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OFFICE OF GOVERNMENT ETHICS

5 CFR Part 2635

RIN 3209–AAO4

Standards of Ethical Conduct for Employees of the Executive Branch; Definition of Compensation for Purposes of Prohibition on Acceptance of Compensation in Connection With Certain Teaching, Speaking and Writing Activities

AGENCY: Office of Government Ethics (OGE).

ACTION: Final rule; amendment.

SUMMARY: The Office of Government Ethics is adopting as final, with minor, nonsubstantive modifications, an interim rule amending the prohibition on employees' receipt of compensation for outside teaching, speaking and writing, as set forth in the Standards of Ethical Conduct for Employees of the Executive Branch. The amendment permits employees other than covered noncareer employees to accept travel expenses incurred in connection with covered teaching, speaking and writing activities.

EFFECTIVE DATE: December 31, 2001.

FOR FURTHER INFORMATION CONTACT: William E. Gressman, Senior Associate General Counsel, Office of Government Ethics; telephone: 202–208–8000; TDD: 202–208–8025; FAX: 202–208–8037.

SUPPLEMENTARY INFORMATION: On September 5, 2000, OGE published for comment an interim rule amending 5 CFR 2635.807(a) to allow employees other than covered noncareer employees to accept from outside sources travel expenses incurred in connection with certain outside teaching, speaking, and writing activities considered ''related to official duties'' under the rule. See 65 FR 53650–53652. As more fully explained in the preamble to the interim rule, *id.* at 53650–53651, the purpose of the amendment was to bring § 2635.807(a) into conformity with the May 30, 1995, decision by the United States Court of Appeals for the District of Columbia Circuit in *Sanjour* v. *Environmental Protection Agency*, 56 F.3d 85 (*en banc*), as clarified in the April 14, 1998, decision on remand by the United States District Court for the District of Columbia, 7 F. Supp.2d 14 (D.D.C. 1998).

The Office of Government Ethics received three sets of comments in response to publication of the interim rule. One agency, noting that Examples 1 and 2 conclude that the speaking activities there addressed are ''related to her duties'' or ''related to duties,'' suggested we clarify that the speaking activities are related to *official* duties. We have followed this suggestion. Including the word ''official'' provides clarity and is more consistent with the language defining teaching, speaking or writing as related ''to the employee's *official* duties'' (emphasis added) in the circumstances set forth in paragraphs (A) through (E) of § 2635.807(a)(2)(i). The change also conforms to the language used at the conclusion of Example 3.

The same agency also recommended that we delete the word ''career'' in the final sentence of Example 1, which currently provides, ''travel expenses incurred in connection with the speaking engagement * * * are not prohibited compensation for a career GS–15 employee.'' We have also adopted this recommendation. Under 5 CFR 2636.303(a), a GS–15 employee is not a ''covered noncareer employee'' because his/her rate of basic pay is not, by definition, ''equal to or greater than 120 percent of the minimum rate of basic pay payable for GS–15 of the General Schedule.'' The emphasis on the employee's ''career'' status is thus unnecessary and could have the unfortunate effect of misleading some readers into thinking that the travel expense reimbursements *would* be prohibited compensation for a *noncareer* employee paid at or below the GS–15 level.

Two employees commenting together applauded the relaxation of the travel expenses ban as an opportunity to ''expand the dissemination of federal program information'' and, further, suggested that we expand the definition of ''teaching, speaking, or writing relate[d] * * * to duties'' to include less formal activities so that travel expenses may be accepted for travel to any ''function at which a Federal presence is desired.'' These commenters misunderstand the purpose of the amendment. The amendment is intended to allow employees, other than covered noncareer employees, who are involved in teaching, speaking and writing activities *in their private capacities* to accept travel reimbursements incurred in connection with those activities. The intent is not to facilitate *official* travel. In the absence of specific statutory authority such as 31 U.S.C. 1353, 5 U.S.C. 4111 or 7342, or agency gift acceptance statutes, augmentation of agency appropriations through acceptance of non-Federal contributions for agency travel is prohibited. Moreover, employee acceptance, *in a private capacity*, of non-Federal contributions of travel expenses incurred in connection with *official* speech could raise concerns under 18 U.S.C. 209. The first sentence of the note following paragraph (a)(2)(iii)(D) is intended to alert employees to the possible implications of section 209 where travel expenses are incurred in connection with teaching, speaking, or writing undertaken as an employee, *i.e.*, officially.

An additional suggestion by these employees—''that sponsoring/inviting organizations be allowed to contribute honorariums, which would otherwise be payable to an individual, to legitimate volunteer/charitable organizations, without reference/designation to the Federal employee''—similarly misconstrues the reach of § 2635.807. The compensation bar applies only to executive branch employees. Nothing in the rule prohibits outside organizations from any form of giving on their own to charitable or for-profit organizations.

One agency recommended that we add to § 2635.807 a ''definition of 'travel expenses' in order to avoid any confusion about what this phrase is deemed to cover (transportation, lodging, incidentals, meals, etc.).'' We have not followed this suggestion. For purposes of the compensation prohibition, existing § 2635.807(a)(2)(iii) makes clear that the term ''compensation'' is comprehensive of any ''consideration, remuneration or income * * * given for or in connection with the employee's teaching, speaking

or writing activities'' and explicitly includes ''transportation, lodgings and meals.'' The exception at paragraph (a)(2)(iii)(D) is equally clear, excluding from the definition of ''compensation'' ''travel expenses, consisting of transportation, lodgings or meals, incurred in connection with the teaching, speaking or writing activity'' by employees other than covered noncareer employees.

That agency also suggested that, in Example 1, we say that ''the speaking engagement'' rather than the ''speech'' is related to duties under § 2635.807(a)(2)(i)(C) because the nexus to the employee's work is not the content of the speech but, rather, the fact that the employee is involved in drafting a regulation that will affect the organization that extended the speaking invitation. We have changed the wording to ''speaking activity,'' a phrase used elsewhere in the regulation.

The same agency asked that we consider adding a note addressing the responsibility of employees who file financial disclosure forms to report on their forms any travel expenses they accept under the amended rule. We have added to the note following paragraph (a)(2)(iii)(D) a second sentence that alerts filers of financial disclosure reports of their obligation to report travel and travel reimbursements.

Finally, OGE is updating the citation in Example 4 to the General Services Administration's regulation implementing 31 U.S.C. 1353.

Matters of Regulatory Procedure

Executive Order 12866

In promulgating this final rule amendment, the Office of Government Ethics has adhered to the regulatory philosophy and the applicable principles of regulation set forth in section 1 of Executive Order 12866, Regulatory Review and Planning. The amendment has also been reviewed by the Office of Management and Budget under that Executive order.

Executive Order 12988

As Director of the Office of Government Ethics, I have reviewed this final amendatory regulation in light of section 3 of Executive Order 12988, Civil Justice Reform, and certify that it meets the applicable standards provided therein.

Regulatory Flexibility Act

As Director of the Office of Government Ethics, I certify under the Regulatory Flexibility Act (5 U.S.C. chapter 6) that this amendatory rule will not have a significant economic impact on a substantial number of small entities because it primarily affects Federal executive branch employees.

Paperwork Reduction Act

The Paperwork Reduction Act (44 U.S.C. chapter 35) does not apply because this amendment does not contain information collection requirements that require the approval of the Office of Management and Budget.

Congressional Review Act

The Office of Government Ethics has determined that this amendatory rulemaking is a nonmajor rule under the Congressional Review Act (5 U.S.C. chapter 8) and has provided a report thereon to the United States Senate, House of Representatives and General Accounting Office in accordance with that law.

Unfunded Mandates Reform Act

For purposes of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. chapter 25, subchapter II), this rule will not significantly or uniquely affect small governments and will not result in increased expenditures by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (as adjusted for inflation).

List of Subjects in 5 CFR Part 2635

Conflict of interests, Executive branch standards of ethical conduct, Government employees.

Approved: September 18, 2001.

Amy L. Comstock,

Director, Office of Government Ethics.

Accordingly, for the reasons set forth in the preamble, the Office of Government Ethics is adopting the interim rule amending 5 CFR part 2635, which was published at 65 FR 53650–53652 on September 5, 2000, as final with the following changes:

PART 2635—STANDARDS OF ETHICAL CONDUCT FOR EMPLOYEES OF THE EXECUTIVE BRANCH

1. The authority citation for part 2635 continues to read as follows:

Authority: 5 U.S.C. 7301, 7351, 7353; 5 U.S.C. App. (Ethics in Government Act of 1978); E.O. 12674, 54 FR 15159, 3 CFR, 1989 Comp., p. 215, as modified by E.O. 12731, 55 FR 42547, 3 CFR, 1990 Comp., p. 306.

Subpart H—Outside Activities

2. In § 2635.807, paragraph (a)(2)(iii)(D) and Example 3 following paragraph (a)(2)(iii)(D) are republished, and the Note and Examples 1, 2 and 4 following paragraph (a)(2)(iii)(D) are revised to read as follows:

§ 2635.807 Teaching, speaking and writing.

(a) * * *

(2) * * *

(iii) * * *

(D) In the case of an employee other than a covered noncareer employee as defined in 5 CFR 2636.303(a), travel expenses, consisting of transportation, lodgings or meals, incurred in connection with the teaching, speaking or writing activity.

Note to Paragraph (a)(2)(iii): Independent of § 2635.807(a), other authorities, such as 18 U.S.C. 209, in some circumstances may limit or entirely preclude an employee's acceptance of travel expenses. In addition, employees who file financial disclosure reports should be aware that, subject to applicable thresholds and exclusions, travel and travel reimbursements accepted from sources other than the United States Government must be reported on their financial disclosure reports.

Example 1 to paragraph (a)(2)(iii): A GS–15 employee of the Forest Service has developed and marketed, in her private capacity, a speed reading technique for which popular demand is growing. She is invited to speak about the technique by a representative of an organization that will be substantially affected by a regulation on land management which the employee is in the process of drafting for the Forest Service. The representative offers to pay the employee a $200 speaker's fee and to reimburse all her travel expenses. She may accept the travel reimbursements, but not the speaker's fee. The speaking activity is related to her official duties under § 2635.807(a)(2)(i)(C) and the fee is prohibited compensation for such speech; travel expenses incurred in connection with the speaking engagement, on the other hand, are not prohibited compensation for a GS–15 employee.

Example 2 to paragraph (a)(2)(iii): Solely because of her recent appointment to a Cabinet-level position, a Government official is invited by the Chief Executive Officer of a major international corporation to attend firm meetings to be held in Aspen for the purpose of addressing senior corporate managers on the importance of recreational activities to a balanced lifestyle. The firm offers to reimburse the official's travel expenses. The official may not accept the offer. The speaking activity is related to official duties under § 2635.807(a)(2)(i)(B) and, because she is a covered noncareer employee as defined in § 2636.303(a) of this chapter, the travel expenses are prohibited compensation as to her.

Example 3 to paragraph (a)(2)(iii): A GS–14 attorney at the Federal Trade Commission (FTC) who played a lead role in a recently concluded merger case is invited to speak about the case, in his private capacity, at a conference in New York. The attorney has no public speaking responsibilities on behalf of the FTC apart from the judicial and administrative proceedings to which he is assigned. The sponsors of the conference offer to reimburse the attorney for expenses incurred in connection with his travel to

New York. They also offer him, as compensation for his time and effort, a free trip to San Francisco. The attorney may accept the travel expenses to New York, but not the expenses to San Francisco. The lecture relates to his official duties under paragraphs (a)(2)(i)(E)(*1*) and (a)(2)(i)(E)(*2*) of § 2635.807, but because he is not a covered noncareer employee as defined in § 2636.303(a) of this chapter, the expenses associated with his travel to New York are not a prohibited form of compensation as to him. The travel expenses to San Francisco, on the other hand, not incurred in connection with the speaking activity, are a prohibited form of compensation. If the attorney were a covered noncareer employee he would be barred from accepting the travel expenses to New York as well as the travel expenses to San Francisco.

Example 4 to paragraph (a)(2)(iii): An advocacy group dedicated to improving treatments for severe pain asks the National Institutes of Health (NIH) to provide a conference speaker who can discuss recent advances in the agency's research on pain. The group also offers to pay the employee's travel expenses to attend the conference. After performing the required conflict of interest analysis, NIH authorizes acceptance of the travel expenses under 31 U.S.C. 1353 and the implementing General Services Administration regulation, as codified under 41 CFR chapter 304, and authorizes an employee to undertake the travel. At the conference the advocacy group, as agreed, pays the employee's hotel bill and provides several of his meals. Subsequently the group reimburses the agency for the cost of the employee's airfare and some additional meals. All of the payments by the advocacy group are permissible. Since the employee is speaking officially and the expense payments are accepted under 31 U.S.C. 1353, they are not prohibited compensation under § 2635.807(a)(2)(iii). The same result would obtain with respect to expense payments made by non-Government sources properly authorized under an agency gift acceptance statute, the Government Employees Training Act, 5 U.S.C. 4111, or the foreign gifts law, 5 U.S.C. 7342.

* * * * *

[FR Doc. 01–29800 Filed 11–29–01; 8:45 am]

BILLING CODE 6345–01–U

DEPARTMENT OF AGRICULTURE

Farm Service Agency

7 CFR Part 723

RIN 0560–AG40

Amendments to the Tobacco Marketing Quota Regulations

AGENCY: Farm Service Agency, USDA.

ACTION: Final rule; correction.

SUMMARY: This is a correction of a document the United States Department of Agriculture (USDA) Farm Service Agency (FSA) published in the **Federal Register** of October 23, 2001 that amended its tobacco marketing quota regulations. In that rule, a paragraph number was left out of the instruction for revision number 5. This document adds that paragraph number.

EFFECTIVE DATE: October 23, 2001.

FOR FURTHER INFORMATION CONTACT: Joe Lewis, Jr. (202) 720–0795

SUPPLEMENTARY INFORMATION: FSA published a document entitled, ''Amendments to the Tobacco Marketing Quota Regulations'' on October 23, 2001, (66 FR 53509). The paragraph number in revision number 5 was listed as § 723.206(c)(1), but should have been § 723.206(c)(1)(i). This correction adds that sub-paragraph number.

In rule FR Doc. 01–26543 published on October 23, 2001, (66 FR 53507) make the following correction: On page 53509, revise instruction 5 to read as follows:

''5. Revise § 723.206(c)(1)(i) to read as follows:''.

Signed at Washington, DC on November 7, 2001.

James R. Little,

Administrator, Farm Service Agency and Executive Vice President, Commodity Credit Corporation.

[FR Doc. 01–29706 Filed 11–29–01; 8:45 am]

BILLING CODE 3410–05–P

DEPARTMENT OF AGRICULTURE

Agricultural Marketing Service

7 CFR Part 924

[Docket No. FV01–924–1 FIR]

Fresh Prunes Grown in Designated Counties in Washington and Umatilla County, OR; Decreased Assessment Rate

AGENCY: Agricultural Marketing Service, USDA.

ACTION: Final rule.

SUMMARY: The Department of Agriculture (USDA) is adopting, as a final rule, without change, an interim final rule which decreases the assessment rate established for the Washington-Oregon Fresh Prune Marketing Committee (Committee) for the 2001–2002 and subsequent fiscal periods from $1.50 to $1.00 per ton of fresh prunes handled. The Committee locally administers the marketing order which regulates the handling of fresh prunes grown in designated counties in Washington and Umatilla County, Oregon. Authorization to assess fresh prune handlers enables the Committee to incur expenses that are reasonable and necessary to administer the program. The fiscal period began April 1 and ends March 31. The assessment rate will remain in effect indefinitely unless modified, suspended, or terminated.

EFFECTIVE DATE: December 31, 2001.

FOR FURTHER INFORMATION CONTACT: Teresa Hutchinson, Northwest Marketing Field Office, Fruit and Vegetable Programs, AMS, USDA, 1220 SW Third Avenue, suite 385, Portland, OR 97204; telephone: (503) 326–2724, Fax: (503) 326–7440; or George Kelhart, Technical Advisor, Marketing Order Administration Branch, Fruit and Vegetable Programs, AMS, USDA, P.O. Box 96456, room 2525–S, Washington, DC 20090–6456; telephone: (202) 720–2491, Fax: (202) 720–8938.

Small businesses may request information on complying with this regulation by contacting Jay Guerber, Marketing Order Administration Branch, Fruit and Vegetable Programs, AMS, USDA, P.O. Box 96456, room 2525–S, Washington, DC 20090–6456; telephone: (202) 720–2491, Fax: (202) 720–8938, or E-mail: *Jay.Guerber@usda.gov.*

SUPPLEMENTARY INFORMATION: This rule is issued under Marketing Order No. 924, as amended (7 CFR part 924), regulating the handling of fresh prunes grown in designated counties in Washington and Umatilla County, Oregon, hereinafter referred to as the ''order.'' The order is effective under the Agricultural Marketing Agreement Act of 1937, as amended (7 U.S.C. 601–674), hereinafter referred to as the ''Act.''

The USDA is issuing this rule in conformance with Executive Order 12866.

This rule has been reviewed under Executive Order 12988, Civil Justice Reform. Under the marketing order now in effect, Washington-Oregon fresh prune handlers are subject to assessments. Funds to administer the order are derived from such assessments. It is intended that the assessment rate as issued herein will be applicable to all assessable fresh prunes beginning April 1, 2001, and continue until amended, suspended, or terminated. This rule will not preempt any State or local laws, regulations, or policies, unless they present an irreconcilable conflict with this rule.

The Act provides that administrative proceedings must be exhausted before parties may file suit in court. Under section 608c(15)(A) of the Act, any handler subject to an order may file with USDA a petition stating that the order, any provision of the order, or any obligation imposed in connection with

the order is not in accordance with law and request a modification of the order or to be exempted therefrom. Such handler is afforded the opportunity for a hearing on the petition. After the hearing USDA would rule on the petition. The Act provides that the district court of the United States in any district in which the handler is an inhabitant, or has his or her principal place of business, has jurisdiction to review USDA's ruling on the petition, provided an action is filed not later than 20 days after the date of the entry of the ruling.

This rule continues to decrease the assessment rate established for the Committee for the 2001–2002 and subsequent fiscal periods from $1.50 to $1.00 per ton of fresh prunes handled.

The Washington-Oregon fresh prune marketing order provides authority for the Committee, with the approval of USDA, to formulate an annual budget of expenses and collect assessments from handlers to administer the program. The members of the Committee are producers and handlers of Washington-Oregon fresh prunes. They are familiar with the Committee's needs and with the costs for goods and services in their local area and are thus in a position to formulate an appropriate budget and assessment rate. The assessment rate is formulated and discussed in a public meeting. Thus, all directly affected persons have an opportunity to participate and provide input.

For the 1999–2000 and subsequent fiscal periods, the Committee recommended, and USDA approved, an assessment rate that would continue in effect from fiscal period to fiscal period unless modified, suspended, or terminated by USDA upon recommendation and information submitted by the Committee or other information available to USDA.

The Committee met on June 5, 2001, and unanimously recommended 2001–2002 expenditures of $7,804 and an assessment rate of $1.00 per ton of fresh prunes handled. In comparison, last year's budgeted expenditures were $7,803. The assessment rate of $1.00 is $0.50 lower than the rate that was in effect for 2000–2001. At the rate of $1.50 per ton and an estimated 2001–2002 fresh prune production of 4,850 tons, the projected reserve on March 31, 2002, would have exceeded the maximum level authorized by the order (approximately one fiscal period's operational expenses). The reserve on March 31, 2001, was $9,047.

The major expenditures recommended by the Committee for the 2001–2002 fiscal period include $3,461 for salaries, $1,000 for travel, $528 for rent and maintenance, and $475 for its annual audit. Budgeted expenses for these items in 2000–2001 were $3,360, $1,000, $528, and $475, respectively.

The assessment rate recommended by the Committee was derived for the purpose of reducing the operating reserve to a level consistent with the order. As mentioned earlier, fresh prune shipments for the year were estimated at 4,850 tons which should provide $4,850 in assessment income. This income, along with approximately $2,954 from the Committee's authorized reserve, will be adequate to cover the Committee's budgeted expenses of $7,804. With the decreased assessment rate, the reserve of $9,047 (as of March 31, 2001) will be reduced by as much as $2,945, thus leaving a balance of about $6,102 at the end of the 2001–2002 fiscal period. The order permits an operating reserve in an amount not to exceed approximately one fiscal period's operational expenses (§ 924.42).

The assessment rate will continue in effect indefinitely unless modified, suspended, or terminated by USDA upon recommendation and information submitted by the Committee or other available information.

Although this assessment rate is effective for an indefinite period, the Committee will continue to meet prior to or during each fiscal period to recommend a budget of expenses and consider recommendations for modification of the assessment rate. The dates and times of Committee meetings are available from the Committee or USDA. Committee meetings are open to the public and interested persons may express their views at these meetings. The USDA will evaluate Committee recommendations and other available information to determine whether modification of the assessment rate is needed. Further rulemaking will be undertaken as necessary. The Committee's 2001–2002 budget and those for subsequent fiscal periods will be reviewed and, as appropriate, approved by USDA.

Final Regulatory Flexibility Analysis

Pursuant to requirements set forth in the Regulatory Flexibility Act (RFA), the Agricultural Marketing Service (AMS) has considered the economic impact of this rule on small entities. Accordingly, the AMS has prepared this final regulatory flexibility analysis.

The purpose of the RFA is to fit regulatory actions to the scale of business subject to such actions in order that small businesses will not be unduly or disproportionately burdened. Marketing orders issued pursuant to the Act, and the rules issued thereunder, are unique in that they are brought about through group action of essentially small entities acting on their own behalf. Thus, both statutes have small entity orientation and compatibility.

There are approximately 60 producers of fresh prunes in the production area and approximately 12 handlers subject to regulation under the marketing order. Small agricultural producers are defined by the Small Business Administration (13 CFR 121.201) as those having annual receipts less than $750,000 and small agricultural service firms are defined as those whose annual receipts are less than $5,000,000. The standard for determining small agricultural producers was increased from $500,000 to $750,000 in August 2001.

Based on production and producer prices reported by the National Agricultural Statistics Service, and the total number of Washington-Oregon fresh prune producers, the average annual producer revenue is approximately $18,000. In addition, based on Committee records, all of the Washington-Oregon fresh prune handlers ship under $5,000,000 worth of fresh prunes. In view of the foregoing, it can be concluded that the majority of Washington-Oregon fresh prune producers and handlers may be classified as small entities.

This rule continues to decrease the assessment rate established for the Committee and collected from handlers for the 2001–2002 and subsequent fiscal periods from $1.50 to $1.00 per ton of fresh prunes handled. The Committee unanimously recommended 2001–2002 expenditures of $7,804 and an assessment rate of $1.00 per ton of fresh prunes handled. The assessment rate of $1.00 is $0.50 lower than the rate that was in effect for 2000–2001. The quantity of assessable fresh prunes for the 2001–2002 fiscal period is estimated at 4,850 tons. Thus, the $1.00 rate should provide $4,850 in assessment income which along with funds from the Committee's authorized reserve will be adequate to cover budgeted expenses.

The major expenditures recommended by the Committee for the 2001–2002 fiscal period include $3,461 for salaries, $1,000 for travel, $528 for rent and maintenance, and $475 for its annual audit. Budgeted expenses for these items in 2000–2001 were $3,360, $1,000, $528, and $475, respectively.

With a rate of $1.50 per ton and an estimated 2001–2002 fresh prune production of 4,850 tons, the projected reserve on March 31, 2002, would exceed the maximum level authorized by the order (approximately one fiscal period's operational expenses). As of March 31, 2001, the Committee's reserve

was $9,047. With assessment income of $4,850 from the current rate and expenditures of $7,804, the Committee may draw up to $2,945 from its reserve, thus leaving the reserve at approximately $6,102 on March 31, 2002.

The Committee considered alternative levels of assessment but determined that decreasing the assessment rate to $1.00 per ton would be adequate to reduce the reserve to a level lower than approximately one fiscal period's expenses. The Committee decided that an assessment rate of more than $1.00 per ton, but less than $1.50 per ton, would not decrease the reserve to an adequate level. Prior to arriving at this assessment rate, the Committee considered information from various sources, including the Committee's Finance and Executive Committees.

A review of historical information and preliminary information pertaining to the upcoming fiscal period indicates that the producer price for the 2001–2002 marketing season could range between $160 and $275 per ton of fresh prunes handled. Therefore, the estimated assessment revenue for the 2001–2002 fiscal period as a percentage of total grower revenue should range between 0.36 and 0.63 percent.

This action continues to decrease the assessment obligation imposed on handlers. Assessments are applied uniformly on all handlers, and some of the costs may be passed on to producers. However, decreasing the assessment rate reduces the burden on handlers, and may reduce the burden on producers. In addition, the Committee's meeting was widely publicized throughout the Washington-Oregon fresh prune industry and all interested persons were invited to attend the meeting and participate in Committee deliberations on all issues. Like all Committee meetings, the June 5, 2001, meeting was a public meeting and all entities, both large and small, were able to express views on this issue.

This action imposes no additional reporting or recordkeeping requirements on either small or large Washington-Oregon fresh prune handlers. As with all Federal marketing order programs, reports and forms are periodically reviewed to reduce information requirements and duplication by industry and public sector agencies.

The USDA has not identified any relevant Federal rules that duplicate, overlap, or conflict with this rule.

An interim final rule concerning this action was published in the **Federal Register** on August 13, 2001. Copies of the rule were mailed to all Committee members. In addition, the rule was made available through the Internet by the Office of the Federal Register and USDA. A 60-day comment period was provided for interested persons to respond to the interim final rule. The comment period ended October 12, 2001, and no comments were received.

A small business guide on complying with fruit, vegetable, and specialty crop marketing agreements and orders may be viewed at: *http://www.ams.usda.gov/fv/moab.html.* Any questions about the compliance guide should be sent to Jay Guerber at the previously mentioned address in the **FOR FURTHER INFORMATION CONTACT** section.

After consideration of all relevant material presented, including the information and recommendation submitted by the Committee and other available information, it is hereby found that this rule, as hereinafter set forth, will tend to effectuate the declared policy of the Act.

List of Subjects in 7 CFR Part 924

Marketing agreements, Plums, Prunes, Reporting and recordkeeping requirements.

PART 924—FRESH PRUNES GROWN IN DESIGNATED COUNTIES IN WASHINGTON AND UMATILLA COUNTY, OREGON

Accordingly, the interim final rule amending 7 CFR part 924 which was published at 66 FR 42413 on August 13, 2001, is adopted as a final rule without change.

Dated: November 26, 2001.

A.J. Yates,

Administrator, Agricultural Marketing Service.

[FR Doc. 01–29705 Filed 11–29–01; 8:45 am]

BILLING CODE 3410–02–P

DEPARTMENT OF AGRICULTURE

Agricultural Marketing Service

7 CFR Part 931

[Docket No. FV01–931–1 FR]

Fresh Bartlett Pears Grown in Oregon and Washington; Increased Assessment Rate

AGENCY: Agricultural Marketing Service, USDA.

ACTION: Final rule.

SUMMARY: This rule increases the assessment rate established for the Northwest Fresh Bartlett Pear Marketing Committee (Committee) for the 2001–2002 and subsequent fiscal periods from $0.02 to $0.025 per standard box of fresh Bartlett pears. The Committee locally administers the marketing order which regulates the handling of fresh Bartlett pears grown in Oregon and Washington. Authorization to assess fresh Bartlett pear handlers enables the Committee to incur expenses that are reasonable and necessary to administer the program. The fiscal period began July 1 and ends June 30. The assessment rate remains in effect indefinitely unless modified, suspended, or terminated.

EFFECTIVE DATES: December 3, 2001.

FOR FURTHER INFORMATION CONTACT: Gary D. Olson, Northwest Marketing Field Office, Fruit and Vegetable Programs, AMS, USDA, 1220 SW Third Avenue, suite 385, Portland, OR 97204; telephone: (503) 326–2724, Fax: (503) 326–7440 or George J. Kelhart, Technical Advisor, Marketing Order Administration Branch, Fruit and Vegetable Programs, AMS, USDA, room 2525–S, PO Box 96456, Washington, DC 20090–6456; telephone: (202) 720–2491, Fax: (202) 720–8938. Small businesses may request information on complying with this regulation by contacting Jay Guerber, Marketing Order Administration Branch, Fruit and Vegetable Programs, AMS, USDA, room 2525–S, PO Box 96456, Washington, DC 20090–6456; telephone: (202) 720–2491, Fax: (202) 720–8938, or E-mail: *Jay.Guerber@usda.gov.*

SUPPLEMENTARY INFORMATION: This rule is issued under Marketing Agreement No. 141 and Order No. 931 (7 CFR part 931), regulating the handling of fresh Bartlett pears grown in Oregon and Washington, hereinafter referred to as the ''order.'' The order is effective under the Agricultural Marketing Agreement Act of 1937, as amended (7 U.S.C. 601–674), hereinafter referred to as the ''Act.''

The Department of Agriculture (USDA) is issuing this rule in conformance with Executive Order 12866.

This rule has been reviewed under Executive Order 12988, Civil Justice Reform. Under the order now in effect, fresh Bartlett pear handlers are subject to assessments. Funds to administer the order are derived from such assessments. It is intended that the assessment rate as issued herein will be applicable to all assessable fresh Bartlett pears beginning July 1, 2001, and will continue until modified, suspended, or terminated. This rule will not preempt any State or local laws, regulations, or policies, unless they present an irreconcilable conflict with this rule.

The Act provides that administrative proceedings must be exhausted before parties may file suit in court. Under

section 608c(15)(A) of the Act, any handler subject to an order may file with USDA a petition stating that the order, any provision of the order, or any obligation imposed in connection with the order is not in accordance with law and request a modification of the order or to be exempted therefrom. Such handler is afforded the opportunity for a hearing on the petition. After the hearing USDA would rule on the petition. The Act provides that the district court of the United States in any district in which the handler is an inhabitant, or has his or her principal place of business, has jurisdiction to review USDA's ruling on the petition, provided an action is filed not later than 20 days after the date of the entry of the ruling.

This rule increases the assessment rate established for the Committee for the 2001–2002 and subsequent fiscal periods from $0.02 to $0.025 per standard box of fresh Bartlett pears handled.

The fresh Bartlett pear marketing order provides authority for the Committee, with USDA's approval, to formulate an annual budget of expenses and collect assessments from handlers to administer the program. The Committee consists of eight grower members and six handler members, each of whom is familiar with the Committee's needs and with the costs for goods and services in their local area and are thus in a position to formulate an appropriate budget and assessment rate. The budget and assessment rate were discussed at a public meeting and all directly affected persons had an opportunity to participate and provide input.

For the 2000–2001 and subsequent fiscal periods, the Committee recommended, and USDA approved, an assessment rate of $0.02 per standard box that would continue in effect from fiscal period to fiscal period indefinitely unless modified, suspended, or terminated by USDA upon recommendation and information submitted by the Committee or other information available to USDA.

The Committee met on May 31, 2001, and unanimously recommended 2001–2002 expenditures of $76,477 and an assessment rate of $0.025 per standard box of fresh Bartlett pears handled. In comparison, last year's budgeted expenditures were $81,060. The assessment rate of $0.025 is $0.005 higher than the rate in effect prior to this final rule. The Committee recommended an increase in the assessment rate because the $0.02 rate would not have generated enough income to keep its operating reserve at a reasonable level (25,666). Without the increase, the operating reserve would drop below $7,000 which is not adequate administer the program.

Major expenses recommended by the Committee for the 2001–2002 fiscal period include $39,040 for salaries, $5,675 for office rent, and $3,911 for health insurance. Budgeted expenses for these items in 2000–2001 were $44,468, $4,847, and $3,891, respectively.

The Committee developed the $0.025 assessment rate recommendation by considering the 2001–2002 budget and crop estimate, as well as the relatively small size of the current monetary reserve. Assessment income for the fiscal period should approximate $79,700 based on estimated fresh Bartlett pear shipments of 3,188,000 standard boxes, which is adequate to cover budgeted expenses. Funds in the reserve (approximately $18,443) will be kept within the maximum permitted by the order of approximately one fiscal period's operational expenses (§ 931.42).

The assessment rate established in this rule will continue in effect indefinitely unless modified, suspended, or terminated by USDA upon recommendation and information submitted by the Committee or other available information.

Although this assessment rate will remain in effect for an indefinite period, the Committee will continue to meet prior to or during each fiscal period to recommend a budget of expenses and consider recommendations for modification of the assessment rate. The dates and times of Committee meetings are available from the Committee or USDA. Committee meetings are open to the public and interested persons may express their views at these meetings. The USDA will evaluate Committee recommendations and other available information to determine whether modification of the assessment rate is needed. Further rulemaking will be undertaken as necessary. The Committee's 2001–2002 budget has been reviewed and approved by USDA. Those for subsequent fiscal periods will also be reviewed and, as appropriate, approved by USDA.

Final Regulatory Flexibility Analysis

Pursuant to requirements set forth in the Regulatory Flexibility Act (RFA), the Agricultural Marketing Service (AMS) has considered the economic impact of this rule on small entities. Accordingly, AMS has prepared this final regulatory flexibility analysis.

The purpose of the RFA is to fit regulatory actions to the scale of business subject to such actions in order that small businesses will not be unduly or disproportionately burdened. Marketing orders issued pursuant to the Act, and the rules issued thereunder, are unique in that they are brought about through group action of essentially small entities acting on their own behalf. Thus, both statutes have small entity orientation and compatibility.

There are approximately 1,600 producers of fresh Bartlett pears in the production area and approximately 54 handlers subject to regulation under the marketing order. Small agricultural producers are defined by the Small Business Administration (13 CFR 121.201) as those having annual receipts of less than $750,000 and small agricultural service firms are defined as those whose annual receipts are less than $5,000,000.

Based on data provided by the National Agricultural Statistics Service for 1999, the most recent year complete data is available, and the current number of producers, the average annual producer revenue in Washington and Oregon could approximate $23,130 this year. Further, based on Committee records and recent F.O.B. prices reported by the Fruit and Vegetable Market News Service for fresh Bartlett pears, over 98 percent of the regulated handlers ship less that $5,000,000 worth of fresh Bartlett pears on an annual basis. In view of the foregoing, it can be concluded that the majority of fresh Bartlett pear producers and handlers may be classified as small entities.

This rule increases the assessment rate established for the Committee and collected from handlers for the 2001–2002 and subsequent fiscal periods from $0.02 to $0.025 per standard box of fresh Bartlett pears handled. The Committee met on May 31, 2001, and unanimously recommended 2001–2002 expenditures of $76,477 and an assessment rate of $0.025 per standard box of fresh Bartlett pears handled. In comparison, budgeted expenditures for last year totaled $81,060. The assessment rate of $0.025 is $0.005 greater than the rate in effect prior to this final rule, and was recommended by the Committee because the $0.02 rate would not have generated enough income for it to adequately administer the program. At the previous rate of assessment, the Committee's monetary reserve would have dropped below $7,000 and this is not adequate to administer the program.

Major expenses recommended by the Committee for the 2001–2002 fiscal period include $39,040 for salaries, $5,675 for office rent, and $3,911 for health insurance. Budgeted expenses for these items in 2000–2001 were $44,468, $4,847, and $3,891, respectively.

The Committee developed the $0.025 assessment rate recommendation by considering the 2001–2002 budget and crop estimate, as well as the relatively small size of its monetary reserve. Assessment income for the fiscal period should approximate $79,700 based on estimated fresh Bartlett pear shipments of 3,188,000 standard boxes, which is adequate to cover budgeted expenses. Funds in the reserve (approximately $18,443) will be kept within the maximum permitted by the order of approximately one fiscal period's operational expenses (§ 931.42).

The Committee considered alternative levels of assessment but, considering the current relatively low level of funding in the monetary reserve, determined that increasing the assessment rate to $0.025 per standard box to be appropriate. The Committee believes that an assessment rate of more than $0.025 per standard box would have generated income in excess of that needed to adequately administer the program, and if left at the $0.02 rate, or reduced, would have been inadequate to administer the program.

A review of historical information and preliminary information pertaining to the upcoming crop indicates that the producer price for the 2001–2002 marketing season could average about $11.61 per standard box of fresh Bartlett pears handled. Therefore, the Committee's estimated assessment revenue for the 2001–2002 fiscal period as a percentage of total producer revenue should be approximately 0.215 percent.

This action increases the assessment obligation imposed on handlers. While assessments impose some additional costs on handlers, the costs are minimal and uniform on all handlers. Some of the additional costs may be passed on to producers. However, these costs are offset by the benefits derived by the operation of the order. In addition, the Committee's meeting was widely publicized throughout the fresh Bartlett pear industry and all interested persons were invited to attend the meeting and participate in Committee deliberations on all issues. Like all Committee meetings, the May 31, 2001, meeting was a public meeting and all entities, both large and small, were able to express views on this issue. Furthermore, interested persons were invited to submit information on the regulatory and informational impacts of this action on small businesses.

This rule imposes no additional reporting or recordkeeping requirements on either small or large fresh Bartlett pear handlers. As with all Federal marketing order programs, reports and forms are periodically reviewed to reduce information requirements and duplication by industry and public sector agencies.

The USDA has not identified any relevant Federal rules that duplicate, overlap, or conflict with this rule.

A proposed rule concerning this action was published in the **Federal Register** on September 21, 2001 (66 FR 48628). A copy of the proposed ruled was provided to the Committee office which in turn made copies available to producers and handlers. Furthermore, the Office of the Federal Register and the USDA made a copy available on the Internet. A 30-day comment period ending October 22, 2001, was provided for interested persons to respond to the proposal. No comments were received.

A small business guide on complying with fruit, vegetable, and specialty crop marketing agreements and orders may be viewed at: *http://www.ams.usda.gov/fv/moab.html.* Any questions about the compliance guide should be sent to Jay Guerber at the previously mentioned address in the **FOR FURTHER INFORMATION CONTACT** section.

After consideration of all relevant material presented, including the information and recommendation submitted by the Committee and other available information, it is hereby found that this rule, as hereinafter set forth, will tend to effectuate the declared policy of the Act.

Pursuant to 5 U.S.C. 553, it is also found and determined that good cause exists for not postponing the effective date of this rule until 30 days after publication in the **Federal Register** because: (1) Handlers are already receiving 2001–2002 fiscal period pears from producers; (2) the 2001–2002 fiscal period began on July 1, 2001, and the order requires that the rate of assessment for each fiscal period apply to all assessable Bartlett pears handled during such period; and (3) handlers are aware of this action which was unanimously recommended by the Committee at a public meeting. Furthermore, a 30-day comment period was provided for in the proposed rule and no comments were received.

List of Subjects in 7 CFR Part 931

Marketing agreements, Pears, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, 7 CFR part 931 is amended as follows:

PART 931—FRESH BARTLETT PEARS GROWN IN OREGON AND WASHINGTON

1. The authority citation for 7 CFR part 931 continues to read as follows:

Authority: 7 U.S.C. 601–674.

2. Section 931.231 is revised to read as follows:

§ 931.231 Assessment rate.

On and after July 1, 2001, an assessment rate of $0.025 per western standard pear box is established for the Northwest Fresh Bartlett Pear Marketing Committee.

Dated: November 26, 2001.

A.J. Yates,

Administrator, Agricultural Marketing Service.

[FR Doc. 01–29704 Filed 11–29–01; 8:45 am]

BILLING CODE 3410–02–P

FEDERAL ELECTION COMMISSION

11 CFR Part 104

[Notice 2001–17]

Technical Amendments to Election Cycle Reporting

AGENCY: Federal Election Commission.

ACTION: Correcting amendments.

SUMMARY: This document contains corrections to the final regulations regarding election cycle reporting by the authorized committees of candidates for Federal office, which were published in the **Federal Register** of Tuesday, July 11, 2000, (65 FR 42619). The corrections reinstate two paragraphs of 11 CFR 104.3(b)(4)(i) that were inadvertently omitted when the election cycle reporting regulations were published. The two omitted paragraphs contain instructions for authorized committees when reporting expenditures.

DATES: Effective on December 31, 2001.

FOR FURTHER INFORMATION CONTACT: Ms. Rosemary C. Smith, Assistant General Counsel, or Cheryl Fowle, Attorney, 999 E Street, NW., Washington, DC 20463, (202) 694–1650 or (800) 424–9530.

SUPPLEMENTARY INFORMATION:

Background

The final regulations that are the subject of these corrections superseded 11 CFR 104.3(b)(4)(i) as of January 1, 2001, and applied to authorized committees of Federal candidates. In those final regulations, paragraphs (A) and (B) of 11 CFR 104.3(b)(4)(i) were inadvertently deleted. Paragraph (A) defines ''purpose'' of disbursement as it is reported and states examples of

acceptable and unacceptable purpose descriptions to be reported by authorized committees. Paragraph (B) requires authorized committees, when itemizing certain disbursements for which reimbursements are required, to provide a brief explanation of the activity for which reimbursement is required. These provisions have been in Title 11 of the **Code of Federal Regulations** since 1980 and 1995, respectively, and were not affected by the recent statutory changes to the election cycle reporting requirements.

Need for Correction

As published, the final rules inadvertently omit two paragraphs describing information to be reported by authorized committees of Federal candidates.

All committees must report the purpose of itemized disbursements (i.e., those disbursements aggregating in excess of $200). Omitted paragraph (A) contains examples of suitably specific purpose descriptions as well as examples of those descriptions that are unacceptably vague. This paragraph is consistent with the reporting of rules for unauthorized committees (committees other than candidate committees) in 11 CFR 104.3(b)(3).

Omitted paragraph (B) is used in administering the ''personal use'' rules in 11 CFR 113.1. Federal candidates are barred from using campaign funds for personal benefit. Paragraph (B) requires authorized committees of Federal candidates itemizing disbursements for which partial or total reimbursement is required under 11 CFR 113.1(g)(1)(iii)(C) or (D) to provide a brief explanation of the activity for which the reimbursement is made.

Section 801 of Title 5 of the United States Code requires Federal agencies to submit regulations to Congress. These regulations were submitted to the Speaker of the House of Representatives and the President of the Senate on November 26, 2001.

Certification of No Effect Pursuant to 5 U.S.C. § 605(b) [Regulatory Flexibility Act]

This correction will not have significant economic impact on a substantial number of small entities. The basis of this certification is that this correction only requires political committees to once again add information to the reports they are required to file. These regulations were in 11 CFR since 1980 and 1995, respectively, before being inadvertently omitted in 2000.

List of Subjects in 11 CFR Part 104

Campaign funds, Political committees and parties, Reporting and recordkeeping requirements.

Accordingly, 11 CFR part 104 is corrected by making the following correcting amendment:

PART 104—REPORTS BY POLITICAL COMMITTEES

1. The authority citation for part 104 continues to read as follows:

Authority: 2 U.S.C. 431(1), 431(8), 431(9), 432(i), 434, 438(a)(8), 438(b), 439a.

§ 104.3 Contents of reports (2 U.S.C. 434(b), 439a).

* * * * *

2. In § 104.3 add the following paragraphs (b)(4)(i)(A) and (B):

(b) * * *

(4) * * *

(i) * * *

(A) As used in this paragraph, *purpose* means a brief statement or description of why the disbursement was made. Examples of statements or descriptions which meet the requirements of this paragraph include the following: dinner expenses, media, salary, polling, travel, party fees, phone banks, travel expenses, travel expense reimbursement, and catering costs. However, statements or descriptions such as *advance, election day expenses, other expenses, expenses, expense reimbursement, miscellaneous, outside services, get-out-the-vote* and *voter registration* would not meet the requirements of this paragraph for reporting the purpose of an expenditure.

(B) In addition to reporting the purpose described in paragraph (b)(4)(i)(A) of this section, whenever an authorized committee itemizes a disbursement that is partially or entirely a personal use for which reimbursement is required under 11 CFR 113.1(g)(1)(ii)(C) or (D), it shall provide a brief explanation of the activity for which reimbursement is required.

* * * * *

Dated: November 26, 2001.

Danny L. McDonald,

Chairman, Federal Election Commission.

[FR Doc. 01–29679 Filed 11–29–01; 8:45 am]

BILLING CODE 6715–01–P

FEDERAL ELECTION COMMISSION

11 CFR Part 111

[Notice 2001–18]

Extension to Administrative Fines

AGENCY: Federal Election Commission.

ACTION: Final rule; revision of the sunset date.

SUMMARY: The Treasury and General Government Appropriations Act, 2002, amended the Treasury and General Government Appropriations Act, 2000, by extending the expiration date in which the Federal Election Commission (hereinafter ''the Commission'') may assess civil money penalties for violations of the reporting requirements of section 434(a) of the Federal Election Campaign Act (hereinafter ''the Act'' or ''FECA'').

DATES: Effective on December 31, 2001.

FOR FURTHER INFORMATION CONTACT: Ms. Rosemary C. Smith, Assistant General Counsel, or Ms. Mai T. Dinh, Attorney, 999 E Street, NW., Washington, DC 20463, (202) 694–1650 or (800) 424–9530.

SUPPLEMENTARY INFORMATION:

Explanation and Justification

Section 640 of the Treasury and General Government Appropriations Act, 2000, Pub. L. No. 106–58, 106th Cong., 113 Stat. 430, 476–77 (1999), amended § 309(a)(4) of the FECA, 2 U.S.C. 437g(a)(4), to provide for a modified enforcement process for violations of reporting requirements. Under § 437g(a)(4)(C) of the FECA, the Commission may assess a civil money penalty for violations of the reporting requirements of 2 U.S.C. 434(a). This authority, however, was to sunset on December 31, 2001. Pub. L. No. 106–58, 106th Cong., § 640(c). Recently, § 642 of the Treasury and General Government Appropriations Act, 2002, amended the Treasury and General Government Appropriations Act, 2000, by extending the sunset date to include all reports that cover activity between January 1, 2000, to December 31, 2003.

The Commission published final rules on May 19, 2000, to implement the amendment contained in the Treasury and General Government Appropriations Act, 2000. Section 111.30 of the regulations reflects the sunset provision of Pub. L. No. 106–58, 106th Cong., § 640(c). Therefore, the Commission is issuing this final rule to amend section 111.30 to extend the application of the administrative fine regulations, 11 CFR part 111, subpart B, to include all violations relating to reports that cover the period between January 1, 2000, to December 31, 2003.

The Commission is promulgating this final rule without notice or opportunity for comment because it falls under the ''good cause'' exemption of the Administrative Procedures Act, 5 U.S.C. 553(b)(B). The exemption allows

agencies to dispense with notice and comment if the procedures are ''impracticable, unnecessary, or contrary to public interest.'' *Id.* This final rule fulfills the ''good cause'' exemption requirement because a notice and comment period is impracticable in that it would prevent this final rule from taking effect before the administrative fine regulations sunset under the current 11 CFR 111.30. *See Administrative Procedure Act: Legislative History,* S. Doc. No. 248 200 (1946) (''Impracticable' means a situation in which the due and required execution of the agency functions would be unavoidably prevented by its undertaking public rule-making proceedings''). In addition, this final rule merely extends the applicability of the administrative fine regulations and does not change the substantive regulations themselves. Those regulations were already subject to notice and comment when they were proposed in March, 2000, 65 FR 16534, and adopted in May, 2000, 65 FR 31787. Thus, it is appropriate and necessary for the Commission to publish this final rule without providing a notice and comment period. The Commission anticipates, however, that any substantive changes that may be made to the administrative fine rules at a later date will be subject to notice and comment.

Certification of No Effect Pursuant to 5 U.S.C. 605(b) (Regulatory Flexibility Act)

The attached final rule will not have a significant economic impact on a substantial number of small entities. The basis for this certification is that this final rule merely extends the applicability of existing regulations for two more years. The existing regulations have already been certified as not having a significant economic impact on a substantial number of small entities. 65 FR 31793 (2000). Therefore, the extension of these existing regulations will not have a significant economic impact on a substantial number of small entities.

List of Subjects in 11 CFR Part 111

Administrative practice and procedures, Elections, Law enforcement.

For reasons set out in the preamble, subchapter A, Chapter I of Title 11 of the **Code of Federal Regulations** is amended as follows:

PART 111—COMPLIANCE PROCEDURES (2 U.S.C. 437g, 437d(a))

1. The authority for part 111 continues to read as follows:

Authority: 2 U.S.C. 437g, 437d(a), 438(a)(8).

2. 11 CFR 111.30 is revised to read as follows:

§ 111.30. When will subpart B apply?

Subpart B applies to violations of the reporting requirements of 2 U.S.C. 434(a) that relate to the reporting periods that begin on or after July 14, 2000, and end on or before December 31, 2003, committed by political committees and their treasurers.

Dated: November 26, 2001.

Danny L. McDonald,

Chairman, Federal Election Commission.

[FR Doc. 01–29678 Filed 11–29–01; 8:45 am]

BILLING CODE 6715–01–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 2000–NM–115–AD; Amendment 39–12518; AD 2001–24–02]

RIN 2120–AA64

Airworthiness Directives; Boeing Model 707–100, –100B, –300, and –E3A (Military Airplanes); 727–100 and –200; 737–200, –200C, –300, –400, and –500; 747SP and 747SR; 747–100B, –200B, –200C, –200F, –300, –400, and –400D; 757–200 and –200PF; and 767–200 and –300 Series Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule.

SUMMARY: This amendment adopts a new airworthiness directive (AD), applicable to certain Boeing Model 707–100, –100B, –300, and –E3A (military airplanes); 727–100 and –200; 737–200, –200C, –300, –400, and –500; 747SP and 747SR; 747–100B, –200B, –200C, –200F, –300, –400, and –400D; 757–200 and –200PF; and 767–200 and –300 series airplanes. This AD requires inspection of the attachment of the shoulder restraint harness to the mounting bracket on certain observer and attendant seats to determine if a C-clip is used in the attachment, and corrective action, if necessary. This action is necessary to prevent detachment of the shoulder restraint harness of the attendant or observer seat from its mounting bracket during service, which could result in injury to the occupant of the seat. This action is intended to address the identified unsafe condition.

DATES: Effective January 4, 2002.

The incorporation by reference of certain publications listed in the regulations is approved by the Director of the Federal Register as of January 4, 2002.

ADDRESSES: The service information referenced in this AD may be obtained from Boeing Commercial Airplane Group, P.O. Box 3707, Seattle, Washington 98124–2207. 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 Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Keith Ladderud, Aerospace Engineer, Airframe Branch, ANM–120S, FAA, Seattle Aircraft Certification Office, 1601 Lind Avenue, SW., Renton, Washington 98055–4056; telephone (425) 227–2780; fax (425) 227–1181.

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 Boeing Model 707–100, –100B, –300, and –E3A (military airplanes); 727–100 and –200; 737–200, –200C, –300, –400, and –500; 747SP and 747SR; 747–100B, –200B, –200C, –200F, –300, –400, and –400D; 757–200 and –200PF; and 767–200 and –300 series airplanes was published in the **Federal Register** on June 27, 2001 (66 FR 34128). That action proposed to require inspection of the attachment of the shoulder restraint harness to the mounting bracket on certain observer and attendant seats to determine if a C-clip is used in the attachment, and corrective action, if necessary.

Comments

Interested persons have been afforded an opportunity to participate in the making of this amendment. Due consideration has been given to the comments received.

One commenter states that the proposed AD does not apply to its fleet.

Withdraw Proposed AD

Two commenters request that the FAA withdraw the proposed AD. One commenter states that, on its fleet of Model 757 series airplanes, it has not observed any in-service problems with the shoulder restraint harness detaching from the mounting bracket. Therefore, it does not accept that the proposed modification is necessary.

The FAA does not concur. Though the commenter has not observed any problems related to the identified unsafe condition, at least two other operators

have. Therefore, we find that it is necessary to require the modification in this AD.

Another commenter requests that the FAA withdraw the proposed rule because Boeing needs to revise the referenced service bulletins by identifying the individual part numbers of affected seats, rather than identifying the airplanes by serial numbers. The commenter is concerned that the service bulletins and proposed AD identify the subject seats both as ''attendant'' and ''observer'' seats. The commenter notes that the term ''observer seat'' could be construed to include observer seats in the cockpit, which have a different restraint system. The commenter is also concerned that, because the service bulletins identify affected airplanes, not seat part numbers, operators that move seats from one airplane to another could inadvertently install an unmodified seat on an airplane on which all other subject seats have already been modified.

We do not concur that it is necessary to withdraw the proposed rule. The restraint system is attached to the airplane, not to the attendant and observer seats; therefore, identifying the seats by part number would not provide any benefit. Also, the fact that when a seat is moved from one airplane to another, the restraint system for that seat remains with the airplane, should alleviate the commenter's concerns about exchanging seats between airplanes. Furthermore, although the commenter states that airplanes in its fleet have a restraint system on the cockpit observer seats other than the one addressed by this AD, other operators do have airplanes equipped with cockpit observer seats that employ the restraint system identified in this AD. No change to the AD is necessary in this regard.

Extend Compliance Time

One of the commenters who requests withdrawal of the proposed rule asks us to extend the compliance time for the proposed AD if we do not concur to withdraw the proposed rule. The commenter suggests that we extend the compliance time from 18 to 24 months. The commenter's rationale is that it has not observed the unsafe condition on any of its airplane fleet (Model 757 series airplanes).

We concur with the request to extend the compliance time of this AD. In developing a new compliance time for this AD, we considered not only the manufacturer's recommendation, but the degree of urgency associated with addressing the subject unsafe condition, and the average utilization of the affected fleet. In light of all of these factors, we find a 36-month compliance time for initiating the required actions to be warranted, in that it represents an appropriate interval of time allowable for affected airplanes to continue to operate without compromising safety. We have revised paragraph (a) of this AD accordingly.

Revise Preamble of AD

One commenter requests that the ''Differences Between The Service Bulletins and This Proposed AD'' section of the proposed rule be revised to state that only two instances of detachment of the shoulder restraint harness of the attendant or observer seat from the mounting bracket have been reported, though this design has been in use for more than 40 years.

We acknowledge the commenter's remarks on the number of occurrences of the unsafe condition and the duration of service of the design. However, the section referred to by the commenter is not restated in this final rule. Therefore, no change to the AD is necessary in this regard.

Conclusion

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

Cost Impact

The table below estimates the cost impact of the inspection that is required by this AD. The average labor rate is $60 per work hour.

Base model	Number of airplanes/ worldwide	Number of airplanes/ U.S. registry	Number of work hours (@ 0.25 work hour/seat)	Total cost per airplane	Total fleet cost
707	250	21	1	$60	$1,260
727	1,986	881	1	60	52,860
737	921	437	2	120	52,440
747	533	83	5	300	24,900
757	262	257	2	120	30,840
767	573	207	3	180	37,260

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.

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:

2001–24–02 Boeing: Amendment 39–12518. Docket 2000–NM–115–AD.

Applicability: Airplanes as listed in the table below; certificated in any category.

TABLE 1.—APPLICABILITY OF THIS AD

Models and series	As listed in the following Boeing service bulletins
Model 707–100, –100B, –300, and –E3A (Military)	3499, Revision 1, dated May 17, 2001.
Model 727–100 and 727–200	727–25–0295, Revision 1, dated May 17, 2001.
Model 737 –200, –200C, –300, –400, and –500	737–25–1412, Revision 1, dated May 17, 2001.
Model 747SR, 747SP, and 747–100B, –200B, –200C, –200F, –300, –400, and –400D	747–25–3244, Revision 1, dated May 17, 2001.
Model 757–200 and 757–200PF	757–25–0223, Revision 1, dated May 17, 2001.
Model 767–200 and –300	767–25–0288, Revision 1, dated May 17, 2001

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 (c) 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 detachment of the shoulder restraint harness of the attendant or observer seat from its mounting bracket during service, which could result in injury to the occupant of the seat, accomplish the following:

Inspection and Corrective Action

(a) Within 36 months after the effective date of this AD, do a one-time general visual inspection of the attachment of the shoulder restraint harness of each observer or attendant seat to determine if a C-clip is used in the attachment. Do the inspection according to Boeing Service Bulletin 3499, 727–25–0295, 737–25–1412, 747–25–3244, 757–25–0223, or 767–25–0288; all Revision 1; all dated May 17, 2001; as applicable. If the shoulder harness is looped through the bracket and attached to itself with a C-clip, do paragraph (a)(1) or (a)(2) of this AD.

(1) Remove and discard the C-clip, and reattach the shoulder harness to the mounting bracket, according to the service bulletin.

Note 2: Removing and discarding the C-clip and reattaching the shoulder harness to the mounting bracket; according to Boeing Special Attention Service Bulletin 3499, 727–25–0295, 737–25–1412, 747–25–3244, 757–25–0233, or 767–25–0288; all dated April 27, 2000; as applicable; is acceptable for compliance with the requirements of paragraph (a)(1) of this AD.

(2) Install a second C-clip with the clip's opening positioned in the opposite direction of the opening of the existing C-clip, according to the optional method described in Steps 19 and 20 of Figure 1 or 2 of the applicable service bulletin.

Spares

(b) As of the effective date of this AD, do not attach the shoulder restraint harness of an observer or attendant seat on any airplane to the mounting bracket using a C-clip, unless the requirements of paragraph (a)(2) of this AD are done.

Alternative Methods of Compliance

(c) 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, Seattle 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, Seattle ACO.

Note 3: Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the Seattle ACO.

Special Flight Permits

(d) 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

(e) The actions shall be done in accordance with Boeing Service Bulletin 3499, Revision 1, dated May 17, 2001; Boeing Service Bulletin 727–25–0295, Revision 1, dated May 17, 2001; Boeing Service Bulletin 737–25–1412, Revision 1, dated May 17, 2001; Boeing Service Bulletin 747–25–3244, Revision 1, dated May 17, 2001; Boeing Service Bulletin 757–25–0223, Revision 1, dated May 17, 2001; or Boeing Service Bulletin 767–25–0288, Revision 1, dated May 17, 2001; as applicable. 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 Boeing Commercial Airplane Group, P.O. Box 3707, Seattle, Washington 98124–2207. Copies may be inspected at the FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington; or at the Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

Effective Date

(f) This amendment becomes effective on January 4, 2002.

Issued in Renton, Washington, on November 16, 2001.

Kalene C. Yanamura,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 01–29324 Filed 11–29–01; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 2000–NM–19–AD; Amendment 39–12517; AD 2001–24–01]

RIN 2120–AA64

Airworthiness Directives; Boeing Model 767 Series Airplanes Powered by Pratt & Whitney Model PW4000 Series Engines

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule.

SUMMARY: This amendment adopts a new airworthiness directive (AD), applicable to certain Boeing Model 767 series airplanes, that requires a one-time detailed visual inspection of certain wire bundles located in the aft section of the strut forward fairing panel of both engine struts to detect chafing damage, and repair or replacement of wiring, if necessary. This amendment also requires replacement of wires repaired by splicing and damaged wires that require splicing, and replacement of the support brackets of the existing wire bundles with new brackets and clamps, which would terminate the existing requirements. The actions specified by this AD are intended to prevent the potential for dual wire faults from grounded, separated, or shorted wires; which could result in inadvertent takeoff thrust overboost, in-flight loss of thrust, or engine shutdown.

DATES: Effective January 4, 2002.

The incorporation by reference of certain publications listed in the regulations is approved by the Director of the Federal Register as of January 4, 2002.

ADDRESSES: The service information referenced in this AD may be obtained from Boeing Commercial Airplane Group, P.O. Box 3707, Seattle, Washington 98124–2207. 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 Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Dennis Kammers, Aerospace Engineer, Propulsion Branch, ANM–140S, FAA, Seattle Aircraft Certification Office, 1601 Lind Avenue, SW., Renton, Washington 98055–4056; telephone (425) 227–2956; fax (425) 227–1181.

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 Boeing Model 767 series airplanes was published in the **Federal Register** on June 5, 2001 (66 FR 30112). That action proposed to require a one-time detailed visual inspection of certain wire bundles located in the aft section of the strut forward fairing panel of both engine struts to detect chafing damage, and repair or replacement of wiring, if necessary. That action also proposed to require replacement of wires repaired by splicing and damaged wires that require splicing; and replacement of the support brackets of the existing wire bundles with new brackets and clamps, which would terminate the existing requirements.

Interested persons have been afforded an opportunity to participate in the making of this amendment. Due consideration has been given to the comments received.

Request To Allow Credit for Previous Inspections

One commenter, a member airline of the Air Transport Association of America, states that it has already accomplished the proposed inspection of the wire bundles located in the aft section of the strut forward fairing panel of both engine struts per Boeing Standard Wiring Practices Manual D6–54446 (hereinafter called the wiring practices manual), Subjects 20–10–13 and 20–30–12, and no damage was detected. The service instructions in the wiring practices manual include the same instructions as those included in the supplemental NPRM and Boeing Service Bulletin 767–73A0049, Revision 2, dated April 27, 2000. The commenter states that it is concerned about its ability to accomplish the required wire bundle inspection within the proposed compliance time of 180 days. Such a compliance time would require that inspections be accomplished ''on the line'' or ''during overnight visits,'' which could result in scheduling problems. The FAA infers that the commenter considers that the final rule should allow credit for previous accomplishment of the inspection required by paragraph (a) per Revision 2 of the service bulletin or per certain sections of the wiring practices manual.

The FAA concurs that previous accomplishment of inspections, per Boeing Service Bulletin 767–73A0049, Revision 2, dated April 27, 2000, or per Boeing Standard Wiring Practices Manual D6–73A0049, Subjects 20–10–13 or 20–30–12, is adequate and provides an acceptable level of safety. However, in the original NPRM, paragraphs (a)(1), (a)(2), and (a)(3) specify corrective actions, not the inspection; and paragraph (a)(2) includes a reference to wiring practices manual, Subject 20–10–13, not Subject 20–30–12. The airplane manufacturer maintains that wiring practices manual, Subject 20–30–12, includes a more detailed inspection procedure than does Subject 20–10–13. In light of this information, in the final rule we have added a new Note 2 following paragraph (a) to give credit for the accomplishment of previous inspections per the referenced service bulletin or wiring practices manual. In addition, we have renumbered the succeeding notes in the final rule accordingly.

Request To Clarify the Corrective Action

One commenter requests clarification of the corrective action in paragraph (a)(2) of the supplemental NPRM, which proposes replacement of all spliced wires with new wires. The commenter states that Boeing Service Bulletin 767–73A0049 specifies that spliced wires are allowed in the area of inspection and as a temporary repair. If so, what is the reason for not considering that a correctly done splice is acceptable until the next C-check? If splices between the brackets are not allowed, an airline's workload will be increased significantly. The commenter points out that the wiring practices manual has never included procedures that allow splices under a clamp or support fitting.

The FAA concurs with the commenter's request, and we acknowledge that Boeing Service Bulletin 767–73A0049 specifies that spliced wires are acceptable as a temporary repair. However, we point out that in the supplemental NPRM, paragraph (a)(1) proposes a temporary repair except as provided by paragraph (a)(2), which proposes replacement of all spliced wires concurrently with accomplishment of the terminating action specified by paragraph (b)(2). Although a temporary repair was specified for certain conditions, we agree that further clarification of the repair action is necessary. As a result, in the final rule we have revised paragraphs (a), (a)(1), and (a)(2) as follows. We moved the conditional action statement in paragraph (a)(1) regarding ''if any chafing damage of any wire bundle is detected * * *'' to paragraph (a). Paragraph (a)(2) cites paragraph (b) instead of paragraph (b)(2), which clarifies that both the inspection in paragraph (b)(1) and the replacement action in paragraph (b)(2) are required.

Request To Revise the Spares Paragraph

One commenter suggests revising paragraph (d) of the supplemental NPRM. (That paragraph is cited as paragraph (e) in the final rule.) The commenter contends that those requirements should be limited to only those areas specified for Model 767 series airplanes. The part numbers specified in the Boeing service bulletin are installed in other locations on Model 767 series airplanes in addition to those areas specifically addressed by the proposed AD. The commenter also states that the manufacturer intended that the service bulletin address only the specific bracket locations identified in the service bulletin. Further, the manufacturer did not intend to prevent installation of the referenced part number from other locations on Model 767 series airplanes.

The FAA concurs with the commenter's request, and considers that the manufacturer's intention was to limit installation of the support brackets to only certain locations. We have revised paragraph (e) in the final rule to clarify that the spares limitation applies only to the support brackets ''located in the aft section of the strut forward fairing panel of both engine struts,'' as identified in Boeing Service Bulletin 767–73–0051, dated December 20, 2000.

Request To Use Another Type of Tape

One commenter requests approval to use DMS 2186A Type 2 tape (electrical insulation, self-adhering, or high-temperature) instead of TFE–2X Teflon wrap. The commenter states that some of the advantages of DMS 2186A Type 2 tape include: easy application due to elongation, which eases installation; a smooth wrap due to a self-adhering effect, unlike the Teflon tape; good resistance to burns, heat, and abrasion; and good dielectrical breakdown voltage.

The FAA partially concurs. We have determined that any of the Type 2 tapes listed in Subject 20–00–11 of the wiring practices manual are acceptable alternatives to the TFE–2X Teflon wrap specified in Boeing Service Bulletin 767–73A0049. However, the tapes listed in the wiring practices manual do not include DMS 2186A Type 2 tape. The FAA has determined that, if additional tape alternatives are necessary and they are not listed in the wiring practices manual, operators must submit a request for an alternative method of compliance, as provided by paragraph (f) of this AD. To clarify this, we have added a new paragraph (c) in the final rule to specify that any of the Type 2 tapes listed in Subject 20–00–11 of the wiring practices manual is an acceptable alternative to the TFE–2X Teflon wrap specified in the Boeing service bulletin. The succeeding paragraphs in the final rule are renumbered accordingly.

Request To Revise the Compliance Time in the Original NPRM

One commenter requests revising the compliance time for the replacement action in paragraph (a)(2) of the original NPRM. The commenter contends that the replacement action should occur ''after the splice installation'' rather than ''after the effective date of this AD.''

The FAA does not concur with the commenter's request. However, in the supplemental NPRM, we considered that it was necessary to clarify the corrective actions specified in the original NPRM. As a result, we made a number of changes in the supplemental NPRM. We revised paragraph (a)(2) and deleted paragraph (a)(3), but made no change to paragraph (a) or (a)(1). We also point out that paragraph (a)(2) specifies replacement concurrently with the new terminating action specified by paragraph (b)(2). In developing that compliance time, we considered not only the degree of urgency associated with addressing the subject unsafe condition, but the manufacturer's recommendation as to an appropriate compliance time, availability of required parts, and the practical aspect of accomplishing the replacement action. In consideration of these factors, we find that 6,000 flight hours or 18 months ''after the effective date of this AD'' is appropriate. No change to the final rule is necessary in this regard.

To further clarify the corrective action in the final rule, we point out that the compliance time for the terminating action required by paragraph (b) is ''within 6,000 flight hours or 18 months after the effective date of this AD, whichever occurs later,'' which represents the C-check interval for the majority of the affected fleet. We consider that this compliance time will allow operators that had accomplished the temporary splice repair to replace those repairs with new wire at an interval that coincides with a C-check.

Request To Clarify the Term ''Splice''

One commenter requests clarification of the term ''splice'' in the original NPRM. The commenter states that in certain paragraphs of Boeing Service Bulletin 767–73A0049 and in paragraph 2.A of the wiring practices manual, Subject 20–10–13, the term ''splice'' is used incorrectly. That term does not apply to insulation or shield repairs, and we consider that the intent of the service bulletin and the original NPRM is to specify removing those wires that have been cut and mechanically reconnected.

The FAA does not concur that the term ''splice'' was used incorrectly in the original NPRM. However, we agree that the term was used incorrectly in certain paragraphs of the service bulletin and the wiring practices manual. In addition, the airplane manufacturer has informed the FAA that the term ''splice,'' as used in paragraph 2.A.(6) of the wiring practices manual, should have been ''damaged area.'' No change to the final rule is necessary in this regard.

Explanation of Changes Made to the Proposal

The applicability of the supplemental NPRM references Boeing Service Bulletin 767–73–0051, dated December 20, 2000, as the appropriate source of service information for determining the affected Model 767 series airplanes. The service bulletin references Service Bulletin Index Document D624T001, Part 3, for airplane variable number, line number, and serial number data. Because some operators may not readily have access to this secondary source of service information, the FAA has determined that the applicability of the AD should specify the affected airplane line numbers (i.e., line numbers 1 through 821, equipped with Pratt & Whitney PW4000 series engines), which were identified in the Summary of Boeing Service Bulletin 767–73–0051. The applicability of the final rule is changed accordingly.

Conclusion

After careful review of the available data, including the comments noted above, the FAA has determined that air safety and the public interest require the adoption of the rule with the changes previously described. The FAA has determined that these changes will neither increase the economic burden on any operator nor increase the scope of the AD.

Cost Impact

There are approximately 185 Model 767 series airplanes of the affected design in the worldwide fleet. The FAA estimates that 79 airplanes of U.S. registry will be affected by this AD.

It will take approximately 2 work hours per airplane to accomplish the inspection action, and that the average labor rate is $60 per work hour. Based on these figures, the cost impact of the inspection required by this AD on U.S.

operators is estimated to be $9,480, or $120 per airplane.

It will take approximately 3 work hours per airplane to accomplish the replacement action, and that the average labor rate is $60 per work hour. Required parts would cost approximately $1,570 per airplane. Based on these figures, the cost impact of the replacement required by this AD on U.S. operators is estimated to be $138,250, or $1,750 per airplane.

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.

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:

2001–24–01 Boeing: Amendment 39–12517. Docket 2000–NM–19–AD.

Applicability: Model 767 series airplanes, line numbers 1 through 821, equipped with Pratt & Whitney PW4000 series engines; certificated in any category.

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 (f) 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 the potential for dual wire faults from grounded, separated, or shorted wires, which could result in inadvertent takeoff thrust overboost, in-flight loss of thrust, or engine shutdown, accomplish the following:

Detailed Visual Inspection

(a) Prior to the accumulation of 10,000 hours' time-in-service or within 180 days after the effective date of this AD, whichever occurs later: Do a one-time detailed visual inspection of the wire bundles located in the aft section of the strut forward fairing panel of both engine struts to detect chafing damage, per Boeing Service Bulletin 767–73A0049, Revision 3, dated December 20, 2000, or Revision 4, dated April 5, 2001. If any chafing damage of any wire bundle is found, do the actions required by paragraphs (a)(1) and (a)(2) of this AD at the times specified in those paragraphs.

Note 2: Inspections accomplished prior to the effective date of this AD per Boeing Service Bulletin 767–73A0049, Revision 2, dated April 27, 2000, or per Boeing Standard Wiring Practices Manual D6–73A0049, Subject 20–10–13 or 20–30–12, are considered acceptable for compliance with the applicable action specified in this AD.

Note 3: For the purposes of this AD, a detailed visual inspection is defined as: ''An intensive visual examination of a specific structural area, system, installation, or assembly to detect damage, failure, or irregularity. Available lighting is normally supplemented with a direct source of good lighting at intensity deemed appropriate by the inspector. Inspection aids such as mirror, magnifying lenses, etc., may be used. Surface cleaning and elaborate access procedures may be required.''

Corrective Action

(1) Before further flight, repair the wire bundle per the service bulletin, except as provided by paragraph (a)(2) of this AD.

(2) Replace all spliced wires with new wires per the service bulletin, concurrently with accomplishment of the terminating action required by paragraph (b) of this AD.

Terminating Action

(b) Within 6,000 flight hours or 18 months after the effective date of this AD, whichever occurs later, do the actions specified in paragraphs (b)(1) and (b)(2) of this AD per the Accomplishment Instructions of Boeing Service Bulletin 767–73–0051, dated December 20, 2000.

(1) Do a detailed visual inspection of the wire bundles to detect chafing damage; if any damaged wires are found, replace the wires that require a splice repair with new wires concurrently with accomplishment of the terminating action specified in paragraph (b)(2) of this AD.

(2) Replace the existing support bracket of the wire bundle with a new bridge bracket, support bracket, and wire bundle clamps. Accomplishment of this replacement terminates the requirements of this AD.

(c) Any of the Type 2 tapes listed in Boeing Standard Wiring Practices Manual D6–54446, Subject 20–00–11, dated May 1, 2000, are acceptable alternatives to the TFE–2X Teflon wrap specified in Figure 1 of Boeing Service Bulletin 767–73A0049, Revision 3, dated December 20, 2000, or Revision 4, dated April 5, 2001.

Report Inspection Results

(d) Within 10 days after accomplishing the actions required by paragraph (a) or (b) of this AD: Report inspection results, as described in Boeing Service Bulletin 767–73A0049, Revision 3, dated December 20, 2000, or Revision 4, dated April 5, 2001, to Boeing Commercial Airplane Group, P.O. Box 3707, Seattle, Washington 98124–2207. Information collection requirements contained in this AD have been approved by the Office of Management and Budget (OMP) under the provisions of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 *et seq.*) and have been assigned OMB Control Number 2120–0056.

Spares

(e) As of the effective date of this AD, no person shall install on any airplane any support bracket located in the aft section of the strut forward fairing panel of either engine strut, as identified in the ''Existing Part Number'' column of Paragraph 2.E. of Boeing Service

Bulletin 767–73–0051, dated December 20, 2000.

Alternative Methods of Compliance

(f) 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, Seattle 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, Seattle ACO.

Note 4: Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the Seattle ACO.

Special Flight Permit

(g) Special flight permits may be issued per 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

(h) Except as provided by paragraph (c) of this AD, the actions shall be done in accordance with Boeing Service Bulletin 767–73A0049, Revision 3, dated December 20, 2000, or Boeing Service Bulletin 767–73A0049, Revision 4, dated April 5, 2001; and Boeing Service Bulletin 767–73–0051, dated December 20, 2000; as applicable. 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 Boeing Commercial Airplane Group, P.O. Box 3707, Seattle, Washington 98124–2207. Copies may be inspected at the Federal Aviation Administration (FAA), Transport Airplane Directorate, Rules Docket, 1601 Lind Avenue, SW., Renton, Washington; or at the Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

Effective Date

(i) This amendment becomes effective on January 4, 2002.

Issued in Renton, Washington, on November 16, 2001.

Kalene C. Yanamura,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 01–29323 Filed 11–29–01; 8:45 am]

BILLING CODE 4910–13–U

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 2000–NM–358–AD; Amendment 39–12521; AD 2001–24–05]

RIN 2120–AA64

Airworthiness Directives; Airbus Model A319, A320, and A321 Series Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule.

SUMMARY: This amendment supersedes an existing airworthiness directive (AD), applicable to certain Airbus Model A320 series airplanes, that currently requires modification of the autopilot mode engagement/disengagement lever of the rudder artificial feel unit. This amendment requires a different modification of the lever. This amendment also revises the applicability to include Airbus Model A319 and A321 series airplanes, as well as all Model A320 series airplanes. This amendment is prompted by issuance of mandatory continuing airworthiness information by a foreign civil airworthiness authority. The actions specified by this AD are intended to prevent reduced controllability of the airplane due to the failure of the rudder artificial feel unit to disengage properly from autopilot mode during approach and landing.

DATES: Effective January 4, 2002.

The incorporation by reference of certain publications listed in the regulations is approved by the Director of the Federal Register as of January 4, 2002.

ADDRESSES: The service information referenced in this AD may be obtained from Airbus Industrie, 1 Rond Point Maurice Bellonte, 31707 Blagnac Cedex, France. 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 Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Tim Dulin, Aerospace Engineer, International Branch, ANM–116, FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington 98055–4056; telephone: (425) 227–2141; fax (425) 227–1149.

SUPPLEMENTARY INFORMATION: A proposal to amend part 39 of the Federal Aviation Regulations (14 CFR part 39) by superseding AD 99–21–29, amendment 39–11375 (64 FR 56158, October 18, 1999), which is applicable to certain Airbus Model A320 series airplanes, was published in the **Federal Register** on March 29, 2001 (66 FR 17125). The action proposed to require a new modification of the autopilot mode engagement/disengagement lever of the rudder artificial feel unit. The action also proposed to revise the applicability of the existing AD to include Airbus Model A319 and A321 series airplanes, as well as all Model A320 series airplanes.

Comments

Interested persons have been afforded an opportunity to participate in the making of this amendment. Due consideration has been given to the comments received.

Request To Refer to Revised Service Information

Two commenters request that the FAA revise paragraph (a) of the proposed AD to refer to Airbus Service Bulletin A320–27–1130, Revision 01, dated November 23, 2000, instead of the original issue of that service bulletin, which the proposed AD specifies as the appropriate source of service information for the proposed modification. One of the commenters explains that Airbus issued Revision 01 of the service bulletin in response to the commenter's suggestions for improvements and corrections that could be made to the work instructions, as well as to revise the effectivity. The other commenter also asks that, in addition to referring to Revision 01, the proposed AD be revised to refer to ''any subsequently approved revision(s)'' of the service bulletin as appropriate sources of service information.

The FAA partially concurs with the commenters' requests. Since the issuance of the proposed rule, Airbus has issued Revision 01 of the service bulletin, as well as Revision 02 of the service bulletin, dated September 6, 2001. We have determined that accomplishment of the modification required by this AD according to either the original issue, Revision 01, or Revision 02 of the service bulletin is acceptable. Paragraph (a) has been revised to refer to the most recent issue, Revision 02 of the service bulletin, and Note 2 has been added to this AD (and subsequent notes reordered) to state that modification prior to the effective date of this AD according to the original issue or Revision 01 of the service bulletin is acceptable for compliance with paragraph (a) of this AD.

With regard to the second commenter's request to refer to ''any

subsequently approved revision(s)'' of the service bulletin, we do not concur. An AD may only refer to service documents that are submitted and approved by the Office of the Federal Register (OFR) for ''incorporation by reference.'' In order for operators to use later revisions of the referenced document (issued after the publication of the AD), either the AD must be revised to refer to the specific later revisions, or operators must request approval for the use of them as an alternative method of compliance with this AD under the provisions of paragraph (c) of this AD. No further change to the AD is necessary in this regard.

Request To Revise Compliance Time

One commenter requests that the FAA revise the compliance time for the proposed modification from 18 months to 24 months after the effective date of the AD. The commenter states that this change would allow operators to accomplish the modification during a regularly scheduled maintenance visit such as a ''C'' check, which would reduce the impact of the proposed modification on line operations. The commenter also states that an extension of the compliance time would make the compliance time for the proposed AD coincide with those of other ADs and would compensate for increased lead-time necessary for delivery of the kit needed to accomplish the proposed modification.

The FAA does not concur. In developing the compliance time for the modification in this AD, the FAA considered not only the degree of urgency associated with addressing the subject unsafe condition, but also the time necessary to accomplish the modification (estimated at 9 work hours per airplane), and the practical aspect of installing the required modification within an interval of time that parallels normal scheduled maintenance for the majority of affected operators. The FAA finds that 18 months represents an appropriate interval of time allowable wherein the modification can be accomplished during scheduled maintenance for the majority of affected operators, and an acceptable level of safety can be maintained. With regard to the lead-time needed for obtaining the necessary kits, we find that operators will have ample time to order and receive the kits before the compliance threshold. No change to the AD is necessary in this regard.

Request To Differentiate Between Assembly and Subassembly Part Numbers

One commenter requests that the FAA revise paragraph (b) of the proposed AD to differentiate between assembly and subassembly part numbers. The commenter notes that paragraph (b) of the proposed AD contains both artificial feel unit assembly and artificial feel unit subassembly part numbers according to the Airbus Illustrated Parts Catalog.

The FAA does not concur. All parts listed in paragraph (b) are prohibited from being installed on an airplane after the effective date of this AD. In addition, the referenced service bulletin clearly differentiates between artificial feel units with a solenoid and those without a solenoid. No change to the AD is necessary in this regard.

Conclusion

After careful review of the available data, including the comments noted above, the FAA has determined that air safety and the public interest require the adoption of the rule with the changes previously described. The FAA has determined that these changes will neither increase the economic burden on any operator nor increase the scope of the AD.

Cost Impact

There are approximately 291 Model A319, A320, and A321 series airplanes of U.S. registry that will be affected by this AD.

The new modification that is required by this AD will take approximately 9 work hours per airplane to accomplish, at an average labor rate of $60 per work hour. Required parts will be provided by the manufacturer at no cost. Based on these figures, the cost impact of the requirements of this AD on U.S. operators is estimated to be $157,140, or $540 per airplane.

The cost impact figure discussed above is 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.

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 removing amendment 39–11375 (64 FR 56158, October 18, 1999), and by adding a new airworthiness directive (AD), amendment 39–12521, to read as follows:

2001–24–05 Airbus Industrie: Amendment 39–12521. Docket 2000–NM–358–AD. Supersedes AD 99–21–29, Amendment 39–11375.

Applicability: Model A319, A320, and A321 series airplanes, certificated in any category, on which Airbus Modification 28909 was not accomplished during production.

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 (c) 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 reduced controllability of the airplane, due to the failure of the rudder artificial feel unit to disengage properly from autopilot mode during approach and landing, accomplish the following:

Modification

(a) Within 18 months after the effective date of this AD, modify the autopilot mode engagement/disengagement lever of the rudder artificial feel unit, in accordance with paragraphs 3.B. and 3.C. of the Accomplishment Instructions of Airbus Service Bulletin A320–27–1130, Revision 02, dated September 6, 2001.

Note 2: Modification of the autopilot mode engagement/disengagement lever of the rudder artificial feel unit prior to the effective date of this AD in accordance with Airbus Service Bulletin A320–27–1130, dated March 14, 2000, or Revision 01, dated November 23, 2000, is acceptable for compliance with paragraph (a) of this AD.

Spares

(b) As of the effective date of this AD, no person may install a rudder artificial feel unit having any of the following part numbers on any airplane:

D2727040000600
D2727040000651
D2727040000695
D2727040000696
D2727040000800
D2727040000851
D2727040001000
D2727040001051

Alternative Methods of Compliance

(c) 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, International Branch, ANM–116, Transport Airplane Directorate, FAA. Operators shall submit their requests through an appropriate FAA Principal Maintenance Inspector, who may add comments and then send it to the Manager, International Branch, ANM–116.

Note 3: Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the Manager, International Branch, ANM–116.

Special Flight Permits

(d) 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

(e) The actions shall be done in accordance with Airbus Service Bulletin A320–27–1130, Revision 02, dated September 6, 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 Airbus Industrie, 1 Rond Point Maurice Bellonte, 31707 Blagnac Cedex, France. Copies may be inspected at the FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington; or at the Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

Note 4: The subject of this AD is addressed in French airworthiness directive 2000–372–151(B), dated September 6, 2000.

Effective Date

(f) This amendment becomes effective on January 4, 2002.

Issued in Renton, Washington, on November 19, 2001.

Kalene C. Yanamura,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 01–29340 Filed 11–29–01; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 2000–NM–196–AD; Amendment 39–12520; AD 2001–24–04]

RIN 2120–AA64

Airworthiness Directives; McDonnell Douglas Model MD–90–30 Series Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule.

SUMMARY: This amendment adopts a new airworthiness directive (AD), applicable to certain McDonnell Douglas Model MD–90–30 series airplanes, that requires an inspection of the wiring in the left-hand tunnel area of the forward cargo compartment for evidence of chafing, and repair, if necessary. The actions specified by this AD are intended to prevent such chafing, which could result in subsequent shorting to structure, and consequent smoke and possible fire in the airplane. This action is intended to address the identified unsafe condition.

DATES: Effective January 4, 2002.

The incorporation by reference of certain publications listed in the regulations is approved by the Director of the Federal Register as of January 4, 2002.

ADDRESSES: The service information referenced in this AD may be obtained from Boeing Commercial Aircraft Group, Long Beach Division, 3855 Lakewood Boulevard, Long Beach, California 90846, Attention: Data and Service Management, Dept. C1–L5A (D800–0024). 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, Los Angeles Aircraft Certification Office, 3960 Paramount Boulevard, Lakewood, California; or at the Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

FOR FURTHER INFORMATION CONTACT: George Y. Mabuni, Aerospace Engineer, Systems and Equipment Branch, ANM–130L, FAA, Los Angeles Aircraft Certification Office, 3960 Paramount Boulevard, Lakewood, California 90712–4137; telephone (562) 627–5341; fax (562) 627–5210.

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 McDonnell Douglas Model MD–90–30 series airplanes was published in the **Federal Register** on August 28, 2001 (66 FR 45190). That action proposed to require an inspection of the wiring in the left-hand tunnel area of the forward cargo compartment for evidence of chafing, and repair, if necessary.

Comments

Interested persons have been afforded an opportunity to participate in the making of this amendment. No comments were submitted in response to the proposal or the FAA's determination of the cost to the public.

Conclusion

The FAA has determined that air safety and the public interest require the adoption of the rule as proposed.

Cost Impact

There are approximately 12 Model MD–90–30 series airplanes of the affected design in the worldwide fleet. The FAA estimates that 10 airplanes of U.S. registry will be affected by this AD, that it will take approximately 3 work hours per airplane to accomplish the required actions, and that the average labor rate is $60 per work hour. Based on these figures, the cost impact of the AD on U.S. operators is estimated to be $1,800, or $180 per airplane.

The cost impact figure discussed above is 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.

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:

2001–24–04 **McDonnell Douglas:** Amendment 39–12520. Docket 2000–NM–196–AD.

Applicability: Model MD–90–30 series airplanes, certificated in any category; as identified in McDonnell Douglas Alert Service Bulletin MD90–24A003, Revision 01, dated January 11, 2000.

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 (b) 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 chafing of the wiring in the left-hand tunnel area of the forward cargo compartment, which could result in subsequent shorting to structure, and consequent smoke and possible fire in the airplane; accomplish the following:

Inspection and Repair

(a) Within one year after the effective date of this AD, accomplish paragraphs (a)(1) and (a)(2) of this AD per McDonnell Douglas Alert Service Bulletin MD90–24A003, Revision 01, dated January 11, 2000.

(1) Do a one-time general visual inspection of the wiring in the left-hand tunnel area of the forward cargo compartment for evidence of chafing. Prior to further flight, repair any damaged wiring.

(2) Coil and stow any excess wire in the forward cargo compartment, left side, between stations Y=237.000 and Y=256.000.

Note 2: For the purposes of this AD, a general visual inspection is defined as ''A visual examination of an interior or exterior area, installation, or assembly to detect obvious damage, failure, or irregularity. This level of inspection is made under normally available lighting conditions such as daylight, hangar lighting, flashlight, or drop-light, and may require removal or opening of access panels or doors. Stands, ladders, or platforms may be required to gain proximity to the area being checked.''

Note 3: Accomplishment of the actions required by this AD per McDonnell Douglas Service Bulletin MD90–24–003, dated October 27, 1995, prior to the effective date of this AD, is considered acceptable for compliance with the requirements of this AD.

Alternative Methods of Compliance

(b) 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, Los Angeles 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, Los Angeles ACO.

Note 4: Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the Los Angeles ACO.

Special Flight Permits

(c) 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

(d) The actions shall be done in accordance with McDonnell Douglas Alert Service Bulletin MD90–24A003, Revision 01, dated January 11, 2000. 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 Boeing Commercial Aircraft Group, Long Beach Division, 3855 Lakewood Boulevard, Long Beach, California 90846, Attention: Data and Service Management, Dept. C1–L5A (D800–0024). Copies may be inspected at the FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington; or at the FAA, Los Angeles Aircraft Certification Office, 3960 Paramount Boulevard, Lakewood, California; or at the Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

Effective Date

(e) This amendment becomes effective on January 4, 2002.

Issued in Renton, Washington, on November 19, 2001.

Kalene C. Yanamura,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 01–29341 Filed 11–29–01; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 2001–NM–129–AD; Amendment 39–12522; AD 2001–24–06]

RIN 2120–AA64

Airworthiness Directives; Bombardier Model DHC–8–100, –200, and –300 Series Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule.

SUMMARY: This amendment adopts a new airworthiness directive (AD), applicable to certain Bombardier Model DHC–8–100, –200, and –300 series airplanes, that requires installation of a

backup pressure regulating valve on the oil pump of the propeller control unit (PCU) on both engines. The actions specified by this AD are intended to prevent a build-up of oil pressure in the oil pump of the PCU should the existing valve fail. Such failure of the pressure regulating valve could lead to oil leaks, fracture of the pump, inability to maintain engine oil pressure, and inability to feather the propeller, with consequent reduced controllability of the aircraft. This action is intended to address the identified unsafe condition.

DATES: Effective January 4, 2002.

The incorporation by reference of certain publications listed in the regulations is approved by the Director of the Federal Register as of January 4, 2002.

ADDRESSES: The service information referenced in this AD may be obtained from Bombardier, Inc., Bombardier Regional Aircraft Division, 123 Garratt Boulevard, Downsview, Ontario M3K 1Y5, 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: James Delisio, Aerospace Engineer, ANE–171, FAA, New York Aircraft Certification Office, 10 Fifth Street, Third Floor, Valley Stream, New York 11581; telephone (516) 256–7521; 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 DHC–8–100, –200, and –300 series airplanes was published in the **Federal Register** on September 4, 2001 (66 FR 46239). That action proposed to require installation of a backup pressure regulating valve on the oil pump of the propeller control unit (PCU) on both engines.

Comments

Interested persons have been afforded an opportunity to participate in the making of this amendment. No comments were submitted in response to the proposal or the FAA determination of the cost to the public.

Conclusion

The FAA has determined that air safety and the public interest require the adoption of the rule as proposed.

Cost Impact

The FAA estimates that 191 Bombardier Model DHC–8–100, –200, and –300 series airplanes of U.S. registry will be affected by this AD, that it will take approximately 2 work hours per airplane to accomplish the required installation, and that the average labor rate is $60 per work hour. Required parts will cost approximately $1,019 per airplane. Based on these figures, the cost impact of the AD on U.S. operators is estimated to be $217,549, or $1,139 per airplane.

The cost impact figure discussed above is 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.

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:

2001–24–06 Bombardier, Inc. (Formerly de Havilland, Inc.): Amendment 39–12522. Docket 2001–NM–129–AD.

Applicability: Model DHC–8–100, –200, and –300 series airplanes, serial numbers 003 through 554 inclusive; certificated in any category.

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 (b) 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 a build-up of oil pressure in the oil pump of the propeller control unit, should the existing valve fail, which could lead to oil leaks, fracture of the pump, inability to maintain engine oil pressure, and inability to feather the propeller, with consequent reduced controllability of the aircraft, accomplish the following:

Installation

(a) Within 24 months after the effective date of this AD or at the next scheduled shop visit, whichever occurs first, install a backup pressure regulating valve in the oil pump in the propeller control unit on each engine, in accordance with Bombardier Service Bulletin 8–61–31, dated October 17, 2000.

Alternative Methods of Compliance

(b) 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

(c) 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

(d) The installation shall be done in accordance with Bombardier Service Bulletin 8–61–31, dated October 17, 2000. 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., Bombardier Regional Aircraft Division, 123 Garratt Boulevard, Downview, Ontario M3K 1Y5, 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–2001–12, dated March 2, 2001.

Effective Date

(e) This amendment becomes effective on January 4, 2002.

Issued in Renton, Washington, on November 19, 2001.

Kalene C. Yanamura,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 01–29343 Filed 11–29–01; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Parts 91, 121, 135, and 145

[Docket No. FAA–1999–5836; Amendment Nos. 91–269, 121–286, 135–82, 145–27, and SFAR 36–7]

RIN 2120–AC38

Repair Stations

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule; reopening of comment period.

SUMMARY: This action reopens the comment period for a final rule that was published on August 6, 2001. In that document, the FAA updated and revised the regulations for aeronautical repair stations. The FAA also requested comments on the new recordkeeping requirements and its decisions to remove appendix A. This reopening of the comment period is a result of several requests to allow additional time to comment on the paperwork burden associated with the final rule.

DATES: Comments on the paperwork burden associated with the final rule must be received on or before January 29, 2002.

ADDRESSES: Comments on this document should be mailed or delivered, in duplicate, to: U.S. Department of Transportation Dockets, Docket No. FAA–1999–5836, 400 Seventh Street, SW., Room Plaza 401, Washington, DC 20590. Comments may be filed and examined in Room Plaza 401 between 10 a.m. and 5 p.m. weekdays, except Federal holidays. Comments also may be sent electronically to the Dockets Management System (DMS) at the following Internet address: http://dms.dot.gov at any time. Commenters who wish to file comments electronically, should follow the instructions on the DMS web site.

FOR FURTHER INFORMATION CONTACT: Diana L. Frohn, Aircraft Maintenance Division, Air Carrier Maintenance Branch, AFS–330, Federal Aviation Administration, 800 Independence Avenue SW., Washington, DC 20591; telephone (202) 493–4241; facsimile (202) 267–5115.

SUPPLEMENTARY INFORMATION:

Comments Invited

An opportunity for comment on the information collection requirements of the repair station final rule was not provided during the notice of proposed rulemaking stage. Interested persons are invited to submit written data, views, or arguments regarding the information collection requirements as they may desire. Substantive comments should be accompanied by cost estimates. Comments must identify the regulatory docket or notice number and be submitted in duplicate to the DOT Rules Docket address specified above.

All comments received, as well as a report summarizing each substantive public contact with FAA personnel concerning this rulemaking, will be filed in the docket. The docket is available for public inspection before and after the comment closing date.

All comments received on or before the closing date will be considered by the FAA before the effective date of the final rule. Comments filed late will be considered as far as possible without incurring expense or delay.

Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this document must include a pre-addressed, stamped postcard with those comments on which the following statement is made: ''Comments to Docket No. FAA–1999–5836.'' The postcard will date stamped and mailed to the commenter.

Background

On July 30, 2001, the Federal Aviation Administration (FAA) issued Repair Stations; Final Rule with request for comments and direct final rule with request for comments (66 FR 41088, August 6, 2001). Comments to that document were to be received on or before October 5, 2001.

Several organizations have requested an extension of the comment period. By letter dated September 28, 2001, the Aeronautical Repair Station Association, Aircraft Electronics Association, Helicopter Association International, National Air Transportation Association, and National Air Carrier Association jointly requested that FAA extend the comment period until December 31, 2001. The petitioners cited the national security events that occurred on September 11, 2001, to support their requests for an extension. The petitioners indicated that the recent events devastated its member companies. In some cases, the personnel needed to collect, compile, evaluate, and respond to the request for cost estimates have been laid off. In other cases these personnel have been assigned to other responsibilities, making it difficult to respond to the request for comments by the October 5, 2001, deadline. Goodrich Aerostructures Group, also requested that FAA extend the comment period.

The FAA acknowledges that the tragic events of September 11 have required the nation's attention and concurs with the petitioner's request to extend the comment period on the information collection requirements of the final rule. Therefore, the FAA believes as additional 60 days is sufficient to allow interest parties to provide comment.

Extension of Comment Period

In accordance with § 11.47 of Title 14, Code of Federal Regulations, the FAA has reviewed the requests for extension of the comment period to the repair stations final rule. These petitioners have shown a substantive interest in the final rule and good cause for the extension. The FAA also has determined that an extension of the comment period is consistent with the public interest, and that good cause exists for taking this action.

Accordingly, the comment period for Repair Stations; Final Rule request for

comments on the paperwork burden is extended until January 29, 2002.

Issued in Washington, DC, November 19, 2001.

Louis C. Cusimano,

Acting Director, Flight Standards Service.

[FR Doc. 01–29479 Filed 11–29–01; 8:45 am]

BILLING CODE 4910–13–M

PENSION BENEFIT GUARANTY CORPORATION

29 CFR Parts 4011 and 4022

Disclosure to Participants; Benefits Payable in Terminated Single-Employer Plans

AGENCY: Pension Benefit Guaranty Corporation.

ACTION: Final rule.

SUMMARY: This rule amends Appendix D to the Pension Benefit Guaranty Corporation's regulation on Benefits Payable in Terminated Single-Employer Plans by adding the maximum guaranteeable pension benefit that may be paid by the PBGC with respect to a plan participant in a single-employer pension plan that terminates in 2002. This rule also amends the PBGC's regulation on Disclosure to Participants by adding information on 2002 maximum guaranteed benefit amounts to Appendix B. The amendment is necessary because the maximum guarantee amount changes each year, based on changes in the contribution and benefit base under section 230 of the Social Security Act. The effect of the amendment is to advise plan participants and beneficiaries of the increased maximum guarantee amount for 2002.

EFFECTIVE DATE: January 1, 2002.

FOR FURTHER INFORMATION CONTACT: Harold J. Ashner, Assistant General Counsel, Office of the General Counsel, Pension Benefit Guaranty Corporation, 1200 K Street, NW., Washington, DC 20005–4026; 202–326–4024. (For TTY/TDD users, call the Federal relay service toll-free at 1–800–877–8339 and ask to be connected to 202–326–4024.)

SUPPLEMENTARY INFORMATION: Section 4022(b) of the Employee Retirement Income Security Act of 1974 provides for certain limitations on benefits guaranteed by the PBGC in terminating single-employer pension plans covered under Title IV of ERISA. One of the limitations, set forth in section 4022(b)(3)(B), is a dollar ceiling on the amount of the monthly benefit that may be paid to a plan participant (in the form of a life annuity beginning at age 65) by the PBGC. The ceiling is equal to ''$750 multiplied by a fraction, the numerator of which is the contribution and benefit base (determined under section 230 of the Social Security Act) in effect at the time the plan terminates and the denominator of which is such contribution and benefit base in effect in calendar year 1974 [$13,200].'' This formula is also set forth in § 4022.22(b) of the PBGC's regulation on Benefits Payable in Terminated Single-Employer Plans (29 CFR Part 4022). Appendix D to Part 4022 lists, for each year beginning with 1974, the maximum guaranteeable benefit payable by the PBGC to participants in single-employer plans that have terminated in that year.

Section 230(d) of the Social Security Act (42 U.S.C. 430(d)) provides special rules for determining the contribution and benefit base for purposes of ERISA section 4022(b)(3)(B). Each year the Social Security Administration determines, and notifies the PBGC of, the contribution and benefit base to be used by the PBGC under these provisions, and the PBGC publishes an amendment to Appendix D to Part 4022 to add the guarantee limit for the coming year.

The PBGC has been notified by the Social Security Administration that, under section 230 of the Social Security Act, $63,000 is the contribution and benefit base that is to be used to calculate the PBGC maximum guaranteeable benefit for 2001. Accordingly, the formula under section 4022(b)(3)(B) of ERISA and 29 CFR 4022.22(b) is: $750 multiplied by $63,000/$13,200. Thus, the maximum monthly benefit guaranteeable by the PBGC in 2002 is $3,579.55 per month in the form of a life annuity beginning at age 65. This amendment updates Appendix D to Part 4022 to add this maximum guaranteeable amount for plans that terminate in 2002. (If a benefit is payable in a different form or begins at a different age, the maximum guaranteeable amount is the actuarial equivalent of $3,579.55 per month.)

Section 4011 of ERISA requires plan administrators of certain underfunded plans to provide notice to plan participants and beneficiaries of the plan's funding status and the limits of the PBGC's guarantee. The PBGC's regulation on Disclosure to Participants (29 CFR part 4011) implements the statutory notice requirement. This rule amends Appendix B to the regulation on Disclosure to Participants by adding information on 2002 maximum guaranteed benefit amounts. Plan administrators may, subject to the requirements of that regulation, include this information in participant notices.

General notice of proposed rulemaking is unnecessary. The maximum guaranteeable benefit is determined according to the formula in section 4022(b)(3)(B) of ERISA, and these amendments make no change in its method of calculation but simply list 2002 maximum guaranteeable benefit amounts for the information of the public.

The PBGC has determined that this action is not a ''significant regulatory action'' under the criteria set forth in Executive Order 12866.

Because no general notice of proposed rulemaking is required for this regulation, the Regulatory Flexibility Act of 1980 does not apply (5 U.S.C. 601(2)).

List of Subjects

29 CFR Part 4011

Employee benefit plans, Pension insurance, Reporting and recordkeeping requirements.

29 CFR Part 4022

Pension insurance, Pensions, Reporting and recordkeeping requirements.

In consideration of the foregoing, 29 CFR parts 4011 and 4022 are amended as follows:

PART 4011—DISCLOSURE TO PARTICIPANTS

1. The authority citation for part 4011 continues to read as follows:

Authority: 29 U.S.C. 1302(b)(3), 1311.

2. Appendix B to part 4011 is amended by adding a new entry in numerical order to the table to read as follows.

Appendix B to Part 4011.—Table of Maximum Guaranteed Benefits

If a plan terminates in—	The maximum guaranteed benefit for an individual starting to receive benefits at the age listed below is the amount (monthly or annual) listed below:							
	Age 65		Age 62		Age 60		Age 55	
	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual
*	*		*		*	*	*	
2002	$3,579.55	$42,954.60	$2,827.84	$33,934.08	$2,326.71	$27,920.52	$1,610.80	$19,329.60

* * * * *

PART 4022—BENEFITS PAYABLE IN TERMINATED SINGLE-EMPLOYER PLANS

3. The authority citation for part 4022 continues to read as follows:

Authority: 29 U.S.C. 1302, 1322, 1322b, 1341(c)(3)(D), and 1344.

4. Appendix D to part 4022 is amended by adding a new entry to the table to read as follows. The introductory text is republished for the convenience of the reader and remains unchanged.

Appendix D to Part 4022—Maximum Guaranteeable Monthly Benefit

The following table lists by year the maximum guaranteeable monthly benefit payable in the form of a life annuity commencing at age 65 as described by § 4022.22(b) to a participant in a plan that terminated in that year:

Year	Maximum guaranteeable monthly benefit
* * *	* *
2002	3,579.55

Issued in Washington, DC, this 26th day of November 2001.

Hazel Broadnax,

Acting Executive Director, Pension Benefit Guaranty Corporation.

[FR Doc. 01–29763 Filed 11–29–01; 8:45 am]

BILLING CODE 7708–01–P

PENSION BENEFIT GUARANTY CORPORATION

29 CFR Part 4044

Allocation of Assets in Single-Employer Plans; Valuation of Benefits and Assets; Expected Retirement Age

AGENCY: Pension Benefit Guaranty Corporation.

ACTION: Final rule.

SUMMARY: This rule amends the Pension Benefit Guaranty Corporation's regulation on Allocation of Assets in Single-Employer Plans by substituting a new table that applies to any plan being terminated either in a distress termination or involuntarily by the PBGC with a valuation date falling in 2002, and is used to determine expected retirement ages for plan participants. This table is needed in order to compute the value of early retirement benefits and, thus, the total value of benefits under the plan.

EFFECTIVE DATE: January 1, 2002.

FOR FURTHER INFORMATION CONTACT: Harold J. Ashner, Assistant General Counsel, Office of the General Counsel, Pension Benefit Guaranty Corporation, 1200 K Street, NW., Washington, DC 20005–4026; 202–326–4024. (For TTY/TDD users, call the Federal relay service toll-free at 1–800–877–8339 and ask to be connected to 202–326–4024.)

SUPPLEMENTARY INFORMATION: The PBGC's regulation on Allocation of Assets in Single-Employer Plans (29 CFR part 4044) sets forth (in subpart B) the methods for valuing plan benefits of terminating single-employer plans covered under Title IV of the Employee Retirement Income Security Act of 1974. Under ERISA section 4041(c), guaranteed benefits and benefit liabilities under a plan that is undergoing a distress termination must be valued in accordance with part 4044, subpart B. In addition, when the PBGC terminates an underfunded plan involuntarily pursuant to ERISA Section 4042(a), it uses the subpart B valuation rules to determine the amount of the plan's underfunding.

Under § 4044.51(b), early retirement benefits are valued based on the annuity starting date, if a retirement date has been selected, or the expected retirement age, if the annuity starting date is not known on the valuation date. Sections 4044.55 through 4044.57 set forth rules for determining the expected retirement ages for plan participants entitled to early retirement benefits. Appendix D of part 4044 contains tables to be used in determining the expected early retirement ages.

