri uppr extremity w/o&w/dye	0337	9.2075	$502.37	$240.77	$100.47
73221	S		Mri joint upr extrem w/o dye	0336	6.3897	$348.63	$174.31	$69.73
73222	S		Mri joint upr extrem w/dye	0284	7.1165	$388.28	$194.13	$77.66
73223	S		Mri joint upr extr w/o&w/dye	0337	9.2075	$502.37	$240.77	$100.47
73225	E		Mr angio upr extr w/o&w/dye					
73500	X		X-ray exam of hip	0260	0.7802	$42.57	$21.28	$8.51
73510	X		X-ray exam of hip	0260	0.7802	$42.57	$21.28	$8.51
73520	X		X-ray exam of hips	0260	0.7802	$42.57	$21.28	$8.51
73525	S		Contrast x-ray of hip	0275	3.2775	$178.82	$69.09	$35.76
73530	X		X-ray exam of hip	0261	1.3176	$71.89		$14.38
73540	X		X-ray exam of pelvis & hips	0260	0.7802	$42.57	$21.28	$8.51
73542	S		X-ray exam, sacroiliac joint	0275	3.2775	$178.82	$69.09	$35.76
73550	X		X-ray exam of thigh	0260	0.7802	$42.57	$21.28	$8.51
73560	X		X-ray exam of knee, 1 or 2	0260	0.7802	$42.57	$21.28	$8.51
73562	X		X-ray exam of knee, 3	0260	0.7802	$42.57	$21.28	$8.51
73564	X		X-ray exam, knee, 4 or more	0260	0.7802	$42.57	$21.28	$8.51
73565	X		X-ray exam of knees	0260	0.7802	$42.57	$21.28	$8.51
73580	S		Contrast x-ray of knee joint	0275	3.2775	$178.82	$69.09	$35.76
73590	X		X-ray exam of lower leg	0260	0.7802	$42.57	$21.28	$8.51
73592	X		X-ray exam of leg, infant	0260	0.7802	$42.57	$21.28	$8.51
73600	X		X-ray exam of ankle	0260	0.7802	$42.57	$21.28	$8.51
73610	X		X-ray exam of ankle	0260	0.7802	$42.57	$21.28	$8.51
73615	S		Contrast x-ray of ankle	0275	3.2775	$178.82	$69.09	$35.76
73620	X		X-ray exam of foot	0260	0.7802	$42.57	$21.28	$8.51
73630	X		X-ray exam of foot	0260	0.7802	$42.57	$21.28	$8.51
73650	X		X-ray exam of heel	0260	0.7802	$42.57	$21.28	$8.51
73660	X		X-ray exam of toe(s)	0260	0.7802	$42.57	$21.28	$8.51
73700	S		Ct lower extremity w/o dye	0332	3.3936	$185.16	$91.27	$37.03
73701	S		Ct lower extremity w/dye	0283	4.6543	$253.94	$126.27	$50.79
73702	S		Ct lwr extremity w/o&w/dye	0333	5.4241	$295.94	$146.98	$59.19
73706	S		Ct angio lwr extr w/o&w/dye	0662	5.8775	$320.68	$156.47	$64.14
73718	S		Mri lower extremity w/o dye	0336	6.3897	$348.63	$174.31	$69.73

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
73719	S		Mri lower extremity w/dye	0284	7.1165	$388.28	$194.13	$77.66
73720	S		Mri lwr extremity w/o&w/dye	0337	9.2075	$502.37	$240.77	$100.47
73721	S		Mri jnt of lwr extre w/o dye	0336	6.3897	$348.63	$174.31	$69.73
73722	S		Mri joint of lwr extr w/dye	0284	7.1165	$388.28	$194.13	$77.66
73723	S		Mri joint lwr extr w/o&w/dye	0337	9.2075	$502.37	$240.77	$100.47
73725	B		Mr ang lwr ext w or w/o dye					
74000	X		X-ray exam of abdomen	0260	0.7802	$42.57	$21.28	$8.51
74010	X		X-ray exam of abdomen	0260	0.7802	$42.57	$21.28	$8.51
74020	X		X-ray exam of abdomen	0260	0.7802	$42.57	$21.28	$8.51
74022	X		X-ray exam series, abdomen	0261	1.3176	$71.89		$14.38
74150	S		Ct abdomen w/o dye	0332	3.3936	$185.16	$91.27	$37.03
74160	S		Ct abdomen w/dye	0283	4.6543	$253.94	$126.27	$50.79
74170	S		Ct abdomen w/o &w /dye	0333	5.4241	$295.94	$146.98	$59.19
74175	S		Ct angio abdom w/o & w/dye	0662	5.8775	$320.68	$156.47	$64.14
74181	S		Mri abdomen w/o dye	0336	6.3897	$348.63	$174.31	$69.73
74182	S		Mri abdomen w/dye	0284	7.1165	$388.28	$194.13	$77.66
74183	S		Mri abdomen w/o & w/dye	0337	9.2075	$502.37	$240.77	$100.47
74185	B		Mri angio, abdom w orw/o dye					
74190	X		X-ray exam of peritoneum	0263	2.1883	$119.40	$43.58	$23.88
74210	S		Contrst x-ray exam of throat	0276	1.5906	$86.78	$41.72	$17.36
74220	S		Contrast x-ray, esophagus	0276	1.5906	$86.78	$41.72	$17.36
74230	S		Cine/vid x-ray, throat/esoph	0276	1.5906	$86.78	$41.72	$17.36
74235	S		Remove esophagus obstruction	0296	2.8635	$156.24	$69.20	$31.25
74240	S		X-ray exam, upper gi tract	0276	1.5906	$86.78	$41.72	$17.36
74241	S		X-ray exam, upper gi tract	0276	1.5906	$86.78	$41.72	$17.36
74245	S		X-ray exam, upper gi tract	0277	2.4444	$133.37	$60.47	$26.67
74246	S		Contrst x-ray uppr gi tract	0276	1.5906	$86.78	$41.72	$17.36
74247	S		Contrst x-ray uppr gi tract	0276	1.5906	$86.78	$41.72	$17.36
74249	S		Contrst x-ray uppr gi tract	0277	2.4444	$133.37	$60.47	$26.67
74250	S		X-ray exam of small bowel	0276	1.5906	$86.78	$41.72	$17.36
74251	S		X-ray exam of small bowel	0277	2.4444	$133.37	$60.47	$26.67
74260	S		X-ray exam of small bowel	0277	2.4444	$133.37	$60.47	$26.67
74270	S		Contrast x-ray exam of colon	0276	1.5906	$86.78	$41.72	$17.36
74280	S		Contrast x-ray exam of colon	0277	2.4444	$133.37	$60.47	$26.67
74283	S		Contrast x-ray exam of colon	0276	1.5906	$86.78	$41.72	$17.36
74290	S		Contrast x-ray, gallbladder	0276	1.5906	$86.78	$41.72	$17.36
74291	S		Contrast x-rays, gallbladder	0276	1.5906	$86.78	$41.72	$17.36
74300	X		X-ray bile ducts/pancreas	0263	2.1883	$119.40	$43.58	$23.88
74301	X		X-rays at surgery add-on	0263	2.1883	$119.40	$43.58	$23.88
74305	X		X-ray bile ducts/pancreas	0263	2.1883	$119.40	$43.58	$23.88
74320	X		Contrast x-ray of bile ducts	0264	3.0287	$165.25	$79.41	$33.05
74327	S		X-ray bile stone removal	0296	2.8635	$156.24	$69.20	$31.25
74328	N		X-ray bile duct endoscopy					
74329	N		X-ray for pancreas endoscopy					
74330	N		X-ray bile/panc endoscopy					
74340	X		X-ray guide for GI tube	0272	1.4166	$77.29	$38.36	$15.46
74350	X		X-ray guide, stomach tube	0263	2.1883	$119.40	$43.58	$23.88
74355	X		X-ray guide, intestinal tube	0263	2.1883	$119.40	$43.58	$23.88
74360	S		X-ray guide, GI dilation	0296	2.8635	$156.24	$69.20	$31.25
74363	S		X-ray, bile duct dilation	0297	7.7145	$420.91	$172.51	$84.18
74400	S		Contrst x-ray, urinary tract	0278	2.7012	$147.38	$66.07	$29.48
74410	S		Contrst x-ray, urinary tract	0278	2.7012	$147.38	$66.07	$29.48
74415	S		Contrst x-ray, urinary tract	0278	2.7012	$147.38	$66.07	$29.48
74420	S		Contrst x-ray, urinary tract	0278	2.7012	$147.38	$66.07	$29.48
74425	S		Contrst x-ray, urinary tract	0278	2.7012	$147.38	$66.07	$29.48
74430	S		Contrast x-ray, bladder	0278	2.7012	$147.38	$66.07	$29.48
74440	S		X-ray, male genital tract	0278	2.7012	$147.38	$66.07	$29.48
74445	S		X-ray exam of penis	0278	2.7012	$147.38	$66.07	$29.48
74450	S		X-ray, urethra/bladder	0278	2.7012	$147.38	$66.07	$29.48
74455	S		X-ray, urethra/bladder	0278	2.7012	$147.38	$66.07	$29.48
74470	X		X-ray exam of kidney lesion	0264	3.0287	$165.25	$79.41	$33.05
74475	S		X-ray control, cath insert	0297	7.7145	$420.91	$172.51	$84.18
74480	S		X-ray control, cath insert	0296	2.8635	$156.24	$69.20	$31.25
74485	S		X-ray guide, GU dilation	0296	2.8635	$156.24	$69.20	$31.25
74710	X		X-ray measurement of pelvis	0260	0.7802	$42.57	$21.28	$8.51
74740	X		X-ray, female genital tract	0264	3.0287	$165.25	$79.41	$33.05
74742	X		X-ray, fallopian tube	0263	2.1883	$119.40	$43.58	$23.88
74775	S		X-ray exam of perineum	0278	2.7012	$147.38	$66.07	$29.48
75552	S		Heart mri for morph w/o dye	0336	6.3897	$348.63	$174.31	$69.73
75553	S		Heart mri for morph w/dye	0284	7.1165	$388.28	$194.13	$77.66
75554	S		Cardiac MRI/function	0335	6.3499	$346.46	$151.46	$69.29
75555	S		Cardiac MRI/limited study	0335	6.3499	$346.46	$151.46	$69.29
75556	E		Cardiac MRI/flow mapping					
75600	S		Contrast x-ray exam of aorta	0280	19.1015	$1,042.20	$353.85	$208.44
75605	S		Contrast x-ray exam of aorta	0280	19.1015	$1,042.20	$353.85	$208.44

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
75625	S		Contrast x-ray exam of aorta	0280	19.1015	$1,042.20	$353.85	$208.44
75630	S		X-ray aorta, leg arteries	0280	19.1015	$1,042.20	$353.85	$208.44
75635	S		Ct angio abdominal arteries	0662	5.8775	$320.68	$156.47	$64.14
75650	S		Artery x-rays, head & neck	0280	19.1015	$1,042.20	$353.85	$208.44
75658	S		Artery x-rays, arm	0280	19.1015	$1,042.20	$353.85	$208.44
75660	S		Artery x-rays, head & neck	0279	10.7073	$584.20	$174.57	$116.84
75662	S		Artery x-rays, head & neck	0279	10.7073	$584.20	$174.57	$116.84
75665	S		Artery x-rays, head & neck	0280	19.1015	$1,042.20	$353.85	$208.44
75671	S		Artery x-rays, head & neck	0280	19.1015	$1,042.20	$353.85	$208.44
75676	S		Artery x-rays, neck	0280	19.1015	$1,042.20	$353.85	$208.44
75680	S		Artery x-rays, neck	0280	19.1015	$1,042.20	$353.85	$208.44
75685	S		Artery x-rays, spine	0279	10.7073	$584.20	$174.57	$116.84
75705	S		Artery x-rays, spine	0279	10.7073	$584.20	$174.57	$116.84
75710	S		Artery x-rays, arm/leg	0280	19.1015	$1,042.20	$353.85	$208.44
75716	S		Artery x-rays, arms/legs	0280	19.1015	$1,042.20	$353.85	$208.44
75722	S		Artery x-rays, kidney	0280	19.1015	$1,042.20	$353.85	$208.44
75724	S		Artery x-rays, kidneys	0280	19.1015	$1,042.20	$353.85	$208.44
75726	S		Artery x-rays, abdomen	0280	19.1015	$1,042.20	$353.85	$208.44
75731	S		Artery x-rays, adrenal gland	0280	19.1015	$1,042.20	$353.85	$208.44
75733	S		Artery x-rays, adrenals	0280	19.1015	$1,042.20	$353.85	$208.44
75736	S		Artery x-rays, pelvis	0280	19.1015	$1,042.20	$353.85	$208.44
75741	S		Artery x-rays, lung	0279	10.7073	$584.20	$174.57	$116.84
75743	S		Artery x-rays, lungs	0280	19.1015	$1,042.20	$353.85	$208.44
75746	S		Artery x-rays, lung	0279	10.7073	$584.20	$174.57	$116.84
75756	S		Artery x-rays, chest	0279	10.7073	$584.20	$174.57	$116.84
75774	S		Artery x-ray, each vessel	0668	10.2660	$560.12	$237.76	$112.02
75790	S		Visualize A-V shunt	0281	6.6031	$360.27	$115.16	$72.05
75801	X		Lymph vessel x-ray, arm/leg	0264	3.0287	$165.25	$79.41	$33.05
75803	X		Lymph vessel x-ray,arms/legs	0264	3.0287	$165.25	$79.41	$33.05
75805	X		Lymph vessel x-ray, trunk	0264	3.0287	$165.25	$79.41	$33.05
75807	X		Lymph vessel x-ray, trunk	0264	3.0287	$165.25	$79.41	$33.05
75809	X		Nonvascular shunt, x-ray	0263	2.1883	$119.40	$43.58	$23.88
75810	S		Vein x-ray, spleen/liver	0279	10.7073	$584.20	$174.57	$116.84
75820	S		Vein x-ray, arm/leg	0281	6.6031	$360.27	$115.16	$72.05
75822	S		Vein x-ray, arms/legs	0281	6.6031	$360.27	$115.16	$72.05
75825	S		Vein x-ray, trunk	0279	10.7073	$584.20	$174.57	$116.84
75827	S		Vein x-ray, chest	0279	10.7073	$584.20	$174.57	$116.84
75831	S		Vein x-ray, kidney	0287	6.4923	$354.23	$111.33	$70.85
75833	S		Vein x-ray, kidneys	0279	10.7073	$584.20	$174.57	$116.84
75840	S		Vein x-ray, adrenal gland	0287	6.4923	$354.23	$111.33	$70.85
75842	S		Vein x-ray, adrenal glands	0287	6.4923	$354.23	$111.33	$70.85
75860	S		Vein x-ray, neck	0287	6.4923	$354.23	$111.33	$70.85
75870	S		Vein x-ray, skull	0287	6.4923	$354.23	$111.33	$70.85
75872	S		Vein x-ray, skull	0287	6.4923	$354.23	$111.33	$70.85
75880	S		Vein x-ray, eye socket	0287	6.4923	$354.23	$111.33	$70.85
75885	S		Vein x-ray, liver	0279	10.7073	$584.20	$174.57	$116.84
75887	S		Vein x-ray, liver	0280	19.1015	$1,042.20	$353.85	$208.44
75889	S		Vein x-ray, liver	0279	10.7073	$584.20	$174.57	$116.84
75891	S		Vein x-ray, liver	0279	10.7073	$584.20	$174.57	$116.84
75893	N		Venous sampling by catheter					
75894	S		X-rays, transcath therapy	0297	7.7145	$420.91	$172.51	$84.18
75896	S		X-rays, transcath therapy	0297	7.7145	$420.91	$172.51	$84.18
75898	X		Follow-up angiography	0264	3.0287	$165.25	$79.41	$33.05
75900	C		Arterial catheter exchange					
75901	X		Remove cva device obstruct	0264	3.0287	$165.25	$79.41	$33.05
75902	X		Remove cva lumen obstruct	0263	2.1883	$119.40	$43.58	$23.88
75940	X		X-ray placement, vein filter	0187	4.4288	$241.64	$90.71	$48.33
75945	S		Intravascular us	0267	2.4586	$134.14	$65.52	$26.83
75946	S		Intravascular us add-on	0267	2.4586	$134.14	$65.52	$26.83
75952	C		Endovasc repair abdom aorta					
75953	C		Abdom aneurysm endovas rpr					
75954	C		Iliac aneurysm endovas rpr					
75960	S		Transcatheter intro, stent	0280	19.1015	$1,042.20	$353.85	$208.44
75961	S		Retneval, broken catheter	0280	19.1015	$1,042.20	$353.85	$208.44
75962	S		Repair arterial blockage	0280	19.1015	$1,042.20	$353.85	$208.44
75964	S		Repair artery blockage, each	0280	19.1015	$1,042.20	$353.85	$208.44
75966	S		Repair arterial blockage	0280	19.1015	$1,042.20	$353.85	$208.44
75968	S		Repair artery blockage, each	0280	19.1015	$1,042.20	$353.85	$208.44
75970	S		Vascular biopsy	0280	19.1015	$1,042.20	$353.85	$208.44
75978	S		Repair venous blockage	0668	10.2660	$560.12	$237.76	$112.02
75980	S		Contrast xray exam bile duct	0296	2.8635	$156.24	$69.20	$31.25
75982	S		Contrast xray exam bile duct	0297	7.7145	$420.91	$172.51	$84.18
75984	X		Xray control catheter change	0264	3.0287	$165.25	$79.41	$33.05
75989	N		Abscess drainage under x-ray					
75992	S		Atherectomy, x-ray exam	0280	19.1015	$1,042.20	$353.85	$208.44

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
75993	S		Atherectomy, x-ray exam	0280	19.1015	$1,042.20	$353.85	$208.44
75994	S		Atherectomy, x-ray exam	0280	19.1015	$1,042.20	$353.85	$208.44
75995	S		Atherectomy, x-ray exam	0280	19.1015	$1,042.20	$353.85	$208.44
75996	S		Atherectomy, x-ray exam	0280	19.1015	$1,042.20	$353.85	$208.44
75998	N	NI	Fluoroguide for vein device					
76000	X		Fluoroscope examination	0272	1.4166	$77.29	$38.36	$15.46
76001	N		Fluoroscope exam, extensive					
76003	N		Needle localization by x-ray					
76005	N		Fluoroguide for spine inject					
76006	X		X-ray stress view	0260	0.7802	$42.57	$21.28	$8.51
76010	X		X-ray, nose to rectum	0260	0.7802	$42.57	$21.28	$8.51
76012	S		Percut vertebroplasty fluor	0274	3.5931	$196.04	$93.63	$39.21
76013	S		Percut vertebroplasty, ct	0274	3.5931	$196.04	$93.63	$39.21
76020	X		X-rays for bone age	0260	0.7802	$42.57	$21.28	$8.51
76040	X		X-rays, bone evaluation	0260	0.7802	$42.57	$21.28	$8.51
76061	X		X-rays, bone survey	0261	1.3176	$71.89		$14.38
76062	X		X-rays, bone survey	0261	1.3176	$71.89		$14.38
76065	X		X-rays, bone evaluation	0261	1.3176	$71.89		$14.38
76066	X		Joint survey, single view	0260	0.7802	$42.57	$21.28	$8.51
76070	S		CT scan, bone density study	0288	1.2726	$69.43		$13.89
76071	S		Ct bone density, peripheral	0282	1.6834	$91.85	$44.51	$18.37
76075	S		Dexa, axial skeleton study	0288	1.2726	$69.43		$13.89
76076	S		Dexa, peripheral study	0665	0.7257	$39.59		$7.92
76078	X		Radiographic absorptiometry	0261	1.3176	$71.89		$14.38
76080	X		X-ray exam of fistula	0263	2.1883	$119.40	$43.58	$23.88
76082	S	NI	Computer mammogram add-on	0410	0.1523	$8.31		$1.66
76083	A	NI	Computer mammogram add-on					
76085	D	DNG	Computer mammogram add-on					
76086	X		X-ray of mammary duct	0263	2.1883	$119.40	$43.58	$23.88
76088	X		X-ray of mammary ducts	0263	2.1883	$119.40	$43.58	$23.88
76090	S		Mammogram, one breast	0271	0.6499	$35.46	$16.80	$7.09
76091	S		Mammogram, both breasts	0271	0.6499	$35.46	$16.80	$7.09
76092	A		Mammogram, screening					
76093	E		Magnetic image, breast					
76094	E		Magnetic image, both breasts					
76095	X		Stereotactic breast biopsy	0187	4.4288	$241.64	$90.71	$48.33
76096	X		X-ray of needle wire, breast	0289	3.4900	$190.42	$44.80	$38.08
76098	X		X-ray exam, breast specimen	0260	0.7802	$42.57	$21.28	$8.51
76100	X		X-ray exam of body section	0261	1.3176	$71.89		$14.38
76101	X		Complex body section x-ray	0264	3.0287	$165.25	$79.41	$33.05
76102	X		Complex body section x-rays	0264	3.0287	$165.25	$79.41	$33.05
76120	X		Cine/video x-rays	0272	1.4166	$77.29	$38.36	$15.46
76125	X		Cine/video x-rays add-on	0260	0.7802	$42.57	$21.28	$8.51
76140	E		X-ray consultation					
76150	X		X-ray exam, dry process	0260	0.7802	$42.57	$21.28	$8.51
76350	N		Special x-ray contrast study					
76355	S		Ct scan for localization	0283	4.6543	$253.94	$126.27	$50.79
76360	S		Ct scan for needle biopsy	0283	4.6543	$253.94	$126.27	$50.79
76362	S		Ct guide for tissue ablation	0332	3.3936	$185.16	$91.27	$37.03
76370	S		Ct scan for therapy guide	0282	1.6834	$91.85	$44.51	$18.37
76375	S		3d/holograph reconstr add-on	0282	1.6834	$91.85	$44.51	$18.37
76380	S		CAT scan follow-up study	0282	1.6834	$91.85	$44.51	$18.37
76390	E		Mr spectroscopy					
76393	S		Mr guidance for needle place	0335	6.3499	$346.46	$151.46	$69.29
76394	S		Mri for tissue ablation	0335	6.3499	$346.46	$151.46	$69.29
76400	S		Magnetic image, bone marrow	0335	6.3499	$346.46	$151.46	$69.29
76490	S	DG	Us for tissue ablation	0268	1.3081	$71.37		$14.27
76496	X		Fluoroscopic procedure	0272	1.4166	$77.29	$38.36	$15.46
76497	S		Ct procedure	0282	1.6834	$91.85	$44.51	$18.37
76498	S		Mri procedure	0335	6.3499	$346.46	$151.46	$69.29
76499	X		Radiographic procedure	0260	0.7802	$42.57	$21.28	$8.51
76506	S		Echo exam of head	0266	1.6117	$87.94	$43.97	$17.59
76511	S		Echo exam of eye	0266	1.6117	$87.94	$43.97	$17.59
76512	S		Echo exam of eye	0266	1.6117	$87.94	$43.97	$17.59
76513	S		Echo exam of eye, water bath	0265	1.0289	$56.14	$28.07	$11.23
76514	S	NI	Echo exam of eye, thickness	0265	1.0289	$56.14	$28.07	$11.23
76516	S		Echo exam of eye	0266	1.6117	$87.94	$43.97	$17.59
76519	S		Echo exam of eye	0266	1.6117	$87.94	$43.97	$17.59
76529	S		Echo exam of eye	0265	1.0289	$56.14	$28.07	$11.23
76536	S		Us exam of head and neck	0266	1.6117	$87.94	$43.97	$17.59
76604	S		Us exam, chest, b-scan	0266	1.6117	$87.94	$43.97	$17.59
76645	S		Us exam, breast(s)	0265	1.0289	$56.14	$28.07	$11.23
76700	S		Us exam, abdom, complete	0266	1.6117	$87.94	$43.97	$17.59
76705	S		Echo exam of abdomen	0266	1.6117	$87.94	$43.97	$17.59
76770	S		Us exam abdo back wall, comp	0266	1.6117	$87.94	$43.97	$17.59

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
76775	S		Us exam abdo back wall, lim	0266	1.6117	$87.94	$43.97	$17.59
76778	S		Us exam kidney transplant	0266	1.6117	$87.94	$43.97	$17.59
76800	S		Us exam, spinal canal	0266	1.6117	$87.94	$43.97	$17.59
76801	S		Ob us < 14 wks, single fetus	0265	1.0289	$56.14	$28.07	$11.23
76802	S		Ob us < 14 wks, add'l fetus	0265	1.0289	$56.14	$28.07	$11.23
76805	S		Us exam, pg uterus, compl	0266	1.6117	$87.94	$43.97	$17.59
76810	S		Us exam, pg uterus, mult	0265	1.0289	$56.14	$28.07	$11.23
76811	S		Ob us, detailed, sngl fetus	0267	2.4586	$134.14	$65.52	$26.83
76812	S		Ob us, detailed, addl fetus	0266	1.6117	$87.94	$43.97	$17.59
76815	S		Us exam, pg uterus limit	0265	1.0289	$56.14	$28.07	$11.23
76816	S		Us exam pg uterus repeat	0265	1.0289	$56.14	$28.07	$11.23
76817	S		Transvaginal us, obstetric	0265	1.0289	$56.14	$28.07	$11.23
76818	S		Fetal biophys profile w/nst	0266	1.6117	$87.94	$43.97	$17.59
76819	S		Fetal biophys profil w/o nst	0266	1.6117	$87.94	$43.97	$17.59
76825	S		Echo exam of fetal heart	0671	1.6384	$89.39	$44.69	$17.88
76826	S		Echo exam of fetal heart	0697	1.4415	$78.65	$39.32	$15.73
76827	S		Echo exam of fetal heart	0671	1.6384	$89.39	$44.69	$17.88
76828	S		Echo exam of fetal heart	0697	1.4415	$78.65	$39.32	$15.73
76830	S		Transvaginal us, non-ob	0266	1.6117	$87.94	$43.97	$17.59
76831	S		Echo exam, uterus	0266	1.6117	$87.94	$43.97	$17.59
76856	S		Us exam, pelvic, complete	0266	1.6117	$87.94	$43.97	$17.59
76857	S		Us exam, pelvic, limited	0265	1.0289	$56.14	$28.07	$11.23
76870	S		Us exam, scrotum	0266	1.6117	$87.94	$43.97	$17.59
76872	S		Us, transrectal	0266	1.6117	$87.94	$43.97	$17.59
76873	S		Echograp trans r, pros study	0266	1.6117	$87.94	$43.97	$17.59
76880	S		Us exam, extremity	0266	1.6117	$87.94	$43.97	$17.59
76885	S		Us exam infant hips, dynamic	0266	1.6117	$87.94	$43.97	$17.59
76886	S		Us exam infant hips, static	0266	1.6117	$87.94	$43.97	$17.59
76930	S		Echo guide, cardiocentesis	0268	1.3081	$71.37		$14.27
76932	S		Echo guide for heart biopsy	0268	1.3081	$71.37		$14.27
76936	S		Echo guide for artery repair	0268	1.3081	$71.37		$14.27
76937	N	NI	Us guide, vascular access					
76940	S	NI	Us guide, tissue ablation	0268	1.3081	$71.37		$14.27
76941	S		Echo guide for transfusion	0268	1.3081	$71.37		$14.27
76942	S		Echo guide for biopsy	0268	1.3081	$71.37		$14.27
76945	S		Echo guide, villus sampling	0268	1.3081	$71.37		$14.27
76946	S		Echo guide for amniocentesis	0268	1.3081	$71.37		$14.27
76948	S		Echo guide, ova aspiration	0268	1.3081	$71.37		$14.27
76950	S		Echo guidance radiotherapy	0268	1.3081	$71.37		$14.27
76965	S		Echo guidance radiotherapy	0268	1.3081	$71.37		$14.27
76970	S		Ultrasound exam follow-up	0265	1.0289	$56.14	$28.07	$11.23
76975	S		GI endoscopic ultrasound	0266	1.6117	$87.94	$43.97	$17.59
76977	S		Us bone density measure	0340	0.6314	$34.45		$6.89
76986	S		Ultrasound guide intraoper	0266	1.6117	$87.94	$43.97	$17.59
76999	S		Echo examination procedure	0265	1.0289	$56.14	$28.07	$11.23
77261	E		Radiation therapy planning					
77262	E		Radiation therapy planning					
77263	E		Radiation therapy planning					
77280	X		Set radiation therapy field	0304	1.6742	$91.35	$41.52	$18.27
77285	X		Set radiation therapy field	0305	3.6767	$200.60	$91.38	$40.12
77290	X		Set radiation therapy field	0305	3.6767	$200.60	$91.38	$40.12
77295	X		Set radiation therapy field	0310	13.7165	$748.39	$325.27	$149.68
77299	E		Radiation therapy planning					
77300	X		Radiation therapy dose plan	0304	1.6742	$91.35	$41.52	$18.27
77301	S		Radiotherapy dose plan, imrt	1510		$850.00		$170.00
77305	X		Teletx isodose plan simple	0304	1.6742	$91.35	$41.52	$18.27
77310	X		Teletx isodose plan intermed	0304	1.6742	$91.35	$41.52	$18.27
77315	X		Teletx isodose plan complex	0305	3.6767	$200.60	$91.38	$40.12
77321	X		Special teletx port plan	0305	3.6767	$200.60	$91.38	$40.12
77326	X		Radiation therapy dose plan	0305	3.6767	$200.60	$91.38	$40.12
77327	X		Brachytx isodose calc interm	0305	3.6767	$200.60	$91.38	$40.12
77328	X		Brachytx isodose plan compl	0305	3.6767	$200.60	$91.38	$40.12
77331	X		Special radiation dosimetry	0304	1.6742	$91.35	$41.52	$18.27
77332	X		Radiation treatment aid(s)	0303	2.8835	$157.33	$66.95	$31.47
77333	X		Radiation treatment aid(s)	0303	2.8835	$157.33	$66.95	$31.47
77334	X		Radiation treatment aid(s)	0303	2.8835	$157.33	$66.95	$31.47
77336	X		Radiation physics consult	0304	1.6742	$91.35	$41.52	$18.27
77370	X		Radiation physics consult	0305	3.6767	$200.60	$91.38	$40.12
77399	X		External radiation dosimetry	0304	1.6742	$91.35	$41.52	$18.27
77401	S		Radiation treatment delivery	0300	1.4912	$81.36		$16.27
77402	S		Radiation treatment delivery	0300	1.4912	$81.36		$16.27
77403	S		Radiation treatment delivery	0300	1.4912	$81.36		$16.27
77404	S		Radiation treatment delivery	0300	1.4912	$81.36		$16.27
77406	S		Radiation treatment delivery	0300	1.4912	$81.36		$16.27
77407	S		Radiation treatment delivery	0300	1.4912	$81.36		$16.27

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
77408	S		Radiation treatment delivery	0300	1.4912	$81.36		$16.27
77409	S		Radiation treatment delivery	0300	1.4912	$81.36		$16.27
77411	S		Radiation treatment delivery	0300	1.4912	$81.36		$16.27
77412	S		Radiation treatment delivery	0301	2.1340	$116.43		$23.29
77413	S		Radiation treatment delivery	0301	2.1340	$116.43		$23.29
77414	S		Radiation treatment delivery	0301	2.1340	$116.43		$23.29
77416	S		Radiation treatment delivery	0301	2.1340	$116.43		$23.29
77417	X		Radiology port film(s)	0260	0.7802	$42.57	$21.28	$8.51
77418	S		Radiation tx delivery, imrt	0412	5.3904	$294.11		$58.82
77427	E		Radiation tx management, x5					
77431	E		Radiation therapy management					
77432	E		Stereotactic radiation trmt					
77470	S		Special radiation treatment	0299	5.7618	$314.37		$62.87
77499	E		Radiation therapy management					
77520	S		Proton trmt, simple w/o comp	0664	9.7295	$530.85		$106.17
77522	S		Proton trmt, simple w/comp	0664	9.7295	$530.85		$106.17
77523	S		Proton trmt, intermediate	1511		$950.00		$190.00
77525	S		Proton treatment, complex	1511		$950.00		$190.00
77600	S		Hyperthermia treatment	0314	4.6041	$251.20	$101.77	$50.24
77605	S		Hyperthermia treatment	0314	4.6041	$251.20	$101.77	$50.24
77610	S		Hyperthermia treatment	0314	4.6041	$251.20	$101.77	$50.24
77615	S		Hyperthermia treatment	0314	4.6041	$251.20	$101.77	$50.24
77620	S		Hyperthermia treatment	0314	4.6041	$251.20	$101.77	$50.24
77750	S		Infuse radioactive materials	0300	1.4912	$81.36		$16.27
77761	S		Apply intrcav radiat simple	0312	3.6637	$199.90		$39.98
77762	S		Apply intrcav radiat interm	0312	3.6637	$199.90		$39.98
77763	S		Apply intrcav radiat compl	0312	3.6637	$199.90		$39.98
77776	S		Apply interstit radiat simpl	0312	3.6637	$199.90		$39.98
77777	S		Apply interstit radiat inter	0312	3.6637	$199.90		$39.98
77778	S		Apply interstit radiat compl	0651	10.2314	$558.24		$111.65
77781	S		High intensity brachytherapy	0313	16.2481	$886.51		$177.30
77782	S		High intensity brachytherapy	0313	16.2481	$886.51		$177.30
77783	S		High intensity brachytherapy	0313	16.2481	$886.51		$177.30
77784	S		High intensity brachytherapy	0313	16.2481	$886.51		$177.30
77789	S		Apply surface radiation	0300	1.4912	$81.36		$16.27
77790	N		Radiation handling					
77799	S		Radium/radioisotope therapy	0313	16.2481	$886.51		$177.30
78000	S		Thyroid, single uptake	0389	1.6328	$89.09	$44.54	$17.82
78001	S		Thyroid, multiple uptakes	0389	1.6328	$89.09	$44.54	$17.82
78003	S		Thyroid suppress/stimul	0389	1.6328	$89.09	$44.54	$17.82
78006	S		Thyroid imaging with uptake	0390	2.7907	$152.26	$76.13	$30.45
78007	S		Thyroid image. mult uptakes	0391	3.1956	$174.36	$87.18	$34.87
78010	S		Thyroid imaging	0390	2.7907	$152.26	$76.13	$30.45
78011	S		Thyroid imaging with flow	0390	2.7907	$152.26	$76.13	$30.45
78015	S		Thyroid met imaging	0406	4.3955	$239.82	$119.91	$47.96
78016	S		Thyroid met imaging/studies	0406	4.3955	$239.82	$119.91	$47.96
78018	S		Thyroid met imaging, body	0406	4.3955	$239.82	$119.91	$47.96
78020	S		Thyroid met uptake	0399	1.5273	$83.33	$41.66	$16.67
78070	S		Parathyroid nuclear imaging	0391	3.1956	$174.36	$87.18	$34.87
78075	S		Adrenal nuclear imaging	0391	3.1956	$174.36	$87.18	$34.87
78099	S		Endocrine nuclear procedure	0390	2.7907	$152.26	$76.13	$30.45
78102	S		Bone marrow imaging, ltd	0400	3.8242	$208.65	$104.32	$41.73
78103	S		Bone marrow imaging, mult	0400	3.8242	$208.65	$104.32	$41.73
78104	S		Bone marrow imaging, body	0400	3.8242	$208.65	$104.32	$41.73
78110	S		Plasma volume, single	0393	4.4354	$242.00	$121.00	$48.40
78111	S		Plasma volume, multiple	0393	4.4354	$242.00	$121.00	$48.40
78120	S		Red cell mass, single	0393	4.4354	$242.00	$121.00	$48.40
78121	S		Red cell mass, multiple	0393	4.4354	$242.00	$121.00	$48.40
78122	S		Blood volume	0393	4.4354	$242.00	$121.00	$48.40
78130	S		Red cell survival study	0393	4.4354	$242.00	$121.00	$48.40
78135	S		Red cell survival kinetics	0393	4.4354	$242.00	$121.00	$48.40
78140	S		Red cell sequestration	0393	4.4354	$242.00	$121.00	$48.40
78160	S		Plasma iron turnover	0393	4.4354	$242.00	$121.00	$48.40
78162	S		Radioiron absorption exam	0393	4.4354	$242.00	$121.00	$48.40
78170	S		Red cell iron utilization	0393	4.4354	$242.00	$121.00	$48.40
78172	S		Total body iron estimation	0393	4.4354	$242.00	$121.00	$48.40
78185	S		Spleen imaging	0400	3.8242	$208.65	$104.32	$41.73
78190	S		Platelet survival, kinetics	0389	1.6328	$89.09	$44.54	$17.82
78191	S		Platelet survival	0389	1.6328	$89.09	$44.54	$17.82
78195	S		Lymph system imaging	0400	3.8242	$208.65	$104.32	$41.73
78199	S		Blood/lymph nuclear exam	0400	3.8242	$208.65	$104.32	$41.73
78201	S		Liver imaging	0394	4.3714	$238.51	$119.25	$47.70
78202	S		Liver imaging with flow	0394	4.3714	$238.51	$119.25	$47.70
78205	S		Liver imaging (3D)	0394	4.3714	$238.51	$119.25	$47.70
78206	S		Liver image (3d) with flow	0394	4.3714	$238.51	$119.25	$47.70

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78215	S		Liver and spleen imaging	0394	4.3714	$238.51	$119.25	$47.70
78216	S		Liver & spleen image/flow	0394	4.3714	$238.51	$119.25	$47.70
78220	S		Liver function study	0394	4.3714	$238.51	$119.25	$47.70
78223	S		Hepatobiliary imaging	0394	4.3714	$238.51	$119.25	$47.70
78230	S		Salivary gland imaging	0395	3.9536	$215.71	$107.85	$43.14
78231	S		Serial salivary imaging	0395	3.9536	$215.71	$107.85	$43.14
78232	S		Salivary gland function exam	0395	3.9536	$215.71	$107.85	$43.14
78258	S		Esophageal motility study	0395	3.9536	$215.71	$107.85	$43.14
78261	S		Gastric mucosa imaging	0395	3.9536	$215.71	$107.85	$43.14
78262	S		Gastroesophageal reflux exam	0395	3.9536	$215.71	$107.85	$43.14
78264	S		Gastric emptying study	0395	3.9536	$215.71	$107.85	$43.14
78267	A		Breath tst attain/anal c-14					
78268	A		Breath test analysis, c-14					
78270	S		Vit B-12 absorption exam	0389	1.6328	$89.09	$44.54	$17.82
78271	S		Vit b-12 absrp exam, int fac	0389	1.6328	$89.09	$44.54	$17.82
78272	S		Vit B-12 absorp, combined	0389	1.6328	$89.09	$44.54	$17.82
78278	S		Acute GI blood loss imaging	0395	3.9536	$215.71	$107.85	$43.14
78282	S		GI protein loss exam	0395	3.9536	$215.71	$107.85	$43.14
78290	S		Meckel's divert exam	0395	3.9536	$215.71	$107.85	$43.14
78291	S		Leveen/shunt patency exam	0395	3.9536	$215.71	$107.85	$43.14
78299	S		GI nuclear procedure	0395	3.9536	$215.71	$107.85	$43.14
78300	S		Bone imaging, limited area	0396	4.1883	$228.52	$114.26	$45.70
78305	S		Bone imaging, multiple areas	0396	4.1883	$228.52	$114.26	$45.70
78306	S		Bone imaging, whole body	0396	4.1883	$228.52	$114.26	$45.70
78315	S		Bone imaging, 3 phase	0396	4.1883	$228.52	$114.26	$45.70
78320	S		Bone imaging (3D)	0396	4.1883	$228.52	$114.26	$45.70
78350	X		Bone mineral, single photon	0261	1.3176	$71.89		$14.38
78351	E		Bone mineral, dual photon					
78399	S		Musculoskeletal nuclear exam	0396	4.1883	$228.52	$114.26	$45.70
78414	S		Non-imaging heart function	0398	4.5091	$246.02	$123.01	$49.20
78428	S		Cardiac shunt imaging	0398	4.5091	$246.02	$123.01	$49.20
78445	S		Vascular flow imaging	0397	2.2183	$121.03	$60.51	$24.21
78455	S		Venous thrombosis study	0397	2.2183	$121.03	$60.51	$24.21
78456	S		Acute venous thrombus image	0397	2.2183	$121.03	$60.51	$24.21
78457	S		Venous thrombosis imaging	0397	2.2183	$121.03	$60.51	$24.21
78458	S		Ven thrombosis images, bilat	0397	2.2183	$121.03	$60.51	$24.21
78459	S		Heart muscle imaging (PET)	0285	14.1508	$772.08	$334.45	$154.42
78460	S		Heart muscle blood, single	0398	4.5091	$246.02	$123.01	$49.20
78461	S		Heart muscle blood, multiple	0377	6.8830	$375.54	$187.76	$75.11
78464	S		Heart image (3d), single	0398	4.5091	$246.02	$123.01	$49.20
78465	S		Heart image (3d), multiple	0377	6.8830	$375.54	$187.76	$75.11
78466	S		Heart infarct image	0398	4.5091	$246.02	$123.01	$49.20
78468	S		Heart infarct image (ef)	0398	4.5091	$246.02	$123.01	$49.20
78469	S		Heart infarct image (3D)	0398	4.5091	$246.02	$123.01	$49.20
78472	S		Gated heart, planar, single	0398	4.5091	$246.02	$123.01	$49.20
78473	S		Gated heart, multiple	0376	4.4510	$242.85	$121.42	$48.57
78478	S		Heart wall motion add-on	0399	1.5273	$83.33	$41.66	$16.67
78480	S		Heart function add-on	0399	1.5273	$83.33	$41.66	$16.67
78481	S		Heart first pass, single	0398	4.5091	$246.02	$123.01	$49.20
78483	S		Heart first pass, multiple	0376	4.4510	$242.85	$121.42	$48.57
78491	E		Heart image (pet), single					
78492	E		Heart image (pet), multiple					
78494	S		Heart image, spect	0398	4.5091	$246.02	$123.01	$49.20
78496	S		Heart first pass add-on	0399	1.5273	$83.33	$41.66	$16.67
78499	S		Cardiovascular nuclear exam	0398	4.5091	$246.02	$123.01	$49.20
78580	S		Lung perfusion imaging	0401	3.3736	$184.07	$92.03	$36.81
78584	S		Lung V/Q image single breath	0378	5.4852	$299.28	$149.63	$59.86
78585	S		Lung V/Q imaging	0378	5.4852	$299.28	$149.63	$59.86
78586	S		Aerosol lung image, single	0401	3.3736	$184.07	$92.03	$36.81
78587	S		Aerosol lung image, multiple	0401	3.3736	$184.07	$92.03	$36.81
78588	S		Perfusion lung image	0378	5.4852	$299.28	$149.63	$59.86
78591	S		Vent image, 1 breath, 1 proj	0401	3.3736	$184.07	$92.03	$36.81
78593	S		Vent image, 1 proj, gas	0401	3.3736	$184.07	$92.03	$36.81
78594	S		Vent image, mult proj, gas	0401	3.3736	$184.07	$92.03	$36.81
78596	S		Lung differential function	0378	5.4852	$299.28	$149.63	$59.86
78599	S		Respiratory nuclear exam	0401	3.3736	$184.07	$92.03	$36.81
78600	S		Brain imaging, ltd static	0402	5.4063	$294.97	$147.48	$58.99
78601	S		Brain imaging, ltd w/flow	0402	5.4063	$294.97	$147.48	$58.99
78605	S		Brain imaging, complete	0402	5.4063	$294.97	$147.48	$58.99
78606	S		Brain imaging, compl w/flow	0402	5.4063	$294.97	$147.48	$58.99
78607	S		Brain imaging (3D)	0402	5.4063	$294.97	$147.48	$58.99
78608	E		Brain imaging (PET)					
78609	E		Brain imaging (PET)					
78610	S		Brain flow imaging only	0402	5.4063	$294.97	$147.48	$58.99
78615	S		Cerebral vascular flow image	0402	5.4063	$294.97	$147.48	$58.99

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78630	S		Cerebrospinal fluid scan	0403	3.8402	$209.53	$104.76	$41.91
78635	S		CSF ventriculography	0403	3.8402	$209.53	$104.76	$41.91
78645	S		CSF shunt evaluation	0403	3.8402	$209.53	$104.76	$41.91
78647	S		Cerebrospinal fluid scan	0403	3.8402	$209.53	$104.76	$41.91
78650	S		CSF leakage imaging	0403	3.8402	$209.53	$104.76	$41.91
78660	S		Nuclear exam of tear flow	0403	3.8402	$209.53	$104.76	$41.91
78699	S		Nervous system nuclear exam	0402	5.4063	$294.97	$147.48	$58.99
78700	S		Kidney imaging, static	0404	3.7303	$203.53	$101.76	$40.71
78701	S		Kidney imaging with flow	0404	3.7303	$203.53	$101.76	$40.71
78704	S		Imaging renogram	0404	3.7303	$203.53	$101.76	$40.71
78707	S		Kidney flow/function image	0404	3.7303	$203.53	$101.76	$40.71
78708	S		Kidney flow/function image	0405	4.3432	$236.97	$118.48	$47.39
78709	S		Kidney flow/function image	0405	4.3432	$236.97	$118.48	$47.39
78710	S		Kidney imaging (3D)	0404	3.7303	$203.53	$101.76	$40.71
78715	S		Renal vascular flow exam	0404	3.7303	$203.53	$101.76	$40.71
78725	S		Kidney function study	0389	1.6328	$89.09	$44.54	$17.82
78730	S		Urinary bladder retention	0404	3.7303	$203.53	$101.76	$40.71
78740	S		Ureteral reflux study	0404	3.7303	$203.53	$101.76	$40.71
78760	S		Testicular imaging	0404	3.7303	$203.53	$101.76	$40.71
78761	S		Testicular imaging/flow	0404	3.7303	$203.53	$101.76	$40.71
78799	S		Genitourinary nuclear exam	0404	3.7303	$203.53	$101.76	$40.71
78800	S		Tumor imaging, limited area	0406	4.3955	$239.82	$119.91	$47.96
78801	S		Tumor imaging, mult areas	0406	4.3955	$239.82	$119.91	$47.96
78802	S		Tumor imaging, whole body	0406	4.3955	$239.82	$119.91	$47.96
78803	S		Tumor imaging (3D)	0406	4.3955	$239.82	$119.91	$47.96
78804	S	NI	Tumor imaging, whole body	1508		$650.00		$130.00
78805	S		Abscess imaging, ltd area	0406	4.3955	$239.82	$119.91	$47.96
78806	S		Abscess imaging, whole body	0406	4.3955	$239.82	$119.91	$47.96
78807	S		Nuclear localization/abscess	0406	4.3955	$239.82	$119.91	$47.96
78810	E		Tumor imaging (PET)					
78890	N		Nuclear medicine data proc					
78891	N		Nuclear med data proc					
78990	E		Provide diag radionuclide(s)					
78999	S		Nuclear diagnostic exam	0389	1.6328	$89.09	$44.54	$17.82
79000	S		Init hyperthyroid therapy	0407	3.5841	$195.55	$97.77	$39.11
79001	S		Repeat hyperthyroid therapy	0407	3.5841	$195.55	$97.77	$39.11
79020	S		Thyroid ablation	0407	3.5841	$195.55	$97.77	$39.11
79030	S		Thyroid ablation, carcinoma	0407	3.5841	$195.55	$97.77	$39.11
79035	S		Thyroid metastatic therapy	0407	3.5841	$195.55	$97.77	$39.11
79100	S		Hematopoetic nuclear therapy	0407	3.5841	$195.55	$97.77	$39.11
79200	S		Intracavitary nuclear trmt	0407	3.5841	$195.55	$97.77	$39.11
79300	S		Interstitial nuclear therapy	0407	3.5841	$195.55	$97.77	$39.11
79400	S		Nonhemato nuclear therapy	0407	3.5841	$195.55	$97.77	$39.11
79403	S	NI	Hematopoetic nuclear therapy	1507		$550.00		$110.00
79420	S		Intravascular nuclear ther	0407	3.5841	$195.55	$97.77	$39.11
79440	S		Nuclear joint therapy	0407	3.5841	$195.55	$97.77	$39.11
79900	N		Provide ther radiopharm(s)					
79999	S		Nuclear medicine therapy	0407	3.5841	$195.55	$97.77	$39.11
80048	A		Basic metabolic panel					
80050	E		General health panel					
80051	A		Electrolyte panel					
80053	A		Comprehen metabolic panel					
80055	A		Obstetric panel					
80061	A		Lipid panel					
80069	A		Renal function panel					
80074	A		Acute hepatitis panel					
80076	A		Hepatic function panel					
80100	A		Drug screen, qualitate/multi					
80101	A		Drug screen, single					
80102	A		Drug confirmation					
80103	N		Drug analysis, tissue prep					
80150	A		Assay of amikacin					
80152	A		Assay of amitriptyline					
80154	A		Assay of benzodiazepines					
80156	A		Assay, carbamazepine, total					
80157	A		Assay, carbamazepine, free					
80158	A		Assay of cyclosporine					
80160	A		Assay of desipramine					
80162	A		Assay of digoxin					
80164	A		Assay, dipropylacetic acid					
80166	A		Assay of doxepin					
80168	A		Assay of ethosuximide					
80170	A		Assay of gentamicin					
80172	A		Assay of gold					
80173	A		Assay of haloperidol					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
80174	A		Assay of imipramine					
80176	A		Assay of lidocaine					
80178	A		Assay of lithium					
80182	A		Assay of nortriptyline					
80184	A		Assay of phenobarbital					
80185	A		Assay of phenytoin, total					
80186	A		Assay of phenytoin, free					
80188	A		Assay of primidone					
80190	A		Assay of procainamide					
80192	A		Assay of procainamide					
80194	A		Assay of quinidine					
80196	A		Assay of salicylate					
80197	A		Assay of tacrolimus					
80198	A		Assay of theophylline					
80200	A		Assay of tobramycin					
80201	A		Assay of topiramate					
80202	A		Assay of vancomycin					
80299	A		Quantitative assay, drug					
80400	A		Acth stimulation panel					
80402	A		Acth stimulation panel					
80406	A		Acth stimulation panel					
80408	A		Aldosterone suppression eval					
80410	A		Calcitonin stimul panel					
80412	A		CRH stimulation panel					
80414	A		Testosterone response					
80415	A		Estradiol response panel					
80416	A		Renin stimulation panel					
80417	A		Renin stimulation panel					
80418	A		Pituitary evaluation panel					
80420	A		Dexamethasone panel					
80422	A		Glucagon tolerance panel					
80424	A		Glucagon tolerance panel					
80426	A		Gonadotropin hormone panel					
80428	A		Growth hormone panel					
80430	A		Growth hormone panel					
80432	A		Insulin suppression panel					
80434	A		Insulin tolerance panel					
80435	A		Insulin tolerance panel					
80436	A		Metyrapone panel					
80438	A		TRH stimulation panel					
80439	A		TRH stimulation panel					
80440	A		TRH stimulation panel					
80500	X		Lab pathology consultation	0343	0.4617	$25.19	$12.55	$5.04
80502	X		Lab pathology consultation	0342	0.2162	$11.80	$5.88	$2.36
81000	A		Urinalysis, nonauto w/scope					
81001	A		Urinalysis, auto w/scope					
81002	A		Urinalysis nonauto w/o scope					
81003	A		Urinalysis, auto, w/o scope					
81005	A		Urinalysis					
81007	A		Urine screen for bacteria					
81015	A		Microscopic exam of urine					
81020	A		Urinalysis, glass test					
81025	A		Urine pregnancy test					
81050	A		Urinalysis, volume measure					
81099	A		Urinalysis test procedure					
82000	A		Assay of blood acetaldehyde					
82003	A		Assay of acetaminophen					
82009	A		Test for acetone/ketones					
82010	A		Acetone assay					
82013	A		Acetylcholinesterase assay					
82016	A		Acylcarnitines, qual					
82017	A		Acylcarnitines, quant					
82024	A		Assay of acth					
82030	A		Assay of adp & amp					
82040	A		Assay of serum albumin					
82042	A		Assay of urine albumin					
82043	A		Microalbumin, quantitative					
82044	A		Microalbumin, semiquant					
82055	A		Assay of ethanol					
82075	A		Assay of breath ethanol					
82085	A		Assay of aldolase					
82088	A		Assay of aldosterone					
82101	A		Assay of urine alkaloids					
82103	A		Alpha-1-antitrypsin, total					
82104	A		Alpha-1-antitrypsin, pheno					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
82105	A		Alpha-fetoprotein, serum					
82106	A		Alpha-fetoprotein, amniotic					
82108	A		Assay of aluminum					
82120	A		Amines, vaginal fluid qual					
82127	A		Amino acid, single qual					
82128	A		Amino acids, mult qual					
82131	A		Amino acids, single quant					
82135	A		Assay, aminolevulinic acid					
82136	A		Amino acids, quant, 2-5					
82139	A		Amino acids, quan, 6 or more					
82140	A		Assay of ammonia					
82143	A		Amniotic fluid scan					
82145	A		Assay of amphetamines					
82150	A		Assay of amylase					
82154	A		Androstanediol glucuronide					
82157	A		Assay of androstenedione					
82160	A		Assay of androsterone					
82163	A		Assay of angiotensin II					
82164	A		Angiotensin I enzyme test					
82172	A		Assay of apolipoprotein					
82175	A		Assay of arsenic					
82180	A		Assay of ascorbic acid					
82190	A		Atomic absorption					
82205	A		Assay of barbiturates					
82232	A		Assay of beta-2 protein					
82239	A		Bile acids, total					
82240	A		Bile acids, cholylglycine					
82247	A		Bilirubin, total					
82248	A		Bilirubin, direct					
82252	A		Fecal bilirubin test					
82261	A		Assay of biotinidase					
82270	A		Test for blood, feces					
82273	A		Test for blood, other source					
82274	A		Assay test for blood, fecal					
82286	A		Assay of bradykinin					
82300	A		Assay of cadmium					
82306	A		Assay of vitamin D					
82307	A		Assay of vitamin D					
82308	A		Assay of calcitonin					
82310	A		Assay of calcium					
82330	A		Assay of calcium					
82331	A		Calcium infusion test					
82340	A		Assay of calcium in urine					
82355	A		Calculus analysis, qual					
82360	A		Calculus assay, quant					
82365	A		Calculus spectroscopy					
82370	A		X-ray assay, calculus					
82373	A		Assay, c-d transfer measure					
82374	A		Assay, blood carbon dioxide					
82375	A		Assay, blood carbon monoxide					
82376	A		Test for carbon monoxide					
82378	A		Carcinoembryonic antigen					
82379	A		Assay of carnitine					
82380	A		Assay of carotene					
82382	A		Assay, urine catecholamines					
82383	A		Assay, blood catecholamines					
82384	A		Assay, three catecholamines					
82387	A		Assay of cathepsin-d					
82390	A		Assay of ceruloplasmin					
82397	A		Chemiluminescent assay					
82415	A		Assay of chloramphenicol					
82435	A		Assay of blood chloride					
82436	A		Assay of urine chloride					
82438	A		Assay, other fluid chlorides					
82441	A		Test for chlorohydrocarbons					
82465	A		Assay, bld/serum cholesterol					
82480	A		Assay, serum cholinesterase					
82482	A		Assay, rbc cholinesterase					
82485	A		Assay, chondroitin sulfate					
82486	A		Gas/liquid chromatography					
82487	A		Paper chromatography					
82488	A		Paper chromatography					
82489	A		Thin layer chromatography					
82491	A		Chromotography, quant, sing					
82492	A		Chromotography, quant, mult					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
82495	A		Assay of chromium					
82507	A		Assay of citrate					
82520	A		Assay of cocaine					
82523	A		Collagen crosslinks					
82525	A		Assay of copper					
82528	A		Assay of corticosterone					
82530	A		Cortisol, free					
82533	A		Total cortisol					
82540	A		Assay of creatine					
82541	A		Column chromotography, qual					
82542	A		Column chromotography, quant					
82543	A		Column chromotograph/isotope					
82544	A		Column chromotograph/isotope					
82550	A		Assay of ck (cpk)					
82552	A		Assay of cpk in blood					
82553	A		Creatine, MB fraction					
82554	A		Creatine, isoforms					
82565	A		Assay of creatinine					
82570	A		Assay of urine creatinine					
82575	A		Creatinine clearance test					
82585	A		Assay of cryofibrinogen					
82595	A		Assay of cryoglobulin					
82600	A		Assay of cyanide					
82607	A		Vitamin B-12					
82608	A		B-12 binding capacity					
82615	A		Test for urine cystines					
82626	A		Dehydroepiandrosterone					
82627	A		Dehydroepiandrosterone					
82633	A		Desoxycorticosterone					
82634	A		Deoxycortisol					
82638	A		Assay of dibucaine number					
82646	A		Assay of dihydrocodeinone					
82649	A		Assay of dihydromorphinone					
82651	A		Assay of dihydrotestosterone					
82652	A		Assay of dihydroxyvitamin d					
82654	A		Assay of dimethadione					
82657	A		Enzyme cell activity					
82658	A		Enzyme cell activity, ra					
82664	A		Electrophoretic test					
82666	A		Assay of epiandrosterone					
82668	A		Assay of erythropoietin					
82670	A		Assay of estradiol					
82671	A		Assay of estrogens					
82672	A		Assay of estrogen					
82677	A		Assay of estriol					
82679	A		Assay of estrone					
82690	A		Assay of ethchlorvynol					
82693	A		Assay of ethylene glycol					
82696	A		Assay of etiocholanolone					
82705	A		Fats/lipids, feces, qual					
82710	A		Fats/lipids, feces, quant					
82715	A		Assay of fecal fat					
82725	A		Assay of blood fatty acids					
82726	A		Long chain fatty acids					
82728	A		Assay of ferritin					
82731	A		Assay of fetal fibronectin					
82735	A		Assay of fluoride					
82742	A		Assay of flurazepam					
82746	A		Blood folic acid serum					
82747	A		Assay of folic acid, rbc					
82757	A		Assay of semen fructose					
82759	A		Assay of rbc galactokinase					
82760	A		Assay of galactose					
82775	A		Assay galactose transferase					
82776	A		Galactose transferase test					
82784	A		Assay of gammaglobulin igm					
82785	A		Assay of gammaglobulin ige					
82787	A		Igg 1, 2, 3 or 4, each					
82800	A		Blood pH					
82803	A		Blood gases: pH, pO2 & pCO2					
82805	A		Blood gases W/02 saturation					
82810	A		Blocd gases, O2 sat only					
82820	A		Hemoglobin-oxygen affinity					
82926	A		Assay of gastric acid					
82928	A		Assay of gastric acid					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
82938	A		Gastrin test					
82941	A		Assay of gastrin					
82943	A		Assay of glucagon					
82945	A		Glucose other fluid					
82946	A		Glucagon tolerance test					
82947	A		Assay, glucose, blood quant					
82948	A		Reagent strip/blood glucose					
82950	A		Glucose test					
82951	A		Glucose tolerance test (GTT)					
82952	A		GTT-added samples					
82953	A		Glucose-tolbutamide test					
82955	A		Assay of g6pd enzyme					
82960	A		Test for G6PD enzyme					
82962	A		Glucose blood test					
82963	A		Assay of glucosidase					
82965	A		Assay of gdh enzyme					
82975	A		Assay of glutamine					
82977	A		Assay of GGT					
82978	A		Assay of glutathione					
82979	A		Assay, rbc glutathione					
82980	A		Assay of glutethimide					
82985	A		Glycated protein					
83001	A		Gonadotropin (FSH)					
83002	A		Gonadotropin (LH)					
83003	A		Assay, growth hormone (hgh)					
83008	A		Assay of guanosine					
83010	A		Assay of haptoglobin, quant					
83012	A		Assay of haptoglobins					
83013	A		H pylori analysis					
83014	A		H pylori drug admin/collect					
83015	A		Heavy metal screen					
83018	A		Quantitative screen, metals					
83020	A		Hemoglobin electrophoresis					
83021	A		Hemoglobin chromotography					
83026	A		Hemoglobin, copper sulfate					
83030	A		Fetal hemoglobin, chemical					
83033	A		Fetal hemoglobin assay, qual					
83036	A		Glycated hemoglobin test					
83045	A		Blood methemoglobin test					
83050	A		Blood methemoglobin assay					
83051	A		Assay of plasma hemoglobin					
83055	A		Blood sulfhemoglobin test					
83060	A		Blood sulfhemoglobin assay					
83065	A		Assay of hemoglobin heat					
83068	A		Hemoglobin stability screen					
83069	A		Assay of urine hemoglobin					
83070	A		Assay of hemosiderin, qual					
83071	A		Assay of hemosiderin, quant					
83080	A		Assay of b hexosaminidase					
83088	A		Assay of histamine					
83090	A		Assay of homocystine					
83150	A		Assay of for hva					
83491	A		Assay of corticosteroids					
83497	A		Assay of 5-hiaa					
83498	A		Assay of progesterone					
83499	A		Assay of progesterone					
83500	A		Assay, free hydroxyproline					
83505	A		Assay, total hydroxyproline					
83516	A		Immunoassay, nonantibody					
83518	A		Immunoassay, dipstick					
83519	A		Immunoassay, nonantibody					
83520	A		Immunoassay, RIA					
83525	A		Assay of insulin					
83527	A		Assay of insulin					
83528	A		Assay of intrinsic factor					
83540	A		Assay of iron					
83550	A		Iron binding test					
83570	A		Assay of idh enzyme					
83582	A		Assay of ketogenic steroids					
83586	A		Assay 17- ketosteroids					
83593	A		Fractionation, ketosteroids					
83605	A		Assay of lactic acid					
83615	A		Lactate (LD) (LDH) enzyme					
83625	A		Assay of ldh enzymes					
83632	A		Placental lactogen					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
83633	A		Test urine for lactose					
83634	A		Assay of urine for lactose					
83655	A		Assay of lead					
83661	A		L/s ratio, fetal lung					
83662	A		Foam stability, fetal lung					
83663	A		Fluoro polanze, fetal lung					
83664	A		Lamellar bdy, fetal lung					
83670	A		Assay of lap enzyme					
83690	A		Assay of lipase					
83715	A		Assay of blood lipoproteins					
83716	A		Assay of blood lipoproteins					
83718	A		Assay of lipoprotein					
83719	A		Assay of blood lipoprotein					
83721	A		Assay of blood lipoprotein					
83727	A		Assay of lrh hormone					
83735	A		Assay of magnesium					
83775	A		Assay of md enzyme					
83785	A		Assay of manganese					
83788	A		Mass spectrometry qual					
83789	A		Mass spectrometry quant					
83805	A		Assay of meprobamate					
83825	A		Assay of mercury					
83835	A		Assay of metanephrines					
83840	A		Assay of methadone					
83857	A		Assay of methemalbumin					
83858	A		Assay of methsuximide					
83864	A		Mucopolysaccharides					
83866	A		Mucopolysaccharides screen					
83872	A		Assay synovial fluid mucin					
83873	A		Assay of csf protein					
83874	A		Assay of myoglobin					
83880	A		Natriuretic peptide					
83883	A		Assay, nephelometry not spec					
83885	A		Assay of nickel					
83887	A		Assay of nicotine					
83890	A		Molecule isolate					
83891	A		Molecule isolate nucleic					
83892	A		Molecular diagnostics					
83893	A		Molecule dot/slot/blot					
83894	A		Molecule gel electrophor					
83896	A		Molecular diagnostics					
83897	A		Molecule nucleic transfer					
83898	A		Molecule nucleic ampli					
83901	A		Molecule nucleic ampli					
83902	A		Molecular diagnostics					
83903	A		Molecule mutation scan					
83904	A		Molecule mutation identify					
83905	A		Molecule mutation identify					
83906	A		Molecule mutation identify					
83912	A		Genetic examination					
83915	A		Assay of nucleotidase					
83916	A		Oligoclonal bands					
83918	A		Organic acids, total, quant					
83919	A		Organic acids, qual, each					
83921	A		Organic acid, single, quant					
83925	A		Assay of opiates					
83930	A		Assay of blood osmolality					
83935	A		Assay of urine osmolality					
83937	A		Assay of osteocalcin					
83945	A		Assay of oxalate					
83950	A		Oncoprotein, her-2/neu					
83970	A		Assay of parathormone					
83986	A		Assay of body fluid acidity					
83992	A		Assay for phencyclidine					
84022	A		Assay of phenothiazine					
84030	A		Assay of blood pku					
84035	A		Assay of phenylketones					
84060	A		Assay acid phosphatase					
84061	A		Phosphatase, forensic exam					
84066	A		Assay prostate phosphatase					
84075	A		Assay alkaline phosphatase					
84078	A		Assay alkaline phosphatase					
84080	A		Assay alkaline phosphatases					
84081	A		Amniotic fluid enzyme test					
84085	A		Assay of rbc pg6d enzyme					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
84087	A		Assay phosphohexose enzymes					
84100	A		Assay of phosphorus					
84105	A		Assay of urine phosphorus					
84106	A		Test for porphobilinogen					
84110	A		Assay of porphobilinogen					
84119	A		Test urine for porphyrins					
84120	A		Assay of urine porphyrins					
84126	A		Assay of feces porphyrins					
84127	A		Assay of feces porphyrins					
84132	A		Assay of serum potassium					
84133	A		Assay of urine potassium					
84134	A		Assay of prealbumin					
84135	A		Assay of pregnanediol					
84138	A		Assay of pregnanetriol					
84140	A		Assay of pregnenolone					
84143	A		Assay of 17-hydroxypregneno					
84144	A		Assay of progesterone					
84146	A		Assay of prolactin					
84150	A		Assay of prostaglandin					
84152	A		Assay of psa, complexed					
84153	A		Assay of psa, total					
84154	A		Assay of psa, free					
84155	A		Assay of protein, serum					
84156	A	NI	Assay of protein, urine					
84157	A	NI	Assay of protein, other					
84160	A		Assay of protein, any source					
84165	A		Electrophoreisis of proteins					
84181	A		Western blot test					
84182	A		Protein, western blot test					
84202	A		Assay RBC protoporphyrin					
84203	A		Test RBC protoporphyrin					
84206	A		Assay of proinsulin					
84207	A		Assay of vitamin b-6					
84210	A		Assay of pyruvate					
84220	A		Assay of pyruvate kinase					
84228	A		Assay of quinine					
84233	A		Assay of estrogen					
84234	A		Assay of progesterone					
84235	A		Assay of endocrine hormone					
84238	A		Assay, nonendocrine receptor					
84244	A		Assay of renin					
84252	A		Assay of vitamin b-2					
84255	A		Assay of selenium					
84260	A		Assay of serotonin					
84270	A		Assay of sex hormone globul					
84275	A		Assay of sialic acid					
84285	A		Assay of silica					
84295	A		Assay of serum sodium					
84300	A		Assay of urine sodium					
84302	A		Assay of sweat sodium					
84305	A		Assay of somatomedin					
84307	A		Assay of somatostatin					
84311	A		Spectrophotometry					
84315	A		Body fluid specific gravity					
84375	A		Chromatogram assay, sugars					
84376	A		Sugars, single, qual					
84377	A		Sugars, multiple, qual					
84378	A		Sugars, single, quant					
84379	A		Sugars multiple quant					
84392	A		Assay of urine sulfate					
84402	A		Assay of testosterone					
84403	A		Assay of total testosterone					
84425	A		Assay of vitamin b-1					
84430	A		Assay of thiocyanate					
84432	A		Assay of thyroglobulin					
84436	A		Assay of total thyroxine					
84437	A		Assay of neonatal thyroxine					
84439	A		Assay of free thyroxine					
84442	A		Assay of thyroid activity					
84443	A		Assay thyroid stim hormone					
84445	A		Assay of tsi					
84446	A		Assay of vitamin e					
84449	A		Assay of transcortin					
84450	A		Transferase (AST) (SGOT)					
84460	A		Alanine amino (ALT) (SGPT)					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
84466	A		Assay of transferrin					
84478	A		Assay of triglycerides					
84479	A		Assay of thyroid (t3 or t4)					
84480	A		Assay, triiodothyronine (t3)					
84481	A		Free assay (FT-3)					
84482	A		T3 reverse					
84484	A		Assay of troponin, quant					
84485	A		Assay duodenal fluid trypsin					
84488	A		Test feces for trypsin					
84490	A		Assay of feces for trypsin					
84510	A		Assay of tyrosine					
84512	A		Assay of troponin, qual					
84520	A		Assay of urea nitrogen					
84525	A		Urea nitrogen semi-quant					
84540	A		Assay of urine/urea-n					
84545	A		Urea-N clearance test					
84550	A		Assay of blood/uric acid					
84560	A		Assay of urine/uric acid					
84577	A		Assay of feces/urobilinogen					
84578	A		Test urine urobilinogen					
84580	A		Assay of urine urobilinogen					
84583	A		Assay of urine urobilinogen					
84585	A		Assay of urine vma					
84586	A		Assay of vip					
84588	A		Assay of vasopressin					
84590	A		Assay of vitamin a					
84591	A		Assay of nos vitamin					
84597	A		Assay of vitamin k					
84600	A		Assay of volatiles					
84620	A		Xylose tolerance test					
84630	A		Assay of zinc					
84681	A		Assay of c-peptide					
84702	A		Chorionic gonadotropin test					
84703	A		Chorionic gonadotropin assay					
84830	A		Ovulation tests					
84999	A		Clinical chemistry test					
85002	A		Bleeding time test					
85004	A		Automated diff wbc count					
85007	A		Differential WBC count					
85008	A		Nondifferential WBC count					
85009	A		Differential WBC count					
85013	A		Spun microhematocrit					
85014	A		Hematocrit					
85018	A		Hemoglobin					
85025	A		Automated hemogram					
85027	A		Automated hemogram					
85032	A		Manual cell count, each					
85041	A		Red blood cell (RBC) count					
85044	A		Reticulocyte count					
85045	A		Reticulocyte count					
85046	A		Reticyte/hgb concentrate					
85048	A		White blood cell (WBC) count					
85049	A		Automated platelet count					
85055	A	NI	Reticulated platelet assay					
85060	X		Blood smear interpretation	0342	0.2162	$11.80	$5.88	$2.36
85097	X		Bone marrow interpretation	0343	0.4617	$25.19	$12.55	$5.04
85130	A		Chromogenic substrate assay					
85170	A		Blood clot retraction					
85175	A		Blood clot lysis time					
85210	A		Blood clot factor II test					
85220	A		Blood clot factor V test					
85230	A		Blood clot factor VII test					
85240	A		Blood clot factor VIII test					
85244	A		Blood clot factor VIII test					
85245	A		Blood clot factor VIII test					
85246	A		Blood clot factor VIII test					
85247	A		Blood clot factor VIII test					
85250	A		Blood clot factor IX test					
85260	A		Blood clot factor X test					
85270	A		Blood clot factor XI test					
85280	A		Blood clot factor XII test					
85290	A		Blood clot factor XIII test					
85291	A		Blood clot factor XIII test					
85292	A		Blood clot factor assay					
85293	A		Blood clot factor assay					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
85300	A		Antithrombin III test					
85301	A		Antithrombin III test					
85302	A		Blood clot inhibitor antigen					
85303	A		Blood clot inhibitor test					
85305	A		Blood clot inhibitor assay					
85306	A		Blood clot inhibitor test					
85307	A		Assay activated protein c					
85335	A		Factor inhibitor test					
85337	A		Thrombomodulin					
85345	A		Coagulation time					
85347	A		Coagulation time					
85348	A		Coagulation time					
85360	A		Euglobulin lysis					
85362	A		Fibrin degradation products					
85366	A		Fibrinogen test					
85370	A		Fibrinogen test					
85378	A		Fibrin degradation					
85379	A		Fibrin degradation, quant					
85380	A		Fibrin degradation, vte					
85384	A		Fibrinogen					
85385	A		Fibrinogen					
85390	A		Fibrinolysins screen					
85396	N	NI	Clotting assay, whole blood					
85400	A		Fibrinolytic plasmin					
85410	A		Fibrinolytic antiplasmin					
85415	A		Fibrinolytic plasminogen					
85420	A		Fibrinolytic plasminogen					
85421	A		Fibrinolytic plasminogen					
85441	A		Heinz bodies, direct					
85445	A		Heinz bodies, induced					
85460	A		Hemoglobin, fetal					
85461	A		Hemoglobin, fetal					
85475	A		Hemolysin					
85520	A		Heparin assay					
85525	A		Heparin neutralization					
85530	A		Heparin-protamine tolerance					
85536	A		Iron stain peripheral blood					
85540	A		Wbc alkaline phosphatase					
85547	A		RBC mechanical fragility					
85549	A		Muramidase					
85555	A		RBC osmotic fragility					
85557	A		RBC osmotic fragility					
85576	A		Blood platelet aggregation					
85597	A		Platelet neutralization					
85610	A		Prothrombin time					
85611	A		Prothrombin test					
85612	A		Viper venom prothrombin time					
85613	A		Russell viper venom, diluted					
85635	A		Reptilase test					
85651	A		Rbc sed rate, nonautomated					
85652	A		Rbc sed rate, automated					
85660	A		RBC sickle cell test					
85670	A		Thrombin time, plasma					
85675	A		Thrombin time, titer					
85705	A		Thromboplastin inhibition					
85730	A		Thromboplastin time, partial					
85732	A		Thromboplastin time, partial					
85810	A		Blood viscosity examination					
85999	A		Hematology procedure					
86000	A		Agglutinins, febrile					
86001	A		Allergen specific igg					
86003	A		Allergen specific IgE					
86005	A		Allergen specific IgE					
86021	A		WBC antibody identification					
86022	A		Platelet antibodies					
86023	A		Immunoglobulin assay					
86038	A		Antinuclear antibodies					
86039	A		Antinuclear antibodies (ANA)					
86060	A		Antistreptolysin o, titer					
86063	A		Antistreptolysin o, screen					
86077	A		Physician blood bank service					
86078	A		Physician blood bank service					
86079	A		Physician blood bank service					
86140	A		C-reactive protein					
86141	A		C-reactive protein, hs					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
86146	A		Glycoprotein antibody					
86147	A		Cardiolipin antibody					
86148	A		Phospholipid antibody					
86155	A		Chemotaxis assay					
86156	A		Cold agglutinin, screen					
86157	A		Cold agglutinin, titer					
86160	A		Complement, antigen					
86161	A		Complement/function activity					
86162	A		Complement, total (CH50)					
86171	A		Complement fixation, each					
86185	A		Counterimmunoelectrophoresis					
86215	A		Deoxyribonuclease, antibody					
86225	A		DNA antibody					
86226	A		DNA antibody, single strand					
86235	A		Nuclear antigen antibody					
86243	A		Fc receptor					
86255	A		Fluorescent antibody, screen					
86256	A		Fluorescent antibody, titer					
86277	A		Growth hormone antibody					
86280	A		Hemagglutination inhibition					
86294	A		Immunoassay, tumor, qual					
86300	A		Immunoassay, tumor, ca 15-3					
86301	A		Immunoassay, tumor, ca 19-9					
86304	A		Immunoassay, tumor, ca 125					
86308	A		Heterophile antibodies					
86309	A		Heterophile antibodies					
86310	A		Heterophile antibodies					
86316	A		Immunoassay, tumor other					
86317	A		Immunoassay,infectious agent					
86318	A		Immunoassay,infectious agent					
86320	A		Serum immunoelectrophoresis					
86325	A		Other immunoelectrophoresis					
86327	A		Immunoelectrophoresis assay					
86329	A		Immunodiffusion					
86331	A		Immunodiffusion ouchterlony					
86332	A		Immune complex assay					
86334	A		Immunofixation procedure					
86336	A		Inhibin A					
86337	A		Insulin antibodies					
86340	A		Intrinsic factor antibody					
86341	A		Islet cell antibody					
86343	A		Leukocyte histamine release					
86344	A		Leukocyte phagocytosis					
86353	A		Lymphocyte transformation					
86359	A		T cells, total count					
86360	A		T cell, absolute count/ratio					
86361	A		T cell, absolute count					
86376	A		Microsomal antibody					
86378	A		Migration inhibitory factor					
86382	A		Neutralization test, viral					
86384	A		nitroblue tetrazolium dye					
86403	A		Particle agglutination test					
86406	A		Particle agglutination test					
86430	A		Rheumatoid factor test					
86431	A		Rheumatoid factor, quant					
86485	X		Skin test, candida	0341	0.1365	$7.45	$3.03	$1.49
86490	X		Coccidioidomycosis skin test	0341	0.1365	$7.45	$3.03	$1.49
86510	X		Histoplasmosis skin test	0341	0.1365	$7.45	$3.03	$1.49
86580	X		TB intradermal test	0341	0.1365	$7.45	$3.03	$1.49
86585	X		TB tine test	0341	0.1365	$7.45	$3.03	$1.49
86586	X		Skin test, unlisted	0341	0.1365	$7.45	$3.03	$1.49
86590	A		Streptokinase, antibody					
86592	A		Blood serology, qualitative					
86593	A		Blood serology, quantitative					
86602	A		Antinomyces antibody					
86603	A		Adenovirus antibody					
86606	A		Aspergillus antibody					
86609	A		Bacterium antibody					
86611	A		Bartonella antibody					
86612	A		Blastomyces antibody					
86615	A		Bordetella antibody					
86617	A		Lyme disease antibody					
86618	A		Lyme disease antibody					
86619	A		Borrelia antibody					
86622	A		Brucella antibody					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
86625	A		Campylobacter antibody					
86628	A		Candida antibody					
86631	A		Chlamydia antibody					
86632	A		Chlamydia igm antibody					
86635	A		Coccidioides antibody					
86638	A		Q fever antibody					
86641	A		Cryptococcus antibody					
86644	A		CMV antibody					
86645	A		CMV antibody, IgM					
86648	A		Diphtheria antibody					
86651	A		Encephalitis antibody					
86652	A		Encephalitis antibody					
86653	A		Encephalitis antibody					
86654	A		Encephalitis antibody					
86658	A		Enterovirus antibody					
86663	A		Epstein-barr antibody					
86664	A		Epstein-barr antibody					
86665	A		Epstein-barr antibody					
86666	A		Ehrlichia antibody					
86668	A		Francisella tularensis					
86671	A		Fungus antibody					
86674	A		Giardia lamblia antibody					
86677	A		Helicobacter pylori					
86682	A		Helminth antibody					
86684	A		Hemophilus influenza					
86687	A		Htlv-i antibody					
86688	A		Htlv-ii antibody					
86689	A		HTLV/HIV confirmatory test					
86692	A		Hepatitis, delta agent					
86694	A		Herpes simplex test					
86695	A		Herpes simplex test					
86696	A		Herpes simplex type 2					
86698	A		Histoplasma					
86701	A		HIV-1					
86702	A		HIV-2					
86703	A		HIV-1/HIV-2, single assay					
86704	A		Hep b core antibody, total					
86705	A		Hep b core antibody, igm					
86706	A		Hep b surface antibody					
86707	A		Hep be antibody					
86708	A		Hep a antibody, total					
86709	A		Hep a antibody, igm					
86710	A		Influenza virus antibody					
86713	A		Legionella antibody					
86717	A		Leishmania antibody					
86720	A		Leptospira antibody					
86723	A		Listeria monocytogenes ab					
86727	A		Lymph choriomeningitis ab					
86729	A		Lympho venereum antibody					
86732	A		Mucormycosis antibody					
86735	A		Mumps antibody					
86738	A		Mycoplasma antibody					
86741	A		Neisseria meningitidis					
86744	A		Nocardia antibody					
86747	A		Parvovirus antibody					
86750	A		Malaria antibody					
86753	A		Protozoa antibody nos					
86756	A		Respiratory virus antibody					
86757	A		Rickettsia antibody					
86759	A		Rotavirus antibody					
86762	A		Rubella antibody					
86765	A		Rubeola antibody					
86768	A		Salmonella antibody					
86771	A		Shigella antibody					
86774	A		Tetanus antibody					
86777	A		Toxoplasma antibody					
86778	A		Toxoplasma antibody, igm					
86781	A		Treponema pallidum, confirm					
86784	A		Trichinella antibody					
86787	A		Varicella-zoster antibody					
86790	A		Virus antibody nos					
86793	A		Yersinia antibody					
86800	A		Thyroglobulin antibody					
86803	A		Hepatitis c ab test					
86804	A		Hep c ab test, confirm					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
86805	A		Lymphocytotoxicity assay					
86806	A		Lymphocytotoxicity assay					
86807	A		Cytotoxic antibody screening					
86808	A		Cytotoxic antibody screening					
86812	A		HLA typing, A, B, or C					
86813	A		HLA typing, A, B, or C					
86816	A		HLA typing, DR/DQ					
86817	A		HLA typing, DR/DQ					
86821	A		Lymphocyte culture, mixed					
86822	A		Lymphocyte culture, primed					
86849	A		Immunology procedure					
86850	X		RBC antibody screen	0345	0.2550	$13.91	$3.10	$2.78
86860	X		RBC antibody elution	0346	0.3866	$21.09	$5.32	$4.22
86870	X		RBC antibody identification	0346	0.3866	$21.09	$5.32	$4.22
86880	X		Coombs test, direct	0409	0.1390	$7.58	$2.32	$1.52
86885	X		Coombs test, indirect, qual	0409	0.1390	$7.58	$2.32	$1.52
86886	X		Coombs test, indirect, titer	0409	0.1390	$7.58	$2.32	$1.52
86890	X		Autologous blood process	0347	0.9610	$52.43	$13.20	$10.49
86891	X		Autologous blood, op salvage	0345	0.2550	$13.91	$3.10	$2.78
86900	X		Blood typing, ABO	0409	0.1390	$7.58	$2.32	$1.52
86901	X		Blood typing, Rh (D)	0409	0.1390	$7.58	$2.32	$1.52
86903	X		Blood typing, antigen screen	0345	0.2550	$13.91	$3.10	$2.78
86904	X		Blood typing, patient serum	0345	0.2550	$13.91	$3.10	$2.78
86905	X		Blood typing, RBC antigens	0345	0.2550	$13.91	$3.10	$2.78
86906	X		Blood typing, Rh phenotype	0345	0.2550	$13.91	$3.10	$2.78
86910	E		Blood typing, paternity test					
86911	E		Blood typing, antigen system					
86920	X		Compatibility test	0346	0.3866	$21.09	$5.32	$4.22
86921	X		Compatibility test	0345	0.2550	$13.91	$3.10	$2.78
86922	X		Compatibility test	0346	0.3866	$21.09	$5.32	$4.22
86927	X		Plasma, fresh frozen	0346	0.3866	$21.09	$5.32	$4.22
86930	X		Frozen blood prep	0347	0.9610	$52.43	$13.20	$10.49
86931	X		Frozen blood thaw	0347	0.9610	$52.43	$13.20	$10.49
86932	X		Frozen blood freeze/thaw	0347	0.9610	$52.43	$13.20	$10.49
86940	A		Hemolysins/agglutinins, auto					
86941	A		Hemolysins/agglutinins					
86945	X		Blood product/irradiation	0346	0.3866	$21.09	$5.32	$4.22
86950	X		Leukacyte transfusion	0347	0.9610	$52.43	$13.20	$10.49
86965	X		Pooling blood platelets	0346	0.3866	$21.09	$5.32	$4.22
86970	X		RBC pretreatment	0345	0.2550	$13.91	$3.10	$2.78
86971	X		RBC pretreatment	0345	0.2550	$13.91	$3.10	$2.78
86972	X		RBC pretreatment	0345	0.2550	$13.91	$3.10	$2.78
86975	X		RBC pretreatment, serum	0345	0.2550	$13.91	$3.10	$2.78
86976	X		RBC pretreatment, serum	0345	0.2550	$13.91	$3.10	$2.78
86977	X		RBC pretreatment, serum	0345	0.2550	$13.91	$3.10	$2.78
86978	X		RBC pretreatment, serum	0345	0.2550	$13.91	$3.10	$2.78
86985	X		Split blood or products	0347	0.9610	$52.43	$13.20	$10.49
86999	X		Transfusion procedure	0345	0.2550	$13.91	$3.10	$2.78
87001	A		Small animal inoculation					
87003	A		Small animal inoculation					
87015	A		Specimen concentration					
87040	A		Blood culture for bacteria					
87045	A		Feces culture, bacteria					
87046	A		Stool cultr, bacteria, each					
87070	A		Culture, bacteria, other					
87071	A		Culture bacteri aerobic othr					
87073	A		Culture bacteria anaerobic					
87075	A		Cultr bacteria, except blood					
87076	A		Culture anaerobe ident, each					
87077	A		Culture aerobic identify					
87081	A		Culture screen only					
87084	A		Culture of specimen by kit					
87086	A		Urine culture/colony count					
87088	A		Urine bacteria culture					
87101	A		Skin fungi culture					
87102	A		Fungus isolation culture					
87103	A		Blood fungus culture					
87106	A		Fungi identification, yeast					
87107	A		Fungi identification, mold					
87109	A		Mycoplasma					
87110	A		Chlamydia culture					
87116	A		Mycobacteria culture					
87118	A		Mycobacteric identification					
87140	A		Culture type immunofluoresc					
87143	A		Culture typing, glc/hplc					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
87147	A		Culture type, immunologic					
87149	A		Culture type, nucleic acid					
87152	A		Culture type pulse field gel					
87158	A		Culture typing, added method					
87164	A		Dark field examination					
87166	A		Dark field examination					
87168	A		Macroscopic exam arthropod					
87169	A		Macroscopic exam parasite					
87172	A		Pinworm exam					
87176	A		Tissue homogenization, cultr					
87177	A		Ova and parasites smears					
87181	A		Microbe susceptible, diffuse					
87184	A		Microbe susceptible, disk					
87185	A		Microbe susceptible, enzyme					
87186	A		Microbe susceptible, mic					
87187	A		Microbe susceptible, mic					
87188	A		Microbe suscept, macrobroth					
87190	A		Microbe suscept, mycobacteri					
87197	A		Bactericidal level, serum					
87205	A		Smear, gram stain					
87206	A		Smear, fluorescent/acid stai					
87207	A		Smear, special stain					
87210	A		Smear, wet mount, saline/ink					
87220	A		Tissue exam for fungi					
87230	A		Assay, toxin or antitoxin					
87250	A		Virus inoculate, eggs/animal					
87252	A		Virus inoculation, tissue					
87253	A		Virus inoculate tissue, addl					
87254	A		Virus inoculation, shell via					
87255	A		Genet virus isolate, hsv					
87260	A		Adenovirus ag, if					
87265	A		Pertussis ag, if					
87267	A		Enterovirus antibody, dfa					
87269	A	NI	Giardia ag, if					
87270	A		Chlamydia trachomatis ag, if					
87271	A		Cryptosporidum/gardia ag, if					
87272	A		Cryptosporidium ag, if					
87273	A		Herpes simplex 2, ag, if					
87274	A		Herpes simplex 1, ag, if					
87275	A		Influenza b, ag, if					
87276	A		Influenza a, ag, if					
87277	A		Legionella micdadei, ag, if					
87278	A		Legion pneumophilia ag, if					
87279	A		Parainfluenza, ag, if					
87280	A		Respiratory syncytial ag, if					
87281	A		Pneumocystis carinii, ag, if					
87283	A		Rubeola, ag, if					
87285	A		Treponema pallidum, ag, if					
87290	A		Varicella zoster, ag, if					
87299	A		Antibody detection, nos, if					
87300	A		Ag detection, polyval, if					
87301	A		Adenovirus ag, eia					
87320	A		Chylmd trach ag, eia					
87324	A		Clostridium ag, eia					
87327	A		Cryptococcus neoform ag, eia					
87328	A		Cryptosporidium ag, eia					
87329	A	NI	Giardia ag, eia					
87332	A		Cytomegalovirus ag, eia					
87335	A		E coli 0157 ag, eia					
87336	A		Entamoeb hist dispr, ag, eia					
87337	A		Entamoeb hist group, ag, eia					
87338	A		Hpylori, stool, eia					
87339	A		H pylori ag, eia					
87340	A		Hepatitis b surface ag, eia					
87341	A		Hepatitis b surface, ag, eia					
87350	A		Hepatitis be ag, eia					
87380	A		Hepatitis delta ag, eia					
87385	A		Histoplasma capsul ag, eia					
87390	A		Hiv-1 ag, eia					
87391	A		Hiv-2 ag, eia					
87400	A		Influenza a/b, ag, eia					
87420	A		Resp syncytial ag, eia					
87425	A		Rotavirus ag, eia					
87427	A		Shiga-like toxin ag, eia					
87430	A		Strep a ag, eia					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
87449	A		Ag detect nos, eia, mult					
87450	A		Ag detect nos, eia, single					
87451	A		Ag detect polyval, eia, mult					
87470	A		Bartonella, dna, dir probe					
87471	A		Bartonella, dna, amp probe					
87472	A		Bartonella, dna, quant					
87475	A		Lyme dis, dna, dir probe					
87476	A		Lyme dis, dna, amp probe					
87477	A		Lyme dis, dna, quant					
87480	A		Candida, dna, dir probe					
87481	A		Candida, dna, amp probe					
87482	A		Candida, dna, quant					
87485	A		Chylmd pneum, dna, dir probe					
87486	A		Chylmd pneum, dna, amp probe					
87487	A		Chylmd pneum, dna, quant					
87490	A		Chylmd trach, dna, dir probe					
87491	A		Chylmd trach, dna, amp probe					
87492	A		Chylmd trach, dna, quant					
87495	A		Cytomeg, dna, dir probe					
87496	A		Cytomeg, dna, amp probe					
87497	A		Cytomeg, dna, quant					
87510	A		Gardner vag, dna, dir probe					
87511	A		Gardner vag, dna, amp probe					
87512	A		Gardner vag, dna, quant					
87515	A		Hepatitis b, dna, dir probe					
87516	A		Hepatitis b, dna, amp probe					
87517	A		Hepatitis b, dna, quant					
87520	A		Hepatitis c, ma, dir probe					
87521	A		Hepatitis c, ma, amp probe					
87522	A		Hepatitis c, ma, quant					
87525	A		Hepatitis g, dna, dir probe					
87526	A		Hepatitis g, dna, amp probe					
87527	A		Hepatitis g, dna, quant					
87528	A		Hsv, dna, dir probe					
87529	A		Hsv, dna, amp probe					
87530	A		Hsv, dna, quant					
87531	A		Hhv-6, dna, dir probe					
87532	A		Hhv-6, dna, amp probe					
87533	A		Hhv-6, dna, quant					
87534	A		Hiv-1, dna, dir probe					
87535	A		Hiv-1, dna, amp probe					
87536	A		Hiv-1, dna, quant					
87537	A		Hiv-2, dna, dir probe					
87538	A		Hiv-2, dna, amp probe					
87539	A		Hiv-2, dna, quant					
87540	A		Legion pneumo, dna, dir prob					
87541	A		Legion pneumo, dna, amp prob					
87542	A		Legion pneumo, dna, quant					
87550	A		Mycobacteria, dna, dir probe					
87551	A		Mycobacteria, dna, amp probe					
87552	A		Mycobacteria, dna, quant					
87555	A		M.tuberculo, dna, dir probe					
87556	A		M.tuberculo, dna, amp probe					
87557	A		M.tuberculo, dna, quant					
87560	A		M.avium-intra, dna, dir prob					
87561	A		M.avium-intra, dna, amp prob					
87562	A		M.avium-intra, dna, quant					
87580	A		M.pneumon, dna, dir probe					
87581	A		M.pneumon, dna, amp probe					
87582	A		M.pneumon, dna, quant					
87590	A		N.gonorrhoeae, dna, dir prob					
87591	A		N.gonorrhoeae, dna, amp prob					
87592	A		N.gonorrhoeae, dna, quant					
87620	A		Hpv, dna, dir probe					
87621	A		Hpv, dna, amp probe					
87622	A		Hpv, dna, quant					
87650	A		Strep a, dna, dir probe					
87651	A		Strep a, dna, amp probe					
87652	A		Strep a, dna, quant					
87660	A	NI	Trichomonas vagin, dir probe					
87797	A		Detect agent nos, dna, dir					
87798	A		Detect agent nos, dna, amp					
87799	A		Detect agent nos, dna, quant					
87800	A		Detect agnt mult, dna, direc					
87801	A		Detect agnt mult, dna, ampli					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
87802	A		Strep b assay w/optic					
87803	A		Clostridium toxin a w/optic					
87804	A		Influenza assay w/optic					
87810	A		Chylmd trach assay w/optic					
87850	A		N. gonorrhoeae assay w/optic					
87880	A		Strep a assay w/optic					
87899	A		Agent nos assay w/optic					
87901	A		Genotype, dna, hiv reverse t					
87902	A		Genotype, dna, hepatitis C					
87903	A		Phenotype, dna hiv w/culture					
87904	A		Phenotype, dna hiv w/clt add					
87999	A		Microbiology procedure					
88000	E		Autopsy (necropsy), gross					
88005	E		Autopsy (necropsy), gross					
88007	E		Autopsy (necropsy), gross					
88012	E		Autopsy (necropsy), gross					
88014	E		Autopsy (necropsy), gross					
88016	E		Autopsy (necropsy), gross					
88020	E		Autopsy (necropsy), complete					
88025	E		Autopsy (necropsy), complete					
88027	E		Autopsy (necropsy), complete					
88028	E		Autopsy (necropsy), complete					
88029	E		Autopsy (necropsy), complete					
88036	E		Limited autopsy					
88037	E		Limited autopsy					
88040	E		Forensic autopsy (necropsy)					
88045	E		Coroner's autopsy (necropsy)					
88099	E		Necropsy (autopsy) procedure					
88104	X		Cytopathology, fluids	0343	0.4617	$25.19	$12.55	$5.04
88106	X		Cytopathology, fluids	0343	0.4617	$25.19	$12.55	$5.04
88107	X		Cytopathology, fluids	0343	0.4617	$25.19	$12.55	$5.04
88108	X		Cytopath, concentrate tech	0343	0.4617	$25.19	$12.55	$5.04
88112	X	NI	Cytopath, cell enhance tech	0343	0.4617	$25.19	$12.55	$5.04
88125	X		Forensic cytopathology	0342	0.2162	$11.80	$5.88	$2.36
88130	A		Sex chromatin identification					
88140	A		Sex chromatin identification					
88141	N		Cytopath, c/v, interpret					
88142	A		Cytopath, c/v, thin layer					
88143	A		Cytopath c/v thin layer redo					
88147	A		Cytopath, c/v, automated					
88148	A		Cytopath, c/v, auto rescreen					
88150	A		Cytopath, c/v, manual					
88152	A		Cytopath, c/v, auto redo					
88153	A		Cytopath, c/v, redo					
88154	A		Cytopath, c/v, select					
88155	A		Cytopath, c/v, index add-on					
88160	X		Cytopath smear, other source	0342	0.2162	$11.80	$5.88	$2.36
88161	X		Cytopath smear, other source	0343	0.4617	$25.19	$12.55	$5.04
88162	X		Cytopath smear, other source	0343	0.4617	$25.19	$12.55	$5.04
88164	A		Cytopath tbs, c/v, manual					
88165	A		Cytopath tbs, c/v, redo					
88166	A		Cytopath tbs, c/v, auto redo					
88167	A		Cytopath tbs, c/v, select					
88172	X		Cytopathology eval of fna	0343	0.4617	$25.19	$12.55	$5.04
88173	X		Cytopath eval, fna, report	0343	0.4617	$25.19	$12.55	$5.04
88174	A		Cytopath, c/v auto, in fluid					
88175	A		Cytopath c/v auto fluid redo					
88180	X		Cell marker study	0343	0.4617	$25.19	$12.55	$5.04
88182	X		Cell marker study	0344	0.6291	$34.32	$17.16	$6.86
88199	A		Cytopathology procedure					
88230	A		Tissue culture, lymphocyte					
88233	A		Tissue culture, skin/biopsy					
88235	A		Tissue culture, placenta					
88237	A		Tissue culture, bone marrow					
88239	A		Tissue culture, tumor					
88240	A		Cell cryopreserve/storage					
88241	A		Frozen cell preparation					
88245	A		Chromosome analysis, 20-25					
88248	A		Chromosome analysis, 50-100					
88249	A		Chromosome analysis, 100					
88261	A		Chromosome analysis, 5					
88262	A		Chromosome analysis, 15-20					
88263	A		Chromosome analysis, 45					
88264	A		Chromosome analysis, 20-25					
88267	A		Chromosome analys, placenta					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
88269	A		Chromosome analys, amniotic					
88271	A		Cytogenetics, dna probe					
88272	A		Cytogenetics, 3-5					
88273	A		Cytogenetics, 10-30					
88274	A		Cytogenetics, 25-99					
88275	A		Cytogenetics, 100-300					
88280	A		Chromosome karyotype study					
88283	A		Chromosome banding study					
88285	A		Chromosome count, additional					
88289	A		Chromosome study, additional					
88291	A		Cyto/molecular report					
88299	X		Cytogenetic study	0342	0.2162	$11.80	$5.88	$2.36
88300	X		Surgical path, gross	0342	0.2162	$11.80	$5.88	$2.36
88302	X		Tissue exam by pathologist	0342	0.2162	$11.80	$5.88	$2.36
88304	X		Tissue exam by pathologist	0343	0.4617	$25.19	$12.55	$5.04
88305	X		Tissue exam by pathologist	0343	0.4617	$25.19	$12.55	$5.04
88307	X		Tissue exam by pathologist	0344	0.6291	$34.32	$17.16	$6.86
88309	X		Tissue exam by pathologist	0344	0.6291	$34.32	$17.16	$6.86
88311	X		Decalcify tissue	0342	0.2162	$11.80	$5.88	$2.36
88312	X		Special stains	0342	0.2162	$11.80	$5.88	$2.36
88313	X		Special stains	0342	0.2162	$11.80	$5.88	$2.36
88314	X		Histochemical stain	0342	0.2162	$11.80	$5.88	$2.36
88318	X		Chemical histochemistry	0342	0.2162	$11.80	$5.88	$2.36
88319	X		Enzyme histochemistry	0342	0.2162	$11.80	$5.88	$2.36
88321	X		Microslide consultation	0342	0.2162	$11.80	$5.88	$2.36
88323	X		Microslide consultation	0343	0.4617	$25.19	$12.55	$5.04
88325	X		Comprehensive review of data	0344	0.6291	$34.32	$17.16	$6.86
88329	X		Path consult introp	0342	0.2162	$11.80	$5.88	$2.36
88331	X		Path consult intraop, 1 bloc	0343	0.4617	$25.19	$12.55	$5.04
88332	X		Path consult intraop, add'l	0342	0.2162	$11.80	$5.88	$2.36
88342	X		Immunohistochemistry	0344	0.6291	$34.32	$17.16	$6.86
88346	X		Immunofluorescent study	0343	0.4617	$25.19	$12.55	$5.04
88347	X		Immunofluorescent study	0344	0.6291	$34.32	$17.16	$6.86
88348	X		Electron microscopy	0661	3.2576	$177.74	$88.87	$35.55
88349	X		Scanning electron microscopy	0661	3.2576	$177.74	$88.87	$35.55
88355	X		Analysis, skeletal muscle	0344	0.6291	$34.32	$17.16	$6.86
88356	X		Analysis, nerve	0344	0.6291	$34.32	$17.16	$6.86
88358	X		Analysis, tumor	0344	0.6291	$34.32	$17.16	$6.86
88361	X	NI	Immunohistochemistry, tumor	0344	0.6291	$34.32	$17.16	$6.86
88362	X		Nerve teasing preparations	0344	0.6291	$34.32	$17.16	$6.86
88365	X		Tissue hybridization	0344	0.6291	$34.32	$17.16	$6.86
88371	A		Protein, western blot tissue					
88372	A		Protein analysis w/probe					
88380	A		Microdissection					
88399	A		Surgical pathology procedure					
88400	A		Bilirubin total transcut					
89050	A		Body fluid cell count					
89051	A		Body fluid cell count					
89055	A		Leukocyte assessment, fecal					
89060	A		Exam,synovial fluid crystals					
89100	X		Sample intestinal contents	0360	1.7313	$94.46	$42.45	$18.89
89105	X		Sample intestinal contents	0360	1.7313	$94.46	$42.45	$18.89
89125	A		Specimen fat stain					
89130	X		Sample stomach contents	0360	1.7313	$94.46	$42.45	$18.89
89132	X		Sample stomach contents	0360	1.7313	$94.46	$42.45	$18.89
89135	X		Sample stomach contents	0360	1.7313	$94.46	$42.45	$18.89
89136	X		Sample stomach contents	0360	1.7313	$94.46	$42.45	$18.89
89140	X		Sample stomach contents	0360	1.7313	$94.46	$42.45	$18.89
89141	X		Sample stomach contents	0360	1.7313	$94.46	$42.45	$18.89
89160	A		Exam feces for meat fibers					
89190	A		Nasal smear for eosinophils					
89220	X	NI	Sputum specimen collection	0343	0.4617	$25.19	$12.55	$5.04
89225	A	NI	Starch granules, feces					
89230	X	NI	Collect sweat for test	0344	0.6291	$34.32	$17.16	$6.86
89235	A	NI	Water load test					
89240	A	NI	Pathology lab procedure					
89250	X		Cultr oocyte/embryo <4 days	0348	0.8194	$44.71		$8.94
89251	X		Cultr oocyte/embryo <4 days	0348	0.8194	$44.71		$8.94
89252	X	DG	Assist oocyte fertilization	0348	0.8194	$44.71		$8.94
89253	X		Embryo hatching	0348	0.8194	$44.71		$8.94
89254	X		Oocyte identification	0348	0.8194	$44.71		$8.94
89255	X		Prepare embryo for transfer	0348	0.8194	$44.71		$8.94
89256	X	DG	Prepare cryopreserved embryo	0348	0.8194	$44.71		$8.94
89257	X		Sperm identification	0348	0.8194	$44.71		$8.94
89258	X		Cryopreservation; embryo(s)	0348	0.8194	$44.71		$8.94

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
89259	X		Cryopreservation, sperm	0348	0.8194	$44.71		$8.94
89260	X		Sperm isolation, simple	0348	0.8194	$44.71		$8.94
89261	X		Sperm isolation, complex	0348	0.8194	$44.71		$8.94
89264	X		Identify sperm tissue	0348	0.8194	$44.71		$8.94
89268	X	NI	Insemination of oocytes	0348	0.8194	$44.71		$8.94
89272	X	NI	Extended culture of oocytes	0348	0.8194	$44.71		$8.94
89280	X	NI	Assist oocyte fertilization	0348	0.8194	$44.71		$8.94
89281	X	NI	Assist oocyte fertilization	0348	0.8194	$44.71		$8.94
89290	X	NI	Biopsy, oocyte polar body	0348	0.8194	$44.71		$8.94
89291	X	NI	Biopsy, oocyte polar body	0348	0.8194	$44.71		$8.94
89300	A		Semen analysis w/huhner					
89310	A		Semen analysis					
89320	A		Semen analysis, complete					
89321	A		Semen analysis & motility					
89325	A		Sperm antibody test					
89329	A		Sperm evaluation test					
89330	A		Evaluation, cervical mucus					
89335	X	NI	Cryopreserve testicular tiss	0348	0.8194	$44.71		$8.94
89342	X	NI	Storage/year; embryo(s)	0348	0.8194	$44.71		$8.94
89343	X	NI	Storage/year; sperm/semen	0348	0.8194	$44.71		$8.94
89344	X	NI	Storage/year; reprod tissue	0348	0.8194	$44.71		$8.94
89346	X	NI	Storage/year; oocyte	0348	0.8194	$44.71		$8.94
89350	X	DG	Sputum specimen collection	0343	0.4617	$25.19	$12.55	$5.04
89352	X	NI	Thawing cryopresrved; embryo	0348	0.8194	$44.71		$8.94
89353	X	NI	Thawing cryopresrved; sperm	0348	0.8194	$44.71		$8.94
89354	X	NI	Thaw cryoprsvrd; reprod tiss	0348	0.8194	$44.71		$8.94
89355	A	DG	Exam feces for starch					
89356	X	NI	Thawing cryopresrved; oocyte	0348	0.8194	$44.71		$8.94
89360	X	DG	Collect sweat for test	0343	0.4617	$25.19	$12.55	$5.04
89365	A	DG	Water load test					
89399	A	DG	Pathology lab procedure					
90281	E		Human ig, im					
90283	E		Human ig, iv					
90287	E		Botulinum antitoxin					
90288	E		Botulism ig, iv					
90291	E		Cmv ig, iv					
90296	K		Diphtheria antitoxin	0355	0.2749	$15.00		$3.00
90371	E		Hep b ig, im					
90375	K		Rabies ig, im/sc	0356	0.7698	$42.00		$8.40
90376	K		Rabies ig, heat treated	0356	0.7698	$42.00		$8.40
90378	E		Rsv ig, im, 50mg					
90379	K		Rsv ig, iv	0356	0.7698	$42.00		$8.40
90384	E		Rh ig, full-dose, im					
90385	K		Rh ig, minidose, im	0356	0.7698	$42.00		$8.40
90386	E		Rh ig, iv					
90389	N		Tetanus ig, im					
90393	K		Vaccina ig, im	0356	0.7698	$42.00		$8.40
90396	K		Varicella-zoster ig, im	0356	0.7698	$42.00		$8.40
90399	E		Immune globulin					
90471	N		Immunization admin					
90472	N		Immunization admin, each add					
90473	E		Immune admin oral/nasal					
90474	E		Immune admin oral/nasal addl					
90476	N		Adenovirus vaccine, type 4					
90477	N		Adenovirus vaccine, type 7					
90581	K		Anthrax vaccine, sc	0355	0.2749	$15.00		$3.00
90585	N		Bcg vaccine, percut					
90586	K		Bcg vaccine, intravesical	0356	0.7698	$42.00		$8.40
90632	N		Hep a vaccine, adult im					
90633	N		Hep a vacc, ped/adol, 2 dose					
90634	N		Hep a vacc, ped/adol, 3 dose					
90636	K		Hep a/hep b vacc, adult im	0355	0.2749	$15.00		$3.00
90645	N		Hib vaccine, hboc, im					
90646	N		Hib vaccine, prp-d, im					
90647	N		Hib vaccine, prp-omp, im					
90648	N		Hib vaccine, prp-t, im					
90655	L	NI	Flu vaccine, 6-35 mo, im					
90657	L		Flu vaccine, 6-35 mo, im					
90658	L		Flu vaccine, 3 yrs, im					
90659	L	DG	Flu vaccine, whole, im					
90660	E		Flu vaccine, nasal					
90665	N		Lyme disease vaccine, im					
90669	E		Pneumococcal vacc, ped <5					
90675	K		Rabies vaccine, im	0356	0.7698	$42.00		$8.40
90676	K		Rabies vaccine, id	0356	0.7698	$42.00		$8.40

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
90680	N		Rotovirus vaccine, oral					
90690	N		Typhoid vaccine, oral					
90691	N		Typhoid vaccine, im					
90692	N		Typhoid vaccine, h-p, sc/id					
90693	K		Typhoid vaccine, akd, sc	0356	0.7698	$42.00		$8.40
90698	N	NI	Dtap-hib-ip vaccine, im					
90700	N		Dtap vaccine, im					
90701	N		Dtp vaccine, im					
90702	N		Dt vaccine < 7, im					
90703	N		Tetanus vaccine, im					
90704	N		Mumps vaccine, sc					
90705	N		Measles vaccine, sc					
90706	N		Rubella vaccine, sc					
90707	N		Mmr vaccine, sc					
90708	N		Measles-rubella vaccine, sc					
90710	N		Mmrv vaccine, sc					
90712	N		Oral poliovirus vaccine					
90713	N		Poliovirus, ipv, sc					
90715	N	NI	Tdap vaccine > 7 im					
90716	K		Chicken pox vaccine, sc	0355	0.2749	$15.00		$3.00
90717	N		Yellow fever vaccine, sc					
90718	N		Td vaccine > 7, im					
90719	N		Diphtheria vaccine, im					
90720	N		Dtp/hib vaccine, im					
90721	N		Dtap/hib vaccine, im					
90723	K		Dtap-hep b-ipv vaccine, im	0356	0.7698	$42.00		$8.40
90725	K		Cholera vaccine, injectable	0355	0.2749	$15.00		$3.00
90727	N		Plague vaccine, im					
90732	L		Pneumococcal vaccine					
90733	N		Meningococcal vaccine, sc					
90734	N	NI	Meningococcal vaccine, im					
90735	N		Encephalitis vaccine, sc					
90740	K		Hepb vacc, ill pat 3 dose im	0356	0.7698	$42.00		$8.40
90743	K		Hep b vacc, adol, 2 dose, im	0356	0.7698	$42.00		$8.40
90744	K		Hepb vacc ped/adol 3 dose im	0356	0.7698	$42.00		$8.40
90746	K		Hep b vaccine, adult, im	0356	0.7698	$42.00		$8.40
90747	K		Hepb vacc, ill pat 4 dose im	0356	0.7698	$42.00		$8.40
90748	K		Hep b/hib vaccine, im	0355	0.2749	$15.00		$3.00
90749	N		Vaccine toxoid					
90780	B		IV infusion therapy, 1 hour					
90781	B		IV infusion, additional hour					
90782	X		Injection, sc/im	0353	0.3982	$21.73		$4.35
90783	X		Injection, ia	0359	0.8000	$43.65		$8.73
90784	X		Injection, iv	0359	0.8000	$43.65		$8.73
90788	X		Injection of antibiotic	0359	0.8000	$43.65		$8.73
90799	X		Ther/prophylactic/dx inject	0352	0.1230	$6.71		$1.34
90801	S		Psy dx interview	0323	1.8689	$101.97	$21.26	$20.39
90802	S		Intac psy dx interview	0323	1.8689	$101.97	$21.26	$20.39
90804	S		Psytx, office, 20-30 min	0322	1.2802	$69.85		$13.97
90805	S		Psytx, off, 20-30 min w/e&m	0322	1.2802	$69.85		$13.97
90806	S		Psytx, off, 45-50 min	0323	1.8689	$101.97	$21.26	$20.39
90807	S		Psytx, off, 45-50 min w/e&m	0323	1.8689	$101.97	$21.26	$20.39
90808	S		Psytx, office, 75-80 min	0323	1.8689	$101.97	$21.26	$20.39
90809	S		Psytx, off, 75-80, w/e&m	0323	1.8689	$101.97	$21.26	$20.39
90810	S		Intac psytx, off, 20-30 min	0322	1.2802	$69.85		$13.97
90811	S		Intac psytx, 20-30, w/e&m	0322	1.2802	$69.85		$13.97
90812	S		Intac psytx, off, 45-50 min	0323	1.8689	$101.97	$21.26	$20.39
90813	S		Intac psytx, 45-50 min w/e&m	0323	1.8689	$101.97	$21.26	$20.39
90814	S		Intac psytx, off, 75-80 min	0323	1.8689	$101.97	$21.26	$20.39
90815	S		Intac psytx, 75-80 w/e&m	0323	1.8689	$101.97	$21.26	$20.39
90816	S		Psytx, hosp, 20-30 min	0322	1.2802	$69.85		$13.97
90817	S		Psytx, hosp, 20-30 min w/e&m	0322	1.2802	$69.85		$13.97
90818	S		Psytx, hosp, 45-50 min	0323	1.8689	$101.97	$21.26	$20.39
90819	S		Psytx, hosp, 45-50 min w/e&m	0323	1.8689	$101.97	$21.26	$20.39
90821	S		Psytx, hosp, 75-80 min	0323	1.8689	$101.97	$21.26	$20.39
90822	S		Psytx, hosp, 75-80 min w/e&m	0323	1.8689	$101.97	$21.26	$20.39
90823	S		Intac psytx, hosp, 20-30 min	0322	1.2802	$69.85		$13.97
90824	S		Intac psytx, hsp 20-30 w/e&m	0322	1.2802	$69.85		$13.97
90826	S		Intac psytx, hosp, 45-50 min	0323	1.8689	$101.97	$21.26	$20.39
90827	S		Intac psytx, hsp 45-50 w/e&m	0323	1.8689	$101.97	$21.26	$20.39
90828	S		Intac psytx, hosp, 75-80 min	0323	1.8689	$101.97	$21.26	$20.39
90829	S		Intac psytx, hsp 75-80 w/e&m	0323	1.8689	$101.97	$21.26	$20.39
90845	S		Psychoanalysis	0323	1.8689	$101.97	$21.26	$20.39
90846	S		Family psytx w/o patient	0324	2.4473	$133.53		$26.71
90847	S		Family psytx w/patient	0324	2.4473	$133.53		$26.71

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
90849	S		Multiple family group psytx	0325	1.4865	$81.10	$18.27	$16.22
90853	S		Group psychotherapy	0325	1.4865	$81.10	$18.27	$16.22
90857	S		Intac group psytx	0325	1.4865	$81.10	$18.27	$16.22
90862	X		Medication management	0374	1.1252	$61.39		$12.28
90865	S		Narcosynthesis	0323	1.8689	$101.97	$21.26	$20.39
90870	S		Electroconvulsive therapy	0320	5.3785	$293.46	$80.06	$58.69
90871	E		Electroconvulsive therapy					
90875	E		Psychophysiological therapy					
90876	E		Psychophysiological therapy					
90880	S		Hypnotherapy	0323	1.8689	$101.97	$21.26	$20.39
90882	E		Environmental manipulation					
90885	N		Psy evaluation of records					
90887	N		Consultation with family					
90889	N		Preparation of report					
90899	S		Psychiatric service/therapy	0322	1.2802	$69.85		$13.97
90901	A		Biofeedback train, any meth					
90911	S		Biofeedback peri/uro/rectal	0321	1.2387	$67.58	$21.78	$13.52
90918	A		ESRD related services, month					
90919	A		ESRD related services, month					
90920	A		ESRD related services, month					
90921	A		ESRD related services, month					
90922	A		ESRD related services, day					
90923	A		Esrd related services, day					
90924	A		Esrd related services, day					
90925	A		Esrd related services, day					
90935	S		Hemodialysis, one evaluation	0170	5.9678	$325.61		$65.12
90937	E		Hemodialysis, repeated eval					
90939	N		Hemodialysis study, transcut					
90940	N		Hemodialysis access study					
90945	S		Dialysis, one evaluation	0170	5.9678	$325.61		$65.12
90947	E		Dialysis, repeated eval					
90989	B		Dialysis training, complete					
90993	B		Dialysis training, incompl					
90997	E		Hemoperfusion					
90999	B		Dialysis procedure					
91000	X		Esophageal intubation	0361	3.5510	$193.75	$83.23	$38.75
91010	X		Esophagus motility study	0361	3.5510	$193.75	$83.23	$38.75
91011	X		Esophagus motility study	0361	3.5510	$193.75	$83.23	$38.75
91012	X		Esophagus motility study	0361	3.5510	$193.75	$83.23	$38.75
91020	X		Gastric motility	0361	3.5510	$193.75	$83.23	$38.75
91030	X		Acid perfusion of esophagus	0361	3.5510	$193.75	$83.23	$38.75
91032	X		Esophagus, acid reflux test	0361	3.5510	$193.75	$83.23	$38.75
91033	X		Prolonged acid reflux test	0361	3.5510	$193.75	$83.23	$38.75
91052	X		Gastric analysis test	0361	3.5510	$193.75	$83.23	$38.75
91055	X		Gastric intubation for smear	0360	1.7313	$94.46	$42.45	$18.89
91060	X		Gastric saline load test	0360	1.7313	$94.46	$42.45	$18.89
91065	X		Breath hydrogen test	0360	1.7313	$94.46	$42.45	$18.89
91100	X		Pass intestine bleeding tube	0360	1.7313	$94.46	$42.45	$18.89
91105	X		Gastric intubation treatment	0360	1.7313	$94.46	$42.45	$18.89
91110	S	NI	Gi tract capsule endoscopy	1508		$650.00		$130.00
91122	T		Anal pressure record	0156	2.4747	$135.02	$40.52	$27.00
91123	N		Irrigate fecal impaction					
91132	X		Electrogastrography	0360	1.7313	$94.46	$42.45	$18.89
91133	X		Electrogastrography w/test	0360	1.7313	$94.46	$42.45	$18.89
91299	X		Gastroenterology procedure	0360	1.7313	$94.46	$42.45	$18.89
92002	V		Eye exam, new patient	0601	0.9816	$53.56		$10.71
92004	V		Eye exam, new patient	0602	1.5041	$82.07		$16.41
92012	V		Eye exam established pat	0600	0.9278	$50.62		$10.12
92014	V		Eye exam & treatment	0602	1.5041	$82.07		$16.41
92015	E		Refraction					
92018	T		New eye exam & treatment	0699	2.2303	$121.69	$47.46	$24.34
92019	S		Eye exam & treatment	0699	2.2303	$121.69	$47.46	$24.34
92020	S		Special eye evaluation	0230	0.7619	$41.57	$14.97	$8.31
92060	S		Special eye evaluation	0230	0.7619	$41.57	$14.97	$8.31
92065	S		Orthoptic/pleoptic training	0230	0.7619	$41.57	$14.97	$8.31
92070	N		Fitting of contact lens					
92081	S		Visual field examination(s)	0230	0.7619	$41.57	$14.97	$8.31
92082	S		Visual field examination(s)	0698	0.9599	$52.37	$18.72	$10.47
92083	S		Visual field examination(s)	0698	0.9599	$52.37	$18.72	$10.47
92100	N		Serial tonometry exam(s)					
92120	S		Tonography & eye evaluation	0230	0.7619	$41.57	$14.97	$8.31
92130	S		Water provocation tonography	0698	0.9599	$52.37	$18.72	$10.47
92135	S		Opthalmic dx imaging	0230	0.7619	$41.57	$14.97	$8.31
92136	S		Ophthalmic biometry	0230	0.7619	$41.57	$14.97	$8.31
92140	S		Glaucoma provocative tests	0698	0.9599	$52.37	$18.72	$10.47

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92225	S		Special eye exam, initial	0698	0.9599	$52.37	$18.72	$10.47
92226	S		Special eye exam, subsequent	0698	0.9599	$52.37	$18.72	$10.47
92230	T		Eye exam with photos	0699	2.2303	$121.69	$47.46	$24.34
92235	T		Eye exam with photos	0699	2.2303	$121.69	$47.46	$24.34
92240	S		Icg angiography	0231	2.1883	$119.40	$50.94	$23.88
92250	S		Eye exam with photos	0230	0.7619	$41.57	$14.97	$8.31
92260	S		Ophthalmoscopy/dynamometry	0230	0.7619	$41.57	$14.97	$8.31
92265	S		Eye muscle evaluation	0231	2.1883	$119.40	$50.94	$23.88
92270	S		Electro-oculography	0698	0.9599	$52.37	$18.72	$10.47
92275	S		Electroretinography	0231	2.1883	$119.40	$50.94	$23.88
92283	S		Color vision examination	0230	0.7619	$41.57	$14.97	$8.31
92284	S		Dark adaptation eye exam	0698	0.9599	$52.37	$18.72	$10.47
92285	S		Eye photography	0230	0.7619	$41.57	$14.97	$8.31
92286	S		Internal eye photography	0698	0.9599	$52.37	$18.72	$10.47
92287	S		Internal eye photography	0231	2.1883	$119.40	$50.94	$23.88
92310	E		Contact lens fitting					
92311	X		Contact lens fitting	0362	2.6984	$147.23		$29.45
92312	X		Contact lens fitting	0362	2.6984	$147.23		$29.45
92313	X		Contact lens fitting	0362	2.6984	$147.23		$29.45
92314	E		Prescription of contact lens					
92315	X		Prescription of contact lens	0362	2.6984	$147.23		$29.45
92316	X		Prescription of contact lens	0362	2.6984	$147.23		$29.45
92317	X		Prescription of contact lens	0362	2.6984	$147.23		$29.45
92325	X		Modification of contact lens	0362	2.6984	$147.23		$29.45
92326	X		Replacement of contact lens	0362	2.6984	$147.23		$29.45
92330	S		Fitting of artificial eye	0230	0.7619	$41.57	$14.97	$8.31
92335	N		Fitting of artificial eye					
92340	E		Fitting of spectacles					
92341	E		Fitting of spectacles					
92342	E		Fitting of spectacles					
92352	X		Special spectacles fitting	0362	2.6984	$147.23		$29.45
92353	X		Special spectacles fitting	0362	2.6984	$147.23		$29.45
92354	X		Special spectacles fitting	0362	2.6984	$147.23		$29.45
92355	X		Special spectacles fitting	0362	2.6984	$147.23		$29.45
92358	X		Eye prosthesis service	0362	2.6984	$147.23		$29.45
92370	E		Repair & adjust spectacles					
92371	X		Repair & adjust spectacles	0362	2.6984	$147.23		$29.45
92390	E		Supply of spectacles					
92391	E		Supply of contact lenses					
92392	E		Supply of low vision aids					
92393	E		Supply of artificial eye					
92395	E		Supply of spectacles					
92396	E		Supply of contact lenses					
92499	S		Eye service or procedure	0230	0.7619	$41.57	$14.97	$8.31
92502	T		Ear and throat examination	0251	1.7880	$97.56		$19.51
92504	N		Ear microscopy examination					
92506	A		Speech/hearing evaluation					
92507	A		Speech/hearing therapy					
92508	A		Speech/hearing therapy					
92510	A		Rehab for ear implant					
92511	T		Nasopharyngoscopy	0071	0.8799	$48.01	$12.89	$9.60
92512	X		Nasal function studies	0363	0.8641	$47.15	$17.44	$9.43
92516	X		Facial nerve function test	0660	1.7353	$94.68	$30.66	$18.94
92520	X		Laryngeal function studies	0660	1.7353	$94.68	$30.66	$18.94
92526	A		Oral function therapy					
92531	N		Spontaneous nystagmus study					
92532	N		Positional nystagmus test					
92533	N		Caloric vestibular test					
92534	N		Optokinetic nystagmus test					
92541	X		Spontaneous nystagmus test	0363	0.8641	$47.15	$17.44	$9.43
92542	X		Positional nystagmus test	0363	0.8641	$47.15	$17.44	$9.43
92543	X		Caloric vestibular test	0363	0.8641	$47.15	$17.44	$9.43
92544	X		Optokinetic nystagmus test	0363	0.8641	$47.15	$17.44	$9.43
92545	X		Oscillating tracking test	0363	0.8641	$47.15	$17.44	$9.43
92546	X		Sinusoidal rotational test	0660	1.7353	$94.68	$30.66	$18.94
92547	X		Supplemental electrical test	0363	0.8641	$47.15	$17.44	$9.43
92548	X		Posturography	0660	1.7353	$94.68	$30.66	$18.94
92551	E		Pure tone hearing test, air					
92552	X		Pure tone audiometry, air	0364	0.4459	$24.33	$9.06	$4.87
92553	X		Audiometry, air & bone	0365	1.2132	$66.19	$18.95	$13.24
92555	X		Speech threshold audiometry	0364	0.4459	$24.33	$9.06	$4.87
92556	X		Speech audiometry, complete	0364	0.4459	$24.33	$9.06	$4.87
92557	X		Comprehensive hearing test	0365	1.2132	$66.19	$18.95	$13.24
92559	E		Group audiometric testing					
92560	E		Bekesy audiometry, screen					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92561	X		Bekesy audiometry, diagnosis	0365	1.2132	$66.19	$18.95	$13.24
92562	X		Loudness balance test	0364	0.4459	$24.33	$9.06	$4.87
92563	X		Tone decay hearing test	0364	0.4459	$24.33	$9.06	$4.87
92564	X		Sisi hearing test	0364	0.4459	$24.33	$9.06	$4.87
92565	X		Stenger test, pure tone	0364	0.4459	$24.33	$9.06	$4.87
92567	X		Tympanometry	0364	0.4459	$24.33	$9.06	$4.87
92568	X		Acoustic reflex testing	0364	0.4459	$24.33	$9.06	$4.87
92569	X		Acoustic reflex decay test	0364	0.4459	$24.33	$9.06	$4.87
92571	X		Filtered speech hearing test	0364	0.4459	$24.33	$9.06	$4.87
92572	X		Staggered spondaic word test	0364	0.4459	$24.33	$9.06	$4.87
92573	X		Lombard test	0364	0.4459	$24.33	$9.06	$4.87
92575	X		Sensorineural acuity test	0365	1.2132	$66.19	$18.95	$13.24
92576	X		Synthetic sentence test	0364	0.4459	$24.33	$9.06	$4.87
92577	X		Stenger test, speech	0365	1.2132	$66.19	$18.95	$13.24
92579	X		Visual audiometry (vra)	0365	1.2132	$66.19	$18.95	$13.24
92582	X		Conditioning play audiometry	0365	1.2132	$66.19	$18.95	$13.24
92583	X		Select picture audiometry	0364	0.4459	$24.33	$9.06	$4.87
92584	X		Electrocochleography	0660	1.7353	$94.68	$30.66	$18.94
92585	S		Auditor evoke potent, compre	0216	2.8535	$155.69	$67.98	$31.14
92586	S		Auditor evoke potent, limit	0218	1.1404	$62.22		$12.44
92587	X		Evoked auditory test	0363	0.8641	$47.15	$17.44	$9.43
92588	X		Evoked auditory test	0363	0.8641	$47.15	$17.44	$9.43
92589	X		Auditory function test(s)	0364	0.4459	$24.33	$9.06	$4.87
92590	E		Hearing aid exam, one ear					
92591	E		Hearing aid exam, both ears					
92592	E		Hearing aid check, one ear					
92593	E		Hearing aid check, both ears					
92594	E		Electro hearng aid test, one					
92595	E		Electro hearng aid tst, both					
92596	X		Ear protector evaluation	0365	1.2132	$66.19	$18.95	$13.24
92597	A		Voice Prosthetic Evaluation					
92601	X	NI	Cochlear implt f/up exam < 7	0365	1.2132	$66.19	$18.95	$13.24
92602	X	NI	Reprogram cochlear implt < 7	0365	1.2132	$66.19	$18.95	$13.24
92603	X	NI	Cochlear implt f/up exam 7 >	0365	1.2132	$66.19	$18.95	$13.24
92604	X	NI	Reprogram cochlear implt 7 >	0365	1.2132	$66.19	$18.95	$13.24
92605	A		Eval for nonspeech device rx					
92606	A		Non-speech device service					
92607	A		Ex for speech device rx, 1hr					
92608	A		Ex for speech device rx addl					
92609	A		Use of speech device service					
92610	A		Evaluate swallowing function					
92611	A		Motion fluoroscopy/swallow					
92612	A		Endoscopy swallow tst (fees)					
92613	E		Endoscopy swallow tst (fees)					
92614	A		Laryngoscopic sensory test					
92615	E		Eval laryngoscopy sense tst					
92616	A		Fees w/laryngeal sense test					
92617	E		Interprt fees/laryngeal test					
92700	X		Ent procedure/service	0364	0.4459	$24.33	$9.06	$4.87
92950	S		Heart/lung resuscitation cpr	0094	2.6345	$143.74	$48.58	$28.75
92953	S		Temporary external pacing	0094	2.6345	$143.74	$48.58	$28.75
92960	S		Cardioversion electric, ext	0679	5.4887	$299.47	$95.30	$59.89
92961	S		Cardioversion, electric, int	0679	5.4887	$299.47	$95.30	$59.89
92970	C		Cardioassist, internal					
92971	C		Cardioassist, external					
92973	T		Percut coronary thrombectomy	1541		$250.00		$50.00
92974	T		Cath place, cardio brachytx	1559		$2,250.00		$450.00
92975	C		Dissolve clot, heart vessel					
92977	T		Dissolve clot, heart vessel	0676	2.7315	$149.03	$40.30	$29.81
92978	S		Intravasc us, heart add-on	0670	27.4483	$1,497.61	$542.37	$299.52
92979	S		Intravasc us, heart add-on	0670	27.4483	$1,497.61	$542.37	$299.52
92980	T		Insert intracoronary stent	0104	82.6713	$4,510.63		$902.13
92981	T		Insert intracoronary stent	0104	82.6713	$4,510.63		$902.13
92982	T		Coronary artery dilation	0083	59.2047	$3,230.27		$646.05
92984	T		Coronary artery dilation	0083	59.2047	$3,230.27		$646.05
92986	T		Revision of aortic valve	0083	59.2047	$3,230.27		$646.05
92987	T		Revision of mitral valve	0083	59.2047	$3,230.27		$646.05
92990	T		Revision of pulmonary valve	0083	59.2047	$3,230.27		$646.05
92992	C		Revision of heart chamber					
92993	C		Revision of heart chamber					
92995	T		Coronary atherectomy	0082	110.2196	$6,013.69	$1,293.59	$1,202.74
92996	T		Coronary atherectomy add-on	0082	110.2196	$6,013.69	$1,293.59	$1,202.74
92997	T		Pul art balloon repr, percut	0081	35.0285	$1,911.19		$382.24
92998	T		Pul art balloon repr, percut	0081	35.0285	$1,911.19		$382.24
93000	B		Electrocardiogram, complete					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93005	S		Electrocardiogram, tracing	0099	0.3703	$20.20		$4.04
93010	A		Electrocardiogram report					
93012	N		Transmission of ecg					
93014	B		Report on transmitted ecg					
93015	B		Cardiovascular stress test					
93016	B		Cardiovascular stress test					
93017	X		Cardiovascular stress test	0100	1.5862	$86.54	$41.44	$17.31
93018	B		Cardiovascular stress test					
93024	X		Cardiac drug stress test	0100	1.5862	$86.54	$41.44	$17.31
93025	X		Microvolt t-wave assess	0100	1.5862	$86.54	$41.44	$17.31
93040	B		Rhythm ECG with report					
93041	S		Rhythm ECG, tracing	0099	0.3703	$20.20		$4.04
93042	B		Rhythm ECG, report					
93224	B		ECG monitor/report, 24 hrs					
93225	X		ECG monitor/record, 24 hrs	0097	1.0635	$58.03	$23.80	$11.61
93226	X		ECG monitor/report, 24 hrs	0097	1.0635	$58.03	$23.80	$11.61
93227	B		ECG monitor/review, 24 hrs					
93230	B		ECG monitor/report, 24 hrs					
93231	X		Ecg monitor/record, 24 hrs	0097	1.0635	$58.03	$23.80	$11.61
93232	X		ECG monitor/report, 24 hrs	0097	1.0635	$58.03	$23.80	$11.61
93233	B		ECG monitor/review, 24 hrs					
93235	B		ECG monitor/report, 24 hrs					
93236	X		ECG monitor/report, 24 hrs	0097	1.0635	$58.03	$23.80	$11.61
93237	B		ECG monitor/review, 24 hrs					
93268	B		ECG record/review					
93270	X		ECG recording	0097	1.0635	$58.03	$23.80	$11.61
93271	X		Ecg/monitoring and analysis	0097	1.0635	$58.03	$23.80	$11.61
93272	B		Ecg/review, interpret only					
93278	S		ECG/signal-averaged	0099	0.3703	$20.20		$4.04
93303	S		Echo transthoracic	0269	3.2309	$176.28	$87.24	$35.26
93304	S		Echo transthoracic	0697	1.4415	$78.65	$39.32	$15.73
93307	S		Echo exam of heart	0269	3.2309	$176.28	$87.24	$35.26
93308	S		Echo exam of heart	0697	1.4415	$78.65	$39.32	$15.73
93312	S		Echo transesophageal	0270	5.8546	$319.43	$146.79	$63.89
93313	S		Echo transesophageal	0270	5.8546	$319.43	$146.79	$63.89
93314	N		Echo transesophageal					
93315	S		Echo transesophageal	0270	5.8546	$319.43	$146.79	$63.89
93316	S		Echo transesophageal	0270	5.8546	$319.43	$146.79	$63.89
93317	N		Echo transesophageal					
93318	S		Echo transesophageal intraop	0270	5.8546	$319.43	$146.79	$63.89
93320	S		Doppler echo exam, heart	0671	1.6384	$89.39	$44.69	$17.88
93321	S		Doppler echo exam, heart	0697	1.4415	$78.65	$39.32	$15.73
93325	S		Doppler color flow add-on	0697	1.4415	$78.65	$39.32	$15.73
93350	S		Echo transthoracic	0269	3.2309	$176.28	$87.24	$35.26
93501	T		Right heart catheterization	0080	36.0160	$1,965.07	$838.92	$393.01
93503	T		Insert/place heart catheter	0103	11.6202	$634.01	$223.63	$126.80
93505	T		Biopsy of heart lining	0103	11.6202	$634.01	$223.63	$126.80
93508	T		Cath placement, angiography	0080	36.0160	$1,965.07	$838.92	$393.01
93510	T		Left heart catheterization	0080	36.0160	$1,965.07	$838.92	$393.01
93511	T		Left heart catheterization	0080	36.0160	$1,965.07	$838.92	$393.01
93514	T		Left heart catheterization	0080	36.0160	$1,965.07	$838.92	$393.01
93524	T		Left heart catheterization	0080	36.0160	$1,965.07	$838.92	$393.01
93526	T		Rt & Lt heart catheters	0080	36.0160	$1,965.07	$838.92	$393.01
93527	T		Rt & Lt heart catheters	0080	36.0160	$1,965.07	$838.92	$393.01
93528	T		Rt & Lt heart catheters	0080	36.0160	$1,965.07	$838.92	$393.01
93529	T		Rt, lt heart catheterization	0080	36.0160	$1,965.07	$838.92	$393.01
93530	T		Rt heart cath, congenital	0080	36.0160	$1,965.07	$838.92	$393.01
93531	T		R & l heart cath, congenital	0080	36.0160	$1,965.07	$838.92	$393.01
93532	T		R & l heart cath, congenital	0080	36.0160	$1,965.07	$838.92	$393.01
93533	T		R & l heart cath, congenital	0080	36.0160	$1,965.07	$838.92	$393.01
93539	N		Injection, cardiac cath					
93540	N		Injection, cardiac cath					
93541	N		Injection for lung angiogram					
93542	N		Injection for heart x-rays					
93543	N		Injection for heart x-rays					
93544	N		Injection for aortography					
93545	N		Inject for coronary x-rays					
93555	N		Imaging, cardiac cath					
93556	N		Imaging, cardiac cath					
93561	N		Cardiac output measurement					
93562	N		Cardiac output measurement					
93571	N		Heart flow reserve measure					
93572	N		Heart flow reserve measure					
93580	T		Transcath closure of asd	1559		$2,250.00		$450.00
93581	T		Transcath closure of vsd	1559		$2,250.00		$450.00

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93600	T		Bundle of His recording	0087	39.8161	$2,172.41		$434.48
93602	T		Intra-atrial recording	0087	39.8161	$2,172.41		$434.48
93603	T		Right ventricular recording	0087	39.8161	$2,172.41		$434.48
93609	T		Map tachycardia, add-on	0087	39.8161	$2,172.41		$434.48
93610	T		Intra-atrial pacing	0087	39.8161	$2,172.41		$434.48
93612	T		Intraventricular pacing	0087	39.8161	$2,172.41		$434.48
93613	T		Electrophys map 3d, add-on	0087	39.8161	$2,172.41		$434.48
93615	T		Esophageal recording	0087	39.8161	$2,172.41		$434.48
93616	T		Esophageal recording	0087	39.8161	$2,172.41		$434.48
93618	T		Heart rhythm pacing	0087	39.8161	$2,172.41		$434.48
93619	T		Electrophysiology evaluation	0085	35.4126	$1,932.15	$426.25	$386.43
93620	T		Electrophysiology evaluation	0085	35.4126	$1,932.15	$426.25	$386.43
93621	T		Electrophysiology evaluation	0085	35.4126	$1,932.15	$426.25	$386.43
93622	T		Electrophysiology evaluation	0085	35.4126	$1,932.15	$426.25	$386.43
93623	T		Stimulation, pacing heart	0087	39.8161	$2,172.41		$434.48
93624	S		Electrophysiologic study	0084	10.5226	$574.12		$114.82
93631	T		Heart pacing, mapping	0087	39.8161	$2,172.41		$434.48
93640	S		Evaluation heart device	0084	10.5226	$574.12		$114.82
93641	S		Electrophysiology evaluation	0084	10.5226	$574.12		$114.82
93642	S		Electrophysiology evaluation	0084	10.5226	$574.12		$114.82
93650	T		Ablate heart dysrhythm focus	0086	44.9389	$2,451.91	$833.33	$490.38
93651	T		Ablate heart dysrhythm focus	0086	44.9389	$2,451.91	$833.33	$490.38
93652	T		Ablate heart dysrhythm focus	0086	44.9389	$2,451.91	$833.33	$490.38
93660	S		Tilt table evaluation	0101	4.4040	$240.29	$105.27	$48.06
93662	S		Intracardiac ecg (ice)	0670	27.4483	$1,497.61	$542.37	$299.52
93668	E		Peripheral vascular rehab					
93701	S		Bioimpedance, thoracic	0099	0.3703	$20.20		$4.04
93720	B		Total body plethysmography					
93721	X		Plethysmography tracing	0368	0.9319	$50.85	$25.42	$10.17
93722	B		Plethysmography report					
93724	S		Analyze pacemaker system	0690	0.4074	$22.23	$10.63	$4.45
93727	S		Analyze ilr system	0690	0.4074	$22.23	$10.63	$4.45
93731	S		Analyze pacemaker system	0690	0.4074	$22.23	$10.63	$4.45
93732	S		Analyze pacemaker system	0690	0.4074	$22.23	$10.63	$4.45
93733	S		Telephone analy, pacemaker	0690	0.4074	$22.23	$10.63	$4.45
93734	S		Analyze pacemaker system	0690	0.4074	$22.23	$10.63	$4.45
93735	S		Analyze pacemaker system	0690	0.4074	$22.23	$10.63	$4.45
93736	S		Telephonic analy, pacemaker	0690	0.4074	$22.23	$10.63	$4.45
93740	X		Temperature gradient studies	0367	0.5887	$32.12	$15.16	$6.42
93741	S		Analyze ht pace device sngl	0689	0.5533	$30.19		$6.04
93742	S		Analyze ht pace device sngl	0689	0.5533	$30.19		$6.04
93743	S		Analyze ht pace device dual	0689	0.5533	$30.19		$6.04
93744	S		Analyze ht pace device dual	0689	0.5533	$30.19		$6.04
93760	E		Cephalic thermogram					
93762	E		Peripheral thermogram					
93770	N		Measure venous pressure					
93784	E		Ambulatory BP monitoring					
93786	X		Ambulatory BP recording	0097	1.0635	$58.03	$23.80	$11.61
93788	E		Ambulatory BP analysis					
93790	B		Review/report BP recording					
93797	S		Cardiac rehab	0095	0.5994	$32.70	$16.35	$6.54
93798	S		Cardiac rehab/monitor	0095	0.5994	$32.70	$16.35	$6.54
93799	S		Cardiovascular procedure	0096	1.7176	$93.71	$46.85	$18.74
93875	S		Extracranial study	0096	1.7176	$93.71	$46.85	$18.74
93880	S		Extracranial study	0267	2.4586	$134.14	$65.52	$26.83
93882	S		Extracranial study	0267	2.4586	$134.14	$65.52	$26.83
93886	S		Intracranial study	0267	2.4586	$134.14	$65.52	$26.83
93888	S		Intracranial study	0266	1.6117	$87.94	$43.97	$17.59
93922	S		Extremity study	0096	1.7176	$93.71	$46.85	$18.74
93923	S		Extremity study	0096	1.7176	$93.71	$46.85	$18.74
93924	S		Extremity study	0096	1.7176	$93.71	$46.85	$18.74
93925	S		Lower extremity study	0267	2.4586	$134.14	$65.52	$26.83
93926	S		Lower extremity study	0267	2.4586	$134.14	$65.52	$26.83
93930	S		Upper extremity study	0267	2.4586	$134.14	$65.52	$26.83
93931	S		Upper extremity study	0266	1.6117	$87.94	$43.97	$17.59
93965	S		Extremity study	0096	1.7176	$93.71	$46.85	$18.74
93970	S		Extremity study	0267	2.4586	$134.14	$65.52	$26.83
93971	S		Extremity study	0267	2.4586	$134.14	$65.52	$26.83
93975	S		Vascular study	0267	2.4586	$134.14	$65.52	$26.83
93976	S		Vascular study	0267	2.4586	$134.14	$65.52	$26.83
93978	S		Vascular study	0267	2.4586	$134.14	$65.52	$26.83
93979	S		Vascular study	0267	2.4586	$134.14	$65.52	$26.83
93980	S		Penile vascular study	0267	2.4586	$134.14	$65.52	$26.83
93981	S		Penile vascular study	0267	2.4586	$134.14	$65.52	$26.83
93990	S		Doppler flow testing	0267	2.4586	$134.14	$65.52	$26.83

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
94010	X		Breathing capacity test	0368	0.9319	$50.85	$25.42	$10.17
94014	X		Patient recorded spirometry	0367	0.5887	$32.12	$15.16	$6.42
94015	X		Patient recorded spirometry	0369	2.4984	$136.32	$44.18	$27.26
94016	A		Review patient spirometry					
94060	X		Evaluation of wheezing	0368	0.9319	$50.85	$25.42	$10.17
94070	X		Evaluation of wheezing	0369	2.4984	$136.32	$44.18	$27.26
94150	X		Vital capacity test	0367	0.5887	$32.12	$15.16	$6.42
94200	X		Lung function test (MBC/MVV)	0367	0.5887	$32.12	$15.16	$6.42
94240	X		Residual lung capacity	0368	0.9319	$50.85	$25.42	$10.17
94250	X		Expired gas collection	0367	0.5887	$32.12	$15.16	$6.42
94260	X		Thoracic gas volume	0368	0.9319	$50.85	$25.42	$10.17
94350	X		Lung nitrogen washout curve	0368	0.9319	$50.85	$25.42	$10.17
94360	X		Measure airflow resistance	0367	0.5887	$32.12	$15.16	$6.42
94370	X		Breath airway closing volume	0367	0.5887	$32.12	$15.16	$6.42
94375	X		Respiratory flow volume loop	0367	0.5887	$32.12	$15.16	$6.42
94400	X		CO2 breathing response curve	0367	0.5887	$32.12	$15.16	$6.42
94450	X		Hypoxia response curve	0367	0.5887	$32.12	$15.16	$6.42
94620	X		Pulmonary stress test/simple	0368	0.9319	$50.85	$25.42	$10.17
94621	X		Pulm stress test/complex	0369	2.4984	$136.32	$44.18	$27.26
94640	S		Airway inhalation treatment	0077	0.2837	$15.48	$7.74	$3.10
94642	S		Aerosol inhalation treatment	0078	0.7917	$43.20	$14.55	$8.64
94656	S		Initial ventilator mgmt	0079	2.1494	$117.27		$23.45
94657	S		Continued ventilator mgmt	0079	2.1494	$117.27		$23.45
94660	S		Pos airway pressure, CPAP	0068	1.0807	$58.96	$29.48	$11.79
94662	S		Neg press ventilation, cnp	0079	2.1494	$117.27		$23.45
94664	S		Aerosol or vapor inhalations	0077	0.2837	$15.48	$7.74	$3.10
94667	S		Chest wall manipulation	0077	0.2837	$15.48	$7.74	$3.10
94668	S		Chest wall manipulation	0077	0.2837	$15.48	$7.74	$3.10
94680	X		Exhaled air analysis, o2	0367	0.5887	$32.12	$15.16	$6.42
94681	X		Exhaled air analysis, o2/co2	0368	0.9319	$50.85	$25.42	$10.17
94690	X		Exhaled air analysis	0367	0.5887	$32.12	$15.16	$6.42
94720	X		Monoxide diffusing capacity	0368	0.9319	$50.85	$25.42	$10.17
94725	X		Membrane diffusion capacity	0368	0.9319	$50.85	$25.42	$10.17
94750	X		Pulmonary compliance study	0367	0.5887	$32.12	$15.16	$6.42
94760	N		Measure blood oxygen level					
94761	N		Measure blood oxygen level					
94762	N		Measure blood oxygen level					
94770	X		Exhaled carbon dioxide test	0367	0.5887	$32.12	$15.16	$6.42
94772	X		Breath recording, infant	0369	2.4984	$136.32	$44.18	$27.26
94799	X		Pulmonary service/procedure	0367	0.5887	$32.12	$15.16	$6.42
95004	X		Percut allergy skin tests	0370	0.9185	$50.11	$11.58	$10.02
95010	X		Percut allergy titrate test	0370	0.9185	$50.11	$11.58	$10.02
95015	X		Id allergy titrate-drug/bug	0370	0.9185	$50.11	$11.58	$10.02
95024	X		Id allergy test, drug/bug	0370	0.9185	$50.11	$11.58	$10.02
95027	X		Skin end point titration	0370	0.9185	$50.11	$11.58	$10.02
95028	X		Id allergy test-delayed type	0370	0.9185	$50.11	$11.58	$10.02
95044	X		Allergy patch tests	0370	0.9185	$50.11	$11.58	$10.02
95052	X		Photo patch test	0370	0.9185	$50.11	$11.58	$10.02
95056	X		Photosensitivity tests	0370	0.9185	$50.11	$11.58	$10.02
95060	X		Eye allergy tests	0370	0.9185	$50.11	$11.58	$10.02
95065	X		Nose allergy test	0370	0.9185	$50.11	$11.58	$10.02
95070	X		Bronchial allergy tests	0369	2.4984	$136.32	$44.18	$27.26
95071	X		Bronchial allergy tests	0369	2.4984	$136.32	$44.18	$27.26
95075	X		Ingestion challenge test	0361	3.5510	$193.75	$83.23	$38.75
95078	X		Provocative testing	0370	0.9185	$50.11	$11.58	$10.02
95115	X		Immunotherapy, one injection	0352	0.1230	$6.71		$1.34
95117	X		Immunotherapy injections	0353	0.3982	$21.73		$4.35
95120	B		Immunotherapy, one injection					
95125	B		Immunotherapy, many antigens					
95130	B		Immunotherapy, insect venom					
95131	B		Immunotherapy, insect venoms					
95132	B		Immunotherapy, insect venoms					
95133	B		Immunotherapy, insect venoms					
95134	B		Immunotherapy, insect venoms					
95144	X		Antigen therapy services	0371	0.4105	$22.40		$4.48
95145	X		Antigen therapy services	0371	0.4105	$22.40		$4.48
95146	X		Antigen therapy services	0371	0.4105	$22.40		$4.48
95147	X		Antigen therapy services	0371	0.4105	$22.40		$4.48
95148	X		Antigen therapy services	0371	0.4105	$22.40		$4.48
95149	X		Antigen therapy services	0371	0.4105	$22.40		$4.48
95165	X		Antigen therapy services	0371	0.4105	$22.40		$4.48
95170	X		Antigen therapy services	0371	0.4105	$22.40		$4.48
95180	X		Rapid desensitization	0370	0.9185	$50.11	$11.58	$10.02
95199	X		Allergy immunology services	0370	0.9185	$50.11	$11.58	$10.02
95250	T		Glucose monitoring, cont	1540		$150.00		$30.00

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
95805	S		Multiple sleep latency test	0209	11.5435	$629.82	$280.58	$125.96
95806	S		Sleep study, unattended	0213	2.9055	$158.53	$65.74	$31.71
95807	S		Sleep study, attended	0209	11.5435	$629.82	$280.58	$125.96
95808	S		Polysomnography, 1-3	0209	11.5435	$629.82	$280.58	$125.96
95810	S		Polysomnography, 4 or more	0209	11.5435	$629.82	$280.58	$125.96
95811	S		Polysomnography w/cpap	0209	11.5435	$629.82	$280.58	$125.96
95812	S		Electroencephalogram (EEG)	0213	2.9055	$158.53	$65.74	$31.71
95813	S		Eeg, over 1 hour	0213	2.9055	$158.53	$65.74	$31.71
95816	S		Electroencephalogram (EEG)	0214	2.2176	$120.99	$58.12	$24.20
95819	S		Electroencephalogram (EEG)	0214	2.2176	$120.99	$58.12	$24.20
95822	S		Sleep electroencephalogram	0214	2.2176	$120.99	$58.12	$24.20
95824	S		Eeg, cerebral death only	0214	2.2176	$120.99	$58.12	$24.20
95827	S		night electroencephalogram	0209	11.5435	$629.82	$280.58	$125.96
95829	S		Surgery electrocorticogram	0214	2.2176	$120.99	$58.12	$24.20
95830	B		Insert electrodes for EEG					
95831	A		Limb muscle testing, manual					
95832	A		Hand muscle testing, manual					
95833	A		Body muscle testing, manual					
95834	A		Body muscle testing, manual					
95851	A		Range of motion measurements					
95852	A		Range of motion measurements					
95857	S		Tensilon test	0218	1.1404	$62.22		$12.44
95858	S		Tensilon test & myogram	0215	0.6457	$35.23	$15.76	$7.05
95860	S		Muscle test, one limb	0218	1.1404	$62.22		$12.44
95861	S		Muscle test, 2 limbs	0218	1.1404	$62.22		$12.44
95863	S		Muscle test, 3 limbs	0218	1.1404	$62.22		$12.44
95864	S		Muscle test, 4 limbs	0218	1.1404	$62.22		$12.44
95867	S		Muscle test, head or neck	0218	1.1404	$62.22		$12.44
95868	S		Muscle test cran nerve bilat	0218	1.1404	$62.22		$12.44
95869	S		Muscle test, thor paraspinal	0215	0.6457	$35.23	$15.76	$7.05
95870	S		Muscle test, nonparaspinal	0215	0.6457	$35.23	$15.76	$7.05
95872	S		Muscle test, one fiber	0218	1.1404	$62.22		$12.44
95875	S		Limb exercise test	0215	0.6457	$35.23	$15.76	$7.05
95900	S		Motor nerve conduction test	0215	0.6457	$35.23	$15.76	$7.05
95903	S		Motor nerve conduction test	0215	0.6457	$35.23	$15.76	$7.05
95904	S		Sense nerve conduction test	0215	0.6457	$35.23	$15.76	$7.05
95920	S		Intraop nerve test add-on	0216	2.8535	$155.69	$67.98	$31.14
95921	S		Autonomic nerv function test	0218	1.1404	$62.22		$12.44
95922	S		Autonomic nerv function test	0218	1.1404	$62.22		$12.44
95923	S		Autonomic nerv function test	0215	0.6457	$35.23	$15.76	$7.05
95925	S		Somatosensory testing	0216	2.8535	$155.69	$67.98	$31.14
95926	S		Somatosensory testing	0216	2.8535	$155.69	$67.98	$31.14
95927	S		Somatosensory testing	0216	2.8535	$155.69	$67.98	$31.14
95930	S		Visual evoked potential test	0218	1.1404	$62.22		$12.44
95933	S		Blink reflex test	0215	0.6457	$35.23	$15.76	$7.05
95934	S		H-reflex test	0215	0.6457	$35.23	$15.76	$7.05
95936	S		H-reflex test	0215	0.6457	$35.23	$15.76	$7.05
95937	S		Neuromuscular junction test	0218	1.1404	$62.22		$12.44
95950	S		Ambulatory eeg monitoring	0213	2.9055	$158.53	$65.74	$31.71
95951	S		EEG monitoring/videorecord	0209	11.5435	$629.82	$280.58	$125.96
95953	S		EEG monitoring/computer	0209	11.5435	$629.82	$280.58	$125.96
95954	S		EEG monitoring/giving drugs	0214	2.2176	$120.99	$58.12	$24.20
95955	S		EEG during surgery	0213	2.9055	$158.53	$65.74	$31.71
95956	S		Eeg monitoring, cable/radio	0214	2.2176	$120.99	$58.12	$24.20
95957	S		EEG digital analysis	0214	2.2176	$120.99	$58.12	$24.20
95958	S		EEG monitoring/function test	0213	2.9055	$158.53	$65.74	$31.71
95961	S		Electrode stimulation, brain	0216	2.8535	$155.69	$67.98	$31.14
95962	S		Electrode stim, brain add-on	0216	2.8535	$155.69	$67.98	$31.14
95965	S		Meg, spontaneous	1528		$5,250.00		$1,050.00
95966	S		Meg, evoked, single	1516		$1,450.00		$290.00
95967	S		Meg, evoked, each add'l	1511		$950.00		$190.00
95970	S		Analyze neurostim, no prog	0692	1.1057	$60.33	$30.16	$12.07
95971	S		Analyze neurostim, simple	0692	1.1057	$60.33	$30.16	$12.07
95972	S		Analyze neurostim, complex	0692	1.1057	$60.33	$30.16	$12.07
95973	S		Analyze neurostim, complex	0692	1.1057	$60.33	$30.16	$12.07
95974	S		Cranial neurostim, complex	0692	1.1057	$60.33	$30.16	$12.07
95975	S		Cranial neurostim, complex	0692	1.1057	$60.33	$30.16	$12.07
95990	T		Spin/brain pump refil & main	0125	2.1606	$117.88		$23.58
95991	T	NI	Spin/brain pump refil & main	0125	2.1606	$117.88		$23.58
95999	S		Neurological procedure	0215	0.6457	$35.23	$15.76	$7.05
96000	S		Motion analysis, video/3d	1503		$150.00		$30.00
96001	S		Motion test w/ft press meas	1503		$150.00		$30.00
96002	S		Dynamic surface emg	1503		$150.00		$30.00
96003	S		Dynamic fine wire emg	1503		$150.00		$30.00
96004	E		Phys review of motion tests					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
96100	X		Psychological testing	0373	2.0899	$114.03		$22.81
96105	A		Assessment of aphasia					
96110	X		Developmental test, lim	0373	2.0899	$114.03		$22.81
96111	X		Developmental test, extend	0373	2.0899	$114.03		$22.81
96115	X		Neurobehavior status exam	0373	2.0899	$114.03		$22.81
96117	X		Neuropsych test battery	0373	2.0899	$114.03		$22.81
96150	S		Assess hlth/behave, init	0322	1.2802	$69.85		$13.97
96151	S		Assess hlth/behave, subseq	0322	1.2802	$69.85		$13.97
96152	S		Intervene hlth/behave, indiv	0322	1.2802	$69.85		$13.97
96153	S		Intervene hlth/behave, group	0322	1.2802	$69.85		$13.97
96154	S		Interv hlth/behav, fam w/pt	0322	1.2802	$69.85		$13.97
96155	S		Interv hlth/behav fam no pt	0322	1.2802	$69.85		$13.97
96400	B		Chemotherapy, sc/im					
96405	B		Intralesional chemo admin					
96406	B		Intralesional chemo admin					
96408	B		Chemotherapy, push technique					
96410	B		Chemotherapy,infusion method					
96412	B		Chemo, infuse method add-on					
96414	B		Chemo, infuse method add-on					
96420	B		Chemotherapy, push technique					
96422	B		Chemotherapy,infusion method					
96423	B		Chemo, infuse method add-on					
96425	B		Chemotherapy,infusion method					
96440	B		Chemotherapy, intracavitary					
96445	B		Chemotherapy, intracavitary					
96450	B		Chemotherapy, into CNS					
96520	T		Port pump refill & main	0125	2.1606	$117.88		$23.58
96530	T		Pump refilling, maintenance	0125	2.1606	$117.88		$23.58
96542	B		Chemotherapy injection					
96545	B		Provide chemotherapy agent					
96549	B		Chemotherapy, unspecified					
96567	T		Photodynamic tx, skin	1540		$150.00		$30.00
96570	T		Photodynamic tx, 30 min	1541		$250.00		$50.00
96571	T		Photodynamic tx, addl 15 min	1541		$250.00		$50.00
96900	S		Ultraviolet light therapy	0001	0.4237	$23.12	$7.09	$4.62
96902	N		Trichogram					
96910	S		Photochemotherapy with UV-B	0001	0.4237	$23.12	$7.09	$4.62
96912	S		Photochemotherapy with UV-A	0001	0.4237	$23.12	$7.09	$4.62
96913	S		Photochemotherapy, UV-A or B	0683	1.5489	$84.51	$30.42	$16.90
96920	T		Laser tx, skin < 250 sq cm	0012	0.7694	$41.98	$11.18	$8.40
96921	T		Laser tx, skin 250-500 sq cm	0012	0.7694	$41.98	$11.18	$8.40
96922	T		Laser tx, skin > 500 sq cm	0013	1.1272	$61.50	$14.20	$12.30
96999	T		Dermatological procedure	0010	0.6480	$35.36	$10.08	$7.07
97001	A		Pt evaluation					
97002	A		Pt re-evaluation					
97003	A		Ot evaluation					
97004	A		Ot re-evaluation					
97005	E		Athletic train eval					
97006	E		Athletic train reeval					
97010	A		Hot or cold packs therapy					
97012	A		Mechanical traction therapy					
97014	E		Electric stimulation therapy					
97016	A		Vasopneumatic device therapy					
97018	A		Paraffin bath therapy					
97020	A		Microwave therapy					
97022	A		Whirlpool therapy					
97024	A		Diathermy treatment					
97026	A		Infrared therapy					
97028	A		Ultraviolet therapy					
97032	A		Electrical stimulation					
97033	A		Electric current therapy					
97034	A		Contrast bath therapy					
97035	A		Ultrasound therapy					
97036	A		Hydrotherapy					
97039	A		Physical therapy treatment					
97110	A		Therapeutic exercises					
97112	A		Neuromuscular reeducation					
97113	A		Aquatic therapy/exercises					
97116	A		Gait training therapy					
97124	A		Massage therapy					
97139	A		Physical medicine procedure					
97140	A		Manual therapy					
97150	A		Group therapeutic procedures					
97504	A		Orthotic training					
97520	A		Prosthetic training					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
97530	A		Therapeutic activities					
97532	A		Cognitive skills development					
97533	A		Sensory integration					
97535	A		Self care mngment training					
97537	A		Community/work reintegration					
97542	A		Wheelchair mngment training					
97545	A		Work hardening					
97546	A		Work hardening add-on					
97601	A		Wound(s) care, selective					
97602	N		Wound(s) care non-selective					
97703	A		Prosthetic checkout					
97750	A		Physical performance test					
97755	A	NI	Assistive technology assess					
97780	E		Acupuncture w/o stimul					
97781	E		Acupuncture w/stimul					
97799	A		Physical medicine procedure					
97802	A		Medical nutrition, indiv, in					
97803	A		Med nutrition, indiv, subseq					
97804	A		Medical nutrition, group					
98925	S		Osteopathic manipulation	0060	0.2788	$15.21		$3.04
98926	S		Osteopathic manipulation	0060	0.2788	$15.21		$3.04
98927	S		Osteopathic manipulation	0060	0.2788	$15.21		$3.04
98928	S		Osteopathic manipulation	0060	0.2788	$15.21		$3.04
98929	S		Osteopathic manipulation	0060	0.2788	$15.21		$3.04
98940	S		Chiropractic manipulation	0060	0.2788	$15.21		$3.04
98941	S		Chiropractic manipulation	0060	0.2788	$15.21		$3.04
98942	S		Chiropractic manipulation	0060	0.2788	$15.21		$3.04
98943	E		Chiropractic manipulation					
99000	B		Specimen handling					
99001	B		Specimen handling					
99002	E		Device handling					
99024	B		Postop follow-up visit					
99025	B	DG	Initial surgical evaluation					
99026	E		In-hospital on call service					
99027	E		Out-of-hosp on call service					
99050	B		Medical services after hrs					
99052	B		Medical services at night					
99054	B		Medical servcs, unusual hrs					
99056	B		Non-office medical services					
99058	B		Office emergency care					
99070	B		Special supplies					
99071	B		Patient education materials					
99075	E		Medical testimony					
99078	N		Group health education					
99080	B		Special reports or forms					
99082	B		Unusual physician travel					
99090	B		Computer data analysis					
99091	E		Collect/review data from pt					
99100	B		Special anesthesia service					
99116	B		Anesthesia with hypothermia					
99135	B		Special anesthesia procedure					
99140	E		Emergency anesthesia					
99141	N		Sedation, iv/im or inhalant					
99142	N		Sedation, oral/rectal/nasal					
99170	T		Anogenital exam, child	0191	0.1853	$10.11	$2.93	$2.02
99172	E		Ocular function screen					
99173	E		Visual acuity screen					
99175	N		Induction of vomiting					
99183	B		Hyperbaric oxygen therapy					
99185	N		Regional hypothermia					
99186	N		Total body hypothermia					
99190	C		Special pump services					
99191	C		Special pump services					
99192	C		Special pump services					
99195	X		Phlebotomy	0372	0.5607	$30.59	$10.09	$6.12
99199	B		Special service/proc/report					
99201	V		Office/outpatient visit, new	0600	0.9278	$50.62		$10.12
99202	V		Office/outpatient visit, new	0600	0.9278	$50.62		$10.12
99203	V		Office/outpatient visit, new	0601	0.9816	$53.56		$10.71
99204	V		Office/outpatient visit, new	0602	1.5041	$82.07		$16.41
99205	V		Office/outpatient visit, new	0602	1.5041	$82.07		$16.41
99211	V		Office/outpatient visit, est	0600	0.9278	$50.62		$10.12
99212	V		Office/outpatient visit, est	0600	0.9278	$50.62		$10.12
99213	V		Office/outpatient visit, est	0601	0.9816	$53.56		$10.71
99214	V		Office/outpatient visit, est	0602	1.5041	$82.07		$16.41