Table I in appendix D (Selection of Retirement Rate Category) is used to determine whether a participant has a low, medium, or high probability of retiring early. The determination is based on the year a participant would reach ''unreduced retirement age'' (*i.e.,* the earlier of the normal retirement age or the age at which an unreduced benefit is first payable) and the participant's monthly benefit at unreduced retirement age. The table applies only to plans with valuation dates in the current year and is updated annually by the PBGC to reflect changes in the cost of living, etc.

Tables II–A, II–B, and II–C (Expected Retirement Ages for Individuals in the Low, Medium, and High Categories respectively) are used to determine the expected retirement age after the probability of early retirement has been determined using Table I. These tables establish, by probability category, the expected retirement age based on both the earliest age a participant could retire under the plan and the unreduced retirement age. This expected retirement age is used to compute the value of the early retirement benefit and, thus, the total value of benefits under the plan.

This document amends appendix D to replace Table I–01 with Table I–02 in order to provide an updated correlation, appropriate for calendar year 2002, between the amount of a participant's benefit and the probability that the participant will elect early retirement. Table I–02 will be used to value benefits in plans with valuation dates during calendar year 2002.

The PBGC has determined that notice of and public comment on this rule are impracticable and contrary to the public interest. Plan administrators need to be able to estimate accurately the value of plan benefits as early as possible before initiating the termination process. For that purpose, if a plan has a valuation date in 2002, the plan administrator needs the updated table being promulgated in this rule. Accordingly, the public interest is best served by

issuing this table expeditiously, without an opportunity for notice and comment, to allow as much time as possible to estimate the value of plan benefits with the proper table for plans with valuation dates in early 2002.

The PBGC has determined that this action is not a ''significant regulatory action'' under the criteria set forth in Executive Order 12866.

Because no general notice of proposed rulemaking is required for this regulation, the Regulatory Flexibility Act of 1980 does not apply (5 U.S.C. 601(2)).

List of Subjects in 29 CFR Part 4044

Pension insurance, Pensions.

In consideration of the foregoing, 29 CFR part 4044 is amended as follows:

PART 4044—[AMENDED]

1. The authority citation for part 4044 continues to read as follows:

Authority: 29 U.S.C. 1301(a), 1302(b)(3), 1341, 1344, 1362.

2. Appendix D to part 4044 is amended by removing Table I–01 and adding in its place Table I–02 to read as follows:

Appendix D to Part 4044—Tables Used to Determine Expected Retirement Age

TABLE I–02—SELECTION OF RETIREMENT RATE CATEGORY

[For Plans with valuation dates after December 31, 2001, and before January 1, 2003]

Participant reaches URA in year—	Participant's retirement rate category is—			
	Low [1] if monthly benefit at URA is less than—	Medium [2] if monthly benefit at URA is		High [3] if monthly benefit at URA is greater than—
		From	To	
2003	458	458	1,936	1,936
2004	471	471	1,988	1,988
2005	483	483	2,042	2,042
2006	497	497	2,097	2,097
2007	510	510	2,154	2,154
2008	524	524	2,212	2,212
2009	538	538	2,272	2,272
2010	552	552	2,333	2,333
2011	567	567	2,396	2,396
2012 or later	583	583	2,461	2,461

[1] Table II–A.
[2] Table II–B.
[3] Table II–C.

* * * * *

Issued in Washington, DC, this 26th day of November, 2001.

Hazel Broadnax,

Acting Executive Director, Pension Benefit Guaranty Corporation.

[FR Doc. 01–29764 Filed 11–29–01; 8:45 am]

BILLING CODE 7708–01–P

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 117

[CGD01–01–204]

Drawbridge Operation Regulations: Jamaica Bay and Connecting Waterways, NY

AGENCY: Coast Guard, DOT.

ACTION: Notice of temporary deviation from regulations.

SUMMARY: The Commander, First Coast Guard District, has issued a temporary deviation from the drawbridge operation regulations for the Beach Channel Railroad Bridge, mile 6.7, across Jamaica Bay in Queens County, New York. This temporary deviation will allow the bridge to remain in the closed position at various times between December 1, 2001 and December 20, 2001. This temporary deviation is necessary to facilitate structural repairs at the bridge.

DATES: This deviation is effective from December 1, 2001 through December 20, 2001.

FOR FURTHER INFORMATION CONTACT: Joseph Schmied, Project Officer, First Coast Guard District, at (212) 668–7195.

SUPPLEMENTARY INFORMATION:

The Beach Channel Railroad Bridge has a vertical clearance in the closed position of 26 feet at mean high water and 31 feet at mean low water. The existing regulations require the draw to open on signal at all times; however, a temporary final rule was published on May 31, 2001, (66 FR 29483) entitled Drawbridge Operation Regulations Jamaica Bay and connecting waterways, New York. Under this temporary final rule the bridge owner was allowed to require a twenty-four hours advance notice for openings from May 18, 2001 through November 30, 2001, to facilitate structural maintenance at the bridge.

The bridge owner, New York City Transit, has requested a temporary deviation from the drawbridge operating regulations to facilitate additional structural maintenance at the bridge.

Additional deteriorated structural components were discovered during the approved maintenance repairs authorized under the existing temporary final rulemaking in effect until November 30, 2001. The nature of the required additional structural repairs will require the bridge to be closed to navigation and rail traffic during the implementation of this work.

This deviation to the operating regulations will allow the bridge to remain in the closed position during the following time periods: 6 a.m. December 03 through 9 p.m. December 06, 2001, 6 a.m. December 10 through 9 p.m. December 13, 2001, 6 a.m. December 17 through 9 p.m. December 20, 2001.

This deviation from the operating regulations is authorized under 33 CFR 117.35, and will be performed with all due speed in order to return the bridge to normal operation as soon as possible.

Dated: November 2, 2001.

G. N. Naccara,

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

[FR Doc. 01–29760 Filed 11–29–01; 8:45 am]

BILLING CODE 4910–15–U

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 165

[CGD01–01–214]

RIN 2115–AA97

Safety and Security Zones; Liquid Natural Gas Carrier Transits and Anchorage Operations, Boston, Marine Inspection Zone and Captain of the Port Zone

AGENCY: Coast Guard, DOT.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is establishing temporary safety and security zones for Liquid Natural Gas Carrier (LNGC) vessels within the Boston Marine Inspection Zone and Captain of the Port Zone. These safety and security zones will temporarily close all waters within a 500-yard radius of all LNGC vessels anchored in Broad Sound and while moored at the Distrigas waterfront facility in the Mystic River, Everett Massachusetts. These safety and security zones also temporarily close all navigable waters and internal waters of the United States within the Boston Marine Inspection Zone and Captain of the Port Zone, two miles ahead and one mile astern, and 1000-yards on each side of any LNGC vessel anytime a vessel is within the internal waters of the United States and out to 12 nautical miles. Entry into or movement within these zones is prohibited without prior authorization from the Captain of the Port. These zones are needed to safeguard the LNGC vessels, the public and the surrounding area from sabotage or other subversive acts, accidents, or other events of a similar nature, and are needed to protect persons, vessels and others in the maritime community from the safety hazards associated with the transit and limited maneuverability of a large tank vessel.

DATES: This rule is effective from 12:01 a.m. November 13, 2001, until 11:59 p.m. June 15, 2002.

ADDRESSES: Documents as indicated in this preamble are available for inspection or copying at Marine Safety Office Boston, 455 Commercial Street, Boston, MA between the hours of 8 a.m. and 3 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: Chief Petty Officer Michael Popovich, Marine Safety Office Boston, Waterways Safety & Response Division, at (617) 223–3000.

SUPPLEMENTARY INFORMATION:

Regulatory History

We did not publish a notice of proposed rulemaking (NPRM) for this regulation. Under 5 U.S.C. 553, the Coast Guard finds that good cause exists for not publishing an NPRM. On September 11, 2001, two commercial aircraft were hijacked from Logan Airport in Boston, Massachusetts and flown into the World Trade Center in New York, New York inflicting catastrophic human casualties and property damage. A similar attack was conducted on the Pentagon on the same day. National security and intelligence officials warn that future terrorist attacks against civilian targets may be anticipated. Due to the flammable nature of the Liquid Natural Gas Carrier (LNGC) vessel cargo, this rulemaking is urgently required to prevent possible terrorist strikes against LNGC vessels within and adjacent to waters within the Boston Marine Inspection Zone and Captain of the Port Zone. The delay inherent in the NPRM process is contrary to the public interest insofar as it would render LNGC vessels transiting the port of Boston vulnerable to subversive activity, sabotage or terrorist attack, and immediate action is necessary to protect persons, vessels and others in the maritime community from the hazards associated with the transit and limited maneuverability of a large tank vessel.

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**. The measures contemplated by the rule are intended to prevent possible terrorist attacks against LNGC vessels, and to protect other vessels, waterfront facilities, the public and the port of Boston from potential sabotage or other subversive acts, accidents or other causes of a similar nature. In addition, the zones protect persons, vessels and others in the maritime community from the hazards associated with the transit and limited maneuverability of a large tank vessel. Immediate action is required to accomplish these objectives. Any delay in the effective date of this rule is impracticable and contrary to the public interest. These zones should have minimal impact on the users of the Boston Marine Inspection Zone and Captain of the Port Zone, Boston Harbor and Broad Sound as LNGC vessel transits are infrequent, vessels have ample water to transit around the zones while at anchor in Broad Sound, the zones established while the vessel is transiting are moving safety and security zones, allowing vessels to transit ahead, behind or after passage of an LNGC vessel, and public notifications will be made prior to an LNGC transit via local notice to mariners and marine information broadcasts.

Background and Purpose

In light of the terrorist attacks in New York City and Washington, D.C. on September 11, 2001, safety and security zones are being established to safeguard the LNGC vessels, the public and the surrounding area from sabotage or other subversive acts, accidents, or other events of a similar nature, and to protect persons, vessels and others in the maritime community from the hazards associated with the transit and limited maneuverability of a large tank vessel. These safety and security zones prohibit entry into or movement within the specified areas.

This rulemaking establishes safety and security zones in a radius around LNGC vessels while the vessels are anchored in Broad Sound, and while moored at the Distrigas waterfront facility. It also creates a moving safety zone any time an LNGC vessel is within Boston Marine Inspection Zone and Captain of the Port Zone, as defined in 33 CFR 3.05–10, in the internal waters of the United States and the navigable waters of the United States. Under the Ports and Waterways Safety Act (PWSA), navigable waters of the United States includes all waters of the territorial sea of the United States as described in Presidential Proclamation No. 5928 of December 27, 1988. This Presidential Proclamation declared that the territorial sea of the United States extends to 12 nautical miles from the baselines of the United States determined in accordance with international law. This regulation establishes safety and security zones with identical boundaries covering the following areas of the Boston Marine Inspection Zone and Captain of the Port Zone: (1) In the waters of Broad Sound bounded by a line starting at position 42° 25′ N, 070° 58′ W; then running southeast to position 42° 22′ N, 070° 56′ W; then running east to position 42° 22′ N, 070° 50′ W; then running north to position 42° 25′ N, 070° 50′ W; then running west back to the starting point; all waters within a 500-yard radius of any anchored Liquid Natural Gas Carrier; (2) all waters within a 500-yard radius of any LNGC vessel moored at the DISTRIGAS Facility, in Everett, Massachusetts; (3) Except as provided in sections (1) and (2) above, in the internal waters of the United States and the navigable waters of the United States, as defined by 33 U.S.C. 1222(5), that are within the Boston Marine Inspection Zone and Captain of the Port

Zone, as defined in 33 CFR 3.05–10, two miles ahead and one mile astern, and 1000-yards on each side of any LNGC vessel.

This rulemaking also temporarily suspends a safety zone for liquefied natural gas tank vessel (LNG) transits into Boston Harbor, located at 33 CFR 165.110(a). 33 CFR 165.110 establishes a safety zone bounded by the limits of the Boston Main Ship Channel and extending two miles ahead and one mile astern of a loaded LNG vessel transiting the Boston North Channel and Boston Harbor. That safety zone ends when the vessel reaches the Distrigas waterfront facility in the Mystic River, Everett, Massachusetts. Section 165.110 also establishes a safety zone extending 150-feet around a loaded LNG vessel while the vessel is alongside the Distrigas facility, and the vessel remains in a loaded condition or is transferring liquefied natural gas. Section 165.110 recognizes the safety concerns with transits of large tank vessels, but is inadequate to protect LNGC vessels from possible terrorist attack, sabotage or other subversive acts. National security and intelligence officials warn that future terrorist attacks against civilian targets may be anticipated. Due to the flammable nature of LNGC vessels and impact the ignition of this cargo would have on the port of Boston and surrounding areas, increased protection of these vessels is necessary. In comparison to 33 CFR 165.110, this rulemaking provides increased protection for LNGC vessels as follows: It establishes safety and security zones around LNGC vessels anchored in Broad Sound; it increases protection for LNGC vessels moored at the Distrigas facility from 150-feet to 500-yards around a vessel; and it provides continuous protection for LNGC vessels 2 miles ahead, 1 mile astern, and 1000-yards on each side of LNGC vessels anytime a vessel is within the internal waters of the United States and out to 12 nautical miles, seaward from the baselines of the United States, as determined by international law, within the Boston Marine Inspection Zone and Captain of the Port Zone, rather than limiting this protection to the limits of the Boston Main Ship Channel while a vessel is transiting Boston Harbor and Boston North Channel. The increased protection provided in this rulemaking also recognizes the safety concerns associated with an unloaded LNGC vessel. 33 CFR 165.110 only establishes safety zones around loaded LNG tank vessels or while the vessel is transferring its cargo. This rulemaking establishes safety and security zones around any LNGC vessels, loaded or unloaded, while anchored in Broad Sound, moored at the Distrigas facility, and any time a LNGC vessel is located in the Boston Marine Inspection Zone and Captain of the Port Zone, including the internal waters and out to 12 nautical miles from the baseline of the United States. These zones provide necessary protection to unloaded vessels, which continue to pose a safety/security hazard. This rulemaking also recognizes the continued need for safety zones around LNGC vessels, which are necessary to protect persons, facilities, vessels and others in the maritime community, from the hazards associated with the transit and limited maneuverability of a large tank vessel.

No person or vessel may enter or remain in the prescribed safety and security zones at any time without the permission of the Captain of the Port. Each person or vessel in a safety and security zone shall obey any direction or order of the Captain of the Port. The Captain of the Port may take possession and control of any vessel in a security zone and/or remove any person, vessel, article or thing from a security zone. No person may board, take or place any article or thing on board any vessel or waterfront facility in a security zone without permission of the Captain of the Port. These regulations are issued under authority contained in 50 U.S.C. 191, 33 U.S.C. 1223, 1225 and 1226.

Any violation of any safety or security zone described herein, is punishable by, among others, civil penalties (not to exceed $25,000 per violation, where each day of a continuing violation is a separate violation), criminal penalties (imprisonment for not more than 10 years and a fine of not more than $100,000), in rem liability against the offending vessel, and license sanctions.

Regulatory Evaluation

This rule is not a ''significant regulatory action'' under section 3(f) of Executive Order 12866 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 Transportation (DOT) (44 FR 11040, February 26, l979).

The Coast Guard expects the economic impact of this rule to be so minimal that a full Regulatory Evaluation under paragraph 10e of the regulatory policies and procedures of DOT is unnecessary.

The effect of this regulation will not be significant for several reasons: the minimal time that vessels will be restricted from the areas, there is ample room for vessels to navigate around the zones in Broad Sound and, in most portions of the navigable waters of the United States, vessels can transit ahead, behind, and after passage of LNGC vessels, and advance notifications will be made to the local maritime community by marine information broadcasts.

Small Entities

Under the Regulatory Flexibility Act (5 U.S.C. 601–612), the Coast Guard considered whether this rule would 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.

The Coast Guard certifies under 5 U.S.C. 605(b) that this rule will not have a significant economic impact on a substantial number of small entities. This rule will 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 Broad Sound or Boston Harbor. For the reasons enumerated in the Regulatory Evaluation section above, these safety and security zones will not have a significant economic impact on a substantial number of small entities.

Assistance for Small Entities

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121), we want to assist small entities in understanding this rule so that they can better evaluate its effects on them and participate in the rulemaking process. If your small business or organization would be affected by this rule and you have questions concerning its provisions or options for compliance, please call Chief Petty Officer Michael Popovich, telephone (617) 223–3000. 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 comments on actions by employees of the Coast Guard, call 1–888–REG–FAIR (1–888–734–3247).

Collection of Information

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

Federalism

The Coast Guard analyzed this rule under Executive Order 13132 and has determined that this rule does not have implications for federalism under that Order.

Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) governs the issuance of Federal regulations that require unfunded mandates. An unfunded mandate is a regulation that requires a State, local, or tribal government or the private sector to incur direct costs without the Federal Government having first provided the funds to pay those costs. This rule would not impose an unfunded mandate.

Taking of Private Property

This rule would 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

The Coast Guard analyzed this rule under Executive Order 13045, Protection of Children from Environmental Health Risks and Security Risks. This rule is not an economically significant rule and does not pose an environmental risk to health or risk to security 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. A rule with tribal implications has 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.

Environment

The Coast Guard considered the environmental impact of this rule and concluded that, under figure 2–1, (34)(g), of Commandant Instruction M16475.lD, this rule is categorically excluded from further environmental documentation. A ''Categorical Exclusion Determination'' is available in the docket where indicated under **ADDRESSES.**

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. It has not been designated by the Administrator of the Office of Information and Regulatory Affairs as a significant energy action. Therefore, it does not require a Statement of Energy Effects under Executive Order 13211.

List of Subjects in 33 CFR Part 165

Harbors, Marine security, Navigation (water), Reporting and recordkeeping requirements, Security measures, Waterways.

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

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

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

Authority: 33 U.S.C. 1231; 50 U.S.C. 191, 33 CFR 1.05–1(g), 6.04–1, 6.04–6, 160.5; 49 CFR 1.46.

2. From 12:01 a.m. November 13, 2001 until 11:59 p.m. June 15, 2002, suspend § 165.110.

3. From 12:01 a.m. November 13, 2001 until 11:59 p.m. June 15, 2002 temporarily add § 165.T01–214 to read as follows:

§ 165.T01–214 Safety and Security Zone: Liquid Natural Gas Carrier Transits and Anchorage Operations, Boston, Massachusetts.

(a) *Location.* The following areas are safety and security zones:

(1) In the waters of Broad Sound bounded by a line starting at position 42° 25′ N, 070° 58′ W; then running southeast to position 42° 22′ N, 070° 56′ W; then running east to position 42° 22′ N, 070° 50′ W; then running north to position 42° 25′ N, 070° 50′ W; then running west back to the starting point; all waters within a 500-yard radius of any anchored Liquid Natural Gas Carrier (LNGC) vessel;

(2) All waters of the Mystic River within a 500-yard radius of any LNGC vessel moored at the Distrigas Facility, Everett, Massachusetts;

(3) Except as provided in paragraphs (1) and (2) of this section, in the internal waters of the United States and the navigable waters of the United States, as defined by 33 U.S.C. 1222(5), that are within the Boston Marine Inspection Zone and Captain of the Port Zone, as defined in 33 CFR 3.05–10, two miles ahead and one mile astern, and 1000-yards on each side of any LNGC vessel.

(b) *Effective period.* This section is effective from 12:01 a.m. November 13, 2001, until 11:59 p.m. June 15, 2001.

(c) *Regulations.*

(1) In accordance with the general regulations in §§ 165.23 and 165.33 of this part, entry into or movement within this zone is prohibited unless authorized by the Captain of the Port, Boston.

(2) All vessel operators shall comply with the instructions of the COTP or the designated on-scene U.S. Coast Guard patrol personnel. On-scene Coast Guard patrol personnel include commissioned, warrant, and petty officers of the Coast Guard on board Coast Guard, Coast Guard Auxiliary, local, state, and federal law enforcement vessels.

(3) No person may enter the waters within the boundaries of the safety and security zones unless previously authorized by the Captain of the Port, Boston or his authorized patrol representative.

Dated: November 13, 2001.

B. M. Salerno,

Captain, U.S. Coast Guard, Captain of the Port, Boston, Massachusetts.

[FR Doc. 01–29761 Filed 11–29–01; 8:45 am]

BILLING CODE 4910–15–U

LIBRARY OF CONGRESS

Copyright Office

37 CFR Part 253

[Docket No. 2001–9 CARP]

Cost of Living Adjustment for Performance of Musical Compositions by Colleges and Universities

AGENCY: Copyright Office, Library of Congress.

ACTION: Final rule.

SUMMARY: The Copyright Office of the Library of Congress announces a cost of living adjustment of 2.1% in the royalty rates paid by colleges, universities, or

other nonprofit educational institutions that are not affiliated with National Public Radio for the use of copyrighted published nondramatic musical compositions. The cost of living adjustment is based on the change in the Consumer Price Index from October, 2000, to October, 2001.

EFFECTIVE DATE: January 1, 2002.

FOR FURTHER INFORMATION CONTACT: Tanya M. Sandros, Senior Attorney, Copyright Arbitration Royalty Panel, P.O. Box 70977, Southwest Station, Washington, DC 20024. Telephone: (202) 707–8380. Telefax: (202) 252–3423.

SUPPLEMENTARY INFORMATION: Section 118 of the Copyright Act, 17 U.S.C., creates a compulsory license for the use of published nondramatic musical works and published pictorial, graphic, and sculptural works in connection with noncommercial broadcasting. Terms and rates for this compulsory license, applicable to parties who are not subject to privately negotiated licenses, are published in 37 CFR part 253 and are subject to adjustment at five-year intervals. 17 U.S.C. 118(c). The last proceeding to adjust the terms and rates for the section 118 license began in 1996. 61 FR 54458 (October 18, 1996).

On January 14, 1998, the Copyright Office announced final regulations governing the terms and rates of copyright royalty payments with respect to certain uses by public broadcasting entities of published nondramatic musical works, and published pictorial, graphic, and sculptural works, including the 1998 rates for the public performance of musical compositions in the ASCAP, BMI, and SESAC repertories by public broadcasting entities licensed to colleges and universities. 63 FR 2142 (January 14, 1998).

Pursuant to these regulations, on December 1 of each year ''the Librarian of Congress shall publish a notice of the change in the cost of living during the period from the most recent Index published prior to the previous notice, to the most recent Index published prior to December 1, of that year.'' 37 CFR 253.10(a). The regulations also require that the Librarian publish a revised schedule of rates for the public performance of musical compositions in the ASCAP, BMI, and SESAC repertories by public broadcasting entities licensed to colleges and universities, reflecting the change in the Consumer Price Index. 37 CFR 253.10(b).

Accordingly, the Copyright Office of the Library of Congress is hereby announcing the change in the Consumer Price Index and performing the annual cost of living adjustment to the rates set out in § 253.5(c). 63 FR 2142 (January 14, 1998).

The change in the cost of living as determined by the Consumer Price Index (all consumers, all items) during the period from the most recent Index published before December 1, 2000, to the most recent Index published before December 1, 2001, is 2.1% (2000's figure was 174.0; the figure for 2001 is 177.7, based on 1982–1984=100 as a reference base). Rounding off to the nearest dollar, the adjustment in the royalty rate for the use of musical compositions in the repertory of ASCAP and BMI is $244, each, and $66 for the use of musical compositions in the repertory of SESAC.

List of Subjects in 37 CFR Part 253

Copyright, Radio, Television.

Final Regulation

For the reasons set forth in the preamble, part 253 of title 37 of the Code of Federal Regulations is amended as follows:

PART 253—USE OF CERTAIN COPYRIGHTED WORKS IN CONNECTION WITH NONCOMMERCIAL EDUCATIONAL BROADCASTING

1. The authority citation for part 253 continues to read as follows:

Authority: 17 U.S.C. 118, 801(b)(1) and 803.

2. 37 CFR 253.5 is amended by revising paragraphs (c)(1) through (c)(3).

§ 253.5 Performance of musical compositions by public broadcasting entities licensed to colleges and universities.

* * * * *

(c) * * *

(1) For all such compositions in the repertory of ASCAP, $244 annually.

(2) For all such compositions in the repertory of BMI, $244 annually.

(3) For all such compositions in the repertory of SESAC, $66 annually.

* * * * *

Dated: November 26, 2001.

Marybeth Peters,

Register of Copyrights.

[FR Doc. 01–29785 Filed 11–29–01; 8:45 am]

BILLING CODE 1410–33–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[AZ 086–0047; FRL–7105–3]

Revisions to the Arizona State Implementation Plan, Maricopa County Environmental Services Department

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: EPA is finalizing approval of a revision to the Maricopa County Environmental Services Department (MCESD) portion of the Arizona State Implementation Plan (SIP). This revision was proposed in the **Federal Register** on May 24, 2001 and concerns volatile organic compound (VOC) emissions from automotive windshield washer fluid. We are approving a local rule that regulates these emission sources under the Clean Air Act as amended in 1990 (CAA or the Act).

EFFECTIVE DATE: This rule is effective on December 31, 2001.

ADDRESSES: You can inspect copies of the administrative record for this action at EPA's Region IX office during normal business hours. You can inspect copies of the submitted SIP revision at the following locations:

Environmental Protection Agency, Region IX, 75 Hawthorne Street, San Francisco, CA 94105–3901.

Environmental Protection Agency, Air Docket (6102), Ariel Rios Building, 1200 Pennsylvania Avenue, NW., Washington DC 20460.

Arizona Department of Environmental Quality, 3033 North Central Avenue, Phoenix, AZ 85012.

Maricopa County Environmental Services Department, Air Quality Division, 1001 North Central Avenue, Suite 201, Phoenix, AZ 85004.

FOR FURTHER INFORMATION CONTACT: Yvonne Fong, Rulemaking Office (AIR–4), U.S. Environmental Protection Agency, Region IX, (415) 947–4117.

SUPPLEMENTARY INFORMATION: Throughout this document, ''we,'' ''us'' and ''our'' refer to EPA.

I. Proposed Action

On May 24, 2001 (66 FR 28685), EPA proposed to approve the following rule into the Arizona SIP.

Local Agency	Rule #	Rule Title	Adopted	Submitted
MCESD	344	Automobile Windshield Washer Fluid.	04/07/99	08/04/99

We proposed to approve this rule because we determined that it complied with the relevant CAA requirements. Our proposed action contains more information on the rule and our evaluation.

II. Public Comments and EPA Responses

EPA's proposed action provided a 30-day public comment period. During this period, we received comments from the following party.

1. D. Douglas Fratz and Joseph T. Yost, Consumer Specialty Products Association (CSPA); letter dated June 22, 2001.

CSPA's comments pertain to the test method, Maricopa County Reference Method #100 (RM 100), used for determining compliance, and to the consistency of MCESD Rule 344 with other consumer product regulations. CSPA's comments and our responses are summarized below.

Comment: Because RM 100 reports results as total organic carbon and different VOCs have different percentages of carbon, it is not possible to accurately convert RM 100 results into the terms in which the limits of MCESD Rule 344 are expressed, mass of VOC.

Response: Conversion of RM 100 test results from mass of carbon to the mass of VOC is relatively simple for windshield washer fluids (WWF) containing a single VOC and slightly more complex for WWFs containing multiple VOCs.

Converting the mass of carbon from the test result to mass of VOC involves multiplying the test results by the ratio of molecular weights. Based on EPA's survey used to develop the national Consumer Products Rule (40 CFR part 59, subpart C) and the California Air Resources Board's (CARB) consumer products speciation profile [1] for automobile WWFs, the predominant VOC used in WWFs is methanol. If methanol is the only VOC present, the conversion factor from mass of carbon to mass of VOC is 32/12. For WWFs containing multiple VOCs, the conversion from mass of carbon to mass of VOC can still be done if the VOCs and their approximate proportions are known.

RM 100 allows the use of either infrared (IR) or flame ionization (FID) detectors. If an IR or FID detector is calibrated with methanol, and methanol is the only VOC present, then a laboratory could report results directly as percent methanol. If VOCs other than methanol are present, then this method would tend to overestimate the total mass of VOC. Only if the results from these methods exceed the limits of MCESD Rule 344 would further data reduction and investigation using the above mass of carbon to mass of VOC conversion method be necessary. EPA may also approve other methods should they be submitted for evaluation.

Comment: RM 100 will overestimate the total organic carbon associated with VOCs for WWFs containing one or more exempt compounds because it does not distinguish between organic carbon from VOCs and organic carbon from non-precursor organic compounds.

Response: Maricopa County's list of non-precursor organic compounds is the same as EPA's. There are relatively few compounds on that list that could be used in WWFs because many are not soluble in water. Acetone is one of the few compounds that is soluble in water but is unlikely to be used in WWFs because of its potential to damage a vehicle's paint. If WWFs contain exempt solvents, manufacturers would be allowed to subtract the mass of exempt solvents from the mass of VOC and could petition the MCESD for an alternative method by which to do that.

Comment: RM 100 will overestimate the total organic carbon associated with VOCs because it does not distinguish between volatile organic compounds and non-volatile organic compounds. Certain compounds in WWFs, like organic dyes or other non-volatile organic compounds, cannot participate in the atmospheric photochemical reactions that produce ozone because they do not volatilize to the air.

Response: While it is difficult to know how significantly dyes or other non-volatile organic compounds might increase the total VOC content of WWFs, a review of material safety data sheets indicates that the actual mass of dyes and other non-volatile organic compounds added to WWFs tends to be small. If the amount of non-volatile organic compounds is considerable and may influence a compliance determination, EPA recommends the manufacturer petition the MCESD for alternative methods to exclude the mass of dyes and non-volatile organic compounds from the mass of VOCs.

Comment: Rule 344 is problematically inconsistent with analogous federal and California regulations. Specifically, many products that would comply with a 10 percent VOC limitation according to EPA and California regulations may not comply with that same limitation under the provisions of MCESD Rule 344 because: (1) There is no process to sell-through a product that exceeds the VOC limit but was manufactured before the effective date of the rule, (2) ''low vapor pressure'' (LVP) compounds that are not volatile are not exempted, (3) the types of ''reasonable prudent precautions'' allowed in all other consumer product rules to assure that a non-complying product sold in the County will be resold for use outside the County are artificially restricted under the rule, (4) concentrated product labels with dilution instructions resulting in stronger WWF formulations for users outside of Maricopa County are not allowed, and (5) an ''innovative products'' provision which allows products to exceed the applicable VOC limit if the use of such ''innovative products'' ultimately results in lower VOC emissions is not allowed.

Response: While we appreciate that consistency is desirable for affected industry, state and local agencies have broad authority to develop regulations and are not required to be consistent in all regards. In fact, section 59.211 of the final national Consumer Products Rule explicitly provides that states and their political subdivisions retain authority to adopt and enforce their own additional regulations affecting these products. Accordingly, MCESD may impose more stringent requirements for WWFs as part of its SIP and its election to do so is not a basis for EPA to disapprove the SIP. See *Union Electric Co.* v. *EPA*, 427 U.S. 246, 265–66 (1976). EPA favors national uniformity in consumer and commercial product regulation, but recognizes that some localities may need more stringent regulation to combat more serious and more intransigent ozone nonattainment problems.

Furthermore, while California consumer products regulations allow products to be sold, supplied, or offered for sale up to three years after the

[1] Consumer Products, Aerosol Coatings, and Architectural Coatings—Emissions and Speciation Profiles, *http://www.arb.ca.gov/emisinv/ speciate/ CProds&ACtqsprof.htm.*

effective date of the rule, MCESD Rule 344 is consistent with the national Consumer Products Rule which does not contain a sell-through period. As explained in the background document,[2] manufacturers' current ''just in time'' inventory practices and the expense and lack of sufficient storage space do not create large stockpiles of noncomplying products which might warrant a sell-through period. EPA considers the incorporation of a sell-through period to be at the discretion of the local agency.

The amount of LVP compounds such as surfactants or ethylene glycol used in WWFs tends to be minimal so as not to affect a product's ability to clean and evaporate quickly without leaving a residue. A review of the CARB's Initial Statement of Reasons for Proposed Amendments to the California Consumer Products Regulation dated September 10, 1999 indicates that surfactants in a possible windshield washer formulation may account for 0.05 weight percent. As stated above, EPA cannot object to MCESD Rule 344 taking a more stringent approach than the national Consumer Products Rule and concurs with MCESD's decision to not exempt LVP compounds in Rule 344.

Section 303 of MCESD rule 344 exempts non-complying WWFs destined for use outside of Maricopa County. Section 303 also specifies the information required to prove that non-complying products sold within Maricopa County are actually destined for use outside of the County. Although MCESD Rule 344 is more prescriptive than California's Consumer Products Rule which allows manufacturers and distributors of non-compliant products some flexibility to take ''reasonable prudent precautions'' to assure that the consumer product is not distributed in California, Rule 344, as written, meets EPA's enforceability requirements.

MCESD adopted requirements in section 302e of Rule 344 that prohibit the dilution of WWFs that would yield solutions that exceed the VOC limit of the rule. Labeling products with directions which yield WWFs that are more concentrated than the 10% VOC limit is potentially confusing to the end user in the County and may create more enforcement problems. The requirement that all dilution instructions for concentrated products never exceed 10% ensures that MCESD will achieve the emissions reductions expected from Rule 344. EPA supports MCESD's intent to establish clear, enforceable labeling requirements.

Inclusion of an innovative products provision in MCESD Rule 344 would allow greater flexibility for manufacturers to meet Rule 344's VOC content limit. However, California has had a 10% VOC limit for WWFs since 1993 and no innovative product requests for WWFs have been submitted to CARB. Therefore, EPA considers Maricopa County's limit of 10% to be reasonable and achievable.

III. EPA Action

None of the submitted comments change our assessment that the submitted rule complies with the relevant CAA requirements. Therefore, as authorized in section 110(k)(3) of the Act, EPA is fully approving this rule into the Arizona SIP.

IV. Administrative Requirements

Under Executive Order 12866 (58 FR 51735, October 4, 1993), this action is not a ''significant regulatory action'' and therefore is not subject to review by the Office of Management and Budget. For this reason, this action is also not subject to Executive Order 32111, ''Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use'' (66 FR 28355, May 22, 2001). This action merely approves state law as meeting federal requirements and imposes no additional requirements beyond those imposed by state law. Accordingly, the Administrator certifies that this rule will not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*). Because this rule approves pre-existing requirements under state law and does not impose any additional enforceable duty beyond that required by state law, it does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4).

This rule also does not have tribal implications because it will 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, as specified by Executive Order 13175 (65 FR 67249, November 9, 2000). This action also does not have Federalism implications because it does 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 (64 FR 43255, August 10, 1999). This action merely approves a state rule implementing a Federal standard, and does not alter the relationship or the distribution of power and responsibilities established in the Clean Air Act. This rule also is not subject to Executive Order 13045, ''Protection of Children from Environmental Health Risks and Safety Risks'' (62 FR 19885, April 23, 1997), because it is not economically significant.

In reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the Clean Air Act. In this context, in the absence of a prior existing requirement for the State to use voluntary consensus standards (VCS), EPA has no authority to disapprove a SIP submission for failure to use VCS. It would thus be inconsistent with applicable law for EPA, when it reviews a SIP submission, to use VCS in place of a SIP submission that otherwise satisfies the provisions of the Clean Air Act. Thus, the requirements of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) do not apply. This rule does not impose an information collection burden under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.).

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. EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the 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).

Under section 307(b)(1) of the Clean Air Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by January 29, 2002. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this rule for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and

[2] National Volatile Organic Compound Emission Standards For Consumer Products—Background for Promulgated Standards EPA–453/R–98–008b August 1998.

shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements. (See section 307(b)(2).)

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Incorporation by reference, Intergovernmental relations, Ozone, Reporting and recordkeeping requirements, Volatile organic compounds.

Dated: October 31, 2001.

Wayne Nastri,

Regional Administrator, Region IX.

Part 52, Chapter I, Title 40 of the Code of Federal Regulations is amended as follows:

PART 52—[AMENDED]

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

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

Subpart D—Arizona

2. Section 52.120 is amended by adding paragraph (c)(94)(i)(E) to read as follows:

§ 52.120 Identification of plan.

* * * * *

(c) * * *

(94) * * *

(i) * * *

(E) Rule 344, adopted on April 7, 1999.

* * * * *

[FR Doc. 01–29550 Filed 11–29–01; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[IL211–1a; FRL–7108–8]

Approval and Promulgation of Implementation Plans; Illinois

AGENCY: Environmental Protection Agency (EPA).

ACTION: Direct final rule.

SUMMARY: The EPA is approving revisions to volatile organic compound (VOC) rules for Bema Film Systems, Incorporated (Bema). This flexographic printing facility is located in DuPage County, Illinois. The Illinois Environmental Protection Agency (IEPA) submitted the revised rules on March 28, 2001 as amendments to its State Implementation Plan (SIP). The revisions consist of an adjusted standard from the Flexographic Printing Rule, 35 IAC 218.401(a), (b), and (c). The Illinois Pollution Control Board (Board) approved this adjusted standard because the Board considers this to be the Reasonably Achievable Control Technology (RACT) for Bema. The Board concluded that complying with the Flexographic Printing Rule requirements would be technically infeasible or economically unreasonable for this facility. The EPA concurs. The adjusted standard requirements include a reduction in trading allotments should Bema's emissions trigger participation in the Illinois market-based emissions trading system, maintaining daily records, conducting trials of compliant inks, and reviewing alternate control technologies.

DATES: This rule is effective on January 29, 2002, unless the EPA receives relevant adverse written comments by December 31, 2001. If adverse written comment is received, the EPA will publish a timely withdrawal of the rule in the **Federal Register** and inform the public that the rule will not take effect.

ADDRESSES: You should mail written comments to: J. Elmer Bortzer, Chief, Regulation Development Section, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604.

You may inspect copies of Illinois' submittal at: Regulation Development Section, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604.

FOR FURTHER INFORMATION CONTACT: Matt Rau, Environmental Engineer, Regulation Development Section, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604, Telephone: (312) 886–6524.

SUPPLEMENTARY INFORMATION: Throughout this document wherever ''we,'' ''us,'' or ''our'' are used we mean the EPA.

Table of Contents

I. What is the EPA approving?
II. What are the changes from the current rule?
III. What is the EPA's analysis of the supporting materials?
IV. What are the environmental effects of these actions?
V. What rulemaking actions are the EPA taking?
VI. Administrative requirements.

I. What Is the EPA Approving?

The EPA is approving an adjusted standard from the Flexographic Printing Rule for Bema. Bema is to comply with the requirements in its adjusted standard. The requirements include a reduction of the market-based emissions trading system baseline, maintaining daily records of inks and VOC content, conducting trials of compliant inks, and reviewing alternate control technologies.

II. What Are the Changes From the Current Rule?

The adjusted standard changes the VOC rule Bema must follow. Bema's facility is located in the metropolitan Chicago severe ozone non-attainment area. Bema, with a permitted VOC emissions limit of 77.4 tons per year (TPY), is classified as a major source because it can emit more than 25 TPY of VOC. Chicago area flexographic printers classified as major VOC sources are subject to the Flexographic Printing Rule. This rule requires printers to either use compliant inks (low or no VOC content) or use a VOC emissions control device. Limiting VOC emissions will help to reduce ozone because VOC can chemically react in the atmosphere to form ozone.

The adjusted standard given to Bema changes its requirements to reduce the market-based emissions trading system allotment baseline, maintaining daily records, and to conduct trials with compliant inks and control devices. The market-based trading system will allow Bema to buy emissions allotments from companies which can reduce their VOC emissions at a lower cost than Bema can. The net VOC emissions of all participants meets the desired reductions.

III. What Is the EPA's Analysis of the Supporting Materials?

Illinois included information on compliant ink trials and control device studies at Bema. The Flexographic Printing Rule requires sources to use either compliant inks or to use a control device to limit VOC emissions. To evaluate what RACT is for Bema, the first consideration is to determine what options would work. The costs of the options that will work are then estimated. The economic burden on the company is then considered. If the compliance costs are determined to be too high, this option is not considered RACT.

Bema ran trials of printing with compliant inks. It also determined what control technologies would work and their cost. The Illinois Pollution Control Board concluded that using either compliant inks or a control device would not be RACT for Bema. The EPA concurs. The adjusted standard requirements are considered RACT by

the Board. Printing on plastic with compliant inks is rather difficult. The low VOC content in Bema's exhaust causes control devices to have high operational costs. Similar printers have been granted adjusted standards with comparable requirements.

IV. What Are the Environmental Effects of These Actions?

Bema is located in the Chicago severe ozone non-attainment area. Its permitted VOC limit is 77.4 TPY, but its actual emissions are 18 to 30 TPY. VOC can chemically react to form ozone, so limiting VOC emissions in an ozone non-attainment area is desired. Should Bema trigger participation in the Illinois market-based emissions trading program, the adjusted standard lowers its baseline which will require Bema to acquire more trading allotments. Bema can buy emission allotments from other participants. All participants need to own allotments covering their VOC emissions for the ozone season (May 1 to September 30). The trading program reduces the total VOC emissions from the Chicago area. The total area wide emissions are limited by the number of allotments distributed by IEPA to the participants.

V. What Rulemaking Actions Are the EPA Taking?

The EPA is approving, through direct final rulemaking, revisions to the VOC emissions rules for Bema Film Systems in DuPage County, Illinois. These revisions are the required compliance with an adjusted standard to the Flexographic Printing Rule. The Illinois Pollution Control determined that the adjusted standard is RACT for Bema. The requirements of the adjusted standard include reducing the market-based emissions trading system baseline, maintaining daily records, conducting compliant ink trials, and investigation of alternative control devices.

We are publishing this action without a prior proposal because we view these as non-controversial revisions and anticipate no adverse comments. However, in the ''Proposed Rules'' section of today's **Federal Register**, we are publishing a separate document that serves as the proposal to approve the SIP revision if adverse written comments are filed. This rule will be effective on January 29, 2002. If the EPA receives an adverse written comment, we will publish a final rule informing the public that this rule will not take effect. We will address all public comments in a subsequent final rule based on the proposed rule. The EPA does not intend to institute a second comment period on this action. Any parties interested in commenting on this action must do so now.

VI. Administrative Requirements

Under Executive Order 12866 (58 FR 51735, October 4, 1993), this action is not a ''significant regulatory action'' and therefore is not subject to review by the Office of Management and Budget. For this reason, this action is also not subject to Executive Order 13211, ''Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use'' (66 FR 28355, May 22, 2001). This action merely approves state law as meeting Federal requirements and imposes no additional requirements beyond those imposed by state law. Accordingly, the Administrator certifies that this rule will not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*). Because this rule approves pre-existing requirements under state law and does not impose any additional enforceable duty beyond that required by state law, it does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Public Law 104–4).

This rule also does not have tribal implications because it will 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, as specified by Executive Order 13175 (65 FR 67249, November 9, 2000). This action also does not have Federalism implications because it does 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 (64 FR 43255, August 10, 1999). This action merely approves a state rule implementing a Federal standard, and does not alter the relationship or the distribution of power and responsibilities established in the Clean Air Act. This rule also is not subject to Executive Order 13045 ''Protection of Children from Environmental Health Risks and Safety Risks'' (62 FR 19885, April 23, 1997), because it is not economically significant.

In reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the Clean Air Act. In this context, in the absence of a prior existing requirement for the State to use voluntary consensus standards (VCS), EPA has no authority to disapprove a SIP submission for failure to use VCS. It would thus be inconsistent with applicable law for EPA, when it reviews a SIP submission, to use VCS in place of a SIP submission that otherwise satisfies the provisions of the Clean Air Act. Thus, the requirements of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) do not apply. This rule does not impose an information collection burden under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

The Congressional Review Act, 5 U.S.C. section 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. EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the 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. section 804(2).

Under section 307(b)(1) of the Clean Air Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by January 29, 2002. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this rule for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements. (See section 307(b)(2).)

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Hydrocarbons, Incorporation by reference, Intergovernmental relations, Ozone, Reporting and recordkeeping requirements, Volatile organic compounds.

Dated: November 9, 2001.

David A. Ullrich,

Deputy Regional Administrator, Region 5.

For the reasons stated in the preamble, part 52, chapter I, title 40 of the Code of Federal Regulations is amended as follows:

PART 52 [AMENDED]

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

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

Subpart O—Illinois

2. Section 52.720 is amended by adding paragraph (c)(161) to read as follows:

§ 52.720 Identification of plan.

* * * * *

(c) * * *

(161) On March 28, 2001, Illinois submitted revisions to volatile organic compound rules for Bema Film Systems, Incorporated in DuPage County, Illinois. The revisions consist of AS 00–11, an adjusted standard to the Flexographic Printing Rule, 35 IAC 218.401 (a), (b), and (c). The adjusted standard requirements include reducing the allotment baseline for the Illinois market-based emissions trading system, maintaining daily records, conducting trials of compliant inks, and reviewing alternate control technologies.

(i) Incorporation by reference.

AS 00–11, an adjusted standard from the Volatile Organic Compound emission limits for Bema Film Systems, Inc. contained in Illinois Administrative Code Title 35: Environmental Regulations for the State of Illinois, Subtitle B: Air Pollution, Chapter I: Pollution Control Board, Subchapter c: Emission Standards and Limitations for Stationary Sources, Part 218.401 (a), (b), and (c). Effective on January 18, 2001.

(ii) Other material.

(A) November 14, 2001, letter from Dennis A. Lawler, Manager, Division of Air Pollution Control, Illinois Environmental Protection Agency to Jay Bortzer, Chief, Regulation Development Section, Air and Radiation Division, USEPA, Region 5, indicating that the effective date of the adjusted standard for Bema Film Systems, Inc. AS 00–11, is January 18, 2001, the date that AS 00–11 was adopted by the Illinois Pollution Control Board.

[FR Doc. 01–29663 Filed 11–29–01; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[IL213–1a; FRL–7107–7]

Approval and Promulgation of Implementation Plans; Illinois

AGENCY: Environmental Protection Agency (EPA).

ACTION: Direct final rule.

SUMMARY: The EPA is approving revisions to volatile organic compound (VOC) rules for Vonco Products, Incorporated (Vonco). This flexographic printing facility is located in Lake County, Illinois. The Illinois Environmental Protection Agency (IEPA) submitted the revised rules on March 28, 2001 as amendments to its State Implementation Plan (SIP). The revisions consist of an adjusted standard from the Flexographic Printing Rule, 35 IAC 218.401(a), (b), and (c). The Illinois Pollution Control Board (Board) approved this adjusted standard because the Board considers this to be the Reasonably Achievable Control Technology (RACT) for Vonco. The Board concluded that complying with the Flexographic Printing Rule requirements would be either technically infeasible or economically unreasonable for this facility. The EPA concurs. The adjusted standard requirements include a reduction in trading allotments should Vonco's emissions trigger participation in the Illinois market-based emissions trading system, maintaining daily records, conducting trials of compliant inks, and reviewing alternate control technologies.

DATES: This rule is effective on January 29, 2002, unless the EPA receives relevant adverse written comments by December 31, 2001. If adverse written comment is received, the EPA will publish a timely withdrawal of the rule in the **Federal Register** and inform the public that the rule will not take effect.

ADDRESSES: You should mail written comments to: J. Elmer Bortzer, Chief, Regulation Development Section, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604.

You may inspect copies of Illinois' submittal at: Regulation Development Section, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604.

FOR FURTHER INFORMATION CONTACT: Matt Rau, Environmental Engineer, Regulation Development Section, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604, Telephone: (312) 886–6524, E-Mail: *rau.matthew@epa.gov.*

SUPPLEMENTARY INFORMATION: Throughout this document wherever ''we,'' ''us,'' or ''our'' are used we mean the EPA.

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I. What is the EPA approving?
II. What are the changes from the current rule?
III. What is the EPA's analysis of the supporting materials?
IV. What are the environmental effects of these actions?
V. What rulemaking actions are the EPA taking?
VI. Administrative requirements.

I. What Is the EPA Approving?

The EPA is approving an adjusted standard from the Flexographic Printing Rule for Vonco. Vonco is to comply with the requirements in its adjusted standard. The requirements include a reduction in the market-based emissions trading system baseline, maintaining daily records of inks and VOC content, conducting trials of compliant inks, and reviewing alternate control technologies.

II. What Are the Changes From the Current Rule?

The adjusted standard changes the VOC rule Vonco must follow. Vonco's facility is located in the metropolitan Chicago severe ozone non-attainment area. Vonco, with a permitted VOC emissions limit of 55.8 tons per year (TPY), is classified as a major source because it can emit more than 25 TPY of VOC. Chicago area flexographic printers classified as major VOC sources are subject to the Flexographic Printing Rule. This rule requires printers to either use compliant inks (low or no VOC content) or use a VOC emissions control device. Limiting VOC emissions will help to reduce ozone because VOC can chemically react in the atmosphere to form ozone.

The adjusted standard given to Vonco changes its requirements to reduce the market-based emissions trading system allotment baseline, maintaining daily records, and conducting trials with compliant inks and control devices. The market-based trading system will allow Vonco to buy emissions allotments from companies which can reduce their VOC emissions at a lower cost than Vonco can. The net VOC emissions of all participants meet the desired reductions.

III. What Is the EPA's Analysis of the Supporting Materials?

Illinois included information on compliant ink trials and control device studies at Vonco. The Flexographic Printing Rule requires sources to use either compliant inks or to use a control device to limit VOC emissions. To evaluate what RACT is for Vonco, the first consideration is to determine what options would work. The costs of the options that will work are then estimated and the economic burden on the company is considered. If the compliance costs of an option are determined to be too high, this option is not considered RACT.

Vonco ran trials of printing with compliant inks. It also determined what control technologies would work and their costs. The Illinois Pollution Control Board concluded that using either compliant inks or a control device would not be RACT for Vonco. The EPA concurs. Printing on plastic with compliant inks is rather difficult. Low VOC content in Vonco's exhaust causes control devices to have high operational costs. The adjusted standard requirements are considered RACT by the Board. Similar printers have been granted adjusted standards with comparable requirements.

IV. What Are the Environmental Effects of These Actions?

Vonco is located in the Chicago severe ozone non-attainment area. It is permitted to emit up to 55.8 TPY of VOC. The actual VOC emissions from this facility are about 20–25 TPY. VOC can chemically react to form ozone, so limiting VOC emissions in an ozone non-attainment area is desired. Should Vonco trigger participation in the Illinois market-based emissions trading program, the adjusted standard lowers its baseline which will require Vonco to acquire more trading allotments. Vonco can buy emission allotments from other participants. Participants need to own allotments covering their VOC emissions for the ozone season (May 1 to September 30). The trading program reduces the total VOC emissions from the Chicago area. The total area wide emissions are limited by the number of allotments distributed by IEPA to participants.

V. What Rulemaking Actions Is the EPA Taking?

The EPA is approving, through direct final rulemaking, revisions to the volatile organic compound rules for Vonco Products, Incorporated of Lake County, Illinois. These revisions are the required compliance with an adjusted standard to the Flexographic Printing Rule. The Illinois Pollution Control Board determined that the adjusted standard is RACT for Vonco. The requirements of the adjusted standard include reducing the market-based emissions trading system allotment baseline, maintaining daily records, conducting compliant ink trials, and investigation of alternative control devices.

We are publishing this action without a prior proposal because we view these as non-controversial revisions and anticipate no adverse comments. However, in the Proposed Rules section of today's **Federal Register**, we are publishing a separate document that serves as the proposal to approve the SIP revision if adverse written comments are filed. This rule will be effective on January 29, 2002. If the EPA receives an adverse written comment, we will publish a final rule informing the public that this rule will not take effect. We will address all public comments in a subsequent final rule based on the proposed rule. The EPA does not intend to institute a second comment period on this action. Any parties interested in commenting on this action must do so now.

VI. Administrative Requirements

Under Executive Order 12866 (58 FR 51735, October 4, 1993), this action is not a ''significant regulatory action'' and therefore is not subject to review by the Office of Management and Budget. For this reason, this action is also not subject to Executive Order 13211, ''Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use'' (66 FR 28355, May 22, 2001). This action merely approves state law as meeting Federal requirements and imposes no additional requirements beyond those imposed by state law. Accordingly, the Administrator certifies that this rule will not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*). Because this rule approves pre-existing requirements under state law and does not impose any additional enforceable duty beyond that required by state law, it does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Public Law 104–4).

This rule also does not have tribal implications because it will 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, as specified by Executive Order 13175 (65 FR 67249, November 9, 2000). This action also does not have Federalism implications because it does 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 (64 FR 43255, August 10, 1999). This action merely approves a state rule implementing a Federal standard, and does not alter the relationship or the distribution of power and responsibilities established in the Clean Air Act. This rule also is not subject to Executive Order 13045 ''Protection of Children from Environmental Health Risks and Safety Risks'' (62 FR 19885, April 23, 1997), because it is not economically significant.

In reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the Clean Air Act. In this context, in the absence of a prior existing requirement for the State to use voluntary consensus standards (VCS), EPA has no authority to disapprove a SIP submission for failure to use VCS. It would thus be inconsistent with applicable law for EPA, when it reviews a SIP submission, to use VCS in place of a SIP submission that otherwise satisfies the provisions of the Clean Air Act. Thus, the requirements of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) do not apply. This rule does not impose an information collection burden under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

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. EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the 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).

Under section 307(b)(1) of the Clean Air Act, petitions for judicial review of

this action must be filed in the United States Court of Appeals for the appropriate circuit by January 29, 2002. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this rule for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements. (See section 307(b)(2).)

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Incorporation by reference, Intergovernmental relations, Reporting and recordkeeping requirements, Volatile organic compounds.

Dated: November 9, 2001.

David A. Ullrich,

Deputy Regional Administrator, Region 5.

For the reasons stated in the preamble, part 52, chapter I, title 40 of the Code of Federal Regulations is amended as follows:

PART 52—[AMENDED]

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

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

Subpart O—Illinois

2. Section 52.720 is amended by adding paragraph (c)(162) to read as follows:

§ 52.720 Identification of plan.

* * * * *

(c) * * *

(162) On March 28, 2001, Illinois submitted revisions to volatile organic compound rules for Vonco Products, Incorporated in Lake County, Illinois. The revisions consist of AS 00–12, an adjusted standard to the Flexographic Printing Rule, 35 IAC 218.401 (a), (b), and (c). The adjusted standard requirements include reducing the allotment baseline for the Illinois market-based emissions trading system, maintaining daily records, conducting trials of compliant inks, and reviewing alternate control technologies.

(i) Incorporation by reference.

AS 00–12, an adjusted standard from the Volatile Organic Compound emission limits applicable to Vonco Products, Inc. contained in Illinois Administrative Code Title 35: Environmental Regulations for the State of Illinois, Subtitle B: Air Pollution, Chapter I: Pollution Control Board, Subchapter c: Emission Standards and Limitations for Stationary Sources, Part 218.401 (a), (b), and (c). Effective on January 18, 2001.

(ii) Other material.

(A) November 14, 2001, letter from Dennis A. Lawler, Manager, Division of Air Pollution Control, Illinois Environmental Protection Agency to Jay Bortzer, Chief, Regulation Development Section, Air and Radiation Division, USEPA, Region 5, indicating that the effective date of the adjusted standard for Vonco Products, Inc. AS 00–12, is January 18, 2001, the date that AS 00–12 was adopted by the Illinois Pollution Control Board.

[FR Doc. 01–29655 Filed 11–29–01; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[MO 0142–1142a; FRL–7110–5]

Approval and Promulgation of Implementation Plans; State of Missouri

AGENCY: Environmental Protection Agency (EPA).

ACTION: Direct final rule.

SUMMARY: EPA is approving a State Implementation Plan (SIP) revision submitted by the state of Missouri. This approval pertains to revisions to a rule which restricts emissions of particulate matter from industrial processes. The effect of this approval is to ensure Federal enforceability of the state air program rules and to maintain consistency between the state-adopted rules and the approved SIP.

DATES: This direct final rule will be effective January 29, 2002 unless EPA receives adverse comments by December 31, 2001. If adverse comments are received, EPA will publish a timely withdrawal of the direct final rule in the **Federal Register** informing the public that the rule will not take effect.

ADDRESSES: Comments may be mailed to Wayne Kaiser, Environmental Protection Agency, Air Planning and Development Branch, 901 North 5th Street, Kansas City, Kansas 66101.

Copies of documents relative to this action are available for public inspection during normal business hours at the above-listed Region 7 location. The interested persons wanting to examine these documents should make an appointment with the office at least 24 hours in advance.

FOR FURTHER INFORMATION CONTACT: Wayne Kaiser at (913) 551–7603.

SUPPLEMENTARY INFORMATION

Throughout this document whenever ''we,'' ''us,'' or ''our'' is used, we mean EPA. This section provides additional information by addressing the following questions:

What is a SIP?
What is the Federal approval process for a SIP?
What does Federal approval of a state regulation mean to me?
What is being addressed in this action?
Have the requirements for approval of a SIP revision been met?
What action is EPA taking?

What Is a SIP?

Section 110 of the Clean Air Act (CAA) requires states to develop air pollution regulations and control strategies to ensure that state air quality meets the national ambient air quality standards established by EPA. These ambient standards are established under section 109 of the CAA, and they currently address six criteria pollutants. These pollutants are: Carbon monoxide, nitrogen dioxide, ozone, lead, particulate matter, and sulfur dioxide.

Each state must submit these regulations and control strategies to us for approval and incorporation into the Federally-enforceable SIP.

Each Federally-approved SIP protects air quality primarily by addressing air pollution at its point of origin. These SIPs can be extensive, containing state regulations or other enforceable documents and supporting information such as emission inventories, monitoring networks, and modeling demonstrations.

What Is the Federal Approval Process for a SIP?

In order for state regulations to be incorporated into the Federally-enforceable SIP, states must formally adopt the regulations and control strategies consistent with state and Federal requirements. This process generally includes a public notice, public hearing, public comment period, and a formal adoption by a state-authorized rulemaking body.

Once a state rule, regulation, or control strategy is adopted, the state submits it to us for inclusion into the SIP. We must provide public notice and seek additional public comment regarding the proposed Federal action on the state submission. If adverse comments are received, they must be addressed prior to any final Federal action by us.

All state regulations and supporting information approved by EPA under section 110 of the CAA are incorporated into the Federally-approved SIP.

Records of such SIP actions are maintained in the Code of Federal Regulations (CFR) at Title 40, part 52, entitled ''Approval and Promulgation of Implementation Plans.'' The actual state regulations which are approved are not reproduced in their entirety in the CFR outright but are ''incorporated by reference,'' which means that we have approved a given state regulation with a specific effective date.

What Does Federal Approval of a State Regulation Mean to Me?

Enforcement of the state regulation before and after it is incorporated into the Federally-approved SIP is primarily a state responsibility. However, after the regulation is Federally approved, we are authorized to take enforcement action against violators. Citizens are also offered legal recourse to address violations as described in section 304 of the CAA.

What Is Being Addressed in This Document?

On October 24, 2001, we received a request from the Missouri Department of Natural Resources to approve as an amendment to the Missouri SIP revisions to rule 10 CSR 10–6.400, Restriction of Emission of Particulate Matter From Industrial Processes.

The underlying rule generally establishes particulate matter emission limits for industrial processes through the use of process weight rate tables and process emission calculations. The emission limits were approved into the SIP a number of years ago. In acting on the revisions to the rule discussed below, EPA has not reevaluated the emission limits to determine their adequacy with respect to attainment and maintenance of the NAAQS. However, EPA believes that the revisions to the rule discussed below are approvable because they strengthen the underlying rule.

The state has revised its existing SIP approved rule with the following revisions. Section (1), applicability requirements, was clarified by specifically listing certain exemption categories in the rule. Also, section (1)(C) was added, which states that if another, more stringent state rule applies to particulate matter emission units, then this rule does not apply.

In the definitions section of the rule, paragraph (2)(B)(1) was added to fully explain the definition of process weight. In subsection (2)(C), language was deleted in order for the definition of a jobbing cupola to be the same throughout the state.

In paragraph (3)(A)(3), relating to calculating compliance with the emission limits when a control device is used, language was added which provides that the control equipment must be required by an enforceable restriction. This will help ensure that circumvention of the rule does not occur.

Finally, section (4), reporting and recordkeeping, was added. This section requires that records of any tests performed to determine the amount of particulate matter emitted from a unit shall be kept on-site and available for inspection for five years.

The revised rule was adopted by the Missouri Air Conservation Commission on April 26, 2001, and became effective on September 30, 2001.

Have the Requirements for Approval of a SIP Revision Been Met?

The state submittal has met the public notice requirements for SIP submissions in accordance with 40 CFR 51.102. The submittal also satisfied the completeness criteria of 40 CFR part 51, appendix V. In addition, as explained above and in more detail in the technical support document which is part of this action, the revision meets the substantive SIP requirements of the CAA, including section 110 and implementing regulations.

What Action Is EPA Taking?

We are processing this action as a final action because the revisions make routine changes to the existing rules which are noncontroversial. Therefore, we do not anticipate any adverse comments. Please note that if EPA receives adverse comment on an amendment, paragraph, or section of this rule and if that provision is severed from the remainder of the rule, EPA may adopt as final those provisions of the rule that are not the subject of an adverse comment.

Administrative Requirements

Under Executive Order 12866 (58 FR 51735, October 4, 1993), this action is not a ''significant regulatory action'' and therefore is not subject to review by the Office of Management and Budget. For this reason, this action is also not subject to Executive Order 13211, ''Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use'' (66 FR 28355, May 22, 2001). This action merely approves state law as meeting Federal requirements and imposes no additional requirements beyond those imposed by state law. Accordingly, the Administrator certifies that this rule will not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*). Because this rule approves pre-existing requirements under state law and does not impose any additional enforceable duty beyond that required by state law, it does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Public Law 104–4).

This rule also does not have tribal implications because it will 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, as specified by Executive Order 13175 (65 FR 67249, November 9, 2000). This action also does not have Federalism implications because it does 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 (64 FR 43255, August 10, 1999). This action merely approves a state rule implementing a Federal standard, and does not alter the relationship or the distribution of power and responsibilities established in the CAA. This rule also is not subject to Executive Order 13045, ''Protection of Children from Environmental Health Risks and Safety Risks'' (62 FR 19885, April 23, 1997), because it is not economically significant.

In reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the CAA. In this context, in the absence of a prior existing requirement for the State to use voluntary consensus standards (VCS), EPA has no authority to disapprove a SIP submission for failure to use VCS. It would thus be inconsistent with applicable law for EPA, when it reviews a SIP submission, to use VCS in place of a SIP submission that otherwise satisfies the provisions of the Clean Air Act. Thus, the requirements of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) do not apply. This rule does not impose an information collection burden under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

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. EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the 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).

Under section 307(b)(1) of the CAA, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by January 29, 2002. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this rule for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements. (*See* section 307(b)(2).)

List of Subjects 40 CFR Part 52

Environmental protection, Air pollution control, Intergovernmental relations, Lead, Particulate matter, Reporting and recordkeeping requirements.

Dated: November 17, 2001

William W. Rice,

Acting Regional Administrator, Region 7.

Chapter I, title 40 of the Code of Federal Regulations is amended as follows:

PART 52—[AMENDED]

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

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

Subpart AA—Missouri

2. In § 52.1320(c) the table is amended under Chapter 6 by revising the entry for ''10–6.400'' to read as follows:

§ 52.1320 Identification of plan.

* * * * *

(c) * * *

EPA—APPROVED MISSOURI REGULATIONS

Missouri citation	Title	State effective date	EPA approval date	Explanation
	Missouri Department of Natural Resources			
*	* * * *	*		*
	Chapter 6—Air Quality Standards, Definitions, Sampling and Reference Methods, and Air Pollution Control regulations for the State of Missouri			
*	* * * *	*		*
10–6.400	Restriction of Emission of Particulate Matter From Industrial Processes	09/30/01	11/30/01	
*	* * * *	*		*

* * * * *

[FR Doc. 01–29650 Filed 11–29–01; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[IN122–1a; FRL–7107–9]

Approval and Promulgation of Implementation Plans; Indiana

AGENCY: Environmental Protection Agency (EPA).

ACTION: Direct final rule.

SUMMARY: The Indiana Department of Environmental Management (IDEM) submitted a revised opacity rule on October 21, 1999, as a requested revision to its State Implementation Plan (SIP). The revisions amend portions of Indiana's opacity rule concerning the startup and shutdown of operations, terminology used in discussing averaging periods, time periods for temporary exemptions, alternative opacity limits, and conflicts between visible emission readings and continuous opacity monitor (COM) data.

A major new component of this rule authorizes the State to incorporate source-specific startup and shutdown provisions into federally enforceable operating permits for certain utility boilers, as long as those provisions fall within a range established in the rule. Indiana provided a modeling analysis showing that the revised startup and shutdown provisions will not have an adverse impact on air quality. In addition, the revisions clarifying averaging periods and resolving conflicts between monitored and visual opacity readings will aid enforcement of the opacity rule.

DATES: This rule is effective on January 29, 2002, unless the EPA receives relevant adverse written comments by December 31, 2001. If adverse comment is received, the EPA will publish a timely withdrawal of the rule in the **Federal Register** and inform the public that the rule will not take effect.

ADDRESSES: You should mail written comments to: J. Elmer Bortzer, Chief, Regulation Development Section, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604.

You may inspect copies of Indiana's submittal at: Regulation Development Section, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604.

FOR FURTHER INFORMATION CONTACT: Matt Rau, Environmental Engineer, Regulation Development Section, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604, Telephone: (312) 886–6524.

SUPPLEMENTARY INFORMATION: Throughout this document wherever ''we,'' ''us,'' or ''our'' are used we mean the EPA.

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IV. What are the environmental effects of these alternate limits in 326 IAC 5–1–3?
V. What rulemaking action is the EPA taking?
VI. Administrative requirements.

I. What Is the EPA Approving?

The EPA is approving revisions to Indiana's opacity rule. IDEM submitted this revised opacity regulation to the EPA on October 21, 1999, as a requested revision to its SIP. The revisions address applicable requirements concerning the startup and shutdown of operations, the terminology used in discussing averaging periods, time periods for temporary exemptions, alternative opacity limits, and conflicts between visible emission readings and COM data. The boiler startup and shutdown revisions satisfy the Clean Air Act requirements and the EPA policy on such provisions. Other rule revisions aid the enforcement of the opacity rules.

II. What Are the Changes From the Current Rules?

The State's submission revises several sections of Indiana's opacity rule, 326 IAC Article 5. The revisions involve permanent alternative opacity limits (AOLs) for utility boilers, conflicts between COM data and visible emission readings, clarification of averaging periods, temporary AOLs for non-boiler sources, and exemptions for sources with consolidated Title V permit limits.

A. Provisions for Utility Boilers

The major new component of these revisions allows certain utility boilers to obtain source-specific AOLs during startup and shutdown periods in their federally enforceable operating permits. The AOL must fall within a range established in the rule, 326 IAC 5–1–3(e). This provision is for power plants using coal-fired boilers and electrostatic precipitators (ESPs).

B. Conflicts Between COM Data and Visual Opacity Readings

The current SIP version states that if there is a conflict between opacity readings recorded by a COM and those taken by a human observer, the COM data will prevail. The EPA requested this rule be revised to make enforcement easier. Indiana revised the rule, 326 IAC 5–1–4(b), to state that data from either a COM or a human observer may be used to show a violation of opacity limits. The basis for this change is that there are certain instances in which opacity readings from an observer may be more accurate than those from a COM. For example, sulfur in a high-temperature gas stream exists in a gaseous state inside a smokestack and would not register on a COM. Once the gas stream comes in contact with the atmosphere, however, chemical reactions and cooling occur, causing visible emissions which can be seen by an observer.

C. Clarification of Averaging Periods

The current version of this rule, 326 IAC 5–1–2, states that the limits are not to be exceeded ''in 24 consecutive readings'' with readings taken every 15 seconds. The revised rule states that the limits are not to be exceeded in ''any one 6-minute averaging period.'' The limits themselves are unchanged. Indiana made a similar clarification of time averaging periods for temporary AOLs. Under 326 IAC 5–1–3(a) and (b), Indiana may provide temporary AOLs to certain sources for startup, shutdown, and ash removal. Both of these revisions improve the ability to enforce the rule by making it clearer and more consistent with the opacity test method. The test method (40 CFR 60, Appendix A, Method 9) calls for opacity readings to be taken by an observer every 15 seconds, and for these readings to be averaged on a 6-minute basis.

D. Temporary Alternative Opacity Limitations for Non-Boiler Sources

New provisions in 326 IAC 5–1–3(c) authorize Indiana to grant temporary AOLs to non-boiler sources. These sources now may apply for a short-term opacity AOL for startup, shutdown, and ash removal situations. IDEM will submit any temporary AOLs to the EPA as site-specific SIP revisions. The EPA will review them for compliance with Clean Air Act requirements and EPA policy. This rule revision does not directly effect any SIP emissions limits.

E. Opacity Limit Exemptions for Title V Sources.

Indiana's rule had provided an exemption from opacity limits for any source with a specific opacity limit in a Title V permit. The rule, 326 IAC 5–1–1, allowed sources to consolidate multiple limits into a single limit in the Title V permit. This is known as ''streamlining.'' The EPA had informed Indiana that the exemption was inappropriate because it had impermissibly suggested that Title V permits could create SIP exemptions. As a result, Indiana removed the exemption from 326 IAC 5–1–1.

III. What Is the EPA's Analysis of the Supporting Materials?

The EPA used the September 20, 1999, memorandum entitled ''State Implementation Plans: Policy Regarding Excess Emissions During Malfunctions, Startup, and Shutdown'' to evaluate the exemptions provisions in 326 IAC 5–1–3(e). To be approved, the provisions must meet the seven requirements in this memorandum. The requirements are:

1. The revision must be limited to specific, narrowly-defined source categories using specific control strategies;
2. Use of the control strategy for this source category must be technically infeasible during startup or shutdown periods;
3. The frequency and duration of operation in startup or shutdown mode must be minimized;
4. As part of its justification of the SIP revision, the state should analyze the potential worst-case emissions that could occur during startup and shutdown;
5. All possible steps must be taken to minimize the impact of emissions during startup and shutdown on ambient air quality;
6. At all times, the facility must be operated in a manner consistent with good practice for minimizing emissions;
7. The owner or operator's actions during startup and shutdown periods must be documented by properly signed, concurrent operating logs, or other relevant evidence;

Indiana has met all seven requirements. Language in Indiana's rules meets requirements three, five, six, and seven. An October 10, 2001, letter from IDEM states that the AOL will only be given to 22 power plants using coal-fired boilers with ESPs. This satisfies the first requirement. IDEM supplied technical documentation on the infeasibility of ESPs during startup and shutdown to meet requirement two. Indiana provided modeling analysis of the potential worst case emissions to meet the fourth requirement, as discussed in section IV below.

In addition to the supporting material for the exemptions in 326 IAC 5–1–3(e), Indiana provided support for its other opacity revisions. Revised language in 326 IAC 5–1–2 clarifies the averaging period for opacity level readings. The averaging period is now ''any one (1) six (6) minute averaging period.'' The former limit of ''twenty-four (24) consecutive readings'' (readings are taken every 15 seconds) was revised to aid enforcement of the opacity rules. Indiana also submitted revisions to 326 IAC 5–1–3 (a), and (b) which provide sources short-term temporary alternate opacity limits for startup, shutdown, and ash blowing. The AOLs in sections (a) will now be granted for up to ''two (2) six (6) minute averaging periods'' in any twenty-four hour period. Previously, the limit was stated as ''twelve (12) continuous minutes.'' Section (b) similarly changes a ''six (6) continuous minutes'' to ''one (1) six (6) minute'' averaging period. The 326 IAC 5–1–3 (a) and (b) revisions also aid rule enforcement.

Indiana also revised 326 IAC 5–1–3 (c) to include non-boiler sources located outside of Lake County with similar AOLs to those of 326 IAC 5–1–3 (a) and (b). Language in 326 IAC 5–1–1 allowing an opacity limits exemption for any source with a specific opacity limit in a Title V permit was removed. This exemption was removed because it had impermissibly suggested that Title V permits could create SIP exemptions.

Indiana held two public hearings on the opacity rule revisions, giving interested parties an opportunity to comment. It held the first public hearing on December 3, 1997 and the second on June 3, 1998. Transcripts of the public hearing are included in the submittal. Representatives from electric utilities, a university, and a cement company made comments at the hearings. These comments were generally supportive of the rule revisions. There were two commentors who expressed concern about 326 IAC 5–1–4(b). This section addresses conflicts between visual opacity readings and those taken with a COM. Indiana further revised this section in response to the comments. Section 5–1–4(b) now states that either visual or COM readings may be used. The method decision will be made based on which method is determined to be most accurate given the case-specific circumstances. Considering the comments made during the two hearings and how Indiana addressed the comments, the EPA does not anticipate receiving any adverse comments on this matter.

IV. What Are the Environmental Effects of These Alternative Limits in 326 IAC 5–1–3?

Indiana submitted a modeling analysis aimed at assessing the worst-case impact of the alternate limits in 326 IAC 5–1–3(e). This modeling analysis addresses the fourth requirement of EPA's September 20, 1999 policy. Of the 22 eligible facilities, IDEM modeled PSI Energy's power plant in Edwardsport because it has the shortest stacks (183 feet) and the most significant impact from building downwash. A conservative emissions rate was calculated by estimating uncontrolled emissions under full-load operating conditions for a conservative eight-hour startup period. IDEM developed a conservative estimate of background concentrations in the area of the Edwardsport plant. It showed that application of this background value to the other relevant power plants (none of which is in the Lake County non-attainment area) would provide a similar degree of conservatism.

Indiana used five years of meteorological data. The Edwardsport modeling results show an ambient particulate matter of 10μm or less in diameter (PM–10) concentration of 98.6 $\mu g/m^3$, well below the 24-hour average PM–10 standard of 150 $\mu g/m^3$. Thus, IDEM has demonstrated that the startup and shutdown AOL in 326 IAC 5–1–3 is not expected to cause a violation of the PM–10 air quality standards.

The EPA further examined whether air quality problems could arise from multiple sources operating in startup or shutdown mode simultaneously. With one exception, the relevant power plants are isolated from each other. The one exception is for two facilities in Warrick County. Because the two facilities are about 3 kilometers apart, and because these facilities have significantly higher stacks than the Edwardsport facility, EPA is satisfied that simultaneous operation in startup or shutdown mode at these two facilities will not cause air quality problems. In addition, because operation in startup or shutdown mode (particularly eight hours of such operation) is infrequent, simultaneous operation in these modes at more than one source is unlikely. Consequently, the EPA believes that granting the exemption requested by Indiana will not jeopardize continued attainment of the air quality standards.

V. What Rulemaking Action Is the EPA Taking?

The EPA is approving, through direct final rulemaking, revisions to Indiana's opacity rule. The revised regulation address provisions concerning the startup and shutdown of operations, terminology used in discussing averaging periods, time periods for temporary exemptions, alternative opacity limits, and conflicts between visible readings and COM data.

We are publishing this action without a prior proposal because we view these as noncontroversial revisions and anticipate no adverse comments. However, in the ''Proposed Rules'' section of today's **Federal Register**, we are publishing a separate document that serves as the proposal to approve the SIP revision if adverse written comments are filed. This rule will be effective on January 29, 2002 without further notice unless we receive relevant adverse written comments by December 31, 2001. If the EPA receives adverse written comment, we will publish a final rule informing the public that this rule will not take effect. We will address all public comments in a subsequent final rule based on the proposed rule. The EPA does not intend to institute a second comment period. Any parties interested in commenting on these actions must do so at this time.

VI. Administrative Requirements

Under Executive Order 12866 (58 FR 51735, October 4, 1993), this action is not a ''significant regulatory action'' and therefore is not subject to review by the Office of Management and Budget. For this reason, this action is also not subject to Executive Order 13211, ''Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use'' (66 FR 28355, May 22, 2001). This action merely approves state law as meeting Federal requirements and imposes no additional requirements beyond those imposed by state law. Accordingly, the Administrator certifies that this rule will not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*). Because this rule approves pre-existing requirements under state law and does not impose any additional enforceable duty beyond that required by state law, it does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Public Law 104–4).

This rule also does not have tribal implications because it will 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,

as specified by Executive Order 13175 (65 FR 67249, November 9, 2000). This action also does not have Federalism implications because it does 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 (64 FR 43255, August 10, 1999). This action merely approves a state rule implementing a Federal standard, and does not alter the relationship or the distribution of power and responsibilities established in the Clean Air Act. This rule also is not subject to Executive Order 13045 ''Protection of Children from Environmental Health Risks and Safety Risks'' (62 FR 19885, April 23, 1997), because it is not economically significant.

In reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the Clean Air Act. In this context, in the absence of a prior existing requirement for the State to use voluntary consensus standards (VCS), EPA has no authority to disapprove a SIP submission for failure to use VCS. It would thus be inconsistent with applicable law for EPA, when it reviews a SIP submission, to use VCS in place of a SIP submission that otherwise satisfies the provisions of the Clean Air Act. Thus, the requirements of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) do not apply. This rule does not impose an information collection burden under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.).

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. EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the 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).

Under section 307(b)(1) of the Clean Air Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by January 29, 2002. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this rule for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements.

(*See* section 307(b)(2).)

List of Subjects in 40 CFR Part 52

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

Dated: November 8, 2001.

Norman Niedergang,

Acting Regional Administrator, Region 5.

For the reasons stated in the preamble, part 52, chapter I, title 40 of the Code of Federal Regulations is amended as follows:

PART 52—[AMENDED]

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

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

Subpart P—Indiana

2. Section 52.770 is amended by adding paragraph (c)(146) to read as follows:

§ 52.770 Identification of plan.

* * * * *

(c) * * *

(146) On October 21, 1999, Indiana submitted revised state opacity regulations. The submittal amends 326 IAC 5–1–1, 5–1–2, 5–1–3, 5–1–4(b), and 5–1–5(b). The revisions address provisions concerning the startup and shutdown of operations, averaging period terminology, temporary exemptions, alternative opacity limits, and conflicts between continuous opacity monitor and visual readings.

(i) Incorporation by reference.

Opacity limits for Indiana contained in Indiana Administrative Code Title 326: Air Pollution Control Board, Article 5: Opacity Regulations. Filed with the Secretary of State on October 9, 1998 and effective on November 8, 1998. Published in 22 Indiana Register 426 on November 1, 1998.

[FR Doc. 01–29648 Filed 11–29–01; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 62

[IL210–1a; FRL–7111–1]

Approval and Promulgation of State Implementation Plans; Illinois

AGENCY: Environmental Protection Agency (EPA).

ACTION: Direct final rule.

SUMMARY: The EPA is approving a negative declaration submitted by the State of Illinois which indicates there is no need for regulations covering existing Small Municipal Waste Combustors (MWC) in the State of Illinois. The State's negative declaration regarding this category of sources was submitted in a letter dated June 25, 2001, and was based on a systematic search of records and permits. This search resulted in the determination that there are no affected small MWC units in Illinois.

DATES: This rule is effective on January 29, 2002, unless EPA receives adverse written comments by December 31, 2001. If adverse comment is received, EPA will publish a timely withdrawal of the rule in the **Federal Register** and inform the public that the rule will not take effect.

ADDRESSES: Written comments should be sent to: J. Elmer Bortzer, Chief, Regulation Development Section, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, 77 West Jackson Boulevard, Chicago, Illinois 60604.

A copy of the negative declaration is available for inspection at the U.S. Environmental Protection Agency, Region 5, Air and Radiation Division, 77 West Jackson Boulevard, Chicago, Illinois 60604. (Please telephone John Paskevicz at (312) 886–6084 before visiting the Region 5 Office.)

FOR FURTHER INFORMATION CONTACT: John Paskevicz, Environmental Engineer, Regulation Development Section, Air Programs Branch (AR–18J), EPA, Region 5, Chicago, Illinois 60604, (312) 886–6084.

SUPPLEMENTARY INFORMATION: Throughout this document wherever ''we'', ''us'', or ''our'' is used we mean EPA.

Table of Contents

I. What is the background for this action?
II. Negative declarations and their justification.
III. EPA review of Illinois' negative declaration.
IV. Administrative Requirements.

I. What is the Background for This Action?

In December 2000, the EPA finalized two rules for new and existing commercial and industrial solid waste incinerator (CISWI) units and small MWC units. These rules were promulgated based on section 111(d) and section 129 of the Clean Air Act (Act) Amendments of 1990. The Federal rules include emission guidelines for existing units and standards of performance for new, modified or reconstructed sources. The rules for small MWC units were published in the **Federal Register** on December 6, 2000, (65 FR 76378) under 40 CFR part 60, subpart BBBB (Emission Guidelines for Small Municipal Waste Combustion Units.) Rules for new sources of small MWC were published in the **Federal Register** on December 6, 2000, (65 FR 76350) under 40 CFR part 60, subpart AAAA (New Source Performance Standards for New Small Municipal Waste Combustion Units). The regulatory text and other background information for these final rulemakings can be accessed electronically from the EPA Technology Transfer Network website. For small MWC the web site address is: *http://www.epa.gov/ttn/atw/129/mwc/rimwc2.html.*

Provisions of sections 111(d) and 129 require States to either develop plans to control emissions from small MWC or to report that there are no facilities in the State as described in the federal rule. States in which a designated existing facility is operating a small MWC shall submit to EPA a plan to implement and enforce the emission guidelines or submit a negative declaration letter. Section 129 requires that the State plan be at least as protective as the emission guidelines and must provide for compliance by the affected facilities no later than 3 years after EPA approves the State plan, but no later than 5 years after EPA promulgates the emission guidelines. Sections 111(d) and 129 also require EPA to develop, implement and enforce a Federal Implementation Plan if a State fails to submit an approvable State plan. The small MWC plan must address regulatory applicability, increments of progress for retrofit, operator training and certification, operating practices, emission limits, continuous emission monitoring, stack testing, record keeping, and reporting, and requirements for air curtain combustors. States are required to follow the requirements of 40 CFR part 60, subpart B regarding the adoption and submittal of State plans for designated facilities.

In addition to the publication of the emission guidelines document, EPA notified each of the States of the requirements listed in the rule. On February 23, 2001, EPA, Region 5 asked Illinois to provide information so EPA could determine if the State was required to develop and submit the required plan. Prompted by this letter, the State began a detailed review of its permit system and other databases to ascertain the status of small MWC facilities.

II. Negative Declarations and Their Justification

The EPA does not require States to develop plans or regulations to control emissions from sources for which there are none present in the State (40 CFR 62.06). If it is thought that this might be the case, the State carefully examines its emissions inventory and operating permits before initiating the planning and regulation development process. If a careful examination of the emissions inventory finds no sources for a particular source category, then the State prepares and submits to EPA a negative declaration stating there are no sources in the State for that source category. This is done in lieu of submitting a control strategy.

On June 25, 2001, the State of Illinois submitted to EPA a negative declaration regarding the need for a regulation covering small MWC. The Illinois Environmental Protection Agency (IEPA) evaluated the applicability criteria in the final emission guidelines (subpart BBBB 60.1550 through 60.1565) and searched the standard industrial classification codes (SIC) 4953 and 9511. These source types were used as typical examples of potentially affected sources as we reported in 65 FR 76378. The State also included, in its search, other unspecified types of potentially affected sources which are not classified with SICs. These are referenced by their source classification codes as solid waste disposal by incineration.

The search resulted in a preliminary list of 437 sources of potentially affected incinerator units in the State. IEPA then examined the permit information for each of the incinerator or combustor units for type of waste, maximum operating rate and capabilities. None of the units exceeded the 35 tons per day cut off capacity for municipal solid waste. The IEPA concluded that there were no affected small MWC units in Illinois.

This conclusion is consistent with the conclusion drawn by EPA in its nation-wide inventory of small MWC. In its review, EPA did not find any small MWC sources in Illinois. (65 FR 76382)

III. EPA Review of Illinois' Negative Declaration

EPA has examined the State's negative declaration regarding the lack of need for a regulation controlling emissions from small MWCs. EPA agrees there are no unregulated small incinerators in Illinois which would require the adoption of rules to control this source category. If a new source chooses to locate in this area, it would be required to comply with new source review requirements published for small MWC on December 6, 2000 (65 FR 76350). If, at a later date, an existing small MWC unit is identified in the State, a Federal Implementation Plan implementing the emission guidelines contained in Subpart BBBB will automatically apply to that MWC unit until the State's plan is approved.

EPA is publishing this action without prior proposal because EPA views this as a noncontroversial revision and anticipates no adverse comments. However, in a separate document in this **Federal Register** publication, EPA is proposing to approve the State negative declaration should adverse written comments be filed. This action will be effective without further notice unless EPA receives relevant adverse written comment by December 31, 2001. Should EPA receive such comments, it will publish a final rule informing the public that this action will not take effect. Any parties interested in commenting on this action should do so at this time. If no comments are received, the public is advised that this action will be effective on January 29, 2002.

IV. Administrative Requirements

Under Executive Order 12866 (58 FR 51735, October 4, 1993), this action is not a ''significant regulatory action'' and therefore is not subject to review by the Office of Management and Budget. This action merely approves state law as meeting federal requirements and imposes no additional requirements beyond those imposed by state law. Accordingly, the Administrator certifies that this rule will not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*). Because this rule approves Illinois' declaration that there are no small MWC's located in Illinois which would be subject to an MWC regulation if one were adopted. Therefore, the State does not need to adopt a MWC regulation. Any new MWC's built in Illinois will be subject to New Source Performance Standards. Because this

rule approves state negative declarations and does not impose any additional enforceable duty, it does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Public Law 104–4). This rule also 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, as specified by Executive Order 13175 (65 FR 67249, November 9, 2000), nor will it 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 (64 FR 43255, August 10, 1999), because it merely approves a state declaration that a rule implementing a federal standard, is unnecessary and does not alter the relationship or the distribution of power and responsibilities established in the Clean Air Act. This rule also is not subject to Executive Order 13045 (62 FR 19885, April 23, 1997), because it is not economically significant.

In reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the Clean Air Act. In this context, in the absence of a prior existing requirement for the State to use voluntary consensus standards (VCS), EPA has no authority to disapprove a SIP submission for failure to use VCS. It would thus be inconsistent with applicable law for EPA, when it reviews a SIP submission, to use VCS in place of a SIP submission that otherwise satisfies the provisions of the Clean Air Act. Thus, the requirements of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) do not apply. As required by section 3 of Executive Order 12988 (61 FR 4729, February 7, 1996), in issuing this rule, EPA has taken the necessary steps to eliminate drafting errors and ambiguity, minimize potential litigation, and provide a clear legal standard for affected conduct. EPA has complied with Executive Order 12630 (53 FR 8859, March 15, 1988) by examining the takings implications of the rule in accordance with the AAttorney General's Supplemental Guidelines for the Evaluation of Risk and Avoidance of Unanticipated Takings@ issued under the executive order. This rule does not impose an information collection burden under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

The Congressional Review Act, 5 U.S.C. section 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. EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the 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. section 804(2). This rule will be effective January 29, 2002 unless EPA receives adverse written comments by December 31, 2001.

Under section 307(b)(1) of the Clean Air Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by January 29, 2002. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this rule for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements. (See section 307(b)(2).)

List of Subjects in 40 CFR Part 62

Environmental protection, Administrative practice and procedure, Air pollution control, Intergovernmental relations, Reporting and recordkeeping requirements.

Dated: November 14, 2001.

Norman Niedergang,

Acting Deputy Regional Administrator, Region 5.

For the reasons stated in the preamble, part 62, chapter I, title 40 of the Code of Federal Regulations is amended as follows:

PART 62—[AMENDED]

1. The authority citation for part 62 continues to read as follows:

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

Subpart O—Illinois

2. A new center heading and § 62.3335 are added to read as follows:

EMISSIONS FROM SMALL MUNICIPAL WASTE COMBUSTION UNITS WITH THE CAPACITY TO COMBUST AT LEAST 35 TONS PER DAY OF MUNICIPAL SOLID WASTE BUT NO MORE THAN 250 TONS PER DAY OF MUNICIPAL SOLID WASTE AND COMMENCED CONSTRUCTION ON OR BEFORE AUGUST 30, 1999

§ 62.3335 Identification of plan—negative declaration.

On June 25, 2001, the State of Illinois certified to the satisfaction of the United States Environmental Protection Agency that no major sources categorized as small Municipal Waste Combustors are located in the State of Illinois.

[FR Doc. 01–29774 Filed 11–29–01; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 281

[FRL–7110–8]

Minnesota; Final Approval of State Underground Storage Tank Program

AGENCY: Environmental Protection Agency.

ACTION: Notice of final determination on the State of Minnesota's application for final approval.

SUMMARY: The State of Minnesota has applied for approval of its Underground Storage Tank Program for petroleum and hazardous substances under Subtitle I of the Resource Conservation and Recovery Act (RCRA). The Environmental Protection Agency (EPA) has reviewed Minnesota's application and has reached a final determination that Minnesota's Underground Storage Tank Program for petroleum and hazardous substances satisfies all of the requirements necessary to qualify for approval. Thus, the EPA is granting final approval to the State of Minnesota to operate its Underground Storage Tank Program for petroleum and hazardous substances.

EFFECTIVE DATE: Final approval for the State of Minnesota's Underground Storage Tanks Program shall be effective on December 31, 2001.

FOR FURTHER INFORMATION CONTACT: Mr. Andrew Tschampa, Chief, Underground Storage Tank Section, U.S. EPA, Region 5, 77 West Jackson Blvd., Chicago, Illinois, Telephone: (312) 886–6136.

SUPPLEMENTARY INFORMATION:

A. Background

Section 9004 of the Resource Conservation and Recovery Act (RCRA)

authorizes the Environmental Protection Agency (EPA) to approve State Underground Storage Tank Programs to operate in the State in lieu of the Federal Underground Storage Tank (UST) Program. To qualify for final authorization, a State's Program must: (1) Be ''no less stringent'' than the Federal Program for the seven elements set forth at RCRA Section 9004(a) (1) through (7); and (2) provide for adequate enforcement of compliance with UST standards of RCRA Section 9004(a). Note that RCRA Sections 9005 (on information-gathering) and 9006 (on Federal enforcement) by their terms apply even in States with Programs approved by the EPA under RCRA Section 9004. Thus, the Agency retains its authority under RCRA Sections 9005 and 9006, 42 U.S.C. 6991d and 6991e, and other applicable statutory and regulatory provisions to undertake inspections and enforcement actions in approved States. With respect to such an enforcement action, the Agency will rely on Federal sanctions, Federal inspection authorities, and Federal procedures rather than the State authorized analogues to these provisions.

On May 11, 2000, the State of Minnesota submitted an official application to obtain final program approval to administer the Underground Storage Tank Program for petroleum and hazardous substances. On August 6, 2001, the EPA published a tentative decision announcing its intent to grant Minnesota final approval. Further background on the tentative decision to grant approval appears at 66 FR 40954–40957, August 6, 2001.

Along with the tentative determination, the EPA announced the availability of the application for public comment and the date of a public hearing on the application. The EPA requested advance notice for testimony and reserved the right to cancel the public hearing for lack of public interest. Since there was no public request, the public hearing was cancelled. No public comments were received regarding the EPA's approval of Minnesota's Underground Storage Tank Program.

The State of Minnesota is not approved to operate the Underground Storage Tank Program in Indian Country within the State's borders.

B. Decision

I conclude that the State of Minnesota's application for final program approval meets all of the statutory and regulatory requirements established by Subtitle I of RCRA. Accordingly, Minnesota is granted final approval to operate its Underground Storage Tank Program for petroleum and hazardous substances. The State of Minnesota now has the responsibility for managing all regulated underground storage tank facilities within its border and carrying out all aspects of the Underground Storage Tank Program except with regard to Indian Country where the EPA will have regulatory authority. Minnesota also has primary enforcement responsibility, although the EPA retains the right to conduct enforcement actions under Section 9006 of RCRA.

C. Administrative Requirements

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, the 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 one year. Before promulgating an EPA rule for which a written statement is needed, Section 205 of the UMRA generally requires the 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 the 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 why that alternative was not adopted. Before the 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 the EPA regulatory proposals with significant Federal intergovernmental mandates, and informing, educating, and advising small governments on compliance with the regulatory requirements.

Today's rule contains no Federal mandates (under the regulatory provisions of Title II of the UMRA) for State, Local or Tribal Governments or the private sector. The UMRA generally excludes from the definition of ''Federal intergovernmental mandate'' duties that arise from participation in a voluntary Federal program. Minnesota's participation in the EPA's State Program approval process under RCRA Subtitle I is voluntary. Thus, today's rule is not subject to the requirements of Sections 202 and 205 of the UMRA.

In addition, the EPA has determined that this rule contains no regulatory requirements that might significantly or uniquely affect small governments. Although small governments may own and/or operate underground storage tanks, they are already subject to the regulatory requirements under the existing State requirements that the EPA is now approving and, thus, are not subject to any additional significant or unique requirements by virtue of this action. Thus, the requirements of Section 203 of the UMRA also do not apply to today's rule.

Regulatory Flexibility Act (RFA) (as Amended by the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA), 5 U.S.C. 601 et seq.

The RFA generally requires an agency to prepare a regulatory flexibility analysis of any rule subject to notice and comment rule making requirements under the Administrative Procedure Act or any other statute unless the agency certifies that the rule will not have a significant economic impact on a substantial number of small entities. Small entities include small businesses, small organizations, and small governmental jurisdictions.

For purposes of assessing the impacts of today's action on small entities, a small entity is defined as: (1) A small business as specified in the Small Business Administration regulations; (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; and (3) a small organization that is any not-for-profit enterprise which is independently owned and operated and is not dominant in its field.

After considering the economic impacts of this action on small entities, I certify that this action will not have a significant economic impact on a substantial number of small entities. This action does not impose any new requirements on small entities because small entities that own and/or operate underground storage tanks are already subject to the State underground storage

tank requirements which the EPA is now approving. This action merely approves for the purpose of RCRA Section 9004 those existing State Requirements.

Submission to Congress and the Comptroller General

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 this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in today's **Federal Register**. This rule is not a ''major rule'' as defined by 5 U.S.C. 804(2).

Compliance With Executive Order 12866

The Office of Management and Budget has exempted this rule from the requirements of Executive Order 12866.

Compliance With Executive Order 13045 (Children's Health)

Executive Order 13045, ''Protection of Children from Environmental Health Risks and Safety Risks,'' applies to any rule that: (1) The Office of Management and Budget determines is ''economically significant'' as defined under Executive Order 12866, and (2) concerns an environmental health or safety risk that the 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.

The EPA interprets Executive Order 13045 as applying only to those regulatory actions that are based on health or safety risks, such that the analysis required under section 5–501 of the Order has the potential to influence the regulation. This rule is not subject to Executive Order 13045 because it approves a State program.

Compliance With 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 6, 2000), requires the 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.'' ''Policies that have Tribal implications'' is defined in the Executive Order to include regulations that have ''substantial direct effects on one or more Indian Tribes, on the relationship between the Federal Government and the Indian Tribes, or on the distribution of power and responsibilities between the Federal Government and Indian Tribes.''

This rule does not have Tribal implications. It will not have substantial direct effects on Tribal Governments, 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, as specified in Executive Order 13175. Minnesota is not approved to implement the RCRA Underground Storage Tank Program in Indian Country. This action has no effect on the Underground Storage Tank Program that the EPA implements in the Indian Country within the State. Thus, Executive Order 13175 does not apply to this rule.

Compliance With Executive Order 13132 (Federalism)

Executive Order 13132, entitled ''Federalism'' (64 FR 43255, August 10, 1999), requires the 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.''

Under Section 6 of Executive Order 13132, the EPA may not issue a regulation that has Federalism implications, that imposes substantial direct compliance costs, and that is not required by statute, unless the Federal Government provides the funds necessary to pay the direct compliance costs incurred by State and Local Governments, or EPA consults with State and Local Officials early in the process of developing the proposed regulation. The EPA also may not issue a regulation that has Federalism implications and that preempts State law unless the Agency consults with State and Local Officials early in the process of developing the proposed regulation.

This action does not have Federalism implications. It will not have a substantial direct effect on 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, because it affects only one State. This action simply provides the EPA approval of Minnesota's voluntary proposal for its State Underground Storage Tank Program to operate in lieu of the Federal Underground Storage Tank Program in that State. Thus, the requirements of Section 6 of the Executive Order do not apply.

National Technology Transfer and Advancement Act

As noted in the proposed rule, 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) directs the 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 (e.g., materials specifications, test methods, sampling procedures, and business practices) that are developed or adopted by voluntary consensus standards bodies. The NTTAA directs the EPA to provide Congress, through OMB, explanations when the Agency decides not to use available and applicable voluntary consensus standards.

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

Paperwork Reduction Act

Under the Paperwork Reduction Act, 44 U.S.C. 3501 *et seq.*, Federal agencies must consider the paperwork burden imposed by any information request contained in a proposed rule or a final rule. This rule will not impose any information requirements upon the regulated community.

Executive Order 13211 (Energy Effects)

This rule is not subject to Executive Order 13211, ''Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use'' (66 Fed. Reg. 28355 (May 22, 2001) because it is not a significant regulatory action under Executive Order 12866.

List of Subjects in 40 CFR Part 281

Environmental protection, Administrative practice and procedure, Hazardous substances, Intergovernmental relations, Reporting and recordkeeping requirements.

Authority: This notice is issued under the authority of Section 9004 of the Solid Waste Disposal Act as amended 42 U.S.C. 6912(a), 6974(b), 6991c.

Dated: November 14, 2001.

Norman Niedergang,

Acting Regional Administrator, Region V.

[FR Doc. 01–29778 Filed 11–29–01; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 300

[FRL–7109–3]

National Oil and Hazardous Substances Pollution Contingency Plan; National Priorities List

AGENCY: Environmental Protection Agency (EPA).

ACTION: Direct final notice of deletion of the Fort Devens-Sudbury Training Annex Superfund Site from the National Priorities List.

SUMMARY: EPA-New England is publishing a direct final notice of deletion of the Fort Devens-Sudbury Training Annex Superfund Site (Site), located in Stow, Sudbury, Maynard, and Hudson, Massachusetts, from the National Priorities List (NPL).

The NPL, promulgated pursuant to section 105 of the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA) of 1980, as amended, is appendix B of 40 CFR part 300, which is the National Oil and Hazardous Substances Pollution Contingency Plan (NCP). This direct final notice of deletion is being published by EPA with the concurrence of the Commonwealth of Massachusetts, through the Department of Environmental Protection (MADEP) because EPA has determined that all appropriate response actions under CERCLA have been completed and, therefore, further remedial action pursuant to CERCLA is not appropriate.

DATES: This direct final deletion will be effective January 29, 2002 unless EPA receives adverse comments by December 31, 2001. If adverse comments are received, EPA will publish a timely withdrawal of the direct final deletion in the **Federal Register** informing the public that the deletion will not take effect.

ADDRESSES: Comments may be mailed to Christine Williams, Remedial Project Manager, U.S. Environmental Protection Agency-New England, One Congress Street, Suite 1100 (HBT), Boston, Massachusetts 02114–2023, (617) 918–1384, Fax (617) 918–1291, e-mail: *williams.christine@epa.gov*

Information Repository: Comprehensive information about the Site is available for viewing and copying at the Site information repository located at: Devens—RFTA, by appointment only Monday through Friday 8 am to 5 pm, (978) 796–3835 or (978) 796–2205.

FOR FURTHER INFORMATION CONTACT: Christine Williams, Remedial Project Manager, U.S. Environmental Protection Agency, One Congress Street, Suite 1100 (HBT), Boston, Massachusetts 02114–2023, (617) 918–1384, Fax (617) 918–1291, e-mail: *williams.christine@epa.gov*

SUPPLEMENTARY INFORMATION:

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I. Introduction
II. NPL Deletion Criteria
III. Deletion Procedures
IV. Basis for Site Deletion
V. Deletion Action

I. Introduction

EPA-New England is publishing this direct final notice of deletion of the Ft-Devens Sudbury Training Annex Superfund Site from the NPL.

The EPA identifies sites that appear to present a significant risk to public health or the environment and maintains the NPL as the list of those sites. As described in § 300.425(e)(3) of the NCP, sites deleted from the NPL remain eligible for remedial actions if conditions at a deleted site warrant such action.

Because EPA considers this action to be noncontroversial and routine, EPA is taking it without prior publication of a notice of intent to delete. This action will be effective January 29, 2002 unless EPA receives adverse comments by December 31, 2001 on this notice or the parallel notice of intent to delete published in the Proposed Rules section of today's **Federal Register**. If adverse comments are received within the 30-day public comment period on this notice or the notice of intent to delete, EPA will publish a timely withdrawal of this direct final notice of deletion before the effective date of the deletion and the deletion will not take effect. EPA will, as appropriate, prepare a response to comments and continue with the deletion process on the basis of the notice of intent to delete and the comments already received. There will be no additional opportunity to comment.

Section II of this document explains the criteria for deleting sites from the NPL. Section III discusses the procedures that EPA is using for this action. Section IV discusses the Ft-Devens Sudbury Training Annex Superfund Site and demonstrates how it meets the deletion criteria. Section V discusses EPA's action to delete the site from the NPL unless adverse comments are received during the public comment period.

II. NPL Deletion Criteria

Section 300.425(e) of the NCP provides that releases may be deleted from the NPL where no further response is appropriate. In making a determination to delete a release from the NPL, EPA shall consider, in consultation with the State, whether any of the following criteria has been met:

(i) Responsible parties or other persons have implemented all appropriate response actions required;

(ii) All appropriate Fund-financed (Hazardous Substance Superfund Response Trust Fund) response under CERCLA has been implemented, and no further response action by responsible parties is appropriate; or

(iii) The remedial investigation (RI) has shown that the release poses no significant threat to public health or the environment and, therefore, taking of remedial measures is not appropriate.

Even if a site is deleted from the NPL, where hazardous substances, pollutants, or contaminants remain at the deleted site above levels that allow for unlimited use and unrestricted exposure, CERCLA section 121(c), 42 U.S.C. 9621(c) requires that a subsequent review of the site will be conducted at least every five years after the initiation of the remedial action at the deleted site to ensure that the action remains protective of public health and the environment. In the case of this Site, a five-year review is necessary since all hazardous substances, pollutants and contaminants have not been removed from the Site. If new information becomes available which indicates a need for further action, EPA may initiate remedial actions. Whenever there is a significant release from a site deleted from the NPL, the deleted site may be restored to the NPL without the application of the hazard ranking system.

In the case of the Ft. Devens Sudbury Training Annex, the selected remedies are protective of human health and the environment. The Army will maintain the landfill cover and will perform long-

term groundwater monitoring. The first five-year review was conducted by EPA, the Commonwealth of Massachusetts Department of Environmental Protection, and the Army this year (2001). Copies are located at the Repository previously noted. The remedies were deemed protective. Reviews will be conducted every five years hereafter.

III. Deletion Procedures

The following procedures apply to deletion of the Site:

(1) The EPA consulted with the Commonwealth of Massachusetts on the deletion of the Site from the NPL prior to developing this direct final notice of deletion.

(2) The Commonwealth of Massachusetts concurred with the deletion of the Site from the NPL.

(3) Concurrently with the publication of this direct final notice of deletion, a notice of the availability of the parallel notice of intent to delete published today in the Proposed Rules section of the **Federal Register** is being published in a major local newspaper of general circulation at or near the Site and is being distributed to appropriate federal, state and local government officials and other interested parties; the newspaper notice announces the 30-day public comment period concerning the notice of intent to delete the Site from the NPL.

(4) The EPA places copies of the documents supporting the deletion in the Site information repository identified above.

(5) If adverse comments are received within the 30-day public comment period on this action, EPA will publish a timely notice of withdrawal of this direct final notice of deletion before its effective date and will prepare a response to comments and continue with the deletion process on the basis of the notice of intent to delete and the comments already received.