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
99215	V		Office/outpatient visit, est	0602	1.5041	$82.07		$16.41
99217	N		Observation care discharge					
99218	N		Observation care					
99219	N		Observation care					
99220	N		Observation care					
99221	E		Initial hospital care					
99222	E		Initial hospital care					
99223	E		Initial hospital care					
99231	E		Subsequent hospital care					
99232	E		Subsequent hospital care					
99233	E		Subsequent hospital care					
99234	N		Observ/hosp same date					
99235	N		Observ/hosp same date					
99236	N		Observ/hosp same date					
99238	E		Hospital discharge day					
99239	E		Hospital discharge day					
99241	V		Office consultation	0600	0.9278	$50.62		$10.12
99242	V		Office consultation	0600	0.9278	$50.62		$10.12
99243	V		Office consultation	0601	0.9816	$53.56		$10.71
99244	V		Office consultation	0602	1.5041	$82.07		$16.41
99245	V		Office consultation	0602	1.5041	$82.07		$16.41
99251	C		Initial inpatient consult					
99252	C		Initial inpatient consult					
99253	C		Initial inpatient consult					
99254	C		Initial inpatient consult					
99255	C		Initial inpatient consult					
99261	C		Follow-up inpatient consult					
99262	C		Follow-up inpatient consult					
99263	C		Follow-up inpatient consult					
99271	V		Confirmatory consultation	0600	0.9278	$50.62		$10.12
99272	V		Confirmatory consultation	0600	0.9278	$50.62		$10.12
99273	V		Confirmatory consultation	0601	0.9816	$53.56		$10.71
99274	V		Confirmatory consultation	0602	1.5041	$82.07		$16.41
99275	V		Confirmatory consultation	0602	1.5041	$82.07		$16.41
99281	V		Emergency dept visit	0610	1.3691	$74.70	$19.57	$14.94
99282	V		Emergency dept visit	0610	1.3691	$74.70	$19.57	$14.94
99283	V		Emergency dept visit	0611	2.3967	$130.77	$36.16	$26.15
99284	V		Emergency dept visit	0612	4.1476	$226.30	$54.12	$45.26
99285	V		Emergency dept visit	0612	4.1476	$226.30	$54.12	$45.26
99288	B		Direct advanced life support					
99289	N		Pt transport, 30-74 min					
99290	N		Pt transport, addl 30 min					
99291	S		Critical care, first hour	0620	8.9992	$491.01	$142.30	$98.20
99292	N		Critical care, add'l 30 min					
99293	C		Ped critical care, initial					
99294	C		Ped critical care, subseq					
99295	C		Neonatal critical care					
99296	C		Neonatal critical care					
99298	C		Neonatal critical care					
99299	C		Ic, lbw infant 1500-2500 gm					
99301	B		Nursing facility care					
99302	B		Nursing facility care					
99303	B		Nursing facility care					
99311	B		Nursing fac care, subseq					
99312	B		Nursing fac care, subseq					
99313	B		Nursing fac care, subseq					
99315	B		Nursing fac discharge day					
99316	B		Nursing fac discharge day					
99321	B		Rest home visit, new patient					
99322	B		Rest home visit, new patient					
99323	B		Rest home visit, new patient					
99331	B		Rest home visit, est pat					
99332	B		Rest home visit, est pat					
99333	B		Rest home visit, est pat					
99341	B		Home visit, new patient					
99342	B		Home visit, new patient					
99343	B		Home visit, new patient					
99344	B		Home visit, new patient					
99345	B		Home visit, new patient					
99347	B		Home visit, est patient					
99348	B		Home visit, est patient					
99349	B		Home visit, est patient					
99350	B		Home visit, est patient					
99354	N		Prolonged service, office					
99355	N		Prolonged service, office					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
99356	C		Prolonged service, inpatient					
99357	C		Prolonged service, inpatient					
99358	N		Prolonged serv, w/o contact					
99359	N		Prolonged serv, w/o contact					
99360	B		Physician standby services					
99361	E		Physician/team conference					
99362	E		Physician/team conference					
99371	B		Physician phone consultation					
99372	B		Physician phone consultation					
99373	B		Physician phone consultation					
99374	B		Home health care supervision					
99377	B		Hospice care supervision					
99379	B		Nursing fac care supervision					
99380	B		Nursing fac care supervision					
99381	E		Prev visit, new, infant					
99382	E		Prev visit, new, age 1-4					
99383	E		Prev visit, new, age 5-11					
99384	E		Prev visit, new, age 12-17					
99385	E		Prev visit, new, age 18-39					
99386	E		Prev visit, new, age 40-64					
99387	E		Prev visit, new, 65 & over					
99391	E		Prev visit, est, infant					
99392	E		Prev visit, est, age 1-4					
99393	E		Prev visit, est, age 5-11					
99394	E		Prev visit, est, age 12-17					
99395	E		Prev visit, est, age 18-39					
99396	E		Prev visit, est, age 40-64					
99397	E		Prev visit, est, 65 & over					
99401	E		Preventive counseling, indiv					
99402	E		Preventive counseling, indiv					
99403	E		Preventive counseling, indiv					
99404	E		Preventive counseling, indiv					
99411	E		Preventive counseling, group					
99412	E		Preventive counseling, group					
99420	E		Health risk assessment test					
99429	E		Unlisted preventive service					
99431	V		Initial care, normal newborn	0600	0.9278	$50.62		$10.12
99432	N		Newborn care, not in hosp					
99433	C		Normal newborn care/hospital					
99435	E		Newborn discharge day hosp					
99436	N		Attendance, birth					
99440	S		Newborn resuscitation	0094	2.6345	$143.74	$48.58	$28.75
99450	E		Life/disability evaluation					
99455	B		Disability examination					
99456	B		Disability examination					
99499	B		Unlisted e&m service					
99500	E		Home visit, prenatal					
99501	E		Home visit, postnatal					
99502	E		Home visit, nb care					
99503	E		Home visit, resp therapy					
99504	E		Home visit mech ventilator					
99505	E		Home visit, stoma care					
99506	E		Home visit, im injection					
99507	E		Home visit, cath maintain					
99509	E		Home visit day life activity					
99510	E		Home visit, sing/m/fam couns					
99511	E		Home visit, fecal/enema mgmt					
99512	E		Home visit for hemodialysis					
99551	E	DG	Home infus, pain mgmt, iv/sc					
99552	E	DG	Hm infus pain mgmt, epid/ith					
99553	E	DG	Home infuse, tocolytic tx					
99554	E	DG	Home infus, hormone/platelet					
99555	E	DG	Home infuse, chemotheraphy					
99556	E	DG	Home infus, antibio/fung/vir					
99557	E	DG	Home infuse, anticoagulant					
99558	E	DG	Home infuse, immunotherapy					
99559	E	DG	Home infus, periton dialysis					
99560	E	DG	Home infus, entero nutrition					
99561	E	DG	Home infuse, hydration tx					
99562	E	DG	Home infus, parent nutrition					
99563	E	DG	Home admin, pentamidine					
99564	E	DG	Hme infus, antihemophil agnt					
99565	E	DG	Home infus, proteinase inhib					
99566	E	DG	Home infuse, iv therapy					
99567	E	DG	Home infuse, sympath agent					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
99568	E	DG	Home infus, misc drug, daily					
99569	E	DG	Home infuse, each addl tx					
99600	E		Home visit nos					
99601	E	NI	Home infusion/visit, 2 hrs					
99602	E	NI	Home infusion, each addtl hr					
A0021	E		Outside state ambulance serv					
A0080	E		Noninterest escort in non er					
A0090	E		Interest escort in non er					
A0100	E		Nonemergency transport taxi					
A0110	E		Nonemergency transport bus					
A0120	E		Noner transport mini-bus					
A0130	E		Noner transport wheelch van					
A0140	E		Nonemergency transport air					
A0160	E		Noner transport case worker					
A0170	E		Noner transport parking fees					
A0180	E		Noner transport lodgng recip					
A0190	E		Noner transport meals recip					
A0200	E		Noner transport lodgng escrt					
A0210	E		Noner transport meals escort					
A0225	A		Neonatal emergency transport					
A0380	A		Basic life support mileage					
A0382	A		Basic support routine suppls					
A0384	A		Bls defibrillation supplies					
A0390	A		Advanced life support mileag					
A0392	A		Als defibrillation supplies					
A0394	A		Als IV drug therapy supplies					
A0396	A		Als esophageal intub suppls					
A0398	A		Als routine disposble suppls					
A0420	A		Ambulance waiting 1/2 hr					
A0422	A		Ambulance 02 life sustaining					
A0424	A		Extra ambulance attendant					
A0425	A		Ground mileage					
A0426	A		Als 1					
A0427	A		ALS1-emergency					
A0428	A		bls					
A0429	A		BLS-emergency					
A0430	A		Fixed wing air transport					
A0431	A		Rotary wing air transport					
A0432	A		PI volunteer ambulance co					
A0433	A		als 2					
A0434	A		Specialty care transport					
A0435	A		Fixed wing air mileage					
A0436	A		Rotary wing air mileage					
A0800	A		Amb trans 7pm-7am					
A0888	E		Noncovered ambulance mileage					
A0999	A		Unlisted ambulance service					
A4206	A		1 CC sterile syringe&needle					
A4207	A		2 CC sterile syringe&needle					
A4208	A		3 CC sterile syringe&needle					
A4209	E		5+ CC sterile syringe&needle					
A4210	E		Nonneedle injection device					
A4211	B		Supp for self-adm injections					
A4212	B		Non coring needle or stylet					
A4213	E		20+ CC syringe only					
A4214	A	DG	30 CC sterile water/saline					
A4215	E		Sterile needle					
A4216	A	NI	Sterile water/saline, 10 ml					
A4217	A	NI	Sterile water/saline, 500 ml					
A4220	N	NI	Infusion pump refill kit					
A4221	A		Maint drug infus cath per wk					
A4222	A		Drug infusion pump supplies					
A4230	A		Infus insulin pump non needl					
A4231	A		Infusion insulin pump needle					
A4232	E		Syringe w/needle insulin 3cc					
A4244	E		Alcohol or peroxide per pint					
A4245	E		Alcohol wipes per box					
A4246	E		Betadine/phisohex solution					
A4247	E		Betadine/iodine swabs/wipes					
A4248	N		Chlorhexidine antisept					
A4250	E		Urine reagent strips/tablets					
A4253	A		Blood glucose/reagent strips					
A4254	A		Battery for glucose monitor					
A4255	A		Glucose monitor platforms					
A4256	A		Calibrator solution/chips					
A4257	A		Replace Lensshield Cartridge					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4258	A		Lancet device each					
A4259	A		Lancets per box					
A4260	E		Levonorgestrel implant					
A4261	E		Cervical cap contraceptive					
A4262	N		Temporary tear duct plug					
A4263	N		Permanent tear duct plug					
A4265	A		Paraffin					
A4266	E		Diaphragm					
A4267	E		Male condom					
A4268	E		Female condom					
A4269	E		Spermicide					
A4270	A		Disposable endoscope sheath					
A4280	A		Brst prsths adhsv attchmnt					
A4281	E		Replacement breastpump tube					
A4282	E		Replacement breastpump adpt					
A4283	E		Replacement breastpump cap					
A4284	E		Replcmnt breast pump shield					
A4285	E		Replcmnt breast pump bottle					
A4286	E		Replcmnt breastpump lok ring					
A4290	E		Sacral nerve stim test lead					
A4300	N		Cath impl vasc access portal					
A4301	N		Implantable access syst perc					
A4305	A		Drug delivery system >=50 ML					
A4306	A		Drug delivery system <=5 ML					
A4310	A		Insert tray w/o bag/cath					
A4311	A		Catheter w/o bag 2-way latex					
A4312	A		Cath w/o bag 2-way silicone					
A4313	A		Catheter w/bag 3-way					
A4314	A		Cath w/drainage 2-way latex					
A4315	A		Cath w/drainage 2-way silcne					
A4316	A		Cath w/drainage 3-way					
A4319	A	DG	Sterile H2O irrigation solut					
A4320	A		Irrigation tray					
A4321	A		Cath therapeutic irrig agent					
A4322	A		Irrigation syringe					
A4323	A	DG	Saline irrigation solution					
A4324	A		Male ext cath w/adh coating					
A4325	A		Male ext cath w/adh strip					
A4326	A		Male external catheter					
A4327	A		Fem urinary collect dev cup					
A4328	A		Fem urinary collect pouch					
A4330	A		Stool collection pouch					
A4331	A		Extension drainage tubing					
A4332	A		Lubricant for cath insertion					
A4333	A		Urinary cath anchor device					
A4334	A		Urinary cath leg strap					
A4335	A		Incontinence supply					
A4338	A		Indwelling catheter latex					
A4340	A		Indwelling catheter special					
A4344	A		Cath indw foley 2 way silicn					
A4346	A		Cath indw foley 3 way					
A4347	A		Male external catheter					
A4348	A		Male ext cath extended wear					
A4351	A		Straight tip urine catheter					
A4352	A		Coude tip urinary catheter					
A4353	A		Intermittent urinary cath					
A4354	A		Cath insertion tray w/bag					
A4355	A		Bladder irrigation tubing					
A4356	A		Ext ureth clmp or compr dvc					
A4357	A		Bedside drainage bag					
A4358	A		Urinary leg or abdomen bag					
A4359	A		Urinary suspensory w/o leg b					
A4361	A		Ostomy face plate					
A4362	A		Solid skin barrier					
A4364	A		Adhesive, liquid or equal					
A4365	A		Adhesive remover wipes					
A4366	A		Ostomy vent					
A4367	A		Ostomy belt					
A4368	A		Ostomy filter					
A4369	A		Skin barrier liquid per oz					
A4371	A		Skin barrier powder per oz					
A4372	A		Skin barrier solid 4x4 equiv					
A4373	A		Skin barrier with flange					
A4375	A		Drainable plastic pch w fcpl					
A4376	A		Drainable rubber pch w fcplt					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4377	A		Drainable plstic pch w/o fp					
A4378	A		Drainable rubber pch w/o fp					
A4379	A		Urinary plastic pouch w fcpl					
A4380	A		Urinary rubber pouch w fcplt					
A4381	A		Urinary plastic pouch w/o fp					
A4382	A		Urinary hvy plstc pch w/o fp					
A4383	A		Urinary rubber pouch w/o fp					
A4384	A		Ostomy faceplt/silicone ring					
A4385	A		Ost skn barrier sld ext wear					
A4387	A		Ost clsd pouch w att st barr					
A4388	A		Drainable pch w ex wear barr					
A4389	A		Drainable pch w st wear barr					
A4390	A		Drainable pch ex wear convex					
A4391	A		Urinary pouch w ex wear barr					
A4392	A		Urinary pouch w st wear barr					
A4393	A		Urine pch w ex wear bar conv					
A4394	A		Ostomy pouch liq deodorant					
A4395	A		Ostomy pouch solid deodorant					
A4396	A		Peristomal hernia supprt blt					
A4397	A		Irrigation supply sleeve					
A4398	A		Ostomy irrigation bag					
A4399	A		Ostomy irrig cone/cath w brs					
A4400	A		Ostomy irrigation set					
A4402	A		Lubricant per ounce					
A4404	A		Ostomy ring each					
A4405	A		Nonpectin based ostomy paste					
A4406	A		Pectin based ostomy paste					
A4407	A		Ext wear ost skn barr <=4sq≧					
A4408	A		Ext wear ost skn barr >4sq≧					
A4409	A		Ost skn barr w flng <=4 sq≧					
A4410	A		Ost skn barr w flng >4sq≧					
A4413	A		2 pc drainable ost pouch					
A4414	A		Ostomy sknbarr w flng <=4sq≧					
A4415	A		Ostomy skn barr w flng >4sq≧					
A4416	A	NI	Ost pch clsd w barrier/filtr					
A4417	A	NI	Ost pch w bar/bltinconv/fltr					
A4418	A	NI	Ost pch clsd w/o bar w filtr					
A4419	A	NI	Ost pch for bar w flange/flt					
A4420	A	NI	Ost pch clsd for bar w lk fl					
A4421	A		Ostomy supply misc					
A4422	A		Ost pouch absorbent material					
A4424	A	NI	Ost pch drain w bar & filter					
A4425	A	NI	Ost pch drain for barrier fl					
A4426	A	NI	Ost pch drain 2 piece system					
A4427	A	NI	Ost pch drain/barr lk flng/f					
A4428	A	NI	Urine ost pouch w faucet/tap					
A4429	A	NI	Urine ost pch bar w lock fln					
A4430	A	NI	Ost pch urine w lock flng/ft					
A4431	A	NI	Urine ost pch bar w lock fln					
A4432	A	NI	Ost pch urine w lock flng/ft					
A4433	A	NI	Urine ost pch bar w lock fln					
A4434	A	NI	Ost pch urine w lock flng/ft					
A4450	A		Non-waterproof tape					
A4452	A		Waterproof tape					
A4455	A		Adhesive remover per ounce					
A4458	E		Reusable enema bag					
A4462	A		Abdmnl drssng holder/binder					
A4465	A		Non-elastic extremity binder					
A4470	A		Gravlee jet washer					
A4480	A		Vabra aspirator					
A4481	A		Tracheostoma filter					
A4483	A		Moisture exchanger					
A4490	E		Above knee surgical stocking					
A4495	E		Thigh length surg stocking					
A4500	E		Below knee surgical stocking					
A4510	E		Full length surg stocking					
A4521	E		Adult size diaper sm each					
A4522	E		Adult size diaper med each					
A4523	E		Adult size diaper lg each					
A4524	E		Adult size diaper xl each					
A4525	E		Adult size brief sm each					
A4526	E		Adult size brief med each					
A4527	E		Adult size brief lg each					
A4528	E		Adult size brief xl each					
A4529	E		Child size diaper sm/med ea					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4530	E		Child size diaper lg each					
A4531	E		Child size brief sm/med each					
A4532	E		Child size brief lg each					
A4533	E		Youth size diaper each					
A4534	E		Youth size brief each					
A4535	E		Disp incont liner/shield ea					
A4536	E		Prot underwr wshbl any sz ea					
A4537	E		Under pad reusable any sz ea					
A4538	E		Reusable diaper from dpr svc					
A4550	B		Surgical trays					
A4554	E		Disposable underpads					
A4556	A		Electrodes, pair					
A4557	A		Lead wires, pair					
A4558	A		Conductive paste or gel					
A4561	N		Pessary rubber, any type					
A4562	N		Pessary, non rubber,any type					
A4565	A		Slings					
A4570	E		Splint					
A4575	E		Hyperbaric o2 chamber disps					
A4580	E		Cast supplies (plaster)					
A4590	E		Special casting material					
A4595	A		TENS suppl 2 lead per month					
A4606	A		Oxygen probe used w oximeter					
A4608	A		Transtracheal oxygen cath					
A4609	A		Trach suction cath clsed sys					
A4610	A		Trach sctn cath 72h clsedsys					
A4611	A		Heavy duty battery					
A4612	A		Battery cables					
A4613	A		Battery charger					
A4614	A		Hand-held PEFR meter					
A4615	A		Cannula nasal					
A4616	A		Tubing (oxygen) per foot					
A4617	A		Mouth piece					
A4618	A		Breathing circuits					
A4619	A		Face tent					
A4620	A		Variable concentration mask					
A4621	A	DG	Tracheotomy mask or collar					
A4622	A	DG	Tracheostomy or laringectomy					
A4623	A		Tracheostomy inner cannula					
A4624	A		Tracheal suction tube					
A4625	A		Trach care kit for new trach					
A4626	A		Tracheostomy cleaning brush					
A4627	E		Spacer bag/reservoir					
A4628	A		Oropharyngeal suction cath					
A4629	A		Tracheostomy care kit					
A4630	A		Repl bat t.e.n.s. own by pt					
A4631	A	DG	Wheelchair battery					
A4632	E		Infus pump rplcemnt battery					
A4633	A*		Uvl replacement bulb					
A4634	A		Replacement bulb th lightbox					
A4635	A		Underarm crutch pad					
A4636	A		Handgrip for cane etc					
A4637	A		Repl tip cane/crutch/walker					
A4638	Y	NI	Repl batt pulse gen sys					
A4639	A		Infrared ht sys replcmnt pad					
A4640	A		Alternating pressure pad					
A4641	N		Diagnostic imaging agent					
A4642	K		Satumomab pendetide per dose	0704	2.2811	$124.46		$24.89
A4643	N		High dose contrast MRI					
A4644	N	DG	Contrast 100-199 MGs iodine					
A4645	N	DG	Contrast 200-299 MGs iodine					
A4646	N	DG	Contrast 300-399 MGs iodine					
A4647	N		Supp- paramagnetic contr mat					
A4649	A		Surgical supplies					
A4651	A		Calibrated microcap tube					
A4652	A		Microcapillary tube sealant					
A4653	A		PD catheter anchor belt					
A4656	A		Dialysis needle					
A4657	A		Dialysis syringe w/wo needle					
A4660	A		Sphyg/bp app w cuff and stet					
A4663	A		Dialysis blood pressure cuff					
A4670	E		Automatic bp monitor, dial					
A4671	E	NI	Disposable cycler set					
A4672	E	NI	Drainage ext line, dialysis					
A4673	E	NI	Ext line w easy lock connect					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4674	E	NI	Chem/antisept solution, 8oz					
A4680	A		Activated carbon filter, ea					
A4690	A		Dialyzer, each					
A4706	A		Bicarbonate conc sol per gal					
A4707	A		Bicarbonate conc pow per pac					
A4708	A		Acetate conc sol per gallon					
A4709	A		Acid conc sol per gallon					
A4712	A	DG	Sterile water inj per 10 ml					
A4714	A		Treated water per gallon					
A4719	A		≧Y set≧ tubing					
A4720	A		Dialysat sol fld vol > 249cc					
A4721	A		Dialysat sol fld vol > 999cc					
A4722	A		Dialys sol fld vol > 1999cc					
A4723	A		Dialys sol fld vol > 2999cc					
A4724	A		Dialys sol fld vol > 3999cc					
A4725	A		Dialys sol fld vol > 4999cc					
A4726	A		Dialys sol fld vol > 5999cc					
A4728	E	NI	Dialysate solution, non-dex					
A4730	A		Fistula cannulation set, ea					
A4736	A		Topical anesthetic, per gram					
A4737	A		Inj anesthetic per 10 ml					
A4740	A		Shunt accessory					
A4750	A		Art or venous blood tubing					
A4755	A		Comb art/venous blood tubing					
A4760	A		Dialysate sol test kit, each					
A4765	A		Dialysate conc pow per pack					
A4766	A		Dialysate conc sol add 10 ml					
A4770	A		Blood collection tube/vacuum					
A4771	A		Serum clotting time tube					
A4772	A		Blood glucose test strips					
A4773	A		Occult blood test strips					
A4774	A		Ammonia test strips					
A4802	A		Protamine sulfate per 50 mg					
A4860	A		Disposable catheter tips					
A4870	A		Plumb/elec wk hm hemo equip					
A4890	A		Repair/maint cont hemo equip					
A4911	A		Drain bag/bottle					
A4913	A		Misc dialysis supplies noc					
A4918	A		Venous pressure clamp					
A4927	A		Non-sterile gloves					
A4928	A		Surgical mask					
A4929	A		Tourniquet for dialysis, ea					
A4930	A		Sterile, gloves per pair					
A4931	A		Reusable oral thermometer					
A4932	E		Reusable rectal thermometer					
A5051	A		Pouch clsd w barr attached					
A5052	A		Clsd ostomy pouch w/o barr					
A5053	A		Clsd ostomy pouch faceplate					
A5054	A		Clsd ostomy pouch w/flange					
A5055	A		Stoma cap					
A5061	A		Pouch drainable w barrier at					
A5062	A		Dmble ostomy pouch w/o barr					
A5063	A		Drain ostomy pouch w/flange					
A5071	A		Urinary pouch w/barrier					
A5072	A		Urinary pouch w/o barrier					
A5073	A		Urinary pouch on barr w/flng					
A5081	A		Continent stoma plug					
A5082	A		Continent stoma catheter					
A5093	A		Ostomy accessory convex inse					
A5102	A		Bedside drain btl w/wo tube					
A5105	A		Urinary suspensory					
A5112	A		Urinary leg bag					
A5113	A		Latex leg strap					
A5114	A		Foam/fabric leg strap					
A5119	A		Skin barrier wipes box pr 50					
A5121	A		Solid skin barrier 6x6					
A5122	A		Solid skin barrier 8x8					
A5126	A		Disk/foam pad +or- adhesive					
A5131	A		Appliance cleaner					
A5200	A		Percutaneous catheter anchor					
A5500	A		Diab shoe for density insert					
A5501	A		Diabetic custom molded shoe					
A5503	A		Diabetic shoe w/roller/rockr					
A5504	A		Diabetic shoe with wedge					
A5505	A		Diab shoe w/metatarsal bar					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A5506	A		Diabetic shoe w/off set heel					
A5507	A		Modification diabetic shoe					
A5508	A		Diabetic deluxe shoe					
A5509	A		Direct heat form shoe insert					
A5510	A		Compression form shoe insert					
A5511	A		Custom fab molded shoe inser					
A6000	E		Wound warming wound cover					
A6010	A		Collagen based wound filler					
A6011	A		Collagen gel/paste wound fil					
A6021	A		Collagen dressing <=16 sq in					
A6022	A		Collagen drsg>6<=48 sq in					
A6023	A		Collagen dressing >48 sq in					
A6024	A		Collagen dsg wound filler					
A6025	E		Silicone gel sheet, each					
A6154	A		Wound pouch each					
A6196	A		Alginate dressing <=16 sq in					
A6197	A		Alginate drsg >16 <=48 sq in					
A6198	A		alginate dressing > 48 sq in					
A6199	A		Alginate drsg wound filler					
A6200	A		Compos drsg <=16 no border					
A6201	A		Compos drsg >16<=48 no bdr					
A6202	A		Compos drsg >48 no border					
A6203	A		Composite drsg <= 16 sq in					
A6204	A		Composite drsg >16<=48 sq in					
A6205	A		Composite drsg > 48 sq in					
A6206	A		Contact layer <= 16 sq in					
A6207	A		Contact layer >16<= 48 sq in					
A6208	A		Contact layer > 48 sq in					
A6209	A		Foam drsg <=16 sq in w/o bdr					
A6210	A		Foam drg >16<=48 sq in w/o b					
A6211	A		Foam drg > 48 sq in w/o brdr					
A6212	A		Foam drg <=16 sq in w/border					
A6213	A		Foam drg >16<=48 sq in w/bdr					
A6214	A		Foam drg > 48 sq in w/border					
A6215	A		Foam dressing wound filler					
A6216	A		Non-sterile gauze<=16 sq in					
A6217	A		Non-sterile gauze>16<=48 sq					
A6218	A		Non-sterile gauze > 48 sq in					
A6219	A		Gauze <= 16 sq in w/border					
A6220	A		Gauze >16 <=48 sq in w/bordr					
A6221	A		Gauze > 48 sq in w/border					
A6222	A		Gauze <=16 in no w/sal w/o b					
A6223	A		Gauze >16<=48 no w/sal w/o b					
A6224	A		Gauze > 48 in no w/sal w/o b					
A6228	A		Gauze <= 16 sq in water/sal					
A6229	A		Gauze >16<=48 sq in watr/sal					
A6230	A		Gauze > 48 sq in water/salne					
A6231	A		Hydrogel dsg<=16 sq in					
A6232	A		Hydrogel dsg>16<=48 sq in					
A6233	A		Hydrogel dressing >48 sq in					
A6234	A		Hydrocolld drg <=16 w/o bdr					
A6235	A		Hydrocolld drg >16<=48 w/o b					
A6236	A		Hydrocolld drg > 48 in w/o b					
A6237	A		Hydrocolld drg <=16 in w/bdr					
A6238	A		Hydrocolld drg >16<=48 w/bdr					
A6239	A		Hydrocolld drg > 48 in w/bdr					
A6240	A		Hydrocolld drg filler paste					
A6241	A		Hydrocolloid drg filler dry					
A6242	A		Hydrogel drg <=16 in w/o bdr					
A6243	A		Hydrogel drg >16<=48 w/o bdr					
A6244	A		Hydrogel drg >48 in w/o bdr					
A6245	A		Hydrogel drg <= 16 in w/bdr					
A6246	A		Hydrogel drg >16<=48 in w/b					
A6247	A		Hydrogel drg > 48 sq in w/b					
A6248	A		Hydrogel drsg gel filler					
A6250	A		Skin seal protect moisturizr					
A6251	A		Absorpt drg <=16 sq in w/o b					
A6252	A		Absorpt drg >16 <=48 w/o bdr					
A6253	A		Absorpt drg > 48 sq in w/o b					
A6254	A		Absorpt drg <=16 sq in w/bdr					
A6255	A		Absorpt drg >16<=48 in w/bdr					
A6256	A		Absorpt drg > 48 sq in w/bdr					
A6257	A		Transparent film <= 16 sq in					
A6258	A		Transparent film >16<=48 in					
A6259	A		Transparent film > 48 sq in					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A6260	A		Wound cleanser any type/size					
A6261	A		Wound filler gel/paste /oz					
A6262	A		Wound filler dry form / gram					
A6266	A		Impreg gauze no h20/sal/yard					
A6402	A		Sterile gauze <= 16 sq in					
A6403	A		Sterile gauze>16 <= 48 sq in					
A6404	A		Sterile gauze > 48 sq in					
A6407	A	NI	Packing strips, non-impreg					
A6410	A		Sterile eye pad					
A6411	A		Non-sterile eye pad					
A6412	E		Occlusive eye patch					
A6421	A	DG	Pad bandage >=3 <5in w /roll					
A6422	A	DG	Conf bandage ns >=3<5≧w/roll					
A6424	A	DG	Conf bandage ns >=5≧w /roll					
A6426	A	DG	Conf bandage s >=3<5≧ w/roll					
A6428	A	DG	Conf bandage s >=5≧ w /roll					
A6430	A	DG	Lt compres bdg >=3<5≧w /roll					
A6432	A	DG	Lt compres bdg >=5≧w /roll					
A6434	A	DG	Mo compres bdg >=3<5≧w /roll					
A6436	A	DG	Hi compres bdg >=3<5≧w /roll					
A6438	A	DG	Self-adher bdg >=3<5≧w /roll					
A6440	A	DG	Zinc paste bdg >=3<5≧w /roll					
A6441	A	NI	Pad band w>=3≧ <5≧/yd					
A6442	A	NI	Conform band n/s w<3≧/yd					
A6443	A	NI	Conform band n/s w>=3≧<5≧/yd					
A6444	A	NI	Conform band n/s w>=5≧/yd					
A6445	A	NI	Conform band s w <3≧/yd					
A6446	A	NI	Conform band s w>=3≧ <5≧/yd					
A6447	A	NI	Conform band s w >=5≧/yd					
A6448	A	NI	Lt compres band <3≧/yd					
A6449	A	NI	Lt compres band >=3≧ <5≧/yd					
A6450	A	NI	Lt compres band >=5≧/yd					
A6451	A	NI	Mod compres band w>=3≧<5≧/yd					
A6452	A	NI	High compres band w>=3≧<5≧yd					
A6453	A	NI	Self-adher band w <3≧/yd					
A6454	A	NI	Self-adher band w>=3≧ <5≧/yd					
A6455	A	NI	Self-adher band >=5≧/yd					
A6456	A	NI	Zinc paste band w >=3≧<5≧/yd					
A6501	A		Compres bumgarment bodysuit					
A6502	A		Compres bumgarment chinstrp					
A6503	A		Compres bumgarment facehood					
A6504	A		Cmprsbumgarment glove-wrist					
A6505	A		Cmprsbumgarment glove-elbow					
A6506	A		Cmprsbumgrmnt glove-axilla					
A6507	A		Cmprs bumgarment foot-knee					
A6508	A		Cmprs bumgarment foot-thigh					
A6509	A		Compres bum garment jacket					
A6510	A		Compres bum garment leotard					
A6511	A		Compres burn garment panty					
A6512	A		Compres bum garment, noc					
A6550	Y	NI	Neg pres wound ther drsg set					
A6551	Y	NI	Neg press wound ther canistr					
A7000	A		Disposable canister for pump					
A7001	A		Nondisposable pump canister					
A7002	A		Tubing used w suction pump					
A7003	A		Nebulizer administration set					
A7004	A		Disposable nebulizer sml vol					
A7005	A		Nondisposable nebulizer set					
A7006	A		Filtered nebulizer admin set					
A7007	A		Lg vol nebulizer disposable					
A7008	A		Disposable nebulizer prefill					
A7009	A		Nebulizer reservoir bottle					
A7010	A		Disposable corrugated tubing					
A7011	A		Nondispos corrugated tubing					
A7012	A		Nebulizer water collec devic					
A7013	A		Disposable compressor filter					
A7014	A		Compressor nondispos filter					
A7015	A		Aerosol mask used w nebulize					
A7016	A		Nebulizer dome & mouthpiece					
A7017	A		Nebulizer not used w oxygen					
A7018	A		Water distilled w/nebulizer					
A7019	A	DG	Saline solution dispenser					
A7020	A	DG	Sterile H2O or NSS w lgv neb					
A7025	A		Replace chest compress vest					
A7026	A		Replace chst cmprss sys hose					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A7030	A		CPAP full face mask					
A7031	A		Replacement facemask interfa					
A7032	A		Replacement nasal cushion					
A7033	A		Replacement nasal pillows					
A7034	A		Nasal application device					
A7035	A		Pos airway press headgear					
A7036	A		Pos airway press chinstrap					
A7037	A		Pos airway pressure tubing					
A7038	A		Pos airway pressure filter					
A7039	A		Filter, non disposable w pap					
A7042	A		Implanted pleural catheter					
A7043	A		Vacuum drainagebottle/tubing					
A7044	A		PAP oral interface					
A7046	Y	NI	Repl water chamber, PAP dev					
A7501	A		Tracheostoma valve w diaphra					
A7502	A		Replacement diaphragm/fplate					
A7503	A		HMES filter holder or cap					
A7504	A		Tracheostoma HMES filter					
A7505	A		HMES or trach valve housing					
A7506	A		HMES/trachvalve adhesivedisk					
A7507	A		Integrated filter & holder					
A7508	A		Housing & Integrated Adhesiv					
A7509	A		Heat & moisture exchange sys					
A7520	A	NI	Trach/laryn tube non-cuffed					
A7521	A	NI	Trach/laryn tube cuffed					
A7522	A	NI	Trach/laryn tube stainless					
A7523	A	NI	Tracheostomy shower protect					
A7524	A	NI	Tracheostoma stent/stud/bttn					
A7525	A	NI	Tracheostomy mask					
A7526	A	NI	Tracheostomy tube collar					
A9150	B		Misc/exper non-prescript dru					
A9270	E		Non-covered item or service					
A9280	E	NI	Alert device, noc					
A9300	E		Exercise equipment					
A9500	K		Technetium TC 99m sestamibi	1600	1.1782	$64.28		$12.86
A9502	K		Technetium TC99M tetrofosmin	0705	1.0642	$58.06		$11.61
A9503	N		Technetium TC 99m medronate					
A9504	N		Technetium tc 99m apcitide					
A9505	K		Thallous chloride TL 201/mci	1603	0.3645	$19.89		$3.98
A9507	K		Indium/111 capromab pendetid	1604	12.6045	$687.71		$137.54
A9508	K		Iobenguane sulfate I-131, per 0.5 mCi	1045	3.0392	$165.82		$33.16
A9510	N		Technetium TC99m Disofenin					
A9511	K		Technetium TC 99m depreotide	1095	0.6940	$37.87		$7.57
A9512	N		Technetiumtc99mpertechnetate					
A9513	N		Technetium tc-99m mebrofenin					
A9514	N		Technetiumtc99mpyrophosphate					
A9515	N		Technetium tc-99m pentetate					
A9516	N		I-123 sodium iodide capsule					
A9517	K		Th I131 so iodide cap millic	1064	0.1004	$5.48		$1.10
A9518	D	DNG	I-131 sodium iodide solution					
A9519	N		Technetiumtc-99mmacroag albu					
A9520	N		Technetiumtc-99m sulfur clld					
A9521	K		Technetiumtc-99m exametazine	1096	3.8609	$210.65		$42.13
A9522	B		Indium111ibritumomabtiuxetan					
A9523	B		Yttrium90ibritumomabtiuxetan					
A9524	K		Iodinated I-131 serumalbumin, per 5uci	9100	0.0066	$0.36		$0.07
A9525	N	NI	Low/iso-osmolar contrast mat					
A9526	K	NI	Ammonia N-13, per dose	9025	2.6372	$143.89		$28.78
A9527	B	NI	I-131 tositumomab therapeut					
A9528	K	NI	Dx I131 so iodide cap millic	1064	0.1004	$5.48		$1.10
A9529	K	NI	Dx I131 so iodide sol millic	1065	0.1189	$6.49		$1.30
A9530	K	NI	Th I131 so iodide sol millic	1065	0.1189	$6.49		$1.30
A9531	N	NI	Dx I131 so iodide microcurie					
A9532	N	NI	I-125 serum albumin micro					
A9533	B	NI	I-131 tositumomab diagnostic					
A9534	B	NI	I-131 tositumomab therapeut					
A9600	K		Strontium-89 chloride	0701	7.3835	$402.85		$80.57
A9605	K		Samarium sm153 lexidronamm	0702	16.0268	$874.44		$174.89
A9699	N		Noc therapeutic radiopharm					
A9700	E		Echocardiography Contrast	9202	2.1737	$118.60		$23.72
A9900	A		Supply/accessory/service					
A9901	A		Delivery/set up/dispensing					
A9999	Y	NI	DME supply or accessory, nos					
B4034	A		Enter feed supkit syr by day					
B4035	A		Enteral feed supp pump per d					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
B4036	A		Enteral feed sup kit grav by					
B4081	A		Enteral ng tubing w/ stylet					
B4082	A		Enteral ng tubing w/o stylet					
B4083	A		Enteral stomach tube levine					
B4086	A		Gastrostomy/jejunostomy tube					
B4100	E		Food thickener oral					
B4150	A		Enteral formulae category i					
B4151	A		Enteral formulae cat1natural					
B4152	A		Enteral formulae category ii					
B4153	A		Enteral formulae categoryIII					
B4154	A		Enteral formulae category IV					
B4155	A		Enteral formulae category v					
B4156	A		Enteral formulae category vi					
B4164	A		Parenteral 50% dextrose solu					
B4168	A		Parenteral sol amino acid 3.					
B4172	A		Parenteral sol amino acid 5.					
B4176	A		Parenteral sol amino acid 7-					
B4178	A		Parenteral sol amino acid >					
B4180	A		Parenteral sol carb > 50%					
B4184	A		Parenteral sol lipids 10%					
B4186	A		Parenteral sol lipids 20%					
B4189	A		Parenteral sol amino acid &					
B4193	A		Parenteral sol 52-73 gm prot					
B4197	A		Parenteral sol 74-100 gm pro					
B4199	A		Parenteral sol > 100gm prote					
B4216	A		Parenteral nutrition additiv					
B4220	A		Parenteral supply kit premix					
B4222	A		Parenteral supply kit homemi					
B4224	A		Parenteral administration ki					
B5000	A		Parenteral sol renal-amirosy					
B5100	A		Parenteral sol hepatic-fream					
B5200	A		Parenteral sol stres-bmch c					
B9000	A		Enter infusion pump w/o alrm					
B9002	A		Enteral infusion pump w/ ala					
B9004	A		Parenteral infus pump portab					
B9006	A		Parenteral infus pump statio					
B9998	A		Enteral supp not otherwise c					
B9999	A		Parenteral supp not othrws c					
C1010	K	DG	Blood, L/R, CMV-NEG	1010		$121.78		$24.36
C1011	K	DG	Platelets, HLA-m, L/R, unit	1011		$499.77		$99.95
C1015	K	DG	Plt, pher,L/R,CMV, irrad	1020		$495.22		$99.04
C1016	K	DG	BLOOD,L/R,FROZ/DEGLY/Washed	1016		$301.68		$60.34
C1017	K	DG	Plt, APH/PHER,L/R,CMV-NEG	1017		$393.15		$78.63
C1018	K	DG	Blood, L/R, IRRADIATED	1018		$132.40		$26.48
C1020	K	DG	RBC, frz/deg/wsh, L/R, irrad	1021		$336.04		$67.21
C1021	K	DG	RBC, L/R, CMV neg, irrad	1022		$201.12		$40.22
C1022	K	DG	Plasma, frz within 24 hour	0955		$95.00		$19.00
C1079	K		CO 57/58 per 0.5 uCi	1079	1.2556	$68.51		$13.70
C1080	K	NI	I-131 tositumomab, dx	1080		$2,260.00		$452.00
C1081	K	NI	I-131 tositumomab, tx	1081		$19,565.00		$3,913.00
C1082	K	NF	In-111 ibritumomab tiuxetan	9118		$2,260.00		$452.00
C1083	K	NF	Yttrium 90 ibritumomab tiuxetan	9117		$19,565.00		$3,913.00
C1088	T		LASER OPTIC TR Sys	1557		$1,850.00		$370.00
C1091	K		IN111 oxyquinoline,per0.5mCi	1091	4.1151	$224.52		$44.90
C1092	K		IN 111 pentetate per 0.5 mCi	1092	3.9855	$217.45		$43.49
C1122	K		Tc 99M ARCITUMOMAB PER VIAL	1122	9.8014	$534.77		$106.95
C1166	K	DG	CYTARABINE LIPOSOMAL, 10 mg	1166	5.1134	$278.99		$55.80
C1167	K	DG	EPIRUBICIN HCL, 2 mg	1167	0.3744	$20.43		$4.09
C1178	K		BUSULFAN IV, 6 Mg	1178	5.4930	$299.70		$59.94
C1200	K		TC 99M Sodium Glucoheptonat	1200	0.5550	$30.28		$6.06
C1201	K		TC 99M SUCCIMER, PER Vial	1201	1.4706	$80.24		$16.05
C1300	S		HYPERBARIC Oxygen	0659	3.0228	$164.93		$32.99
C1305	K		Apligraf	1305	15.0691	$822.19		$164.44
C1713	N	NF	Anchor/screw bn/bn,tis/bn					
C1714	N	NF	Cath, trans atherectomy, dir					
C1715	N	NF	Brachytherapy needle					
C1716	K		Brachytx source, Gold 198	1716	1.3811	$75.35		$15.07
C1717	N	NF	Brachytx source, HDR Ir-192					
C1718	K		Brachytx source, Iodine 125	1718	0.6843	$37.34		$7.47
C1719	K		Brachytx sour,Non-HDR Ir-192	1719	0.3187	$17.39		$3.48
C1720	K		Brachytx sour, Palladium 103	1720	0.8187	$44.67		$8.93
C1721	N	NF	AICD, dual chamber					
C1722	N	NF	AICD, single chamber					
C1724	N	NF	Cath, trans atherec,rotation					
C1725	N	NF	Cath, translumin non-laser					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C1726	N	NF	Cath, bal dil, non-vascular					
C1727	N	NF	Cath, bal tis dis, non-vas					
C1728	N	NF	Cath, brachytx seed adm					
C1729	N	NF	Cath, drainage					
C1730	N	NF	Cath, EP, 19 or few elect					
C1731	N	NF	Cath, EP, 20 or more elec					
C1732	N	NF	Cath, EP, diag/abl, 3D/vect					
C1733	N	NF	Cath, EP, othr than cool-tip					
C1750	N	NF	Cath, hemodialysis,long-term					
C1751	N	NF	Cath, inf, per/cent/midline					
C1752	N	NF	Cath,hemodialysis,short-term					
C1753	N	NF	Cath, intravas ultrasound					
C1754	N	NF	Catheter, intradiscal					
C1755	N	NF	Catheter, intraspinal					
C1756	N	NF	Cath, pacing, transesoph					
C1757	N	NF	Cath, thrombectomy/embolect					
C1758	N	NF	Catheter, ureteral					
C1759	N	NF	Cath, intra echocardiography					
C1760	N	NF	Closure dev, vasc					
C1762	N	NF	Conn tiss, human(inc fascia)					
C1763	N	NF	Conn tiss, non-human					
C1764	N	NF	Event recorder, cardiac					
C1765	N		Adhesion barrier					
C1766	N	NF	Intro/sheath,strble,non-peel					
C1767	N	NF	Generator, neurostim, imp					
C1768	N	NF	Graft, vascular					
C1769	N	NF	Guide wire					
C1770	N	NF	Imaging coil, MR, insertable					
C1771	N	NF	Rep dev, urinary, w/sling					
C1772	N	NF	Infusion pump, programmable					
C1773	N	NF	Ret dev, insertable					
C1774	K	DG	Darbepoetin alfa, 1 mcg	0734		$3.24		$0.65
C1775	K		FDG, per dose (4-40 mCi/ml)	1775	5.9471	$324.48		$64.90
C1776	N	NF	Joint device (implantable)					
C1777	N	NF	Lead, AICD, endo single coil					
C1778	N	NF	Lead, neurostimulator					
C1779	N	NF	Lead, pmkr, transvenous VDD					
C1780	N	NF	Lens, intraocular (new tech)					
C1781	N	NF	Mesh (implantable)					
C1782	N	NF	Morcellator					
C1783	H		Ocular imp, aqueous drain ev	1783				
C1784	N	NF	Ocular dev, intraop, det ret					
C1785	N	NF	Pmkr, dual, rate-resp					
C1786	N	NF	Pmkr, single, rate-resp					
C1787	N	NF	Patient progr, neurostim					
C1788	N	NF	Port, indwelling, imp					
C1789	N	NF	Prosthesis, breast, imp					
C1813	N	NF	Prosthesis, penile, inflatab					
C1814	H	NF	Retinal tamp, silicone oil	1814				
C1815	N	NF	Pros, urinary sph, imp					
C1816	N	NF	Receiver/transmitter, neuro					
C1817	N	NF	Septal defect imp sys					
C1818	H		Integrated keratoprosthesis	1818				
C1819	H	NI	Tissue localization-excision dev	1819				
C1874	N	NF	Stent, coated/cov w/del sys					
C1875	N	NF	Stent, coated/cov w/o del sy					
C1876	N	NF	Stent, non-coa/non-cov w/del					
C1877	N	NF	Stent, non-coat/cov w/o del					
C1878	N	NF	Matrl for vocal cord					
C1879	N	NF	Tissue marker, implantable					
C1880	N	NF	Vena cava filter					
C1881	N	NF	Dialysis access system					
C1882	N	NF	AICD, other than sing/dual					
C1883	N	NF	Adapt/ext, pacing/neuro lead					
C1884	H	NI	Embolization Protect syst	1884				
C1885	N	NF	Cath, translumin angio laser					
C1887	N	NF	Catheter, guiding					
C1888	H		Catheter, ablation, non-cardiac, endovascular (implantable).	1888				
C1891	N	NF	Infusion pump,non-prog, perm					
C1892	N	NF	Intro/sheath,fixed,peel-away					
C1893	N	NF	Intro/sheath, fixed,non-peel					
C1894	N	NF	Intro/sheath, non-laser					
C1895	N	NF	Lead, AICD, endo dual coil					
C1896	N	NF	Lead, AICD, non sing/dual					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C1897	N	NF	Lead, neurostim test kit					
C1898	N	NF	Lead, pmkr, other than trans					
C1899	N	NF	Lead, pmkr/AICD combination					
C1900	H		Lead coronary venous	1900				
C2614	H		Probe, perc lumb disc	2614				
C2615	N	NF	Sealant, pulmonary, liquid					
C2616	K		Brachytx source, Yttrium-90	2616	176.2339	$9,615.50		$1,923.10
C2617	N	NF	Stent, non-cor, tem w/o del					
C2618	N		Probe, cryoablation					
C2619	N	NF	Pmkr, dual, non rate-resp					
C2620	N	NF	Pmkr, single, non rate-resp					
C2621	N	NF	Pmkr, other than sing/dual					
C2622	N	NF	Prosthesis, penile, non-inf					
C2625	N	NF	Stent, non-cor, tem w/del sy					
C2626	N	NF	Infusion pump, non-prog,temp					
C2627	N	NF	Cath, suprapubic/cystoscopic					
C2628	N	NF	Catheter, occlusion					
C2629	N	NF	Intro/sheath, laser					
C2630	N	NF	Cath, EP, cool-tip					
C2631	N	NF	Rep dev, urinary, w/o sling					
C2632	H		Brachytx sol, I-125, per mCi	2632				
C2633	K	NI	Brachytx source, Cesium-131	2633	0.8187	$44.67		$8.93
C8900	S		MRA w/cont, abd	0284	7.1165	$388.28	$194.13	$77.66
C8901	S		MRA w/o cont, abd	0336	6.3897	$348.63	$174.31	$69.73
C8902	S		MRA w/o fol w/cont, abd	0337	9.2075	$502.37	$240.77	$100.47
C8903	S		MRI w/cont, breast, uni	0284	7.1165	$388.28	$194.13	$77.66
C8904	S		MRI w/o cont, breast, uni	0336	6.3897	$348.63	$174.31	$69.73
C8905	S		MRI w/o fol w/cont, brst, un	0337	9.2075	$502.37	$240.77	$100.47
C8906	S		MRI w/cont, breast, bi	0284	7.1165	$388.28	$194.13	$77.66
C8907	S		MRI w/o cont, breast, bi	0336	6.3897	$348.63	$174.31	$69.73
C8908	S		MRI w/o fol w/cont, breast,	0337	9.2075	$502.37	$240.77	$100.47
C8909	S		MRA w/cont, chest	0284	7.1165	$388.28	$194.13	$77.66
C8910	S		MRA w/o cont, chest	0336	6.3897	$348.63	$174.31	$69.73
C8911	S		MRA w/o fol w/cont, chest	0337	9.2075	$502.37	$240.77	$100.47
C8912	S		MRA w/cont, lwr ext	0284	7.1165	$388.28	$194.13	$77.66
C8913	S		MRA w/o cont, lwr ext	0336	6.3897	$348.63	$174.31	$69.73
C8914	S		MRA w/o fol w/cont, lwr ext	0337	9.2075	$502.37	$240.77	$100.47
C8918	S	NF	MRA w/cont, pelvis	0284	7.1165	$388.28	$194.13	$77.66
C8919	S	NF	MRA w/o cont, pelvis	0336	6.3897	$348.63	$174.31	$69.73
C8920	S	NF	MRA w/o fol w/cont, pelvis	0337	9.2075	$502.37	$240.77	$100.47
C9000	N		Na chromateCr51, per 0.25mCi					
C9003	K		Palivizumab, per 50 mg	9003	6.3077	$344.15		$68.83
C9007	N		Baclofen Intrathecal kit-1am					
C9008	K		Baclofen Refill Kit-500mcg	9008	0.1264	$6.90		$1.38
C9009	K		Baclofen Refill Kit-2000mcg	9009	0.7499	$40.92		$8.18
C9010	K	DG	Baclofen Refill Kit-4000mcg	9010	0.7739	$42.22		$8.44
C9013	K		Co 57 cobaltous chloride	9013	1.0386	$56.67		$11.33
C9102	N		51 Na Chromate, 50mCi					
C9103	N		Na Iothalamate I-125, 10 uCi					
C9105	K		Hep B imm glob, per 1 ml	9105	1.3074	$71.33		$14.27
C9109	K		Tirofiban hcl, 6.25 mg	9109	2.1737	$118.60		$23.72
C9111	D	DNG	Inj, bivalirudin, 250mg vial					
C9112	G		Perflutren lipid micro, 2ml	9112		$148.20		$22.15
C9113	G		Inj pantoprazole sodium, via	9113		$25.08		$3.75
C9116	D	DNG	Ertapenem sodium, per 1 gm			$23.74		
C9119	D	DNG	Injection, pegfilgrastim					
C9120	D	DNG	Injection, fulvestrant					
C9121	G		Injection, argatroban	9121		$16.35		$2.44
C9123	G	NF	Transcyte, per 247 sq cm	9123		$770.93		$115.23
C9200	G		Orcel, per 36 cm2	9200		$1,135.25	$	$169.69
C9201	G		Dermagraft, per 37.5 sq cm	9201		$577.60		$86.34
C9202	K	NF	Octafluoropropane	9202	2.1737	$118.60		$23.72
C9203	G	NF	Perflexane lipid micro	9203		$142.50		$21.30
C9204	D	DNG	Ziprasidone mesylate					
C9205	G		Oxaliplatin	9205		$94.46		$14.12
C9207	G	NI	Injection, bortezomib	9207		$1,039.68		$155.40
C9208	G	NF	Injection, agalsidase beta	9208		$123.78		$18.50
C9209	G	NF	Injection, laronidase	9209		$644.10		$96.28
C9210	G	NI	Injection, palonosetron HCL	9210		$307.80		$46.01
C9211	G	NI	Inj, alefacept, IV	9211		$665.00		$99.40
C9212	G	NI	Inj, alefacept, IM	9212		$472.63		$70.65
C9503	K	DG	Fresh frozen plasma, ea unit	9503		$69.74		$13.95
C9701	T		Stretta System	1557		$1,850.00		$370.00
C9703	T		Bard Endoscopic Suturing Sys	1555		$1,650.00		$330.00
C9704	T	NI	Inj inert subs upper GI	1556		$1,750.00		$350.00

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C9711	T	DG	H.E.L.P. Apheresis System	1552		$1,350.00		$270.00
D0120	E		Periodic oral evaluation					
D0140	E		Limit oral eval problm focus					
D0150	S		Comprehensve oral evaluation	0330	0.5745	$31.35		$6.27
D0160	E		Extensv oral eval prob focus					
D0170	E		Re-eval,est pt,problem focus					
D0180	E		Comp periodontal evaluation					
D0210	E		Intraor complete film series					
D0220	E		Intraoral periapical first f					
D0230	E		Intraoral periapical ea add					
D0240	S		Intraoral occlusal film	0330	0.5745	$31.35		$6.27
D0250	S		Extraoral first film	0330	0.5745	$31.35		$6.27
D0260	S		Extraoral ea additional film	0330	0.5745	$31.35		$6.27
D0270	S		Dental bitewing single film	0330	0.5745	$31.35		$6.27
D0272	S		Dental bitewings two films	0330	0.5745	$31.35		$6.27
D0274	S		Dental bitewings four films	0330	0.5745	$31.35		$6.27
D0277	S		Vert bitewings-sev to eight	0330	0.5745	$31.35		$6.27
D0290	E		Dental film skull/facial bon					
D0310	E		Dental saliography					
D0320	E		Dental tmj arthrogram incl i					
D0321	E		Dental other tmj films					
D0322	E		Dental tomographic survey					
D0330	E		Dental panoramic film					
D0340	E		Dental cephalometric film					
D0350	E		Oral/facial images					
D0415	E		Bacteriologic study					
D0425	E		Caries susceptibility test					
D0460	S		Pulp vitality test	0330	0.5745	$31.35		$6.27
D0470	E		Diagnostic casts					
D0472	S		Gross exam, prep & report	0330	0.5745	$31.35		$6.27
D0473	S		Micro exam, prep & report	0330	0.5745	$31.35		$6.27
D0474	S		Micro w exam of surg margins	0330	0.5745	$31.35		$6.27
D0480	S		Cytopath smear prep & report	0330	0.5745	$31.35		$6.27
D0502	S		Other oral pathology procedu	0330	0.5745	$31.35		$6.27
D0999	S		Unspecified diagnostic proce	0330	0.5745	$31.35		$6.27
D1110	E		Dental prophylaxis adult					
D1120	E		Dental prophylaxis child					
D1201	E		Topical fluor w prophy child					
D1203	E		Topical fluor w/o prophy chi					
D1204	E		Topical fluor w/o prophy adu					
D1205	E		Topical fluoride w/ prophy a					
D1310	E		Nutri counsel-control caries					
D1320	E		Tobacco counseling					
D1330	E		Oral hygiene instruction					
D1351	E		Dental sealant per tooth					
D1510	S		Space maintainer fxd unilat	0330	0.5745	$31.35		$6.27
D1515	S		Fixed bilat space maintainer	0330	0.5745	$31.35		$6.27
D1520	S		Remove unilat space maintain	0330	0.5745	$31.35		$6.27
D1525	S		Remove bilat space maintain	0330	0.5745	$31.35		$6.27
D1550	S		Recement space maintainer	0330	0.5745	$31.35		$6.27
D2140	E		Amalgam one surface permanen					
D2150	E		Amalgam two surfaces permane					
D2160	E		Amalgam three surfaces perma					
D2161	E		Amalgam 4 or > surfaces perm					
D2330	E		Resin one surface-anterior					
D2331	E		Resin two surfaces-anterior					
D2332	E		Resin three surfaces-anterio					
D2335	E		Resin 4/> surf or w incis an					
D2390	E		Ant resin-based cmpst crown					
D2391	E		Post 1 srfc resinbased cmpst					
D2392	E		Post 2 srfc resinbased cmpst					
D2393	E		Post 3 srfc resinbased cmpst					
D2394	E		Post >=4srfc resinbase cmpst					
D2410	E		Dental gold foil one surface					
D2420	E		Dental gold foil two surface					
D2430	E		Dental gold foil three surfa					
D2510	E		Dental inlay metalic 1 surf					
D2520	E		Dental inlay metallic 2 surf					
D2530	E		Dental inlay metl 3/more sur					
D2542	E		Dental onlay metallic 2 surf					
D2543	E		Dental onlay metallic 3 surf					
D2544	E		Dental onlay metl 4/more sur					
D2610	E		Inlay porcelain/ceramic 1 su					
D2620	E		Inlay porcelain/ceramic 2 su					
D2630	E		Dental onlay porc 3/more sur					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D2642	E		Dental onlay porcelin 2 surf					
D2643	E		Dental onlay porcelin 3 surf					
D2644	E		Dental onlay porc 4/more sur					
D2650	E		Inlay composite/resin one su					
D2651	E		Inlay composite/resin two su					
D2652	E		Dental inlay resin 3/mre sur					
D2662	E		Dental onlay resin 2 surface					
D2663	E		Dental onlay resin 3 surface					
D2664	E		Dental onlay resin 4/mre sur					
D2710	E		Crown resin laboratory					
D2720	E		Crown resin w/ high noble me					
D2721	E		Crown resin w/ base metal					
D2722	E		Crown resin w/ noble metal					
D2740	E		Crown porcelain/ceramic subs					
D2750	E		Crown porcelain w/ h noble m					
D2751	E		Crown porcelain fused base m					
D2752	E		Crown porcelain w/ noble met					
D2780	E		Crown 3/4 cast hi noble met					
D2781	E		Crown 3/4 cast base metal					
D2782	E		Crown 3/4 cast noble metal					
D2783	E		Crown 3/4 porcelain/ceramic					
D2790	E		Crown full cast high noble m					
D2791	E		Crown full cast base metal					
D2792	E		Crown full cast noble metal					
D2799	E		Provisional crown					
D2910	E		Dental recement inlay					
D2920	E		Dental recement crown					
D2930	E		Prefab stnlss steel crwn pri					
D2931	E		Prefab stnlss steel crown pe					
D2932	E		Prefabricated resin crown					
D2933	E		Prefab stainless steel crown					
D2940	E		Dental sedative filling					
D2950	E		Core build-up incl any pins					
D2951	E		Tooth pin retention					
D2952	E		Post and core cast + crown					
D2953	E		Each addtnl cast post					
D2954	E		Prefab post/core + crown					
D2955	E		Post removal					
D2957	E		Each addtnl prefab post					
D2960	E		Laminate labial veneer					
D2961	E		Lab labial veneer resin					
D2962	E		Lab labial veneer porcelain					
D2970	S		Temporary- fractured tooth	0330	0.5745	$31.35		$6.27
D2980	E		Crown repair					
D2999	S		Dental unspec restorative pr	0330	0.5745	$31.35		$6.27
D3110	E		Pulp cap direct					
D3120	E		Pulp cap indirect					
D3220	E		Therapeutic pulpotomy					
D3221	E		Gross pulpal debridement					
D3230	E		Pulpal therapy anterior prim					
D3240	E		Pulpal therapy posterior pri					
D3310	E		Anterior					
D3320	E		Root canal therapy 2 canals					
D3330	E		Root canal therapy 3 canals					
D3331	E		Non-surg tx root canal obs					
D3332	E		Incomplete endodontic tx					
D3333	E		Internal root repair					
D3346	E		Retreat root canal anterior					
D3347	E		Retreat root canal bicuspid					
D3348	E		Retreat root canal molar					
D3351	E		Apexification/recalc initial					
D3352	E		Apexification/recalc interim					
D3353	E		Apexification/recalc final					
D3410	E		Apicoect/perirad surg anter					
D3421	E		Root surgery bicuspid					
D3425	E		Root surgery molar					
D3426	E		Root surgery ea add root					
D3430	E		Retrograde filling					
D3450	E		Root amputation					
D3460	S		Endodontic endosseous implan	0330	0.5745	$31.35		$6.27
D3470	E		Intentional replantation					
D3910	E		Isolation- tooth w rubb dam					
D3920	E		Tooth splitting					
D3950	E		Canal prep/fitting of dowel					
D3999	S		Endodontic procedure	0330	0.5745	$31.35		$6.27

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D4210	E		Gingivectomy/plasty per quad					
D4211	E		Gingivectomy/plasty per toot					
D4240	E		Gingival flap proc w/ planin					
D4241	E		Gngvl flap w rootplan 1-3 th					
D4245	E		Apically positioned flap					
D4249	E		Crown lengthen hard tissue					
D4260	S		Osseous surgery per quadrant	0330	0.5745	$31.35		$6.27
D4261	E		Osseous surgl-3teethperquad					
D4263	S		Bone replce graft first site	0330	0.5745	$31.35		$6.27
D4264	S		Bone replce graft each add	0330	0.5745	$31.35		$6.27
D4265	E		Bio mtrls to aid soft/os reg					
D4266	E		Guided tiss regen resorble					
D4267	E		Guided tiss regen nonresorb					
D4268	S		Surgical revision procedure	0330	0.5745	$31.35		$6.27
D4270	S		Pedicle soft tissue graft pr	0330	0.5745	$31.35		$6.27
D4271	S		Free soft tissue graft proc	0330	0.5745	$31.35		$6.27
D4273	S		Subepithelial tissue graft	0330	0.5745	$31.35		$6.27
D4274	E		Distal/proximal wedge proc					
D4275	E		Soft tissue aliograft					
D4276	E		Con tissue w dble ped graft					
D4320	E		Provision splnt intracoronal					
D4321	E		Provisional splint extracoro					
D4341	E		Periodontal scaling & root					
D4342	E		Periodontal scaling 1-3teeth					
D4355	S		Full mouth debridement	0330	0.5745	$31.35		$6.27
D4381	S		Localized chemo delivery	0330	0.5745	$31.35		$6.27
D4910	E		Penodontal maint procedures					
D4920	E		Unscheduled dressing change					
D4999	E		Unspecified periodontal proc					
D5110	E		Dentures complete maxillary					
D5120	E		Dentures complete mandible					
D5130	E		Dentures immediat maxillary					
D5140	E		Dentures immediat mandible					
D5211	E		Dentures maxill part resin					
D5212	E		Dentures mand part resin					
D5213	E		Dentures maxill part metal					
D5214	E		Dentures mandibl part metal					
D5281	E		Removable partial denture					
D5410	E		Dentures adjust cmplt maxil					
D5411	E		Dentures adjust cmplt mand					
D5421	E		Dentures adjust part maxill					
D5422	E		Dentures adjust part mandbl					
D5510	E		Dentur repr broken compl bas					
D5520	E		Replace denture teeth complt					
D5610	E		Dentures repair resin base					
D5620	E		Rep part denture cast frame					
D5630	E		Rep partial denture clasp					
D5640	E		Replace part denture teeth					
D5650	E		Add tooth to partial denture					
D5660	E		Add clasp to partial denture					
D5670	E		Replc tth&acrlc on mtl frmwk					
D5671	E		Replc tth&acrlc mandibular					
D5710	E		Dentures rebase cmplt maxil					
D5711	E		Dentures rebase cmplt mand					
D5720	E		Dentures rebase part maxill					
D5721	E		Dentures rebase part mandbl					
D5730	E		Denture reln cmplt maxil ch					
D5731	E		Denture reln cmplt mand chr					
D5740	E		Denture reln part maxil chr					
D5741	E		Denture reln part mand chr					
D5750	E		Denture reln cmplt max lab					
D5751	E		Denture reln cmplt mand lab					
D5760	E		Denture reln part maxil lab					
D5761	E		Denture reln part mand lab					
D5810	E		Denture interm cmplt maxill					
D5811	E		Denture interm cmplt mandbl					
D5820	E		Denture interm part maxill					
D5821	E		Denture interm part mandbl					
D5850	E		Denture tiss conditn maxill					
D5851	E		Denture tiss condtin mandbl					
D5860	E		Overdenture complete					
D5861	E		Overdenture partial					
D5862	E		Precision attachment					
D5867	E		Replacement of precision att					
D5875	E		Prosthesis modification					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D5899	E		Removable prosthodontic proc					
D5911	S		Facial moulage sectional	0330	0.5745	$31.35		$6.27
D5912	S		Facial moulage complete	0330	0.5745	$31.35		$6.27
D5913	E		Nasal prosthesis					
D5914	E		Auricular prosthesis					
D5915	E		Orbital prosthesis					
D5916	E		Ocular prosthesis					
D5919	E		Facial prosthesis					
D5922	E		Nasal septal prosthesis					
D5923	E		Ocular prosthesis interim					
D5924	E		Cranial prosthesis					
D5925	E		Facial augmentation implant					
D5926	E		Replacement nasal prosthesis					
D5927	E		Auricular replacement					
D5928	E		Orbital replacement					
D5929	E		Facial replacement					
D5931	E		Surgical obturator					
D5932	E		Postsurgical obturator					
D5933	E		Refitting of obturator					
D5934	E		Mandibular flange prosthesis					
D5935	E		Mandibular denture prosth					
D5936	E		Temp obturator prosthesis					
D5937	E		Trismus appliance					
D5951	E		Feeding aid					
D5952	E		Pediatric speech aid					
D5953	E		Adult speech aid					
D5954	E		Superimposed prosthesis					
D5955	E		Palatal lift prosthesis					
D5958	E		Intraoral con def inter plt					
D5959	E		Intraoral con def mod palat					
D5960	E		Modify speech aid prosthesis					
D5982	E		Surgical stent					
D5983	S		Radiation applicator	0330	0.5745	$31.35		$6.27
D5984	S		Radiation shield	0330	0.5745	$31.35		$6.27
D5985	S		Radiation cone locator	0330	0.5745	$31.35		$6.27
D5986	E		Fluoride applicator					
D5987	S		Commissure splint	0330	0.5745	$31.35		$6.27
D5988	E		Surgical splint					
D5999	E		Maxillofacial prosthesis					
D6010	E		Odontics endosteal implant					
D6020	E		Odontics abutment placement					
D6040	E		Odontics eposteal implant					
D6050	E		Odontics transosteal implnt					
D6053	E		Implnt/abtmnt spprt remv dnt					
D6054	E		Implnt/abtmnt spprt remvprtl					
D6055	E		Implant connecting bar					
D6056	E		Prefabricated abutment					
D6057	E		Custom abutment					
D6058	E		Abutment supported crown					
D6059	E		Abutment supported mtl crown					
D6060	E		Abutment supported mtl crown					
D6061	E		Abutment supported mtl crown					
D6062	E		Abutment supported mtl crown					
D6063	E		Abutment supported mtl crown					
D6064	E		Abutment supported mtl crown					
D6065	E		Implant supported crown					
D6066	E		Implant supported mtl crown					
D6067	E		Implant supported mtl crown					
D6068	E		Abutment supported retainer					
D6069	E		Abutment supported retainer					
D6070	E		Abutment supported retainer					
D6071	E		Abutment supported retainer					
D6072	E		Abutment supported retainer					
D6073	E		Abutment supported retainer					
D6074	E		Abutment supported retainer					
D6075	E		Implant supported retainer					
D6076	E		Implant supported retainer					
D6077	E		Implant supported retainer					
D6078	E		Implnt/abut suprtd fixd dent					
D6079	E		Implnt/abut suprtd fixd dent					
D6080	E		Implant maintenance					
D6090	E		Repair implant					
D6095	E		Odontics repr abutment					
D6100	E		Removal of implant					
D6199	E		Implant procedure					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D6210	E		Prosthodont high noble metal					
D6211	E		Bridge base metal cast					
D6212	E		Bridge noble metal cast					
D6240	E		Bridge porcelain high noble					
D6241	E		Bridge porcelain base metal					
D6242	E		Bridge porcelain nobel metal					
D6245	E		Bridge porcelain/ceramic					
D6250	E		Bridge resin w/high noble					
D6251	E		Bridge resin base metal					
D6252	E		Bridge resin w/noble metal					
D6253	E		Provisional pontic					
D6545	E		Dental retainr cast metl					
D6548	E		Porcelain/ceramic retainer					
D6600	E		Porcelain/ceramic inlay 2srf					
D6601	E		Porc/ceram inlay >= 3 surfac					
D6602	E		Cst hgh nble mtl inlay 2 srf					
D6603	E		Cst hgh nble mtl inlay >=3sr					
D6604	E		Cst bse mtl inlay 2 surfaces					
D6605	E		Cst bse mtl inlay >= 3 surfa					
D6606	E		Cast noble metal inlay 2 sur					
D6607	E		Cst noble mtl inlay >=3 surf					
D6608	E		Onlay porc/crmc 2 surfaces					
D6609	E		Onlay porc/crmc >=3 surfaces					
D6610	E		Onlay cst hgh nbl mtl 2 srfc					
D6611	E		Onlay cst hgh nbl mtl >=3srf					
D6612	E		Onlay cst base mtl 2 surface					
D6613	E		Onlay cst base mtl >=3 surfa					
D6614	E		Onlay cst nbl mtl 2 surfaces					
D6615	E		Onlay cst nbl mtl >=3 surfac					
D6720	E		Retain crown resin w hi nble					
D6721	E		Crown resin w/base metal					
D6722	E		Crown resin w/noble metal					
D6740	E		Crown porcelain/ceramic					
D6750	E		Crown porcelain high noble					
D6751	E		Crown porcelain base metal					
D6752	E		Crown porcelain noble metal					
D6780	E		Crown 3/4 high noble metal					
D6781	E		Crown 3/4 cast based metal					
D6782	E		Crown 3/4 cast noble metal					
D6783	E		Crown 3/4 porcelain/ceramic					
D6790	E		Crown full high noble metal					
D6791	E		Crown full base metal cast					
D6792	E		Crown full noble metal cast					
D6793	E		Provisional retainer crown					
D6920	S		Dental connector bar	0330	0.5745	$31.35		$6.27
D6930	E		Dental recement bridge					
D6940	E		Stress breaker					
D6950	E		Precision attachment					
D6970	E		Post & core plus retainer					
D6971	E		Cast post bridge retainer					
D6972	E		Prefab post & core plus reta					
D6973	E		Core build up for retainer					
D6975	E		Coping metal					
D6976	E		Each addtnl cast post					
D6977	E		Each addtl prefab post					
D6980	E		Bridge repair					
D6985	E		Pediatric partial denture fx					
D6999	E		Fixed prosthodontic proc					
D7111	S		Coronal remnants deciduous t	0330	0.5745	$31.35		$6.27
D7140	S		Extraction erupted tooth/exr	0330	0.5745	$31.35		$6.27
D7210	S		Rem imp tooth w mucoper flp	0330	0.5745	$31.35		$6.27
D7220	S		Impact tooth remov soft tiss	0330	0.5745	$31.35		$6.27
D7230	S		Impact tooth remov part bony	0330	0.5745	$31.35		$6.27
D7240	S		Impact tooth remov comp bony	0330	0.5745	$31.35		$6.27
D7241	S		Impact tooth rem bony w/comp	0330	0.5745	$31.35		$6.27
D7250	S		Tooth root removal	0330	0.5745	$31.35		$6.27
D7260	S		Oral antral fistula closure	0330	0.5745	$31.35		$6.27
D7261	S		Primary closure sinus perf	0330	0.5745	$31.35		$6.27
D7270	E		Tooth reimplantation					
D7272	E		Tooth transplantation					
D7280	E		Exposure impact tooth orthod					
D7281	E		Exposure tooth aid eruption					
D7282	E		Mobilize erupted/malpos toot					
D7285	E		Biopsy of oral tissue hard					
D7286	E		Biopsy of oral tissue soft					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D7287	E		Cytology sample collection					
D7290	E		Repositioning of teeth					
D7291	S		Transseptal fiberotomy	0330	0.5745	$31.35		$6.27
D7310	E		Alveoplasty w/ extraction					
D7320	E		Alveoplasty w/o extraction					
D7340	E		Vestibuloplasty ridge extens					
D7350	E		Vestibuloplasty exten graft					
D7410	E		Rad exc lesion up to 1.25 cm					
D7411	E		Excision benign lesion>1.25c					
D7412	E		Excision benign lesion compl					
D7413	E		Excision malig lesion<=1.25c					
D7414	E		Excision malig lesion>1.25cm					
D7415	E		Excision malig les complicat					
D7440	E		Malig tumor exc to 1.25 cm					
D7441	E		Malig tumor > 1.25 cm					
D7450	E		Rem odontogen cyst to 1.25cm					
D7451	E		Rem odontogen cyst > 1.25 cm					
D7460	E		Rem nonodonto cyst to 1.25cm					
D7461	E		Rem nonodonto cyst > 1.25 cm					
D7465	E		Lesion destruction					
D7471	E		Rem exostosis any site					
D7472	E		Removal of torus palatinus					
D7473	E		Remove torus mandibularis					
D7485	E		Surg reduct osseoustuberosit					
D7490	E		Mandible resection					
D7510	E		I&d absc intraoral soft tiss					
D7520	E		I&d abscess extraoral					
D7530	E		Removal fb skin/areolar tiss					
D7540	E		Removal of fb reaction					
D7550	E		Removal of sloughed off bone					
D7560	E		Maxillary sinusotomy					
D7610	E		Maxilla open reduct simple					
D7620	E		Clsd reduct simpl maxilla fx					
D7630	E		Open red simpl mandible fx					
D7640	E		Clsd red simpl mandible fx					
D7650	E		Open red simp malar/zygom fx					
D7660	E		Clsd red simp malar/zygom fx					
D7670	E		Closd rductn splint alveolus					
D7671	E		Alveolus open reduction					
D7680	E		Reduct simple facial bone fx					
D7710	E		Maxilla open reduct compound					
D7720	E		Clsd reduct compd maxilla fx					
D7730	E		Open reduct compd mandble fx					
D7740	E		Clsd reduct compd mandble fx					
D7750	E		Open red comp malar/zygma fx					
D7760	E		Clsd red comp malar/zygma fx					
D7770	E		Open reduc compd alveolus fx					
D7771	E		Alveolus clsd reduc stblz te					
D7780	E		Reduct compnd facial bone fx					
D7810	E		Tmj open reduct-dislocation					
D7820	E		Closed tmp manipulation					
D7830	E		Tmj manipulation under anest					
D7840	E		Removal of tmj condyle					
D7850	E		Tmj meniscectomy					
D7852	E		Tmj repair of joint disc					
D7854	E		Tmj excisn of joint membrane					
D7856	E		Tmj cutting of a muscle					
D7858	E		Tmj reconstruction					
D7860	E		Tmj cutting into joint					
D7865	E		Tmj reshaping components					
D7870	E		Tmj aspiration joint fluid					
D7871	E		Lysis + lavage w catheters					
D7872	E		Tmj diagnostic arthroscopy					
D7873	E		Tmj arthroscopy lysis adhesn					
D7874	E		Tmj arthroscopy disc reposit					
D7875	E		Tmj arthroscopy synovectomy					
D7876	E		Tmj arthroscopy discectomy					
D7877	E		Tmj arthroscopy debridement					
D7880	E		Occlusal orthotic appliance					
D7899	E		Tmj unspecified therapy					
D7910	E		Dent sutur recent wnd to 5cm					
D7911	E		Dental suture wound to 5 cm					
D7912	E		Suture complicate wnd > 5 cm					
D7920	E		Dental skin graft					
D7940	S		Reshaping bone orthognathic	0330	0.5745	$31.35		$6.27

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D7941	E		Bone cutting ramus closed					
D7943	E		Cutting ramus open w/graft					
D7944	E		Bone cutting segmented					
D7945	E		Bone cutting body mandible					
D7946	E		Reconstruction maxilla total					
D7947	E		Reconstruct maxilla segment					
D7948	E		Reconstruct midface no graft					
D7949	E		Reconstruct midface w/graft					
D7950	E		Mandible graft					
D7955	E		Repair maxillofacial defects					
D7960	E		Frenulectomy/frenulotomy					
D7970	E		Excision hyperplastic tissue					
D7971	E		Excision pericoronal gingiva					
D7972	E		Surg redct fibrous tuberosit					
D7980	E		Sialolithotomy					
D7981	E		Excision of salivary gland					
D7982	E		Sialodochoplasty					
D7983	E		Closure of salivary fistula					
D7990	E		Emergency tracheotomy					
D7991	E		Dental coronoidectomy					
D7995	E		Synthetic graft facial bones					
D7996	E		Implant mandible for augment					
D7997	E		Appliance removal					
D7999	E		Oral surgery procedure					
D8010	E		Limited dental tx primary					
D8020	E		Limited dental tx transition					
D8030	E		Limited dental tx adolescent					
D8040	E		Limited dental tx adult					
D8050	E		Intercep dental tx primary					
D8060	E		Intercep dental tx transitn					
D8070	E		Compre dental tx transition					
D8080	E		Compre dental tx adolescent					
D8090	E		Compre dental tx adult					
D8210	E		Orthodontic rem appliance tx					
D8220	E		Fixed appliance therapy habt					
D8660	E		Preorthodontic tx visit					
D8670	E		Periodic orthodontc tx visit					
D8680	E		Orthodontic retention					
D8690	E		Orthodontic treatment					
D8691	E		Repair ortho appliance					
D8692	E		Replacement retainer					
D8999	E		Orthodontic procedure					
D9110	N		Tx dental pain minor proc					
D9210	E		Dent anesthesia w/o surgery					
D9211	E		Regional block anesthesia					
D9212	E		Trigeminal block anesthesia					
D9215	E		Local anesthesia					
D9220	E		General anesthesia					
D9221	E		General anesthesia ea ad 15m					
D9230	N		Analgesia					
D9241	E		Intravenous sedation					
D9242	E		IV sedation ea ad 30 m					
D9248	N		Sedation (non-iv)					
D9310	E		Dental consultation					
D9410	E		Dental house call					
D9420	E		Hospital call					
D9430	E		Office visit during hours					
D9440	E		Office visit after hours					
D9450	E		Case presentation tx plan					
D9610	E		Dent therapeutic drug inject					
D9630	S		Other drugs/medicaments	0330	0.5745	$31.35		$6.27
D9910	E		Dent appl desensitizing med					
D9911	E		Appl desensitizing resin					
D9920	E		Behavior management					
D9930	S		Treatment of complications	0330	0.5745	$31.35		$6.27
D9940	S		Dental occlusal guard	0330	0.5745	$31.35		$6.27
D9941	E		Fabrication athletic guard					
D9950	S		Occlusion analysis	0330	0.5745	$31.35		$6.27
D9951	S		Limited occlusal adjustment	0330	0.5745	$31.35		$6.27
D9952	S		Complete occlusal adjustment	0330	0.5745	$31.35		$6.27
D9970	E		Enamel microabrasion					
D9971	E		Odontoplasty 1-2 teeth					
D9972	E		Extrnl bleaching per arch					
D9973	E		Extrnl bleaching per tooth					
D9974	E		Intrnl bleaching per tooth					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D9999	E		Adjunctive procedure					
E0100	A		Cane adjust/fixed with tip					
E0105	A		Cane adjust/fixed quad/3 pro					
E0110	A		Crutch forearm pair					
E0111	A		Crutch forearm each					
E0112	A		Crutch underarm pair wood					
E0113	A		Crutch underarm each wood					
E0114	A		Crutch underarm pair no wood					
E0116	A		Crutch underarm each no wood					
E0117	A		Underarm springassist crutch					
E0118	E	NI	Crutch substitute					
E0130	A		Walker rigid adjust/fixed ht					
E0135	A		Walker folding adjust/fixed					
E0140	Y	NI	Walker w trunk support					
E0141	A		Rigid walker wheeled wo seat					
E0142	A	DG	Walker rigid wheeled with se					
E0143	A		Walker folding wheeled w/o s					
E0144	A		Enclosed walker w rear seat					
E0145	A	DG	Walker whled seat/crutch att					
E0146	A	DG	Folding walker wheels w seat					
E0147	A		Walker variable wheel resist					
E0148	A		Heavyduty walker no wheels					
E0149	A		Heavy duty wheeled walker					
E0153	A		Forearm crutch platform atta					
E0154	A		Walker platform attachment					
E0155	A		Walker wheel attachment,pair					
E0156	A		Walker seat attachment					
E0157	A		Walker crutch attachment					
E0158	A		Walker leg extenders set of4					
E0159	A		Brake for wheeled walker					
E0160	A		Sitz type bath or equipment					
E0161	A		Sitz bath/equipment w/faucet					
E0162	A		Sitz bath chair					
E0163	A		Commode chair stationry fxd					
E0164	A		Commode chair mobile fixed a					
E0165	A	DG	Commode chair stationry det					
E0166	A		Commode chair mobile detach					
E0167	A		Commode chair pail or pan					
E0168	A		Heavyduty/wide commode chair					
E0169	A		Seatlift incorp commodechair					
E0175	A		Commode chair foot rest					
E0176	A		Air pressre pad/cushion nonp					
E0177	A		Water press pad/cushion nonp					
E0178	A		Gel pressre pad/cushion nonp					
E0179	A		Dry pressre pad/cushion nonp					
E0180	A		Press pad alternating w pump					
E0181	A		Press pad alternating w/ pum					
E0182	A		Pressure pad alternating pum					
E0184	A		Dry pressure mattress					
E0185	A		Gel pressure mattress pad					
E0186	A		Air pressure mattress					
E0187	A		Water pressure mattress					
E0188	E		Synthetic sheepskin pad					
E0189	E		Lambswool sheepskin pad					
E0190	E	NI	Positioning cushion					
E0191	A		Protector heel or elbow					
E0192	A		Pad wheelchr low press/posit					
E0193	A		Powered air flotation bed					
E0194	A		Air fluidized bed					
E0196	A		Gel pressure mattress					
E0197	A		Air pressure pad for mattres					
E0198	A		Water pressure pad for mattr					
E0199	A		Dry pressure pad for mattres					
E0200	A		Heat lamp without stand					
E0202	A		Phototherapy light w/ photom					
E0203	A		Therapeutic lightbox tabletp					
E0205	A		Heat lamp with stand					
E0210	A		Electric heat pad standard					
E0215	A		Electric heat pad moist					
E0217	A		Water circ heat pad w pump					
E0218	E		Water circ cold pad w pump					
E0220	A		Hot water bottle					
E0221	A		Infrared heating pad system					
E0225	A		Hydrocollator unit					
E0230	A		Ice cap or collar					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0231	E		Wound warming device					
E0232	E		Warming card for NWT					
E0235	A		Paraffin bath unit portable					
E0236	A		Pump for water circulating p					
E0238	A		Heat pad non-electric moist					
E0239	A		Hydrocollator unit portable					
E0240	E	NI	Bath/shower chair					
E0241	E		Bath tub wall rail					
E0242	E		Bath tub rail floor					
E0243	E		Toilet rail					
E0244	E		Toilet seat raised					
E0245	E		Tub stool or bench					
E0246	E		Transfer tub rail attachment					
E0247	E	NI	Trans bench w/wo comm open					
E0248	E	NI	HDtrans bench w/wo comm open					
E0249	A		Pad water circulating heat u					
E0250	A		Hosp bed fixed ht w/ mattres					
E0251	A		Hosp bed fixd ht w/o mattres					
E0255	A		Hospital bed var ht w/ mattr					
E0256	A		Hospital bed var ht w/o matt					
E0260	A		Hosp bed semi-electr w/ matt					
E0261	A		Hosp bed semi-electr w/o mat					
E0265	A		Hosp bed total electr w/ mat					
E0266	A		Hosp bed total elec w/o matt					
E0270	E		Hospital bed institutional t					
E0271	A		Mattress innerspring					
E0272	A		Mattress foam rubber					
E0273	E		Bed board					
E0274	E		Over-bed table					
E0275	A		Bed pan standard					
E0276	A		Bed pan fracture					
E0277	A		Powered pres-redu air mattrs					
E0280	A		Bed cradle					
E0290	A		Hosp bed fx ht w/o rails w/m					
E0291	A		Hosp bed fx ht w/o rail w/o					
E0292	A		Hosp bed var ht w/o rail w/o					
E0293	A		Hosp bed var ht w/o rail w/					
E0294	A		Hosp bed semi-elect w/ mattr					
E0295	A		Hosp bed semi-elect w/o matt					
E0296	A		Hosp bed total elect w/ matt					
E0297	A		Hosp bed total elect w/o mat					
E0300	Y	NI	Enclosed ped crib hosp grade					
E0301	Y	NI	HD hosp bed, 350-600 lbs					
E0302	Y	NI	Ex hd hosp bed > 600 lbs					
E0303	Y	NI	Hosp bed hvy dty xtra wide					
E0304	Y	NI	Hosp bed xtra hvy dty x wide					
E0305	A		Rails bed side half length					
E0310	A		Rails bed side full length					
E0315	E		Bed accessory brd/tbl/supprt					
E0316	A		Bed safety enclosure					
E0325	A		Urinal male jug-type					
E0326	A		Urinal female jug-type					
E0350	E		Control unit bowel system					
E0352	E		Disposable pack w/bowel syst					
E0370	E		Air elevator for heel					
E0371	A		Nonpower mattress overlay					
E0372	A		Powered air mattress overlay					
E0373	A		Nonpowered pressure mattress					
E0424	A		Stationary compressed gas 02					
E0425	E		Gas system stationary compre					
E0430	E		Oxygen system gas portable					
E0431	A		Portable gaseous 02					
E0434	A		Portable liquid 02					
E0435	E		Oxygen system liquid portabl					
E0439	A		Stationary liquid 02					
E0440	E		Oxygen system liquid station					
E0441	A		Oxygen contents, gaseous					
E0442	A		Oxygen contents, liquid					
E0443	A		Portable 02 contents, gas					
E0444	A		Portable 02 contents, liquid					
E0445	A		Oximeter non-invasive					
E0450	A		Volume vent stationary/porta					
E0454	A		Pressure ventilator					
E0455	A		Oxygen tent excl croup/ped t					
E0457	A		Chest shell					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0459	A		Chest wrap					
E0460	A		Neg press vent portabl/statn					
E0461	A		Vol vent noninvasive interfa					
E0462	A		Rocking bed w/ or w/o side r					
E0470	Y	NI	RAD w/o backup non-inv intfc					
E0471	Y	NI	RAD w/backup non inv intrfc					
E0472	Y	NI	RAD w backup invasive intrfc					
E0480	A		Percussor elect/pneum home m					
E0481	E		Intrpulmnry percuss vent sys					
E0482	A		Cough stimulating device					
E0483	A		Chest compression gen system					
E0484	A		Non-elec oscillatory pep dvc					
E0500	A		Ippb all types					
E0550	A		Humidif extens supple w ippb					
E0555	A		Humidifier for use w/ regula					
E0560	A		Humidifier supplemental w/ i					
E0561	Y	NI	Humidifier nonheated w PAP					
E0562	Y	NI	Humidifier heated used w PAP					
E0565	A		Compressor air power source					
E0570	A		Nebulizer with compression					
E0571	A		Aerosol compressor for svneb					
E0572	A		Aerosol compressor adjust pr					
E0574	A		Ultrasonic generator w svneb					
E0575	A		Nebulizer ultrasonic					
E0580	A		Nebulizer for use w/ regulat					
E0585	A		Nebulizer w/ compressor & he					
E0590	A		Dispensing fee dme neb drug					
E0600	A		Suction pump portab hom modl					
E0601	A		Cont airway pressure device					
E0602	E		Manual breast pump					
E0603	A		Electric breast pump					
E0604	A		Hosp grade elec breast pump					
E0605	A		Vaporizer room type					
E0606	A		Drainage board postural					
E0607	A		Blood glucose monitor home					
E0610	A		Pacemaker monitr audible/vis					
E0615	A		Pacemaker monitr digital/vis					
E0616	N		Cardiac event recorder					
E0617	A		Automatic ext defibrillator					
E0618	A		Apnea monitor					
E0619	A		Apnea monitor w recorder					
E0620	A		Cap bld skin piercing laser					
E0621	A		Patient lift sling or seat					
E0625	E		Patient lift bathroom or toi					
E0627	A		Seat lift incorp lift-chair					
E0628	A		Seat lift for pt fum-electr					
E0629	A		Seat lift for pt fum-non-el					
E0630	A		Patient lift hydraulic					
E0635	A		Patient lift electric					
E0636	A		PT support & positioning sys					
E0637	Y	NI	Sit-stand w seatlift wheeled					
E0638	Y	NI	Standing frame sys wheeled					
E0650	A		Pneuma compresor non-segment					
E0651	A		Pneum compressor segmental					
E0652	A		Pneum compres w/cal pressure					
E0655	A		Pneumatic appliance half arm					
E0660	A		Pneumatic appliance full leg					
E0665	A		Pneumatic appliance full arm					
E0666	A		Pneumatic appliance half leg					
E0667	A		Seg pneumatic appl full leg					
E0668	A		Seg pneumatic appl full arm					
E0669	A		Seg pneumatic appli half leg					
E0671	A		Pressure pneum appl full leg					
E0672	A		Pressure pneum appl full arm					
E0673	A		Pressure pneum appl half leg					
E0675	Y	NI	Pneumatic compression device					
E0691	A		Uvl pnl 2 sq ft or less					
E0692	A		Uvl sys panel 4 ft					
E0693	A		Uvl sys panel 6 ft					
E0694	A		Uvl md cabinet sys 6 ft					
E0700	E		Safety equipment					
E0701	A		Helmet w face guard prefab					
E0710	E		Restraints any type					
E0720	A		Tens two lead					
E0730	A		Tens four lead					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0731	A		Conductive garment for tens/					
E0740	E		Incontinence treatment systm					
E0744	A		Neuromuscular stim for scoli					
E0745	A		Neuromuscular stim for shock					
E0746	E		Electromyograph biofeedback					
E0747	A		Elec osteogen stim not spine					
E0748	A		Elec osteogen stim spinal					
E0749	N		Elec osteogen stim implanted					
E0752	N		Neurostimulator electrode					
E0754	A		Pulsegenerator pt programmer					
E0755	E		Electronic salivary reflex s					
E0756	N		Implantable pulse generator					
E0757	N		Implantable RF receiver					
E0758	A		External RF transmitter					
E0759	A		Replace rdfrquncy transmittr					
E0760	E		Osteogen ultrasound stimltor					
E0761	E		Nontherm electromgntc device					
E0765	E		Nerve stimulator for tx n&v					
E0776	A		Iv pole					
E0779	A		Amb infusion pump mechanical					
E0780	A		Mech amb infusion pump <8hrs					
E0781	A		External ambulatory infus pu					
E0782	N		Non-programble infusion pump					
E0783	N		Programmable infusion pump					
E0784	A		Ext amb infusn pump insulin					
E0785	N		Replacement impl pump cathet					
E0786	N		Implantable pump replacement					
E0791	A		Parenteral infusion pump sta					
E0830	N		Ambulatory traction device					
E0840	A		Tract frame attach headboard					
E0850	A		Traction stand free standing					
E0855	A		Cervical traction equipment					
E0860	A		Tract equip cervical tract					
E0870	A		Tract frame attach footboard					
E0880	A		Trac stand free stand extrem					
E0890	A		Traction frame attach pelvic					
E0900	A		Trac stand free stand pelvic					
E0910	A		Trapeze bar attached to bed					
E0920	A		Fracture frame attached to b					
E0930	A		Fracture frame free standing					
E0935	A		Exercise device passive moti					
E0940	A		Trapeze bar free standing					
E0941	A		Gravity assisted traction de					
E0942	A		Cervical head harness/halter					
E0943	A	DG	Cervical pillow					
E0944	A		Pelvic belt/harness/boot					
E0945	A		Belt/harness extremity					
E0946	A		Fracture frame dual w cross					
E0947	A		Fracture frame attachmnts pe					
E0948	A		Fracture frame attachmnts ce					
E0950	E		Tray					
E0951	E		Loop heel					
E0952	E		Toe loop/holder, each					
E0953	E		Pneumatic tire					
E0954	E		Wheelchair semi-pneumatic ca					
E0955	Y	NI	Cushioned headrest					
E0956	Y	NI	W/c lateral trunk/hip suppor					
E0957	Y	NI	W/c medial thigh support					
E0958	A		Whlchr att- conv 1 arm drive					
E0959	B		Amputee adapter					
E0960	Y	NI	W/c shoulder harness/straps					
E0961	B		Wheelchair brake extension					
E0962	A		Wheelchair 1 inch cushion					
E0963	A		Wheelchair 2 inch cushion					
E0964	A		Wheelchair 3 inch cushion					
E0965	A		Wheelchair 4 inch cushion					
E0966	B		Wheelchair head rest extensi					
E0967	B		Wheelchair hand rims					
E0968	A		Wheelchair commode seat					
E0969	B		Wheelchair narrowing device					
E0970	B		Wheelchair no. 2 footplates					
E0971	B		Wheelchair anti-tipping devi					
E0972	A		Transfer board or device					
E0973	B		Wheelchair adjustabl height					
E0974	B		Wheelchair grade-aid					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0975	B	DG	Wheelchair reinforced seat u					
E0976	B	DG	Wheelchair reinforced back u					
E0977	B		Wheelchair wedge cushion					
E0978	B		Wheelchair belt w/airplane b					
E0979	B	DG	Wheelchair belt with velcro					
E0980	B		Wheelchair safety vest					
E0981	Y	NI	Seat upholstery, replacement					
E0982	Y	NI	Back upholstery, replacement					
E0983	Y	NI	Add pwr joystick					
E0984	Y	NI	Add pwr tiller					
E0985	Y	NI	W/c seat lift mechanism					
E0986	Y	NI	Man w/c push-rim pow assist					
E0990	B		Whellchair elevating leg res					
E0991	B	DG	Wheelchair upholstry seat					
E0992	B		Wheelchair solid seat insert					
E0993	B	DG	Wheelchair back upholstery					
E0994	B		Wheelchair arm rest					
E0995	B		Wheelchair calf rest					
E0996	B		Wheelchair tire solid					
E0997	B		Wheelchair caster w/ a fork					
E0998	B		Wheelchair caster w/o a fork					
E0999	B		Wheelchr pneumatic tire w/wh					
E1000	B		Wheelchair tire pneumatic ca					
E1001	B		Wheelchair wheel					
E1002	Y	NI	Pwr seat tilt					
E1003	Y	NI	Pwr seat recline					
E1004	Y	NI	Pwr seat recline mech					
E1005	Y	NI	Pwr seat recline pwr					
E1006	Y	NI	Pwr seat combo w/o shear					
E1007	Y	NI	Pwr seat combo w/shear					
E1008	Y	NI	Pwr seat combo pwr shear					
E1009	Y	NI	Add mech leg elevation					
E1010	Y	NI	Add pwr leg elevation					
E1011	A		Ped wc modify width adjustm					
E1012	A		Int seat sys planar ped w/c					
E1013	A		Int seat sys contour ped w/c					
E1014	A		Reclining back add ped w/c					
E1015	A		Shock absorber for man w/c					
E1016	A		Shock absorber for power w/c					
E1017	A		HD shck absrbr for hd man wc					
E1018	A		HD shck absrber for hd powwc					
E1019	Y	NI	HD feature power seat					
E1020	A		Residual limb support system					
E1021	Y	NI	Ex hd feature power seat					
E1025	A		Pedwc lat/thor sup nocontour					
E1026	A		Pedwc contoured lat/thor sup					
E1027	A		Ped wc lat/ant support					
E1028	Y	NI	W/c manual swingaway					
E1029	Y	NI	W/c vent tray fixed					
E1030	Y	NI	W/c vent tray gimbaled					
E1031	A		Rollabout chair with casters					
E1035	B		Patient transfer system					
E1037	A		Transport chair, ped size					
E1038	A		Transport chair, adult size					
E1050	A		Whelchr fxd full length arms					
E1060	A		Wheelchair detachable arms					
E1065	B		Wheelchair power attachment					
E1066	B	DG	Wheelchair battery charger					
E1069	B	DG	Wheelchair deep cycle batter					
E1070	A		Wheelchair detachable foot r					
E1083	A		Hemi-wheelchair fixed arms					
E1084	A		Hemi-wheelchair detachable a					
E1085	A		Hemi-wheelchair fixed arms					
E1086	A		Hemi-wheelchair detachable a					
E1087	A		Wheelchair lightwt fixed arm					
E1088	A		Wheelchair lightweight det a					
E1089	A		Wheelchair lightwt fixed arm					
E1090	A		Wheelchair lightweight det a					
E1091	D	DNG	Wheelchair youth					
E1092	A		Wheelchair wide w/ leg rests					
E1093	A		Wheelchair wide w/ foot rest					
E1100	A		Whchr s-recl fxd arm leg res					
E1110	A		Wheelchair semi-recl detach					
E1130	A		Whlchr stand fxd arm ft rest					
E1140	A		Wheelchair standard detach a					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E1150	A		Wheelchair standard w/ leg r					
E1160	A		Wheelchair fixed arms					
E1161	A		Manual adult wc w tiltinspac					
E1170	A		Whlchr ampu fxd arm leg rest					
E1171	A		Wheelchair amputee w/o leg r					
E1172	A		Wheelchair amputee detach ar					
E1180	A		Wheelchair amputee w/ foot r					
E1190	A		Wheelchair amputee w/ leg re					
E1195	A		Wheelchair amputee heavy dut					
E1200	A		Wheelchair amputee fixed arm					
E1210	A		Whlchr moto ful arm leg rest					
E1211	A		Wheelchair motorized w/ det					
E1212	A		Wheelchair motorized w full					
E1213	A		Wheelchair motorized w/ det					
E1220	A		Whlchr special size/constrc					
E1221	A		Wheelchair spec size w foot					
E1222	A		Wheelchair spec size w/ leg					
E1223	A		Wheelchair spec size w foot					
E1224	A		Wheelchair spec size w/ leg					
E1225	A		Wheelchair spec sz semi-recl					
E1226	B		W/ch access anti-rollback					
E1227	B		Wheelchair spec sz spec ht a					
E1228	A		Wheelchair spec sz spec ht b					
E1230	A		Power operated vehicle					
E1231	A		Rigid ped w/c tilt-in-space					
E1232	A		Folding ped wc tilt-in-space					
E1233	A		Rig ped wc tltnspc w/o seat					
E1234	A		Fld ped wc tltnspc w/o seat					
E1235	A		Rigid ped wc adjustable					
E1236	A		Folding ped wc adjustable					
E1237	A		Rgd ped wc adjstabl w/o seat					
E1238	A		Fld ped wc adjstabl w/o seat					
E1240	A		Whchr litwt det arm leg rest					
E1250	A		Wheelchair lightwt fixed arm					
E1260	A		Wheelchair lightwt foot rest					
E1270	A		Wheelchair lightweight leg r					
E1280	A		Whchr h-duty det arm leg res					
E1285	A		Wheelchair heavy duty fixed					
E1290	A		Wheelchair hvy duty detach a					
E1295	A		Wheelchair heavy duty fixed					
E1296	A		Wheelchair special seat heig					
E1297	A		Wheelchair special seat dept					
E1298	A		Wheelchair spec seat depth/w					
E1300	E		Whirlpool portable					
E1310	A		Whirlpool non-portable					
E1340	A		Repair for DME, per 15 min					
E1353	A		Oxygen supplies regulator					
E1355	A		Oxygen supplies stand/rack					
E1372	A		Oxy suppl heater for nebuliz					
E1390	A		Oxygen concentrator					
E1391	Y	NI	Oxygen concentrator, dual					
E1399	N	NI	Durable medical equipment mi					
E1405	A		O2/water vapor enrich w/heat					
E1406	A		O2/water vapor enrich w/o he					
E1500	A		Centrifuge					
E1510	A		Kidney dialysate delivry sys					
E1520	A		Heparin infusion pump					
E1530	A		Replacement air bubble detec					
E1540	A		Replacement pressure alarm					
E1550	A		Bath conductivity meter					
E1560	A		Replace blood leak detector					
E1570	A		Adjustable chair for esrd pt					
E1575	A		Transducer protect/fld bar					
E1580	A		Unipuncture control system					
E1590	A		Hemodialysis machine					
E1592	A		Auto interm peritoneal dialy					
E1594	A		Cycler dialysis machine					
E1600	A		Deli/install chrg hemo equip					
E1610	A		Reverse osmosis h2o purı sys					
E1615	A		Deionizer H2O purı system					
E1620	A		Replacement blood pump					
E1625	A		Water softening system					
E1630	A		Reciprocating peritoneal dia					
E1632	A		Wearable artificial kidney					
E1634	E	NI	Peritoneal dialysis clamp					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E1635	A		Compact travel hemodialyzer					
E1636	A		Sorbent cartridges per 10					
E1637	A		Hemostats for dialysis, each					
E1639	A		Dialysis scale					
E1699	A		Dialysis equipment noc					
E1700	A		Jaw motion rehab system					
E1701	A		Repl cushions for jaw motion					
E1702	A		Repl measr scales jaw motion					
E1800	A		Adjust elbow ext/flex device					
E1801	A		SPS elbow device					
E1802	A		Adjst forearm pro/sup device					
E1805	A		Adjust wrist ext/flex device					
E1806	A		SPS wrist device					
E1810	A		Adjust knee ext/flex device					
E1811	A		SPS knee device					
E1815	A		Adjust ankle ext/flex device					
E1816	A		SPS ankle device					
E1818	A		SPS forearm device					
E1820	A		Soft interface material					
E1821	A		Replacement interface SPSD					
E1825	A		Adjust finger ext/flex devc					
E1830	A		Adjust toe ext/flex device					
E1840	A		Adj shoulder ext/flex device					
E1902	A		AAC non-electronic board					
E2000	A		Gastric suction pump hme mdl					
E2100	A		Bld glucose monitor w voice					
E2101	A		Bld glucose monitor w lance					
E2120	Y	NI	Pulse gen sys tx endolymp fl					
E2201	Y	NI	Man w/ch acc seat w>=20≧<24≧					
E2202	Y	NI	Seat width 24-27 in					
E2203	Y	NI	Frame depth less than 22 in					
E2204	Y	NI	Frame depth 22 to 25 in					
E2300	Y	NI	Pwr seat elevation sys					
E2301	Y	NI	Pwr standing					
E2310	Y	NI	Electro connect btw control					
E2311	Y	NI	Electro connect btw 2 sys					
E2320	Y	NI	Hand chin control					
E2321	Y	NI	Hand interface joystick					
E2322	Y	NI	Mult mech switches					
E2323	Y	NI	Special joystick handle					
E2324	Y	NI	Chin cup interface					
E2325	Y	NI	Sip and puff interface					
E2326	Y	NI	Breath tube kit					
E2327	Y	NI	Head control interface mech					
E2328	Y	NI	Head/extremity control inter					
E2329	Y	NI	Head control nonproportional					
E2330	Y	NI	Head control proximity switc					
E2331	Y	NI	Attendant control					
E2340	Y	NI	W/c wdth 20-23 in seat frame					
E2341	Y	NI	W/c wdth 24-27 in seat frame					
E2342	Y	NI	W/c dpth 20-21 in seat frame					
E2343	Y	NI	W/c dpth 22-25 in seat frame					
E2350	Y	NI	W/c hd pt wt > 250 lbs					
E2351	Y	NI	Electronic SGD interface					
E2360	Y	NI	22nf nonsealed leadacid					
E2361	Y	NI	22nf sealed leadacid battery					
E2362	Y	NI	Gr24 nonsealed leadacid					
E2363	Y	NI	Gr24 sealed leadacid battery					
E2364	Y	NI	U1nonsealed leadacid battery					
E2365	Y	NI	U1 sealed leadacid battery					
E2366	Y	NI	Battery charger, single mode					
E2367	Y	NI	Battery charger, dual mode					
E2399	Y	NI	Noc interface					
E2402	Y	NI	Neg press wound therapy pump					
E2500	Y	NI	SGD digitized pre-rec <=8min					
E2502	Y	NI	SGD prerec msg >8min <=20min					
E2504	Y	NI	SGD prerec msg>20min <=40min					
E2506	Y	NI	SGD prerec msg > 40 min					
E2508	Y	NI	SGD spelling phys contact					
E2510	Y	NI	SGD w multi methods msg/accs					
E2511	Y	NI	SGD sftwre prgrm for PC/PDA					
E2512	Y	NI	SGD accessory, mounting sys					
E2599	Y	NI	SGD accessory noc					
G0001	A		Drawing blood for specimen					
G0008	L		Admin influenza virus vac					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0009	L		Admin pneumococcal vaccine					
G0010	K		Admin hepatitis b vaccine	0355	0.2749	$15.00		$3.00
G0025	D	DNG	Collagen skin test kit					
G0027	A	NI	Semen analysis					
G0030	S		PET imaging prev PET single	0285	14.1508	$772.08	$334.45	$154.42
G0031	S		PET imaging prev PET multple	0285	14.1508	$772.08	$334.45	$154.42
G0032	S		PET follow SPECT 78464 singl	0285	14.1508	$772.08	$334.45	$154.42
G0033	S		PET follow SPECT 78464 mult	0285	14.1508	$772.08	$334.45	$154.42
G0034	S		PET follow SPECT 76865 singl	0285	14.1508	$772.08	$334.45	$154.42
G0035	S		PET follow SPECT 78465 mult	0285	14.1508	$772.08	$334.45	$154.42
G0036	S		PET follow comry angio sing	0285	14.1508	$772.08	$334.45	$154.42
G0037	S		PET follow comry angio mult	0285	14.1508	$772.08	$334.45	$154.42
G0038	S		PET follow myocard perf sing	0285	14.1508	$772.08	$334.45	$154.42
G0039	S		PET follow myocard perf mult	0285	14.1508	$772.08	$334.45	$154.42
G0040	S		PET follow stress echo singl	0285	14.1508	$772.08	$334.45	$154.42
G0041	S		PET follow stress echo mult	0285	14.1508	$772.08	$334.45	$154.42
G0042	S		PET follow ventriculogm sing	0285	14.1508	$772.08	$334.45	$154.42
G0043	S		PET follow ventriculogm mult	0285	14.1508	$772.08	$334.45	$154.42
G0044	S		PET following rest ECG singl	0285	14.1508	$772.08	$334.45	$154.42
G0045	S		PET following rest ECG mult	0285	14.1508	$772.08	$334.45	$154.42
G0046	S		PET follow stress ECG singl	0285	14.1508	$772.08	$334.45	$154.42
G0047	S		PET follow stress ECG mult	0285	14.1508	$772.08	$334.45	$154.42
G0101	V		CA screen;pelvic/breast exam	0600	0.9278	$50.62		$10.12
G0102	N		Prostate ca screening; dre					
G0103	A		Psa, total screening					
G0104	S		CA screen;flexi sigmoidscope	0159	2.7823	$151.81		$37.95
G0105	T		Colorectal scrn; hi risk ind	0158	7.4244	$405.08		$101.27
G0106	S		Colon CA screen;barium enema	0157	2.5693	$140.18		$28.04
G0107	A		CA screen; fecal blood test					
G0108	A		Diab manage trn per indiv					
G0109	A		Diab manage trn ind/group					
G0110	A	DG	Nett pulm-rehab educ; ind					
G0111	A	DG	Nett pulm-rehab educ; group					
G0112	A	DG	Nett;nutrition guid, initial					
G0113	A	DG	Nett;nutrition guid,subseqnt					
G0114	A	DG	Nett; psychosocial consult					
G0115	A	DG	Nett; psychological testing					
G0116	A	DG	Nett; psychosocial counsel					
G0117	S		Glaucoma scrn hgh risk direc	0230	0.7619	$41.57	$14.97	$8.31
G0118	S		Glaucoma scrn hgh risk direc	0230	0.7619	$41.57	$14.97	$8.31
G0120	S		Colon ca scrn; barium enema	0157	2.5693	$140.18		$28.04
G0121	T		Colon ca scrn not hi rsk ind	0158	7.4244	$405.08		$101.27
G0122	E		Colon ca scrn; barium enema					
G0123	A		Screen cerv/vag thin layer					
G0124	A		Screen c/v thin layer by MD					
G0125	S		PET img WhBD sgl pulm rng	1516		$1,450.00		$290.00
G0127	T		Trim nail(s)	0009	0.6652	$36.29	$8.34	$7.26
G0128	B		CORF skilled nursing service					
G0129	P		Partial hosp prog service	0033	5.2569	$286.82		$57.36
G0130	X		Single energy x-ray study	0260	0.7802	$42.57	$21.28	$8.51
G0141	E		Scr c/v cyto,autosys and md					
G0143	A		Scr c/v cyto,thinlayer,rescr					
G0144	A		Scr c/v cyto,thinlayer,rescr					
G0145	A		Scr c/v cyto,thinlayer,rescr					
G0147	A		Scr c/v cyto, automated sys					
G0148	A		Scr c/v cyto, autosys, rescr					
G0151	B		HHCP-serv of pt,ea 15 min					
G0152	B		HHCP-serv of ot,ea 15 min					
G0153	B		HHCP-svs of s/l path,ea 15mn					
G0154	B		HHCP-svs of m,ea 15 min					
G0155	B		HHCP-svs of csw,ea 15 min					
G0156	B		HHCP-svs of aide,ea 15 min					
G0166	T		Extml counterpulse, per tx	0678	2.0659	$112.72		$22.54
G0167	B	DG	Hyperbaric oz tx;no md reqrd					
G0168	X		Wound closure by adhesive	0340	0.6314	$34.45		$6.89
G0173	S		Stereo radoisurgery,complete	1528		$5,250.00		$1,050.00
G0175	V		OPPS Service,sched team conf	0602	1.5041	$82.07		$16.41
G0176	P		OPPS/PHP;activity therapy	0033	5.2569	$286.82		$57.36
G0177	P		OPPS/PHP; train & educ serv	0033	5.2569	$286.82		$57.36
G0179	E		MD recertification HHA PT					
G0180	E		MD certification HHA patient					
G0181	E		Home health care supervision					
G0182	E		Hospice care supervision					
G0186	T		Dstry eye lesn,fdr vssl tech	0235	5.0749	$276.89	$72.04	$55.38
G0202	A		Screeningmammographydigital					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0204	S		Diagnosticmammographydigital	0669	0.9009	$49.15		$9.83
G0206	S		Diagnosticmammographydigital	0669	0.9009	$49.15		$9.83
G0210	S		PET img whbd ring dxlung ca	1516		$1,450.00		$290.00
G0211	S		PET img whbd ring init lung	1516		$1,450.00		$290.00
G0212	S		PET img whbd ring restag lun	1516		$1,450.00		$290.00
G0213	S		PET img whbd ring dx colorec	1516		$1,450.00		$290.00
G0214	S		PET img whbd ring init colre	1516		$1,450.00		$290.00
G0215	S		PET img whbd restag col	1516		$1,450.00		$290.00
G0216	S		PET img whbd ring dx melanom	1516		$1,450.00		$290.00
G0217	S		PET img whbd ring init melan	1516		$1,450.00		$290.00
G0218	S		PET img whbd ring restag mel	1516		$1,450.00		$290.00
G0219	E		PET img whbd ring noncov ind					
G0220	S		PET img whbd ring dx lymphom	1516		$1,450.00		$290.00
G0221	S		PET img whbd ring init lymph	1516		$1,450.00		$290.00
G0222	S		PET img whbd ring resta lymp	1516		$1,450.00		$290.00
G0223	S		PET img whbd reg ring dx hea	1516		$1,450.00		$290.00
G0224	S		PETimg whbd reg ring ini hea	1516		$1,450.00		$290.00
G0225	S		PET img whbd rin.g restag hea	1516		$1,450.00		$290.00
G0226	S		PET img whbd dx esophag	1516		$1,450.00		$290.00
G0227	S		PET img whbd ring ini esopha	1516		$1,450.00		$290.00
G0228	S		PET img whbd ring restg esop	1516		$1,450.00		$290.00
G0229	S		PET img metabolic brain ring	1516		$1,450.00		$290.00
G0230	S		PET myocard viability ring	1516		$1,450.00		$290.00
G0231	S		PET WhBD colorec; gamma cam	1516		$1,450.00		$290.00
G0232	S		PET whbd lymphoma; gamma cam	1516		$1,450.00		$290.00
G0233	S		PET whbd melanoma; gamma cam	1516		$1,450.00		$290.00
G0234	S		PET WhBD pulm nod; gamma cam	1516		$1,450.00		$290.00
G0236	D	DNG	Digital film convert diag ma					
G0237	S		Therapeutic procd strg endur	0411	0.4367	$23.83		$4.77
G0238	S		Oth resp proc, indiv	0411	0.4367	$23.83		$4.77
G0239	S		Oth resp proc, group	0411	0.4367	$23.83		$4.77
G0242	S		Multisource photon ster plan	1516		$1,450.00		$290.00
G0243	S		Multisour photon stero treat	1528		$5,250.00		$1,050.00
G0244	S		Observ care by facility topt	0339	3.8356	$209.27		$41.85
G0245	V		Initial Foot Exam PTLOPS	0600	0.9278	$50.62		$10.12
G0246	V		Follow-up Eval of Foot PTLOPS	0600	0.9278	$50.62		$10.12
G0247	T		Routine footcare w LOPS	0009	0.6652	$36.29	$8.34	$7.26
G0248	S		Demonstrate use home INR mon	1503		$150.00		$30.00
G0249	S		Provide test material,equipm	1503		$150.00		$30.00
G0250	E		MD review interpret of test					
G0251	S		Linear acc based stero radio	1513		$1,150.00		$230.00
G0252	E		PET imaging initial dx					
G0253	S		PET image brst dection recur	1516		$1,450.00		$290.00
G0254	S		PET image brst eval to tx	1516		$1,450.00		$290.00
G0255	E		Current percep threshold tst					
G0256	D	DNG	Prostate brachy w palladium					
G0257	S		Unsched dialysis ESRD pt hos	0170	5.9678	$325.61		$65.12
G0259	N		Inject for sacroiliac joint					
G0260	T		Inj for sacroiliac jt anesth	0204	2.1711	$118.46	$40.13	$23.69
G0261	D	DNG	Prostate brachy w iodine see					
G0262	S	DG	Sm intestinal image capsule	1508		$650.00		$130.00
G0263	N		Adm with CHF, CP, asthma					
G0264	V		Assmt otr CHF, CP, asthma	0600	0.9278	$50.62		$10.12
G0265	A		Cryopresevation Freeze+stora					
G0266	A		Thawing + expansion froz cel					
G0267	S		Bone marrow or psc harvest	0110	3.6718	$200.34		$40.07
G0268	X		Removal of impacted wax md	0340	0.6314	$34.45		$6.89
G0269	N		Occlusive device in vein art					
G0270	A		MNT subs tx for change dx					
G0271	A		Group MNT 2 or more 30 mins					
G0272	X	DG	Naso/oro gastric tube pl MD	0272	1.4166	$77.29	$38.36	$15.46
G0273	D	DNG	Pretx planning, non-Hodgkins					
G0274	D	DNG	Radiopharm tx, non-Hodgkins					
G0275	N		Renal angio, cardiac cath					
G0278	N		Iliac art angio,cardiac cath					
G0279	A		Excorp shock tx, elbow epi					
G0280	A		Excorp shock tx other than					
G0281	A		Elec stim unattend for press					
G0282	A		Elect stim wound care not pd					
G0283	A		Elec stim other than wound					
G0288	S		Recon, CTA for pre & post sug	1506		$450.00		$90.00
G0289	N		Arthro, loose body + chondro					
G0290	T		Drug-eluting stents, single	0656	103.4907	$5,646.56		$1,129.31
G0291	T		Drug-eluting stents,each add	0656	103.4907	$5,646.56		$1,129.31
G0292	S		Adm exp drugs,clinical trial	1503		$150.00		$30.00