Deletion of a site from the NPL does not itself create, alter, or revoke any individual's rights or obligations. Deletion of a site from the NPL does not in any way alter EPA's right to take enforcement actions, as appropriate. The NPL is designed primarily for informational purposes and to assist EPA management. Section 300.425(e)(3) of the NCP states that the deletion of a site from the NPL does not preclude eligibility for future response actions, should future conditions warrant such actions.

IV. Basis for Site Deletion

The following information provides EPA's rationale for deleting the Site from the NPL:

Site Location

The Ft. Devens Sudbury Training Annex (Site) lies in Middlesex County, Massachusetts, 20 miles west of Boston, and occupies approximately 2,300 acres within the towns of Hudson, Stow, Maynard, and Sudbury. The combined population of these four towns is approximately 50,000. The remaining area of contamination (A7) is located on the northern boundary of the Annex, adjacent to the Assabet River and within the boundaries of the town of Stow. Where developed land is adjacent to the Annex, it is residential. Green Meadow elementary school is approximately 1,000 feet northeast of the Annex boundary and Maynard High School 2,000 feet northeast.

Site Background and History

The Site was established as an Army ammunition storage point during WW II and since then has been used for ordnance research and development, materials research, and troop training. Research and development stopped in 1982 and there has been no training allowed since 1992. The Army stored PCB transformers from at least 1982 to 1985 at the Site. In 1985, a transformer was found to have been leaking due to a bullet hole. An estimated 100 to 200 gallons of PCB oil were released onto the ground. In 1986 the Army released the first remedial investigation focusing on 11 other areas of concern across the Site. The Site was placed on the EPA National Priorities List (NPL) as a Superfund Site in 1990 due to the known releases and in May 1991 the Army signed an Interagency Agreement with the EPA stipulating that site investigations (SI) and cleanup actions would follow CERCLA/Superfund Amendments and Reauthorization Act (SARA), under the regulatory guidance of the National Contingency Plan (NCP) 40 CFR part 300. A Technical Review Committee (TRC) was formed at this time also to, in part, provide a forum for discussion of citizens' concerns.

In 1995 the Site was placed on the Base Realignment and Closure (BRAC 95) list. The Site is planned to be transferred in three parts to (1) the United States Fish and Wildlife Service (F&WS) (2,205.2 acres), (completed), (2) U.S. Air Force (AF) (4.148 acres) (under negotiation), and (3) the Federal Emergency Management Agency (FEMA) (71.525 acres) (under negotiation). Puffer Pond (approximately 24 acres), which is defined by Massachusetts law to be a Great Pond (i.e., a natural pond with an area of 20 acres or more), is owned by the Commonwealth of Massachusetts and wholly located within property transferred to United States Fish and Wildlife Service.

The Site consists of five operable units (OU):

OU1–A7, the Old Gravel Pit Landfill, is about 2 acres in extent within a fenced area of 10 acres. It was used as a dump for general refuse, demolition debris, and chemical lab waste disposal. The lab waste area was limited to a pit of about 5,000 sq. ft. General refuse was reportedly buried at shallow depths since 1941, with occasional burning to reduce volume. A7 was also used by the public for unauthorized surface dumping during the 1970's, until access was restricted. This landfill was capped in 1997.

OU2–A9, the Petroleum, Oil and Lubricants (POL) Burn Area, was used from the 1950's to the 1980's for testing flame-retardant clothing and by the Massachusetts Fire Fighting Academy (MFFA). During the fire training two unlined trenches were filled with water, topped off with fuel oil and ignited. In 1988 approximately 1,100 yards of contaminated soil were excavated and removed from these training trenches and transported to a hazardous waste facility. An underground storage tank was also removed from this area.

OU3–A4, Waste Dump, contains a surface dump and a building foundation dated to the late 1600's. The site reportedly was used for the burial of unidentified chemical wastes and drums over a three to four year period from the late 1960s to early 1970s.

OU4–P11 and P13, Building T405 Dump Area and Massachusetts Fire Fighting Academy (MFFA). P–11 and P–13 areas were used for ordnance research and development; laboratory research on foamed plastics, organic chemicals, flame testing, meteorological projects, insecticide and rodenticide research; and training of Massachusetts State Police, Massachusetts Air National Guard, Massachusetts Army National Guard, and MFFA.

OU5–P37, P36 and A12, Former Raytheon Building T–106, T104 underground storage tank (UST) Area, and poly-chlorinated bi-phenyl (PCB) Transformer Remediation Area (in between the two buildings). T104 was used for research and development of missile guidance and radar systems and as a staging area for PCB transformers from at least 1982 to 1985. T106 was used for the assembly of electronic equipment. In 1988, two 1,000 gallon heating oil USTs were removed from near the two buildings. At A–12, in 1985, a transformer was found to have been leaking due to a bullet hole. An estimated 100 to 200 gallons of PCB oil

were released onto the ground. By the time the removal action was completed, over 175 tons of contaminated soils were removed.

Remedial Investigation/Feasibility Study (RI/FS) Results and Record of Decision (ROD) Findings for Operable Units (OU) 1 and 2

Remedial Investigations of these areas of concern were conducted in 1992 and 1993 and found the contamination at A7 in surface and subsurface soils, groundwater, surface water, and sediment. Contamination occurs in three distinct areas: the solid waste disposal area covering the central and eastern portion with hot spots of metals and organochloric pesticides; the laboratory waste disposal pit in the west-central portion containing pesticides, chlorinated solvents, and unknown lab waste hazards; and groundwater contamination.

At A9, after early soil removal actions, contamination was still found in the surface and subsurface soils and in the groundwater. Metals were found above Massachusetts standards in surface and subsurface soils. In groundwater, chlorinated and non-chlorinated volatile organics, PAHs, and semi-volatile organics were found to exceed federal Maximum Contaminant Levels (MCLs) or Massachusetts standards.

Human Health Risks for both A7 and A9 were evaluated for current use and for future use. The future use included a residential scenario, which is the most conservative assessment for human health. Risks at both A7 and A9 were unacceptably high under the residential conditions and therefore remediation was required for the surface and subsurface soils. An ecological risk assessment for the two areas concluded that the level of contamination would not be likely to adversely affect terrestrial or aquatic wildlife.

The focused FS evaluated a presumptive containment remedy for the landfill and an additional soil removal for A–9.

OU1 and OU2 ROD Findings

A7 and A9 were divided into two remedial action operable units. The first Operable Unit (OU) was a source control OU. Lab waste and its contaminated soil was excavated and transported off-Site to a licensed hazardous waste facility. Solid waste and contaminated soil from A7 and A9 was used as subgrade as part of the construction of the Resource Conservation and Recovery Act (RCRA) Subtitle C multi-layer landfill cap at A7. The ROD required the Army to cover the landfill and to perform landfill cap operation and maintenance (O&M), groundwater and landfill gas monitoring, and to conduct 5 year reviews of the Site.

The second Operable Unit was a management of migration OU groundwater investigation for A7 and A9. Groundwater contamination at A–9 was found to be attenuating and no unacceptable human health or ecological risk was found. However, this No Further Action ROD included the commitment to long term monitoring in groundwater at A7 as required by the Final Operations & Maintenance Plan dated 1997 (semi-annual for VOCs, pesticides, & metals) as part of the remedy included in the Source Control ROD of 1995 for OU 1 and OU2.

RI/FS Results and ROD Findings for OU3(A–4), OU4 (P–11 and P–12), and OU5 (A12, P–36 & P–37)

Site investigation and remedial investigation (SI/RI) activities were performed in 1992 and 1993. Field work and laboratory analysis of additional samples to further characterize the areas of concern were performed in 1996. Low levels of contamination were found in all media after removal actions were performed at some areas, however, no groundwater plumes were found. None of the areas of concern in OUs 3, 4, or 5 posed unacceptable risks to human health or the environment. No Action RODs were signed for each of the OUs in 1996 and 1997.

Response Actions for OU1 and 2 (The Only Remedial Action (RA) Performed at the Site)

In 1995 a Record of Decision (ROD) documented the remedial action for the Source Control OU.

The major components include:

- Excavation and off-Site treatment and disposal of laboratory waste at A7;
- Excavation of contaminated soil from A9 and consolidation at A7;
- Consolidation of contaminated soil and solid waste at A7 to within the limits of the landfill cap;
- Construction of a Resource Conservation and Recovery Act (RCRA) Subtitle C landfill cap at A7;
- Environmental monitoring and operation and maintenance (O&M) at A7; Institutional controls at A7 to limit future use and to restrict access and required five-year reviews at A7.

In 1997 the Record of Decision for No Action Under CERCLA for A4 and the Management of Migration OU at A7 and A9 was signed. This ROD included the commitment to long term monitoring as required by the Final Operations & Maintenance Plan 1997 (semi-annual for VOCs, pesticides & metals) of groundwater at A7 as part of the remedy included in the Source Control ROD of 1995 for OU1 and OU2. Groundwater contamination at A–9 was found to be attenuating. No unacceptable human health or ecological risk was found.

The only Remedial Action (RA) at the Site (capping at OU1) began on July 31, 1996 and ended on October 27, 1997. RA cleanup activities at the Site were consistent with the NCP, the ROD, and were protective of human health and the environment. Remedial Design/Remedial Action (RD/RA) plans for all phases of construction included a Quality Assurance Project Plan (QAPP) and incorporated all EPA and State quality assurance and quality control procedures and protocols during the RA. EPA analytical methods were used for the confirmatory and monitoring samples taken during all RA activities. EPA determined, in October 1997, that the analytical results were accurate to the degree necessary to assure satisfactory execution of the RA. The results showed that the cleanup standards were met and were consistent with the ROD and the remedial design plans and specifications.

Operations & Maintenance

The Army is responsible for conducting long-term maintenance and upkeep of the landfill cover and for monitoring landfill gas, and groundwater in accordance with the approved Long-Term Operation, Maintenance, and Monitoring Plan.

Five-Year Reviews

CERCLA requires a five-year review of all sites with hazardous substances remaining above the health-based levels for unrestricted use of the site. Since the containment of hazardous materials within the landfill, the five-year review process will be used to ensure that human health and the environment remain protected in the future. The first five-year review was performed in 2001 by the Army. EPA concurred with the Army's assessment that the remedies remain protective of human health and the environment. For future five-year reviews, EPA will review the Army's annual reports and consolidated five-year review on the operation and maintenance of A7, and perform a five-year review inspection. The Army will provide the next five-year review prior to July 8, 2006.

Community Involvement

Public participation activities have been satisfied as required in CERCLA section 113(k), 42 U.S.C. 9613(k), and CERCLA section 117, 42 U.S.C. 9617. Documents in the deletion docket which EPA relied on for recommendation of

the deletion from the NPL are available to the public in the information repository noted above.

Quarterly, informal public meetings were held in the surrounding towns from 1991 to December 2000 and prior to and after each remedial action. Representatives from EPA, MADEP, and the Army with their consultants and contractors were present. These meetings proved to be extremely helpful in providing the public, especially the residents of adjoining neighborhoods, with important information regarding activities associated with all the investigations and each remedial action. These meetings were also particularly useful for the agencies and the Army in hearing and addressing the residents' concerns regarding on-site activities. The Army plans to continue these informal meetings to announce the findings of five-year reviews. The most recent meeting was held on November 14, 2001.

V. Deletion Action

The EPA, with concurrence from the Commonwealth of Massachusetts, has determined that all appropriate responses under CERCLA have been completed, and that no further response actions under CERCLA are necessary. Therefore, EPA is deleting the Site from the NPL.

Because EPA considers this action to be noncontroversial and routine, EPA is taking it without prior publication of a notice of intent to delete. This action will become effective January 29, 2002 unless EPA receives adverse comments by December 31, 2001. If adverse comments are received within the 30-day public comment period, EPA will publish a timely withdrawal of this direct final notice of deletion before the effective date of the deletion and it will not take effect. EPA will prepare a response to comments, as approriate, and continue with the traditional deletion process on the basis of the notice of intent to delete and the comments already received. There will be no additional opportunity to comment. If EPA receives no adverse comment(s), this deletion will become effective January 29, 2002.

List of Subjects in 40 CFR Part 300

Environmental protection, Air pollution control, Chemicals, Hazardous waste, Hazardous substances, Intergovernmental relations, Penalties, Reporting and recordkeeping requirements, Superfund, Water pollution control, Water supply.

Dated: November 15, 2001.

Robert W. Varney,

Regional Administrator, U.S. EPA-New England.

For the reasons set out in this document, 40 CFR part 300 continues to read as follows:

PART 300—[Amended].

1. The authority citation for part 300 continues to read as follows:

Authority: 33 U.S.C. 1321(c)(2); 42 U.S.C. 9601–9657; E.O. 12777, 56 FR 54757, 3 CFR, 1991 Comp.; p. 351; E.O. 12580, 52 FR 2923, 3 CFR, 1987 Comp., p. 193.

Appendix B—[Amended]

2. Table 2 of Appendix B to part 300 is amended under Fort Devens-Sudbury Training Annex Superfund Site by removing the entry for ''Fort Devens-Sudbury Training Annex, Middlesex County.''

[FR Doc. 01–29552 Filed 11–29–01; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 20

[CC Docket No. 94–102; FCC 01–293]

Wireless E911 Service, Petition of City of Richardson, TX

AGENCY: Federal Communications Commission.

ACTION: Final rule; announcement of effective date.

SUMMARY: The Commission has received Office of Management and Budget (OMB) approval for revised paperwork information burdens to OMB No. 3060–0813, contained in the Order regarding a petition for clarification and/or declaratory ruling filed by the City of Richardson, Texas. The effective date for revisions made certain rule sections was held in abeyance until OMB approval for these revised burdens was granted. This document is needed to notify the public that OMB has approved these burdens and to announce that these rules are now effective.

DATES: The revision to 47 CFR 20.18(j) published at 66 FR 55618 (November 2, 2001) is effective November 30, 2001.

FOR FURTHER INFORMATION CONTACT: Jane Phillips, 202–418–1310.

SUPPLEMENTARY INFORMATION: The Federal Communications Commission has received OMB approval for the following public information collection pursuant to the Paperwork Reduction Act of 1995, Public Law 96–511. The rules adopted in this proceeding (*see* 66 FR 55618, November 2, 2001) are therefore effective with the publication of this announcement in the **Federal Register**. An agency may not conduct or sponsor a collection of information unless it displays a currently valid control number. Notwithstanding any other provisions of law, no person shall be subject to any penalty for failing to comply with a collection of information subject to the Paperwork Reduction Act (PRA) that does not display a valid control number. Questions concerning the OMB control numbers and expiration dates should be directed to Judy Boley, Federal Communications Commission (202) 418–0214.

Federal Communications Commission

OMB Control No.: 3060–0813.
Expiration Date: 5/31/02.
Title: Revision of the Commission's Rules to Ensure Compatibility with Enhanced 911 Calling Systems.
Form No.: N/A.
Estimated Annual Burden: 198,200 burden hours annually; 1 hour per response; 42,324 respondents.
Description: The demonstration of E911 capability will be required only when a requesting PSAP's E911 capability is challenged by the wireless carrier, and will be used by the carrier to verify that the requesting PSAP is in reality capable of receiving and using E911 data and that the carrier must therefore provide E911 service.

Federal Communications Commission.

William F. Caton,

Deputy Secretary.

[FR Doc. 01–29806 Filed 11–29–01; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Parts 54 and 69

[CC Docket Nos. 96–45, 98–77, 98–166 and 00–256; FCC 01–304]

Multi-Association Group (MAG) Plan for Regulation of Interstate Services of Non-Price Cap Incumbent Local Exchange Carriers and Interexchange Carriers; Federal-State Joint Board on Universal Service.

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: In this document, the Commission modifies its rules to reform the interstate access charge and universal service support system for incumbent local exchange carriers

subject to rate-of-return regulation (non-price cap or rate-of-return carriers). The Commission's actions are based on pending Commission proposals that build on interstate access charge reforms previously implemented for price cap carriers, the record developed in the above-stated proceedings, and consideration of the Multi-Association Group (MAG) plan.

DATES: Effective December 31, 2001, except for the amendments to §§ 54.307(b) and (c), and §§ 54.315(a) and (f)(1) through (f)(4), 54.902(a) through (c), 54.903(a)(1) through (a)(4), 54.904(a), (b), and (d) which contain information collection requirements that have not been approved by the Office of Management and Budget (OMB). The Commission will publish a document in the **Federal Register** announcing the effective date of those sections.

FOR FURTHER INFORMATION CONTACT: William Scher, Attorney, Common Carrier Bureau, Accounting Policy Division, (202) 418–7400; Douglas Slotten, Attorney, Common Carrier Bureau, Competitive Pricing Division, (202) 418–1520.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Second Report and Order and Further Notice of Proposed Rulemaking in CC Docket Nos. 00–256, Fifteenth Report and Order in CC Docket No. 96–45, and Report and Order in CC Docket No. 98–77 and 98–166 released on November 8, 2001. The full text of this document is available for public inspection during regular business hours in the FCC Reference Center, Room CY–A257, 445 Twelfth Street, SW., Washington, DC, 20554 or at: *http://hraunfoss.fcc.gov/edocs_public/attachmatch/FCC–01–304A1.doc*.

I. Summary

1. In the Order, we take the following actions to reform the interstate access charge and universal service support system for rate-of-return carriers:

- We increase Subscriber Line Charge (SLC) caps for rate-of-return carriers to the levels established for price cap carriers. The residential and single-line business SLC cap will increase to $5.00 on January 1, 2002, and may increase up to $6.00 on July 1, 2002, and $6.50 on July 1, 2003, subject to a cost review study for the SLC caps of price cap carriers. The multi-line business SLC cap will increase to $9.20 on January 1, 2002. The revised SLC caps, which conform to those already implemented for most subscribers nationwide, will foster efficient competition and greater choice for consumers, while ensuring that SLC rates in rural areas remain affordable and reasonably comparable to those in urban areas. Lifeline support will be increased in an amount equal to any SLC rate increases for low-income subscribers.
- We modify our rules to allow limited SLC deaveraging, which will enhance the competitiveness of rate-of-return carriers by giving them important pricing flexibility. The SLC deaveraging method we adopt combines the safeguards adopted for price cap carriers with the flexibility of the Rural Task Force universal service support disaggregation scheme, in order to address the significant diversity among rate-of-return carriers.
- We find that the Carrier Common Line (CCL) charge, an inefficient cost recovery mechanism and implicit subsidy, should be removed from the common line rate structure. This measure will rationalize the access rate structure and move per-minute switched access rates towards lower, cost-based levels. To replace the CCL charge, a new universal service support mechanism will be implemented beginning on July 1, 2002. The CCL charge will be eliminated as of July 1, 2003, when SLC caps are scheduled to reach their maximum levels.
- We adopt measures to reform the local switching and transport rate structure. In particular, we shift the non-traffic sensitive costs of local switch line ports to the common line category, and reallocate the remaining costs contained in the Transport Interconnection Charge (TIC) to other access rate elements. These measures align the rate structure more closely with the manner in which costs are incurred and reduce per-minute switched access charges.
- We do not adopt proposals to prescribe a single, target rate for per-minute charges, either on an optional or a mandatory basis. The reforms that we adopt in this Order will reduce per-minute charges for all rate-of-return carriers, while giving them the flexibility to establish rates based on their own costs in the areas they serve.
- We address proposals to modify the rate structure for general support facilities (GSF) costs, marketing expenses, and special access services. We generally conclude that a different approach is warranted from that adopted for price cap carriers to avoid imposing undue administrative burdens on small local telephone companies serving rural and high-cost areas.
- We create a new universal service support mechanism, Interstate Common Line Support, to convert implicit support in the access rate structure to explicit support that is available to all eligible telecommunications carriers. Interstate Common Line Support will recover any shortfall between the allowed common line revenues of rate-of-return carriers and their SLC revenues, thereby replacing the CCL charge. The new support mechanism will ensure that changes in the rate structure do not affect the overall recovery of interstate access costs by rate-of-return carriers serving high-cost areas.
- We do not adopt MAG proposals to impose new requirements on interexchange carriers regarding optional calling plans, minimum monthly fees, and pass-through of savings from lower access rates. Among other things, we conclude that these requirements are unnecessary, inconsistent with our deregulatory approach to the interexchange services market, and would entail undue administrative costs and burdens.
- We streamline the rules for the introduction of new switched access services by extending to rate-of-return carriers the same flexibility that price cap carriers now have, with the exception of certain cost support and notice requirements.
- We terminate the proceeding in CC Docket No. 98–166 for prescription of the authorized rate of return, which was set at 11.25 percent in 1990.

II. Procedural Issues

A. Ex Parte Presentations

2. This is a permit but disclose rulemaking proceeding. Ex parte presentations are permitted, except during the Sunshine Agenda period, provided that they are disclosed as provided in the Commission's rules.

B. Final Regulatory Flexibility Act

3. As required by the Regulatory Flexibility Act (RFA), an Initial Regulatory Flexibility Analysis (IRFA) was incorporated into the *MAG NPRM* (66 FR 7725, January 25, 2001). An IRFA also was incorporated into the *1998 NPRM* (63 FR 38774, July 20, 1998), in CC Docket No. 98–77. The Commission sought written public comment on the proposals in the 1998 NPRM and on the MAG plan, including comment on the IRFAs. This present Final Regulatory Flexibility Analysis (FRFA) conforms to the RFA, as amended. To the extent that any statement in this FRFA is perceived as creating ambiguity with respect to our rules or statements made in the Order, the rules and statements set forth in the Order shall be controlling.

1. Need for, and Objectives of, the Rules

4. In the Order, the Commission modifies its interstate access charge and

universal service support system for incumbent local exchange carriers (LECs) subject to rate-of-return regulation. Consistent with the mandate of the 1996 Act, this Order is designed to foster competition and efficient pricing in the market for interstate access services, and to create universal service mechanisms that will be secure in an increasingly competitive environment. By simultaneously removing implicit support from the rate structure and replacing it with explicit, portable support, this Order will provide a more equal footing for competitors in local and long distance markets, while ensuring that consumers in all areas of the country, especially those living in high-cost, rural areas, have access to telecommunications services at affordable and reasonably comparable rates. This Order also is tailored to the needs of small and mid-sized local telephone companies serving rural and high-cost areas, and will help provide certainty and stability for such carriers, encourage investment in rural America, and provide important consumer benefits.

5. Examination of the record in this proceeding demonstrates the need for interstate access charge and universal service reform for rate-of-return carriers. Rate-of-return carriers receive implicit support for universal service from various sources, including the interstate access rate structure. For example, recovery of non-traffic sensitive costs through per-minute rates creates an implicit support flow from high-to low-volume users of interstate long distance service. Implicit support is incompatible with a competitive market for local exchange and exchange access services. As the Commission noted in 1997, ''where rates are significantly above cost, consumers may choose to bypass the incumbent LEC's switched access network, even if the LEC is the most efficient provider. Conversely, where rates are subsidized (as in the case of consumers in high-cost areas), rates will be set below cost and an otherwise efficient provider would have no incentive to enter the market.'' Rate-of-return carriers have expressed particular concern that high per-minute charges may place them at a disadvantage in competing for high-volume customers, jeopardizing an important source of revenue. In addition, higher rates and implicit subsidies may discourage efficient local and long distance competition in rural areas and limit consumer choice. Although there may not be significant competition in many high-cost, rural areas, rate-of-return carriers are not insulated from competitive pressures.

6. By rationalizing the rate structure for recovery of interstate loop costs, this Order will foster competition for residential subscribers in rural areas by facilities-based carriers. By reducing per-minute switched access rates towards cost-based levels, it will enhance incentives for interexchange carriers to originate service in rural areas and facilitate long distance toll rate averaging. To a large extent, these modifications already have been implemented for the vast majority of subscribers nationwide.

7. At the same time, this Order is tailored to the specific challenges faced by small carriers serving rural and high-cost areas. Although per-minute switched access charges will be reduced for all rate-of-return carriers, they will retain the flexibility to establish rates based on their own costs in the areas they serve, rather than being forced to conform to a prescribed target rate. Rate-of-return carriers will continue to be permitted to set rates based on the authorized rate of return of 11.25 percent. And a new, uncapped universal service support mechanism will provide certainty and stability by ensuring that the rate structure modifications adopted do not affect overall recovery of interstate access costs by rate-of-return carriers. The Order adopts a cautious approach which rationalizes the access rate structure and converts identifiable implicit subsidies to explicit support, without endangering this important revenue stream for rate-of-return carriers.

2. Summary of Significant Issues Raised by the Public Comments in Response to the IRFA

8. The Multi-Association Group (MAG), which is comprised of the National Rural Telecom Association, National Telephone Cooperative Association, Organization for the Promotion and Advancement of Small Telecommunications Companies, and the United States Telecom Association, argued that adoption of its comprehensive proposal for regulatory reform for rate-of-return carriers would benefit small business entities, including small incumbent LECs, interexchange carriers, and new entrants. According to the MAG, its plan would permit small rate-of-return carriers to control their administrative and regulatory burdens by permitting them to analyze and select the type of regulation that best suits their situation. The MAG also asserted that of a modified version of its plan would introduce more uncertainty for small carriers, but it did not provide support for this assertion. However, commenters have raised significant concerns about certain features of the MAG plan, and the Commission was persuaded that some of these concerns have merit, as discussed below.

9. The Commission received a Congressional inquiry from Congressman John D. Dingell, asking that the Commission devote significant staff resources to the MAG proceeding, in particular, and to understanding the unique challenges of service in high-cost areas, in general. The Chairman responded to Congressman Dingell by letter, noting that the Commission has taken numerous measures to lessen the regulatory burdens of small local telephone companies, and is committed to continuing the examination of our rules and processes to ensure that small local telephone companies are provided with appropriate regulatory flexibility. The response also stated that the Commission has attempted to scrutinize carefully the potential impact of proposed regulations on small incumbent telephone companies.

10. The Commission received a Congressional inquiry from Senators Thomas A. Daschle, Craig Thomas, Blanche Lambert Lincoln, Tim Johnson, Tom Harkin, Charles E. Grassley, Byron L. Dorgan, Kent Conrad, and Max S. Baucus, noting that significant legal and market changes had occurred since the MAG plan was developed, including two court decisions regarding universal service. The letter requested that the Commission delay its final decision in the MAG proceeding until all interested parties, including members of Congress, have had an opportunity to comment on any new proposal that the Commission might consider. The Chairman responded to this inquiry by letter, stating that it is the Commission's duty, pursuant to the Administrative Procedures Act, to consider the extensive input received from all interested parties regarding the MAG proposal. The Chairman's response noted that all interested parties have had a substantial opportunity to comment on the MAG plan and on other, related Commission proposals that build on prior reforms for large carriers. The response stated that it was important to proceed expeditiously with access charge and universal service reform for rate-of-return carriers, while continuing to explore other issues raised by the MAG proposal. The Chairman's response noted that a substantial number of interested parties had raised concerns about the wholesale adoption of the MAG proposal and had suggested possible modifications to it. The

response also agreed that it is important that the Commission take into account recent court decisions relevant to interpretation of the universal service provisions of the Act.

11. The Commission also received Congressional inquiries from Senator Conrad Burns and Congressman Dennis Rehberg, Congressman Douglas K. Bereuter, Congressman John E. Sununu, and Congressman Lee Terry regarding the Commission's consideration of interstate access charge and universal service reform for rate-of-return carriers. They generally expressed concerns about the potential impact of reform on rural telecommunications customers and the companies that serve them, and urged the Commission to seek additional comment before adopting measures other than those proposed in the MAG plan.

12. The Commission believes that it is important to proceed expeditiously with access charge and universal service reform for rate-of-return carriers, while continuing to explore other issues raised by the MAG proposal. The Commission has adopted a cautious approach to reform. The new, uncapped support mechanism it creates will ensure that rate structure changes do not affect small carriers' overall recovery of the costs of interstate access service. In addition, the Order permits carriers to continue to set rates based on the authorized rate of return of 11.25 percent. These measures will promote regulatory stability and encourage investment in rural America. The Commission also is seeking additional comment on a number of issues, including the potential impact of modifications to Long Term Support on membership in the pools, the MAG's incentive regulation proposal for small carriers, and on other means of providing opportunities for rural telephone companies to increase their cost efficiency in ways that will benefit carriers and the communities they serve.

13. The Commission also received general comments related to the needs of small local telephone companies. Examination of the record indicates that rate-of-return carriers are typically small, rural telephone companies concentrated in one area. They generally have higher operating and equipment costs than large, price cap carriers due to lower subscriber density, smaller exchanges, and limited economies of scale. They also rely more heavily on revenues from interstate access charges and universal service support. Numerous commenters argued that, although such carriers may incur costs in the same manner as large carriers, their size, diversity, and regulatory history warrant special consideration in adopting interstate access charge and universal service reforms. The Commission's actions in response to such concerns are discussed in detail below. As an example, the Commission does not require small carriers to conduct cost studies to determine the portion of local switching costs attributable to line ports. Rather, we adopt a proxy of 30 percent.

3.Description and Estimate of the Number of Small Entities to Which Rules Will Apply

14. The RFA directs agencies to provide a description of, and, where feasible, an estimate of the number of small entities that may be affected by the rules adopted herein. The RFA generally defines ''small entity'' as having the same meaning as the term ''small business,'' ''small organization,'' and ''small governmental jurisdiction.'' In addition, the term ''small business'' has the same meaning as the term ''small business concern'' under the Small Business Act, unless the Commission has developed one or more definitions that are appropriate to its activities. Under the Small Business Act, a ''small business concern'' is one that: (1) Is independently owned and operated; (2) is not dominant in its field of operation; and (3) meets any additional criteria established by the SBA.

15. We have included small incumbent carriers in this RFA analysis. As noted above, a ''small business'' under the RFA is one that, *inter alia,* meets the pertinent small business size standard (*e.g.,* a telephone communications business having 1,500 or fewer employees), and ''is not dominant in its field of operation.'' The SBA's Office of Advocacy contends that, for RFA purposes, small incumbent carriers are not dominant in their field of operation because any such dominance is not ''national'' in scope. We have therefore included small incumbent carriers in this RFA analysis, although we emphasize that this RFA action has no effect on the Commission's analyses and determinations in other, non-RFA contexts.

16. *Local Exchange Carriers.* Neither the Commission nor the SBA has developed a specific definition for small providers of local exchange services. The closest applicable definition under the SBA rules is for telephone communications companies other than radiotelephone (wireless) companies. According to the most recent *Trends in Telephone Service* data, 1,335 incumbent carriers reported that they were engaged in the provision of local exchange services. We do not have data specifying the number of these carriers that are either dominant in their field of operations, are not independently owned and operated, or have more than 1,500 employees, and thus are unable at this time to estimate with greater precision the number of local exchange carriers that would qualify as small business concerns under the SBA's definition. Of this number, 13 entities are price cap carriers not subject to rules adopted herein. Consequently, we estimate that 1,335 or fewer providers of local exchange service are small entities that may be affected by the rules.

17. *Competitive Local Exchange Carriers.* Neither the Commission nor the SBA has developed a specific definition of small providers of local exchange service. The closest applicable definition under SBA rules is for telephone communications companies other than radiotelephone (wireless) companies. According to the Commission's *Trends in Telephone Service* data, 349 companies reported that they were engaged in the provision of either competitive access provider services or competitive LEC services. The Commission does not have data specifying the number of these carriers that are either dominant in their field of operations, are not independently owned and operated, or have more than 1,500 employees, and thus is unable at this time to estimate with greater precision the number of competitive LECs that would qualify as small business concerns under the SBA's definition. Consequently, the Commission estimates that fewer than 349 providers of local exchange service are small entities that may be affected by the rules.

18. *Interexchange Carriers.* Neither the Commission nor the SBA has developed a definition of small entities specifically applicable to providers of interexchange services. The closest applicable definition under the SBA rules is for telephone communications companies other than radiotelephone (wireless) companies. According to the most recent *Trends in Telephone Service* data, 204 carriers reported that their primary telecommunications service activity was the provision of interexchange services. We do not have data specifying the number of these carriers that are not independently owned and operated or have more than 1,500 employees, and thus are unable at this time to estimate with greater precision the number of IXCs that would qualify as small business concerns under the SBA's definition. Consequently, we estimate that there are

204 or fewer small entity IXCs that may be affected by the rules.

19. *Competitive Access Providers.* Neither the Commission nor the SBA has developed a definition of small entities specifically applicable to competitive access services providers (CAPs). The closest applicable definition under the SBA rules is for telephone communications companies other than radiotelephone (wireless) companies. According to the most recent Trends in Telephone Service data, 349 CAPs/competitive local exchange carriers and 60 other local exchange carriers reported that they were engaged in the provision of competitive local exchange services. We do not have data specifying the number of these carriers that are not independently owned and operated, or have more than 1,500 employees, and thus are unable at this time to estimate with greater precision the number of CAPs that would qualify as small business concerns under the SBA's definition. Consequently, we estimate that there are 349 or fewer small entity CAPs and 60 or fewer other local exchange carriers that may be affected.

20. *Wireless Telephony.* Neither the Commission nor the SBA has developed a definition of small entities specifically applicable to wireless telephony including cellular, personal communications service (PCS) and Specialized Mobile Radio (SMR) telephony carriers. Therefore, the applicable definition of small entity is the definition under the SBA rules applicable to radiotelephone (wireless) companies. This provides that a small entity is a radiotelephone company employing no more than 1,500 persons. According to the most recent Trends in Telephone Report data, 806 carriers reported that they were engaged in the provision of either cellular service, PCS services, or SMR services, which are placed together in the data. Of these 806 carriers, 323 reported that they have 1,500 or fewer employees. We do not have data specifying the number of these carriers that are not independently owned and operated or have more than 1,500 employees, and thus are unable at this time to estimate with greater precision the number of wireless telephone carriers that would qualify as small business concerns under the SBA's definition. Consequently, we estimate that there are 806 or fewer small wireless telephony service carriers that may be affected.

21. The broadband PCS spectrum is divided into six frequency blocks designated A through F, and the Commission has held auctions for each block. The Commission defined ''small entity'' for Blocks C and F as an entity that has average gross revenues of less than $40 million in the three previous calendar years. For Block F, an additional classification for ''very small business'' was added and is defined as an entity that, together with their affiliates, has average gross revenues of not more than $15 million for the preceding three calendar years. These regulations defining ''small entity'' in the context of broadband PCS auctions have been approved by the SBA. No small businesses within the SBA-approved definition bid successfully for licenses in Blocks A and B. There were 90 winning bidders that qualified as small entities in the Block C auctions. A total of 93 small and very small business bidders won approximately 40 percent of the 1,479 licenses for Blocks D, E, and F. Based on this information, we conclude that the number of small broadband PCS licensees will include the 90 winning C Block bidders and the 93 qualifying bidders in the D, E, and F blocks, for a total of 183 small entity PCS providers as defined by the SBA and the Commission's auction rules.

22. The Commission awards bidding credits in auctions for geographic area 800 MHz and 900 MHz SMR licenses to firms that had revenues of no more than $15 million in each of the three previous calendar years. In the context of both the 800 MHz and 900 MHz SMR, a definition of ''small entity'' has been approved by the SBA. These fees apply to SMR providers in the 800 MHz and 900 MHz bands that either hold geographic area licenses or have obtained extended implementation authorizations. We do not know how many firms provide 800 MHz or 900 MHz geographic area SMR service pursuant to extended implementation authorizations, nor how many of these providers have annual revenues of no more than $15 million.

23. *Rural Radiotelephone Service.* The Commission has not adopted a definition of small entity specific to the Rural Radiotelephone Service. A significant subset of the Rural Radiotelephone Service is the Basic Exchange Telephone Radio Systems (BETRS). We will use the SBA's definition applicable to radiotelephone companies, *i.e.,* an entity employing no more than 1,500 persons. There are approximately 1,000 licensees in the Rural Radiotelephone Service, and we estimate that almost all of them qualify as small entities under the SBA's definition.

24. *Fixed Microwave Services.* Microwave services include common carrier, private-operational fixed, and broadcast auxiliary radio services. At present, there are approximately 22,015 common carrier fixed licensees and 61,670 private operational-fixed licensees and broadcast auxiliary radio licensees in the microwave services. The Commission has not defined a small business specifically with respect to microwave services. For purposes of this FRFA, we utilize the SBA's definition applicable to radiotelephone companies—*i.e.,* an entity with no more than 1,500 persons. We estimate, for this purpose, that all of the Fixed Microwave licensees (excluding broadcast auxiliary licensees) would qualify as small entities under the SBA definition for radiotelephone companies.

25. *39 GHz Licensees.* The Commission defined ''small entity'' for 39 GHz licenses as an entity that has average gross revenues of less than $40 million in the three previous calendar years. An additional classification for ''very small business'' was added and is defined as an entity that, together with their affiliates, has average gross revenues of not more than $15 million for the preceding three calendar years. These regulations defining ''small entity'' in the context of 39 GHz auctions have been approved by the SBA. The auction of the 2,173 39 GHz licenses began on April 12, 2000 and closed on May 8, 2000. The 18 bidders who claimed small business status won 849 licenses.

4. Description of Projected Reporting, Recordkeeping, and Other Compliance Requirements

26. Pursuant to the Order, all rate-of-return carriers will be required to modify their access tariffs to comply with the new SLC caps, to become effective on January 1, 2002, and on July 1, 2002, and July 1, 2003, subject to a cost review proceeding for the SLC caps of price cap carriers. This function would be performed by the National Exchange Carrier Association (NECA) for those carriers that participate in the NECA common line pool, as most small carriers do. Those rate-of-return carriers filing their own tariffs also would have to make a tariff filing to reflect the access charge modifications.

27. The CCL charge will be removed from the common line rate structure of rate-of-return carriers as of July 1, 2003. From July 1, 2002 to June 30, 2003, rate-of-return carriers may impose a transitional CCL charge on all switched access minutes to recover, for each residential and single-line business line in their study area, the difference between the residential SLC and the lesser of $6.50 or their average cost per line.

28. All rate-of-return carriers will be required to modify their access tariffs by reallocating line port costs from local switching to the common line category. To ease the burden of implementing this rate structure modification on small rate-of-return carriers, we will permit them to shift 30 percent of their local switching costs to the common line category in lieu of conducting a cost study. Carriers electing this cost study approach must base their costs studies on geographically-averaged costs, and submit the cost study in support of the tariff filing relying on the cost study. Once a rate-of-return carrier has performed a cost study to support its tariff, it may rely on that cost study for subsequent tariff filings.

29. We require rate-of-return carriers to recover through a separate end-user charge the costs of ISDN line ports and line ports associated with other services that exceed the costs of a line port used for basic analog service.

30. We require rate-of-return carriers to reallocate the costs recovered from the transport interconnection charge (TIC) to all other access categories. NECA will be required to establish for carriers that participated in the NECA pool during the tariff year ending June 30, 2001, an individual carrier dollar limit based on its traffic volumes and the TIC rate for the twelve-month period ending June 30, 2001. Each carrier that was not in the pool during the tariff year ending on June 30, 2001, must determine its TIC limit and report it to NECA for purposes of administering future pool membership changes.

31. We permit, but do not require, rate-of-return carriers to establish the following local switching and transport rate elements: A flat charge for dedicated trunk port costs; a flat charge for the costs of DS1/voice grade multiplexers associated with terminating dedicated trunks at analog switches; a per-minute charge for shared trunk ports and any associated DS1/voice grade multiplexer costs; a flat charge for the costs of trunk ports used to terminate dedicated trunks on the serving wire center side of the tandem switch; individual charges for multiplexer costs associated with tandem switches; and a separate per-message call setup charge.

32. We require rate-of-return carriers that use general purpose computers to provide non-regulated billing and collection services to allocate a portion of their GSF costs to the billing and collection category. To accommodate the fact that rate-of-return carriers are not required to maintain separate land, buildings, office furniture, and general purpose computer investment accounts, we only require these carriers to apply the modified Big Three Expense Factor used by price cap carriers to the general purpose computer investment detail to determine the amount to be allocated to billing and collection. Carriers also may use the general purpose computer investment amount they develop for a period of three years. Carriers whose billing and collection activities are performed exclusively by service bureaus will not be subject to these requirements. Many small carriers use service bureaus exclusively to perform billing and collection services and, therefore, will not be affected by these requirements.

33. Rate-of-return carriers electing to disaggregate their Interstate Common Line Support must submit a detailed description of their disaggregation plan, including information that will enable competitors to verify and reproduce the algorithm used to determine zone support levels, and a geographic description and map of each such zone with the Commission, the relevant state regulatory agency, and USAC. This is not a new compliance requirement because carriers would have to file the above-stated materials in order to disaggregate other forms of high-cost support pursuant to the *Rural Task Force Order* (66 FR 30080, June 5, 2001).

34. Rate-of-return carriers seeking Interstate Common Line Support will be required to file on an annual basis their projected common line revenue requirement for each study area in which they operate. Average schedule companies will not be required to submit common line revenue requirements, but instead will be required to submit information that USAC determines is necessary in order for it to calculate common line revenue requirements for average schedule companies. To enable USAC to begin distributing Interstate Common Line Support to carriers on July 1, 2002, carriers will be required to submit projected common line revenue requirements for July 1, 2002, to June 30, 2003, by March 31, 2002. Carriers will be permitted to submit corrections to their projected common line revenue requirements until April 10, 2002. After April 10, 2002, any corrections to projected common line revenue requirements shall be made in the form of true-ups using actual cost data. Rate-of-return carriers will be required to submit projected common line revenue requirements for subsequent years on the same schedule.

35. To ensure that Interstate Common Line Support amounts reflect a carrier's actual common line costs, rate-of-return carriers will be required to update projected common line cost data with actual costs on an annual basis. Average schedule companies will not be required to calculate or submit their actual costs. Rate-of-return carriers also will be permitted to update their actual cost data on a quarterly basis.

36. Consistent with rules adopted in the *Rural Task Force Order,* rate-of-return carriers will file their line counts with USAC, by disaggregation zone and customer class, in accordance with the schedule in §§ 36.611 and 36.612 of our rules. Line count data for rural rate-of-return carrier study areas in which a competitive eligible telecommunications carrier has not begun providing service will be filed on an annual basis. Line count data will be filed on a regular quarterly basis upon competitive entry in rural rate-of-return carrier study areas. Non-rural rate-of-return carriers currently are required to file line count data on a quarterly basis regardless of whether a competitor is present and that requirement will not change. Competitive eligible telecommunications carriers will file their line counts with USAC, by disaggregation zone and customer class on a quarterly basis, in accordance with the schedule in § 54.307 of our rules.

37. Carriers seeking Interstate Common Line Support must file a certification with the Commission and USAC. These requirements will create additional reporting requirements, but such reporting is necessary to ensure compliance with section 254(e) of the Act.

38. We require all incumbent LECs, including rate-of-return carriers, to recover universal service contributions only through end user charges. Rate-of-return carriers that choose to impose end-user charges for the recovery of universal service contributions must make corresponding reductions in their access charges to avoid double recovery.

5. Steps Taken To Minimize Significant Economic Impact on Small Entities, and Significant Alternatives Considered

39. The Commission has taken numerous steps to minimize significant economic impact on small entities of the interstate access charge and universal service reforms adopted in this Order. Overall, the Commission's approach is tailored to the specific challenges faced by small local telephone companies serving rural and high-cost areas. Although per-minute switched access charges will be reduced for all rate-of-return carriers, these carriers will retain the flexibility to establish rates based on their own costs in the areas they serve, rather than being forced to conform to a prescribed target rate. Rate-of-return

carriers will continue to be permitted to set rates based on the authorized rate of return of 11.25 percent. And the new, uncapped support mechanism created by this Order will provide certainty and stability by ensuring that the rate structure modifications we adopt do not affect overall recovery of interstate access costs. The Order adopts a cautious approach which rationalizes the access rate structure and converts identifiable implicit subsidies to explicit support, without endangering this important revenue stream for rate-of-return carriers.

40. The Commission also has taken steps to minimize the administrative burdens imposed on small carriers as a result of access charge and universal service reform. The Order does not create a separate non-primary residential line SLC cap. Instead, it applies the same SLC cap to primary and non-primary residential lines, concluding that this approach will simplify the common line rate structure and avoid the administrative costs associated with administering the distinction. The Order also provides that a separate cost showing to justify residential and single-line business SLC cap increases above $5.00 will not be required for rate-of-return carriers, concluding that such a requirement is unnecessary and would create undue administrative burdens. The Order provides that rate-of-return carriers may deaverage SLC rates in accordance with universal service support disaggregation plans established pursuant to the *Rural Task Force Order,* a measure which will minimize administrative burdens on small carriers, as well as confusion among competitive carriers, by ensuring that carriers do not have multiple overlapping zones within their services for universal service support and SLC rates, as well as providing the flexibility necessary to accommodate the diversity among small local telephone companies.

41. To ease the burden on small local telephone companies of reallocating line port costs from local switching to the common line category, carriers will be permitted to shift 30 percent of their local switching costs to the common line category in lieu of conducting a cost study. A carrier conducting a cost study may use the results in future tariff filings.

42. The Order permits, but does not require, rate-of-return carriers to establish a number of local switching and transport rate elements, concluding that these rate structure modifications should be optional to avoid undue administrative burdens on small rate-of-return carriers, and to allow carriers to make individual determinations as to whether the costs of establishing new rate elements are warranted by the potential efficiency gains.

43. To accommodate the fact that rate-of-return carriers are not required to maintain the account detail that provides separate land, buildings, office furniture, and general-purpose computer investment detail in order to implement the allocator adopted for price cap carriers for GSF costs, we only require them to apply the modified Big Three Expense Factor used by price cap carriers to general purpose computer investment to determine the amount to be allocated to the billing and collection category, thereby removing costs of non-regulated activities from the regulated rate base. We also permit rate-of-return carriers to use the general purpose computer investment amount they develop for a period of three years. This procedure recognizes the limitations of the accounting system and the administrative burdens of developing further disaggregated investment detail. Rate-of-return carriers whose billing and collection activities are performed exclusively by service bureaus will continue to allocate GSF pursuant to § 69.307(c) of our rules, which specifically addresses the situation in which rate-of-return carriers obtain all billing and collection services they provide to interexchange carriers from unregulated affiliates or from unaffiliated third parties.

44. The Order does not require rate-of-return carriers to recover marketing expenses through the common line recovery mechanisms, reasoning that determination of the costs to be reallocated would be more difficult for small carriers than for large, price cap carriers because small carriers are not required to keep more detailed Class A accounts, and that the costs in question represent only a small portion of rate-of-return carriers' interstate access revenues.

45. The Order generally adopts the same plan for disaggregation and targeting of Interstate Common Line Support as recently adopted for intrastate high-cost support for rural carriers, which will result in minimal additional administrative burdens for carriers that elect to disaggregate their support. Rate-of-return carriers choosing to disaggregate their Interstate Common Line Support must submit a detailed description of the disaggregation plan, including information that will enable competitors to verify and reproduce the algorithm used to determine zone support levels, and a geographic description and map of each such zone with the Commission, the relevant state regulatory agency, and USAC, as discussed further below. These geographic descriptions and zone maps are identical to the ones that carriers must submit pursuant to the requirements of the *Rural Task Force Order,* and thus create no additional reporting requirements.

46. The Order limits as much as possible the filing requirements associated with the new Interstate Common Line Support mechanism, generally requiring carriers to file the minimum amount of information necessary for the proper functioning of the mechanism. Consistent with their average schedule status, average schedule companies will not be required to submit common line revenues requirements, but instead will be required to submit information that USAC determines is necessary in order for it to calculate common line revenue requirements for average schedule companies. Additionally, rural rate-of-return carriers and their competitors are required to file line count data on a quarterly basis only upon competitive entry by an eligible telecommunications carrier. The data that will be filed is similar to data that small carriers already prepare and submit to NECA to enable them to develop rates and operate the common line pool, but differs in important respects. The Order permits small carriers to file quarterly ''true ups'' to enable carriers that experience unforeseen costs to file actual cost data and receive increased per-line amounts of Interstate Common Line Support. The true-up option allows carriers to avoid over-or under-payment and to obtain the correct level of support for their particular revenue requirements.

47. The Order streamlines the part 69 waiver requirement for introduction of new services by rate-of-return carriers, concluding that streamlined filing requirements will eliminate unnecessary administrative burdens on small carriers.

48. The Commission considered a number of significant alternatives in this proceeding. The Commission sought comment on the MAG plan, a comprehensive proposal addressing numerous issues facing rate-of-return carriers, including access charge reform and universal service support, on January 5, 2001, stating its intention to fully and expeditiously consider the MAG plan. Based on the significant concerns about features of the MAG plan raised by commenters, the Commission has determined that adoption of the plan in its entirety would not benefit consumers or service the public interest. For example, the Commission determined that the MAG's

proposals that certain access charge reforms be optional, and that only those carriers electing the MAG incentive regulation proposal be eligible for new, explicit universal service support to replace implicit support in access charges, are inconsistent with the mandate of the 1996 Act and could preclude many small carriers from fully participating in interstate access charge reform, leading to increased access rate disparities among local telephone companies that is not in the public interest.

49. The Commission also has considered proposals for adoption of a target rate for the per-minute access charges of rate-of-return carriers, either on an optional or a mandatory basis. The Commission rejects these proposals and concludes that none of these proposals is supported by cost data and that the non-prescriptive, market-based approach to access charge reform adopted in the Order is more consistent with the competitive and universal service goals of the 1996 Act. The comments filed in this proceeding indicate a wide variation in cost patterns, density, and other operational characteristics among rate-of-return carriers. The access charge reform approach adopted in this Order accommodates this diversity by reallocating costs and removing implicit support to create more efficient rate structures, while allowing carriers to establish rates based on their own costs.

50. The Commission also considered and rejected proposals by some commenters for the establishment of a presubscribed interexchange carrier charge, or PICC, a flat, monthly charge assessed on the interexchange carrier with which an end user is presubscribed, for rate-of-return carriers in lieu of raising SLCs for rate-of-return carriers and/or removing the CCL charge from the common line rate structure. The Commission concludes that a PICC should not be introduced into the common line rate structure of rate-of-return carriers. Establishment of a PICC would force interexchange carriers to recover the cost of the PICC from all of their customers, and contribute to rate disparities between the two groups of carriers, thereby increasing the burden on interexchange carriers of compliance with the geographic rate averaging and rate integration requirements of section 254(g).

51. The Commission also considered and rejected the imposition of a cap on the explicit interstate support mechanism established in this Order, concluding that a cap is not appropriate under the circumstances. Many rate-of-return carriers are small, rural carriers that serve high-cost regions. Small carriers generally are more dependent on their interstate access charge revenue streams and universal service support than large carriers and, therefore, more sensitive to disruption of those streams. The absence of a cap will ensure that the rate structure modifications adopted in this Order do not affect the overall recovery of interstate loop costs by small carriers.

6. Report to Congress

52. The Commission will send a copy of this Order, including this FRFA, in a report to be sent to Congress pursuant to the Congressional Review Act. In addition, the Commission will send a copy of this Order, including this FRFA, to the Chief Counsel for Advocacy of the Small Business Administration. A copy of this Order and FRFA (or summaries thereof) will also be published in the **Federal Register**.

C. Paperwork Reduction Act Analysis

53. The action contained herein has been analyzed with respect to the Paperwork Reduction Act of 1995 and found to impose new or modified reporting and recordkeeping requirements or burdens on the public. Implementation of these new or modified reporting and recordkeeping requirements will be subject to approval by the Office of Management and Budget (OMB) as prescribed by the Act, and will go into effect upon announcement in the **Federal Register** of OMB approval.

III. Ordering Clauses

54. Accordingly, it is ordered that, pursuant to the authority contained in sections 1–4, 201–205, 214, 218–220, 254, 303(r), 403, 405, and 410 of the Communications Act of 1934, as amended, this Second Report and Order in CC Docket No. 00–256, Fifteenth Report and Order in CC Docket No. 96–45, and Report and Order in CC Docket Nos. 98–77 and 98–166 is adopted.

55. Part 54 and 69 of the Commission's rules, are amended as set forth, effective December 31, 2001, except for §§ 54.307(b), 54.307(c), 54.315(a), 54.315(f)(1) through 54.315(f)(4), 54.902(a), 54.902(b), 54.902(c), 54.903(a)(1) through 54.903(a)(4), 54.904(a), 54.904(b), and 54.904(d), which contain information collection requirements that have not been approved by the Office of Management Budget (OMB). The Commission will publish a document in the **Federal Register** announcing the effective date of those sections.

56. It is further ordered that § 65.101 of the Commission's rules is stayed.

57. It is further ordered that the Commission's Consumer Information Bureau, Reference Information Center, shall send a copy of this Order, including the Final Regulatory Flexibility Analysis, to the Chief Counsel for Advocacy of the Small Business Administration.

List of Subjects

47 CFR Part 54

Reporting and recordkeeping requirements, Telecommunications, Telephone.

47 CFR Part 69

Communications common carriers, Reporting and recordkeeping requirements, Telephone.

Federal Communications Commission.

William F. Caton,

Deputy Secretary.

Final Rules

For the reasons discussed in the preamble, the Federal Communications Commission amends 47 CFR parts 54 and 69 as follows:

PART 54—UNIVERSAL SERVICE

1. The authority citation continues to read as follows:

Authority: 47 U.S.C. 1, 4(i), 201, 205, 214, and 254 unless otherwise noted.

2. Amend § 54.5 by adding the following definition in alphabetical order:

§ 54.5 Terms and definitions.

* * * * *

Rate-of-Return Carrier. ''Rate-of-return carrier'' shall refer to any incumbent local exchange carrier not subject to price cap regulation as that term is defined in § 61.3(x) of this chapter.

* * * * *

3. Amend § 54.307 by adding a third sentence to paragraph (a)(1), by revising the second and third sentences of paragraph (b), and by revising paragraph (c) to read as follows:

§ 54.307 Support to a competitive eligible telecommunications carrier.

(a) * * *

(1) * * * A competitive eligible telecommunications carrier serving loops in the service area of a rate-of-return carrier shall be eligible to receive Interstate Common Line Support for each line it serves in the service area in accordance with the formula in § 54.901.

* * * * *

(b) * * * For a competitive eligible telecommunications carrier serving

loops in the service area of a rural incumbent local exchange carrier, as that term is defined in § 54.5, the carrier must report, by customer class, the number of working loops it serves in the service area, disaggregated by cost zone if disaggregation zones have been established within the service area pursuant to § 54.315. For a competitive eligible telecommunications carrier serving loops in the service area of a non-rural telephone company, the carrier must report the number of working loops it serves in the service area, by customer class if the non-rural telephone company receives Interstate Common Line Support pursuant to § 54.901 and by disaggregation zone if disaggregation zones have been established within the service area pursuant to § 54.315 of this subpart, and the number of working loops it serves in each wire center in the service area.

* * *

(c) A competitive eligible telecommunications carrier must submit the data required pursuant to paragraph (b) of this section according to the schedule.

(1) No later than July 31st of each year, submit data as of December 31st of the previous calendar year;

(2) No later than September 30th of each year, submit data as of March 31st of the existing calendar year;

(3) No later than December 30th of each year, submit data as of June 30th of the existing calendar year;

(4) No later than March 30th of each year, submit data as of September 30th of the previous calendar year.

4. Amend § 54.315 by revising the section heading, paragraphs (a), (b)(4), (c)(5), (e)(1), (e)(4) through (e)(7), and (f)(1) through (f)(4) to read as follows:

§ 54.315 Disaggregation and targeting of high-cost support.

(a) On or before May 15, 2002, all rural incumbent local exchange carriers and rate-of-return carriers for which high-cost universal service support pursuant to §§ 54.301, 54.303, and/or 54.305 of this subpart, subpart K of this part, and/or part 36 subpart F is available must select a disaggregation path as described in paragraphs (b), (c), or (d) of this section. In study areas in which a competitive carrier was designated as a competitive eligible telecommunications carrier prior to June 19, 2001, the rural incumbent local exchange carrier or rate-of-return carrier may only disaggregate support pursuant to paragraphs (b), (c), or (d)(1)(iii) of this section. A rural incumbent local exchange carrier or rate-of-return carrier failing to select a disaggregation path as described in paragraphs (b), (c), or (d) of this section by May 15, 2002, will not be permitted to disaggregate and target federal high-cost support unless ordered to do so by a state commission as that term is defined in § 54.5.

(b) * * *

(4) A state commission may require, on its own motion, upon petition by an interested party, or upon petition by the rural incumbent local exchange carrier or rate-of-return carrier, the disaggregation and targeting of support under paragraphs (c) or (d) of this section.

* * * * *

(c) * * *

(5) A state commission may require, on its own motion, upon petition by an interested party, or upon petition by the rural incumbent local exchange carrier or rate-of-return carrier, the disaggregation and targeting of support in a different manner.

* * * * *

(e) * * *

(1) Support available to the carrier's study area under its disaggregation plan shall equal the total support available to the study area without disaggregation.

* * * * *

(4) Per-line support amounts for each disaggregation zone shall be recalculated whenever the carrier's total annual support amount changes using the changed support amount and lines at that point in time.

(5) Per-line support for each category of support in each disaggregation zone shall be determined such that the ratio of support between disaggregation zones is maintained and that the product of all of the carrier's lines for each disaggregation zone multiplied by the per-line support for those zones when added together equals the sum of the carrier's total support.

(6) Until a competitive eligible telecommunications carrier is certified in a study area, monthly payments to the incumbent carrier will be made based on total annual amounts for its study area divided by 12.

(7) When a competitive eligible telecommunications carrier is certified in a study area, per-line amounts used to determine the competitive eligible telecommunications carrier's disaggregated support shall be based on the incumbent carrier's then-current total support levels, lines, disaggregated support relationships, and, in the case of support calculated under subpart K of this part, customer classes.

(f) * * *

(1) A carrier certifying under paragraph (b) of this section that it will not disaggregate and target high-cost universal service support shall submit to the Administrator a copy of the certification submitted to the state commission, or the Federal Communications Commission, when not subject to state jurisdiction.

(2) A carrier electing to disaggregate and target support under paragraph (c) of this section shall submit to the Administrator a copy of the order approving the disaggregation and targeting plan submitted by the carrier to the state commission, or the Federal Communications Commission, when not subject to state jurisdiction, and a copy of the disaggregation and targeting plan approved by the state commission or the Federal Communications Commission.

(3) A carrier electing to disaggregate and target support under paragraph (d) of this section shall submit to the Administrator a copy of the self-certification plan including the information submitted to the state commission pursuant to paragraphs (d)(2)(i) and (d)(2)(iv) of this section or the Federal Communications Commission.

(4) A carrier electing to disaggregate and target support under paragraph (c) or (d) of this section must submit to the Administrator maps which precisely identify the boundaries of the designated disaggregation zones of support within the carrier's study area.

5. Amend § 54.701 by revising paragraph (g)(1)(iii) to read as follows:

§ 54.701 Administrator of universal service support mechanisms.

* * * * *

(g)(1) * * *

(iii) The High Cost and Low Income Division, which shall perform duties and functions in connection with the high cost and low income support mechanism, the interstate access universal service support mechanism for price cap carriers described in subpart J of this part, and the interstate common line support mechanism for rate-of-return carriers described in subpart K of this part, under the direction of the High Cost and Low Income Committee of the Board, as set forth in § 54.705(c).

6. Amend § 54.702 by revising paragraph (a) and the second sentence of paragraph (i) to read as follows:

§ 54.702 Administrator's functions and responsibilities.

(a) The Administrator, and the divisions therein, shall be responsible for administering the schools and libraries support mechanism, the rural health care support mechanism, the high cost support mechanism, the low income support mechanism, the

interstate access universal service support mechanism described in subpart J of this part, and the interstate common line support mechanism described in subpart K of this part.

* * * * *

(i) * * * The Administrator shall keep separate accounts for the amounts of money collected and disbursed for eligible schools and libraries, rural health care providers, low-income consumers, interstate access universal service support, interstate common line support, and high-cost and insular areas.

* * * * *

7. Amend § 54.705 by revising paragraphs (c)(1) introductory text, (c)(1)(i), (c)(1)(ii), (c)(1)(iv), and (c)(1)(v) to read as follows:

§ 54.705 Committees of the Administrator's Board of Directors.

* * * * *

(c) *High Cost and Low Income Committee*—(1) *Committee functions.* The High Cost and Low Income Committee shall oversee the administration of the high cost and low income support mechanisms, the interstate access universal service support mechanism for price cap carriers described in subpart J of this part, and the interstate common line support mechanism for rate-of-return carriers described in subpart K of this part by the High Cost and Low Income Division. The High Cost and Low Income Committee shall have the authority to make decisions concerning:

(i) How the Administrator projects demand for the high cost, low income, interstate access universal service, and interstate common line support mechanisms;

(ii) Development of applications and associated instructions as needed for the high cost, low income, interstate access universal service, and interstate common line support mechanisms;

* * * * *

(iv) Performance of audits of beneficiaries under the high cost, low income, interstate access universal service and interstate common line support mechanisms; and

(v) Development and implementation of other functions unique to the high cost, low income, interstate access universal service and interstate common line support mechanisms.

* * * * *

8. Amend § 54.715 by revising the third sentence of paragraph (c) to read as follows:

§ 54.715 Administrative expenses of the Administrator.

* * * * *

(c) * * * The administrative expenses incurred by the Administrator in connection with the schools and libraries support mechanism, the rural health care support mechanism, the high cost support mechanism, the low income support mechanism, the interstate access universal service support mechanism, and the interstate common line support mechanism shall be deducted from the annual funding of each respective support mechanism.

* * *

9. Add subpart K to part 54 to read as follows:

Subpart K—Interstate Common Line Support Mechanism for Rate-of-Return Carriers

Sec.

54.901 Calculation of Interstate Common Line Support.
54.902 Calculation of Interstate Common Line Support for transferred exchanges.
54.903 Obligations of rate-of-return carriers and the Administrator.
54.904 Carrier certification.

§ 54.901 Calculation of Interstate Common Line Support.

(a) Interstate Common Line Support available to a rate-of-return carrier shall equal the Common Line Revenue Requirement per Study Area as calculated in accordance with part 69 of this chapter minus:

(1) The study area revenues obtained from end user common line charges at their allowable maximum as determined by §§ 69.104(n) and 69.104(o) of this chapter;

(2) The carrier common line charge revenues to be phased out pursuant to § 69.105 of this chapter;

(3) The special access surcharge pursuant to § 69.114 of this chapter;

(4) The line port costs in excess of basic analog service pursuant to § 69.130 of this chapter; and

(5) Any Long Term Support for which the carrier is eligible or, if the carrier ceased participation in the NECA common line pool after October 11, 2001, any Long Term Support for which the carrier would have been eligible if it had not ceased its participation in the pool.

(b) The per-line Interstate Common Line Support available to a competitive eligible telecommunications carrier serving lines in a study area served by a rate-of-return carrier shall be calculated by the Administrator as follows:

(1) If the rate-of-return carrier has disaggregated the support it receives in the study area pursuant to § 54.315, the Administrator shall calculate the amount of Interstate Common Line Support targeted to each disaggregation zone by the rate-of-return carrier (targeted Interstate Common Line Support). If the rate-of-return carrier has chosen not to disaggregate its support for a study area pursuant to § 54.315, then the entirety of its Interstate Common Line Support for the study area shall be considered targeted Interstate Common Line Support for purposes of performing the calculations in this section.

(2) In each disaggregation zone or undisaggregated study area, the Administrator shall calculate the Average Interstate Common Line Support by dividing the rate-of-return carrier's targeted Interstate Common Line Support by its total lines served.

(3) The Administrator shall then calculate the Interstate Common Line Support available to the competitive eligible telecommunications carrier for each line it serves for each customer class in a disaggregation zone or undisaggregated study area by the following formula:

(i) If the Average Interstate Common Line Support is greater than $2.70 multiplied by the number of residential and single-line business lines served by the rate-of-return carrier in the disaggregation zone or undisaggregated study area, then:

(A) Interstate Common Line Support per Multi-Line Business Line = (Average Interstate Common Line Support − $2.70 × residential and single-line business lines served by the rate-of-return carrier) ÷ (total lines served by the rate-of-return carrier); and

(B) Interstate Common Line Support per Residential and Single-Line Business Line = Interstate Common Line Support per Multi-Line Business Line + $2.70.

(ii) If the Average Interstate Common Line Support is less than or equal to $2.70 multiplied by residential and single-line business lines served by the rate-of-return carrier in the disaggregation zone or undisaggregated study area, but greater than $0, then:

(A) Interstate Common Line Support per Multi-Line Business Line = $0; and

(B) Interstate Common Line Support per Residential and Single-Line Business Line = Average Interstate Common Line Support ÷ residential and single line business lines served by the rate-of-return carrier.

(iii) If the Average Interstate Common Line Support is equal to $0, then the competitive eligible telecommunications carrier shall receive no Interstate Common Line Support for lines served in that disaggregation zone or undisaggregated study area.

§ 54.902 Calculation of Interstate Common Line Support for transferred exchanges.

(a) In the event that a rate-of-return carrier acquires exchanges from an entity that is also a rate-of-return carrier, Interstate Common Line Support for the transferred exchanges shall be distributed as follows.

(1) Each carrier may report its updated line counts to reflect the transfer in the next quarterly line count filing pursuant to § 54.903(a) that applies to the period in which the transfer occurred. During a transition period from the filing of the updated line counts until the end of the funding year, the Administrator shall adjust the Interstate Common Line Support received by each carrier based on the updated line counts and the per-line Interstate Common Line Support, categorized by customer class and, if applicable, disaggregation zone, of the selling carrier. If the acquiring carrier does not file a quarterly update of its line counts, it will not receive Interstate Common Line Support for those lines during the transition period.

(2) Each carriers' projected data for the following funding year filed pursuant to § 54.903(c) shall reflect the transfer of exchanges.

(3) Each carriers' actual data filed pursuant to § 54.903(d) shall reflect the transfer of exchanges. All post-transaction Interstate Common Line Support shall be subject to true up by the Administrator pursuant to § 54.903(e).

(b) In the event that a rate-of-return carrier acquires exchanges from a price cap carrier that are incorporated into one of the rate-of-return carrier's existing study areas, Interstate Common Line Support for the transferred exchanges shall be distributed as follows.

(1) The acquiring carrier may report its updated line counts for the study area into which the acquired lines are incorporated in the next quarterly line count filing pursuant to § 54.903(a) that applies to the period in which the transfer occurred. During a transition period from the filing of the updated line counts until the end of the funding year, the Administrator shall adjust the Interstate Common Line Support received by the acquiring carrier based on the updated line counts and the per-line amounts Interstate Common Line Support for the study area served by the acquiring carrier. If necessary, the Administrator shall develop an average per-line support amount to reflect various per-line amounts in multiple disaggregation zones served by the acquiring carrier. If the acquiring carrier does not file a quarterly update of its line counts, it will not receive Interstate Common Line Support for those lines during the transition period.

(2) The acquiring carrier's projected data for the following funding year filed pursuant to § 54.903(c) shall reflect the transfer of exchanges.

(3) The acquiring carrier's actual data filed pursuant to § 54.903(d) shall reflect the transfer of exchanges. All post-transaction Interstate Common Line Support shall be subject to true up by the Administrator pursuant to § 54.903(e).

(c) In the event that a rate-of-return carrier acquires exchanges from a price cap carrier that are not incorporated into one of the rate-of-return carrier's existing study areas, Interstate Common Line Support for the transferred exchanges shall be distributed as follows.

(1) The acquiring rate-of-return may submit to the Administrator a projected Interstate Common Line Revenue Requirement for the acquired exchanges for the remainder of the funding year in the next quarterly report to the Administrator. The Administrator shall distribute Interstate Common Line Support pursuant to the partial year projected Interstate Common Line Revenue Requirement for the remainder of the funding year. If the acquiring carrier does not file a projected Interstate Common Line Revenue Requirement, it will not receive Interstate Common Line Support for those exchanges during the transition period.

(2) The acquiring carrier's projected data for the following funding year filed pursuant to § 54.903(c) shall reflect the transfer of exchanges.

(3) The acquiring carrier's actual data filed pursuant to § 54.903(d) shall reflect the transfer of exchanges. All post-transaction Interstate Common Line Support shall be subject to true up by the Administrator pursuant to § 54.903(e).

(d) In the event that an entity other than a rate-of-return carrier acquires exchanges from a rate-of-return carrier, per-line Interstate Common Line Support will not transfer.

(e) This section does not alter any Commission rule governing the sale or transfer of exchanges, including the definition of ''study area'' in part 36.

§ 54.903 Obligations of rate-of-return carriers and the Administrator.

(a) To be eligible for Interstate Common Line Support, each rate-of-return carrier shall make the following filings with the Administrator.

(1) On March 31, 2002, each rate-of-return carrier shall submit to the Administrator the number of lines it serves as of September 30, 2001, within each rate-of-return carrier study area, by disaggregation zone if disaggregation zones have been established within that study area pursuant to § 54.315, showing residential and single-line business line counts and multi-line business line counts separately. For purposes of this report, and for purposes of computing support under this subpart, the residential and single-line business class lines reported include lines assessed the residential and single-line business End User Common Line charge pursuant to § 69.104 of this chapter, and the multi-line business class lines reported include lines assessed the multi-line business End User Common Line charge pursuant to § 69.104 of this chapter. For purposes of this report, and for purposes of computing support under this subpart, lines served using resale of the rate-of-return local exchange carrier's service pursuant to section 251(c)(4) of the Communications Act of 1934, as amended, shall be considered lines served by the rate-of-return carrier only and must be reported accordingly. Beginning July 31, 2002, each rate-of-return carrier shall submit the information described in this paragraph in accordance with the schedule in § 36.611 of this chapter.

(2) Each rate-of-return carrier in service areas where a competitive eligible telecommunications carrier has initiated service and reported line count data pursuant to § 54.307(c) shall submit the information in paragraph (a) of this section in accordance with the schedule in § 36.612 of this chapter. A rate-of-return carrier may submit the information in paragraph (a) of this section in accordance with the schedule in § 36.612 of this chapter, even if it is not required to do so. If a rate-of-return carrier makes a filing under this paragraph, it shall separately indicate any lines that it has acquired from another carrier that it has not previously reported pursuant to paragraph (a) of this section, identified by customer class and the carrier from which the lines were acquired.

(3) Each rate-of-return carrier shall submit to the Administrator, on March 31, 2002, and annually thereafter on March 31st information needed to calculate the Projected Annual Common Line Revenue Requirement for each of its study areas in the upcoming funding year. A rate-of-return carrier's Projected Annual Common Line Revenue Requirement shall be calculated in accordance with part 69 of this chapter. The funding year shall be July 1st of the current year through June 30th of the

next year. Rate-of-return carriers will be permitted to submit corrections to their projected Annual Common Line Revenue Requirement until April 10, 2002, and annually thereafter until April 10th.

(4) Each rate-of-return carrier shall submit to the Administrator, on July 31, 2003, and annually thereafter on July 31st, the carrier's common line costs as defined in part 69 of this chapter for each study area in which it operates for the previous calendar year. Such data shall be used by the Administrator to make adjustments to monthly per-line Interstate Common Line Support amounts in the following calendar year to the extent of any difference between the carrier's Projected Annual Common Line Revenue Requirement and the carrier's actual costs during the relevant period. A rate-of-return carrier may update the information submitted on July 31st one or more times quarterly on a rolling year basis according to the schedule in § 36.612 of this chapter.

(b) Upon receiving the information required to be filed in paragraph (a) of this section, the Administrator shall:

(1) Perform the calculations described in § 54.901;

(2) Publish the results of these calculations showing Interstate Common Line Support Per Line available in each rate-of-return carrier study area, by Disaggregation Zone and customer class;

(3) Perform periodic reconciliation of projected common line revenue requirements based on data provided by carriers pursuant to paragraph (a)(3) of this section and actual common line revenue requirements based on data provided by carriers pursuant to paragraph (a)(4) of this section;

(4) Collect the funds necessary to provide support pursuant to this subpart in accordance with subpart H of this part;

(5) Distribute support calculated pursuant to the rules contained in this subpart; and

(6) Report quarterly to the Commission on the collection and distribution of funds under this subpart as described in § 54.702(i). Fund distribution reporting will be by state and by eligible telecommunications carrier within the state.

§ 54.904 Carrier certification.

(a) *Certification.* Carriers that desire to receive support pursuant to this subpart shall file a certification with the Administrator and the Federal Communications Commission stating that all Interstate Common Line Support provided to such carrier will be used only for the provision, maintenance, and upgrading of facilities and services for which the support is intended. Support provided pursuant to this subpart shall only be provided to the extent that the carrier has filed the requisite certification pursuant to this section.

(b) *Certification format.* A certification pursuant to this section may be filed in the form of a letter from an authorized representative for the carrier, and must be filed with both the Administrator and the Office of the Secretary of the Federal Communication Commission clearly referencing CC Docket No. 96–45, on or before the filing deadlines set forth in paragraph (d) of this section.

(c) All of the certifications filed by carriers pursuant to this section shall become part of the public record maintained by the Commission.

(d) *Filing deadlines.* In order for a rate-of-return carrier, and/or an eligible telecommunications carrier serving lines in the service area of a rate-of-return carrier, to receive Interstate Common Line Support, such carrier must file an annual certification, as described in paragraph (b) of this section, on the date that it first files its line count information pursuant to § 54.903, and thereafter on June 30th of each year.

PART 69—ACCESS CHARGES

10. The authority citation continues to read as follows:

Authority: 47 U.S.C. 154, 201, 202, 203, 205, 218, 220, 254, 403.

11. Amend § 69.2 by adding a new paragraph (ww) to read as follows:

§ 69.2 Definitions.

* * * * *

(ww) *Interstate Common Line Support (ICLS)* means funds that are provided pursuant to § 54.901 of this chapter.

12. Amend § 69.4 by revising paragraph (b)(2), by removing and reserving paragraph (c), by revising paragraphs (d) and (g), and by adding a new paragraph (j) to read as follows:

§ 69.4 Charges to be filed.

* * * * *

(b) * * *

(2) Carrier common line, provided that after June 30, 2003, non-price cap local exchange carriers may not assess a carrier common line charge;

* * * * *

(c) [Reserved.]

(d) Recovery of Contributions to the Universal Service Support Mechanisms by Incumbent Local Exchange Carriers.

(1) [Reserved.]

(2)(i) Local exchange carriers may recover their contributions to the universal service support mechanisms only through explicit, interstate, end-user charges assessed pursuant to either § 69.131 or § 69.158 that are equitable and nondiscriminatory.

(ii) Local exchange carriers may not recover any of their contributions to the universal service support mechanisms through access charges imposed on interexchange carriers.

* * * * *

(g) Local exchange carriers may establish appropriate rate elements for a new service, within the meaning of § 61.3(x) of this chapter, in any tariff filing.

* * * * *

(j) In addition to the charges specified in paragraph (b) of this section, the carrier's carrier charges for access service filed with this Commission by non-price cap local exchange carriers may include charges for each of the following elements:

(1) Dedicated local switching trunk port;

(2) Shared local switching trunk port;

(3) Dedicated tandem switching trunk port;

(4) Multiplexers associated with tandem switching;

(5) DS1/voice grade multiplexers associated with analog switches; and

(6) Per-message call setup.

13. Amend § 69.104 by revising the first sentence of paragraph (a), by revising paragraphs (c) through (f), by removing and reserving paragraphs (j) through (l), and by adding new paragraphs (n) through (r) to read as follows:

§ 69.104 End user common line for non-price cap incumbent local exchange carriers.

(a) This section is applicable only to incumbent local exchange carriers that are not subject to price cap regulation as that term is defined in § 61.3(ee) of this chapter. * * *

* * * * *

(c) Until December 31, 2001, except as provided in paragraphs (d) through (h) of this section, the single-line rate or charge shall be computed by dividing one-twelfth of the projected annual revenue requirement for the End User Common Line element by the projected average number of local exchange service subscriber lines in use during such annual period.

(d)(1) Until December 31, 2001, if the monthly charge computed in accordance with paragraph (c) of this section exceeds $6, the charge for each local exchange service subscriber line,

except a residential line, a single-line business line, or a line used for Centrex-CO service that was in place or on order as of July 27, 1983, shall be $6.

(2) Until December 31, 2001, the charge for each subscriber line associated with a public telephone shall be equal to the monthly charge computed in accordance with paragraph (d)(1) of this section.

(e) Until December 31, 2001, the monthly charge for each residential and single-line business local exchange service subscriber shall be the charge computed in accordance with paragraph (c) of this section, or $3.50, whichever is lower.

(f) Except as provided in § 54.403 of this chapter, the charge for each residential local exchange service subscriber line shall be the same as the charge for each single-line business local exchange service subscriber line.

* * * * *

(j) [Reserved.]

(k) [Reserved.]

(l) [Reserved.]

* * * * *

(n)(1) Beginning January 1, 2002, except as provided in paragraph (r) of this section, the maximum monthly charge for each residential or single-line business local exchange service subscriber line shall be the lesser of:

(i) One-twelfth of the projected annual revenue requirement for the End User Common Line element divided by the projected average number of local exchange service subscriber lines in use during such annual period; or

(ii) The following:

(A) Beginning January 1, 2002, $5.00.

(B) Beginning July 1, 2002, $6.00.

(C) Beginning July 1, 2003, $6.50.

(2) In the event that GDP-PI exceeds 6.5% or is less than 0%, the maximum monthly charge in paragraph (n)(1)(ii) of this section will be adjusted in the same manner as the adjustment in § 69.152(d)(2).

(o)(1) Beginning on January 1, 2002, except as provided in paragraph (r) of this section, the maximum monthly End User Common Line Charge for multi-line business lines will be the lesser of:

(i) $9.20; or

(ii) One-twelfth of the projected annual revenue requirement for the End User Common Line element divided by the projected average number of local exchange service subscriber lines in use during such annual period;

(2) In the event that GDP-PI is greater than 6.5% or is less than 0%, the maximum monthly charge in paragraph (o)(1)(i) of this section will be adjusted in the same manner as the adjustment in § 69.152(k)(2).

(p) Beginning January 1, 2002, non-price cap local exchange carriers shall assess:

(1) No more than one End User Common Line charge as calculated under the applicable method under paragraph (n) of this section for Basic Rate Interface integrated services digital network (ISDN) service.

(2) No more than five End User Common Line charges as calculated under paragraph (o) of this section for Primary Rate Interface ISDN service.

(q) In the event a non-price cap local exchange carrier charges less than the maximum End User Common Line charge for any subscriber lines, the carrier may not recover the difference between the amount collected and the maximum from carrier common line charges, Interstate Common Line Support, or Long Term Support.

(r) *End User Common Line Charge Deaveraging.* Beginning on January 1, 2002, non-price cap local exchange carriers may geographically deaverage End User Common Line charges subject to the following conditions.

(1) In order for a non-price cap local exchange carrier to be allowed to deaverage End User Common Line charges within a study area, the non-price cap local exchange carrier must have:

(i) State commission-approved geographically deaveraged rates for UNE loops within that study area; or

(ii) A universal service support disaggregation plan established pursuant to § 54.315 of this chapter.

(2) All geographic deaveraging of End User Common Line charges by customer class within a study area must be according to the state commission-approved UNE loop zone, or the universal service support disaggregation plan established pursuant to § 54.315 of this chapter.

(3) Within a given zone, Multi-line Business End User Common Line rates cannot fall below Residential and Single-Line Business rates.

(4) For any given class of customer in any given zone, the End User Common Line Charge in that zone must be greater than or equal to the End User Common Line charge in the zone with the next lower cost per line.

(5) A non-price cap local exchange carrier shall not receive more through deaveraged End User Common Line charges than it would have received if it had not deaveraged its End User Common Line charges.

(6) *Maximum charge.* The maximum zone deaveraged End User Common Line Charge that may be charged in any zone is the applicable cap specified in paragraphs (n) or (o) of this section.

(7) *Voluntary Reductions.* A ''Voluntary Reduction'' is one in which the non-price cap local exchange carrier charges End User Common Line rates below the maximum charges specified in paragraphs (n)(1) or (o)(1) of this section other than through offset of net increases in End User Common Line charge revenues or through increases in other zone deaveraged End User Common Line charges.

14. Amend § 69.105 by revising paragraph (a) and by adding a new paragraph (d) to read as follows:

§ 69.105 Carrier common line for non-price cap local exchange carriers.

(a) This section is applicable only to local exchange carriers that are not subject to price cap regulation as that term is defined in § 61.3(ee) of this chapter. Until June 30, 2003, a charge that is expressed in dollars and cents per line per access minute of use shall be assessed upon all interexchange carriers that use local exchange common line facilities for the provision of interstate or foreign telecommunications services, except that the charge shall not be assessed upon interexchange carriers to the extent they resell MTS or MTS-type services of other common carriers (OCCs).

* * * * *

(d) From July 1, 2002, to June 30, 2003, the carrier common line charge calculations pursuant to this section shall be limited to an amount equal to the number of projected residential and single-line business lines multiplied by the difference between the residential and single-line business End User Common Line rate cap and the lesser of $6.50 or the non-price cap local exchange carrier's average cost per line.

15. Amend § 69.106 by revising paragraph (g) and by adding a new paragraph (h) to read as follows:

§ 69.106 Local switching.

* * * * *

(g) A local exchange carrier may recover signaling costs associated with call setup through a call setup charge imposed upon all interstate interexchange carriers that use that local exchange carrier's facilities to originate or terminate interstate interexchange or foreign services. This charge must be expressed as dollars and cents per call attempt and may be assessed on originating calls handed off to the interexchange carrier's point of presence and on terminating calls received from an interexchange carrier's point of presence, whether or not that call is completed at the called location. Local exchange carriers may not recover

through this charge any costs recovered through other rate elements.

(h) Except as provided in § 69.118, non-price cap local exchange carriers may establish rate elements for local switching as follows:

(1) Non-price cap local exchange carriers may separate from the projected annual revenue requirement for the Local Switching element those costs projected to be incurred for ports (including cards and DS1/voice-grade multiplexers required to access end offices equipped with analog switches) on the trunk side of the local switch. Non-price cap local exchange carriers electing to assess these charges shall further identify costs incurred for dedicated trunk ports separately from costs incurred for shared trunk ports.

(i) Non-price cap local exchange carriers electing to assess trunk port charges shall recover dedicated trunk port costs identified pursuant to paragraph (h)(1) of this section through flat-rated charges expressed in dollars and cents per trunk port and assessed upon the purchaser of the dedicated trunk terminating at the port.

(ii) Non-price cap local exchange carriers electing to assess trunk port charges shall recover shared trunk port costs identified pursuant to paragraph (h)(1) of this section through charges assessed upon purchasers of shared transport. This charge shall be expressed in dollars and cents per access minute of use. The charge shall be computed by dividing the projected costs of the shared ports by the historical annual access minutes of use calculated for purposes of recovery of common transport costs in § 69.111(c).

(2) Non-price cap local exchange carriers shall recover the projected annual revenue requirement for the Local Switching element that are not recovered in paragraph (h)(1) of this section through charges that are expressed in dollars and cents per access minute of use and assessed upon all interexchange carriers that use local exchange switching facilities for the provision of interstate or foreign services. The maximum charge shall be computed by dividing the projected remainder of the annual revenue requirement for the Local Switching element by the historical annual access minutes of use for all interstate or foreign services that use local exchange switching facilities.

16. Amend § 69.111 by adding a new paragraph (m) to read as follows:

§ 69.111 Tandem-switched transport and tandem charge.

* * * * *

(m) In addition to the charges described in this section, non-price cap local exchange carriers may establish separate charges for multiplexers and dedicated trunk ports used in conjunction with the tandem switch as follows:

(1)(i) Non-price cap local exchange carriers may establish a flat-rated charge for dedicated DS3/DS1 multiplexing on the serving wire center side of the tandem switch provided in conjunction with dedicated DS3 transport service from the serving wire center to the tandem switch. This charge shall be assessed on interexchange carriers purchasing tandem-switched transport in proportion to the number of DS3 trunks provisioned for that interexchange carrier between the serving wire center and the tandem switch.

(ii) Non-price cap local exchange carriers may establish a flat-rated charge for dedicated DS1/voice-grade multiplexing provided on the serving wire center side of analog tandem switches. This charge may be assessed on interexchange carriers purchasing tandem-switched transport in proportion to the interexchange carrier's transport capacity on the serving wire center side of the tandem.

(2) Non-price cap local exchange carriers may recover the costs of dedicated trunk ports on the serving wire center side of the tandem switch through flat-rated charges expressed in dollars and cents per trunk port and assessed upon the purchaser of the dedicated trunk terminating at the port.

17. Amend § 69.124 by revising paragraph (a) to read as follows:

§ 69.124 Interconnection charge.

(a) Until December 31, 2001, local exchange carriers not subject to price cap regulation shall assess an interconnection charge expressed in dollars and cents per access minute upon all interexchange carriers and upon all other persons using the telephone company switched access network.

* * * * *

18. Add § 69.130 to subpart B to read as follows:

§ 69.130 Line port costs in excess of basic analog service.

To the extent that the costs of ISDN line ports, and line ports associated with other services, exceed the costs of a line port used for basic, analog service, non-price cap local exchange carriers may recover the difference through a separate monthly end-user charge, provided that no portion of such excess cost may be recovered through other common line access charges, or through Interstate Common Line Support.

19. Add § 69.131 to subpart B to read as follows:

§ 69.131 Universal service end user charges.

To the extent the company makes contributions to the Universal Service Support Mechanisms pursuant to §§ 54.706 and 54.709 of this chapter and the non-price cap local exchange carrier seeks to recover some or all of the amount of such contribution, the non-price cap local exchange carrier shall recover those contributions through a charge to end users other than Lifeline users. The charge to recover these contributions is not part of any other element established pursuant to part 69. Such a charge may be assessed on a per-line basis or as a percentage of interstate retail revenues, and at the option of the local exchange carrier it may be combined for billing purposes with other end user retail rate elements. A non-price cap local exchange carrier opting to assess the Universal Service end-user rate element on a per-line basis may apply that charge using the ''equivalency'' relationships established for the multi-line business PICC for Primary Rate ISDN service, as per § 69.153(d), and for Centrex lines, as per § 69.153(e).

20. Amend § 69.306 by revising paragraph (d) to read as follows:

§ 69.306 Central office equipment (COE).

* * * * *

(d) COE Category 3 (Local Switching Equipment) shall be assigned to the Local Switching element except as provided in paragraph (a) of this section; and that,

(1) For telephone companies subject to price cap regulation set forth in part 61 of this chapter, line-side port costs shall be assigned to the Common Line rate element; and

(2) Beginning January 1, 2002, for non-price cap local exchange carriers, line-side port costs shall be assigned to the Common Line rate element. Such amount shall be determined after any local switching support has been removed from the interstate Local Switching revenue requirement. Non-price cap local exchange carriers may use thirty percent of the interstate Local Switching revenue requirement, minus any local switching support, as a proxy for allocating line port costs to the Common Line category.

* * * * *

21. Amend § 69.307 by revising paragraph (c) and by adding a new paragraph (e) to read as follows:

§ 69.307 General support facilities.

* * * * *

(c)(1) Until June 30, 2002, for all local exchange carriers not subject to price cap regulation and for other carriers that acquire all of the billing and collection services that they provide to interexchange carriers from unregulated affiliates through affiliate transactions, from unaffiliated third parties, or from both of these sources, all other General Support Facilities investments shall be apportioned among the interexchange category, the billing and collection category, and Common Line, Local Switching, Information, Transport, and Special Access elements on the basis of Central Office Equipment, Information Origination/Termination Equipment, and Cable and Wire Facilities, combined.

(2) Beginning July 1, 2002, for all local exchange carriers that acquire all of the billing and collection services that they provide to interexchange carriers from unregulated affiliates through affiliate transactions, from unaffiliated third parties, or from both of these sources, all other General Support Facilities investments shall be apportioned among the interexchange category, the billing and collection category, and Common Line, Local Switching, Information, Transport, and Special Access elements on the basis of Central Office Equipment, Information Origination/Termination Equipment, and Cable and Wire Facilities, combined.

* * * * *

(e) Beginning July 1, 2002, for non-price cap local exchange carriers not covered by § 69.307(c)(2), a portion of General purpose computer investment shall be apportioned to the billing and collection category on the basis of the Big Three Expense Factors allocator, defined in § 69.2, modified to exclude expenses that are apportioned on the basis of allocators that include General Support Facilities investment. The remaining General Support Facilities investments shall be apportioned among the interexchange category, the billing and collection category, and Common Line, Local Switching, Information, Transport, and Special Access Elements on the basis of Central Office Equipment, Information Origination/Termination Equipment, and Cable and Wire Facilities, combined.

22. Add § 69.415 to subpart E to read as follows:

§ 69.415 Reallocation of certain transport expenses.

(a) Beginning January 1, 2002, non-price cap local exchange carriers shall reallocate a portion of the costs otherwise assigned to the transport category to the common line, local switching, information, and special access elements.

(b) The amount to be reallocated is limited to the total revenues recovered through the interconnection charge assessed pursuant to § 69.124 for the 12-month period ending June 30, 2001.

(c) The reallocation of the amount in paragraph (b) of this section shall be based on each access element's projected revenue requirement divided by the total revenue requirement of all the access elements, provided that:

(1) Local switching support shall not be included in the local switching category's projected revenue requirement, or in the total projected revenue requirement;

(2) A non-price cap local exchange carrier's universal service contribution shall not be included in the numerator or the denominator of the allocation formula;

(3) The amount determined in paragraph (b) of this section shall be excluded from the transport revenue requirement and from the total projected revenue requirement for purposes of the allocation calculations; and

(4) The common line revenue requirement shall include long term support as provided in § 54.303 of this chapter and, beginning July 1, 2002, shall include Interstate Common Line Support as provided in § 54.901 of this chapter.

23. Amend § 69.501 by revising paragraphs (b), (c), and (e) and by adding a new paragraph (f) to read as follows:

§ 69.501 General.

* * * * *

(b) Until December 31, 2001, any portion of the Common Line element annual revenue requirement that is attributable to CPE investment or expense or surrogate CPE investment or expense shall be assigned to the Carrier Common Line element or elements.

(c) Until December 31, 2001, any portion of the Common Line element annual revenue requirement that is attributable to customer premises wiring included in IOT investment or expense shall be assigned to the Carrier Common Line element or elements.

* * * * *

(e) Until December 31, 2001, any portion of the Common Line element revenue requirement that is not assigned to Carrier Common Line elements pursuant to paragraphs (b) and (c) of this section shall be apportioned between End User Common Line and Carrier Common Line pursuant to § 69.502. Such portion of the Common Line element annual revenue requirement shall be described as the base factor portion for purposes of this subpart.

(f) Beginning January 1, 2002, the Common Line element revenue requirement shall be apportioned between End User Common Line and Carrier Common Line pursuant to § 69.502. The Common Line element annual revenue requirement shall be described as the base factor portion for purposes of this subpart.

24. Amend § 69.502 by adding new paragraphs (d) and (e) to read as follows:

§ 69.502 Base factor allocation.

* * * * *

(d) Beginning July 1, 2002, the portion of per-line support that carriers receive pursuant to § 54.901 of this chapter; and

(e) Line port costs in excess of basic analog service pursuant to § 69.130.

25. Amend § 69.603 by adding a new sentence immediately before the last sentence of paragraph (g) and a new sentence at the end of paragraph (h)(5) to read as follows:

§ 69.603 Association functions.

* * * * *

(g) * * * Beginning July 1, 2002, Interstate Common Line Support revenues shall be included in the allocation base for Category I.B expenses. * * *

(h) * * *

(5) * * * Beginning July 1, 2002, Interstate Common Line Support shall be subject to this provision.

* * * * *

26. Amend § 69.609 by adding a second sentence to paragraph (b) to read as follows:

§ 69.609 End User Common Line hypothetical net balances.

* * * * *

(b) * * * For purposes of this calculation, access revenues collected shall include any revenues foregone because of a voluntary reduction made pursuant to § 69.104(r)(7).

[FR Doc. 01–29739 Filed 11–29–01; 8:45 am]

BILLING CODE 6712–01–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 17

RIN 1080–AI17

Endangered and Threatened Wildlife and Plants; Emergency Rule To List the Columbia Basin Distinct Population Segment of the Pygmy Rabbit (*Brachylagus idahoensis*) as Endangered

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Emergency rule.

SUMMARY: We, the U.S. Fish and Wildlife Service (Service), exercise our authority under the Endangered Species Act of 1973, as amended (Act), to emergency list the Columbia Basin distinct population segment of the pygmy rabbit (*Brachylagus idahoensis*) as endangered. This population segment consists of a single, wild colony totaling fewer than 50 individuals in Douglas County, central Washington, and a small captive population.

The Columbia Basin pygmy rabbit is imminently threatened by a recent significant decrease in population that has caused it to be susceptible to the combined influence of catastrophic environmental events, habitat or resource failure, disease, predation, and loss of genetic heterogeneity. We find that these threats constitute an immediate and significant risk to the well-being of the Columbia Basin pygmy rabbit. Because of the need to make protective measures afforded by the Act immediately available to this species, we find that an emergency rule action is justified. This emergency rule provides Federal protection pursuant to the Act for a period of 240 days. A proposed rule to list the Columbia Basin pygmy rabbit as endangered is published concurrently with this emergency rule in the proposed rule section of this issue of the **Federal Register**.

DATES: This emergency rule becomes effective immediately on November 30, 2001, and expires July 29, 2002.

ADDRESSES: The complete file for this emergency rule is available for inspection, by appointment, during normal business hours at the U.S. Fish and Wildlife Service, Upper Columbia Fish and Wildlife Office, 11103 East Montgomery Drive, Spokane, Washington 99206.

FOR FURTHER INFORMATION CONTACT: Christopher Warren at the address listed above (telephone 509/891–6839; facsimile 509/891–6748; electronic mail: *chris_warren@fws.gov*).

SUPPLEMENTARY INFORMATION:

Background

The pygmy rabbit (*Brachylagus idahoensis*) is a member of the family Leporidae, which includes hares and rabbits. The species has been placed in a number of genera since it was first described in 1891 (Washington Department of Fish and Wildlife (WDFW) 1995), when it was classified as *Lepus idahoensis*. In 1904, it was reclassified and placed in the genus *Brachylagus*, and in 1930, it was again reclassified and placed in the genus *Sylvilagus* (WDFW 1995). More recent examination of dentition (Hibbard 1963) and analysis of blood proteins (Johnson 1968) suggests that the pygmy rabbit differs significantly from species within either the *Lepus* or *Sylvilagus* genera. The pygmy rabbit is now generally considered to be within the monotypic genus Brachylagus, and again classified as *B. idahoensis* (Green and Flinders 1980a; WDFW 1995). There are no recognized subspecies of the pygmy rabbit (Dalquest 1948; Green and Flinders 1980a).

The pygmy rabbit is the smallest Leporid in North America, with mean adult weights from 375 to 462 grams (0.83 to 1.02 pounds), and lengths from 23.5 to 29.5 centimeters (cm) (9.3 to 11.6 inches (in)) (Orr 1940; Janson 1946; Wilde 1978; Gahr 1993; WDFW 1995). Females tend to be slightly larger than males. The overall color of pygmy rabbits is slate-gray tipped with brown. Their legs, chest, and nape are tawny cinnamon-brown, their bellies are whitish, and the entire edges of their ears are pale buff. Their ears are short (3.5 to 5.2 cm (1.4 to 2.0 in)), rounded, and thickly furred inside and out. Their tails are small (1.5 to 2.4 cm (0.6 to 0.9 in)), uniform in color, and nearly unnoticeable in the wild (Orr 1940; Janson 1946; WDFW 1995). The pygmy rabbit is distinguishable from other Leporids by its small size, short ears, gray color, small hind legs, and lack of white on the tail.

Pygmy rabbits typically are found in areas of tall, dense sagebrush (*Artemisia* spp.) cover, and are highly dependent on sagebrush to provide both food and shelter throughout the year (Orr 1940; Green and Flinders 1980a; WDFW 1995). The winter diet of pygmy rabbits is composed of up to 99 percent sagebrush (Wilde 1978), which is unique among Leporids (White *et al.* 1982). During spring and summer, their diet consists of roughly 51 percent sagebrush, 39 percent grasses (particularly native bunch-grasses, such as *Agropyron* spp. and *Poa* spp.), and 10 percent forbs (Green and Flinders 1980b). There is evidence that pygmy rabbits preferentially select native grasses as forage during this period in comparison to other available foods. In addition, total grass cover relative to forbs and shrubs may be reduced within pygmy rabbit colonies as a result of its use as a food source during spring and summer (Green and Flinders 1980b).

The pygmy rabbit is believed to be one of only two Leporids in North America that digs its own burrows (Nelson 1909; Green and Flinders 1980a; WDFW 1995), the other being the volcano rabbit (*Romerolagus diazi*) found in central Mexico (Durrell and Mallinson 1970). Pygmy rabbit burrows typically are found in relatively deep, loose soils of wind-borne (*i.e.*, loess) or water-borne (*e.g.*, alluvial fan) origin. Pygmy rabbits occasionally make use of burrows abandoned by other species, such as the yellow-bellied marmot (*Marmota flaviventris*) or badger (*Taxida taxus*) (Wilde 1978; Green and Flinders 1980a; WDFW 1995) and may occur in areas of shallower or more compact soils that support sufficient shrub cover (Bradfield 1974). During winter, pygmy rabbits make extensive use of snow burrows to access sagebrush forage (Bradfield 1974; Katzner and Parker 1997).

Pygmy rabbits, especially juveniles, likely use their burrows as protection from predators and inclement weather (Bailey 1936; Bradfield 1974). The burrows frequently have multiple entrances, some of which are concealed at the base of larger sagebrush plants (WDFW 1995). Burrows are relatively simple and shallow, often no more than 2 meters (m) (6.6 feet (ft)) in length and usually less than 1 m (3.3 ft) deep with no distinct chambers (Bradfield 1974; Green and Flinders 1980a; Gahr 1993). Burrows typically are dug into gentle slopes or mound/inter-mound areas of more level or dissected topography (Wilde 1978; Kehne 1991; Gahr 1993). In general, the number of active burrows in a colony increases over the summer as the number of juveniles increases. However, the number of active burrows may not be directly related to the number of individuals in a given colony because some individual pygmy rabbits appear to maintain multiple burrows, while some individual burrows are used by multiple individuals (Gahr 1993; WDFW 1995).

Pygmy rabbits begin breeding in their second year and, in Washington, breeding occurs from February through July (WDFW 1995). Females may have up to three litters per year and average six young per litter (Green 1978; Wilde

1978). Breeding appears to be highly synchronous in a colony, and juveniles are often identifiable to cohorts (Wilde 1978). No evidence of nests, nesting material, or lactating females with young has been found in burrows (Bradfield 1974; Gahr 1993; WDFW 1995). Individual juveniles have been found under clumps of sagebrush, although it is not known precisely where the young are born in the wild or if they may be routinely hidden at the bases of scattered shrubs or within burrows (Wilde 1978).

Recent information on captive pygmy rabbits indicates that females may excavate specialized ''natal'' burrows for their litters in the vicinity of their regular burrows (P. Swenson, Oregon Zoo, pers. comm., 2001; L. Shipley, Washington State University (WSU), pers. comm., 2001). Apparently, females begin to dig and supply nesting material (*e.g.*, grass clippings) to these burrows several days prior to giving birth and may give birth and nurse their young at the ground surface in a small depression near the burrow's entrance. After nursing, the young return to the burrow and the female refills the burrow entrance with loose soil and otherwise disguises the immediate area to avoid detection. Other ''dead-end'' burrows that females construct nearby apparently are associated with the natal burrows. Females may also alter their defecation and latrine habits while pregnant and nursing (P. Swenson, pers. comm., 2001). Further work with captive and wild pygmy rabbits should shed additional light on the details of their reproductive strategy.

Pygmy rabbits may be active at any time of the day or night and appear to be most active during mid-morning (Bradfield 1974; Green and Flinders1980a; Gahr 1993). Pygmy rabbits maintain a low stance, have a deliberate gait, and are relatively slow and vulnerable in more open areas. They can evade predators by maneuvering through the dense shrub cover of their preferred habitats, often along established trails, or by escaping into their burrows (Bailey 1936; Severaid 1950; Bradfield 1974).

Pygmy rabbits tend to have relatively small home ranges during winter, remaining within roughly 30 m (98 ft) of their burrows (Orr 1940; Janson 1946; Gahr 1993; Katzner and Parker 1997), although some snow burrows may extend outward up to 100 m (328 ft) (Bradfield 1974). They have larger home ranges during spring and summer (Orr 1940; Janson 1946; Gahr 1993; Katzner and Parker 1997). During the breeding season in Washington, females tend to make relatively short movements within a small core area and have home ranges covering roughly 2.7 hectares (ha) (6.7 acres (ac)); males tend to make longer movements, traveling among a number of females, resulting in home ranges covering roughly 20.2 ha (49.9 ac) (Gahr 1993). These home range estimates in Washington are considerably larger than for pygmy rabbit populations in other areas of their historic range (WDFW 1995; Katzner and Parker 1997). Pygmy rabbits may travel up to 1.2 kilometers (km) (0.75 miles (mi)) from their burrows (Gahr 1993), and there are a few records of apparently dispersing individuals moving up to 3.5 km (2.17 mi) (Green and Flinders 1979; Katzner and Parker 1998).

The annual mortality rate of adult pygmy rabbits may be as high as 88 percent, while over 50 percent of juveniles apparently die within roughly 5 weeks of their emergence (Wilde 1978; WDFW 1995). However, the mortality rates of adult and juvenile pygmy rabbits can vary considerably between years, and even between juvenile cohorts within years (Wilde 1978). Predation is the main cause of pygmy rabbit mortality (Green 1979). Potential predators include badgers (*Taxidea taxus*), long-tailed weasels (*Mustela frenata*), coyotes (*Canis latrans*), bobcats (*Felis rufus*), great horned owls (*Bubo virginianus*), long-eared owls (*Asio otus*), ferruginous hawks (*Buteo regalis*), and northern harriers (*Circus cyaneus*) (Janson 1946; Gashwiler *et al.* 1960; Green 1978; Wilde 1978; WDFW 1995).

Population cycles are not known in pygmy rabbits, although local, relatively rapid population declines have been noted in several States (Bradfield 1974; Weiss and Verts 1984; WDFW 1995). After initial declines, pygmy rabbit populations may not have the same capacity for rapid increases in numbers as other Leporids due to their close association with specific components of sagebrush ecosystems (Wilde 1978; Green and Flinders 1980b; WDFW 1995).

Distribution and Status

The historic distribution of the pygmy rabbit included much of the semi-arid, shrub steppe region of the Great Basin and adjacent intermountain zones of the conterminous western United States (Green and Flinders 1980a), and likely included portions of Montana, Idaho, Wyoming, Utah, Nevada, California, Oregon, and Washington (Figure 1).