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0293	S		Non-cov surg proc,clin trial	1505		$350.00		$70.00
G0294	S		Non-cov proc, clinical trial	1502		$75.00		$15.00
G0295	E		Electromagnetic therapy onc					
G0296	S	NF	PET imge restag thyrod cance	1516		$1,450.00		$290.00
G0297	T	NF	Insert single chamber/cd	0107	337.1304	$18,394.17	$3,699.14	$3,678.83
G0298	T	NF	Insert dual chamber/cd	0107	337.1304	$18,394.17	$3,699.14	$3,678.83
G0299	T	NF	Inser/repos single icd+leads	0108	433.2998	$23,641.27		$4,728.25
G0300	T	NF	Insert reposit lead dual+gen	0108	433.2998	$23,641.27		$4,728.25
G0302	S	NI	Pre-op service LVRS complete	1509		$750.00		$150.00
G0303	S	NI	Pre-op service LVRS 10-15dos	1507		$550.00		$110.00
G0304	S	NI	Pre-op service LVRS 1-9 dos	1504		$250.00		$50.00
G0305	S	NI	Post op service LVRS min 6	1504		$250.00		$50.00
G0306	A	NI	CBC/diffwbc w/o platelet					
G0307	A	NI	CBC without platelet					
G0323	A	NI	ESRD related svs home mo 20+					
G0324	A	NI	ESRD related svs home/dy/2y					
G0325	A	NI	ESRD relate home/dy 2-11yr					
G0326	A	NI	ESRD relate home/dy 12-19y					
G0327	A	NI	ESRD relate home/dy 20+yrs					
G0338	S	NI	Linear accelerator stero pln	1516		$1,450.00		$290.00
G0339	S	NI	Robot lin-radsurg com, first	1528		$5,250.00		$1,050.00
G0340	S	NI	Robot lin-radsurg fractx 2-5	1525		$3,750.00		$750.00
G3001	S	NI	Admin + supply, tositumomab	1522		$2,250.00		$450.00
G9001	B		MCCD, initial rate					
G9002	B		MCCD,maintenance rate					
G9003	B		MCCD, risk adj hi, initial					
G9004	B		MCCD, risk adj lo, initial					
G9005	B		MCCD, risk adj, maintenance					
G9006	B		MCCD, Home monitoring					
G9007	B		MCCD, sch team conf					
G9008	B		Mccd,phys coor-care ovrsght					
G9009	E		MCCD, risk adj, level 3					
G9010	E		MCCD, risk adj, level 4					
G9011	E		MCCD, risk adj, level 5					
G9012	E		Other Specified Case Mgmt					
G9016	E		Demo-smoking cessation coun					
J0120	N		Tetracyclin injection					
J0130	K		Abciximab injection	1605	5.3048	$289.44		$57.89
J0150	K		Injection adenosine 6 MG	0379	0.2078	$11.34		$2.27
J0151	D	DNG	Adenosine injection					
J0152	K	NI	Adenosine injection	0917	1.0393	$56.71		$11.34
J0170	N		Adrenalin epinephrin inject					
J0190	N		Inj biperiden lactate/5 mg					
J0200	N		Alatrofloxacin mesylate					
J0205	K		Alglucerase injection	0900		$37.13		$7.43
J0207	K		Amifostine	7000	5.3041	$289.40		$57.88
J0210	N		Methyldopate hcl injection					
J0215	B		Alefacept					
J0256	K		Alpha 1 proteinase inhibitor	0901		$3.43		$0.69
J0270	B		Alprostadil for injection					
J0275	B		Alprostadil urethral suppos					
J0280	N		Aminophyllin 250 MG inj					
J0282	N		Amiodarone HCl					
J0285	N		Amphotencin B					
J0287	K		Amphotericin b lipid complex	9024	0.3823	$20.86		$4.17
J0288	K		Ampho b cholesteryl sulfate	9024	0.3823	$20.86		$4.17
J0289	K		Amphotericin b liposome inj	9024	0.3823	$20.86		$4.17
J0290	N		Ampicillin 500 MG inj					
J0295	N		Ampicillin sodium per 1.5 gm					
J0300	N		Amobarbital 125 MG inj					
J0330	N		Succinycholine chloride inj					
J0350	K		Injection anistreplase 30 u	1606	27.7939	$1,516.46		$303.29
J0360	N		Hydralazine hcl injection					
J0380	N		Inj metaraminol bitartrate					
J0390	N		Chloroquine injection					
J0395	N		Arbutamine HCl injection					
J0456	N		Azithromycin					
J0460	N		Atropine sulfate injection					
J0470	N		Dimecaprol injection					
J0475	N		Baclofen 10 MG injection					
J0476	B		Baclofen intrathecal trial					
J0500	N		Dicyclomine injection					
J0515	N		Inj benztropine mesylate					
J0520	N		Bethanechol chloride inject					
J0530	N		Penicillin g benzathine inj					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J0540	N		Penicillin g benzathine inj					
J0550	N		Penicillin g benzathine inj					
J0560	N		Penicillin g benzathine inj					
J0570	N		Penicillin g benzathine inj					
J0580	N		Penicillin g benzathine inj					
J0583	G	NI	Bivalirudin	9111		$1.60		$0.04
J0585	K		Botulinum toxin a per unit	0902	0.0588	$3.21		$0.64
J0587	K		Botulinum toxin type B	9018	0.1279	$6.98		$1.40
J0592	N		Buprenorphine hydrochloride					
J0595	N	NI	Butorphanol tartrate 1 mg					
J0600	N		Edetate calcium disodium inj					
J0610	N		Calcium gluconate injection					
J0620	N		Calcium glycer & lact/10 ML					
J0630	N		Calcitonin salmon injection					
J0636	N		Inj calcitriol per 0.1 mcg					
J0637	K		Caspofungin acetate	9019	0.5432	$29.64		$5.93
J0640	N		Leucovorin calcium injection					
J0670	N		Inj mepivacaine HCL/10 ml					
J0690	N		Cefazolin sodium injection					
J0692	N		Cefepime HCl for injection					
J0694	N		Cefoxitin sodium injection					
J0696	N		Ceftriaxone sodium injection					
J0697	N		Sterile cefuroxime injection					
J0698	N		Cefotaxime sodium injection					
J0702	N		Betamethasone acet&sod phosp					
J0704	N		Betamethasone sod phosp/4 MG					
J0706	N		Caffeine citrate injection					
J0710	N		Cephapirin sodium injection					
J0713	N		Inj ceftazidime per 500 mg					
J0715	N		Ceftizoxime sodium / 500 MG					
J0720	N		Chloramphenicol sodium injec					
J0725	N		Chorionic gonadotropin/1000u					
J0735	N		Clonidine hydrochloride					
J0740	N		Cidofovir injection					
J0743	N		Cilastatin sodium injection					
J0744	N		Ciprofloxacin iv					
J0745	N		Inj codeine phosphate /30 MG					
J0760	N		Colchicine injection					
J0770	N		Colistimethate sodium inj					
J0780	N		Prochlorperazine injection					
J0800	N		Corticotropin injection					
J0835	N		Inj cosyntropin per 0.25 MG					
J0850	K		Cytomegalovirus imm IV /vial	0903	5.3368	$291.18		$58.24
J0880	E		Darbepoetin alfa injection					
J0895	N		Deferoxamine mesylate inj					
J0900	N		Testosterone enanthate inj					
J0945	N		Brompheniramine maleate inj					
J0970	N		Estradiol valerate injection					
J1000	N		Depo-estradiol cypionate inj					
J1020	N		Methylprednisolone 20 MG inj					
J1030	N		Methylprednisolone 40 MG inj					
J1040	N		Methylprednisolone 80 MG inj					
J1051	N		Medroxyprogesterone inj					
J1055	E		Medrxyprogester acetate inj					
J1056	E		MA/EC contraceptiveinjection					
J1060	N		Testosterone cypionate 1 ML					
J1070	N		Testosterone cypionat 100 MG					
J1080	N		Testosterone cypionat 200 MG					
J1094	N		Inj dexamethasone acetate					
J1100	N		Dexamethasone sodium phos					
J1110	N		Inj dihydroergotamine mesylt					
J1120	N		Acetazolamid sodium injectio					
J1160	N		Digoxin injection					
J1165	N		Phenytoin sodium injection					
J1170	N		Hydromorphone injection					
J1180	N		Dyphylline injection					
J1190	K		Dexrazoxane HCl injection	0726	2.0616	$112.48		$22.50
J1200	N		Diphenhydramine hcl injectio					
J1205	N		Chlorothiazide sodium inj					
J1212	N		Dimethyl sulfoxide 50% 50 ML					
J1230	N		Methadone injection					
J1240	N		Dimenhydrinate injection					
J1245	K		Dipyridamole injection	0380	0.2525	$13.78		$2.76
J1250	N		Inj dobutamine HCL/250 mg					
J1260	N		Dolasetron mesylate					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J1270	N		Injection, doxercalciferol					
J1320	N		Amitriptyline injection					
J1325	N		Epoprostenol injection					
J1327	K		Eptifibatide injection	1607	0.1465	$7.99		$1.60
J1330	N		Ergonovine maleate injection					
J1335	G	NI	Ertapenem injection	9116		$23.74		$3.55
J1364	N		Erythro lactobionate /500 MG					
J1380	N		Estradiol valerate 10 MG inj					
J1390	N		Estradiol valerate 20 MG inj					
J1410	N		Inj estrogen conjugate 25 MG					
J1435	N		Injection estrone per 1 MG					
J1436	N		Etidronate disodium inj					
J1438	K		Etanercept injection	1608	1.8762	$102.37		$20.47
J1440	K		Filgrastim 300 mcg injection	0728	2.2631	$123.48		$24.70
J1441	K		Filgrastim 480 mcg injection	7049	3.2251	$175.96		$35.19
J1450	N		Fluconazole					
J1452	N		Intraocular Fomivirsen na					
J1455	N		Foscarnet sodium injection					
J1460	N		Gamma globulin 1 CC inj					
J1470	B		Gamma globulin 2 CC inj					
J1480	B		Gamma globulin 3 CC inj					
J1490	B		Gamma globulin 4 CC inj					
J1500	B		Gamma globulin 5 CC inj					
J1510	B		Gamma globulin 6 CC inj					
J1520	B		Gamma globulin 7 CC inj					
J1530	B		Gamma globulin 8 CC inj					
J1540	B		Gamma globulin 9 CC inj					
J1550	B		Gamma globulin 10 CC inj					
J1560	B		Gamma globulin > 10 CC inj					
J1563	K		Immune globulin, 1 g	0905	0.8057	$43.96		$8.79
J1564	K		Immune globulin 10 mg	9021	0.0080	$0.44		$0.09
J1565	K		RSV-ivig	0906	0.8910	$48.61		$9.72
J1570	K		Ganciclovir sodium injection	0907	0.5918	$32.29		$6.46
J1580	N		Garamycin gentamicin inj					
J1590	N		Gatifloxacin injection					
J1595	N		Injection glatiramer acetate					
J1600	N		Gold sodium thiomaleate inj					
J1610	N		Glucagon hydrochloride/1 MG					
J1620	N		Gonadorelin hydroch/ 100 mcg					
J1626	K		Granisetron HCl injection	0764	0.1044	$5.70		$1.14
J1630	N		Haloperidol injection					
J1631	N		Haloperidol decanoate inj					
J1642	N		Inj heparin sodium per 10 u					
J1644	N		Inj heparin sodium per 1000u					
J1645	N		Dalteparin sodium					
J1650	N		Inj enoxaparin sodium					
J1652	N		Fondaparinux sodium					
J1655	N		Tinzaparin sodium injection					
J1670	N		Tetanus immune globulin inj					
J1700	N		Hydrocortisone acetate inj					
J1710	N		Hydrocortisone sodium ph inj					
J1720	N		Hydrocortisone sodium succ i					
J1730	N		Diazoxide injection					
J1742	N		Ibutilide fumarate injection					
J1745	K		Infliximab injection	7043	0.7122	$38.86		$7.77
J1750	N		Iron dextran					
J1756	N		Iron sucrose injection					
J1785	K		Injection imiglucerase /unit	0916		$3.71		$0.74
J1790	N		Droperidol injection					
J1800	N		Propranolol injection					
J1810	E		Droperidol/fentanyl inj					
J1815	N		Insulin injection					
J1817	N		Insulin for insulin pump use					
J1825	K		Interferon beta-1a	0909	3.3868	$184.79		$36.96
J1830	K		Interferon beta-1b / .25 MG	0910	1.8421	$100.51		$20.10
J1835	N		Itraconazole injection					
J1840	N		Kanamycin sulfate 500 MG inj					
J1850	N		Kanamycin sulfate 75 MG inj					
J1885	N		Ketorolac tromethamine inj					
J1890	N		Cephalothin sodium injection					
J1910	N	DG	Kutapressin injection					
J1940	N		Furosemide injection					
J1950	K		Leuprolide acetate /3.75 MG	0800	3.3525	$182.92		$36.58
J1955	B		Inj levocarnitine per 1 gm					
J1956	N		Levofloxacin injection					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J1960	N		Levorphanol tartrate inj					
J1980	N		Hyoscyamine sulfate inj					
J1990	N		Chlordiazepoxide injection					
J2000	N	DG	Lidocaine injection					
J2001	N	NI	Lidocaine injection					
J2010	N		Lincomycin injection					
J2020	K		Linezolid injection	9001	0.2771	$15.12		$3.02
J2060	N		Lorazepam injection					
J2150	N		Mannitol injection					
J2175	N		Meperidine hydrochl /100 MG					
J2180	N		Meperidine/promethazine inj					
J2185	N	NI	Meropenem					
J2210	N		Methylergonovin maleate inj					
J2250	N		Inj midazolam hydrochloride					
J2260	K		Inj milrinone lactate, per 5 mg	7007	0.2129	$11.62		$2.32
J2270	N		Morphine sulfate injection					
J2271	N		Morphine so4 injection 100mg					
J2275	N		Morphine sulfate injection					
J2280	N	NI	Inj, moxifloxacin 100 mg					
J2300	N		Inj nalbuphine hydrochloride					
J2310	N		Inj naloxone hydrochloride					
J2320	N		Nandrolone decanoate 50 MG					
J2321	N		Nandrolone decanoate 100 MG					
J2322	N		Nandrolone decanoate 200 MG					
J2324	G		Nesiritide, per 0.5 mg vial	9114		$151.62		$22.66
J2352	D	DNG	Octreotide acetate injection					
J2353	K	NI	Octreotide injection, depot	1207	1.2049	$65.74		$13.15
J2354	K	NI	Octreotide inj, non-depot	7031	0.0264	$1.44		$0.29
J2355	K		Oprelvekin injection	7011		$248.16		$49.63
J2360	N		Orphenadrine injection					
J2370	N		Phenylephrine hcl injection					
J2400	N		Chloroprocaine hcl injection					
J2405	N		Ondansetron hcl injection					
J2410	N		Oxymorphone hcl injection					
J2430	K		Pamidronate disodium /30 MG	0730	3.1949	$174.32		$34.86
J2440	N		Papaverin hcl injection					
J2460	N		Oxytetracycline injection					
J2501	N		Paricalcitol					
J2505	G	NI	Injection, pegfilgrastim 6mg	9119		$2,802.50		$418.90
J2510	N		Penicillin g procaine inj					
J2515	N		Pentobarbital sodium inj					
J2540	N		Penicillin g potassium inj					
J2543	N		Piperacillin/tazobactam					
J2545	Y		Pentamidine isethionte/300mg					
J2550	N		Promethazine hcl injection					
J2560	N		Phenobarbital sodium inj					
J2590	N		Oxytocin injection					
J2597	N		Inj desmopressin acetate					
J2650	N		Prednisolone acetate inj					
J2670	N		Totazoline hcl injection					
J2675	N		Inj progesterone per 50 MG					
J2680	N		Fluphenazine decanoate 25 MG					
J2690	N		Procainamide hcl injection					
J2700	N		Oxacillin sodium injeciton					
J2710	N		Neostigmine methylslfte inj					
J2720	N		Inj protamine sulfate/10 MG					
J2725	N		Inj protirelin per 250 mcg					
J2730	N		Pralidoxime chloride inj					
J2760	N		Phentolaine mesylate inj					
J2765	N		Metoclopramide hcl injection					
J2770	N		Quinupristin/dalfopristin					
J2780	N		Ranitidine hydrochloride inj					
J2783	N	NI	Rasburicase					
J2788	K		Rho d immune globulin 50 mcg	9023	0.0310	$1.69		$0.34
J2790	K		Rho d immune globulin inj	0884	0.1863	$10.16		$2.03
J2792	K		Rho(D) immune globulin h, sd	1609	0.1789	$9.76		$1.95
J2795	N		Ropivacaine HCl injection					
J2800	N		Methocarbamol injection					
J2810	N		Inj theophylline per 40 MG					
J2820	K		Sargramostim injection	0731	0.2991	$16.32		$3.26
J2910	N		Aurothioglucose injeciton					
J2912	N		Sodium chloride injection					
J2916	N		Na ferric gluconate complex					
J2920	N		Methylprednisolone injection					
J2930	N		Methylprednisolone injection					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J2940	N		Somatrem injection					
J2941	K		Somatropin injection	7034	0.7547	$41.18		$8.24
J2950	N		Promazine hcl injection					
J2993	K		Reteplase injection	9005	10.4165	$568.33		$113.67
J2995	K		Inj streptokinase /250000 IU	0911	1.5733	$85.84		$17.17
J2997	K		Alteplase recombinant	7048	0.2856	$15.58		$3.12
J3000	N		Streptomycin injection					
J3010	N		Fentanyl citrate injeciton					
J3030	N		Sumatriptan succinate / 6 MG					
J3070	N		Pentazocine hcl injection					
J3100	K		Tenecteplase injection	9002	23.7669	$1,296.75		$259.35
J3105	N		Terbutaline sulfate inj					
J3120	N		Testosterone enanthate inj					
J3130	N		Testosterone enanthate inj					
J3140	N		Testosterone suspension inj					
J3150	N		Testosteron propionate inj					
J3230	N		Chlorpromazine hcl injection					
J3240	K		Thyrotropin injection	9108		$572.00		$114.40
J3245	K		Tirofiban hydrochloride	7041	4.176	$227.85		$45.57
J3250	N		Trimethobenzamide hcl inj					
J3260	N		Tobramycin sulfate injection					
J3265	N		Injection torsemide 10 mg/ml					
J3280	N		Thiethylperazine maleate inj					
J3301	N		Triamcinolone acetonide inj					
J3302	N		Triamcinolone diacetate inj					
J3303	N		Triamcinolone hexacetonl inj					
J3305	K		Inj trimetrexate glucoronate	7045	1.1246	$61.36		$12.27
J3310	N		Perphenazine injeciton					
J3315	G		Triptorelin pamoate	9122		$398.62		$59.58
J3320	N		Spectinomycn di-hcl inj					
J3350	N		Urea injection					
J3360	N		Diazepam injection					
J3364	N		Urokinase 5000 IU injection					
J3365	K		Urokinase 250,000 IU inj	7036	3.7855	$206.54		$41.31
J3370	N		Vancomycin hcl injection					
J3395	K		Verteporfin injection	1203	16.4439	$897.20		$179.44
J3400	N		Triflupromazine hcl inj					
J3410	N		Hydroxyzine hcl injection					
J3411	N	NI	Thiamine hcl 100 mg					
J3415	N	NI	Pyridoxine hcl 100 mg					
J3420	N		Vitamin b12 injection					
J3430	N		Vitamin k phytonadione inj					
J3465	N	NI	Injection, voriconazole					
J3470	N		Hyaluronidase injection					
J3475	N		Inj magnesium sulfate					
J3480	N		Inj potassium chloride					
J3485	N		Zidovudine					
J3486	G	NI	Ziprasidone mesylate	9204		$20.79		$3.11
J3487	G		Zoledronic acid	9115		$217.43		$32.50
J3490	N		Drugs unclassified injection					
J3520	E		Edetate disodium per 150 mg					
J3530	N		Nasal vaccine inhalation					
J3535	E		Metered dose inhaler drug					
J3570	E		Laetrile amygdalin vit B17					
J3590	N		Unclassified biologics					
J7030	N		Normal saline solution infus					
J7040	N		Normal saline solution infus					
J7042	N		5% dextrose/normal saline					
J7050	N		Normal saline solution infus					
J7051	N		Sterile saline/water					
J7060	N		5% dextrose/water					
J7070	N		D5w infusion					
J7100	N		Dextran 40 infusion					
J7110	N		Dextran 75 infusion					
J7120	N		Ringers lactate infusion					
J7130	N		Hypertonic saline solution					
J7190	K		Factor viii	0925		$0.51		$0.10
J7191	K		Factor VIII (porcine)	0926		$1.52		$0.30
J7192	K		Factor viii recombinant	0927		$1.01		$0.20
J7193	K		Factor IX non-recombinant	0931		$0.51		$0.10
J7194	K		Factor ix complex	0928		$0.51		$0.10
J7195	K		Factor IX recombinant	0932		$1.01		$0.20
J7197	N		Antithrombin iii injection					
J7198	K		Anti-inhibitor	0929		$1.01		$0.20
J7199	B		Hemophilia clot factor noc					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J7300	E		Intraut copper contraceptive					
J7302	E		Levonorgestrel iu contracept					
J7303	E	NI	Contraceptive vaginal ring					
J7308	N		Aminolevulinic acid hcl top					
J7310	K		Ganciclovir long act implant	0913	1.5861	$86.54		$17.31
J7317	K		Sodium hyaluronate injection	7316	2.5436	$138.78		$27.76
J7320	K		Hylan G-F 20 injection	1611	2.2628	$123.46		$24.69
J7330	E		Cultured chondrocytes implnt					
J7340	E		Metabolic active D/E tissue					
J7342	N		Metabolically active tissue					
J7350	N		Injectable human tissue					
J7500	N		Azathioprine oral 50mg					
J7501	N		Azathioprine parenteral					
J7502	K		Cyclosporine oral 100 mg	0888	0.0470	$2.56		$0.51
J7504	K		Lymphocyte immune globulin	0890	2.3439	$127.89		$25.58
J7505	K		Monoclonal antibodies	7038	5.8803	$320.84		$64.17
J7506	N		Prednisone oral					
J7507	K		Tacrolimus oral per 1 MG	0891	0.0246	$1.34		$0.27
J7508	B	DG	Tacrolimus oral per 5 MG					
J7509	N		Methylprednisolone oral					
J7510	N		Prednisolone oral per 5 mg					
J7511	K		Antithymocyte globuln rabbit	9104	2.9978	$163.56		$32.71
J7513	K		Daclizumab, parenteral	1612		$393.78		$78.76
J7515	N		Cyclosporine oral 25 mg					
J7516	N		Cyclosporin parenteral 250mg					
J7517	K		Mycophenolate mofetil oral	9015	0.0374	$2.04		$0.41
J7520	K		Sirolimus, oral	9020	0.0529	$2.89		$0.58
J7525	K		Tacrolimus injection	9006	0.1048	$5.72		$1.14
J7599	N		Immunosuppressive drug noc					
J7608	Y		Acetylcysteine inh sol u d					
J7618	Y		Albuterol inh sol con					
J7619	Y		Albuterol inh sol u d					
J7621	Y	NI	(Levo)albuterol/Ipra-bromide					
J7622	A		Beclomethasone inhalatn sol					
J7624	A		Betamethasone inhalation sol					
J7626	A		Budesonide inhalation sol					
J7628	Y		Bitolterol mes inhal sol con					
J7629	Y		Bitolterol mes inh sol u d					
J7631	Y		Cromolyn sodium inh sol u d					
J7633	N		Budesonide concentrated sol					
J7635	Y		Atropine inhal sol con					
J7636	Y		Atropine inhal sol unit dose					
J7637	Y		Dexamethasone inhal sol con					
J7638	Y		Dexamethasone inhal sol u d					
J7639	Y		Domase alpha inhal sol u d					
J7641	A		Flunisolide, inhalation sol					
J7642	Y		Glycopyrrolate inhal sol con					
J7643	Y		Glycopyrrolate inhal sol u d					
J7644	Y		Ipratropium brom inh sol u d					
J7648	Y		Isoetharine hcl inh sol con					
J7649	Y		Isoetharine hcl inh sol u d					
J7658	Y		Isoproterenolhcl inh sol con					
J7659	Y		Isoproterenol hcl inh sol ud					
J7668	Y		Metaproterenol inh sol con					
J7669	Y		Metaproterenol inh sol u d					
J7680	Y		Terbutaline so4 inh sol con					
J7681	Y		Terbutaline so4 inh sol u d					
J7682	Y		Tobramycin inhalation sol					
J7683	Y		Triamcinolone inh sol con					
J7684	Y		Triamcinolone inh sol u d					
J7699	Y		Inhalation solution for DME					
J7799	Y		Non-inhalation drug for DME					
J8499	E		Oral prescrip drug non chemo					
J8510	K		Oral busulfan	7015	0.0288	$1.57		$0.31
J8520	K		Capecitabine, oral, 150 mg	7042	0.0302	$1.65		$0.33
J8521	E		Capecitabine, oral, 500 mg					
J8530	N		Cyclophosphamide oral 25 MG					
J8560	K		Etoposide oral 50 MG	0802	0.5016	$27.37		$5.47
J8600	N		Melphalan oral 2 MG					
J8610	N		Methotrexate oral 2.5 MG					
J8700	K		Temozolmide	1086	0.0690	$3.76		$0.75
J8999	B		Oral prescription drug chemo					
J9000	K		Doxorubic hcl 10 MG vl chemo	0847	0.1212	$6.61		$1.32
J9001	K		Doxorubicin hcl liposome inj	7046	4.6982	$256.34		$51.27
J9010	K		Alemtuzumab injection	9110	7.7873	$424.88		$84.98

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J9015	K		Aldesleukin/single use vial	0807		$680.35		$136.07
J9017	K		Arsenic trioxide	9012	0.4933	$26.91		$5.38
J9020	K		Asparaginase injection	0814	0.2957	$16.13		$3.23
J9031	K		Bcg live intravesical vac	0809	1.9015	$103.75		$20.75
J9040	K		Bleomycin sulfate injection	0857	2.9427	$160.56		$32.11
J9045	K		Carboplatin injection	0811	1.5849	$86.47		$17.29
J9050	N		Carmus bischl nitro inj					
J9060	K		Cisplatin 10 MG injection	0813	0.3985	$21.74		$4.35
J9062	B		Cisplatin 50 MG injection					
J9065	K		Inj cladribine per 1 MG	0858	0.6931	$37.82		$7.56
J9070	K		Cyclophosphamide 100 MG inj	0815	0.0868	$4.74		$0.95
J9080	B		Cyclophosphamide 200 MG inj					
J9090	B		Cyclophosphamide 500 MG inj					
J9091	B		Cyclophosphamide 1.0 grm inj					
J9092	B		Cyclophosphamide 2.0 grm inj					
J9093	K		Cyclophosphamide lyophilized	0816	0.0825	$4.50		$0.90
J9094	B		Cyclophosphamide lyophilized					
J9095	B		Cyclophosphamide lyophilized					
J9096	B		Cyclophosphamide lyophilized					
J9097	B		Cyclophosphamide lyophilized					
J9098	K	NI	Cytarabine liposome	1166	5.1134	$278.99		$55.80
J9100	K		Cytarabine hcl 100 MG inj	0817	0.0930	$5.07		$1.01
J9110	B		Cytarabine hcl 500 MG inj					
J9120	N		Dactinomycin actinomycin d					
J9130	K		Dacarbazine 100 mg inj	0819	0.0974	$5.31		$1.06
J9140	B		Dacarbazine 200 MG inj					
J9150	K		Daunorubicin	0820	1.3557	$73.97		$14.79
J9151	K		Daunorubicin citrate liposom	0821	2.9976	$163.55		$32.71
J9160	K		Denileukin diftitox, 300 mcg	1084		$1,232.88		$246.58
J9165	N		Diethylstilbestrol injection					
J9170	K		Docetaxel	0823	4.0499	$220.97		$44.19
J9178	K	NI	Inj, epirubicin hcl, 2 mg	1167	0.3744	$20.43		$4.09
J9180	B	DG	Epirubicin HCl injection					
J9181	K		Etoposide 10 MG inj	0824	0.0836	$4.56		$0.91
J9182	B		Etoposide 100 MG inj					
J9185	K		Fludarabine phosphate inj	0842	3.7708	$205.74		$41.15
J9190	N		Fluorouracil injection					
J9200	K		Floxuridine injection	0827	2.0928	$114.19		$22.84
J9201	K		Gemcitabine HCl	0828	1.4742	$80.43		$16.09
J9202	K		Goserelin acetate implant	0810	5.2265	$285.16		$57.03
J9206	K		Irinotecan injection	0830	1.8428	$100.55		$20.11
J9208	K		Ifosfomide injection	0831	1.9435	$106.04		$21.21
J9209	K		Mesna injection	0732	0.5211	$28.43		$5.69
J9211	K		Idarubicin hcl injection	0832	3.2663	$178.21		$35.64
J9212	N		Interferon alfacon-1					
J9213	K		Interferon alfa-2a inj	0834	0.3777	$20.61		$4.12
J9214	K		Interferon alfa-2b inj	0836	0.2003	$10.93		$2.19
J9215	K		Interferon alfa-n3 inj	0865	1.4598	$79.65		$15.93
J9216	K		Interferon gamma 1-b inj	0838		$180.15		$36.03
J9217	K		Leuprolide acetate suspnsion	9217	5.7252	$312.37		$62.47
J9218	K		Leuprolide acetate injeciton	0861	0.7991	$43.60		$8.72
J9219	K		Leuprolide acetate implant	7051	67.2039	$3,666.71		$733.34
J9230	N		Mechlorethamine hcl inj					
J9245	K		Inj melphalan hydrochl 50 MG	0840	4.6719	$254.90		$50.98
J9250	N		Methotrexate sodium inj					
J9260	B		Methotrexate sodium inj					
J9263	B	NI	Oxaliplatin					
J9265	K		Paclitaxel injection	0863	2.0553	$112.14		$22.43
J9266	N		Pegaspargase/singl dose vial					
J9268	K		Pentostatin injection	0844	17.7045	$965.98		$193.20
J9270	K		Plicamycin (mithramycin) inj	0860	0.2826	$15.42		$3.08
J9280	K		Mitomycin 5 MG inj	0862	0.9719	$53.03		$10.61
J9290	B		Mitomycin 20 MG inj					
J9291	B		Mitomycin 40 MG inj					
J9293	K		Mitoxantrone hydrochl / 5 MG	0864	3.1832	$173.68		$34.74
J9300	K		Gemtuzumab ozogamicin	9004		$2,022.90		$404.58
J9310	K		Rituximab cancer treatment	0849	5.6158	$306.40		$61.28
J9320	K		Streptozocin injection	0850	1.1948	$65.19		$13.04
J9340	K		Thiotepa injection	0851	1.0984	$59.93		$11.99
J9350	K		Topotecan	0852	7.9435	$433.41		$86.68
J9355	K		Trastuzumab	1613	0.7434	$40.56		$8.11
J9357	K		Valrubicin, 200 mg	1614	8.4635	$461.78		$92.36
J9360	N		Vinblastine sulfate inj					
J9370	N		Vincristine sulfate 1 MG inj					
J9375	B		Vincristine sulfate 2 MG inj					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J9380	B		Vincristine sulfate 5 MG inj					
J9390	K		Vinorelbine tartrate/10 mg	0855	1.1874	$64.79		$12.96
J9395	G	NI	Injection, Fulvestrant	9120		$87.58		$87.58
J9600	K		Porfimer sodium	0856	29.2205	$1,594.30		$318.86
J9999	N		Chemotherapy drug.					
K0001	A		Standard wheelchair					
K0002	A		Stnd hemi (low seat) whlchr					
K0003	A		Lightweight wheelchair					
K0004	A		High strength ltwt whlchr					
K0005	A		Ultralightweight wheelchair					
K0006	A		Heavy duty wheelchair					
K0007	A		Extra heavy duty wheelchair					
K0009	A		Other manual wheelchair/base					
K0010	A		Stnd wt frame power whlchr					
K0011	A		Stnd wt pwr whlchr w control					
K0012	A		Ltwt portbl power whlchr					
K0014	A		Other power whlchr base					
K0015	A		Detach non-adjus hght armrst					
K0016	A	DG	Detach adjust armrst cmplete					
K0017	A		Detach adjust armrest base					
K0018	A		Detach adjust armrst upper					
K0019	A		Arm pad each					
K0020	A		Fixed adjust armrest pair					
K0022	A	DG	Reinforced back upholstery					
K0023	A		Planr back insrt foam w/strp					
K0024	A		Plnr back insrt foam w/hrdwr					
K0025	A	DG	Hook-on headrest extension					
K0026	A	DG	Back upholst lgtwt whlchr					
K0027	A	DG	Back upholst other whlchr					
K0028	A	DG	Manual fully reclining back					
K0029	A	DG	Reinforced seat upholstery					
K0030	A	DG	Solid plnr seat sngl dnsfoam					
K0031	A	DG	Safety belt/pelvic strap					
K0032	A	DG	Seat uphols lgtwt whlchr					
K0033	A	DG	Seat upholstery other whlchr					
K0035	A	DG	Heel loop with ankle strap					
K0036	A	DG	Toe loop each					
K0037	A		High mount flip-up footrest					
K0038	A		Leg strap each					
K0039	A		Leg strap h style each					
K0040	A		Adjustable angle footplate					
K0041	A		Large size footplate each					
K0042	A		Standard size footplate each					
K0043	A		Ftrst lower extension tube					
K0044	A		Ftrst upper hanger bracket					
K0045	A		Footrest complete assembly					
K0046	A		Elevat legrst low extension					
K0047	A		Elevat legrst up hangr brack					
K0048	A	DG	Elevate legrest complete					
K0049	A	DG	Calf pad each					
K0050	A		Ratchet assembly					
K0051	A		Cam relese assem ftrst/lgrst					
K0052	A		Swingaway detach footrest					
K0053	A		Elevate footrest articulate					
K0054	A	DG	Seat wdth 10-12/15/17/20 wc					
K0055	A	DG	Seat dpth 15/17/18 ltwt wc					
K0056	A		Seat ht 17 or 21 ltwt wc					
K0057	A	DG	Seat wdth 19/20 hvy dty wc					
K0058	A	DG	Seat dpth 17/18 power wc					
K0059	A		Plastic coated handrim each					
K0060	A		Steel handrim each					
K0061	A		Aluminum handrim each					
K0062	A	DG	Handrim 8-10 vert/obliq proj					
K0063	A	DG	Hndrm 12-16 vert/obliq proj					
K0064	A		Zero pressure tube flat free					
K0065	A		Spoke protectors					
K0066	A		Solid tire any size each					
K0067	A		Pneumatic tire any size each					
K0068	A		Pneumatic tire tube each					
K0069	A		Rear whl complete solid tire					
K0070	A		Rear whl compl pneum tire					
K0071	A		Front castr compl pneum tire					
K0072	A		Frnt cstr cmpl sem-pneum tir					
K0073	A		Caster pin lock each					
K0074	A		Pneumatic caster tire each					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
K0075	A		Semi-pneumatic caster tire					
K0076	A		Solid caster tire each					
K0077	A		Front caster assem complete					
K0078	A		Pneumatic caster tire tube					
K0079	A	DG	Wheel lock extension pair					
K0080	A	DG	Anti-rollback device pair					
K0081	A		Wheel lock assembly complete					
K0082	A	DG	22 nf deep cycl acid battery					
K0083	A	DG	22 nf gel cell battery each					
K0084	A	DG	Grp 24 deep cycl acid battry					
K0085	A	DG	Group 24 gel cell battery					
K0086	A	DG	U-1 lead acid battery each					
K0087	A	DG	U-1 gel cell battery each					
K0088	A	DG	Battry chrgr acid/gel cell					
K0089	A	DG	Battery charger dual mode					
K0090	A		Rear tire power wheelchair					
K0091	A		Rear tire tube power whlchr					
K0092	A		Rear assem cmplt powr whlchr					
K0093	A		Rear zero pressure tire tube					
K0094	A		Wheel tire for power base					
K0095	A		Wheel tire tube each base					
K0096	A		Wheel assem powr base complt					
K0097	A		Wheel zero presure tire tube					
K0098	A		Drive belt power wheelchair					
K0099	A		Pwr wheelchair front caster					
K0100	A	DG	Amputee adapter pair					
K0102	A		Crutch and cane holder					
K0103	A	DG	Transfer board < 25≧					
K0104	A		Cylinder tank carrier					
K0105	A		Iv hanger					
K0106	A		Arm trough each					
K0107	A	DG	Wheelchair tray					
K0108	A		W/c component-accessory NOS					
K0112	A	DG	Trunk vest supprt innr frame					
K0113	A	DG	Trunk vest suprt w/o inr frm					
K0114	A		Whlchr back suprt inr frame					
K0115	A		Back module orthotic system					
K0116	A		Back & seat modul orthot sys					
K0195	A		Elevating whlchair leg rests					
K0268	A	DG	Humidifier nonheated w PAP					
K0415	B		RX antiemetic drg, oral NOS					
K0416	B		Rx antiemetic drg,rectal NOS					
K0452	A		Wheelchair bearings					
K0455	A		Pump uninterrupted infusion					
K0460	A	DG	WC power add-on joystick					
K0461	A	DG	WC power add-on tiller cntrl					
K0462	A		Temporary replacement eqpmnt					
K0531	A	DG	Heated humidifier used w pap					
K0532	A	DG	Noninvasive assist wo backup					
K0533	A	DG	Noninvasive assist w backup					
K0534	A	DG	Invasive assist w backup					
K0538	A	DG	Neg pressure wnd thrpy pump					
K0539	A	DG	Neg pres wnd thrpy dsg set					
K0540	A	DG	Neg pres wnd thrp canister					
K0541	A	DG	SGD prerecorded msg <= 8 min					
K0542	A	DG	SGD prerecorded msg > 8 min					
K0543	A	DG	SGD msg formed by spelling					
K0544	A	DG	SGD w multi methods msg/accs					
K0545	A	DG	SGD sftwre prgrm for PC/PDA					
K0546	A	DG	SGD accessory,mounting systm					
K0547	A	DG	SGD accessory NOC					
K0548	N	NI	Insulin lispro					
K0549	A	DG	Hosp bed hvy dty xtra wide					
K0550	A	DG	Hosp bed xtra hvy dty x wide					
K0552	Y	NF	Supply/Ext inf pump syr type					
K0556	A	DG	Socket insert w lock mech					
K0557	A	DG	Socket insert w/o lock mech					
K0558	A	DG	Intl custm cong/atyp insert					
K0559	A	DG	Initial custom socket insert					
K0560	N	DG	Mcp joint 2-piece for implant					
K0581	A	DG	Ost pch clsd w barrier/filtr					
K0582	A	DG	Ost pch w bar/bltinconv/filtr					
K0583	A	DG	Ost pch clsd w/o bar w filtr					
K0584	A	DG	Ost pch for bar w flange/flt					
K0585	A	DG	Ost pch clsd for bar w lk fl					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
K0586	A	DG	Ost pch for bar w lk fl/fltr					
K0587	A	DG	Ost pch drain w bar & filter					
K0588	A	DG	Ost pch drain for barrier fl					
K0589	A	DG	Ost pch drain 2 piece system					
K0590	A	DG	Ost pch drain/barr lk flng/f					
K0591	A	DG	Urine ost pouch w faucet/tap					
K0592	A	DG	Urine ost pouch w bltinconv					
K0593	A	DG	Ost urine pch w b/bltin conv					
K0594	A	DG	Ost pch urine w barrier/tapv					
K0595	A	DG	Os pch urine w bar/fange/tap					
K0596	A	DG	Urine ost pch bar w lock fln					
K0597	A	DG	Ost pch urine w lock flng/ft					
K0600	Y	NF	Functional neuromuscular stim					
K0601	Y	NF	Repl batt silver oxide 1.5 v					
K0602	Y	NF	Repl batt silver oxide 3 v					
K0603	Y	NF	Repl batt alkaline 1.5 v					
K0604	Y	NF	Repl batt lithium 3.6 v					
K0605	Y	NF	Repl batt lithium 4.5 v					
K0606	Y	NF	AED garment w/elec analysis					
K0607	Y	NF	Repl batt for AED device					
K0608	Y	NF	Repl garment for AED					
K0609	Y	NF	Repl electrode for AED					
K0610	E	DG	Peritoneal dialysis clamp					
K0611	E	DG	Disposable cycler set					
K0612	E	DG	Drainage ext line, dialysis					
K0613	E	DG	Ext line w/easy lock connect					
K0614	E	DG	Chem/antiseptic solution, 8oz					
K0615	Y	DG	SGD prerec mes >8min <20min					
K0616	Y	DG	SGD prerec mes >20min <40min					
K0617	Y	DG	SGD prerec mes >40min					
K0618	A		TLSO 2 piece rigid shell					
K0619	A		TLSO 3 piece rigid shell					
K0620	A		Tubular elastic dressing					
K0621	A	DG	Gauze, non-impreg pack strip					
K0622	A	DG	Confrm band non str <3in/rol					
K0623	A	DG	Confrm band sterl>3in/roll					
K0624	A	DG	Lite compress wdth<3in/roll					
K0625	A	DG	Self adher wdth <3 in, roll					
K0626	A	DG	Self adher wdth >=5 in, roll					
L0100	A		Cranial orthosis/helmet mold					
L0110	A		Cranial orthosis/helmet nonm					
L0112	A	NI	Cranial cervical orthosis					
L0120	A		Cerv flexible non-adjustable					
L0130	A		Flex thermoplastic collar mo					
L0140	A		Cervical semi-rigid adjustab					
L0150	A		Cerv semi-rig adj molded chn					
L0160	A		Cerv semi-rig wire occ/mand					
L0170	A		Cervical collar molded to pt					
L0172	A		Cerv col thermplas foam 2 pi					
L0174	A		Cerv col foam 2 piece w thor					
L0180	A		Cer post col occ/man sup adj					
L0190	A		Cerv collar supp adj cerv ba					
L0200	A		Cerv col supp adj bar & thor					
L0210	A		Thoracic rib belt					
L0220	A		Thor rib belt custom fabrica					
L0450	A		TLSO flex prefab thoracic					
L0452	A		tlso flex custom fab thoraci					
L0454	A		TLSO flex prefab sacrococ-T9					
L0456	A		TLSO flex prefab					
L0458	A		TLSO 2Mod symphis-xipho pre					
L0460	A		TLSO2Mod symphysis-stern pre					
L0462	A		TLSO 3Mod sacro-scap pre					
L0464	A		TLSO 4Mod sacro-scap pre					
L0466	A		TLSO rigid frame pre soft ap					
L0468	A		TLSO rigid frame prefab pelv					
L0470	A		TLSO rigid frame pre subclav					
L0472	A		TLSO rigid frame hyperex pre					
L0474	A		TLSO rigid frame pre pelvic					
L0476	A		TLSO flexion compres jac pre					
L0478	A		TLSO flexion compres jac cus					
L0480	A		TLSO rigid plastic custom fa					
L0482	A		TLSO rigid lined custom fab					
L0484	A		TLSO rigid plastic cust fab					
L0486	A		TLSO rigidlined cust fab two					
L0488	A		TLSO rigid lined pre one pie					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L0490	A		TLSO rigid plastic pre one					
L0500	A		Lso flex surgical support					
L0510	A		Lso flexible custom fabricat					
L0515	A		Lso flex elas w/ rig post pa					
L0520	A		Lso a-p-l control with apron					
L0530	A		Lso ant-pos control w apron					
L0540	A		Lso lumbar flexion a-p-l					
L0550	A		Lso a-p-l control molded					
L0560	A		Lso a-p-l w interface					
L0561	A		Prefab lso					
L0565	A		Lso a-p-l control custom					
L0600	A		Sacroiliac flex surg support					
L0610	A		Sacroiliac flexible custm fa					
L0620	A		Sacroiliac semi-rig w apron					
L0700	A		Ctlso a-p-l control molded					
L0710	A		Ctlso a-p-l control w/ inter					
L0810	A		Halo cervical into jckt vest					
L0820	A		Halo cervical into body jack					
L0830	A		Halo cerv into milwaukee typ					
L0860	A		Magnetic resonanc image comp					
L0861	A	NI	Halo repl liner/interface					
L0960	A		Post surgical support pads					
L0970	A		Tlso corset front					
L0972	A		Lso corset front					
L0974	A		Tlso full corset					
L0976	A		Lso full corset					
L0978	A		Axillary crutch extension					
L0980	A		Peroneal straps pair					
L0982	A		Stocking supp grips set of f					
L0984	A		Protective body sock each					
L0999	A		Add to spinal orthosis NOS					
L1000	A		Ctlso milwauke initial model					
L1005	A		Tension based scoliosis orth					
L1010	A		Ctlso axilla sling					
L1020	A		Kyphosis pad					
L1025	A		Kyphosis pad floating					
L1030	A		Lumbar bolster pad					
L1040	A		Lumbar or lumbar rib pad					
L1050	A		Sternal pad					
L1060	A		Thoracic pad					
L1070	A		Trapezius sling					
L1080	A		Outrigger					
L1085	A		Outrigger bil w/ vert extens					
L1090	A		Lumbar sling					
L1100	A		Ring flange plastic/leather					
L1110	A		Ring flange plas/leather mol					
L1120	A		Covers for upright each					
L1200	A		Fumsh initial orthosis only					
L1210	A		Lateral thoracic extension					
L1220	A		Anterior thoracic extension					
L1230	A		Milwaukee type superstructur					
L1240	A		Lumbar derotation pad					
L1250	A		Anterior asis pad					
L1260	A		Anterior thoracic derotation					
L1270	A		Abdominal pad					
L1280	A		Rib gusset (elastic) each					
L1290	A		Lateral trochanteric pad					
L1300	A		Body jacket mold to patient					
L1310	A		Post-operative body jacket					
L1499	A		Spinal orthosis NOS					
L1500	A		Thkao mobility frame					
L1510	A		Thkao standing frame					
L1520	A		Thkao swivel walker					
L1600	A		Abduct hip flex frejka w cvr					
L1610	A		Abduct hip flex frejka covr					
L1620	A		Abduct hip flex pavlik harne					
L1630	A		Abduct control hip semi-flex					
L1640	A		Pelv band/spread bar thigh c					
L1650	A		HO abduction hip adjustable					
L1652	A		HO bi thighcuffs w sprdr bar					
L1660	A		HO abduction static plastic					
L1680	A		Pelvic & hip control thigh c					
L1685	A		Post-op hip abduct custom fa					
L1686	A		HO post-op hip abduction					
L1690	A		Combination bilateral HO					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L1700	A		Leg perthes orth toronto typ					
L1710	A		Legg perthes orth newington					
L1720	A		Legg perthes orthosis trilat					
L1730	A		Legg perthes orth scottish r					
L1750	A		Legg perthes sling					
L1755	A		Legg perthes patten bottom t					
L1800	A		Knee orthoses elas w stays					
L1810	A		Ko elastic with joints					
L1815	A		Elastic with condylar pads					
L1820	A		Ko elas w/ condyle pads & jo					
L1825	A		Ko elastic knee cap					
L1830	A		Ko immobilizer canvas longit					
L1831	A	NI	Knee orth pos locking joint					
L1832	A		KO adj jnt pos rigid support					
L1834	A		Ko w/0 joint rigid molded to					
L1836	A		Rigid KO wo joints					
L1840	A		Ko derot ant cruciate custom					
L1843	A		KO single upright custom fit					
L1844	A		Ko w/adj jt rot cntrl molded					
L1845	A		Ko w/ adj flex/ext rotat cus					
L1846	A		Ko w adj flex/ext rotat mold					
L1847	A		KO adjustable w air chambers					
L1850	A		Ko swedish type					
L1855	A		Ko plas doub upright jnt mol					
L1858	A		Ko polycentric pneumatic pad					
L1860	A		Ko supracondylar socket mold					
L1870	A		Ko doub upright lacers molde					
L1880	A		Ko doub upright cuffs/lacers					
L1885	A	DG	Knee upright w/resistance					
L1900	A		Afo spring wir drsflx calf bd					
L1901	A		Prefab ankle orthosis					
L1902	A		Afo ankle gauntlet					
L1904	A		Afo molded ankle gauntlet					
L1906	A		Afo multiligamentus ankle su					
L1907	A	NI	AFO supramalleolar custom					
L1910	A		Afo sing bar clasp attach sh					
L1920	A		Afo sing upright w/ adjust s					
L1930	A		Afo plastic					
L1940	A		Afo molded to patient plasti					
L1945	A		Afo molded plas rig ant tib					
L1950	A		Afo spiral molded to pt plas					
L1951	A	NI	AFO spiral prefabricated					
L1960	A		Afo pos solid ank plastic mo					
L1970	A		Afo plastic molded w/ankle j					
L1971	A	NI	AFO w/ankle joint, prefab					
L1980	A		Afo sing solid stirrup calf					
L1990	A		Afo doub solid stirrup calf					
L2000	A		Kafo sing fre stirr thi/calf					
L2010	A		Kafo sng solid stirrup w/o j					
L2020	A		Kafo dbl solid stirrup band/					
L2030	A		Kafo dbl solid stirrup w/o j					
L2035	A		KAFO plastic pediatric size					
L2036	A		Kafo plas doub free knee mol					
L2037	A		Kafo plas sing free knee mol					
L2038	A		Kafo w/o joint multi-axis an					
L2039	A		KAFO,plstic,medlat rotat con					
L2040	A		Hkafo torsion bil rot straps					
L2050	A		Hkafo torsion cable hip pelv					
L2060	A		Hkafo torsion ball bearing j					
L2070	A		Hkafo torsion unilat rot str					
L2080	A		Hkafo unilat torsion cable					
L2090	A		Hkafo unilat torsion ball br					
L2102	E	DG	Afo tibial fx cast plstr mol					
L2104	E	DG	Afo tib fx cast synthetic mo					
L2106	A		Afo tib fx cast plaster mold					
L2108	A		Afo tib fx cast molded to pt					
L2112	A		Afo tibial fracture soft					
L2114	A		Afo tib fx semi-rigid					
L2116	A		Afo tibial fracture rigid					
L2122	E	DG	Kafo fem fx cast plaster mol					
L2124	E	DG	Kafo fem fx cast synthet mol					
L2126	A		Kafo fem fx cast thermoplas					
L2128	A		Kafo fem fx cast molded to p					
L2132	A		Kafo femoral fx cast soft					
L2134	A		Kafo fem fx cast semi-rigid					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L2136	A		Kafo femoral fx cast rigid					
L2180	A		Plas shoe insert w ank joint					
L2182	A		Drop lock knee					
L2184	A		Limited motion knee joint					
L2186	A		Adj motion knee jnt lerman t					
L2188	A		Quadrilateral brim					
L2190	A		Waist belt					
L2192	A		Pelvic band & belt thigh fla					
L2200	A		Limited ankle motion ea jnt					
L2210	A		Dorsiflexion assist each joi					
L2220	A		Dorsi & plantar flex ass/res					
L2230	A		Split flat caliper stirr & p					
L2240	A		Round caliper and plate atta					
L2250	A		Foot plate molded stirrup at					
L2260	A		Reinforced solid stirrup					
L2265	A		Long tongue stirrup					
L2270	A		Varus/valgus strap padded/li					
L2275	A		Plastic mod low ext pad/line					
L2280	A		Molded inner boot					
L2300	A		Abduction bar jointed adjust					
L2310	A		Abduction bar-straight					
L2320	A		Non-molded lacer					
L2330	A		Lacer molded to patient mode					
L2335	A		Anterior swing band					
L2340	A		Pre-tibial shell molded to p					
L2350	A		Prosthetic type socket molde					
L2360	A		Extended steel shank					
L2370	A		Patten bottom					
L2375	A		Torsion ank & half solid sti					
L2380	A		Torsion straight knee joint					
L2385	A		Straight knee joint heavy du					
L2390	A		Offset knee joint each					
L2395	A		Offset knee joint heavy duty					
L2397	A		Suspension sleeve lower ext					
L2405	A		Knee joint drop lock ea jnt					
L2415	A		Knee joint cam lock each joi					
L2425	A		Knee disc/dial lock/adj flex					
L2430	A		Knee jnt ratchet lock ea jnt					
L2435	A		Knee joint polycentric joint					
L2492	A		Knee lift loop drop lock rin					
L2500	A		Thi/glut/ischia wgt bearing					
L2510	A		Th/wght bear quad-lat brim m					
L2520	A		Th/wght bear quad-lat brim c					
L2525	A		Th/wght bear nar m-l brim mo					
L2526	A		Th/wght bear nar m-l brim cu					
L2530	A		Thigh/wght bear lacer non-mo					
L2540	A		Thigh/wght bear lacer molded					
L2550	A		Thigh/wght bear high roll cu					
L2570	A		Hip clevis type 2 posit jnt					
L2580	A		Pelvic control pelvic sling					
L2600	A		Hip clevis/thrust bearing fr					
L2610	A		Hip clevis/thrust bearing lo					
L2620	A		Pelvic control hip heavy dut					
L2622	A		Hip joint adjustable flexion					
L2624	A		Hip adj flex ext abduct cont					
L2627	A		Plastic mold recipro hip & c					
L2628	A		Metal frame recipro hip & ca					
L2630	A		Pelvic control band & belt u					
L2640	A		Pelvic control band & belt b					
L2650	A		Pelv & thor control gluteal					
L2660	A		Thoracic control thoracic ba					
L2670	A		Thorac cont paraspinal uprig					
L2680	A		Thorac cont lat support uprs					
L2750	A		Plating chrome/nickel pr bar					
L2755	A		Carbon graphite lamination					
L2760	A		Extension per extension per					
L2768	A		Ortho sidebar disconnect					
L2770	A		Low ext orthosis per bar/jnt					
L2780	A		Non-corrosive finish					
L2785	A		Drop lock retainer each					
L2795	A		Knee control full kneecap					
L2800	A		Knee cap medial or lateral p					
L2810	A		Knee control condylar pad					
L2820	A		Soft interface below knee se					
L2830	A		Soft interface above knee se					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L2840	A		Tibial length sock fx or equ					
L2850	A		Femoral lgth sock fx or equa					
L2860	A		Torsion mechanism knee/ankle					
L2999	A		Lower extremity orthosis NOS					
L3000	B		Ft insert ucb berkeley shell					
L3001	B		Foot insert remov molded spe					
L3002	B		Foot insert plastazote or eq					
L3003	B		Foot insert silicone gel eac					
L3010	B		Foot longitudinal arch suppo					
L3020	B		Foot longitud/metatarsal sup					
L3030	B		Foot arch support remov prem					
L3031	E	NI	Foot lamin/prepreg composite					
L3040	B		Ft arch suprt premold longit					
L3050	B		Foot arch supp premold metat					
L3060	B		Foot arch supp longitud/meta					
L3070	B		Arch suprt att to sho longit					
L3080	B		Arch supp att to shoe metata					
L3090	B		Arch supp att to shoe long/m					
L3100	B		Hallus-valgus nght dynamic s					
L3140	B		Abduction rotation bar shoe					
L3150	B		Abduct rotation bar w/o shoe					
L3160	B		Shoe styled positioning dev					
L3170	B		Foot plastic heel stabilizer					
L3201	B		Oxford w supinat/pronat inf					
L3202	B		Oxford w/ supinat/pronator c					
L3203	B		Oxford w/ supinator/pronator					
L3204	B		Hightop w/ supp/pronator inf					
L3206	B		Hightop w/ supp/pronator chi					
L3207	B		Hightop w/ supp/pronator jun					
L3208	B		Surgical boot each infant					
L3209	B		Surgical boot each child					
L3211	B		Surgical boot each junior					
L3212	B		Benesch boot pair infant					
L3213	B		Benesch boot pair child					
L3214	B		Benesch boot pair junior					
L3215	B		Orthopedic ftwear ladies oxf					
L3216	B		Orthoped ladies shoes dpth i					
L3217	B		Ladies shoes hightop depth i					
L3219	B		Orthopedic mens shoes oxford					
L3221	B		Orthopedic mens shoes dpth i					
L3222	B		Mens shoes hightop depth inl					
L3224	A		Woman's shoe oxford brace					
L3225	A		Man's shoe oxford brace					
L3230	B		Custom shoes depth inlay					
L3250	B		Custom mold shoe remov prost					
L3251	B		Shoe molded to pt silicone s					
L3252	B		Shoe molded plastazote cust					
L3253	B		Shoe molded plastazote cust					
L3254	B		Orth foot non-stndard size/w					
L3255	B		Orth foot non-standard size/					
L3257	B		Orth foot add charge split s					
L3260	B		Ambulatory surgical boot eac					
L3265	B		Plastazote sandal each					
L3300	B		Sho lift taper to metatarsal					
L3310	B		Shoe lift elev heel/sole neo					
L3320	B		Shoe lift elev heel/sole cor					
L3330	B		Lifts elevation metal extens					
L3332	B		Shoe lifts tapered to one-ha					
L3334	B		Shoe lifts elevation heel /i					
L3340	B		Shoe wedge sach					
L3350	E		Shoe heel wedge					
L3360	B		Shoe sole wedge outside sole					
L3370	B		Shoe sole wedge between sole					
L3380	B		Shoe clubfoot wedge					
L3390	B		Shoe outflare wedge					
L3400	B		Shoe metatarsal bar wedge ro					
L3410	B		Shoe metatarsal bar between					
L3420	B		Full sole/heel wedge btween					
L3430	B		Sho heel count plast reinfor					
L3440	B		Heel leather reinforced					
L3450	B		Shoe heel sach cushion type					
L3455	B		Shoe heel new leather standa					
L3460	B		Shoe heel new rubber standar					
L3465	B		Shoe heel thomas with wedge					
L3470	B		Shoe heel thomas extend to b					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L3480	B		Shoe heel pad & depress for					
L3485	B		Shoe heel pad removable for					
L3500	B		Ortho shoe add leather insol					
L3510	B		Orthopedic shoe add rub insl					
L3520	B		O shoe add felt w leath insl					
L3530	B		Ortho shoe add half sole					
L3540	B		Ortho shoe add full sole					
L3550	B		O shoe add standard toe tap					
L3560	B		O shoe add horseshoe toe tap					
L3570	B		O shoe add instep extension					
L3580	B		O shoe add instep velcro clo					
L3590	B		O shoe convert to sof counte					
L3595	B		Ortho shoe add march bar					
L3600	B		Trans shoe calip plate exist					
L3610	B		Trans shoe caliper plate new					
L3620	B		Trans shoe solid stirrup exi					
L3630	B		Trans shoe solid stirrup new					
L3640	B		Shoe dennis browne splint bo					
L3649	B		Orthopedic shoe modifica NOS					
L3650	A		Shlder fig 8 abduct restrain					
L3651	A		Prefab shoulder orthosis					
L3652	A		Prefab dbl shoulder orthosis					
L3660	A		Abduct restrainer canvas&web					
L3670	A		Acromio/clavicular canvas&we					
L3675	A		Canvas vest SO					
L3677	E		SO hard plastic stabilizer					
L3700	A		Elbow orthoses elas w stays					
L3701	A		Prefab elbow orthosis					
L3710	A		Elbow elastic with metal joi					
L3720	A		Forearm/arm cuffs free motio					
L3730	A		Forearm/arm cuffs ext/flex a					
L3740	A		Cuffs adj lock w/ active con					
L3760	A		EO withjoint, Prefabricated					
L3762	A		Rigid EO wo joints					
L3800	A		Whfo short opponen no attach					
L3805	A		Whfo long opponens no attach					
L3807	A		WHFO,no joint, prefabricated					
L3810	A		Whfo thumb abduction bar					
L3815	A		Whfo second m.p. abduction a					
L3820	A		Whfo ip ext asst w/ mp ext s					
L3825	A		Whfo m.p. extension stop					
L3830	A		Whfo m.p. extension assist					
L3835	A		Whfo m.p. spring extension a					
L3840	A		Whfo spring swivel thumb					
L3845	A		Whfo thumb ip ext ass w/ mp					
L3850	A		Action wrist w/ dorsiflex as					
L3855	A		Whfo adj m.p. flexion contro					
L3860	A		Whfo adj m.p. flex ctrl & i.					
L3890	B		Torsion mechanism wrist/elbo					
L3900	A		Hinge extension/flex wrist/f					
L3901	A		Hinge ext/flex wrist finger					
L3902	A		Whfo ext power compress gas					
L3904	A		Whfo electric custom fitted					
L3906	A		Wrist gauntlet molded to pt					
L3907	A		Whfo wrst gauntlt thmb spica					
L3908	A		Wrist cock-up non-molded					
L3909	A		Prefab wrist orthosis					
L3910	A		Whfo swanson design					
L3911	A		Prefab hand finger orthosis					
L3912	A		Flex glove w/elastic finger					
L3914	A		WHO wrist extension cock-up					
L3916	A		Whfo wrist extens w/ outrigg					
L3917	A	NI	Prefab metacarpl fx orthosis					
L3918	A		HFO knuckle bender					
L3920	A		Knuckle bender with outrigge					
L3922	A		Knuckle bend 2 seg to flex j					
L3923	A		HFO, no joint, prefabricated					
L3924	A		Oppenheimer					
L3926	A		Thomas suspension					
L3928	A		Finger extension w/ clock sp					
L3930	A		Finger extension with wrist					
L3932	A		Safety pin spring wire					
L3934	A		Safety pin modified					
L3936	A		Palmer					
L3938	A		Dorsal wrist					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L3940	A		Dorsal wrist w/ outrigger at					
L3942	A		Reverse knuckle bender					
L3944	A		Reverse knuckle bend w/ outr					
L3946	A		HFO composite elastic					
L3948	A		Finger knuckle bender					
L3950	A		Oppenheimer w/ knuckle bend					
L3952	A		Oppenheimer w/ rev knuckle 2					
L3954	A		Spreading hand					
L3956	A		Add joint upper ext orthosis					
L3960	A		Sewho airplan desig abdu pos					
L3962	A		Sewho erbs palsey design abd					
L3963	A		Molded w/ articulating elbow					
L3964	A		Seo mobile arm sup att to wc					
L3965	A		Arm supp att to wc rancho ty					
L3966	A		Mobile arm supports reclinin					
L3968	A		Friction dampening arm supp					
L3969	A		Monosuspension arm/hand supp					
L3970	A		Elevat proximal arm support					
L3972	A		Offset/lat rocker arm w/ ela					
L3974	A		Mobile arm support supinator					
L3980	A		Upp ext fx orthosis humeral					
L3982	A		Upper ext fx orthosis rad/ul					
L3984	A		Upper ext fx orthosis wrist					
L3985	A		Forearm hand fx orth w/ wr h					
L3986	A		Humeral rad/ulna wrist fx or					
L3995	A		Sock fracture or equal each					
L3999	A		Upper limb orthosis NOS					
L4000	A		Repl girdle milwaukee orth					
L4010	A		Replace trilateral socket br					
L4020	A		Replace quadlat socket brim					
L4030	A		Replace socket bnm cust fit					
L4040	A		Replace molded thigh lacer					
L4045	A		Replace non-molded thigh lac					
L4050	A		Replace molded calf lacer					
L4055	A		Replace non-molded calf lace					
L4060	A		Replace high roll cuff					
L4070	A		Replace prox & dist upright					
L4080	A		Repl met band kafo-afo prox					
L4090	A		Repl met band kafo-afo calf/					
L4100	A		Repl leath cuff kafo prox th					
L4110	A		Repl leath cuff kafo-afo cal					
L4130	A		Replace pretibial shell					
L4205	A		Ortho dvc repair per 15 min					
L4210	A		Orth dev repair/repl minor p					
L4350	A		Pneumatic ankle cntrl splint					
L4360	A		Pneumatic walking splint					
L4370	A		Pneumatic full leg splint					
L4380	A		Pneumatic knee splint					
L4386	A		Non-pneumatic walking splint					
L4392	A		Replace AFO soft interface					
L4394	A		Replace foot drop spint					
L4396	A		Static AFO					
L4398	A		Foot drop splint recumbent					
L5000	A		Sho insert w arch toe filler					
L5010	A		Mold socket ank hgt w/ toe f					
L5020	A		Tibial tubercle hgt w/ toe f					
L5050	A		Ank symes mold sckt sach ft					
L5060	A		Symes met fr leath socket ar					
L5100	A		Molded socket shin sach foot					
L5105	A		Plast socket jts/thgh lacer					
L5150	A		Mold sckt ext knee shin sach					
L5160	A		Mold socket bent knee shin s					
L5200	A		Kne sing axis fric shin sach					
L5210	A		No knee/ankle joints w/ ft b					
L5220	A		No knee joint with artic ali					
L5230	A		Fem focal defic constant fri					
L5250	A		Hip canad sing axi cons fric					
L5270	A		Tilt table locking hip sing					
L5280	A		Hemipelvect canad sing axis					
L5301	A		BK mold socket SACH ft endo					
L5311	A		Knee disart, SACH ft, endo					
L5321	A		AK open end SACH					
L5331	A		Hip disart canadian SACH ft					
L5341	A		Hemipelvectomy canadian SACH					
L5400	A		Postop dress & 1 cast chg bk					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L5410	A		Postop dsg bk ea add cast ch					
L5420	A		Postop dsg & 1 cast chg ak/d					
L5430	A		Postop dsg ak ea add cast ch					
L5450	A		Postop app non-wgt bear dsg					
L5460	A		Postop app non-wgt bear dsg					
L5500	A		Init bk ptb plaster direct					
L5505	A		Init ak ischal plstr direct					
L5510	A		Prep BK ptb plaster molded					
L5520	A		Perp BK ptb thermopls direct					
L5530	A		Prep BK ptb thermopls molded					
L5535	A		Prep BK ptb open end socket					
L5540	A		Prep BK ptb laminated socket					
L5560	A		Prep AK ischial plast molded					
L5570	A		Prep AK ischial direct form					
L5580	A		Prep AK ischial thermo mold					
L5585	A		Prep AK ischial open end					
L5590	A		Prep AK ischial laminated					
L5595	A		Hip disartic sach thermopls					
L5600	A		Hip disart sach laminat mold					
L5610	A		Above knee hydracadence					
L5611	A		Ak 4 bar link w/fric swing					
L5613	A		Ak 4 bar ling w/hydraul swig					
L5614	A		4-bar link above knee w/swng					
L5616	A		Ak univ multiplex sys frict					
L5617	A		AK/BK self-aligning unit ea					
L5618	A		Test socket symes					
L5620	A		Test socket below knee					
L5622	A		Test socket knee disarticula					
L5624	A		Test socket above knee					
L5626	A		Test socket hip disarticulat					
L5628	A		Test socket hemipelvectomy					
L5629	A		Below knee acrylic socket					
L5630	A		Syme typ expandabl wall sckt					
L5631	A		Ak/knee disartic acrylic soc					
L5632	A		Symes type ptb brim design s					
L5634	A		Symes type poster opening so					
L5636	A		Symes type medial opening so					
L5637	A		Below knee total contact					
L5638	A		Below knee leather socket					
L5639	A		Below knee wood socket					
L5640	A		Knee disarticulat leather so					
L5642	A		Above knee leather socket					
L5643	A		Hip flex inner socket ext fr					
L5644	A		Above knee wood socket					
L5645	A		Bk flex inner socket ext fra					
L5646	A		Below knee air cushion socke					
L5647	A		Below knee suction socket					
L5648	A		Above knee air cushion socke					
L5649	A		Isch containmt/narrow m-l so					
L5650	A		Tot contact ak/knee disart s					
L5651	A		Ak flex inner socket ext fra					
L5652	A		Suction susp ak/knee disart					
L5653	A		Knee disart expand wall sock					
L5654	A		Socket insert symes					
L5655	A		Socket insert below knee					
L5656	A		Socket insert knee articulat					
L5658	A		Socket insert above knee					
L5661	A		Multi-durometer symes					
L5665	A		Multi-durometer below knee					
L5666	A		Below knee cuff suspension					
L5668	A		Socket insert w/o lock lower					
L5670	A		Bk molded supracondylar susp					
L5671	A		BK/AK locking mechanism					
L5672	A		Bk removable medial brim sus					
L5673	A	NI	Socket insert w lock mech					
L5674	A		Bk suspension sleeve					
L5675	A		Bk heavy duty susp sleeve					
L5676	A		Bk knee joints single axis p					
L5677	A		Bk knee joints polycentric p					
L5678	A		Bk joint covers pair					
L5679	A	NI	Socket insert w/o lock mech					
L5680	A		Bk thigh lacer non-molded					
L5681	A	NI	Intl custm cong/latyp insert					
L5682	A		Bk thigh lacer glut/ischia m					
L5683	A	NI	Initial custom socket insert					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L5684	A		Bk fork strap					
L5686	A		Bk back check					
L5688	A		Bk waist belt webbing					
L5690	A		Bk waist belt padded and lin					
L5692	A		Ak pelvic control belt light					
L5694	A		Ak pelvic control belt pad/l					
L5695	A		Ak sleeve susp neoprene/equa					
L5696	A		Ak/knee disartic pelvic join					
L5697	A		Ak/knee disartic pelvic band					
L5698	A		Ak/knee disartic silesian ba					
L5699	A		Shoulder harness					
L5700	A		Replace socket below knee					
L5701	A		Replace socket above knee					
L5702	A		Replace socket hip					
L5704	A		Custom shape cover BK					
L5705	A		Custom shape cover AK					
L5706	A		Custom shape cvr knee disart					
L5707	A		Custom shape cvr hip disart					
L5710	A		Kne-shin exo sng axi mnl loc					
L5711	A		Knee-shin exo mnl lock ultra					
L5712	A		Knee-shin exo frict swg & st					
L5714	A		Knee-shin exo variable frict					
L5716	A		Knee-shin exo mech stance ph					
L5718	A		Knee-shin exo frct swg & sta					
L5722	A		Knee-shin pneum swg frct exo					
L5724	A		Knee-shin exo fluid swing ph					
L5726	A		Knee-shin ext jnts fld swg e					
L5728	A		Knee-shin fluid swg & stance					
L5780	A		Knee-shin pneum/hydra pneum					
L5781	A		Lower limb pros vacuum pump					
L5782	A		HD low limb pros vacuum pump					
L5785	A		Exoskeletal bk ultralt mater					
L5790	A		Exoskeletal ak ultra-light m					
L5795	A		Exoskel hip ultra-light mate					
L5810	A		Endoskel knee-shin mnl lock					
L5811	A		Endo knee-shin mnl lck ultra					
L5812	A		Endo knee-shin frct swg & st					
L5814	A		Endo knee-shin hydral swg ph					
L5816	A		Endo knee-shin polyc mch sta					
L5818	A		Endo knee-shin frct swg & st					
L5822	A		Endo knee-shin pneum swg frc					
L5824	A		Endo knee-shin fluid swing p					
L5826	A		Miniature knee joint					
L5828	A		Endo knee-shin fluid swg/sta					
L5830	A		Endo knee-shin pneum/swg pha					
L5840	A		Multi-axial knee/shin system					
L5845	A		Knee-shin sys stance flexion					
L5846	A		Knee-shin sys microprocessor					
L5847	A		Microprocessor cntrl feature					
L5848	A		Knee-shin sys hydraul stance					
L5850	A		Endo ak/hip knee extens assi					
L5855	A		Mech hip extension assist					
L5910	A		Endo below knee alignable sy					
L5920	A		Endo ak/hip alignable system					
L5925	A		Above knee manual lock					
L5930	A		High activity knee frame					
L5940	A		Endo bk ultra-light material					
L5950	A		Endo ak ultra-light material					
L5960	A		Endo hip ultra-light materia					
L5962	A		Below knee flex cover system					
L5964	A		Above knee flex cover system					
L5966	A		Hip flexible cover system					
L5968	A		Multiaxial ankle w dorsiflex					
L5970	A		Foot external keel sach foot					
L5972	A		Flexible keel foot					
L5974	A		Foot single axis ankle/foot					
L5975	A		Combo ankle/foot prosthesis					
L5976	A		Energy storing foot					
L5978	A		Ft prosth multiaxial ankl/ft					
L5979	A		Multi-axial ankle/ft prosth					
L5980	A		Flex foot system					
L5981	A		Flex-walk sys low ext prosth					
L5982	A		Exoskeletal axial rotation u					
L5984	A		Endoskeletal axial rotation					
L5985	A		Lwr ext dynamic prosth pylon					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L5986	A		Multi-axial rotation unit					
L5987	A		Shank ft w vert load pylon					
L5988	A		Vertical shock reducing pylo					
L5989	A		Pylon w elctmc force sensor					
L5990	A		User adjustable heel height					
L5995	A		Lower ext pros heavyduty fea					
L5999	A		Lowr extremity prosthes NOS					
L6000	A		Par hand robin-aids thum rem					
L6010	A		Hand robin-aids little/nng					
L6020	A		Part hand robin-aids no fing					
L6025	A		Part hand disart myoelectric					
L6050	A		Wrst MLd sck flx hng tri pad					
L6055	A		Wrst mold sock w/exp interfa					
L6100	A		Elb mold sock flex hinge pad					
L6110	A		Elbow mold sock suspension t					
L6120	A		Elbow mold doub split soc ste					
L6130	A		Elbow stump activated lock h					
L6200	A		Elbow mold outsid lock hinge					
L6205	A		Elbow molded w/ expand inter					
L6250	A		Elbow inter loc elbow forarm					
L6300	A		Shlder disart int lock elbow					
L6310	A		Shoulder passive restor comp					
L6320	A		Shoulder passive restor cap					
L6350	A		Thoracic intern lock elbow					
L6360	A		Thoracic passive restor comp					
L6370	A		Thoracic passive restor cap					
L6380	A		Postop dsg cast chg wrst/elb					
L6382	A		Postop dsg cast chg elb dis/					
L6384	A		Postop dsg cast chg shlder/t					
L6386	A		Postop ea cast chg & realign					
L6388	A		Postop applicat rigid dsg on					
L6400	A		Below elbow prosth tiss shap					
L6450	A		Elb disart prosth tiss shap					
L6500	A		Above elbow prosth tiss shap					
L6550	A		Shldr disar prosth tiss shap					
L6570	A		Scap thorac prosth tiss shap					
L6580	A		Wrist/elbow bowden cable mol					
L6582	A		Wrist/elbow bowden cbl dir f					
L6584	A		Elbow fair lead cable molded					
L6586	A		Elbow fair lead cable dir fo					
L6588	A		Shdr fair lead cable molded					
L6590	A		Shdr fair lead cable direct					
L6600	A		Polycentric hinge pair					
L6605	A		Single pivot hinge pair					
L6610	A		Flexible metal hinge pair					
L6615	A		Disconnect locking wrist uni					
L6616	A		Disconnect insert locking wr					
L6620	A		Flexion/extension wrist unit					
L6623	A		Spring-ass rot wrst w/ latch					
L6625	A		Rotation wrst w/ cable lock					
L6628	A		Quick disconn hook adapter o					
L6629	A		Lamination collar w/ couplin					
L6630	A		Stainless steel any wrist					
L6632	A		Latex suspension sleeve each					
L6635	A		Lift assist for elbow					
L6637	A		Nudge control elbow lock					
L6638	A		Elec lock on manual pw elbow					
L6640	A		Shoulder abduction joint pai					
L6641	A		Excursion amplifier pulley t					
L6642	A		Excursion amplifier lever ty					
L6645	A		Shoulder flexion-abduction j					
L6646	A		Multipo locking shoulder jnt					
L6647	A		Shoulder lock actuator					
L6648	A		Ext pwrd shlder lock/unlock					
L6650	A		Shoulder universal joint					
L6655	A		Standard control cable extra					
L6660	A		Heavy duty control cable					
L6665	A		Teflon or equal cable lining					
L6670	A		Hook to hand cable adapter					
L6672	A		Harness chest/shlder saddle					
L6675	A		Harness figure of 8 sing con					
L6676	A		Harness figure of 8 dual con					
L6680	A		Test sock wrist disart/bel e					
L6682	A		Test sock elbw disart/above					
L6684	A		Test socket shldr disart/tho					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L6686	A		Suction socket					
L6687	A		Frame typ socket bel elbow/w					
L6688	A		Frame typ sock above elb/dis					
L6689	A		Frame typ socket shoulder di					
L6690	A		Frame typ sock interscap-tho					
L6691	A		Removable insert each					
L6692	A		Silicone gel insert or equal					
L6693	A		Lockingelbow forearm cntrbal					
L6700	A		Terminal device model #3					
L6705	A		Terminal device model #5					
L6710	A		Terminal device model #5x					
L6715	A		Terminal device model #5xa					
L6720	A		Terminal device model #6					
L6725	A		Terminal device model #7					
L6730	A		Terminal device model #7lo					
L6735	A		Terminal device model #8					
L6740	A		Terminal device model #8x					
L6745	A		Terminal device model #88x					
L6750	A		Terminal device model #10p					
L6755	A		Terminal device model #10x					
L6765	A		Terminal device model #12p					
L6770	A		Terminal device model #99x					
L6775	A		Terminal device model#555					
L6780	A		Terminal device model #ss555					
L6790	A		Hooks-accu hook or equal					
L6795	A		Hooks-2 load or equal					
L6800	A		Hooks-aprl vc or equal					
L6805	A		Modifier wrist flexion unit					
L6806	A		Trs grip vc or equal					
L6807	A		Term device grip1/2 or equal					
L6808	A		Term device infant or child					
L6809	A		Trs super sport passive					
L6810	A		Pincher tool otto bock or eq					
L6825	A		Hands dorrance vo					
L6830	A		Hand aprl vc					
L6835	A		Hand sierra vo					
L6840	A		Hand becker imperial					W≤
L6845	A		Hand becker lock grip					
L6850	A		Term dvc-hand becker plylite					
L6855	A		Hand robin-aids vo					
L6860	A		Hand robin-aids vo soft					
L6865	A		Hand passive hand					
L6867	A		Hand detroit infant hand					
L6868	A		Passive inf hand steeper/hos					
L6870	A		Hand child mitt					
L6872	A		Hand nyu child hand					
L6873	A		Hand mech inf steeper or equ					
L6875	A		Hand bock vc					
L6880	A		Hand bock vo					
L6881	A		Autograsp feature ul term dv					
L6882	A		Microprocessor control uplmb					
L6890	A		Production glove					
L6895	A		Custom glove					
L6900	A		Hand restorat thumb/1 finger					
L6905	A		Hand restoration multiple fi					
L6910	A		Hand restoration no fingers					
L6915	A		Hand restoration replacmnt g					
L6920	A		Wrist disarticul switch ctrl					
L6925	A		Wrist disart myoelectronic c					
L6930	A		Below elbow switch control					
L6935	A		Below elbow myoelectronic ct					
L6940	A		Elbow disarticulation switch					
L6945	A		Elbow disart myoelectronic c					
L6950	A		Above elbow switch control					
L6955	A		Above elbow myoelectronic ct					
L6960	A		Shldr disartic switch contro					
L6965	A		Shldr disartic myoelectronic					
L6970	A		Interscapular-thor switch ct					
L6975	A		Interscap-thor myoelectronic					
L7010	A		Hand otto back steeper/eq sw					
L7015	A		Hand sys teknik village swit					
L7020	A		Electronic greifer switch ct					
L7025	A		Electron hand myoelectronic					
L7030	A		Hand sys teknik vill myoelec					
L7035	A		Electron greifer myoelectro					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L7040	A		Prehensile actuator hosmer s					
L7045	A		Electron hook child michigan					
L7170	A		Electronic elbow hosmer swit					
L7180	A		Electronic elbow utah myoele					
L7185	A		Electron elbow adolescent sw					
L7186	A		Electron elbow child switch					
L7190	A		Elbow adolescent myoelectron					
L7191	A		Elbow child myoelectronic ct					
L7260	A		Electron wrist rotator otto					
L7261	A		Electron wrist rotator utah					
L7266	A		Servo control steeper or equ					
L7272	A		Analogue control unb or equa					
L7274	A		Proportional ctl 12 volt uta					
L7360	A		Six volt bat otto bock/eq ea					
L7362	A		Battery chrgr six volt otto					
L7364	A		Twelve volt battery utah/equ					
L7366	A		Battery chrgr 12 volt utah/e					
L7367	A		Replacemnt lithium ionbatter					
L7368	A		Lithium ion battery charger					
L7499	A		Upper extremity prosthes NOS					
L7500	A		Prosthetic dvc repair hourly					
L7510	A		Prosthetic device repair rep					
L7520	A		Repair prosthesis per 15 min					
L7900	A		Male vacuum erection system					
L8000	A		Mastectomy bra					
L8001	A		Breast prosthesis bra & form					
L8002	A		Brst prsth bra & bilat form					
L8010	A		Mastectomy sleeve					
L8015	A		Ext breastprosthesis garment					
L8020	A		Mastectomy form					
L8030	A		Breast prosthesis silicone/e					
L8035	A		Custom breast prosthesis					
L8039	A		Breast prosthesis NOS					
L8040	A		Nasal prosthesis					
L8041	A		Midfacial prosthesis					
L8042	A		Orbital prosthesis					
L8043	A		Upper facial prosthesis					
L8044	A		Hemi-facial prosthesis					
L8045	A		Auricular prosthesis					
L8046	A		Partial facial prosthesis					
L8047	A		Nasal septal prosthesis					
L8048	A		Unspec maxillofacial prosth					
L8049	A		Repair maxillofacial prosth					
L8100	E		Compression stocking BK18-30					
L8110	A		Compression stocking BK30-40					
L8120	A		Compression stocking BK40-50					
L8130	E		Gc stocking thighlngth 18-30					
L8140	E		Gc stocking thighlngth 30-40					
L8150	E		Gc stocking thighlngth 40-50					
L8160	E		Gc stocking full lngth 18-30					
L8170	E		Gc stocking full lngth 30-40					
L8180	E		Gc stocking full lngth 40-50					
L8190	E		Gc stocking waistlngth 18-30					
L8195	E		Gc stocking waistlngth 30-40					
L8200	E		Gc stocking waistlngth 40-50					
L8210	E		Gc stocking custom made					
L8220	E		Gc stocking lymphedema					
L8230	E		Gc stocking garter belt					
L8239	E		G compression stocking NOS					
L8300	A		Truss single w/ standard pad					
L8310	A		Truss double w/ standard pad					
L8320	A		Truss addition to std pad wa					
L8330	A		Truss add to std pad scrotal					
L8400	A		Sheath below knee					
L8410	A		Sheath above knee					
L8415	A		Sheath upper limb					
L8417	A		Pros sheath/sock w gel cushn					
L8420	A		Prosthetic sock multi ply BK					
L8430	A		Prosthetic sock multi ply AK					
L8435	A		Pros sock multi ply upper lm					
L8440	A		Shrinker below knee					
L8460	A		Shrinker above knee					
L8465	A		Shrinker upper limb					
L8470	A		Pros sock single ply BK					
L8480	A		Pros sock single ply AK					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L8485	A		Pros sock single ply upper l					
L8490	A		Air seal suction reten systm					
L8499	A		Unlisted misc prosthetic ser					
L8500	A		Artificial larynx					
L8501	A		Tracheostomy speaking valve					
L8505	A		Artificial larynx, accessory					
L8507	A		Trach-esoph voice pros pt in					
L8509	A		Trach-esoph voice pros md in					
L8510	A		Voice amplifier					
L8511	A	NI	Indwelling trach insert					
L8512	A	NI	Gel cap for trach voice pros					
L8513	A	NI	Trach pros cleaning device					
L8514	A	NI	Repl trach puncture dilator					
L8600	N		Implant breast silicone/eq					
L8603	N		Collagen imp urinary 2.5 ml					
L8606	N		Synthetic implnt urinary 1ml					
L8610	N		Ocular implant					
L8612	N		Aqueous shunt prosthesis					
L8613	N		Ossicular implant					
L8614	N		Cochlear device/system					
L8619	A		Replace cochlear processor					
L8630	N		Metacarpophalangeal implant					
L8631	A	NI	MCP joint repl 2 pc or more					
L8641	N		Metatarsal joint implant					
L8642	N		Hallux implant					
L8658	N		Interphalangeal joint spacer					
L8659	A	NI	Interphalangeal joint repl					
L8670	N		Vascular graft, synthetic					
L8699	N		Prosthetic implant NOS					
L9900	A		O&P supply/accessory/service					
M0064	X		Visit for drug monitoring	0374	1.1252	$61.39		$12.28
M0075	E		Cellular therapy					
M0076	E		Prolotherapy					
M0100	E		Intragastric hypothermia					
M0300	E		IV chelationtherapy					
M0301	E		Fabric wrapping of aneurysm					
P2028	A		Cephalin floculation test					
P2029	A		Congo red blood test					
P2031	E		Hair analysis					
P2033	A		Blood thymol turbidity					
P2038	A		Blood mucoprotein					
P3000	A		Screen pap by tech w md supv					
P3001	B		Screening pap smear by phys					
P7001	E		Culture bacterial urine					
P9010	K		Whole blood for transfusion	0950		$87.93		$17.59
P9011	K		Blood split unit	0957		$41.44		$8.29
P9012	K		Cryoprecipitate each unit	0952		$29.31		$5.86
P9016	K		RBC leukocytes reduced	0954		$119.26		$23.85
P9017	K		Plasma 1 donor frz w/in 8 hr	0955		$95.00		$19.00
P9019	K		Platelets, each unit	0957		$41.44		$8.29
P9020	K		Plaelet rich plasma unit	0958		$53.56		$10.71
P9021	K		Red blood cells unit	0959		$86.41		$17.28
P9022	K		Washed red blood cells unit	0960		$160.69		$32.14
P9023	K		Frozen plasma, pooled, sd	0949		$124.31		$24.86
P9031	K		Platelets leukocytes reduced	1013		$49.52		$9.90
P9032	K		Platelets, irradiated	9500		$74.79		$14.96
P9033	K		Platelets leukoreduced irrad	0954		$119.26		$23.85
P9034	K		Platelets, pheresis	9501		$408.81		$81.76
P9035	K		Platelet pheres leukoreduced	9501		$408.81		$81.76
P9036	K		Platelet pheresis irradiated	9502		$443.68		$88.74
P9037	K		Plate pheres leukoredu irrad	1019		$406.28		$81.26
P9038	K		RBC irradiated	9505		$108.65		$21.73
P9039	K		RBC deglycerolized	9504		$183.44		$36.69
P9040	K		RBC leukoreduced irradiated	9504		$183.44		$36.69
P9041	K		Albumin (human),5%, 50ml	0961	0.2802	$15.29		$3.06
P9043	K		Plasma protein fract,5%,50ml	0956		$92.98		$18.60
P9044	K		Cryoprecipitatereducedplasma	1009		$37.39		$7.48
P9045	K		Albumin (human), 5%, 250 ml	0963	1.0901	$59.48		$11.90
P9046	K		Albumin (human), 25%, 20 ml	0964	0.3741	$20.41		$4.08
P9047	K		Albumin (human), 25%, 50ml	0965	0.8869	$48.39		$9.68
P9048	K		Plasmaprotein fract,5%,250ml	0966		$464.90		$92.98
P9050	K		Granulocytes, pheresis unit	9506		$1,248.66		$249.73
P9051	K	NI	Blood, l/r, cmv-neg	1010		$121.78		$24.36
P9052	K	NI	Platelets, hla-m, l/r, unit	1011		$499.77		$99.95
P9053	K	NI	Plt, pher, l/r cmv-neg, irr	1020		$495.22		$99.04

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
P9054	K	NI	Blood, l/r, froz/degly/wash	1016		$301.68		$60.34
P9055	K	NI	Plt, aph/pher, l/r, cmv-neg	1017		$393.15		$78.63
P9056	K	NI	Blood, l/r, irradiated	1018		$132.40		$26.48
P9057	K	NI	RBC, frz/deg/wsh, l/r, irrad	1021		$336.04		$67.21
P9058	K	NI	RBC, l/r, cmv-neg, irrad	1022		$201.12		$40.22
P9059	K	NI	Plasma, frz between 8-24hour	0955		$95.00		$19.00
P9060	K	NI	Fr frz plasma donor retested	9503		$69.74		$13.95
P9604	A		One-way allow prorated trip					
P9612	N		Catheterize for urine spec					
P9615	N		Urine specimen collect mult					
Q0035	X		Cardiokymography	0100	1.5862	$86.54	$41.44	$17.31
Q0081	T		Infusion ther other than che	0120	1.9114	$104.29	$28.21	$20.86
Q0083	S		Chemo by other than infusion	0116	0.7996	$43.63		$8.73
Q0084	S		Chemotherapy by infusion	0117	3.0360	$165.65	$42.54	$33.13
Q0085	E		Chemo by both infusion and o					
Q0086	A	DG	Physical therapy evaluation/					
Q0091	T		Obtaining screen pap smear	0191	0.1853	$10.11	$2.93	$2.02
Q0092	N		Set up port xray equipment					
Q0111	A		Wet mounts/ w preparations					
Q0112	A		Potassium hydroxide preps					
Q0113	A		Pinworm examinations					
Q0114	A		Fern test					
Q0115	A		Post-coital mucous exam					
Q0136	K		Non esrd epoetin alpha inj	0733	0.1802	$9.83		$1.97
Q0137	K	NI	Darbepoetin alfa, non esrd	0734		$3.24		$0.65
Q0144	E		Azithromycin dihydrate, oral					
Q0163	N		Diphenhydramine HCl 50mg					
Q0164	N		Prochlorperazine maleate 5mg					
Q0165	B		Prochlorperazine maleate10mg					
Q0166	K		Granisetron HCl 1 mg oral	0765	0.6322	$34.49		$6.90
Q0167	N		Dronabinol 2.5mg oral					
Q0168	B		Dronabinol 5mg oral					
Q0169	N		Promethazine HCl 12.5mg oral					
Q0170	B		Promethazine HCl 25 mg oral					
Q0171	N		Chlorpromazine HCl 10mg oral					
Q0172	B		Chlorpromazine HCl 25mg oral					
Q0173	N		Trimethobenzamide HCl 250mg					
Q0174	N		Thiethylperazine maleate10mg					
Q0175	N		Perphenazine 4mg oral					
Q0176	B		Perphenazine 8mg oral					
Q0177	N		Hydroxyzine pamoate 25mg					
Q0178	B		Hydroxyzine pamoate 50mg					
Q0179	N		Ondansetron HCl 8mg oral					
Q0180	K		Dolasetron mesylate oral	0763	0.7514	$41.00		$8.20
Q0181	E		Unspecified oral anti-emetic					
Q0182	B	NI	Nonmetabolic act d/e tissue					
Q0183	N		Nonmetabolic active tissue					
Q0187	K		Factor viia recombinant	1409		$1,083.93		$216.79
Q1001	N		Ntiol category 1					
Q1002	N		Ntiol category 2					
Q1003	N		Ntiol category 3					
Q1004	N		Ntiol category 4					
Q1005	N		Ntiol category 5					
Q2001	E		Oral cabergoline 0.5 mg					
Q2002	N		Elliotts b solution per ml					
Q2003	K		Aprotinin, 10,000 kiu	7019	0.0215	$1.17		$0.23
Q2004	N		Bladder calculi irrig sol					
Q2005	K		Corticorelin ovine triflutat	7024	4.1221	$224.91		$44.98
Q2006	K		Digoxin immune fab (ovine)	7025	4.9694	$271.14		$54.23
Q2007	K		Ethanolamine oleate 100 mg	7026	0.5099	$27.82		$5.56
Q2008	K		Fomepizole, 15 mg	7027	0.1325	$7.23		$1.45
Q2009	K		Fosphenytoin, 50 mg	7028	0.0895	$4.88		$0.98
Q2010	N	DG	Glatiramer acetate, per dose					
Q2011	K		Hemin, per 1 mg	7030	0.0118	$0.64		$0.13
Q2012	N		Pegademase bovine, 25 iu					
Q2013	K		Pentastarch 10% solution	7040	0.4838	$26.40		$5.28
Q2014	N		Sermorelin acetate, 0.5 mg					
Q2017	K		Teniposide, 50 mg	7035	2.5185	$137.41		$27.48
Q2018	K		Urofollitropin, 75 iu	7037	1.1634	$63.48		$12.70
Q2019	K		Basiliximab	1615		$1,425.06		$285.01
Q2020	E		Histrelin acetate					
Q2021	N		Lepirudin					
Q2022	K		VonWillebrandFactrCmplxperIU	1618		$1.01		$0.20
Q3000	K	NF	Rubidium-Rb-82	9025	2.6372	$143.89		$28.78
Q3001	N		Brachytherapy Radioelements					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
Q3002	K		Gallium ga 67	1619	0.2056	$11.22		$2.24
Q3003	K		Technetium tc99m bicisate	1620	3.3666	$183.69		$36.74
Q3004	N		Xenon xe 133					
Q3005	K		Technetium tc99m mertiatide	1622	0.3782	$20.63		$4.13
Q3006	N		Technetium tc99m glucepatate					
Q3007	K		Sodium phosphate p32	1624	1.2941	$70.61		$14.12
Q3008	K		Indium 111-in pentetreotide	1625	8.2447	$449.84		$89.97
Q3009	N		Technetium tc99m oxidronate					
Q3010	N		Technetium tc99mlabeledrbcs					
Q3011	K		Chromic phosphate p32	1628	1.8057	$98.52		$19.70
Q3012	K		Cyanocobalamin cobalt co57	1089	1.0460	$57.07		$11.41
Q3014	A		Telehealth facility fee					
Q3019	A		ALS emer trans no ALS serv					
Q3020	A		ALS nonemer trans no ALS se					
Q3021	E		Ped hepatitis b vaccine inj					
Q3022	E		Hepatitis b vaccine adult ds					
Q3023	E		Injection hepatitis Bvaccine					
Q3025	K		IM inj interferon beta 1-a	9022	1.1290	$61.60		$12.32
Q3026	N		Subc inj interferon beta-1a					
Q3031*	N	NI	Collagen skin test					
Q4001	B		Cast sup body cast plaster					
Q4002	B		Cast sup body cast fiberglas					
Q4003	B		Cast sup shoulder cast plstr					
Q4004	B		Cast sup shoulder cast fbrgl					
Q4005	B		Cast sup long arm adult plst					
Q4006	B		Cast sup long arm adult fbrg					
Q4007	B		Cast sup long arm ped plster					
Q4008	B		Cast sup long arm ped fbrgls					
Q4009	B		Cast sup sht arm adult plstr					
Q4010	B		Cast sup sht arm adult fbrgl					
Q4011	B		Cast sup sht arm ped plaster					
Q4012	B		Cast sup sht arm ped fbrglas					
Q4013	B		Cast sup gauntlet plaster					
Q4014	B		Cast sup gauntlet fiberglass					
Q4015	B		Cast sup gauntlet ped plster					
Q4016	B		Cast sup gauntlet ped fbrgls					
Q4017	B		Cast sup lng arm splint plst					
Q4018	B		Cast sup lng arm splint fbrg					
Q4019	B		Cast sup lng arm splnt ped p					
Q4020	B		Cast sup lng arm splnt ped f					
Q4021	B		Cast sup sht arm splint plst					
Q4022	B		Cast sup sht arm splint fbrg					
Q4023	B		Cast sup sht arm splnt ped p					
Q4024	B		Cast sup sht arm splnt ped f					
Q4025	B		Cast sup hip spica plaster					
Q4026	B		Cast sup hip spica fiberglas					
Q4027	B		Cast sup hip spica ped plstr					
Q4028	B		Cast sup hip spica ped fbrgl					
Q4029	B		Cast sup long leg plaster					
Q4030	B		Cast sup long leg fiberglass					
Q4031	B		Cast sup lng leg ped plaster					
Q4032	B		Cast sup lng leg ped fbrgls					
Q4033	B		Cast sup lng leg cylinder pl					
Q4034	B		Cast sup lng leg cylinder fb					
Q4035	B		Cast sup lngleg cylndr ped p					
Q4036	B		Cast sup lngleg cylndr ped f					
Q4037	B		Cast sup shrt leg plaster					
Q4038	B		Cast sup shrt leg fiberglass					
Q4039	B		Cast sup shrt leg ped plster					
Q4040	B		Cast sup shrt leg ped fbrgls					
Q4041	B		Cast sup lng leg splnt plstr					
Q4042	B		Cast sup lng leg splnt fbrgl					
Q4043	B		Cast sup lng leg splnt ped p					
Q4044	B		Cast sup lng leg splnt ped f					
Q4045	B		Cast sup sht leg splnt plstr					
Q4046	B		Cast sup sht leg splnt fbrgl					
Q4047	B		Cast sup sht leg splnt ped p					
Q4048	B		Cast sup sht leg splnt ped f					
Q4049	B		Finger splint, static					
Q4050	B		Cast supplies unlisted					
Q4051	B		Splint supplies misc					
Q4052	K	DG	Octreotide injection, depot	1207	1.2049	$65.74		$13.15
Q4053	D	DNG	Pegfilgrastim, per 1 mg					
Q4054	A	NI	Darbepoetin alfa, esrd use					
Q4055	A	NI	Epoetin alfa, esrd use					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
Q4075	N	NI	Acyclovir, 5 mg					
Q4076	N	NI	Dopamine hcl, 40 mg					
Q4077	N	NI	Treprostinil, 1 mg					
Q4078	K	DG	Ammonia N-13, per dose	9025	2.6372	$143.89		$28.78
Q9920	A	DG	Epoetin with hct <= 20					
Q9921	A	DG	Epoetin with hct = 21					
Q9922	A	DG	Epoetin with hct = 22					
Q9923	A	DG	Epoetin with hct = 23					
Q9924	A	DG	Epoetin with hct = 24					
Q9925	A	DG	Epoetin with hct = 25					
Q9926	A	DG	Epoetin with hct = 26					
Q9927	A	DG	Epoetin with hct = 27					
Q9928	A	DG	Epoetin with hct = 28					
Q9929	A	DG	Epoetin with hct = 29					
Q9930	A	DG	Epoetin with hct = 30					
Q9931	A	DG	Epoetin with hct = 31					
Q9932	A	DG	Epoetin with hct = 32					
Q9933	A	DG	Epoetin with hct = 33					
Q9934	A	DG	Epoetin with hct = 34					
Q9935	A	DG	Epoetin with hct = 35					
Q9936	A	DG	Epoetin with hct = 36					
Q9937	A	DG	Epoetin with hct = 37					
Q9938	A	DG	Epoetin with hct = 38					
Q9939	A	DG	Epoetin with hct = 39					
Q9940	A	DG	Epoetin with hct >= 40					
R0070	N		Transport portable x-ray					
R0075	N		Transport port x-ray multipl					
R0076	N		Transport portable EKG					
V2020	A		Vision svcs frames purchases					
V2025	E		Eyeglasses delux frames					
V2100	A		Lens spher single plano 4.00					
V2101	A		Single visn sphere 4.12-7.00					
V2102	A		Singl visn sphere 7.12-20.00					
V2103	A		Spherocylindr 4.00d/12-2.00d					
V2104	A		Spherocylindr 4.00d/2.12-4d					
V2105	A		Spherocylinder 4.00d/4.25-6d					
V2106	A		Spherocylinder 4.00d/>6.00d					
V2107	A		Spherocylinder 4.25d/12-2d					
V2108	A		Spherocylinder 4.25d/2.12-4d					
V2109	A		Spherocylinder 4.25d/4.25-6d					
V2110	A		Spherocylinder 4.25d/over 6d					
V2111	A		Spherocylindr 7.25d/.25-2.25					
V2112	A		Spherocylindr 7.25d/2.25-4d					
V2113	A		Spherocylindr 7.25d/4.25-6d					
V2114	A		Spherocylinder over 12.00d					
V2115	A		Lens lenticular bifocal					
V2116	A	DG	Nonaspheric lens bifocal					
V2117	A	DG	Aspheric lens bifocal					
V2118	A		Lens aniseikonic single					
V2121	A	NI	Lenticular lens, single					
V2199	A		Lens single vision not oth c					
V2200	A		Lens spher bifoc plano 4.00d					
V2201	A		Lens sphere bifocal 4.12-7.0					
V2202	A		Lens sphere bifocal 7.12-20.					
V2203	A		Lens sphcyl bifocal 4.00d/.1					
V2204	A		Lens sphcy bifocal 4.00d/2.1					
V2205	A		Lens sphcy bifocal 4.00d/4.2					
V2206	A		Lens sphcy bifocal 4.00d/ove					
V2207	A		Lens sphcy bifocal 4.25-7d/.					
V2208	A		Lens sphcy bifocal 4.25-7/2.					
V2209	A		Lens sphcy bifocal 4.25-7/4.					
V2210	A		Lens sphcy bifocal 4.25-7/ov					
V2211	A		Lens sphcy bifo 7.25-12/.25-					
V2212	A		Lens sphcyl bifo 7.25-12/2.2					
V2213	A		Lens sphcyl bifo 7.25-12/4.2					
V2214	A		Lens sphcyl bifocal over 12.					
V2215	A		Lens lenticular bifocal					
V2216	A	DG	Lens lenticular nonaspheric					
V2217	A	DG	Lens lenticular aspheric bif					
V2218	A		Lens aniseikonic bifocal					
V2219	A		Lens bifocal seg width over					
V2220	A		Lens bifocal add over 3.25d					
V2221	A	NI	Lenticular lens, bifocal					
V2299	A		Lens bifocal speciality					
V2300	A		Lens sphere trifocal 4.00d					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
V2301	A		Lens sphere trifocal 4.12-7.					
V2302	A		Lens sphere trifocal 7.12-20					
V2303	A		Lens sphcy trifocal 4.0/.12-					
V2304	A		Lens sphcy trifocal 4.0/2.25					
V2305	A		Lens sphcy trifocal 4.0/4.25					
V2306	A		Lens sphcyl trifocal 4.00/>6					
V2307	A		Lens sphcy trifocal 4.25-7/.					
V2308	A		Lens sphc trifocal 4.25-7/2.					
V2309	A		Lens sphc trifocal 4.25-7/4.					
V2310	A		Lens sphc trifocal 4.25-7/>6					
V2311	A		Lens sphc trifo 7.25-12/.25-					
V2312	A		Lens sphc trifo 7.25-12/2.25					
V2313	A		Lens sphc trifo 7.25-12/4.25					
V2314	A		Lens sphcyl trifocal over 12					
V2315	A		Lens lenticular trifocal					
V2316	A	DG	Lens lenticular nonaspheric					
V2317	A	DG	Lens lenticular aspheric tri					
V2318	A		Lens aniseikonic trifocal					
V2319	A		Lens trifocal seg width > 28					
V2320	A		Lens trifocal add over 3.25d					
V2321	A	NI	Lenticular lens, trifocal					
V2399	A		Lens trifocal speciality					
V2410	A		Lens variab asphericity sing					
V2430	A		Lens variable asphericity bi					
V2499	A		Variable asphericity lens					
V2500	A		Contact lens pmma spherical					
V2501	A		Cntct lens pmma-toric/prism					
V2502	A		Contact lens pmma bifocal					
V2503	A		Cntct lens pmma color vision					
V2510	A		Cntct gas permeable sphericl					
V2511	A		Cntct toric prism ballast					
V2512	A		Cntct lens gas permbl bifocl					
V2513	A		Contact lens extended wear					
V2520	A		Contact lens hydrophilic					
V2521	A		Cntct lens hydrophilic toric					
V2522	A		Cntct lens hydrophil bifocl					
V2523	A		Cntct lens hydrophil extend					
V2530	A		Contact lens gas impermeable					
V2531	A		Contact lens gas permeable					
V2599	A		Contact lens/es other type					
V2600	A		Hand held low vision aids					
V2610	A		Single lens spectacle mount					
V2615	A		Telescop/othr compound lens					
V2623	A		Plastic eye prosth custom					
V2624	A		Polishing artifical eye					
V2625	A		Enlargemnt of eye prosthesis					
V2626	A		Reduction of eye prosthesis					
V2627	A		Scleral cover shell					
V2628	A		Fabrication & fitting					
V2629	A		Prosthetic eye other type					
V2630	N		Anter chamber intraocul lens					
V2631	N		Iris support intraoclr lens					
V2632	N		Post chmbr intraocular lens					
V2700	A		Balance lens					
V2710	A		Glass/plastic slab off prism					
V2715	A		Prism lens/es					
V2718	A		Fresnell prism press-on lens					
V2730	A		Special base curve					
V2740	A	DG	Rose tint plastic					
V2741	A	DG	Non-rose tint plastic					
V2742	A	DG	Rose tint glass					
V2743	A	DG	Non-rose tint glass					
V2744	A		Tint photochromatic lens/es					
V2745	A	NI	Tint, any color/solid/grad					
V2750	A		Anti-reflective coating					
V2755	A		UV lens/es					
V2756	E	NI	Eye glass case					
V2760	A		Scratch resistant coating					
V2761	E	NI	Mirror coating					
V2762	A	NI	Polarization, any lens					
V2770	A		Occluder lens/es					
V2780	A		Oversize lens/es					
V2781	B		Progressive lens per lens					
V2782	A	NI	Lens, 1.54-1.65 p/1.60-1.79g					
V2783	A	NI	Lens, >= 1.66 p/>=1.80 g					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
V2784	A	NI	Lens polycarb or equal					
V2785	F		Corneal tissue processing					
V2786	A	NI	Occupational multifocal lens					
V2790	N		Amniotic membrane					
V2797	A	NI	Vis item/svc in other code					
V2799	A		Miscellaneous vision service					
V5008	E		Hearing screening					
V5010	E		Assessment for hearing aid					
V5011	E		Hearing aid fitting/checking					
V5014	E		Hearing aid repair/modifying					
V5020	E		Conformity evaluation					
V5030	E		Body-worn hearing aid air					
V5040	E		Body-worn hearing aid bone					
V5050	E		Hearing aid monaural in ear					
V5060	E		Behind ear hearing aid					
V5070	E		Glasses air conduction					
V5080	E		Glasses bone conduction					
V5090	E		Hearing aid dispensing fee					
V5095	E		Implant mid ear hearing pros					
V5100	E		Body-worn bilat hearing aid					
V5110	E		Hearing aid dispensing fee					
V5120	E		Body-worn binaur hearing aid					
V5130	E		In ear binaural hearing aid					
V5140	E		Behind ear binaur hearing ai					
V5150	E		Glasses binaural hearing aid					
V5160	E		Dispensing fee binaural					
V5170	E		Within ear cros hearing aid					
V5180	E		Behind ear cros hearing aid					
V5190	E		Glasses cros hearing aid					
V5200	E		Cros hearing aid dispens fee					
V5210	E		In ear bicros hearing aid					
V5220	E		Behind ear bicros hearing ai					
V5230	E		Glasses bicros hearing aid					
V5240	E		Dispensing fee bicros					
V5241	E		Dispensing fee, monaural					
V5242	E		Hearing aid, monaural, cic					
V5243	E		Hearing aid, monaural, itc					
V5244	E		Hearing aid, prog, mon, cic					
V5245	E		Hearing aid, prog, mon, itc					
V5246	E		Hearing aid, prog, mon, ite					
V5247	E		Hearing aid, prog, mon, bte					
V5248	E		Hearing aid, binaural, cic					
V5249	E		Hearing aid, binaural, itc					
V5250	E		Hearing aid, prog, bin, cic					
V5251	E		Hearing aid, prog, bin, itc					
V5252	E		Hearing aid, prog, bin, ite					
V5253	E		Hearing aid, prog, bin, bte					
V5254	E		Hearing id, digit, mon, cic					
V5255	E		Hearing aid, digit, mon, itc					
V5256	E		Hearing aid, digit, mon, ite					
V5257	E		Hearing aid, digit, mon, bte					
V5258	E		Hearing aid, digit, bin, cic					
V5259	E		Hearing aid, digit, bin, itc					
V5260	E		Hearing aid, digit, bin, ite					
V5261	E		Hearing aid, digit, bin, bte					
V5262	E		Hearing aid, disp, monaural					
V5263	E		Hearing aid, disp, binaural					
V5264	E		Ear mold/insert					
V5265	E		Ear mold/insert, disp					
V5266	E		Battery for hearing device					
V5267	E		Hearing aid supply/accessory					
V5268	E		ALD Telephone Amplifier					
V5269	E		Alerting device, any type					
V5270	E		ALD, TV amplifier, any type					
V5271	E		ALD, TV caption decoder					
V5272	E		Tdd					
V5273	E		ALD for cochlear implant					
V5274	E		ALD unspecified					
V5275	E		Ear impression					
V5298	E		Hearing aid noc					
V5299	B		Hearing service					
V5336	E		Repair communication device					
V5362	E		Speech screening					
V5363	E		Language screening					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

CPT/HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
V5364	E		Dysphagia screening					

ADDENDUM D1.—PAYMENT STATUS INDICATORS FOR THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

Indicator	Item/code/service	Status
A	Services furnished to a Hospital Outpatient that are paid under a Fee Schedule/Payment System other than OPPS, e.g.: • Ambulance Services • Clinical Diagnostic Laboratory Services • Non-Implantable Prosthetic and Orthotic Devices • EPO for ESRD Patients • Physical, Occupational, and Speech Therapy • Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital. • Screening Mammography	Not paid under OPPS. Paid by Intermediaries under a Fee Schedule/Payment System other than OPPS.
B	Codes that are not recognized by OPPS when submitted on an Outpatient Hospital Part B bill type (12x, 13x, and 14x).	Not paid under OPPS. • May be paid by Intermediaries when submitted on a different bill type, e.g., 75x (CORF), but not paid under OPPS. • An alternate code that is recognized by OPPS when submitted on an Outpatient Hospital Part B bill type (12x, 13x, and 14x) may be available.
C	Inpatient Procedures	Not paid under OPPS. Admit patient; Bill as Inpatient.
D	Deleted Codes	Not paid under OPPS. Not paid under Medicare.
E	Items, Codes, and Services: • That are not covered by Medicare based on Statutory Exclusion. • That are not covered by Medicare for reasons other than Statutory Exclusion. • That are not recognized by Medicare but for which an alternate code for the same item or service may be available. • For which separate payment is not provided by Medicare	Not paid under OPPS.
F	Corneal Tissue Acquisition; Certain CRNA Services	Not paid under OPPS. Paid at reasonable cost.
G	Drug/Biological Pass-Through	Paid under OPPS; Separate APC payment includes Pass-Through amount.
H	Device Category Pass-Through	Paid under OPPS; Separate cost-based Pass-Through payment.
K	Non Pass-Through Drugs and Biologicals; Radiopharmaceutical Agents; Certain Brachytherapy Sources.	Paid under OPPS; Separate APC payment.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Not paid under OPPS. Paid at reasonable cost; Not subject to deductible or coinsurance.
N	Items and Services packaged into APC Rates	Paid under OPPS. However, payment is packaged into payment for other services, including Outliers. Therefore, there is no separate APC payment.
P	Partial Hospitalization	Paid under OPPS; Per diem APC payment.
S	Significant Procedure, Not Discounted when Multiple	Paid under OPPS; Separate APC payment.
T	Significant Procedure, Multiple Procedure Reduction Applies	Paid under OPPS; Separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPPS; Separate APC payment.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than Home Health Agencies bill to DMERC.
X	Ancillary Service	Paid under OPPS; Separate APC payment.

ADDENDUM D2.—CODE CONDITIONS

Code condition	Descriptor
DG	Deleted code with a grace period; Payment will be made under the deleted code during the 90-day grace period.
DNG	Deleted code with no grace period; Payment will not be made under the deleted code after December 31, 2003.
NF	New code final APC assignment; Comments were accepted on a proposed APC assignment in the Proposed Rule; APC assignment is no longer open to comment.
NI	New code interim APC assignment; Comments will be accepted on the interim APC assignment for the new code.

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
0001T	C	Endovas repr abdo ao aneurys
0001T	C	Endovas repr abdo ao aneurys
0005T	C	Perc cath stent/brain cv art

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
0006T	C	Perc cath stent/brain cv art
0007T	C	Perc cath stent/brain cv art
00174	C	Anesth, pharyngeal surgery
00176	C	Anesth, pharyngeal surgery
00192	C	Anesth, facial bone surgery
00214	C	Anesth, skull drainage
00215	C	Anesth, skull repair/fract
0021T	C	Fetal oximetry, trnsvag/cerv
0024T	C	Transcath cardiac reduction
0033T	C	Endovasc taa repr incl subcl
0034T	C	Endovasc taa repr w/o subcl
0035T	C	Insert endovasc prosth, taa
0036T	C	Endovasc prosth, taa, add-on
0037T	C	Artery transpose/endovas taa
0038T	C	Rad endovasc taa rpr w/cover
0039T	C	Rad s/i, endovasc taa repair
00404	C	Anesth, surgery of breast
00406	C	Anesth, surgery of breast
0040T	C	Rad s/i, endovasc taa prosth
00452	C	Anesth, surgery of shoulder
00474	C	Anesth, surgery of rib(s)
0048T	C	Implant ventricular device
0049T	C	External circulation assist
0050T	C	Removal circulation assist
0051T	C	Implant total heart system
00524	C	Anesth, chest drainage
0052T	C	Replace component heart syst
0053T	C	Replace component heart syst
00540	C	Anesth, chest surgery
00542	C	Anesth, release of lung
00580	C	Anesth, heart/lung transplnt
00604	C	Anesth, sitting procedure
00622	C	Anesth, removal of nerves
00632	C	Anesth, removal of nerves
00634	C	Anesth for chemonucleolysis
00670	C	Anesth, spine, cord surgery
00792	C	Anesth, hemorr/excise liver
00794	C	Anesth, pancreas removal
00796	C	Anesth, for liver transplant
00802	C	Anesth, fat layer removal
00844	C	Anesth, pelvis surgery
00846	C	Anesth, hysterectomy
00848	C	Anesth, pelvic organ surg
00864	C	Anesth, removal of bladder
00865	C	Anesth, removal of prostate
00866	C	Anesth, removal of adrenal
00868	C	Anesth, kidney transplant
00882	C	Anesth, major vein ligation
00904	C	Anesth, perineal surgery
00908	C	Anesth, removal of prostate
00928	C	Anesth, removal of testis
00932	C	Anesth, amputation of penis
00934	C	Anesth, penis, nodes removal
00936	C	Anesth, penis, nodes removal
00944	C	Anesth, vaginal hysterectomy
01140	C	Anesth, amputation at pelvis
01150	C	Anesth, pelvic tumor surgery
01190	C	Anesth, pelvis nerve removal
01212	C	Anesth, hip disarticulation
01214	C	Anesth, hip arthroplasty
01232	C	Anesth, amputation of femur
01234	C	Anesth, radical femur surg
01272	C	Anesth, femoral artery surg
01274	C	Anesth, femoral embolectomy
01402	C	Anesth, knee arthroplasty
01404	C	Anesth, amputation at knee

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
01442	C	Anesth, knee artery surg
01444	C	Anesth, knee artery repair
01486	C	Anesth, ankle replacement
01502	C	Anesth, lwr leg embolectomy
01632	C	Anesth, surgery of shoulder
01634	C	Anesth, shoulder joint amput
01636	C	Anesth, forequarter amput
01638	C	Anesth, shoulder replacement
01652	C	Anesth, shoulder vessel surg
01654	C	Anesth, shoulder vessel surg
01656	C	Anesth, arm-leg vessel surg
01756	C	Anesth, radical humerus surg
01990	C	Support for organ donor
15756	C	Free muscle flap, microvasc
15757	C	Free skin flap, microvasc
15758	C	Free fascial flap, microvasc
16035	C	Incision of burn scab, initi
16036	C	Incise burn scab, addl incis
19200	C	Removal of breast
19220	C	Removal of breast
19271	C	Revision of chest wall
19272	C	Extensive chest wall surgery
19361	C	Breast reconstruction
19364	C	Breast reconstruction
19367	C	Breast reconstruction
19368	C	Breast reconstruction
19369	C	Breast reconstruction
20660	C	Apply, rem fixation device
20661	C	Application of head brace
20662	C	Application of pelvis brace
20663	C	Application of thigh brace
20664	C	Halo brace application
20802	C	Replantation, arm, complete
20805	C	Replant forearm, complete
20808	C	Replantation hand, complete
20816	C	Replantation digit, complete
20822	C	Replantation digit, complete
20824	C	Replantation thumb, complete
20827	C	Replantation thumb, complete
20838	C	Replantation foot, complete
20930	C	Spinal bone allograft
20931	C	Spinal bone allograft
20936	C	Spinal bone autograft
20937	C	Spinal bone autograft
20938	C	Spinal bone autograft
20955	C	Fibula bone graft, microvasc
20956	C	Iliac bone graft, microvasc
20957	C	Mt bone graft, microvasc
20962	C	Other bone graft, microvasc
20969	C	Bone/skin graft, microvasc
20970	C	Bone/skin graft, iliac crest
20972	C	Bone/skin graft, metatarsal
20973	C	Bone/skin graft, great toe
21045	C	Extensive jaw surgery
21141	C	Reconstruct midface, lefort
21142	C	Reconstruct midface, lefort
21143	C	Reconstruct midface, lefort
21145	C	Reconstruct midface, lefort
21146	C	Reconstruct midface, lefort
21147	C	Reconstruct midface, lefort
21150	C	Reconstruct midface, lefort
21151	C	Reconstruct midface, lefort
21154	C	Reconstruct midface, lefort
21155	C	Reconstruct midface, lefort
21159	C	Reconstruct midface, lefort
21160	C	Reconstruct midface, lefort

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004] *

CPT/HCPCS	NPRM SI	Description
21172	C	Reconstruct orbit/forehead
21175	C	Reconstruct orbit/forehead
21179	C	Reconstruct entire forehead
21180	C	Reconstruct entire forehead
21182	C	Reconstruct cranial bone
21183	C	Reconstruct cranial bone
21184	C	Reconstruct cranial bone
21188	C	Reconstruction of midface
21193	C	Reconst lwr jaw w/o graft
21194	C	Reconst lwr jaw w/graft
21195	C	Reconst lwr jaw w/o fixation
21196	C	Reconst lwr jaw w/fixation
21247	C	Reconstruct lower jaw bone
21255	C	Reconstruct lower jaw bone
21256	C	Reconstruction of orbit
21268	C	Revise eye sockets
21343	C	Treatment of sinus fracture
21344	C	Treatment of sinus fracture
21346	C	Treat nose/jaw fracture
21347	C	Treat nose/jaw fracture
21348	C	Treat nose/jaw fracture
21356	C	Treat cheek bone fracture
21360	C	Treat cheek bone fracture
21365	C	Treat cheek bone fracture
21366	C	Treat cheek bone fracture
21385	C	Treat eye socket fracture
21386	C	Treat eye socket fracture
21387	C	Treat eye socket fracture
21395	C	Treat eye socket fracture
21408	C	Treat eye socket fracture
21422	C	Treat mouth roof fracture
21423	C	Treat mouth roof fracture
21431	C	Treat craniofacial fracture
21432	C	Treat craniofacial fracture
21433	C	Treat craniofacial fracture
21435	C	Treat craniofacial fracture
21436	C	Treat craniofacial fracture
21495	C	Treat hyoid bone fracture
21510	C	Drainage of bone lesion
21557	C	Remove tumor, neck/chest
21615	C	Removal of rib
21616	C	Removal of rib and nerves
21620	C	Partial removal of sternum
21627	C	Sternal debridement
21630	C	Extensive sternum surgery
21632	C	Extensive sternum surgery
21705	C	Revision of neck muscle/rib
21740	C	Reconstruction of sternum
21750	C	Repair of sternum separation
21810	C	Treatment of rib fracture(s)
21825	C	Treat sternum fracture
22110	C	Remove part of neck vertebra
22112	C	Remove part, thorax vertebra
22114	C	Remove part, lumbar vertebra
22116	C	Remove extra spine segment
22210	C	Revision of neck spine
22212	C	Revision of thorax spine
22214	C	Revision of lumbar spine
22216	C	Revise, extra spine segment
22220	C	Revision of neck spine
22222	C	Revision of thorax spine
22224	C	Revision of lumbar spine
22226	C	Revise, extra spine segment
22318	C	Treat odontoid fx w/o graft
22319	C	Treat odontoid fx w/graft
22325	C	Treat spine fracture

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
22326	C	Treat neck spine fracture
22327	C	Treat thorax spine fracture
22328	C	Treat each add spine fx
22532	C	Lat thorax spine fusion
22533	C	Lat lumbar spine fusion
22534	C	Lat thor/lumb, add'l seg
22548	C	Neck spine fusion
22554	C	Neck spine fusion
22556	C	Thorax spine fusion
22558	C	Lumbar spine fusion
22585	C	Additional spinal fusion
22590	C	Spine & skull spinal fusion
22595	C	Neck spinal fusion
22600	C	Neck spine fusion
22610	C	Thorax spine fusion
22630	C	Lumbar spine fusion
22632	C	Spine fusion, extra segment
22800	C	Fusion of spine
22802	C	Fusion of spine
22804	C	Fusion of spine
22808	C	Fusion of spine
22810	C	Fusion of spine
22812	C	Fusion of spine
22818	C	Kyphectomy, 1-2 segments
22819	C	Kyphectomy, 3 or more
22830	C	Exploration of spinal fusion
22840	C	Insert spine fixation device
22841	C	Insert spine fixation device
22842	C	Insert spine fixation device
22843	C	Insert spine fixation device
22844	C	Insert spine fixation device
22845	C	Insert spine fixation device
22846	C	Insert spine fixation device
22847	C	Insert spine fixation device
22848	C	Insert pelv fixation device
22849	C	Reinsert spinal fixation
22850	C	Remove spine fixation device
22851	C	Apply spine prosth device
22852	C	Remove spine fixation device
22855	C	Remove spine fixation device
23200	C	Removal of collar bone
23210	C	Removal of shoulder blade
23220	C	Partial removal of humerus
23221	C	Partial removal of humerus
23222	C	Partial removal of humerus
23332	C	Remove shoulder foreign body
23472	C	Reconstruct shoulder joint
23900	C	Amputation of arm & girdle
23920	C	Amputation at shoulder joint
24149	C	Radical resection of elbow
24900	C	Amputation of upper arm
24920	C	Amputation of upper arm
24930	C	Amputation follow-up surgery
24931	C	Amputate upper arm & implant
24940	C	Revision of upper arm
25900	C	Amputation of forearm
25905	C	Amputation of forearm
25909	C	Amputation follow-up surgery
25915	C	Amputation of forearm
25920	C	Amputate hand at wrist
25924	C	Amputation follow-up surgery
25927	C	Amputation of hand
25931	C	Amputation follow-up surgery
26551	C	Great toe-hand transfer
26553	C	Single transfer, toe-hand
26554	C	Double transfer, toe-hand

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
26556	C	Toe joint transfer
26992	C	Drainage of bone lesion
27005	C	Incision of hip tendon
27006	C	Incision of hip tendons
27025	C	Incision of hip/thigh fascia
27030	C	Drainage of hip joint
27036	C	Excision of hip joint/muscle
27054	C	Removal of hip joint lining
27070	C	Partial removal of hip bone
27071	C	Partial removal of hip bone
27075	C	Extensive hip surgery
27076	C	Extensive hip surgery
27077	C	Extensive hip surgery
27078	C	Extensive hip surgery
27079	C	Extensive hip surgery
27090	C	Removal of hip prosthesis
27091	C	Removal of hip prosthesis
27120	C	Reconstruction of hip socket
27122	C	Reconstruction of hip socket
27125	C	Partial hip replacement
27130	C	Total hip arthroplasty
27132	C	Total hip arthroplasty
27134	C	Revise hip joint replacement
27137	C	Revise hip joint replacement
27138	C	Revise hip joint replacement
27140	C	Transplant femur ridge
27146	C	Incision of hip bone
27147	C	Revision of hip bone
27151	C	Incision of hip bones
27156	C	Revision of hip bones
27158	C	Revision of pelvis
27161	C	Incision of neck of femur
27165	C	Incision/fixation of femur
27170	C	Repair/graft femur head/neck
27175	C	Treat slipped epiphysis
27176	C	Treat slipped epiphysis
27177	C	Treat slipped epiphysis
27178	C	Treat slipped epiphysis
27179	C	Revise head/neck of femur
27181	C	Treat slipped epiphysis
27185	C	Revision of femur epiphysis
27187	C	Reinforce hip bones
27215	C	Treat pelvic fracture(s)
27217	C	Treat pelvic ring fracture
27218	C	Treat pelvic ring fracture
27222	C	Treat hip socket fracture
27226	C	Treat hip wall fracture
27227	C	Treat hip fracture(s)
27228	C	Treat hip fracture(s)
27232	C	Treat thigh fracture
27236	C	Treat thigh fracture
27240	C	Treat thigh fracture
27244	C	Treat thigh fracture
27245	C	Treat thigh fracture
27248	C	Treat thigh fracture
27253	C	Treat hip dislocation
27254	C	Treat hip dislocation
27258	C	Treat hip dislocation
27259	C	Treat hip dislocation
27280	C	Fusion of sacroiliac joint
27282	C	Fusion of pubic bones
27284	C	Fusion of hip joint
27286	C	Fusion of hip joint
27290	C	Amputation of leg at hip
27295	C	Amputation of leg at hip
27303	C	Drainage of bone lesion

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
27365	C	Extensive leg surgery
27445	C	Revision of knee joint
27447	C	Total knee arthroplasty
27448	C	Incision of thigh
27450	C	Incision of thigh
27454	C	Realignment of thigh bone
27455	C	Realignment of knee
27457	C	Realignment of knee
27465	C	Shortening of thigh bone
27466	C	Lengthening of thigh bone
27468	C	Shorten/lengthen thighs
27470	C	Repair of thigh
27472	C	Repair/graft of thigh
27475	C	Surgery to stop leg growth
27477	C	Surgery to stop leg growth
27479	C	Surgery to stop leg growth
27485	C	Surgery to stop leg growth
27486	C	Revise/replace knee joint
27487	C	Revise/replace knee joint
27488	C	Removal of knee prosthesis
27495	C	Reinforce thigh
27506	C	Treatment of thigh fracture
27507	C	Treatment of thigh fracture
27511	C	Treatment of thigh fracture
27513	C	Treatment of thigh fracture
27514	C	Treatment of thigh fracture
27519	C	Treat thigh fx growth plate
27535	C	Treat knee fracture
27536	C	Treat knee fracture
27540	C	Treat knee fracture
27556	C	Treat knee dislocation
27557	C	Treat knee dislocation
27558	C	Treat knee dislocation
27580	C	Fusion of knee
27590	C	Amputate leg at thigh
27591	C	Amputate leg at thigh
27592	C	Amputate leg at thigh
27596	C	Amputation follow-up surgery
27598	C	Amputate lower leg at knee
27645	C	Extensive lower leg surgery
27646	C	Extensive lower leg surgery
27702	C	Reconstruct ankle joint
27703	C	Reconstruction, ankle joint
27712	C	Realignment of lower leg
27715	C	Revision of lower leg
27720	C	Repair of tibia
27722	C	Repair/graft of tibia
27724	C	Repair/graft of tibia
27725	C	Repair of lower leg
27727	C	Repair of lower leg
27880	C	Amputation of lower leg
27881	C	Amputation of lower leg
27882	C	Amputation of lower leg
27886	C	Amputation follow-up surgery
27888	C	Amputation of foot at ankle
28800	C	Amputation of midfoot
28805	C	Amputation thru metatarsal
31225	C	Removal of upper jaw
31230	C	Removal of upper jaw
31290	C	Nasal/sinus endoscopy, surg
31291	C	Nasal/sinus endoscopy, surg
31292	C	Nasal/sinus endoscopy, surg
31293	C	Nasal/sinus endoscopy, surg
31294	C	Nasal/sinus endoscopy, surg
31360	C	Removal of larynx
31365	C	Removal of larynx

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
31367	C	Partial removal of larynx
31368	C	Partial removal of larynx
31370	C	Partial removal of larynx
31375	C	Partial removal of larynx
31380	C	Partial removal of larynx
31382	C	Partial removal of larynx
31390	C	Removal of larynx & pharynx
31395	C	Reconstruct larynx & pharynx
31584	C	Treat larynx fracture
31587	C	Revision of larynx
31725	C	Clearance of airways
31760	C	Repair of windpipe
31766	C	Reconstruction of windpipe
31770	C	Repair/graft of bronchus
31775	C	Reconstruct bronchus
31780	C	Reconstruct windpipe
31781	C	Reconstruct windpipe
31786	C	Remove windpipe lesion
31800	C	Repair of windpipe injury
31805	C	Repair of windpipe injury
32035	C	Exploration of chest
32036	C	Exploration of chest
32095	C	Biopsy through chest wall
32100	C	Exploration/biopsy of chest
32110	C	Explore/repair chest
32120	C	Re-exploration of chest
32124	C	Explore chest free adhesions
32140	C	Removal of lung lesion(s)
32141	C	Remove/treat lung lesions
32150	C	Removal of lung lesion(s)
32151	C	Remove lung foreign body
32160	C	Open chest heart massage
32200	C	Drain, open, lung lesion
32215	C	Treat chest lining
32220	C	Release of lung
32225	C	Partial release of lung
32310	C	Removal of chest lining
32320	C	Free/remove chest lining
32402	C	Open biopsy chest lining
32440	C	Removal of lung
32442	C	Sleeve pneumonectomy
32445	C	Removal of lung
32480	C	Partial removal of lung
32482	C	Bilobectomy
32484	C	Segmentectomy
32486	C	Sleeve lobectomy
32488	C	Completion pneumonectomy
32491	C	Lung volume reduction
32500	C	Partial removal of lung
32501	C	Repair bronchus add-on
32520	C	Remove lung & revise chest
32522	C	Remove lung & revise chest
32525	C	Remove lung & revise chest
32540	C	Removal of lung lesion
32650	C	Thoracoscopy, surgical
32651	C	Thoracoscopy, surgical
32652	C	Thoracoscopy, surgical
32653	C	Thoracoscopy, surgical
32654	C	Thoracoscopy, surgical
32655	C	Thoracoscopy, surgical
32656	C	Thoracoscopy, surgical
32657	C	Thoracoscopy, surgical
32658	C	Thoracoscopy, surgical
32659	C	Thoracoscopy, surgical
32660	C	Thoracoscopy, surgical
32661	C	Thoracoscopy, surgical

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
32662	C	Thoracoscopy, surgical
32663	C	Thoracoscopy, surgical
32664	C	Thoracoscopy, surgical
32665	C	Thoracoscopy, surgical
32800	C	Repair lung hernia
32810	C	Close chest after drainage
32815	C	Close bronchial fistula
32820	C	Reconstruct injured chest
32850	C	Donor pneumonectomy
32851	C	Lung transplant, single
32852	C	Lung transplant with bypass
32853	C	Lung transplant, double
32854	C	Lung transplant with bypass
32900	C	Removal of rib(s)
32905	C	Revise & repair chest wall
32906	C	Revise & repair chest wall
32940	C	Revision of lung
32997	C	Total lung lavage
33015	C	Incision of heart sac
33020	C	Incision of heart sac
33025	C	Incision of heart sac
33030	C	Partial removal of heart sac
33031	C	Partial removal of heart sac
33050	C	Removal of heart sac lesion
33120	C	Removal of heart lesion
33130	C	Removal of heart lesion
33140	C	Heart revascularize (tmr)
33141	C	Heart tmr w/other procedure
33200	C	Insertion of heart pacemaker
33201	C	Insertion of heart pacemaker
33236	C	Remove electrode/thoracotomy
33237	C	Remove electrode/thoracotomy
33238	C	Remove electrode/thoracotomy
33243	C	Remove eltrd/thoracotomy
33245	C	Insert epic eltrd pace-defib
33246	C	Insert epic eltrd/generator
33250	C	Ablate heart dysrhythm focus
33251	C	Ablate heart dysrhythm focus
33253	C	Reconstruct atria
33261	C	Ablate heart dysrhythm focus
33300	C	Repair of heart wound
33305	C	Repair of heart wound
33310	C	Exploratory heart surgery
33315	C	Exploratory heart surgery
33320	C	Repair major blood vessel(s)
33321	C	Repair major vessel
33322	C	Repair major blood vessel(s)
33330	C	Insert major vessel graft
33332	C	Insert major vessel graft
33335	C	Insert major vessel graft
33400	C	Repair of aortic valve
33401	C	Valvuloplasty, open
33403	C	Valvuloplasty, w/cp bypass
33404	C	Prepare heart-aorta conduit
33405	C	Replacement of aortic valve
33406	C	Replacement of aortic valve
33410	C	Replacement of aortic valve
33411	C	Replacement of aortic valve
33412	C	Replacement of aortic valve
33413	C	Replacement of aortic valve
33414	C	Repair of aortic valve
33415	C	Revision, subvalvular tissue
33416	C	Revise ventricle muscle
33417	C	Repair of aortic valve
33420	C	Revision of mitral valve
33422	C	Revision of mitral valve

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
33425	C	Repair of mitral valve
33426	C	Repair of mitral valve
33427	C	Repair of mitral valve
33430	C	Replacement of mitral valve
33460	C	Revision of tricuspid valve
33463	C	Valvuloplasty, tricuspid
33464	C	Valvuloplasty, tricuspid
33465	C	Replace tricuspid valve
33468	C	Revision of tricuspid valve
33470	C	Revision of pulmonary valve
33471	C	Valvotomy, pulmonary valve
33472	C	Revision of pulmonary valve
33474	C	Revision of pulmonary valve
33475	C	Replacement, pulmonary valve
33476	C	Revision of heart chamber
33478	C	Revision of heart chamber
33496	C	Repair, prosth valve clot
33500	C	Repair heart vessel fistula
33501	C	Repair heart vessel fistula
33502	C	Coronary artery correction
33503	C	Coronary artery graft
33504	C	Coronary artery graft
33505	C	Repair artery w/tunnel
33506	C	Repair artery, translocation
33510	C	CABG, vein, single
33511	C	CABG, vein, two
33512	C	CABG, vein, three
33513	C	CABG, vein, four
33514	C	CABG, vein, five
33516	C	Cabg, vein, six or more
33517	C	CABG, artery-vein, single
33518	C	CABG, artery-vein, two
33519	C	CABG, artery-vein, three
33521	C	CABG, artery-vein, four
33522	C	CABG, artery-vein, five
33523	C	Cabg, art-vein, six or more
33530	C	Coronary artery, bypass/reop
33533	C	CABG, arterial, single
33534	C	CABG, arterial, two
33535	C	CABG, arterial, three
33536	C	Cabg, arterial, four or more
33542	C	Removal of heart lesion
33545	C	Repair of heart damage
33572	C	Open coronary endarterectomy
33600	C	Closure of valve
33602	C	Closure of valve
33606	C	Anastomosis/artery-aorta
33608	C	Repair anomaly w/conduit
33610	C	Repair by enlargement
33611	C	Repair double ventricle
33612	C	Repair double ventricle
33615	C	Repair, modified fontan
33617	C	Repair single ventricle
33619	C	Repair single ventricle
33641	C	Repair heart septum defect
33645	C	Revision of heart veins
33647	C	Repair heart septum defects
33660	C	Repair of heart defects
33665	C	Repair of heart defects
33670	C	Repair of heart chambers
33681	C	Repair heart septum defect
33684	C	Repair heart septum defect
33688	C	Repair heart septum defect
33690	C	Reinforce pulmonary artery
33692	C	Repair of heart defects
33694	C	Repair of heart defects

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
33697	C	Repair of heart defects
33702	C	Repair of heart defects
33710	C	Repair of heart defects
33720	C	Repair of heart defect
33722	C	Repair of heart defect
33730	C	Repair heart-vein defect(s)
33732	C	Repair heart-vein defect
33735	C	Revision of heart chamber
33736	C	Revision of heart chamber
33737	C	Revision of heart chamber
33750	C	Major vessel shunt
33755	C	Major vessel shunt
33762	C	Major vessel shunt
33764	C	Major vessel shunt & graft
33766	C	Major vessel shunt
33767	C	Major vessel shunt
33770	C	Repair great vessels defect
33771	C	Repair great vessels defect
33774	C	Repair great vessels defect
33775	C	Repair great vessels defect
33776	C	Repair great vessels defect
33777	C	Repair great vessels defect
33778	C	Repair great vessels defect
33779	C	Repair great vessels defect
33780	C	Repair great vessels defect
33781	C	Repair great vessels defect
33786	C	Repair arterial trunk
33788	C	Revision of pulmonary artery
33800	C	Aortic suspension
33802	C	Repair vessel defect
33803	C	Repair vessel defect
33813	C	Repair septal defect
33814	C	Repair septal defect
33820	C	Revise major vessel
33822	C	Revise major vessel
33824	C	Revise major vessel
33840	C	Remove aorta constriction
33845	C	Remove aorta constriction
33851	C	Remove aorta constriction
33852	C	Repair septal defect
33853	C	Repair septal defect
33860	C	Ascending aortic graft
33861	C	Ascending aortic graft
33863	C	Ascending aortic graft
33870	C	Transverse aortic arch graft
33875	C	Thoracic aortic graft
33877	C	Thoracoabdominal graft
33910	C	Remove lung artery emboli
33915	C	Remove lung artery emboli
33916	C	Surgery of great vessel
33917	C	Repair pulmonary artery
33918	C	Repair pulmonary atresia
33919	C	Repair pulmonary atresia
33920	C	Repair pulmonary atresia
33922	C	Transect pulmonary artery
33924	C	Remove pulmonary shunt
33930	C	Removal of donor heart/lung
33935	C	Transplantation, heart/lung
33940	C	Removal of donor heart
33945	C	Transplantation of heart
33960	C	External circulation assist
33961	C	External circulation assist
33967	C	Insert ia percut device
33968	C	Remove aortic assist device
33970	C	Aortic circulation assist
33971	C	Aortic circulation assist

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
33973	C	Insert balloon device
33974	C	Remove intra-aortic balloon
33975	C	Implant ventricular device
33976	C	Implant ventricular device
33977	C	Remove ventricular device
33978	C	Remove ventricular device
33979	C	Insert intracorporeal device
33980	C	Remove intracorporeal device
34001	C	Removal of artery clot
34051	C	Removal of artery clot
34151	C	Removal of artery clot
34401	C	Removal of vein clot
34451	C	Removal of vein clot
34502	C	Reconstruct vena cava
34800	C	Endovasc abdo repair w/tube
34802	C	Endovasc abdo repr w/device
34804	C	Endovasc abdo repr w/device
34805	C	Endovasc abdo repair w/pros
34808	C	Endovasc abdo occlud device
34812	C	Xpose for endoprosth, aortic
34813	C	Femoral endovas graft add-on
34820	C	Xpose for endoprosth, iliac
34825	C	Endovasc extend prosth, init
34826	C	Endovasc exten prosth, addl
34830	C	Open aortic tube prosth repr
34831	C	Open aortoiliac prosth repr
34832	C	Open aortofemor prosth repr
34833	C	Xpose for endoprosth, iliac
34834	C	Xpose, endoprosth, brachial
34900	C	Endovasc iliac repr w/graft
35001	C	Repair defect of artery
35002	C	Repair artery rupture, neck
35005	C	Repair defect of artery
35013	C	Repair artery rupture, arm
35021	C	Repair defect of artery
35022	C	Repair artery rupture, chest
35045	C	Repair defect of arm artery
35081	C	Repair defect of artery
35082	C	Repair artery rupture, aorta
35091	C	Repair defect of artery
35092	C	Repair artery rupture, aorta
35102	C	Repair defect of artery
35103	C	Repair artery rupture, groin
35111	C	Repair defect of artery
35112	C	Repair artery rupture,spleen
35121	C	Repair defect of artery
35122	C	Repair artery rupture, belly
35131	C	Repair defect of artery
35132	C	Repair artery rupture, groin
35141	C	Repair defect of artery
35142	C	Repair artery rupture, thigh
35151	C	Repair defect of artery
35152	C	Repair artery rupture, knee
35161	C	Repair defect of artery
35162	C	Repair artery rupture
35182	C	Repair blood vessel lesion
35189	C	Repair blood vessel lesion
35211	C	Repair blood vessel lesion
35216	C	Repair blood vessel lesion
35221	C	Repair blood vessel lesion
35241	C	Repair blood vessel lesion
35246	C	Repair blood vessel lesion
35251	C	Repair blood vessel lesion
35271	C	Repair blood vessel lesion
35276	C	Repair blood vessel lesion
35281	C	Repair blood vessel lesion

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
35301	C	Rechanneling of artery
35311	C	Rechanneling of artery
35331	C	Rechanneling of artery
35341	C	Rechanneling of artery
35351	C	Rechanneling of artery
35355	C	Rechanneling of artery
35361	C	Rechanneling of artery
35363	C	Rechanneling of artery
35371	C	Rechanneling of artery
35372	C	Rechanneling of artery
35381	C	Rechanneling of artery
35390	C	Reoperation, carotid add-on
35400	C	Angioscopy
35450	C	Repair arterial blockage
35452	C	Repair arterial blockage
35454	C	Repair arterial blockage
35456	C	Repair arterial blockage
35480	C	Atherectomy, open
35481	C	Atherectomy, open
35482	C	Atherectomy, open
35483	C	Atherectomy, open
35501	C	Artery bypass graft
35506	C	Artery bypass graft
35507	C	Artery bypass graft
35508	C	Artery bypass graft
35509	C	Artery bypass graft
35510	C	Artery bypass graft
35511	C	Artery bypass graft
35512	C	Artery bypass graft
35515	C	Artery bypass graft
35516	C	Artery bypass graft
35518	C	Artery bypass graft
35521	C	Artery bypass graft
35522	C	Artery bypass graft
35525	C	Artery bypass graft
35526	C	Artery bypass graft
35531	C	Artery bypass graft
35533	C	Artery bypass graft
35536	C	Artery bypass graft
35541	C	Artery bypass graft
35546	C	Artery bypass graft
35548	C	Artery bypass graft
35549	C	Artery bypass graft
35551	C	Artery bypass graft
35556	C	Artery bypass graft
35558	C	Artery bypass graft
35560	C	Artery bypass graft
35563	C	Artery bypass graft
35565	C	Artery bypass graft
35566	C	Artery bypass graft
35571	C	Artery bypass graft
35582	C	Vein bypass graft
35583	C	Vein bypass graft
35585	C	Vein bypass graft
35587	C	Vein bypass graft
35600	C	Harvest artery for cabg
35601	C	Artery bypass graft
35606	C	Artery bypass graft
35612	C	Artery bypass graft
35616	C	Artery bypass graft
35621	C	Artery bypass graft
35623	C	Bypass graft, not vein
35626	C	Artery bypass graft
35631	C	Artery bypass graft
35636	C	Artery bypass graft
35641	C	Artery bypass graft

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
35642	C	Artery bypass graft
35645	C	Artery bypass graft
35646	C	Artery bypass graft
35647	C	Artery bypass graft
35650	C	Artery bypass graft
35651	C	Artery bypass graft
35654	C	Artery bypass graft
35656	C	Artery bypass graft
35661	C	Artery bypass graft
35663	C	Artery bypass graft
35665	C	Artery bypass graft
35666	C	Artery bypass graft
35671	C	Artery bypass graft
35681	C	Composite bypass graft
35682	C	Composite bypass graft
35683	C	Composite bypass graft
35691	C	Arterial transposition
35693	C	Arterial transposition
35694	C	Arterial transposition
35695	C	Arterial transposition
35697	C	Reimplant artery each
35700	C	Reoperation, bypass graft
35701	C	Exploration, carotid artery
35721	C	Exploration, femoral artery
35741	C	Exploration popliteal artery
35800	C	Explore neck vessels
35820	C	Explore chest vessels
35840	C	Explore abdominal vessels
35870	C	Repair vessel graft defect
35901	C	Excision, graft, neck
35905	C	Excision, graft, thorax
35907	C	Excision, graft, abdomen
36510	C	Insertion of catheter, vein
36660	C	Insertion catheter, artery
36822	C	Insertion of cannula(s)
36823	C	Insertion of cannula(s)
37140	C	Revision of circulation
37145	C	Revision of circulation
37160	C	Revision of circulation
37180	C	Revision of circulation
37181	C	Splice spleen/kidney veins
37182	C	Insert hepatic shunt (tips)
37183	C	Remove hepatic shunt (tips)
37195	C	Thrombolytic therapy, stroke
37616	C	Ligation of chest artery
37617	C	Ligation of abdomen artery
37618	C	Ligation of extremity artery
37660	C	Revision of major vein
37788	C	Revascularization, penis
38100	C	Removal of spleen, total
38101	C	Removal of spleen, partial
38102	C	Removal of spleen, total
38115	C	Repair of ruptured spleen
38380	C	Thoracic duct procedure
38381	C	Thoracic duct procedure
38382	C	Thoracic duct procedure
38562	C	Removal, pelvic lymph nodes
38564	C	Removal, abdomen lymph nodes
38724	C	Removal of lymph nodes, neck
38746	C	Remove thoracic lymph nodes
38747	C	Remove abdominal lymph nodes
38765	C	Remove groin lymph nodes
38770	C	Remove pelvis lymph nodes
38780	C	Remove abdomen lymph nodes
39000	C	Exploration of chest
39010	C	Exploration of chest

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
39200	C	Removal chest lesion
39220	C	Removal chest lesion
39499	C	Chest procedure
39501	C	Repair diaphragm laceration
39502	C	Repair paraesophageal hernia
39503	C	Repair of diaphragm hernia
39520	C	Repair of diaphragm hernia
39530	C	Repair of diaphragm hernia
39531	C	Repair of diaphragm hernia
39540	C	Repair of diaphragm hernia
39541	C	Repair of diaphragm hernia
39545	C	Revision of diaphragm
39560	C	Resect diaphragm, simple
39561	C	Resect diaphragm, complex
39599	C	Diaphragm surgery procedure
41130	C	Partial removal of tongue
41135	C	Tongue and neck surgery
41140	C	Removal of tongue
41145	C	Tongue removal, neck surgery
41150	C	Tongue, mouth, jaw surgery
41153	C	Tongue, mouth, neck surgery
41155	C	Tongue, jaw, & neck surgery
42426	C	Excise parotid gland/lesion
42845	C	Extensive surgery of throat
42894	C	Revision of pharyngeal walls
42953	C	Repair throat, esophagus
42961	C	Control throat bleeding
42971	C	Control nose/throat bleeding
43045	C	Incision of esophagus
43100	C	Excision of esophagus lesion
43101	C	Excision of esophagus lesion
43107	C	Removal of esophagus
43108	C	Removal of esophagus
43112	C	Removal of esophagus
43113	C	Removal of esophagus
43116	C	Partial removal of esophagus
43117	C	Partial removal of esophagus
43118	C	Partial removal of esophagus
43121	C	Partial removal of esophagus
43122	C	Partial removal of esophagus
43123	C	Partial removal of esophagus
43124	C	Removal of esophagus
43135	C	Removal of esophagus pouch
43300	C	Repair of esophagus
43305	C	Repair esophagus and fistula
43310	C	Repair of esophagus
43312	C	Repair esophagus and fistula
43313	C	Esophagoplasty congenital
43314	C	Tracheo-esophagoplasty cong
43320	C	Fuse esophagus & stomach
43324	C	Revise esophagus & stomach
43325	C	Revise esophagus & stomach
43326	C	Revise esophagus & stomach
43330	C	Repair of esophagus
43331	C	Repair of esophagus
43340	C	Fuse esophagus & intestine
43341	C	Fuse esophagus & intestine
43350	C	Surgical opening, esophagus
43351	C	Surgical opening, esophagus
43352	C	Surgical opening, esophagus
43360	C	Gastrointestinal repair
43361	C	Gastrointestinal repair
43400	C	Ligate esophagus veins
43401	C	Esophagus surgery for veins
43405	C	Ligate/staple esophagus
43410	C	Repair esophagus wound

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
43415	C	Repair esophagus wound
43420	C	Repair esophagus opening
43425	C	Repair esophagus opening
43460	C	Pressure treatment esophagus
43496	C	Free jejunum flap, microvasc
43500	C	Surgical opening of stomach
43501	C	Surgical repair of stomach
43502	C	Surgical repair of stomach
43510	C	Surgical opening of stomach
43520	C	Incision of pyloric muscle
43605	C	Biopsy of stomach
43610	C	Excision of stomach lesion
43611	C	Excision of stomach lesion
43620	C	Removal of stomach
43621	C	Removal of stomach
43622	C	Removal of stomach
43631	C	Removal of stomach, partial
43632	C	Removal of stomach, partial
43633	C	Removal of stomach, partial
43634	C	Removal of stomach, partial
43635	C	Removal of stomach, partial
43638	C	Removal of stomach, partial
43639	C	Removal of stomach, partial
43640	C	Vagotomy & pylorus repair
43641	C	Vagotomy & pylorus repair
43800	C	Reconstruction of pylorus
43810	C	Fusion of stomach and bowel
43820	C	Fusion of stomach and bowel
43825	C	Fusion of stomach and bowel
43832	C	Place gastrostomy tube
43840	C	Repair of stomach lesion
43842	C	Gastroplasty for obesity
43843	C	Gastroplasty for obesity
43846	C	Gastric bypass for obesity
43847	C	Gastric bypass for obesity
43848	C	Revision gastroplasty
43850	C	Revise stomach-bowel fusion
43855	C	Revise stomach-bowel fusion
43860	C	Revise stomach-bowel fusion
43865	C	Revise stomach-bowel fusion
43880	C	Repair stomach-bowel fistula
44005	C	Freeing of bowel adhesion
44010	C	Incision of small bowel
44015	C	Insert needle cath bowel
44020	C	Explore small intestine
44021	C	Decompress small bowel
44025	C	Incision of large bowel
44050	C	Reduce bowel obstruction
44055	C	Correct malrotation of bowel
44110	C	Excise intestine lesion(s)
44111	C	Excision of bowel lesion(s)
44120	C	Removal of small intestine
44121	C	Removal of small intestine
44125	C	Removal of small intestine
44126	C	Enterectomy w/o taper, cong
44127	C	Enterectomy w/taper, cong
44128	C	Enterectomy cong, add-on
44130	C	Bowel to bowel fusion
44132	C	Enterectomy, cadaver donor
44133	C	Enterectomy, live donor
44135	C	Intestine transplnt, cadaver
44136	C	Intestine transplant, live
44139	C	Mobilization of colon
44140	C	Partial removal of colon
44141	C	Partial removal of colon
44143	C	Partial removal of colon

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
44144	C	Partial removal of colon
44145	C	Partial removal of colon
44146	C	Partial removal of colon
44147	C	Partial removal of colon
44150	C	Removal of colon
44151	C	Removal of colon/ileostomy
44152	C	Removal of colon/ileostomy
44153	C	Removal of colon/ileostomy
44155	C	Removal of colon/ileostomy
44156	C	Removal of colon/ileostomy
44160	C	Removal of colon
44202	C	Lap resect s/intestine singl
44203	C	Lap resect s/intestine, addl
44204	C	Laparo partial colectomy
44205	C	Lap colectomy part w/ileum
44210	C	Laparo total proctocolectomy
44211	C	Laparo total proctocolectomy
44212	C	Laparo total proctocolectomy
44300	C	Open bowel to skin
44310	C	Ileostomy/jejunostomy
44314	C	Revision of ileostomy
44316	C	Devise bowel pouch
44320	C	Colostomy
44322	C	Colostomy with biopsies
44345	C	Revision of colostomy
44346	C	Revision of colostomy
44602	C	Suture, small intestine
44603	C	Suture, small intestine
44604	C	Suture, large intestine
44605	C	Repair of bowel lesion
44615	C	Intestinal stricturoplasty
44620	C	Repair bowel opening
44625	C	Repair bowel opening
44626	C	Repair bowel opening
44640	C	Repair bowel-skin fistula
44650	C	Repair bowel fistula
44660	C	Repair bowel-bladder fistula
44661	C	Repair bowel-bladder fistula
44680	C	Surgical revision, intestine
44700	C	Suspend bowel w/prosthesis
44800	C	Excision of bowel pouch
44820	C	Excision of mesentery lesion
44850	C	Repair of mesentery
44899	C	Bowel surgery procedure
44900	C	Drain app abscess, open
44901	C	Drain app abscess, percut
44950	C	Appendectomy
44955	C	Appendectomy add-on
44960	C	Appendectomy
45110	C	Removal of rectum
45111	C	Partial removal of rectum
45112	C	Removal of rectum
45113	C	Partial proctectomy
45114	C	Partial removal of rectum
45116	C	Partial removal of rectum
45119	C	Remove rectum w/reservoir
45120	C	Removal of rectum
45121	C	Removal of rectum and colon
45123	C	Partial proctectomy
45126	C	Pelvic exenteration
45130	C	Excision of rectal prolapse
45135	C	Excision of rectal prolapse
45136	C	Excise ileoanal reservior
45540	C	Correct rectal prolapse
45541	C	Correct rectal prolapse
45550	C	Repair rectum/remove sigmoid

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
45562	C	Exploration/repair of rectum
45563	C	Exploration/repair of rectum
45800	C	Repair rect/bladder fistula
45805	C	Repair fistula w/colostomy
45820	C	Repair rectourethral fistula
45825	C	Repair fistula w/colostomy
46705	C	Repair of anal stricture
46715	C	Repair of anovaginal fistula
46716	C	Repair of anovaginal fistula
46730	C	Construction of absent anus
46735	C	Construction of absent anus
46740	C	Construction of absent anus
46742	C	Repair of imperforated anus
46744	C	Repair of cloacal anomaly
46746	C	Repair of cloacal anomaly
46748	C	Repair of cloacal anomaly
46751	C	Repair of anal sphincter
47010	C	Open drainage, liver lesion
47015	C	Inject/aspirate liver cyst
47100	C	Wedge biopsy of liver
47120	C	Partial removal of liver
47122	C	Extensive removal of liver
47125	C	Partial removal of liver
47130	C	Partial removal of liver
47133	C	Removal of donor liver
47140	C	Partial removal, donor liver
47141	C	Partial removal, donor liver
47142	C	Partial removal, donor liver
47360	C	Repair liver wound
47361	C	Repair liver wound
47362	C	Repair liver wound
47380	C	Open ablate liver tumor rf
47381	C	Open ablate liver tumor cryo
47400	C	Incision of liver duct
47420	C	Incision of bile duct
47425	C	Incision of bile duct
47460	C	Incise bile duct sphincter
47480	C	Incision of gallbladder
47550	C	Bile duct endoscopy add-on
47570	C	Laparo cholecystoenterostomy
47600	C	Removal of gallbladder
47605	C	Removal of gallbladder
47610	C	Removal of gallbladder
47612	C	Removal of gallbladder
47620	C	Removal of gallbladder
47700	C	Exploration of bile ducts
47701	C	Bile duct revision
47711	C	Excision of bile duct tumor
47712	C	Excision of bile duct tumor
47715	C	Excision of bile duct cyst
47716	C	Fusion of bile duct cyst
47720	C	Fuse gallbladder & bowel
47721	C	Fuse upper gi structures
47740	C	Fuse gallbladder & bowel
47741	C	Fuse gallbladder & bowel
47760	C	Fuse bile ducts and bowel
47765	C	Fuse liver ducts & bowel
47780	C	Fuse bile ducts and bowel
47785	C	Fuse bile ducts and bowel
47800	C	Reconstruction of bile ducts
47801	C	Placement, bile duct support
47802	C	Fuse liver duct & intestine
47900	C	Suture bile duct injury
48000	C	Drainage of abdomen
48001	C	Placement of drain, pancreas
48005	C	Resect/debride pancreas

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
48020	C	Removal of pancreatic stone
48100	C	Biopsy of pancreas, open
48120	C	Removal of pancreas lesion
48140	C	Partial removal of pancreas
48145	C	Partial removal of pancreas
48146	C	Pancreatectomy
48148	C	Removal of pancreatic duct
48150	C	Partial removal of pancreas
48152	C	Pancreatectomy
48153	C	Pancreatectomy
48154	C	Pancreatectomy
48155	C	Removal of pancreas
48180	C	Fuse pancreas and bowel
48400	C	Injection, intraop add-on
48500	C	Surgery of pancreatic cyst
48510	C	Drain pancreatic pseudocyst
48520	C	Fuse pancreas cyst and bowel
48540	C	Fuse pancreas cyst and bowel
48545	C	Pancreatorrhaphy
48547	C	Duodenal exclusion
48556	C	Removal, allograft pancreas
49000	C	Exploration of abdomen
49002	C	Reopening of abdomen
49010	C	Exploration behind abdomen
49020	C	Drain abdominal abscess
49021	C	Drain abdominal abscess
49040	C	Drain, open, abdom abscess
49041	C	Drain, percut, abdom abscess
49060	C	Drain, open, retrop abscess
49061	C	Drain, percut, retroper absc
49062	C	Drain to peritoneal cavity
49201	C	Remove abdom lesion, complex
49215	C	Excise sacral spine tumor
49220	C	Multiple surgery, abdomen
49255	C	Removal of omentum
49425	C	Insert abdomen-venous drain
49428	C	Ligation of shunt
49605	C	Repair umbilical lesion
49606	C	Repair umbilical lesion
49610	C	Repair umbilical lesion
49611	C	Repair umbilical lesion
49900	C	Repair of abdominal wall
49904	C	Omental flap, extra-abdom
49905	C	Omental flap
49906	C	Free omental flap, microvasc
50010	C	Exploration of kidney
50020	C	Renal abscess, open drain
50040	C	Drainage of kidney
50045	C	Exploration of kidney
50060	C	Removal of kidney stone
50065	C	Incision of kidney
50070	C	Incision of kidney
50075	C	Removal of kidney stone
50100	C	Revise kidney blood vessels
50120	C	Exploration of kidney
50125	C	Explore and drain kidney
50130	C	Removal of kidney stone
50135	C	Exploration of kidney
50205	C	Biopsy of kidney
50220	C	Remove kidney, open
50225	C	Removal kidney open, complex
50230	C	Removal kidney open, radical
50234	C	Removal of kidney & ureter
50236	C	Removal of kidney & ureter
50240	C	Partial removal of kidney
50280	C	Removal of kidney lesion

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
50290	C	Removal of kidney lesion
50300	C	Removal of donor kidney
50320	C	Removal of donor kidney
50340	C	Removal of kidney
50360	C	Transplantation of kidney
50365	C	Transplantation of kidney
50370	C	Remove transplanted kidney
50380	C	Reimplantation of kidney
50400	C	Revision of kidney/ureter
50405	C	Revision of kidney/ureter
50500	C	Repair of kidney wound
50520	C	Close kidney-skin fistula
50525	C	Repair renal-abdomen fistula
50526	C	Repair renal-abdomen fistula
50540	C	Revision of horseshoe kidney
50545	C	Laparo radical nephrectomy
50546	C	Laparoscopic nephrectomy
50547	C	Laparo removal donor kidney
50548	C	Laparo remove k/ureter
50570	C	Kidney endoscopy
50572	C	Kidney endoscopy
50574	C	Kidney endoscopy & biopsy
50575	C	Kidney endoscopy
50576	C	Kidney endoscopy & treatment
50578	C	Renal endoscopy/radiotracer
50580	C	Kidney endoscopy & treatment
50600	C	Exploration of ureter
50605	C	Insert ureteral support
50610	C	Removal of ureter stone
50620	C	Removal of ureter stone
50630	C	Removal of ureter stone
50650	C	Removal of ureter
50660	C	Removal of ureter
50700	C	Revision of ureter
50715	C	Release of ureter
50722	C	Release of ureter
50725	C	Release/revise ureter
50727	C	Revise ureter
50728	C	Revise ureter
50740	C	Fusion of ureter & kidney
50750	C	Fusion of ureter & kidney
50760	C	Fusion of ureters
50770	C	Splicing of ureters
50780	C	Reimplant ureter in bladder
50782	C	Reimplant ureter in bladder
50783	C	Reimplant ureter in bladder
50785	C	Reimplant ureter in bladder
50800	C	Implant ureter in bowel
50810	C	Fusion of ureter & bowel
50815	C	Urine shunt to intestine
50820	C	Construct bowel bladder
50825	C	Construct bowel bladder
50830	C	Revise urine flow
50840	C	Replace ureter by bowel
50845	C	Appendico-vesicostomy
50860	C	Transplant ureter to skin
50900	C	Repair of ureter
50920	C	Closure ureter/skin fistula
50930	C	Closure ureter/bowel fistula
50940	C	Release of ureter
51060	C	Removal of ureter stone
51525	C	Removal of bladder lesion
51530	C	Removal of bladder lesion
51535	C	Repair of ureter lesion
51550	C	Partial removal of bladder
51555	C	Partial removal of bladder

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
51565	C	Revise bladder & ureter(s)
51570	C	Removal of bladder
51575	C	Removal of bladder & nodes
51580	C	Remove bladder/revise tract
51585	C	Removal of bladder & nodes
51590	C	Remove bladder/revise tract
51595	C	Remove bladder/revise tract
51596	C	Remove bladder/create pouch
51597	C	Removal of pelvic structures
51800	C	Revision of bladder/urethra
51820	C	Revision of urinary tract
51840	C	Attach bladder/urethra
51841	C	Attach bladder/urethra
51845	C	Repair bladder neck
51860	C	Repair of bladder wound
51865	C	Repair of bladder wound
51900	C	Repair bladder/vagina lesion
51920	C	Close bladder-uterus fistula
51925	C	Hysterectomy/bladder repair
51940	C	Correction of bladder defect
51960	C	Revision of bladder & bowel
51980	C	Construct bladder opening
53085	C	Drainage of urinary leakage
53415	C	Reconstruction of urethra
53448	C	Remov/replc ur sphinctr comp
54125	C	Removal of penis
54130	C	Remove penis & nodes
54135	C	Remove penis & nodes
54332	C	Revise penis/urethra
54336	C	Revise penis/urethra
54390	C	Repair penis and bladder
54411	C	Remov/replc penis pros, comp
54417	C	Remv/replc penis pros, compl
54430	C	Revision of penis
54535	C	Extensive testis surgery
54560	C	Exploration for testis
54650	C	Orchiopexy (Fowler-Stephens)
55600	C	Incise sperm duct pouch
55605	C	Incise sperm duct pouch
55650	C	Remove sperm duct pouch
55801	C	Removal of prostate
55810	C	Extensive prostate surgery
55812	C	Extensive prostate surgery
55815	C	Extensive prostate surgery
55821	C	Removal of prostate
55831	C	Removal of prostate
55840	C	Extensive prostate surgery
55842	C	Extensive prostate surgery
55845	C	Extensive prostate surgery
55862	C	Extensive prostate surgery
55865	C	Extensive prostate surgery
55866	C	Laparo radical prostatectomy
56630	C	Extensive vulva surgery
56631	C	Extensive vulva surgery
56632	C	Extensive vulva surgery
56633	C	Extensive vulva surgery
56634	C	Extensive vulva surgery
56637	C	Extensive vulva surgery
56640	C	Extensive vulva surgery
57110	C	Remove vagina wall, complete
57111	C	Remove vagina tissue, compl
57112	C	Vaginectomy w/nodes, compl
57270	C	Repair of bowel pouch
57280	C	Suspension of vagina
57282	C	Repair of vaginal prolapse
57292	C	Construct vagina with graft

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
57305	C	Repair rectum-vagina fistula
57307	C	Fistula repair & colostomy
57308	C	Fistula repair, transperine
57311	C	Repair urethrovaginal lesion
57335	C	Repair vagina
57531	C	Removal of cervix, radical
57540	C	Removal of residual cervix
57545	C	Remove cervix/repair pelvis
58140	C	Removal of uterus lesion
58146	C	Myomectomy abdom complex
58150	C	Total hysterectomy
58152	C	Total hysterectomy
58180	C	Partial hysterectomy
58200	C	Extensive hysterectomy
58210	C	Extensive hysterectomy
58240	C	Removal of pelvis contents
58260	C	Vaginal hysterectomy
58262	C	Vag hyst including t/o
58263	C	Vag hyst w/t/o & vag repair
58267	C	Vag hyst w/urinary repair
58270	C	Vag hyst w/enterocele repair
58275	C	Hysterectomy/revise vagina
58280	C	Hysterectomy/revise vagina
58285	C	Extensive hysterectomy
58290	C	Vag hyst complex
58291	C	Vag hyst incl t/o, complex
58292	C	Vag hyst t/o & repair, compl
58293	C	Vag hyst w/uro repair, compl
58294	C	Vag hyst w/enterocele, compl
58400	C	Suspension of uterus
58410	C	Suspension of uterus
58520	C	Repair of ruptured uterus
58540	C	Revision of uterus
58605	C	Division of fallopian tube
58611	C	Ligate oviduct(s) add-on
58700	C	Removal of fallopian tube
58720	C	Removal of ovary/tube(s)
58740	C	Revise fallopian tube(s)
58750	C	Repair oviduct
58752	C	Revise ovarian tube(s)
58760	C	Remove tubal obstruction
58770	C	Create new tubal opening
58805	C	Drainage of ovarian cyst(s)
58822	C	Drain ovary abscess, percut
58825	C	Transposition, ovary(s)
58940	C	Removal of ovary(s)
58943	C	Removal of ovary(s)
58950	C	Resect ovarian malignancy
58951	C	Resect ovarian malignancy
58952	C	Resect ovarian malignancy
58953	C	Tah, rad dissect for debulk
58954	C	Tah rad debulk/lymph remove
58960	C	Exploration of abdomen
59100	C	Remove uterus lesion
59120	C	Treat ectopic pregnancy
59121	C	Treat ectopic pregnancy
59130	C	Treat ectopic pregnancy
59135	C	Treat ectopic pregnancy
59136	C	Treat ectopic pregnancy
59140	C	Treat ectopic pregnancy
59325	C	Revision of cervix
59350	C	Repair of uterus
59514	C	Cesarean delivery only
59525	C	Remove uterus after cesarean
59620	C	Attempted vbac delivery only
59830	C	Treat uterus infection

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
59850	C	Abortion
59851	C	Abortion
59852	C	Abortion
59855	C	Abortion
59856	C	Abortion
59857	C	Abortion
60254	C	Extensive thyroid surgery
60270	C	Removal of thyroid
60271	C	Removal of thyroid
60502	C	Re-explore parathyroids
60505	C	Explore parathyroid glands
60520	C	Removal of thymus gland
60521	C	Removal of thymus gland
60522	C	Removal of thymus gland
60540	C	Explore adrenal gland
60545	C	Explore adrenal gland
60600	C	Remove carotid body lesion
60605	C	Remove carotid body lesion
60650	C	Laparoscopy adrenalectomy
61105	C	Twist drill hole
61107	C	Drill skull for implantation
61108	C	Drill skull for drainage
61120	C	Burr hole for puncture
61140	C	Pierce skull for biopsy
61150	C	Pierce skull for drainage
61151	C	Pierce skull for drainage
61154	C	Pierce skull & remove clot
61156	C	Pierce skull for drainage
61210	C	Pierce skull, implant device
61250	C	Pierce skull & explore
61253	C	Pierce skull & explore
61304	C	Open skull for exploration
61305	C	Open skull for exploration
61312	C	Open skull for drainage
61313	C	Open skull for drainage
61314	C	Open skull for drainage
61315	C	Open skull for drainage
61316	C	Implt cran bone flap to abdo
61320	C	Open skull for drainage
61321	C	Open skull for drainage
61322	C	Decompressive craniotomy
61323	C	Decompressive lobectomy
61332	C	Explore/biopsy eye socket
61333	C	Explore orbit/remove lesion
61334	C	Explore orbit/remove object
61340	C	Relieve cranial pressure
61343	C	Incise skull (press relief)
61345	C	Relieve cranial pressure
61440	C	Incise skull for surgery
61450	C	Incise skull for surgery
61458	C	Incise skull for brain wound
61460	C	Incise skull for surgery
61470	C	Incise skull for surgery
61480	C	Incise skull for surgery
61490	C	Incise skull for surgery
61500	C	Removal of skull lesion
61501	C	Remove infected skull bone
61510	C	Removal of brain lesion
61512	C	Remove brain lining lesion
61514	C	Removal of brain abscess
61516	C	Removal of brain lesion
61517	C	Implt brain chemotx add-on
61518	C	Removal of brain lesion
61519	C	Remove brain lining lesion
61520	C	Removal of brain lesion
61521	C	Removal of brain lesion