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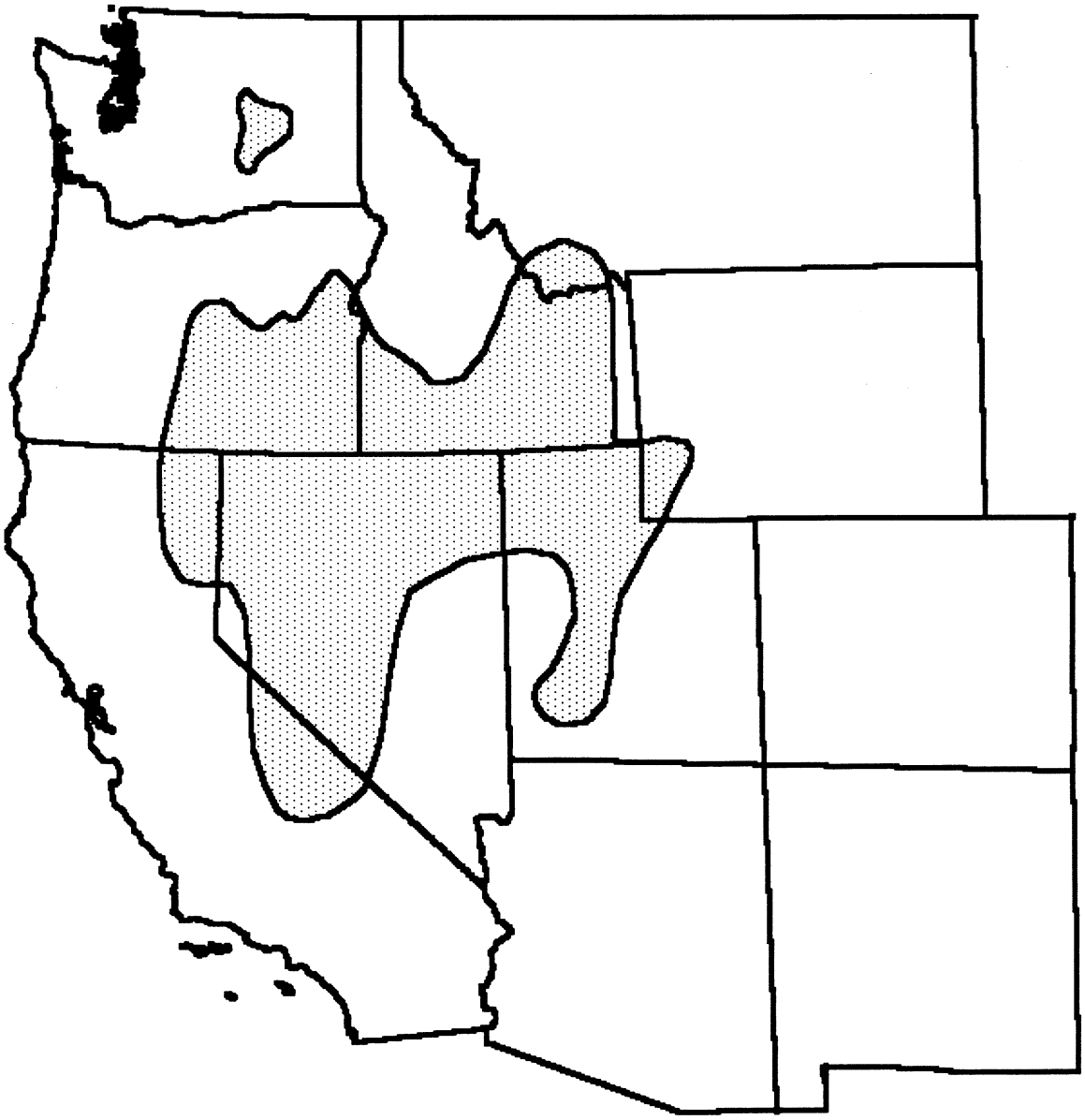

Figure 1. The approximate historic range-wide distribution of the pygmy rabbit (after Weiss and Verts 1984 and WDFW 1995).

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Currently, pygmy rabbits are not distributed continuously across their range, nor were they historically. Rather, they are found in areas within their broader distribution where sagebrush cover is sufficiently tall and dense, and where soils are sufficiently deep and loose to allow burrowing (Bailey 1936; Green and Flinders 1980a; Weiss and Verts 1984; WDFW 1995). The local distribution of these habitat patches, and thus pygmy rabbits, likely shifts across the landscape in response to various sources of disturbance (*e.g.*, fire, flooding, grazing, and crop production) combined with long- and short-term weather patterns. Historically, more dense vegetation along permanent and intermittent stream corridors, alluvial fans, and sagebrush plains probably provided travel corridors or dispersal habitat for pygmy rabbits between appropriate use areas (Green and Flinders 1980a; Weiss and Verts 1984; WDFW 1995). Since European settlement of the western United States, more dense vegetation associated with human activities (*e.g.*, fence rows, roadway shoulders, crop margins, and abandoned fields) also may have acted as avenues of dispersal between local populations of pygmy rabbits (Green and Flinders 1980a; Pritchett *et al.* 1987).

Prehistoric Distribution

The population segment of the pygmy rabbit within the Columbia Basin, a geographic area that extends from northern Oregon through eastern Washington (Quigley *et al.* 1997), is believed to have been disjunct from the remainder of the species' range since at least the early Holocene (10,000 to 7,000 years before present (BP)), as suggested by fossil records (Grayson 1987; Lyman 1991). This separation is in contrast to the relatively short-term, local patterns of isolation, extirpation, and recolonization that likely occur throughout pygmy rabbit range (above). The pygmy rabbit has been present in the Columbia Basin for at least 100,000 years and had a broader distribution during the mid-Holocene (roughly 7,000 to 3,000 years BP) (Lyman 1991). Gradual climate change affecting the distribution and composition of sagebrush communities is thought to have resulted in a reduction of pygmy rabbit range within the Columbia Basin during the late Holocene (3,000 years BP to present) (Grayson 1987; Lyman 1991).

Historic and Current Distribution

Pygmy rabbits have been considered rare for many years, with local areas of occurrence in Washington (Dalquest 1948), although there is little comprehensive information available regarding their historic distribution and abundance in the State (WDFW 1995). Museum specimens and reliable sight records indicate that, during the first half of the 1900s, pygmy rabbits probably occurred in at least five Washington counties, including Douglas, Grant, Lincoln, Adams, and Benton (Figure 2). Once thought to be extirpated from the State, pygmy rabbits were again located in Washington in 1979. Intensive surveys in 1987 and 1988 discovered five small colonies of pygmy rabbits in southern Douglas County; three occurred on State lands and two on private lands (WDFW 1995). With the exception of a single site record from Benton County in 1979, pygmy rabbits have been found only in southern Douglas and northern Grant Counties since 1956 (WDFW 2000a). The Washington Wildlife Commission designated the pygmy rabbit as a State threatened species in 1990 and reclassified it as endangered in 1993 (WDFW 1995).

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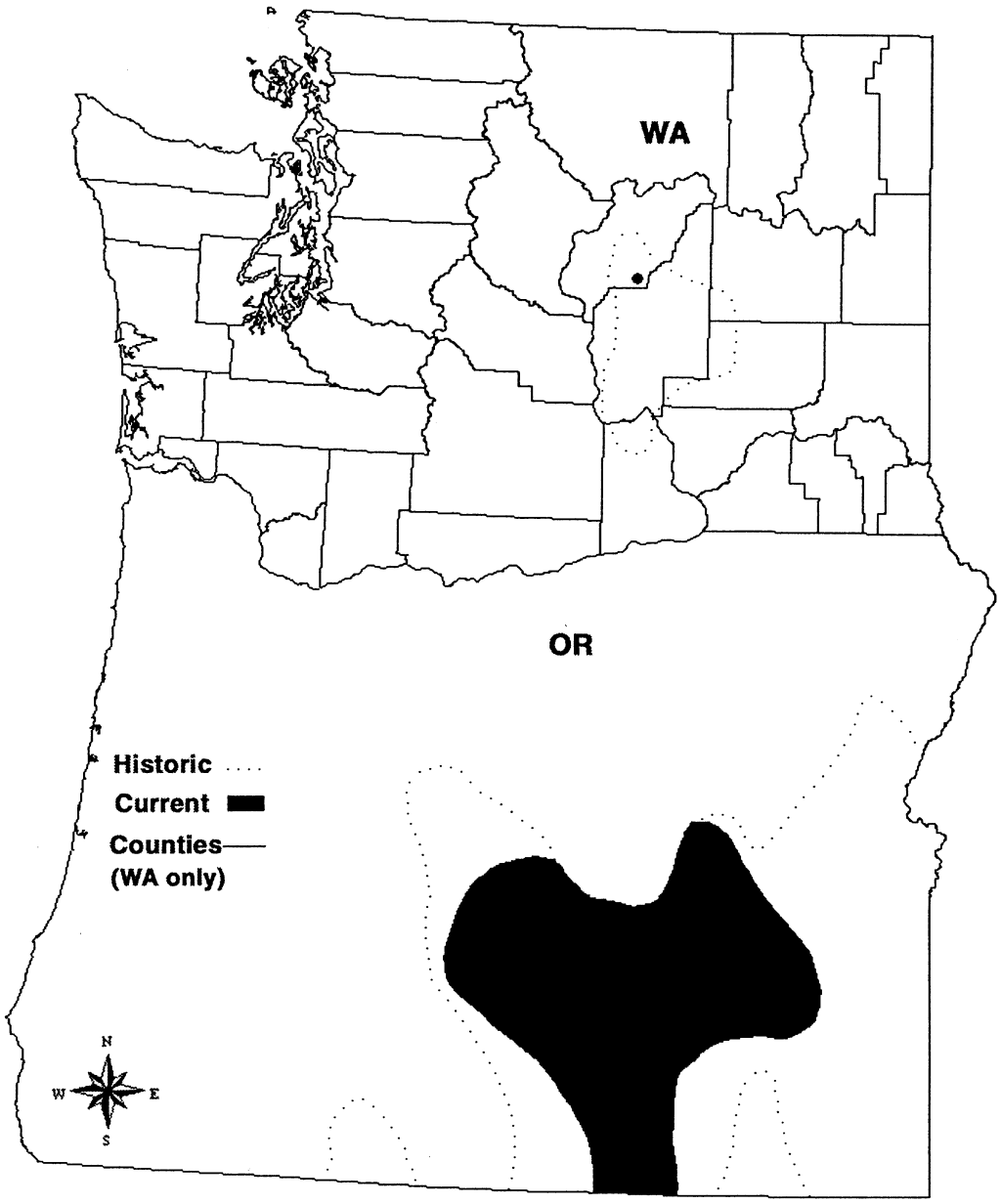

Figure 2. The approximate historic and current distribution of the pygmy rabbit in Washington and Oregon (after Weiss and Verts 1984, WDFW 1995).

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The number of pygmy rabbit colonies and active burrows in Washington has declined over the past decade (WDFW 2001a). Four of the five colonies located in 1987 and 1988 were very small, with fewer than 100 active burrows (WDFW 1995); the largest colony (at the State-owned Sagebrush Flat site in Douglas County) contained roughly 588 active burrows in 1993, when it was estimated to support fewer than 150 rabbits (Gahr 1993). While an additional colony was discovered on private land in northern Grant County in 1997, three of the small colonies originally located became extirpated during the 1990s, leaving just three known colonies in 1999 (WDFW 2001a).

One of the three remaining sites experienced a catastrophic fire in 1999 and declined to three active burrows, while the newly discovered site declined for unknown reasons to two active burrows following the winter of 1999–2000 (WDFW 2001a). These two colonies are now thought to be extirpated (WDFW 2001b; D. Hays and T. McCall, WDFW, pers. comm., 2001). In addition, during the winter of 1997–1998, the number of active pygmy rabbit burrows at Sagebrush Flat declined by approximately 50 percent, and has continued to decline each year since (WDFW 2001a). The entire wild pygmy rabbit population in Washington is now considered to consist of fewer than 50 individuals, possibly from just one known colony at Sagebrush Flat in Douglas County (T. McCall, pers. comm., 2001).

Although habitat loss and fragmentation likely have played a primary role in the long-term prehistoric and historic decline of the pygmy rabbit in Washington, it is unlikely that these factors have directly influenced the post-1995 declines at Sagebrush Flat and the extirpations of some of the smaller populations (WDFW 2001a). Once populations decrease below a certain threshold, they become at risk of extirpation from a number of sources, including disease, predation, catastrophic event (*e.g.*, fire), and random environmental events (*e.g.* extreme weather) (WDFW 2001a). The remaining wild population of pygmy rabbits in Washington is currently at such risk and without immediate intervention, it likely will become extirpated within the near future.

Previous Federal Action

We added the pygmy rabbit to our candidate species list on November 21, 1991, as a category 2 species (56 FR 58804). A category 2 species was one for which we possessed information indicating that a proposal to list it as threatened or endangered under the Act was possibly appropriate, but for which conclusive data on biological vulnerability and threats was not available to support a proposed rule. On February 28, 1996, we discontinued the designation of category 2 species as candidates for listing under the Act (61 FR 7596). Species that were formerly category 2 candidates currently are watched, managed, and protected by the States they occupy and by the Service field offices in those States, but have no Federal regulatory status. We are currently planning a status review of the pygmy rabbit range-wide to determine if further Federal regulatory protection for the species is appropriate.

The processing of this emergency rule conforms with our updated Listing Priority Guidance, published in the **Federal Register** on October 22, 1999 (64 FR 57114). The guidance clarifies the order in which we process rule-makings. Highest priority is given to processing emergency listing rules for any species determined to face a significant risk to its well-being. Second priority is the processing of final determinations on proposed additions to the lists of endangered and threatened wildlife and plants. Third priority is processing new proposals to add species to the lists. The processing of administrative petition findings (petitions filed under section 4 of the Act) is the fourth priority.

Current Management Actions

The WDFW has undertaken a variety of conservation actions for pygmy rabbits in Washington since 1979 (WDFW 1995; WDFW 2001a). These actions have included population surveys, habitat inventories, land acquisitions, habitat restoration, land management agreements, initiation of studies on the effects of grazing, and emergency predator control. Some of these efforts have been partially funded by the Bonneville Power Administration. As funding sources and staffing levels allow, WDFW efforts to conserve pygmy rabbits in the wild will continue (D. Hays, pers. comm., 2001).

During the fall of 2000, in cooperation with the Oregon Zoo, the WDFW initiated a study of husbandry techniques for pygmy rabbits (WDFW 2001a). This study used five pygmy rabbits captured in Idaho and was undertaken to improve the information base for proposed captive rearing and release efforts for Washington's pygmy rabbits. Due to the continuing decline of pygmy rabbit colonies and active burrows in Washington, the WDFW, in cooperation with WSU, expedited their captive rearing efforts for pygmy rabbits in Washington during the spring of 2001 (WDFW 2001b; D. Hays, pers. comm., 2001).

The immediate goal of the effort for pygmy rabbits in Washington is to capture up to 20 animals to establish a captive breeding stock. The actual number and type (gender, age, family unit) of pygmy rabbits taken from the wild will be based partly on information from the ongoing husbandry study, and partly on estimates of what is needed to allow for appropriate manipulation of genetic lineages to better manage this population's unique genetic profile. Pygmy rabbits that are not considered essential to the captive rearing effort will be left in the wild, and ongoing management to protect this wild portion of the population will continue.

During the spring and early summer of 2001, eleven pygmy rabbits (seven female, four male) were captured from the Washington population as an initial source for captive breeding efforts (D. Hays, pers. comm., 2001). One male subsequently died, and the cause of its death is being investigated. The ten remaining rabbits appear to have adjusted well to the captive-rearing facilities and reproductive behavior has been observed, including the birth of a litter of five offspring (two female, three male) that was conceived in the wild (L. Shipley, pers. comm., 2001; D. Hays, pers. comm., 2001). The intent is to capture additional animals this year that will complement the genetic profiles and potential breeding scenarios of those already in captivity (D. Hays, pers. comm., 2001).

Ultimately, the goal of the captive rearing effort is to release Washington's pygmy rabbits back into wild habitats within the State where viable colonies can become re-established and the wild population can be recovered (WDFW 2001b; D. Hays, pers. comm., 2001). The number and size of the wild colonies necessary for recovery is yet to be determined. Pygmy rabbits within captive propagation facilities will not be counted toward recovery of the species; the captive propagation program affords an opportunity to protect and maintain the Columbia Basin pygmy rabbit until environmental conditions become more favorable to the survival of the species in the wild through natural cycles and as a result of habitat protection and enhancement. The timing and objectives for the release phase of the program will be further developed as the captive-rearing effort becomes established. The WDFW will remain the lead agency for these efforts, and has developed a Science Advisory Group to provide recommendations and technical oversight for the conservation program.

The group currently comprises State and Federal agency personnel, public zoo and university experts, representatives from non-governmental organizations, and private individuals with interests in the conservation of Washington's pygmy rabbits.

The Nature Conservancy (TNC), a non-governmental natural resource advocacy organization, has acquired, or obtained easements on, portions of the remaining shrub steppe habitat in southern Douglas and northern Grant Counties, including a recent acquisition of approximately 6,900 ha (17,000 ac) adjacent to the WDFW's Sagebrush Flat site. As appropriate, TNC lands in central Washington will be managed to support the conservation efforts for pygmy rabbits (C. Warner, TNC, pers. comm., 2001).

Portions of the remaining shrub steppe habitat in southern Douglas and northern Grant Counties are under the jurisdiction of the U.S. Bureau of Land Management (BLM) and the Washington Department of Natural Resources. Conservation measures for pygmy rabbits are also considered in the management of these agency lands (N. Hedges, BLM, pers. comm., 2001; D. Hays, pers. comm., 2001). Many of the existing and future land acquisitions and management actions of the TNC, BLM, and State agencies in this area are targeted at sites recently used by pygmy rabbits and at providing connectivity of appropriate habitats between these sites.

Large areas of privately owned lands in Douglas County are currently withdrawn from crop production and, under the 1985 Federal Conservation Reserve Program (CRP) (U.S. Department of Agriculture 1998), are planted to native and non-native vegetation. These lands, some of which have been set aside since the late 1980s, provide grass and shrub cover that may improve the habitat conditions of areas potentially occupied or used as dispersal corridors by pygmy rabbits. New and re-signed program contracts completed in 1998 increased the acreage of CRP lands in Douglas County. However, contracts extend for just 10 years and new standards for CRP lands are being implemented that require replanting of significant acreage under existing contracts (USDA 1998; Schroeder, WDFW, pers. comm., 2001). Presently, it is unclear what effects the CRP lands and recent changes to the program may have on pygmy rabbits in Washington.

Currently, we are assisting private landowners and their conservation districts with development of a county-wide Habitat Conservation Plan (HCP) for agricultural lands in Douglas County, Washington. When completed, the Foster Creek HCP will include measures to protect pygmy rabbits and will complement other, ongoing conservation efforts in Douglas County.

Distinct Vertebrate Population Segment

Pursuant to the Act, we must consider for listing any species, subspecies, or, for vertebrates, any distinct population segment (DPS) of these taxa if there is sufficient information to indicate that such action may be warranted. To implement the measures prescribed by the Act and Congressional guidance, the Service and National Marine Fisheries Service developed a joint policy in 1996 that addresses the recognition of DPSs for potential listing actions (61 FR 4722). The policy allows for more refined application of the Act that better reflects the biological needs of the taxon being considered, and avoids the inclusion of entities that do not require its protective measures.

Under our DPS policy, three elements are considered in a decision regarding the status of a possible DPS as endangered or threatened under the Act. Two of these elements are used to assess whether a population segment under consideration for listing constitutes a DPS; these elements are (1) the population segment's discreteness from the remainder of the taxon, and (2) the population segment's significance to the taxon to which it belongs. A systematic application of the above elements is appropriate, with discreteness criteria applied first, followed by significance analysis. If we determine that a population segment being considered for listing represents a DPS, then the third element, the status of the population in relation to the Act's standards for listing (*i.e.*, is the population segment, when treated as if it were a species, endangered or threatened), is evaluated based on the five listing factors established by the Act.

Discreteness

Discreteness may be demonstrated by either, or both, of the following: (1) Physical, physiological, ecological, behavioral, morphological, or genetic discontinuity between population segments, or (2) international governmental boundaries between which differences in regulatory mechanisms exist that are significant with regard to conservation of the taxon. The pygmy rabbit does not occur outside of the lower 48 conterminous United States and, therefore, the international boundary criterion does not apply to this emergency rule.

The population segment of the pygmy rabbit occupying the Columbia Basin has been physically discrete from the remainder of the taxon for several millennia (see Distribution and Status, above). In addition, there is recent evidence that the Columbia Basin population segment is ecologically and genetically discrete from the remainder of the taxon (see Significance, below). Based on this information, we find that the population segment of the pygmy rabbit within the Columbia Basin is discrete from the remainder of the taxon pursuant to the Act. Behavior, morphological, or physiological differences between pygmy rabbits of the Columbia Basin DPS and those from the remainder of the range are not known at this time, but given the genetic distinction and length of temporal separation, such differences would not be considered anomalous.

Significance

Our DPS policy provides several examples of the types of information that may demonstrate the significance of a discrete population segment to the remainder of its taxon, including, but not limited to (1) persistence of the population segment in an ecological setting unusual or unique for the taxon; (2) evidence that the population segment differs markedly from other population segments in its genetic characteristics; and (3) evidence that loss of the population segment would result in a significant gap in the range of the taxon. The following significance factors, presented in order of their significance, have bearing on the population segment of the pygmy rabbit that remains in central Washington.

Markedly different genetic characteristics. Several studies have been initiated to investigate the pygmy rabbit's genetic profile (WDFW 2000c; WDFW 2001a; Cegelski and Waits, undated). To date, the genetics analyses include recent (c. 1990 to present) samples from Washington, Idaho, and Montana, and museum specimens (c. 1900s to 1970s) from Washington, Montana, Idaho, Oregon, with a median date of 1949 (K. Warheit, WDFW, pers. comm., 2001; WDFW 2001c). Analyses have included both mitochondrial DNA and nuclear DNA markers (WDFW 2001c).

Results from recent genetic analyses indicate that the Washington population of the pygmy rabbit (the Columbia Basin population segment) is distinct and only distantly related to the other pygmy rabbit populations (WDFW 2001c; K. Warheit, pers. comm., 2001). In analyses of both mitochondrial and nuclear DNA indices, a single haplotype found to be

present in Washington pygmy rabbits was also found to be distinct from the three haplotypes shared by Oregon, Idaho, and Montana pygmy rabbits. These differences are consistent between recent (WA versus ID and MT) and museum (WA versus OR, ID, and MT) samples. The data also indicate that the Washington pygmy rabbit population diverged (*i.e.*, was genetically isolated) from the Montana and Idaho populations approximately 40,000 to 115,000 years ago, although a more conservative estimate would indicate 10,000 to 25,000 years of isolation (WDFW 2001c). These genetic differences more likely than not are similar to subspecific differences recognized in other mammals; exact taxonomic resolution will require additional study (WDFW 2001c).

The Columbia Basin population segment also exhibits significantly less genetic diversity compared to the other pygmy rabbit populations—a likely result of long-term isolation. Peripheral and isolated populations may experience increased directional selection due to marginal or varied habitats or species compositions at range peripheries, exhibit adaptations specific to these differing selective pressures, demonstrate genetic consequences of reduced gene flow dependent on varying levels of isolation, or have different responses to anthropogenic influences (Levin 1970; MacArthur 1972; Morain 1984; Lacy 1987; Hengeveld 1990; Saunders et al. 1991; Hoffmann and Blows 1994; Furlow and Armijo-Prewitt 1995; Garcia-Ramos and Kirkpatrick 1997). In addition, the level of genetic diversity found in tissue samples collected in Washington in the 1990s showed a continued and accelerated reduction in genetic variability, which may be associated with a recent rapid decline in population size and health (WDFW 2001c). Data showing a reduced within-individual genetic diversity suggest that the Washington population segment also may be experiencing a small degree of inbreeding (WDFW 2001c).

Based upon the above results of genetic analyses, it is clear that (1) the unique characteristics of the Columbia Basin population segment of pygmy rabbits represent an important component in the evolutionary legacy of the species and, therefore, a genetic resource worthy of conservation; and (2) efforts should be undertaken to address the recent decline in genetic diversity within this population segment (K. Warheit, pers. comm., 2001).

Persistence in an unusual or unique ecological setting. With regard to the historic distribution of the pygmy rabbit, several studies have defined and mapped landscape-level ecosystem components of Washington and Oregon and, to varying degrees, address the management of natural resources within these regional ecosystems (Daubenmire 1988; Franklin and Dyrness 1988; Keane *et al.* 1996; Quigley *et al.* 1997; Wisdom *et al.* 1998). There are a number of differences between these studies, however, the ecosystem mapping units that result are relatively consistent. This landscape level approach is important in determining if the population segment of the pygmy rabbit that remains in central Washington may occupy an unusual or unique ecological setting. In addition, its utility is valuable for determining the bounds of any potential DPS in the region, as required by our DPS policy.

During the early 1900s, the pygmy rabbit populations in Washington and Oregon (Figure 2) occurred in five ecosystems identified by the above studies. For the purposes of this DPS analysis, we refer to these ecosystems as the Columbia Basin, High Lava Plains, Northern Great Basin, Owyhee Uplands, and Modoc Plateau (after Quigley *et al.* 1997). The Columbia Basin occurs in Washington and northern Oregon; the other four ecosystems occur in central and southern Oregon (Figure 3). These ecosystems are interspersed to varying degrees with forested habitats of the Southern and Eastern Cascades ecosystems to the west, Okanogan Highlands to the north, and the Bitterroot and Blue Mountains to the east; and steppe (grassland) habitats of the Palouse Prairie to the east.

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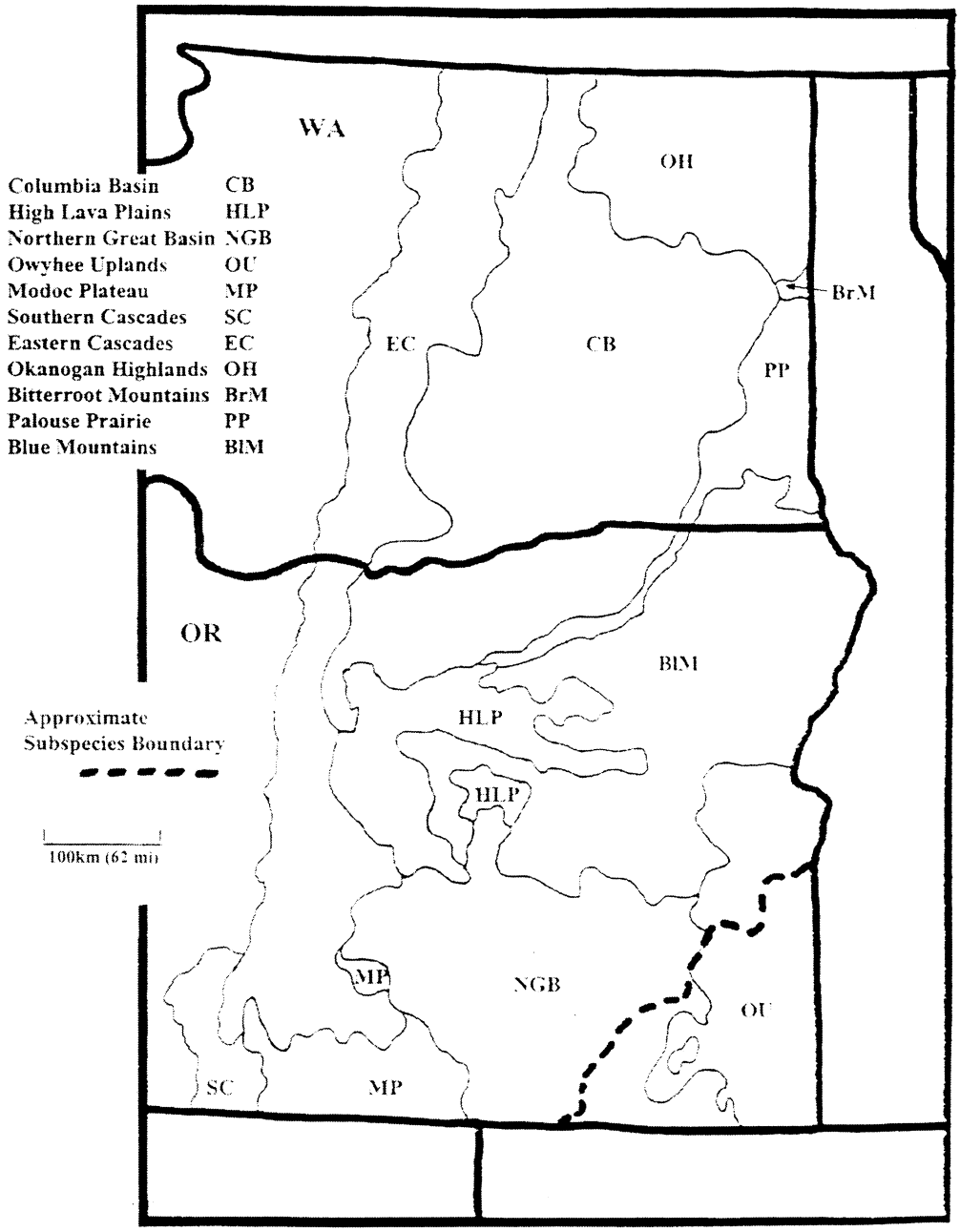

Figure 3. The ecosystems of eastern Washington and Oregon (as modified from Daubenmire 1988, Franklin and Dyrness 1988, Keane et al. 1996, and Quigley et al. 1997).

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The population segment of the pygmy rabbit in central Washington occurs entirely within the Columbia Basin, and has been the only representation of the taxon within this ecosystem for thousands of years. During the early 1900s, the population segment of the pygmy rabbit in central and southern Oregon was apparently locally dispersed across the High Lava Plains, Northern Great Basin, Owyhee Uplands, and Modoc Plateau (cf. Figures 2 and 3). The distribution of the pygmy rabbit in Oregon has likely declined during the last century (Weiss and Verts 1984; WDFW 2000b) and, currently, occurs primarily within the Northern Great Basin ecosystem.

A number of significant differences are found between the Columbia Basin and the balance of pygmy rabbit range in central and southern Oregon (Table 1). In general, the Columbia Basin is lower in elevation, contains soils of varying origin, and has been influenced by different geological processes. These structural differences, combined with regional climatic conditions, significantly influence the broad plant associations found within each ecosystem (Daubenmire 1988; Franklin and Dyrness 1988). Historically, transitional steppe habitats were much more prevalent in the Columbia Basin than in the ecosystems of central and southern Oregon. In contrast, juniper (*Juniperus* spp) woodlands and salt-desert shrub habitats were much more common in central and southern Oregon. Finally, there are significant differences in the type and distribution of sagebrush taxa among the ecosystems (Table 1).

TABLE 1.—DIFFERENCES IN ECOSYSTEM ELEMENTS BETWEEN REGIONS OCCUPIED BY THE EXTANT POPULATION SEGMENTS OF THE PYGMY RABBIT IN WASHINGTON AND OREGON (AFTER WINWARD 1980, DAUBENMIRE 1988, FRANKLIN AND DYRNESS 1988, MCNAB AND AVERS 1994, DOBLER ET AL. 1996, AND QUIGLEY ET AL. 1997).

ECOSYSTEM ELEMENTS: GEOLOGIC, EDAPHIC, AND TRANSITIONAL HABITATS

Population segment	Elevations	Soils	Channeled scablands	Internally-drained playas	Steppe	Juniper woodland	Salt-desert shrub
Columbia Basin	<3,000 ft	Deep/Loamy Glacial/Eolian.	Prominent (north).	Rare/Absent	Abundant (east)	Rare/Absent	Rare/Absent.
Central/Southern Oregon.	>3,500 ft	Thin/Rocky Volcanic (HLP) Deep/Alluvial (NGB, OU) [1].	Rare/Absent	Prominent (NGB, OU).	Rare/Absent	Abundant (HLP) Present (NGB, OU).	Abundant (NGB, OU).

ECOSYSTEM ELEMENTS: SAGEBRUSH (ARTEMSIA) TAXA [2]

Population segment	Basin ssp	Wyoming ssp	Mountain ssp	Low	Three-tip	Stiff	Early	Silver	Black
Columbia Basin.	Dominant	Present (west)	Rare/Absent ..	Rare/Absent ..	Abundant (north).	Abundant	Rare/Absent ..	Rare/Absent ..	Rare/Absent.
Central/Southern Oregon.	Rare/Absent ..	Dominant	Abundant	Abundant	Present (OU)	Present	Present (HLP)	Present (NGB, OU).	Present (NGB, OU).

[1] Element primarily applies to the ecosystems noted: HLP—High Lava Plains; NGB—Northern Great Basin; OU—Owyhee Uplands.
[2] Big Sagebrush (*A. tridentata*) Subspecies (ssp): Basin—*A.t. tridentata*, Wyoming—*A.t. wyomingensis*, Mountain—*A.t. vaseyana*; Low—*A. arbuscula*; Three-tip—*A. tripartita*; Stiff—*A. rigida*; Early—*A. longiloba*; Silver—*A. cana*; Black—*A. nova*.

There are a number of broad habitat associations in common between the Columbia Basin and the ecosystems of central and southern Oregon (Daubenmire 1988; Franklin and Dyrness 1988). However, even within these common habitat associations, notable differences exist. In general, the composition of forb species differs considerably between the Columbia Basin and the ecosystems in central and southern Oregon (*cf* Daubenmire 1988 and Franklin and Dyrness 1988). Even when the same forb species may be present, the two regions typically support different subspecies or varieties of these taxa (Hitchcock and Cronquist 1973).

Currently, it is unclear if pygmy rabbits occupying the Columbia Basin are different behaviorally or morphologically from other pygmy rabbits throughout the remainder of their historic range. However, based on the above information and the pygmy rabbit's close association with sagebrush ecosystems, we conclude that the Columbia Basin represents a unique ecological setting for the taxon due to its different geologic, climatic, edaphic (soil), and plant community components. The unique elements of the Columbia Basin respectively hold unique management implications for pygmy rabbits within this ecosystem (see Table 1).

Conclusion of DPS Evaluation. Based on the above consideration of the Washington population of the pygmy rabbit's discreteness and significance to the remainder of the species, we find that the population segment does represent a DPS. The population's discreteness is due to both its spatial and temporal separation from the remainder of the species. These separations are translated into ecological, physical, and genetic differences that account for the population's discreteness. The population segment's significance to the remainder of the taxon is due to (1) The unique genetic characteristics it possesses, (2) the significant gap in the historic range of the taxon that its loss would represent, and (3) the unique ecological setting of the Columbia Basin in which it persists.

As required by our DPS policy, we have determined that the bounds of this DPS are conterminous with the historic distribution of the pygmy rabbit within the Columbia Basin ecosystem (Figure 2). We refer to this population segment as the Columbia Basin pygmy rabbit for the remainder of this emergency rule and the accompanying proposed rule.

Status

After a thorough review and consideration of all available information, we have determined that the Columbia Basin pygmy rabbit is a DPS. To determine if the DPS should be listed as threatened or endangered, we

evaluate on the five factors described in section 4(a)(1) of the Act. These factors and their application to the Columbia Basin pygmy rabbit follows.

Summary of Factors Affecting the Species

After a thorough review and consideration of all available information, we have determined that the Columbia Basin pygmy rabbit warrants classification as an endangered species. We followed procedures found in section 4 of the Act and regulations promulgated to implement the listing provisions of the Act (50 CFR part 424). We may determine a species to be endangered or threatened due to one or more of the five factors described in section 4(a)(1). These factors and their application to the Columbia Basin pygmy rabbit follows.

A. *Present or threatened destruction, modification, or curtailment of habitat or range.* Reduction of the shrub steppe habitat of the Columbia Basin that is required by the pygmy rabbit began in the historic past and currently threatens extant populations of the species. During the first half of the 1900s, large portions of more mesic (moist) shrub steppe habitats on deeper soils within the Columbia Basin were converted for dryland crop production (Daubenmire 1988; Franklin and Dyrness 1988; WDFW 1995). During the mid-1900s, large-scale irrigation projects led to further conversion of more xeric (dry) shrub steppe habitats on deeper soils within the Columbia Basin for irrigated agriculture (WDFW 1995; Franklin and Dyrness 1988; U.S. Department of Interior (USDI) 1998). While currently at reduced levels, conversion of shrub steppe habitats to both dryland and irrigated crop production within the Columbia Basin continues. In addition, urban and rural developments (*e.g.,* housing, industrial facilities, transportation corridors) in central Washington permanently remove native shrub steppe habitats.

In 1994, it was estimated that approximately 60 percent of the original shrub steppe habitat in Washington had been converted for human uses (Dobler 1994). The Columbia Basin pygmy rabbit can not occupy these converted sites. Due to the small home ranges and relatively restricted movements of pygmy rabbits, conversion of native habitats in the Columbia Basin also removes or severely limits their dispersal corridors between suitable habitats.

A number of other, often interacting, influences affect the remaining native shrub steppe habitat within the Columbia Basin, including altered fire frequencies, invasion by non-native species, recreational activities, and grazing. Sagebrush is easily killed by fire and, when it occurs at increased frequencies, can remove sagebrush from the vegetation assemblage (Daubenmire 1988). In the absence of a sufficient seed source, sagebrush can not readily reinvade sites where it has been removed, and it may be many years before it can become reestablished (WDFW 1995). Due to a variety of factors (see below), the fire frequency has increased over portions of the remaining shrub steppe habitat within the Columbia Basin. Because of their close association with tall, dense stands of sage brush, pygmy rabbits are precluded from occupying frequently burned areas.

Various non-native, invasive plant species, such as cheatgrass and knapweed (*Centauria* spp), have become well established throughout the Columbia Basin (Daubenmire 1988; Franklin and Dyrness 1988). Areas with dense cover of cheatgrass are apparently avoided by pygmy rabbits (Weiss and Vert 1984). In addition, these newly established plant communities often provide fine fuels that can carry a fire. Combined with widespread unimproved road access and informal recreational activities that provide multiple sources of ignition, the establishment of non-native species increases the risk of fire and further reduces the security of areas that could potentially support the Columbia Basin pygmy rabbit (WDFW 1995).

Land managed for grazing is often cleared of sagebrush to increase the production of grasses and forbs as forage for cattle (WDFW 1995; Rauscher 1997). Clearing large areas of sagebrush cover removes habitat patches potentially used by the Columbia Basin pygmy rabbit. In addition, it can reduce the value of more marginal stands of sagebrush that may act as dispersal corridors for pygmy rabbits, further fragmenting the remaining suitable habitats. Cattle may also damage pygmy rabbit burrow systems through trampling (Rauscher 1997; N. Siegel, WSU, pers. comm., 2001). Much of the remaining shrub steppe habitat in the Columbia Basin is managed for livestock grazing (WDFW 1995; N. Hedges, pers. comm., 2001).

Excessive grazing removes current herbaceous growth and residual cover of native grasses and forbs, and can increase the density of various non-native, invasive species and young sagebrush stands (Daubenmire 1988; WDFW 1995). In some instances, this disturbance may eventually result in the growth of the tall, dense stands of sagebrush (Ellison 1960), potentially improving cover conditions for pygmy rabbits. However, grazing at these levels potentially reduces the forage base of grasses and forbs for Columbia Basin pygmy rabbits during spring and summer (Green and Flinders 1980b; Rauscher 1997). Excessive grazing may also cause structural damage to dense stands of older sagebrush due to trampling. This acts to open the canopies of these sites and potentially makes them less suitable as cover for Columbia Basin pygmy rabbits (Gahr 1993; Rauscher 1997). Currently, it is unclear if light or moderate levels of grazing may be compatible with pygmy rabbit conservation efforts, or, due to the current threat of extirpation, if any grazing is appropriate at this time. However, there are several ongoing studies investigating the effects of different grazing strategies on Columbia Basin pygmy rabbits and their habitat (WDFW 1995; Sayler *et al.* 2001; L. Shipley, pers. comm., 2001).

Due to the above combined influences, Washington's native shrub steppe habitats, including those considered essential to the long-term security of the Columbia Basin pygmy rabbit, are considered among the least-protected areas in the State (Cassidy 1997). Although many factors are affecting the decline of the Columbia Basin pygmy rabbit, the current population crisis is indirectly due to a lack of good, quality habitat that offers a balance of nutritional forage to maintain a healthy, disease-free, and growing population (see factor C) and cover for protection from predators and extreme weather conditions (see factors C and E).

B. *Over-utilization for commercial, recreational, scientific, or educational purposes.* Pygmy rabbits are often difficult to distinguish from species of cottontail rabbits (*Sylvilagus* spp.) (Garber 1993; WDFW 1995). Because of this, accidental shooting of Columbia Basin pygmy rabbits may occur in association with hunting of other small game species in Washington (WDFW 1979). Due to their extremely low numbers, restricted distribution, and preference for dense habitats, combined with relatively few visitors to the Sagebrush Flat site, the risk from incidental shooting of Columbia Basin pygmy rabbits is nominal (WDFW 1995; D. Hays, pers. comm., 2001). However, in such reduced populations, this possible source of mortality could lead to extirpation, if it is not controlled.

Investigations that require trapping, handling, and captivity of pygmy rabbits can result in mortality from several causes, including exposure (due to

excessively high or low temperatures), direct injury from entanglement in traps, trap predation, intra-specific fighting, and capture stress (Bailey 1936; Severaid 1950; Wilde 1978; Gahr 1993; Rauscher 1997). Capture-related mortality rates (including recaptures) reported for pygmy rabbits are roughly 3 percent (Gahr 1993), 5 percent (Wilde 1978), and 13 percent (Rauscher 1997). The mortality rate for one study approached 20 percent when the total number of captured animals was considered (11 deaths of 58 individuals). All of the mortalities in this study occurred in just one portion of the study area (Rauscher 1997). Trapping methods, daily and seasonal timing, study location, holding facilities, and husbandry techniques may all affect the level of capture-related mortality incurred.

Some pygmy rabbit burrows are relatively shallow and may collapse when walked on by humans or any similarly large animal (Wilde 1978). In addition, investigations of pygmy rabbits often entail the destruction of individual burrows, measuring of the vegetation community and other site characteristics immediately surrounding burrow systems, and/or disturbance to the general area occupied by colonies (Janson 1946; Bradfield 1974; Green 1978; Wilde 1978; Gahr 1993; Gabler 1997; Rauscher 1997).

It is unlikely that any of the above activities alone have played a significant role in the long-term population decline and range reduction of the Columbia Basin pygmy rabbit. However, due to the vulnerability of the extant population, any source of mortality that does not contribute directly to efforts to conserve the remaining wild and captive portions of the Columbia Basin pygmy rabbit population may contribute to its extirpation.

C. *Disease or predation.* Pygmy rabbits often harbor a high parasite load (Gahr 1993; WDFW 1995). Some of the parasites of pygmy rabbits, including ticks, fleas, and lice, can be vectors of disease. Episodes of plague and tularemia from these vectors have been reported in populations of a number of other Leporid species and are often rapidly spreading and fatal (Quan 1993). Severe disease epidemics have not been reported in pygmy rabbits, and parasites have not been viewed as a significant threat to the species (Davis 1939; Gahr 1993). However, recent evidence of plague found in a coyote in Sagebrush Flat has raised concern (WDFW 2001a). The potential for disease outbreaks within the remaining wild and captive portions of the Columbia Basin pygmy rabbit population remain, particularly where the population is stressed by predation and lack of adequate nutrition. The level of risk from disease to the Columbia Basin population segment is currently being investigated (WDFW 2001a).

Predation is thought to be a major cause of mortality among pygmy rabbits (Green 1979; Wilde 1978). While pygmy rabbits have adapted to the presence of a wide variety of predators that occur throughout their historic distribution (Janson 1946; Gashwiler *et al.* 1960; Green 1978; Wilde 1978; WDFW 1995), the threat of predation on the single extant population is great. Predation is not likely to represent a significant threat to relatively large, well-distributed pygmy rabbit populations. However, due to the extremely small size and localized occurrence of the Columbia Basin pygmy rabbit population, reducing or eliminating predation may play a significant role in conservation efforts for the remaining wild and captive portions of this population segment.

D. *Inadequacy of existing regulatory mechanisms.* The Washington State classification of the Columbia Basin pygmy rabbit as endangered makes it illegal to attempt to kill, injure, capture, harass, possess, or control individuals of the species (WDFW 1995). However, illegal or incidental shooting of pygmy rabbits may occur in association with hunting seasons for other small game species (see factor C above). In addition, State designation does not provide regulatory protection of the habitats considered essential to the long-term security of the Columbia Basin pygmy rabbit.

Currently, we are assisting private landowners with development of a county-wide HCP to protect important plant and animal species on agricultural lands in Douglas County. However, there are no regulatory protections for unlisted species during development of HCPs, and recovery of listed species may not be assured through management actions undertaken solely on private lands.

Revegetation standards under the CRP promote the improvement of habitats potentially used by the Columbia Basin pygmy rabbit, and the CRP restricts livestock grazing on contract lands except under severe drought conditions (M. Ruud, Farm Service Agency, pers. comm., 2001). However, these measures are not specifically promulgated for the protection of the Columbia Basin pygmy rabbit, and there are few other mechanisms that regulate grazing practices or the conversion of native habitats on privately owned lands.

E. *Other natural or human-caused factors affecting the species continued existence.* Presently, the primary threats to the Columbia Basin pygmy rabbit population are associated with its extremely small size, limited distribution, and level of fragmentation (see Reasons for Emergency Determination). Small populations are susceptible to random weather events (*e.g.,* severe storms, drought, and extended cold spells), changes in cover and food resources, disease outbreaks, altered predation or parasite populations, and fire. Small populations are also more susceptible to demographic and genetic problems (Caughly and Gunn 1996). These threat factors, which may act in concert, include natural variation in survival and reproductive success of individuals, chance imbalanced of sex ratios, changes in gene frequencies due to genetic drift, and lack of genetic diversity caused by inbreeding. Due to these combined influences, and its inability to be ''rescued'' by nearby populations should it become extirpated, the Columbia Basin pygmy rabbit population is currently believed to be below the level necessary to ensure its long-term viability (WDFW 1995).

Conclusion of Status Evaluation. Based upon our evaluation of the above five factors that may threaten the Columbia Basin DPS of the pygmy rabbit, using the best scientific and commercial data available, we have determined the DPS to be in danger of extinction. The recent loss of populations within the DPS, the very small number of individuals within the remaining single wild population, and the threats to this population concerned us to the extent that we decided to further evaluate the status of this DPS and to consider an emergency listing, as an endangered species. This further evaluation of the DPS's status is discussed below.

Reasons for Emergency Determination

Under section 4(b)(7) of the Act, we must consider development of an emergency rule to list a species if threats to the species constitute an emergency posing a significant risk to its well-being. Such an emergency listing expires 240 days following its publication in the **Federal Register** unless, during the 240-day period, we develop a final rule to list the species under our normal listing procedures. Below, we discuss the reasons why emergency listing of the Columbia Basin pygmy rabbit as endangered is necessary. In accordance with the Act, we will withdraw this emergency rule

if, at any time after its publication, we determine that substantial evidence does not exist to warrant such a rule.

The immediate concerns for the Columbia Basin pygmy rabbit are associated with the population's extremely small size, history of fragmentation and extirpation, and the recent, dramatic decline in its distribution and abundance. In addition to the relatively large-scale impacts to native shrub steppe habitats, various other human-caused and naturally occurring impacts of lesser magnitude now pose significant and imminent risks to this population segment. Due to the combined influence of the following threats-environmental stochasticity and catastrophe, predation, disease, and reduced genetic fitness-extirpation of the Columbia Basin pygmy rabbit from the wild may occur at any time (WDFW 2001b). In addition, the risks to the captive portion of the population and the potential for extinction of the Columbia Basin pygmy rabbit remain high.

Environmental Stochasticity and Catastrophes

Environmental stochasticities (random events) include the bad winters, resource failures, plagues of predators, and such that deliver shocks to populations. If a population is large enough, then such a shock can be withstood, although mortality within the population may be high. Often the population can rebound over time and recover its population numbers, either through birth or immigration from nearby populations. In the case of the Columbia pygmy rabbit, however, the size of the extant population is too small to withstand shock, even a small one, and be able to rebound; moreover, no neighboring population exists to ''rescue'' it through immigration.

While there are numerous examples of possible stochastic events that could affect the Columbia pygmy rabbit, fire has already had a catastrophic effect on the species and remains a real threat to the last remaining population. Fire was implicated in the loss of the only pygmy rabbit colony ever recorded in Benton County, Washington, in 1979 (WDFW 1995), and was directly associated with the recent loss of one of the few remaining colonies in Douglas County in 1999 (WDFW 2001b). The WDFW has taken measures to reduce the risk from fire at the Sagebrush Flat site (*e.g.,* constructing firebreaks). However, unimproved road access and informal recreational activities provide continuing sources (*e.g.,* people and vehicles) of uncontrolled fires at Sagebrush Flat (WDFW 1995). Due to the population's small size, restriction to one known site in the wild, and reliance on relatively tall, dense stands of sagebrush, natural and human-caused fire represents a significant threat to the Columbia Basin pygmy rabbit in the wild.

While plague is common in other Leporid species, it is not known in pygmy rabbits. However, evidence of plague was reported in a coyote taken from the site of one of the recently extirpated pygmy rabbit colonies (WDFW 2001a). The potential occurrence of plague in this colony is currently being investigated using blood samples obtained prior to its extirpation (D. Hays, pers. comm., 2001). Additional studies have been proposed to investigate the occurrence of diseases and their possible control in wild and captive populations of pygmy rabbits (C. Brand, National Wildlife Health Center, pers. comm., 2001). Because so few Columbia Basin pygmy rabbits remain, disease epidemic remains a significant threat to both the wild and captive portions of this population segment.

Emergency listing the Columbia Basin pygmy rabbit will increase regulatory efficiency in favor of protection for the species from stochasticity and the funding to support immediate recovery activities necessary for the species' survival. Protections could include increased population numbers and distribution in the wild to withstand catastrophe, and control of the sources of stochasticity and catastrophe where possible.

Predation

Populations of pygmy rabbits have coexisted with various levels of grazing throughout their historic range for many years (WDFW 1995). However, due to the extremely low number and restricted distribution of Columbia Basin pygmy rabbits, any additional mortality or population stress associated with grazing practices potentially represents a significant threat to the security of the wild portion of this population segment. The effects of different grazing strategies on Columbia Basin pygmy rabbits are not well understood (WDFW 1995). However, Gahr (1993) found that male pygmy rabbits at the Sagebrush Flat site made longer movements, resulting in larger home ranges, during the breeding season in recently grazed areas as opposed to areas that had not been grazed for nearly 40 years. In addition, relative to unit size, there are more pygmy rabbit burrows in the ungrazed areas of Sagebrush Flat than the recently grazed areas (L. Shipley and N. Siegel, pers. comm., 2001). These results suggest that Columbia Basin pygmy rabbits may be more susceptible to predation in areas used for livestock grazing due to the necessarily longer movements away from cover and fewer burrows available for escape.

Due to recent, confirmed evidence of coyote predation on pygmy rabbits, the WDFW implemented an emergency coyote control program during the fall-winter periods of 1998–1999 and 1999–2000 (WDFW 2000a). Coyotes were removed, by shooting, traps, and snares, over roughly 20 square miles around and including the Sagebrush Flat site. The level of effort to control coyotes varied in different years and areas, and the efficacy of this program to protect the Columbia Basin pygmy rabbit is unknown. A variety of other avian and terrestrial predators may occur on sites currently occupied by the Columbia Basin pygmy rabbit. Because of the relatively restricted distribution of this population segment, combined with potential impacts from livestock grazing (above), predators may have a reduced search area or increased success rate for pygmy rabbits at these sites.

Within the captive breeding population sites of the Columbia Basin pygmy rabbit, several measures (*e.g.,* double fencing and monitoring) have been taken to reduce the risk of predation (L. Shipley and R. Sayler, WSU, pers. comm., 2001). However, while the risk has been reduced, currently only a single captive-rearing facility is in operation and the potential for predators to access some of the outdoor cages at this facility remains.

Even low levels of predation represent a significant risk to the immediate security of both the wild and captive portions of this species. Emergency listing of the Columbia Basin pygmy rabbit as endangered will increase the regulatory protections and resources for predator control and other forms of range management until this population can withstand ''normal'' predation pressure.

Viability, Fitness

Genetic indices indicate that the Columbia Basin pygmy rabbit has significantly less genetic diversity than the remainder of the taxon. In addition, this population segment has undergone an accelerated loss of genetic diversity since the mid-1900s. Severe loss of genetic diversity may make the Columbia Basin pygmy rabbit more susceptible to extinction due to inbreeding depression. Reduced genetic diversity and the relatively few family lineages remaining in the Columbia Basin pygmy rabbit population also may complicate captive breeding strategies

conducted to reestablish a minimum effective population size (*i.e.,* the number of individuals contributing to reproduction). Ultimately, an appropriate effective population size will help to ensure the maintenance and enhancement of the genetic heterogeneity still present within this population segment (K. Warheit, pers. comm., 2001).

Reproductive fitness is not only a function of genetic health, however; nutritional stress also may have a devastating effect on reproductive fitness and the overall viability of a population, particularly in the defense of diseases and plagues; animal populations are ultimately limited by the capacity of the environment to support them. The preliminary results of an ongoing study indicate that pygmy rabbits occupying sites where cattle grazing occurs may have a greater proportion of their spring and summer diets composed of sagebrush as opposed to the grasses that they require at this time of year, which is usually as much as 40 percent (L. Shipley and N. Siegel, pers. comm., 2001). This result provides support for the contention that livestock may compete directly with pygmy rabbits for available forage (Green and Flinders 1980b; Rauscher 1997), thus causing the rabbits to become nutritionally stressed at a time when they require grass in their diet or the population level to become lower than the land would support without the influence of livestock.

Summary of Emergency Determination

Due to the extremely small size of the Columbia Basin pygmy rabbit population, even a low level of mortality due to stochastic events, disease, nutritional stress, and predation represents a significant risk to the immediate security of both the wild and captive portions of the species. Emergency listing of the Columbia Basin pygmy rabbit as endangered will increase the regulatory protections and resources available to the species in predator control and other forms of range management that are designed to improve the nutritional capacity of the habitat in favor of the pygmy rabbit. Recovery of the Columbia Basin pygmy rabbit is dependent upon a self-sustaining wild population that can withstand the threats that could lead to extinction. Reestablishment, therefore, of a wild population through the use of a rigorous captive propagation program is a necessary step towards recovery.

Critical Habitat

Critical habitat is defined in section 3 of the Act as—(i) the specific area within the geographical area occupied by a species, at the time it is listed in accordance with the Act, on which are found those biological features (I) essential to the conservation of the species and (II) that may require special management considerations or protection; and (ii) specific areas outside the geographical area occupied by a species at the time it is listed, upon a determination that such areas are essential for the conservation of the species. '''Conservation''' means the use of all methods and procedures needed to bring the species to the point at which listing under the Act is no longer necessary.

Section 4(a)(3) of the Act and its implementing regulations (50 CFR 424.12) require that, to the maximum extent prudent and determinable, the Secretary of the Interior (Secretary) designate critical habitat at the time the species is determined to be endangered or threatened. The implementing regulations state that critical habitat is not determinable if information sufficient to perform the required analyses of impacts of the designation is lacking, or if the biological needs of the species are not sufficiently well known to permit identification of an area as critical habitat. Section 4(b)(2) of the Act requires us to consider economic and other relevant impacts of designating a particular area as critical habitat on the basis of the best scientific data available. The Secretary may exclude any area from critical habitat if she determines that the benefits of such exclusion outweigh the conservation benefits, unless to do so would result in the extinction of the species.

We find that designation of critical habitat for the Columbia Basin pygmy rabbit is not determinable at this time because information sufficient to perform the required analyses of the impacts of the designation is lacking. We specifically solicit this information in the proposed rule (see Public Comments Solicited section), published in this same issue of the **Federal Register**. When a ''not determinable'' finding is made, we must, within 2 years of the publication date of the original proposed rule, designate critical habitat, unless the designation is found to be not prudent. We will protect the Columbia Basin pygmy rabbit and its habitat through section 7 consultations to determine whether Federal actions are likely to jeopardize the continued existence of the species, through the recovery process, through enforcement of take prohibitions under section 9 of the Act, and through the section 10 process for activities on non-Federal lands with no Federal nexus.

Available Conservation Measures

Conservation measures provided to species listed as endangered or threatened under the Act include recognition, requirements for Federal protection, prohibitions against certain activities, and development of recovery plans. Recognition through listing encourages conservation actions by Federal, State, and tribal agencies, non-governmental conservation groups, and private individuals. The Act provides for potential land acquisition and cooperation with the States and requires that recovery actions be carried out for listed species. Below, we discuss the requirements of Federal agencies, considerations for protection and conservation actions, and the prohibitions against taking and harm for the Columbia Basin pygmy rabbit.

Section 7(a) of the Act requires Federal agencies to evaluate their actions with respect to any species that is proposed or listed as endangered or threatened, and with respect to its critical habitat when it is designated. Federal agencies are required to confer with us on any action that is likely to jeopardize the continued existence of a proposed species or result in destruction or adverse modification of proposed critical habitat. When a species is listed as threatened or endangered, Federal agencies must ensure that the activities they authorize, fund, or carry out are not likely to jeopardize the continued existence of such a species, or to destroy or adversely modify its critical habitat. If a Federal action may affect a listed species or its critical habitat, the responsible Federal agency must enter into consultation with us. Federal agency actions that may require consultation for the Columbia Basin pygmy rabbit include, but are not limited to, those within the jurisdictions of the U.S. Fish and Wildlife Service, Bureau of Land Management, Bureau of Reclamation, Natural Resources Conservation Service, and Farm Service Agency.

We believe that protection and recovery of the Columbia Basin pygmy rabbit, in both wild and in captive breeding populations, will require reduction of the threats from uncontrolled fire, excessive livestock grazing, altered predation patterns, disease, and loss of genetic viability. These threats should be considered for management actions in habitats currently and potentially occupied by the Columbia Basin pygmy rabbit, and those deemed important for dispersal between their appropriate use areas. Monitoring should also be undertaken

for any management actions or scientific investigations designed to address these threats or their potential impacts.

Listing the Columbia Basin pygmy rabbit provides for the development and implementation of a recovery plan for the species. This plan will bring together Federal, State, and local efforts for conservation of the species. A recovery plan will establish a framework for agencies to coordinate their recovery efforts. The plan will set recovery priorities and estimate the costs of the tasks necessary to accomplish the priorities. It will also describe the site-specific management actions necessary to achieve conservation and survival of the species.

Listing will require us to review and provide direction or guidance on any actions that may affect the Columbia Basin pygmy rabbit on lands or activities under Federal jurisdiction, State plans developed pursuant to section 6 of the Act, scientific investigations and efforts to enhance the propagation or survival of the population segment pursuant to section 10(a)(1)(A) of the Act, and Conservation Plans developed for non-Federal lands and activities pursuant to section 10(a)(1)(B) of the Act.

Considerations for management actions and scientific investigations to address the above threats to the Columbia Basin pygmy rabbit include, but are not limited to:

(1) *Fire:* Implementation of agreements between fire-fighting districts to provide adequate coverage, construction of fire breaks, availability of fire-fighting equipment, fire-fighting techniques, weed control, use of prescribed fire, and removal or restriction of unimproved road access and informal recreational activities;

(2) *Livestock Grazing:* Season(s) of use, stocking rate(s) and type(s), location of supplemental watering and salting, loading and transport facilities, exclusion fencing, and removal;

(3) *Predation:* Identification of primary predators and predation patterns, development of protocols for fence removal and/or new fence construction, and predator deterrents and/or lethal control of predators to protect the wild and captive portions of the population;

(4) *Disease:* Identification and control of potential disease and disease vectors in wild and captive portions of the population;

(5) *Capture, Husbandry, and Release:* Development of protocols for capture and handling, establishment of multiple holding facilities for captive stock, inventory and evaluation of appropriate release sites, and development of release protocols;

(6) *Genetics:* Identification of additional genetic markers, implementation of an appropriate breeding scenario, and establishment of a minimum effective population for captive breeding and release efforts.

The Act sets forth a series of general prohibitions and exceptions that apply to all endangered wildlife species. The prohibitions make it illegal for any person subject to the jurisdiction of the United States to take (including harass, harm, pursue, hunt, shoot, wound, kill, trap, capture, collect, or attempt any such conduct), import or export, transport in interstate or foreign commerce in the course of commercial activity, or sell or offer for sale in interstate or foreign commerce any endangered wildlife species. It is also illegal to possess, sell, deliver, carry, transport, or ship any such wildlife that has been taken illegally. Certain exceptions apply to our agents and State conservation agencies. Permits may be issued to carry out otherwise prohibited activities involving listed species. Such permits are available for scientific purposes, to enhance the propagation or survival of the species, or for incidental take in connection with otherwise lawful activities.

It is our policy, published in the **Federal Register** on July 1, 1994 (59 FR 34272), to identify, to the maximum extent practical at the time a species is listed, those activities that would or would not constitute a violation of section 9 of the Act. The intent of this policy is to increase public awareness of the effect of a listing on proposed and ongoing activities within a species' range. For the Columbia Basin pygmy rabbit, activities that we believe are unlikely to result in a violation of section 9 include:

(1) Possession, delivery, or movement, including interstate transport and import into or export from the United States of dead specimens of Columbia Basin pygmy rabbits that were collected prior to the date of publication of this emergency listing rule in the **Federal Register**;

(2) Any action authorized, funded, or carried out by a Federal agency that may affect the Columbia Basin pygmy rabbit when the action is conducted in accordance with incidental take statement issued under section 7 of the Act;

(3) Any action carried out for scientific research or to enhance the propagation or survival of the Columbia Basin pygmy rabbit that is conducted in accordance with the conditions of a section 10(a)(1)(A) permit; and

(4) Any indidental take of the Columbia Basin pygmy rabbit resulting from an otherwise lawful activity conducted in accordance with the conditions of an incidental take permit issued under section 10(a)(1)(B) of the Act. Non-Federal applicants design a conservation plan (HCP) for the species and apply for an incidental take permit. These are developed for listed species and are designed to minimize and mitigate impacts to the species to the greatest extent practicable.

Activities that we believe could potentially result in a violation of section 9 include, but are not limited to:

(1) Activities authorized, funded, or carried out by Federal agencies (*e.g.,* land exchanges, land clearing, prescribed burning, grazing, pest control, utility line or pipeline construction, mineral and housing development, off-road vehicle use, recreational trail and campground development, and road construction) that may affect the Columbia Basin pygmy rabbit or its critical habitat when such activities are not conducted in accordance with an incidental take statement issued under section 7 of the Act;

(2) Unauthorized possession, trapping, handling, collecting, or release of pygmy rabbits within the historic range of the Columbia Basin pygmy rabbit. Research efforts involving these activities will require a permit under section 10(a)(1)(A) of the Act;

(3) Activities that directly or indirectly result in the death or injury of Columbia Basin pygmy rabbits, or that modify occupied habitat and kill or injure them by significantly impairing their essential behavioral patterns (*e.g.,* shooting, poisoning, habitat conversion, grazing, road and trail construction, water development and impoundment, mineral extraction or processing, off-road vehicle use, and unauthorized application of herbicides or pesticides in violation of label restrictions). Otherwise lawful activities that incidentally take Columbia Basin pygmy rabbits will require a permit under section 10(a)(1)(B) of the Act.

Questions regarding specific activities should be directed to our Upper Columbia Fish and Wildlife Office (see **ADDRESSES** section). Requests for copies of the regulations regarding listed wildlife, including prohibitions and issuance of permits under the Act, may be addressed to the U.S. Fish and Wildlife Service, Ecological Services, Endangered Species Permits, 911 Northeast 11th Avenue, Portland, Oregon 97232–4181 (telephone (503) 231–2063; facsimile (503) 231–6243).

National Environmental Policy Act

We have determined that environmental assessments and environmental impact statements, as defined in the National Environmental Policy Act of 1969, need not be prepared in connection with regulations adopted pursuant to section 4(a) of the Endangered Species Act of 1973, as amended. We published a notice outlining our reasons for this determination in the **Federal Register** on October 25, 1983 (48 FR 49244).

Paperwork Reduction Act

This rule does not contain any new collections of information other than those already approved under the Paperwork Reduction Act, 44 U.S.C. 3501 *et seq.*, and assigned Office of Management and Budget clearance number 1018–0094. 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 control number. For additional information concerning permit and associated requirements for endangered species, see 50 CFR 17.21 and 17.22.

Executive Order 13211

On May 18, 2001, the President issued an Executive Order (E.O. 13211) on regulations that significantly affect energy supply, distribution, and use. Executive Order 13211 requires agencies to prepare Statements of Energy Effects when undertaking certain actions. This rule is not expected to significantly affect energy supplies, distribution, or use. Although this rule is a significant regulatory action under Executive Order 12866, it is not expected to significantly affect energy supplies, distribution, or use. Therefore, this action is not a significant energy action and no Statement of Energy Effects is required.

References Cited

A complete list of references cited herein is available upon request from the Upper Columbia Fish and Wildlife Office (see **ADDRESSES** section).

Author

The primary author of this emergency rule is Christopher Warren of the Upper Columbia Fish and Wildlife Office (see **ADDRESSES** section).

List of Subjects in 50 CFR Part 17

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

Regulation Promulgation

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

PART 17—[AMENDED]

1. The authority citation for part 17 will read as follows:

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

2. In § 17.11(h), add the following to the List of Endangered and Threatened Wildlife in alphabetical order under MAMMALS:

§ 17.11 Endangered and threatened wildlife.

* * * * *

(h) * * *

Species		Historic Range	Vertebrate population where endangered or threatened	Status	When listed	Critical habitat	Special rules
Common name	Scientific name						
MAMMALS							
*	*	*	*	*	*	*	
Rabbit, Columbia Basin pygmy.	*Brachylagus idahoensis*.	U.S.A. (Western conterminous States).	U.S.A. (WA—Douglas, Grant, Lincoln, Adams, Benton Counties).	E	.....	NA	NA
*	*	*	*	*	*	*	

Dated: November 21, 2001.

Marshall P. Jones, Jr.,

Acting Director, Fish and Wildlife Service.

[FR Doc. 01–29615 Filed 11–29–01; 8:45 am]

BILLING CODE 4310–55–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Parts 223 and 224

[I.D. 111901A]

Exemption to No-entry Zone Around Chirikof Island, AK

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

ACTION: Notification of authorized exemption to the 3-nautical mile (nm) no-entry zone around Chirikof Island, AK.

SUMMARY: Pursuant to regulations under the Endangered Species Act, the Regional Administrator, Alaska Region, NMFS, is authorizing an exemption to the 3-nm, no-entry zone around Chirikof Island for the sole purpose of livestock removal by the U.S. Fish and Wildlife Service. Regulations allow an exemption to the no-entry zone, provided that the activity is authorized by the Regional Administrator, Alaska Region, NMFS, that the activity will not have a significant adverse effect on Steller sea lions, and that no readily available and acceptable alternative site exists for the activity.

SUPPLEMENTARY INFORMATION: On October 4, 2001, the U.S. Fish And Wildlife Service (USFWS) requested an exemption under Federal regulations for the management of the Steller sea lions (at 50 CFR parts 223 and 224) to allow for passage through the 3–nm no-entry zone in the Southwest Anchorage of Chirikof Island to facilitate livestock removal. Chirikof Island is part of the Alaska Maritime National Wildlife Refuge. The USFWS is working cooperatively with a private consortium to remove unauthorized livestock from refuge lands on Chirikof Island to facilitate the natural recovery of the ecosystem health of the island after more than a century of livestock grazing. This activity is part of an overall effort to remove introduced animals, including cattle and feral foxes, from the island.

USFWS proposes to remove livestock over a 2–year period beginning in October 2001. All activities will occur

in areas outside the exclusion zones established for the listed Steller sea lion rookery, except at the Southwest Anchorage of the island, which is located several miles from, and out of sight of, the rookery. Therefore, the rookery should not be disturbed by this activity.

Regulations governing endangered species (50 CFR part 224) state that provisions in part 223 also apply to the endangered western stock of Steller sea lions. Section 223.202 (b)(5) allows an exemption to the no-entry zone provided that the activity is authorized by the Regional Administrator, Alaska Region, NMFS, that the activity will not have a significant adverse effect on Steller sea lions, and that no readily available and acceptable alternative site exists for the activity. The Regional Administrator has determined that this activity will not adversely affect Steller sea lions. Therefore, NMFS granted an exemption from the 3–nm no-entry restriction around Chirikof Island, AK for the removal of livestock and other appropriate feral wildlife by the USFWS. All other provisions included in 50 CFR 223.202 (a) apply.

Dated: November 23, 2001.

David Cottingham

Acting Director, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. 01–29767 Filed 11–29–01; 8:45 am]

BILLING CODE 3510–22–S

Proposed Rules

Federal Register
Vol. 66, No. 231
Friday, November 30, 2001

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.

DEPARTMENT OF THE INTERIOR

Office of Surface Mining Reclamation and Enforcement

30 CFR Part 916

[SPATS No. KS–022–FOR]

Kansas Regulatory Program

AGENCY: Office of Surface Mining Reclamation and Enforcement, Interior.

ACTION: Proposed rule; public comment period and opportunity for public hearing.

SUMMARY: We, the Office of Surface Mining Reclamation and Enforcement (OSM), are announcing receipt of a proposed amendment to the Kansas regulatory program (Kansas program) under the Surface Mining Control and Reclamation Act of 1977 (SMCRA or the Act). The Kansas Department of Health and Environment, Surface Mining Section (Kansas) is proposing to consolidate and revise its approved revegetation success guidelines. The amendment is intended to revise the Kansas program to be consistent with the corresponding Federal regulations and to improve operational efficiency.

This document gives the times and locations that the Kansas program and the proposed amendment to that program are available for public inspection, the comment period during which you may submit written comments on the proposed amendment, and the procedures that we will follow for the public hearing, if one is requested.

DATES: We will accept written comments until 4:00 p.m., c.s.t., December 31, 2001. If requested, we will hold a public hearing on the amendment on December 26, 2001. We will accept requests to speak at the hearing until 4:00 p.m., c.s.t. on December 17, 2001.

ADDRESSES: You should mail or hand deliver written comments and requests to speak at the hearing to John W. Coleman, Mid-Continent Regional Coordinating Center, at the address listed below.

You may review copies of the Kansas program, the amendment, a listing of any scheduled public hearings, and all written comments received in response to this document at the addresses listed below during normal business hours, Monday through Friday, excluding holidays. You may receive one free copy of the amendment by contacting OSM's Mid-Continent Regional Coordinating Center.

John W. Coleman, Mid-Continent Regional Coordinating Center, Office of Surface Mining, Alton Federal Building, 501 Belle Street, Alton, Illinois 62002, Telephone: (618) 463–6460.

Kansas Department of Health and Environment, Surface Mining Section, 4033 Parkview Drive, Frontenac, Kansas 66763, Telephone: (620) 231–8540.

FOR FURTHER INFORMATION CONTACT: John W. Coleman, Mid-Continent Regional Coordinating Center. Telephone: (618) 463–6460. Internet: jcoleman@osmre.gov.

SUPPLEMENTARY INFORMATION:

I. Background on the Kansas Program

Section 503(a) of the Act permits a State to assume primacy for the regulation of surface coal mining and reclamation operations on non-Federal and non-Indian lands within its borders by demonstrating that its program includes, among other things, ''* * * a State law which provides for the regulation of surface coal mining and reclamation operations in accordance with the requirements of this Act * * *; and rules and regulations consistent with regulations issued by the Secretary pursuant to this Act.'' See 30 U.S.C. 1253(a)(1) and (7). On the basis of these criteria, the Secretary of the Interior conditionally approved the Kansas program on January 21, 1981. You can find background information on the Kansas program, including the Secretary's findings, the disposition of comments, and the conditions of approval in the January 21, 1981, **Federal Register** (46 FR 5892). You can find later actions concerning the Kansas program at 30 CFR 916.10, 916.12, 916.15, and 916.16.

II. Description of the Proposed Amendment

By letter dated October 9, 2001 (Administrative Record No. KS–622), Kansas sent us an amendment to its program under SMCRA and the Federal regulations at 30 CFR 732.17(b). Kansas sent the amendment in response to deficiencies that we identified in Kansas' revegetation success guidelines in a previous final rule on August 19, 1992 (57 FR 37430). The amendment also includes changes made at Kansas' own initiative. Kansas proposes to amend the Kansas revegetation success guidelines entitled ''Revegetation Standards for Success and Statistically Valid Sampling Techniques for Measuring Revegetation Success.'' A brief summary of the changes are discussed below. The full text of the program amendment is available for your inspection at the locations listed above under **ADDRESSES.**

A. Preface

Kansas revised the preface to reflect the current revisions to its revegetation success guidelines. Kansas also removed language from the preface that was not approved by us in the August 19, 1992, final rule decision. The removed language appeared to exempt specific permits from certain requirements of Kansas' revegetation success guidelines.

B. Definitions

Kansas defined the following terms that are used throughout the Kansas revegetation success guidelines: Animal Unit Month (A.U.M.); Cropland; Desirable; Diverse; Effective; Forage; Global Positioning System (GPS); Historically Cropped; Kansas Department of Wildlife and Parks (KDWP); Kansas State University (KSU); Natural Resources Conservation Service (NRCS); Permanent; Previously Mined; Prime Farmland; Surface Mining Section (SMS); and Total Cover.

C. Tables

Kansas added three new tables. Table 1 contains productivity and ground cover vegetation requirements for Phase II and Phase III bond release of pasture land and grazing land; wildlife habitat, recreation, shelter belts, and forest products; and industrial, commercial, or residential land uses. Table 2 lists productivity and ground cover vegetation requirements for Phase II and

Phase III bond release of prime farmland. Table 3 contains productivity and ground cover vegetation requirements for Phase II and Phase III bond release of cropland.

D. Chapter I. Ground Cover Success

Kansas consolidated the substantive provisions of its approved ground cover success standards for all land uses in this chapter.

Section A covers the standard for ground cover on prime farmland, cropland, and pasture/grazing land. Section B discusses the standard for ground cover on previously mined areas. Section C provides the standard for ground cover on wildlife habitat, recreation, shelter belt, and forest product land use areas that have topsoil. Section D contains standards for ground cover on industrial, commercial, or residential land use areas that have topsoil. Sections E and F provide general information on pre-mining ground cover sampling criteria and techniques. Section G contains specific pre-mining ground cover sampling techniques. Section H provides specific post-mining ground cover sampling criteria. Finally, Section I covers specific post-mining ground cover sampling techniques.

E. Chapter II. Forage Production Success Standard

Kansas revised and consolidated the substantive provisions of its approved forage production success standards for all applicable land uses in this chapter. Kansas also added whole field harvest to the methods of data collection for forage.

Section A discusses the use of the United States Department of Agriculture, Natural Resources Conservation Service (USDA–NRCS) soil survey database for determining productivity of cool season grass seed mixtures. This database lists crop yields by the soil mapping units contained in the published county soil surveys for Kansas. Section A also discusses the USDA–NRCS database in Technical Guide Notice KS–145. This database is used for determining productivity of native grass seed mixtures. Section B contains information on methods of calculation using the Animal Unit Month (A.U.M.) values listed in the USDA–NRCS soil surveys for Kansas. Section C provides productivity standards for prime farmland forage crops. Section D covers the productivity standards for cropland forage crops. Section E covers the productivity standard for previously mined lands reconstructed to pasture and grazing land. Section F contains information on the productivity standards for pasture and grazing land. Section G discusses the methods of data collection, including use of representative areas with test plots or whole field harvesting. Section H contains specific forage crop production sampling criteria. Finally, Section I covers specific forage crop production sampling techniques.

F. Chapter III. Productivity Standard Databases for Row Crops

Kansas revised and consolidated the substantive provisions of its approved row crop production success standards for prime and non-prime farmland in this chapter. Kansas also added corn as an acceptable row crop under specified conditions.

Section A discusses the acceptable row crops for revegetation productivity. Section B contains information on the method of row crop production success standard calculations. Section C provides row crop sampling criteria. Section D contains the following sampling methods for data collection involving representative areas: test plots, whole field sampling, and whole field harvesting. Section E provides productivity sampling criteria for prime farmland row crops. Section F discusses productivity sampling criteria for non-prime farmland row crops. Finally, Section G contains row crop sampling techniques involving test plots and whole field sampling for grain sorghum (milo), wheat, soybeans, and corn.

In response to deficiencies that we identified in the August 19, 1992, final decision on Kansas' current revegetation success guidelines, Kansas revised its row crop sampling techniques for grain sorghum and wheat. To address the deficiencies, Kansas added provisions that require operators to make determinations of statistical sample adequacy based on sample weights corrected to a standard moisture content.

G. Chapter IV. Stem Density

Kansas consolidated its productivity success standards for trees and shrubs in this chapter. Section A discusses the general success standards for fish and wildlife habitat, recreation, shelter belt, and forest product land uses. Section B contains the Phase II and Phase III productivity success standards for these land uses. Section C provides information on productivity sampling criteria. Section D contains stem density sampling techniques. Section E discusses previously mined areas that are reclaimed to fish and wildlife habitat, recreation, shelter belt, or forest product land uses.

H. Appendix A, Plant Species List

Appendix A lists the plant species that are unacceptable for all land uses with specified exceptions. It lists the acceptable tree species for fish and wildlife habitat, recreation, shelter belt, and forest product land uses. It also lists the acceptable shrub and vine species for fish and wildlife habitat, recreation, and shelter belt land uses. In addition, it lists the acceptable legume species based on land use for revegetation productivity and ground cover. Finally, it lists the acceptable grass species based on land use for revegetation productivity and ground cover.

I. Appendix B, Animal Unit Month-Methods of Production Success Standard Calculations

Kansas is proposing a new Animal Unit Month (A.U.M.) value for use in calculating forage production. Kansas defines the A.U.M. as the monthly average pounds of forage needed to support each 1,000 pounds of cattle. Kansas submitted calculations and documentation to support an A.U.M. equal to 760 pounds of forage. Appendix B contains tables showing two methods of calculating the success standard for grain sorghum, soybeans, wheat, and corn by soil type. The documentation also included two methods of calculating forage production based on A.U.M. per soil type for cool season grass seed mixtures and warm season grass seed mixtures.

J. Appendix C, Production Data

Appendix C contains the USDA-NRCS Technical Guide Notice KS–145. This technical guide provides crop yields for wheat, grain sorghum, and soybeans by soil mapping units for specific counties in Kansas.

Appendix C also contains the USDA-NRCS Technical Guide Notice 210 for Kansas. This technical guide provides land capability and yields per acre of cropland for wheat, grain sorghum, and soybeans by soil mapping units for specific counties in Kansas.

K. Appendix D, Planting Reports

Appendix D contains the following planting reports: Forage/Pastureland Seeding Report; Cropland Seeding Report; Wildlife Seeding Report; and Woodland/Wildlife Seeding Report.

L. Appendix E, Reference Area Criteria

Kansas moved its previously approved provisions for reference areas to Appendix E. Kansas made minor wording changes throughout the provisions. Kansas also added the following new criterion to its list of

essential criteria for comparing revegetated and reference areas:

6. Seeding of the reference area will be at the same time as seeding of the revegetated area.

M. Appendix F, Representative Sample Field Area Definition and Test Plot Criteria

Appendix F discusses the use of data from representative sample field areas to prove row crop production success. This data is obtained from individual row crop test plots.

N. Appendix G, Measuring Grain Moisture

Appendix G contains a technical guidance document on using moisture meters for measuring the moisture content of grain. The document ''Measuring Grain Moisture Content On-Farm'' was published by the Kansas State University, Cooperative Extension Service.

III. Public Comment Procedures

Under the provisions of 30 CFR 732.17(h), we are seeking comments on whether the proposed amendment satisfies the applicable program approval criteria of 30 CFR 732.15. If we approve the amendment, it will become part of the Kansas program.

Written Comments: If you submit written or electronic comments on the proposed rule during the 30-day comment period, they should be specific, should be confined to issues pertinent to the notice, and should explain the reason for your recommendation(s). We may not be able to consider or include in the Administrative Record comments delivered to an address other than the one listed above (see **ADDRESSES**).

Electronic Comments: Please submit Internet comments as an ASCII, WordPerfect, or Word file avoiding the use of special characters and any form of encryption. Please also include ''Attn: SPATS NO. KS–022–FOR'' and your name and return address in your Internet message. If you do not receive a confirmation that we have received your Internet message, contact the Mid-Continent Regional Coordinating Center at (618) 463–6460.

Availability of Comments: Our practice is to make comments, including names and home addresses of respondents, available for public review during regular business hours at OSM's Mid-Continent Regional Coordinating Center (see **ADDRESSES**). Individual respondents may request that we withhold their home address from the administrative record, which we will honor to the extent allowable by law. There also may be circumstances in which we would withhold from the administrative record a respondent's identity, as allowable by law. If you wish us to withhold your name and/or address, you must state this prominently at the beginning of your comment. However, we will not consider anonymous comments. We will make all submissions from organizations or businesses, and from individuals identifying themselves as representatives or officials of organizations or businesses, available for public inspection in their entirety.

Public Hearing: If you wish to speak at the public hearing, contact the person listed under **FOR FURTHER INFORMATION CONTACT** by 4:00 p.m., c.s.t. on December 17, 2001. We will arrange the location and time of the hearing with those persons requesting the hearing. If no one requests an opportunity to speak at the public hearing, the hearing will not be held.

To assist the transcriber and ensure an accurate record, we request, if possible, that each person who speaks at a public hearing provide us with a written copy of his or her testimony. The public hearing will continue on the specified date until all persons scheduled to speak have been heard. If you are in the audience and have not been scheduled to speak and wish to do so, you will be allowed to speak after those who have been scheduled. We will end the hearing after all persons scheduled to speak and persons present in the audience who wish to speak have been heard.

If you are disabled and need a special accommodation to attend a public hearing, contact the person listed under **FOR FURTHER INFORMATION CONTACT**.

Public Meeting: If only one person requests an opportunity to speak at a hearing, a public meeting, rather than a public hearing, may be held. If you wish to meet with us to discuss the proposed amendment, you may request a meeting by contacting the person listed under **FOR FURTHER INFORMATION CONTACT.** All such meetings are open to the public and, if possible, we will post notices of meetings at the locations listed under **ADDRESSES.** We will also make a written summary of each meeting a part of the Administrative Record.

IV. Procedural Determinations

Executive Order 12866—Regulatory Planning and Review

This rule is exempt from review by the Office of Management and Budget under Executive Order 12866.

Executive Order 12630—Takings

This rule does not have takings implications. This determination is based on the analysis performed for the counterpart Federal regulations.

Executive Order 13132—Federalism

This rule does not have federalism implications. SMCRA delineates the roles of the Federal and State governments with regard to the regulation of surface coal mining and reclamation operations. One of the purposes of SMCRA is to ''establish a nationwide program to protect society and the environment from the adverse effects of surface coal mining operations.'' Section 503(a)(1) of SMCRA requires that State laws regulating surface coal mining and reclamation operations be ''in accordance with'' the requirements of SMCRA, and section 503(a)(7) requires that State programs contain rules and regulations ''consistent with'' regulations issued by the Secretary under SMCRA.

Executive Order 12988—Civil Justice Reform

The Department of the Interior has conducted the reviews required by section 3 of Executive Order 12988 and has determined that, to the extent allowed by law, this rule meets the applicable standards of subsections (a) and (b) of that section. However, these standards are not applicable to the actual language of State regulatory programs and program amendments because each program is drafted and promulgated by a specific State, not by OSM. Under sections 503 and 505 of SMCRA (30 U.S.C. 1253 and 1255) and 30 CFR 730.11, 732.15, and 732.17(h)(10), decisions on proposed State regulatory programs and program amendments submitted by the States must be based solely on a determination of whether the submittal is consistent with SMCRA and its implementing Federal regulations and whether the other requirements of 30 CFR Parts 730, 731, and 732 have been met.

Executive Order 13211—Regulations That Significantly Affect the Supply, Distribution, or Use of Energy

On May 18, 2001, the President issued Executive Order 13211 which requires agencies to prepare a Statement of Energy Effects for a rule that is (1) considered significant under Executive Order 12866 and (2) likely to have a significant adverse effect on the supply, distribution, or use of energy. Because this rule is exempt from review under Executive Order 12866 and is not expected to have a significant adverse

effect on the supply, distribution, or use of energy, a Statement of Energy Effects is not required.

National Environmental Policy Act

Section 702(d) of SMCRA (30 U.S.C. 1292(d)) provides that a decision on a proposed State regulatory program provision does not constitute a major Federal action within the meaning of section 102(2)(C) of the National Environmental Policy Act (NEPA) (42 U.S.C. 4332(2)(C)). A determination has been made that such decisions are categorically excluded from the NEPA process (516 DM 8.4.A).

Paperwork Reduction Act

This rule does not contain information collection requirements that require approval by the Office of Management and Budget under the Paperwork Reduction Act (44 U.S.C. 3507 *et seq.*).

Regulatory Flexibility Act

The Department of the Interior has determined that this rule will not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*). The State submittal which is the subject of this rule is based upon counterpart Federal regulations for which an economic analysis was prepared and certification made that such regulations would not have a significant economic effect upon a substantial number of small entities. Accordingly, this rule will ensure that existing requirements previously promulgated by OSM will be implemented by the State. In making the determination as to whether this rule would have a significant economic impact, the Department relied upon the data and assumptions for the counterpart Federal regulations.

Small Business Regulatory Enforcement Fairness Act

This rule is not a major rule under 5 U.S.C. 804(2), the Small Business Regulatory Enforcement Fairness Act. This rule:

a. Does not have an annual effect on the economy of $100 million.

b. Will not cause a major increase in costs or prices for consumers, individual industries, federal, state, or local government agencies, or geographic regions.

c. Does not have significant adverse effects on competition, employment, investment, productivity, innovation, or the ability of U.S.-based enterprises to compete with foreign-based enterprises.

This determination is based upon the fact that the State submittal which is the subject of this rule is based upon counterpart Federal regulations for which an analysis was prepared and a determination made that the Federal regulation was not considered a major rule.

Unfunded Mandates

This rule will not impose a cost of $100 million or more in any given year on any governmental entity or the private sector.

List of Subjects in 30 CFR Part 916

Intergovernmental relations, Surface mining, Underground mining.

Dated: November 15, 2001.

Charles E. Sandberg,

Acting Regional Director, Mid-Continent Regional Coordinating Center.

[FR Doc. 01–29759 Filed 11–29–01; 8:45 am]

BILLING CODE 4310–05–P

DEPARTMENT OF THE TREASURY

31 CFR Part 1

Internal Revenue Service: Privacy Act; Proposed Implementation

AGENCY: Department of the Treasury.

ACTION: Proposed rule.

SUMMARY: In accordance with the requirements of the Privacy Act of 1974, 5 U.S.C. 552a, as amended, the Department of the Treasury, Internal Revenue Service (IRS) gives notice of a proposed rule to exempt a new system of records entitled ''Treasury/IRS 60.000—Employee Protection System Records'' from certain provisions of the Privacy Act. The exemptions are intended to comply with the legal prohibitions against the disclosure of certain kinds of information and to protect certain information, about individuals, maintained in this system of records.

DATES: Comments must be received no later than December 31, 2001.

ADDRESSES: Please submit comments to Office of Governmental Liaison and Disclosure, Internal Revenue Service, 1111 Constitution Ave., NW., Washington, DC 20224, CL:GLD:D. Persons wishing to review the comments should call (202) 622–5164 to make an appointment. This is not a toll free number.

FOR FURTHER INFORMATION CONTACT: Chief, Office of Employee Protection, Internal Revenue Service, 477 Michigan Avenue, Detroit, Michigan 48226, telephone (313) 628–3742. This is not a toll free number.

SUPPLEMENTARY INFORMATION: Under 5 U.S.C. 552a(k)(2), the head of an agency may promulgate rules to exempt a system of records from certain provisions of 5 U.S.C. 552a, if the system is investigatory material compiled for law enforcement purposes. The IRS compiles records in this system for law enforcement purposes. Treasury/IRS 60.000-Employee Protection System Records, contains records that enable the IRS to investigate incidents in which individuals assault, harass, or otherwise threaten IRS employees engaged in the assessment and collection of taxes. The IRS will use the information to ensure the protection of IRS employees and to notify IRS employees of the need to approach a taxpayer with caution.

The IRS is hereby giving notice of a proposed rule to exempt Treasury/IRS 60.000-Employee Protection System Records, from certain provisions of the Privacy Act pursuant to 5 U.S.C. 552a(k)(2). The proposed exemption is from provisions 552a(c)(3), (d)(1), (d)(2), (d)(3), (d)(4), (e)(1), (e)(4)(G), (H), (I), and (f) because the system contains investigatory material compiled for law enforcement purposes. The following are the reasons why this system of records maintained by the IRS is exempt pursuant to 5 U.S.C. 552a(k)(2) of the Privacy Act of 1974.

(1) 5 U.S.C. 552a(c)(3). This provision of the Privacy Act provides for the release of the disclosure accounting required by 5 U.S.C. 552a(c)(1) and (2) to the individual named in the record at his/her request. The reasons for exempting this system of records from the foregoing provision are:

(i) The release of disclosure accounting would put the subject of an investigation on notice that an investigation exists and that such person is the subject of that investigation.

(ii) Such release would provide the subject of an investigation with an accurate accounting of the date, nature, and purpose of each disclosure and the name and address of the person or agency to whom the disclosure was made. The release of such information to the subject of an investigation would provide the subject with significant information concerning the nature of the investigation and could result in the altering or destruction of documentary evidence, the improper influencing of witnesses, and other activities that could impede or compromise the investigation.

(iii) Release to the individual of the disclosure accounting would alert the individual as to which agencies were investigating the subject and the scope of the investigation and could aid the individual in impeding or

compromising investigations by those agencies.

(2) 5 U.S.C. 552a(d)(1), (d) (2), (d)(3), (d)(4), (e)(4)(G), (H), and (f). These provisions of the Privacy Act relate to an individual's right to be notified of the existence of records pertaining to such individual; requirements for identifying an individual who requested access to records; the agency procedures relating to access to records and the contest of the information contained in such records and the administrative remedies available to the individual in the event of adverse determinations by an agency concerning access to or amendment of information contained in record systems. The reasons for exempting this system of records from the foregoing provisions are as follows: To notify an individual at the individual's request of the existence of an investigative file pertaining to such individual or to grant access to an investigative file pertaining to such individual could interfere with investigative and enforcement proceedings; deprive co-defendants of a right to a fair trial or an impartial adjudication; constitute an unwarranted invasion of the personal privacy of others; disclose the identity of confidential sources and reveal confidential information supplied by such sources; and disclose investigative techniques and procedures.

(3) 5 U.S.C. 552a(e)(1). This provision of the Privacy Act requires each agency to maintain in its records only such information about an individual as is relevant and necessary to accomplish a purpose of the agency required to be accomplished by statute or executive order. The reasons for exempting this system of records from the foregoing are as follows:

(i) The IRS will limit its inquiries to information that is necessary for the protection of IRS employees engaged in the assessment and collection of taxes. However, an exemption from the foregoing is needed because, particularly in the early stages of an investigation, it is not possible to determine the relevance or necessity of specific information.

(ii) Relevance and necessity are questions of judgment and timing. What appears relevant and necessary when first received may subsequently be determined to be irrelevant or unnecessary. It is only after the information is evaluated that the relevance and necessity of such information can be established with certainty.

(iii) Not all violations of law discovered by the IRS fall within its investigative jurisdiction. To promote effective law enforcement, the IRS may disclose such violations to other law enforcement agencies, including State, local and foreign agencies that have jurisdiction over the offenses to which the information relates. Otherwise, the IRS might be placed in the position of having to ignore information relating to violations of law not within its jurisdiction when that information comes to IRS's attention during the collation and analysis of information in its records.

(4) 5 U.S.C. 552a(e)(4)(1). This provision of the Privacy Act requires the publication of the categories of sources of records in each system of records. The reasons an exemption from this provision has been claimed are as follows:

(i) Revealing categories of sources of information could disclose investigative techniques and procedures;

(ii) Revealing categories of sources of information could cause sources that supply information to investigators to refrain from giving such information because of fear of reprisal, or fear of breach of promises of anonymity and confidentiality.

As required by Executive Order 12866, it has been determined that this proposed rule is not a significant regulatory action, and therefore, does not require a regulatory impact analysis.

Pursuant to the requirements of the Regulatory Flexibility Act, 5 U.S.C. 601–612, it is hereby certified that these regulations will not significantly affect a substantial number of small entities. The proposed rule imposes no duties or obligations on small entities.

In accordance with the provisions of the Paperwork Reduction Act of 1995, the Department of the Treasury has determined that this proposed rule would not impose new record keeping, application, reporting, or other types of information collection requirements because the types of records to be maintained are being transferred to this system of records from other systems of records already in existence, specifically the systems of records entitled ''Treasury/IRS 60.001–Assault and Threat Investigation Files, Inspection'' and ''Treasury/IRS 60.007–Miscellaneous Information File, Inspection.''

List of Subjects in 31 CFR Part 1

Privacy.

Part 1 of Title 31 of the Code of Federal Regulations is amended as follows:

PART 1—[AMENDED]

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

Authority: 5 U.S.C. 301 and 31 U.S.C. 321. Subpart A also issued under 5 U.S.C. 552, as amended. Subpart C also issued under 5 U.S.C. 552a.

2. Section 1.36 paragraph (g)(1)(viii) is amended by adding the following text to the table in numerical order:

§ 1.36 Systems exempt in whole or in part from provisions of 5 U.S.C. 552a and this subpart.

* * * * *

(g) * * *
(1) * * *
(viii) * * *

Number	Name of system
* * * * *	
60.000	Employee Protection System Records.
* * * * *	

* * * * *

Dated: November 7, 2001.

W. Earl Wright, Jr.,

Chief Management and Administrative Programs Officer.

[FR Doc. 01–29710 Filed 11–29–01; 8:45 am]

BILLING CODE 4830–01–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[IL211–1b; FRL–7108–7]

Approval and Promulgation of Implementation Plans; Illinois

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: The EPA is proposing to approve revisions to volatile organic compound (VOC) rules for Bema Film Systems, Incorporated (Bema). This flexographic printing facility is located in DuPage County, Illinois. The March 28, 2001, revisions consist of an adjusted standard from the Flexographic Printing Rule, 35 IAC 218.401(a),(b), and (c). The adjusted standard requirements include a reduction in trading allotments should Bema's emissions trigger participation in the Illinois market-based emissions trading system, maintaining daily records of inks and VOC content, conducting trials of compliant inks, and reviewing alternate control technologies. The Illinois Pollution Control Board approved this adjusted standard because the Board considers this to be Reasonably Achievable Control Technology for Bema. The EPA concurs.

DATES: The EPA must receive written comments by December 31, 2001.

ADDRESSES: You should mail written comments to: J. Elmer Bortzer, Chief, Regulation Development Section, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604.

You may inspect copies of Illinois' submittal at: Regulation Development Section, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604.

FOR FURTHER INFORMATION CONTACT: Matt Rau, Environmental Engineer, Regulation Development Section, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604, Telephone: (312) 886–6524.

SUPPLEMENTARY INFORMATION: Throughout this document wherever ''we,'' ''us,'' or ''our'' are used we mean the EPA.

Table of Contents

I. What actions are the EPA taking today?
II. Where can I find more information about this proposal and the corresponding direct final rule?

I. What Actions Are the EPA Taking Today?

The EPA is proposing to approve revisions to VOC rules for Bema of DuPage County, Illinois. The revisions consist of an adjusted standard from the Flexographic Printing Rule, 35 IAC 218.401(a),(b), and (c). The adjusted standard requirements include reducing the market-based emissions trading system baseline, maintaining daily records of inks and VOC content, conducting trials of compliant inks, and reviewing alternate control technologies. The adjusted standard reduces the emissions trading program baseline for Bema. If its emissions trigger participation in the program, the market-based trading system will allow Bema to buy emissions allotments from companies which can reduce their VOC emissions at a lower cost than Bema can. The total VOC emissions of all participants meets the desired reductions. Limiting VOC emissions will help to reduce ozone because VOC can chemically react in the atmosphere to form ozone.

II. Where Can I Find More Information About This Proposal and the Corresponding Direct Final Rule?

For additional information see the direct final rule published in the rules section of this **Federal Register**.

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Intergovernmental relations, Reporting and recordkeeping requirements, Volatile organic compounds.

Dated: November 9, 2001.

David A. Ullrich,

Deputy Regional Administrator, Region 5.

[FR Doc. 01–29662 Filed 11–29–01; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[IL213–1b; FRL–7107–6]

Approval and Promulgation of Implementation Plans; Illinois

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: The EPA is proposing to approve revisions to volatile organic compound (VOC) rules for Vonco Products, Incorporated (Vonco). This flexographic printing facility is located in Lake County, Illinois. The March 28, 2001, revisions consist of an adjusted standard from the Flexographic Printing Rule, 35 IAC 218.401(a), (b), and (c). The adjusted standard conditions include a reduction in trading allotments should Vonco's emissions trigger participation in the Illinois market-based emissions trading system, maintaining daily records of inks and VOC content, conducting trials of compliant inks, and reviewing alternate control technologies. The Illinois Pollution Control Board approved this adjusted standard because the Board considers this to be Reasonably Achievable Control Technology for Vonco.

DATES: The EPA must receive written comments by December 31, 2001.

ADDRESSES: You should mail written comments to: J. Elmer Bortzer, Chief, Regulation Development Section, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604.

You may inspect copies of Illinois' submittal at: Regulation Development Section, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604.

FOR FURTHER INFORMATION CONTACT: Matt Rau, Environmental Engineer, Regulation Development Section, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604, Telephone: (312) 886–6524.

SUPPLEMENTARY INFORMATION: Throughout this document wherever ''we,'' ''us,'' or ''our'' are used we mean the EPA.

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I. What actions are the EPA taking today?
II. Where can I find more information about this proposal and the corresponding direct final rule?

I. What Actions Are the EPA Taking Today?

The EPA is proposing to approve revisions to VOC rules for Vonco of Lake County, Illinois. The revisions consist of an adjusted standard from the Flexographic Printing Rule. The adjusted standard conditions include reducing the market-based emissions trading system baseline, maintaining daily records of inks and VOC content, conducting trials of compliant inks, and reviewing alternate control technologies.

The adjusted standard reduces the emissions trading program baseline for Vonco. If its emissions trigger participation in the program, the market-based trading system will allow Vonco to buy emissions allotments from companies which can reduce their VOC emissions at a lower cost than Vonco can. The total VOC emissions of all participants meets the desired reductions. Limiting VOC emissions will help to reduce ozone because VOC can chemically react in the atmosphere to form ozone.

II. Where Can I Find More Information About This Proposal and the Corresponding Direct Final Rule?

For additional information see the direct final rule published in the rules section of this **Federal Register**.

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Intergovernmental relations, Reporting and recordkeeping requirements, Volatile organic compounds.

Dated: November 9, 2001.

David A. Ullrich,

Deputy Regional Administrator, Region 5.

[FR Doc. 01–29656 Filed 11–29–01; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[MO 0142–1142; FRL–7110–4]

Approval and Promulgation of Implementation Plans; State of Missouri

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: EPA proposes to approve a State Implementation Plan (SIP) revision submitted by the state of Missouri. This approval pertains to revisions to the state's rule which restricts emissions of particulate matter from industrial processes. In the final rules section of the **Federal Register**, EPA is approving the state's SIP revision as a direct final rule without prior proposal because the Agency views this as a noncontroversial revision amendment and anticipates no relevant adverse comments to this action. A detailed rationale for the approval is set forth in the direct final rule. If no relevant adverse comments are received in response to this action, no further activity is contemplated in relation to this action. If EPA receives relevant adverse comments, the direct final rule will be withdrawn and all public comments received will be addressed in a subsequent final rule based on this proposed action. EPA will not institute a second comment period on this action. Any parties interested in commenting on this action should do so at this time. Please note that if EPA receives adverse comment on an amendment, paragraph, or section of this rule and if that provision is severed from the remainder of the rule, EPA may adopt as final those provisions of the rule that are not the subject of an adverse comment.

DATES: Comments on this proposed action must be received in writing by December 31, 2001.

ADDRESSES: Comments may be mailed to Wayne Kaiser, Environmental Protection Agency, Air Planning and Development Branch, 901 North 5th Street, Kansas City, Kansas 66101.

FOR FURTHER INFORMATION CONTACT: Wayne Kaiser at (913) 551–7603.

SUPPLEMENTARY INFORMATION: See the information provided in the direct final rule which is located in the rules section of the **Federal Register**.

Dated: November 17, 2001.

William W. Rice,

Acting Regional Administrator, Region 7.

[FR Doc. 01–29651 Filed 11–29–01; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[IN122–1b; FRL–7107–8]

Approval and Promulgation of Implementation Plans; Indiana

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: The EPA is proposing to approve revisions to Indiana's opacity rules. The Indiana Department of Environmental Management (IDEM) submitted revised opacity rules on October 21, 1999, as a requested revision to its State Implementation Plan (SIP). The revisions address the provisions of Indiana's opacity rule concerning the startup and shutdown of operations, the terminology used in discussing averaging periods, time periods for temporary exemptions, alternative opacity limits, and conflicts between visible opacity readings and continuous opacity monitor data.

A major new component of this rule is a provision that allows the State to incorporate source-specific startup and shutdown provisions into federal operating permits for certain utility boilers, as long as those provisions fall within a range established in the rule. All of the revisions satisfy EPA guidelines.

DATES: The EPA must receive written comments by December 31, 2001.

ADDRESSES: You should mail written comments to: J. Elmer Bortzer, Chief, Regulation Development Section, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604.

You may inspect copies of Indiana's submittal at: Regulation Development Section, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604.

FOR FURTHER INFORMATION CONTACT: Matt Rau, Environmental Engineer, Regulation Development Section, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604, Telephone: (312) 886–6524.

SUPPLEMENTARY INFORMATION: Throughout this document wherever ''we,'' ''us,'' or ''our'' are used we mean the EPA.

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I. What actions are the EPA taking today?
II. Where can I find more information about this proposal and the corresponding direct final rule?

I. What Actions Are the EPA Taking Today?

The EPA is proposing to approve revisions to Indiana's opacity rules. The revisions address the provisions of Indiana's opacity rule concerning the startup and shutdown of operations, the terminology used in discussing averaging periods, time periods for temporary exemptions, alternative opacity limits, and conflicts between visible emission readings and COM data.

II. Where Can I Find More Information About This Proposal and the Corresponding Direct Final Rule?

For additional information see the direct final rule published in the rules section of this **Federal Register**.

List of Subjects in 40 CFR Part 52

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

Dated: November 8, 2001.

Norman Niedergang,

Acting Regional Administrator, Region 5.

[FR Doc. 01–29649 Filed 11–29–01; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 62

[IL210–1b; FRL–7110–9]

Approval and Promulgation of Implementation Plans; Illinois

AGENCY: Environmental Protection Agency (EPA)

ACTION: Proposed rule.

SUMMARY: The EPA is proposing to approve, through direct final procedure, a negative declaration submitted by Illinois which indicates there is no need for regulations covering existing Small Municipal Waste Combustors (MWC) in the State. The negative declaration was submitted in a letter dated June 25, 2001, to satisfy a Federal requirement to

develop a plan to control emissions from small MWCs or to declare there are no sources of this type in the State.

In the Final Rules Section of this **Federal Register**, EPA is approving the State's negative declaration request as a direct final rule without prior proposal because EPA views this action as noncontroversial and anticipates no adverse comments. The rationale for approval is set forth in the direct final rule. If no written adverse comments are received in response to the direct final rule, no further activity is contemplated in relation to this proposed rule. If EPA receives meaningful written adverse comments, the direct final rule will be withdrawn and all public comments received will be addressed in a subsequent final rule based on this proposed rule. If no adverse written comments are received, the direct final rule will take effect on the date stated in that document and no further activity will be taken on this proposed rule. Any party interested in commenting on this negative declaration should do so at this time.

DATES: Comments on this action must be received by December 31, 2001.

ADDRESSES: Written comments should be mailed to: J. Elmer Bortzer, Chief, Regulation Development Section, Air Programs Branch (AR–18J), USEPA, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604.

A copy of the State's negative declaration request is available for inspection at the above address.