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
61522	C	Removal of brain abscess
61524	C	Removal of brain lesion
61526	C	Removal of brain lesion
61530	C	Removal of brain lesion
61531	C	Implant brain electrodes
61533	C	Implant brain electrodes
61534	C	Removal of brain lesion
61535	C	Remove brain electrodes
61536	C	Removal of brain lesion
61537	C	Removal of brain tissue
61538	C	Removal of brain tissue
61539	C	Removal of brain tissue
61540	C	Removal of brain tissue
61541	C	Incision of brain tissue
61542	C	Removal of brain tissue
61543	C	Removal of brain tissue
61544	C	Remove & treat brain lesion
61545	C	Excision of brain tumor
61546	C	Removal of pituitary gland
61548	C	Removal of pituitary gland
61550	C	Release of skull seams
61552	C	Release of skull seams
61556	C	Incise skull/sutures
61557	C	Incise skull/sutures
61558	C	Excision of skull/sutures
61559	C	Excision of skull/sutures
61563	C	Excision of skull tumor
61564	C	Excision of skull tumor
61566	C	Removal of brain tissue
61567	C	Incision of brain tissue
61570	C	Remove foreign body, brain
61571	C	Incise skull for brain wound
61575	C	Skull base/brainstem surgery
61576	C	Skull base/brainstem surgery
61580	C	Craniofacial approach, skull
61581	C	Craniofacial approach, skull
61582	C	Craniofacial approach, skull
61583	C	Craniofacial approach, skull
61584	C	Orbitocranial approach/skull
61585	C	Orbitocranial approach/skull
61586	C	Resect nasopharynx, skull
61590	C	Infratemporal approach/skull
61591	C	Infratemporal approach/skull
61592	C	Orbitocranial approach/skull
61595	C	Transtemporal approach/skull
61596	C	Transcochlear approach/skull
61597	C	Transcondylar approach/skull
61598	C	Transpetrosal approach/skull
61600	C	Resect/excise cranial lesion
61601	C	Resect/excise cranial lesion
61605	C	Resect/excise cranial lesion
61606	C	Resect/excise cranial lesion
61607	C	Resect/excise cranial lesion
61608	C	Resect/excise cranial lesion
61609	C	Transect artery, sinus
61610	C	Transect artery, sinus
61611	C	Transect artery, sinus
61612	C	Transect artery, sinus
61613	C	Remove aneurysm, sinus
61615	C	Resect/excise lesion, skull
61616	C	Resect/excise lesion, skull
61618	C	Repair dura
61619	C	Repair dura
61624	C	Occlusion/embolization cath
61680	C	Intracranial vessel surgery
61682	C	Intracranial vessel surgery

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
61684	C	Intracranial vessel surgery
61686	C	Intracranial vessel surgery
61690	C	Intracranial vessel surgery
61692	C	Intracranial vessel surgery
61697	C	Brain aneurysm repr, complx
61698	C	Brain aneurysm repr, complx
61700	C	Brain aneurysm repr, simple
61702	C	Inner skull vessel surgery
61703	C	Clamp neck artery
61705	C	Revise circulation to head
61708	C	Revise circulation to head
61710	C	Revise circulation to head
61711	C	Fusion of skull arteries
61720	C	Incise skull/brain surgery
61735	C	Incise skull/brain surgery
61750	C	Incise skull/brain biopsy
61751	C	Brain biopsy w/ ct/mr guide
61760	C	Implant brain electrodes
61770	C	Incise skull for treatment
61850	C	Implant neuroelectrodes
61860	C	Implant neuroelectrodes
61863	C	Implant neuroelectrode
61864	C	Implant neuroelectrde, add'l
61867	C	Implant neuroelectrode
61868	C	Implant neuroelectrde, add'l
61870	C	Implant neuroelectrodes
61875	C	Implant neuroelectrodes
62000	C	Treat skull fracture
62005	C	Treat skull fracture
62010	C	Treatment of head injury
62100	C	Repair brain fluid leakage
62115	C	Reduction of skull defect
62116	C	Reduction of skull defect
62117	C	Reduction of skull defect
62120	C	Repair skull cavity lesion
62121	C	Incise skull repair
62140	C	Repair of skull defect
62141	C	Repair of skull defect
62142	C	Remove skull plate/flap
62143	C	Replace skull plate/flap
62145	C	Repair of skull & brain
62146	C	Repair of skull with graft
62147	C	Repair of skull with graft
62148	C	Retr bone flap to fix skull
62161	C	Dissect brain w/scope
62162	C	Remove colloid cyst w/scope
62163	C	Neuroendoscopy w/fb removal
62164	C	Remove brain tumor w/scope
62165	C	Remove pituit tumor w/scope
62180	C	Establish brain cavity shunt
62190	C	Establish brain cavity shunt
62192	C	Establish brain cavity shunt
62200	C	Establish brain cavity shunt
62201	C	Establish brain cavity shunt
62220	C	Establish brain cavity shunt
62223	C	Establish brain cavity shunt
62256	C	Remove brain cavity shunt
62258	C	Replace brain cavity shunt
63043	C	Laminotomy, addl cervical
63044	C	Laminotomy, addl lumbar
63075	C	Neck spine disk surgery
63076	C	Neck spine disk surgery
63077	C	Spine disk surgery, thorax
63078	C	Spine disk surgery, thorax
63081	C	Removal of vertebral body
63082	C	Remove vertebral body add-on

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
63085	C	Removal of vertebral body
63086	C	Remove vertebral body add-on
63087	C	Removal of vertebral body
63088	C	Remove vertebral body add-on
63090	C	Removal of vertebral body
63091	C	Remove vertebral body add-on
63101	C	Removal of vertebral body
63102	C	Removal of vertebral body
63103	C	Remove vertebral body add-on
63170	C	Incise spinal cord tract(s)
63172	C	Drainage of spinal cyst
63173	C	Drainage of spinal cyst
63180	C	Revise spinal cord ligaments
63182	C	Revise spinal cord ligaments
63185	C	Incise spinal column/nerves
63190	C	Incise spinal column/nerves
63191	C	Incise spinal column/nerves
63194	C	Incise spinal column & cord
63195	C	Incise spinal column & cord
63196	C	Incise spinal column & cord
63197	C	Incise spinal column & cord
63198	C	Incise spinal column & cord
63199	C	Incise spinal column & cord
63200	C	Release of spinal cord
63250	C	Revise spinal cord vessels
63251	C	Revise spinal cord vessels
63252	C	Revise spinal cord vessels
63265	C	Excise intraspinal lesion
63266	C	Excise intraspinal lesion
63267	C	Excise intraspinal lesion
63268	C	Excise intraspinal lesion
63270	C	Excise intraspinal lesion
63271	C	Excise intraspinal lesion
63272	C	Excise intraspinal lesion
63273	C	Excise intraspinal lesion
63275	C	Biopsy/excise spinal tumor
63276	C	Biopsy/excise spinal tumor
63277	C	Biopsy/excise spinal tumor
63278	C	Biopsy/excise spinal tumor
63280	C	Biopsy/excise spinal tumor
63281	C	Biopsy/excise spinal tumor
63282	C	Biopsy/excise spinal tumor
63283	C	Biopsy/excise spinal tumor
63285	C	Biopsy/excise spinal tumor
63286	C	Biopsy/excise spinal tumor
63287	C	Biopsy/excise spinal tumor
63290	C	Biopsy/excise spinal tumor
63300	C	Removal of vertebral body
63301	C	Removal of vertebral body
63302	C	Removal of vertebral body
63303	C	Removal of vertebral body
63304	C	Removal of vertebral body
63305	C	Removal of vertebral body
63306	C	Removal of vertebral body
63307	C	Removal of vertebral body
63308	C	Remove vertebral body add-on
63700	C	Repair of spinal herniation
63702	C	Repair of spinal herniation
63704	C	Repair of spinal herniation
63706	C	Repair of spinal herniation
63707	C	Repair spinal fluid leakage
63709	C	Repair spinal fluid leakage
63710	C	Graft repair of spine defect
63740	C	Install spinal shunt
64752	C	Incision of vagus nerve
64755	C	Incision of stomach nerves

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

CPT/HCPCS	NPRM SI	Description
64760	C	Incision of vagus nerve
64763	C	Incise hip/thigh nerve
64766	C	Incise hip/thigh nerve
64804	C	Remove sympathetic nerves
64809	C	Remove sympathetic nerves
64818	C	Remove sympathetic nerves
64866	C	Fusion of facial/other nerve
64868	C	Fusion of facial/other nerve
65273	C	Repair of eye wound
69155	C	Extensive ear/neck surgery
69535	C	Remove part of temporal bone
69554	C	Remove ear lesion
69950	C	Incise inner ear nerve
69970	C	Remove inner ear lesion
75900	C	Arterial catheter exchange
75952	C	Endovasc repair abdom aorta
75953	C	Abdom aneurysm endovas rpr
75954	C	Iliac aneurysm endovas rpr
92970	C	Cardioassist, internal
92971	C	Cardioassist, external
92975	C	Dissolve clot, heart vessel
92992	C	Revision of heart chamber
92993	C	Revision of heart chamber
99190	C	Special pump services
99191	C	Special pump services
99192	C	Special pump services
99251	C	Initial inpatient consult
99252	C	Initial inpatient consult
99253	C	Initial inpatient consult
99254	C	Initial inpatient consult
99255	C	Initial inpatient consult
99261	C	Follow-up inpatient consult
99262	C	Follow-up inpatient consult
99263	C	Follow-up inpatient consult
99293	C	Ped critical care, initial
99294	C	Ped critical care, subseq
99295	C	Neonatal critical care
99296	C	Neonatal critical care
99298	C	Neonatal critical care
99299	C	Ic, lbw infant 1500-2500 gm
99356	C	Prolonged service, inpatient
99357	C	Prolonged service, inpatient
99433	C	Normal newborn care/hospital

ADDENDUM H—WAGE INDEX FOR URBAN AREAS

Urban area (constituent counties)	Wage index
0040 [2] Abilene, TX	0.7780
Taylor, TX	
0060 Aguadilla, PR	0.4306
Aguada, PR	
Aguadilla, PR	
Moca, PR	
0080 Akron, OH	0.9442
Portage, OH	
Summit, OH	
0120 Albany, GA	1.0863
Dougherty, GA	
Lee, GA	
0160 [2] Albany-Schenectady-Troy, NY	0.8526
Albany, NY	
Montgomery, NY	

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Schoharie, NY	
0200 Albuquerque, NM	0.9300
Bernalillo, NM	
Sandoval, NM	
Valencia, NM	
0220 Alexandria, LA	0.8037
Rapides, LA	
0240 Allentown-Bethlehem-Easton, PA	0.9721
Carbon, PA	
Lehigh, PA	
Northampton, PA	
0280 Altoona, PA	0.8827
Blair, PA	
0320 Amarillo, TX	0.8986

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Potter, TX	
Randall, TX	
0380 Anchorage, AK	1.2351
Anchorage, AK	
0440 Ann Arbor, MI	1.1074
Lenawee, MI	
Livingston, MI	
Washtenaw, MI	
0450 Anniston, AL	0.8090
Calhoun, AL	
0460 [2] Appleton-Oshkosh-Neenah, WI	0.9304
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
0470 Arecibo, PR	0.4155
Arecibo, PR	
Camuy, PR	

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Hatillo, PR	
0480 Asheville, NC	0.9720
Buncombe, NC	
Madison, NC	
0500 Athens, GA	0.9818
Clarke, GA	
Madison, GA	
Oconee, GA	
0520 [1] Atlanta, GA	1.0130
Barrow, GA	
Bartow, GA	
Carroll, GA	
Cherokee, GA	
Clayton, GA	
Cobb, GA	
Coweta, GA	
DeKalb, GA	
Douglas, GA	
Fayette, GA	
Forsyth, GA	
Fulton, GA	
Gwinnett, GA	
Henry, GA	
Newton, GA	
Paulding, GA	
Pickens, GA	
Rockdale, GA	
Spalding, GA	
Walton, GA	
0560 Atlantic-Cape May, NJ	1.0795
Atlantic, NJ	
Cape May, NJ	
0580 Auburn-Opelika, AL	0.8494
Lee, AL	
0600 Augusta-Aiken, GA-SC	0.9625
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Edgefield, SC	
0640 [1] Austin-San Marcos, TX	0.9609
Bastrop, TX	
Caldwell, TX	
Hays, TX	
Travis, TX	
Williamson, TX	
0680 [2] Bakersfield, CA	0.9967
Kern, CA	
0720 [1] Baltimore, MD	0.9919
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Anne's, MD	
0733 Bangor, ME	0.9904
Penobscot, ME	
0743 Barnstable-Yarmouth, MA	1.2956
Barnstable, MA	
0760 Baton Rouge, LA	0.8406
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
0840 Beaumont-Port Arthur, TX	0.8424
Hardin, TX	
Jefferson, TX	
Orange, TX	
0860 Bellingham, WA	1.1757
Whatcom, WA	
0870 Benton Harbor, MI	0.8935
Berrien, MI	
0875 [1] Bergen-Passaic, NJ	1.1731
Bergen, NJ	
Passaic, NJ	
0880 Billings, MT	0.8961
Yellowstone, MT	
0920 Biloxi-Gulfport-Pascagoula, MS	0.9029
Hancock, MS	
Harrison, MS	
Jackson, MS	
0960 [2] Binghamton, NY	0.8526
Broome, NY	
Tioga, NY1000 Birmingham, AL	0.9212
Blount, AL	
Jefferson, AL	
St. Clair, AL	
Shelby, AL1010 Bismarck, ND	0.8033
Burleigh, ND	
Morton, ND	
1020 [2] Bloomington, IN	0.8824
Monroe, IN	
1040 Bloomington-Normal, IL	0.8832
McLean, IL	
1080 Boise City, ID	0.9232
Ada, ID	
Canyon, ID	
1123 [1] Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	1.1233
Bristol, MA	
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Worcester, MA	
Hillsborough, NH	
Merrimack, NH	
Rockingham, NH	
Strafford, NH	
1125 Boulder-Longmont, CO	1.0049
Boulder, CO	
1145 Brazoria, TX	0.8137
Brazoria, TX	
1150 Bremerton, WA	1.0580
Kitsap, WA	
1240 Brownsville-Harlingen-San Benito, TX	1.0303
Cameron, TX	
1260 Bryan-College Station, TX	0.9019
Brazos, TX	
1280 [1] Buffalo-Niagara Falls, NY	0.9604
Erie, NY	
Niagara, NY	
1303 Burlington, VT	0.9704
Chittenden, VT	
Franklin, VT	
Grand Isle, VT	
1310 Caguas, PR	0.4201
Caguas, PR	
Cayey, PR	
Cidra, PR	
Gurabo, PR	
San Lorenzo, PR	
1320 Canton-Massillon, OH	0.9071
Carroll, OH	
Stark, OH	
1350 Casper, WY	0.9209
Natrona, WY	
1360 Cedar Rapids, IA	0.8874
Linn, IA	
1400 Champaign-Urbana, IL	0.9907
Champaign, IL	
1440 Charleston-North Charleston, SC	0.9332
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
1480 Charleston, WV	0.8880
Kanawha, WV	
Putnam, WV	
1520 [1] Charlotte-Gastonia-Rock Hill, NC-SC	0.9730
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Stanly, NC	
Union, NC	
York, SC	
1540 Charlottesville, VA	1.0025
Albemarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
1560 Chattanooga, TN-GA	0.9086
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
1580 [2] Cheyenne, WY	0.9110
Laramie, WY	
1600 [1] Chicago, IL	1.0892
Cook, IL	
DeKalb, IL	
DuPage, IL	
Grundy, IL	
Kane, IL	
Kendall, IL	
Lake, IL	
McHenry, IL	
Will, IL	
1620 Chico-Paradise, CA	1.0193
Butte, CA	
1640 [1] Cincinnati, OH-KY-IN	0.9413
Dearborn, IN	
Ohio, IN	
Boone, KY	
Campbell, KY	
Gallatin, KY	
Grant, KY	
Kenton, KY	
Pendleton, KY	
Brown, OH	
Clermont, OH	
Hamilton, OH	
Warren, OH	
1660 Clarksville-Hopkinsville, TN-KY	0.8354
Christian, KY	
Montgomery, TN	
1680 [1] Cleveland-Lorain-Elyria, OH	0.9671
Ashtabula, OH	
Cuyahoga, OH	
Geauga, OH	

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Lake, OH	
Lorain, OH	
Medina, OH	
1720 Colorado Springs, CO	0.9833
El Paso, CO	
1740 Columbia, MO	0.8695
Boone, MO	
1760 Columbia, SC	0.8902
Lexington, SC	
Richland, SC	
1800 Columbus, GA-AL	0.8694
Russell, AL	
Chattahoochee, GA	
Harris, GA	
Muscogee, GA	
1840 [1] Columbus, OH	0.9648
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
1880 Corpus Christi, TX	0.8521
Nueces, TX	
San Patricio, TX	
1890 Corvallis, OR	1.1516
Benton, OR	
1900 [2] Cumberland, MD-WV (MD Hospitals)	0.9125
Allegany, MD	
Mineral, WV	
1900 Cumberland, MD-WV (WV Hospitals)	0.8200
Allegany, MD	
Mineral, WV	
1920 [1] Dallas, TX	0.9974
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Henderson, TX	
Hunt, TX	
Kaufman, TX	
Rockwall, TX	
1950 Danville, VA.	
Danville City, VA	
Pittsylvania, VA	0.9035
1960 Davenport-Moline-Rock Island, IA-IL	0.8985
Scott, IA	
Henry, IL	
Rock Island, IL	
2000 Dayton-Springfield, OH	0.9529
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
2020 Daytona Beach, FL	0.9060
Flagler, FL	
Volusia, FL	
2030 Decatur, AL	0.8828
Lawrence, AL	
Morgan, AL	
2040 [2] Decatur, IL	0.8254
Macon, IL	
2080 [1] Denver, CO	1.0837
Adams, CO	
Arapahoe, CO	
Broomfield, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
2120 Des Moines, IA	0.9106
Dallas, IA	
Polk, IA	
Warren, IA	
2160 [1] Detroit, MI	1.0101
Lapeer, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
St. Clair, MI	
Wayne, MI	
2180 Dothan, AL	0.7765
Dale, AL	
Houston, AL	
2190 Dover, DE	0.9805
Kent, DE	
2200 Dubuque, IA	0.8886
Dubuque, IA	
2240 Duluth-Superior, MN-WI	1.0171
St. Louis, MN	
Douglas, WI	
2281 Dutchess County, NY	1.0934
Dutchess, NY	
2290 [2] Eau Claire, WI	0.9304
Chippewa, WI	
Eau Claire, WI	
2320 El Paso, TX	0.9196
El Paso, TX	
2330 Elkhart-Goshen, IN	0.9783
Elkhart, IN	
2335 [2] Elmira, NY	0.8526
Chemung, NY	
2340 Enid, OK	0.8559
Garfield, OK	
2360 Erie, PA	0.8601
Erie, PA	
2400 Eugene-Springfield, OR	1.1456
Lane, OR	
2440 [2] Evansville-Henderson, IN-KY (IN Hospitals)	0.8824
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2440 Evansville-Henderson, IN-KY (KY Hospitals)	0.8429
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2520 Fargo-Moorhead, ND-MN	0.9797
Clay, MN	
Cass, ND	
2560 Fayetteville, NC	0.8986
Cumberland, NC	
2580 Fayetteville-Springdale-Rogers, AR	0.8396
Benton, AR	
Washington, AR	
2620 Flagstaff, AZ-UT	1.1333
Coconino, AZ	
Kane, UT	
2640 Flint, MI	1.0858
Genesee, MI	
2650 Florence, AL	0.7797
Colbert, AL	
Lauderdale, AL	
2655 Florence, SC	0.8709
Florence, SC	
2670 Fort Collins-Loveland, CO	1.0148
Larimer, CO	
2680 [1] Ft. Lauderdale, FL	1.0479
Broward, FL	
2700 Fort Myers-Cape Coral, FL	0.9816
Lee, FL	
2710 Fort Pierce-Port St. Lucie, FL	1.0124
Martin, FL	
St. Lucie, FL	
2720 Fort Smith, AR-OK	0.8424
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
2750 Fort Walton Beach, FL	0.8966
Okaloosa, FL	
2760 Fort Wayne, IN	0.9585
Adams, IN	
Allen, IN	
De Kalb, IN	
Huntington, IN	
Wells, IN	
Whitley, IN	
2800 [1] Forth Worth-Arlington, TX	0.9359
Hood, TX	
Johnson, TX	
Parker, TX	
Tarrant, TX	
2840 Fresno, CA	1.0142
Fresno, CA	
Madera, CA	
2880 Gadsden, AL	0.8229
Etowah, AL	
2900 Gainesville, FL	0.9693
Alachua, FL	
2920 Galveston-Texas City, TX	0.9279
Galveston, TX	
2960 Gary, IN	0.9410
Lake, IN	
Porter, IN	
2975 [2] Glens Falls, NY	0.8526
Warren, NY	
Washington, NY	
2980 Goldsboro, NC	0.8622
Wayne, NC	
2985 Grand Forks, ND-MN (ND Hospitals)	0.8636
Polk, MN	
Grand Forks, ND	
2985 [2] Grand Forks, ND-MN (MN Hospitals)	0.9345
Polk, MN	
Grand Forks, ND	
2995 Grand Junction, CO	0.9921
Mesa, CO	
3000 [1] Grand Rapids-Muskegon-Holland, MI	0.9469
Allegan, MI	
Kent, MI	
Muskegon, MI	
Ottawa, MI	
3040 Great Falls, MT	0.8918
Cascade, MT	
3060 Greeley, CO	0.9453
Weld, CO	
3080 Green Bay, WI	0.9518
Brown, WI	
3120 [1] Greensboro-Winston-Salem-High Point, NC	0.9166

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Alamance, NC	
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
3150 Greenville, NC	0.9167
Pitt, NC	
3160 Greenville-Spartanburg-Anderson, SC	0.9335
Anderson, SC	
Cherokee, SC	
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
3180 Hagerstown, MD	0.9172
Washington, MD	
3200 Hamilton-Middletown, OH	0.9214
Butler, OH	
3240 Harrisburg-Lebanon-Carlisle, PA	0.9164
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
3283 [1] [2] Hartford, CT	1.2183
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
3285 [2] Hattiesburg, MS	0.7778
Forrest, MS	
Lamar, MS	
3290 Hickory-Morganton-Lenoir, NC	0.9242
Alexander, NC	
Burke, NC	
Caldwell, NC	
Catawba, NC	
3320 Honolulu, HI	1.1116
Honolulu, HI	
3350 Houma, LA	0.7771
Lafourche, LA	
Terrebonne, LA	
3360 [1] Houston, TX	0.9834
Chambers, TX	
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
3400 Huntington-Ashland, WV-KY-OH	0.9595
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
3440 Huntsville, AL	0.9245
Limestone, AL	
Madison, AL	
3480 [1] Indianapolis, IN	0.9916
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Madison, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
3500 Iowa City, IA	0.9548
Johnson, IA	
3520 Jackson, MI	0.8986
Jackson, MI	
3560 Jackson, MS	0.8399
Hinds, MS	
Madison, MS	
Rankin, MS	
3580 Jackson, TN	0.8984
Madison, TN	
Chester, TN	
3600 [1] Jacksonville, FL	0.9563
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
3605 Jacksonville, NC	0.8544
Onslow, NC	
3610 [2] Jamestown, NY	0.8526
Chautauqua, NY	
3620 [2] Janesville-Beloit, WI	0.9304
Rock, WI	
3640 Jersey City, NJ	1.1115
Hudson, NJ	
3660 Johnson City-Kingsport-Bristol, TN-VA (TN Hospitals)	0.8256
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3660 [2] Johnson City-Kingsport-Bristol, TN-VA (VA Hospitals)	0.8498
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3680 [2] Johnstown, PA	0.8378
Cambria, PA	
Somerset, PA	
3700 Jonesboro, AR	0.7809
Craighead, AR	
3710 Joplin, MO	0.8681
Jasper, MO	
Newton, MO	
3720 Kalamazoo-Battlecreek, MI	1.0500
Calhoun, MI	
Kalamazoo, MI	
Van Buren, MI	
3740 Kankakee, IL	1.0419
Kankakee, IL	
3760 [1] Kansas City, KS-MO	0.9715
Johnson, KS	
Leavenworth, KS	
Miami, KS	
Wyandotte, KS	
Cass, MO	
Clay, MO	
Clinton, MO	
Jackson, MO	
Lafayette, MO	
Platte, MO	
Ray, MO	
3800 Kenosha, WI	0.9761
Kenosha, WI	
3810 Killeen-Temple, TX	0.9159
Bell, TX	
Coryell, TX	
3840 Knoxville, TN	0.8820
Anderson, TN	
Blount, TN	
Knox, TN	
Loudon, TN	
Sevier, TN	
Union, TN	
3850 Kokomo, IN	0.9045
Howard, IN	
Tipton, IN	
3870 [2] La Crosse, WI-MN	0.9304
Houston, MN	
La Crosse, WI	
3880 Lafayette, LA	0.8225
Acadia, LA	
Lafayette, LA	
St. Landry, LA	
St. Martin, LA	
3920 [2] Lafayette, IN	0.8824
Clinton, IN	
Tippecanoe, IN	
3960 Lake Charles, LA	0.7841
Calcasieu, LA	
3980 [2] Lakeland-Winter Haven, FL	0.8855
Polk, FL	
4000 Lancaster, PA	0.9282
Lancaster, PA	
4040 Lansing-East Lansing, MI	0.9714
Clinton, MI	
Eaton, MI	
Ingham, MI	
4080 Laredo, TX	0.8091
Webb, TX	
4100 Las Cruces, NM	0.8688
Dona Ana, NM	
4120 [1] Las Vegas, NV-AZ	1.1528
Mohave, AZ	
Clark, NV	
Nye, NV	
4150 [2] Lawrence, KS	0.8074
Douglas, KS	
4200 Lawton, OK	0.8267
Comanche, OK	
4243 Lewiston-Auburn, ME	0.9383
Androscoggin, ME	
4280 Lexington, KY	0.8685
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Madison, KY	
Scott, KY	
Woodford, KY	
4320 Lima, OH	0.9522
Allen, OH	
Auglaize, OH	
4360 Lincoln, NE	1.0033
Lancaster, NE	
4400 Little Rock-North Little Rock, AR	0.8923

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
4420 Longview-Marshall, TX	0.9113
Gregg, TX	
Harrison, TX	
Upshur, TX	
4480 [1] Los Angeles-Long Beach, CA	1.1832
Los Angeles, CA	
4520 [1] Louisville, KY-IN	0.9242
Clark, IN	
Floyd, IN	
Harrison, IN	
Scott, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
4600 Lubbock, TX	0.8272
Lubbock, TX	
4640 Lynchburg, VA	0.9134
Amherst, VA	
Bedford, VA	
Bedford City, VA	
Campbell, VA	
Lynchburg City, VA	
4680 Macon, GA	0.8975
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Twiggs, GA	
4720 Madison, WI	1.0264
Dane, WI	
4800 Mansfield, OH	0.9180
Crawford, OH	
Richland, OH	
4840 Mayaguez, PR	0.4795
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
Sabana Grande, PR	
San German, PR	
4880 McAllen-Edinburg-Mission, TX	0.8381
Hidalgo, TX	
4890 Medford-Ashland, OR	1.0772
Jackson, OR	
4900 Melbourne-Titusville-Palm Bay, FL	0.9776
Brevard, Fl	
4920 [1] Memphis, TN-AR-MS	0.9009
Crittenden, AR	
DeSoto, MS	
Fayette, TN	
Shelby, TN	
Tipton, TN	
4940 [2] Merced, CA	0.9967
Merced, CA	
5000 [1] Miami, FL	0.9894
Dade, FL	
5015 [1] Middlesex-Somerset-Hunterdon, NJ	1.1366
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
5080 [1] Milwaukee-Waukesha, WI	0.9988
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
5120 [1] Minneapolis-St. Paul, MN-WI	1.1001
Anoka, MN	
Carver, MN	
Chisago, MN	
Dakota, MN	
Hennepin, MN	
Isanti, MN	
Ramsey, MN	
Scott, MN	
Sherburne, MN	
Washington, MN	
Wright, MN	
Pierce, WI	
St. Croix, WI	
5140 Missoula, MT	0.8884
Missoula, MT	
5160 Mobile, AL	0.7994
Baldwin, AL	
Mobile, AL	
5170 Modesto, CA	1.1275
Stanislaus, CA	
5190 [1] Monmouth-Ocean, NJ	1.1083
Monmouth, NJ	
Ocean, NJ	
5200 Monroe, LA	0.7922
Ouachita, LA	
5240 Montgomery, AL	0.7907
Autauga, AL	
Elmore, AL	
Montgomery, AL	
5280 [2] Muncie, IN	0.8824
Delaware, IN	
5330 Myrtle Beach, SC	0.9112
Horry, SC	
5345 Naples, FL	0.9790
Collier, FL	
5360 [1] Nashville, TN	0.9855
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
5380 [1] Nassau-Suffolk, NY	1.3140
Nassau, NY	
Suffolk, NY	
5483 [1] New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2468
Fairfield, CT	
New Haven, CT	
5523 [2] New London-Norwich, CT	1.2183
New London, CT	
5560 [1] New Orleans, LA	0.9174
Jefferson, LA	
Orleans, LA	
Plaquemines, LA	
St. Bernard, LA	
St. Charles, LA	
St. James, LA	
St. John The Baptist, LA	
St. Tammany, LA	
5600 [1] New York, NY	1.4018
Bronx, NY	
Kings, NY	
New York, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
5640 [1] Newark, NJ	1.1518
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Warren, NJ	
5660 Newburgh, NY-PA	1.1509
Orange, NY	
Pike, PA	
5720 [1] Norfolk-Virginia Beach-Newport News, VA-NC	0.8619
Currituck, NC	
Chesapeake City, VA	
Gloucester, VA	
Hampton City, VA	
Isle of Wight, VA	
James City, VA	
Mathews, VA	
Newport News City, VA	
Norfolk City, VA	
Poquoson City, VA	
Portsmouth City, VA	
Suffolk City, VA	
Virginia Beach City VA	
Williamsburg City, VA	
York, VA	
5775 [1] Oakland, CA	1.5119
Alameda, CA	
Contra Costa, CA	
5790 Ocala, FL	0.9728
Marion, FL	
5800 Odessa-Midland, TX	0.9327
Ector, TX	
Midland, TX	
5880 [1] Oklahoma City, OK	0.8984
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
5910 Olympia, WA	1.0963
Thurston, WA	
5920 Omaha, NE-IA	0.9745
Pottawattamie, IA	
Cass, NE	
Douglas, NE	
Sarpy, NE	
Washington, NE	
5945 [1] Orange County, CA	1.1492
Orange, CA	
5960 [1] Orlando, FL	0.9654
Lake, FL	
Orange, FL	
Osceola, FL	
Seminole, FL	
5990 Owensboro, KY	0.8374
Daviess, KY	
6015 [2] Panama City, FL	0.8855
Bay, FL	
6020 Parkersburg-Marietta, WV-OH (WV Hospitals)	0.8039
Washington, OH	

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Wood, WV	
6020 [2] Parkersburg-Marietta, WV-OH (OH Hospitals)	0.8820
Washington, OH	
Wood, WV	
6080 [2] Pensacola, FL	0.8855
Escambia, FL	
Santa Rosa, FL	
6120 Peoria-Pekin, IL	0.8734
Peoria, IL	
Tazewell, IL	
Woodford, IL	
6160 [1] Philadelphia, PA-NJ	1.0883
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Salem, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
6200 [1] Phoenix-Mesa, AZ	1.0129
Maricopa, AZ	
Pinal, AZ	
6240 Pine Bluff, AR	0.7865
Jefferson, AR	
6280 [1] Pittsburgh, PA	0.8901
Allegheny, PA	
Beaver, PA	
Butler, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
6323 [2] Pittsfield, MA	1.0432
Berkshire, MA	
6340 Pocatello, ID	0.9249
Bannock, ID	
6360 Ponce, PR	0.4708
Guayanilla, PR	
Juana Diaz, PR	
Penuelas, PR	
Ponce, PR	
Villalba, PR	
Yauco, PR	
6403 Portland, ME	0.9949
Cumberland, ME	
Sagadahoc, ME	
York, ME	
6440 [1] Portland-Vancouver, OR-WA	1.1213
Clackamas, OR	
Columbia, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Clark, WA	
6483 [1] Providence-Warwick-Pawtucket, RI	1.0977
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	
6520 Provo-Orem, UT	0.9976
Utah, UT	
6560 [2] Pueblo, CO	0.9328
Pueblo, CO	
6580 Punta Gorda, FL	0.9510
Charlotte, FL	

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
6600 [2] Racine, WI	0.9304
Racine, WI	
6640 [1] Raleigh-Durham-Chapel Hill, NC	0.9959
Chatham, NC	
Durham, NC	
Franklin, NC	
Johnston, NC	
Orange, NC	
Wake, NC	
6660 Rapid City, SD	0.8806
Pennington, SD	
6680 Reading, PA	0.9133
Berks, PA	
6690 Redding, CA	1.1352
Shasta, CA	
6720 Reno, NV	1.0682
Washoe, NV	
6740 Richland-Kennewick-Pasco, WA	1.0609
Benton, WA	
Franklin, WA	
6760 Richmond-Petersburg, VA	0.9349
Charles City County, VA	
Chesterfield, VA	
Colonial Heights City, VA	
Dinwiddie, VA	
Goochland, VA	
Hanover, VA	
Henrico, VA	
Hopewell City, VA	
New Kent, VA	
Petersburg City, VA	
Powhatan, VA	
Prince George, VA	
Richmond City, VA	
6780 [1] Riverside-San Bernardino, CA	1.1348
Riverside, CA	
San Bernardino, CA	
6800 Roanoke, VA	0.8700
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
6820 Rochester, MN	1.1739
Olmsted, MN	
6840 [1] Rochester, NY	0.9430
Genesee, NY	
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
6880 Rockford, IL	0.9666
Boone, IL	
Ogle, IL	
Winnebago, IL	
6895 Rocky Mount, NC	0.9076
Edgecombe, NC	
Nash, NC	
6920 [1] Sacramento, CA	1.1845
El Dorado, CA	
Placer, CA	
Sacramento, CA	
6960 Saginaw-Bay City-Midland, MI	1.0032
Bay, MI	
Midland, MI	
Saginaw, MI	

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
6980 St. Cloud, MN	0.9679
Benton, MN	
Stearns, MN	
7000 [2] St. Joseph, MO	0.8056
Andrew, MO	
Buchanan, MO	
7040 [1] St. Louis, MO-IL	0.9033
Clinton, IL	
Jersey, IL	
Madison, IL	
Monroe, IL	
St. Clair, IL	
Franklin, MO	
Jefferson, MO	
Lincoln, MO	
St. Charles, MO	
St. Louis, MO	
St. Louis City, MO	
Warren, MO	
7080 Salem, OR	1.0482
Marion, OR	
Polk, OR	
7120 Salinas, CA	1.4339
Monterey, CA	
7160 [1] Salt Lake City-Ogden, UT	0.9913
Davis, UT	
Salt Lake, UT	
Weber, UT	
7200 San Angelo, TX	0.8535
Tom Green, TX	
7240 [1] San Antonio, TX	0.8870
Bexar, TX	
Comal, TX	
Guadalupe, TX	
Wilson, TX	
7320 [1] San Diego, CA	1.1147
San Diego, CA	
7360 [1] San Francisco, CA	1.4514
Marin, CA	
San Francisco, CA	
San Mateo, CA	
7400 [1] San Jose, CA	1.4626
Santa Clara, CA	
7440 [1] San Juan-Bayamon, PR	0.4909
Aguas Buenas, PR	
Barceloneta, PR	
Bayamon, PR	
Canovanas, PR	
Carolina, PR	
Catano, PR	
Ceiba, PR	
Comerio, PR	
Corozal, PR	
Dorado, PR	
Fajardo, PR	
Florida, PR	
Guaynabo, PR	
Humacao, PR	
Juncos, PR	
Los Piedras, PR	
Loiza, PR	
Luguillo, PR	
Manati, PR	
Morovis, PR	
Naguabo, PR	
Naranjito, PR	
Rio Grande, PR	
San Juan, PR	
Toa Alta, PR	
Toa Baja, PR	

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Trujillo Alto, PR	
Vega Alta, PR	
Vega Baja, PR	
Yabucoa, PR	
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.1429
San Luis Obispo, CA	
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0441
Santa Barbara, CA	
7485 Santa Cruz-Watsonville, CA	1.2942
Santa Cruz, CA	
7490 Santa Fe, NM	1.0653
Los Alamos, NM	
Santa Fe, NM	
7500 Santa Rosa, CA	1.2877
Sonoma, CA	
7510 Sarasota-Bradenton, FL	0.9971
Manatee, FL	
Sarasota, FL	
7520 Savannah, GA	0.9488
Bryan, GA	
Chatham, GA	
Effingham, GA	
7560 Scranton—Wilkes-Barre—Hazleton, PA	0.8412
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Wyoming, PA	
7600 [1] Seattle-Bellevue-Everett, WA	1.1562
Island, WA	
King, WA	
Snohomish, WA	
7610 [2] Sharon, PA	0.8378
Mercer, PA	
7620 [2] Sheboygan, WI	0.9304
Sheboygan, WI	
7640 Sherman-Denison, TX	0.9700
Grayson, TX	
7680 Shreveport-Bossier City, LA	0.9083
Bossier, LA	
Caddo, LA	
Webster, LA	
7720 Sioux City, IA-NE	0.8993
Woodbury, IA	
Dakota, NE	
7760 Sioux Falls, SD	0.9309
Lincoln, SD	
Minnehaha, SD	
7800 South Bend, IN	0.9821
St. Joseph, IN	
7840 Spokane, WA	1.0901
Spokane, WA	
7880 Springfield, IL	0.8944
Menard, IL	
Sangamon, IL	
7920 Springfield, MO	0.8457
Christian, MO	
Greene, MO	
Webster, MO	
8003 Springfield, MA	1.0543
Hampden, MA	
Hampshire, MA	
8050 State College, PA	0.8740
Centre, PA	
8080 [2] Steubenville-Weirton, OH-WV (OH Hospitals)	0.8820
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8080 Steubenville-Weirton, OH-WV (WV Hospitals)	0.8398
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8120 Stockton-Lodi, CA	1.0404
San Joaquin, CA	
8140 [2] Sumter, SC	0.8498
Sumter, SC	
8160 Syracuse, NY	0.9412
Cayuga, NY	
Madison, NY	
Onondaga, NY	
Oswego, NY	
8200 Tacoma, WA	1.1116
Pierce, WA	
8240 [2] Tallahassee, FL	0.8855
Gadsden, FL	
Leon, FL	
8280 [1] Tampa-St. Petersburg-Clearwater, FL	0.9103
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
8320 [2] Terre Haute, IN	0.8824
Clay, IN	
Vermillion, IN	
Vigo, IN	
8360 Texarkana, AR-Texarkana, TX	0.8150
Miller, AR	
Bowie, TX	
8400 Toledo, OH	0.9397
Fulton, OH	
Lucas, OH	
Wood, OH	
8440 Topeka, KS	0.9108
Shawnee, KS	
8480 Trenton, NJ	1.0517
Mercer, NJ	
8520 [2] Tucson, AZ	0.9270
Pima, AZ	
8560 Tulsa, OK.	
Creek, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	0.9185
8600 Tuscaloosa, AL	0.8212
Tuscaloosa, AL	
8640 Tyler, TX	0.9404
Smith, TX	
8680 [2] Utica-Rome, NY	0.8526
Herkimer, NY	
Oneida, NY	
8720 Vallejo-Fairfield-Napa, CA	1.3425
Napa, CA	
Solano, CA	
8735 Ventura, CA	1.1064
Ventura, CA	
8750 Victoria, TX	0.8184
Victoria, TX	
8760 Vineland-Millville-Bridgeton, NJ	1.0405
Cumberland, NJ	
8780 [2] Visalia-Tulare-Porterville, CA	0.9967
Tulare, CA	
8800 Waco, TX	0.8394
McLennan, TX	
8840 [1] Washington, DC-MD-VA-WV	1.0904
District of Columbia, DC	
Calvert, MD	
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	
Alexandria City, VA	
Arlington, VA	
Clarke, VA	
Culpeper, VA	
Fairfax, VA	
Fairfax City, VA	
Falls Church City, VA	
Fauquier, VA	
Fredericksburg City, VA	
King George, VA	
Loudoun, VA	
Manassas City, VA	
Manassas Park City, VA	
Prince William, VA	
Spotsylvania, VA	
Stafford, VA	
Warren, VA	
Berkeley, WV	
Jefferson, WV	
8920 [2] Waterloo-Cedar Falls, IA	0.8416
Black Hawk, IA	
8940 Wausau, WI	0.9783
Marathon, WI	
8960 [1] West Palm Beach-Boca Raton, FL	0.9798
Palm Beach, FL	
9000 [2] Wheeling, WV-OH (WV Hospitals)	0.8018
Belmont, OH	
Marshall, WV	
Ohio, WV	
9000 [2] Wheeling, WV-OH (OH Hospitals)	0.8820
Belmont, OH	
Marshall, WV	
Ohio, WV	
9040 Wichita, KS	0.9238
Butler, KS	
Harvey, KS	
Sedgwick, KS	
9080 Wichita Falls, TX	0.8341
Archer, TX	
Wichita, TX	
9140 [2] Williamsport, PA	0.8378
Lycoming, PA	
9160 Wilmington-Newark, DE-MD	1.0882
New Castle, DE	
Cecil, MD	
9200 Wilmington, NC	0.9563
New Hanover, NC	
Brunswick, NC	
9260 [2] Yakima, WA	1.0388
Yakima, WA	
9270 [2] Yolo, CA	0.9967
Yolo, CA	
9280 York, PA	0.9119
York, PA	
9320 Youngstown-Warren, OH	0.9214
Columbiana, OH	

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Mahoning, OH Trumbull, OH	
9340 Yuba City, CA	1.0196
Sutter, CA Yuba, CA	
9360 [2] Yuma, AZ	0.9270
Yuma, AZ	

[1] Large Urban Area
[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2004.

ADDENDUM I.—WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage Index
Alabama	0.7492
Alaska	1.1886
Arizona	0.9270
Arkansas	0.7734
California	0.9967
Colorado	0.9328
Connecticut	1.2183
Delaware	0.9595
Florida	0.8855
Georgia	0.8595
Hawaii	0.9958
Idaho	0.8974
Illinois	0.8254
Indiana	0.8824
Iowa	0.8416
Kansas	0.8074
Kentucky	0.7974
Louisiana	0.7467
Maine	0.8812
Maryland	0.9125
Massachusetts	1.0432
Michigan	0.8877
Minnesota	0.9345
Mississippi	0.7778
Missouri	0.8056
Montana	0.8800
Nebraska	0.8822
Nevada	0.9806
New Hampshire	1.0030
New Jersey [1]	.....
New Mexico	0.8270
New York	0.8526
North Carolina	0.8456
North Dakota	0.7778
Ohio	0.8820
Oklahoma	0.7537
Oregon	0.9994
Pennsylvania	0.8378
Puerto Rico	0.4018
Rhode Island [1]	.....
South Carolina	0.8498
South Dakota	0.8195
Tennessee	0.7886
Texas	0.7780
Utah	0.8974
Vermont	0.9534
Virginia	0.8498
Washington	1.0388
West Virginia	0.8018
Wisconsin	0.9304
Wyoming	0.9110

[1] All counties within the State are classified as urban.

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED

Area	Wage index
Akron, OH	0.9442
Albany, GA	1.0664
Albuquerque, NM (NM hospitals)	0.9300
Albuquerque, NM (CO hospitals)	0.9328
Alexandria, LA	0.8037
Allentown-Bethlehem-Easton, PA	0.9721
Altoona, PA	0.8827
Amarillo, TX	0.8858
Anchorage, AK	1.2351
Ann Arbor, MI	1.0846
Anniston, AL	0.7975
Asheville, NC	0.9477
Athens, GA	0.9564
Atlanta, GA	0.9990
Atlantic-Cape May, NJ	1.0531
Augusta-Aiken, GA-SC	0.9433
Austin-San Marcos, TX	0.9609
Bangor, ME	0.9904
Barnstable-Yarmouth, MA	1.2720
Baton Rouge, LA	0.8406
Bellingham, WA	1.1305
Benton Harbor, MI	0.8935
Bergen-Passaic, NJ	1.1731
Billings, MT	0.8961
Biloxi-Gulfport-Pascagoula, MS	0.8407
Binghamton, NY	0.8428
Birmingham, AL	0.9212
Bismarck, ND	0.8033
Bloomington-Normal, IL	0.8832
Boise City, ID	0.9232
Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	1.1233
Burlington, VT	0.9332
Caguas, PR	0.4201
Casper, WY	0.9209
Champaign-Urbana, IL	0.9460
Charleston-North Charleston, SC	0.9332
Charleston, WV (WV Hospitals)	0.8568
Charleston, WV (OH Hospitals)	0.8820
Charlotte-Gastonia-Rock Hill, NC-SC	0.9730
Charlottesville, VA	0.9877
Chattanooga, TN-GA	0.9086
Chicago, IL	1.0752
Cincinnati, OH-KY-IN	0.9413
Clarksville-Hopkinsville, TN-KY	0.8354
Cleveland-Lorain-Elyria, OH	0.9671
Columbia, MO	0.8557
Columbia, SC	0.8902
Columbus, GA-AL	0.8595
Columbus, OH	0.9648
Corpus Christi, TX	0.8521
Corvallis, OR	1.1241
Dallas, TX	0.9974
Davenport-Moline-Rock Island, IA-IL	0.8985
Dayton-Springfield, OH	0.9529
Decatur, AL	0.8580
Denver, CO	1.0664
Des Moines, IA	0.9106
Detroit, MI	1.0101
Dothan, AL	0.7765
Duluth-Superior, MN-WI	1.0171
Elkhart-Goshen, IN	0.9554
Erie, PA	0.8526
Eugene-Springfield, OR	1.0977
Fargo-Moorhead, ND-MN	0.9501
Fayetteville, NC	0.8817
Flagstaff, AZ-UT	1.1079
Flint, MI	1.0703
Florence, AL	0.7797
Fort Collins-Loveland, CO	1.0148
Ft. Lauderdale, FL	1.0479
Fort Pierce-Port St. Lucie, FL	1.0124
Fort Smith, AR-OK	0.8077
Fort Walton Beach, FL	0.8804
Forth Worth-Arlington, TX	0.9359
Gadsden, AL	0.8229
Gainesville, FL	0.9693
Grand Forks, ND-MN	0.8636
Grand Junction, CO	0.9921
Grand Rapids-Muskegon-Holland, MI	0.9469
Great Falls, MT	0.8918
Greeley, CO	0.9453
Green Bay, WI	0.9518
Greensboro-Winston-Salem-High Point, NC	0.9058
Greenville, NC	0.9167
Hamilton-Middletown, OH	0.9214
Harrisburg-Lebanon-Carlisle, PA	0.9164
Hartford, CT	1.1359
Hickory-Morganton-Lenoir, NC	0.9113
Honolulu, HI	1.1116
Houston, TX	0.9834
Huntington-Ashland, WV-KY-OH	0.9076
Huntsville, AL	0.9120
Indianapolis, IN	0.9916
Iowa City, IA	0.9404
Jackson, MS	0.8399
Jackson, TN	0.8819
Jacksonville, FL	0.9563
Johnson City-Kingsport-Bristol, TN-VA (VA Hospitals)	0.8498
Johnson City-Kingsport-Bristol, TN-VA (KY Hospitals)	0.8256
Jonesboro, AR (AR Hospitals)	0.7809
Jonesboro, AR (MO Hospitals)	0.8056
Joplin, MO	0.8558
Kalamazoo-Battlecreek, MI	1.0500
Kansas City, KS-MO	0.9715
Knoxville, TN	0.8820
Kokomo, IN	0.9045
Lafayette, LA	0.8225
Lakeland-Winter Haven, FL	0.8855
Las Vegas, NV-AZ	1.1401
Lawton, OK	0.8140
Lexington, KY	0.8475
Lima, OH	0.9522
Lincoln, NE	0.9597
Little Rock-North Little Rock, AR	0.8923
Longview-Marshall, TX	0.8943
Los Angeles-Long Beach, CA	1.1832
Louisville, KY-IN	0.9118
Lubbock, TX	0.8272
Lynchburg, VA	0.8941
Macon, GA	0.8975
Madison, WI	1.0117

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index
Medford-Ashland, OR	1.0425
Melbourne-Titusville-Palm Bay, FL	0.9776
Memphis, TN-AR-MS	0.8786
Miami, FL	0.9894
Milwaukee-Waukesha, WI	0.9829
Minneapolis-St. Paul, MN-WI	1.1001
Missoula, MT	0.8884
Mobile, AL	0.7994
Modesto, CA	1.1148
Monmouth-Ocean, NJ	1.1083
Monroe, LA	0.7922
Montgomery, AL	0.7907
Nashville, TN	0.9591
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2468
New Orleans, LA	0.9174
New York, NY	1.4018
Newark, NJ	1.1518
Newburgh, NY-PA	1.1048
Oakland, CA	1.5119
Odessa-Midland, TX	0.9076
Oklahoma City, OK	0.8984
Olympia, WA	1.0963
Omaha, NE-IA	0.9745
Orange County, CA	1.1492
Orlando, FL	0.9654
Peoria-Pekin, IL	0.8734
Philadelphia, PA-NJ	1.0883
Phoenix-Mesa, AZ	1.0129
Pittsburgh, PA	0.8901
Pittsfield, MA	0.9795
Pocatello, ID	0.9249
Portland, ME	0.9658
Portland-Vancouver, OR-WA	1.1213
Provo-Orem, UT	0.9976
Raleigh-Durham-Chapel Hill, NC	0.9725
Rapid City, SD	0.8806
Reading, PA	0.8998
Redding, CA	1.1352
Reno, NV	1.0682
Richland-Kennewick-Pasco, WA (WA Hospitals)	1.0388
Richland-Kennewick-Pasco, WA (ID Hospitals)	1.0215
Richmond-Petersburg, VA	0.9349
Roanoke, VA	0.8700
Rochester, MN	1.1739
Rockford, IL	0.9441
Sacramento, CA	1.1845
Saginaw-Bay City-Midland, MI	0.9751
St. Cloud, MN	0.9679
St. Joseph, MO	0.8578
St. Louis, MO-IL	0.9033
Salinas, CA	1.4339
Salt Lake City-Ogden, UT	0.9913
San Antonio, TX	0.8870
Santa Fe, NM	0.9524
Santa Rosa, CA	1.2877
Sarasota-Bradenton, FL	0.9971
Savannah, GA	0.9488
Seattle-Bellevue-Everett, WA	1.1562
Sherman-Denison, TX	0.9203
Shreveport-Bossier City, LA	0.8937
Sioux City, IA-NE (NE Hospitals)	0.8822
Sioux City, IA-NE (SD Hospitals)	0.8785
Sioux Falls, SD	0.9184
South Bend, IN	0.9715
Spokane, WA	1.0717
Springfield, IL	0.8944
Springfield, MO	0.8259
Syracuse, NY	0.9412
Tampa-St. Petersburg-Clearwater, FL	0.9103
Texarkana, AR-Texarkana, TX	0.7969
Toledo, OH	0.9397
Topeka, KS	0.9108
Tucson, AZ	0.9270
Tulsa, OK	0.8938
Tuscaloosa, AL	0.8101
Tyler, TX	0.9155
Vallejo-Fairfield-Napa, CA	1.3425
Victoria, TX	0.8184
Waco, TX	0.8394
Washington, DC-MD-VA-WV	1.0904
Waterloo-Cedar Falls, IA	0.8416
Wausau, WI	0.9783
West Palm Beach-Boca Raton, FL	0.9798
Wichita, KS	0.9004
Wichita Falls, TX	0.8341
Wilmington-Newark, DE-MD	1.0710
Wilmington, NC	0.9424
Youngstown-Warren, OH	0.9214
Rural Florida	0.8699
Rural Illinois (IA Hospitals)	0.8416
Rural Illinois (MO Hospitals)	0.8254
Rural Kentucky	0.7974
Rural Louisiana	0.7467
Rural Minnesota	0.9345
Rural Missouri	0.8056
Rural Nebraska	0.8822
Rural Nevada	0.9276
Rural New Hampshire	1.0030
Rural Texas	0.7780
Rural Washington	1.0388
Rural Wyoming	0.8984

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Part IV

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 400, 405, and 426
Medicare Program: Review of National Coverage Determinations and Local Coverage Determinations; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 400, 405, and 426

[CMS–3063–F]

RIN 0938–AK60

Medicare Program: Review of National Coverage Determinations and Local Coverage Determinations

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

ACTION: Final rule.

SUMMARY: This final rule will create a new process to allow certain Medicare beneficiaries to challenge national coverage determinations (NCDs) and local coverage determinations (LCDs). It will implement portions of section 522 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. The right to challenge NCDs and LCDs will be distinct from the existing appeal rights that Medicare beneficiaries have for the adjudication of Medicare claims.

EFFECTIVE DATE: The provisions set forth in this final rule are effective December 8, 2003.

FOR FURTHER INFORMATION CONTACT: Vadim Lubarsky, 410–786–0840 for National Coverage Determinations. Misty Whitaker, 410–786–3087 for Local Coverage Determinations.

SUPPLEMENTARY INFORMATION:

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Note: The former name of the Centers for Medicare & Medicaid Services (CMS) was the Health Care Financing Administration (HCFA). The terms CMS and HCFA can be used interchangeably.

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

ALJ—Administrative Law Judge
CAC—Carrier Advisory Committee
CMP—Comprehensive Medical Plan
DMERC—Durable Medical Equipment Regional Carrier
FI—Fiscal Intermediary
HCPP—Health Care Prepayment Plan
HMO—Health Maintenance Organization
LCD—Local Coverage Determination
LMRP—Local Medical Review Policy
M+C—Medicare+Choice
MCAC—Medical Coverage Advisory Committee
NCD–National Coverage Determination
QIO—Quality Improvement Organization
RHHI—Regional Home Health Intermediary

I. Background

A. Background of Rulemaking

On August 22, 2002, we issued a proposed rule (67 FR 54534) implementing certain provisions of section 522 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), proposing a process for the review of local coverage determinations (LCDs) and national coverage determinations (NCDs). The notice and comment period closed on October 21, 2002. We received 31 timely comments, which were quite useful in identifying issues and concerns. We have made significant changes to this final rule to address the public comments. We believe that these changes will contribute to a fairer and more efficient process. Significant changes to the proposed rule based on public comments, which are discussed in section III, below, include:

- More broadly defining beneficiaries "in need."
- Reducing the burden for physician certification requirements.
- Allowing for participation in the BIPA section 522 adjudicatory process as an amicus curiae (friend of the court) for NCD appeals.
- Creating a mechanism to allow new evidence to be received subject to time-limited remands.
- Expanding the effect of a final decision by the Administrative law judge (ALJ) or the HHS Departmental Appeals Board (Board).

B. Overview of Existing Statutes, Regulations, and Policies

Medicare is the nation's largest health insurance program covering approximately 41 million Americans. Beneficiaries consist primarily of individuals 65 years of age or older, some disabled people under 65 years of age, and people with end-stage renal disease (permanent kidney failure treated with dialysis or a transplant).

The original Medicare program consists of two parts. Part A, known as the hospital insurance program, covers certain care provided to inpatients in hospitals, critical access hospitals, skilled nursing facilities, as well as hospice care and some home health care. Part B, the supplementary medical insurance program, covers certain physicians' services, outpatient hospital care, and other medical services that are not covered under Part A. While the original Medicare program covers many health care items and services, it does not cover all health care expenses. The Medicare statute specifically excludes from coverage certain items and services under section 1862(a) of the Social Security Act (the Act).

In addition to the original Medicare program, beneficiaries may elect to receive health care coverage under the Medicare+Choice (M+C) program under Part C of the Medicare program. This program provides beneficiaries with various options, including the right to choose a Medicare managed care plan or a Medicare private fee-for-service plan. Under the M+C program, an individual is entitled to those items and services (other than hospice care) for which benefits are available under Part A and Part B. An M+C plan may provide additional health care items and services that are not covered under the original Medicare program.

The Act gives beneficiaries specific rights to challenge particular types of decisions. We are committed to providing beneficiaries an opportunity to fully exercise these statutory rights. Moreover, we are committed to resolution of these disputes in a fair and efficient manner.

C. Claims Appeal Process

Under the original Medicare program, a beneficiary may generally obtain health services from any institution, agency, or person qualified to participate in the Medicare program that undertakes to provide the service to the individual. Assuming that a qualified provider or supplier has furnished medical care, the health care provider or supplier, or, in some cases, a beneficiary would submit a claim for benefits under

the Medicare program. If the claim is for an item or service that falls within a Medicare benefit category, is reasonable and necessary for the individual, and is not otherwise statutorily excluded, a government contractor (either a fiscal intermediary for claims under Part A or Part B, or a carrier for claims under Part B) would pay the claim. However, if the Medicare contractor determines that the medical care is not covered under the Medicare program, the Medicare contractor would deny the claim.

This final rule does not seek to significantly alter the existing claims appeal process. Nor does this rule significantly alter our existing regulations for M+C beneficiaries as established at § 422.560 through § 422.622. However, it does create an expanded definition of aggrieved party to include a beneficiary who received a service, but whose claim for the service was denied, extending an opportunity to that beneficiary to file a complaint under § 426.400 or § 426.500. For further discussion of the claims appeal process please consult the proposed rule.

D. National Coverage Determinations (NCDs)

Section 1869(f)(1) of the Act defines national coverage determination as "a determination by the Secretary with respect to whether or not a particular item or service is covered nationally under title XVIII, but does not include a determination of what code, if any, is assigned to a particular item or service covered under this title or a determination with respect to the amount of payment made for a particular item or service so covered." For the full discussion of NCDs please consult our proposed rule at 67 FR 54535 published on August 22, 2002.

E. Local Medical Review Policy (LMRP)

As explained in the preamble to the proposed rule, Local Medical Review Policies are contractor-specific policies that identify the circumstances under which particular items or services will be (or will not be) considered covered and correctly coded. An LMRP is not controlling authority for ALJs or the Board in the claims appeals process. These guidelines simply help to ensure that similar claims are processed in a consistent manner within those jurisdictions. LMRPs may not conflict with an NCD, but may be written in the absence of, or as an adjunct to, an NCD.

An LMRP may contain any or all of the following:

- Coding provisions.
- Benefit category provisions.
- Statutory exclusion provisions.
- Provisions related to the authority under section 1862(a)(1)(A) of the Act, which prohibits payment for any expenses incurred for services that are not reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member.

Some LMRPs contain only a single type of provision, while other LMRPs contain all four types. The provisions described in bullets two through four above constitute coverage provisions.

For further information on LMRPs please consult our proposed rule at 67 FR 54535.

F. Local Coverage Determinations

Section 522 of BIPA does not use the term "LMRP," but uses the term "Local Coverage Determination" (LCD). Section 522 of BIPA amends section 1869(f)(2)(B) of the Act, to define LCD as "a determination by a fiscal intermediary or a carrier under part A or part B, as applicable, respecting whether or not a particular item or service is covered on an intermediary-or carrier-wide basis under such parts, in accordance with section 1862(a)(1)(A)."

An LMRP may contain four different types of provisions (coding, benefit category, statutory exclusion, and reasonable and necessary). Section 1869(f)(2)(B) of the Act limits an LCD as a determination only under section 1862(a)(1)(A) of the Act's "reasonable and necessary provision." For the purposes of this regulation, we will use the term "reasonable and necessary provision" to describe section 1862(a)(1)(A) of the Act. We intend to work with contractors to divide LMRPs into separate LCD and non-LCD documents; however, it is likely that LMRPs will continue to exist for the next several years. During this time, the term LCD will refer to both of the following:

- Separate, stand-alone documents entitled "LCDs" that contain only reasonable and necessary language; and
- The reasonable and necessary provisions of an LMRP.

G. Differences Between NCDs and LMRPs/LCDs

Under our claims appeals process, ALJs may consider, but are not bound by, LMRPs or LCDs. Thus, an ALJ may rule that Medicare payment is due on a particular item or service received by a beneficiary, based on the particular circumstances represented by the case, even if the contractor's LMRP or LCD clearly prohibits payment for the particular service (We note that a regulation which may impact ALJ consideration of LCDs in claims appeal cases has been proposed. *See* 67 FR 69328, 69351.) On the other hand, contractors and ALJs are bound by NCDs. ALJs may not review an NCD.

H. Individual Claim Determinations

In addition to policy determinations, contractors may make individual claim determinations, even in the absence of an NCD, LMRP, or LCD. In circumstances when there is no published policy on a particular topic, decisions are made based on the individual's particular factual situation. *See Heckler* v. *Ringer*, 466 U.S. 602, 617 (1984) (recognizing that the Secretary has discretion to either establish a generally applicable rule or to allow individual adjudication).

I. Impact of Section 522 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)

1. Overview of the Legislation

Section 522 of the BIPA created a new review process that enables certain beneficiaries to challenge LCDs and NCDs. These appeal rights are distinct from the existing appeal rights for the adjudication of Medicare claims. This section also creates additional avenues for beneficiaries to seek judicial review. Before BIPA, the statute did not provide an administrative avenue to challenge the facial validity of LCDs or NCDs.

2. Differences Between the Claims Appeal Process and the LCD/NCD Review Processes

The existing claims appeal rights were not significantly changed by section 522 of the BIPA. Our claims appeal regulations will continue to provide detailed administrative appeal rights for beneficiaries whose claims are denied. These claims appeal procedures permit beneficiaries to challenge the initial claims denial and include *de novo* review by an independent ALJ. If still dissatisfied after exhausting all administrative remedies, a beneficiary has a right to seek judicial review in a Federal district court. This claim appeal system enables beneficiaries to submit any relevant information pertaining to an individual claim. Moreover, because LCDs are not controlling authorities for ALJs, when an ALJ does not find an LCD persuasive, an individual claim appeal could result in the claim being paid without the need to challenge the underlying LCD. We have proposed rules that would modify the claims appeals process at 67 FR 69312 (November 15, 2002).

Section 522 of the BIPA created a review process that is separate and

independent from the claims appeal process. This process will be different, because the nature of the challenge and the relevant evidence is different. The procedures used in this process will be different from the claims appeals process. Review of an LCD or NCD requires examination of an entire policy, or specific provisions contained therein, and not just one claim denial. Therefore, such reviews may lead to changes that impact other beneficiaries if the policies are found to be unreasonable. A beneficiary, thus, may elect to pursue a claims denial through the claims appeal process, seek review of an LCD or NCD using the process in this final rule, or both. In no way does filing a 522 challenge, or a decision on a 522 challenge, affect beneficiary appeal rights or other issues that may arise in the claims appeal process.

Complaints under section 522 of the BIPA are subject to standing rules. Namely, under section 1869(f)(5) of the Act "[a]n action under this subsection seeking review of a national coverage determination or local coverage determination may be initiated only by individuals entitled to benefits under part A, or enrolled under part B, or both, who are in need of the items or services that are the subject of the coverage determination." In this final rule, we are interpreting the standing provision to include individuals who have received the item or service and whose initial claim was denied based on an LCD or NCD and, thus, are in need of Medicare coverage. We will also permit the estates of certain individuals to have standing. Only individuals who have standing may bring a challenge under section 522 of the BIPA, and in this final rule, we refer to these individuals as "aggrieved parties."

As discussed in the proposed rule, the aggrieved party may not assign the right to bring a challenge under section 522 of the BIPA to anyone else. However, the aggrieved party is permitted to obtain assistance from any individual in pursuing the challenge. (We discuss the difference between assigning rights and receiving assistance in section IV of this final rule.)

The definition of an "aggrieved party" will permit an individual to bring a challenge to an LCD or NCD in advance of receiving an item or service, or after the LCD or NCD is applied to a claim causing the claim to be denied. As we discuss in greater detail in section IV.E of this preamble, a successful challenge would permit the individual to have his or her specific claim reviewed without reference to the challenged policy. Claims that are otherwise payable can be paid. In addition, a successful challenge to an LCD or NCD may result in the following:

- The policy being retired/withdrawn in its entirety, or
- The policy being revised to effectuate the Board decision, or the ALJ decision if it is not appealed to the Board.

3. The Reconsideration Process

We previously established a procedure by which individuals could seek reconsideration of policies established in an LCD or NCD. The procedures for NCDs were set forth in the September 26, 2003 notice (68 FR 55634, 55641). The procedures for LCDs were set forth in the Program Integrity Manual, Chapter 13, Section 11.

4. The Role of Other Interested Individuals or Entities

The section 522 review process is intended to be initiated only by aggrieved parties. However, consistent with several public comments, we are expanding § 426.510(f) to allow for limited participation in an NCD challenge by other individuals as amicus curiae when the individuals or entities meet the standards set forth in these regulations. Please note that the reconsideration process described in section I.I.3 of this preamble remains the appropriate process by which all other interested entities may submit new evidence pertaining to the review of current LCDs and NCDs.

5. Differences Between an LCD/NCD Review and an LCD/NCD Reconsideration

The main difference between an LCD/NCD review under section 522 of the BIPA and an LCD/NCD reconsideration is the avenue an individual chooses to take to initiate a change to a coverage policy and who may initiate the review. All interested parties, including an aggrieved party, may request a reconsideration of an LCD or NCD, rather than filing a complaint to initiate the review of an LCD or NCD. Conversely, only an aggrieved party may file a complaint to initiate the review of an LCD or NCD. If the aggrieved party believes that we, or the contractor, misinterpreted evidence or excluded available evidence in making the coverage determination or has new evidence to submit, then the aggrieved party has the option to file a request for a reconsideration by the contractor or us, respectively, or to file a complaint to seek review by an adjudicator.

In the reconsideration process, all interested parties, not just aggrieved parties, have the opportunity to submit new scientific and medical evidence for review by individuals with medical and scientific expertise. The reconsideration process permits experts to make judgments about those policies, rather than using an adjudicatory proceeding.

II. Provisions of the Proposed Rule

For a discussion of the specific provisions of the proposed rule, please see 67 FR 54534–54563. The significant changes to the final rule, based on public comments, are reflected in section III, below.

III. Analysis of and Response to Public Comments

We received 31 comments from the public on the proposed rule. Summaries of the major comments received and our responses to those comments are set forth below.

Definition of an NCD

Comment: We received several comments on our interpretation of what qualifies as an NCD, and which policies are subject to review. Some public comments stated that we interpreted the statute too narrowly, and that additional policies should be subject to review; other public comments suggested that we interpreted the statute too broadly, and that benefit category determinations should not be defined as NCDs, and should not be subject to review before the Board.

Response: Our definition of an NCD is consistent with the statutory language, and we are not accepting the public comments that suggest the definition is either too broad or too narrow. We continue to believe that the statute is clear, and that the Congress has created a new definition of NCD to include benefit category determinations. The Congress's definition of an NCD is now broader than the prior statute at section 1869(b)(3) of the Act. Moreover, it is broader than the definition of LCD that is specifically limited to determinations made in accordance with section 1862(a)(1)(A) of the Act. We presume that the Congress acted intentionally and precisely in defining an NCD, and we are following that definition in this final rule.

Definition of LCD

Comment: One commenter suggested that an LCD should be synonymous with LMRP.

Response: Because the statutory definition of an LCD is limited to the reasonable and necessary provisions in section 1862(a)(1)(A) of the Act, we could not make the definition of an LCD synonymous with the definition of an LMRP. As discussed earlier in this preamble, an LMRP may contain coding,

benefit category, and statutory exclusion provisions that are not based on section 1862(a)(1)(A) of the Act.

Comment: Several commenters suggested that both procedure codes and diagnosis codes be included within the definition of LCD. These commenters stated that the final regulation should not preclude an aggrieved party from challenging the reasonable and necessary provisions of an LCD that contain diagnosis codes.

Response: An LCD or LMRP provision stating that a service is not reasonable and necessary for specified diagnoses (whether listed in text or listed by ICD–9 diagnosis code) is considered part of the LCD.

Definition of an Aggrieved Party

Comments: We received two comments in support of our proposed definition of an aggrieved party as a beneficiary in need of a service and who has not yet received the service that is the subject of the coverage determination. While these commenters felt that it is correct to allow aggrieved parties to initiate the review of an LCD or NCD, they wrote that opening up the LCD/NCD review process to beneficiaries who have already received the service would result in unnecessarily complicated adjudications. However, over half of all commenters on the rule suggested that the definition was too narrow and should be expanded. Some commenters stated that the proposed definition was far too restrictive and suggested that we remove the requirement that the service not be received at the time the complaint is filed. One commenter pointed out that the proposed definition would insulate certain LCDs and NCDs from ever being challenged because some LCDs/NCDs address services that are only used in emergency or urgent situations where the beneficiary would be incapable of filing a challenge prior to receiving the service. Some commenters suggested that beneficiaries would lose their section 522 rights if they chose not to forego urgent treatment. One commenter suggested that we revise the definition to require that the beneficiary be in need of coverage for a service. One commenter specifically requested the establishment of an emergency appeals process.

Response: In response to these comments, we have interpreted the statutory requirements more broadly and have expanded the definition of aggrieved party to require that the beneficiary be in need of coverage of a service. Therefore, the definition includes beneficiaries who have already received the service. We believe this change obviates the need for an emergency appeals process because a beneficiary can obtain an emergency service and then seek review without forgoing his or her rights. In order to define which beneficiaries have standing as aggrieved parties, we have added a requirement in § 426.400(b)(2) and § 426.500(b)(2) that aggrieved parties, who have received a service and have filed a claim, must file their section 522 challenge within 120 days of the date of the initial denial notice from the contractor.

Comment: One commenter stated that beneficiaries should be allowed to challenge coverage NCDs as well as non-coverage NCDs.

Response: We conclude in this final rule that a beneficiary is aggrieved by an NCD only if it denies coverage for a service which that beneficiary needs. Therefore, the ALJ/Board may accept a complaint regarding an NCD that limits coverage. Since the Congress provided for review upon the filing of a complaint by an aggrieved party, we believe that the Congress intended the process to be available only when the beneficiary is in need of coverage for an item or service that would be denied or has been denied, under an LCD or NCD.

Allowing a Beneficiary To Assign Appeal Rights

Comment: We received a number of public comments suggesting that the aggrieved party should be able to assign LCD or NCD review rights under section 522 of the BIPA to another person or entity. Several of the comments suggested that the procedures were complex and that, by enabling a beneficiary to assign the rights to another person, it would relieve the beneficiary of the burden of participating in the process and would be more equitable, or, perhaps, more efficient. One commenter suggested that permitting providers to be aggrieved parties would have been consistent with an earlier proposal in a Senate bill. Some commenters suggested that allowing physicians or other interested parties to assist the beneficiary in requesting review would be useful to beneficiaries. Other commenters recognized that the Medicare program permitted the assignment of rights in other contexts.

On the other hand, one commenter noted that the statute requires a beneficiary in need to initiate a review. Another commenter agreed with our proposal, and believed it would be inappropriate under the statute to permit the assignment of rights to request a review of an LCD or NCD to other interested parties. That commenter noted that the "Medicare program is fundamentally a beneficiary, or patient, program designed to assure access to clinically sound services."

Response: We are retaining our position that an aggrieved party may not assign legal rights to request a review of an LCD or NCD to a third party, but are clarifying our rules to ensure that a challenger is not precluded from obtaining assistance or representation from individuals or entities who may assist the beneficiary in pursuing the individual's appeal.

We agree with the commenter who suggested that the statute was clear in this regard. The standing provision in section 1869(f)(5) of the Act is precise. Moreover, as one commenter correctly observed, a broader standing provision, that would have enabled other interested parties to file complaints about LCDs and NCDs, existed in earlier drafts of the legislation. It appears that the Congress's narrowing of the language in the final bill was intentional and deliberate. We do not believe it would be consistent with this history to expand the scope of individuals who have a legal right to initiate and pursue a challenge to an LCD or NCD.

We do, however, agree that beneficiaries may seek assistance from knowledgeable physicians, suppliers, providers, manufacturers, and attorneys in developing the individual's request for review. The individual is free to consult with these individuals and to follow those suggestions, recommendations, or advice. Thus, while these individuals may assist the beneficiary in navigating the adjudicatory process in an efficient manner, the beneficiary may not assign his or her legal right to request a review of an LCD or an NCD to a third party.

Comment: A commenter suggests that dually eligible Medicare and Medicaid beneficiaries have already assigned rights to third party payment to Medicaid agencies by virtue of sections 1902(a)(45) and 1912 of the Act, and § 433.137 of the Medicaid regulations, and that States, therefore, should be allowed to participate in the process.

Response: We disagree with the commenter. The provisions of the Act and regulations cited concern the assignment of rights to seek medical support or payments and in providing information to assist the State in pursuing financially liable third parties. In contrast, a person initiating a challenge to an LCD or NCD is seeking to have a coverage policy held invalid and is not establishing a right to medical support or payment. Should a dually eligible beneficiary prevail in a policy challenge, a State may benefit in the

claims adjudication process if it is determined that the policy was invalid. Furthermore, although this adjudicatory process is not available to a State directly, a State may always request reconsideration of an LCD or NCD.

Dismissal of Complaint Upon Death of Beneficiary

Comments: We received comments about the proposed policy that would have dismissed complaints if the beneficiary died after initiating a section 522 challenge. Approximately one third of the commenters were opposed to this policy, and only one supported it. That commenter concluded that since the deceased would no longer be considered "in need," it would be appropriate to dismiss the claim. The majority of those who commented objected to permitting an estate to appeal a claim without permitting the estate to continue a challenge to the policy that could determine the outcome of the appeal, thereby denying meaningful relief. One commenter indicated that the policy of automatic dismissal of a complaint upon death runs contrary to Federal common law that allows for the survival of remedial, as distinguished from penal or punitive, claims. In describing the burdens created by an automatic dismissal, the commenters referred to the potential for delay, the requirement to seek meaningful redress in Federal court rather than through the administrative appeals process, wasted resources expended prior to the death of the beneficiary in LCD/NCD challenges, and the potential for devastating financial burdens on the estates of deceased beneficiaries.

Response: We have revised the final rule to permit the estate of a beneficiary, as a successor in interest, to continue a challenge in those cases where the aggrieved party received the service and filed a timely complaint prior to death. In addition, we will allow an estate to initiate a challenge within 120 days of the issuance of a denial notice.

Acceptability of Complaints

Comments: Some commenters stated their belief that the complaint filing process in the proposed rule was overly complex. One commenter suggested that complaints should be deemed acceptable if sent to the ALJ, the local Social Security office, carrier or fiscal intermediary (FI), or the Board.

Response: We have revised the final rule to simplify and clarify the complaint filing procedures and to make them more beneficiary-friendly. We have eliminated a number of requirements that we believe are unnecessary. However, it is the duty of the beneficiary to file the complaint correctly under these regulations. Nevertheless, we will issue instructions advising our contractors of procedures for a misdirected LCD/NCD complaint. These instructions will inform the contractor that it should forward the complaint to the proper location and notify the beneficiary.

Physician Certification

Comment: Some commenters stated that physician documentation of medical need is a reasonable way of determining whether beneficiaries have a basis for challenging LCDs/NCDs. However, other commenters felt that the physician certification requirements imposed unnecessary new paperwork burdens on physicians. Some commenters argued that it was unrealistic to require physicians to be certain of the intricacies of Medicare policies. Others felt these requirements would prove to be a significant impediment to the process and suggested that the original physician order for the service suffice as certification that the beneficiary needed the service. Finally, a number of commenters suggested that non-physician practitioners should be allowed to document the beneficiary's need.

Response: We have revised the certification requirements at § 426.400(c) and § 426.500(c) in this final regulation by clarifying that the certification of need can be in the form of a written order for the service in question or other documentation in the medical record, thus significantly simplifying the certification requirements. We have also removed the requirement that the practitioner predict that payment would be denied. However, we continue to believe that the beneficiary's treating physician—not any treating practitioner—is best situated to determine "in need" status, both because he or she is the primary caregiver and also is responsible for the beneficiary's overall care.

Joint Complaints

Comments: We proposed permitting multiple parties to file a single complaint. We received one comment in support of the joint complaint option noting that it permits more effective resource utilization in addressing complaints. One commenter recommended that the criterion for joint complaints should not require "a similar medical condition," rather that the adverse impact created by the LCD or NCD should create standing. Another commenter asserted that requiring a similar medical condition was unnecessary and inconsistent with the Federal Rules of Civil Procedure and that requiring a challenge to the same provisions of the same policy should be sufficient.

Response: In response to the comments concerning the requirement of a "similar medical condition" for the filing of a joint complaint, we believe that this requirement is reasonable, given the specific focus of these adjudications. Moreover, the Federal Rules of Civil Procedure are not controlling on our administrative proceedings. We believe that these procedures appropriately fit the specific requirements for LCD and NCD adjudications and are consistent with the Secretary's authority (42 U.S.C. 405(a)). Moreover, we do not eliminate the possibility of combining actions based upon different medical conditions if a party believes, and the ALJ/Board finds, that there are other bases for consolidating complaints.

Adjudicator Consolidation of Complaints

Comment: We received three comments on adjudicator authority to consolidate complaints. One commenter recommended merging the provisions for joint and consolidated complaints or, alternatively, having the provisions cross-reference one another. Another commenter objected to the consolidation of complaints without the aggrieved party having reviewed the other complaint(s) to determine whether or not the consolidation might negatively impact the individual's specific issue with the LCD or NCD. Another commenter questioned whether the consolidation might result in lengthening the process if an adjudicator combined a later complaint with an earlier one.

Response: We believe that preserving the procedures for aggrieved parties to file joint complaints and for adjudicators to consolidate complaints promotes efficiency in adjudicating challenges to LCDs and NCDs. While we recognize that the two procedures support a common goal, we note that they are separate and distinct and therefore should remain in their respective sections. With respect to the comments concerning the possibility that a party might find consolidation adverse or burdensome, we believe it is appropriate for the adjudicator to determine whether consolidation is appropriate under the specific circumstances. We will allow any aggrieved party who feels disadvantaged by consolidation to raise these issues to the ALJ/Board. We have added language to § 426.410(e) and § 426.510(e) to

clarify that the ALJ/Board may not consolidate complaints if doing so would unduly delay the ALJ/Board decision.

Amending a Complaint

Comment: Several commenters indicated that they were concerned that the proposed rule allowed a beneficiary to amend a complaint only once and then required the ALJ/Board to dismiss the challenge if the aggrieved party failed to submit an acceptable amended complaint.

Response: The statute requires that the section 522 challenge begin with the filing of a complaint. We believe that it would be inefficient if an aggrieved party had an unlimited number of attempts to file an acceptable complaint. A complaint is a significant document in identifying issues on appeal and leads to the production of the record. The final rule continues to allow the aggrieved party one opportunity to amend an unacceptable complaint before a time penalty is imposed.

Withdrawal of Complaint—Six-Month Limit on Refiling

Comment: We received two comments in support of our proposal to establish a six-month limitation if an aggrieved party withdraws a complaint. One commenter was opposed, stating that if the aggrieved party has new evidence, he or she should be allowed to file another complaint regardless of the timeframe. We received two additional comments suggesting that, if the aggrieved party has new evidence, he or she should be allowed to file another complaint without a time limitation.

Response: We continue to believe that the six-month time limit is necessary to ensure the efficient use of scarce resources. If the aggrieved party withdraws a complaint, that aggrieved party must still wait six months before filing a new complaint on the same LCD/NCD. However, we have clarified that, once an acceptable complaint has been filed, if the aggrieved party identifies new evidence that was not available at the filing of the original complaint, the aggrieved party may submit that new evidence at any time without withdrawing and resubmitting the complaint.

Aggrieved Party Submitting a Brief

Comment: We received one comment suggesting that an aggrieved party should have the opportunity to submit a brief after the aggrieved party has had the opportunity to review the record upon which the LCD or NCD was based.

Response: We agree that an aggrieved party should have an opportunity to make his or her case. In seeking to make this process accessible to Medicare beneficiaries, who may or may not have legal representation, we did not want to mandate that parties submit legal briefs in support of their claims. However, in view of the changes we have made to the review process in this final rule, particularly for the introduction and use of new evidence, we are clarifying that, while briefs are not required in all cases, the adjudicator may request or permit the parties to submit written briefs and that the aggrieved party has the option to retain representation and to submit these written briefs.

Educating Beneficiaries and Providers About the Process

Comment: Many commenters stressed the importance of having a well-constructed and advertised educational campaign for providers and beneficiaries. Some commenters suggested that a template for an acceptable complaint, a physician's certification, and an acceptable appeal of an ALJ's decision be available on the CMS Web site to assist beneficiaries in filing an acceptable complaint. Another commenter suggested that beneficiaries should be informed of their rights in the LCD or NCD review process and that one means of providing this might be to include it with advanced beneficiary notice (ABN) forms. Another commenter encouraged us to inform beneficiaries clearly as to their financial obligations while the complaint is pending. Several other commenters suggested that we provide model language for use by Medicare managed care organizations to use in their evidence of coverage documents.

Response: In the proposed rule (67 FR 54547), we explained our intent to produce a user-friendly guide that beneficiaries may use in accessing the section 522 process. We will work with the ALJs and Board to develop educational materials to inform the public of—

(1) The elements of an acceptable complaint;

(2) The standards for treating physician certifications; and

(3) The elements of an acceptable appeal of an ALJ decision. We intend to prepare this educational material (including templates) and make it publicly available, but we will not delay implementation of the final rule to wait for these materials to be developed. We will work with ALJs and the Board to make available to Medicare managed care organizations and Medicaid State agencies, relevant information on complaints and decisions. We do not intend to revise ABNs as part of this educational program.

Allowing Participation by Interested Entities

Comment: Several commenters believed that we should allow for more public participation of interested entities in the process, along with submission of evidence by those parties.

Response: The LCD and NCD reconsideration processes currently exist to give all interested entities the right to request and participate in reconsiderations of these policies. These processes will continue to exist to provide an avenue for all interested entities to submit evidence that they consider pertinent. In contrast, the adjudicatory process created by section 522 is initiated only by a beneficiary in need of coverage, and not by all interested individuals. We are concerned that allowing any member of the public to submit evidence would make these adjudicatory proceedings unwieldy. We are modifying this final rule at § 426.513, however, to permit participation as *amicus curiae,* in the NCD process. We recognize that NCD reviews may impact a large number of stakeholders apart from the aggrieved parties initiating the review. We believe that the nationwide effect of an NCD review decision requires public notice and opportunities for input in a way that LCD reviews do not. In addition, this impact may be significant, even where no change to existing policy results from the review, such as when the Board concludes that an NCD record is complete and contains adequate information to support the validity of the NCD.

Anyone who has information that can assist the Board in reviewing an NCD challenge is permitted to request participation as an *amicus curiae.* Given the nationwide effect of an NCD review decision, the process must strike a careful balance between providing reasonable opportunities for input by those who may ultimately be substantially affected by any decision, and creating a workable process to address the issues presented by the aggrieved party seeking review. Because of the regional nature and high number of LCDs, allowing the opportunity for *amicus curiae* participation in the review of LCDs would create an inefficient process. However, at any time, any party within the contractor's jurisdiction who wishes to bring forward new evidence relating to a policy may do so through the contractor's LCD reconsideration process. This process is frequently used

and is an efficient method to bring new evidence to the contractor's attention.

Making NCD Complaints and Documentation Available and Announcing the Proceedings

Comments: A number of commenters suggested that all interested parties should have notice of an LCD/NCD complaint and have the opportunity to participate in the proceedings. One commenter recommended the use of an on-line docketing system whereby the public could learn of LCD/NCD challenges and determinations made by the ALJs and Board in these cases.

Response: The statute does not require that we develop such a nationwide online docketing system. While the concept is interesting, an online docketing system is beyond the scope of this regulation. Currently, we are exploring options for the best way to docket and track challenges.

Changes in NCDs may determine the health care services, technologies, and treatments to which beneficiaries have access. The denial of coverage for a service that is allegedly reasonable and necessary may have an adverse impact on others across the nation. Hence, it is important that the review decisions are based on a comprehensive and well-developed record.

In addition, the general public may have a substantial interest in the outcome of some NCD reviews. NCD review decisions will constitute a legal precedent with respect to the outcome. Board decisions will clarify the extent of available Medicare coverage.

Therefore, under the final rule, the Board will make available to the public information about all NCD complaints by means of posting on the Internet. This method will provide the broadest possible public notice, without unreasonably delaying review of the complaint already filed. Any request to participate as an *amicus* must then generally be filed within the timeframes set by the Board.

Although LCDs are also important, LCDs are regional in nature. Because LCD reviews generally impact only a limited geographic area, we will not require the ALJs to make public all LCD complaints.

Notice to Managed Care Organizations (MCOs) and State Agencies

Comment: Several commenters suggested that Medicare managed care organizations (MCOs) and State agencies receive timely notification when a challenge is filed at each stage of review, when an ALJ/Board decision is made, and when a revised LCD/NCD is effective. One commenter suggested that the regulation be revised to require the ALJ or the Board to notify MCOs when an enrollee challenges an LCD/NCD.

Response: We will work with the ALJs and the Board to make available to MCOs and State agencies, relevant information about complaints and decisions.

Mediation

Comment: We received one comment for and one comment against using mediation in an evidence-based review process.

Response: We have added a provision authorizing the Board to stay the review proceedings for a reasonable time when all parties voluntarily engage in settlement negotiations, with or without the assistance of an impartial mediator. In general, we do not consider it appropriate to negotiate about clinical issues that affect the health or safety of Medicare beneficiaries. In some instances, however, it may be worthwhile to explore alternative and less costly means of resolving a dispute. Mediation may be useful to narrow the issues in dispute in order to make the review process more efficient. Using alternative means of resolving disputes is consistent with the Federal Administrative Dispute Resolution Act and HHS policy. Under this final rule, the ALJ or the Board could not compel mediation. Where the parties consent to mediation, the ALJ or the Board may provide an impartial mediator or assist the parties in finding an impartial mediator acceptable to them.

Automatic Dismissal When a Contractor Retires an LCD or CMS Withdraws an NCD

Comments: One commenter agreed that, if an NCD is withdrawn, the purpose for the review has been eliminated and the claims can be adjudicated without consideration of the repealed NCD, but objected to the statement that the repeal will have the same effect as a decision under § 426.560(b). The commenter, however, interpreted section § 426.560(b) as permitting a contractor to continue to rely on a withdrawn NCD.

Response: Retiring an LCD or withdrawing an NCD would result in the retired/withdrawn policy no longer applying in the claims adjudication process for services rendered on or after the date that the policy is retired/withdrawn. Moreover, the aggrieved party would be granted individual claim review. Since a claimant would receive the same relief that would have been available had the adjudicator found that the relevant LCD or NCD was not valid, there would be no reason to continue the appeal.

Comment: One commenter recommended against automatic dismissal if a policy were retired or withdrawn. As an alternative, the commenter suggested giving the adjudicator discretion to dismiss "where the decision normally occurs" and opined that since a retired or withdrawn policy may be reconsidered or reaffirmed, the automatic dismissal provision effectively nullifies the entire policy appeal process.

Response: When we retire/withdraw an LCD/NCD we will not apply those policies for services furnished after the retirement/withdrawal date and we will reprocess the aggrieved party's affected claims without applying the retired/withdrawn policy. If, in the future, the contractor or CMS issues a new LCD/NCD on that subject the change would be adopted after an opportunity for public comment. Any such change would be prospective in nature, and a new LCD/NCD would be subject to challenge under this final rule.

Comment: Two commenters indicated that automatic dismissal would not permit an ALJ's or the Board's findings to be used in the appeal of claims decisions based upon the invalidated policy.

Response: Because the ALJ or the Board would not be required to make a decision in a case where the contractor/CMS retired/withdrew the LCD/NCD, there would be no Board decision with precedential effect. However, we believe our approach conserves resources for all parties and adjudicators.

Timeline for Beneficiary Getting the LCD/NCD Record

Comment: We received one comment on the timing of the LCD/NCD record production requirement. That commenter suggested that we should create a 45-day response timeframe to ensure that the review process proceeds without inordinate delays.

Response: We agree that the establishment of timeframes will promote the efficiency of the BIPA 522 process. However, we believe that the time required will vary with the size and scope of the record requested. Therefore, we have revised the final rule at § 426.410(d) and § 426.510(d) to state that the contractor or CMS must generally produce the record within 30 days, subject to extension for good cause shown.

Timeline for an Aggrieved Party to Review the LCD or NCD Record

Comment: One commenter suggested that 30 days might not be enough time

for the aggrieved party to review the record, particularly for an individual pursuing a complaint with minimal outside assistance. The commenter recommended a 45-to-60-day timeframe for the aggrieved party to respond.

Response: We accept the commenter's suggestion to increase the time for review of the record. While we have maintained the 30-day timeframe, we have added an exception for good cause shown, for review and response to the relevant LCD or NCD record, if additional time is required.

No Evidence To Support an LCD/NCD

Comment: We received several comments stating that where no record exists to support an LCD/NCD, the beneficiary should not have to introduce new evidence.

Response: We expect it would be a rare event that no record exists. In that rare event, we agree with the commenter. We have made changes to clarify that, in the rare event that no evidence exists to support an LCD or NCD, we will either voluntarily retire/withdraw the policy, or request the ALJ/Board to strike down the applicable provision(s) of the policy, whichever is the more expeditious option.

New Evidence

Comment: Approximately half of the commenters made comments on the issue of new evidence. Most of the comments stated that allowing us to have an automatic stay, coupled with the absence of specific deadlines, would unduly delay the review process. Other commenters suggested that the stay should be a matter of ALJ/Board discretion. Numerous comments specifically requested that the ALJ or Board review all evidence, including new evidence, to allow for a more efficient process.

Response: We agree that a more efficient and time-sensitive adjudicatory process is important, and we have addressed several aspects of these comments in the final rule. We have taken considerable steps to create an efficient adjudicatory process that still preserves the important role of the clinical and scientific experts in making LCDs and NCDs.

We have eliminated the proposed automatic stay when new evidence is submitted. Instead, our final rule will require that, if new evidence has been received by the ALJ/Board that would otherwise be admissible, the ALJ/Board will review the new evidence after the period for discovery and the taking of evidence is complete, and decide if it has the potential to significantly affect the LCD/NCD provision in question. If not, the review will continue. If the ALJ/Board determines that the new evidence has the potential to significantly affect the validity of the LCD/NCD, the ALJ/Board will stay the proceedings and forward the material to the contractor or to us for a brief review. The contractor/CMS will have 10 days to provide a statement indicating whether or not: (1) A reconsideration will be initiated, or (2) the policy will be revised or retired/withdrawn. If the Agency undertakes a reconsideration, it must be completed within a period set by the ALJ/Board that is not more than 90 days. We believe this 90-day timeframe is reasonable due to the potentially large body of evidence that must be reviewed. Following a reconsideration, the contractor/CMS will prepare and submit the new LCD/NCD record, and the ALJ/Board proceedings will continue on the revised LCD/NCD. If the contractor/CMS chooses not to initiate a reconsideration, the ALJ/Board proceedings will continue on the original LCD/NCD as supplemented with the new evidence. The aggrieved party will have an opportunity to submit a statement about whether the record still fails to support the validity of the LCD/NCD. The contractor/CMS will have an opportunity to respond. No further evidence will be taken at this stage, and the ALJ/Board will proceed to make a determination on the merits.

We have also made changes to the definition of "new evidence" to clarify that new evidence means evidence that was not considered by the contractor or CMS.

When Does the Review Stop?

Comments: In the proposed rule, we specifically asked for comments on alternatives for structuring the review process. We proposed to divide the decision making process for cases at the ALJ/Board level into two stages and thereby establish the prerequisites for discovery under the statutory framework set forth at section 1869(f)(1)(A)(iii)(I) and section 1869(f)(2)(A)(i)(I) of the Act. Under the proposed regulation, in order to obtain discovery, a challenger was required to first file a motion with the Board or ALJ alleging that the record was incomplete or lacked adequate information to support the validity of the determination. Only if the record was incomplete or otherwise inadequate would an aggrieved party be able to pursue discovery. Even if the challenger did not file such a discovery motion, however, a beneficiary could seek a decision on whether the determination was based on reasonable findings of fact, reasonable interpretations of law, and reasonable applications of fact to law.

We outlined another possible approach in our proposed rule at 67 FR 54542. That approach would require a party to file a statement regarding whether that party considers the record complete and adequate, and an "offer of proof" supporting factual allegations about incompleteness. The adjudicator would then decide whether the record is complete and adequate to support the decision and would prepare a written decision. If the adjudicator found that the record was complete and adequate, this decision would be a final Agency action appealable to the court.

There were two public comments on this issue. One commenter suggested that, if the adjudicator found that the record was incomplete or inadequate, the Board would be legally required to determine that the "NCD is not reasonable." This commenter believed that the Board would be precluded from allowing discovery or any other new evidence at this point, but must automatically rule against CMS. A commenter appeared to prefer the following approach: "If, upon review of the record, the aggrieved party does not have objections to the completeness or adequacy of the LCD or NCD record, then what is the basis of the aggrieved parties complaint? Presumably the coverage policy would be challenged on the basis that it is inconsistent with current clinical or scientific evidence. In such case, a motion by the aggrieved party would appear to be a necessary part of the complaint process and an appropriate step given the limited time and resources of adjudicators, CMS and contractors." The commenter "believed that the aggrieved party should challenge the completeness or adequacy of the record before an adjudicator should make a determination with respect thereto."

Response: We have re-examined our proposed procedures in light of the public comments and the unique statutory language in section 1869(f)(1)(A)(iii)(I) and section 1869(f)(2)(A)(i)(I) of the Act. In this final rule, we clarify at § 426.400 and § 426.500, the procedural and substantive steps involved in the appeal. The revised procedures incorporate approaches from both alternatives discussed in the proposed rule. We believe that the revised procedures are fair, consistent with the statutory framework, and will enable the ALJs and Board to fairly resolve challenges to LCDs and NCDs in an expeditious manner.

The administrative review provisions in BIPA section 522 are unique. While

the reviews are, at the outset, based on the medical and scientific evidence that the contractor/CMS considered in issuing the LCD/NCD, and the statute requires that the adjudicator "shall review the record," it does permit discovery in some limited circumstances and also permits that adjudicator to consult with "appropriate scientific and clinical experts." Obviously, new evidence obtained through discovery or testimony could not have been considered by the agency when the policy predates the new evidence. Thus, the procedures are not entirely based on the record, but new evidence and testimony may influence the ALJ's/Board's decision in some cases.

It is possible that an aggrieved party would attempt to challenge an LCD/NCD for several reasons. For instance, a challenger may believe that a policy that was correct when it was issued has become outdated and is no longer valid in light of advances in medicine. Those challengers may be most interested in presenting new medical evidence in support of changing the policy rather than challenging the original factual basis for the policy. As noted previously, we are modifying our procedures to allow a party to submit new evidence to the ALJ/Board. We have modified the procedures at § 426.340 to allow the ALJ/Board to make a preliminary determination on whether the new evidence submitted would have a significant bearing on the validity of the LCD/NCD. If the evidence is found significant, it would be sent to the contractor/CMS to determine whether the contractor/CMS agrees that the evidence warrants a formal reconsideration. As mentioned earlier, the reconsideration process would be time limited but would allow the public to submit medical and scientific evidence and allow the agency to fully develop the record in light of advances in medical science. Following the time-limited reconsideration, a supplemental record would be filed and the adjudication could continue, if necessary.

This approach will provide the contractor/CMS the initial opportunity to permit medical and scientific experts to examine the new evidence and to make findings of fact concerning the new evidence. Among other things, the statute requires that the ALJ/Board "shall defer only to the reasonable findings of fact" and it was impossible for the agency to have made findings on evidence that did not yet exist or that had not been furnished to the agency for consideration. We believe this approach is necessary to ensure that the medical and scientific opinions of the agency experts illuminate the record, since these appeals could involve very technical medical and scientific material related to the new evidence.

While it is possible that the challenger may submit credible medical and scientific studies that warrant a formal reconsideration, it is also possible that the evidence submitted would not be either relevant or persuasive, or that a challenger may seek to challenge the policy on other grounds. Because the public comments have highlighted the different types of disputes that may be presented, we have modified our procedures in attempt to fairly, yet expeditiously, resolve any type of challenge that may be presented. Our revised approach would allow the ALJ or the Board to resolve some cases without need for a reconsideration and would also allow the review proceedings to be resolved in a more expeditious manner. To resolve any confusion, we will describe the significant procedural and substantive steps of the review.

Under the revised procedures at § 426.425 and § 426.525, all aggrieved parties, after reviewing the LCD or NCD record, will be able to file a statement that includes the challenger's arguments as to why the record is not complete, or not adequate to support the validity of the LCD/NCD under the reasonableness standard. This may be the most important step in the review process from the aggrieved party's perspective because this is the opportunity to present any arguments for the LCD/NCD being held invalid. (*See* § 426.425(a), § 426.525(a)). CMS or the contractor will have 30 days to submit a response to this statement. (*See* § 426.425(b), § 426.525(b)).

After evaluating the materials and the record, our revised procedures will permit the ALJ/Board to make a prompt decision in the nature of a summary judgment if the case warrants this approach. For instance, if applying the reasonableness standard, the adjudicator finds that record is complete and has adequate information to support the validity of the LCD or NCD, the ALJ or the Board may issue a decision that "the record is complete and adequate" to support the policy. (*See* § 426.425(c)(1), and § 426.525(c)(1)). For cases involving an NCD, the aggrieved party would have the right to challenge this final agency action in Federal court. (Section 1869(f)(1)(A)(v) of the Act). For cases involving an LCD, the aggrieved party would have the right to challenge the ALJ's decision at the Board, and potentially in Federal Court. (§ 426.465).

If, on the other hand, after evaluating the materials submitted by the parties and the record, the ALJ/Board determines that the record is not complete or not adequate to support the validity of the LCD/NCD, the adjudicator will permit discovery and the taking of evidence. Following discovery and the taking of evidence as set forth in these final rules, the ALJ/Board will issue a final decision. (*See* § 426.447, § 426.547). Those final decisions may also be appealed in appropriate circumstances.

Although we recognize that one commenter suggested that the ALJ or the Board would be legally required to hold invalid the LCD/NCD rather than allowing the agency to supplement the record, the case cited is not relevant given the unique language and history of BIPA section 522. The ALJs and the Board are not acting as a Federal court reviewing final agency action. The case relied on by the commenter concerned the scope of review under the judicial review provisions of the Administrative Procedure Act, 5 U.S.C. 706. Moreover, under prior provisions for court review of NCDs, even courts were required to permit us to supplement the record before declaring an NCD invalid. We believe our approach is consistent with the specific requirements of the statute.

Scope and Weight of Evidence

Comment: One commenter believed that the proposed rule would have the effect of excluding highly relevant information such as physicians' standards of practice and their professional opinions from the review process. Another commenter believed that we should define the hierarchy of evidence strength to assure proper weighting by the ALJ or Board when considering scientific and clinical information.

Response: We are not accepting the recommendation to include a hierarchy of evidence in order to allow flexibility in analyzing evidence. We recognize that many types of evidence have value, and will consider clinical experience, as well as other forms of medical, technical, and scientific evidence in making LCDs and NCDs. We note that the ALJ/Board may seek input from clinical and scientific experts at their discretion. There is no prohibition against the ALJ or the Board seeking the input of practicing physicians or considering standards of practice.

Discovery

Comment: We received several comments on the nature and scope of discovery. One commenter supported the limitation upon discovery that

would allow contractors to produce existing records rather than requiring them to develop and produce new documentation.

Response: We appreciate the commenter's support of our proposals and have taken its views into account in considering the comments of those commenters who recommended revisions.

Comment: One commenter objected to our proposal not to initiate discovery between parties until after an adjudicator has made a determination about the adequacy of the record. The commenter suggested that discovery should be available any time after the complaint is filed.

Response: We note that the statute establishes the timing of discovery. Section 1869(f)(1)(A)(iii)(I) and section 1869(f)(2)(A)(i)(I) of the Act provide for discovery and the taking of evidence only in instances where an ALJ or the Board has reviewed the record and made a determination that it is incomplete or lacks adequate information to support the validity of the LCD or NCD at issue. Therefore, we believe that an initial determination regarding the completeness and adequacy of a record must precede the initiation of discovery between parties.

Comment: Several commenters opposed our rule limiting discovery to requests for documents only. The commenters suggested that parties should be permitted to use interrogatories and other discovery means. A commenter also objected to the rules at § 426.435 and § 426.535 setting forth the subpoena procedures on the basis that they are inconsistent with the Federal Rules of Civil Procedure, particularly with respect to the 30-day notice requirement. Finally, one commenter suggested that discovery should not be restricted to material relating to a specific LCD or NCD but should include other policies that might be relevant to an evaluation of whether a coverage policy is reasonable.

Response: The BIPA gives a right to discovery, but does not specify permissible forms and does not require that these administrative proceedings follow the discovery or subpoena rules set forth in the Federal Rules of Civil Procedure or the rules of any other administrative proceedings. We proposed limiting discovery to requests for documents and believe this approach is consistent with other Departmental rules permitting discovery. (*See,* for example, 42 CFR 1005.7). After consideration of the comments, however, we are expanding discovery under § 426.432(c) and § 426.532(c) to include the opportunity to submit 10 written interrogatory questions. This is intended to be a limited opportunity, available when needed to promote the overall efficiency of the review proceeding, that we expect ALJs and the Board to narrowly construe to minimize the burden on the agency. We are also revising § 426.432(e) and § 426.532(e) to exclude written interrogatories from the list of unavailable discovery. We are not allowing for depositions, requests for admissions, or other types of discovery because we view them as unnecessary for this kind of administrative proceeding and because this limitation will reduce the time and expense associated with these appeals. We believe that limiting discovery in this way will ensure the timely and efficient disposition of LCD and NCD challenges.

Comment: A commenter objected to an adjudicator's issuance of a protective order without the employment of a balancing test to determine whether the moving party has a sufficient basis for requesting the order. Another commenter objected to the absence of any provision authorizing a beneficiary or the Board to compel disclosure of documents by us.

Response: Sections 426.432(b)(2) and 426.532(b)(2) set forth criteria that adjudicators must utilize in determining whether to grant or deny protective orders. We believe that these criteria are sufficient to evaluate the merits of a request for a protective order without developing an additional balancing test. As a result, we will not be incorporating the commenter's suggestion into this final rule. Furthermore, we believe that a process for compelling disclosure of all documents by us is not necessary because these regulations already set forth and define the scope of what must be provided through discovery.

Expert Witness

Comment: One commenter objected to the restrictions on the introduction of expert evidence, having interpreted them as permitting oral testimony by an expert witness only if written evidence were submitted.

Response: Sections 426.440(e) and 426.540(e) do not require that a witness provide a written report, but rather require that any expert witness providing written testimony be available for oral cross examination. Under § 426.440(d) and § 425.540(d), the ALJ or the Board may require or permit expert witnesses to submit a written report. Moreover, it is common practice for expert witnesses to submit written reports in order to use hearing time efficiently and to focus questioning effectively.

Withholding Evidence Deemed To Be Proprietary

In the proposed rule, we sought to limit disclosure of "proprietary data" based on the parenthetical phrase included in section 1862(a) of the Act in the paragraph that follows. The provision in this paragraph establishes several procedural requirements that the Secretary must follow in making NCDs. The provision states:

> In making a national coverage determination (as defined in paragraph (1)(B) of section 1869(f)) the Secretary shall ensure that the public is afforded notice and an opportunity to comment prior to implementation by the Secretary of the determination; meetings of advisory committees established under section 1114(f) with respect to the determination are made on the record; in making the determination, the Secretary has considered the applicable information (including clinical experience and medical, technical, and scientific evidence) with respect to the subject matter of the determination; and in the determination, provide a clear statement of the basis for the determination (including responses to comments received from the public), the assumptions underlying that basis, and make available to the public the data (other than proprietary data) considered in making the determination.

The reference to "proprietary data" reflects a limitation on disclosure to the public. We specifically invited public comments "on the scope of proprietary data and the extent to which this material should not be disclosed" (67 FR 54541). Comments we received on this issue follow.

Comment: We received several public comments concerning proprietary data and information disclosure. Several commenters agreed with the proposal to limit disclosure of proprietary data. One commenter suggested that the record contain only the materials referenced in the LCD. One commenter indicated that it should apply to the studies and analysis purchased or performed by a contractor. Another commenter observed that patient specific information should also be protected and disseminated only with patient permission.

Other commenters opposed the concept. One commenter asked that the regulation be revised to state that the record contains "all the information presented to the Agency and/or the Medicare contractor when the coverage determination was being established[.]" One commenter suggested that the record should be expanded to include relevant information that comes to CMS "after a policy is published." Another commenter wrote that, "a contractor or CMS can withhold from the reviewing body information it believes to be

proprietary, creating a huge loophole that allows the withholding of evidence in support of the beneficiary's claim. Because the proposed regulation provides for very limited discovery, a beneficiary will have very little opportunity to determine whether supporting documentation has been withheld." Other commenters suggested that "these proposed regulations be revised to state that the record includes any document or materials that were presented to CMS or the contractor in the development of the LCD or NCD."

Another commenter suggested that when we compile the record of the LCD or NCD, we should also produce an index of all material that was excluded, and then seek a protective order from the adjudicator to exclude that material from the record. We would be required to state for each document the specific basis for a claim of privilege or the specific provisions of Federal statute authorizing the withholding or prohibiting disclosure. A beneficiary would be given an opportunity to respond and object.

Response: In section 1862(a) of the Act, the Congress provided that the Secretary was not required to disclose "proprietary data" to the public when making available the data considered in making the determination. We believe it is likely that this exception serves to encourage manufacturers and others to submit evidence that would be useful in making LCDs/NCDs. Prior to this statute, manufacturers may have been reluctant to submit valuable business and commercial data if they believed it would be publicly disclosed as part of a record in a judicial proceeding. This provision enables the Secretary to receive and consider proprietary data and to assure that proprietary data would not be disclosed without the expressed consent of the individual or entity that submitted the documents. This may enable the contractor/CMS to make LCDs/NCDs, including determinations that may expand Medicare coverage, more rapidly and accurately.

We are aware that there is tension in the statute between the specific right given to an aggrieved party to seek discovery during the appeal process (section 1869(f)(1)(A)(iii)(I) of the Act), and the opportunity that the Secretary is given to withhold from the public "proprietary data." The public comments include cogent views from both perspectives. The Secretary has the discretion and challenge to balance these competing interests, and must resolve this issue in order to implement the expanded appeal rights that the Congress has provided.

We are resolving this tension by issuing this regulation to inform the public that we will withhold proprietary data from the public during the ALJ or the Board process. We do not expect to have proprietary data in our possession in most cases. In the rare instance that we obtain and consider proprietary data, this information will be presented to the ALJ or the Board under seal but will not be disclosed to any party or disclosed as part of the public record of the LCD/NCD proceedings. We believe that the Congress's concern about disclosure of proprietary information to the public in section 1862(a) of the Act suggests that the Congress did not intend to mandate disclosure of that same data during the LCD/NCD appeal. The limited assurance of maintaining confidentiality during the process of preparing an LCD/NCD, but not during the administrative appeal, would discourage manufacturers from submitting crucial confidential information.

At § 426.110, we are specifically defining "proprietary data" and "privileged information" as information from a source external to CMS or a contractor, or protected health information, that meets the following criteria: (1) It is ordinarily protected from disclosure pursuant to 45 CFR Part 164, under the Trade Secrets Act (18 U.S.C. 1905) or under Exemptions 4 or 5 of the Freedom of Information Act (5 U.S.C. 552) as specifically interpreted in our Departmental regulations at 45 CFR 5.65; and (2) the party who possesses the right to protection of the information from public release or disclosure has not provided its consent to the public release or disclosure of the information. Any information submitted by the public that is not marked as proprietary will not be considered proprietary. We may review this assertion in determining whether the information is proprietary data. Any information received that is not designated as "proprietary data" will not be considered "proprietary data." In order for proprietary data to be considered and given weight in LCD or NCD reviews, any such proprietary data submitted by a manufacturer of a drug or device should contain true and complete records of all clinical and scientific data existent and, therefore, any submission must include an affidavit that the data consists of true and correct copies of all data submitted by the manufacturer to any other Federal or State agency or department in relation to that drug or device. This is to limit the possibility that review decisions are based on partial or biased presentations of available evidence. Consistent with this requirement, CMS will request such certifications when receiving proprietary data for its initial NCD analysis, and would anticipate a similar procedure by carriers or intermediaries in their LCD analysis.

We believe this relatively narrow exception will still provide beneficiaries adequate access to all of the evidence that is typically considered in making LCDs/NCDs. There is a great deal of helpful and useful information available in publicly disclosable documents that are relevant to the subjects that we consider. In many cases the proprietary data may just reaffirm conclusions that are consistent with publicly available sources. While we recognize that this resolution may be somewhat awkward for a party challenging an LCD/NCD, we believe this result is in the best interests of the public. This approach will support more accurate and rapid coverage determinations through greater access to more data and may lead to faster and better LCDs/NCDs that may increase access to new advances in medicine and technology.

For the comment that we provide an index of all excluded material, we are adopting this comment in part. In the rare event that we rely on proprietary and privileged data in formulating a coverage decision, these data will be given to the ALJ/Board under seal. In this rare event, these data will not be furnished to the aggrieved party; rather, we, or our contractors, will include an index that lists all of the excluded material as part of the LCD/NCD record. To implement the statutory protections for proprietary data and privileged information in section 1862(a) of the Act, we are not furnishing proprietary and privileged data as part of the public record, but the seal will be maintained on that information for use by a court in relation to an NCD review. In the event that a court seeks to obtain or requires disclosure of proprietary data or privileged information, CMS or the Department will seek to have a protective order applied to that information, to prohibit any recipients of the information from further disclosing the information or from using it for any purpose other than the challenge. The statutory protection accorded this data ensures the availability of the best relevant information whether proprietary or not, and maximizes flexibility in developing coverage determinations.

Consulting Scientific and Clinical Experts

Comment: We received two comments requesting a clearer definition of who could be considered a scientific or

clinical expert, and requesting that those with conflicts of interest not be considered as experts. A related comment stated that the ALJs/Board may solicit testimony from any expert on issues relevant to the LCD/NCD provision(s) in question.

Response: We agree with these comments. We are clarifying that scientific and clinical experts consulted by the ALJ/Board must be independent and impartial and have significant experience and published work pertaining to the subject of the review to be considered experts.

Comment: A commenter objected to the rule allowing the Board to call its own witnesses. The commenter suggested that the rule would compromise the role of the Board by placing it in an advocacy position.

Response: While we appreciate the commenter's concern regarding the appropriate role of the Board, we are obligated to comply with statutory requirements, and section 1869(f)(1)(A)(iii)(II) of the Act specifically provides that the Board "may, as appropriate, consult with appropriate scientific and clinical experts." Therefore, we believe it proper to interpret this statutory provision to permit adjudicators to call their own witnesses when reviewing LCDs or NCDs. Moreover, similar provisions exist in many administrative procedures, especially those involving public health or safety.

Witness and Legal Fees

Comment: One commenter referred to § 426.445 and questioned whether or not we would pay for witness fees for contractors' witnesses and legal fees incurred in connection with LCD review.

Response: The compensation of Medicare contractors and their witnesses is an internal policy matter, which need not be resolved in this final rule.

Role of CAC/MCAC

Comment: Two commenters suggested that members of the Contractor Advisory Committee (CAC) and members of the Medicare Coverage Advisory Committee (MCAC) should have substantial input into the LCD/NCD review process.

Response: The CAC/MCAC members already serve an important role in developing certain Medicare policies. We believe it would be inappropriate for these individuals to serve as expert witnesses in these proceedings. Therefore, we are not revising the final rule in response to this comment.

Burden of Proof

Comment: We received several comments regarding the proper burden of proof in the adjudicatory proceedings when an LCD or NCD is challenged. One commenter believed we should make it clearer that the burden of proof was on the challenger to show that an item or service is safe and effective for the proposed indication. Two commenters believed we should stop requiring proponents to show that Medicare coverage is appropriate. These commenters suggest that the Social Security Act places the burden of proof on us if it wishes to deny Medicare coverage and suggested that the contractor/CMS should have the burden of showing why evidence supports retention of an LCD or NCD.

Response: We disagree with the commenters who suggest that the burden of proof should rest on the government. The Social Security Act contains no "presumption that services are covered." Rather, the Act expressly provides that "[n]otwithstanding any other provision of this title, no payment may be made * * * for expenses incurred for items or services * * * not reasonable and necessary * * *." (Section 1862(a)(1)(A) of the Act (42 U.S.C. 1395y(a)(1)(A)). Courts have recognized that this language "which bars benefits for services 'not reasonable and necessary' for diagnosis or treatment, is not reasonably interpreted as an affirmative mandate to extend coverage to all necessary services." *Goodman* v. *Sullivan,* 891 F.2d 449, 450 (2d Cir. 1989). Moreover, section 205(a) of the Social Security Act, 42 U.S.C. 405(a), expressly incorporated in title XVIII by section 1872, 42 U.S.C. 1395ii, permits the Secretary to adopt "reasonable and proper rules and regulations to regulate and provide for the nature and extent of proofs and evidence" and the method of furnishing that evidence. In light of this authority, we are clarifying our final rule at § 426.330 to more clearly place the burden of production and persuasion on the individual challenging an LCD or NCD.

Reasonableness Standard

In the proposed rule, we adopted a reasonableness standard requiring the adjudicator to determine whether the findings of fact, interpretations of law, and applications of fact to law by CMS or the contractor were reasonable. Comments on this issue follow.

Comment: One commenter supported the approach we had taken to define reasonableness. One commenter suggested that we need a better definition of reasonableness. Two commenters stated that the reasonableness standard is too "soft" or "lax" for a meaningful review, and instead, a substantial evidence or "de novo" standard should be used. One commenter suggested that a "totality of the circumstances test" should be used.

Response: We proposed a standard of review that was consistent with the specific language of the statute. Therefore, we believe it would not be appropriate to use any other standard. We use the "reasonableness standard" as the standard that an ALJ or the Board must apply when conducting an LCD or an NCD review. In determining whether LCDs or NCDs are valid, the adjudicator must uphold a challenged policy (or a provision or provisions of a challenged policy) if the findings of fact, interpretations of law, and applications of fact to law by the contractor or us are reasonable based on the LCD or NCD record and the record developed before the ALJ/Board. We are using the statutory language from sections 1869(f)(1)(A)(iii) and (f)(2)(A)(i) of the Act, which instructs adjudicators to defer only to the reasonable findings of fact, reasonable interpretations of law, and reasonable applications of fact to law by the Secretary.

The logical corollary is that the ALJs and the Board must accord deference if the contractor's or CMS's findings of fact, interpretations of law, and application of fact to law are reasonable. The concept of deference is one that is generally applied by courts to administrative decisionmaking, in recognition of the expertise of a program agency. Thus, we view the statute as setting out a reasonableness standard that recognizes the expertise of the contractors and CMS in the Medicare program—specifically, in the area of coverage requiring the exercise of clinical or scientific judgment.

So long as the outcome is one that could be reached by a rational person, based on the evidence in the record as a whole (including logical inferences drawn from that evidence), the determination must be upheld. This is not simply based on the quantity of the evidence submitted, but also includes an evaluation of the persuasiveness of the material. If the contractor or CMS has a logical reason as to why some evidence is given more weight than other evidence, the ALJs and the Board may not overturn the determination simply because they would have accorded more weight to the evidence in support of coverage. In some situations, different judgments by different contractors may be supportable, especially if explained by differences

such as the ready availability of qualified medical professionals in one contractor's area, but not in another. Moreover, an ALJ or the Board may not determine that an LCD is unreasonable solely on the basis that another Medicare contractor has issued an LCD that permits coverage of the service at issue, under the clinical circumstances presented by the complaint.

For legal interpretations, the reasonableness standard would not be met if an interpretation is in direct conflict with the plain language of the statute or regulation being interpreted. Moreover, an interpretation in an LCD would not meet the reasonableness standard if it directly conflicts with an NCD or with a CMS Ruling. So long as an interpretation is one of the readings permitted by the plain language of the law and can be reconciled with relevant policy, however, it must be upheld, even if the ALJ or the Board might have reached a different result if interpreting the statute or regulation in the first instance.

Authority of ALJs and the Board

Comment: Some comments supported the limited authority granted to the ALJs/Board in issuing decisions, and many comments requested that the ALJ/Board be granted greater authority in issuing decisions. A number of comments suggested that the proposed rule restricted ALJ/Board authority so that the main outcome of a decision of unreasonableness would be contractor/CMS reconsideration, and that a decision of unreasonableness should result in the policy being null and void. Furthermore, numerous comments suggested that authority is not granted to the ALJ or the Board in the way that the Congress intended, and that the contractor/CMS retains too much authority over the process.

Response: We have revised the final regulation to allow for greater authority for the adjudicators in several respects. In appropriate cases, the ALJ/Board may find a provision(s) of the LCD/NCD invalid and may limit that holding to a beneficiary's clinical indication (or similar condition). Furthermore, the contractor or CMS would effectuate the ALJ/Board decision within 30 days (if not sooner), by either retiring or withdrawing the policy or revising the policy that would be applied prospectively. This means that neither the contractor nor CMS will apply a policy that has been held invalid to a claim of the aggrieved party or to any other similar Medicare claim with date(s) of service beginning on or after 30 days of the adjudicatory decision. Even though we are giving broader effect to the ALJ/Board decision by extending the decision to others on a prospective basis, we continue to believe that the Congress intended that CMS or its contractors would have the authority to develop clinical policies. Thus, we will maintain in the final rule the prohibition against adjudicators developing new language for LCDs and NCDs.

After a policy has been held invalid, it will not be applied to the beneficiary who raised the challenge or to others who receive services after the effective date of the invalidation. CMS or the contractor may issue a new or revised LCD/NCD that does not include the invalid provision(s). The new or revised LCD/NCD would be applied prospectively. The new/revised LCD/NCD would also be subject to challenge under this review process.

Please note that whenever we discuss claim relief or dates of service in the context of an ALJ or DAB decision holding invalid an LCD or NCD, the references should be read to include pre-service requests denied by an M+C organization and the dates of pre-service requests. The application of this regulation in the M+C context is discussed further below.

Effective Dates

Comment: Several commenters stated that timeframes should be set in this process to reflect the timeframes set in the NCD process notice.

Response: We agree with the concept of timeframes, but do not reference the "NCD process notice" since that notice does not speak to this issue, and we have added language to § 426.460 and § 426.560 requiring that contractors/CMS either—

1. Retire/withdraw the LCD/NCD in its entirety within 30 days of the ALJ/Board decision; or

2. Issue a revised LCD/NCD removing the invalid provisions, effective for claims with dates of service after the 30th day of the ALJ/Board decision.

If the Board issues a decision finding an NCD provision invalid and the NCD is revised to reflect the Board's decision, all contractors must review and appropriately revise any related LCDs so as not to be in conflict with the revised NCD. If we choose to withdraw the entire NCD, the contractors must review and appropriately revise any LCDs so as not to rely on the withdrawn NCD as the basis for the LCD.

Precedential Value of ALJ/Board Decisions

Comment: One commenter stated that previous ALJ/Board decisions should be controlling precedent. Another commenter recommended that ALJs/Board be bound by previous ALJ decisions on local policies in other jurisdictions.

Response: We have revised the final rule at § 426.431(a) to require ALJs to treat as precedential Board LCD and NCD decisions, and to require the Board to follow its own applicable precedents. We believe this will improve the efficiency of the review process. Because of differences in the local practice of medicine, we do not believe it would be prudent for ALJs to treat as precedential other ALJ decisions on an LCD challenge.

Appeals of Decisions Involving Joint Complaints and Consolidated Reviews

Comment: One commenter requested that for joint appeals, aggrieved parties should be prohibited from appealing decisions to higher levels unless all parties to the initial appeal agree to appeal.

Response: We will not require in this final rule that all parties must agree to appeal an ALJ decision as a prerequisite for the appeal to continue. Even if some individuals decide not to pursue an appeal, other parties in the case may exercise their appeal rights. Section 426.470 of the regulation allows the Board to consolidate similar appeals.

Appeal of ALJ Decision/Board Review of ALJ Decisions

Comment: One commenter suggested that we should not be allowed to appeal ALJ decisions to the Board due to conflicts of interest. Another commenter objected to having the Board overturn ALJ decisions that were favorable to the aggrieved party due to potential burdens on the beneficiary. Another commenter felt that the regulation should not require the Board to affirm or reverse the ALJ decision in its entirety and suggested that the Board should have the discretion to reverse a decision in part. We received one comment suggesting the Board should not support a policy based on a rationale that is not stated in the supporting documents that were submitted. We also received three comments requesting that the Board not be limited to fundamental rules of procedures, and that it have broader discretion in reviewing ALJ decisions.

Response: Nothing in the statutory language of section 522 suggests that the Congress intended to bar the government from appealing an adverse decision of an ALJ. We believe that such an appeal is warranted as a mechanism to ensure that ALJs are applying the statute and regulations correctly, even if we rarely employ this strategy. Because the statute provides that ALJ decisions

may be reviewed by the Board, we have retained the language allowing either the contractor or CMS to seek Board review of ALJ decisions. Furthermore, our final rule provides flexibility in the Board's review of ALJ decisions.

We have modified the final rule at § 426.476(b) to provide that the Board will review an ALJ decision on appeal to determine whether it contains any material error, including any failure to properly apply the reasonableness standard. The Board will not reverse a decision for harmless error, but may remand if a prejudicial procedural error was made. Further, if the ALJ erred in determining that the LCD record was complete and adequate to support the validity of the LCD, the Board will reverse and remand the case to the ALJ to complete discovery and the taking of evidence. We believe that this standard of review provides appropriate discretion for Board review of ALJ decisions.

Impact on Medicare+Choice (M+C)

Comment: One commenter suggested that we should clarify an M+C organization's obligations when a complaint is under review by both the section 522 process and the M+C organization's existing appeals process.

Response: If an M+C enrollee files both an LCD/NCD review request and a request for reconsideration of an adverse organization determination for the same item or service, the M+C organization should adjudicate the reconsideration using the coverage policies in place on the date the service or item was requested (in the case of a pre-service determination) or provided (in the case of a payment determination). If the LCD/NCD under review is subsequently found to be unreasonable, then the aggrieved party who sought review of the LCD/NCD is entitled to have the previously adjudicated organization determinations or reconsidered determinations reopened and adjudicated without consideration of the invalid LCD/NCD provision(s). M+C organizations would be responsible for reopening and adjudicating organization determinations, and the independent review entity (IRE) would be responsible for reopening and adjudicating reconsidered determinations.

Comment: One commenter requested that we clarify the obligations of M+C organizations when an enrollee has an appeal pending at the time the revised LCD/NCD becomes effective.

Response: The type of organization determination being reconsidered (payment or pre-service) will determine an M+C organization's obligations when an enrollee has a reconsideration pending at the time a revised LCD/NCD becomes effective. Consistent with original Medicare, LCD/NCD changes may only be applied prospectively to requests for payment. Therefore, when an enrollee requests reconsideration of a payment determination and the reconsideration is pending at the time a revised LCD/NCD becomes effective, the M+C organization should apply the LCD/NCD in place at the time the item or service was provided. In responding to a request for reconsideration of a pre-service determination that would be affected by a revised LCD/NCD, an M+C organization should dismiss the appeal and reopen the adverse organization determination on the basis of new and material evidence. The M+C organization should then apply the revised LCD/NCD in effect and issue a revised organization determination.

We recognize the importance of ensuring timely transmission of ALJ/Board decisions and intend to work closely with the Medicare managed care industry to make certain that an effective method of communicating LCD/NCD changes is in place.

Comment: Another M+C-related comment stated that claims that were adjudicated using the invalidated LCD/NCD should be eligible for a new decision (so long as the appeals timeframes have not passed).

Response: As noted in the comment above, LCD/NCD changes can only be applied prospectively to requests for payment, as was the case under original Medicare. Therefore, regardless of subsequent policy changes, for purposes of reconsidering a payment determination, the relevant LCD/NCD is the policy in effect at the time the item or service was provided.

Comment: One commenter requested that we clarify whether a decision made under individual claim review is considered an "organization determination," as defined under parts 417 and 422, giving rise to appeal rights.

Response: When an M+C organization reopens and adjudicates an organization determination under § 426.460(b)(1), the M+C organization must issue a revised organization determination, which gives rise to appeal rights under parts 417 and 422. An enrollee could benefit from a revised LCD/NCD by filing a new request for an organization determination.

Comment: One commenter requested clarification as to whether our statutory obligation, under section 1852(a)(5) of the Act, to make fee-for-service payments for a significant cost, midyear change in benefits would apply if a significant cost threshold for an NCD is met as a result of a decision by the Board to revise an NCD.

Response: Section 1852(a)(5) of the Act provides that if an NCD or legislative change in benefits effective in the middle of an M+C contract year generates a significant change in the costs to a M+C organization of providing benefits that are the subject of the NCD, and if this significant change in costs was not incorporated into the M+C payment rates at the time the NCD becomes effective, the NCD does not apply to the M+C contracts until the first contract year after new M+C rates are published. Moreover, section 1853(c)(7) of the Act provides that, if there is a change in benefits resulting in a significant increase in costs to the M+C organization, we will adjust appropriately the M+C payment rates to reflect this change. The M+C organization must provide coverage of the NCD or legislative change in benefits by furnishing or arranging for the NCD service or legislative change in benefits. However, the M+C organization is not required to pay or assume risk for the costs of that service or benefit until the contract year for which payments are adjusted to take into account the cost of the NCD service or legislative change in benefits. Section 422.109 has been revised to define "significant cost" thresholds, and notes that, if the costs for new coverage or a change in benefits is significant, CMS will pay on a fee-for-service basis on behalf of the M+C organization for the new benefit until the M+C rates are appropriately adjusted. (These provisions do not apply if the change in benefits does not meet either significant cost threshold described at § 422.109.)

Automatic Stay Upon Appeal

Comment: Three commenters disagreed with the automatic stay of an ALJ decision when the contractor/CMS appeals a decision to the Board.

Response: We disagree. We believe it would be disruptive to beneficiaries overall to have ALJ decisions implement policies only to have these policies reversed by the Board. This would create both an inefficient and confusing process. Furthermore, a contrary ruling would require the expenditure of significant resources to implement an ALJ decision only to have to change the decision if the Board reverses.

Dual Track Process

Comment: We received one comment for and one comment against allowing aggrieved parties the option to pursue both a reconsideration and a review under these rules.

Response: We believe that both options should be available to aggrieved parties, in order to allow for the parties to seek a decision in the most appropriate way possible, and to allow the most flexibility to these parties.

Expedited Judicial Review

Comment: Several commenters suggested that the final regulations should address section 1869(f)(3) of the Act, which relates to circumstances where a challenger may seek expedited judicial review when there are no material issues of fact in dispute.

Response: We are not adopting these comments. This section of the statute does not require regulatory action by CMS because it is related to the jurisdiction of the judicial branch of the government. The statute is self-implementing and does not require additional rulemaking by the Secretary.

IV. Provisions of the Final Rule

A. Overview

We are establishing that a Medicare beneficiary who qualifies as an aggrieved party may challenge an LCD or an NCD (or specific provisions therein) by filing a complaint concerning an LCD with the office designated by CMS on the Medicare Web site, *http://www.medicare.gov/coverage/static/appeals.asp* (information on the designated office will be available by calling 1–800-Medicare) or by filing a complaint concerning an NCD with the Board of HHS. After a complaint is filed, the adjudicator determines whether the complaint is acceptable.

In this final rule, we are adding in § 400.202 a definition of "Local coverage determination (LCD)" and revising the definition of "National coverage determination (NCD)." The definitions are specific to Medicare and reflect the definitions for these terms found in section 522 of BIPA. With one exception described below, this final rule makes clear that a determination of the code assigned to a service, if any, or a determination with respect to the amount of payment to be made for the service is not included in the definition of an LCD or an NCD. We have clarified that diagnosis codes used in an LMRP to describe when a service is considered medically necessary are also part of the LCD. We use the term "Services" as defined in § 400.202 to include both "items and services."

In § 405.732, "Review of a national coverage decision (NCD)," we revise paragraph (a) regarding appeals of Part A cases, to state that an NCD is a determination by the Secretary with respect to whether or not a particular item or service is covered nationally under title XVIII. An NCD does not include a determination of what code, if any, is assigned to a particular item or service covered under title XVIII or a determination with respect to the amount of payment made for a particular item or service. NCDs are made under section 1862(a)(1) of the Act or other applicable provisions of the Act. An NCD is binding on all Medicare carriers, fiscal intermediaries, QIOs, HMOs, CMPs, HCPPs, the Medicare Appeals Council, and ALJs.

This final rule revises § 405.732(b) to specify that an ALJ may not disregard, set aside, or otherwise review an NCD. An ALJ may review the facts of a particular case to determine whether an NCD applies to a specific claim for benefits and, if so, whether the NCD has been applied correctly to the claim.

We are revising § 405.732(c) to specify that for initial determinations and NCD challenges under section 1862(a)(1) of the Act, arising before October 1, 2002, a court's review of an NCD is limited to whether the record is incomplete or otherwise lacks adequate information to support the validity of the decision, unless the case has been remanded to the Secretary to supplement the record regarding the NCD. In such cases, the court may not invalidate an NCD except upon review of the supplemental record. For Part B appeals, we are making similar changes.

In § 405.860, "Review of a national coverage decision (NCD)," we revise paragraph (a) regarding appeals of Part B cases to specify that an NCD is a determination by the Secretary with respect to whether or not a particular item or service is covered nationally under title XVIII. An NCD does not include a determination of what code, if any, is assigned to a particular item or service covered under title XVIII or a determination with respect to the amount of payment made for a particular item or service. NCDs are made under section 1862(a)(1) of the Act or other applicable provisions of the Act. An NCD is binding on all Medicare carriers, fiscal intermediaries, QIOs, HMOs, CMPs, HCPPs, Medicare Appeals Council, and ALJs.

We are revising § 405.860(b) to specify that an ALJ may not disregard, set aside, or otherwise review an NCD. An ALJ may review the facts of a particular case to determine whether an NCD applies to a specific claim for benefits and, if so, whether the NCD has been applied correctly to the claim.

In § 405.860(c), we specify that for initial determinations and NCD challenges under section 1862(a)(1) of the Act, arising before October 1, 2002, a court's review of an NCD is limited to whether the record is incomplete or otherwise lacks adequate information to support the validity of the decision, unless the case has been remanded to the Secretary to supplement the record regarding the NCD. The court may not determine that an item or service is covered except upon review of the supplemental record.

We are also adding a new part 426, titled "Reviews of Local and National Coverage Determinations," to title 42 of the CFR to include the following subparts:

- Subpart A contains general provisions applicable to the entire part.
- Subpart B is reserved.
- Subpart C contains the general provisions applicable to the review of LCDs and NCDs.
- Subpart D contains the provisions specific to the review of LCDs
- Subpart E contains the provisions specific to the review of NCDs.

B. Subpart A (General Provisions)

Subpart A of part 426 specifies the general provisions applicable to the entire part. Section 426.100, "Basis and scope," sets forth the basis (under sections 1869(f)(1) and (f)(2) of the Act), and the scope specifies the requirements and procedures for the review of LCDs and NCDs. In § 426.110, we define the terms used in part 426 whose definitions may not otherwise be implicit.

Under section 522 of BIPA, only an "aggrieved party" may file a complaint to initiate the review of an LCD or an NCD. In this final rule, we define "aggrieved party" as a Medicare beneficiary who is entitled to benefits under Part A, enrolled under Part B, or both (including an individual enrolled in fee-for-service Medicare, in a Medicare+Choice plan, or in another Medicare managed care plan), and is in need of coverage for a service that is the subject of an applicable LCD (in the relevant jurisdiction) or an NCD as documented by the beneficiary's treating physician. We revised the final rule to include also as an aggrieved party a beneficiary who has already received the service and is in need of coverage, or the estate of a deceased beneficiary in need of coverage.

Based on comments on our proposed rule, in this final rule we allow an aggrieved party's estate to pursue an LCD/NCD challenge if the aggrieved party died after filing a proper complaint and the aggrieved party received the service for which coverage is sought. We also allow the aggrieved

party's estate to file a complaint within 120 days of receipt of the denial notice.

In § 426.110 we define the following:

• "Board" to mean the Departmental Appeals Board.

• Clinical and scientific experts that are consulted by the ALJ or the Board as independent and impartial individuals, with significant experience and/or published work pertaining to the subject of the review.

• "Contractor" as a carrier (including a DMERC) or a fiscal intermediary (FI) (including an RHHI) that has jurisdiction for the LCD at issue.

• "Deemed NCD" as a determination that the Secretary makes in response to a request for an NCD by an aggrieved party under section 1869(f)(4)(B) and (C) of the Act, that no national coverage or noncoverage determination is appropriate, or the Secretary's failure to meet the deadline under section 1869(f)(4)(A)(iv) of the Act. Section 1869(f)(4)(C) of the Act deems certain decisions of the Secretary to be NCDs for purposes of administrative review. Please see our proposed rule for further discussion of deemed NCDs (67 FR 5434).

• "New evidence" is clinical or scientific evidence that was not previously considered by the contractor or by us before the LCD or NCD was issued.

• "Party" as an aggrieved party, which is an individual or estate who has the right to participate in the LCD or NCD review process, and, as appropriate, a contractor or CMS. In the case of an LCD review, we may choose whether to be a party in the review along with or instead of the contractor. These reviews involve challenges to important CMS policies that may impact many beneficiaries. We note that we are always a party to an NCD review and contractors would not participate in an NCD review.

• "Proprietary data" and "privileged information" are information from a source external to CMS or a contractor, or protected health information that meets the following criteria: (1) It is ordinarily protected from disclosure pursuant to 45 CFR Part 164, under the Trade Secrets Act (18 U.S.C. 1905), or under Exemption 4 or 5 of the Freedom of Information Act (5 U.S.C. 552) as specifically interpreted in our Departmental regulations at 45 CFR 5.65, and (2) the party who possesses the right to protection of the information from public release or disclosure has not provided its consent to the public release or disclosure of that information. Members of the public that send us proprietary data must mark these documents as such, and include the legal basis for any such assertion. Any information received from the public that is not designated as "proprietary data" will not be considered "proprietary."

• "Reasonableness standard" is the standard that an ALJ or the Board must apply when conducting an LCD or an NCD review. In determining whether LCDs or NCDs are valid, the adjudicator must uphold a challenged policy (or a provision or provisions of a challenged policy) if the findings of fact, interpretations of law, and applications of fact to law by the contractor or CMS are reasonable based on the LCD or NCD record and the relevant record developed before the ALJ/Board.

• "Supplemental LCD/NCD record" is a record that the contractor/CMS provides to the ALJ/Board and any aggrieved party and consists of all materials received and considered during a reconsideration. Materials that are already in the record before the ALJ/Board (for example, new evidence presented in the taking of evidence or hearing) need not be provided but may be incorporated by reference in the supplement to the LCD/NCD record. The contractor/CMS may provide statements, evidence, or other submissions to the ALJ/Board during the proceedings, as provided elsewhere in these regulations, but such submissions are not considered as supplementing the LCD/NCD record.

• "Treating physician" is the physician who is the beneficiary's primary clinician with responsibility for overseeing the beneficiary's care and either approving or providing the service at issue in the challenge.

In § 426.120, we explain how deadlines are calculated. In § 426.130, we explain that any documents submitted to the ALJ/Board after the initial challenge, excluding privileged or proprietary data, must also be served on all other parties simultaneously. These sections have been added to provide additional guidance in implementing the requirements of this final rule.

C. Subpart B (Reserved)

We are reserving subpart B.

D. Subpart C (General Provisions for the Review of LCDs and NCDs)

The general provisions common to both the review of LCDs and NCDs are established in subpart C. In § 426.300(a), we state that the review of a challenged provision (or provisions) of an LCD is conducted by an ALJ only upon the receipt of an acceptable complaint as described in § 426.400. We also state in § 426.300(b) that the review of a challenged provision (or provisions) of an NCD is conducted by the Board only upon the receipt of an acceptable complaint as described in § 426.500. An acceptable complaint must be filed with the applicable adjudicator by an aggrieved party. Additionally, § 426.300(c) would allow for the review of deemed NCDs, a process that would parallel the review of NCDs.

In § 426.310(a), we explain that LCD and NCD reviews are largely independent of the claims appeal processes set forth in part 405, subparts F and G; part 417, subpart Q; and part 422, subpart M. In § 426.310(b), we require the aggrieved party to notify the ALJ/Board of any pending claim or appeal related to the LCD/NCD appeal.

In § 426.320(a), we explain that only an aggrieved party may initiate a review to challenge an LCD or NCD (including a deemed NCD), or an existing specific provision or provisions of an LCD or an NCD by filing an acceptable complaint. In § 426.320(b), we explain that neither an ALJ nor the Board will recognize as valid any attempt to assign rights under section 1869(f) of the Act.

In § 426.325, we describe the policies that are, and are not, subject to this review. Under this requirement, an aggrieved party would be allowed only to challenge an LCD or NCD. Conversely, an aggrieved party may not use this process to challenge anything that does not meet the definition of an LCD or an NCD (*see* § 426.325). For example, draft LCDs or NCDs, and coverage decision memos would be excluded from review as they are predecisional. LCD and NCD provisions that are no longer in effect are excluded from review. Other interpretive policies that are not LCDs or NCDs would also not be subject to review under this process. Provisions of contractor policies that are based on things other than the reasonable and necessary provision of section 1862(a)(1)(A) of the Act, such as benefit category determinations, statutory exclusion determinations, and HCPCS/Revenue Code coding determinations, would not be subject to review under this part. In addition, any M+C or other managed care plan policy, rule, or procedure is not subject to review under this process. Individual claim determinations by adjudicators are also not subject to review under this process.

In § 426.330, we state that the aggrieved party filing the complaint bears the burden of proof and the burden of persuasion for the issue or issues raised in the complaint. The burden of persuasion will be judged by a preponderance of the evidence.

Section 426.340 provides procedures to be followed after discovery and the taking of evidence are complete. If an aggrieved party has submitted new evidence pertaining to an LCD or NCD which the ALJ or the Board finds admissible, the ALJ/Board must review the new evidence and decide if the new evidence has the potential to significantly affect the evaluation of the LCD/NCD provision(s) in question under the reasonableness standard. If the ALJ or the Board determines that the new evidence does not have the potential to significantly affect the ALJ's or the Board's evaluation of LCD/NCD provisions, the review shall go forward to a decision on the merits. If the ALJ or the Board decides that the new evidence has the potential to significantly affect the evaluation of the policy, the ALJ or the Board must stay the proceedings and send the new evidence to the contractor or CMS. The contractor or CMS has 10 days upon receiving the evidence from the ALJ or the Board to provide a statement indicating whether a revision/reconsideration will be initiated. If the contractor or CMS informs the ALJ or the Board that a revision/reconsideration has been or will be initiated, then the stay shall continue and the ALJ or the Board shall set appropriate timeframes (not more than 90 days) by which the revision/reconsideration will be completed. If the contractor or CMS chooses not to initiate a revision/reconsideration and does not retire/withdraw the LCD/NCD, the ALJ or the Board proceedings will continue on the original LCD/NCD.

E. Subpart D (The Review of an LCD) and Subpart E (The Review of an NCD)

In subparts D and E, we set forth the procedures for the review of LCDs and NCDs, respectively. The process for LCD and NCD reviews is largely the same with the exception of the following:

- LCDs are based on section 1862(a)(1)(A) of the Act; NCDs may also be based on other statutory provisions.
- LCD reviews are conducted by an ALJ; NCD reviews are conducted by the Board.
- ALJs and contractors participate in an LCD review; there is no role for ALJs or contractors in an NCD review.
- We are not always a party to an LCD review, but are always a party to an NCD review.
- Amicus participation is not allowed when reviewing an LCD, but may be allowed when reviewing an NCD.
- Board decisions regarding NCDs will be made available on the Medicare Internet site, without beneficiary-identifying information.

For the purpose of this preamble, we consolidate the discussion of the requirements and policy decisions when possible. Sections 426.400 and 426.500 contain the requirements for filing an acceptable complaint regarding a provision or provisions of an LCD and an NCD, respectively. In both cases, a complaint must be in writing and must be from an aggrieved party. In § 426.400(a), we require that complaints regarding LCDs be submitted to the office designated by CMS on the Medicare Web site, *http://www.medicare.gov/coverage/static/appeals.asp* (information on the designated office will be available by calling 1–800–Medicare) or by filing a complaint concerning an NCD with the Board of HHS (*see* § 426.500(a)). Should the appropriate office change in the future, this regulation shall be read to conform to that change, and the information will be made publicly available. We have simplified and clarified the complaint-filing procedures.

In § 426.400(b) and § 426.500(b), we explain the circumstances under which a complaint will be considered timely received. A complaint will not be considered timely unless it is received by the office designated by CMS/Board of HHS within—(1) 6 months of the written statement from each aggrieved party's treating physician for aggrieved parties who choose to file an LCD/NCD challenge before receiving the service; or (2) 120 days of the initial denial notice for aggrieved parties who choose to file an LCD/NCD challenge after receiving the service.

In § 426.400(c)(1) and § 426.500(c)(1), we require a valid complaint to contain beneficiary-identifying information and a written statement from the treating physician indicating that the beneficiary needs the service that is the subject of the LCD/NCD. We also require the information in § 426.400(c)(2) and (c)(3) and § 426.500(c)(2) and (c)(3), which is necessary to identify the LCD or NCD (or the specific provision or provisions of the LCD or NCD) that is (are) adversely affecting the aggrieved party. In addition, we require a statement from the aggrieved party that explains the rationale for the complaint.

In § 426.400(c)(4) and § 426.500(c)(4), we also allow the aggrieved party to submit copies of material clinical or scientific evidence that supports the complaint. We require that any proprietary data submitted be marked as "proprietary data" and include the legal basis for so identifying it. In addition, in § 426.400(c)(4) and § 426.500(c)(4), we require that, in order to be considered and given weight in LCD or NCD reviews, any such proprietary data submitted by a manufacturer of a drug or device must include an affidavit that the data consists of true and correct copies of all data submitted by the manufacturer to the Food and Drug Administration in relation to that drug or device. In § 426.400(d), we state that two or more aggrieved parties may initiate the review of an LCD by filing a single written complaint with the ALJ if the conditions in § 426.400(d)(1)(i) and (ii) are met. Similarly, in § 426.500(d), we state that two or more aggrieved parties may initiate the review of an NCD by filing a single complaint with the Board if the conditions in § 426.500(d)(1)(i) and (ii) are met.

Based on public comments, we have added § 426.403 and § 426.503 to allow the aggrieved party to submit new evidence without withdrawing the complaint.

Section 426.405 specifies the authority of the ALJ during an LCD review, including authority during a hearing, if applicable. Similarly, in § 426.505, we set forth the specific authority of the Board during an NCD review, if applicable.

Sections 426.406 and 426.506 prohibit *ex parte* contacts so that no party or person (except employees or consultants of the ALJ/Board's office) may communicate in any way with the ALJ/Board on any substantive matter at issue in a case, unless on notice and opportunity for all parties to participate. This provision does not prohibit a person or party from inquiring about the status of a case or asking routine questions concerning administrative functions or procedures.

In § 426.410, we establish the ALJ's role in docketing and evaluating the acceptability of LCD complaints. These procedures are very similar to the Board's role in docketing and evaluating the acceptability of NCD complaints in § 426.510. Under the procedures, the adjudicatory body receives and dockets the complaint, evaluates the acceptability of the complaint, and resolves any consolidation issues. The appeal will be docketed under the name of the LCD or NCD rather than the aggrieved party or parties to protect the privacy of the party/parties.

In § 426.410 and § 426.510, we establish the criteria that a complaint must meet to be considered as an acceptable complaint by an ALJ or the Board. An aggrieved party must file the complaint; the complaint must meet all of the requirements of a valid complaint regarding an LCD in § 426.400, or regarding an NCD in § 426.500, and may only challenge a policy that meets the definition of an LCD or an NCD.

If a complaint is deemed to be unacceptable after being evaluated under § 426.410(b) or § 426.510(b), the applicable adjudicator will provide the aggrieved party (or parties) one opportunity to amend the unacceptable complaint within a timeframe set forth by the adjudicator (*see* § 426.410(c) and § 426.510(c)). If the aggrieved party (or parties) does not submit an acceptable amended complaint within this timeframe, the adjudicator will issue a decision dismissing the unacceptable complaint. The aggrieved party will be precluded from filing another complaint on the same issue for 6 months.

If, after having been evaluated under § 426.410(b) or § 426.510(b), a complaint is accepted, the adjudicator will send a letter to the aggrieved party (or parties) acknowledging the complaint and informing them of the docket number (*see* § 426.410(d)). The adjudicator will also forward a copy of the complaint and the acknowledgement letter to the applicable contractor and to us, and request that we or the contractor send a copy of the LCD record to the ALJ and all parties to the LCD review. The corresponding section in § 426.510(d) will require the adjudicator to follow the same process for NCDs, with the exception that the Board will make available to the public information concerning the complaint on its Web site (*see* § 426.510(f)) and specify a time period for affected parties to request amicus participation.

In § 426.410(e) and § 426.510(e), we allow for adjudicators to consolidate complaints regarding LCDs and NCDs, respectively. Under this provision, several complaints may be consolidated into one review if the complaints are appropriately similar. The review processes are not changed by a decision to consolidate complaints into one review.

In § 426.510(f) and § 426.513, we describe the opportunity and extent to which interested parties may participate in the NCD review process as amicus curiae.

In § 426.415, we explain that we may provide information to the ALJ, and all parties to the LCD review, identifying the person who would represent the contractor or CMS in the LCD review process. We can determine whether the contractor or CMS will participate in the review. Under the corresponding section in § 426.515, we provide a copy of the NCD record (as described in § 426.518) to the Board and all parties to the NCD review within 30 days of receiving the Board's order.

In § 426.416 and § 426.516, we describe the role of Medicare managed care organizations and Medicaid State agencies in the LCD and NCD review process. In § 426.417 and § 426.517, we describe the role of contractors and CMS in reviewing any new evidence.

Sections 426.418 and 426.518 describe, respectively, the elements of a contractor's LCD record and our NCD record, furnished to the aggrieved party. Sections 426.419 and 426.519 describe, respectively, the elements of a contractor's LCD record and our NCD record furnished to the ALJ or Board. These sections have been added in response to comments, and to facilitate the review process when privileged or proprietary data is submitted. Generally, an LCD or NCD record is composed of documents and materials that the contractor or we considered during the development of the LCD or NCD. Any MCAC transcripts would also be considered part of an NCD record. In the cases where comments are submitted, a "comment and response" summary document is sufficient for inclusion in the LCD record. In § 426.418(b) and § 426.518(b), we do not include privileged information or proprietary data, or any new evidence, as part of the record furnished to the aggrieved party. In § 426.419 and § 426.519, we state that official records presented to the Board may contain proprietary data or privileged information, if the information was considered in reaching the LCD or NCD under review. In these instances, the proprietary data and privileged information is filed under seal and is protected from inappropriate disclosure according to all applicable statutes and regulations, or common law privileges.

In § 426.420(a) and (b), we allow a contractor to retire the LCD under review or revise the LCD to remove or amend the provision in question before the date the ALJ issues a decision regarding the LCD. Retiring an LCD (or provision of the LCD) means that the contractor may no longer use that LCD in the adjudication of claims on a prospective basis. We also provide the aggrieved party individual claim review under § 426.460(b). Thus, in most cases, there would no longer be a need for an LCD review because relief would be provided. In § 426.520(a), we may withdraw an NCD under review or revise an NCD to remove or amend the provision in question before the date the Board issues a decision regarding that NCD. Withdrawing an NCD (or provision of the NCD) means this policy is no longer a controlling authority for our contractors and certain adjudicators. Thus, there no longer would be a need for an NCD review. In § 426.420(b), § 426.420(c), § 426.420(d), § 426.420(e) and § 426.520(b), § 426.520(c), § 426.520(d), § 426.520(e), we describe the process for LCDs and NCDs that are revised or reconsidered while under review. In cases where an LCD/NCD provision(s) has been revised, but not completely removed, the review continues because relief may not have been provided. This responds to comments received, and will ensure that aggrieved parties receive coverage relief when they prevail.

Under § 426.423 and § 426.523, we are permitting aggrieved parties who filed the complaint to withdraw complaints regarding LCDs and NCDs, respectively. We allow an aggrieved party to withdraw a complaint before the applicable adjudicator issues a decision regarding the complaint by simply sending a written notice to the ALJ, to the applicable contractor, and to us (if applicable) for LCDs, or to the Board and to us for NCDs (*see* § 426.423(b) and § 426.523(b)). Under this process, the adjudicator issues a decision (discussed later in this section of the preamble) dismissing the complaint, and the aggrieved party may not file another complaint to the same coverage determination for 6 months.

In the case of a joint complaint, one or more aggrieved parties may withdraw from the review without affecting the status of any remaining aggrieved party or parties named in the complaint. The adjudicator would issue a decision dismissing the complaint for the aggrieved party or parties who wish to withdraw, and the review would continue until the adjudicator issued a decision on the merits, or until each aggrieved party withdrew its complaint. Similarly, if the adjudicator had decided to hold a consolidated review, an aggrieved party or parties who are part of the consolidated review may withdraw without affecting the status of the other aggrieved party or parties who are part of the consolidated review (*See* § 426.423(c) and § 426.523(c)).

Sections 426.425(a) and 426.525(a) contain the processes for LCD and NCD reviews, respectively, that take place once the record has been filed. Section 522 of the BIPA added sections 1869(f)(1)(A)(iii) and 1869(f)(2)(A)(i) of the Act, which specify that the adjudicators of NCD and LCD reviews, respectively, "* * * shall review the record and shall permit discovery and the taking of evidence to evaluate the reasonableness of the determination, if the [adjudicator] determines that the record is incomplete or lacks adequate information to support the validity of the determination." Therefore, we allow the aggrieved party who submitted the complaint to file a statement alleging that the LCD record (or the NCD record

in the case of an NCD review) is not complete, or not adequate to support the validity of the coverage determination, under the reasonableness standard. This statement will be filed after the aggrieved party has had adequate time to review the record (30 days after receipt of the record, with a possible extension for good cause shown). The statement will be submitted to the adjudicator, to the contractor (if an LCD review), and to us (if applicable). In § 426.425(b) and § 426.525(b), we explain that the contractor/CMS has 30 days to respond.

In § 426.425(c) and § 426.525(c), we explain that, after the time for filing has expired, the ALJ or the Board will evaluate whether the record is complete and adequate to support the validity of the policy by applying the reasonableness standard. If the adjudicator determines that the record is not complete, not adequate to support the validity of the coverage determination, or both, the adjudicator will notify all parties to the review of this decision and allow discovery (as proposed in § 426.432 and § 426.532 and discussed later in this section of the preamble). If the adjudicator determines that the record is complete and adequate to support the validity of the coverage determination, the adjudicator will issue a decision finding the LCD/NCD record complete and adequate to support the validity of the LCD/NCD and the review process ends. In § 426.425(d) and § 426.525(d), we state that the process described in (a), (b), and (c) applies whenever an LCD/NCD record is supplemented.

Under § 426.431 and § 426.531, we describe the process that adjudicators will use to review the provision(s) named in a complaint based on the reasonableness standard. The actions of this process include the following:

- Confining the LCD/NCD review to the provision(s) of the LCD/NCD raised in the aggrieved party's complaint;
- Conducting a hearing, unless the matter can be decided on the written record;
- Closing the LCD/NCD review record to the taking of evidence;
- Issuing a decision as described in § 426.447 and § 426.547. We further state that ALJs may consider previous ALJ decisions regarding the LCD provisions with the same issues and facts and the same clinical conditions. We also provide that ALJs must treat as precedential any previous Board decision that involves the same LCD provision(s), same specific issues and facts in question, and same clinical conditions. We also provide that the Board will follow applicable Board precedent regarding the same NCD provisions and the same clinical conditions.

In addition, the adjudicator has the option, under § 426.431(b) and 426.531(b), to consult with appropriate scientific or clinical experts, and to consider previous ALJ decisions (discussed in the section of the preamble on § 426.440 and § 426.540).

In § 426.431(c) and § 426.531(c), we explain that ALJs and the Board must follow all applicable laws and regulations, and NCDs, with the exception that the Board is not bound by the NCD that is before it.

Under § 426.432 and § 426.532, paragraph (a), if the ALJ or the Board orders discovery, the ALJ or the Board will establish a reasonable timeframe for discovery and ensure that a party to the LCD or NCD review who receives a discovery request has certain rights. In paragraph (b), we state that any party receiving a discovery request may file a motion for a protective order before the date of production of the discovery.

Under § 426.432 and § 426.532, we also set forth the rules for discovery during an LCD or NCD review, respectively.

We have eliminated proposed § 426.432(a)(3) and § 426.532(a)(3) because we do not expect any non-parties to be required to submit evidence in these proceedings.

In § 426.432(c) and § 426.532(c), we list the types of discovery that are available. In § 426.432(d) and § 426.532(d), we explain what the term discovery includes and state that discovery does not require the creation of any document. In § 426.432(e) and § 426.532(e), we identify forms of discovery that are not available. We believe that this is consistent with normal practice and will avoid unnecessary delays in the coverage determination reviews.

For proprietary data or privileged information, § 426.432(f) and § 426.532(f), we have clarified that the ALJ/Board may not, under any circumstances, disclose this material to the public without consent from the party who possesses the right to protection of the information.

In § 426.432(g) and § 426.532(g), we state that the ALJ/Board will notify all parties in writing of the date when the discovery period will close.

While reviewing a provision of an LCD or NCD, the adjudicator may, if necessary, issue subpoenas. In § 426.435 and § 426.535, we describe the process for obtaining and responding to subpoenas during a coverage determination review. A request for a subpoena to require the attendance of an individual at a hearing (or provide evidence at a hearing) must be filed with the adjudicator by a party to the coverage determination review at least 30 days before the date of a hearing. In addition to designating the witnesses (and their locations) and the evidence to be produced by those witnesses, the subpoena must state the facts that the party expects the witness to establish, and state whether these facts could be established by other evidence or without the use of a subpoena.

The subpoena sections also detail the role of adjudicators in granting subpoenas, the role of a party in serving a subpoena, and the role and rights of the individual receiving a subpoena (including the right to file a motion to quash a subpoena). In addition, in § 426.435(h) and § 426.535(h), we also set forth the remedy afforded under section 205(e) of the Act, if a subpoena is not obeyed.

We describe the rules relating to evidence in coverage determination reviews in § 426.440 and § 426.540. In § 426.440(a) and § 426.540(a), we state the ALJ or the Board is not bound by the Federal Rules of Evidence, but may apply the rules, if appropriate. In § 426.440(b) and § 426.540(b), we provide that the ALJ or the Board must exclude evidence that is clearly irrelevant, immaterial, or unduly repetitive. Sections 426.440(c) and § 426.540(c) provide admission of, and protection for the submission of proprietary/privileged information under seal. Sections 426.440(d) and § 426.540(d) address the authority of the ALJ/Board over the use of expert witnesses. Under § 426.440(e) and § 426.540(e), we require experts submitting reports to be available for cross-examination at an evidentiary hearing. Under § 426.440(f) and § 426.540(f), we require that, unless otherwise ordered by the adjudicator for good cause shown, all documents and other evidence be open to examination by all parties to the review, except as set forth in § 426.440(c) and § 426.540(c).

Under § 426.444 and § 426.544, we describe an adjudicator's dismissal for cause of a complaint regarding an LCD or an NCD, respectively. A dismissal is effectuated by the issuance of a decision dismissing a complaint. In general, an adjudicator may dismiss a complaint if an aggrieved party fails to attend or participate in a pre-hearing conference (the pre-hearing may be conducted by telephone) or hearing without good cause shown or fails to comply with a lawful order from an adjudicator (*see* § 426.444(a) and § 426.544(a)). Under § 426.444(b) and § 426.544(b), we require that the adjudicator dismiss

complaints that fail to meet the requirements for acceptable complaints, including complaints regarding inapplicable policies or determinations. We also require the adjudicator to dismiss a complaint if the aggrieved party withdraws the complaint, or if the complaint seeks review of a matter beyond the adjudicator's authority.

Under § 426.444(b)(6), we also require an ALJ to dismiss a complaint if the applicable contractor notifies the ALJ that the LCD is being retired or revised to remove the provision in question. Similarly, in § 426.544(b)(6), the complaint must be dismissed when we notify the Board that the NCD (or provision of the NCD) is no longer in effect.

In § 426.445 and § 426.545, we require that witness fees, for appearances during a hearing, be paid by the party seeking to present the witness.

Under § 426.446 and § 426.546, we require that an ALJ and the Board, respectively, ensure that any hearing conducted regarding a LCD or NCD review is open to the public and electronically, mechanically, or stenographically recorded. These sections require that, except for privileged information and proprietary data, all evidence upon which the adjudicator relies for a decision be contained in the public record, and that any pertinent document or record be incorporated into the record of the LCD/NCD hearing.

Under § 426.447 and § 426.547, we set forth the procedures for the issuance and notification of ALJ and Board decisions, respectively. Within 90 days from closing the review record to the taking of evidence, the applicable adjudicator is required either to issue a decision, including a description of appeal rights, or to provide notice that the decision is pending, and an approximate date a decision will be issued. In § 426.547(b), we explain that Board decisions regarding NCDs will be available on the Medicare Web site of the Department of Health and Human Services and that steps will be taken to ensure the privacy of the parties to the review.

Under § 426.450, we describe the required elements of an ALJ's decision regarding an LCD. In § 426.550, we describe the required elements of the Board's decision regarding an NCD. Since Board decisions will be published, identifying information about beneficiaries may be placed in an accompanying cover letter giving notice of the decision. This cover letter, however, will not be published, in order to preserve beneficiaries' privacy. As discussed earlier in this section of the preamble, a decision may include the dismissal of a complaint or a finding that the LCD/NCD record is complete and adequate to support the validity of the LCD/NCD under the reasonableness standard. If the ALJ/Board decision neither dismisses the complaint nor finds that record complete and adequate, the decision must contain a statement pertaining to each provision listed in the complaint and state whether the provision is valid or invalid under the reasonableness standard. We also require that the decision include the information in § 426.450(b) and § 426.550(b), which include LCD review or NCD review identifying information, claim information (if known), the basis for the decision (including findings of fact, interpretations of laws, and application of facts to the law), a summary of the evidence reviewed during the review, and a statement about appeal rights. We provide that the materiality of any proprietary data or privileged information in the validity determination should be discussed in the decision without disclosing the substance or contents of the sealed evidence. In addition, a separate statement prepared and maintained under seal will explain the rationale for the treatment of the proprietary data or privileged information, including any necessary discussion of the data themselves. This statement will accompany the proprietary data or privileged information under seal if the decision is appealed to the next level of review.

In § 426.455 and § 426.555, we require that an ALJ or the Board decision be prohibited from doing any of the following:

- Ordering us or our contractors to add any language to an LCD or NCD or to pay a specific claim.
- Establishing a time limit for the creation of a new or revised LCD or NCD.
- Reviewing or evaluating an LCD or NCD other than the LCD or NCD under review.
- Including a requirement for us or our contractors that specifies payment, coding, or systems changes for an LCD or NCD, or deadlines for implementing these changes.
- Ordering or addressing how we or our contractors should implement an LCD or NCD.

As a result of comments we received on our proposed rule, we revised the requirements concerning ALJ or the Board decisions to allow such a decision to direct us or our contractors to delete language from a provision of an LCD or NCD, when the adjudicator finds provision(s) unreasonable with respect to the aggrieved party's clinical indications, and for same or similar conditions. While we have revised the rule accordingly, we continue to believe that ALJs or the Board should be prohibited from ordering us or our contractors to add language to a LCD or NCD provision and have maintained the prohibition in this final rule. The ALJ/Board decision requiring a contractor or CMS to strike an LCD/NCD provision may be written narrowly. In one example, an aggrieved party with condition X challenges an LCD stating that a particular service is covered for conditions Y and Z and contains the following sentence: "This procedure is considered not reasonable or necessary for all other conditions." The ALJ may find that this sentence is invalid for condition X. The contractor would have several options for effectuating this decision. First, the contractor could remove the sentence altogether leaving coverage of all conditions other than Y and Z to individual consideration. Second, the contractor could add condition X to the list of covered conditions. Third, the contractor could revise the LCD to state that the service is covered for conditions Y and Z, individual consideration will determine coverage for condition X, and that the service is not covered for all other conditions.

In § 426.457 and § 426.557, we explain that ALJ or the Board decisions may be written narrowly to hold specific provision(s) invalid as applied to specific clinical indications and for similar conditions.

In § 426.458, we describe the ALJ's review record furnished to the public, and to the Board, and specify that proprietary data or privileged information must be under seal.

In § 426.460 and § 426.560, we describe the effect of ALJ or the Board decisions issued under § 426.447 and § 426.547. Although an ALJ or the Board will now be allowed to order us or our contractors to strike down a LCD or NCD provision, we continue to believe that the exact wording of a new coverage determination should be made by the contractor or by us. These policies affect other beneficiaries and, thus, these determinations must be made by clinicians and scientific experts who have the necessary specialized training. Thus, we and the contractor will remain the entities responsible for ensuring that the clinical and scientific policies are sound, in order to ensure the best quality of care for beneficiaries.

The effect of an ALJ or Board decision will depend on the outcome of the coverage determination review. If the

adjudicator finds that the provision(s) named in the complaint was (were) valid under the reasonableness standard, the aggrieved party or parties (in the case of an LCD review) could appeal that decision to the Board or (in the case of NCD review) may challenge the final Departmental action in Federal court.

If the adjudicator found that the provision(s) listed in the complaint was (were) invalid under the reasonableness standard and the contractor or we do not appeal this decision to the Board in a timely manner, the contractor must or we will do several things. First, there would be individual claim review for the aggrieved party or parties named in the complaint(s).

- If the aggrieved party received a (fee-for-service or managed care) service that was the subject of the challenged coverage determination, then the contractor (if applicable) or Medicare managed care organization will not use the provision(s) of the coverage determination that was (were) found invalid in the adjudication of that claim.
- If the aggrieved party has not received the service, the individual may obtain the service and file a claim, which could be reviewed by the contractor, without using the provision that has been found invalid.

Neither the first level appeal reviewer nor the hearing officer is bound by the invalid provision. Specifically, we will instruct the contractor to make a claim determination without using the LCD or NCD provision(s) that has been found invalid in each of the following situations: (1) The claim has not been adjudicated or; (2) the claim was denied. It is important to note that individual claim review can only be provided to an aggrieved party if his or her individual claim or appeal has not been paid during the individual claims adjudication process. Furthermore, the contractor/CMS will not use the invalid provision as guidance to deny claims.

Second, there would be coverage policy relief. Within 30 days of the issuance of an ALJ or the Board decision, the contractor or CMS must either retire/withdraw the LCD/NCD or revise the LCD/NCD to remove the provisions found to be invalid by the ALJ or the Board. The effective date of the retirement/withdrawal or revision must be for dates of service no later than the 30th day following issuance of the ALJ or Board decision. As discussed earlier, the retirement of a coverage determination or removal of a provision of a coverage determination means that it can no longer be used in the adjudication of claims with dates of service after the effective date of the ALJ/Board decision.

Under § 426.462 and § 426.562, "Notice of an ALJ's decision," and "Notice of the Board's decision," we require that, after the ALJ or the Board, respectively, has made a decision regarding an LCD or NCD complaint, the ALJ or the Board send a written notice of the decision to each party. The notice must state the outcome of the review and inform each party to the determination of his or her rights to seek further review if he or she is dissatisfied with the determination, and the time limit under which an appeal must be requested.

Under § 426.463 and § 426.563, "Future New/Revised LCDs/NCDs," we state that the contractor and CMS may not reinstitute an LCD/NCD provision found to be unreasonable by an ALJ/Board unless the contractor/CMS has a different basis (such as additional evidence). However, nothing in this regulation shall be construed to prevent contractors or CMS from developing new or revised/reconsidered LCD/NCD provisions, as long as these provisions are developed using a different basis and evidence.

In the remainder of the sections proposed in subpart D, we set forth the procedure for appealing an ALJ's decision regarding an LCD review. In § 426.465(a), we state that an aggrieved party may appeal part or all of an ALJ's decision that states that a provision of the LCD listed in the complaint is valid under the reasonableness standard or that dismisses a complaint (with certain exceptions). We also allow an aggrieved party who was part of a joint complaint or a consolidated LCD review to appeal an ALJ's decision either independently or as a group.

In § 426.465(b), we state that a contractor or CMS may appeal to the Board an ALJ decision that an LCD was unreasonable. Because we allow Board consolidation of similar appeals, we believe that it is not necessary to prohibit aggrieved parties from appealing to higher levels if one or more parties to a joint complaint withdraw from that complaint.

In § 426.465(c), we require that the implementation of the ALJ decision will be stayed pending review by the Board.

In § 426.465(d), we establish that we do not allow an aggrieved party to appeal a dismissal in certain circumstances, namely, if the aggrieved party who filed the complaint withdraws the complaint, or because the contractor retired the LCD or revised the LCD to remove the provision in question.

Under § 426.465(e), we require that an appeal would have to be submitted to the Board within 30 days of the date the ALJ's decision was issued. We believe this is a reasonable timeframe to allow a party to make a decision on whether to appeal and to prepare the necessary documents, but we permit the Board to consider a late appeal if good cause is shown by the party.

Section 426.465(f) lists the necessary components of an appeal to identify the relevant parties and issues.

In § 426.565, "Board's role in making an LCD or NCD review record available," we require that upon a request from a Federal Court, the Board must provide to the Federal Court, a copy of the Board's LCD or NCD review record (as described in § 426.567).

In § 426.566, we state that a Board decision is subject to judicial review.

In § 426.468, we explain that an aggrieved party who initiates an LCD review, but does not appeal any part or parts of an ALJ's decision to the Board in a timely manner, waives his or her right to any further review of that part or those parts.

In § 426.470, we state that the Board's role in docketing and evaluating the acceptability of appeals of ALJ decisions is similar to the process that an ALJ would use in docketing and evaluating the acceptability of a complaint. The Board assigns a number to the appeal and determines if it meets all of the requirements of an acceptable appeal proposed in § 426.465. Unlike the evaluation of an initial complaint, however, we require, in § 426.470(c), that the Board issue a decision dismissing an unacceptable appeal, instead of allowing an opportunity to amend an unacceptable appeal.

Upon the request from the Board to provide copies of the LCD review record under § 426.470, we require that an ALJ send a copy of the LCD review record to the Board.

Once the Board has accepted an appeal to an ALJ's decision and received the ALJ's LCD review record, we describe in § 426.476 the steps that the Board will take in reviewing the ALJ's decision. In addition to reviewing the ALJ's LCD review record and the ALJ's decision, the Board must allow the contractor or, if applicable, allow us, to submit a statement to the Board and the aggrieved party responding to the appeal. The final required step in the Board review of an ALJ's decision is to issue a Board decision. We require that the Board must evaluate the ALJ's application of the reasonableness standard to determine if the ALJ's decision was erroneous.

We believe that the Board review of an appeal of an ALJ's decision should remain a paper review of existing materials. Accordingly, we establish, in § 426.476(b), that the Board will determine whether the ALJ decision contains any material error, and prohibit the Board from considering any evidence that is not a part of the ALJ's LCD review record. We establish that the Board will remand the case for discovery and the taking of evidence if the ALJ erroneously determined that the contractor's record was complete, or if the ALJ permitted a prejudicial procedural error. In § 426.476(c), we establish the Board's scope of review and that the Board is bound by applicable laws, regulations, and NCDs when reviewing appeals of ALJ decisions. These include the applicable provisions of the Act, our regulations and rulings, and NCDs.

In § 426.476(d), we require the Board to dismiss an appeal of an ALJ's decision if the contractor retired the LCD or revised the LCD to remove the provision(s) in question during the appeal.

In § 426.478, we allow the contractor to retire an LCD or revise the LCD to remove the provision(s) in question during the Board's review of the ALJ's decision. As stated in the previous paragraph, this would lead to the Board dismissing the appeal.

In § 426.480, we allow a party to withdraw an appeal of an ALJ's decision. The provisions proposed in this section, for a party acting alone or as part of a joint or consolidated appeal, would be the same as the provisions for withdrawing a complaint in § 426.423.

In § 426.482, we require the issuance and notification of a Board decision regarding an appealed ALJ decision. These provisions are the same as the provisions we described for the issuance and notification of an ALJ decision.

In § 426.484, we set forth the mandatory provisions of a Board decision regarding an appealed ALJ decision. We require the Board to either dismiss the appeal or, for each part of the ALJ's decision named in the appeal, to uphold, modify or reverse that part or all of the ALJ's decision. Because the Board is conducting a review of the ALJ's decision using the ALJ's LCD review record, and is not conducting a *de novo* review of the LCD itself, a Board decision upholding, modifying or reversing each part, or all of the ALJ's decision is the proper outcome. The Board's decision must include the information necessary to identify the appeal, and the rationale for the Board's decision.

In § 426.486, we prohibit the Board's decision from including those provisions that we exclude from the ALJ's decision, for the reasons discussed earlier in this preamble. In § 426.487, "Board's Record on Appeal of an ALJ Decision," we state in paragraph (a) that except as provided in paragraph (b) of this section, the Board's LCD review record furnished to the public consists of any document or material that the Board compiled or considered during an LCD review.

Paragraph (b) states that the LCD review record furnished to the Court under appeal includes, under seal, material that is privileged or proprietary.

Paragraph (c) states that in any instance where proprietary data or privileged information is contained in the LCD record and the information goes to court, CMS or the Department will seek to have a protective order issued for that information, as appropriate.

In § 426.587, "Record for Appeal of a Board/NCD decision," we set forth in paragraph (a) that, except as provided in paragraph (b) of this section, the Board's NCD review record furnished to the court consists of any document or material that the Board compiled or considered during an NCD review. CMS or the Department may seek to have a protective order issued with respect to proprietary data or privileged information.

We describe in paragraph (b) that the NCD review record furnished the court maintain the seal on material that is privileged or proprietary. CMS or the Department may seek to have a protective order issued with respect to those documents.

In § 426.488, we set forth the effect of a Board decision. Section 426.488(a) explains the relief that is provided to a successful challenger. Moreover, there may be coverage relief for the aggrieved party. We also describe the effect of the Board reversing an ALJ decision.

We permit the Board to remand cases to the ALJ in a limited number of circumstances. In § 426.489(a), we explain the process the Board must follow to remand a case to the ALJ. In § 426.489(b), we explain required action by an ALJ upon a Board remand. In § 426.490, a decision by the Board would constitute a final Agency action and would be subject to judicial review. Neither the contractor nor we may appeal a Board decision.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 30-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 required 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 have solicited public comment on each of these issues for the following sections of this document that contain information collection requirements:

Sections 426.400 and 426.500

Sections 426.400, Procedure for filing an acceptable complaint to a provision (or provisions) of an LCD, and 426.500, Procedure for filing an acceptable complaint to a provision or provisions of an NCD, state that an aggrieved party may initiate a review of an LCD or NCD, respectively, by filing a written complaint. These sections also identify the information required in the complaint to qualify as an aggrieved party as defined in § 426.110, as well as the process and information needed for an aggrieved party to withdraw a complaint. The required documentation includes a copy of the written authorization to represent the beneficiary, if the beneficiary has a representative, and a copy of a written statement from the treating physician that the beneficiary needs a service that is the subject of the LCD.

Based on the lack of public comments, we continue to estimate that there will be 1,000 LCD complaints per year and that it will take the aggrieved party 4 hours to draft the complaint and gather the information to send to us. The national burden would be 4,000 hours annually. We estimate that there will be 15 to 20 NCD complaints per year. It will take 4 hours, maximum, to gather the information and to write each complaint. Thus, we estimate a total of 80 hours per year to comply with the requirement.

The estimate of 4 hours is based on previous experience in both the local and national coverage development processes, and the estimated time to submit beneficiary and policy-specific information (for example, name,

address, and policy challenged) and collect and photocopy scientific and clinical evidence. It should actually take less than that amount of time in NCD challenges, since the aggrieved party has already sent us the information and merely has to send it again.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Regulations Development and Issuances Group, Attn.: Dawn Willinghan, Attn: CMS–3063–F, Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Brenda Aguilar, CMS Desk Officer.

VI. Regulatory Impact Statement

A. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), as amended by Executive Order 13258, and the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), as amended. 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 annually). Based on provider, beneficiary, and Agency costs, our analysis indicates that the costs involved with the implementation of this rule will not exceed $100 million annually. Therefore, this rule is not considered a major rule.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $5 million or less annually. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. 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.

For these reasons, we are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined that this rule would not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditures in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. We do not believe that this rule would have an effect on the governments mentioned, nor would the private sector costs associated with the rule be greater than $110 million.

B. Federalism

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. This final rule will not have a substantial effect on State or local governments.

C. Anticipated Effects

1. Effects on Medicare Beneficiaries

In developing this rule, we considered how to make it user-friendly for the individual beneficiaries who qualify as aggrieved parties to initiate the review of an LCD or an NCD. Possible access obstacles for some aggrieved parties include limited financial resources, limited mobility, various disabilities, absence of legal representation, and difficulty in compiling and presenting scientific and clinical materials. We have sought to include means to alleviate these obstacles as much as possible through this rule, but would also expect the ALJs and the Board to use the flexibility in this rule to respond to obstacles that may confront individual aggrieved parties in particular cases.

Some concerns may remain about how to facilitate participation, especially when evidence is taken in person, by aggrieved parties with limited mobility or resources. This final rule seeks to address this by providing for most evidence to be submitted in written form and by allowing use of a variety of electronic means for remote attendance at any oral proceeding, if one is needed. In addition, the rule provides flexibility for ALJs and the Board to tailor proceedings in each case to best reflect the needs of the parties, the appropriate scope of participation, and the nature of the issues presented.

While we require some documentation to support a complainant's assertions of being an aggrieved party (*see* § 426.400 and § 426.500), we will accept that documentation as sufficient to show standing to challenge an LCD or an NCD. By limiting this documentation, we seek to simplify the process for the beneficiary, to alleviate privacy concerns about confidential medical records and other patient-specific information, and to reduce any intrusive discovery burden on beneficiaries.

Our intent is to ensure that beneficiaries fully understand these rights. When this final rule is published, we expect to produce a user-friendly guide that beneficiaries may use to assist them in accessing this process.

We have also provided for appropriate measures to be taken to address confidentiality and privilege issues relating to privileged or confidential trade secrets, commercial information, or financial information.

2. Effects on Providers

We do not believe that the provisions of this rule will have a significant effect on providers, since the Congress developed the BIPA 522 process for beneficiaries. Providers may be requested, however, to supply documentation that an aggrieved party is in need of a specific service, and to assist in representing an aggrieved party. In addition, we have clarified in the final rule that this document may be in the form of an order or other existing language from the beneficiary's medical record and need not be newly created material. It is also possible for a provider to be subpoenaed under § 426.435 and § 426.535, but § 426.445 and § 426.545 will allow for compensation under this circumstance. While there may be time requirements placed on providers and expert witnesses in this respect, there will be no additional monetary expenses. As a

result, we believe that the rule will have an insignificant economic impact on health care providers or the health care industry as a whole.

3. Effects on the Medicare Program

The Medicare program would incur certain significant administrative costs associated with coverage determination reviews, the cost of being a party to coverage determination reviews, the cost of reevaluating policies, and the cost of changes to the claim review and appeals procedures.

D. Alternatives Considered

We considered various alternative approaches for implementing the ALJ or the Board decisions with respect to an LCD and NCD. One alternative we considered was to allow an ALJ or the Board to specify the type of relief that would be afforded to the aggrieved party in those instances in which an ALJ or the Board issued a finding of unreasonable under the reasonableness standard. We contemplated whether it would be feasible based on the record developed in this proceeding for an ALJ or the Board to order us to make payment for a particular claim for the individual. We determined, however, that because the record in a policy challenge adjudication focuses on the challenged policy, and not on the beneficiary's particular medical circumstances or entitlement to Medicare benefits, it is not possible to allow an ALJ or the Board to order payment in those circumstances. In some cases, other statutory restrictions may apply for a particular claim that would prevent Medicare from making payment even if the LCD or NCD were found unreasonable. For instance, if care were furnished by an excluded physician in other than an emergency situation, section 1862(e)(1) of the Act would bar Medicare payment. There are other examples where rules other than an NCD may lead to the denial of a claim (such as statutory exclusion). To avoid redundant claims/appeals processes, individual review is performed through our existing claims appeals procedures, but the LCD or NCD that was found unreasonable by the ALJ or the Board will not be applied.

Further, we do not believe that it is appropriate for an ALJ or the Board to add language to coverage determinations. LCDs and NCDs are based on clinical and scientific evidence to develop policies that are both sound and effective, and continue to ensure the highest quality of covered care for Medicare recipients. For the sake of continuing to ensure that aggrieved parties receive the same quality care as all other Medicare recipients, and for the sake of efficiently administering this process, we believe that clinicians and scientific experts are best suited to continue to develop these policies.

In accordance with the provisions of Executive Order 12866, as amended by Executive Order 13258, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 400

Grant programs-health, Health facilities, Health maintenance organizations (HMO), Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 426

Administrative practice and procedure, Medicare, Reporting and recordkeeping requirements.

■ For the reasons set forth in the preamble, Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as follows:

PART 400—INTRODUCTION; DEFINITIONS

■ 1. The authority citation for part 400 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh) and 44 U.S.C. Chapter 35.

■ 2. Amend § 400.202 by adding the definitions of "Departmental Appeals Board," and "Local coverage determination (LCD)," and by revising the definition of "National coverage determination (NCD)" to read as follows:

§ 400.202 Definitions specific to Medicare.