FOR FURTHER INFORMATION CONTACT: John Paskevicz, Engineer, Regulation Development Section, Air Programs Branch (AR–18J), USEPA, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604, (312) 886–6084.

SUPPLEMENTARY INFORMATION: Throughout this document whenever ''we,'' ''us,'' or ''our'' are used we mean the EPA.

I. What Actions Are EPA Taking Today?
II. Where can I find more information about this proposal and corresponding direct final rule?

III. What Actions Are EPA Taking Today?

The EPA is proposing to approve a negative declaration submitted by the State of Illinois which indicates there is no need for regulations to control emissions from small Minicipal Waste Combustors in the State. The State performed an analysis which shows that there are no small MWCs in Illinois.

II. Where Can I Find More Information About This Proposal and Corresponding Direct Final Rule?

For additional information see the direct final rule published in the rules section of this **Federal Register**.

Authority: 42 U.S.C. 4201–7601q.

Dated: November 14, 2001.

Norman Niedergang,

Acting Deputy Regional Administrator, Region 5.

[FR Doc. 01–29775 Filed 11–29–01; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 300

[FRL–7109–4]

National Oil and Hazardous Substance Pollution Contingency Plan; National Priorities List

AGENCY: Environmental Protection Agency.

ACTION: Notice of intent to delete the Fort Devens-Sudbury Training Annex Superfund Site from the National Priorities List.

SUMMARY: The Environmental Protection Agency (EPA)—New England is issuing a notice of intent to delete the Fort Devens-Sudbury Training Annex Superfund Site (Site) located in Stow, Sudbury, Maynard, and Hudson, Massachusetts, from the National Priorities List (NPL) and requests public comments on this notice of intent. The NPL, promulgated pursuant to section 105 of the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA) of 1980, as amended, is found at appendix B of 40 CFR part 300 of the National Oil and Hazardous Substances Pollution Contingency Plan (NCP). The EPA and the Commonwealth of Massachusetts, through the Department of Environmental Protection, have determined that all appropriate response actions under CERCLA, other than operation and maintenance and five-year reviews, have been completed. However, this deletion does not preclude future actions under Superfund.

In the ''Rules and Regulations'' Section of today's **Federal Register**, we are publishing a direct final notice of deletion of the Fort Devens-Sudbury Training Annex Superfund Site without prior notice of intent to delete because we view this as a noncontroversial revision and anticipate no adverse comment(s). We have explained our reasons for this deletion in the preamble to the direct final deletion. If we receive no adverse comment(s) on this notice of intent to delete or the direct final notice of deletion, we will not take further action on this notice of intent to delete. If we receive adverse comment(s), we will withdraw the direct final notice of deletion and it will not take effect. We will, as appropriate, address all public comments in a subsequent final deletion notice based on this notice of intent to delete. We will not institute a second comment period on this notice of intent to delete. Any parties interested in commenting must do so at this time. For additional information, see the direct final notice of deletion which is located in the Rules section of this **Federal Register**.

DATES: Comments concerning this Site must be received by December 31, 2001.

ADDRESSES: Written comments should be addressed to: James Murphy, Community Involvement Coordinator, U.S. EPA, One Congress Street, Suite 1100, (RAA), Boston, Massachusetts 02114–2023, (617) 918–1028 or 1–800–252–3402 extension 81028—toll-free.

FOR FURTHER INFORMATION CONTACT: Christine Williams, Remedial Project Manager, U.S. EPA, One Congress Street, Suite 1100, (HBT), Boston, Massachusetts 02114–2023, (617) 918–1384 or 1–800–252–3402 extension 81384—toll-free.

SUPPLEMENTARY INFORMATION: For additional information, see the Direct Final Notice of Deletion which is located in the Rules section of this **Federal Register**.

Information Repository: A repository has been established to provide detailed information concerning this decision at the following address: Devens-RFTA, Devens, MA, by appointment only Monday through Friday 8 am to 3 pm, (978) 796–3835 or (978) 796–2205.

List of Subjects in 40 CFR Part 300

Environmental protection, Air pollution control, Chemicals, Hazardous waste, Hazardous substances, Intergovernmental relations, Penalties, Reporting and recordkeeping requirements, Superfund, Water pollution control, Water supply.

Authority: 33 U.S.C. 1321(c)(2); 42 U.S.C. 9601–9657; E.O. 12777, 56 FR 54757, 3 CFR, 1991 Comp., p. 351; E.O. 12580, 52 FR 2923; 3 CFR, 1987 Comp., p. 193.

Dated: November 15, 2001.

Robert W. Varney,

Regional Administrator, U.S. EPA New England.

[FR Doc. 01–29553 Filed 11–29–01; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 300

[FRL–7110–1]

National Priorities List for Uncontrolled Hazardous Waste Sites; Notice of Amendment to Proposed Listing of the Smeltertown-Operable Unit 3 (CoZinCo) Superfund Site, Salida, Chaffee County, CO

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of amendment to proposed listing.

SUMMARY: In accordance with the requirements of section 122(h)(1) of the Comprehensive Environmental Response, Compensation, and Liability Act, as amended (''CERCLA''), 42 U.S.C. 9622(h)(1), notice is hereby given that the proposal to list the Smeltertown-Operable Unit 3 site on the National Priorities List (NPL) is amended to exclude the CoZinCo facility from the scope of listing under section 122(h) of CERCLA, 42 U.S.C. 9622(h). The Smeltertown-Operable Unit 3 Site is located in Salida, Chaffee County, Colorado (the Site). This amendment was initially proposed on May 11, 2000 (65 FR 30489). CoZinCo, Inc., submitted comments on July 10, 2000, supporting the amendment, but disputing the rationale for such action. On August 14, 2000, CoZinCo, Inc., amended its comments, withdrawing its request for a written response from EPA regarding the Agency's rationale for the amendment for the proposed NPL listing. On August 25, 2000, CoZinCo, Inc. withdrew its comments in their entirety. No other comments were received by EPA.

FOR FURTHER INFORMATION CONTACT: Andrea Madigan, Legal Enforcement Attorney (ENF–L) Legal Enforcement Program, U.S. Environmental Protection Agency, 999 18th Street, Suite 300, Denver, Colorado 80202–2466, (303) 312–6904.

Dated: November 15, 2001.

Diane L. Sipe,

Acting Assistant Regional Administrator, Office of Enforcement, Compliance and Environmental Justice, Region VIII.

[FR Doc. 01–29657 Filed 11–29–01; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 51

[CC Docket No. 01–318, CC Docket No. 98–56, CC Docket No. 98–157, CC Docket No. 96–98, CC Docket No. 98–141; FCC 01–331]

Performance Measurements and Standards for Unbundled Network Elements and Interconnection

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: This document seeks comment on whether the Commission should adopt a select group of measurements and standards for evaluating incumbent local exchange carrier (LEC) performance in the provisioning of facilities that are used by their carrier-customers to compete for end-user customers. In particular, the Commission offers for comment performance measurements and standards that could apply to the key aspects of pre-ordering, ordering, provisioning, and maintaining those facilities and services that are critically important to ensuring that competitive LECs can enter the market for local exchange services, as contemplated by the Telecommunications Act of 1996. The Commission therefore seeks comment on measurements and standards for collocation, loop, transport, and interconnection trunk facilities. The Commission also seeks comment on enforcement policies and guidelines should the Commission promulgate national measurements and standards for unbundled network elements and interconnection.

DATES: Comments are due December 31, 2001 and Reply Comments are due January 22, 2002.

FOR FURTHER INFORMATION CONTACT: Cathy Carpino, Attorney Advisor, Policy and Program Planning Division, Common Carrier Bureau, (202) 418–1580.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Notice of Proposed Rulemaking (NPRM) in CC Docket No. 01–318, FCC 01–331, adopted November 8, 2001, and released November 19, 2001. The complete text of this NPRM is available for inspection and copying during normal business hours in the FCC Reference Information Center, Portals II, 445 12th Street, SW., Room CY–A257, Washington, DC, 20554. This document may also 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.* It is also available on the Commission's website at *http://www.fcc.gov.*

Synopsis of the Notice of Proposed Rulemaking

1. Background. The Commission intends to fold all relevant proceedings relating to measurements and standards for UNEs and interconnection into the instant proceeding. Toward that end, the Commission terminates CC Docket No. 98–56 and urges all interested parties that filed comment in that docket to participate in this proceeding. Moreover, the Commission incorporates by reference the record generated by the Association for Local Telecommunications Services' petition related to UNE and interconnection measurements and standards. Finally, the Commission requests further comment on a 90-day collocation provisioning interval and incorporates by reference the record on this issue created in CC Docket Nos. 98–147 and 96–98.

2. Legal Authority, Enforcement and Scope. Although the Commission seeks comment on whether to adopt national performance measurements and standards, its authority to do so is clear, pursuant to sections 201(b), 251 and 252 of the Communications Act of 1934, as amended (Act). The Commission recognizes that many state commissions have adopted extensive performance measurements, standards, and penalty plans to capture incumbent LECs' performance in provisioning UNEs, interconnection trunks and collocation. Accordingly, the Commission seeks comment on how to build on states' efforts in developing national performance measures and standards.

3. The Commission seeks comment on whether and how state and federal performance requirements could be harmonized and streamlined through the adoption of national measurements and standards. Should this harmonization not occur, however, the adoption of national measurements and standards could increase overall reporting burdens on incumbent LECs. Thus, the Commission seeks comment on the possibility of national performance measurements and standards reducing an incumbent's reporting requirements and on the likelihood of differences between state and national performance requirements. In particular, the Commission seeks comment on whether it is consistent with the deregulatory emphasis of the Act to have separate sets of federal and

state performance measurements and standards.

4. The Commission seeks comment as to whether it should exercise the full panoply of enforcement mechanisms available to it under the Act to enforce any national measurements and standards it might adopt. Should the Commission establish specific enforcement policies or guidelines for responding to violations? The Commission also seeks comment on whether national measurements, standards, and reporting requirements for UNEs, interconnection trunks, and collocation should apply to all incumbent LECs and not just to some category of incumbent LECs.

5. Performance measurements and standards. The Commission sets forth for comment a core set of twelve performance measurements for four basic functions obtained from the incumbent LEC: pre-ordering, ordering, provisioning, and maintenance and repair services. The Commission seeks comment on the following questions, among others, with respect to those twelve measurements: (1) Are there other performance metrics that better measure an incumbent LEC's performance and are less burdensome? (2) What associated penalties, if any, should apply if the incumbent LEC does not meet the standard established for a particular metric? and (3) What are the appropriate definitions, exclusions, business rules, and levels of disaggregation to apply to the metrics set forth for comment?

6. Implementation, Reporting Procedures, Performance Evaluation and Statistical Issues. The Commission seeks comment regarding: (1) Data validation and audits procedures, (2) whether national performance measures and standards would benefit from workshops based on general guidance from the Commission regarding scope, number and applicability of performance measures and standards, (3) periodic review of the measurements and sunset provisions, and (4) reporting procedures.

Initial Regulatory Flexibility Analysis

7. As required by the Regulatory Flexibility Act (RFA), as amended, the Commission has prepared this Initial Regulatory Flexibility Analysis (IRFA) of the possible significant economic impact on a substantial number of small entities by the policies and rules proposed in this document. Written public comments are requested on this IRFA. Comments must be identified as responses to the IRFA and must be filed by the deadlines for comments on the document provided above. The Commission will send a copy of the document, including this IRFA, to the Chief Counsel for Advocacy of the Small Business Administration (SBA). In addition, this document will be published in the **Federal Register**.

Need for, and Objectives of, the Proposed Rules

8. In this document, the Commission seeks comment on whether it should adopt a limited number of measurements and standards for evaluating incumbent LEC performance with respect to pre-ordering, ordering, provisioning, repair, and maintenance functions that are critical for competitive carriers to compete for end-user customers. We seek comment on the use and scope of any performance requirements and, as a threshold matter, on how to balance competitors' concerns about poor provisioning of UNEs, interconnection trunks and collocation with the incumbent LECs' concern about the number and cost of state and federal measurements and standards. Moreover, we seek comment on whether these are problems for which intervention in the form of national measurements and standards is more beneficial than harmful, and expect that the comments we receive in response to this document will inform our decision. In addition, we seek comment on how these standards may benefit the industry in general by increasing the uniformity of expectations and creating clear, predictable, and enforceable standards. Finally, we seek comment on the most appropriate periodic review or sunset mechanism should we adopt a set of measurements and standards.

Legal Basis

9. The legal basis for any action that may be taken pursuant to this document is contained in sections 1, 2, 4, 201, 202, 251, 252 and 303(r) of the Communications Act of 1934, as amended, 47 U.S.C. 151, 152, 154, 201, 202, 251, 252 and 303(r).

Description and Estimate of the Number of Small Entities to Which the Proposed Rules Will Apply

10. The RFA directs agencies to provide a description of, and, where feasible, an estimate of the number of small entities that will be affected by any rules. The RFA defines the term ''small entity'' as having the same meaning as the terms ''small business,'' ''small organization,'' and ''small business concern'' under section 3 of the Small Business Act. A small business concern is one which: (1) Is independently owned and operated; (2) is not dominant in its field of operation; and (3) satisfies any additional criteria established by the SBA.

11. We have included small incumbent LECs in this present RFA analysis. As noted above, a ''small business'' under the RFA is one that, *inter alia,* meets the pertinent small business size standard (*e.g.,* a telephone communications business having 1,500 or fewer employees), and ''is not dominant in its field of operation.'' The SBA's Office of Advocacy contends that, for RFA purposes, small incumbent LECs are not dominant in their field of operation because any such dominance is not ''national'' in scope. We have therefore included small incumbent LECs in this RFA analysis, although we emphasize that this RFA action has no effect on Commission analyses and determinations in other, non-RFA contexts.

12. *Local Exchange Carriers.* The most reliable source of information regarding the number of LECs nationwide appears to be the data that we collect annually in connection with the Telecommunications Relay Service. According to our most recent data, there are 1,335 incumbent LECs. Additionally, it appears that 1,037 of these entities have 1,500 or fewer employees although we are uncertain whether all of these carriers are independently owned and operated.

Description of Projected Reporting, Recordkeeping and Other Compliance Requirements

13. This document acknowledges that the reporting requirements may require incumbent LECs to modify existing computer systems to collect the necessary data and that there may be a certain level of expense involved in generating performance measurements and statistical analyses. However, as noted below, the Commission already requires several BOCs to file such performance reports. Moreover, many states require certain carriers to report their performance with respect to similar, if not identical, measurements and standards. To date, states where the BOC has received section 271 approval have reporting requirements that are more extensive than those contemplated in this document. Therefore, we expect that any proposal we may adopt pursuant to this document will not substantially increase existing reporting, recordkeeping or other compliance requirements. Finally, the document requests comment on how national performance measurements and standards could serve to minimize inconsistent or redundant state and federal requirements, and thereby not

increase incumbent LECs' overall regulatory burdens.

Steps Taken to Minimize Significant Economic Impact on Small Entities, and Significant Alternatives Considered

14. The RFA requires an agency to describe any significant alternatives that it has considered in reaching its proposed approach, which may include the following four alternatives (among others): (1) The establishment of differing compliance or reporting requirements or timetables that take into account the resources available to small entities; (2) the clarification, consolidation, or simplification of compliance or reporting requirements under the rule for small entities; (3) the use of performance, rather than design, standards; and (4) an exemption from coverage of the rule, or any part thereof, for small entities.

15. A key objective of this proceeding is to adopt performance measurements and reporting requirements that will not ultimately increase the overall regulatory burdens on carriers, particularly small entities. As explained in detail, a primary goal in considering whether to establish national performance measurements and standards is whether such requirements can serve to rationalize the multiple regulatory requirements imposed on carriers. Additionally, the document expressly seeks comment on how adopted rules should be modified to take into account any particular concerns of small, midsized or rural incumbent LECs. The document also requests comment on how measurements could be tailored to address the unique characteristics of the areas in which these carriers are located. Finally, we seek comment on whether, as an alternative, small entities should file reports less frequently than larger incumbent LECs and whether the Commission should delay the implementation of any new reporting requirements for small entities.

Federal Rules that May Duplicate, Overlap, or Conflict with the Proposed Rules

16. A modest amount of duplication, overlap, or conflict may exist between the measurements offered for comment in this document and the measurements that certain BOCs report as part of their merger conditions. This document requests comment on whether and how federal performance requirements could be harmonized and possibly streamlined through the adoption of national measurements and standards, expressly mentioning the Commission's Merger Orders. Again, a goal of this proceeding is to minimize inconsistent or redundant federal requirements.

Ordering Clauses

17. Accordingly, pursuant to Sections 1, 2, 4, 201, 202, 251, 252 and 303(r) of the Communications Act of 1934, as amended, 47 U.S.C. 151, 152, 154, 201, 202, 251, 252 and 303(r), *a Notice of Proposed Rulemaking is Adopted.*

18. CC Docket No. *98–56 is hereby Terminated.*

19. Commission's Consumer Information Bureau, Reference Information Center, *Shall Send* a copy of this document, including the Initial Regulatory Flexibility Analysis, to the Chief Counsel for Advocacy of the Small Business Administration.

Federal Communications Commission

Magalie Roman Salas,

Secretary.

[FR Doc. 01–29746 Filed 11–29–01; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Parts 54 and 69

[CC Docket No. 00–256; FCC 01–304]

Multi-Association Group (MAG) Plan for Regulation of Interstate Services of Non-Price Cap Incumbent Local Exchange Carriers and Interexchange Carriers

AGENCY: Federal Communications Commission.

ACTION: Further notice of proposed rule.

SUMMARY: In this document, the Commission considers methods by which to build on the access charge reforms adopted for rate-of-return carriers in the companion Report and Order. Second, the Commission will consider the appropriate degree and timing of pricing flexibility for rate-of-return carriers. Third, the Commission seeks further comment on the MAG's proposed changes to the Commission's ''all-or-nothing'' rule. In these ways, the Commission seeks to improve the efficiency of the provision of telecommunications services in rural America by ultimately relying on markets to discipline prices and service quality and, whenever possible, to reduce regulatory oversight. Finally, the Commission seeks comment on merging the Long Term Support (LTS) mechanism into Interstate Common Line Support as of July 1, 2003, when the Carrier Common Line (CCL) charge will be eliminated.

DATES: Comments are due on or before December 31, 2001. Reply comments are due on or before January 29, 2002.

ADDRESSES: 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 appear in the caption of this proceeding, commenters must submit two additional copies for each additional docket or rulemaking number. All filings must be sent to the Commission's Secretary, Magalie Roman Salas, Office of the Secretary, Federal Communications Commission, 445 12th Street, SW., Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Douglas Slotten, Attorney, Common Carrier Bureau, Competitive Pricing Division, (202) 418–1520. Regarding LTS, contact William Scher, Attorney, Common Carrier Bureau, Accounting Policy Division, (202) 418–7400.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Further Notice of Proposed Rulemaking (FNPRM) in CC Docket No. 00–256 released on November 8, 2001. The full text of this document is available for public inspection during regular business hours in the FCC Reference Center, Room CY–A257, 445 Twelfth Street, SW., Washington, DC, 20554 or at <*http://hraunfoss.fcc.gov/edocs_public/attachmatch/FCC–01–304A1.doc.*>

I. Further Notice of Proposed Rulemaking

A. Alternative Regulation

1. In this section, we critique the MAG proposal for introducing incentive regulation for rate-of-return carriers. This evaluation will form a foundation on which to discuss the development of an appropriate alternative regulation plan for rate-of-return carriers. We then explore several options for alternative regulation and seek input to assist in setting the parameters of any plan to be adopted.

a. Critique of MAG's Incentive Regulation Proposal

2. Based on the present record, we are unable to conclude that the MAG's incentive regulation plan should be adopted. The MAG's incentive regulation plan does not properly balance carrier and customer interests given the current regulatory environment for those carriers. In addition to the broad concerns we identify in this section with the plan as proposed, other issues will be raised in the discussion addressing the development of an alternative regulatory structure for rate-of-return carriers.

3. Initially, we agree with those parties asserting that the inflation-adjusted Revenue Per Line (RPL) component of the MAG's incentive plan would allow carriers to increase their revenues without any recognition of the productivity gains that historically have been realized by the telephone industry. Thus, it is not clear that rates under the MAG incentive plan would be just and reasonable, as required by section 201(b) of the Act. Under the MAG plan, all the benefits of productivity or efficiency improvements would accrue to the carrier in the form of higher returns and none of the benefits accrue to access customers.

4. One possible solution would be to establish one or more productivity offsets or X-factors. The record, however, is not adequate to determine an X-factor or factors that would be appropriate for all rate-of-return carriers that might elect incentive regulation. This task is particularly difficult because of the diversity of rate-of-return carriers. Therefore, an optional alternative regulation plan might be appropriate for rate-of-return carriers, as urged by a number of commenters. An X-factor could be needed to keep rate-of-return carriers' rates reasonable because competitive conditions in most rate-of-return carrier markets cannot be relied upon to act as a check on rate-of-return carriers' ability to implement anti-competitive prices.

5. We also find that the plan as structured does not insure that adequate investment or service quality levels will necessarily be maintained. Several parties have alleged that any incentive plan must contain controls to ensure that consumers are not harmed in this regard. Rate-of-return carriers electing incentive regulation, as proposed, might have the incentive to reduce costs by reducing investment (and therefore depreciation) and maintenance levels in order to achieve greater profits that it may then retain, without there being any benefit to consumers in the form of assurances of continued investment and maintenance of rate-of-return carrier facilities, or of the sharing of any efficiency gains with customers.

b. Principles

6. An alternative regulation plan initially must ensure that rates remain just and reasonable, as required by section 201(b). This is the fundamental underpinning of all regulatory models. To ensure that rates remain just and reasonable and that a carrier not receive a windfall from the elimination of any existing inefficiencies, the benefits to be realized from the adoption of an alternative regulation plan should be shared equitably between the carrier and its customers. Under price cap regulation, the Commission initialized rates after reviewing the cost of capital and employed an X-factor productivity adjustment to ensure that price cap carrier rates reflected industry average productivity improvements, while permitting price cap carriers that could be more efficient to keep some or all of any increased earnings. We invite parties to comment on how this goal might be realized most effectively with regard to rate-of-return carriers, and whether something akin to the price cap methods should be used, or whether some other effective alternative exists.

7. We seek comment on whether the rewards a rate-of-return carrier electing an alternative regulation plan might realize should be related to the risk the carrier assumes. Under such an approach, the less stringent the X-factor offset, the smaller the increased profits the carrier would be permitted to retain. We also ask parties to comment on whether a range of options should be offered to rate-of-return carriers, and whether the same set of options should be offered to all rate-of-return carriers. If only a limited set of options is to be offered to some rate-of-return carriers, what characteristics of a carrier or its environment should determine the set of options to be offered? We invite parties to comment on these considerations generally and on how the correct relationships might be determined to ensure that rates remain just and reasonable.

8. The design of an alternative regulation plan must also address the incentives an alternative regulation plan gives rate-of-return carriers to reduce investment in plant and equipment, or to reduce expenditures on maintaining service quality, in order to increase profits at the expense of maintaining adequate investment or service quality. Section 254(b) identifies the availability of comparable services in rural areas as a criteria in assessing universal service. The achievement of these goals clearly requires investment in rural areas, which must therefore be supported by any alternative regulation plan we adopt.

9. Rate-of-return regulation has worked well in extending service to rural America, along with our universal service program and the work of state commissions to support service in these areas. We seek comment on how to maintain quality assurance and expansion of new and advanced services in rural and non-rural areas served by rate-of-return carriers under any alternative regulatory plan we might adopt. As we develop an alternative regulation plan for rate-of-return carriers, are there state programs we can rely on as means to ensure that adequate investment and service quality will be maintained? Such programs could include various types of state programs that oversee small company activities and focus on investment and service quality. In addition, certain indicia of competition, such as the designation of an eligible telecommunications carrier in the rate-of-return carrier's service area, might also permit us to conclude that the incentives to invest and maintain service quality are present. We invite parties to comment on the extent to which regulatory and competitive conditions could be effective tools in developing a workable alternative regulatory mechanism. Parties should address how the different possible components of an alternative regulatory plan discussed below might be modified as regulatory or competitive conditions change.

10. Finally, we believe that an alternative regulatory plan must minimize the administrative burdens on small carriers and regulatory intervention in their operations, while achieving the other principles noted. In this regard, an alternative regulation plan should consider the size of the carriers that will be subject to the plan and be no more restrictive than necessary to achieve the necessary public interest objectives. We therefore invite parties to address the impact any alternative regulation plan might have on small incumbent local telephone companies, as required by the Regulatory Flexibility Act.

11. As we proceed, it will be with a focus on these objectives. We invite parties to comment on the validity of these objectives and how they apply to the different measures of any alternative regulation plan proposed. We also ask parties to identify additional principles that should be applied to the development of an alternative regulatory mechanism. In the following section we address several specific considerations associated with developing an alternative regulatory plan.

c. Issues in Developing an Alternative Regulatory Plan

12. *Optionality.* The scope of an alternative regulation plan affects in significant ways the design of that plan. Several rate-of-return carrier interests assert that any alternative regulation plan must be optional because of the diversity among rate-of-return carriers in their operating conditions. On the other hand, AT&T urges us to make an alternative regulation plan applicable to the largest rate-of-return carriers on a

mandatory basis. Given the wide variations among rate-of-return carrier operating conditions, we believe it would be extremely difficult to establish a mandatory alternative regulatory plan for all rate-of-return carriers. We invite parties to comment on the extent to which an alternative regulation plan should be completely optional, or whether it should be mandatory for a subset of larger rate-of-return carriers. Parties should address what criteria should be used to determine which carriers would be subject to alternative regulation on a mandatory basis. We also seek comment on whether any optional alternative regulation plan should be one-way, so that, once made, a carrier could not return to rate-of-return regulation. Alternatively, are there certain conditions, such as when earnings are sufficiently low for a sufficiently long period of time, or simply after a specified period of time, or after each review period, when a carrier could be permitted to return to rate-of-return regulation? Parties are invited to address what those conditions might be and how rates should be determined upon return to rate-of-return regulation.

13. *Alternative regulation in a pooling context.* The MAG's incentive regulation plan was designed to work within the National Exchange Carrier Association (NECA) pooling structure. Today, nearly all rate-of-return carriers participate in the NECA common line pool, and more than sixty percent of the minutes of rate-of-return carriers are charged at NECA rates. This offers many administrative benefits to carriers and to the Commission, particularly in the form of tariff administration. It may, however, blunt some of the benefits that may be realized from an alternative regulatory plan. If cost savings that a carrier realizes are included in the pool settlements process, rather than being retained by the carrier achieving the efficiency gains or reflected in lower rates to the customers, the carrier will have little incentive to pursue cost efficiencies. We invite parties to comment on whether an alternative regulation plan can and should be designed to work within the NECA pooling structure, whether there are ways for NECA to revise its pooling procedures to facilitate meaningful incentive regulation, or whether rate-of-return carriers should be required to leave the pool to avail themselves of any alternative regulatory plan. Parties should also address how an alternative regulatory plan would apply to those rate-of-return carriers outside the NECA pools, including any problems created if a rate-of-return carrier was, for example, in the common line pool but not the traffic sensitive pool.

14. *Use of revenue per line (RPL).* The MAG proposes to use a RPL amount as the basis for establishing its incentive plan, adjusting the RPL amount annually for inflation. Thus, a rate-of-return carrier electing incentive regulation would settle with the NECA pool on the basis of its inflation-adjusted RPL amount. A rate-of-return carrier's costs and its settlement amount from NECA would therefore no longer be linked. The rate-of-return carrier would thus have the incentive to reduce its operating costs since it could retain the difference between the RPL amount and its actual costs, if lower. On the other hand, if its costs were higher than the RPL amount, it would not receive additional settlements. Several commenters oppose the use of a revenue cap, alleging that a rate-of-return carrier would have every incentive to reduce its investment and expenses since these no longer affect their settlements with the NECA pool. In response, the MAG argues that Path A incentive regulation under its plan differs from both price cap regulation and revenue cap regulation.

15. We invite parties to comment on the use of an RPL amount as a starting point for an alternative regulatory plan. We specifically invite comment on whether the MAG's contention that RPL is different from a revenue cap is correct. We ask parties to comment on the extent to which the presence of competition or an external check would affect a carrier's incentives in an RPL system, and how such factors could be included in an alternative regulatory system for rate-of-return carriers. Parties should also address how to respond to the concern expressed in the record that rate-of-return carriers would have every incentive in the year they choose to enter an alternative regulation program to maximize their costs and plant investment, in order to maximize their initial rates.

16. We also ask parties to address whether there are other approaches to establishing an alternative regulatory mechanism that would work better than RPL over a broader range of competitive and regulatory landscapes. For example, would it be possible and preferable to use baskets of traffic-sensitive and non-traffic-sensitive service revenues or prices as the baseline against which to measure rate-of-return carrier productivity? Parties proposing alternatives should be specific in laying out their plan and should address how their plan is consistent with the principles enumerated. Parties should also address what an appropriate alternative regulatory plan should be if we were to conclude that a rate-of-return carrier must leave the NECA pool to participate in such a plan.

17. In addition, we invite parties to address whether, rather than developing a new alternative regulatory plan for rate-of-return carriers, we should establish a method by which rate-of-return carriers would be eligible to adopt the CALLS plan. Parties should particularly address what modifications if any, would be necessary in the indexing and universal service aspects of the CALLS plan to make it appropriate for rate-of-return carriers, without jeopardizing the position of any party currently subject to the CALLS plan.

18. *Productivity and sharing considerations.* The MAG incentive plan does not contemplate any initial rate reduction, or a recurring productivity offset (X-factor). Under the MAG plan, rates initially would be based on a rate-of-return carrier's settlements from the NECA pools at the time the carrier elected incentive regulation, and increased by inflation in future years. Several parties assert that any plan must have a productivity factor in order to keep rates just and reasonable, contending that the telephone industry traditionally has achieved greater productivity than that reflected in the GDP–PI. Several parties also contend that an incentive plan for rate-of-return carriers must include a sharing mechanism, as the original price cap plan did.

19. We invite parties to comment on the extent to which a productivity offset or initial rate reduction should be part of any alternative regulatory plan for rate-of-return carriers. This is a difficult issue for rate-of-return carriers due to the variations in their operating conditions. Many smaller rate-of-return carriers' investment patterns are lumpy, with only occasional significant new investments, as when they replace a switch or a major trunking facility. Some rate-of-return carriers may not realize sufficient demand growth to realize any scale economies. These smaller carriers might not be interested in an alternative regulation plan that included a productivity offset. It would be helpful if parties addressed the means by which we should establish any productivity offset and the level at which it should be set. These comments should take into account the possibility that the alternative plan would, for some or all rate-of-return carriers, be optional. Thus, only those rate-of-return carriers that thought they could exceed

the productivity threshold might elect the alternative regulatory plan.

20. Several uncertainties exist in initiating an alternative regulatory plan if it is optional. It will be unclear how many rate-of-return carriers may elect any plan until such time as they are required to exercise that option. Furthermore, calculation of a productivity offset will be imprecise due to lack of knowledge of which carriers would be participating. We therefore invite parties to comment on whether an alternative regulatory plan for rate-of-return carriers should include a sharing mechanism to account for the difficulty in the calculation of an appropriate X-factor. Parties should also address the level at which, and the extent to which, any sharing should be required, whether sharing requirements should be linked to service quality levels, and the relationship between the levels of any X-factor and sharing obligations.

21. As the Commission has noted previously, sharing mechanisms have significant incentive-blunting characteristics caused by the reduced incentive to increase efficiency if the carrier can only retain a portion of the savings. We therefore seek comment on whether a system of regulation with a lag might be appropriate for rate-of-return carriers. Under such a plan, a productivity offset would be established based on an appropriate industry grouping. Rate-of-return carriers electing the alternative regulation plan would be permitted to keep any increased profits realized from increased efficiency or line growth. After some period of time, such as three years, the Commission would reexamine the productivity offset and adjust it prospectively, reflecting the realized experience of the previous three years. We invite parties to comment on the use of regulation with a lag. They should address the setting of the productivity offset in this context, as well as the length of time between reviews. We invite parties to comment on whether RPL is the appropriate baseline against which to apply the productivity offset under this scenario and whether the RPL level should be based on an individual carrier's revenues or on some grouping of carriers. Parties should also address whether a sharing or a lag plan introduces the fewest efficiency disincentives and is most likely to create proper incentives.

22. *Low-end adjustment.* As with price cap regulation, the MAG proposes a low-end-adjustment factor. Unlike the low-end adjustment for price cap carriers, however, the low-end adjustment proposed by the MAG would ensure that rate-of-return carriers electing incentive regulation would not earn below the low-end adjustment. It would do this by providing for a prospective revenue payment from the NECA pool that would give it the difference between what it actually earned and the low-end adjustment over a twelve-month period. Price cap carriers, on the other hand, are only permitted to adjust their price cap indexes to allow them to set prospective rates at a level that would allow them to earn at the level of the low-end adjustment. We invite parties to comment on the need for a low-end adjustment and on how to establish the proper level. We specifically ask parties to address whether a low-end adjustment in an alternative regulatory plan should protect against earnings below that level during a particular tariff period, or whether it should be used to retarget rates so that the carrier will have an opportunity to earn that level in the future tariffing period, as is done in the price cap context. We also invite parties to comment on whether there is any need for a higher low-end adjustment for smaller rate-of-return carriers, and if a higher low-end adjustment is necessary, how the higher low-end adjustment should be determined, which carriers should be covered, and the extent to which the low-end adjustment should be higher. Finally, we ask whether, if rate-of-return carriers are granted pricing flexibility, they should be required to forego the automatic low-end adjustment just as price cap carriers do.

23. *Monitoring.* The adoption of an alternative regulatory plan would alter the incentives of carriers, and establish new parameters regulating those carriers electing the alternative plan. We invite parties to comment on whether there is any need to establish reporting requirements to monitor service quality and carrier investment in an alternative regulatory regime, or whether it will be possible to rely on competitive conditions or state investment and service quality standards to control any adverse effects of the new incentives. Finally, we ask parties to comment on how often we should review an alternative regulatory plan. Because conditions change over time, it may periodically be necessary to modify some of the parameters based on the new circumstances, or a better understanding on our part of how they are working with respect to the rate-of-return LECs electing the alternative plan. Parties are also invited to suggest precise methodologies for modifying the relevant parameters.

24. *Other issues.* Finally, we invite parties to comment on other concerns they may have with the Commission's possible adoption of an alternative regulatory plan for rate-of-return carriers. In particular, parties are encouraged to address issues relating to the timing of the election to be governed by the alternative regulatory plan. For example, should the election be available only on one fixed date, or should carriers have the option to elect at a time of their own choosing?

B. Pricing Flexibility

1. Discussion

25. With this FNPRM, we extend our consideration of pricing flexibility to rate-of-return carriers, as we indicated we would do in the *1998 FNPRM.* In this section we seek comment on methods of extending pricing flexibility to rate-of-return carriers in addition to those already available to them under current rules or under the rules adopted in the Companion Order.

a. Types of Pricing Flexibility

26. In this FNPRM, we focus on three types of pricing flexibility for rate-of-return carriers: geographic deaveraging within a study area; volume and term discounts; and contract pricing.

27. These three pricing flexibility options offer incumbent local exchange carriers (LECs) significant ability to price their services closer to cost and to respond to competitive entry. Geographic deaveraging within a study area would permit rate-of-return carriers to price in a manner that reflects cost differences from one geographic location to another. Volume and term discounts would permit rate-of-return carriers to reflect economies related to capacity differences and to the certainties offered by term contracts. Finally, contract pricing would permit rate-of-return carriers to respond to requests for proposals and to address more complex communications needs of customers. These pricing alternatives would, once available, make rate-of-return carriers' pricing structures more efficient and permit them to respond to competition

28. While there are clear benefits from pricing flexibility, there are also competitive concerns raised by their introduction. Thus, if introduced too soon, pricing flexibility might be used to erect a barrier to competitive entry. For example, a rate-of-return carrier could deaverage its rates so that the attractive customers received very low rates, or it could lock up customers before entry began through the use of lengthy term contracts. In addition, in offering

deaveraged rates or volume and term discounts, a carrier could, absent some restriction, increase rates excessively for remote customers or for low-volume customers to offset reductions resulting from the introduction of deaveraged rates or volume discounts for higher-volume customers. Such practices could inhibit competitive entry and deny customers in rate-of-return carrier service areas the benefits of competition.

29. We invite parties to comment on our proposal to extend pricing flexibility to rate-of-return carriers in the forms noted. In doing so, parties should address how the unique characteristics of rate-of-return carriers may affect the benefits and risks associated with pricing flexibility. They should identify any differences in the benefits and risks that may exist in relation to common line, local switching, and transport and special access services separately. Parties should also address whether any special rules for pricing flexibility are needed to prevent anti-competitive behavior from inhibiting the development of competition in these markets. For example, should the number of zones rate-of-return carriers are permitted to establish be fewer than price cap carriers are permitted, or should the degree of deaveraging or volume and term discounts be limited due to the rate-of-return carriers' smaller size? In a recent waiver order, we conditioned the grant of volume and term pricing flexibility for transport and the TIC on the carrier calculating a rate using the requirements of §§ 69.106(b) and 69.124(b) and (c) of the Commission's rules to establish a ceiling rate for the associated non-discounted access service offering. We invite parties to comment on whether such a restriction should be imposed on the introduction of pricing flexibility on rate-of-return carriers to preclude anti-competitive behavior.

30. Parties should also address the impact that permitting pricing flexibility would have on the NECA pooling process. Would NECA need to establish exception rates for those rate-of-return LECs qualifying for pricing flexibility, and, if so, how burdensome would this be on NECA? Are there other ways of handling pricing flexibility within the pooling process that would be less burdensome? Parties also should address whether permitting pricing flexibility within the pooling process would be so burdensome on NECA, or offer anti-competitive opportunities to rate-of-return carriers, that rate-of-return carriers should be required to leave the NECA pool as a condition of obtaining pricing flexibility.

31. We also invite parties to identify other forms of pricing flexibility that may be appropriate for the development of an efficient, competitive exchange access marketplace. Parties suggesting other forms of pricing flexibility should evaluate the benefits and risks of those forms of pricing flexibility, as well as the conditions under which such pricing flexibility might be appropriately granted to rate-of-return carriers.

b. Timing of Pricing Flexibility

32. The determination of when pricing flexibility should be granted to rate-of-return carriers is a more difficult question than which types of pricing flexibility to consider granting. It is the opportunity to exercise pricing flexibility prematurely that presents the greatest anti-competitive risk to the development of competition. To address these concerns for price cap carriers, we granted some pricing flexibility immediately and designed a two-phased approach for determining when further pricing flexibility could be obtained by price cap carriers. Each phase had its own trigger to determine when a price cap carrier qualified for the pricing flexibility offered under each phase. We invite parties to comment on the extent to which pricing flexibility should be granted to rate-of-return carriers immediately, and which types of pricing flexibility should be deferred until some appropriate level of competition in a rate-of-return carrier service area has been established. Parties should comment on whether a two-phased approach for rate-of-return carriers should be used given their small size.

33. The decision to immediately permit geographic deaveraging of transport and special access services within a study area was premised in part on the fact that price cap carriers were facing some degree of competition in their service areas. This is not necessarily the case for all rate-of-return carriers. We therefore ask parties to comment on whether immediate geographic deaveraging of transport and special access services within a study area is warranted, or whether some degree of competition should be required before such pricing flexibility is permitted. We are particularly concerned about an incumbent LEC's ability to use pricing flexibility to preclude competitive entry. Parties should also address what the standard should be for determining when deaveraging should be permitted, if it is not permitted immediately.

34. For pricing flexibility other than geographic deaveraging of transport and special access services, the Commission established competitive criteria for determining when a price cap carrier could qualify for such pricing flexibility. The criteria required price cap carriers to demonstrate that competitors have made irreversible, sunk investments in the facilities needed to provide the services at issue, or that competitors have established a significant market presence (i.e., that competition for a particular service within the MSA is sufficient to preclude the incumbent from exploiting any individual market power over a sustained period) for provision of the services at issue, for Phases 1 and 2, respectively. We believe it is necessary to adopt criteria to determine when rate-of-return carriers may offer services using pricing flexibility plans. To that end, we invite parties to address whether a standard similar to that used for price cap carriers should be used for rate-of-return carriers. To assist us in evaluating different criteria, it would be especially useful if parties would address how they anticipate competition developing in rate-of-return carrier service areas, given their generally small customer base.

35. Parties are invited to address the appropriate competitive criteria that should determine when any particular pricing flexibility should be permitted. We recognize that the competitive levels used for price cap carriers may be overly restrictive for the smaller rate-of-return carriers. We ask parties to suggest appropriate levels. Parties should also address other proposals that have been made in various contexts, including the existence of a carrier in the service area with eligible telecommunications status, the issuance of a request for proposals by a customer in the rate-of-return carrier's service area, the filing by a rate-of-return carrier of a tariff offering UNEs, and the receipt by a rate-of-return carrier of a request for UNEs.

36. For price cap carriers, the Commission used the Metropolitan Statistical Area (MSA) as the geographic scope within which to measure competition to determine if pricing flexibility should be permitted. For most rate-of-return carriers, MSAs are not relevant and thus could not be the measurement base. Given the generally smaller size of rate-of-return carriers, it seems appropriate to use the study area as the basis on which to measure competitiveness in determining whether pricing flexibility is warranted for rate-of-return carriers. We seek comment on the use of study areas as the measurement base. We also solicit

suggestions of other, more appropriate measures.

37. We also invite parties to comment on whether any rate-of-return carrier services should be permitted to be filed on one day's notice and whether any services should be treated as non-dominant services. For price cap carriers, we required that services be removed from price cap baskets when the services were offered under contract to preclude cross-subsidization. A similar mechanism does not exist for rate-of-return carriers. If we were to permit contract pricing, what measures would be necessary to ensure that rate-of-return carriers did not cross-subsidize the non-dominant services with revenues from their other access services?

C. All-or-Nothing Rule

1. Issues for Comment

38. The ''all-or-nothing'' rules were created a little more than ten years ago, and the rationale for the rules has withstood the scrutiny of the United States Court of Appeals for the D.C. Circuit. We would like to explore more precisely whether our regulatory policy—generally not to permit affiliated carriers to operate under different systems of regulation—is still serving the public interest; what, if any, circumstances and conditions that prompted these rules in the past have changed; and whether, or why, the MAG's proposed rule changes would be the correct and necessary solution to address any problems with the rules. We encourage interested parties from all industry segments to expand the discussion of why these rules should be retained, repealed or modified.

39. Further, we invite comment on whether the ''all-or-nothing'' restrictions unreasonably and unfairly limit affiliated companies from selecting regulatory options that would enable them to operate more efficiently, especially in light of the highly diverse service areas of some carriers. In the course of this analysis, some general questions to consider include the following. What, if anything, is different today than when the Commission previously considered this issue? Would customers be better off and would competition be better served with or without the rules? Are the rules working effectively since the waiver process allows the Commission to grant carriers exceptions to the ''all-or-nothing'' restrictions as a means of ''fine tuning'' our regulation here? What impact does an increasingly competitive environment have on whether these rules should be retained or eliminated?

40. Some commenters argue that the ''all-or-nothing'' rules in mergers and acquisitions limit a carrier's ability to choose the most appropriate and efficient form of regulation, to the detriment of both the carrier and its customers. For example, when ALLTEL, a rate-of-return carrier, merged with Aliant, a price cap carrier, the Commission agreed with ALLTEL's reasons for desiring to remain a rate-of-return carrier. But ALLTEL, ''not seeking to maintain separate affiliates under different systems of regulation,'' also was required to revert Aliant, which had elected price cap regulation, to rate-of-return regulation. Aliant, however, subsequently sought a waiver, contending price cap regulation benefited its customers, and was granted permission to continue operating temporarily as a price cap carrier. Does this example suggest that the ''all-or-nothing'' regulatory requirements are overly restrictive, or out of step with marketplace realities? Does it suggest that the purpose served by the rules may be overshadowed by any regulatory inefficiency that may result?

41. Some rate-of-return carriers contend the affiliate withdrawal rule also works against selecting the most appropriate and efficient form of regulation for diverse study areas because they must all elect the same common line pool status as a group and move to price cap regulation together. Some affiliates may be ready to accept the risk and potential reward of incentive regulation, while other affiliates might not be in a position to leave rate-of-return regulation. These incumbent LECs also advocate repeal of this rule in combination with geographic deaveraging as a pricing flexibility measure to enable them to respond to competition from competitive carriers for high-volume business customers. In this way, incumbent LECs would have flexibility to depool and deaverage rates within study areas by filing their own common line tariffs based on their own costs where competition was a threat, and also make decisions for other study areas based on their particular market and service conditions. Opposing parties, however, contend that such pricing flexibility would be premature until local markets become sufficiently competitive to prevent incumbent LECs from engaging in cross-subsidization and predatory pricing. Furthermore, they object to repealing this rule because it would result in parent companies removing their low-cost companies from the pool and leaving their high-cost areas in, thus driving NECA pool rates higher. Are there any other considerations to note in assessing whether the affiliate withdrawal rule is promoting the public interest? What would be the impact and consequences of higher NECA pool rates resulting from the exit of low-cost carriers?

42. We also seek comment on whether the ''all-or-nothing'' restrictions are currently necessary to prevent cost shifting and gaming. Commenters disagreed on this issue and on whether our present accounting and allocation rules provide existing and sufficient safeguards against cost shifting. Some parties contend these rules have outlived their usefulness, and are not needed to address cost shifting and gaming concerns because they are more speculative than real. Others argue that cost shifting and gaming concerns are still valid, and that their elimination would be anti-competitive and could result in cost manipulation. TDS asserts that the rules have begun to erode with no evidence of cost shifting or gaming, citing exceptions adopted by the Commission to the pooling ''all-or-nothing'' rules in mergers and acquisitions, common ownership of cost-based and average schedule companies, the ability of average schedule companies to remain in the pool if their depooling affiliate changes from rate-of-return regulation to price caps, waivers allowing price cap exchanges to revert to rate-of-return regulation following mergers and acquisitions, and common ownership of incumbent and competitive carriers. We invite further comment on whether these examples warrant greater relaxation, or elimination, of the ''all-or-nothing'' requirements. Specifically, is the risk of cost-shifting and gaming outweighed by regulatory efficiency gains that could result from eliminating the ''all-or-nothing'' requirements? Is the Commission's policy behind the rule—to avoid creating cost-shifting incentives as opposed to correcting actual abuses—serving the public interest? Has the competitive environment made cost shifting or gaming concerns less or more relevant? Are there alternative accounting and reporting rules that could substantially reduce cost shifting concerns? Would it be reasonable to impose more stringent reporting requirements on carriers that seek waivers of the ''all-or-nothing'' requirements?

43. We also seek comment to resolve a related issue: how rate-of-return carriers that are required to convert to price cap regulation in a merger or acquisition, or choose to convert to price cap regulation, will receive universal service support. Under the

current rules, a rate-of-return carrier upon converting to price cap regulation is required to withdraw from the NECA common line pool and is no longer eligible for LTS. Interstate access universal service support for price cap carriers is funded by a capped, interstate access support mechanism created in the *Interstate Access Support Order* (65 FR 57739, September 26, 2000), but the Commission in that order ''did not explicitly address how entry of new carriers into price caps affects distribution of interstate access universal service support.'' This question is particularly significant for potential price cap companies like Puerto Rico Telephone Company that could be a large recipient of the support. We invite commenters to address how entry of new carriers into price cap regulation would affect distribution of interstate access universal service support for price cap carriers. As a transitional measure for rate-of-return carriers that convert to price cap regulation, should we allow retention of LTS or Interstate Common Line Support? Instead of receiving the same amount of support that the carrier received under rate-of-return regulation, should the previous support amount be added to the total interstate access universal service support available under the *Interstate Access Support Order* and then divided among all price cap carriers pursuant to the formula established in that order? We seek input on any other related considerations or ideas to resolve this question of universal service support for new price cap carriers on a going forward basis.

D. Consolidation of Long Term Support and Interstate Common Line Support

1. Discussion

44. We tentatively conclude that LTS will be merged with Interstate Common Line Support as of July 1, 2003, after which participation in the NECA common line pool will not be required for receipt of universal service support. We believe that merging LTS with Interstate Common Line Support is warranted in the interest of administrative simplicity, because LTS no longer will serve an independent purpose after the CCL charge is phased out. Because the CCL charge will be eliminated, LTS will not be required to reduce the costs recovered through CCL charges. Moreover, carriers now receiving LTS will be eligible for Interstate Common Line Support to meet their common line revenue requirements not recovered through SLC charges. Most carriers will receive Interstate Common Line Support in an amount equal to or greater than the amount of LTS support they now receive. If retained, LTS's practical effect would be merely to reduce the Interstate Common Line Support received by each pooling carrier.

45. We also believe that merging LTS with Interstate Common Line Support is warranted in the interest of promoting competition. Restricting eligibility for universal service support to pooling carriers hampers the competitiveness of incumbent LECs by forcing them to choose between universal service support and the freedom to set rates outside the NECA common line pool. The Commission previously maintained this restriction in part due to the risk-sharing benefits of pooling, but we believe that this risk-sharing function will be diminished substantially by conversion of the CCL charge to explicit universal service support. The pool's averaged CCL rates spread across pooling companies the risks related to recovery of residual common line costs through a per-minute charge. Unlike a per-minute charge, however, per-line universal service support is not subject to unpredictability and variation.

46. We seek comment on these tentative conclusions. We recognize that the proposed elimination of LTS as a separate, pooling-restricted support mechanism may impact membership in the NECA common line pool. Nevertheless, we anticipate that the pool will continue to perform important administrative functions, such as tariff filings for many small carriers for whom such burdens would be excessive in the absence of the ability to pool, as well as risk-sharing functions related to the recovery of traffic sensitive costs. We invite interested parties to comment on these issues.

II. Procedural Issues

A. Ex Parte Presentations

47. This is a permit but disclose rulemaking proceeding. Ex parte presentations are permitted, except during the Sunshine Agenda period, provided that they are disclosed as provided in the Commission's rules.

B. Initial Regulatory Flexibility Analysis

48. As required by the Regulatory Flexibility Act (RFA), the Commission has prepared this Initial Regulatory Flexibility Analysis (IRFA) of the possible significant economic impact on small entities by the proposals in this FNPRM.

1. Need for, and Objectives of, the Proposed Rules

49. The Commission consistently has expressed its commitment to providing incentives for smaller telephone companies to become more efficient and innovative. As proposed, however, the MAG incentive plan does not appear to provide incentives for cost efficiency gains that will benefit consumers through lower rates and improved services. The FNPRM seeks additional comment on the MAG incentive plan, and on other means of providing opportunities for rate-of-return carriers to increase their efficiency and competitiveness in the interstate access services market in a manner that would benefit both rate-of-return carriers and their customers. Among other things, the FNPRM seeks comment on the establishment of one or more X-factors, ways to insure that adequate investment and service quality levels are maintained, and whether any incentive regulation adopted by the Commission for small carriers should be optional.

50. The FNPRM also seeks comment on extending additional pricing flexibility to rate-of-return carriers, on the continued need for the ''all-or-nothing'' rule, which provides that if an individual rate-of-return carrier or study area converts to price cap regulation, all of its affiliates or study areas must also do so, except for those using average schedules, and on the Commission's tentative conclusion that LTS should be merged with Interstate Common Line Support as of July 1, 2003, after which participation in the NECA common line pool will not be required for receipt of universal service support. These proposals are intended to enhance the competitiveness of rate-of-return carriers and to ensure that the Commission's rules continue to be consistent with conditions in the telecommunications marketplace.

2. Legal Basis

51. This rulemaking action is supported by sections 4(i), 4(j), 201–205, 254, and 403 of the Communications Act of 1934, as amended.

3. Description and Estimate of the Number of Small Entities To Which the FNPRM will Apply

52. In the Final Regulatory Flexibility Analysis (FRFA), the Commission's action in this Order affects local exchange carriers, competitive local exchange carriers, interexchange carriers, competitive access providers, cellular licensees, broadband Personal Communications Services, Rural Radiotelephone Service, Specialized Mobile Radio, fixed microwave services, and 39 GHz licensees. This Initial Regulatory Flexibility Act potentially will affect the same entities discussed in the FRFA, and we incorporate the

descriptions of those entities by reference.

4. Description of Projected Reporting, Recordkeeping, and Other Compliance Requirements

53. The FNPRM explores options for developing an alternative regulatory structure that would be available to those rate-of-return carriers electing it. It considers the widely varying operating circumstances of rate-of-return carriers, the implications of competitive and intrastate regulatory conditions on the options available, and the need to facilitate and ensure the deployment of advanced services in rural America. If adopted, alternative regulation may require additional recordkeeping. For example, carriers could be required to file cost studies with this Commission or other appropriate state agency detailing annual revenues, revenues per study area, and effective per-line support for each universal service zone. The FNPRM also addresses the continued need for the Commission's all-or-nothing rule, and the appropriate degree and timing of pricing flexibility for small rate-of-return carriers. Repeal or modification of the all-or-nothing rule might allow carriers to depool and deaverage rates within study areas by filing their own common line tariffs.

5. Steps Taken To Minimize Significant Economic Impact on Small Entities, and Significant Alternatives Considered

54. The RFA requires an agency to describe any significant alternatives that it has considered in reaching its proposed approach, which may include the following four alternatives (among others): (1) The establishment of differing compliance or reporting requirements or timetables that take into account the resources available to small entities; (2) the clarification, consolidation, or simplification of compliance or reporting requirements under the rule for small entities; (3) the use of performance, rather than design, standards; and (4) an exemption from coverage of the rule, or any part thereof, for small entities.

55. The proposals in the FNPRM could have varying positive or negative impacts on rate-of-return carriers, including any such small carriers. Many of the proposals involve elective options, so that a small entity should be able to assess the potential impacts as part of its decision-making process. Public comments are welcomed on modifications to the proposals contained in the FNPRM that would reduce any potential impacts on small entities. Specifically, suggestions are sought on different compliance or reporting requirements that would take into account the resources of small entities; clarification, consolidation, or simplification of compliance and reporting requirements for small entities that would be subject to the rules; and whether waiver or forbearance from the rules for small entities would be feasible or appropriate. How would the establishment of one or more X-factors impact small carriers? How can we insure that adequate investment and service quality levels are maintained? How would the adoption of an alternative regulation plan affect rate-of-return carriers, and how would a low-end adjustment affect such plan? Should we retain, repeal, or modify our ''all-or-nothing rule''? How would potential modification or repeal affect smaller carriers? Finally, what would be the impact on small carriers of eliminating LTS as a separate, pooling-restricted universal service support mechanism? Comments should be supported by specific economic analysis.

6. Federal Rules That May Duplicate, Overlap, or Conflict With the Proposed Rules

56. None.

C. Comment Filing Procedures

57. Pursuant to §§ 1.415 and 1.419 of the Commission's rules, interested parties may file comments on or before December 31, 2001, and reply comments on or before January 29, 2002. Comments may be filed using the Commission's Electronic Comment Filing System (ECFS) or by filing paper copies.

58. 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.

59. 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 appear in the caption of this proceeding, commenters must submit two additional copies for each additional docket or rulemaking number. All filings must be sent to the Commission's Secretary, Magalie Roman Salas, Office of the Secretary, Federal Communications Commission, 445 12th Street, SW., Washington, DC 20554.

60. Parties who choose to file by paper should also submit their comments on diskette. These diskettes should be submitted to: Competitive Pricing Division, Common Carrier Bureau, Federal Communications Commission, 445 12th Street, SW., Washington, DC 20554. Such a submission should be on a 3.5-inch diskette formatted in an IBM compatible format using Word 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 docket numbers, in this case CC Docket Nos. 00–256 and 96–45), 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 CYB402, Washington, DC 20554.

61. The full text of this document is 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. This document also 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.*

III. Ordering Clauses

62. It is further ordered that, pursuant to the authority contained in sections 4(i), 4(j), 201–205, 254, and 403 of the Communications Act of 1934, as amended, 47 U.S.C. 154(i), 154(j), 201–205, 254, and 403, this Further Notice of Proposed Rulemaking in CC Docket No. 00–256 is adopted.

63. It is further ordered that the Commission's Consumer Information Bureau, Reference Information Center,

shall send a copy of this Further Notice of Proposed Rulemaking in CC Docket No. 00–256, including the Initial Regulatory Flexibility Analysis, to the Chief Counsel for Advocacy of the Small Business Administration.

List of Subjects

47 CFR Part 54

Reporting and recordkeeping requirements, Telecommunications, Telephone.

47 CFR Part 69

Communications common carriers, Reporting and recordkeeping requirements, Telephone.

Federal Communications Commission.

William F. Caton,

Deputy Secretary.

[FR Doc. 01–29740 Filed 11–29–01; 8:45 am]

BILLING CODE 6712–01–P

DEPARTMENT OF TRANSPORTATION

National Highway Traffic Safety Administration

49 CFR Part 571

[DOT Docket No. NHTSA–01–8885; Notice 2]

RIN 2127–AH81

Glare From Headlamps and Other Front Mounted Lamps Federal Motor Vehicle Safety Standard No. 108; Lamps, Reflective Devices, and Associated Equipment

AGENCY: National Highway Traffic Safety Administration (NHTSA), DOT.

ACTION: Reopening of comment period for a notice of request for comment.

SUMMARY: This document reopens the comment period on a notice of request for comment on the issue of glare from the front of motor vehicles at night.

DATES: Comments on DOT Docket No. NHTSA–01–8885 must be received by January 28, 2002.

ADDRESSES: Comments should refer to DOT Docket No. NHTSA–01–8885 and be submitted to: Docket Management, Room PL–401, 400 Seventh Street, SW., Washington, DC, 20590.

You may call the Docket at 202–366–9324. You may visit the Docket from 10 a.m. to 5 p.m., Monday through Friday, except on Federal holidays.

FOR FURTHER INFORMATION CONTACT: Mr. Richard L. Van Iderstine, Office of Crash Avoidance Standards at (202) 366–5275. His Fax number is (202) 366–4329.

SUPPLEMENTARY INFORMATION: On September 28, 2001, we (NHTSA) published in the **Federal Register** (66 FR 49594) a notice of notice of request for comment on the issues related to glare produced by lamps mounted on the fronts of vehicles. This document had a comment due date of November 27, 2001.

In a letter dated November 8, 2001, North American Lighting, Inc., (NAL) asked for an extra 60 days to comment on the Notice. NAL stated that the 46 questions asked in the Notice were substantially complicated by asking for explanations. NAL stated that many would require searching company records and/or performing additional testing to provide an accurate response. It stated that there is often a 30-day lead time for scheduling laboratory testing, and for scheduling staff work loads. NAL added that with the lean times for the industry, resources are already overcommitted in the effort to forestall workforce reductions. It stated that the extra 60 days would allow it to perform the supporting research and testing to thoroughly answer the questions posed to it in the Notice, while reducing the imposition of the workforce in the forthcoming holiday period.

In a letter dated November 9, 2001, the Advocates for Highway and Auto Safety (Advocates) asked for an extra 30 days to comment on the Notice. Advocates stated that the topics covered by this notice were so extensive that it would be impossible to provide a comprehensive response in a timely fashion. It stated further, that because of the overarching importance of driver safety and adequate nighttime illumination afforded by headlighting, it believes that additional time for comment is justified.

Additionally, because of recent events that have caused disruptions in United States Postal Service deliveries of mail to the Department of Transportation's Docket Management System, the following notice was placed on that System's homepage on October 25, 2001. ''NEW MAIL DELIVERY/DOCUMENT FILING PROCEDURES. Currently, the Department of Transportation (DOT) is not receiving United States Postal Service (USPS) deliveries. It is unclear how long this will continue. We wish to advise the public that we will take this into account, with respect to DOT rulemakings documents that have comment periods that may close before mail delivery resumes. We will do everything that we can to ensure that we consider comments that would otherwise have been received before the close of the comment period. (For example, we generally have the authority to consider late-filed comments and will do so to the extent that we can; we will also take note of the date of the postmark for late-filed comments.)

* * * * *

''Although U.S. mail delivery by the USPS is not being accepted, deliveries are accepted from alternate delivery carriers. * * *

''Where appropriate, filers are encouraged to use the Electronic Submission System on the Dockets web page (dms.dot.gov) by clicking on ES Submit and following the online instructions.''

Because we agree with the two petitioners and because of the events temporarily ending mail delivery, we have decided that it is in the public interest to grant these requests. Accordingly, the public comment closing date for DOT Docket NHTSA–01–8885 is reopen from November 27, 2001 to Monday, January 28, 2002.

Authority: 49 U.S.C. 322, 30111, 30115, 30117, and 30166; delegation of authority at 49 CFR 1.50 and 501.8.

Issued on: November 26, 2001.

Stephen R. Kratzke,

Associate Administrator for Safety Performance Standards.

[FR Doc. 01–29762 Filed 11–29–01; 8:45 am]

BILLING CODE 4910–59–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 17

RIN 1080–AI17

Endangered and Threatened Wildlife and Plants; Proposed Rule To List the Columbia Basin Distinct Population Segment of the Pygmy Rabbit (*Brachylagus idahoensis*) as Endangered

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Proposed rule.

SUMMARY: We, the U.S. Fish and Wildlife Service (Service), propose to list the Columbia Basin distinct population segment of the pygmy rabbit (*Brachylagus idahoensis*) as endangered pursuant to the Endangered Species Act of 1973, as amended (Act). An emergency rule listing this population segment as endangered for a period of 240 days is published concurrently in this issue of the **Federal Register**.

Historically, the Columbia Basin pygmy rabbit occurred in dense, shrub steppe habitats in five central Washington counties. Currently, this

population segment is known from a single wild colony totaling fewer than 50 individuals in Douglas County, Washington, and a small captive population. Due to its small population, the Columbia Basin pygmy rabbit is imminently threatened by the combined influence of catastrophic environmental events, habitat/resource failure, disease, predation, and loss of genetic heterogeneity. We solicit additional information and data that may assist us in making a final decision on this proposed listing, as well as determining critical habitat for the rabbit.

DATES: Comments from all interested parties must be received by January 29, 2002. Public hearing requests must be received by January 14, 2002.

ADDRESSES: Submit comments to U.S. Fish and Wildlife Service, Upper Columbia Fish and Wildlife Office, 11103 East Montgomery Drive, Spokane, Washington 99206. For information and instruction on commenting, see the PUBLIC COMMENTS SOLICITED section below. Comments and materials received, as well as supporting information used to prepare this proposed rule, will be available for public inspection, by appointment, during normal business hours at the above address.

FOR FURTHER INFORMATION CONTACT: Christopher Warren at the address listed above (telephone 509/891–6839; facsimile 509/891–6748; electronic mail: *chris_warren@fws.gov*).

SUPPLEMENTARY INFORMATION:

Background

For a discussion of background biological information, previous Federal action, factors affecting the species, critical habitat, and conservation measures available to listed and proposed species, consult the emergency rule to list the Columbia Basin distinct population segment of the pygmy rabbit published concurrently in this issue of the **Federal Register**.

Peer Review

In accordance with our policy published on July 1, 1994 (59 FR 34270), we will solicit the expert opinions of three appropriate and independent specialists regarding this proposed rule. The purpose of such review is to ensure listing decisions are based on scientifically sound data, assumptions, and analyses. We will send these peer reviewers copies of this proposed rule immediately following publication in the **Federal Register**. We will invite these peer reviewers to comment, during the public comment period, on the specific assumptions and conclusions regarding the proposed listing and designation of critical habitat.

We will consider all comments and information received during the 60-day comment period on this proposed rule in making a final decision on the proposal. Accordingly, the final determination may differ from this proposal.

Public Hearings

The Act provides for one or more public hearings on this proposal, if requested. Requests for public hearings must be made at least 15 days prior to the close of the public comment period. Such a request for a public hearing for this proposed rule may be sent to the Supervisor, Upper Columbia Fish and Wildlife Office (see **ADDDRESES** section). We will schedule at least one public hearing on this proposal, if requested, and announce the date, time, and place of any hearings in the **Federal Register** and local newspapers at least 15 days prior to the first hearing.

Clarity of the Rule

Executive Order 12866 requires each agency to write regulations and notices that are easy to understand. We invite your comments on how to make this proposed rule easier to understand, including answers to questions such as the following—(1) Are the requirements in the proposed rule clearly stated? (2) Does the proposed rule contain technical jargon that interferes with the clarity? (3) Does the format of the proposed rule (grouping and order of the sections, use of headings, paragraphing, etc.) aid or reduce its clarity? (4) Is the description of the proposed rule in the **SUPPLEMENTARY INFORMATION** section of the preamble helpful in understanding the proposed rule? What else could we do to make this proposed rule easier to understand?

Send a copy of any comments that concern how we could make this rule easier to understand to the office identified in the **ADDRESSES** section at the beginning of this document.

Public Comments Solicited

We intend that any final listing action resulting from this proposed rule to list the Columbia Basin pygmy rabbit will be as accurate and effective as possible. Therefore, we request comments or suggestions from the general public, other concerned governmental agencies, the scientific community, industry, or any other interested party concerning this proposed rule. Comments are particularly sought concerning:

(1) Biological, commercial trade, or other relevant data regarding any threat (or lack thereof) to the pygmy rabbit, both within the Columbia Basin population area and range-wide;

(2) Information regarding the range, distribution, and population size of this distinct population segment, including the locations of any additional colonies of the Columbia Basin pygmy rabbit;

(3) Information regarding the range, distribution, and population size of the pygmy rabbit range-wide;

(4) Information (*e.g.*, maps, data, unpublished reports) and justification regarding why any habitat should or should not be determined to be critical habitat for the Columbia Basin pygmy rabbit as provided by section 4 of the Act;

(5) Current and planned activities in the subject area and their potential impacts on the Columbia Basin pygmy rabbit.

If you wish to comment, you may submit your comments and materials concerning this proposal by any one of several methods: (1) You may submit written comments and information to the Field Supervisor at the address provided in the **ADDRESSES** section above; (2) You may comment electronically via the Internet to ''*fw1cbprabbit@r1.fws.gov*''. Please submit e-mail comments as an ASCII file, avoiding the use of special characters and any form of encryption. Please note that the Internet address will be closed at the termination of the public comment period; if you do not receive a confirmation from the system that we have received your e-mail message, contact us directly by calling our Upper Columbia Fish and Wildlife Office at 590/891–6748; and (3) You also may hand-deliver comments to our Upper Columbia Fish and Wildlife Office at 11103 East Montgomery Drive, Spokane, Washington.

Our practice is to make comments, including names and home addresses of respondents, available for public review during regular business hours. Individual respondents may request that we withhold their home address from the rule making record, which we will honor to the extent allowable by law. In some circumstances, we would withhold from the rule making record a respondent's identity, as allowable by law. If you wish us to withhold your name and/or address, you must state this prominently at the beginning of your comment. However, we will not consider anonymous comments. To the extent consistent with applicable law, we will make all submissions from organizations or businesses, and from individuals identifying themselves as representatives or officials of organizations or businesses, available

for public inspection in their entirety. Comments and materials received will be available for public inspection, by appointment, during normal business hours at the above address.

National Environmental Policy Act

We have determined that environmental assessments and environmental impact statements, as defined in the National Environmental Policy Act of 1969, need not be prepared in connection with regulations adopted pursuant to section 4(a) of the Endangered Species Act of 1973, as amended. We published a notice outlining our reasons for this determination in the **Federal Register** on October 25, 1983 (48 FR 49244).

Paperwork Reduction Act

This rule does not contain any new collections of information other than those already approved under the Paperwork Reduction Act and assigned Office of Management and Budget clearance number 1018–0094. 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 control number. For additional information concerning permit and associated requirements for endangered species, see 50 CFR 17.21 and 17.22.

Executive Order 13211

On May 18, 2001, the President issued an Executive Order (E.O. 13211) on regulations that significantly affect energy supply, distribution, and use. Executive Order 13211 requires agencies to prepare Statements of Energy Effects when undertaking certain actions. This rule is not expected to significantly affect energy supplies, distribution, or use. Therefore, this action is not a significant energy action and no Statement of Energy Effects is required.

References Cited

A complete list of references cited in the emergency rule to list the Columbia Basin distinct population segment of the pygmy rabbit as endangered, published concurrently in this issue of the **Federal Register**, is available upon request from the Upper Columbia Fish and Wildlife Office (see **ADDRESSES** section).

Author

The primary author of this proposed rule is Christopher Warren of the Upper Columbia Fish and Wildlife Office (see **ADDRESSES** section).

List of Subjects in 50 CFR Part 17

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

Proposed Regulation Promulgation

For the reasons given in the preamble to the emergency rule listing the Columbia Basin distinct population segment of the pygmy rabbit as endangered, published concurrently in this issue of the **Federal Register**, we propose to amend part 17, subchapter B of chapter I, title 50 of the Code of Federal Regulations, as set forth below:

PART 17—[AMENDED]

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

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

2. In § 17.11(h), add the following to the List of Endangered and Threatened Wildlife in alphabetical order under MAMMALS:

§ 17.11 Endangered and threatened wildlife.

* * * * *

(h) * * *

Species		Historic range	Vertebrate population where endangered or threatened	Status	When listed	Critical habitat	Special rules
Common name	Scientific name						
Mammals							
*	*	*	*	*	*	*	
Rabbit, Columbia Basin pygmy.	*Brachylagus idahoensis*.	U.S.A. (Western conterminous States).	U.S.A. (WA—Douglas, Grant, Lincoln, Adams, Benton Counties).	E	.....	NA	NA
*	*	*	*	*	*	*	

Dated: November 21, 2001.

Marshall P. Jones, Jr.,

Acting Director, Fish and Wildlife Service.

[FR Doc. 01–29612 Filed 11–29–01; 8:45 am]

BILLING CODE 4310–55–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 679

[I.D. 090701F]

Fisheries of the Exclusive Economic Zone Off Alaska; King and Tanner Crab Fisheries in the Bering Sea/Aleutian Islands

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

ACTION: Reopening of scoping and comment period.

SUMMARY: NMFS is reopening the scoping and comment period for the Environmental Impact Statement (EIS) on the Fishery Management Plan for Bering Sea/Aleutian Islands (BSAI) King and Tanner Crabs (FMP).

DATES: Written comments must be received by December 10, 2001.

ADDRESSES: Written comments on issues and alternatives for the EIS should be sent to Sue Salveson, Assistant Regional Administrator for Sustainable Fisheries, Alaska Region, NMFS, P.O. Box 21668, Juneau, AK, 99802, Attn: Lori Gravel, or delivered to the Federal Building, 709 West 9th Street, Juneau, AK, 99802. Comments may be sent via facsimile (fax) to 907–586–7557. NMFS will not accept comments by e-mail or Internet.

FOR FURTHER INFORMATION CONTACT: Gretchen Harrington, (907) 586-7228 or email gretchen.harrington@noaa.gov.

SUPPLEMENTARY INFORMATION: NMFS published in the **Federal Register** a notice of intent to prepare an EIS on the BSAI crab FMP that announced scoping meetings and requested written public comments (66 FR 48410, September 20, 2001). The reason for undertaking the analysis, and the issues to be analyzed, are detailed in that notice of intent and not repeated here.

Scoping for the EIS began on September 20, 2001. This notice reopens the scoping period from November 16 to December 10, 2001, to provide the public with additional time to submit written comments. NMFS is reopening the scoping period at the request of members of the public. No further public scoping meetings are presently planned or anticipated.

Scoping is an early and open process for determining the scope of issues to be addressed and for identifying the significant issues related to the proposed action. A principal objective of the scoping and public involvement process is to identify a reasonable range of management alternatives that, with adequate analysis, will delineate critical issues and provide a clear basis for distinguishing among those alternatives and selecting a preferred alternative.

NMFS is seeking written public comments on the scope of issues that should be addressed in the EIS, the range of alternatives that should be considered for management of the BSAI crab fisheries, and on the environmental, social, and economic issues to be considered in the analysis.

The proposed action to be addressed in the EIS is the rationalization of the BSAI crab fisheries. An EIS is necessary to take a programmatic look at the FMP and possible alternatives to the FMP in light of proposed programs to rationalize the BSAI crab fisheries. The rationalization programs under consideration will result in substantial changes to many of the current management measures and possibly the framework of the FMP. These programmatic changes may significantly affect the environment.

Given this proposed action, the scope of the EIS will be a programmatic review of the FMP, examining all activities addressing the conduct of the BSAI crab fisheries, including components of proposed rationalization programs and potential changes to the management of the fisheries under these programs. The scope of the analysis is intended to be broad enough for the North Pacific Fishery Management Council and NMFS to make an informed decision on a rationalization program and undertake further analysis of other changes to the FMP as necessary with the implementation of these programs.

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

Dated: November 26, 2001.

Jonathan Kurland

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

[FR Doc. 01–29772 Filed 11–27–01; 3:39 pm]

BILLING CODE 3510–22–S

Notices

Federal Register
Vol. 66, No. 231
Friday, November 30, 2001

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.

DEPARTMENT OF AGRICULTURE

Agricultural Marketing Service

[Doc. # TM–01–10]

Notice of Program Continuation

AGENCY: Agricultural Marketing Service, USDA.

ACTION: Notice inviting proposals for fiscal year (FY) 2002 grant funds under the federal-state marketing improvement program.

SUMMARY: Notice is hereby given that the Federal-State Marketing Improvement Program (FSMIP) was allocated $1,347,000 in the Federal budget for FY 2002. Funds remain available for this program. States interested in obtaining funds under the program are invited to submit Proposals. While only State Departments of Agriculture or other appropriate State Agencies are eligible to apply for funds, State Agencies are encouraged to involve industry groups and community-based organizations in the development of proposals and the conduct of projects.

DATES: Funds will be allocated on the basis of one round of consideration. Proposals will be accepted through February 15, 2002.

ADDRESSES: Proposals may be sent to: FSMIP Staff, Transportation and Marketing Programs, Agricultural Marketing Service (AMS), U.S. Department of Agriculture, 1400 Independence Avenue, SW, Room 4009 South Building, Washington, DC 20250.

FOR FURTHER INFORMATION CONTACT: Janise Zygmont, FSMIP Staff Officer, (202) 720–2704.

SUPPLEMENTARY INFORMATION: FSMIP is authorized under section 204(b) of the Agricultural Marketing Act of 1946 (7 U.S.C. 1621 *et seq.*). The program is a matching fund program designed to assist State Departments of Agriculture or other appropriate State agencies in conducting studies or developing innovative approaches related to the marketing of agricultural products. Other organizations interested in participating in this program should contact their State Department of Agriculture's Marketing Division to discuss their proposal.

Proposals are submitted by the State Agency and must be accompanied by a completed Standard Form (SF)–424 with SF–424A attached. FSMIP funds may not be used for advertising or, with limited exceptions, for the purchase of equipment or facilities. Guidelines may be obtained from your State Department of Agriculture or the above AMS contact.

Starting with FY 2002, FSMIP funds will be allocated on the basis of only one round of competition. In previous years, FSMIP grants were allocated on the basis of two rounds. Moving to one round will enable FSMIP staff to give more attention to project oversight, ongoing consultation with researchers, and wider dissemination of research results. The change should result in more efficient management of FSMIP projects at both the State and Federal levels.

Funds can be requested for a wide range of marketing research and marketing service activities, including projects aimed at:

(1) Developing and testing new or more efficient methods of processing, packaging, handling, storing, transporting, and distributing food and other agricultural products;

(2) Assessing customer response to new or alternative agricultural products or marketing services and evaluating potential opportunities for U.S. producers, processors and other agribusinesses, in both domestic and international markets; and,

(3) Identifying problems and impediments in existing channels of trade between producers and consumers of agricultural products and devising improved marketing practices, facilities, or systems to address such problems.

While all proposals which fall within the FSMIP guidelines will be considered, States are encouraged to submit proposals that have regional or national significance, and that foster innovation in the following arenas:

(1) Global Economy—preparing U.S. producers to market profitably in a rapidly changing global environment where 96 percent of the world's consumers reside outside the United States;

(2) Consumer-Driven Agriculture—responding to consumer concerns about health and food safety; developing new products that address the needs of the mobile, time-pressed consumer; and studying the uses and value to consumers of food labeling and packaging alternatives;

(3) Agricultural Diversity—identifying niche market opportunities; exploring new markets for agricultural products, such as for industrial and nutraceutical applications; developing value-added products that meet consumer needs while enabling producers to retain a larger share of the food dollar; and developing marketing tools and strategies that will foster long term sustainability of the environment and viable rural communities; and

(4) Technical Innovation—exploring ways improve food safety and reduce the threat of plant and animal diseases in marketing channels such as through improved handling and packaging; and fostering ways to transport and distribute food and agricultural products more efficiently both domestically and overseas.

Copies of the FSMIP guidelines may be obtained by contacting the person listed as the contact for further information. FSMIP is listed in the ''Catalog of Federal Domestic Assistance'' under number 10.156 and subject agencies must adhere to Title VI of the Civil Rights Act of 1964, which bars discrimination in all Federally assisted programs.

Authority: 7 U.S.C. 1621–1627.

Dated: November 20, 2001.

A.J. Yates,

Administrator, Agricultural Marketing Service.

[FR Doc. 01–29703 Filed 11–29–01; 8:45 am]

BILLING CODE 3410–02–P

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

[Docket No. 01–108–1]

Public Meeting; Veterinary Biologics

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Advance notice of public meeting and request for suggested agenda topics.

SUMMARY: We are issuing this notice to inform producers and users of veterinary biological products and other interested individuals that we will be holding our 11th annual public meeting to discuss regulatory and policy issues related to the manufacture, distribution, and use of veterinary biological products. We are planning the meeting agenda and are requesting suggestions for topics of general interest to producers and other interested individuals.

DATES: The public meeting will be held from Tuesday, April 2, through Thursday, April 4, 2002, from 8 a.m. to approximately 5 p.m. on Tuesday and Wednesday, and from 8 a.m. to approximately noon on Thursday.

ADDRESSES: The public meeting will be held in the Scheman Building at the Iowa State Center, Iowa State University, Ames, IA.

FOR FURTHER INFORMATION CONTACT: For further information on agenda topics, contact Mr. Steven A. Karli, Director, Center for Veterinary Biologics, VS, APHIS, 510 South 17th Street, Suite 104, Ames, IA 50010–8197; phone (515) 232–5785; fax (515) 232–7120; or e-mail *CVB@aphis.usda.gov*. For registration information, contact Ms. Kay Wessman at the same address and fax number; phone (515) 232–5785 extension 127; or e-mail *kay.wessman@aphis.usda.gov*.

SUPPLEMENTARY INFORMATION: Since 1989, the Animal and Plant Health Inspection Service (APHIS) has held 10 public meetings in Ames, IA, on veterinary biologics. The meetings provide an opportunity for the exchange of information among APHIS representatives, producers and users of veterinary biological products, and other interested individuals. APHIS is planning the agenda for the 11th annual public meeting, which will be held April 2 through 4, 2002.

The agenda for the meeting is not yet complete. The theme for this year's public meeting is emergency animal health management. The goal of this year's public meeting is to address issues related to the management of diseases that currently affect or have the potential to affect animal populations in the United States. The agenda may include, but will not be limited to, discussions on: (1) Diagnostics and vaccines—their role in foreign animal disease control; (2) Veterinary Services safeguarding review; (3) biosecurity and response activities; (4) animal care; and (5) international harmonization. In addition, many information stations will be available for the dissemination of information on APHIS' veterinary biologics program.

Before finalizing the agenda, APHIS is seeking suggestions for additional meeting topics from the interested public. We would also like to invite interested individuals to use this meeting to present their ideas and suggestions concerning the licensing, manufacturing, testing, and distribution of veterinary biologics.

Please submit suggested meeting topics and proposed presentation titles to either of the persons listed under **FOR FURTHER INFORMATION CONTACT** on or before December 21, 2001. For proposed presentations, please include the name(s) of the presenter(s) and the approximate amount of time that will be needed for each presentation.

After the agenda is finalized, APHIS will announce the agenda topics in the **Federal Register**.

Done in Washington, DC, this 27th day of November, 2001.

W. Ron DeHaven,

Acting Administrator, Animal and Plant Health Inspection Service.

[FR Doc. 01–29725 Filed 11–29–01; 8:45 am]

BILLING CODE 3410–34–U

DEPARTMENT OF AGRICULTURE

Food and Nutrition Service

Agency Information Collection Activities: Proposed Collection; Comment Request—Report of Coupon Issuance and Commodity Distribution for Disaster Relief

AGENCY: Food and Nutrition Service, USDA.

ACTION: Notice.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, the Food and Nutrition Service (FNS) is publishing for public comment a summary of a proposed information collection. The proposed collection is an extension of a collection currently approved for the Food Stamp Program and the Food Distribution Program.

DATES: Comments on this notice must be received by January 29, 2002 to be assured of consideration.

ADDRESSES: Send comments and requests for copies of this information collection to Alan Rich, Program Reports, Analysis and Monitoring Branch, Budget Division, Food and Nutrition Service, USDA, 3101 Park Center Drive, Alexandria, VA 22302.

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 use of appropriate, automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

All comments will be summarized and included in the request for Office of Management and Budget approval of the information collection. All comments will become a matter of public record.

FOR FURTHER INFORMATION CONTACT: Alan Rich, (703) 305–2113.

SUPPLEMENTARY INFORMATION:

Title: Report of Coupon Issuance and Commodity Distribution for Disaster Relief.

OMB Number: 0584–0037.

Expiration Date: December 31, 2001.

Type of Request: Extension of a currently approved collection.

Abstract: Food distribution in disaster situations is authorized under section 32 of the Act of August 24, 1935 (7 U.S.C. 612c); section 416 of the Agricultural Act of 1949 (7 U.S.C. 1431); section 709 of the Food and Agriculture Act of 1965 (7 U.S.C. 1446a–l); section 4(a) of the Agriculture and Consumer Protection Act of 1973 (7 U.S.C. 612c note); and by sections 412 and 413 of the Disaster Relief and Emergency Assistance Act (42 U.S.C. 5179, 5180). Program implementing regulations are contained in 7 CFR part 250. In accordance with section 250.43(f), distributing agencies shall provide a summary report to the agency within 45 days following termination of the disaster assistance.

Respondents: State agencies that administer USDA disaster relief activities.

Number of Respondents: 55.

Estimated Number of Responses per Respondent: The number of responses is estimated to be 1.82 responses per State agency per year.

Estimate of Burden: Public reporting burden for this collection of information is estimated to average 25 minutes per respondent for each submission.

Estimated Total Annual Burden on Respondents: 97 hours.

Dated: November 20, 2001.

George A. Braley,

Acting Administrator, Food and Nutrition Service.

[FR Doc. 01–29708 Filed 11–29–01; 8:45 am]

BILLING CODE 3410–30–U

DEPARTMENT OF AGRICULTURE

Forest Service

Land and Resource Management Plan Revision Schedule

AGENCY: Forest Service, USDA.

ACTION: Notice.

SUMMARY: As required by the Land and Resource Management Planning Rule adopted in November 2000, the Chief of the Forest Service has developed a Plan Revision Schedule for National Forest System units that have not completed revisions of their plans. This notice sets out the schedule and an explanation of some of the factors that affected scheduling decisions.

ADDRESSES: Questions about the revision schedule can be sent to the Director, Ecosystem Management Coordination Staff (3CEN Yates), Forest Service, USDA, PO Box 96090, Washington, DC 20090–6090.

FOR FURTHER INFORMATION CONTACT: Karen Liu, Planning Staff, EMC, (202) 205–1329; or via email at *kliu@fs.fed.us.*

SUPPLEMENTARY INFORMATION: The Chief's Land and Resource Management Plan (LRMP) Revision Schedule sets priorities for plan revisions based on several considerations. Those National Forest System (NFS) units facing a multitude of ecological and social concerns such as impaired waters, imperiled species, fire risk, forest health, undue human pressure, or persistent poverty were considered as high priorities for revision. Although the National Forest Management Act requires LRMPs to be revised at least every 15 years, funding and staffing shortages have prevented many National Forests and Grasslands from undertaking and completing plan revisions. In an effort to further reduce departures from the 15-year requirement, the schedule also gives priority to scheduling plan revisions that have not met the 15-year revision requirement. NFS units with recent significant amendments without the issues identified previously were considered as low priorities for revision. There was also an attempt to group NFS units with similar ecological, social, and economic settings to improve planning efficiency and, thereby, reduce planning costs.

The three tables at the end of this document display the National LRMP Revision Schedule for each unit of the National Forest System. Table 1 lists anticipated start dates for new plan revisions. Table 2 lists plan revisions already underway. The lists in Tables 1 and 2 are not organized by Region but are listed sequentially in order of the revision initiation date. Table 3 lists plan revisions completed as of November 1, 2001.

Publication of this schedule does not constitute an initiation of a plan revision process for any NFS unit. In addition, this notice and publication of the schedule does not, in itself, constitute an action subject to the NEPA procedures of 40 CFR parts 1500–1508 or Forest Service Handbook 1909.15. Finally, the Revision Schedule will be revised as needed to account for new information and changed conditions. Future changes to the schedule will be posted on the Forest Service Ecosystem Management Coordination staff website at *www.fs.fed.us/emc.*

Dated: November 21, 2001.

Dale N. Bosworth,

Chief.

TABLE 1.—FOREST PLANS NEEDING REVISION

Region	State	Administrative unit	Required revision date	Revision initiation date	Revision completion date
R–1	MT	Lolo National Forest	2001	2002	2006
R–4	UT	Dixie National Forest	2001	2002	2006
R–4	UT	Fishlake National Forest	2001	2002	2006
R–4	UT	Manti-LaSal National Forest	2001	2002	2006
R–8	AR	Ouachita National Forest	2001	2002	2006
R–8	AR	Ozark-St. Francis National Forest	2001	2002	2006
R–9	MO	Mark Twain National Forest	2001	2002	2006
R–9	OH	Wayne National Forest	2003	2002	2006
R–9	WV	Monongahela National Forest	2001	2002	2006
R–1	ID	Clearwater National Forest	2002	2003	2007
R–1	ID	Nez Perce National Forest	2002	2003	2007
R–1	MT	Bitterroot National Forest	2002	2003	2007
R–4	NV	Humboldt-Toiyabe National Forest	2001	2003	2007
R–6	WA	Colville National Forest	2003	2003	2007
R–6	WA	Okanogan National Forest	2004	2003	2007
R–6	WA	Wenatchee National Forest	2005	2003	2007
R–9	MI	Hiawatha National Forest	2001	2003	2007
R–9	MI	Huron-Manistee National Forest	2001	2003	2007
R–9	MI	Ottawa National Forest	2001	2003	2007
R–9	PA	Allegheny National Forest	2001	2003	2007
R–1	MT	Custer National Forest	2002	2004	2008
R–1	MT	Gallatin National Forest	2002	2004	2008
R–2	WY	Shoshone National Forest	2001	2004	2008
R–4	UT	Ashley National Forest	2001	2004	2008
R–5	CA	Inyo National Forest	2003	2004	2008
R–5	CA	Sequoia National Forest	2003	2004	2008
R–5	CA	Sierra National Forest	2007	2004	2008
R–6	OR	Malheur National Forest	2005	2004	2008
R–6	OR	Umatilla National Forest	2005	2004	2008
R–6	OR	Wallowa-Whitman National Forest	2005	2004	2008
R–8	KY	Land Between the Lakes National Forest (new plan)	NA	2004	2008
R–1	MT	Helena National Forest	2001	2005	2009

TABLE 1.—FOREST PLANS NEEDING REVISION—Continued

Region	State	Administrative unit	Required revision date	Revision initiation date	Revision completion date
R–1	MT	Lewis & Clark National Forest	2001	2005	2009
R–3	AZ	Coronado National Forest	2001	2005	2009
R–3	AZ	Kaibab National Forest (North Kaibab Ranger District Only)	2003	2005	2009
R–3	AZ	Tonto National Forest (Except the Payson Ranger District)	2000	2005	2009
R–4	ID	Salmon-Challis National Forest	2002	2005	2009
R–4	WY	Bridger-Teton National Forest	2005	2005	2009
R–8	MS	National Forests in Mississippi	2000	2005	2009
R–8	NC	Nantahala-Pisgah National Forest	2002	2005	2009
R–8	NC	Uwharrie National Forest	2001	2005	2009
R–3	AZ	Apache-Sitgreaves National Forest	2002	2006	2010
R–3	AZ	Coconino National Forest	2002	2006	2010
R–3	AZ	Kaibab (Except the North Kaibab Ranger District)	2003	2006	2010
R–3	AZ	Prescott National Forest	2002	2006	2010
R–3	AZ	Tonto National Forest (Payson Ranger District Only)	2000	2006	2010
R–3	NM	Cibola National Forest (Magdalena Ranger District Only)	2000	2006	2010
R–3	NM	Gila National Forest	2001	2006	2010
R–3	NM	Lincoln National Forest	2001	2006	2010
R–5	CA	Lassen National Forest	2008	2006	2010
R–5	CA	Modoc National Forest	2006	2006	2010
R–5	CA	Plumas National Forest	2003	2006	2010
R–6	OR	Fremont National Forest	2004	2006	2010
R–6	OR	Winema National Forest	2005	2006	2010
R–3	NM	Carson National Forest	2001	2007	2011
R–3	NM	Cibola National Forest (Except Magdalena Ranger District)	2000	2007	2011
R–3	NM	Santa Fe National Forest	2002	2007	2011
R–5	CA	Eldorado National Forest	2004	2007	2011
R–5	CA	Lake Tahoe Basin Management Unit	2003	2007	2011
R–5	CA	Stanislaus National Forest	2006	2007	2011
R–5	CA	Tahoe National Forest	2005	2007	2011
R–6	OR	Deschutes National Forest	2005	2007	2011
R–6	OR	Ochoco National Forest	2004	2007	2011
R–6	OR	Rogue River National Forest	2005	2007	2011
R–6	OR	Siskiyou National Forest	2004	2007	2011
R–6	OR	Umpqua National Forest	2005	2007	2011
R–6	WA	Gifford Pinchot National Forest	2005	2007	2011
R–5	CA	Klamath National Forest	2010	2008	2012
R–5	CA	Mendocino National Forest	2010	2008	2012
R–5	CA	Shasta-Trinity National Forest	2010	2008	2012
R–5	CA	Six Rivers National Forest	2010	2008	2012
R–6	OR	Mt. Hood National Forest	2005	2008	2012
R–6	OR	Siuslaw National Forest	2005	2008	2012
R–6	OR	Willamette National Forest	2005	2008	2012
R–6	WA	Mt. Baker-Snoqualmie National Forest	2005	2008	2012
R–6	WA	Olympic National Forest	2005	2008	2012

TABLE 2.—PLAN REVISIONS ALREADY UNDERWAY

Region	State	Administrative unit	Required revision date	Revision initiation date	Revision completion date
R–10	AK	Chugach National Forest	1999	1997	2002
R–1	ND	Dakota Prairie National Grasslands	NA	1997	2002
R–2	CO	White River National Forest	1999	1997	2002
R–2	NE	Nebraska National Forest	1999	1997	2002
R–2	WY	Thunder Basin National Grasslands	2000	1997	2002
R–8	NC	Croatan National Forest	2001	1996	2002
R–8	AL	National Forests in Alabama	2001	1996	2003
R–2	WY	Medicine Bow National Forest (Except Thunder Basin National Grasslands)	2000	1999	2004
R–4	ID	Boise National Forest	2005	1998	2002
R–4	ID	Caribou National Forest	2000	1999	2002
R–4	ID	Payette National Forest	2003	1998	2002
R–4	ID	Sawtooth National Forest	2002	1999	2002
R–4	UT	Uinta National Forest	1999	1999	2002
R–4	UT	Wasatch-Cache National Forest	2000	1999	2002
R–8	GA	Chattahoochee-Oconee National Forest	2000	1996	2003
R–8	KY	Daniel Boone National Forest	2000	1996	2003
R–8	SC	Francis Marion-Sumter National Forest (Sumter Only)	2000	1996	2003
R–8	TN	Cherokee National Forest	2001	1996	2003
R–8	VA	George Washington-Jefferson National Forest (Jefferson Only)	2000	1996	2003

TABLE 2.—PLAN REVISIONS ALREADY UNDERWAY—Continued

Region	State	Administrative unit	Required revision date	Revision initiation date	Revision completion date
R–9	WI	Chequamegon-Nicolet National Forest	2001	1996	2003
R–1	MT	Kootenai National Forest	2002	1996	2004
R–9	MN	Chippewa National Forest	2001	1997	2003
R–9	MN	Superior National Forest	2001	1997	2003
R–9	IL	Midewin National Tallgrass Prairie (New Plan)	NA	1998	2002
R–2	CO	Grand Mesa-Uncompahgre-Gunnison National Forest	1998	1999	2004
R–2	CO	San Juan National Forest	1998	1999	2004
R–2	WY	Bighorn National Forest	2000	1999	2004
R–2	CO	Pike-San Isabel National Forest	1999	1999	2005
R–9	IL	Shawnee National Forest	2001	2000	2004
R–9	IN	Hoosier National Forest	2000	2000	2004
R–9	NH	White Mountain National Forest	2001	2000	2004
R–5	CA	Angeles National Forest	2002	2001	2005
R–5	CA	Cleveland National Forest	2001	2001	2005
R–5	CA	Los Padres National Forest	2003	2001	2005
R–5	CA	San Bernardino National Forest	2004	2001	2005
R–1	ID	Idaho Panhandle National Forest	2002	2001	2005
R–1	MT	Beaverhead-Deerlodge National Forest	2001	2001	2005
R–1	MT	Flathead National Forest	2001	2001	2005
R–9	VT	Green Mountain and Finger Lakes National Forest	2002	2001	2005

TABLE 3.—PLAN REVISIONS COMPLETED AS OF NOVEMBER 1, 2001

Region	State	Administrative unit	Required revision date	Revision initiation date	Revision completion date
R–2	CO	Araphaho-Roosevelt National Forest			1998
R–2	CO	Rio Grande National Forest			1997
R–2	CO	Routt National Forest			1998
R–2	SD	Black Hills National Forest			1997
R–4	ID	Targhee National Forest			1997
R–8	FL	National Forests in Florida			1999
R–8	LA	Kisatchie National Forest			1999
R–8	PR	Caribbean National Forest			1997
R–8	SC	Francis Marion-Sumter National Forest (Francis Marion Only)			1996
R–8	TX	National Forests and Grasslands in Texas			1996
R–8	VA	George Washington-Jefferson National Forest (George Washington Only)			1993
R–10	AK	Tongass National Forest			1997

[FR Doc. 01–29780 Filed 11–29–01; 8:45 am]
BILLING CODE 3410–11–P

COMMITTEE FOR PURCHASE FROM PEOPLE WHO ARE BLIND OR SEVERELY DISABLED

Procurement List; Proposed Additions

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

ACTION: Proposed additions to Procurement List.

SUMMARY: The Committee is proposing to add to the Procurement List commodities and a service to be furnished by nonprofit agencies employing persons who are blind or have other severe disabilities.

COMMENTS MUST BE RECEIVED ON OR BEFORE: December 31, 2001.

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 possible impact of the proposed actions.

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

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 commodities and service to the Government.

2. The action will result in authorizing small entities to furnish the commodities and service 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 commodities and service 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.

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

Commodities

Stand, Office Machine
7110–00–601–9835
7110–00–601–9849
7110–01–136–1563
NPA: Knox County ARC Knoxville, Tennessee
GOVERNMENT AGENCY: GSA/National Furniture Center for Zones 2 and 3

Undershirt, Man's, Brown
8420–01–112–1472
8420–01–112–1473
8420–01–112–1474
8420–01–112–1475
8420–01–112–1476
8420–01–112–1477
8420–01–112–1478
8420–01–112–1479
(Additional 500,000 shirts/increase from 1,600,000 to 2,100,000)
NPA: The Arkansas Lighthouse for the Blind Little Rock, Arkansas
GOVERNMENT AGENCY: Defense Supply Center Philadelphia Cleaner, Tobacco Pipe
9920–00–292–9946
NPA: Rochester Psychiatric Center Rochester, New York
GOVERNMENT AGENCY: GSA/Industrial Products Contracting Division

Service

Food Service Attendant, 174th FW/LGC, NYANG, Hancock Field, 6001 E Malloy Road, Syracuse, NY
NPA: Oswego Industries, Inc. Fulton, New York
GOVERNMENT AGENCY: New York Air National Guard

Sheryl D. Kennerly,

Director, Information Management.

[FR Doc. 01–29782 Filed 11–29–01; 8:45 am]

BILLING CODE 6353–01–P

COMMITTEE FOR PURCHASE FROM PEOPLE WHO ARE BLIND OR SEVERELY DISABLED

Agency Information Collection Activities; Proposed Information Collection; Comment Request

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

ACTION: Proposed collection, Comment request for renewal of existing information collection instruments (Committee Form 401 and Committee Form 402).

SUMMARY: The Committee for Purchase From People Who Are Blind or Severely Disabled is inviting public comment on the proposed collection of information. Under the Paperwork Reduction Act of 1995, Federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, and to allow 60 days for public comment in response to the notice. This notice solicits comments on requirements relating to the initial certification of nonprofit agencies serving people who are blind or who have other severe disabilities (Committee Forms 401 and 402). The Committee is particularly interested in comments that help the agency to: (1) Evaluate 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; (2) Evaluate 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; (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, e.g., permitting electronic submissions of responses.

DATES: Submit comments on or before January 29, 2002.

ADDRESSES: Comments and requests for copies of the proposed information collection instruments should be submitted to: Janet Yandik, Information Management Specialist, Committee for Purchase From People Who Are Blind or Severely Disabled, Jefferson Plaza 2, Suite 10800, 1421 Jefferson Davis Highway, Arlington, VA 22202–3259; e-mail: jyandik@jwod.gov; phone: (703) 603–7746, fax (703) 603–0655.

FOR FURTHER INFORMATION CONTACT: Same as above.

SUPPLEMENTARY INFORMATION: The Committee has two initial certification forms, one for nonprofit agencies serving people who are blind and one for nonprofit agencies primarily serving people who have other severe disabilities. The information included on the forms is required to ensure that nonprofit agencies requesting to participate in the Committee's program continue to meet the requirements of 41 USC 46–48c.

Title: Initial Certification—Qualified Nonprofit Agency Serving People Who Are Blind, Committee Form 401.

OMB Number: 3037–0004.

Agency Number: 3037.

Frequency: 1 time.

Affected Public: Nonprofit agencies serving people who are blind seeking to participate in the Javits-Wagner-O'Day (JWOD) program.

Number of Respondents: 5.

Estimated Time Per Respondent: 1 hour.

Total Burden Hours: 5.

Total Annual costs: $0.

Title: Initial Certification—Qualified Nonprofit Agency Serving People Who Are Severely Disabled, Committee Form 402.

OMB Number: 3037–0003.

Agency Number: 3037.

Frequency: 1 time.

Affected Public: Nonprofit agencies serving people who are severely disabled seeking to participate in the JWOD program.

Number of Respondents: 50.

Estimated Time Per Respondent: 1 hour.

Total Burden Hours: for 50.

Total Annual costs: $0.

Sheryl D. Kennerly,

Director, Information Management.

[FR Doc. 01–29784 Filed 11–29–01; 8:45 am]

BILLING CODE 6353–01–P

COMMITTEE FOR PURCHASE FROM PEOPLE WHO ARE BLIND OR SEVERELY DISABLED

Procurement List Proposed Addition; Correction

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

ACTION: Proposed addition to Procurement List.

SUMMARY: In the document appearing on page 57703, FR Doc. 01–28751, in the issue of November 16, 2001, in the second column the Committee published a notice of proposed addition to the Procurement List of, among other things, Janitorial/Custodial, Naval Sea Systems Command (NAVSEA) Building, Washington Navy Yard, DC. This notice is amended to include additional Buildings.

COMMENTS MUST BE RECEIVED ON OR BEFORE: December 31, 2001

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

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 service to the Government.

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

The following service is proposed for addition to Procurement List for production by the nonprofit agencies listed:

Service

Janitorial/Custodial

Naval Sea Systems Command (NAVSEA)
Buildings 22, 28, 104, 176, 197, 201, 213 and 214
Washington Navy Yard, DC
NPA: Melwood Horticultural Training Center, Upper Marlboro, Maryland.
Government Agency: Department of the Navy/NAVSEA.

Sheryl D. Kennerly,

Director, Information Management.

[FR Doc. 01–29783 Filed 11–29–01; 8:45 am]

BILLING CODE 6353–01–P

UNITED STATES COMMISSION ON CIVIL RIGHTS

Sunshine Act Meeting

AGENCY: U.S. Commission on Civil Rights

DATE AND TIME: Friday, December 7, 2001, 9:30 a.m.

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

STATUS:

Agenda

I. Approval of Agenda
II. Approval of Minutes of November 9, 2001 Meeting
III. Announcements
IV. Staff Director's Report
V. State Advisory Committee Appointments for Alaska, California, Iowa, Mississippi, New Jersey, Nevada, North Carolina, Pennsylvania (interim), South Carolina, Vermont, and Washington
VI. Program Planning
VII. Future Agenda Items

Michael L. Foreman,

Acting Deputy General Counsel.

[FR Doc. 01–29853 Filed 11–28–01; 1:00 pm]

BILLING CODE 6335–01–M

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 112601B]

New England Fishery Management Council; Public Meetings

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

ACTION: Notice of public meeting.

SUMMARY: The New England Fishery Management Council (Council) is scheduling a public meeting of its Groundfish Oversight Committee in December 2001. Recommendations from the Committee will be brought to the full Council for formal consideration and action, if appropriate.

DATES: The meeting will held on Monday, December 17, 2001, at 9:30 a.m.

ADDRESSES: The meeting will be held at the Holiday Inn, 31 Hampshire Street, Mansfield, MA 02048; telephone: 508–339–2200.

Council address: New England Fishery Management Council, 50 Water Street, Newburyport, MA 01950.

FOR FURTHER INFORMATION CONTACT: Paul J. Howard, Executive Director, New England Fishery Management Council; 978–465–0492.

SUPPLEMENTARY INFORMATION: The Groundfish Oversight Committee will review the draft Framework Adjustment 36 to the Northeast Multispecies Fishery Management Plan (FMP), including the Draft Supplemental Environmental Impact Statement (DSEIS). Management measures in Framework 36 are designed to reduce fishing mortality for groundfish stocks consistent with Amendment 7 to the FMP, reduce regulatory discards of Gulf of Maine cod, extend or revise the Western Gulf of Maine closed area, provide access to Closed Area II to target yellowtail flounder, expand the authorized area for the northern shrimp fishery, allow access to groundfish closed areas by tuna purse seine vessels, and increase the trip limit for the Cultivator Shoals whiting fishery. Fishing mortality must be reduced for Gulf of Maine and Georges Bank cod to meet the objectives of the FMP. Most of the measures in the framework target these reductions. Measures under consideration include (but are not limited to) changes in seasonal and year round closed areas, increases in mesh size, restrictions on the deployment or use of gear, changes in trip limits, reductions in days-at-sea or restrictions on the use of days-at-sea, and modifications to gear to reduce bycatch of cod. Regulatory changes are also being considered for the recreational fishery, including increases in minimum size limits for cod, restrictions on access to closed areas, and area closures for recreational fishers. The Groundfish Oversight Committee will review the draft framework document and analysis of impacts, and may identify a preferred alternative. The recommendations of the Committee will be considered by the full Council at a meeting on December 19, 2001. After the draft framework and DSEIS is approved by the Council, it will be available for public review and comment prior to the final selection of management measures in March 2002. After completing review of the draft Framework 36, the Committee will meet in a closed session to discuss Groundfish Advisory Panel applications.