* * * * *

Departmental Appeals Board means: (1) Except as provided in paragraphs (2) and (3) of this definition, a Board established in the office of the Secretary, whose members act in panels to provide impartial review of disputed decisions made by operating components of the Department or by ALJs.

(2) For purposes of review of ALJ decisions under part 405, subparts G and H; part 417, subpart Q; part 422, subpart M; and part 478, subpart B of this chapter, the Medicare Appeals Council designated by the Board Chair.

(3) For purposes of part 426 of this chapter, a Member of the Board and, at the discretion of the Board Chair, any other Board staff appointed by the Board Chair to perform a review under that part.

* * * * *

Local coverage determination (LCD) means a decision by a fiscal intermediary or a carrier under Medicare Part A or Part B, as applicable, whether to cover a particular service on an intermediary-wide or carrier-wide basis in accordance with section 1862(a)(1)(A) of the Act. An LCD may provide that a service is not reasonable and necessary for certain diagnoses and/or for certain diagnosis codes. An LCD does not include a determination of which procedure code, if any, is assigned to a service or a determination with respect to the amount of payment to be made for the service.

* * * * *

National coverage determination (NCD) means a decision that CMS makes regarding whether to cover a particular service nationally under title XVIII of the Act. An NCD does not include a determination of what code, if any, is assigned to a service or a determination with respect to the amount of payment to be made for the service.

* * * * *

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

■ 3. The authority citation for part 405 continues to read as follows:

Authority: Secs. 1102, 1861, 1862(a), 1871, 1874, 1881, and 1888(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).

■ 4. Revise § 405.732 to read follows:

§ 405.732 Review of a national coverage determination (NCD).

(a) *General rule.* (1) An NCD is a determination by the Secretary for whether or not a particular item or service is covered nationally under title XVIII of the Act.

(2) An NCD does not include a determination of what code, if any, is assigned to a particular item or service covered under title XVIII or a determination for the amount of payment made for a particular item or service.

(3) NCDs are made under section 1862(a)(1) of the Act or other applicable provisions of the Act.

(4) An NCD is binding on all Medicare carriers, fiscal intermediaries, QIOs, HMOs, CMPs, HCPPs, the Medicare Appeals Council, and ALJs.

(b) *Review by ALJ.* (1) An ALJ may not disregard, set aside, or otherwise review an NCD.

(2) An ALJ may review the facts of a particular case to determine whether an NCD applies to a specific claim for benefits and, if so, whether the NCD has been applied correctly to the claim.

(c) *Review by Court.* For initial determinations and NCD challenges under section 1862(a)(1) of the Act, arising before October 1, 2002, a court's review of an NCD is limited to whether the record is incomplete or otherwise lacks adequate information to support the validity of the decision, unless the case has been remanded to the Secretary to supplement the record regarding the NCD. In these cases, the court may not invalidate an NCD except upon review of the supplemental record.

■ 5. Revise § 405.860 to read as follows:

§ 405.860 Review of a national coverage determination (NCD).

(a) *General rule.* (1) An NCD is a determination by the Secretary for whether or not a particular item or service is covered nationally under title XVIII of the Act.

(2) An NCD does not include a determination of what code, if any, is assigned to a particular item or service covered under title XVIII or a determination for the amount of payment made for a particular item or service.

(3) NCDs are made under section 1862(a)(1) of the Act or other applicable provisions of the Act.

(4) An NCD is binding on all Medicare carriers, fiscal intermediaries, QIOs, HMOs, CMPs, HCPPs, the Medicare Appeals Council, and ALJs.

(b) *Review by ALJ.* (1) An ALJ may not disregard, set aside, or otherwise review an NCD.

(2) An ALJ may review the facts of a particular case to determine whether an NCD applies to a specific claim for benefits and, if so, whether the NCD is applied correctly to the claim.

(c) *Review by Court.* For initial determinations and NCD challenges under section 1862(a)(1) of the Act, arising before October 1, 2002, a court's review of an NCD is limited to whether the record is incomplete or otherwise lacks adequate information to support the validity of the decision, unless the case is remanded to the Secretary to supplement the record regarding the NCD. In these cases, the court may not invalidate an NCD except upon review of the supplemental record.

■ 6. Add part 426 to subchapter B to read as follows:

PART 426—REVIEWS OF LOCAL AND NATIONAL COVERAGE DETERMINATIONS

Subpart A—General Provisions

Sec.

Subpart B—[Reserved]

Subpart C—General Provisions for the Review of LCDs and NCDs

Subpart D—Review of an LCD

Subpart E—Review of an NCD

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh)

Subpart A—General Provisions

§ 426.100 Basis and scope.

(a) *Basis.* This part implements sections 1869(f)(1) and (f)(2) of the Act, which provide for the review of LCDs, NCDs, and certain determinations that are deemed to be NCDs by statute.

(b) *Scope.* This subpart establishes the requirements and procedures for the review of LCDs and NCDs.

§ 426.110 Definitions.

For the purposes of this part, the following definitions apply:

Aggrieved party means a Medicare beneficiary, or the estate of a Medicare beneficiary, who—

(1) Is entitled to benefits under Part A, enrolled under Part B, or both (including an individual enrolled in fee-for-service Medicare, in a Medicare+Choice plan, or in another Medicare managed care plan);

(2) Is in need of coverage for a service that is denied based on an applicable LCD (in the relevant jurisdiction) or an NCD, regardless of whether the service was received; and

(3) Has obtained documentation of the need by the beneficiary's treating physician.

Board means the Departmental Appeals Board.

Clinical and scientific experts mean experts that are consulted by the ALJ or Board as independent and impartial individuals, with significant experience and/or published work, pertaining to the subject of the review.

Contractor means a carrier (including a Durable Medical Equipment Regional Carrier), or a fiscal intermediary (including a Regional Home Health Intermediary) that has jurisdiction for the LCD at issue.

Deemed NCD means a determination that the Secretary makes, in response to a request for an NCD under section 1869(f)(4)(B) and (C) of the Act, that no national coverage or noncoverage determination is appropriate, or the Secretary's failure to meet the deadline under section 1869(f)(4)(A)(iv) of the Act.

New evidence means clinical or scientific evidence that was not previously considered by the contractor or CMS before the LCD or NCD was issued.

Party means an aggrieved party, which is an individual, or estate who has a right to participate in the LCD or NCD review process, and, as appropriate, a contractor or CMS.

Proprietary data and *Privileged information* means information from a source external to CMS or a contractor, or protected health information, that meets the following criteria:

(1) It is ordinarily protected from disclosure in accordance with 45 CFR part 164, under the Trade Secrets Act (18 U.S.C. 1905) or under Exemptions 4 or 5 of the Freedom of Information Act (5 U.S.C. 552) as specified in 45 CFR 5.65.

(2) The party who possesses the right to protection of the information from public release or disclosure has not provided its consent to the public release or disclosure of the information. Any information submitted by the public that is not marked proprietary is not considered proprietary.

Reasonableness standard means the standard that an ALJ or the Board must apply when conducting an LCD or an NCD review. In determining whether LCDs or NCDs are valid, the adjudicator must uphold a challenged policy (or a provision or provisions of a challenged policy) if the findings of fact, interpretations of law, and applications of fact to law by the contractor or CMS are reasonable based on the LCD or NCD record and the relevant record developed before the ALJ or the Board.

Supplemental LCD/NCD record is a record that the contractor/CMS provides to the ALJ/Board and any aggrieved party and consists of all materials received and considered during a reconsideration. Materials that are already in the record before the ALJ/Board (for example, new evidence presented in the taking of evidence or hearing) need not be provided but may be incorporated by reference in the supplement to the LCD/NCD record. The contractor/CMS may provide statements, evidence, or other submissions to the ALJ/Board during the proceedings, as provided elsewhere in these regulations, but these submissions are not considered as supplementing the LCD/NCD record.

Treating physician means the physician who is the beneficiary's primary clinician with responsibility for overseeing the beneficiary's care and either approving or providing the service at issue in the challenge.

§ 426.120 Calculation of deadlines.

In counting days, Saturdays, Sundays, and Federal holidays are included. If a due date falls on a Saturday, Sunday, or Federal holiday, the due date is the next Federal working day.

§ 426.130 Party submissions.

Any party submitting material, except for material for which a privilege is asserted, or proprietary data, to the ALJ or the Board after that party's initial challenge must serve the material on all other parties at the same time.

Subpart B—[Reserved]

Subpart C—General Provisions for the Review of LCDs and NCDs

§ 426.300 Review of LCDs, NCDs, and deemed NCDs.

(a) Upon the receipt of an acceptable LCD complaint as described in § 426.400, an ALJ conducts a review of a challenged provision (or provisions) of an LCD using the reasonableness standard.

(b) Upon the receipt of an acceptable NCD complaint as described in § 426.500, the Board conducts an NCD review of a challenged provision (or provisions) of an NCD using the reasonableness standard.

(c) The procedures established in this part governing the review of NCDs also apply in cases in which a deemed NCD is challenged.

§ 426.310 LCD and NCD reviews and individual claim appeals.

(a) LCD and NCD reviews are distinct from the claims appeal processes set forth in part 405, subparts G and H; part 417, subpart Q; and part 422, subpart M of this chapter.

(b) An aggrieved party must notify the ALJ or the Board, as appropriate, regarding the submission and disposition of any pending claim or appeal relating to the subject of the aggrieved party's LCD or NCD complaint. This reporting obligation continues through the entire LCD or NCD review process.

§ 426.320 Who may challenge an LCD or NCD.

(a) Only an aggrieved party may initiate a review of an LCD or NCD (including a deemed NCD), or provisions of an LCD or NCD by filing an acceptable complaint.

(b) Neither an ALJ nor the Board recognizes as valid any attempt to assign rights to request review under section 1869(f) of the Act.

§ 426. 325 What may be challenged.

(a) Only LCDs or NCDs (including deemed NCDs) that are currently effective may be challenged.

(b) Some items are not reviewable under this part, including the following:

(1) Pre-decisional materials, including—

(i) Draft LCDs;

(ii) Template LCDs or suggested LCDs; and

(iii) Draft NCDs, including national coverage decision memoranda.

(2) Retired LCDs or withdrawn NCDs.

(3) LCD or NCD provisions that are no longer in effect due to revisions or reconsiderations.

(4) Interpretive policies that are not an LCD or NCD.

(5) Contractor decisions that are not based on section 1862(a)(1)(A) of the Act.

(6) Contractor claims processing edits.

(7) Payment amounts or methodologies.

(8) Procedure coding issues, including determinations, methodologies, definitions, or provisions.

(9) Contractor bulletin articles, educational materials, or Web site frequently asked questions.

(10) Any M+C organization or managed care plan policy, rule, or procedure.

(11) An individual claim determination.

(12) Any other policy that is not an LCD or an NCD as set forth in § 400.202 of this chapter.

§ 426.330 Burden of proof.

During an LCD or NCD review, an aggrieved party bears the burden of proof and the burden of persuasion for the issue(s) raised in a complaint. The burden of persuasion is judged by a preponderance of the evidence.

§ 426.340 Procedures for review of new evidence.

(a) The process for review of new evidence is initiated once the ALJ/Board completes the taking of evidence.

(b) If an aggrieved party has submitted new evidence pertaining to the LCD/NCD provision(s) in question, and the ALJ or the Board finds that evidence admissible, the ALJ or the Board reviews the record as a whole and decide whether the new evidence has the potential to significantly affect the ALJ's or the Board's evaluation of the LCD/NCD provision(s) in question under the reasonableness standard.

(c) If the ALJ or the Board determines that the new evidence does not have the potential to significantly affect the ALJ's or the Board's evaluation of the LCD/NCD provision(s) in question under the reasonableness standard, this evidence is included in the review record, and the review goes forward to a decision on the merits.

(d) If the ALJ or the Board determines that the new evidence has the potential to significantly affect the ALJ's or the Board's evaluation of the LCD or NCD provision(s) in question under the reasonableness standard, then the ALJ or the Board—

(1) Stays the proceedings and ensures that the contractor or CMS, whichever is appropriate, has a copy of the new evidence for its examination; and

(2) Allows the contractor/CMS 10 days, generally, to examine the new evidence, and to decide whether the contractor or CMS initiates a reconsideration.

(e) If the contractor or CMS informs the ALJ or the Board by the end of the 10 days that a reconsideration is initiated, and then the ALJ or the Board—

(1) Continues the stay in proceedings; and

(2) Sets a reasonable timeframe, not more than 90 days, by which the contractor or CMS completes the reconsideration.

(f) The ALJ or Board lifts the stay in proceedings and continues the review on the challenged provision(s) of the original LCD or NCD, including the new evidence in the review record, if the contractor or CMS—

(1) Informs the ALJ or Board that a reconsideration is not initiated; or

(2) The 90-day reconsideration timeframe is not met.

(g) If an LCD or NCD is reconsidered and revised within the timeframe allotted by the ALJ or Board, then the revised LCD or NCD and any supplement to the LCD or NCD record is forwarded to the ALJ or the Board and all parties and the review proceeds on the LCD or NCD.

Subpart D—Review of an LCD

§ 426.400 Procedure for filing an acceptable complaint concerning a provision (or provisions) of an LCD.

(a) *The complaint.* An aggrieved party may initiate a review of an LCD by filing a written complaint with the office designated by CMS on the Medicare Web site, *http://www.medicare.gov/coverage/static/appeals.asp.*

(b) *Timeliness of a complaint.* An LCD complaint is not considered timely unless it is filed with the office designated by CMS within—

(1) 6 months of the issuance of a written statement from each aggrieved party's treating practitioner, in the case of aggrieved parties who choose to file an LCD challenge before receiving the service; or

(2) 120 days of the initial denial notice, in the case of aggrieved parties who choose to file an LCD challenge after receiving the service.

(c) *Components of a valid complaint.* A complaint must include the following:

(1) *Beneficiary-identifying information:*

(i) Name.

(ii) Mailing address.

(iii) State of residence, if different from mailing address.

(iv) Telephone number, if any.

(v) Health Insurance Claim number, if applicable.

(vi) E-mail address, if applicable.

(2) *If the beneficiary has a representative,* the representative-identifying information must include the following:

(i) Name.

(ii) Mailing address.

(iii) Telephone number.

(iv) E-mail address, if any.

(v) Copy of the written authorization to represent the beneficiary.

(3) *Treating physician written statement.* A copy of a written statement from the treating physician that the beneficiary needs the service that is the subject of the LCD. This statement may be in the form of a written order for the service or other documentation from the beneficiary's medical record (such as progress notes or discharge summary) indicating that the beneficiary needs the service.

(4) *LCD-identifying information:*

(i) Name of the contractor using the LCD.

(ii) Title of LCD being challenged.

(iii) The specific provision (or provisions) of the LCD adversely affecting the aggrieved party.

(5) *Aggrieved party statement.* A statement from the aggrieved party explaining what service is needed and why the aggrieved party thinks that the provision(s) of the LCD is (are) not valid under the reasonableness standard.

(6) *Clinical or scientific evidence.* (i) Copies of clinical or scientific evidence that support the complaint and an explanation for why the aggrieved party thinks that this evidence shows that the LCD is not reasonable.

(ii) Any documents or portions of documents that include proprietary data must be marked "proprietary data," and include a legal basis for that assertion.

(iii) Proprietary data submitted by a manufacturer concerning a drug or device for which the manufacturer has submitted information to the Food and Drug Administration, must be considered and given substantive weight only when supported by an affidavit certifying that the submission contains true and correct copies of all data submitted by the manufacturer to the Food and Drug Administration in relation to that drug or device.

(d) *Joint complaints*—(1) *Conditions for a joint complaint.* Two or more aggrieved parties may initiate the review of an LCD by filing a single written complaint with the ALJ if all of the following conditions are met:

(i) Each aggrieved party named in the joint complaint has a similar medical condition or there are other bases for combining the complaints.

(ii) Each aggrieved party named in the joint complaint is filing the complaint

in regard to the same provision(s) of the same LCD.

(2) *Components of a valid joint complaint.* A joint complaint must contain the following information:

(i) The beneficiary-identifying information described in paragraph (c)(1) of this section for each aggrieved party named in the joint complaint.

(ii) The LCD-identifying information described in paragraph (c)(2) of this section.

(iii) The documentation described in paragraphs (c)(3) and (c)(4) of this section.

(3) *Timeliness of a joint complaint.* Aggrieved parties, who choose to seek review of an LCD—

(i) Before receiving the service, must file with the ALJ a joint complaint within 6 months of the written statement from each aggrieved party's treating physician.

(ii) After receiving the service, must file with the ALJ a complaint within 120 days of each aggrieved party's initial denial notice.

§ 426.403 Submitting new evidence once an acceptable complaint is filed.

Once an acceptable complaint is filed, the aggrieved party may submit additional new evidence without withdrawing the complaint until the ALJ closes the record.

§ 426.405 Authority of the ALJ.

(a) An ALJ conducts a fair and impartial hearing, avoids unnecessary delay, maintains order, and ensures that all proceedings are recorded.

(b) An ALJ defers only to reasonable findings of fact, reasonable interpretations of law, and reasonable applications of fact to law by the Secretary.

(c) The ALJ has the authority to do any of the following:

(1) Review complaints by an aggrieved party (or aggrieved parties).

(2) Dismiss complaints that fail to comply with § 426.400.

(3) Set and change the date, time, and place of a hearing upon reasonable notice to the parties.

(4) Continue or recess a hearing for a reasonable period of time.

(5) Hold conferences to identify or simplify the issues, or to consider other matters that may aid in the expeditious disposition of the proceeding.

(6) Consult with scientific and clinical experts on his or her own motion concerning clinical or scientific evidence.

(7) Set schedules for submission of exhibits and written reports of experts.

(8) Administer oaths and affirmations.

(9) Examine witnesses.

(10) Issue subpoenas requiring the attendance of witnesses at hearings as permitted by this part.

(11) Issue subpoenas requiring the production of existing documents before, and relating to, the hearing as permitted by this part.

(12) Rule on motions and other procedural matters.

(13) Stay the proceedings in accordance with § 426.340.

(14) Regulate the scope and timing of documentary discovery as permitted by this part.

(15) Regulate the course of a hearing and the conduct of representatives, parties, and witnesses.

(16) Receive, rule on, exclude, or limit evidence, as provided in § 426.340.

(17) Take official notice of facts, upon motion of a party.

(18) Decide cases, upon the motion of a party, by summary judgment when there is no disputed issue of material fact.

(19) Conduct any conference, argument, or hearing in person or, upon agreement of the parties, by telephone, picture-tel, or any other means.

(20) Issue decisions.

(21) Exclude a party from an LCD review for failure to comply with an ALJ order or procedural request without good cause shown.

(22) Stay the proceedings for a reasonable time when all parties voluntarily agree to mediation or negotiation, and provide mediation services upon request.

(d) The ALJ does not have authority to do any of the following under this part:

(1) Conduct an LCD review or conduct LCD hearings on his or her own motion or on the motion of a nonaggrieved party.

(2) Issue a decision based on any new evidence without following § 426.340, regarding procedures for review of new evidence.

(3) Review any decisions by contractors to develop a new or revised LCD.

(4) Conduct a review of any draft, retired, archived, template, or suggested LCDs.

(5) Conduct a review of any policy that is not an LCD, as defined in § 400.202 of this chapter.

(6) Conduct a review of any NCD according to section 1869(f)(1)(A)(i) of the Act.

(7) Conduct a review of the merits of an unacceptable LCD complaint as discussed in § 426.410.

(8) Allow participation by individuals or entities other than—

(i) The aggrieved party and/or his/her representative;

(ii) CMS and/or the contractor; and

(iii) Experts called by the parties or the ALJ.

(9) Compel the parties to participate in a mediation process or to engage in settlement negotiations.

(10) Deny a request for withdrawal of a complaint by an aggrieved party.

(11) Compel the contractor to conduct studies, surveys, or develop new information to support an LCD record.

(12) Deny a contractor the right to reconsider, revise or retire an LCD.

(13) Find invalid applicable Federal statutes, regulations, rulings, or NCDs.

(14) Enter a decision specifying terms to be included in an LCD.

§ 426.406 *Ex parte* contacts.

No party or person (except employees of the ALJ's office) communicates in any way with the ALJ on any substantive matter at issue in a case, unless on notice and opportunity for all parties to participate. This provision does not prohibit a person or party from inquiring about the status of a case or asking routine questions concerning administrative functions or procedures.

§ 426.410 Docketing and evaluating the acceptability of LCD complaints.

(a) *Docketing the complaint.* The office designated by CMS does the following upon receiving a complaint regarding an LCD:

Dockets the complaint.

Determines whether the complaint is—

(i) The first challenge to a particular LCD; or

(ii) Related to a pending LCD review.

(3) Forwards the complaint to the ALJ that conducts the review. In cases related to pending reviews, the complaint generally is forwarded to the ALJ who is conducting the review.

(b) *Evaluating the acceptability of the complaint.* The ALJ assigned to the LCD review determines if the complaint is acceptable by confirming all of the following:

(1) The complaint is being submitted by an aggrieved party or, in the case of a joint complaint, that each individual named in the joint complaint is an aggrieved party. (In determining if a complaint is acceptable, the ALJ assumes that the facts alleged by the treating physician's documentation regarding the aggrieved party's (or parties') clinical condition are true.)

(2) The complaint meets the requirements for a valid complaint in § 426.400 and does not challenge one of the documents in § 426.325(b).

(c) *Unacceptable complaint.* (1) If the ALJ determines that the complaint is unacceptable, the ALJ must provide the

aggrieved party (or parties) one opportunity to amend the unacceptable complaint.

(2) If the aggrieved party (or parties) fail(s) to submit an acceptable amended complaint within a reasonable timeframe as determined by the ALJ, the ALJ must issue a decision dismissing the unacceptable complaint.

(3) If a complaint is determined unacceptable after one amendment, the beneficiary is precluded from filing again for 6 months after being informed that it is unacceptable.

(d) *Acceptable complaint.* If the ALJ determines that the complaint (or amended complaint) is acceptable, the ALJ does the following:

(1) Sends a letter to the aggrieved party (or parties) acknowledging the complaint and informing the aggrieved party (or parties) of the docket number and the deadline for the contractor to produce the LCD record.

(2) Forwards a copy of the complaint, any evidence submitted in the complaint, and the letter described in paragraph (d)(1) of this section to the applicable contractor and CMS.

(3) Requires CMS or the contractor to send a copy of the LCD record to the ALJ and all parties to the LCD review within 30 days of receiving the ALJ's letter, the copy of the complaint, and any associated evidence, subject to extension for good cause shown.

(e) *Consolidation of complaints regarding an LCD*—(1) *Criteria for consolidation.* If a review is pending regarding a particular LCD provision(s) and no decision has been issued ending the review, and a new acceptable complaint is filed, the ALJ consolidates the complaints and conducts a consolidated LCD review if all of the following criteria are met:

(i) The complaints are in regard to the same provision(s) of the same LCD or there are other bases for consolidating the complaints.

(ii) The complaints contain common questions of law, common questions of fact, or both.

(iii) Consolidating the complaints does not unduly delay the ALJ's decision.

(2) *Decision to consolidate complaints.* If an ALJ decides to consolidate complaints, the ALJ does the following:

(i) Provides notification that the LCD review is consolidated and informs all parties of the docket number of the consolidated review.

(ii) Makes a single record of the proceeding.

(iii) Considers the relevant evidence introduced in each LCD complaint as introduced in the consolidated review.

(3) *Decision not to consolidate complaints.* If an ALJ decides not to consolidate complaints, the ALJ conducts separate LCD reviews for each complaint.

§ 426.415 CMS' role in the LCD review.

CMS may provide to the ALJ, and all parties to the LCD review, information identifying the person who represents the contractor or CMS, if necessary, in the LCD review process.

§ 426.416 Role of Medicare Managed Care Organizations (MCOs) and State agencies in the LCD review.

Medicare MCOs and Medicaid State agencies have no role in the LCD review process. However, once the ALJ has issued its decision, the decision is made available to all Medicare MCOs and State agencies.

§ 426.417 Contractor's statement regarding new evidence.

(a) The contractor may review any new evidence that is submitted, regardless of whether the ALJ has stayed the proceedings, including but not limited to—

(1) New evidence submitted with the initial complaint;

(2) New evidence submitted with an amended complaint;

(3) New evidence produced during discovery;

(4) New evidence produced when the ALJ consults with scientific and clinical experts; and

(5) New evidence presented during any hearing.

(b) The contractor may submit a statement regarding whether the new evidence is significant under § 426.340, within such deadline as the ALJ may set.

§ 426.418 LCD record furnished to aggrieved party.

(a) *Elements of a contractor's LCD record furnished to the aggrieved party.* Except as provided in paragraph (b) of this section, the contractor's LCD record consists of any document or material that the contractor considered during the development of the LCD, including, but not limited to, the following:

(1) The LCD being challenged.

(2) Any medical evidence considered on or before the date the LCD was issued, including, but not limited to, the following:

(i) Scientific articles.

(ii) Technology assessments.

(iii) Clinical guidelines.

(iv) Statements from clinical experts, medical textbooks, claims data, or other indication of medical standard of practice.

(3) Comment and Response Document (a summary of comments received by the contractor concerning the draft LCD).

(4) An index of documents considered that are excluded under paragraph (b) of this section.

(b) *Elements of the LCD record not furnished to the aggrieved party.* The LCD record furnished to the aggrieved party does not include the following:

(1) Proprietary data or privileged information.

(2) Any new evidence.

§ 426.419 LCD record furnished to the ALJ.

The LCD record furnished to the ALJ includes the following:

(a) Documents included in § 426.418(a).

(b) Privileged information and proprietary data considered that must be filed with the ALJ under seal.

§ 426.420 Retiring or revising an LCD under review.

(a) A contractor may retire an LCD or LCD provision under review before the date the ALJ issues a decision regarding that LCD. Retiring an LCD or LCD provision under review has the same effect as a decision under § 426.460(b).

(b) A contractor may revise an LCD under review to remove or amend the LCD provision listed in the complaint through the reconsideration process before the date the ALJ issues a decision regarding that LCD. Revising an LCD under review to remove the LCD provision in question has the same effect as a decision under § 426.460(b).

(c) A contractor must notify the ALJ within 48 hours of—

(1) Retiring an LCD or LCD provision that is under review; or

(2) Issuing a revised version of the LCD that is under review.

(d) If the contractor issues a revised LCD, the contractor forwards a copy of the revised LCD to the ALJ.

(e) The ALJ must take the following actions upon receiving a notice that the contractor has retired or revised an LCD under review:

(1) If, before the ALJ issues a decision, the ALJ receives notice that the contractor has retired the LCD or revised the LCD to completely remove the provision in question, the ALJ must dismiss the complaint and inform the aggrieved party(ies) who sought the review that he or she or they receive individual claim review without the retired/withdrawn provision(s).

(2) If, before the ALJ issues a decision, the ALJ receives notice that the contractor has revised the LCD provision in question but has not removed it altogether, the ALJ must continue the review based on the

revised LCD. In this case, the contractor must send a copy of the supplemental record to the ALJ and all parties. In that circumstance, the ALJ permits the aggrieved party to respond to the revised LCD and supplemental record.

§ 426.423 Withdrawing a complaint regarding an LCD under review.

(a) *Circumstance under which an aggrieved party may withdraw a complaint regarding an LCD.* An aggrieved party who filed a complaint regarding an LCD may withdraw the complaint before the ALJ issues a decision regarding that LCD. The aggrieved party may not file another complaint concerning the same coverage determination for 6 months.

(b) *Process for an aggrieved party withdrawing a complaint regarding an LCD.* To withdraw a complaint regarding an LCD, the aggrieved party who filed the complaint must send a written withdrawal notice to the ALJ (*see* § 426.400), CMS (if applicable), and the applicable contractor. Supplementing an acceptable complaint with new evidence does not constitute a withdrawal of a complaint, as described in § 426.403.

(c) *Actions the ALJ must take upon receiving a notice announcing the intent to withdraw a complaint regarding an LCD*—(1) *LCD reviews involving one aggrieved party.* If the ALJ receives a withdrawal notice regarding an LCD before the date the ALJ issued a decision regarding that LCD, the ALJ issues a decision dismissing the complaint under § 426.444 and informs the aggrieved party that he or she may not file another complaint to the same coverage determination for 6 months.

(2) *LCD reviews involving joint complaints.* If the ALJ receives a notice from an aggrieved party who is named in a joint complaint withdrawing a complaint regarding an LCD before the date the ALJ issued a decision regarding that LCD, the ALJ issues a decision dismissing only that aggrieved party from the complaint under § 426.444. The ALJ continues the LCD review if there is one or more aggrieved party who does not withdraw from the joint complaint.

(3) *Consolidated LCD reviews.* If the ALJ receives a notice from an aggrieved party who is part of a consolidated LCD review withdrawing a complaint regarding an LCD before the date the ALJ issued a decision regarding that LCD, the ALJ removes that aggrieved party from the consolidated LCD review and issues a decision dismissing that aggrieved party's complaint under § 426.444. The ALJ continues the LCD review if there are one or more aggrieved parties who does not withdraw from the joint complaint.

§ 426.425 LCD review.

(a) *Opportunity for the aggrieved party, after his or her review of the LCD record, to state why the LCD is not valid.* Upon receipt of the contractor's LCD record, the aggrieved party files a statement explaining why the contractor's LCD record is not complete, or not adequate to support the validity of the LCD under the reasonableness standard. This statement must be submitted to the ALJ and to the contractor, or CMS, as appropriate, within 30 days (or within the additional time as allowed by the ALJ for good cause shown) of the date the aggrieved party receives the contractor's LCD record.

(b) *Contractor response.* The contractor has 30 days after receiving the aggrieved party's statement to submit a response to the ALJ in order to defend the LCD.

(c) *ALJ evaluation.* (1) After the aggrieved party files a statement and the contractor responds, as described in § 426.425(a) and § 426.425(b), or the time for filing has expired, the ALJ applies the reasonableness standard to determine whether the LCD record is complete and adequate to support the validity of the LCD.

(2) Issuance of a decision finding the record complete and adequate to support the validity of the LCD ends the review process.

(3) If the ALJ determines that the LCD record is not complete and adequate to support the validity of the LCD, the ALJ permits discovery and the taking of evidence in accordance with § 426.432 and § 426.440 and evaluates the LCD in accordance with § 426.431.

(d) The process described in paragraphs (a), (b), and (c) of this section applies when an LCD record has been supplemented, except that discovery and the taking of evidence are not repeated. The period for the aggrieved party to file a statement begins when the aggrieved party receives the supplement.

§ 426.431 ALJ's review of the LCD to apply the reasonableness standard.

(a) *Required steps.* To review the provision(s) listed in the aggrieved party's complaint based on the reasonableness standard, an ALJ must:

(1) Confine the LCD review to the provision(s) of the LCD raised in the aggrieved party's complaint.

(2) Conduct a hearing, unless the matter can be decided on the written record.

(3) Close the LCD review record to the taking of evidence.

(4) Treat as precedential any previous Board decision under § 426.482 that involves the same LCD provison(s), same specific issue and facts in question, and the same clinical conditions.

(5) Issue a decision as described in § 426.447.

(b) *Optional steps.* The ALJ may do the following to apply the reasonableness standard to the provision(s) listed in the aggrieved party's complaint:

(1) Consult with appropriate scientific or clinical experts concerning evidence.

(2) Consider any previous ALJ decision made under § 426.447 regarding the same provision(s) of the LCD under review and for the same clinical conditions.

(c) *Authority for ALJs in LCD reviews when applying the reasonableness standard.* In applying the reasonableness standard to a provision (or provisions) of an LCD, the ALJ must follow all applicable laws, regulations, rulings, and NCDs.

§ 426.432 Discovery.

(a) *General rule.* If the ALJ orders discovery, the ALJ must establish a reasonable timeframe for discovery.

(b) *Proiective order*—(1) *Request for a protective order.* Any party receiving a discovery request may file a motion for a protective order before the date of production of the discovery.

(2) *The ALJ granting of a protective order.* The ALJ may grant a motion for a protective order if (s)he finds that the discovery sought—

(i) Is irrelevant or unduly repetitive;

(ii) Is unduly costly or burdensome; or

(iii) Unduly delays the proceeding.

(c) *Types of discovery available.* A party may obtain discovery via a request for the production of documents, and/or via the submission of up to 10 written interrogatory questions, relating to a specific LCD.

(d) *Types of documents.* For the purpose of this section, the term "documents" includes relevant information, reports, answers, records, accounts, papers, and other data and documentary evidence. Nothing contained in this section is interpreted to require the creation of a document.

(e) *Types of discovery not available.* Requests for admissions, depositions, or any other forms of discovery, other than those permitted under paragraph (c) of this section, are not authorized.

(f) *Privileged information and proprietary data.* The ALJ must not, under any circumstance, order the disclosure of privileged information or proprietary data filed under seal without the consent of the party who

possesses the right to protection of the information.

(g) *Notification.* The ALJ notifies all parties in writing when the discovery period closes.

§ 426.435 Subpoenas.

(a) *Purpose of a subpoena.* A subpoena requires the attendance of an individual at a hearing and may also require a party to produce evidence authorized under § 426.440 at or before the hearing.

(b) *Filing a motion for a subpoena.* A party seeking a subpoena must file a written motion with the ALJ not less than 30 days before the date fixed for the hearing. The motion must do all of the following:

(1) Designate the witnesses.

(2) Specify any evidence to be produced.

(3) Describe the address and location with sufficient particularity to permit the witnesses to be found.

(4) State the pertinent facts that the party expects to establish by the witnesses or documents and whether other evidence may establish without the use of a subpoena.

(c) *Response to a motion for a subpoena.* Within 15 days after the written motion requesting issuance of a subpoena is served on all parties, any party may file an opposition to the motion or other response.

(d) *Extension for good cause shown.* The ALJ may modify the deadlines specified in paragraphs (b) and (c) of this section for good cause shown.

(e) *Motion for a subpoena granted.* If the ALJ grants a motion requesting issuance of a subpoena, the subpoena must do the following:

(1) Be issued in the name of the ALJ.

(2) Include the docket number and title of the LCD under review.

(3) Provide notice that the subpoena is issued according to sections 1872 and 205(d) and (e) of the Act.

(4) Specify the time and place at which the witness is to appear and any evidence the witness is to produce.

(f) *Delivery of the subpoena.* The party seeking the subpoena serves it by personal delivery to the individual named, or by certified mail return receipt requested, addressed to the individual at his or her last dwelling place or principal place of business.

(g) *Motion to quash a subpoena.* The individual to whom the subpoena is directed may file with the ALJ a motion to quash the subpoena within 10 days after service.

(h) *Refusal to obey a subpoena.* The exclusive remedy for contumacy by, or refusal to obey, a subpoena duly served upon any person is specified in section 205(e) of the Act (42 U.S.C. 405(e)) except that any reference to the "Commissioner of Social Security" shall be considered a reference to the "Secretary."

§ 426.440 Evidence.

(a) Except as provided in this part, the ALJ is not bound by the Federal Rules of Evidence. However, the ALJ may apply the Federal Rules of Evidence when appropriate, for example, to exclude unreliable evidence.

(b) The ALJ must exclude evidence that (s)he determines is clearly irrelevant, immaterial, or unduly repetitive.

(c) The ALJ may accept privileged information or proprietary data, but must maintain it under seal.

(d) The ALJ may permit the parties to introduce the testimony of expert witnesses on scientific and clinical issues, rebuttal witnesses, and other relevant evidence. The ALJ may require that the testimony of expert witnesses be submitted in the form of a written report, accompanied by the curriculum vitae of the expert preparing the report.

(e) Experts submitting reports must be available for cross-examination at an evidentiary hearing upon request of the ALJ or a party to the proceeding, or the reports will be excluded from the record.

(f) Except as set forth in paragraph (c) of this section or unless otherwise ordered by the ALJ for good cause shown, all documents and other evidence offered or taken for the record are open to examination by all parties.

§ 426.444 Dismissals for cause.

(a) The ALJ may, at the request of any party, or on his or her own motion, dismiss a complaint if the aggrieved party fails to do either of the following:

(1) Attend or participate in a prehearing conference (the pre-hearing may be conducted by telephone) or hearing without good cause shown.

(2) Comply with a lawful order of the ALJ without good cause shown.

(b) The ALJ must dismiss any complaint concerning LCD provision(s) if the following conditions exist:

(1) The ALJ does not have the authority to rule on that provision under § 426.405(d).

(2) The complaint is not timely. (*See* § 426.400(b).)

(3) The complaint is not filed by an aggrieved party.

(4) The complaint is filed by an individual who fails to provide an adequate statement of need for the service from the treating physician.

(5) The complaint challenges a provision or provisions of an NCD. (*See* § 426.405, regarding the authority of the ALJ.)

(6) The contractor notifies the ALJ that the LCD provision(s) is (are) no longer in effect.

(7) The aggrieved party withdraws the complaint. (*See* § 426.423 for requirements related to withdrawing a complaint regarding an LCD under review.)

§ 426.445 Witness fees.

(a) A witness testifying at a hearing before an ALJ receives the same fees and mileage as witnesses in Federal district courts of the United States. If the witness qualifies as an expert, he or she is entitled to an expert witness fee. Witness fees are paid by the party seeking to present the witness.

(b) If an ALJ requests expert testimony, the appropriate office overseeing the ALJ is responsible for paying all applicable fees and mileage, unless the expert waives payment.

§ 426.446 Record of hearing.

The ALJ must ensure that all hearings are open to the public and are electronically, mechanically or stenographically reported. Except for privileged information and proprietary data that are filed under seal, all evidence upon which the ALJ relies for decision must be admitted into the public record. All medical reports, exhibits, and any other pertinent document, either in whole or in material part, must be offered, marked for identification, and retained in the case record.

§ 426.447 Issuance and notification of an ALJ's decision.

An ALJ must issue to all parties to the LCD review, within 90 days of closing the LCD review record to the taking of evidence, one of the following:

(a) A written decision, including a description of appeal rights.

(b) A written notification stating that a decision is pending, and an approximate date of issuance for the decision.

§ 426.450 Mandatory provisions of an ALJ's decision.

(a) *Findings.* An ALJ's decision must include one of the following:

(1) A determination that the provision of the LCD is valid under the reasonableness standard.

(2) A determination that the provision of the LCD is not valid under the reasonableness standard.

(3) A statement dismissing the complaint regarding the LCD and a rationale for the dismissal.

(4) A determination that the LCD record is complete and adequate to

support the validity of the LCD provisions under the reasonableness standard.

(b) *Other information.* An ALJ's decision must include all of the following:

(1) The date of issuance.

(2) The docket number of the LCD review.

(3) A statement as to whether the aggrieved party has filed a claim for the service(s) named in the complaint, the date(s)-of-service, and the disposition, if known.

(4) A basis for concluding that the LCD was or was not valid based on the application of the reasonableness standard to the record before the ALJ, including the contractor's:

(i) Findings of fact.

(ii) Interpretations of law.

(iii) Applications of fact to law.

(5) A summary of the evidence reviewed. If proprietary or privileged data were submitted under seal, the decision must state whether the data were material and what role they played in the determination, but without disclosing the substance or contents of the evidence under seal. A separate statement of the rationale for the ALJ's treatment of the sealed evidence must be prepared and kept under seal itself. If the ALJ decision is appealed to the Board, this statement must be provided to the Board under seal.

(6) A statement regarding appeal rights.

§ 426.455 Prohibited provisions of an ALJ's decision.

An ALJ's decision may not do any of the following:

(a) Order CMS or its contractors to add any language to a provision or provisions of an LCD.

(b) Order CMS or its contractors to pay a specific claim.

(c) Set a time limit for CMS or its contractors to establish a new or revised LCD.

(d) Review or evaluate an LCD other than the LCD under review.

(e) Include a requirement for CMS or its contractors that specifies payment, coding, or systems changes for an LCD, or deadlines for implementing these types of changes.

(f) Order or address how a contractor(s) must implement an LCD.

§ 426.457 Optional provisions of an ALJ's decision.

When appropriate, the ALJ may limit a decision holding invalid a specific provision(s) of an LCD to specific clinical indications and for similar conditions.

§ 426.458 ALJ's LCD review record.

(a) *Elements of the ALJ's LCD review record furnished to the public.* Except as provided in paragraph (b) of this section, the ALJ's LCD review record consists of any document or material that the ALJ compiled or considered during the LCD review, including, but not limited to, the following:

(1) The LCD complaint.

(2) The LCD and LCD record.

(3) The supplemental LCD record, if applicable.

(4) Transcripts of record.

(5) Any other relevant evidence gathered under § 426.440.

(6) The ALJ's decision.

(b) *Elements of the ALJ's LCD review record furnished to the Board under seal.* The ALJ's review record must include, under seal, any proprietary data or privileged information maintained under seal, and such data or information must not be included in the review record furnished to the public.

§ 426.460 Effect of an ALJ's decision.

(a) *Valid under the reasonableness standard.* If the ALJ finds that the provision or provisions of the LCD named in the complaint is (are) valid under the reasonableness standard, the aggrieved party or parties may appeal that (those) part(s) of the ALJ decision to the Board under § 426.465.

(b) *Not valid under the reasonableness standard.* If the ALJ finds that the provision or provisions of the LCD named in the complaint is (are) invalid under the reasonableness standard, and no appeal is filed by the contractor or CMS under § 426.465(b), the contractor, the M+C organization, or other Medicare managed care organization must provide the following—

(1) *Individual claim review.* (i) If neither the contractor nor CMS appeals the ALJ decision under § 426.425(b), and if the party's claim or appeal(s) was previously denied, the contractor, an M+C organization or another Medicare managed care organization must reopen the claim of the party who challenged the LCD and adjudicate the claim without using the provision(s) of the LCD that the ALJ found invalid.

(ii) If a revised LCD is issued, the contractor, the M+C organization, and any other Medicare managed care organization within the contractor's jurisdiction uses the revised LCD in reviewing claim or appeal submissions or request for services delivered or services performed on or after the effective date of the revised LCD.

(iii) If the aggrieved party who sought the review has not yet submitted a claim, the contractor adjudicates the claim without using the provision(s) of the LCD that the ALJ found invalid.

(iv) In either case, the claim and any subsequent claims for the service provided under the same circumstances is adjudicated without using the LCD provision(s) found invalid.

(2) *Coverage determination relief.* If neither the contractor nor CMS appeals the ALJ decision under § 426.425(b), the contractor implements the ALJ decision within 30 days. Any change in policy applies prospectively to requests for service or claims filed with dates of service after the implementation of the ALJ decision.

§ 426.462 Notice of an ALJ's decision.

After the ALJ has made a decision regarding an LCD complaint, the ALJ sends a written notice of the decision to each party. The notice must—

(a) State the outcome of the review; and

(b) Inform each party to the determination of his or her rights to seek further review if he or she is dissatisfied with the determination, and the time limit under which an appeal must be requested.

§ 426.463 Future new or revised LCDs.

The contractor may not reinstate an LCD provision(s) found to be unreasonable unless the contractor has a different basis (such as additional evidence) than what the ALJ evaluated.

§ 426.465 Appealing part or all of an ALJ's decision.

(a) *Circumstances under which an aggrieved party may appeal part or all of an ALJ's decision.* An aggrieved party (including one or more aggrieved parties named in a joint complaint and an aggrieved party who is part of a consolidated LCD review) may appeal to the Board any part of an ALJ's decision that does the following:

(1) States that a provision of an LCD is valid under the reasonableness standard; or

(2) Dismisses a complaint regarding an LCD (except as prohibited in paragraph (b) of this section).

(b) *Circumstance under which a contractor or CMS may appeal part or all of an ALJ's decision.* A contractor or CMS may appeal to the Board any part of an ALJ's decision that states that a provision (or provisions) of an LCD is (are) unreasonable.

(c) *Stay of an implementation pending appeal.* (1) If an ALJ's decision finds a provision or provisions of an LCD unreasonable, an appeal by a contractor or CMS stays implementation as described under § 426.460(b) until the Board issues a final decision.

(2) The appeal request must be submitted to the Board in accordance with paragraph (e) of this section.

(d) *Circumstances under which an ALJ's decision may not be appealed.* An ALJ's decision dismissing a complaint is not subject to appeal in either of the following circumstances:

(1) The contractor has retired the LCD provision(s) under review.

(2) The aggrieved party who filed the complaint has withdrawn the complaint.

(e) *Receipt of the appeal by the Board.* Unless there is good cause shown, an appeal described in paragraphs (a) or (b) of this section must be filed with the Board within 30 days of the date the ALJ's decision was issued.

(f) *Filing an appeal.* (1) To file an appeal described in paragraph (a) of this section, an aggrieved party, who sought LCD review, a contractor, or CMS must send the following to the Board:

(i) The full names and addresses of the parties, including the name of the LCD.

(ii) The date of issuance of the ALJ's decision.

(iii) The docket number that appears on the ALJ's decision.

(iv) A statement identifying the part(s) of the ALJ's decision that are being appealed.

(2) If an appeal described in paragraph (a) of this section is filed with the Board later than the date described in paragraph (c) of this section, it must include a rationale stating why the Board must accept the late appeal.

(3) An appeal described in paragraph (a) of this section must include a statement explaining why the ALJ's decision should be reversed.

§ 426.468 Decision to not appeal an ALJ's decision.

(a) Failure to timely appeal without good cause shown waives the right to challenge any part(s) of the ALJ's decision under § 426.465.

(b) Unless the Board finds good cause shown for late filing, an untimely appeal is dismissed.

(c) If a party does not timely appeal any part(s) of the ALJ's decision on an LCD review to the Board, as provided in this subpart, then the ALJ's decision is final and not subject to further review.

§ 426.470 Board's role in docketing and evaluating the acceptability of appeals of ALJ decisions.

(a) *Docketing the appeal.* The Board does the following upon receiving an appeal of part or all of an ALJ's decision:

(1) Dockets the appeal either separately or with similar appeals.

(2) Assigns a docket number.

(b) *Evaluating the acceptability of the appeal.* The Board determines if the appeal is acceptable by confirming that the appeal meets all of the criteria in § 426.465.

(c) *Unacceptable appeal.* If the Board determines that an appeal is unacceptable, the Board must dismiss the appeal.

(d) *Acceptable appeal.* If the Board determines that an appeal is acceptable, the Board does the following:

(1) Sends a letter to the appellant to acknowledge that the appeal is acceptable, and informs them of the docket number.

(2) Forwards a copy of the appeal and the letter described in paragraph (d)(1) of this section to all parties involved in the appeal.

(3) Requires the ALJ to send a copy of the ALJ's LCD review record (maintaining any sealed documents) to the Board and a copy of the public record to all parties involved in the appeal.

(e) *No participation as amicus curiae.* The Board may not allow participation by amicus participants in the review of an LCD.

§ 426.476 Board review of an ALJ's decision.

(a) *Review steps.* If the Board determines that an appeal is acceptable, the Board—

(1) Permits the party that did not file the appeal an opportunity to respond to the appeal;

(2) Hears oral argument (which may be held by telephone) if the Board determines that oral argument would be helpful to the Board's review of the ALJ decision;

(3) Reviews the LCD review record and the parties' arguments; and

(4) Issues a written decision either upholding, modifying, or reversing the ALJ decision, or remanding the case to the ALJ for further proceedings.

(b) *Standard of review.* (1) *In general.* The Board determines whether the ALJ decision contains any material error, including any failure to properly apply the reasonableness standard.

(2) If the ALJ erred in determining that the contractor's record was complete and adequate to support the validity of the LCD, the Board remands the case to the ALJ for discovery and the taking of evidence.

(3) If a party alleges a prejudicial error of procedure, and the Board determines that such an error was made, the Board may remand the case to the ALJ for further proceedings consistent with the Board decision or may take other appropriate steps to correct the procedural error.

(4) Harmless error is not a basis for reversing an ALJ decision.

(c) *Scope of review.* In reaching its conclusions, the Board is bound by applicable laws, regulations, and NCDs.

(d) *Dismissal as moot.* The Board dismisses an appeal by an aggrieved party of an ALJ decision finding that an LCD was valid if the contractor notifies the Board that it has retired the LCD or revised the LCD to remove the LCD provision in question.

§ 426.478 Retiring or revising an LCD during the Board's review of an ALJ's decision.

A contractor may retire or revise an LCD during the Board's review of an ALJ's decision using the same process described in § 426.420. If an LCD is retired or revised to remove completely the challenged provision(s), the aggrieved party who sought the review is entitled to individual claim review provided at § 426.488(b).

§ 426.480 Withdrawing an appeal of an ALJ's decision.

(a) *Withdrawal of an appeal of an ALJ's decision.* A party who filed an appeal of an ALJ's decision may withdraw the appeal before the Board issues a decision regarding the ALJ's decision.

(b) *Process of withdrawing an appeal of an ALJ's decision.* To withdraw an appeal of an ALJ's decision, the party who filed the appeal must send a written notice announcing the intent to withdraw to the Board and to any other party.

(c) *Actions the Board must take upon receiving a notice announcing the intent to withdraw an appeal of an ALJ's decision*—(1) *Appeals involving one aggrieved party, or initiated by CMS or a contractor.* If the Board receives a notice withdrawing an appeal of an ALJ's decision before the Board has issued its decision, the Board must issue a decision dismissing the appeal.

(2) *Appeals involving joint complaints.* If the Board receives a notice withdrawing an appeal from an aggrieved party who is named in a joint appeal before the Board issues its decision, the Board must issue a decision dismissing only that aggrieved party from the appeal. The Board must continue its review of the ALJ's decision for the remaining aggrieved party or parties.

§ 426.482 Issuance and notification of a Board decision.

The Board must issue a written decision, including a description of appeal rights, to all parties to the review of the ALJ decision.

§ 426.484 Mandatory provisions of a Board decision.

(a) *Findings.* A Board decision must include at least one of the following:

(1) A statement upholding the part(s) of the ALJ decision named in the appeal.

(2) A statement reversing the part(s) of the ALJ decision named in the appeal.

(3) A statement modifying the part(s) of the ALJ decision named in the appeal.

(4) A statement dismissing the appeal of an ALJ decision and a rationale for the dismissal.

(b) *Other information.* A Board decision must include all of the following:

(1) The date of issuance.

(2) The docket number of the review of the ALJ decision.

(3) A summary of the ALJ's decision.

(4) A rationale for the basis of the Board's decision.

§ 426.486 Prohibited provisions of a Board decision.

A Board decision must not do any of the following:

(a) Order CMS or its contractors to add any language to a provision or provisions of an LCD.

(b) Order CMS or its contractors to pay a specific claim.

(c) Set a time limit to establish a new or revised LCD.

(d) Review or evaluate an LCD other than the LCD named in the ALJ's decision.

(e) Include a requirement for CMS or its contractors that specifies payment, coding, or system changes for an LCD or deadlines for implementing these changes.

(f) Order CMS or its contractors to implement an LCD in a particular manner.

§ 426.487 Board's record on appeal of an ALJ's decision.

(a) *Elements of the Board's LCD review record furnished to the public.* Except as provided in paragraph (b) of this section, the Board's LCD review record consists of any document or material that the Board compiled or considered during an LCD review, including, but not limited to, the following:

(1) The LCD complaint.

(2) The LCD and LCD record.

(3) The supplemental LCD record, if applicable.

(4) Transcripts of record.

(5) Any other relevant evidence gathered under § 426.440.

(6) The ALJ's decision.

(7) The Board's decision.

(b) *Elements of the Board's LCD appeal record furnished to the court under seal.* The Board's LCD review record must include, under seal, any proprietary data or privileged information submitted and reviewed in the LCD review process, and that data or information must not be included in the review record furnished to the public, but the information must be maintained, under seal, by the Board.

(c) *Protective order.* In any instance where proprietary data or privileged information is used in the LCD process and a court seeks to obtain or require disclosure of any proprietary data or privileged information contained in the LCD record, CMS or the Department will seek to have a protective order issued for that information, as appropriate.

§ 426.488 Effect of a Board decision.

(a) *The Board's decision upholds an ALJ decision that an LCD is valid or reverses an ALJ decision that an LCD is invalid.* If the Board's decision upholds the ALJ decision that an LCD is valid under the reasonableness standard or reverses an ALJ decision that an LCD is invalid, the contractor or CMS is not required to take any action.

(b) *The Board's decision upholds an ALJ determination that the LCD is invalid.* If the Board's decision upholds an ALJ determination that the LCD is invalid, then the contractor, the M+C organization, or other Medicare managed care organization implements the decision as described in § 426.460(b).

(c) *The Board's decision reverses a dismissal or an ALJ decision that the LCD is valid.* If the Board reverses an ALJ decision dismissing a complaint or holding that an LCD is valid without requiring discovery or the taking of evidence, the Board remands to the ALJ and the LCD review continues. If the Board reverses an ALJ decision holding that an LCD is valid that is reached after the ALJ has completed discovery and the taking of evidence, the Board may remand the case to the ALJ for further proceedings, or the Board may find that the provision(s) of the LCD named in the complaint is (are) invalid under the reasonableness standard, and the contractor, the M+C organization, or other Medicare managed care organization provides the relief in § 426.460(b).

§ 426.489 Board remands.

(a) *Notice when case is remanded to the ALJ.* If the Board remands a case to the ALJ, the Board—

(1) Notifies each aggrieved party who sought the LCD review, through his or her representative or at his or her last known address, the contractor, and CMS of the Board's remand decision; and

(2) Explains why the case is being remanded and the specific actions ordered by the Board.

(b) *Action by an ALJ on remand.* An ALJ takes any action that is ordered by the Board and may take any additional action that is not inconsistent with the Board's remand order.

§ 426.490 Board decision.

A decision by the Board (other than a remand) constitutes a final agency action and is subject to judicial review. Neither the contractor nor CMS may appeal a Board decision.

Subpart E—Review of an NCD

§ 426.500 Procedure for filing an acceptable complaint concerning a provision (or provisions) of an NCD.

(a) *The complaint.* An aggrieved party may initiate a review of an NCD by filing a written complaint with the Department of Health and Human Services Departmental Appeals Board.

(b) *Timeliness of a complaint.* An NCD complaint is not considered timely unless it is filed with the Board within—

(1) 6 months of the written statement from each aggrieved party's treating physician, in the case of aggrieved parties who choose to file an NCD challenge before receiving the service; or

(2) 120 days of the initial denial notice, in the case of aggrieved parties who choose to file an NCD challenge after receiving the service.

(c) *Components of a valid complaint.* A complaint must include the following:

(1) *Beneficiary-identifying information:*

(i) Name.

(ii) Mailing address.

(iii) State of residence, if different from mailing address.

(iv) Telephone number, if any.

(v) Health Insurance Claim number, if applicable.

(vi) Email address, if applicable.

(2) *If the beneficiary has a representative,* the representative's indetifying information must include the following:

(i) Name.

(ii) Address.

(iii) Telephone number.

(iv) E-mail address (if any)

(v) Copy of the written authorization to represent the beneficiary.

(3) *Treating physician written statement.* A copy of a written statement from the treating physician that the beneficiary needs the service that is the

subject of the NCD. This statement may be in the form of a written order for the service or other documentation from the beneficiary's medical record (such as progress notes or discharge summary) indicating that the beneficiary needs the service.

(4) *NCD-identifying information:*

(i) Title of NCD being challenged.

(ii) The specific provision or provisions of the NCD adversely affecting the aggrieved party.

(5) *Aggrieved party statement.* A statement from the aggrieved party explaining what service is needed and why the aggrieved party thinks that the provision(s) of the NCD is (are) not valid under the reasonableness standard.

(6) *Clinical or scientific evidence.* (i) Copies of clinical or scientific evidence that supports the complaint and an explanation for why the aggrieved party thinks that this evidence shows that the NCD is not reasonable.

(ii) Any documents or portions of documents that include proprietary data must be marked "proprietary data," and include a legal basis for that assertion.

(iii) Proprietary data submitted by a manufacturer concerning a drug or device for which the manufacturer has submitted information to the Food and Drug Administration, must be considered and given substantive weight only when supported by an affidavit certifying that the submission contains true and correct copies of all data submitted by the manufacturer to the Food and Drug Administration in relation to that drug or device.

(d) *Joint complaints*—(1) *Conditions for a joint complaint.* Two or more aggrieved parties may initiate the review of an NCD by filing a single written complaint with the Board if all of the following conditions are met:

(i) Each aggrieved party named in the joint complaint has a similar medical condition or there are other bases for combining the complaints.

(ii) Each aggrieved party named in the joint complaint is filing the complaint in regard to the same provision(s) of the same NCD.

(2) *Components of a valid joint complaint.* A joint complaint must contain the following information:

(i) The beneficiary-identifying information described in paragraph (c)(1) of this section for each aggrieved party named in the joint complaint.

(ii) The NCD-identifying information described in paragraph (c)(2) of this section.

(iii) The documentation described in paragraphs (c)(3) and (c)(4) of this section.

(3) *Timeliness of a joint complaint.* Aggrieved parties, who choose to seek review of an NCD—

(i) Before receiving the service, must file with the Board a joint complaint within 6 months of the written statement from each aggrieved party's treating physician; or

(ii) After receiving the service, must file with the Board a complaint within 120 days of each aggrieved party's initial denial notice.

§ 426.503 Submitting new evidence once an acceptable complaint has been filed.

Once an acceptable complaint has been filed, the aggrieved party may submit additional new evidence without withdrawing the complaint until the Board closes the record.

§ 426.505 Authority of the Board.

(a) The Board conducts a fair and impartial hearing, avoids unnecessary delay, maintains order, and ensures that all proceedings are recorded.

(b) The Board defers only to reasonable findings of fact, reasonable interpretations of law, and reasonable applications of fact to law by the Secretary.

(c) The Board has the authority to do any of the following:

(1) Review complaints by an aggrieved party (or aggrieved parties).

(2) Dismiss complaints that fail to comply with § 426.500.

(3) Set and change the date, time, and place of a hearing upon reasonable notice to the parties.

(4) Continue or recess a hearing for a reasonable period of time.

(5) Hold conferences to identify or simplify the issues, or to consider other matters that may aid in the expeditious disposition of the proceeding.

(6) Consult with scientific and clinical experts on its own motion, concerning clinical or scientific evidence.

(7) Set schedules for submission of exhibits and written reports of experts.

(8) Administer oaths and affirmations.

(9) Examine witnesses.

(10) Issue subpoenas requiring the attendance of witnesses at hearings as permitted by this part.

(11) Issue subpoenas requiring the production of existing documents before, and relating to, the hearing as permitted by this part.

(12) Rule on motions and other procedural matters.

(13) Stay the proceeding in accordance with § 426.340.

(14) Regulate the scope and timing of documentary discovery as permitted by this part.

(15) Regulate the course of a hearing and the conduct of representatives, parties, and witnesses.

(16) Receive, rule on, exclude, or limit evidence, as provided in this regulation.

(17) Take official notice of facts, upon motion of a party.

(18) Decide cases, upon the motion of a party, by summary judgment when there is no disputed issue of material fact.

(19) Conduct any conference, argument, or hearing in person or, upon agreement of the parties, by telephone, picture-tel, or any other means.

(20) Issue decisions.

(21) Exclude a party from an NCD review for failure to comply with a Board order or procedural request without good cause.

(22) Stay the proceedings for a reasonable time when all parties voluntarily agree to mediation or negotiation, and provide mediation services upon request.

(d) The Board does not have authority to do any of the following under this part:

(1) Conduct an LCD review or conduct LCD hearings, except as provided by § 426.465.

(2) Conduct an NCD review or conduct NCD hearings on its own motion or on the motion of a nonaggrieved party.

(3) Issue a decision based on any new evidence without following § 426.340, regarding procedures for review of new evidence.

(4) Review any decisions by CMS to develop a new or revised NCD.

(5) Conduct a review of any draft NCDs, coverage decision memoranda, or withdrawn NCDs.

(6) Conduct a review of the merits of an unacceptable NCD complaint as discussed in § 426.510.

(7) Conduct an NCD review of any policy that is not an NCD, as defined in § 400.202 of this chapter.

(8) Allow participation by individuals or entities other than—

(i) The aggrieved party and/or his or her representative;

(ii) CMS and/or the contractor;

(iii) Experts called by the parties or Board; or

(iv) Third parties with a clearly identifiable and substantial interest in the outcome of the dispute who have petitioned for and been granted permission by the Board to participate in the proceedings as *amicus curiae*.

(9) Compel the parties to participate in a mediation process or to engage in settlement negotiations.

(10) Deny a request for withdrawal of a complaint by an aggrieved party.

(11) Compel CMS to conduct studies, surveys, or develop new information to support an NCD record.

(12) Deny CMS the right to reconsider, revise, or withdraw an NCD.

(13) Subject to the timely filing requirements, deny an aggrieved party, CMS, or its contractor the right to appeal an ALJ decision.

(14) Find invalid applicable Federal statutes, regulations, or rulings.

(15) Enter a decision specifying terms to be included in an NCD.

§ 426.506 *Ex parte* contacts.

No party or person (except Board staff) communicates in any way with the Board on any substantive matter at issue in a case, unless on notice and opportunity for all parties to participate. This provision does not prohibit a person or party from inquiring about the status of a case or asking routine questions concerning administrative functions or procedures.

§ 426.510 Docketing and evaluating the acceptability of NCD complaints.

(a) *Docketing the complaint.* The Board does the following upon receiving a complaint regarding an NCD:

(1) Dockets the complaint.

(2) Determines whether the complaint is—

(i) The first challenge to a particular NCD; or

(ii) Related to a pending NCD review.

(3) Forwards the complaint to the Board member who conducts the review.

(b) *Evaluating the acceptability of the complaint.* The Board determines if the complaint is acceptable by confirming all of the following:

(1) The complaint is being submitted by an aggrieved party or, in the case of a joint complaint, that each individual named in the joint complaint is an aggrieved party. (In determining if a complaint is acceptable, the Board assumes that the facts alleged by the treating physician's documentation regarding the aggrieved party's (or parties') clinical condition are true.)

(2) The complaint meets the requirements for a valid complaint in § 426.500 and is not one of the documents in § 426.325(b).

(c) *Unacceptable complaint.* (1) If the Board determines that the complaint is unacceptable, the Board must provide the aggrieved party (or parties) one opportunity to amend the unacceptable complaint.

(2) If the aggrieved party (or parties) fail(s) to submit an acceptable amended complaint within a reasonable timeframe as determined by the Board, the Board must issue a decision dismissing the unacceptable complaint.

(3) If a complaint is determined to be unacceptable after one amendment, the beneficiary is precluded from filing again for 6 months after being informed that it is unacceptable.

(d) *Acceptable complaint.* If the Board determines that the complaint (or amended complaint) is acceptable, the Board does the following:

(1) Sends a letter to the aggrieved party (or parties) acknowledging the complaint and informing the aggrieved party (or parties) of the docket number and the deadline for CMS to produce the NCD record.

(2) Forwards a copy of the complaint, any evidence submitted in the complaint, and the letter described in paragraph (d)(1) of this section to CMS.

(3) Requires CMS to send a copy of the NCD record to the Board and all parties to the NCD review within 30 days of receiving the Board's letter, a copy of the complaint, and any associated evidence, subject to extension for good cause shown.

(e) *Consolidation of complaints regarding an NCD*—(1) *Criteria for condideration.* If a review is pending regarding a particular NCD provision(s) and no decision has been issued ending the review, and a new acceptable complaint is filed, the Board consolidates the complaints and conducts a consolidated NCD review if all of the following criteria are met:

(i) The complaints are in regard to the same provision(s) of the same NCD, or there are other bases for consolidating the complaints.

(ii) The complaints contain common questions of law, common questions of fact, or both.

(iii) Consolidating the complaints does not unduly delay the Board's decision.

(2) *Decision to consolidate complaint.* If the Board decides to consolidate complaints, the Board does the following:

(i) Provides notification that the NCD review is consolidated and informs all parties of the docket number of the consolidated review.

(ii) Makes a single record of the proceeding.

(iii) Considers the relevant evidence introduced in each NCD complaint as introduced in the consolidated review.

(3) *Decision not to consolidate complaints.* If the Board decides not to consolidate complaints, the Board conducts separate NCD reviews for each complaint.

(f) *Public notice of complaint and opportunity for interested parties to participate.* (1) If an acceptable complaint is the first complaint the Board has received challenging the particular NCD or provision, then the Board posts notice on its Web site that it has received the complaint, specifying a time period for requests to participate in the review process.

(2) If an acceptable complaint challenges an NCD provision when review is pending and no decision has been issued ending the review, the Board may supplement the public notice on its Web site and extend the time for participation requests if indicated.

(3) The Board may allow participation, in the manner and by the deadlines established by the Board, when an NCD is being challenged and the Board decides that—

(i) The *amicus* participant has a clearly identifiable and substantial interest in the outcome of the dispute;

(ii) Participation would clarify the issues or otherwise be helpful in resolution of the dispute;

(iii) Participation does not result in substantial delay; and

(iv) The petition for participation meets the criteria in § 426.513.

§ 426.513 Participation as *amicus curiae*.

(a) *Petition for participation.* Any person or organization that wishes to participate as *amicus curiae* must timely file with the Board a petition that concisely states—

(1) The petitioner's interest in the hearing;

(2) Who will represent the petitioner; and

(3) The issues on which the petitioner intends to present argument.

(b) *The nature of the proposed amicus participation.* An *amicus curiae* is not a party to the hearing but may participate by—

(1) Submitting a written statement of position to the Board before the beginning of the hearing;

(2) Presenting a brief oral statement or other evidence at the hearing, at the point in the proceedings specified by the Board; and

(3) Submitting a brief or a written statement when the parties submit briefs.

(c) *Service by amicus curiae.* Serving copies of any briefs or written statements on all parties.

§ 426.515 CMS' role in making the NCD record available.

CMS will provide a copy of the NCD record (as described in § 426.518) to the Board and all parties to the NCD review within 30 days of the receipt of the Board's order.

§ 426.516 Role of Medicare Managed Care Organizations (MCOs) and State agencies in the NCD review process.

Medicare MCOs and Medicaid State agencies may participate in the NCD review process only if they meet the *amicus* participant criteria listed in § 426.510(f)(3) and § 426.513.

§ 426.517 CMS' statement regarding new evidence.

(a) CMS may review any new evidence that is submitted, regardless of whether the Board has stayed the proceedings, including but not limited to new evidence:

(1) Submitted with the initial complaint;

(2) Submitted with an amended complaint;

(3) Produced during discovery;

(4) Produced when the Board consults with scientific and clinical experts; and

(5) Presented during any hearing.

(b) CMS may submit a statement regarding whether the new evidence is significant under § 426.340, by a deadline set by the Board.

§ 426.518 NCD record furnished to the aggrieved party.

(a) *Elements of the NCD record furnished to the aggrieved party.* Except as provided in paragraph (b) of this section, the NCD record consists of any document or material that CMS considered during the development of the NCD, including, but not limited to, the following:

(1) The NCD being challenged.

(2) Any medical evidence considered on or before the date the NCD was issued, including, but not limited to, the following:

(i) Scientific articles.

(ii) Technology assessments.

(iii) Clinical guidelines.

(iv) Statements from clinical experts, medical textbooks, claims data, or other indication of medical standard of practice.

(v) MCAC transcripts.

(3) Public comments received during the notice and comment period.

(4) Coverage decision memoranda.

(5) An index of documents considered that are excluded under paragraph (b) of this section.

(b) *Elements of the NCD record not furnished to the aggrieved party.* The NCD record furnished to the aggrieved party does not include the following:

(1) Proprietary data or privileged information.

(2) Any new evidence.

§ 426.519 NCD record furnished to the Board.

The NCD record furnished to the Board includes—

(a) Documents included in § 426.518(a); and

(b) Privileged information and proprietary data considered that must be filed with the Board under seal.

§ 426.520 Withdrawing an NCD under review or issuing a revised or reconsidered NCD.

(a) CMS may withdraw an NCD or NCD provision under review before the date the Board issues a decision regarding that NCD. Withdrawing an NCD or NCD provision under review has the same effect as a decision under § 426.560(b).

(b) CMS may revise an NCD under review to remove or amend the NCD provision listed in the complaint through the reconsideration process before the date the Board issues a decision regarding that NCD. Revising an NCD under review to remove the NCD provision in question has the same effect as a decision under § 426.560(b).

(c) CMS must notify the Board within 48 hours of—

(1) Withdrawing an NCD or NCD provision that is under review; or

(2) Issuing a revised or reconsidered version of the NCD that is under review.

(d) If CMS issues a revised or reconsidered NCD, CMS forwards a copy of the revised/reconsidered NCD to the Board.

(e) The Board must take the following actions upon receiving a notice that CMS has withdrawn or revised/reconsidered an NCD under review:

(1) If, before the Board issues a decision, the Board receives notice that CMS has withdrawn the NCD or revised the NCD to completely remove the provision in question, the Board must dismiss the complaint and inform the aggrieved party (ies) who sought the review that he or she or they will receive individual claim review without the retired/withdrawn provisions.

(2) If, before the Board issues a decision, the Board receives notice that CMS has revised the NCD provision in question but has not removed it altogether, the Board must continue the review based on the revised NCD. In this case, CMS must send a copy of the supplemental record to the Board and all parties. In that circumstance, the Board permits the aggrieved party to respond to the revised NCD and the supplemental record.

§ 426.523 Withdrawing a complaint regarding an NCD under review.

(a) *Circumstance under which an aggrieved party withdraws a complaint regarding an NCD.* An aggrieved party who filed a complaint regarding an NCD may withdraw the complaint before the Board issues a decision regarding that NCD. The aggrieved party may not file another complaint concerning the same coverage determination for 6 months.

(b) *Process for an aggrieved party withdrawing a complaint regarding an NCD.* To withdraw a complaint regarding an NCD, the aggrieved party who filed the complaint must send a written withdrawal notice to the Board (*see* § 426.500) and CMS. Supplementing an acceptable complaint with new evidence does not constitute a withdrawal of a complaint, as described in § 426.503.

(c) *Actions the Board must take upon receiving a notice announcing the intent to withdraw a complaint regarding an NCD*—(1) *NCD reviews involving one aggrieved party.* If the Board receives a withdrawal notice regarding an NCD before the date the Board issued a decision regarding that NCD, the Board issues a decision dismissing the complaint under § 426.544 and informs the aggrieved party that he or she may not file another complaint to the same coverage determination for 6 months.

(2) *NCD reviews involving joint complaints.* If the Board receives a notice from an aggrieved party who is named in a joint complaint withdrawing a complaint regarding an NCD before the date the Board issued a decision regarding that NCD, the Board issues a decision dismissing only that aggrieved party from the complaint under § 426.544. The Board continues the NCD review if there is one or more aggrieved party who does not withdraw from the joint complaint.

(3) *Consolidated NCD reviews.* If the Board receives a notice from an aggrieved party who is part of a consolidated NCD review withdrawing a complaint regarding an NCD before the date the Board issued a decision regarding that NCD, the Board removes that aggrieved party from the consolidated NCD review and issues a decision dismissing that aggrieved party's complaint under § 426.544. The Board continues the NCD review if there is one or more aggrieved party who does not withdraw from the joint complaint.

§ 426.525 NCD review.

(a) *Opportunity for the aggrieved party after his or her review of the NCD record to state why the NCD is not valid.* Upon receipt of the NCD record, the aggrieved party files a statement explaining why the NCD record is not complete, or not adequate to support the validity of the NCD under the reasonableness standard. This statement must be submitted to the Board and CMS, within 30 days (or within additional time as allowed by the Board for good cause shown) of the date the aggrieved party receives the NCD record.

(b) *CMS response.* CMS has 30 days, after receiving the aggrieved party's

statement, to submit a response to the Board in order to defend the NCD.

(c) *Board evaluation.* (1) After the aggrieved party files a statement and CMS responds as described in § 426.525(a) and § 426.525(b), or the time for filing has expired, the Board applies the reasonableness standard to determine whether the NCD record is complete and adequate to support the validity of the NCD.

(2) Issuance of a decision finding the record complete and adequate to support the validity of the NCD ends the review process.

(3) If the Board determines that the NCD record is not complete and adequate to support the validity of the NCD, the Board permits discovery and the taking of evidence in accordance with § 426.532 and § 426.540, and evaluate the NCD in accordance with § 426.531.

(d) The process described in paragraphs (a), (b), and (c) of this section applies when an NCD record has been supplemented, except that discovery and the taking of evidence is not repeated. The period for the aggrieved party to file a statement begins when the aggrieved party receives the supplement.

§ 426.531 Board's review of the NCD to apply the reasonableness standard.

(a) *Required steps.* The Board must do the following to review the provision(s) listed in the aggrieved party's complaint based on the reasonableness standard:

(1) Confine the NCD review to the provision(s) of the NCD raised in the aggrieved party's complaint.

(2) Conduct a hearing unless the matter can be decided on the written record.

(3) Close the NCD review record to the taking of evidence.

(4) Treat as precedential any previous Board decision made under § 426.547 that involves the same NCD provision(s), same specific issue and facts in question, and the same clinical conditions.

(5) Issue a decision as described in § 426.547.

(b) *Optional steps.* The Board may consult with appropriate scientific or clinical experts concerning clinical and scientific evidence to apply the reasonableness standard to the provision(s) listed in the aggrieved party's complaint.

(c) *Authority for the Board in NCD reviews when applying the reasonableness standard.* In applying the reasonableness standard to a provision (or provisions) of an NCD, the Board must follow all applicable laws and regulations, as well as NCDs other than the one under review.

§ 426.532 Discovery.

(a) *General rule.* If the Board orders discovery, the Board must establish a reasonable timeframe for discovery.

(b) *Protective order*—(1) *Request for a protective order.* Any party receiving a discovery request may file a motion for a protective order before the date of production of the discovery.

(2) *The Board granting of a protective order.* The Board may grant a motion for a protective order if it finds that the discovery sought—

(i) Is irrelevant or unduly repetitive;

(ii) Is unduly costly or burdensome; or

(iii) Will unduly delay the proceeding.

(c) *Types of discovery available.* A party may obtain discovery via a request for the production of documents, and/or via the submission of up to 10 written interrogatory questions, relating to a specific NCD.

(d) *Types of documents.* For the purpose of this section, the term documents includes relevant information, reports, answers, records, accounts, papers, and other data and documentary evidence. Nothing contained in this section will be interpreted to require the creation of a document.

(e) *Types of discovery not available.* Requests for admissions, depositions, or any other forms of discovery, other than those permitted under paragraph (c) of this section, are not authorized.

(f) *Privileged information or proprietary data.* The Board must not under any circumstances order the disclosure of privileged information or proprietary data filed under seal without the consent of the party who possesses the right to protection of the information.

(g) *Notification.* The Board notifies all parties in writing when the discovery period will be closed.

§ 426.535 Subpoenas.

(a) *Purpose of a subpoena.* A subpoena requires the attendance of an individual at a hearing and may also require a party to produce evidence authorized under § 426.540 at or before the hearing.

(b) *Filing a motion for a subpoena.* A party seeking a subpoena must file a written motion with the Board not less than 30 days before the date fixed for the hearing. The motion must do all of the following:

(1) Designate the witnesses.

(2) Specify any evidence to be produced.

(3) Describe the address and location with sufficient particularity to permit the witnesses to be found.

(4) State the pertinent facts that the party expects to establish by witnesses or documents and state whether those facts could be established by evidence other than by the use of a subpoena.

(c) *Response to a motion for a subpoena.* Within 15 days after the written motion requesting issuance of a subpoena is served on all parties, any party may file an opposition to the motion or other response.

(d) *Extension for good cause shown.* The Board may modify the deadlines specified in paragraphs (b) and (c) of this section for good cause shown.

(e) *Motion for a subpoena granted.* If the Board grants a motion requesting issuance of a subpoena, the subpoena must do the following:

(1) Be issued in the name of the presiding Board member.

(2) Include the docket number and title of the NCD under review.

(3) Provide notice that the subpoena is issued according to sections 1872 and 205(d) and (e) of the Act.

(4) Specify the time and place at which the witness is to appear and any evidence the witness is to produce.

(f) *Delivery of the subpoena.* The party seeking the subpoena serves it by personal delivery to the individual named, or by certified mail return receipt requested, addressed to the individual at his or her last dwelling place or principal place of business.

(g) *Motion to quash a subpoena.* The individual to whom the subpoena is directed may file with the Board a motion to quash the subpoena within 10 days after service.

(h) *Refusal to obey a subpoena.* The exclusive remedy for contumacy by, or refusal to obey, a subpoena duly served upon any person is specified in section 205(e) of the Act (42 U.S.C. 405(e)) except that any reference to the "Commissioner of Social Security" shall be considered a reference to the "Secretary."

§ 426.540 Evidence.

(a) Except as provided in this part, the Board is not bound by the Federal Rules of Evidence. However, the Board may apply the Federal Rules of Evidence when appropriate, for example, to exclude unreliable evidence.

(b) The Board must exclude evidence that it determines is clearly irrelevant or immaterial, or unduly repetitive.

(c) The Board may accept privileged information or proprietary data, but must maintain it under seal.

(d) The Board may permit the parties to introduce the testimony of expert witnesses on scientific and clinical issues, rebuttal witnesses, and other relevant evidence. The Board may require that the testimony of expert witnesses be submitted in the form of a

written report, accompanied by the curriculum vitae of the expert preparing the report.

(e) Experts submitting reports must be available for cross-examination at an evidentiary hearing upon request of the Board or a party to the proceeding, or the report will be excluded from the record.

(f) Except as set forth in paragraph (c) of this section or unless otherwise ordered by the Board for good cause shown, all documents and other evidence offered or taken for the record is open to examination by all parties.

§ 426.544 Dismissals for cause.

(a) The Board may, at the request of any party, or on its own motion, dismiss a complaint if the aggrieved party fails to do either of the following:

(1) Attend or participate in a prehearing conference (the prehearing may be conducted by telephone) or hearing without good cause shown.

(2) Comply with a lawful order of the Board without cause shown.

(b) The Board must dismiss any complaint concerning NCD provision(s) if the following conditions exist:

(1) The Board does not have the authority to rule on that provision under § 426.505(d).

(2) The complaint is not timely. (*See* § 426.500(b)).

(3) The complaint is not filed by an aggrieved party.

(4) The complaint is filed by an individual who fails to provide an adequate statement of need for the service from the treating physician.

(5) The complaint challenges a provision or provisions of an LCD except as provided in § 426.476, regarding the Board's review of an ALJ decision. (*See* § 426.505, regarding the authority of the Board.)

(6) CMS notifies the Board that the NCD provision(s) is (are) no longer in effect.

(7) The aggrieved party withdraws the complaint. (*See* § 426.523, for requirements for withdrawing a complaint regarding an NCD under review.)

§ 426.545 Witness fees.

(a) A witness testifying at a hearing before the Board receives the same fees and mileage as witnesses in Federal district courts of the United States. If the witness qualifies as an expert, he or she is entitled to an expert witness fee. Witness fees are paid by the party seeking to present the witness.

(b) If the Board requests expert testimony, the Board is responsible for paying all applicable fees and mileage, unless the expert waives payment.

§ 426.546 Record of hearing.

The Board must ensure that all hearings are open to the public and are electronically, mechanically, or stenographically reported. Except for privileged information and proprietary data that are filed under seal, all evidence upon which the Board relies for decision must be admitted into the public record. All medical reports, exhibits, and any other pertinent document, either in whole or in material part, must be offered, marked for identification, and retained in the case record.

§ 426.547 Issuance, notification, and posting of a Board's decision.

The Board must do the following:

(a) Issue to all parties to the NCD review, within 90 days of closing the NCD review record to the taking of evidence, one of the following:

(1) A written decision, including a description of appeal rights.

(2) A written notification stating that a decision is pending, and an approximate date of issuance for the decision.

(b) Make the decision available at the HHS Medicare Internet site. The posted decision does not include any information that identifies any individual, provider of service, or supplier.

§ 426.550 Mandatory provisions of the Board's decision.

(a) *Findings.* The Board's decision must include one of the following:

(1) A determination that the provision of the NCD is valid under the reasonableness standard.

(2) A determination that the provision of the NCD is not valid under the reasonableness standard.

(3) A statement dismissing the complaint regarding the NCD, and a rationale for the dismissal.

(4) A determination that the LCD or NCD record is complete and adequate to support the validity of the LCD or NCD provisions under the reasonableness standard.

(b) *Other information.* The Board's decision must include all of the following:

(1) The date of issuance.

(2) The docket number of the NCD review.

(3) A statement as to whether the aggrieved party has filed a claim for the service(s) named in the complaint, the date(s)-of-service, and the disposition, if known.

(4) A basis for concluding that the NCD was or was not valid based on the application of the reasonableness standard to the record before the Board, including CMS':

(i) Findings of fact.

(ii) Interpretations of law.

(iii) Applications of fact to law.

(5) A summary of the evidence reviewed. Where proprietary or privileged data were submitted under seal, the decision must state whether the data were material and what role they played in the determination, but without disclosing the substance or contents of the evidence under seal. A separate statement of the rationale for the Board's treatment of the sealed evidence must be prepared and kept under seal itself. If the Board decision is appealed to the court, this statement must be provided to the court, under seal.

(6) A statement regarding the right to judicial review.

§ 426.555 Prohibited provisions of the Board's decision.

The Board's decision may not do any of the following:

(a) Order CMS to add any language to a provision or provisions of an NCD.

(b) Order CMS or its contractors to pay a specific claim.

(c) Set a time limit for CMS to establish a new or revised NCD.

(d) Review or evaluate an NCD other than the NCD under review.

(e) Include a requirement for CMS or its contractors that specifies payment, coding, or systems changes for an NCD, or deadlines for implementing these types of changes.

(f) Order or address how CMS implements an NCD.

§ 426.557 Optional provisions of the Board's decision.

When appropriate, the Board may limit a decision holding invalid a specific provision(s) of an NCD to specific clinical indications and for similar conditions.

§ 426.560 Effect of the Board's decision.

(a) *Valid under the reasonableness standard.* If the Board finds that the provision (or provisions) of an NCD named in the complaint is (are) valid under the reasonableness standard, the aggrieved party may challenge the final agency action in Federal court.

(b) *Not valid under the reasonableness standard.* If the Board finds that the provision (or provisions) of an NCD named in the complaint is (are) invalid under the reasonableness standard, then CMS instructs its contractor, M+C organization, or other Medicare managed care organization to provide the following—

(1) Individual claim review. (i) If the aggrieved party's claim/appeal(s) was previously denied, the contractor, an

M+C organization, or another Medicare managed care organization must reopen the claim of the party who challenged the LCD and adjudicate the claim without using the provision(s) of the NCD that the Board found invalid.

(ii) If a revised NCD is issued, contractors, M+C organizations, and other Medicare managed care organizations must use the revised NCD in reviewing claim/appeal submissions or request for services delivered or services performed on or after the effective date of the revised NCD.

(iii) If the aggrieved party who sought review has not yet submitted a claim, the contractor must adjudicate the claim without using the provision(s) of the NCD that the Board found invalid.

(iv) In either case, the claim and any subsequent claims for the service provided under the same circumstances, must be adjudicated without using the NCD provision(s) found invalid.

(2) *Coverage determination relief.* Within 30 days, CMS implements the Board decision. Any change in policy is applied prospectively to requests for service or claims filed with dates of service after the implementation of the Board decision.

§ 426.562 Notice of the Board's decision.

After the Board has made a decision regarding an NCD complaint, the Board sends a written notice of the decision to each party. The notice must—

(a) State the outcome of the review; and

(b) Inform each party to the determination of his or her rights to seek further review if he or she is dissatisfied with the determination, and the time limit under which an appeal must be requested.

§ 426.563 Future new or revised or reconsidered NCDs.

CMS may not reinstate an NCD provision(s) found to be unreasonable unless CMS has a different basis (such as additional evidence) than what the Board evaluated.

§ 426.565 Board's role in making an LCD or NCD review record available.

Upon a request from a Federal Court, the Board must provide to the Federal Court a copy of the Board's LCD or NCD review record (as described in § 426.587).

§ 426.566 Board decision.

A decision by the Board constitutes a final agency action and is subject to judicial review. CMS may not appeal a Board decision.

§ 426.587 Record for appeal of a Board NCD decision.

(a) *Elements of the Board's NCD review record furnished to the public.* Except as provided in paragraph (b) of this section, the Board's NCD review record consists of any document or material that the Board compiled or considered during an NCD review, including, but not limited to, the following:

(1) The NCD complaint.

(2) The NCD and NCD record.

(3) The supplemental NCD record, if applicable.

(4) Transcripts of record.

(5) Any other evidence relevant gathered under § 426.540.

(6) The Board's decision.

(b) *Documents excluded from the NCD review record furnished to the court.* The NCD review record furnished to the court maintains the seal on privileged information or proprietary data that is maintained under seal by the Board. In the event a court seeks to obtain or requires disclosure of any documents excluded from the NCD record as privileged information or proprietary data, CMS or the Department seeks to have a protective order issued for those documents, as appropriate.

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: July 1, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: October 30, 2003.

Tommy G. Thompson,

Secretary.

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The items in this list were editorially compiled as an aid to Federal Register users. Inclusion or exclusion from this list has no legal significance.

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Air quality implementation plans; approval and promulgation; various States:
- Nevada; published 9-8-03

HOMELAND SECURITY DEPARTMENT

Coast Guard

Regattas and marine parades:
- Isle of Wight Bay fireworks display; published 10-8-03

INTERIOR DEPARTMENT

Fish and Wildlife Service

Migratory bird permits:
- Double-crested cormorant management; published 10-8-03

TRANSPORTATION DEPARTMENT

Federal Aviation Administration

Airworthiness directives:
- Fairchild Aircraft, Inc.; published 9-23-03
- Saab; published 10-3-03

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AGRICULTURE DEPARTMENT

Agricultural Marketing Service

Oranges, grapefruit, tangerines, and tangelos grown in Florida, and imported; comments due by 11-10-03; published 9-9-03 [FR 03-22948]

AGRICULTURE DEPARTMENT

Animal and Plant Health Inspection Service

Plant related quarantine; foreign:
- Eucalyptus logs, lumber and wood chips from South America; comments due by 11-14-03; published 9-15-03 [FR 03-23432]

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Forest Service

National Forest System land and resource management planning; comments due by 11-10-03; published 9-10-03 [FR 03-22977]

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Endangered and threatened species:
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Endangered Species Act; interagency cooperation:
- National Fire Plan; implementation; comments due by 11-10-03; published 10-9-03 [FR 03-25621]

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- Caribbean, Gulf, and South Atlantic fisheries—
  - Gulf of Mexico king mackerel, Spanish mackerel, and cobia; comments due by 11-13-03; published 10-14-03 [FR 03-25924]
  - Gulf of Mexico red snapper; comments due by 11-12-03; published 10-27-03 [FR 03-27035]
  - Gulf of Mexico shrimp; comments due by 11-14-03; published 9-30-03 [FR 03-24737]
- West Coast States and Western Pacific fisheries—
  - Pacific Coast Groundfish Fishery Management Plan; comments due by 11-14-03; published 10-15-03 [FR 03-26075]
  - Pacific whiting; comments due by 11-13-03; published 10-29-03 [FR 03-27248]

International fisheries regulations:
- Fraser River sockeye and pink salmon; inseason orders; comments due by 11-10-03; published 10-24-03 [FR 03-26928]

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- 21st Century Strategic Plan; implementation; comments due by 11-12-03; published 9-12-03 [FR 03-23010]

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- Government source inspection requirements; elimination; comments due by 11-14-03; published 9-15-03 [FR 03-23341]

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- Unique item identification and valuation; supplement; comments due by 11-10-03; published 10-10-03 [FR 03-25827]

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Federal Energy Regulatory Commission

Electric rate and corporate regulation filings:
- Virginia Electric & Power Co. et al.; Open for comments until further notice; published 10-1-03 [FR 03-24818]

ENVIRONMENTAL PROTECTION AGENCY

Air quality implementation plans; approval and promulgation; various States:
- California; comments due by 11-13-03; published 10-14-03 [FR 03-25800]
- Kentucky; comments due by 11-13-03; published 10-14-03 [FR 03-25798]
- Nevada; comments due by 11-10-03; published 10-10-03 [FR 03-25802]
- New Mexico; comments due by 11-10-03; published 10-9-03 [FR 03-25543]
- Pennsylvania; comments due by 11-10-03; published 10-10-03 [FR 03-25634]

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  - Oregon; comments due by 11-10-03; published 10-10-03 [FR 03-25525]

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- National primary drinking water regulations—
  - Long Term 2 Enhanced Surface Water Treatment Rule; comments due by 11-10-03; published 8-11-03 [FR 03-18295]

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FEDERAL COMMUNICATIONS COMMISSION

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LIST OF PUBLIC LAWS

This is a continuing list of public bills from the current session of Congress which have become Federal laws. It may be used in conjunction with "PLUS" (Public Laws Update Service) on 202–741–6043. This list is also available online at *http://www.nara.gov/fedreg/plawcurr.html.*

The text of laws is not published in the **Federal**

Register but may be ordered in "slip law" (individual pamphlet) form from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402 (phone, 202–512–1808). The text will also be made available on the Internet from GPO Access at *http://www.access.gpo.gov/nara/nara005.html*. Some laws may not yet be available.

S. 3/P.L. 108–105

Partial-Birth Abortion Ban Act of 2003 (Nov. 5, 2003; 117 Stat. 1201)

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