Although non-emergency issues not contained in this agenda may come before this group for discussion, those issues may not be the subject of formal action during this meeting. Action will be restricted to those issues specifically listed in this notice and any issues arising after publication of this notice that require emergency action under section 305(c) of the Magnuson-Stevens Act, provided the public has been notified of the Council's intent to take final action to address the emergency.

Special Accommodations

This meeting is physically accessible to people with disabilities. Requests for sign language interpretation or other auxiliary aids should be directed to Paul

J. Howard (see **ADDRESSES**) at least 5 days prior to the meeting dates.

Dated: November 27, 2001.

Richard W. Surdi,

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

[FR Doc. 01–29771 Filed 11–29–01; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 112001A]

Endangered Species; Permits

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

ACTION: Receipt of an application for a research permit (1353).

SUMMARY: Notice is hereby given of the following actions regarding permits for takes of endangered and threatened species for the purposes of scientific research and/or enhancement under the Endangered Species Act (ESA): NMFS has received an application for a scientific research permit from Dr. Steve W. Ross, of NC National Estuarine Research Reserve.

DATES: Comments or requests for a public hearing on this new application must be received at the appropriate address or fax number no later than 5 p.m. eastern standard time on December 31, 2001.

ADDRESSES: Written comments on this new application should be sent to the appropriate office as indicated below. Comments may also be sent via fax to the number indicated for the application. Comments will not be accepted if submitted via e-mail or the Internet. The application and related documents are available for review in the indicated office, by appointment:

Permits, Conservation and Education Division, F/PR1, 1315 East West Highway, Silver Spring, MD 20910 (phone:301–713–1401, fax: 301–713–0376).

FOR FURTHER INFORMATION CONTACT: Lillian Becker, Silver Spring, MD (phone: 301–713–2319, fax: 301–713–0376, e-mail: Lillian.Becker@noaa.gov)

SUPPLEMENTARY INFORMATION:

Authority

Issuance of permits and permit modifications, as required by the Endangered Species Act of 1973 (16 U.S.C. 1531–1543) (ESA), is based on a finding that such permits/modifications: (1) are applied for in good faith; (2) would not operate to the disadvantage of the listed species which are the subject of the permits; and (3) are consistent with the purposes and policies set forth in section 2 of the ESA. Scientific research and/or enhancement permits are issued under section 10 (a)(1)(A) of the ESA. Authority to take listed species is subject to conditions set forth in the permits. Permits and modifications are issued in accordance with and are subject to the ESA and NMFS regulations governing listed fish and wildlife permits (50 CFR parts 222–226).

Those individuals requesting a hearing on an application listed in this notice should set out the specific reasons why a hearing on that application would be appropriate (see **ADDRESSES**). The holding of such hearing is at the discretion of the Assistant Administrator for Fisheries, NOAA. All statements and opinions contained in the permit action summaries are those of the applicant and do not necessarily reflect the views of NMFS.

Species Covered in This Notice

The following species are covered in this notice:

Endangered Shortnose Sturgeon (*Acipenser brevirostrum*)

Application 1353

The shortnose sturgeon, *Acipenser brevirostrum*, is the only federally listed endangered marine fish in North Carolina. In the late 1800's, NC shortnose and Atlantic sturgeon supported the largest sturgeon fishery in the southeastern U.S. Due to habitat loss and overfishing, NC sturgeon populations declined until both species were considered in danger of extinction in the state. This research will sample and track the shortnose sturgeon of the rivers of NC, including the Cape Fear river system, the Brunswick River, and the Northeast Cape Fear River. The fish will be collected by gillnetting, trawling, and electroshocking. They will then be documented for measurements, disease and catch per unit effort. The fish will then be tagged with an internal ultrasonic transmitter and released. The tagged fish will be monitored for the life of the battery of the implants, approximately 7 months.

Dated: November 26, 2001.

Ann Terbush,

Chief, Permits, Conservation and Education Division, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. 01–29768 Filed 11–29–01; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 110801B]

Marine Mammals; File No. 376–1520–01

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

ACTION: Denial of amendment to permit.

SUMMARY: Notice is hereby given that a request for an amendment to scientific research Permit No. 376–1520–01, submitted by James H.W. Hain, Associated Scientists at Woods Hole, Box 721, Woods Hole, MA 02543 has been denied.

ADDRESSES: The application and related documents are available for review upon written request or by appointment in the following office(s):

Permits and Documentation Division, F/PR1, Office of Protected Resources, NMFS, 1315 East-West Highway, Room 13705, Silver Spring, MD 20910; phone (301) 713–2289; fax (301) 713–0376;

Regional Administrator, Northeast Region, NMFS, One Blackburn Drive, Gloucester, MA 01930–2298; phone (978) 281–9200; fax (978) 281–9371; and

Regional Administrator, Southeast Region, NMFS, 9721 Executive Center Drive North, St. Petersburg, FL 33702-2432; phone (727) 570–5301; fax (727) 570–5320.

FOR FURTHER INFORMATION CONTACT: Tammy Adams or Ruth Johnson, (301) 713–2289.

SUPPLEMENTARY INFORMATION: On July 31, 2001, A notice was published in the **Federal Register** (66 FR 39493) that an application for a permit amendment had been filed by the above named individual. The requested permit amendment has been denied pursuant to the Marine Mammal Protection Act of 1972 (16 U.S.C. 1361 *et seq.*), the Regulations Governing the Taking and Importing of Marine Mammals (50 CFR part 216), the Endangered Species Act of 1973, as amended (ESA; 16 U.S.C. 1531 *et seq.*), and the regulations governing the taking, importing, and exporting of endangered and threatened species (50 CFR 222–226).

Permit No. 376–1520–01 authorizes the Holder to approach a variety of cetacean species to conduct photo-identification and behavioral observations. The approach distances in the permit are currently limited to: up to 100 ft. (31 m) by vessel, 200 ft. (61 m) directly above and 350 ft. (107 m) slant range by aircraft for all species

except North Atlantic right whales (*Eubalaena glacialis*), and up to 700 ft. (213 m) directly above and at slant range in fixed- and rotary-winged aircraft, and 500 ft. (152 m) directly above and 350 ft (107 m) slant range using an aerostat (blimp) for right whales. The permit holder requested an amendment to the permit to allow approaching North Atlantic right whales up to 100 ft. (31 m) in a variety of small vessels, including kayaks, for the purpose of photo-identification.

Dated: November 26, 2001.

Ann D. Terbush,

Chief, Permits, Conservation and Education Division, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. 01–29766 Filed 11–29–01; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 112001B]

Marine Mammals; File No. 1022–1659

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

ACTION: Receipt of application.

SUMMARY: Notice is hereby given that Doyle A. Hanan, Ph.D., P.O. Box 8914, Rancho Santa Fe, California 92067, has applied in due form for a permit to take California sea lions (*Zalophus californianus*) for purposes of scientific research.

DATES: Written or telefaxed comments must be received on or before December 31, 2001.

ADDRESSES: The application and related documents are available for review upon written request or by appointment in the following office(s):

Permits and Documentation Division, Office of Protected Resources, NMFS, 1315 East-West Highway, Room 13705, Silver Spring, MD 20910; phone (301) 713–2289; fax (301) 713–0376; and

Southwest Region, NMFS, 501 West Ocean Blvd., Suite 4200, Long Beach, CA 90802–4213; phone (562) 980–4001; fax (562) 980–4018.

FOR FURTHER INFORMATION CONTACT: Amy Sloan or Ruth Johnson, (301) 713–2289.

SUPPLEMENTARY INFORMATION: The subject permit is requested under the authority of the Marine Mammal Protection Act of 1972, as amended (MMPA; 16 U.S.C. 1361 *et seq.*), and the Regulations Governing the Taking and Importing of Marine Mammals (50 CFR part 216).

The applicant proposes to test the hypothesis that relatively few local California sea lions break through bait receiver walls and damage bait fish at various California harbors. To test this, the applicant proposes to radio tag and track sea lions that exhibit territorial behavior near bait receivers and document interaction patterns at bait receivers. The results of this study will help institute measures to eliminate intentional or accidental feeding of sea lions at selected bait receivers.

In compliance with the National Environmental Policy Act of 1969 (42 U.S.C. 4321 *et seq.*), an initial determination has been made that the activity proposed is categorically excluded from the requirement to prepare an environmental assessment or environmental impact statement.

Written comments or requests for a public hearing on this application should be mailed to the Chief, Permits and Documentation Division, F/PR1, Office of Protected Resources, NMFS, 1315 East-West Highway, Room 13705, Silver Spring, MD 20910. Those individuals requesting a hearing should set forth the specific reasons why a hearing on this particular request would be appropriate.

Comments may also be submitted by facsimile at (301) 713–0376, provided the facsimile is confirmed by hard copy submitted by mail and postmarked no later than the closing date of the comment period. Please note that comments will not be accepted by e-mail or by other electronic media.

Concurrent with the publication of this notice in the **Federal Register**, NMFS is forwarding copies of this application to the Marine Mammal Commission and its Committee of Scientific Advisors.

Dated: November 26, 2001.

Ann D. Terbush,

Chief, Permits and Documentation Division, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. 01–29769 Filed 11–29–01; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 072600B]

Marine Mammals; File Application No. 1004–1656

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

ACTION: Receipt of application.

SUMMARY: Notice is hereby given that Funtime, Inc. d/b/a Six Flags Worlds of Adventure, 1060 North Aurora Road, Aurora, OH 44202, has applied in due form for a permit to import two killer whales (*Orcinus orca*) for the purposes of public display.

DATES: Written or telefaxed comments must be received on or before December 31, 2001.

ADDRESSES: The application and related documents are available for review upon written request or by appointment in the following office(s):

Permits, Conservation and Education Division, Office of Protected Resources, NMFS, 1315 East-West Highway, Room 13705, Silver Spring, MD 20910 (301/713–2289);

Regional Administrator, Northeast Region, NMFS, One Blackburn Drive, Glouster, MA, 01930–2298 (978/281–9116).

Written comments or requests for a public hearing on this request should be submitted to the Chief, Permits, Conservation and Education Division, F/PR1, Office of Protected Resources, NMFS, 1315 East-West Highway, Room 13705, Silver Spring, MD 20910. Those individuals requesting a hearing should set forth the specific reasons why a hearing on this particular permit request would be appropriate.

Comments may also be submitted by facsimile at (301) 713–0376, provided the facsimile is confirmed by hard copy submitted by mail and postmarked no later than the closing date of the comment period. Please note that comments will not be accepted by e-mail or other electronic media.

FOR FURTHER INFORMATION CONTACT: Jennifer Skidmore or Amy Sloan,(301/713–2289).

SUPPLEMENTARY INFORMATION: The subject application for Permit No. 1004–1656–00 is requested under the authority of the Marine Mammal Protection Act of 1972, as amended (16 U.S.C. 1361 *et seq.*), and the Regulations Governing the Taking and Importing of Marine Mammals (50 CFR part 216).

The applicant requests authorization to import two killer whales (*Orcinus orca*), one adult female from Marineland S.A., Antibes, France and one adult male from Mundo Marino, Buenos Aires, Argentina, to Funtime, Inc. d/b/a Six Flags Worlds of Adventure in Aurora, Ohio. The applicant requests these imports for the purpose of public display. The receiving facility, Six Flags Worlds of Adventure, 1060 North

Aurora Road, Aurora, OH 44202 is: (1) open to the public on regularly scheduled basis with access that is not limited or restricted other than by charging an admission fee; (2) offers an educational program based on professionally accepted standards of the AZA and the Alliance for Marine Mammal Parks and Aquariums; and (3) holds an Exhibitor's License, number 31–C–0137, issued by the U.S. Department of Agriculture under the Animal Welfare Act.

In addition to determining whether the applicant meets the three public display criteria, NMFS must determine whether the applicant has demonstrated that the proposed activity is humane and does not represent any unnecessary risks to the health and welfare of marine mammals; that the proposed activity by itself or in combination with other activities, will not likely have a significant adverse impact on the species or stock; and that the applicant's expertise, facilities and resources are adequate to accomplish successfully the objectives and activities stated in the application.

In compliance with the National Environmental Policy Act of 1969 (42 U.S.C. 4321 *et seq.*), an initial determination has been made that the activity proposed is categorically excluded from the requirement to prepare an environmental assessment or environmental impact statement.

Concurrent with the publication of this notice in the **Federal Register**, NMFS is forwarding copies of this application to the Marine Mammal Commission and its Committee of Scientific Advisors.

Dated: November 26, 2001.

Ann D. Terbush,

Chief, Permits, Conservation and Education Division, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. 01–29770 Filed 11–29–01; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF DEFENSE

GENERAL SERVICES ADMINISTRATION

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[OMB Control No. 9000–0035]

Federal Acquisition Regulation; Proposed Collection; Claims and Appeals

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 claims and appeals. The clearance currently expires on March 31, 2002.

Public comments are particularly invited on: Whether this collection of information is necessary for the proper performance of functions of the FAR, and whether it will have practical utility; whether our estimate of the public burden of this collection of information is accurate, and based on valid assumptions and methodology; ways to enhance the quality, utility, and clarity of the information to be collected; and ways in which we can minimize the burden of the collection of information on those who are to respond, through the use of appropriate technological collection techniques or other forms of information technology.

DATES: Submit comments on or before January 29, 2002.

ADDRESSES: Submit comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: FAR Desk Officer, OMB, Room 10102, NEOB, Washington, DC 20503, and a copy to the General Services Administration, FAR Secretariat (MVP), 1800 F Street, NW., Room 4035, Washington, DC 20405.

FOR FURTHER INFORMATION CONTACT: Rhonda Cundiff, Acquisition Policy Division, GSA (202) 501-0044.

SUPPLEMENTARY INFORMATION:

A. Purpose

It is the Government's policy to try to resolve all contractual issues by mutual agreement at the contracting officer's level without litigation. Contractor's claims must be submitted in writing to the contracting officer for a decision. Claims exceeding $100,000 must be accompanied by a certification that (1) the claim is made in good faith; (2) supporting data are accurate and complete; and (3) the amount requested accurately reflects the contract adjustment for which the contractor believes the Government is liable. Contractors may appeal the contracting officer's decision by submitting written appeals to the appropriate officials.

B. Annual Reporting Burden

Respondents: 4,500.
Responses Per Respondent: 3.
Annual Responses: 13,500.
Hours Per Response: 1.
Total Burden Hours: 13,500.

Obtaining Copies of Proposals

Requester may obtain a copy of the proposal from the General Services Administration, FAR Secretariat (MVP), Room 4035, 1800 F Street, NW, Washington, DC 20405, telephone (202) 501-4755. Please cite OMB Control No. 9000-0035, Claims and Appeals, in all correspondence.

Dated: November 26, 2001.

Al Matera,

Director, Acquisition Policy Division.

[FR Doc. 01–29791 Filed 11–29–01; 8:45 am]

BILLING CODE 6820–EP–P

DEPARTMENT OF DEFENSE

Department of the Army; Corps of Engineers

Intent To Prepare A Joint Supplemental Environmental Impact Statement/Environmental Impact Report (SEIS/R) for the Hamilton Army Airfield Wetland Restoration Project To Include The Bel Marin Keys Unit V Property, Marin County, CA

AGENCY: U.S. Army Corps of Engineers, DOD.

ACTION: Notice of intent.

SUMMARY: The U.S. Army Corps of Engineers, San Francisco District (Corps) in collaboration with the California Coastal Conservancy (Conservancy) and the San Francisco Bay Conservation and Development Commission (BCDC) are proposing to restore wetlands on the 1,610-acre Bel Marin Keys Unit V (BMKV) property as an expansion of the Hamilton Wetland Restoration Project at the Hamilton Army Air Field (HAAF). This SEIS/R will supplement the combined EIS/R, which was prepared for the Hamilton Wetland Restoration Project in 1998.

FOR FURTHER INFORMATION CONTACT: Questions about the proposed action and SEIS/R can be answered by: Eric Jolliffe, U.S. Army Corps of Engineers, San Francisco District, 333 Market St., 7th floor, San Francisco, CA 94105, *ejolliffe@spd.usace.army.mil*, (415) 977–8543. Information on the project can be found on the web at *http://www.coastalconservancy.ca.gov/belmarin.* Written comments can also be

submitted via email by sending the comments to: *belmarinkeys@jsanet.com.*

SUPPLEMENTARY INFORMATION: Pursuant to section 102(2)(c) of the National Environmental Policy Act (NEPA) of 1969 as implemented by the Council on Environmental Quality regulations (40 CFR parts 1500–1508), the California Environmental Quality Act (CEQA), and Public Law 102–484 section 2834, as amended by Public Law 104–106 section 2867, the Department of the Army and the California State Coastal Conservancy hereby give notice of intent to prepare a joint SEIS/R for Hamilton Army Airfield Wetland Restoration Project, Marin County, California to include the addition of the Bel Marin Keys Unit V property. The Corps is the lead agency for this project under the National Environmental Policy Act (NEPA). The Conservancy is the lead agency for this project under the California Environmental Quality Act (CEQA). A joint SEIS/R will be prepared to comply with the requirements of NEPA and CEQA. An EIS/R for the Hamilton Wetland Restoration Project was completed in December 1998. The Hamilton project is presently in final engineering design and is expected to commence in the summer of 2002. In 2001, The Conservancy purchased the BMKV property with the intent of including it as an expansion of the Hamilton project.

1. Proposed Action

The 1,610-acre Bel Marin Keys Unit V (BMKV) property is located in unincorporated Marin County, southeast of the city of Novato. The project area historically supported subtidal bay, tidal wetland, and possibly freshwater marsh habitat but levees constructed during the early 20th century separated the area from the tidal influence of San Pablo Bay and drained the site. The area has remained in agricultural use for the last century and it currently supports hay production. The site has subsided to below sea level. Approximately 90 percent of the tidal wetlands that existed around the San Francisco Bay in 1800 have been destroyed by diking or filling for purposes of agriculture, development, or salt production.

The proposed action is expected to include restoration of the majority of the BMKV parcel to wetlands through, at a minimum, site grading, and breaching of one or more of the existing levees separating the site from San Pablo Bay or other adjacent water bodies. The Corps and the Conservancy are currently developing the Conceptual Wetland Restoration Plan for the BMKV parcel that will identify the general details of the proposed action and potential alternatives for analysis in the SEIR/S.

The goal of this project is to create a diverse array of wetland and wildlife habitats at the BMKV and HAAF sites that benefit endangered species as well as other migratory and resident species.

2. Project Alternatives

As noted above, the Corps and the Conservancy are currently developing the Conceptual Wetland Restoration Plan for the BMKV parcel. The SEIS/R will include at a minimum the following alternatives:

- No Action Alternative—The BMKV parcel would remain in its present state without any active intervention to alter habitats. The parcel would not be added to the Hamilton Wetland Restoration Project.
- Restoration of Wetlands Using Natural Sedimentation—Wetlands would be restored on the BMKV parcel through the use of one or more breaches in the levees that separate the site from San Pablo Bay and possibly other adjacent water bodies. Wetland establishment would occur on the site through deposition of sedimentation due to flows through the breach or breaches.
- Restoration of Wetlands Using Dredge Material—Wetlands would be restored on the BMKV parcel through the use of one or more breaches in the levees that separate the site from San Pablo Bay and possibly other adjacent water bodies. Wetland establishment would occur through the deposition of dredged material on the site to raise the elevations above their current subtidal levels.

Within the two general approaches to wetland restoration (natural sedimentation and dredged material), there are a number of other design considerations that the Corps and Conservancy are currently examining through the development of the Conceptual Plan. These considerations may be incorporated into the proposed action or alternatives to be evaluated in the SEIR/S. These include:

- Connection to Adjacent Water Bodies—The site could be connected to San Pablo Bay through breaches in the outboard levee at several different locations. In addition, the site could be connected to Novato Creek or Pacheco Pond either through breaches in the existing levees or culverts. The general location and design of connections will be identified in the Conceptual Plan.
- Protection and/or Relocation of Existing Infrastructure—There is an existing Novato Sanitary District wastewater line that crosses the site leading to an outfall in San Pablo Bay. The line could require additional protection from settling that might occur as a result of the project or relocation, depending on the overall design of the project.
- Treated Wastewater Use—It may be possible to use treated wastewater from the Navato Sanitary District in a freshwater or brackish marsh on a portion of the site.
- Integration with Hamilton Wetland Restoration Project—Part of the BMKV site is separated from the Hamilton (Airfield) Wetland Restoration Site by an existing levee. Connections between the restoration sites may be possible via breaches or culverts through this levee or via degradation or removal of the levee.

This conceptual design process has included a public meeting in the project area and consultation with public agencies and stakeholders with an interest in the project. The conceptual design process will be completed in early 2002. The outcome of the process will be to identify a proposed action and identify alternatives for analysis in the SEIR/S. Input from the public scoping period and the public scoping meeting will be taken into consideration in the selection of the proposed action and alternatives for further analysis.

3. Scoping Process

The Corps and Conservancy are seeking input from interested federal, state, and local agencies, Native American representatives, and other interested private organizations and parties through provision of this notice and holding of a scoping meeting. The scoping meeting will be held at the Marin Humane Society, 171 Bel Marin Keys Boulevard, Novato, CA on December 5, 2001 at 7:00 pm. The purpose of this meeting is to solicit input regarding the environmental issues of concern and the alternatives that should be discussed in the SEIS/R. The public comment period closes December 31, 2001.

4. Availability of SEIS/R

The public will have an additional opportunity to comment on the proposed alternatives after the draft SEIS/R is released to the public in 2002.

Timothy S. O'Rourke,

Lieutenant Colonel, Corps of Engineers, District Engineer.

[FR Doc. 01–29787 Filed 11–29–01; 8:45 am]

BILLING CODE 3710–19–M

DEPARTMENT OF DEFENSE

Department of the Army

Corps of Engineers

Intent To Prepare A Draft Environmental Impact Statement (DEIS) for Navigation Improvements at Unalaska, AK

AGENCY: U.S. Army Corps of Engineers, DoD.

ACTION: Notice of intent.

SUMMARY: The U.S. Army Corps of Engineers, Alaska District, intends to prepare a DEIS for navigation improvements at Unalaska, Alaska. The city of Unalaska, population 4,283, is on Unalaska and Amaknak Islands in the Aleutian Island chain, about 800 miles (1,300 kilometers) southwest of Anchorage, Alaska. Unalaska's economy is based on commercial fishing, fish processing, and fleet services including fuel, repairs and maintenance, trade and transportation. Unalaska has been ranked as the number one port in the nation for seafood volume and value for the past 11 years. The proposed navigation improvements are needed to provide adequate moorage for transient vessels and the Unalaska fleet. Additional moorage would reduce overcrowded conditions at the existing facilities by providing a safer and more efficient moorage area.

FOR FURTHER INFORMATION CONTACT: Bill Abadie (907) 753–2736, Alaska District Corps of Engineers, Environmental Resources Section (CEPOA–EN–CW–ER), P.O. Box 898, Anchorage, AK 99506–0898. E-mail: *william.d.abadie@poa02.usace.army.mil.*

SUPPLEMENTARY INFORMATION: An environmental assessment (EA) was prepared titled ''Navigation Improvements, Draft Feasibility Report, Environmental Assessment and Finding of No Significant Impact'' dated August 2001. The U.S. Army Corps of Engineers subsequently concluded that the action would be a major Federal action that could significantly affect the quality of the human environment. The finding of no significant impact was not signed and a DEIS will be prepared. The DEIS will consider structural and non-structural alternatives including the construction of a breakwater, a dredged basin, and harbor related infrastructure. The August 2001 EA evaluated four alternatives in detail: Alternative 1—Dutch Harbor Site (Spit Site), Alternative 2A—Little South America Site (combination of floating and rubblemound breakwaters), Alternative 2B—Little South America (identical to Alternative 2A except a wave barrier was substituted for the north floating breakwater), and Alternative 3—Captains Bay site (Westward Seafoods Site). Other harbor locations and non-structural alternatives identified during the scoping process will be evaluated.

Issues

The DEIS will consider the needs of the community and commercial vessel operations, impacts to marine intertidal and subtidal communities, fish and wildlife, wetlands, threatened and endangered species, essential fish habitat, water quality, cultural resources, socio-economic resources, the need for practicable and justifiable mitigation, and other resources and concerns identified through scoping, public involvement, and interagency coordination.

Scoping

A copy of this notice and additional public information will be sent to interested parties to initiate scoping. All parties are invited to participate in the scoping process by identifying any additional concerns, issues, studies, and alternatives that should be considered. A scoping meeting will be held in Unalaska at the Grand Aleutian Hotel on Saturday, February 2, 2002, from 10 a.m. to 2 p.m. Significant issues include potential adverse impacts to Steller's eiders, a threatened species, and the justification and identification of compensatory mitigation. The DEIS is tentatively scheduled for release in June 2003.

Luz D. Ortiz,

Army Federal Register Liaison Officer.

[FR Doc. 01–29786 Filed 11–29–01; 8:45 am]

BILLING CODE 3710–NL–M

DEPARTMENT OF ENERGY

[Docket No. EA–227–A]

Application To Export Electric Energy; New York Independent System Operator, Inc.

AGENCY: Office of Fossil Energy, DOE.

ACTION: Notice of application.

SUMMARY: The New York Independent System Operator, Inc. (NYISO) has applied to modify and renew its authority to transmit electric energy from the United States to Canada pursuant to section 202(e) of the Federal Power Act. In addition, NYISO is requesting expedited approval for their application.

DATES: Comments, protests or requests to intervene must be submitted on or before December 17, 2001.

ADDRESSES: Comments, protests or requests to intervene should be addressed as follows: Office of Coal & Power Im/Ex (FE–27), Office of Fossil Energy, U.S. Department of Energy, 1000 Independence Avenue, SW., Washington, DC 20585–0350 (FAX 202–287–5736).

FOR FURTHER INFORMATION CONTACT: Ellen Russell (Program Office) 202–586–9624 or Michael Skinker (Program Attorney) 202–586–2793.

SUPPLEMENTARY INFORMATION: Exports of electricity from the United States to a foreign country are regulated and require authorization under section 202(e) of the Federal Power Act (FPA) (16 U.S.C. 824a(e)).

On October 16, 2001, the Office of Fossil Energy (FE) of the Department of Energy (DOE) received an application from NYISO to modify and renew the electricity export authorization issued in FE Order EA–227 on September 7, 2000. In that Order, FE authorized NYISO, the entity with operational control over generation and transmission facilities within New York State, to export emergency and inadvertent energy to Canada using the international transmission facilities owned and operated by Long Sault, Inc., New York Power Authority, and Niagra Mohawk Power Corporation. In Order EA–227, FE limited the NYISO's exports to Canada to an instantaneous rate of transmission of 1000 megawatts (MW). That two-year Order will expire on September 7, 2002.

FE had based this 1000–MW limit on data contained in Section IX of the document titled, ''Load & Capacity Data, 1995 Report of the Member Electric Systems of the New York Power Pool.'' The updated version of that report for the year 2001 reflects a normal power transfer limit from New York to Ontario of 1675 MW, and an emergency transfer limit of 2150 MW for limited periods of time. In its application, the NYISO requests that FE Order EA–227 be amended to reflect these updated transfer limits and that the amended Order be issued for an additional 5-years.

In numerous electricity export authorizations in which third parties have been authorized to export over existing international transmission facilities that they do not own or operate, FE has indicated that any change to the export limits assigned to those existing facilities would apply to all entities authorized to export over those facilities. If FE ultimately

authorizes the increased export limits requested in this proceeding, those increased limits also would be available to all entities already authorized to use the affected international transmission facilities.

Procedural Matters

Any person desiring to become a party to this proceeding or to be heard by filing comments or protests to this application should file a petition to intervene, comment or protest at the address provided above in accordance with 385.211 or 385.214 of the FERC's rules of practice and procedures (18 CFR 385.211, 385.214). Fifteen copies of each petition and protest should be filed with the DOE on or before the date listed above.

Comments on the NYISO application to export electric energy to Canada should be clearly marked with Docket EA–227. Additional copies are to be filed directly with Michael C. Calimano, Vice President Operations & Reliability, Robert Fernandez, General Counsel, New York Independent System Operator, Inc., 3890 Carman Road, Schenectady, NY 12303 and Arnold H. Quint, Hunton & Williams, 1900 K Street, NW., Suite 1200, Washington, DC 20006.

At the time this notice is being published, delivery of both regular and overnight mail to the Department of Energy headquarters building has been disrupted. DOE will consider facsimile transmissions to 202–287–5736, received before the closing date, as timely. Commenters should also submit original documents using traditional mail systems.

A final decision will be made on this application after the environmental impacts have been evaluated pursuant to the National Environmental Policy Act of 1969, and a determination is made by the DOE that the proposed action will not adversely impact on the reliability of the U.S. electric power supply system.

Copies of this application will be made available, upon request, for public inspection and copying at the address provided above or by accessing the Fossil Energy Home Page at *http://www.fe.doe.gov.* Upon reaching the Fossil Energy Home page, select ''Electricity Regulation'' and then ''Pending Proceedings'' from the options menus.

Issued in Washington, D.C., on November 26, 2001.

Anthony J. Como,

Deputy Director, Electric Power Regulation, Office of Coal & Power Im/Ex, Office of Coal & Power Systems, Office of Fossil Energy.

[FR Doc. 01–29758 Filed 11–29–01; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. EL02–25–000]

Intermountain Rural Electric Association, Complainant, v. Public Service Company of Colorado, Respondent; Notice of Complaint

November 26, 2001.

Take notice that on November 23, 2001, the Intermountain Rural Electric Association (IREA) tendered for filing a ''Complaint And Request For Investigation And Refunds'' against Public Service Company of Colorado (PSCO). IREA's Complaint alleges that PSCO has included costs in the Fuel Cost Adjustment charge under IREA's Power Purchase Agreement with PSCO, on file with the Commission as PSCO Rate Schedule FERC No. 51, which costs and charges are unjust, unreasonable, and unduly discriminatory, and therefore unlawful under the Federal Power Act. IREA seeks refunds, plus interest, of the alleged unlawful charges it has paid to PSCO and a Commission order requiring PSCO to revise its accounting procedures and power marketing activities or, in the alternative, a Commission investigation and hearing, with the outcome subject to refund.

Copies of the Complaint were served, simultaneous with filing with the Commission, on PSCO, its parent company Exel Energy, Inc., and the Public Utilities Commission of the State of Colorado.

Any person desiring to be heard or to protest this filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214). All such motions or protests must be filed on or before December 13, 2001. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Answers to the complaint shall also be due on or before December 13, 2001. Copies of this filing are on file with the Commission and are available for public inspection. This filing may also be viewed on the web at *http://www.ferc.gov* using the ''RIMS'' link, select ''Docket#'' and follow the instructions (call 202–208–2222 for assistance). Comments, protests and interventions may be filed electronically via the Internet in lieu of paper. See, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's web site under the ''e-Filing'' link.

David P. Boergers,

Secretary.

[FR Doc. 01–29722 Filed 11–29–01; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. EG02–18–000]

Pedricktown Cogeneration Limited Partnership; Notice of Application for Commission Determination of Exempt Wholesale Generator Status

November 26, 2001.

Take notice that on October 31, 2001, Pedricktown Cogeneration Limited Partnership (Pedricktown) tendered for filing with the Federal Energy Regulatory Commission (Commission) an application for determination of exempt wholesale generator status pursuant to part 365 of the Commission's regulations.

Pedricktown is a New Jersey limited partnership which owns and operates a steam combustion turbine with a total capacity of approximately 122 MW (the Facility). The Facility is located at 143 Highway 1320, Pedricktown, New Jersey 08067. Pedricktown also maintains certification as a qualifying cogeneration facility in accordance with the Commission's regulations and will continue to do so in conjunction with the EWG status requested in this application.

Any person desiring to be heard concerning the application for exempt wholesale generator status should file a motion to intervene or comments with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214). The Commission will limit its consideration of comments to those that concern the adequacy or accuracy of the application. All such motions and

comments should be filed on or before December 10, 2001, and must be served on the applicant. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection. This filing may also be viewed on the web at *http://www.ferc.gov* using the ''RIMS'' link, select ''Docket#'' and follow the instructions (call 202–208–2222 for assistance). Comments, protests and interventions may be filed electronically via the Internet in lieu of paper. See, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's web site under the ''e-Filing'' link.

David P. Boergers,

Secretary.

[FR Doc. 01–29721 Filed 11–29–01; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RM98–1–000]

Regulations Governing Off-the-Record Communications; Public Notice

November 23, 2001.

This constitutes notice, in accordance with 18 CFR 385.2201(h), of the receipt of exempt and prohibited off-the-record communications.

Order No. 607 (64 FR 51222, September 22, 1999) requires Commission decisional employees, who make or receive an exempt or a prohibited off-the-record communication relevant to the merits of a contested on-the-record proceeding, to deliver a copy of the communication, if written, or a summary of the substance of any oral communication, to the Secretary.

Prohibited communications will be included in a public, non-decisional file associated with, but not part of, the decisional record of the proceeding. Unless the Commission determines that the prohibited communication and any responses thereto should become part of the decisional record, the prohibited off-the-record communication will not be considered by the Commission in reaching its decision. Parties to a proceeding may seek the opportunity to respond to any facts or contentions made in a prohibited off-the-record communication, and may request that the Commission place the prohibited communication and responses thereto in the decisional record. The Commission will grant such requests only when it determines that fairness so requires. Any person identified below as having made a prohibited off-the-record communication should serve the document on all parties listed on the official service list for the applicable proceeding in accordance with Rule 2010, 18 CFR 385.2010.

Exempt off-the-record communications will be included in the decisional record of the proceeding, unless the communication was with a cooperating agency as described by 40 CFR 1501.6, made under 18 CFR 385.2201(e)(1)(v).

The following is a list of exempt and prohibited off-the-record communications received in the Office of the Secretary within the preceding 14 days. Copies of this filing are on file with the Commission and are available for public inspection. The documents may be viewed on the web at *http://www.ferc.gov* using the ''RIMS'' link, select ''Docket#'' and follow the instructions (call 202–208–2222 for assistance).

Exempt

Number and docket nos.	Date	Name
1. Docket Nos. CP01–4–000, CP01–4–000, CP01–8	11–16–01	Karen Jacobs.
2. Docket No. CP97–315–000	11–16–01	Terry Shaffer.
3. Project No. 2042–000	11–16–01	Frank Winchell.
4. Project No. 2042–000	11–16–01	Tim Bachelder.
5. Project No. 2042–000	11–16–01	Duke Engineering.
6. Docket Nos. CP01–176–000 et al	11–16–01	Mark Kline.
7. Docket Nos. CP01–176–000, et al	11–16–01	Barry Wenger.
8. Docket Nos. CP01–176–000, et al	11–16–01	Laura Brinkman.
9. Docket Nos. CP01–176–000, et al	11–16–01	Mark Kline and Mike Timpson.
10. Docket Nos. CP01–176–000, et al	11–16–01	Todd Mattson.
11. Docket Nos. CP01–176–000, et al	11–16–01	Todd Mattson.

Linwood A. Watson, Jr.,

Acting Secretary.

[FR Doc. 01–29723 Filed 11–29–01; 8:45 am]

BILLING CODE 6717–01–P

ENVIRONMENTAL PROTECTION AGENCY

[ER–FRL–6624–2]

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 May 18, 2001 (97 FR 27647).

Draft EISs

ERP No. D–AFS–L65372–AK Rating NS Threemile Timber Sale, Implementation, Petersburg Ranger District, Tongass National Forest, AK.

Summary: EPA Region 10 used a screening tool to conduct a limited review of this action. Based on the screen, EPA does not foresee having any environmental objections to the proposed project. Therefore, EPA will not be conducting a detailed review.

ERP No. D–AFS–L65387–AK Rating NS Helicopter Landing Tours on the Juneau Icefield 2002 to 2006, Combination Fixed-Wing and Helicopter Landing Tour Operations to Antler Glacier Lake, Special Use Permits Issuance, Tongass National Forest, City and Borough of Juneau, AK.

Summary: EPA used a screening tool to conduct a limited review of the draft

EIS and based upon the screen, EPA does not foresee having any environmental objections to the proposed project. Therefore, EPA will not be conducting a detailed review.

ERP No. D–FHW–K40246–CA Rating EC2 CA–905 Freeway or Tollway Construction Project, Route Location, Adoption and Construction, Otay Mesa Port of Entry to I–805, Funding and US Army COE Section 404 Permit Issuance, San Diego County, CA.

Summary: EPA expressed environmental concerns about the project potentially restricting wildlife movement and requested additional information on the indirect and cumulative impacts of the project as well as on certain modeling assumptions.

ERP No. D–FHW–L40214–WA Rating EO2 I–405 Corridor Transportation Improvements, I–5 in the City of Tukwila to I–5 in Snohomish County, Funding and Possible COE Section 404 Permits Issuance, King and Snohomish Counties, CA.

Summary: EPA raised environmental objections to the creation of impervious surface from alternatives 3 and 4 and its effect on watersheds. EPA also expressed concerns about the insufficient assessment of cumulative effects.

ERP No. D–IBR–K39070–CA Rating EC2 American River Pump Station Project, Providing Placer County Water Agency (PCWA) with the Year-Round Access to its Middle Fork Project (MFP) Water Entitlements from the American River, Placer County, CA.

Summary: EPA expressed environmental concerns related to adverse diversion-related Cumulative impacts and proposed increase in Placer County Water Agency's (PCWA) diversion. EPA urged the Bureau and PCWA to develop alternative diversion points and to assure a long-term, sustainable balance between available water supplies, ecosystem health and water supply demand. EPA also requested that the cumulative impact analysis describe potential mitigation measures and other non-Bureau actions.

ERP No. D–NOA–E91009–00 Rating EC1 Dolphin and Wahoo Fishery Management Plan, Establishing Fishery Management Units, Stock Status Determination and Harvesting Restrictions, Initial Regulatory Flexibility Analysis, South Atlantic, Caribbean, and Gulf of Mexico.

Summary: EPA conceptually supports the proposed FMP for dolphin and wahoo and primarily defers to the expertise of the NMFS/Councils on the proposed actions. However, EPA's DEIS comments should be considered/clarified including the role of NMFS versus Councils, permit fees, EFHs in pelagic waters and FMP enforcement.

ERP No. D–TPT–K61154–CA Rating EC2, Presidio Trust Implementation Plan (PTIP), An Updated Plan for the Area B of the Presidio of San Francisco, Implementation, San Francisco Bay Area, Marin County, CA.

Summary: While general management issues are addressed by several of the alternatives, EPA expressed environmental concerns and requested additional information regarding: impacts to wetlands, traffic and air quality.

ERP No. DE–NOA–L64015–AK Rating EC2, Steller Sea Lion Protection Measures in the Alaska Groundfish Fisheries, Fishery Management Plans for Groundfish of the Gulf of Alaska and the Groundfish Fishery of the Bering Sea and Aleutian Islands Area, AK.

Summary: EPA had environmental concerns that alternatives may not adequately conserve the Steller sea lion populations because most alternatives do not address large ecological concerns such as total allowable catch, the lack of information on the long-term cumulative effects of fishing on the fishery and predators of the fish, and the lack of reasonable and prudent measures that mitigate potential future problems. EPA recommended that the final EIS address our concerns and demonstrate that alternatives would successfully protect and recover listed Steller sea lions.

Final EISs

ERP No. F–AFS–L65344–AK, Emerald Bay Timber Sale, Implementation, Ketchikan-Misty Fiords Ranger District, Tongass National Forest, U.S. Coast Guard Bridge Permit, NPDES Permit, and COE Section 10 and 404 Permits, Cleveland Peninsula, AK.

Summary: No formal comment letter was sent to the preparing agency.

ERP No. FS–SFW–B82009–00, Lake Champlain Sea Lamprey Control Long-Term Program, Proposal is to Achieve Fish Population, Recreational Fishery and Economic Benefits Associated with Reduced Sea Lamprey Predation Implementation, Clinton, Essex and Washington Counties, NY and Addison and Chittenden Counties, VT.

Summary: EPA reiterated environmental concerns about the project purpose and need, the appropriate NEPA action for new treatment areas, the time frame to treat the Poultney River, raised new concerns about dioxin contamination and advised the USFWS to continue to coordinate with the EPA on the possibility that a Clean Water Act NPDES permit may be required for lampricide applications.

Dated: November 27, 2001.

B. Katherine Biggs,

Associate Director, NEPA Compliance Division, Office of Federal Activities.

[FR Doc. 01–29788 Filed 11–29–01; 8:45 am]

BILLING CODE 6560–50–U

ENVIRONMENTAL PROTECTION AGENCY

[ER–FRL–6624–1]

Environmental Impact Statements; Notice of Availability

Responsible Agency: Office of Federal Activities, General Information (202) 564–7167 or *www.epa.gov/oeca/ofa*

Weekly receipt of Environmental Impact Statements

Filed November 19, 2001 Through November 23, 2001

Pursuant to 40 CFR 1506.9.

EIS No. 010443, Draft EIS, AFS, WA, Gardin—Taco Ecosystem Restoration Projects, Implementation, Vegetative Restoration, Road Closures, and Decommissioning, and other Road Improvements, Colville National Forest, Newport Ranger District, Pend Oreille and Stevens Counties, WA, Comment Period Ends: January 14, 2002, Contact: Dan Dallas (509) 447–7300.

EIS No. 010444, Final EIS, STB, SD, WY, MN, Powder River Basin Expansion Project, Construction of New Rail Facilities, Finance Docket No. 33407 Dakota, Minnesota and Eastern Railroad, SD, WY and MN, Wait Period Ends: December 31, 2001, Contact: Victoria Rutson (202) 565–1545.

EIS No. 010445, Final EIS, EPA, NC, New Wilmington Ocean Dredged Material Disposal Site, Designation, Wilmington Harbor, North Carolina State Port and the Military Ocean Terminal (Sunny Point (MOTSU), NC, Wait Period Ends: December 31, 2001, Contact: Gary Collins (404) 564–9395.

EIS No. 010446, Draft EIS, AFS, ID, Middle-Black Analysis Project, Proposes Vegetative Management, Watershed Restoration, and Noxious Weed Activities Aimed at Ecosystem Restoration, Clearwater National Forest, North Fork Ranger District, Clearwater County, ID, Comment Period Ends: January 28, 2002, Contact: Douglas Gober (208) 476–4541.

EIS No. 010447, Final EIS, AFS, ID, Iron Honey Resource Area Project, Aquatic, Vegetative and Wildlife Habitat Improvement Activities,

Implementation, Coeur d'Alene River Ranger District, Idaho Panhandle National Forests, Kootenai and Shoshone Counties, ID, Wait Period Ends: December 31, 2001, Contact: Joseph P. Stringer (208) 664–2318.

EIS No. 010448, Draft EIS, NOA, Deep-sea Red Crab (chaceon quinquedens) Fisheries, Fishery Management Plan, Development and Implementation, Norfolk Canyon in the South to the Haque Line in the North, Continental United States and Exclusive Economic Zone (EEZ), Comment Period Ends: January 07, 2002, Contact: Paul J. Howard (978) 465–3116. Under Section 1506.10(d) of the Council on Environmental Quality Regulations for Implementing the Procedural Provisions of the National Environmental Policy Act the US Environmental Protection Agency has Granted a 7-Day Waiver for the above EIS.

EIS No. 010449, Final EIS, FRC, NY, Upper Hudson River Hydroelectric Project, Relicensing the E.J. West Project (FERC No. 2318–002), Stewart Bridge Project (FERC No. 2047–004), Hudson River Project (FERC No. 2482–014) and Feeder Dam Hydroelectric Project (FERC No. 2554–003), Saratoga, Fulton and Hamilton Counties, NY, Wait Period Ends: December 31, 2001, Contact: Lee Emery (202) 219–2779.

EIS No. 010500, Draft Supplement, BIA, NV, Moapa Paiute Energy Center/ Associated Facilities Construction, Operation and Maintenance of a 760 Megawatt (MW) Baseload Natural Gas-Fired Combined Cycle Power Plant, Additional Information, Land Lease and Water Use Approval, R–O–W Grants, Temporary Use, COE Section 10/404 and EPA NPDES Permits, Moapa River Indian Reservation and BLM, Comment Period Ends: January 04, 2002, Contact: Amy L. Heuslien (602) 379–6750. The US Department of Interior's Bureau of Land Management and Bureau of Indian Affairs are Joint Lead Agencies for the above Project.

Amended Notices

EIS No. 010423, Draft EIS, UAF, OK, Altus Air Force Base (AFB), Proposed Airfield Repairs, Improvements, and Adjustments to Aircrew Training, Installation of an Instrument Landing System (ILS) and a Microwave Landing System (MLS), Jackson County, OK, Comment Period Ends: December 31, 2001, Contact: Ron Voorhees (210) 652–3656. Published FR–11–16–01—Correction to State from OR to OK.

EIS No. 010428, Draft EIS, FHW, KY, IN, Louisville-Southern Indiana Ohio River Bridges Projects, To Improve Cross-River Mobility between Jefferson County, KY and Clark County, IN, Coast Guard Bridge Permit, COE Section 10 and 404 Permits, Jefferson County, KY and Clark County, IN, Comment Period Ends: February 25, 2002, Contact: John Ballantyne (502) 223–6747. Published FR 11–16–01 Correction to State from ID to IN.

Dated: November 27, 2001.

B. Katherine Biggs,

Associate Director, NEPA Compliance Division, Office of Federal Activities.

[FR Doc. 01–29789 Filed 11–29–01; 8:45 am]

BILLING CODE 6560–SO–U

COUNCIL ON ENVIRONMENTAL QUALITY

Comment Request; Notice of Public Meeting

AGENCY: Council of Environmental Quality.

ACTION: Request for comments and notice of public meeting.

SUMMARY: The Council on Environmental Quality (CEQ) regulations for implementation of the National Environmental Policy Act (NEPA) includes procedures for referring to CEQ federal interagency disagreements concerning proposed major federal actions that might cause unsatisfactory environmental effects (40 CFR part 1504).

On October 16, 2001 CEQ received a referral from the Department of Commerce National Oceanic and Atmospheric Administration (NOAA) regarding the Department of the Army Corps of Engineers (COE) Final Supplement III to the Final Environmental Impact Statement (FEIS) for the Manteo (Shallowbag) Bay Project (MSBP) located in Dare County, North Carolina. The referral letter from NOAA stated in part:

The selected alternative identifies construction of a dual jetty system and channel deepening from the present 14 feet to a design depth of 20 feet, to improve navigation at Oregon Inlet. The project would be built on the dynamic barrier islands of the Outer Banks. NOAA strongly supports the goal of providing safe navigation for the commercial and recreational fishing vessels using Oregon Inlet. However, we believe there are alternatives that can achieve this goal in an environmentally acceptable manner. Accordingly, NOAA is compelled to disagree with the COE's selected alternative of jetty construction because it would cause unacceptable environmental harm to commercial and recreational fishery resources.

The COE responded to the referral with a cover letter dated November 13, 2001 and five accompanying documents:

- "Literature Review for the Assessment of Larval Fish and Shellfish Movement through Oregon Inlet and the Potential Effects of Inlet Stabilization by Jetties" (July 1980)
- "Oregon Inlet Larval Transport Sensitivity Study" (October 1980)
- Correspondence from David R. Colby, Fishery Biologist, National Marine Fisheries Center, Beaufort, NC (May 1980)
- "Larval Fish and Shellfish Transport through Inlets" (1988)
- "A Brief Review of Flow Circulation in the Vicinity of Natural and Jettied Inlets: Tentative Observations on Implications for Larval Transport at Oregon Inlet, NC"

The COE maintained in the cover letter that their accompanying documents fully address the referral issues elevated by NOAA.

CEQ invites written comments on the issues raised by NOAA. We also intend to hold a public meeting at 7 pm on December 12 to take comment on the issues raised by the referral.

DATES: We will accept written comments until January 18, 2002. The public meeting date and time is December 12, 2001, at 7 p.m.

ADDRESSES: Because of restrictions related to security within the Executive Office of the President, we cannot receive comments via U.S. mail or any other mail delivery system. You may send comments by electronic mail (e-mail) to *ceqreferral@ceq.eop.gov* or you may fax comments to the attention of Bill Perhach at (202) 456–0753. If a commentator does not have access to e-mail or fax to transmit comments, please call Dinah Bear, General Counsel, at (202) 395–7421 to arrange for an alternative system. The public meeting location is the Dare County Administrative Annex, 204 Ananias Street, Manteo, North Carolina.

FOR FURTHER INFORMATION CONTACT: Interested parties can review relevant documents at our website at *http://www.whitehouse.gov/ceq/referrals* or call Bill Perhach at (202) 395–0826 to arrange for transmittal of documents.

SUPPLEMENTARY INFORMATION:

I. Abstract/The Referral Process

One of the duties and functions of CEQ is to review and appraise the various programs and activities of the Federal Government in light of the policy set forth in title I of the National

Environmental Policy Act (NEPA) for the purpose of determining the extent to which such programs and activities are contributing to the achievement of such policy, and to make recommendations to the President with respect thereto. 42 U.S.C. 4344(3). The CEQ referral process permits federal agencies to bring to CEQ interagency disagreements concerning proposed major federal actions that might cause unsatisfactory environmental effects. Under CEQ regulations, 40 CFR part 1504, any federal department or agency may refer a proposed major federal action to CEQ no less than 25 days after the final Environmental Impact Statement (EIS) has been made available to the public commenting agencies, and the Environmental Protection Agency. A federal agency that intends to refer a proposal to CEQ must first notify the lead agency of its intentions at the earliest possible time. If the issues are not resolved between the agencies after publication of the final EIS, and the agency wishes to refer the proposal to CEQ, the referring agency must send a letter and a statement to CEQ and the lead agency and request that no action be taken to implement the proposal until CEQ acts upon the referral. The statement accompanying the referral letter must: (1) Identify the material facts in the controversy; (2) identify environmental policies or requirements that would be violated by the proposal; (3) present the reasons why the referring agency believes the proposal is environmentally unsatisfactory; (4) contain a finding that the issue raised is of national importance; (5) review the steps taken by the referring agency to resolve the matter with the lead agency prior to referral; and (6) offer the referring agency's recommendations in regard to the proposed action. The lead agency for the proposal then has 25 days to respond to the referring agency's letter and statement. Interested parties, both in and outside of government, may deliver written views regarding the referral to CEQ. Within 25 days of the last agency action regarding the referral, CEQ may take one of seven actions:

(1) Conclude that the process of referral and response has successfully resolved the problem.

(2) Initiate discussions with the agencies with the objective of mediation with referring and lead agencies.

(3) Hold public meetings or hearings to obtain additional views and information.

(4) Determine that the issue is not one of national importance and request the referring and lead agencies to pursue their decision process.

(5) Determine that the issues should be further negotiated by the referring and lead agencies and is not appropriate for Council consideration until one or more heads of agencies report to the Council that the agencies' disagreements are irreconcilable.

(6) Publish its findings and recommendations (including where appropriate a finding that the submitted evidence does not support the position of an agency).

(7) When appropriate, submit the referral and response together with the Council's recommendation to the President for action. 40 CFR 1504.3(f). Initiation of mediation, public hearings or meetings, or a determination of further negotiation must be completed by the Council within 60 days of the Council's action under 40 CFR 1504.3(f).

II. Request for Comments

Written comments on the issues raised by NOAA in their referral are requested by January 18, 2002.

Dated: November 27, 2001.

James L. Connaughton,

Chairman, Council on Environmental Quality.

[FR Doc. 01–29801 Filed 11–29–01; 8:45 am]

BILLING CODE 3125–01–P

EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

Sunshine Act Meeting

AGENCY HOLDING THE MEETING: Equal Employment Opportunity Commission.

DATE AND TIME: Tuesday, December 11, 2001 at 1:30 p.m. (Eastern Time).

PLACE: Conference Room on the 9th Floor of the EEOC Office Building, 1801 ''L'' Street, NW., Washington, DC 20507.

STATUS: The meeting will be open to the public.

MATTERS TO BE CONSIDERED:

Open Session

1. Announcement of Notation Votes, and

2. Invited Panelists on Employment Discrimination in the Aftermath of September 11th.

Note: Seating is limited to approximately 125 people. An overflow room will have closed circuit television of the meeting. Members of the public are requested to arrive before 1 p.m. in order to allow sufficient time to complete entry procedures prior to the meeting. Any matters not discussed or concluded may be carried over to a later meeting. (In addition to published notices on EEOC Commission meetings in the **Federal Register**, the Commission also provides a recorded announcement a full week in advance on future Commission meetings.) Please telephone (202) 663–7100 (voice) and (202) 663–4074 (TTD) at any time for information on these meetings.

CONTACT PERSON FOR MORE INFORMATION: Frances M. Hart, Executive Officer on (202) 663–4070.

Dated: November 28, 2001.

Frances M. Hart,

Executive Officer, Executive Secretariat.

[FR Doc. 01–29902 Filed 11–28–01; 2:54 pm]

BILLING CODE 6750–06–M

FEDERAL COMMUNICATIONS COMMISSION

[Report No. 2516]

Petitions for Reconsideration of Action in Rulemaking Proceedings

November 26, 2001.

Petitions for Reconsideration have been filed in the Commission's rulemaking proceedings listed in this Public Notice and published pursuant to 47 CFR section 1.429(e). The full text of this document is available for viewing and copying in Room CY–A257, 445 12th Street, SW., Washington, DC or may be purchased from the Commission's copy contractor, Qualex International (202) 863–2893. Oppositions to these petitions must be filed by December 17, 2001. See section 1.4(b)(1) of the Commission's rules (47 CFR 1.4(b)(1)). Replies to an opposition must be filed within 10 days after the time for filing oppositions has expired.

Subject:

In the Matter of Carriage of the Transmissions of Digital Television Broadcast Stations (CS Docket No. 98–120)

In the Matter of Review of the Commission's Rules and Policies Affecting the Conversion to Digital Television (MM Docket No. 00–39)

Service Rules for the 746–764 and 776–794 MHz Banks, and Revisions to Part 27 of the Commission's Rules (WT Docket No. 99–168)

Magalie Roman Salas,

Secretary.

[FR Doc. 01–29682 Filed 11–29–01; 8:45 am]

BILLING CODE 6712–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Agency Information Collection Activities; Proposed Collections; Comment Request

The Department of Health and Human Services, Office of the Secretary will

periodically publish summaries of proposed information collections projects and solicit public comments in compliance with the requirements of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995. To request more information on the project or to obtain a copy of the information collection plans and instruments, call the OS Reports Clearance Office at (202) 619–2118 or e-mail *Geerie.Jones@HHS.gov.*

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 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.

Proposed Project 1. Temporary Assistance to Needy Families (TANF) Caseload Survey—NEW—The Assistant Secretary for Planning and Evaluation has developed a common TANF beneficiary survey instrument to be used by five states and the District of Columbia awarded TANF caseload grants. The grantees are: California, Colorado, Maryland, Missouri, South Carolina and Washington DC. The purpose of this survey is to develop a better understanding of the characteristics and needs of states' current TANF caseloads. *Respondents:* Individuals; *Number of respondents:* 6500; *Burden per Response:* 45 minutes; *Total Burden:* 4,875 hours.

Send comments via e-mail to *Geerie.Jones@HHS.gov,* or mail to OS Reports Clearance Office, Room 503H, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington DC, 20221. Comments should be received within 60 days of this notice.

Dated: November 20, 2001.

Kerry Weems,

Acting Deputy Assistant Secretary, Budget.

[FR Doc. 01–29797 Filed 11–29–01; 8:45 am]

BILLING CODE 4154–05–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Agency Information Collection Activities; Proposed Collections; Comment Request

The Department of Health and Human Services, Office of the Secretary will periodically publish summaries of proposed information collections projects and solicit public comments in compliance with the requirements of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995. To request more information on the project or to obtain a copy of the information collection plans and instruments, call the OS Reports Clearance Office at (202) 619–2118 or e-mail *Geerie.Jones@HHS.gov.*

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Proposed Project 1. A National Study of Stroke Post-Acute Care and Outcomes—NEW—The Office of the Assistant Secretary for Planning and Evaluation proposes a study to compare risk-adjusted quality indicators related to care provided across the three post-acute care (PAC) settings. The three settings are skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities. Stroke was chosen as the tracer condition for this study because it is a common condition in PAC, accounting for approximately 10% of all Medicare PAC admissions, and because stroke patients are treated in all three PAC settings. *Respondents:* Individuals, Business or other for-profit; Facilities Burden Information—*Number of Respondents:* 74; *Average Burden per Facility:* 9.81 hours; *Facilities Burden Total:* 726 hours—Patients' Burden Information—*Number of Respondents for Informed Consent:* 1051; *Average Burden per Response:* 10 minutes; *Burden for Informed Consent:* 175 hours—*Number of Respondents for Admission Interview:* 1051; *Average Burden per Response:* 37.8 minutes; *Burden for Admission Interview:* 662 hours—*Number of Respondents for 90-day Follow-up Interview:* 915; *Average Burden per Response:* 29.4 minutes; *Burden for 90-day Follow-up Interview:* 448 hours—*Total Patients Burden:* 1,285 hours—*Total Burden:* 2,011 hours.

Send comments via e-mail to *Geerie.Jones@HHS.gov,* or mail to OS Reports Clearance Office, Room 503H, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201. Comments should be received within 60 days of this notice.

Dated: November 20, 2001.

Kerry Weems,

Acting Deputy Assistant Secretary, Budget.

[FR Doc. 01–29798 Filed 11–29–01; 8:45 am]

BILLING CODE 4154–05–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the State Children's Health Insurance Program, and Aid to Needy, Aged, Blind, or Disabled Persons for October 1, 2002 Through September 30, 2003

AGENCY: Office of the Secretary, DHHS.

ACTION: Notice.

SUMMARY: The Federal Medical Assistance Percentages and Enhanced Federal Medical Assistance Percentages for Fiscal Year 2003 have been calculated pursuant to the Social Security Act (the Act). These percentages will be effective from October 1, 2002 through September 30, 2003. This notice announces the calculated ''Federal Medical Assistance Percentages'' and ''Enhanced Federal Medical Assistance Percentages'' that we will use in determining the amount of Federal matching for State medical assistance (Medicaid) and State Children's Health Insurance Program (SCHIP) expenditures, and Foster Care Maintenance and Adoption Assistance payments. The table gives figures for each of the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. Programs under title XIX of the Act exist in each jurisdiction; programs under titles I, X, and XIV operate only in Guam and the Virgin Islands; while a program under title XVI (AABD) operates only in Puerto Rico. Programs under title XXI began functioning in fiscal year 1998. The percentages in this notice apply to State expenditures for assistance payments, most medical services and

medical insurance services. The statute provides separately for Federal matching of administrative costs.

Sections 1905(b) 1101(a)(8)(B) of the Act require the Secretary of Health and Human Services to publish the Federal medical assistance percentages each year. The Secretary is to figure the percentages, by formulas in sections 1905(b) and 1101(a)(8)(B), from the Department of Commerce's statistics of average income per person in each State and in the Nation as a whole. The percentages are within the upper and lower limits given in those two sections of the Act. The statute specifies the percentages to be applied to the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. A provision in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 modified the formula to calculate the percentages to be applied to Alaska only for fiscal years 2001 through 2005.

The ''Federal Medical Assistance Percentages'' are for Medicaid.

The ''Enhanced Federal Medical Assistance Percentages'' are for use in the State Children's Health Insurance Program under Title XXI, and in the Medicaid program for certain children for expenditures for medical assistance described in sections 1905(u)(2) and 1905(u)(3). There is no specific requirement to publish these percentages. We include them in this notice for the convenience of the States.

EFFECTIVE DATES: The percentages listed will be effective for each of the 4 quarter-year periods in the period beginning October 1, 2002 and ending September 30, 2003.

FOR FURTHER INFORMATION CONTACT: Adelle Simmons or Robert Stewart, Office of Health Policy, Office of the Assistant Secretary for Planning and Evaluation, Room 442E—Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, (202) 690–6870.

(Catalog of Federal Domestic Assistance Program Nos. 93.563—Child Support Enforcement; 93.658—Foster Care Title IV–E; 93.659—Adoption Assistance; 93.778—Medical Assistance Program; 93.767—State Children's Health Insurance Program)

Dated: November 28, 2001.

Tommy G. Thompson,

Secretary of Health and Human Services.

BILLING CODE 4110–60–M

Federal Medical Assistance Percentages and Enhanced Federal Medical Assistance Percentages, Effective October 1, 2002-September 30, 2003 (Fiscal Year 2003)

State	Federal Medical Assistance Percentages	Enhanced Federal Medical Assistance Percentages
Alabama	70.60	79.42
Alaska**	58.27	70.79
American Samoa*	50.00	65.00
Arizona	67.25	77.08
Arkansas	74.28	82.00
California	50.00	65.00
Colorado	50.00	65.00
Connecticut	50.00	65.00
Delaware	50.00	65.00
District of Columbia**	70.00	79.00
Florida	58.83	71.18
Georgia	59.60	71.72
Guam*	50.00	65.00
Hawaii	58.77	71.14
Idaho	70.96	79.67
Illinois	50.00	65.00
Indiana	61.97	73.38
Iowa	63.50	74.45
Kansas	60.15	72.11
Kentucky	69.89	78.92
Louisiana	71.28	79.90
Maine	66.22	76.35
Maryland	50.00	65.00
Massachusetts	50.00	65.00
Michigan	55.42	68.79
Minnesota	50.00	65.00
Mississippi	76.62	83.63
Missouri	61.23	72.86
Montana	72.96	81.07
Nebraska	59.52	71.66
Nevada	52.39	66.67
New Hampshire	50.00	65.00
New Jersey	50.00	65.00
New Mexico	74.56	82.19
New York	50.00	65.00
North Carolina	62.56	73.79

North Dakota	68.36	77.85
Northern Mariana Islands*	50.00	65.00
Ohio	58.83	71.18
Oklahoma	70.56	79.39
Oregon	60.16	72.11
Pennsylvania	54.69	68.28
Puerto Rico*	50.00	65.00
Rhode Island	55.40	68.78
South Carolina	69.81	78.87
South Dakota	65.29	75.70
Tennessee	64.59	75.21
Texas	59.99	71.99
Utah	71.24	79.87
Vermont	62.41	73.69
Virgin Islands*	50.00	65.00
Virginia	50.53	65.37
Washington	50.00	65.00
West Virginia	75.04	82.53
Wisconsin	58.43	70.90
Wyoming	61.32	72.92

* For purposes of section 1118 of the Social Security Act, the percentage used under titles I, X, XIV, and XVI and Part A of title IV will be 75 per centum.

** The values for Alaska and the District of Columbia in the table were set for the state plan under titles XIX and XXI and for capitation payments and DSH allotments under those titles. For other purposes, including programs remaining in Title IV of the Act, the percentage for Alaska is 53.99 and for D.C. is 50.00.

[FR Doc. 01–29855 Filed 11–29–01; 8:45 am]
BILLING CODE 4110–60–C

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Findings of Scientific Misconduct

AGENCY: Office of the Secretary, HHS.

ACTION: Notice.

SUMMARY: Notice is hereby given that the Office of Research Integrity (ORI) and the Assistant Secretary for Health have taken final action in the following case:

Jason Elster, Saint Louis University: Based on the report of an investigation conducted by Saint Louis University, Mr. Elster's admission, and additional analysis conducted by ORI in its oversight review, the U.S. Public Health Service (PHS) found that Mr. Elster, former undergraduate research assistant, School of Public Health, Saint Louis University, engaged in scientific misconduct by falsifying or fabricating data in at least eight of the 125 questionnaires he collected with support from Centers for Disease Control and Prevention cooperative agreement U48 CCU710806, ''Rural Chronic Disease Prevention Center.''

Specifically, the objective of the questionnaire was to assess the extent of media exposure by the community and opinions regarding local media coverage of health issues as well as to determine baseline health-related behavior. The intent of the study was to use this information in developing effective strategies for delivering information on disease prevention to the public. No publications were affected, but because of the removal of Mr. Elster's 125 questionnaires from the study, interviews with 125 new participants were required to achieve the sample size needed to have sufficient statistical power.

Mr. Elster has entered into a Voluntary Exclusion Agreement (Agreement) with PHS in which he has voluntarily agreed for a period of three (3) years, beginning on November 13, 2001:

(1) To exclude himself from serving in any advisory capacity to PHS, including but not limited to service on any PHS advisory committee, board, and/or peer review committee, or as a consultant; and

(2) That any institution that submits an application for PHS support for a research project on which his participation is proposed or that uses him in any capacity on PHS supported research, or that submits a report of PHS-funded research in which he is involved, must concurrently submit a plan for supervision of his duties to the funding agency for approval. The supervisory plan must be designed to ensure the scientific integrity of Mr. Elster's research contribution. The institution must also submit a copy of the supervisory plan to ORI.

FOR FURTHER INFORMATION CONTACT: Director, Division of Investigative Oversight, Office of Research Integrity, 5515 Security Lane, Suite 700, Rockville, MD 20852, (301) 443–5330.

Chris B. Pascal,

Director, Office of Research Integrity.

[FR Doc. 01–29744 Filed 11–29–01; 8:45 am]
BILLING CODE 4150–31–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): Preliminary Investigation of Health Effects of Occupational Exposures in Paducah Gaseous Diffusion Plant (PGDP) Workers

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 meeting:

Name: Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): Preliminary Investigation of Health Effects of Occupational Exposures in Paducah Gaseous Diffusion Plant (PGDP) Workers.

Times and Dates:

8 a.m.–8:30 a.m., December 18, 2001 (Open)

8:40 a.m.-12:30 p.m., December 18, 2001 (Closed).

Place: Embassy Suites Hotel, 1900 Diagonal Road, Alexandria, Virginia 22314.

Status: Portions of the meeting will be closed to the public in accordance with provisions set forth in section 552b(c)(4) and (6), Title 5 U.S.C., and the Determination of the Deputy Director for Program Management, CDC, pursuant to Public Law 92–463.

Matters to be Discussed: The meeting will include the review, discussion, and evaluation of application received under the Memorandum of Understanding between the Department of Energy and the Department of Health and Human Services.

Contact Person for More Information: Kathleen Goedel, National Institute for Occupational Safety and Health, CDC, 4676 Columbia Parkway, M/S R–6, Cincinnati, Ohio 45226, telephone 513–841–4560.

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 23, 2001.

John C. Burckhardt,

Acting Director, Management Analysis and Services Office, Centers for Disease Control and Prevention (CDC).

[FR Doc. 01–29732 Filed 11–29–01; 8:45 am]

BILLING CODE 4163–19–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 01N–0249]

Agency Information Collection Activities; Announcement of OMB Approval; Consumer and Producer Surveys on Economic Issues

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing that a collection of information entitled ''Consumer and Producer Surveys on Economic Issues'' has been approved by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995.

FOR FURTHER INFORMATION CONTACT: Peggy Schlosburg, Office of Information Resources Management (HFA–250), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–827–1223.

SUPPLEMENTARY INFORMATION: In the **Federal Register** of August 31, 2001 (66 FR 46018), the agency announced that the proposed information collection had been submitted to OMB for review and clearance under 44 U.S.C. 3507. 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. OMB has now approved the information collection and has assigned OMB control number 0910–0478. The approval expires on May 31, 2003. A copy of the supporting statement for this information collection is available on the Internet at http://www.fda.gov/ohrms/dockets.

Dated: November 21, 2001.

Margaret M. Dotzel,

Associate Commissioner for Policy.

[FR Doc. 01–29743 Filed 11–29–01; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 01N–0319]

Agency Information Collection Activities; Submission for OMB Review; Comment Request; Health and Diet Survey

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing that the proposed collection of information listed below has been submitted to the Office of Management and Budget (OMB) for review and clearance under the Paperwork Reduction Act of 1995.

DATES: Submit written comments on the collection of information by December 31, 2001.

ADDRESSES: Submit written comments on the collection of information to the Office of Information and Regulatory Affairs, OMB, New Executive Office Bldg., 725 17th St. NW., rm. 10235, Washington, DC 20503, Attn: Stuart Shapiro, Desk Officer for FDA

FOR FURTHER INFORMATION CONTACT: Peggy Schlosburg, Office of Information Resources Management (HFA–250), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–827–1223.

SUPPLEMENTARY INFORMATION: In compliance with 44 U.S.C. 3507, FDA has submitted the following proposed collection of information to OMB for review and clearance.

Health and Diet Survey

The authority for FDA to collect the information derives from the authority of the Commissioner of Food and Drugs, as specified in section 903(d)(2) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 393(d)(2)). The Health and Diet Survey will provide FDA information about consumers' knowledge, perceptions, attitudes, and practices related to dietary supplements and food. A nationally representative sample of 2,000 adults in the 48 contiguous States and the District of Columbia will be selected at random and interviewed by telephone. Participation will be voluntary. The survey will collect information about: (1) Prevalence, experience, and purposes of use of dietary supplements; (2) knowledge of health benefits, health risks, and regulation of dietary supplements; (3) sources of dietary

supplement information; (4) perceptions of dietary supplement labels; (5) replacement and combination use of supplements and drugs; (6) adverse experience with dietary supplements; (7) children's and teenagers' use of dietary supplements; (8) knowledge of diet-health relationships; (9) dietary management practices; and (10) use of food labels.

Some of the questions to be asked (items 8 through 10 listed in the previous paragraph) replicate the ones asked in the 1995 Health and Diet Survey. Responses to these questions will help FDA identify and measure any changes in consumer knowledge, perceptions, attitudes, and practices with regard to diet, health, and use of food labels. The information will also help the agency evaluate the effectiveness of the Nutrition Labeling and Education Act of 1990 in promoting the public health.

The agency will use the other questions in the proposed survey to enhance its understanding of consumer knowledge, perceptions, attitudes, and practices regarding dietary supplements. Subsequent to the enactment of the Dietary Supplement Health and Education Act of 1994 (DSHEA), the consumption of dietary supplements in the United States has been increasing. FDA needs current, timely, and policy-relevant consumer information to help it identify needs for and develop consumer education programs and regulatory policies to ensure safe and appropriately labeled supplement products. The survey will help the agency measure prevalence and distribution of consumer knowledge, perceptions, attitudes, and practices. This information can be used to understand and describe the consumer environment that is the intended target of labeling and education initiatives.

In the **Federal Register** of August 7, 2001 (66 FR 41245), the agency requested comments on the proposed collection of information.

FDA received 11 comments in response to the **Federal Register** announcement. Comments generally supported the need of the proposed information collection for the proper performance of FDA's functions. None of the comments were on the estimated burden or ways to minimize the burden of the planned information collection. Issues mentioned in the eight comments received from eight private citizens are beyond the scope of the proposed information collection; these issues will not be discussed here.

One comment urged FDA to include questions regarding consumers' use of and attitudes toward fortified foods. The comment states that the information on fortified foods will help FDA assess the need to revise and update its food fortification policy guidelines and will provide initial direction for the process. Examples of proposed topics of inquiry include: (1) Profile of fortified food users and their patterns of use; (2) consumer knowledge of the upper limits of intake of vitamins and minerals; (3) fortified food consumers' attention to the amounts of particular vitamin or mineral consumed from fortified foods, dietary supplements, and natural food sources; (4) consumer belief of nutritional adequacy from one or two heavily fortified foods; (5) levels of calcium consumption from calcium fortified foods; and (6) whether consumers of calcium-fortified foods consider these foods an adequate substitute for consuming foods naturally rich in calcium such as dairy foods.

FDA notes that, although it has an inherent interest in reviewing and evaluating its current fortification policy, it has more immediate needs of current, timely, national, and policy-relevant consumer information on dietary supplements to carry out its statutory functions. FDA also notes that any inclusion of questions on fortified foods in the proposed instrument would require introduction and explanation of this novice product category that, despite the popularity of certain products, has not been widely recognized by consumers. The introduction and explanation would be needed to provide an appropriate context so participants could shift their attention from dietary-supplement topics to fortified-food topics and could understand the kinds of products under discussion. FDA does not believe the proposed instrument is capable of obtaining valid and useful information on both dietary supplements and fortified foods without significantly increasing participant burden. Thus, the agency has chosen to maintain the focus of the information collection on dietary supplements only.

One comment stated that the proposed information collection is not necessary for the proper enforcement of FDA's statutory obligations because: (1) The information described in the **Federal Register** announcement is already available, and (2) FDA should focus on enforcement of the current regulations that govern dietary supplement products and on completion of those regulations that are still necessary for finalization of the implementation of the DSHEA.

FDA has conducted a thorough literature review to identify extant, accessible, and similar information that could serve the agency's purpose. The agency has concluded that the existing information cannot be used for the purpose of the proposed information collection because: (1) Available consumer surveys have three major limitations that inhibit their use as a substitute for this collection of information: out-of-date information, limited focuses, and regional coverage; and (2) available focus group studies provide qualitative rather than quantitative information.

FDA recognizes its enforcement role in implementing the DSHEA. Part of that role includes establishing regulations and guidelines, where appropriate, to ensure that the dietary supplements currently used by consumers meet the requirements of the DSHEA. The agency is making progress in completing those regulations that are still necessary for finalization of the implementation of the DSHEA. Meanwhile, in order to carry out its enforcement functions efficiently, the agency also needs current, timely, and policy-relevant consumer information that can aid the agency in evaluating its labeling policies and in identifying potentially unsafe products. The proposed collection of information can provide such information. The agency, however, is not aware of the availability of any other source of information that can be used for this purpose.

FDA estimates the burden of this collection of information as follows:

TABLE1.—ESTIMATED ANNUAL REPORTING BURDEN[1]

Activity	No. of Respondents	Annual Frequency per Response	Total Annual Responses	Hours per Response	Total Hours
Cognitive interview	9	1	9	1.5	13.5
Pretest	9	1	9	0.5	4.5
Screener	4,200	1	4,200	0.02	84

TABLE1.—ESTIMATED ANNUAL REPORTING BURDEN[1]—Continued

Activity	No. of Respondents	Annual Frequency per Response	Total Annual Responses	Hours per Response	Total Hours
Survey	2,000	1	2,000	0.5	1,000
Total					1,102

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

These estimates are based on FDA's experience with previous consumer surveys. Prior to the administration of the survey, the agency plans to conduct a series of nine cognitive interviews and a series of nine pretests to ensure the quality of the survey. Cognitive interviews will help the agency understand respondent comprehension of the meanings of questions and words, and how respondents answer questions. Pretests will help the agency examine and reduce problems in the administration of the final questionnaire. The agency will use a screener to select an eligible respondent in each household to participate in the survey.

Dated: November 21, 2001.

Margaret M. Dotzel,

Associate Commissioner for Policy.

[FR Doc. 01–29742 Filed 11–29–01; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket Nos. 01D–0294 and 01D–0295]

Agency Information Collection Activities; Submission for OMB Review; Comment Request; Providing Regulatory Submissions in Electronic Format for Food Additive and Color Additive Petitions

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing that the proposed collection of information listed below has been submitted to the Office of Management and Budget (OMB) for review and clearance under the Paperwork Reduction Act of 1995.

DATES: Submit written comments on the collection of information by December 31, 2001.

ADDRESSES: Submit written comments on the collection of information to the Office of Information and Regulatory Affairs, OMB, New Executive Office Bldg., 725 17th St. NW., rm. 10235, Washington, DC 20503, Attn: Stuart Shapiro, Desk Officer for FDA.

FOR FURTHER INFORMATION CONTACT: Peggy Schlosburg, Office of Information Resources Management (HFA–250), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–827–1223.

SUPPLEMENTARY INFORMATION: In compliance with 44 U.S.C. 3507, FDA has submitted the following proposed collection of information to OMB for review and clearance.

Providing Regulatory Submissions in Electronic Format for Food Additive and Color Additive Petitions

Section 409(a) of the Federal Food, Drug, and Cosmetic Act (the act) (21 U.S.C. 348(a)) provides that a food additive shall be deemed to be unsafe unless: (1) It and its use or intended use are in conformity with a regulation prescribing the condition(s) under which such additive may safely be used; (2) it and its use or intended use conform to the terms of a regulatory exemption for investigational use; or (3) for a food contact substance, the substance and the use of such substance are in conformity with a regulation prescribing the conditions under which such additive may be safely used or a food contact notification submitted under section 409(h) of the act is effective. Individuals or companies submit food additive petitions to obtain approval of a new food additive or to amend the conditions of use permitted under an existing food additive regulation. The regulation in 21 CFR 171.1 specifies the information that a petitioner must submit in order to establish that the proposed use of a food additive is safe for its proposed use. This regulation implements section 409(b)(2) of the act.

Section 721(a) of the act (21 U.S.C. 379e(a)) provides that a color additive shall be deemed to be unsafe unless: (1) The additive and its use are in conformity with a regulation listing such additive for such use, including any provision that describes the condition(s) under which the additive may safely be used and is either batch certified for such use or exempted from the certification requirements; or (2) the additive and its use conform to the terms of an exemption for investigational use issued under section 721(f) of the act. Individuals or companies submit color additive petitions to obtain approval of a new color additive or a change in the conditions of use permitted for a color additive that is already approved. The regulation in 21 CFR 71.1 specifies the information that a petitioner must submit in order to establish that a color additive is safe and suitable for its proposed use.

Respondents to this collection of information are businesses engaged in the manufacture or sale of food, food ingredients, substances used in materials that come into contact with food or engaged in the manufacture or sale of foods, drugs, devices, or cosmetics containing color additives.

The agency estimates that up to 30 percent of the petitioners for both food and color additives will take advantage of the electronic submission process during the first year. By using the guidelines, including the forms that FDA is providing, the petitioner will be able to organize the petition to focus on the information needed to expedite review of the petition. Therefore, we estimate that petitioners will only need to spend approximately 1 hour completing the electronic submission application form (FDA Form 3503 or 3504, as appropriate) because they will have already organized the information needed for the submission into the appropriate categories.

In the **Federal Register** of July 31, 2001 (66 FR 39517), the agency requested comments on the proposed collection of information. No comments were received.

FDA estimates the burden of this collection of information as follows:

TABLE 1.—ESTIMATED ANNUAL REPORTING BURDEN[1]

21 CFR Section/Part/FDA Form	No. of Respondents	Annual Frequency per Response	Total Annual Responses	Hours per Response	Total Hours	Total Operating and Maintenance Costs
Food additive petitions[2]—electronic submissions						
FDA Form 3503	3	1	3	1	3	0
171.1—electronic submissions	3	1	3	4,799	14,397	0
172—electronic submissions	3	1	3	0	0	0
173—electronic submissions	3	1	3	0	0	0
175 through 178—electronic submissions	3	1	3	0	0	0
180—electronic submissions	3	1	3	0	0	0
Subtotal					14,400	0
Color additive petitions[2]—electronic submissions						
FDA Form 3504	1	1	1	1	1	0
70.25—electronic submissions	0	0	0	0	0	0
71.1 category A[3]—electronic submissions	1	1	1	608	608	2,600
71.1 category B[4]—electronic submissions	1	1	1	2,394	2,394	3,000
71.1 category C[5]—electronic submissions	0	0	0	0	0	0
Subtotal					3,003	$5,600
Total					17,403	$5,600

[1] There are no capital costs associated with this collection of information.
[2] The electronic submissions (e-submissions) contain the same petition information required for paper submissions; only the submission format will contain both electronic and paper.
[3] Category A—A color additive petition with minimal testing requirements, such as is typical for medical device color additive petitions (toxicity studies, collection of identity information, analytical information, and administrative details).
[4] Category B—An average color additive petition consisting of analytical work, 90-day feeding study, and the administrative details, which include the drafting of the regulations.
[5] Category C—A petition for a completely new food, drug, or cosmetic color.

Under parts 71 and 171 (21 CFR parts 71 and 171), the agency requires that the petitioner submit the petitions in triplicate. The draft guidance for industry entitled ''Providing Regulatory Submissions to Office of Food Additive Safety in Electronic Format for Food Additive and Color Additive Petitions'' provides that petitioner should include one copy of the petition in electronic format (''electronic copy'') and one copy in paper format (''paper copy''). The submission of an electronic copy, however, is not expected to significantly increase the burden of preparing the submission because it merely serves as a substitute for paper copies. Further, the agency also plans to hold consultations with the petitioners during the time of preparation to ensure that the information that the petitioners submit meets the current requirements in parts 71 and 171 and that it is in the recommended format.

The estimate of burden for electronically submitted food additive petitions is based on the number of new food additive petitions received in fiscal year (FY) 1999 and the total hours expended by petitioners to prepare the petitions. We estimate that during the first year, the electronic submission process will reduce the total time of preparation for food additive petitions by approximately 10 percent of the burden previously estimated for paper petitions (see 65 FR 64222, October 26, 2000). Although the burden varies with the type of petition submitted, an average food additive petition involves review of appropriate scientific studies, as well as the work of drafting the petition itself. The burden varies depending on the complexity of the petition, including the amount and types of data needed for scientific analysis.

The estimate of burden for electronically submitted color additive petitions is based on an average of five new color additive petitions received each year in FY 1998 and 1999. We estimate that during the first year, the electronic submission process will reduce the total time of preparation for color additive petitions by approximately 10 percent of the burden previously estimated for paper petitions (see 64 FR 51128, September 21, 1999). Although the burden varies with the type of petition submitted, an average color additive petition involves analytical work and appropriate toxicology studies, as well as the work of drafting the petition itself.

If an average of five color additive petitions (all submissions) are expected per calendar year, and only one submission per category for categories A and B is an electronic submission, the estimated annual burden for this start-up cost would be approximately $5,600. Based on the assumption that companies will use the same equipment for generating both paper and electronic records after this initial start-up cost, i.e., software and storage media for preparing both paper and electronic submissions, the burden of maintaining electronic equipment and of maintaining electronic records should not increase the burden of preparing such petitions. In fact, the cost of shipping electronic media should be less than shipping paper copies of petitions.

Dated: November 26, 2001.

Margaret M. Dotzel,

Associate Commissioner for Policy.

[FR Doc. 01–29802 Filed 11–29–01; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

Anesthetic and Life Support Drugs Advisory Committee; Notice of Meeting

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

This notice announces a forthcoming meeting of a public advisory committee of the Food and Drug Administration (FDA). The meeting will be open to the public.

Name of Committee: Anesthetic and Life Support Drugs Advisory Committee.

General Function of the Committee: To provide advice and recommendations to the agency on FDA's regulatory issues.

Date and Time: The meeting will be held on January 30 and 31, 2002, from 8 a.m. to 5 p.m.

Location: Holiday Inn, The Ballrooms, Two Montgomery Village Ave., Gaithersburg, MD.

Contact: Kimberly Littleton Topper, Center for Drug Evaluation and Research (HFD–21), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, or by delivery to: 5630 Fishers Lane, rm. 1091, Rockville, MD 20857, 301–827–7001, or FDA Advisory Committee Information Line, 1-800–741–8138 (301–443–0572 in the Washington, DC area), code 12529. Please call the Information Line for up-to-date information on this meeting.

Agenda: On both days, the committee will discuss the medical use of opiate analgesics in various patient populations, including pediatric patients and patients with chronic pain of nonmalignant etiology, as well as the risk to benefit ratio of extending opiate treatment into these populations. It will also address concerns regarding the abuse potential, diversion and increasing incidence of addiction to opiate analgesics, especially to the modified release opiate analgesics.

Procedure: Interested persons may present data, information, or views, orally or in writing, on issues pending before the committee. Written submissions may be made to the contact person by December 21, 2001. On both days, oral presentations from the public will be scheduled between approximately 8:30 a.m. and 9:30 a.m. Time allotted for each presentation may be limited. Those desiring to make formal oral presentations should notify the contact person before December 21, 2001, and submit a brief statement of the general nature of the evidence or arguments they wish to present, the names and addresses of proposed participants, and an indication of the approximate time requested to make their presentation.

Notice of this meeting is given under the Federal Advisory Committee Act (5 U.S.C. app. 2).

Dated: November 21, 2001.

Bonnie Malkin,

Acting Senior Associate Commissioner for Communications and Constituent Relations.

[FR Doc. 01–29741 Filed 11–29–01; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 01N–0450]

Prescription Drug User Fee Act (PDUFA); Public Meeting; Correction

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice of public meeting; correction.

SUMMARY: The Food and Drug Administration (FDA) is correcting a notice that appeared in the **Federal Register** of Monday, November 19, 2001 (66 FR 57967). The document announced a public meeting on the Prescription Drug User Fee Act (PDUFA). The document published with an inadvertent error. This document corrects that error.

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

SUPPLEMENTARY INFORMATION: In FR Doc. 01–29002, appearing in the **Federal Register** of Monday, November 19, 2001, the following correction is made: On page 57968, in the first column, in lines 8, 9, and 10, of the first incomplete paragraph,''http://www.accessdata.fda.gov/scripts/oc/dockets/meetings/meetingdockets.cfm'' is corrected to read ''http://www.accessdata.fda.gov/scripts/oc/dockets/meetings/meetingdocket.cfm.''

Dated: November 26, 2001.

Margaret M. Dotzel,

Associate Commissioner for Policy.

[FR Doc. 01–29804 Filed 11–29–01; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

Notice of Listing of Members of the Food and Drug Administration's Senior Executive Service Performance Review Board

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the members of the FDA Performance Review Board (PRB). This action is intended to ensure that members of the PRBs are appointed in a manner that provides consistency, stability, and objectivity in performance appraisals, and that notice of the appointment of members of the board be published in the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: Arlene S. Karr, Office of Human Resources and Management Services (HFA–408), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–827–4183.

The following persons will serve on FDA's PRB, which oversees the evaluation of performance appraisals of FDA's Senior Executive Service members in accordance with 5 U.S.C. 4314(c)(4):

Linda A. Suydam, Chairperson,
David W. Feigal, Jr.,
William K. Hubbard,
and Jeffrey M. Weber.

Dated: November 20, 2001.

Bernard A. Schwetz,

Acting Principal Deputy Commissioner.

[FR Doc. 01–29803 Filed 11–29–01; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Agency Information Collection Activities: Proposed Collection: Comment Request

In compliance with the requirement for opportunity for public comment on proposed data collection projects (section 3506(c)(2)(A) of Title 44, United States Code, as amended by the Paperwork Reduction Act of 1995, Public Law 104–13), the Health Resources and Services Administration (HRSA) publishes periodic summaries of proposed projects being developed for submission to OMB under the Paperwork Reduction Act of 1995. To

request more information on the proposed project or to obtain a copy of the data collection plans and draft instruments, call the HRSA Reports Clearance Officer on (301) 443–1129.

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 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.

Proposed Project: Application for Certification and Recertification as a Federally Qualified Health Center (FQHC) Look-Alike (OMB No. 0915–0142): Revision

The Health Resources and Services Administration (HRSA) proposes to revise the application guide used by organizations applying for certification or recertification as a Federally Qualified Health Center (FQHC) Look-Alike for purposes of cost-based reimbursement under the Medicaid and Medicare programs. The guide will be revised to reflect legislative, policy, and technical changes since October 1999, the issuance date of the last guidance. Revisions include reference to the Medicare, Medicaid and State Children's Health Insurance Program Benefits Improvement and Protection Act (BIPA) of 2000, section 702, the Medicaid prospective payment system for FQHCs, the elimination of waiver allowances under the Medicaid FQHC benefit and the interpretation and implementation of policy documents issued by HRSA.

The estimated burden is as follows:

Type of report	Number of respondents	Responses per respondent	Hours per response	Total burden hours
Application	25	1	100	2,500
Recertification	75	1	20	1,500
Total	100			4,000

Send comments to Susan G. Queen, Ph.D., HRSA Reports Clearance Officer, Room 14–22, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857. Written comments should be received within 60 days of this notice.

Dated: November 26, 2001.

Jane M. Harrison,

Director, Division of Policy Review and Coordination.

[FR Doc. 01–29745 Filed 11–29–01; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Cancer Institute; Amended Notice of Meeting

Notice is hereby given of a change in the meeting of the National Cancer Institute Special Emphasis Panel, December 6, 2001, 2 p.m. to December 6, 2001, 4 p.m., National Cancer Institute Division of Extramural Activities, Grants Review Branch, 6116 Executive Boulevard, 8th Floor, Rockville, MD, 20852 which was published in the **Federal Register** on November 13, 2001, 66 FR 56833–56834.

The meeting start time has changed from 2 pm to 1 pm. The meeting is closed to the public.

Dated: November 21, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–29690 Filed 11–29–01; 8:45 am]

BILLING CODE 4140–01–M

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 Special Emphasis Panel, Clinical Nutrition Research Unit.

Date: December 18–20, 2001.

Time: 7 p.m. to 6:30 p.m.

Agenda: To review and evaluate grant applications.

Place: Holiday Inn, 5520 Wisconsin Ave, Chevy Chase, MD 20815.

Contact Person: Mary C. Fletcher, Scientific Review Administrator, Grants Review Branch, Division of Extramural Activities, National Cancer Institute, National Institutes of Health, 6116 Executive Boulevard, Rm 8115, Bethesda, MD 20892, 301/496–7413.

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.

Any interested person may file written comments with the committee by forwarding the statement to the Contact Person listed on this notice. The statement should include the name, address, telephone number and when applicable, the business or professional affiliation of the interested person.

(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: November 21, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–29691 Filed 11–29–01; 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 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 a meeting of the National Advisory Research Resources Council.

The meeting will be open to the public as indicated below, with attendance limited to space available. Individuals who plan to attend and need special assistance, such as sign language interpretation or other reasonable accommodations, should notify the Contact Person listed below in advance of the 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/or contract proposals 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 and/or contract proposals, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Advisory Research Resources Council.

Date: January 31, 2002.

Open: 8:30 a.m. to 2:45 p.m.

Agenda: Report of Center Director and other issues.

Place: National Institutes of Health, 9000 Rockville Pike, Building 31C, Conference Room 6, Bethesda, MD 20892.

Closed: 2:45 p.m. to Adjournment.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 9000 Rockville Pike, Building 31C, Conference Room 6, Bethesda, MD 20892.

Contact Person: Louise E. Ramm, PhD, Deputy Director, National Center for Research Resources, National Institutes of Health, Building 31, Room 3B11, Bethesda, MD 20892, 301–496–6023.

Information is also available on the Institute's/Center home page: *www.ncrr.nih.gov/newspub/minutes.htm,* where an agenda and any additional information for the meeting will be posted when available.

(Catalogue of Federal Domestic Assistance Program Nos. 93.306, Comparative Medicine, 93.306; 93.333, Clinical Research, 93.333; 93.371, Biomedical Technology; 93.389, Research Infrastructure, National Institutes of Health, HHS)

Dated: November 20, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–29687 Filed 11–29–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Heart, Lund, and Blood 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 Heart, Lung, and Blood Institute Special Emphasis Panel, Review of Applications.

Date: December 12, 2001.

Time: 1 p.m. to 3 p.m.

Agenda: To review and evaluate grant applications.

Place: Two Rockledge Centre, Room 7214, 6701 Rockledge Drive, Bethesda, MD 20817, (Telephone Conference Call).

Contact Person: Valerie L. Prenger, PhD, Health Scientist Administrator, NIH, NHLBI, DEA, Review Branch, Rockledge Center II, 6701 Rockledge Drive, Suite 7198, Bethesda, MD 20892–7924, (301) 435–0297.

(Catalogue of Federal Domestic Assistance Program Nos. 93.233, National Center for Sleep Disorders Research; 93.837, Heart and Vascular Diseases Research; 93.838, Lung Diseases Research; 93.839, Blood Diseases and Resources Research, National Institutes of Health, HHS)

Dated: November 21, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–29689 Filed 11–29–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Heart, Lung, and Blood 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 Heart, Lung, and Blood Institute Special Emphasis Panel, Review of PA00–004, PA00–005, PA99–087 grant applications.

Date: January 10–11, 2002.

Time: 7 pm to 5 pm.

Agenda: To review and evaluate grant applications.

Place: Marriott Wardman Park Hotel, 2660 Woodley Road, NW, Washington, DC 20008.

Contact Person: Diane M. Reid, MD, Review Branch, Room 7182, Division of Extramural Affairs, National Heart, Lung, and Blood Institute, National Institutes of Health, Bethesda, MD 20892, (301) 435–0277.

(Catalogue of Federal Domestic Assistance Program Nos. 93.233, National Center for Sleep Disorders Research; 93.837, Heart and Vascular Diseases Research; 93.838, Lung Diseases Research; 93.839, Blood Diseases and Resources Research, National Institutes of Health, HHS)

Dated: November 23, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–29696 Filed 11–29–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Child Health and Human Development; 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 Child Health and Human Development Special Emphasis Panel.

Date: December 6, 2001.

Time: 8:30 a.m. to 2 p.m.

Agenda: To review and evaluate grant applications.

Place: Four Points Sheraton, 8400 Wisconsin Avenue, Bethesda, MD 20814.

Contact Person: Marita Hopmann, PhD, Scientific Review Administrator, Division of Scientific Review, National Institute of Child Health and Human Development, 6100 Building, Room 5E01, Bethesda, MD 20892, (301) 435–6911, hopmannm@mail.nih.gov.

(Catalogue of Federal Domestic Assistance Program Nos. 93.209, Contraception and Infertility Loan Repayment Program; 93.864, Population Research; 93.865, Research for Mothers and Children; 93.929, Center for Medical Rehabilitation Research, National Institutes of Health, HHS)

Dated: November 20, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–29683 Filed 11–19–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Arthritis and Musculoskeletal and Skin Diseases; 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 Arthritis and Musculoskeletal and Skin Diseases Special Emphasis Panel.

Date: November 27, 2001.[1]

Time: 12 pm to 2 pm.

Agenda: To review and evaluation grant applications.

Place: Natcher Building, 45 Center Drive, Conference Rooms E1/E2, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Tracy A. Shahan, PHD, Scientific Review Administrator, National Institute of Arthritis and Musculoskeletal and Skin Diseases, Natcher Building, MSC 6500, 45 Center Drive, 5AS–25H, Bethesda, MD 20892, (301) 594–4952.

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. 93.846, Arthritis, Musculoskeletal and Skin Diseases Research, National Institutes of Health, HHS)

Dated: November 20, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–29684 Filed 11–29–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Allergy and Infectious Diseases; 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 Allergy and Infectious Diseases Special Emphasis Panel, Therapeutic Strategies for HIV Disease.

Date: December 13, 2001.

Time: 1 p.m. to 2:15 p.m.

Agenda: To review and evaluate grant applications.

Place: 6700 B Rockledge Drive, Room 2220, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Eleazar Cohen, PhD, Scientific Review Administrator, NIAID/DEA, Scientific Review Program, Room 2220, 6700B Rockledge Drive, MSC–7616, Bethesda, MD 20892, 301–496–2550, *ec17w@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. 93.855, Allergy, Immunology, and Transplantation Research; 93.856, Microbiology and Infectious Diseases Research, National Institutes of Health, HHS)

Dated: November 21, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–29692 Filed 11–29–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Allergy and Infectious Diseases; 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 Allergy and Infectious Diseases Special Emphasis Panel Ecology of Infectious Diseases.

Date: November 28–30, 2001.

Time: November 28, 2001, 9 a.m to adjournment of November 30, 2001.

Agenda: To review and evaluate grant applications.

Place: National Science Foundation, 4201 Wilson Boulevard, Arlington, VA 22230.

Contact Person: Anna L. Ramsey-Ewing, PhD, Scientific Review Administrator, Scientific Review Program, Division of Extramural Activities, NIAID, NIH, Room 2220, 6700–B Rockledge Drive, MSC 7610, Bethesda, MD 20892–7610, 301 496–2550, *ar15o@nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing

[1] **Editorial Note:** This document was received by the Office of the Federal Register on November 26, 2001.

limitations imposed by the review and funding cycle.

(Catalogue of Federal Domestic Assistance Program Nos. 93.855, Allergy, Immunology, and Transplantation Research; 93.856, Microbiology and Infectious Diseases Research, National Institutes of Health, HHS)

Dated: November 21, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–29693 Filed 11–29–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Neurological Disorders and Stroke; 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 Neurological Disorders and Stroke Special Emphasis Panel.

Date: December 6–7, 2001.

Time: 8 am to 5 pm.

Agenda: To review and evaluate grant applications.

Place: Hotel Washington, 515 15th Street, NW., Washington, DC 20004.

Contact Person: Raul A. Saavedra, PhD, Scientific Review Administrator, Scientific Review Branch, Division of Extramural Research, NINDS/NIH/DHHS, Neuroscience Center, 6001 Executive Blvd., Suite 3208, MSC 9529, Bethesda, MD 20892–9529, 301–496–9223.

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 Institute of Neurological Disorders and Stroke Special Emphasis Panel.

Date: December 6, 2001.

Time: 9 AM to 2 PM.

Agenda: To review and evaluate grant applications.

Place: The Grand Westin Hotel, 2350 M Street, NW., Washington, DC 20037.

Contact Person: Alan L. Willard, PhD, Scientific Review Administrator, Scientific Review Branch, Division of Extramural Research, NINDS/NIH/DHHS, Neuroscience Center, 6001 Executive Blvd., Suite 3208, MSC 9529, Bethesda, MD 20892–9529, 301–496–9223.

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 Institute of Neurological Disorders and Stroke Special Emphasis Panel.

Date: December 10, 2001.

Time: 2 PM to 3:30 PM.

Agenda: To review and evaluate grant applications.

Place: 6001 Executive Blvd., Rockville, Rockville, MD 20852, (Telephone Conference Call).

Contact Person: Alan L. Willard, PhD, Scientific Review Administrator, Scientific Review Branch, NINDS/NIH/DHHS, Neuroscience Center, 6001 Executive Blvd., Suite 3208, MSC 9529, Bethesda, MD 20892–9529, 301–496–9223.

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. 93.853, Clinical Research Related to Neurological Disorders; 93.854, Biological Basis Research in the Neurosciences, National Institutes of Health, HHS)

Dated: November 23, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–29695 Filed 11–29–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute on Alcohol Abuse and Alcoholism; 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 on Alcohol Abuse and Alcoholism Special Emphasis Panel, Special Emphasis Panel.

Date: December 4, 2001.

Time: 2 PM to 3:30 PM.

Agenda: To review and evaluate grant applications.

Place: Willco Building, Suite 409, 6000 Executive Boulevard, Rockville, MD 20892, (Telephone Conference Call).

Contact Person: Sean N. O'Rourke, Scientific Review Administrator, Extramural Project Review Branch, National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health, Suite 409, 6000 Executive Boulevard, Bethesda, MD 20892–7003, 301–443–2861.

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. 93.271, Alcohol Research Career Development Awards for Scientists and Clinicians; 93.272, Alcohol National Research Service Awards for Research Training; 93.273, Alcohol Research Programs; 93.891, Alcohol Research Center Grants, National Institutes of Health, HHS)

Dated: November 23, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–29697 Filed 11–29–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute on Alcohol Abuse and Alcoholism; 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 on Alcohol Abuse and Alcoholism Special Emphasis Panel.

Date: December 20, 2001.

Time: 12 pm to 1 pm.

Agenda: To review and evaluate grant applications.

Place: 6000 Executive Blvd., Rm 409, Rockville, MD 20892, (Telephone Conference Call).

Contact Person: L. Tony Beck, PhD, Scientific Review Administrator, National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health, Suite 409, 6000 Executive Blvd., MSC 7003, Bethesda, MD 20892–7003, 301–443–0913, *ibeck@mail.nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.271, Alcohol Research Career Development Awards for Scientists and Clinicians; 93.272, Alcohol National Research Service Awards for Research Training; 93.273, Alcohol Research Programs; 93.891, Alcohol Research Center Grants, National Institutes of Health, HHS)

Dated: November 23, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–29699 Filed 11–29–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Allergy and Infectious Diseases; 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 Allergy and Infectious Diseases Special Emphasis Panel.

Date: December 18, 2001.

Time: 1 pm to 3:30 pm.

Agenda: To review and evaluate grant applications.

Place: 6700–B Rockledge Drive, Room 2220, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Eleazar Cohen, PHD, Scientific Review Administrator, NIAID/DEA, Scientific Review Program, Room 2220, 6700B Rockledge Drive, MSC–7616, Bethesda, MD 20892, 301–496–2550, *ec17w@nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.855, Allergy, Immunology, and Transplantation Research; 93.856, Microbiology and Infectious Diseases Research, National Institutes of Health, HHS)

Dated: November 23, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–29700 Filed 11–29–01; 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.

Date: December 17–18, 2001.

Time: 8 AM to 5 PM.

Agenda: To review and evaluate grant applications.

Place: Hyatt Hotel, One Bethesda Metro Center, Bethesda, MD 20814.

Contact Person: Ned Feder, MD, Scientific Review Administrator, Review Branch, DEA, NIDDK, Room 645, 6707 Democracy Boulevard, National Institutes of Health, Bethesda, MD 20892.

Name of Committee: National Institute of Diabetes and Digestive and Kidney Diseases Special Emphasis Panel.

Date: December 18, 2001.

Time: 8:30 AM to 4 PM.

Agenda: To review and evaluate grant applications.

Place: Bethesda Marriott Suites, 6711 Democracy Boulevard, Bethesda, MD 20817.

Contact Person: Lakshmanan Sankaran, PHD, Scientific Review Administrator, Review Branch, DEA, NIDDK, Room 754, 6707 Democracy Boulevard, National Institutes of Health, Bethesda, MD 20892–6600, (301) 594–7799.

Name of Committee: National Institute of Diabetes and Digestive and Kidney Diseases Special Emphasis Panel.

Date: January 9, 2002.

Time: 12 PM to 5 PM.

Agenda: To review and evaluate grant applications.

Place: Bethesda Marriot, 6711 Democracy Boulevard, Bethesda, MD 20817.

Contact Person: Michele L. Barnard, PHD, Scientific Review Administrator, Review Branch, DEA, NIDDK, National Institutes of Health, Room 753, 6707 Democracy Boulevard, Bethesda, MD 20892, 301/594–8898.

(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: November 23, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–29701 Filed 11–29–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Heart, Lung, and Blood 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 Heart, Lung, and Blood Institute Special Emphasis Panel, Innovative Grant Program.

Date: January 9, 2002.

Time: 10 am to 4 pm.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Zoe E. Huang, MD, Review Branch, Division of Extramural Affairs, National Heart, Lung, and Blood Institute, Bethesda, MD 20892–7924.

(Catalogue of Federal Domestic Assistance Program Nos. 93.233, National Center for Sleep Disorders Research; 93.837, Heart and Vascular Diseases Research; 93.838, Lung Diseases Research; 93.839, Blood Diseases and Resources Research, National Institutes of Health, HHS)

Dated: November 21, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–29688 Filed 11–29–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Meeting

Pursuant to section 10(a) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of a meeting of the Center for Scientific Review Advisory Committee.

The meeting will be open to the public, with attendance limited to space available. Individuals who plan to attend and need special assistance, such as sign language interpretation or other reasonable accommodations, should notify the Contact Person listed below in advance of the meeting.

Name of Committee: Center for Scientific Review Advisory Committee.

Date: January 28–29, 2002.

Time: 8:30 a.m. to 1 p.m.

Agenda: Concerns, issues and discussion regarding the peer review process.

Place: National Institutes of Health, Two Rockledge Center, Conference Room 9100, 6701 Rockledge Drive, Bethesda, MD 20892.

Contact Person: Brent B. Stanfield, PhD, Deputy Director, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 3016, MSC 7776, Bethesda, MD 20892, (301) 435–1114.

Information is also available on the Institute's/Center's home page: *www.csr.nih.gov/drgac/drgac.htm*, where an agenda and any additional information for the meeting will be posted when available.

(Catalogue of Federal Domestic Assistance Program Nos. 93.306, Comparative Medicine, 93.306; 93.333, Clinical Research, 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: November 20, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–29685 Filed 11–29–01; 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.

Date: November 27, 2001.[1]

Time: 8 am to 5 pm.

Agenda: To review and evaluate grant applications.

Place: Holiday Inn Chevy Chase, 5520 Wisconsin Ave, Chevy Chase, MD 20815.

Contact Person: William C. Benzing, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5190, MSC 7846, Bethesda, MD 20892, (301) 435–1254, *benzingw@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.

Date: November 27, 2001.

Time: 2 pm to 3 pm.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Cathleen L. Cooper, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4208, MSC 7812, Bethesda, MD 20892, (301) 435–3566, *cooperc@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.

Date: December 3, 2001.

Time: 12 pm to 1:30 pm.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Charles N. Rafferty, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4114, Bethesda, MD 20892, (301) 435–3562.

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.

Date: December 5, 2001.

Time: 11:30 am to 1 pm.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Larry Pinkus, PHD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4132, MSC 7802, Bethesda, MD 20892, (301) 435–1214.

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.

Date: December 5, 2001.

Time: 3 p.m. to 4 p.m.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: David J. Remondini, PHD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 2210, MSC 7890, Bethesda, MD 20892, (301) 435–1038, *remondid@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.

Date: December 6–7, 2001.

Time: 2 p.m. to 4 p.m.

Agenda: To review and evaluate grant applications.

Place: Latham Hotel, 3000 M Street, NW., Washington, DC 20007–3701.

Contact Person: Carole L. Jelsema, PHD, Scientific Review Administrator, MDCN Scientific Review Group, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5210, MSC 7850, Bethesda, MD 20892, (301) 435–1249, *jelsemac@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.

Date: December 13, 2001.

Time: 2 p.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Michael H. Chaitin, PHD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5202,

[1] **Editorial Note:** This document was received by the Office of the Federal Register on November 26, 2001.

MSC 7850, Bethesda, MD 20892, (301) 435–0910, *chaitinm@csr.nih.gov.*

(Catalogue of Federal Domestic Assistance Programs Nos. 93.306, Comparative Medicine, 93.306; 93.333, Clinical Research, 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: November 20, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–29686 Filed 11–29–01; 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 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: Center for Scientific Review Special Emphasis Panel.

Date: December 5, 2001.

Time: 5 pm to 7 pm.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Priscilla B. Chen, PhD, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4104, MSC 7814, Bethesda, MD 20892, (301) 435–1787.

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, 93.306; 93.333, Clinical Research, 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: November 23, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–29694 Filed 11–29–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Amended Notice of Meeting

Notice is hereby given of a change in the meeting of the Center for Scientific Review Special Emphasis Panel, November 15, 2001, 3 pm to November 15, 2001, 5 pm, NIH, Rockledge 2, Bethesda, MD, 20892 which was published in the **Federal Register** on November 21, 2001, 66 FR 58510.

The meeting will be held December 5, 2001, from 9:30 am to 12 pm. The location remains the same. The meeting is closed to the public.

Dated: November 23, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–29698 Filed 11–29–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Prevention (CSAP) Drug Testing Advisory Board; Notice of Meeting

Pursuant to Pub. L. 92–463, notice is hereby given of the meeting of the Center for Substance Abuse Prevention (CSAP) Drug Testing Advisory Board to be held in December 2001.

A portion of the meeting will be open and will include a Department of Health and Human Services drug testing program update, a Department of Transportation drug testing program update, and an update on the draft guidelines for alternative specimen testing and on-site testing. If anyone needs special accommodations for persons with disabilities, please notify the Contact listed below.

The meeting will include developing the final requirements for specimen validity testing that had been published in the **Federal Register** on August 21, 2001 (66 FR 43876), and evaluation of sensitive National Laboratory Certification Program (NLCP) internal operating procedures and program development issues. Therefore, a portion of the meeting will be closed to the public as determined by the SAMHSA Administrator in accordance with Title 5 U.S.C. 552b(c)(9)(B) and 5 U.S.C. app. 2, sec. 10(d).

A roster of the board members may be obtained from: Mrs. Giselle Hersh, Division of Workplace Programs, 5600 Fishers Lane, Rockwall II, Suite 815, Rockville, MD 20857, Telephone: (301) 443–6014. The transcript for the open session will be available on the following website: http://workplace.samhsa.gov. Additional information for this meeting may be obtained by contacting the individual listed below.

Committee Name: Center for Substance Abuse Prevention Drug Testing Advisory Board.

Meeting Date:

December 4, 2001; 8:30 a.m.–4:30 p.m.

December 5, 2001; 8:30 a.m.–Noon.

Place: Residence Inn by Marriott, 7335 Wisconsin Avenue, Bethesda, Maryland 20814.

Type:

OPEN: December 4, 2001; 8:30 a.m.–10:00.

CLOSED: December 4, 2001; 10:00–4:30 p.m.

CLOSED: December 5, 2001; 8:30 a.m.–Noon

Contact: Donna M. Bush, Ph.D., Executive Secretary; Telephone: (301) 443–6014, and FAX: (301) 443–3031.

This notice is being published less than 15 days prior to the meeting due to the urgent need to meet timing limitations imposed by the review and funding cycle.

Dated: November 27, 2001.

Toian Vaughn,

Committee Management Officer, Substance Abuse and Mental Health Services Administration.

[FR Doc. 01–29805 Filed 11–29–01; 8:45 am]

BILLING CODE 4162–20–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–4644–N–48]

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.

EFFECTIVE DATE: November 30, 2001.

FOR FURTHER INFORMATION CONTACT: Clifford Taffet, Department of Housing and Urban Development, Room 7262, 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 the December 12, 1988 court order in *National Coalition for the Homeless* v. *Veterans Administration*, No. 88–2503–OG (D.D.C.), HUD publishes a Notice, on a weekly basis, identifying unutilized, underutilized, excess and surplus Federal buildings and real property that HUD has reviewed for suitability for use to assist the homeless. Today's Notice is for the purpose of announcing that no additional properties have been determined suitable or unsuitable this week.

Dated: November 23, 2001.

John D. Garrity,

Director, Office of Special Needs Assistance Programs.

[FR Doc. 01–29605 Filed 11–29–01; 8:45 am]

BILLING CODE 4210–29–M

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

Notice of Receipt of Applications for Permit

Endangered Species

The public is invited to comment on the following application(s) for a permit to conduct certain activities with endangered species. This notice is provided pursuant to section 10(c) of the Endangered Species Act of 1973, *as amended* (16 U.S.C. 1531, *et seq.*). Written data, comments, or requests for copies of these complete applications should be submitted to the Director (address below) and must be received within 30 days of the date of this notice.

Applicant: Ralph M. Marcum, Columbiana, AL, PRT–050043.

The applicant requests a permit to import the sport-hunted trophy of one male bontebok (*Damaliscus pygargus dorcas*) culled from a captive herd maintained under the management program of the Republic of South Africa, for the purpose of enhancement of the survival of the species.

Applicant: Jeffrey K. Chaulk, Gaylord, MI, PRT–050038.

The applicant requests a permit to import the sport-hunted trophy of one male bontebok (*Damaliscus pygargus dorcas*) culled from a captive herd maintained under the management program of the Republic of South Africa, for the purpose of enhancement of the survival of the species.

Applicant: Kenneth A. Rowland, Albuquerque, NM, PRT–049995.

The applicant requests a permit to import the sport-hunted trophy of one male bontebok (*Damaliscus pygargus dorcas*) culled from a captive herd maintained under the management program of the Republic of South Africa, for the purpose of enhancement of the survival of the species.

Applicant: Gary L. Keel, Duluth, GA, PRT–049993.

The applicant requests a permit to import the sport-hunted trophy of one male bontebok (*Damaliscus pygargus dorcas*) culled from a captive herd maintained under the management program of the Republic of South Africa, for the purpose of enhancement of the survival of the species.

Applicant: James R. Rhodes, III, North Little Rock, AR, PRT–049898.

The applicant requests a permit to import the sport-hunted trophy of one male bontebok (*Damaliscus pygargus dorcas*) culled from a captive herd maintained under the management program of the Republic of South Africa, for the purpose of enhancement of the survival of the species.

Applicant: Kimbel Jay Stuart, Nicasio, CA, PRT–049806.

The applicant requests a permit to import the sport-hunted trophy of one male bontebok (*Damaliscus pygargus dorcas*) culled from a captive herd maintained under the management program of the Republic of South Africa, for the purpose of enhancement of the survival of the species.

Applicant: National Marine Fisheries Service, La Jolla, CA, PRT-844694.

The applicant requests re-issuance of a permit to import and/or introduce from the sea biological samples collected from wild, captive held, and/or captive hatched leatherback sea turtle (*Dermochelys coriacea*), hawksbill sea turtle (*Eretmochelys imbricata*), green sea turtle (*Chelonia mydas*), kemp's ridley sea turtle (*Lepidochelys kempii*), and olive ridley sea turtle (*L. olivacea*) for the purpose of scientific research. Samples are to be collected opportunistically from salvaged specimens and provided to their facility in its capacity as a National Sea Turtle tissue repository. This notification covers activities conducted by the applicant over a five year period.

Applicant: The Field Museum, Chicago, IL, PRT–049888.

The applicant requests a permit to import one skeleton and one fluid preserved museum specimen of brown lemur (Eulemur fulvus), and one fluid preserved specimen of diademed sifaka (*Propithecus diadema*) that were confiscated by the Malagasy government and transferred to the Universite ' d'Antananarivo, Antananarivo, Madagascar, for the purpose of scientific research.

Applicant: Dr. L. Elizabeth Rasmussen, Oregon Graduate Institute of Science and Technology, Beaverton, OR, PRT—042224.

The applicant requests a permit to export biological samples collected from captive-born/captive-held Asian elephants (*Elephas maximus*) to the Horticultural Research Institute of New Zealand, Palmerston North & Auckland, New Zealand, for the purpose of scientific research. This notification covers activities conducted by the applicant over a five year period

Marine Mammals

The public is invited to comment on the following application(s) for a permit to conduct certain activities with marine mammals. The application(s) was submitted to satisfy requirements of the Marine Mammal Protection Act of 1972, *as amended* (16 U.S.C. 1361 *et seq.*) and the regulations governing marine mammals (50 CFR part 18).

Written data, comments, or requests for copies of these complete applications or requests for a public hearing on these applications should be submitted to the Director (address below) and must be received within 30 days of the date of this notice. Anyone requesting a hearing should give specific reasons why a hearing would be appropriate. The holding of such a hearing is at the discretion of the Director.

Applicant: Richard J. Lorenzo, Bay City, MI, PRT–049975.

The applicant requests a permit to import a polar bear (*Ursus maritimus*) sport hunted from the Lancaster Sound polar bear population in Canada for personal use.

The U.S. Fish and Wildlife Service has information collection approval from OMB through March 31, 2004, OMB Control Number 1018–0093. Federal Agencies may not conduct or sponsor and a person is not required to respond to a collection of information unless it displays a current valid OMB control number.

Documents and other information submitted with these applications are available for review, subject to the requirements of the Privacy Act and Freedom of Information Act, by any party who submits a written request for a copy of such documents within 30 days of the date of publication of this notice to: U.S. Fish and Wildlife Service, Division of Management Authority, 4401 North Fairfax Drive, Room 700, Arlington, Virginia 22203,

telephone 703/358–2104 or fax 703/358–2281.

Dated: November 9, 2001.

Michael S. Moore,

Senior Permit Biologist, Branch of Permits, Division of Management Authority.

[FR Doc. 01–29792 Filed 11–29–01; 8:45 am]

BILLING CODE 4310–55–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

Availability of a Final Revised Recovery Plan for the Oregon Silverspot Butterfly

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice of document availability.

SUMMARY: We, the Fish and Wildlife Service announce the availability of a final revised recovery plan for the Oregon silverspot butterfly (*Speyeria zerene hippolyta*), which will update the original recovery plan that was completed in 1982. This butterfly is distributed in six small areas along the Pacific coast from northern California to southern Washington. The Oregon silverspot butterfly depends upon coastal grasslands that contain the larval host plant (early blue violet), nectar sources, and adult courtship areas. Actions needed for recovery include permanent protection of habitat, restoration and management of native coastal grasslands, and prevention of further habitat fragmentation by minimizing the effects of human disturbance.

ADDRESSES: Recovery plans that have been approved by the U.S. Fish and Wildlife Service are available on the World Wide Web at *http://endangered.fws.gov/recovery/recplans/index.htm*. Recovery plans may also be obtained from: Fish and Wildlife Reference Service, 5430 Grosvenor Lane, Suite 110, Bethesda, Maryland 20814, (301) 429–6403 or 1–800–582–3421. The fee for the plan varies depending on the number of pages of the plan.

FOR FURTHER INFORMATION CONTACT: Rollie White, Endangered Species Division Manager, U.S. Fish and Wildlife Service, Oregon Fish and Wildlife Office, 2600 SE 98th Avenue, Suite 100, Portland, Oregon, 97266; phone (503) 231–6179.

SUPPLEMENTARY INFORMATION:

Background

Restoring an endangered or threatened animal or plant to the point where it is again a secure, self-sustaining member of its ecosystem is a primary goal of our endangered species program. To help guide the recovery effort, we are working to prepare recovery plans for most of the listed species native to the United States. Recovery plans describe actions considered necessary to conserve the species, establish criteria for recognizing the recovery levels for downlisting or delisting them, and estimate time and cost for implementing the recovery measures needed.

The Endangered Species Act of 1973 (Act), as amended (16 U.S.C. 1531 *et seq.*) requires that recovery plans be developed for listed species unless such a plan would not promote the conservation of a particular species. Section 4(f) of the Act, as amended in 1988, requires that during recovery plan development, we provide public notice and an opportunity for public review and comment. We will consider all information presented during a comment period before we approve a new or revised recovery plan. We and other Federal agencies will also take these comments into account in the course of implementing approved recovery plans.

The Oregon silverspot butterfly, which was listed as threatened with critical habitat in 1980, is a small, darkly marked coastal subspecies of the Zerene fritillary butterfly. This subspecies occurs in six small pockets of remaining habitat at Del Norte/Lake Earl in California and Clatsop Plains, Mt. Hebo, Cascade Head, Bray Point and Rock Creek-Big Creek in Oregon. A population in Long Beach, Washington may be extirpated and the population on the Clatsop Plains is extremely low and at risk of extirpation. The original recovery plan was completed in 1982. At the time of listing, the only known viable population occurred in the Rock Creek-Big Creek area. The original recovery plan included recovery actions for the Rock Creek-Big Creek area as well as the rediscovered population of butterflies at Mt. Hebo. Since that time, additional Oregon silverspot populations have been discovered or rediscovered at Cascade Head, Bray Point, Clatsop Plains, and Del Norte.

The open vegetation preferred by the butterfly has always had a patchy distribution that was maintained through wildfire, salt-laden winds, grazing, and controlled burning. Habitat has declined due to residential and commercial development, invasion of exotic plant species, overgrazing, and lack of fire. Current threats to Oregon silverspot butterflies include continued habitat alteration, continued invasion of non-native plants, off-road vehicle use, and vegetation change due to fire suppression.

The revised recovery plan calls for restoring and protecting habitat for the Oregon silverspot butterfly to establish or maintain viable populations in six habitat conservation areas. The revised recovery plan also calls for augmenting declining populations with captive-reared individuals and reintroducing butterflies in areas where they have been extirpated. The plan serves as a guide for all Federal and State agencies whose actions affect the conservation of the Oregon silverspot butterfly.

The objective of the plan is to conserve the Oregon silverspot butterfly so that protection by the Act is no longer necessary. As recovery criteria are met, the status of the species will be reviewed and it will be considered for removal from the List of Endangered and Threatened Wildlife (50 CFR part 17). Major actions necessary to accomplish this objective include permanent management of protected habitat in the habitat conservation areas listed in the plan to maintain native, early successional grassland communities which include early blue violet and native nectar species.

Authority

The authority for this action is section 4(f) of the Endangered Species Act, 16 U.S.C. 1533 (f).

Dated: August 22, 2001.

Rowan W. Gould,

Acting Regional Director, Fish and Wildlife Service, Pacific Region.

[FR Doc. 01–29733 Filed 11–29–01; 8:45 am]

BILLING CODE 4310–55–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

The Priority List Under the Multistate Conservation Grant Program for Conservation Projects Submitted to the U.S. Fish and Wildlife Service by the International Association of Fish and Wildlife Agencies

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice—Multistate Conservation Grant Program.

SUMMARY: The Service is publishing the priority list for the Multistate Conservation Grant Program submitted by the International Association of Fish and Wildlife Agencies. This notice is required by the Fish and Wildlife Programs Improvement and National Wildlife Refuges System Centennial Act

of 2000. Grants may be made from this list.

DATES: This notice is effective upon date of publication in the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: Chris McKay, Grants Manager, U.S. Fish and Wildlife Service, 4401 North Fairfax Drive, Suite 140, Arlington Virginia 22203, (703) 358–1711.

SUPPLEMENTARY INFORMATION: The Fish and Wildlife Programs Improvement and National Wildlife Refuges System Centennial Act of 2000 (Pub. L. 106–408) established a Multistate Conservation Grant Program within the Federal Aid in Wildlife Restoration and Federal Aid in Sport Fish Restoration Acts. The Improvement Act authorizes grants of up to $3 million annually from funds available under each of the Restoration Acts, for a total of up to $6 million annually. Grants may be made from a priority list of projects submitted by the International Association of Fish and Wildlife Agencies (IAFWA), representing the State fish and wildlife agencies. The Service Director, exercising the authority of the Secretary, need not fund all recommended projects, but may not fund projects which are not recommended.

To be eligible for consideration, a project must benefit fish and/or wildlife conservation in at least 26 States, a majority of the States in a Fish and Wildlife Service Region, or a regional association of State fish and wildlife agencies. Grants may be made to a State or group of States, to non-governmental organizations, and, solely for carrying out the National Survey of Fishing, Hunting and Wildlife-Associated Recreation, to the Fish and Wildlife Service.

Title	Applicant	Wildlife funds	Sport fish funds
The 2001 Economic Contributions of Sport Fishing	American Sportfishing Association.		$73,044
National Survey of Fishing, Hunting and Wildlife-Associated Recreation.	USFWS	$1,432,516	1,432,516
Representation of the Northeastern Association of Fish and Wildlife Agencies in International Conventions and Protocols.	Northeast Association of Fish and Wildlife Agencies.	4,500	4,500
The 2001 Economic Contributions of Hunting	IAFWA—Animal Use Issues Task Force.	76,992	
Pumpout Equipment Standards and Lifecycle Testing	States Organization for Boating Access.		299,000
Representationo f the Association of Midwest Fish and Wildlife Agencies in International Conventions and Protocols.	Association of Midwest Fish and Wildlife Agencies.	4,500	4,500
New Computer Models for Trap Testing in the Development of Best Management Practices to Improve Management of State Wildlife Resources.	Northeast Association of Fish and Wildlife Resource Agencies.	76,937	
The Need to Develop a Geographic Information System to Facilitate Integrated Bird Conservation in the Central Hardwoods Bird Conservation Region.	Tennessee Wildlife Resources Agency.	33,750	
Sage-Grouse Interstate Working Group Coordinator	Western Association of Fish and Wildlife Agencies.	120,000	
Management Assistance Team (MAT)	IAFWA	248,340	248,340
Instream Flows for Reverine Resource Stewardship	Wyoming Game and Fish Department.		16,650
Step Outside	National Shooting Sports Foundation.	171,100	
Fish and Wildlife Reference Service	KRA Corporation	236,141	236,141
Fate and Effect of the Aquaculture Therapeutic Potassium Permanganate.	Department of Biological Sciences, Arkansas State University.		59,915
Coordination of Vegetation Establishment and Management on Conservation Reserve Program Lands.	IAFWA—Agricultural Conservation Task Force.	75,000	
Representation of the Western Assocaition of Fish and Wildlife Agencies and its Member States in International Treaties and Protocols.	Western Association of Fish and Wildlife Agencies.	4,500	4,500
Understanding the Relationship Between Waterfowl Hunting Regulations and Hunter Satisfaction/Participation, with Recommendations for Improvements to Agency Management and Conservation Programs.	Wildlife Management Institute	61,450	
Development and Validation of Determinative Analytical Method for the Marker Residue of AQUI–S, a Fish Anesthetic for Public Fish Facilities and Fishery Management.	IAFWA—Fisheries and Water Resources Policy Committee.		49,335
Development of a Model for Infecting Fish with Columnaris to Facilitate Pivotal Efficacy Trials for Treating the Disease with Candidate Therapeutants.	IAFWA—Fisheries and Water Resources Policy Committee.		105,651
New Animal Drug Application (NADA) for Oxytetracycline Immersion Therapy for Diseases of Cool and Warm Water Fish Species Cultured on Public Fish Facilities.	IAFWA—Fisheries and Water Resources Policy Committee.		96,921
Multistate Conservation Grant Program Coordination	IAFWA—Executive Committee	44,460	44,460
Support for State ''Hooked On Fishing—Not On Drugs'' and Fishing Tackle Loaner Programs.	Future Fisherman Foundation		294,200
Bird Conservation for the Nation: Implementation of All-Bird Conservation.	IAFWA—Migratory Bird Committee.	250,000	
Representation of the Southeastern Association of Fish and Wildlife Agencies in International Conventions and Protocols.	Southeast Association of Fish and Wildlife Agencies.	4,500	4,500

Title	Applicant	Wildlife funds	Sport fish funds
Outreach Project—Enhancing Communications Strategies and Improving Administration of State Wildlife Resource Programs through Implementating Best Management Practices (BMP's): A Plan to Assist State Agencies with the Dissemination of New Technology for Furbearer Management.	IAFWA—Furbearer Resources Task Force.	200,000	.....
Science and Civics, Sustaining Wildlife, Involving High School Students and Addressing Wildlife Needs.	Project WILD	26,328	26,328
Total	.....	3,071,014	3,000,501

Both total amounts are over the amount allocated by Congress for this program. Funds allocated, but not spent, from FY 2001 will be used to make up the difference for FY 2002.

Dated: October 16, 2001.

Marshall P. Jones, Jr.,

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

[FR Doc. 01–29702 Filed 11–29–01; 8:45 am]

BILLING CODE 4310–55–M

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

Notice of Issuance of Permit for Marine Mammals

On August 21, 2001, a notice was published in the **Federal Register** (66 FR 43885), that an application had been filed with the Fish and Wildlife Service by Steve Tennant for a permit (PRT–046729) to import one polar bear (*Ursus maritimus*) taken from the Southern Beaufort Sea population, Canada, for personal use.

Notice is hereby given that on November 1, 2001, as authorized by the provisions of the Marine Mammal Protection Act of 1972, *as amended* (16 U.S.C. 1361 *et seq.*) the Fish and Wildlife Service authorized the requested permit subject to certain conditions set forth therein.

Documents and other information submitted for these applications are available for review by any party who submits a written request to the U.S. Fish and Wildlife Service, Division of Management Authority, 4401 North Fairfax Drive, Room 700, Arlington, Virginia 22203, telephone (703) 358–2104 or fax (703) 358–2281.

Dated: November 9, 2001.

Michael S. Moore,

Senior Permit Biologist, Branch of Permits, Division of Management Authority.

[FR Doc. 01–29793 Filed 11–29–01; 8:45 am]

BILLING CODE 4310–55–P

DEPARTMENT OF THE INTERIOR

Bureau of Indian Affairs

Notice of Availability of the Supplemental Draft Environmental Impact Statement for the Proposed Moapa Paiute Energy Center and Associated Facilities, Located on the Moapa River Indian Reservation and on Bureau of Land Management Lands in Clark County, NV

AGENCY: Bureau of Indian Affairs, Interior.

ACTION: Notice.

SUMMARY: This notice advises the public that the Bureau of Indian Affairs (BIA) intends to file a Supplemental Draft Environmental Impact Statement (SDEIS) for the proposed Moapa Paiute Energy Center with the Environmental Protection Agency. It was prepared by the Bureau of Indian Affairs (BIA) and the Bureau of Land Management (BLM), with the cooperation of the Moapa Band of Paiute Indians (Tribe) and the Calpine Corporation (Calpine). The Notice of Availability for the Draft Environmental Impact Statement (DEIS) was published on Friday, March 20, 2001, in the **Federal Register** (66 FR 17437). The proposed action is for the Tribe to lease land and water on the Moapa River Indian Reservation (Reservation) to Calpine for the construction, operation and maintenance of a nominal baseload 760-megawatt, natural gas-fired, combined cycle power plant. In addition, proposed elements associated with the power plant would require permits and easements on Reservation lands and rights-of-way actions or temporary use permits on adjacent, BLM lands. The proposed term for the lease and rights-of-way is 25 years, with the possibility of renewal for an additional 20 years. The purpose of the proposed action is to provide viable economic development for the Tribe and to provide an alternative power supply to meet the growing demand for power in southern Nevada and the southwestern United States.

We are issuing this SDEIS to address and invite public comments on minor changes made to the proposed action since the DEIS was issued. These changes involve structural and routing modifications in the power distribution system for the proposed power plant. The SDEIS actually contains all of the information that we anticipate including in the Final Environmental Impact Statement, in order to provide a full context in which to view the changes. However, we are seeking public comments on the new information only. We will not consider further comments on matters already addressed in the DEIS, or on the public comments on the DEIS included in the SDEIS. We will address any comments we receive on the new information in the SDEIS in the Final Environmental Impact Statement. Details on the project location, proposed action, alternatives and areas of environmental concern, and on the new information addressed in the SDEIS, are provided below (see **SUPPLEMENTARY INFORMATION**).

DATES: Written comments on the SDEIS must arrive by January 14, 2002.

ADDRESSES: You may mail or hand carry written comments to Amy L. Heuslein or Ben Burshia. Written comments for Ms. Heuslein may be mailed to Regional Environmental Protection Officer, Western Regional Office, Bureau of Indian Affairs, Environmental Quality Services, PO Box 10, Phoenix, Arizona 85001, or hand delivered to 400 N. 5th St., 14th Floor, Phoenix, Arizona 85004. Written comments for Mr. Burshia may be mailed to Field Representative, Bureau of Indian Affairs, Southern Paiute Field Station, PO Box 720, St. George, Utah 84771, or hand delivered to 180 N. 200 E., Suite 111, St. George, Utah.

To obtain a hard copy or compact disk of the SDEIS, contact any one of the following: (1) Amy L. Heuslein, Regional Environmental Protection Officer, Western Regional Office, Bureau of Indian Affairs, Environmental Quality Services, PO Box 10, Phoenix, Arizona 85001, telephone 602–379–6750, telefax 602–379–3833, or E-mail *AmyHeuslein@bia.gov;* (2) Ben Burshia,

Field Representative, Bureau of Indian Affairs, Southern Paiute Field Station, PO Box 720, St. George, Utah 84771, telephone 435–674–9720, telefax 435–674–9714, or E-mail *BenBurshia@bia.gov;* (3) Jacqueline Gratton, Realty Specialist, Bureau of Land Management, 4765 Vegas Drive, Las Vegas, Nevada 89108, telephone 702–647–5000, telefax 702–647–5023, or E-mail *Jacqueline—Gratton @nv.blm.gov;* or (4) the Moapa Band of Paiutes, Tribal Hall, Number 1 Lincoln Street, Moapa River Indian Reservation, Moapa, Nevada, 89025, telephone 702–865–2787, extension 202, or telefax 702–865–2875.

A hard copy of the SDEIS will be available for review at the Clark County Library—Urban Branch, 1401 East Flamingo Road, Las Vegas, Nevada, telephone 702–733–7810. Electronic copies of the SDEIS will be available on the BIA Internet web site at *http://www.phxao.az.bia.gov/branches/environment/EIS/EIS.htm,* and on the BLM web site at *http://www.nv.blm.gov.*

FOR FURTHER INFORMATION CONTACT: Amy L. Heuslein, 602–379–6750, or Ben Burshia, 435–674–9720.

SUPPLEMENTARY INFORMATION: The SDEIS incorporates revisions to the DEIS made in response to comments submitted during the 60-day public comment period, plus revisions made in response to changing conditions and new information that affected the design of both action alternatives. These revisions address modifications to the proposed project made after the DEIS was issued. Details on these modifications are provided later in this section.

The project proposed in the SDEIS would use up to 222 acres of Reservation and federal lands under the jurisdiction of the BIA, BLM and the Tribe. It would be located in Clark County, Nevada, approximately 45 miles northeast of the City of Las Vegas, 15 miles southwest of the City of Glendale, and approximately 3 miles northwest of the Interstate 15 and State Route 169 interchange (location of Moapa Tribal Enterprises). The proposed power plant would be located on approximately 65 acres of Reservation land within Sections 14 and 15 of Township 16 South, Range 64 East (reference: Arrow Canyon Southeast U.S. Geological Survey Map 7.5-minute series).

The proposed transmission lines would be located on Reservation and federal lands within Sections 14, 15, 22, 27, 28, 32 and 33 of Township 16 South, Range 64 East; and Section 9 of Township 17 South, Range 64 East (reference: Arrow Canyon Southeast and Dry Lake U.S. Geological Survey Maps 7.5-minute series). The access road for the proposed well field and power plant would be located on Reservation and federal lands within Sections 15, 21, 22, 28 and 33 of Township 16 South, Range 64 East; sections 10 and 15 of Township 17 South, Range 64 East (reference: Arrow Canyon Southeast and Dry Lake U.S. Geological Survey Maps 7.5-minute series).

The proposed nominal 760-megawatt, natural gas-fired, combined cycle power plant project would employ three gas turbines, three heat recovery steam generators and one steam turbine. The stacks would be approximately 145 to 199 feet high and approximately 18 feet in diameter. Up to 7000 acre feet per year of Tribal groundwater would be used for operations and for power plant cooling. Both storm water and process wastewater would be confined to the site. The plant would be fueled by natural gas from the existing Kern River (Williams) natural gas pipeline that is located within an existing right-of-way (administered by the BLM) on the Reservation, approximately 4000 feet from the proposed plant location. The project would include construction of a gas supply lateral pipeline on Reservation land and a power grid interconnection at the Nevada Power Company-owned Crystal Substation, located approximately four miles south-southwest of the power plant.

Power would transmit along a single or double-circuit 500-kV transmission line supported by steel lattice towers, traversing both Reservation land and federal land, within an existing utility corridor. Although only one 500-kV circuit is necessary for the proposed energy center, a second circuit is included as a possibility to allow a generator north of the proposed energy center to interconnect at the Crystal Substation without having to cross the proposed 500-kV circuit. If a second circuit is built, Calpine would employ both circuits in order to increase transmission system reliability until a user for the second circuit has been determined. If a user is determined, Calpine would transfer the rights of a circuit to that user, and the user would be responsible for obtaining separate permitting for its project.

The proposed project includes an access road to connect the site to Interstate Highway 15. A portion of this access road would require new construction. The remainder would make use of an existing frontage road and an existing dirt road, which is proposed to be improved.

The modifications made to the proposed action after the DEIS was issued, and which are addressed in this SDEIS, involve the transmission line for the proposed project. In the DEIS, the proposed line consists of a power grid interconnection at the Nevada Power Company-owned Harry Allen Substation, with two single-circuit, 230-kV transmission lines supported on mono-poles. In this SDEIS, the line consists of an interconnection to the Nevada Power Company's Crystal Substation, with a single or double-circuit 500-kV transmission line supported on steel lattice towers. These modifications were made in order to be consistent with the most recent regional transmission plan identified in the Nevada Power 2001 Resource Plan filing, which was published after the release of the DEIS.

To compare: (1) The power grid connection to the Crystal Substation is seven miles shorter than the connection to the Harry Allen Substation; (2) the width of the right-of-way for the single or double-circuit 500-kV transmission line is150 feet, while the width for the two single-circuit 230-kV transmission lines is 260 feet; (3) the height of the steel lattice towers is between 180 to190 feet, while the width for the 230-kV mono-poles is between 80 and 100 feet; (4) the number of steel lattice towers that would be required is approximately 27, while the number of mono-poles would be approximately 120; and (5) the single or double-circuit 500-kV line would disturb about 40 acres of land, which is approximately 83 acres less than what the two single-circuit 230-kV lines would disturb.

The SDEIS discusses potential impacts of proposed power plant development and operation on environmental and cultural resources in the study area. It describes alternatives that were considered but eliminated from further consideration, and analyzes the proposed action, a southern site alternative, and the no action alternative. Issues addressed in the SDEIS include geology and soils, surface and groundwater resources, biological resources, visual resources, air quality, land use, noise, public services/utilities, hazardous materials, paleontological and cultural resources, socio-economic conditions, environmental justice, Indian trust assets, and cumulative impacts. In addition, the SDEIS describes project modifications in comparison to the DEIS, discusses the reasons for these modifications, explores, but eliminates from further consideration, alternatives for the modifications, and analyzes environmental impacts with respect to the modifications.

Public Participation

The SDEIS was prepared subsequent to the issuance of a DEIS. Public scoping meetings for the DEIS were held August 10 and September 19, 2000, at the Reservation, and August 11 and September 20, 2000, at the North Las Vegas Airport in the City of North Las Vegas, Nevada. The DEIS was made available for public review and comment from March 30, 2001, to May 29, 2001. A Notice of Availability of the DEIS was published in the **Federal Register** on March 30, 2001 (66 FR 17437). Public notices were also published in the Las Vegas Review-Journal, the Las Vegas Sun, and the St. George Spectrum on April 6–8, 2001, and April 13–15, 2001. In addition, copies of the DEIS were mailed to a list of interested parties, including all attendees of the public scoping meetings and anyone who requested a copy, and the DEIS was available from the BIA in hard copy, on CD, and on the Internet. Public hearings on the DEIS were held on April 18, 2001, at the Reservation and April 19, 2001, at the Guy Elementary School in the City of North Las Vegas, Nevada.

Public Comment Solicitation

As an alternative to submitting written comments regarding the content of the SDEIS to the locations identified in the **ADDRESSES** section, interested persons may instead comment via the Internet to *AmyHeuslein@bia.gov* or to *BenBurshia@bia.gov.* Please submit Internet comments as an ASCII file, avoiding the use of special characters and any form of encryption. If you do not receive confirmation from the system that your Internet message was received, contact Amy L. Heuslein at (602) 379–6750, or Ben Burshia at (435) 674–9720, respectively.

Comments, including names and home addresses of respondents, will be available for public review at the mailing addresses shown in the **ADDRESSES** section, during regular business hours, 8 a.m. to 4:30 p.m., Monday through Friday, except holidays. Individuals 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: November 19, 2001.

Neal A. McCaleb,

Assistant Secretary—Indian Affairs.

[FR Doc. 01–29707 Filed 11–29–01; 8:45 am]

BILLING CODE 4310–02–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[ES–020–02–1610–DU]

Notice of Availability and Protest Period of the Proposed Planning Analysis for Arkansas and Louisiana

AGENCY: Bureau of Land Management, Department of the Interior.

ACTION: Notice of availability and protest period.

SUMMARY: The Bureau of Land Management (BLM) has prepared a Proposed Planning Analysis and Environmental Assessment (PA/EA) and a Finding of No Significant Impact (FONSI) that address management of public domain lands in Arkansas and Louisiana. The PA/EA describes and analyzes the proposed action for management of approximately 575 acres in Arkansas and 378 acres in Louisiana. These public lands are isolated tracts in seven counties in Arkansas and four parishes in Louisiana. The affected counties in Arkansas are: Baxter, Cleburne, Crawford, Fulton, Pike, Searcy and Van Buren. The affected parishes in Louisiana are Desoto, Natchitoches, Rapides and St. Martin. Split-estate Federal minerals are not included in this PA/EA. These documents were prepared to fulfill the requirements of the Federal Land Policy and Management Act of 1976 (FLPMA) and the National Environmental Policy Act of 1969 (NEPA).

DATES: Protests on the Proposed PA/EA must be postmarked no later than December 31, 2001. The Proposed PA/EA and FONSI can be reviewed Mondays through Fridays, from 8 a.m. to 4 p.m., at the BLM's Jackson Field Office, 411 Briarwood Drive, Suite 404, Jackson, Mississippi 39206, or by visiting the Web site at *www.es.blm.gov/jfo/pages/lupj.html.*

ADDRESSES: All protests must be filed only with the Director of the BLM and submitted by mail or overnight mail as follows: The address for regular mail is: Director, Bureau of Land Management, Att: Ms. Brenda Williams, Protest Coordinator, WO 210/LS–1075, U.S. Department of the Interior, 1849 C Street, NW., Washington, DC 20240; The address for overnight mail is: Director, Bureau of Land Management, Attn: Ms. Brenda Williams, Protest Coordinator (WO 210); 1620 L Street, NW., Room 1075, Washington, DC 20036. Phone: (202) 452–5110.

FOR FURTHER INFORMATION CONTACT: Duane Winters at (601) 977–5400.

SUPPLEMENTARY INFORMATION: The Proposed Action was developed after review of comments on the Draft PA/EA. Public comments on the Draft PA/EA were received by mail, public meeting, e-mail, and phone calls.

The alternatives that were considered can be summarized as: (1) No Action or Custodial Management, (2) Disposal, and (3) Management through Partnerships. Under the Custodial Management alternative, the BLM would retain the tracts, but would not pro-actively manage them. There would be no actions taken to manage habitats or other resources. When presented to BLM, applications for use would be evaluated on a case-by-case basis. Because this alternative would essentially be a continuation of the current management approach, it is also referred to as the No Action alternative. With the Disposal alternative, BLM would pursue transfer of the tracts out of Federal ownership through various means including sale, exchange or conveyance under the Recreation and Public Purposes Act. In a sale or exchange, priority would be given to transferring the tracts to adjacent land owners. In the Partnership alternative, resource management objectives are developed for each tract. These objectives include the desired conditions, such as type of habitat and recreational opportunity. BLM would actively seek partners, and with their cooperation, develop site specific implementation plans to identify needed management actions.

The Proposed PA/EA describes proposed management, including proposed decisions on disposal, for each of the BLM-administered tracts in Arkansas and Louisiana. Three of the tracts in Arkansas are proposed for disposal. Two tracts in Arkansas are

proposed for withdrawal to the U.S. Forest Service. One tract in Arkansas and one tract in Louisiana are proposed for management with partners. The other six tracts in Arkansas and three tracts in Louisiana are proposed for continued management by the BLM under a modification of the custodial alternative.

The BLM planning process offers an opportunity for administrative review (43 CFR 1610.5–2). Any participant in the planning process who has an interest that is or may be adversely affected by the proposed decisions may file a protest in writing with the BLM Director. (See **DATES** and **ADDRESSES** sections above for the nonextendable deadline and specific addresses for filing protests on this Proposed Plan.) Only those persons or organizations that participated in the planning and analysis process may protest the proposed decisions in the Proposed Plan. Protests may raise only the issues that were previously submitted for the record during the planning and environmental analysis process by the protestor or another participant in the process.

To be considered complete, a protest must include, at a minimum, the following information:

1. The name, mailing address, telephone number, and interest of the person filing the protest.

2. A statement of the part or parts of the plan and the issues being protested. To the extent possible, this should be done by reference to specific pages, paragraphs, sections, tables, or maps included within the Proposed Plan and EA.

3. A copy of all documents addressing the issue(s) that the protesting party submitted during the planning process or a statement of the date they were discussed for the record.

4. A concise statement explaining why the protestor believes the proposed decision(s) is wrong. All relevant facts need to be included in the statement of reasons.

At the end of the 30-day protest period, a decision document can be issued and, excluding any portions under protest, the Proposed Plan will become final. Approval will be withheld on any portion of the Proposed Plan under protest until final action has been completed on that protest.

Dated: November 6, 2001.

Sammy St. Clair,

Acting Field Manager.

[FR Doc. 01–29731 Filed 11–29–01; 8:45 am]

BILLING CODE 4310–GJ–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[UT–030–1020–00]

Notice of Intent To Amend Plan for the Grand Staircase-Escalante National Monuments, et al.

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of intent to prepare a plan amendment for the Grand Staircase-Escalante National Monument Management Plan, the Escalante Management Framework Plan, and the Paria Management Framework Plan with associated Environmental Assessments (EA). The planning area is located in southern Utah.

SUMMARY: Pursuant to the Bureau of Land Management (BLM) Planning Regulations (43 CFR 1600) this notice advises the public that the BLM, Grand Staircase-Escalante National Monument (GSENM) is considering amending the GSENM Management Plan, the Paria Management Framework Plan to reallocate a portion of the Willow Gulch allotment, and the Escalante Management Framework Plan to reallocate the Clark Bench grazing allotment. These amendments will be addressed through two separate EAs. This notice initiates a 30-day comment period on the planning criteria and draft amendments/EAs.

ADDRESSES: For further information, to review the planning documents and to submit written comments, contact: Monument Manager, Grand Staircase-Escalante National Monument, 180 West 300 North, Kanab, Utah, 84741, (435–644–4300). Planning documents and letters received, including names and street addresses of respondents, will be available for public review at the GSENM Office in Kanab, Utah during regular business hours (8 a.m. to 5 p.m.) Monday through Friday, except holidays. Individual respondents may request confidentiality. If you wish to withhold your name or street address from public review and 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. 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. If you are not currently on our mailing list and wish to receive a copy of the planning documents, please send your name and address to the address listed above.

SUPPLEMENTARY INFORMATION: The livestock grazing permittee has voluntarily relinquished all of the existing grazing privileges on the Clark Bench allotment. The Paria Management Plan amendment considers a proposal to close the Clark Bench allotment to grazing and to re-allocate the relinquished animal unit months (AUMs) for wildlife, watershed conservation, and riparian values. One livestock grazing permittee has voluntarily relinquished all of his existing grazing privileges on the Willow Gulch allotment. Grazing privileges held by the other livestock grazing permittee on the Willow Gulch allotment will not be affected. A proposal to re-allocate the relinquished AUMs on the Willow Gulch allotment for wildlife, watershed conservation, and riparian values will be considered through the Escalante Management Framework Plan amendment. The EAs will be prepared by an interdisciplinary team to analyze the impacts of these proposals and alternatives.

The BLM has identified the following planning criteria, which will guide development of the amendments:

1. These plan amendments/EAs are initiated in response to the voluntary relinquishment of the sole grazing preference/permit for the West Clark Bench grazing allotment. Analysis and decisions in the plan amendment/EA apply only to that allotment.

2. These plan amendments/EAs will be completed in compliance with the Federal Land Policy and Management Act, the National Environmental Policy Act, and all other applicable laws.

3. These plan amendments/EAs will be developed using an interdisciplinary approach (e.g., a team approach using a variety of skills and perspectives such as rangeland management specialists, riparian specialists, etc.), with input from interested public, the State of Utah, local governments, and other Federal agencies and entities.

4. Decisions in the plan amendments/EAs will provide for the balance of long-term sustainability with short-term uses.

5. These plan amendments/EAs will incorporate and comply with the Fundamentals of Rangeland Health and Standards and Guidelines for Grazing Administration.

Robert A. Bennett,

Assistant Utah State Director.

[FR Doc. 01–29729 Filed 11–29–01; 8:45 am]

BILLING CODE 4310–DQ–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

Legal Description of Barry M. Goldwater Range Withdrawal, AZ

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice.

SUMMARY: This notice provides official publication of the legal description of the Barry M. Goldwater Range withdrawal in Arizona, as required by Section 3033(a)(1) of Public Law 106–65 (October 5, 1999).

EFFECTIVE DATE: October 5, 1999.

FOR FURTHER INFORMATION CONTACT: Eugene A. Dahlem at the Bureau of Land Management, Phoenix Field Office, 21605 North 7th Avenue, Phoenix, Arizona 85027, (623) 580–5525.

SUPPLEMENTARY INFORMATION: The legal description of the withdrawal for Barry M. Goldwater Range effected by Public Law 106–65 is as follows:

Gila and Salt River Meridian, Arizona

T. 8 S., R. 1 W.,
Sec. 30, SW¼;
Sec. 31, inclusive;
Sec. 32, NW¼, S½;
Sec. 33, SW¼.
T. 9 S., R. 1 W.,
Sec. 3, S½;
Secs. 4 to 11, inclusive;
Sec. 12, SW¼;
Secs. 13 to 36, inclusive.
T. 8 S., R. 2 W.,
Sec. 7, NW¼, S½;
Sec. 8, SW¼;
Sec. 16, S½;
Secs. 17 to 22, inclusive;
Sec. 23, S½;
Sec. 25, NW¼, S½;
Secs. 26 to 36, inclusive.
T. 9 S., R. 2 W.
T. 7 S., R. 3 W.,
Sec. 19, SW¼;
Sec. 28, SW¼;
Sec. 29, NW¼, S½;
Secs. 30 to 33, inclusive;
Sec. 34, S½.
T. 8 S., R. 3 W.,
Sec. 1, SW¼;
Secs. 2 to 36, inclusive.
T. 9 S., R. 3 W.
T. 10 S., R. 3 W.,
Secs. 4 to 9, inclusive;
Secs. 16 to 21, inclusive;
Secs. 28 to 33, inclusive.
T. 7 S., R. 4 W.,
Sec. 14, S½;
Secs. 15 to 23, inclusive;
Sec. 24, NW¼, S½;
Secs. 25 to 36, inclusive.
Tps. 8, 9, and 10 S., R. 4 W.
T. 6 S., R. 5. W.,
Sec. 13, inclusive;
Sec. 14, E½, S½NW¼, SW¼;
Secs. 15, 16, and 17, inclusive;
Sec. 18, lots 3, 4, E½NE¼, SW¼NE¼, SE¼NW¼, E½SW¼, SE¼;
Secs. 19 to 36, inclusive.
Tps. 7 to 10 S., R. 5 W.
T. 6 S., R. 6 W.,
Sec. 13, E½SE¼, SW¼SE¼, SE¼SW¼;
Sec. 22, E½SE¼, SW¼SE¼, S½SW¼;
Sec . 23, S½, E½NE¼, SW¼NE¼, SE¼NW¼;
Secs. 24 to 27, inclusive;
Secs. 34 to 36, inclusive.
T. 7 S., R. 6 W.,
Secs. 1 to 3, inclusive;
Secs. 10 to 36, inclusive.
Tps. 8, 9, and 10 S., R. 6 W.
T. 11 S., R. 6 W.,
Secs. 5 to 8, inclusive;
Secs. 4, 9, 10, and 15, all those portions lying west of the westerly boundaries of the State Route 85 (100 feet) and detention basin (700 feet) rights-of-way, as more particularly identified and described on the official BLM plat maps;
Secs. 16 to 21, inclusive;
Secs. 22 and 27, all those portions lying west of the westerly boundary of the State Route 85 (100 feet) right-of-way, as more particularly identified and described on the official BLM plat maps;
Secs. 28 to 30, inclusive.
T. 7 S., R. 7 W.,
Secs. 13 to 36, inclusive.
Tps. 8 to 10 S., R. 7 W.
T. 7 S., R. 8 W.,
Secs. 13 to 15, inclusive;
Sec. 16, S½;
Sec. 17, S½;
Sec. 18, S½;
Secs. 19 to 36, inclusive.
Tps. 8 and 9 S., R. 8 W., unsurveyed.
T. 10 S., R. 8 W.
T. 7 S., R. 9 W.,
Sec. 13, S½;
Sec. 14, S½;
Secs. 19 to 36, inclusive.
Tps. 8 to 11 S., R 9 W., unsurveyed.
Tps. 8 and 9 S., R. 10 W.
Tps. 10 and 11 S., R. 10 W., unsurveyed.
Tps. 8 to 10 S., R. 11 W.
T. 11 S., R. 11 W., unsurveyed.
Tps. 8 and 9 S., Rs. 11½ and 12 W.
T. 10 S., R. 12 W.
T. 11 S., R. 12 W., unsurveyed.
T. 8 S., R. 13 W.,
Secs. 1 to 3, inclusive;
Secs. 4 to 7, all those portions lying south of the southerly boundary of the railroad right-of-way, as more particularly identified and described on the official BLM plat maps.
Secs. 8 to 36, inclusive.
Tps. 9 and 10 S., R. 13 W.
T. 11 S., R. 13 W., unsurveyed.
T. 8 S., R. 14 W.,
Secs. 11, 12, 14, 15, 16, and 21, all those portions lying south of the southerly boundary of the railroad right-of-way, as more particularly identified and described on the official BLM plat maps;
Sec. 20, all those portions lying south of the southerly boundaries of the railroad right-of-way and the Interstate Highway 8 right-of-way, as more particularly identified and described on the official BLM plat maps;
Secs. 13 and 22 to 36, inclusive.
Tps. 9 and 10 S., R. 14 W.
T. 11 S., R. 14 W., unsurveyed.
T. 8 S., R. 15 W.,
Secs. 33 to 36, inclusive.
Tps. 9 and 10 S., R. 15 W.
T. 11 S., R. 15 W., unsurveyed.
T. 9 S., R. 16 W.,
Secs. 1 and 2;
Secs. 7 to 36, inclusive.
T. 10 S., R. 16 W.
T. 11 S., R. 16 W., unsurveyed.
T. 9 S., R. 17 W., partially surveyed,
Secs. 12 to 16, inclusive;
Sec. 17, S½;
Secs. 19 to 36, inclusive.
T. 10 S., R. 17 W.
Tps. 11 to 14 S., R 17., unsurveyed.
T. 9 S., R. 18 W.,
Sec. 21, SE¼;
Sec. 22, S½;
Secs. 23 to 36, inclusive.
T. 10 S., R. 18 W.
Tps. 11 to 13 S., R. 18 W., unsurveyed.
T. 9 S., R. 19 W.,
Secs. 25 to 36, inclusive.
Tps. 10 to 13 S., R. 19 W., unsurveyed.
T. 9 S., R. 20 W.,
Secs. 25 to 36, inclusive.
Tps. 10 to 12 S., R. 20 W., unsurveyed.
T. 9 S., R. 21 W.,
Secs. 25 to 36, inclusive.
Tps. 10 to 12 S., R. 21 W.
T. 9 S., R. 22 W.,
Secs. 25 to 28, inclusive;
Sec. 29, E½, E½NW¼, SW¼;
Secs. 32 to 36, inclusive.
T. 10 S., R. 22 W.,
Secs. 1 to 5, inclusive;
Sec. 6, E½;
Secs. 7 to 36, inclusive.
Tps. 11 and 12 S., R. 22 W.

The area described contains 1,733,921 acres, more or less, of withdrawn land in Maricopa, Pima and Yuma Counties. The withdrawn area consists of approximately 83,675 acres of former State and Private lands, in scattered parcels owned by the military, and approximately 1,650,246 acres of public lands.

A copy of the legal description and map are available for public inspection in the following offices:

Director (350), Bureau of Land Management, 1620 L Street NW, Room 1000, Washington, DC 20036.
Arizona State Office (952 PR), Bureau of Land Management, 222 North Central Avenue, Phoenix, Arizona 85004–2203.
Bureau of Land Management, Phoenix Field Office, 21605 North 7th Avenue, Phoenix, Arizona 85027.
Bureau of Land Management, Yuma Field Office, 2555 East Gila Ridge Road, Yuma, Arizona 85365–2240.
Commander, 56th Fighter Wing, 7224 North 139th Drive, Luke Air Force Base, Arizona 85309–1420.
Commanding Officer, Marine Corps Air Station Yuma, Yuma, Arizona 85369–9100.
Office of the Secretary of Defense, 1000 Defense Pentagon, Washington, DC 20301–1000.

Dated: October 30, 2001.

Michael A. Taylor,

Field Manager, Phoenix Field Office.

[FR Doc. 01–29730 Filed 11–29–01; 8:45 am]

BILLING CODE 5001–08–P

DEPARTMENT OF THE INTERIOR

Minerals Management Service

Agency Information Collection Activities: Submitted for Office of Management and Budget (OMB) Review; Comment Request

AGENCY: Minerals Management Service (MMS), Interior.

ACTION: Notice of extension of a currently approved information collection (OMB Control Number 1010–0112).

SUMMARY: To comply with the Paperwork Reduction Act of 1995 (PRA), we are submitting to OMB for review and approval an information collection request (ICR) for form MMS–131, Performance Measures Data. We are also soliciting comments from the public on this ICR.

DATES: Submit written comments by December 31, 2001.

ADDRESSES: You may submit comments directly to the Office of Information and Regulatory Affairs, OMB, Attention: Desk Officer for the Department of the Interior (1010–0112), 725 17th Street, NW., Washington, DC 20503. Mail or hand-carry a copy of your comments to the Department of the Interior; Minerals Management Service; Attention: Rules Processing Team; Mail Stop 4024; 381 Elden Street; Herndon, Virginia 20170–4817. If you wish to e-mail your comments to MMS, the e-mail address is: *rules.comments@mms.gov.* Reference ''Information Collection 1010–0112'' in your e-mail subject line. Include your name and return address in your e-mail message and mark your message for return receipt.

FOR FURTHER INFORMATION CONTACT: Alexis London, Rules Processing Team, telephone (703) 787–1600.

SUPPLEMENTARY INFORMATION:

Title: Form MMS–131, Performance Measures Data.

OMB Control Number: 1010–0112.

Abstract: The Outer Continental Shelf (OCS) Lands Act (43 U.S.C. 1331 *et seq.*), as amended, requires the Secretary of the Interior to preserve, protect, and develop OCS oil, gas, and sulphur resources; make such resources available to meet the Nation's energy needs as rapidly as possible; balance orderly energy resource development with protection of the human, marine, and coastal environments; ensure the public a fair and equitable return on the resources of the OCS; and preserve and maintain free enterprise competition. These responsibilities are among those delegated to MMS. MMS generally issues regulations to ensure that operations in the OCS will meet statutory requirements; provide for safety and protect the environment; and result in diligent exploration, development, and production of OCS leases.

In 1991 MMS began promoting, on a voluntary basis, the implementation of a comprehensive Safety and Environmental Management Program (SEMP) for the offshore oil and gas industry as a complement to current regulatory efforts to protect people and the environment during OCS oil and gas exploration and production activities. From the beginning, MMS, the industry as a whole, and individual companies realized that at some point they would want to know the effect of SEMP on safety and environmental management of the OCS. The natural consequence of this interest was the establishment of performance measures. We are requesting OMB approval for a routine renewal of the form MMS–131, Performance Measures Data. There are a few editorial changes, but no changes to the data elements.

The responses to this collection of information are voluntary, although we consider the information to be critical for assessing the effects of the OCS Safety and Environmental Management Program. We can better focus our regulatory and research programs on areas where the performance measures indicate that operators are having difficulty meeting MMS expectations. We are more effective in leveraging resources by redirecting research efforts, promoting appropriate regulatory initiatives, and shifting inspection program emphasis. The performance measures give us valuable quantitative information to use in judging the reasonableness of company requests for alternative compliance or departures under 30 CFR 250.141 and 250.142. We also use the information collected to work with industry representatives to identify and request ''pacesetter'' companies make presentations at periodic workshops.

Knowing how the offshore operators as a group are doing and where their own company ranks provides company management with information to focus their continuous improvement efforts. This leads to more cost-effective prevention actions and, therefore, better cost containment. This information also provides offshore operators and organizations with a credible data source to demonstrate to those outside the industry how well the industry and individual companies are doing.

No questions of a ''sensitive'' nature are asked, and the collection of information involves no proprietary information. We intend to release data collected on form MMS–131 only in a summary format that is not company-specific. We will protect the information according to the Freedom of Information Act (5 U.S.C. 552) and its implementing regulations (43 CFR part 2).

Frequency: The frequency is annual, with responses due during the 1st quarter of each calendar year.

Estimated Number and Description of Respondents: Approximately 100 Federal OCS oil and gas or sulphur lessees.

Estimated Annual Reporting and Recordkeeping ''Hour'' Burden: We estimate the public reporting burden averages 12 hours per response. This includes the time for reviewing instructions, gathering and maintaining data, and completing and reviewing the information. The total annual hour burden is estimated to be 760 hours.

Estimated Annual Reporting and Recordkeeping ''Non-Hour Cost'' Burden: We have identified no ''non-hour cost'' burden associated with form MMS–131.

Public Disclosure Statement: The PRA (44 U.S.C. 3501, *et seq.*) provides that an agency may not conduct or sponsor a collection of information unless it displays a currently valid OMB control number. Until OMB approves a collection of information, you are not obligated to respond.

Comments: Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3501, *et seq.*) requires each agency ''* * * to provide notice * * * and otherwise consult with members of the public and affected agencies concerning each proposed collection of information * * *'' Agencies must specifically solicit comments to: (a) Evaluate whether the proposed collection of information is necessary for the agency to perform its duties, including whether the information is useful; (b) evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) enhance the quality, usefulness, and clarity of the information to be collected; and (d) minimize the burden on the respondents, including the use of automated collection techniques or other forms of information technology.

To comply with the public consultation process, on August 16, 2001, we published a **Federal Register** notice (66 FR 43023) announcing that

we would submit this ICR to OMB for approval. The notice provided the required 60-day comment period. In addition, § 250.199 provides the OMB control numbers for the information collection requirements imposed by the 30 CFR part 250 regulations and forms; specifies that the public may comment at any time on these collections of information; and provides the address to which they should send comments. This information is also contained in the PRA statement on form MMS–131. We have received no comments in response to these efforts.

If you wish to comment in response to this notice, send your comments directly to the offices listed under the **ADDRESSES** section of this notice. The OMB has up to 60 days to approve or disapprove the information collection but may respond after 30 days. Therefore, to ensure maximum consideration, OMB should receive public comments by December 31, 2001.

Public Comment Policy: Our practice is to make comments, including names and home addresses of respondents, available for public review during regular business hours. Individual respondents may request that we withhold their home address from the record, which we will honor to the extent allowable by law. There may be circumstances in which we would withhold from the record a respondent's identity, as allowable by the law. If you wish us to withhold your name and/or address, you must state this prominently at the beginning of your comment. However, we will not consider anonymous comments. We will make all submissions from organizations or businesses, and from individuals identifying themselves as representatives or officials of organizations or businesses, available for public inspection in their entirety.

MMS Information Collection Clearance Officer: Jo Ann Lauterbach, (202) 208–7744.

Dated: November 1, 2001.

E.P. Danenberger,

Chief, Engineering and Operations Division.

[FR Doc. 01–29795 Filed 11–29–01; 8:45 am]

BILLING CODE 4310–MR–W

DEPARTMENT OF THE INTERIOR

Minerals Management Service

Preparation of an Environmental Assessment for Proposed Lease Sale 184 in the Western Gulf of Mexico (2002)

AGENCY: Minerals Management Service, Interior.

ACTION: Preparation of an environmental assessment.

SUMMARY: The Minerals Management Service (MMS) is using the final environmental impact statement (EIS) for proposed lease sales in the Western Planning Area (WPA) of the Gulf of Mexico OCS (OCS EIS/EA, MMS 98–0008, May 1998) to support decisions for proposed WPA Lease Sale 184 (scheduled for August 2002). This would be the first lease sale under the draft proposed Outer Continental Shelf Oil and Gas Leasing Program: 2002–2007. The MMS will prepare an environmental assessment (EA) to determine if there could be new significant impacts not fully analyzed in the May 1998 Final EIS. The information on issues and alternatives received in response to the Call for Information and Notice of Intent to Prepare an EIS for the draft proposed Outer Continental Shelf Oil and Gas Leasing Program: 2002–2007 will also be considered in the EA analysis. Preparation of the EA is the first step in the prelease decision process for Sale 184. The analysis in the EA will reexamine the projected activities and potential environmental effects of the proposal and alternatives in consideration of any new information regarding potential impacts and issues that was not available at the time the 1998 Final WPA multisale EIS was prepared.

FOR FURTHER INFORMATION CONTACT: Minerals Management Service, Gulf of Mexico OCS Region, 1201 Elmwood Park Boulevard, New Orleans, Louisiana 70123–2394, Mr. Alvin Jones, telephone (504) 736–1713.

SUPPLEMENTARY INFORMATION: The proposed action analyzed in the multisale EIS was the offering of all available unleased acreage in the Western Gulf of Mexico Planning Area, with the following exceptions: Blocks A–375 (East Flower Garden Bank) and A–398 (West Flower Garden Bank) in the High Island Area, East Addition, South Extension, designated as a national marine sanctuary; and Blocks 793, 799, and 816 in the Mustang Island Area, identified by the Navy as needed for testing equipment and for training mine warfare personnel. The proposal to be addressed in this EA has been revised to the following extent: four additional blocks or portions of these blocks (High Island Area, East Addition, South Extension, Block A–401; High Island, South Addition, Block A–513; and Garden Banks Blocks 134 and 135), which lie partially within the Flower Garden National Marine Sanctuary, are deferred from the proposed action in light of the President's June 1998 withdrawal of all Marine Sanctuaries from oil and gas leasing. The proposed action includes existing regulations and proposed lease stipulations designed to reduce environmental risks. The EA will also analyze alternatives to exclude blocks near biologically sensitive topographic features, as well as the no action alternative.

After completion of the EA, MMS will determine whether to prepare a Finding of No New Significant Impact (FONNSI) or a supplemental EIS. The MMS will then prepare and send consistency determinations to the affected States to determine whether the proposed sale is consistent with Federally-approved State coastal zone management programs, and then will send a proposed Notice of Sale to the governors for their comments on the size, timing, and location of the proposed sale. The tentative schedule for the steps in the prelease decision process for Sale 184 are listed below: Comments due to MMS, January 19, 2002; EA/FONNSI or Supplemental EIS, March 2002; Proposed Notice of Sale sent to Governors, March 2002; Consistency Determinations sent to States, March 2002; Final Notice of Sale in **Federal Register**, July 2002; Sale, August 2002.

Public Comments

The MMS requests interested parties to submit comments regarding any new information or issues that should be addressed in the EA to Minerals Management Service, Gulf of Mexico OCS Region, Office of Leasing and Environment, Attention: Regional Supervisor (MS 5410), 1201 Elmwood Park Boulevard, New Orleans, Louisiana 70123–2394 by January 19, 2002. Comments should be enclosed in an envelope labeled ''Comments on the Lease Sale 184 EA.''

Dated: November 14, 2001.

Chris C. Oynes,

Regional Director, Gulf of Mexico OCS Region.

[FR Doc. 01–29796 Filed 11–29–01; 8:45 am]

BILLING CODE 4310–MR–P

INTERNATIONAL TRADE COMMISSION

[Investigations Nos. 731–TA–986 and 987 (Preliminary)]

Ferrovanadium From China and South Africa

AGENCY: United States International Trade Commission.

ACTION: Institution of antidumping investigations and scheduling of preliminary phase investigations.

SUMMARY: The Commission hereby gives notice of the institution of investigations and commencement of preliminary phase antidumping investigations Nos. 731–TA–986 and 987 (Preliminary) under section 733(a) of the Tariff Act of 1930 (19 U.S.C. 1673b(a)) (the Act) to determine whether there is a reasonable indication that an industry in the United States is materially injured or threatened with material injury, or the establishment of an industry in the United States is materially retarded, by reason of imports from China and South Africa of ferrovanadium, provided for in subheading 7202.92.00 of the Harmonized Tariff Schedule of the United States, that are alleged to be sold in the United States at less than fair value. Unless the Department of Commerce extends the time for initiation pursuant to section 732(c)(1)(B) of the Act (19 U.S.C. 1673a(c)(1)(B)), the Commission must reach a preliminary determination in the antidumping investigations in 45 days, or in these cases by January 10, 2002. The Commission's views are due at Commerce within five business days thereafter, or by January 17, 2002.

For further information concerning the conduct of these investigations and rules of general application, consult the Commission's rules of practice and procedure, part 201, subparts A through E (19 CFR part 201), and part 207, subparts A and B (19 CFR part 207).

EFFECTIVE DATE: November 26, 2001.

FOR FURTHER INFORMATION CONTACT: Fred Ruggles (202–205–3187), Office of Investigations, U.S. International Trade Commission, 500 E Street SW., Washington, DC 20436. Hearing-impaired persons can obtain information on this matter by contacting the Commission's TDD terminal on 202–205–1810. Persons with mobility impairments who will need special assistance in gaining access to the Commission should contact the Office of the Secretary at 202–205–2000. General information concerning the Commission may also be obtained by accessing its internet server (*http://www.usitc.gov*). The public record for these investigations may be viewed on the Commission's electronic docket (EDIS–ON–LINE) at *http://dockets.usitc.gov/eol/public*.

SUPPLEMENTARY INFORMATION:

Background.—These investigations are being instituted in response to a petition filed on November 26, 2001, by the Ferroalloys Association Vanadium Committee and its members Bear Metallurgical Co., Butler, PA, Shieldalloy Metallurgical Corp., Cambridge, OH, Gulf Chemical & Metallurgical Corp., Freeport, TX, U.S. Vanadium Corp., Danbury, CT, and CS Metals of Louisiana LLC, Convent, LA.

Participation in the investigations and public service list.—Persons (other than petitioners) wishing to participate in the investigations as parties must file an entry of appearance with the Secretary to the Commission, as provided in sections 201.11 and 207.10 of the Commission's rules, not later than seven days after publication of this notice in the **Federal Register**. Industrial users and (if the merchandise under investigation is sold at the retail level) representative consumer organizations have the right to appear as parties in Commission antidumping investigations. The Secretary will prepare a public service list containing the names and addresses of all persons, or their representatives, who are parties to these investigations upon the expiration of the period for filing entries of appearance.

Limited disclosure of business proprietary information *(BPI) under an administrative protective order (APO) and BPI service list.*—Pursuant to section 207.7(a) of the Commission's rules, the Secretary will make BPI gathered in these investigations available to authorized applicants representing interested parties (as defined in 19 U.S.C. 1677(9)) who are parties to the investigations under the APO issued in the investigations, provided that the application is made not later than seven days after the publication of this notice in the **Federal Register**. A separate service list will be maintained by the Secretary for those parties authorized to receive BPI under the APO.

Conference.—The Commission's Director of Operations has scheduled a conference in connection with these investigations for 9:30 a.m. on December 17, 2001, at the U.S. International Trade Commission Building, 500 E Street SW., Washington, DC. Parties wishing to participate in the conference should contact Fred Ruggles (202–205–3187) not later than December 13, 2001, to arrange for their appearance. Parties in support of the imposition of antidumping duties in these investigations and parties in opposition to the imposition of such duties will each be collectively allocated one hour within which to make an oral presentation at the conference. A nonparty who has testimony that may aid the Commission's deliberations may request permission to present a short statement at the conference.

Written submissions.—As provided in sections 201.8 and 207.15 of the Commission's rules, any person may submit to the Commission on or before December 20, 2001, a written brief containing information and arguments pertinent to the subject matter of the investigations. Parties may file written testimony in connection with their presentation at the conference no later than three days before the conference. If briefs or written testimony contain BPI, they must conform with the requirements of sections 201.6, 207.3, and 207.7 of the Commission's rules. The Commission's rules do not authorize filing of submissions with the Secretary by facsimile or electronic means.

In accordance with sections 201.16(c) and 207.3 of the rules, each document filed by a party to the investigations must be served on all other parties to the investigations (as identified by either the public or BPI service list), and a certificate of service must be timely filed. The Secretary will not accept a document for filing without a certificate of service.

Authority: These investigations are being conducted under authority of title VII of the Tariff Act of 1930; this notice is published pursuant to section 207.12 of the Commission's rules.

Issued: November 27, 2001.

By order of the Commission.

Donna R. Koehnke,

Secretary.

[FR Doc. 01–29799 Filed 11–29–01; 8:45 am]

BILLING CODE 7020–02–P

DEPARTMENT OF LABOR

Employment and Training Administration

Notice of Determinations Regarding Eligibility To Apply for Worker Adjustment Assistance and NAFTA Transitional Adjustment Assistance

In accordance with section 223 of the Trade Act of 1974, as amended, the Department of Labor herein presents summaries of determinations regarding eligibility to apply for trade adjustment assistance for workers (TA–W) issued during the period of November, 2001.

In order for an affirmative determination to be made and a certification of eligibility to apply for worker adjustment assistance to be issued, each of the group eligibility requirements of section 222 of the Act must be met.

(1) That a significant number or proportion of the workers in the workers' firm, or an appropriate subdivision thereof, have become totally or partially separated,

(2) That sales or production, or both, of the firm or sub-division have decreased absolutely, and

(3) That increases of imports of articles like or directly competitive with articles produced by the firm or appropriate, subdivision have contributed importantly to the separations, or threat thereof, and to the absolute decline in sales or production.

Negative Determinations for Worker Adjustment Assistance

In each of the following cases the investigation revealed that criterion (3) has not been met. A survey of customers indicated that increased imports did not contribute importantly to worker separations at the firm.

TA–W–39,205; Glass Works WV, LLC, Weston, WV
TA–W–40,304; Quality Mold, Inc., Tool and Die, Erie, PA
TA–W–39,738; Progressive Tool and Die, Inc., Meadville, PA

In the following cases, the investigation revealed that the criteria for eligibility have not been met for the reasons specified.

Increased imports did not contribute importantly to worker separations at the firm.

TA–W–39,791; Tri-Cities Manufacturing, Inc., Tuscumbia, AL
TA–W–39,144; JBF Industries, Inc., Gloversville, NY
TA–W–39,431; Reichard Industries, Inc., Columbia, OH
TA–W–39,565A; Thomaston Mills, Inc., Finishing Div., Finishing Apparel, Thomaston, GA

Affirmative Determinations for Worker Adjustment Assistance

The following certifications have been issued; the date following the company name and location of each determination references the impact date for all workers of such determination.

TA–W–39,565; Thomaston Mills, Inc., Peerless Div., Thomaston, GA A; Finishing Div., Finishing Consumer, Thomaston, GA, B; Lakeside Div., Thomaston, GA, C; Corporation Office, Thomaston, GA, D; New York Office, New York, NY: June 20, 2000.
TA–W–39,528; Fessler Machine Co., Sharon, PA: June 14, 2000.
TA–W–39,251; R and N China Co., Inc., Carrollton, OH: May 2, 2000.
TA–W–39,915; General Cable, Montoursville, PA: August 9, 2000.
TA–W–40,013; Crompton Colors, Inc., Formerly Crompton and Knowles Colors, Inc., Newark, NJ: August 27, 2000.
TA–W–39,435 & A; Mandell Industries, Inc., Oceanside, NY and East Coast Molders, Inc., Oceanside, NY: May 23, 2000.
TA–W–39,800; Van Mar, Inc., Cutting Room, East Brunswick, NJ: July 26, 2000.
TA–W–39,968; Sandvik Special Metals, Kennewick, WA: August 28, 2000.
TA–W–39,472; Garan Manufacturing Corp., Clinton, KY: June 4, 2000.
TA–W–40,305; Abbott Ambulatory Infusion Systems, San Diego, CA: October 9, 2000.
TA–W–39,676; Del Laboratories, Inc., Newark, NJ: July 3, 2000.
TA–W–40,053; Hagale Apparel, Inc., Kinston, NC: April 11, 2001.
TA–W–40,211; DM II, Inc. a/k/a Dani Michaels, New York, NY: September 24, 2000.
TA–W–39,810; Carpenter Technology Corp., Specialty Alloys Operations, Reading, PA and A; Costa Mesa, CA, B; East Hartford, CT, C; Duluth, GA, D; Downers Grove, IL, E; Auburn Hills, MI, F; North Olmsted, OH, G, Ft. Washington, PA, H: Houston, TX: July 30, 2000.

Also, pursuant to title V of the North American Free Trade Agreement Implementation Act (Pub. L. 103–182) concerning transitional adjustment assistance hereinafter called (NAFTA–TAA) and in accordance with section 250 (a), subchapter D, chapter 2, title II, of the Trade Act as amended, the Department of Labor presents summaries of determinations regarding eligibility to apply for NAFTA–TAA issued during the month of November 2001.

In order for an affirmative determination to be made and a certification of eligibility to apply for NAFTA–TAA the following group eligibility requirements of section 250 of the Trade Act must be met:

(1) That a significant number or proportion of the workers in the workers' firm, or an appropriate subdivision thereof, (including workers in any agricultural firm or appropriate subdivision thereof) have become totally or partially separated from employment and either—

(2) That sales or production, or both, of such firm or subdivision have decreased absolutely;

(3) That imports from Mexico or Canada of articles like or directly competitive with articles produced by such firm or subdivision have increased, and that the increases imports contributed importantly to such workers' separations or threat of separation and to the decline in sales or production of such firm or subdivision; or

(4) That there has been a shift in production by such workers' firm or subdivision to Mexico or Canada of which are produced by the firm or subdivision.

Negative Determinations NAFTA–TAA

In each of the following cases the investigation revealed that criteria (3) and (4) were not met. Imports from Canada or Mexico did not contribute importantly to workers' separations. There was no shift in production from the subject firm to Canada or Mexico during the relevant period.

NAFTA–TAA–05516; Tri-Cities Manufacturing, Inc., Tuscumbia, AL
NAFTA–TAA–04978; Industrial Seaming Co., Inc., Granite Falls, NC
NAFTA–TAA–05114; Morgan Machine, Fulton, MO
NAFTA–TAA–05315; Mail Well Envelope Co., Portland, OR
NAFTA–TAA–04777; Monona Wire Corp., Edgewood, IA
NAFTA–TAA–05397; Connely North America, El Paso, TX
NAFTA–TAA–05452; Quality Mold, Inc., Tool and Die, Erie, PA
NAFTA–TAA–04977; Perlos, Inc., Fort Worth, TX
NAFTA–TAA–04930; Jarrett Lumber and Logging, Inc., Bristol, TN

Affirmative Determinations NAFTA–TAA

NAFTA–TAA–04933; Newbold Corp., Rocky Mount, VA: May 15, 2000.
NAFTA–TAA–05396; Intermetro Industries, Wilkes Barre, PA: September 30, 2000.
NAFTA–TAA–05276; Damy Industries, Athens, TN: July 19, 2000.
NAFTA–TAA–05213; Evergreen Sewing, Inc., Seattle, WA: August 8, 2000.
NAFTA–TAA–05264; Pliant Corp., a/k/a Uniplast Films, Inc., Palmer, MA: August 21, 2000.
NAFTA–TAA–05385; Lexington Fabrics, Inc., Geraldine, AL: August 22, 2000.
NAFTA–TAA–05391; J and L Structural, Inc., Ambridge Div., Ambridge, PA: September 29, 2000.

I hereby certify that the aforementioned determinations were issued during the month of November 2001. Copies of these determinations are available for inspection in Room C–5311, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210 during normal business hours or will be mailed to persons who write to the above address.

Dated: November 16, 2001.

Edward A. Tomchick,

Director, Division of Trade Adjustment Assistance.

[FR Doc. 01–29753 Filed 11–29–01; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–40,182]

Aquatech, Inc., Cookeville, TN; Notice of Termination of Investigation

Pursuant to section 221 of the Trade Act of 1974, an investigation was initiated on October 9, 2001 in response to a worker petition, which was filed on behalf of workers at Aquatech, Inc., Cookeville, Tennessee.

The group of workers at Aquatech, Inc., Cookeville, Tennessee was certified on October 2, 2001 (TA–W–39,813C). Consequently, further investigation in this case would serve no purpose, and the investigation has been terminated.

Signed in Washington, DC this 15th day of November, 2001.

Linda G. Poole,

Certifying Officer, Division of Trade Adjustment Assistance.

[FR Doc. 01–29751 Filed 11–29–01; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–38,821]

Donohue Industries, Inc., a Subsidiary of Abitibi Consolidated, Sheldon Mill, Sheldon, TX; Dismissal of Application for Reconsideration

Pursuant to 29 CFR 90.18(C) an application for administrative reconsideration was filed with the Director of the Division of Trade Adjustment Assistance for workers at Donohue Industries, Inc., a Subsidiary of Abitibi Consolidated, Sheldon Mill, Sheldon, Texas. The application contained no new substantial information which would bear importantly on the Department's determination. Therefore, dismissal of the application was issued.

TA–W–38,821; Donohue Industries, Inc., a Subsidiary of Abitibi Consolidated, Sheldon Mill, Sheldon, Texas (November 13, 2001).

Signed at Washington, DC this 19th day of November, 2001.

Edward A. Tomchick,

Director, Division of Trade Adjustment Assistance.

[FR Doc. 01–29748 Filed 11–29–01; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

Investigations Regarding Certifications of Eligibility To Apply for Worker Adjustment Assistance

Petitions have been filed with the Secretary of Labor under section 221(a) of the trade Act of 1974 (''the Act'') and are identified in the Appendix to this notice. Upon receipt of these petitions, the Director of the Division of Trade Adjustment Assistance, Employment and Training Administration, has instituted investigations pursuant to section 221(a) of the Act.

The purpose of each of the investigations is to determine whether the workers are eligible to apply for adjustment assistance under Title II, chapter 2, of the Act. The investigations will further relate, as appropriate, to the determination of the date on which total or partial separations began or threatened to begin and the subdivision of the firm involved.

The petitioners or any other persons showing a substantial interest in the subject matter of the investigations may request a public hearing, provided such request is filed in writing with the Director, Division of Trade Adjustment Assistance, at the address shown below, not later than December 10, 2001.

Interested persons are invited to submit written comments regarding the subject matter of the investigations to the Director, Division of Trade Adjustment Assistance, at the address shown below, not later than December 10, 2001.

The petitions filed in this case are available for inspection at the Office of the Director, Division of Trade Adjustment Assistance, Employment and Training Administration, U.S. Department of Labor, Room C–5311, 200 Constitution Avenue, NW., Washington, DC 20210.

Signed at Washington, DC, this 13th day of November, 2001.

Edward A. Tomchick,

Director, Division of Trade Adjustment Assistance.

APPENDIX

[Petitions institued on 11/13/2001]

TA–W	Subject firm (petitioners)	Location	Date of petition	Product(s)
40,337	General Electric Quartz (Wrks)	Newark, OH	11/02/2001	Quartz Tubing.
40,338	K2 Corp. (Co.)	Vashon, WA	11/02/2001	Down Hill Snow Skis.
40,339	Corwall Wood Products (Co.)	South Paris, ME	10/31/2001	Wooden Housewares.
40,340	Linnton Plywood Assoc. (Co.)	Portland, OR	10/29/2001	Plywood.
40,341	Meadowcraft, Inc. (Co.)	Somerton, AZ	11/01/2001	Wrought Iron Patio Furniture.
40,342	Stinson Seafood (Wrks)	Belfast, ME	10/23/2001	Sardines Processed.
40,343	Specialty Minerals, Inc. (Co.)	Plainwell, MI	11/01/2001	Minerals.
40,344	Bradford Electronics (Co.)	Bradford, PA	11/02/2001	Glass Film Resistors.
40,345	Bombardier Transportation (Co.)	Pittsburgh, PA	10/29/2001	Propulsion Equipment.
40,346	Trophy Holdings, Inc. (Co.)	Knox, IN	11/01/2001	Award and Recognition Components.
40,347	Phelphs Dodge, Miami, Inc. (Co.)	Claypool, AZ	11/02/2001	Copper Cathode.
40,348	Willamette Industries (Co.)	Winston, OR	11/02/2001	Laminated Veneer Lumber.
40,349	Willamette Industries (Co.)	Saginaw, OR	11/02/2001	Small Logs.
40,350	SIG Combibloc, Inc (Wrks)	Columbus, OH	11/06/2001	Aseptic Food Packages, Drink Boxes.
40,351	Libro Shirt Corp. (Co.)	Lykens, PA	11/01/2001	Uniform Shirts.
40,352	Barker Microfarads, Inc (Wrks)	Hillsville, VA	10/26/2001	Capacitors.

APPENDIX—Continued

[Petitions institued on 11/13/2001]

TA–W	Subject firm (petitioners)	Location	Date of petition	Product(s)
40,353	Dynamic Details (Co.)	Garland, TX	10/25/2001	Printed Wiring Boards.
40,354	International Paper (Co.)	Erie, PA	11/02/2001	Hardwood Pulp.
40,355	R.L. Stowe Mills, Inc. (Co.)	Belmont, NC	10/29/2001	Textile Yarn.

[FR Doc. 01–29754 Filed 11–29–01; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–39,241]

Johnson Controls, Inc., Sycamore, IL; Dismissal of Application for Reconsideration

Pursuant to 29 CFR 90.18(C) an application for administrative reconsideration was filed with the Director of the Division of Trade Adjustment Assistance for workers at Johnson Controls, Inc., Sycamore, Illinois. The application contained no new substantial information which would bear importantly on the Department's determination. Therefore, dismissal of the application was issued.

TA–W–39,241; Johnson Controls, Inc., Sycamore, Illinois (November 13, 2001)

Signed at Washington, DC, this 19th day of November, 2001.

Edward A. Tomchick,

Director, Division of Trade Adjustment Assistance.

[FR Doc. 01–29749 Filed 11–29–01; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

Investigations Regarding Certifications of Eligibility To Apply for Worker Adjustment Assistance

Petitioners have been filed with the Secretary of Labor under section 221(a) of the Trade Act of 1974 (''the Act'') and are identified in the Appendix to this notice. Upon receipt of these petitions, the Director of the Division of Trade Adjustment Assistance, Employment and Training Administration, has instituted investigations pursuant to section 221(a) of the Act.

The purpose of each of the investigations is to determine whether the workers are eligible to apply for adjustment assistance under Title II, Chapter 2, of the Act. The investigations will further relate, as appropriate, to the determination of the date on which total or partial separations began or threatened to begin and the subdivision of the firm involved.

The petitioners or any other persons showing a substantial interest in the subject matter of the investigations may request a public hearing, provided, provided such request is filed in writing with the Director, Division of Trade Adjustment Assistance, at the address shown below, not later than December 10, 2001.

Interested persons are invited to submit written comments regarding the subject matter of the investigations to the Director, Division of Trade Adjustment Assistance, at the address shown below, not later than December 10, 2001

The petitions filed in this case are available for inspection at the Office of the Director, Division of Trade Adjustment Assistance, Employment and Training Administration, U.S. Department of Labor, Room C–5311, 200 Constitution Avenue, NW., Washington, DC 20210.

Signed at Washington, DC this 5th day of November, 2001.

Edward A. Tomchick,

Director, Division of Trade Adjustment Assistance.

APPENDIX

[Petitions instituted on 11/05/2001]

TA–W	Subject firm (petitioners)	Location	Date of petition	Product(s)
40,308	Nachi Machining Tech. (USWA)	Macomb, MI	10/15/2001	Machine Tooling.
40,309	Firestone Bridgestone Tube (Wkrs)	Russellville, AR	10/17/2001	Inner Tubes.
40,310	Mulox, Inc. (Wkrs)	Baxley, GA	10/19/2001	Flexable Bulk Containers.
40,311	Buckeye Steel Castings (USWA)	Columbus, OH	10/17/2001	Castings—Railroad Cars.
40,312	Timex Corp. (IAM)	Little Rock, AR	09/10/2001	Plastic Watch Bezels.
40,313	Montgomery Wards (Wkrs)	El Paso, TX	10/15/2001	General Retail.
40,314	Trout Lake Farm (Co.)	Trout Lake, WA	08/03/2001	Echinacea Purpurea.
40,315	BPB America (Wkrs)	Meridian, MS	10/16/2001	Ceiling Tile.
40,316	American Furniture (Wkrs)	Martinsville, VA	10/04/2001	Upholstered Chairs, Couches.
40,317	Texfi Industries (Co.)	Rocky Mountain, NC	10/15/2001	Apparel Fabric.
40,318	Private manufacturing (Wkrs)	El Paso, TX	10/15/2001	Warehousing and Distribution of Garments.
40,319	General Elector (Gemcor) (IAMAW)	West Seneca, NY	10/16/2001	Drivematic Fastening Systems.
40,320	Elk Rapids Engineering (Wkrs)	Elk Rapids, MI	10/17/2001	Controlled Machine Tools.
40,321	Fibermark (PACE)	Rochester, MI	10/17/2001	Industrial Grade Filter Papers.
40,322	Santee Company (The) (Wkrs)	Eden, NC	10/09/2001	Knit Apparel.
40,323	Summitville Carolina (Wkrs)	Morganton, NC	10/16/2001	Glased Paver Tiles.
40,324	Birmingham Steel (USWA)	Joliet, IL	10/10/2001	Steel Rebar.
40,325	Covington Industries (Co.)	Calhoun Falls, SC	11/09/2001	Furniture Fabrics.
40,326	Jones and Vining of ME (Co.)	Lewiston, ME	10/24/2001	Polyurethane Shoe Bottoms.

APPENDIX—Continued

[Petitions instituted on 11/05/2001]

TA–W	Subject firm (petitioners)	Location	Date of petition	Product(s)
40,327	Stora Enso/Niagara Mill (Co.)	Niagara, WI	10/08/2001	Coated Groundwood Printing Papers.
40,328	Drexel Heritage (Wkrs)	Morganton, NC	10/09/2001	Sawblades, Shaper Knives.
40,329	D.K. Mold and Engineering (Co.)	Wyoming, MI	10/23/2001	Dies for Plastic Molder.
40,330	Teasdale Tool Corp. (Co.)	Meadville, PA	10/16/2001	Mold Inserts and Products.
40,331	Georgia Pacific West (AWPPW)	Camas, WA	10/16/2001	Free Sheet, Magnified Pulp.
40,332	Creative Leather & Vinyl (Co.)	Milwaukee, WI	10/18/2001	Cut and Sew Leather—Shoes.
40,333	Lynchburg Foundry Co. (Wkrs)	Radford, VA	09/06/2001	Metal Castings.
40,334	Mattel-Murray (Co.)	Murray, KY	10/26/2001	Children's Toys.
40,335	Phelps Dodge Sierrita (Co.)	Green Valley, AZ	10/26/2001	Copper Cathodes and Concentrates.
40,336	Plaid Clothing Co., Inc. (Co.)	Erlanger, KY	10/29/2001	Men's Suits, Sport Coats.

[FR Doc. 01–29755 Filed 11–29–01; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

Investigations Regarding Certifications of Eligibility To Apply for Worker Adjustment Assistance

Petitions have been filed with the Secretary of Labor under Section 221(a) of the Trade Act of 1974 (''the Act'') and are identified in the Appendix to this notice. Upon receipt of these petitions, the Director of the Division of Trade Adjustment Assistance, Employment and Training Administration, has instituted investigations pursuant to Section 221(a) of the Act.

The purpose of each of the investigations is to determined whether the workers are eligible to apply for adjustment assistance under Title II, Chapter 2, of the Act. The investigations will further relate, as appropriate, to the determination of the date on which total or partial separations began or threatened to begin and the subdivision of the firm involved.

The petitioners or any other persons showing a substantial interest in the subject matter of the investigations may request a public hearing, provided such request is filed in writing with the Director, Division of Trade Adjustment Assistance, at the address shown below, not later than December 10, 2001.

Interested persons are invited to submit written comments regarding the subject matter of the investigations to the Director, Division of Trade Adjustment Assistance, at the address shown below, not later than December 10, 2001.

The petitions filed in this case are available for inspection at the Office of the Director, Division of Trade Adjustment Assistance, Employment and Training Administration, U.S. Department of Labor, Room C–5311, 200 Constitution Avenue, NW., Washington, DC 20210.

Signed at Washington, DC this 29th day of October, 2001.

Edward A. Tomchick,

Director, Division of Trade Adjustment Assistance.

APPENDIX

[Petitions instituted on 10/29/2001]

TA–W	Subject firm (petitioners)	Location	Date of petition	Product(s)
40,259	National Refractories (Co.)	Columbiana, OH	10/15/2001	Refractory Products.
40,260	World Kitchen, Inc. (Co.)	Wauconda, IL	10/05/2001	Knives.
40,261	Capitol Manufacturing Co (Wrks)	Lansing, OH	10/04/2001	Steel Pipe Couplings.
40,262	Parago, Inc. (Co.)	Coppell, TX	10/15/2001	Develop Software.
40,263	Schott Scientific Glass (AFGWU)	Parkersburg, WV	10/12/2001	Beakers, Coffee Pots, Giftware.
40,264	Winona Knitting Mills (Co.)	Winona, MN	10/12/2001	Fabric.
40,265	McGhan Medical (Wrks)	Santa Barbara, CA	09/25/2001	Saline Implant.
40,266	Modern Engineering (Wrks)	Troy, MI	10/08/2001	Engineering.
40,267	Lamb Technicon (Co.)	Warren, MI	10/12/2001	Automated Metal Removal equipment.
40,268	Great Lakes Chemical Corp (Co.)	Nitro, WV	10/15/2001	Chemical Products.
40,269	Wheeling Corrugating (Wrks)	Klamath Falls, OR	10/09/2001	Metal Siding and Roofing.
40,270	Solectron Corp (Wrks)	Research T. Park, NC	10/09/2001	Electronic Boards.
40,271	Symbol Technologies (Wrks)	Bohemia, NY	10/10/2001	Scanner Devices.
40,272	National Metal Industries (Co.)	W. Springfield, MA	10/09/2001	Stainless Steel Legs, Sockets.
40,273	Tect, Inc (Wrks)	Allentown, PA	10/05/2001	T-Shirts.
40,274	A.O. Smith Co. (Wrks)	Owosso, MI	10/05/2001	Component Parts for Electric Motors.
40,275	Tyco Electronics (Wrks)	Glen Rock, PA	10/09/2001	Cable Assembly.
40,276	Cosco, Inc. (Wrks)	Fort Smith, AR	10/08/2001	Mattresses, Mattress Covers.
40,277	Modern Plastic Technics (Wrks)	West Berlin, NJ	10/02/2001	Bar Code Scanning Equipment.
40,278	Beverly Coats, Inc. (UNITE)	Brooklyn, NY	10/02/2001	Ladies' Coats.
40,279	C and C Fashions, Inc (UNITE)	Bronx, NY	10/02/2001	Bridemaid's Dresses.
40,280	Munro and Co, Clarendon (Co.)	Clarendon, AR	10/09/2001	Cut and Stitch Footwear.
40,281	Rezyal Ltd (Co.)	New York, NY	09/15/2001	Pants and Shirts.
40,282	Key Plastics, LLC (Wrks)	Felton, PA	09/10/2001	Plastic Parts, Tools for Molding.
40,283	Picsweet Mushroom Farm (Wrks)	Salem, OR	09/20/2001	Fresh and Processed Mushrooms.
40,284	Carbide/Graphite Group (Co.)	Niagara Falls, NY	09/24/2001	Graphite Electrodes.
40,285	Converter Concepts, Inc (Co.)	Quincy, IL	10/11/2001	Electronic Switches.

APPENDIX—Continued

[Petitions instituted on 10/29/2001]

TA–W	Subject firm (petitioners)	Location	Date of petition	Product(s)
40,286	Tyco Electronics Corp (Wrks)	Rock Hill, SC	10/03/2001	Electrical Connectors.
40,287	Barranco/Ruth of Carolina (Wrks)	Hendersonville, NC	10/10/2001	Children's Dresses.
40,288	Compaq Computer Corp (Wrks)	Houston, TX	09/15/2001	Computers.
40,289	Motorola, Inc (Wrks)	Rolling Meadows, IL	10/09/2001	Telecommunication Systems and Equip.
40,290	Cascade Tissue Group (Co.)	Ransom, PA	10/08/2001	Paper Towels, Facial Tissue.
40,291	U.S. Bronze Foundry (Co.)	Meadville, PA	10/09/2001	Solid Brass Bearings.
40,292	Exolon-Esk Co. (Co.)	Tonawanda, NY	10/01/2001	Abrasives.
40,293	Pittsburgh Tool Steel (USWA)	Monaca, PA	10/08/2001	Cold Drawn Steel.
40,294	Fairfield Glove (Co.)	Cherryville, NC	10/10/2001	Knit Gloves.
40,295	TNS Mills, Inc. (Co.)	Spartanburg, SC	10/11/2001	Woven Fabrics.
40,296	Rubatex Corp. (Wrks)	Bedford, VA	10/09/2001	Rubber Sheet Goods.
40,297	Controls, Inc. (Co.)	Logansport, IN	10/11/2001	Printed Circuit Boards.
40,298	Aventis (Co.)	Mt Pleasant, TN	10/22/2001	Chemical Products—Herbicides.
40,299	Gilbert Paper Co (Co.)	Menasha, WI	10/11/2001	Premium Writing Paper.
40,300	ADC Telecommunications (Wrks)	Minnetonka, MN	10/09/2001	Telecommunications Equipment.
40,301	Faraday LLC (IBEW)	Tecumseh, MI	10/15/2001	Life Safety Items—Fire Alarm Systems.
40,302	Eurotherm Action, Inc (Wrks)	San Diego, CA	10/09/2001	Temperature Transmitters.
40,303	Precision Tool and Design (Wrks)	Erie, PA	10/16/2001	Plastic Injection Molds.
40,304	Quality Mold, Inc. (Wrks)	Erie, PA	10/15/2001	Plastic Injection Molds.
40,305	Abbott Ambulatory (Co.)	San Diego, CA	10/09/2001	Portable Infusion Pumps.
40,306	Allgon Telecom Ltd (Wrks)	Fort Worth, TX	10/12/2001	Terminal Antennas, Cell Phone Antennas.
40,307	Universal Furniture (Wrks)	Goldsboro, NC	10/19/2001	Dining Room Furniture.

[FR Doc. 01–29756 Filed 11–29–01; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[NAFTA–04723]

Taylor Lumber and Treating, Sheridan, OR; Dismissal of Application for Reconsideration

Pursuant to 29 CFR 90.18(C) an application for administrative reconsideration was filed with the Director of the Division of Trade Adjustment Assistance for workers at Taylor Lumber and Treating, Sheridan, Oregon. The application contained no new substantial information which would bear importantly on the Department's determination. Therefore, dismissal of the application was issued.

NAFTA–04723; Taylor Lumber and Treating Sheridan, Oregon (November 13, 2001)

Signed at Washington, DC this 19th day of November, 2001.

Edward A. Tomchick,

Director, Division of Trade Adjustment Assistance.

[FR Doc. 01–29750 Filed 11–29–01; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[NAFTA–5422]

TNS Mills, Inc., Spartansburg, SC; Notice of Termination of Investigation

Pursuant to Title V of the North American Free Trade Agreement Implementation Act (Pub. L. 103–182) concerning transitional adjustment assistance, hereinafter called NAFTA–TAA and in accordance with Section 250(a), Subchapter D, Chapter 2, title II, of the Trade Act of 1974, as amended (19 U.S.C. 2273), an investigation was initiated on October 11, 2001, in response to a petition filed by the company on behalf of workers at TNS Mills, Inc., Spartansburg, South Carolina.

The petitioner has requested that the petition be withdrawn. Consequently, further investigation in this case would serve no purpose, and the investigation has been terminated.

Signed at Washington, DC, this 16th day of November, 2001.

Linda G. Poole,

Acting Director, Office of Trade Adjustment Assistance.

[FR Doc. 01–29757 Filed 11–29–01; 8:45 am]

BILLING CODE 4510–30–P

DEPARTMENT OF LABOR

Employment and Training Administration

[NAFTA–5485]

Welcast Plastics, Harris Welco, J.W. Harris Co., Inc., Barberton, OH; Notice of Termination of Investigation

Pursuant to Title V of the North American Free Trade Agreement Implementation Act (Pub. L. 103–182) concerning transitional adjustment assistance, hereinafter called (NAFTA–TAA), and in accordance with section 250(a), subchapter D, chapter 2, title II, of the Trade Act of 1974, as amended (19 U.S.C. 2273), an investigation was initiated on October 29, 2001 in response to a petition filed by a company official on behalf of workers at Welcast Plastics, Harris Welco Division, J.W. Harris Company, Inc., Barberton, Ohio.

This case is being terminated upon the petitioner's request. Consequently, further investigation in this case would serve no purpose, and the investigation has been terminated.

Signed at Washington, DC, this 9th day of November, 2001.

Linda G. Poole,

Certifying Officer, Division of Trade Adjustment Assistance.

[FR Doc. 01–29752 Filed 11–29–01; 8:45 am]

BILLING CODE 4510–30–M

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 wages 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.

New General Wage Determination Decision

The number of the decisions added to the Government Printing Office document entitled ''General Wage Determinations Issued Under the Davis-Bacon and related Acts'' are listed by Volume and States:

Volume IV

Minnesota
MN010013 (Nov. 30, 2001)

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

Massachusetts
MA010002 (Mar. 2, 2001)
Rhode Island
RI010001 (Mar. 2, 2001)

Volume II

Pennsylvania
PA010009 (Mar. 2, 2001)

Volume III

Georgia
GA010041 (Mar. 2, 2001)
GA010050 (Mar. 2, 2001)
GA010078 (Mar. 2, 2001)
Kentucky
KY010027 (Mar. 2, 2001)

Volume IV

Minnesota
MN010007 (Mar. 2, 2001)

Volume V

Missouri
MO010003 (Mar. 2, 2001)

Volume VI

None

Volume VII

California
CA01002 (Mar. 2, 2001)
CA010004 (Mar. 2, 2001)
CA010005 (Mar. 2, 2001)
CA010009 (Mar. 2, 2001)
CA010013 (Mar. 2, 2001)
CA01028 (Mar. 2, 2001)
CA01029 (Mar. 2, 2001)
CA010030 (Mar. 2, 2001)
CA010033 (Mar. 2, 2001)
Nevada
NV010001 (Mar. 2, 2001)
NV01002 (Mar. 2, 2001)
NV010003 (Mar. 2, 2001)
NV010004 (Mar. 2, 2001)
NV010005 (Mar. 2, 2001)
NV010007 (Mar. 2, 2001)
NV010009 (Mar. 2, 2001)

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 *www.access.gpo.gov/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 2042, (22) 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 21st day of November, 2001.

Terry Sullivan,

Acting Chief, Branch of Construction Wage Determinations.

[FR Doc. 01–29547 Filed 11–29–01; 8:45 am]

BILLING CODE 4510–27–M

NUCLEAR REGULATORY COMMISSION

[Docket No. 50–247, License No. DPR–26]

Entergy Nuclear IP2, Entergy Nuclear Operations, Inc.; Notice of Issuance of Director's Decision

Notice is hereby given that the Director, Office of Nuclear Reactor Regulation, has taken action on the April 24, 2001, petition under section 2.206 Title 10 of the Code of Federal Regulations (10 CFR 2.206) submitted by Mr. David A. Lochbaum (petitioner) on behalf of the Union of Concerned Scientists. The petition was supplemented by letter dated May 3, 2001. The petitioner requested that the Nuclear Regulatory Commission (NRC) issue a Demand for Information (DFI) to licensees that use security personnel supplied by Wackenhut Corporation (Wackenhut), requiring them to provide a docketed response explaining how they comply with the requirement of 10 CFR 26.10 that licensees ''provide reasonable measures for the early detection of persons who are not fit to perform activities within the scope of this part'' and the requirement of 10 CFR 26.20 that ''licensee policy should also address other factors that could affect fitness for duty [FFD] such as mental stress, fatigue and illness.''

The petitioner also requested that the DFI require each licensee to generally describe its policy for the aforementioned factors and to explicitly describe its policy for these factors as applied to the security personnel supplied by Wackenhut.

As a basis for this request, the petitioner stated that:

An individual employed by Wackenhut Corporation and assigned duties as a security officer at Indian Nuclear 2 was fired on June 26, 2000 * * *. The individual had worked five straight 12-hour shifts [(12 hours on shift followed by 12 hours off for 5 straight days)] and declined to report for a sixth straight 12-hour shift because he reported to his management—in writing—that it would be ''physically and mentally exhausting.'' The individual reported to his management—in writing—that he was fully aware of his condition and ''would not want to be negligent in performing [his] duties as a security officer.''

The security officer had unescorted access to Indian Point 2 and thus was covered by 10 CFR part 26 as specified in Section 26.2 * * *.

The petitioner also pointed out that Wackenhut employees are required by terms of their employment application, Collective Bargaining Agreement, and the Security Officer Handbook to report to work when directed.

Thus, the petitioner contends that a worker employed by Wackenhut at an NRC-licensed facility reported to his management that he felt not fit for duty, declined to report for mandated overtime, and was terminated.

The petitioner also stated that ''10 CFR 26.20 requires all licensees to have formal policy and written procedures for factors that could render plant workers not fit for duty. Fatigue is specifically mentioned in 10 CFR 26.20.'' The petitioner contends that the Wackenhut's contractual right conflicts with the Federal regulations in 10 CFR 26.10(a) and (b) and that in this case, the individual essentially provided ''reasonable measures for early detection'' of a condition rendering him not fit to perform activities within the scope of part 26. The petitioner further stated that rather than respecting the individual's judgment or seeking another opinion by a Medical Review Officer or other health care professional, Wackenhut fired that individual.

The petitioner addressed the Petition Review Board (PRB) on May 7, 2001, in a telephone conference call to clarify the bases for his Petition. The transcript of this conference call is available in NRC's Agencywide Documents Access and Management System (ADAMS) (Accession No. ML012150128) and may be electronically viewed at the Commission's Public Document Room at One White Flint North, 11555 Rockville Pike (first floor), Rockville, Maryland.

The NRC sent a copy of the proposed Director's Decision to the petitioner by letter dated September 28, 2001. The petitioner responded with comments by letter dated October 2, 2001. The comments and the staff response to them are enclosures to the Director's Decision.

The Director of the Office of Nuclear Reactor Regulation has decided to grant the petitioner's request to the extent that the NRC will address the petitioner's concerns through the generic communication process. Specifically, the staff is developing a communication to all nuclear power plant licensees subject to the requirements of part 26. The communication will highlight the concerns identified in the petition and articulate the NRC's requirements as they apply to matters involving a worker's self-declaration of FFD. The staff intends to issue the communication in the near future. Further, as the staff proceeds with proposals to revise Part 26 and address worker fatigue through rulemaking, it will consider the need to clarify the NRC's expectations concerning worker declarations of FFD and work scheduling. The reasons for this decision are explained in the Director's Decision pursuant to 10 CFR 2.206 (DD–01–05), the complete text of which is available in ADAMS for electronic viewing at the Commission's Public Document Room (PDR), at One White Flint North, 11555 Rockville Pike (first floor), Rockville, Maryland. The text is also accessible through the ADAMS Public Library on the NRC's Web site, *http://www.nrc.gov/reading-rm.html* (the Public Electronic Reading Room) at Accession No. ML013230169. If you do not have access to ADAMS or have problems in accessing the documents in ADAMS, contact the NRC Public Document Room reference staff at 1–800–397–4209 or 301–415–4737 or by e-mail to *pdr@nrc.gov*.

A copy of the Director's Decision will be filed with the Secretary of the Commission so that the Commission may review it in accordance with 10 CFR 2.206(c) of the Commission's regulations. As provided for by this regulation, the Director's Decision will constitute the final action of the Commission 25 days after the date of the decision unless the Commission, on its own motion, institutes a review of the decision within that time.

Dated at Rockville, Maryland, this 23rd day of November, 2001.

For the Nuclear Regulatory Commission.

R. William Borchardt,

Acting Director, Office of Nuclear Reactor Regulation.

[FR Doc. 01–29781 Filed 11–29–01; 8:45 am]

BILLING CODE 7590–01–P

OFFICE OF MANAGEMENT AND BUDGET

Assessment of Cost and Benefits Associated with the Implementation of Executive Order 13166

AGENCY: Office of Management and Budget, Executive Office of the President.

ACTION: Request for information.

SUMMARY: This notice requests information that will inform the development of an assessment of the costs and benefits associated with the implementation of Executive Order 13166. Executive Order 13166, issued in August of 2000, is designed to ensure that persons with limited English proficiency (LEP) have adequate access to federally funded services, consistent with Title VI of the Civil Rights Act, which prohibits discrimination based on national origin. The Office of Management and Budget (OMB) has been tasked by Congressional appropriators with assessing the total costs and benefits of implementation. The Treasury, and General Government Appropriations Act of 2002 (Public Law 107–67), states that OMB shall submit, ''* * * a report to the Committees on Appropriations that provides an assessment of the total costs and benefits of implementing Executive Order 13166: Provided further, That such an assessment shall be submitted no later than 120 days after enactment of this Act.'' OMB is seeking information that will enable it to comply with this mandate by developing meaningful estimates of costs and benefits of implementation.

DATES: Comments must be received by December 31, 2001.

ADDRESSES: Responses to this request for information should be addressed to Brenda Aguilar of the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC 20503

FOR FURTHER INFORMATION CONTACT: Brenda Aguilar at phone (202) 395–6929; fax: (202) 395–6974; e-mail: *baguilar@omb.eop.gov.*

SUPPLEMENTARY INFORMATION: In Public Law 107–67, Congress directed the OMB to provide, within 120 days of enactment, ''* * * a report to the Committees on Appropriations that provides an assessment of the total costs and benefits of implementing Executive Order 13166* * *.'' One component of OMB's overall data collection strategy is the solicitation of relevant information from the public that will assist us in quantifying these costs and benefits. For the purposes of this solicitation, OMB is seeking both qualitative and quantitative information on the costs and benefits of Executive Order 13166. We recognize that monetizing or even quantifying some of the effects of the Executive Order may be quite difficult. Therefore, while we encourage the public to provide information in quantifiable units (e.g., dollars or time) where possible, we are also interested in descriptions of Executive Order 13166's unquantifiable effects.

Background

Executive Order 13166 was created to, ''* * * improve access to federally conducted and federally assisted programs and activities for persons who, as a result of national origin, are limited in their English proficiency (LEP)* * *.'' To accomplish this goal, Executive Order 13166 mandates that, ''* * * each Federal agency shall examine the services it provides and develop and implement a system by which LEP persons can meaningfully access those services consistent with, and without unduly burdening, the fundamental mission of the agency.'' However, the scope of Executive Order 13166 is not limited to federally operated programs. The Executive Order also requires, ''* * * each Federal agency shall also work to ensure that recipients of Federal financial assistance (recipients) provide meaningful access to their LEP applicants and beneficiaries.'' This means that the Executive Order is intended to apply not only to all federally conducted activities, but also to all entities that receive federal funds, such as State and local governments, and private or nonprofit grantees or contractors. However, by recognizing that the imposition of inflexible and burdensome requirements could, ''unduly'' burden the ''fundamental mission of the agency,'' the Executive Order contemplates weighing of implementation costs and benefits. Further, the DOJ implementing guidance reinforces this by stating, ''What constitutes reasonable steps to ensure meaningful access will be contingent upon a number of factors,'' each of which is discussed in this paper.

Under Executive Order 13166, the Department of Justice (DOJ) has been given the responsibility of assisting agencies with compliance and coordinating the federal government's overall response. Pursuant to this responsibility, DOJ issued implementing guidance in conjunction with the issuance of the Executive Order in August of 2000, and continues to advise federal agencies on how to develop the plans and guidance documents mandated by Executive Order 13166. Agency plans and guidance documents are reviewed and approved by DOJ based upon their consistency with the Executive Order.

The DOJ guidance establishes a framework for agencies to evaluate what constitutes, ''reasonable steps to ensure meaningful access,'' as required by the Executive Order. To do so, the guidance document delineates several factors that may be taken into account in agencies' Executive Order 13166 implementation decisions:

1. *Number or Proportion of LEP Individuals:* The guidance acknowledges that while even, ''programs that serve a few or even one LEP person are still subject to the Title VI obligation to take reasonable steps to provide meaningful opportunities for access' [t]he steps that are reasonable for a recipient who serves one LEP person a year may be different that those expected from a recipient that serves several LEP persons each day.'' For example, in the case of an organization or program that provides services to very few LEP individuals, compliance may involve preparation to use a commercially available interpreter service, rather than any intricate internal planning and procedures.

2. *Frequency of Contact with the Program:* The guidance explains that the, ''[f]requency of contacts between the program or activity and LEP individuals is another factor to be weighed.'' Programs or activities that must be accessed by LEP individuals on a daily basis, as with elementary or secondary school attendance, ''' a recipient has greater duties than if such contact is unpredictable or infrequent.'' DOJ encourages recipients of federal funds to take local conditions into account when determining the frequency of contact, and acknowledges that individual recipients ''should have the flexibility to tailor their services to those needs.''

3. *Nature and Importance of the Program:* Stating that, ''* * * [t]he importance of the recipient's program to beneficiaries will affect the determination of what reasonable steps are required,'' the guidance explains that, ''[m]ore affirmative steps must be taken in programs where the denial or delay of access may have life or death implications than in programs that are not as crucial to one's day-to-day existence.'' The example provided distinguishes between the obligations of a federally assisted school or hospital and those of a federally assisted zoo or theater. Further, DOJ guidance requires federal agencies and their recipients to

consider the long-term importance of the benefit, stating, ''A decision by a federal, state, or local entity to make an activity compulsory, such as elementary and secondary school attendance or medical inoculations, serves as strong evidence of the program's importance.''

4. *Resources Available:* The DOJ guidance further acknowledges that, ''[t]he resources available to a recipient of federal assistance may have an impact on the nature of the steps that recipients must take.'' DOJ recognizes that a small recipient with limited resources may be unable to take the same steps as a larger recipient to provide LEP assistance without ''unduly'' burdening its fundamental mission, particularly when programs serve a limited number of eligible LEP individuals, contact with the program is infrequent, the total cost of providing translation services is relatively high, or the program is not critical to an individual's daily existence.

Continuing, the DOJ guidance asks agencies to address ''the appropriate mix of written and oral language assistance,'' and explains that agencies must decide, ''* * * which documents must be translated, when oral translation is necessary.* * *'' The DOJ guidance states, ''It is the responsibility of the federal assistance-granting agencies, in conducting their Title VI compliance activities, to make more specific judgments by applying their program expertise to concrete cases.''

On October 26, 2001, DOJ issued a memorandum to all agencies that states, ''* * * agencies that have issued Limited English Proficiency (''LEP'') guidance for their recipients pursuant to Executive Order 13166 and Title VI of the Civil Rights Act should, after notifying the Department of Justice (''DOJ''), publish a notice asking for public comment on the guidance documents they have issued. Based on the public comment it receives and this Memorandum, an agency may need to clarify or modify its existing guidance. Agencies that have not yet published guidance documents should submit agency-specific guidance to the Department of Justice. Following approval by the Department of Justice and before finalizing its guidance each agency should obtain public comment on their proposed guidance documents.''

The purpose of issuing the Memorandum was to ensure that the public had an adequate opportunity to review agency guidance prior to its implementation, consistent with the notice and comment provisions of the APA, and to state DOJ's position on a recent Supreme Court case addressing the scope of the Title VI provisions regarding disparate impact regulations. Although the Court held in *Alexander* v. *Sandoval,* 121 S.Ct. 1511 (2001) that there is no private right of action under such regulations, the decision did not invalidate such regulations, and therefore, DOJ explains that Executive Order 13166 ''remains in force.''

Request for Comments

In order to assess the total costs and benefits of implementing Executive Order 13166, it will be necessary to obtain a significant amount of data. While estimating the costs and benefits associated with any policy is difficult, this case will be particularly challenging given the breadth and depth of activities covered by the Executive Order. In a ''Q&A'' document released by DOJ, the scope of Executive Order 13166 is defined as, ''* * * anything a federal agency does''* * * to include, ''the provision of federal benefits or services, the imposition of a burden on a member of the public, and any other activities a federal agency conducts.'' This would include anything from the receipt of benefits such as Social Security to law enforcement activities or the imposition of taxes. Specifically, OMB is seeking information that will provide assistance in:

- Determining how best to quantify the numbers of LEP individuals and which languages they speak.
- Understanding the number of different languages spoken by LEP individuals, and their geographic distribution.
- Characterizing the interactions of LEP individuals with both federal and federally funded entities. For example, how frequently do LEP individuals interact with government at all levels? What types of government services do LEP individuals typically access? Are there types of services that LEP individuals access more or less frequently than non-LEP individuals?
- Determining the costs and benefits of improving English language proficiency among LEP individuals.
- Understanding and quantifying the level of services provided by the government or government funded organizations to address the special needs of LEP individuals prior to Executive Order 13166 and to what extent changes will be necessary to achieve full compliance with Executive Order 13166 and related agency guidance.
- Quantifying and describing the costs to the Federal Government or recipients of federal funds of providing oral and written translation services.
- Quantifying and describing the benefits to LEP individuals and society as a result of having oral and written translation services available, in accordance with Executive Order 13166.
- Identifying any existing studies of the costs and benefits of improving the quality of communications and interactions between LEP individuals and the federal government or federally funded services. We are also interested in studies of similar language or translation issues internationally, (e.g. Canada, European Union, United Nations and OEDC).
- Identifying ''real-world'' case studies that illustrate the costs and benefits of providing translation services to LEP individuals, as envisioned by Executive Order 13166, and related agency guidance. We are seeking examples from multiple perspectives, including LEP individuals, federal agencies/recipients of federal funds, and the international context.
- Identifying existing academic research and ''real-world'' case studies from the following sectors: health, social services/income maintenance, education, transportation, law enforcement and trade, as well as recommendations of additional sectors or perspectives from which to address this issue.
- Identifying any other information or resources that the public believes will assist us in our efforts to assess the benefits and costs of Executive Order 13166.

OMB appreciates any information that persons may have on these and other subjects related to the implementation of Executive Order 13166. After considering the information received, OMB will develop and issue a report to Congress by March 12, 2001.

John D. Graham,

Administrator, Office of Information and Regulatory Affairs.

[FR Doc. 01–29903 Filed 11–29–01; 8:45 am]

BILLING CODE 3110–01–P

SECURITIES AND EXCHANGE COMMISSION

(Release No. 34–45089; File No. SR–ISE–2001–30)

Self-Regulatory Organizations; Notice of Filing and Immediate Effectiveness of Proposed Rule Change by the International Securities Exchange LLC Relating to Fees for Providing ''Bisync Controllers'' to Members

November 21, 2001.

Pursuant to section 19 (b)(1) of the Securities Exchange Act of 1934

(''Act''),[1] and rule 19b–4 [2] thereunder, notice is hereby given that on November 16, 2001, the International Securities Exchange LLC (''ISE'' or ''Exchange'') filed with the Securities and Exchange Commission (the ''Commission'') the proposed rule change as described in Items I, II, and III 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.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to amend its fee schedule to impose a monthly fee of $350 for each ''bisync controller'' the Exchange leases to a member.

The text of the proposed rule change appears below. New text is in italics.

ISE Schedule of Fees

* * * * *

	Amount	Billable unit	Frequency
Access Services			
Gateway			
• Cabinet Installation	$5,000.00	Gateway	One Time.
• Cabinet Move/Add/Change	2,000.00	Gateway	One Time.
•; Cabinet Lease/Maint.	1,400.00	Gateway	Monthly.
• Additional Servers	250.00	Server	Monthly.
• Router Installation/Removal	500.00	Router	One Time.
• Router Lease/Maint.	200.00	Router	Monthly.
• *Bisync Controller*	*350.00*	*Controller*	*Monthly if leased; member can purchase own equipment.*

* * * * *

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 IV 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 purpose of the proposed rule change is to institute a fee to recover the Exchange's cost of providing ''bisync controllers'' to members. The controller allows the ISE to communicate with older protocols that are still in use by certain Electronic Access Members. The rule makes clear that members can purchase their own equipment and thus avoid leasing the controllers from the ISE and incurring this fee.

(2) Statutory Basis

The Exchange believes that the proposed rule change is consistent with section 6 (b) of the Act,[3] in general, and furthers the objectives of section 6 (b)(4), [4] in particular, in that it provides for the equitable allocation of reasonable dues, fees, and other charges among its members and other persons using its facilities.

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 Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

The Exchange has not solicited, and does not intend to solicit, comments on this proposed rule change. The Exchange has not received any unsolicited written comments from members or other interested parties.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The foregoing rule change establishes or changes a due, fee, or charge imposed by the Exchange and, therefore, has become effective upon filing pursuant to section 19 (b)(3)(A)(ii) of the Act [5] and Rule 19b–4 (f)(2) thereunder.[6] At any time within 60 days of the filing of such proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. 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 in the Commission's Public Reference Section. 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–ISE–2001–30 and should be submitted by December 21, 2001.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] 15 U.S.C. 78f (b).

[4] 15 U.S.C. 78f (b)(4).

[5] 15 U.S.C. 78 (s)(b)(3)(A)(ii).

[6] 17 CFR 240.19b–4 (f)(2).

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[7]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 01–29720 Filed 11–29–01; 8:45 am]

BILLING CODE 8010–01–M

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–45101; File No. SR–NASD–2001–76]

Self-Regulatory Organizations; Notice of Filing of Proposed Rule Change and Amendment No. 1 Thereto by the National Association of Securities Dealers, Inc. Amending NASD Rules 4510, 4520 and 4530 Relating to Issuer Entry and Annual Fee Schedules

November 23, 2001.

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 31, 2001, the National Association of Securities Dealers, Inc. (''NASD'' or ''Association'') through its subsidiary The Nasdaq Stock Market, Inc. (''Nasdaq'') 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 NASD. Amendment No. 1 was filed on November 21, 2001.[3] The Commission is publishing this notice to solicit comments on the proposed rule change, as amended, from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The NASD has filed with the Commission a proposed rule change to amend Association Rules 4510, 4520 and 4530 pertaining to Issuer Entry and Annual Fee Schedules for the National and SmallCap Markets for both domestic and non-U.S. listings and make conforming changes.

The text of the proposed rule change appears below. New text is in italics. Deletions are in brackets.

* * * * *

4510. The Nasdaq National Market

(a) Entry Fee

[(1) When an Issuer submits an application for inclusion of any class of its securities in the Nasdaq National Market, it shall pay to The Nasdaq Stock Market, Inc.:

(A) a one-time company listing fee of $5,000 (which shall include a $1,000 non-refundable processing fee); and (B) a fee calculated on total shares outstanding according to the following schedule:

Up to 1 million shares $29,525
1+ to 2 million shares $33,750
2+ to 3 million shares $43,750
3+ to 4 million shares $48,750
4+ to 5 million shares $55,000
5+ to 6 million shares $58,725
6+ to 7 million shares $61,875
7+ to 8 million shares $64,375
8+ to 9 million shares $67,875
9+ to 10 million shares $70,625
10+ to 11 million shares $73,875
11+ to 13 million shares $76,625
12+ to 13 million shares $79,875
13+ to 14 million shares $82,000
14+ to 15 million shares $83,500
15+ to 16 million shares $85,500
Over 16 million shares $90,000]

(1) When a domestic Issuer, or foreign Issuer raising capital in conjunction with its Nasdaq listing, submits an application for inclusion of any class of its securities in The Nasdaq National Market, it shall pay to The Nasdaq Stock Market, Inc. a fee calculated on total shares outstanding, which includes a one-time company listing fee of $5,000 ($1,000 of which is a non-refundable processing fee), according to the following schedule:

Up to 30 million shares $100,000
30+ to 50 million shares $125,000
Over 50 million shares $150,000

(2) When a foreign Issuer not raising capital in conjunction with its Nasdaq listing, including American Depositary Receipts (ADRs), submits an application for inclusion of any class of its securities in The Nasdaq National market, it shall pay to The Nasdaq Stock Market, Inc. a fee calculated on total shares outstanding, which includes a one-time company listing fee of $5,000 ($1.000 of which is a non-refundable processing fee), according to the following schedule:

Up to 3 million shares $50,000
3+ to 5 million shares $75,000
5+ to 30 million shares $100,000
30+ to 50 million shares $125,000
Over 50 million shares $150,000

[(2)]*(3)* Total shares outstanding means the aggregate of all classes of equity securities to be included in [t]*T*he Nasdaq National Market as shown in the Issuer's most recent periodic report or in more recent information held by Nasdaq or, in the case of new issues, as shown in the offering circular, required to be filed with the Issuer's appropriate regulatory authority. In the case of foreign Issuers, total shares outstanding shall include only those shares issued and outstanding in the United States.

[(3)] *(4)* The Board of Directors of The Nasdaq Stock Market, Inc. or its designee may, in its discretion, defer or waive all or any part of the Entry fee prescribed herein.

[(4)] *(5)* If the application is withdrawn or is not approved, the Entry fee (less the non-refundable processing fee) shall be refunded.

(b) Additional Shares

(1)–(4) No Change

(c) Annual Fee—Domestic and Foreign Issues

(1) [As of January 1, 1998, t]*T*he Issuer of each class of securities, *other than an ADR,* that is a domestic or foreign issue listed in [t]*T*he Nasdaq National Market shall pay to The Nasdaq Stock Market, Inc. an Annual fee calculated on total shares outstanding according to the following schedule:

[Up to 1 million shares $10,710
1+ to 2 million shares $10,960
2+ to 3 million shares $11,210
3+ to 4 million shares $11,460
4+ to 5 million shares $11,710
5+ to 6 million shares $11,960
6+ to 7 million shares $12,210
7+ to 8 million shares $12,460
8+ to 9 million shares $12,710
9+ to 10 million shares $12,960
10+ to 11 million shares $17,255
11+ to 12 million shares $17,505
12+ to 13 million shares $17,755
13+ to 14 million shares $18,005
14+ to 15 million shares $18,255
15+ to 16 million shares $18,505
16+ to 20 million shares $18,755
20+ to 25 million shares $22,795
25+ to 50 million shares $26,625
50+ to 75 million shares $32,625
75+ to 100 million shares $43,125
Over 100 million shares $50,000]

Up to 10 million shares $21,225
10+ to 25 million shares $26,500
25+ to 50 million shares $29,820
50+ to 75 million shares $39,150
75+ to 100 million shares $51,750
Over 100 million shares $60,000

(2)–(3) No Change

(4) [The Annual fee shall be based on the total shares outstanding of the class] *Total shares outstanding means the aggregate of all classes of equity* securities included in [t]*T*he Nasdaq National Market as shown in the Issuer's most recent periodic report required to be filed with the Issuer's appropriate

[7] 17 CFR 200.30–3 (a)(12).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4

[3] *See* letter from Sara Nelson Bloom, Associate General Counsel, Nasdaq, to Katherine A. England, Assistant Director, Division of Market Regulation (''Division''), Commission, dated November 21, 2001 (''Amendment No. 1''). In Amendment No. 1, the NASD made clarifying changes to the rule text, provided greater detail as to the basis for the proposed rule change, deleted all references to its request for accelerated approval, and requested that the proposed fees apply as of January 1, 2002.

regulatory authority or in more recent information held by Nasdaq. In the case of foreign Issuers, total shares outstanding shall include only those shares issued and outstanding in the United States.

(d) Annual Fee—American Depositary Receipts (ADRs)

(1) The Issuer of each class of securities that is an ADR listed in [t]*T*he Nasdaq National Market shall pay to The Nasdaq Stock Market, Inc. an Annual fee [to be computed as follows with a maximum Annual fee of $8,000 per Issuer] *calculated on ADRs outstanding according to the following schedule not to exceed $30,000 per Issuer:*

Up to 10 million ADRs $10,000
10+ to 25 million ADRs $15,000
25+ to 50 million ADRs $20,000
50+ to 75 million ADRs $22,500
75+ to 100 million ADRs $25,000
Over 100 million ADRs $30,000

[(A) a $2,000 Nasdaq National Market participation fee; and (B) the sum of $500 or $.0005 per share outstanding, whichever is higher, up to a maximum of $6,000 for class of securities listed in the Nasdaq National Market.]

(2) [The Annual fee shall be based on the total shares outstanding of the class] *ADRs outstanding means the aggregate of all classes of ADRs* included in [t]*T*he Nasdaq National Market as shown in the Issuer's most recent periodic report required to be filed with the Issuer's appropriate regulatory authority or in more recent information held by Nasdaq.

(3)–(4) No change

4520. The Nasdaq SmallCap Market

(a) Entry Fee

(1) When an Issuer submits an application for inclusion of any class of its securities*, other than convertible debentures,* in the Nasdaq SmallCap Market, it shall pay to The Nasdaq Stock Market, Inc.[:] *a fee calculated on total shares outstanding, which includes a one-time company listing fee of $5,000 ($1,000 of which is a non-refundable processing fee), according to the following schedule:*

Up to 1 million shares $9,500
1+ to 5 million shares $19,000
5+ to 10 million shares $30,875
10+ to 15 million shares $40,375
Over 15 million shares $47,500

[(A) a one-time company listing fee of $5,000 (which shall include a $1,000 non-refundable processing fee); and (B) for each class of securities listed, a fee to be computed as follows, with a maximum Entry fee for all classes of securities listed, regardless of the dates those securities are listed, of $10,000 per Issuer (inclusive of the $5,000 company listing fee)

(i) Equity Securities

$1,000 or $.001 per share outstanding, whichever is higher. For purposes of this subparagraph, the term ''equity securities'' includes all securities eligible for inclusion in The Nasdaq SmallCap Market not covered by subparagraph (ii) hereof.*

(ii) Convertible Debentures

$1,000 or $50 per million dollars face amount of debentures outstanding, whichever is higher.]

(2) When an Issuer submits an application for inclusion of any class of convertible debentures in The Nasdaq SmallCap Market, it shall pay to The Nasdaq Stock Market, Inc. a one-time company listing fee of $5,000 (which shall include a $1,000 non-refundable processing fee) and a fee of $1,000 or $50 per million dollars face amount of debentures outstanding, whichever is higher.

[(2)] *(3)* The Board of Directors of The Nasdaq Stock Market, Inc. or its designee may, in its discretion, defer or waive all or any part of the Entry fee prescribed herein.

[(3) The Entry fee shall be based on the total shares outstanding of the class] *(4) Total shares outstanding means the aggregate of all classes of equity securities* to be included in The Nasdaq SmallCap Market as shown in the Issuer's most recent periodic report or in more recent information held by Nasdaq or, in the case of new issues, as shown in the offering circular, required to be filed with the Issuer's appropriate regulatory authority.

[(4)] *(5)* If the application is withdrawn or is not approved, the Entry fee (less the non-refundable processing fee) shall be refunded.

(b) Additional Shares

(1)–(4) No Change

(c) Annual Fee[—Domestic and Foreign Issues]

(1) [As of January 1, 1993, t]*T*he Issuer of a class of securities that is a domestic or foreign issue, *including American Depositary Receipts (ADRs),* listed in The Nasdaq SmallCap Market shall pay to The Nasdaq Stock Market, Inc. an Annual fee to be computed as follows:

(A) [$4,000] *$8,000* for the first issue; plus

(B) [$1,000] *$2,000* for each additional issue.

(2) Notwithstanding paragraph (1), the Issuer of each class of convertible debentures listed in The Nasdaq SmallCap Market shall pay to The Nasdaq Stock Market, Inc. an Annual fee of $500 or $25 per million dollars face amount of debentures outstanding, whichever is higher.

[(2)] *(3)* The Board of Directors of The Nasdaq Stock Market, Inc. or its designee may, in its discretion, defer or waive all or any part of the Annual fee prescribed herein.

[(3)] *(4)* If a class of securities is removed from The Nasdaq SmallCap Market, that portion of the Annual fees for such class of securities attributable to the months following the date of removal shall not be refunded, except such portion shall be applied to Nasdaq National Market fees for that calendar year.

[(d) Annual Fee—American Depositary Receipts (ADRs)

(1) The Issuer of each class of securities that is an ADR listed in The Nasdaq SmallCap Market shall pay to The Nasdaq Stock Market, Inc. an Annual fee to be computed as follows with a maximum Annual fee of $6,000 per Issuer

(A) Equity Securities

$500 or $.0005 per share outstanding, whichever is higher. For purposes of this subparagraph, the term ''equity securities'' includes all securities eligible for inclusion in the Nasdaq SmallCap Market not covered by subparagraph (B) of this paragraph.**

(B) Convertible Debentures

$500 or $25 per million dollars face amount of debentures outstanding, whichever is higher.

(2) The Annual fee shall be based on the total amount of outstanding securities of the class included in The Nasdaq SmallCap Market as shown in the Issuer's most recent periodic report required to be filed with the Issuer's appropriate regulatory authority and received by The Nasdaq Stock Market, Inc.

(3) The Board of Governors of the Association, or its designee may, in its discretion, defer or waive all or any part of the Annual fee prescribed herein.

(4) If a class of securities is removed from The Nasdaq SmallCap Market, that portion of the Annual fees for such class of securities attributable to the months

[* The term ''shares'' shall include common and preferred stock, American Depositary Receipts (ADRs), warrants, partnership interests, or any other security listed on the Nasdaq SmallCap Market. In the case of units, each component, but not the unit itself, shall be considered separately as an ''equity security'' for fee purposes.]

[** See notes to Rule 4520(a)(1)(B)(i), above.]

following the date of removal shall not be refunded, except such portion shall be applied to Nasdaq National Market fees for that calendar year.]

4530. Other Securities

(a) Entry Fee

(1) When an Issuer submits an application for inclusion of any Other Security in The Nasdaq National Market qualified for listing under Rule 4420(f) it shall pay a fee ($1,000 of which is a non-refundable processing fee) calculated on total shares outstanding according to the following schedule:

Up to 1 million shares $5,000
1+ to 2 million shares $10,000
2+ to 3 million shares $15,000
3+ to 4 million shares $17,500
4+ to 5 million shares $20,000
5+ to 6 million shares $22,500
6+ to 7 million shares $25,000
7+ to 8 million shares $27,500
8+ to 9 million shares $30,000
9+ to 10 million shares $32,500
10+ to 15 million shares $37,500
Over 15 million shares $45,000

(2) Total shares outstanding means the aggregate of all classes of Other Securities to be included in The Nasdaq National Market as shown in the Issuer's most recent periodic report or in more recent information held by Nasdaq or, in the case of new issues, as shown in the offering circular, required to be filed with the Issuer's appropriate regulatory authority.

(3) The Board of Directors of The Nasdaq Stock Market, Inc. or its designee may, in its discretion, defer or waive all or any part of the Entry fee prescribed herein.

(4) If the application is withdrawn or is not approved, the Entry fee (less the non-refundable processing fee) shall be refunded.

(b) Annual Fee

(1) The Issuer of Other Securities qualified under Rule 4420(f) for listing on The Nasdaq National Market shall pay to The Nasdaq Stock Market, Inc. an Annual fee calculated on total shares outstanding according to the following schedule:

Up to 1 million shares $6,500
1+ to 2 million shares $7,000
2+ to 3 million shares $7,500
3+ to 4 million shares $8,000
4+ to 5 million shares $8,500
5+ to 6 million shares $9,000
6+ to 7 million shares $9,500
7+ to 8 million shares $10,000
8+ to 9 million shares $10,500
9+ to 10 million shares $11,000
10+ to 11 million shares $11,500
11+ to 12 million shares $12,000
12+ to 13 million shares $12,500
13+ to 14 million shares $13,000
14+ to 15 million shares $13,500
15+ to 16 million shares $14,000
Over 16 million shares $14,500

(2) The Board of Directors of The Nasdaq Stock Market, Inc. or its designee may, in its discretion, defer or waive all or any part of the Annual fee prescribed herein.

(3) Total shares outstanding means the aggregate of all classes of Other Securities as shown in the Issuer's most recent periodic report required to be filed with the Issuer's appropriate regulatory authority or in more recent information held by Nasdaq.

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 NASD 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 IV below. The NASD 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 NASD[4] proposes to amend the Association Rules 4510, 4520 and 4530 pertaining to Issuer Entry and Annual fees on The Nasdaq National Market and SmallCap Market for both domestic and foreign listings. It has been approximately ten years since the NASD amended the Entry and Annual fees for SmallCap[5] and ADR listings,[6] and four years since it amended the National Market Entry and Annual fees.[7] During that extended period, the NASD has committed increased resources to provide regulatory oversight, client coverage, and professional services to listed companies. For example, additional resources were committed to fund regulatory costs associated with the institution of corporate governance requirements on The SmallCap Market in 1997. Additionally, Nasdaq has invested in many market improvements such as Nasdaq Online, the Nasdaq Marketsite, and enhancements to Nasdaq.com, as well as market quality improvements such as decimalization, SuperSoes, and the development of SuperMontage. Nasdaq also plans to commit further resources to fund service enhancements requested by Nasdaq companies. In particular, Nasdaq proposes to create a telephone and technology based corporate-client information center to provide Nasdaq companies with a range of integrated products and services in a more centralized and timely manner.[8]

The NASD proposes to increase Entry and Annual fees for The Nasdaq National Market, including American depositary Receipts (''ADRs''). Nasdaq National Market Entry fees would be split into two fee schedules; one schedule for all U.S. Issuers and foreign Issuers raising capital in conjunction with their listing on Nasdaq; and another schedule for foreign Issuers that are not raising capital in connection with their listing. This second schedule has somewhat lower fees for foreign listings under 5 million shares, in recognition of the fact that these listings are non-capital raising and generally represent secondary market listings. The NASD will also increase its existing National Market Annual fee structure.

The NASD proposes to increase Entry and Annual fees for The Nasdaq SmallCap Market as well. ADRs on the SmallCap Market will follow the same fee schedule as domestic and foreign issues. Finally, the NASD intends to add a new fee schedule to the NASD Rule 4500 Series for Other Securities qualified under NASD Rule 4420(f). Finally, the NASD has requested that the new fees apply as of January 1, 2002 in order to be consistent with the expectations of Nasdaq listed companies and to ease administration of the fees.[9]

(2) Statutory Basis

The NASD believes that the proposed rule change is consistent with the provisions of sections 15A(b)(5)[10] and

[4] The proposed rule change and Amendment No. 1 thereto was submitted by the NASD on behalf of its subsidiary, Nasdaq. Telephone conversation between John Nachmann, Senior Attorney, Nasdaq, and Terri Evans, Assistant Director, Division, Commission, on November 21, 2001.

[5] Telephone conversation between John Nachmann, Senior Attorney, Nasdaq, and Christopher Solgan, Law Clerk, Division, Commission, on November 23, 2001 (clarifying the date of last change). *See* Securities Exchange Act Release No. 30143 (January 2, 1992), 57 FR 726 (January 8, 1992).

[6] Telephone conversation between John Nachmann, Senior Attorney, Nasdaq, and Christopher Solgan, Law Clerk, Division, Commission, on November 23, 2001 (clarifying the date of last change). *See* Securities Exchange Act Release No. 28731 (January 2, 1991), 59 FR 906 (January 9, 1991).

[7] *See* Securities Exchange Act Release No. 39613 (February 2, 1998), 63 FR 6789 (February 10, 1998).

[8] *See* Amendment No. 1, *supra* note 3.

[9] *See* Amendment No. 1, *supra* note 3.

[10] 15 U.S.C. 78*o*–3(b)(5).

(6)[11] of the Act. The proposed rule change is consistent with section 15A(b)(5)[12] in that it provides for the equitable allocation of reasonable dues, fees, and other charges among Issuers using the Nasdaq system. The proposed rule change is also consistent with section 15A(b)(6)[13] in that it is designed to promote just and equitable principles of trade and does not permit unfair discrimination between customers, Issuers, brokers or dealers. As noted above, the fee increase reflects additional costs that Nasdaq incurs for services provided to Issuers.

B. Self-Regulatory Organization's Statement on Burden on Competition

The NASD does not believe that the proposed rule change will result in 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

The NASD neither solicited nor received written comments.

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 Exchange 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 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 in the Commission's Public Reference Room. Copies of such filings will also be available for inspection and copying at the principal office of the Association. All submissions should refer to File No. SR–NASD–2001–76 and should be submitted by December 21, 2001.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[14]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 01–29714 Filed 11–29–01; 8:45 am]

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[11] 15 U.S.C. 78*o*–3(b)(6).

[12] 15 U.S.C. 78*o*–3(b)(5).

[13] 15 U.S.C. 78*o*–3(b)(6).

[14] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–45102; File No. SR–NASD–2001–59]

Self-Regulatory Organizations; Order Granting Approval of Proposed Rule Change by the National Association of Securities Dealers, Inc. Relating to Fees for Historical Research Reports and Licensing the Redistribution of Information From Such Reports

November 26, 2001.

On September 25, 2001, the National Association of Securities Dealers, Inc. (''NASD'' or ''Association''), through its subsidiary, The Nasdaq Stock Market, Inc. (''Nasdaq''), filed with the Securities and Exchange Commission (''Commission''), 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 to amend subsection (p) of NASD Rule 7010, System Services, to modify the fees charged for historical research reports provided through Nasdaq's Nasdaq Trader.com web site, and to establish a fee for licensing the redistribution of information contained in such reports.

The proposal was published in the **Federal Register** on October 22, 2001.[3] The Commission received no comments on the proposal.

The Commission finds that the proposed rule change is consistent with the requirements of the Act and the rules and regulations thereunder applicable to a national securities association[4] and, in particular, the requirements of section 15A of the Act[5] and the rules and regulations thereunder. The Commission finds specifically that the proposed rule change is consistent with sections 15A(b)(5) and (6) of the Act.[6] Section 15A(b)(5) requires the equitable allocation of reasonable fees and charges among members and other users of facilities operated or controlled by a national securities association. Section 15A(b)(6) requires rules that foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in securities, and that are not designed to permit unfair discrimination between customers, issuers, brokers or dealers.

It Is Therefore Ordered, pursuant to section 19(b)(2) of the Act,[7] that the proposed rule change (SR–NASD–2001–59), be, and it hereby is, approved.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[8]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 01–29719 Filed 11–29–01; 8:45 am]

BILLING CODE 8010–01–M

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* Securities Exchange Act Release No. 44940 (October 16, 2001), 66 FR 53462.

[4] In approving this proposed rule change, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. 15 U.S.C. 78c(f).

[5] 15 U.S.C. 78o–3.

[6] 15 U.S.C. 78o–3(b)(5) and (6).

[7] 15 U.S.C. 78s(b)(2).

[8] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–45095; File No. SR–PHLX–2001–68]

Self-Regulatory Organizations; Philadelphia Stock Exchange, Inc.; Order Granting Approval to Proposed Rule Change Regarding Notification of Changes in Business Operations and the Minor Rule Violation Enforcement and Reporting Plan

November 21, 2001.

On July 19, 2001, the Philadelphia Stock Exchange, Inc. (''Phlx'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission''), 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 to adopt an Equity Floor Procedure Advice and an Options Floor Procedure Advice, with fine schedules under the Phlx's

minor rule violation enforcement and reporting plan (''Plan'') containing the requirements for notification established in Phlx Rule 610, Notification of Changes in Business Operations. On September 20, 2001, the Phlx amended the proposal.[3]

The proposed rule change, as amended, was published for comment in the **Federal Register** on October 1, 2001.[4] The Commission received no comments on the proposal.

The Commission finds that the proposed rule change, as amended, is consistent with the requirements of the Act and the rules and regulations thereunder applicable to a national securities exchange[5] and, in particular, the requirements of section 6 of the Act[6] and the rules and regulations thereunder. The Commission finds specifically that the proposed rule change is consistent with section 6(b)(5) of the Act[7] because it will help prevent fraudulent and manipulative acts and practices, as well as promote just and equitable principles of trade. The Commission finds the proposal is consistent with section 6(b)(6) of the Act,[8] because the proposal provides a mechanism for the appropriate discipline for violations of certain rules and regulations.

In addition, the Commission finds the proposal is consistent with section 6(b)(7) of the Act[9] because the proposal provides a fair procedure for the disciplining of members and persons associated with members. The Commission also finds the proposal is consistent with section 6(b)(8) of the Act,[10] in that it furthers the statutory goal of providing a fair procedure for disciplining the Phlx's members and associated persons. Finally, the Commission finds the proposal is consistent with Securities Exchange Act Rule 19d–1(c)(2)[11] that governs minor rule violation plans.

In approving this proposal, the Commission in no way minimizes the importance of compliance with these rules, and all other rules subject to the imposition of fines under the Plan. The Commission believes that the violation of any self-regulatory organization's rules, as well as Commission rules, is a serious matter. However, in an effort to provide the Exchange with greater flexibility in addressing certain violations, the Plan provides a reasonable means to address rule violations that do not rise to the level of requiring formal disciplinary proceedings. The Commission expects that the Phlx will continue to conduct surveillance with due diligence, and make a determination based on its findings whether fines of more or less than the recommended amount are appropriate for violations of rules under the Plan, on a case by case basis, or if a violation requires formal disciplinary action.

It is therefore ordered, pursuant to section 19(b)(2) of the Act,[12] that the proposed rule change (SR–PHLX–2001–68), as amended, be, and it hereby is, approved.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[13]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 01–29715 Filed 11–29–01; 8:45 am]

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[3] The amendment completely replaced and superseded the original proposal.

[4] *See* Securities Exchange Act Release No. 44844 (September 25, 2001), 66 FR 49994.

[5] In approving this proposed rule change, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. 15 U.S.C. 78c(f).

[6] 15 U.S.C. 78f.

[7] 15 U.S.C. 78f(b)(5).

[8] 15 U.S.C. 78f(b)(6).

[9] 15 U.S.C. 78f(b)(7).

[10] 15 U.S.C. 78f(b)(8).

[11] 17 CFR 240.19d–1(c)(2).

[12] 15 U.S.C. 78s(b)(2).

[13] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–45093; File No. SR–Phlx–2001–99]

Self-Regulatory Organizations; Notice of Filing and Immediate Effectiveness of Proposed Rule Change by the Philadelphia Stock Exchange, Inc. To Conform Rule 2001(b)(2)(viii) to the Seventeenth Amendment of the Intermarket Trading System Plan

November 21, 2001.

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 30, 2001, the Philadelphia Stock Exchange, Inc. (''Phlx'' 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 Phlx. The Exchange filed this proposal under section 19(b)(3)(A) of the Act,[3] and Rule 19b–4(f)(6) thereunder,[4] which renders the proposal effective upon filing with the Commission. 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 Phlx proposes to amend subsection (b)(2)(viii) of Exchange Rule 2001 (Intermarket Trading System) to provide for a 30-second commitment period to trade for orders received through the Intermarket Trading System (''ITS''), consistent with the 17th Amendment to the Intermarket Trading System Plan (''ITS Plan'' or ''Plan'').[5] The text of the proposal is below. Additions are in italics; deletions are in brackets.

Rule 2001. Intermarket Trading System

(a) Unchanged.

(b) Provisions of the Plan-By subscribing to and submitting the ITS Plan for filing with the Securities and Exchange Commission, the Exchange has agreed to comply to the best of its ability, and, absent reasonable justification or excuse, to enforce compliance by its members, with the provisions of the ITS Plan. In this connection, the following shall apply:

Intermarket Trading System (''ITS'')

(1) Unchanged

(2) Any ''commitment to trade'', which is transmitted by a member to another participating market center through ITS, shall be firm and irrevocable for the period of time following transmission as is chosen by the sender of the commitment. All such commitments to trade shall, at a minimum:

(i)–(vii) Unchanged

(viii) specify the time period during which the commitment shall be irrevocable, but if the time period is not specified in the commitment, the longer of the [two] *three* options available under the Plan shall be assumed by ITS.

(3)–(6) Unchanged.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] 15 U.S.C. 78s(b)(3)(A).

[4] CFR 240.19b–4(f)(6). The Phlx requested that the Commission waive the 30-day operative delay. The Phlx provided the Commission with notice of its intention to file this proposal on September 20, 2001.

[5] *See* Securities Exchange Act Release No. 44903 (October 3, 2001), 66 FR 52159 (October 12, 2001) (''ITS Plan Amendment No. 17''). The ITS is a National Market System plan, which was designed to facilitate intermarket trading in exchange-listed equity securities based on current quotation information emanating from the linked markets. *See* Securities Exchange Act Release No. 18536 (March 4, 1982), 47 FR 10658 (March 11, 1982) (noticing the restated ITS Plan) and Securities Exchange Act Release No. 19456 (January 27, 1983), 48 FR 4938 (February 3, 1983) (adopting the restated ITS Plan).

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 Phlx 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 IV below. The Phlx 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 purpose of the proposed rule change is to conform Phlx Rule 2001(b)(2)(viii) to ITS Plan Amendment No. 17.[6]

Presently, Phlx Rule 2001 provides that a commitment to trade shall, at a minimum, specify the length of the period in which that commitment is irrevocable, and if such information is not specified, the lesser of the two options available would apply. The two time-periods available currently are one and two minutes.

Among other things, ITS Plan Amendment No. 17 provides for the addition of a third option—a 30-second commitment period.[7] The 30-second option would be available, once installed by the Securities Industry Automation Corporation (''SIAC'') and implemented by the Exchange, on a six-month pilot basis.[8]

Accordingly, the Exchange proposes to amend Phlx Rule 2001, which provides for trading through ITS, by replacing the current language in subsection (b)(2)(viii), which states that there are ''two'' irrevocable time-period options, with the word ''three,'' thereby mirroring ITS Plan Amendment No. 17.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with section 6(b) of the Act,[9] in general, and furthers the objectives of section 6(b)(5),[10] in particular, because it should promote just and equitable principles of trade, facilitate transactions in securities, remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, 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 inappropriate burden on competition.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were either solicited or received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Because the foregoing proposed rule change: (1) Does not significantly affect the protection of investors or the public interest; (2) does not impose any significant burden on competition; and (3) does not become operative for 30 days after the date of filing, or such shorter time as the Commission may designate if consistent with the protection of investors and the public interest; provided that the Exchange has given the Commission written notice of its intent to file the proposed rule change, along with a brief description and text of the proposed rule change, at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission, the proposed rule change has become effective pursuant to section 19(b)(3)(A) of the Act[11] and Rule 19b–4(f)(6)[12] thereunder.

A proposed rule change filed under Rule 19b–4(f)(6) normally does not become operative prior to 30 days after the date of filing. However, Rule 19b–4(f)(6)(iii) permits the Commission to designate a shorter time if such action is consistent with the protection of investors and the public interest. The Phlx seeks to have the proposed rule change become operative immediately.

The Commission, consistent with the protection of investors and the public interest, has determined to make the proposed rule change operative as of October 30, 2001.[13]

At any time within 60 days of the filing of the proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing, including whether the proposed rule change is consisten 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 the Phlx. All submissions should refer to File No. SR–Phlx–2001–99 and should be submitted by December 21, 2001.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[14]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 01–29716 Filed 11–29–01; 8:45 am]

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SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–45086; File No. SR–Phlx–2001–96]

Self-Regulatory Organizations; Notice of Filing and Immediate Effectiveness of Proposed Rule Change and Amendment No. 1 Thereto by the Philadelphia Stock Exchange, Inc. Relating to the Exchange's Options Maintenance Standards

November 19, 2001.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934

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[6] *See supra* note 5.

[7] *See* ITS Plan Amendment No. 17, *supra* note 5.

[8] The Exchange will implement the six-month pilot on November 30, 2001. *See* telephone conversation between Edith Hallahan, Deputy General Counsel, Phlx, and Jennifer Lewis, Attorney, Division of Market Regulation, Commission, on November 16, 2001.

[9] 15 U.S.C. 78f(b).

[10] 15 U.S.C. 78f(b)(5).

[11] 15 U.S.C. 78s(b)(3)(A).

[12] 17 CFR 240.19b–4(f)(6).

[13] For purposes only of accelerating the operative date of this proposal, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. 15 U.S.C. 78c(f).

[14] 17 CFR 200.30–3(a)(12).

(''Act''),[1] and Rule 19b–4 [2] thereunder, notice is hereby given that on October 18, 2001, the Philadelphia Stock Exchange, Inc. (''Exchange'' or ''Phlx'') filed with the Securities and Exchange Commission (''SEC'' or ''Commission'') the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the Phlx. On November 19, 2001, the Phlx submitted 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.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Phlx proposes to amend Phlx Rule 1010, which governs the delisting of options classes on underlying equity securities (''Delisting Criteria Rule'' or ''Phlx Rule 1010'').

The text of the proposed rule change, as amended, is available at the Phlx and the Commission.

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 Phlx included statements concerning the purpose of and basis for the proposed rule change, as amended, 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 IV below. The Phlx 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 purpose of the proposed rule change, as amended, is to amend the Delisting Criteria Rule. The Exchange's Delisting Criteria Rule currently provides that the Exchange may not list additional series on an option class if the underlying security has not closed above $5 for the majority of business days during the preceding six calendar months as measured by the highest closing price reported in any market in which the underlying security traded (''$5 guideline'').[4] The Delisting Criteria Rule provides limited exceptions to the $5 guideline such that series may be added even when the underlying security did not satisfy the $5 guideline if the underlying security met either a separate $3 guideline or a separate $4 guideline.

Change in Guideline Price. The Exchange is proposing to amend its Delisting Criteria Rule in a few respects. First, the Exchange is amending the Delisting Criteria Rule by changing the guideline price (set for in Commentary .01 to Phlx Rule 1010) used to determine whether an underlying security previously approved for Exchange options transactions no longer meets the requirements for the continuance of approval. The Exchange proposes to reduce the guideline price used to make this determination from $5 to $3 in the primary market.[5] In addition, the Exchange proposes to eliminate the requirement for the Exchange to determine the guideline price by looking at whether the security closed above that price for a majority of the business days during the preceding six calendar months. Instead, the Exchange proposes to determine whether the underlying security closed above that price in the primary market in which it is traded (*i.e.,* no proposed to be $3) on the previous trading day. The Exchange is not otherwise proposing to amend the other criteria used to determine whether a class of options meets the requirements for the continuance of approval (such as, the number of shares that must be held by non-insiders, number of holders, and trading volume).

Intra-Day Additions of Series. The Exchange proposes to amend Commentary .02 to Phlx Rule 1010 by reducing from $5 to $3 the price above which the underlying security must be traded in the primary market before the Exchange may add additional series of options intra-day. This means if the Exchange is adding a series intra-day, the underlying security must have closed above $3 the previous day in the primary market (in order to meet the requirement of Commentary .01(4) to Phlx Rule 1010) and must be at $3 or above the primary market at the time the new series is added (in order to meet the requirement of Commentary .02 to Phlx Rule 1010).

Elimination of Commentary .05 to Phlx Rule 1010. The Exchange also is proposing to eliminate Commentary .05 of the Delisting Criteria Rule. Commentary .05 to Phlx Rule 1010 sets forth guidelines for adding classes notwithstanding that the price of the underlying security does not meet the $5 guideline currently set forth in Commentary .01, to Phlx Rule 1010. Notwithstanding the $5 guideline, Commentary .01 to Phlx Rule 1010 currently provides that the Exchange may add series if: (1) the closing price of the underlying security was over $3 for a majority of the days during the six calendar month period preceding the addition, and (2) the closing price of the underlying security must be $4 for a majority of the days during a subsequent six calendar month period. Because the Exchange is proposing to change the initial guideline from $5 to $3, Commentary .05 to Phlx Rule 1010 is no longer needed.

Reasons for Change to Delisting Criteria. The Phlx represents that when many of the delisting criteria were first implemented, the listed options market was in its infancy. Now more than twenty-five yeas after the Phlx first started trading listed options, the Phlx asserts that the listed options market is a mature market with sophisticated investors. The Exchange does not believe that the $5 guideline is necessary to accomplish its presumed intended purpose; *i.e.,* to prevent the proliferation of option classes on underlying securities that lack liquidity needed to maintain fair and orderly markets.[6] The Exchange believes that it should allow the desires of the Exchange's customers and the workings of the marketplace to determine the

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* letter from John Dayton, Assistant Secretary & Counsel, Phlx, to Nancy Sanow, Assistant Director, Division of Market Regulation (''Division''), Commission, dated November 16, 2001 (''Amendment No. 1''). In Amendment No. 1, the Phlx clarified in Commentary .01, subparagraph 4, and Commentary .02 to Phlx Rule 1010 that it will look to the primary market in which the underlying security trades in determining whether the underlying security satisfies the price requirements for adding additional series of options contracts. The Phlx also requested approval for the instant proposed rule change to be reclassified as filed under section 19(b)(3)(A), 15 U.S.C. 78s(b)(3)(A), and Rule 19b–4(f)(6) thereunder, 17 CFR 240.19b–4(f)(6). Lastly, the Phlx requested the original proposal on October 18, 2001, be considered the pre-filing notice required pursuant to Rule 19b–4(f)(6), 17 CFR 240.19b–4(f)(6).

[4] Other factors also must be met for the Exchange to add additional series in a class as described in Commentary .01 to Phlx Rule 1010.

[5] If the underlying security does not meet the guideline price, the Exchange will not open additional series of options of that class and may take other actions, such as prohibiting opening purchase transactions in series of options of that class previously opened.

[6] *See* Securities Exchange Act Release No. 33257 (November 30, 1993), 58 FR 64416 (December 7, 1993).

securities on which the Exchange will list options.[7] The Exchange believes its own business considerations should ensure that the Exchange does not list inappropriate classes of options. In determining to list any number of new option series under the proposed less restrictive standard, the Exchange represents that it must ensure that its own systems and those of Options Price Reporting Authority can handle any increased capacity requirements.

The Exchange represents that another reason for the proposal is that the current rule can be subject to differing interpretations. The Exchange notes that the options exchanges believe differing interpretations have occurred. The Exchange believes that the proposal is more clear because it reduces the standards to only one price guideline and checks that guideline the previous day or intra-day, instead of over the previous six months.

2. Statutory Basis

The Exchange believes that the current proposal should allow the Exchange to provide investors with those options that are most useful and demanded by them without sacrificing investor protection. As such, the Exchange believes the proposed rule change, as amended, is consistent with section 6 of the Act,[8] in general, and with section 6(b)(5) of the Act,[9] in particular, because it should promote just and equitable principles of trade, facilitate transactions in securities, remove impediments to and perfect the mechanism of a free and open market and a national market system, and 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, as amended, will impose any inappropriate burden on competition.

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.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Because the foregoing proposed rule change, as amended: (1) Does not significantly affect the protection of investors or the public interest; (2) does not impose any significant burden on competition; and (3) does not become operative for 30 days after the date of filing, or such shorter time as the Commission may designate if consistent with the protection of investors and the public interest; provided that the self-regulatory organization has given the Commission written notice of its intent to file the proposed rule change, along with the brief description and text of the proposed rule change, at least five business days prior to the date of filing of the proposed rule change,[10] or such shorter time as designated by the Commission, the proposed rule change, as amended, has become effective pursuant to section 19(b)(3)(A) of the Act[11] and Rule 19b–4(f)(6)[12] thereunder.

A proposed rule change filed under Rule 19b–4(f)(6) normally does not become operative prior to 30 days after the date of filing. However, Rule 19b–4(f)(6)(iii) permits the Commission to designate a shorter time if such action is consistent with the protection of investors and the public interest. The Phlx seeks to have the proposed rule change, as amended, become operative immediately. The Commission, consistent with the protection of investors and the public interest, has determined to make the proposed rule change, as amended, operative as of November 20, 2001.[13] The Commission notes that the proposed rule change, as amended, is substantially similar in all material respects to the rule of another exchange that the Commission has already noticed for public comment and approved[14] and, therefore, the proposed rule change raises no new issues of regulatory concern.

At any time within 60 days of the filing of the proposed rule change, as amended, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.[15]

IV. 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 in the Commission's Public Reference Room. Copies of such filing will also be available for inspection and copying at the principal office of the Phlx. All submissions should refer to File No. SR–Phlx–2001–96 and should be submitted by December 21, 2001.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[16]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 01–29717 Filed 11–29–01; 8:45 am]

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[7] Of course, the rule still provides that the security underlying the option must be listed on a national securities exchange or Nasdaq.

[8] 15 U.S.C. 78f.

[9] 15 U.S.C. 78f(b)(5).

[10] *See supra* note 3.

[11] 15 U.S.C. 78s(b)(3)(A).

[12] 17 CFR 240.19b–4(f)(6).

[13] For purposes only of accelerating the operative date of this proposal, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. 15 U.S.C. 78c(f).

[14] *See* Securities Exchange Act Release No. 44964 (October 19, 2001), 66 FR 54559 (October 29, 2001) (order approving File No. SR–CBOE–2001–29).

[15] *See* section 19(b)(3)(C) of the Act, 15 U.S.C. 78(b)(3)(C).

[16] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–45090; file No. SR–Phlx–2001–100

Self-Regulatory Organizations; Notice of Filing and Order Granting Accelerated Approval of Proposed Rule Change and Amendment Nos. 1 and 2 Thereto by the Philadelphia Stock Exchange, Inc. To Extend Its Pilot Program To Disengage Its Automatic Execution System (''AUTO–X'') for a Period of Thirty Seconds After the Number of Contracts Automatically Executed in a Given Option Meets the AUTO–X Minimum Guarantee for That Option

November 21, 2001.

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 30, 2001, the Philadelphia Stock

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

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. On November 8, 2001, the Phlx filed Amendment No. 1 to the proposed rule change.[3] On November 19, 2001, the Phlx 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 to approve the proposal, as amended, on an accelerated basis, for an additional six-month pilot, expiring on May 31, 2002.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Phlx proposes to extend, for an additional six months, its pilot program effecting a systems change to AUTO–X, the automatic execution feature of the Exchange's Automated Options Market System (''AUTOM''),[5] that would disengage AUTO–X for a period of thirty seconds after the number of contracts automatically executed in a given option meets the AUTO–X minimum guarantee for that option. The pilot program was originally approved on a six-month basis for a limited number of eligible options,[6] and subsequently extended for an additional six-month period.[7] Recently, the number of options eligible for the pilot was expanded to include all Phlx-traded options.[8] The current pilot is scheduled to expire on November 30, 2001.

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 Phlx proposes to extend the pilot program for an additional six-month period. On December 1, 2000, the Initial Pilot Program became effective.[9] The pilot program was then extended for an additional six months and is currently scheduled to end on November 30, 2001.[10] The pilot program includes the following features:

- Once an automatic execution occurs in an option via AUTO–X, the system would begin a ''counting'' program, which would count the number of contracts executed automatically for that option, up to the AUTO–X guarantee, regardless of the number of executions.
- When the number of contracts executed automatically for that option meets the AUTO–X guarantee within a fifteen second time frame, the system would cease to automatically execute for that option, and would drop all AUTO–X eligible orders in that option for manual handling by the specialist for a period of thirty seconds to enable the specialist to refresh quotes in that option.[11]
- Upon the expiration of thirty seconds, automatic executions would resume and the ''counting'' program would be set to zero and begin counting the number of contracts executed automatically within a fifteen second time frame again, up to the AUTO–X guarantee.
- Again, when the number of contracts automatically executed meets the AUTO–X guarantee within a fifteen second time frame, the system would drop all subsequent AUTO–X eligible orders for manual handling by the specialist for a period of thirty seconds.

A significant purpose of this pilot program is to enable the Exchange to move towards the dissemination of options quotations with size.[12] The ''counting'' feature of the pilot program functions to disengage AUTO–X for a period of thirty seconds in a given option once the number of contracts automatically executed meets the AUTO–X guarantee for that option within a fifteen-second time frame. A similar ''counting'' mechanism is expected to be utilized upon the implementation of the systems necessary for the dissemination of options quotations with size. Thus, the proposed extension of the pilot program should allow the Exchange to continue its efforts in the process of moving towards the implementation of quotations with size.

The Exchange believes that an extension of the pilot program would enable specialists to continue to provide fair and orderly markets during peak market activity by manually executing orders at correct market prices and refreshing quotations to reflect market demand.

In addition, the Exchange recognizes that the Commission has inquired into the possibility of re-engaging AUTO–X in less than thirty seconds once the specialist revises the quote. The Exchange's Financial Automation, Legal, and Regulatory staff have begun to review the issue, specifically as to whether it is feasible to re-engage AUTO–X for an entire issue based upon

[3] *See* Letter from Richard S. Rudolph, Counsel, Phlx, to Nancy J. Sanow, Assistant Director, Division of Market Regulation (''Division''), Commission, dated November 7, 2001 (''Amendment No. 1''). In Amendment No. 1, the Phlx amended its proposal by deleting a paragraph inadvertently placed in its original filing. The Phlx also clarified that it was taking steps to address the possibility of re-engaging AUTO–X prior to thirty seconds if the specialist revises its quote before thirty seconds.

[4] *See* Letter from Richard S. Rudolph, Counsel, Phlx, to Nancy J. Sanow, Assistant Director, Division, Commission, dated November 16, 2001 (''Amendment No. 2''). In Amendment No. 2, the Phlx confirmed that it has completed all actions required to be taken under its by-laws and rules. The Phlx's Executive Committee, pursuant to delegated authority, approved the proposed rule change for filing with the Commission on November 13, 2001.

[5] AUTOM is the Exchange's electronic order delivery and reporting system, which provides for the automatic entry and routing of equity option and index option orders to the Exchange trading floor. Orders delivered through AUTOM may be executed manually, or certain orders are eligible for AUTOM's automatic execution feature, AUTO–X. Equity option and index option specialists are required by the Exchange to participate in AUTOM and its features and enhancements. Option orders entered by Exchange members into AUTOM are routed to the appropriate specialist unit on the Exchange's trading floor.

[6] *See* Securities Exchange Act Release No. 43652 (December 1, 2000), 65 FR 77059 (December 8, 2000) (SR–Phlx–00–96) (''Initial Pilot Program'').

[7] *See* Securities Exchange Act Release No. 44362 (May 29, 2001), 66 FR 30037 (June 4, 2001) (SR–Phlx–2001–56).

[8] *See* Securities Exchange Act Release No. 44760 (August 31, 2001), 66 FR 47253 (September 11, 2001) (SR–Phlx–2001–79).

[9] *See supra* note 6.

[10] *See supra* note 7.

[11] Any orders delivered in excess of the minimum AUTO–X guarantee will be executed to the guaranteed amount and the excess will be dropped to the specialist for manual execution. *See* Initial Pilot Program, *supra* note 6.

[12] Currently, the size of any disseminated bid or offer by the Exchange is equal to the AUTO–X guarantee for the quoted option, except that the disseminated size of bids and offers of limit orders on the book is ten contracts and is firm regardless of the actual size of such orders. *See* Exchange Options Floor Procedure Advice F–7. The Exchange has established this rule setting forth the size for which its quotes are firm, and periodically publishes that size in accordance with recently amended Rule 11Ac1–1 under the Act (the ''Quote Rule''). *See* Securities Exchange Act Release No. 44145 (April 2, 2001), 66 FR 18662 (April 10, 2001) (SR–Phlx–01–37). The pilot program is designed, in part, to enable the Exchange to roll out the system designed to decrement the disseminated size of Exchange quotes once such system is deployed.

the revision of a quotation in one single series.[13]

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with Section 6 of the Act [14] in general, and with Section 6(b)(5) in particular,[15] in that it is designed to perfect the mechanism of a free and open market and a national market system, protect investors and the public interest and promote just and equitable principles of trade by enabling Exchange specialists to maintain fair and orderly markets during periods of peak market activity.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any inappropriate burden on competition.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

The Exchange did not receive or solicit any written comments on the proposed rule change.

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–2001–100 and should be submitted by December 21, 2001.

IV. Commission's Finding and Order Granting Accelerated Approval of Proposed Rule Change

The Commission finds that the proposed rule change is consistent with the requirements of the Act and the rules and regulations thereunder applicable to a national securities exchange.[16] In particular, the Commission finds that the proposed rule change is consistent with section 6(b)(5) of the Act, which requires that the rules of an exchange be designed to promote just and equitable principles of trade, remove impediments to and perfect the mechanism of a free and open market and a national securities system, and protect investors and the public interest.[17] The Commission believes that an extension of the pilot program for an additional six months should help the Exchange to prepare for disseminating options quotes with size. In addition,the Commission believes that the proposal may assist specialists in maintaining fair and orderly markets during periods of peak market activity.

The Commission recognizes that during the last six-month extension of the pilot program, the Phlx has received no complaints from customers, floor traders, or member firms. The Exchange noted that Phlx Rule 1080(c) provides the Phlx's Options Committee discretion to restrict the use of AUTO–X in any options series. The Exchange also clarified that orders would not be executed at an inferior price simply because they are routed to the specialist for manual handling; the orders would be handled in a manner consistent with the Exchange's rules on priority, parity, and precedence and in compliance with SEC's Quote Rule and Phlx Rule 1082 (''Firm quotations''). In addition, the Commission notes that the Exchange is attempting to address its concern regarding the feasibility of re-engaging AUTO–X for a particular issue prior to thirty seconds if the quote has been revised by the specialist before that time period.[18] Consequently, the Commission believes that extending the pilot program for an additional six months should enable the Phlx to further evaluate the effect of disengaging AUTO–X under certain circumstances.

The Commission notes that the Exchange has represented that it will continue to evaluate the pilot program by reviewing specialists' performance, and by monitoring any complaints relating to the pilot program.[19] Furthermore, the Commission notes that the Exchange has represented that it will continue to post on its website a list of options included in the pilot program, as well as issue a circular to this effect to members, member organizations, participants, and participant organizations explaining the pilot program and the circumstances in which the AUTO–X system will not be available for customer orders.[20]

Finally, the Commission finds good cause, pursuant to section 19(b)(2) of the Act,[21] for approving the proposed rule change, as amended, prior to the thirtieth day after the date of publication of notice thereof the **Federal Register**. The Commission believes that granting accelerated approval to extend the pilot program for an additional six months will allow Phlx to continue, without interruption, the existing operation of its AUTO–X system.

V. Conclusion

It Is Therefore Ordered, pursuant to Section 19(b)(2) of the Act,[22] that the proposed rule change (SR–Phlx–2001–100), as amended, is hereby approved on an accelerated basis, as a six-month pilot, scheduled to expire on May 31, 2002.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[23]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 01–29718 Filed 11–29–01; 8:45 am]

BILLING CODE 8010–01–M

[13] Under Phlx's current pilot program, AUTO–X is programmed to re-engage after thirty seconds regardless of whether the specialist has updated its quote prior to that period of time. Division staff have informed the Phlx that it would not grant the pilot program permanent approval unless the Phlx addresses this issue.

[14] 25 U.S.C. 78f.

[15] 15 U.S.C. 78f(b)(5).

[16] In approving this proposal, the Commission has considered its impact on efficiency, competition, and capital formation. 15 U.S.C. 78c(f).

[17] 15 U.S.C. 78f(b)(5).

[18] *See supra* note 13.

[19] Telephone conversation between Richard S. Rudolph, Counsel, Phlx, and Sapna C. Patel, Attorney, Division, Commission, on November 16, 2001.

[20] *Id.* Phlx also represented that it would include language in its circular clarifying that AURO–X will not be re-engaged until the expiration of the thirty second period, even after a quote is revised. Telephone conversation between Richard S. Rudolph, Counsel, Phlx, and Sapna C. Patel, Attorney, Division, Commission, on November 16, 2001.

[21] 15 U.S.C. 78s(b)(2).

[22] *Id.*

[23] 17 CFR 200.30–3(a)(12).

TRADE AND DEVELOPMENT AGENCY

SES Performance Review Board

AGENCY: Trade and Development Agency.

ACTION: Notice.

SUMMARY: Notice is hereby given of the appointment of members of the Trade and Development Agency's Performance Review Board.

FOR FURTHER INFORMATION CONTACT: Larry P. Bevan, Assistant Director for Management, Trade and Development Agency, 1621 N. Kent Street, Arlington, VA 22209–2131 (703) 875–4357.

SUPPLEMENTARY INFORMATION: Section 4314(c)(1) through (5), U.S.C., requires each agency to establish, in accordance with regulations prescribed by the Office of Personnel Management, one or more SES performance review boards. The board shall review and evaluate the initial appraisal of a senior executive's performance by the supervisor, along with any recommendations to the appointing authority relative to the performance of the senior executive.

The following have been selected as acting members of the Performance Review Board of the Trade and Development Agency: Duff Gillespie, Deputy Assistant Administrator, Center for Population, Health and Nutrition, Bureau for Global Programs, Field Support and Research, U.S. Agency for International Development; Franklin Moore, Deputy Assistant Administrator, Office of Microenterprise Development, Center for Economic Growth and Agricultural Development, U.S. Agency for International Development; and Sandy Owens, Deputy Chief Financial Officer, Office of Financial Management, U.S. Agency for International Development.

Dated: November 27, 2001.

Larry P. Bevan,

Assistant Director for Management.

[FR Doc. 01–29734 Filed 11–29–01; 8:45 am]

BILLING CODE 8040–01–M

OFFICE OF THE UNITED STATES TRADE REPRESENTATIVE

Notice of a New System of Records and Request for Public Comment Pursuant to Privacy Act of 1974

AGENCY: Office of the United States Trade Representative.

ACTION: Notice and request for comments.

SUMMARY: Pursuant to the Privacy Act of 1974, 5 U.S.C. 552(a)(e)(4), the Office of the United States Trade Representative (USTR) is required to publish notice in the **Federal Register** upon the establishment of a system of records on identifiable individuals maintained by the USTR and to provide opportunity to comment. USTR has established a new system of records maintaining information submitted by individuals who are interested in serving on dispute settlement panels under certain trade agreements and seeks comments on the ''routine uses'' of this information.

DATES: Comments should be submitted by December 31, 2001.

ADDRESSES: Comments should be sent to: Attn: Ms. Sybia Harrison, FOIA Officer, Office of the U.S. Trade Representative, 600 17th Street, NW., Washington, DC 20508. Due to the recent disruption of mail to federal agencies in Washington, DC, commentors may also submit their comments by fax: (202) 395–3639, or by e-mail: *boverton@ustr.gov.*

FOR FURTHER INFORMATION CONTACT: Ms. Sybia Harrison, FOIA Officer, (202) 395–3419.

SUPPLEMENTARY INFORMATION: In accordance with international trade agreements, the Office of the U.S. Trade Representative has established a system of records which maintains information by name on the qualifications of individuals who have responded to public solicitations and have indicated their interest in serving on a panel to resolve trade disputes. Specifically, Annex 1901.2 of the North American Free Trade Agreement (NAFTA) and section 123(h) of the Uruguay Round Agreements Act (URAA) (19 U.S.C. 3533(b)) make provision for USTR to maintain rosters of individuals interested in serving on such panels. On a periodic basis, USTR seeks applications through notice in the **Federal Register** from individuals for consideration as potential panelists. Solicitation of panelists under the URAA, was last made on November 9, 1999, 64 FR 61173. Solicitation of panelists under the NAFTA is being done concurrently with the publication of this notice. A specific notice seeking applications appeared on November 16, 2001, 66 FR 57767.

Notice of this systems of record, as required by 5 U.S.C. 552a(r), is being transmitted to Congress and the report required by Office of Management and Budget Circular A–130 has been submitted to the Administrator, Office of Information and Regulatory Affairs.

The notice for this USTR system is set forth as an annex to this notice.

Public Comment on ''Routine Uses''

Written comments concerning the ''routine uses'' sections of the above USTR system of records notice is invited from interested persons pursuant to 5 U.S.C. 552a(e)(11). Comments may be presented in writing to the Office of the United States Trade Representative as indicated above.

John Hopkins,

Assistant U.S. Trade Representative for Administration.

Annex

USTR–6

SYSTEM NAME:

Dispute Settlement Panelists Roster.

SYSTEM LOCATION:

Office of the General Counsel, Office of the United States Trade Representative, 600 17th Street, NW., Washington, DC.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Non-governmental individuals who have expressed an interest in being selected to serve on a dispute settlement panel, or other similar entity, established under trade agreements to resolve trade disputes.

CATEGORIES OF RECORDS IN THE SYSTEM:

Applications from potential panelists typically include, correspondence with the potential panelist, general resume information, statements of citizenship when required, information regarding registration under the Foreign Agents Registration Act (22 U.S.C. 611), lists of publications and speeches, descriptions of professional affiliations, lists of clients, information regarding substantive qualifications in trade law, and names of references. In addition, the system contains disclosure forms submitted by candidate panelists setting forth areas where they may have a potential conflict-of-interest with respect to service on a specific panel. These typically cover financial interests, affiliations, identity of clients of the candidate or the candidate's firm.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

Annex 1901.2 of the North American Free Trade Agreement (NAFTA), section 402 of the NAFTA Implementation Act, as amended (19 U.S.C. 3432), section 123(b) Uruguay Round Agreements Act (19 U.S.C. 3533(b)).

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USE.

Records are used by USTR staff to select potential panelist candidates to resolve trade disputes.

Relevant records in the system of records may be referred, as a routine use to other federal agencies in the course of determining eligibility for the roster, or assessing qualifications for service on a particular panel. Relevant records are also shared with foreign governments,

the World Trade Organization and the NAFTA Secretariat, in the course of making determinations on panel members.

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

Paper.

RETRIEVABILITY:

By name.

SAFEGUARDS:

Stored in a guarded building; released only to authorized personnel.

RETENTION AND DISPOSAL:

Records are maintained in accordance with the Records Schedule for the Office of the General Counsel.

SYSTEM MANAGER(S) AND ADDRESS:

The General Counsel, Office of the U.S. Trade Representative, 600 17th Street, NW., Washington, DC 20508.

NOTIFICATION PROCEDURE:

Contact system manager noted above.

RECORD ACCESS PROCEDURE:

These records are available to the public except in instances where the panelists have asked that certain information be maintained as confidential in accordance with USTR's regulation on business confidential information found at 15 CFR 2003.6.

CONTESTING RECORD PROCEDURES:

See USTR access regulations in 15 CFR part 2005.

RECORD SOURCE CATEGORIES:

The subject individual; the USTR.

[FR Doc. 01–29794 Filed 11–29–01; 8:45 am]

BILLING CODE 3190–01–M

DEPARTMENT OF TRANSPORTATION

Maritime Administration

[Docket Number MARAD–2001–11052]

Requested Administrative Waiver of the Coastwise Trade Laws

AGENCY: Maritime Administration, Department of Transportation.

ACTION: Invitation for public comments on a requested administrative waiver of the Coastwise Trade Laws for the vessel SEA CHATEAU.

SUMMARY: As authorized by Pub. L. 105–383, the Secretary of Transportation, as represented by the Maritime Administration (MARAD), is authorized to grant waivers of the U.S.-build requirement of the coastwise laws under certain circumstances. A request for such a waiver has been received by MARAD. The vessel, and a description of the proposed service, is listed below. Interested parties may comment on the effect this action may have on U.S. vessel builders or businesses in the U.S. that use U.S.-flag vessels. If MARAD determines that in accordance with Pub. L. 105–383 and MARAD's regulations at 46 CFR part 388 (65 FR 6905; February 11, 2000) that the issuance of the waiver will have an unduly adverse effect on a U.S.-vessel builder or a business that uses U.S.-flag vessels, a waiver will not be granted.

DATES: Submit comments on or before December 31, 2001.

ADDRESSES: Comments should refer to docket number MARAD–2001–11052. Written comments may be submitted by hand or by mail to the Docket Clerk, U.S. DOT Dockets, Room PL–401, Department of Transportation, 400 7th St., SW., Washington, DC 20590–0001. You may also send comments electronically via the Internet at *http://dmses.dot.gov/submit/.* All comments will become part of this docket and will be available for inspection and copying at the above address between 10 a.m. and 5 p.m., E.T., Monday through Friday, except federal holidays. An electronic version of this document and all documents entered into this docket is available on the World Wide Web at *http://dms.dot.gov.*

FOR FURTHER INFORMATION CONTACT: Kathleen Dunn, U.S. Department of Transportation, Maritime Administration, MAR–832 Room 7201, 400 Seventh Street, SW., Washington, DC 20590. Telephone 202–366–2307.

SUPPLEMENTARY INFORMATION: Title V of Pub. L. 105–383 provides authority to the Secretary of Transportation to administratively waive the U.S.-build requirements of the Jones Act, and other statutes, for small commercial passenger vessels (no more than 12 passengers). This authority has been delegated to the Maritime Administration per 49 CFR 1.66, Delegations to the Maritime Administrator, as amended. By this notice, MARAD is publishing information on a vessel for which a request for a U.S.-build waiver has been received, and for which MARAD requests comments from interested parties. Comments should refer to the docket number of this notice and the vessel name in order for MARAD to properly consider the comments. Comments should also state the commenter's interest in the waiver application, and address the waiver criteria given in § 388.4 of MARAD'S regulations at 46 CFR part 388.

Vessel Proposed for Waiver of the U.S.-Build Requirement

(1) Name of vessel and owner for which waiver is requested. Name of vessel: SEA CHATEAU. Owner: Gregory Lewis.

(2) Size, capacity and tonnage of vessel. According to the applicant: ''49′6″ over all length fiberglass catamaran sailboat sloop; 27′1″ beam, 3′9″ draft. Gross weight: 11 Tons pursuant to 46 U.S.C. 14502.''

(3) Intended use for vessel, including geographic region of intended operation and trade. According to the applicant: ''Intended use for vessel is for fully crewed day and term charters in the following regions:

A. Puerto Rico and the surrounding islands of Vieques and Culerba

B. Eastern and Atlantic Seaboard area from New England and as far South as South Florida. (the Long Island Sound, New England, and the surrounding Islands, Delaware Bay & Chesapeake Bay, Maryland's Eastern shore * * * as far south as Florida and the Florida Keys in the winter months.)''

(4) Date and Place of construction and (if applicable) rebuilding. Date of construction: 1997. Place of construction: Cape Town, South Africa.

(5) A statement on the impact this waiver will have on other commercial passenger vessel operators. According to the applicant: ''Our vessel is a production made catamaran which we would like to bring and charter in the United States. There are NO U.S. made production catamarans that are direct competitors to this vessel. Although there are some luxury catamarans operating in the United States, the industry is very slight and I feel this will stimulate charter and the sailing industry into the United States waters. Due to the fact that we are a catamaran, we offer a totally different charter experience than a monohull sailboat, therefore we cater to a different market and would not be taking business way from existing monohull sailboats.''

(6) A statement on the impact this waiver will have on U.S. shipyards. According to the applicant: ''I do not believe this waiver will have an adverse impact on U.S. shipyards as there are currently no shipyards producing this type of production catamaran vessel in the United States.''

Dated: November 27, 2001.

By Order of the Maritime Administrator.

Joel C. Richard,

Secretary, Maritime Administration.

[FR Doc. 01–29765 Filed 11–29–01; 8:45 am]

BILLING CODE 4910–81–P

DEPARTMENT OF THE TREASURY

Submission for OMB Review; Comment Request

November 23, 2001.

The Department of Treasury has submitted the following public information collection requirement(s) to OMB for review and clearance under the Paperwork Reduction Act of 1995, Public Law 104–13. Copies of the submission(s) may be obtained by calling the Treasury Bureau Clearance Officer listed. Comments regarding this information collection should be addressed to the OMB reviewer listed and to the Treasury Department Clearance Officer, Department of the Treasury, Room 2110, 1425 New York Avenue, NW., Washington, DC 20220.

DATES: Written comments should be received on or before December 31, 2001 to be assured of consideration.

Bureau of Alcohol, Tobacco and Firearms

OMB Number: 1512–0005.

Form Number: ATF F 3210.1.

Type of Review: Extension.

Title Application for Restoration of Firearms and/or Explosives.

Description: Certain categories of persons are prohibited from possessing explosives and firearms. This form is the basis for ATF investigating the merits of an applicant to have his/her rights restored.

Respondents: Individuals or households, Business or other for-profit.

Estimated Number of Respondents: 5,000.

Estimated Burden Hours Per Respondent: 30 minutes.

Frequency of Response: On occasion.

Estimated Total Reporting Burden: 2,500 hours.

OMB Number: 1512–0029.

Form Number: ATF F 10 (5320.10).

Type of Review: Extension.

Title: Application for Registration of Firearms Acquired by Certain Governmental Entities.

Description: This form is used by State and local government agencies to obtain permission to register otherwise unregisterable firearms for agency use. These agencies obtain a benefit by this registration.

Respondents: Federal Government, Individuals or households, Business or other for-profit, State, Local or Tribal Government.

Estimated Number of Reporting/Recordkeepers: 600.

Estimated Burden Hours Per Respondent/Recordkeeper: 30 minutes.

Frequency of Response: Other (ATF Form 10 is required to be submitted by State and local government entities wishing to register an abandoned or seized and previously unregistered National Firearms Act weapon. The form is required whenever application for such a registration is made.)

Estimated Total Reporting/Recordkeeping Burden: 300 hours.

OMB Number: 1512–0095.

Form Number: ATF F 5154.1.

Type of Review: Extension.

Title: Formula and Process for Nonbeverage Product.

Description: Businesses that use taxpaid alcohol to manufacture nonbeverage products may file a claim for drawback (refund or remittance), if they can substantiate by using ATF Form 5154.1 that the spirits were used in the manufacture of products unfit for beverage use. This determination is based on the formula for the product.

Respondents: Business or other for-profit.

Estimated Number of Recordkeepers: 611.

Estimated Burden Hours Per Recordkeeper: 30 minutes.

Frequency of Response: On occasion.

Estimated Total Recordkeeping Burden: 2,500 hours.

OMB Number: 1512–0222.

Form Number: ATF F 5640.2.

Type of Review: Extension.

Title: Offer in Compromise of Liability Incurred Under Federal Alcohol Administration Act, as Amended.

Description: Persons who have committed violations of the FAA Act may submit an offer in compromise. The offer is a request by the party in violation to compromise penalties for the violations in lieu of civil or criminal action. ATF F 5640.2 identifies the violation(s) to be compromised by the person committing them, amount of offer plus justification for acceptance.

Respondents: Business or other for-profit.

Estimated Number of Respondents: 12.

Estimated Burden Hours Per Respondent: 2 hours.

Frequency of Response: On occasion.

Estimated Total Reporting Burden: 24 hours.

Clearance Officer: Frank Bowers (202) 927–8930, Bureau of Alcohol, Tobacco and Firearms, Room 3200, 650 Massachusetts Avenue, NW., Washington, DC 20226.

OMB Reviewer: Alexander T. Hunt (202) 395–7860, Office of Management and Budget, Room 10202, New Executive Office Building, Washington, DC 20503.

Mary A. Able,

Departmental Reports Management Officer.

[FR Doc. 01–29711 Filed 11–29–01; 8:45 am]

BILLING CODE 4810–31–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Privacy Act of 1974; System of Records

AGENCY: Internal Revenue Service, Treasury.

ACTION: Notice of Proposed New Privacy Act System of Records.

SUMMARY: In accordance with the requirements of the Privacy Act of 1974, as amended, 5 U.S.C. 552a, the Treasury Department, Internal Revenue Service, gives notice of a newly proposed system of records, Treasury/IRS 60.000—Employee Protection System Records. A portion of the existing systems of records (1) Assault and Threat Investigation Files, Inspection—Treasury/IRS 60.001 addressing potentially dangerous taxpayers and (2) the Miscellaneous Information File, Inspection—Treasury/IRS 60.007, will be transferred to the proposed new system of records when the notice is effective.

DATES: Comments must be received no later than December 31, 2001. The system of records will be effective January 9, 2002, unless comments are received which result in a contrary determination.

ADDRESSES: Comments should be sent to the Office of Governmental Liaison and Disclosure, Internal Revenue Service, 1111 Constitution Ave., NW., Washington, DC 20224. Comments will be made available for inspection and copying in the National Office reading room upon request. An appointment for inspecting the comments can be made by calling (202) 622–5164. This is not a toll free number.

FOR FURTHER INFORMATION CONTACT: Chief, Office of Employee Protection, Internal Revenue Service, 477 Michigan Avenue, Detroit, MI, 48226, telephone (313) 628–3742. This is not a toll free number.

SUPPLEMENTARY INFORMATION: The Department is establishing the Employee Protection System Records system of records to enhance the security and safety of Internal Revenue Service employees who are engaged in the assessment and collection of federal

taxes. This system will consist of information furnished by Internal Revenue Service employees or other parties with respect to an individual who is involved in a tax administration matter before the Internal Revenue Service. The records in this system will be maintained for a period of five years, after which the records will be reviewed to determine whether there is a need to maintain the information in the system. This system, being established as a result of the 1998 IRS Restructuring and Reform Act, will consist primarily of records of potentially dangerous taxpayers formerly maintained under the system of records entitled ''Treasury/IRS 60.001—Assault and Threat Investigation Files, Inspection'' and records pertaining to assaults, threats, harassment, and suicide threats maintained under the system of records entitled ''Treasury/IRS 60.007—Miscellaneous Information File, Inspection.'' Because parts of this system are retrieved by individual identifier, the Privacy Act of 1974, as amended, requires a general notice of the existence of this system of records to the public. The records contained in this system of records will include reports by Internal Revenue Service employees of incidents of threats of harm to, or harassment of, employees by individual taxpayers, threats of suicide made by a taxpayer in response to a contact by an Internal Revenue Service employee, results of investigations into those incidents, determinations as to whether the taxpayer should be considered a potentially dangerous taxpayer or a taxpayer who should be approached with caution, and related correspondence.

The new system of records report, as required by 5 U.S.C. 552a(r) of the Privacy Act, has been submitted to the Committee on Government Operations of the House of Representatives, the Committee on Governmental Affairs of the Senate, and the Office of Management and Budget, pursuant to Appendix I to OMB Circular A–130, ''Federal Agency Responsibilities for Maintaining Records About Individuals,'' dated November 30, 2000.

The proposed system of records, Treasury/IRS 60.000—Employee Protection System Records, is published in its entirety below.

Dated: November 7, 2001.

W. Earl Wright, Jr.,

Chief Management and Administrative Programs Officer.

Treasury/IRS 60.000

SYSTEM NAME:

Employee Protection System Records.

SYSTEM LOCATION:

Internal Revenue Service, 477 Michigan Avenue, Detroit, Michigan.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Individuals attempting to interfere with the administration of internal revenue laws through assaults, threats, suicide threats, harassment, filing or threats of filing frivolous criminal or civil legal action against Internal Revenue Service (IRS) employees or the employees' immediate family members, or forcible interference of any officer or employee while discharging the official duties at his/her position. This includes individuals designated as potentially dangerous taxpayers (PDTs), based on reliable evidence or information, from IRS employees or otherwise furnished to the IRS or the Treasury Inspector General for Tax Administration (TIGTA), that fit any of the criteria (1) through (5) below: (1) Individuals who assault employees or members of the employees' immediate families; (2) Individuals who attempt to intimidate or threaten employees or members of the employees' immediate families through specific threats of bodily harm, a show of weapons, the use of animals, or through other specific threatening or intimidating behavior; (3) Individuals who are active members of groups that advocate violence against Internal Revenue Service employees specifically, or against Federal employees generally where advocating such violence could reasonably be understood to threaten the safety of Service employees and impede the performance of their official duties; (4) Individuals who have committed the acts set forth in any of the above criteria, but whose acts have been directed against employees of other governmental agencies at Federal, State, county, or local levels; (5) Individuals who are not designated as potentially dangerous taxpayers through application of the above criteria, but who have demonstrated a clear propensity toward violence through act(s) of violent behavior within the five-year period immediately preceding the time of referral of the individual to the Employee Protection System. (6) These records also include individuals who have threatened suicide and individuals who have filed or threatened to file a frivolous civil or criminal legal action (including liens, civil complaints in a court, and criminal charges) against any IRS employee.

CATEGORIES OF RECORDS IN THE SYSTEM:

(1) Documents reporting the incident; (2) Documentary evidence of the incident (i.e. threatening correspondence, copies of liens and legal actions); (3) Documentation of investigation of incident, with possible report of investigation, statements, affidavits, and related tax information; (4) Records of any legal action resulting from the incident; (5) Local police records of individual named in the incident, if such records are requested or otherwise provided during investigation of the incident; (6) FBI record of individual named in the incident, if such records are requested or otherwise provided during investigation of the incident; (7) Newspaper or periodical items, or information from other sources, provided to the IRS or to TIGTA for investigation of individuals who have demonstrated a clear propensity toward violence; (8) Correspondence regarding the reporting of the incident, referrals for investigation, investigation of the incident; and result of investigation (i.e. designation as potentially dangerous taxpayer, or other designation to alert IRS employees to approach the individual with caution).

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

5 U.S.C. 301; 26 U.S.C. 7801 and 7803.

PURPOSE(S):

This system of records documents reports by Internal Revenue Service employees of attempts by taxpayers to obstruct or impede Internal Revenue Service employees or other law enforcement personnel in the performance of their official duties, investigations into the matters reported, and conclusions as to whether the taxpayers should be considered potentially dangerous taxpayers or should otherwise be approached with caution by employees of the Internal Revenue Service or any other law enforcement organization.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USE:

Disclosure of returns and return information may be made only as provided by 26 U.S.C. 6103. Records other than returns or return information may be used to:

(1) Disclose pertinent information to appropriate Federal, State, local, or foreign agencies responsible for investigating or prosecuting the violations of, or for enforcing or implementing, a statute, rule, regulation, order, or license, where the disclosing agency becomes aware of an indication of a violation or potential violation of a civil or criminal law or regulation;

(2) Disclose information to a Federal, State, or local agency maintaining civil, criminal or other relevant enforcement information or other pertinent information, which has requested information relevant to or necessary to the requesting agency's or the bureau's hiring or retention of an individual, or issuance of a security clearance, license, contract, grant, or other benefit;

(3) Disclose information in a proceeding before a court, adjudicative body, or other administrative body, before which the agency is authorized to appear when: (a) The agency, or (b) any employee of the agency in his or her official capacity, or (c) any employee of the agency, in his or her individual capacity where the Department of Justice or the agency has agreed to represent the employee, or (d) the United States, when the agency determines that the litigation is likely to affect the agency, is a party to litigation or has an interest in such litigation, and the use of such records by the agency is deemed to be relevant and necessary and not otherwise privileged;

(4) Provide information to a congressional office in response to an inquiry made at the request of the individual to whom the record pertains;

(5) Provide information to the news media in accordance with guidelines contained in 28 CFR 50.2 which relate to an agency's functions relating to civil and criminal proceedings, and

(6) Provide information to third parties during the course of an investigation to the extent necessary to obtain information pertinent to an investigation of the incident reported in the record.

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

Paper, or magnetic or electronic media.

RETRIEVABILITY:

By name of individual to whom the record applies, by name of Internal Revenue Service employee reporting an incident, by identification number of the individual to whom the record pertains, by subject or incident involved, and/or by case number.

SAFEGUARDS:

Access controls will not be less than those provided by the Physical Security Handbook, IRM 1.16 and the Automated Information System Security Handbook, IRM 2.10. The records are accessible to employees of the Office of Employee Protection and to personnel of the Treasury Inspector General for Tax Administration, all on a need-to-know basis, and all of whom have been the subject of a background investigation. Disclosure of information through remote terminals is restricted through the use of passwords and sign-on protocols which are periodically changed; these terminals are accessible only to authorized persons.

RETENTION AND DISPOSAL:

Records are maintained in accordance with IRM Handbook No. 1.15.

SYSTEM MANAGER(S) AND ADDRESS:

Chief, Office of Employee Protection, Internal Revenue Service, 477 Michigan Avenue, Detroit, Michigan.

NOTIFICATION PROCEDURE:

This system of records may not be accessed for purposes of determining if the system contains a record pertaining to a particular individual.

RECORD ACCESS PROCEDURES:

This system is exempt and may not be accessed for purposes of inspection or for contest of content of records.

CONTESTING RECORD PROCEDURES:

26 U.S.C. 7852(e) prohibits Privacy Act amendment of tax records.

RECORD SOURCE CATEGORIES:

This system of records is exempt from the Privacy Act provision that requires the record source categories be reported.

EXEMPTIONS CLAIMED FOR THE SYSTEM:

This system is exempt from 5 U.S.C. 552a(c)(3), (d), (e)(1), (e)(4)(G), (H), and (I) and (f) of the Privacy Act pursuant to 5 U.S.C. 552a(k)(2). (See 31 CFR 1.36)

[FR Doc. 01–29709 Filed 11–29–01; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0009]

Proposed Information Collection Activity: Proposed Collection; Comment Request

AGENCY: Veterans Benefits Administration, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: The Veterans Benefits Administration (VBA), Department of Veterans Affairs (VA), 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 for information needed to determine a veteran's eligibility for and entitlement to vocational rehabilitation benefits.

DATES: Written comments and recommendations on the proposed collection of information should be received on or before January 29, 2002.

ADDRESSES: Submit written comments on the collection of information to Nancy J. Kessinger, Veterans Benefits Administration (20S52), Department of Veterans Affairs, 810 Vermont Avenue, NW, Washington, DC 20420 or e-mail: *irmnkess@vba.va.gov*. Please refer to ''OMB Control No. 2900–0009'' in any correspondence.

FOR FURTHER INFORMATION CONTACT: Nancy J. Kessinger at (202) 273–7079 or FAX (202) 275–5947.

SUPPLEMENTARY INFORMATION: Under the PRA of 1995 (Pub. L. 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, VBA invites comments on: (1) Whether the proposed collection of information is necessary for the proper performance of VBA's functions, including whether the information will have practical utility; (2) the accuracy of VBA'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: Disabled Veterans Application for Vocational Rehabilitation (Chapter 31—Title 38 U.S.C.), VA Form 28–1900.

OMB Control Number: 2900–0009.

Type of Review: Extension of a currently approved collection.

Abstract: Service-connected disabled veterans and servicepersons awaiting discharge for disability use VA Form 29–1900 to apply for vocational rehabilitation benefits. The application obtains information needed to evaluate an applicant's claim for benefits.

Affected Public: Individuals or households.

Estimated Annual Burden: 13,500 hours.

Estimated Average Burden Per Respondent: 15 minutes.

Frequency of Response: On occasion.

Estimated Number of Respondents: 54,000.

By direction of the Secretary.

Dated: November 16, 2001.

Donald L. Neilson,

Director, Information Management Service.

[FR Doc. 01–29736 Filed 11–29–01; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

Scientific Review and Evaluation Board for Health Services Research and Development Service, Notice of Meeting

The Department of Veterans Affairs, Veterans Health Administration, gives notice under Pub. L. 92–463, that a meeting of the Scientific Review and Evaluation Board for Health Services Research and Development Service, will be held at the Emily Morgan Hotel, 705 East Houston Street, San Antonio, Texas 78205, January 22–25, 2002. The meeting will convene from 7 p.m. until 9 p.m. on January 22, 2002, from 8 a.m. until 5 p.m. on January 23 and 24, 2002, and from 8 a.m. until 1 p.m. on January 25, 2002. The purpose of the meeting is to review research and development applications concerned with the measurement and evaluation of health care services and with testing new methods of health care delivery and management, and nursing research. Applications are reviewed for scientific and technical merit. Recommendations regarding funding are prepared for the Chief Research and Development Officer.

This meeting will be open to the public at the start of the January 22 session for approximately one half-hour to cover administrative matters and to discuss the general status of the program. The closed portion of the meeting involves discussion, examination, reference to, and oral review of staff and consultant critiques of research protocols and similar documents. During this portion of the meeting, discussion and recommendations will include qualifications of the personnel conducting the studies (the disclosure of which would constitute a clearly unwarranted invasion of personal privacy), as well as research information (the premature disclosure of which would be likely to frustrate significantly the implementation of proposed agency action regarding such research projects). As provided by the subsection 10(d) of Pub. L. 92–463, as amended by Pub. L. 94–409, closing portions of these meetings is in accordance with 5 U.S.C. 552b(c)(6) and (9)(B).

Those who plan to attend the open session should contact Mr. John G. Demakis, Director, Health Services Research and Development Service (124F), Department of Veterans Affairs, 1400 I Street, NW., Suite 780, Washington, DC, at least five days before the meeting. For further information, call (202) 408–3665.

Dated: November 20, 2001.

By Direction of the Secretary.

Nora E. Egan,

Committee Management Officer.

[FR Doc. 01–29737 Filed 11–29–01; 8:45 am]

BILLING CODE 8320–01–M

DEPARTMENT OF VETERANS AFFAIRS

Privacy Act of 1974; System of Records

AGENCY: Department of Veterans Affairs (VA).

ACTION: Notice of new system of records—Compliance Records, Response, and Resolution of Reports of Persons Allegedly Involved in Compliance Violations—VA.

SUMMARY: As required by the Privacy Act of 1974, 5 U.S.C. 552a(e), notice is hereby given that the Department of Veterans Affairs (VA) is adding a new system of records, ''Compliance Records, Response, and Resolution of Reports of Persons Allegedly Involved in Compliance Violations—VA'' (106VA17).

DATES: Comments on the establishment of this system of records must be received no later than December 31, 2001. If no public comment is received during the period allowed for comment or unless otherwise published in the Federal Register by VA, the new system will become effective December 31, 2001.

ADDRESSES: Written comments concerning the proposed new system of records may be submitted to the Office of Regulations Management (02D), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420. Comments will be available for public inspection at the above address in the Office of Regulations Management, Room 1158, between the hours of 8 a.m. and 4:30 p.m., Monday through Friday (except holidays).

FOR FURTHER INFORMATION CONTACT: Veterans Health Administration (VHA) Privacy Act Officer, Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, telephone (727) 320–1839.

SUPPLEMENTARY INFORMATION:

I. Description of the Proposed Systems of Records

The Compliance and Business Integrity (CBI) Program, although originally modeled after Health and Human Services (HHS)–Office of Inspector General's (OIG) hospital compliance program, has evolved into a program that meets program requirements specific to VA. Management of the CBI Program falls under the direction of the VHA Chief Financial Officer (CFO). The CBI Program assures the organizational and business structure within which patient care takes place is in compliance with laws, regulations, policies and standards, which impact the business. It also reduces business risk and serves as a management function that is interdisciplinary in nature, focuses on business processes and acts as a fiduciary of public resources. An integral component of the Compliance and Business Integrity (CBI) Program is the establishment of a Confidential Disclosure Program (CDP) designed to ensure activities of VHA are conducted in compliance with public law, established regulations and recognized standards of business practice. The CDP assures integrity of business and operational processes within VHA by providing a mechanism for employees to raise questions and report concerns about potential non-compliance and is consistent with similar reporting and tracking mechanisms identified by HHS–OIG as integral to effective health care compliance programs. Two elements of the CDP are the CBI Helpline and the Compliance Reporting and Tracking System (CIRTS). Together, they comprise the core of the CDP. VHA has contracted for the CBI Helpline, which serves as an anonymous avenue for employees and others to access the CDP in an attempt to assure the integrity of VHA business and operational processes.

The CBI Helpline is established to control the receipt and disposition of reports and/or concerns related to the following VHA areas: Enrollment; Means Testing; Eligibility; Pre-certification and certification/utilization review; Standards pertaining to documentation, coding and billing; Audits, reviews, inquiries and remediation; Accounts receivable and

payable; Excluded individuals and/or entities screening and sanctions listings; Information protection, record retention, managing requests for information; Provider documentation supporting business processes; Overpayments; Questionable conduct on the part of managers, supervisors or employees as related to business processes; and any other matter relating to the business integrity of VHA operations.

The Compliance Line is primarily for use by VHA employees who observe co-workers at their jobs on a regular basis. However, there is nothing to prevent others, such as veterans or their family members, from observing and reporting suspected compliance violations by VHA staff. VHA employees will be made aware of the Compliance Line and how to use it through general compliance awareness training, as well as various other promotional materials, such as brochures, posters, the creation of a web site, etc. Veterans and their families, and third parties, such as contractors conducting official business with VHA, will have access to information about the Compliance Line through posters and other printed material that may be displayed throughout VHA facilities.

The system of records will cover complainants and subjects of complaints. Complainants may be employees, veterans or their family members, or third parties, such as contractors, who conduct official business with VHA. Subjects of complaints may be VHA staff named individually, or VHA departments or facilities (for example, ''the billing office'' at a particular hospital). Complainants desiring to raise a question and report a concern regarding the integrity of business and operational processes within VHA may report it to the Compliance Office through the Compliance Line. Depending on the nature of the report, it will be appropriately referred to another office (for example, the Office of Inspector General; Office of Resolution Management) or to the Compliance Office. This system of records applies only to those records that are maintained by the Compliance Office.

The system of records will contain personal and demographic information provided through the Compliance Line or other sources by complainants, and personal information that has been collected during an appropriate review/investigation. Such information may include: (1) The name, home and work address and phone number of the complainant; (2) name of the subject of the complaint; (3) name and/or patient number of the veteran patient who received services associated with the complaint; (4) the date when the allegation was reported; (5) the date, location and nature of the alleged wrongdoing; and, (6) the Compliance Office's identification number assigned to the case. The records may also include correspondence between the Compliance Office and the Compliance Line vendor as to the status of each case (open or closed).

The system of records will also contain the information gathered when reports of suspected compliance violations are thoroughly documented and investigated to determine their veracity. Information in the investigation records may include: (1) The name of the subject of an investigation; (2) the names of individuals whose work was reviewed as part of the investigation; (3) the names and/or patient numbers of veteran patients whose medical records were reviewed in order to investigate the allegation; (4) the station at which an investigation took place; (5) the time period when the investigation took place; (6) the nature of the allegation; (7) the outcome of the investigation; (8) the recommended action; and, (9) the Compliance Office's identification number assigned to the case. Information may be in the form of a narrative summary or synopsis, exhibits, or VHA documentation and memoranda.

Records in the system will be a combination of computerized files and paper files. Both paper and electronic records may contain the information listed above, and may relate to complainants and subjects of complaints. All reports of suspected noncompliance will be documented in a computerized database and assigned a unique identification number. This number will also be used to identify any paper files associated with the case as the review or investigation proceeds. Paper files may contain documents collected in association with reviewing the case, such as memoranda, policies, or examples of work produced as a result of the complaint. Both electronic and paper case files will be stored and individually retrieved by the unique identification number, not by name.

Access to information in the database will be restricted to authorized personnel on a need-to-know basis by means of passwords and authorized user identification codes. Computer system documentation will be maintained in a secure environment in the VHA CFO Compliance Office, VA Central Office, and in the Compliance Offices at the network and medical center locations. Access to printouts and data terminals will be limited to authorized personnel in the Compliance Program.

Access to paper file folders will be restricted to authorized personnel on a need-to-know basis. Paper files will be maintained in file cabinets or closets that will be locked after duty hours. These files will be under the control of the Compliance Officer or his/her designee. Buildings are protected from unauthorized access by a protective service.

Computerized records will be retained indefinitely. Periodic system back-ups will be employed for record protection. If disk space is limited, the records will be archived to tape or disk in accordance with established practice. Paper records will be maintained and disposed of in accordance with records disposition authority approved by the Archivist of the United States.

An individual who wishes to know if a computerized or paper record is being maintained by the VHA Compliance Office under his or her name in this system, or wants to learn the contents of such records, will be able to submit a written request or apply in person to the VHA CFO (17), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420. An individual who seeks access to or wishes to contest records maintained under his or her name in this system may write, call or visit the VHA CFO (17), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420.

II. Proposed Routine Use Disclosures of Data in the System

We are proposing to establish the following routine use disclosures of information that will be maintained in the system:

1. To a Member of Congress or staff person acting for the Member when the Member or staff person requests the records on behalf of and at the request of that individual.

Individuals sometimes request the help of a Member of Congress in resolving some issues relating to a matter before VA. The Member of Congress then writes VA, and VA must be able to give sufficient information to be responsive to the inquiry.

2. To a Federal, State or local agency, upon its official request, to the extent that it is relevant and necessary to that agency's decision regarding: the hiring, retention or transfer of an employee, the issuance of a security clearance, the letting of a contract, or the issuance or continuance of a license, grant or other benefit given by that agency. However, in accordance with an agreement with the U.S. Postal Service, disclosures to the U.S. Postal Service for decisions

concerning the employment of veterans will only be made with the veteran's prior written consent.

VA must be able to provide information to agencies conducting background checks on applicants for employment or licensure.

3. To a Federal, State, or local agency maintaining civil or criminal violation records, or other pertinent information in order for VA to obtain information relevant to the hiring, transfer or retention of an employee, letting of a contract, granting of a security clearance, or the issuance of a grant.

VA needs to obtain information from other agencies in order to conduct background and security clearance checks on applicants for VA employment, contractors, or persons requesting a grant.

4. To a Federal, State, local or foreign agency charged with the responsibility of investigating or prosecuting civil, criminal or regulatory violations of law, or charged with enforcing or implementing the statute, regulation, rule or order issued pursuant thereto. The names and addresses of veterans may only be disclosed:

- To a Federal agency when it is relevant to a suspected violation or reasonably imminent violation of law.
- To a State or local agency under a written request when it is relevant to a suspected violation or reasonably imminent violation of law concerning public health or safety.

VA must be able to comply with the requirements of agencies charged with enforcing the law conducting investigations. VA must also be able to provide information to State or local agencies charged with protecting the public health as set forth in State law.

5. Any information in this system may be disclosed to the U.S. Office of Special Counsel, upon its official request, when required for the Special Counsel's review of the complainant's allegations of prohibited personnel practices.

VA must be able to provide pertinent information to the U.S. Office of Special Counsel, an independent Federal investigative and prosecutorial agency, to assist in a review conducted by that agency.

6. Disclosure to other Federal agencies to assist such agencies in preventing and detecting possible fraud or abuse by individuals in their operations and programs.

Abuse of Federal programs costs the Federal Government and taxpayers large sums of money every year. Information contained in VA records may help detect and/or prevent fraud and abuse of other agency programs. VA must be able to assist other Federal agencies in their efforts to detect and prevent fraud or abuse in their programs.

7. Disclosure to a Federal Agency or to a State or local government licensing board and/or to the Federation of State Medical Boards or a similar non-government entity which maintains records concerning individuals' employment histories or concerning the issuance, retention or revocation of licenses, certifications, or registration necessary to practice an occupation, profession or specialty in order:

- For the agency to obtain information relevant to an agency decision concerning the hiring, retention or termination of an employee;
- To inform a Federal agency or licensing boards or the appropriate non-government entities about the health care practices of a terminated, resigned or retired health care employee whose professional health care activity so significantly failed to conform to generally accepted standards of professional medical practice as to raise reasonable concern for the health and safety of patients in the private sector or from another Federal agency; or
- As part of an ongoing computer matching program to accomplish these purposes.

8. Relevant information from this system of records related to final adverse actions taken against a health care provider, supplier, or practitioner may be disclosed to the Health Integrity and Protection Data Bank (HIPDB) (45 CFR part 61).

VA must report final adverse actions to the Department of Health and Human Services National Databank, HIPDB, in accordance with the Health Insurance Portability and Accountability Act of 1996 and promulgated regulation in Title 45, Code of Federal Regulations.

9. Disclosure of relevant information may be made to individuals, organizations, private or public agencies, etc., with whom VA has a contract or agreement to perform such services as VA may deem practicable for the purposes of laws administered by VA, in order for the contractor or subcontractor to perform the services of the contract or agreement.

VA occasionally contracts out certain of its functions when this would contribute to effective and efficient operations. VA must be able to give a contractor whatever information is necessary for the contractor to fulfill its duties. In these situations, safeguards are provided in the contract prohibiting the contractor from using or disclosing the information for any purpose other than that described in the contract.

10. Disclosure to survey teams of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), College of American Pathologists, American Association of Blood Banks, and similar national accreditation agencies or boards with which VA has a contract or agreement to conduct such reviews.

VA must be able to disclose information for program review purposes and the seeking of accreditation and/or certification of health care facilities and programs.

11. Disclosure to the National Archives and Records Administration (NARA) in records management inspections conducted under authority of Title 44 United States Code.

NARA is responsible for archiving old records no longer actively used, but which may be appropriate for preservation and in general for the physical maintenance of the Federal Government's records. VA must be able to turn records over to this agency in order to determine the proper disposition of such records.

III. Compatibility of the Proposed Routine Uses

The Privacy Act permits VA to disclose information about individuals without their consent for a routine use when the information will be used for a purpose that is compatible with the purpose for which VA collected the information. In all of the routine use disclosures described above, the recipient of the information will use the information either in connection with a matter relating to one of VA's programs, or will use the information to provide a benefit to VA, or will disclose as required by law.

The notice of intent to publish and an advance copy of the system notice have been sent to the appropriate Congressional committees and to the Director of the Office of Management and Budget (OMB) as required by 5 U.S.C. 552a(r) (Privacy Act) and guidelines issued by OMB (65 FR 77677), December 12, 2000.

Approved: November 13, 2001.

Anthony J. Principi,

Secretary of Veterans Affairs.

106VA17

SYSTEM NAME:

Compliance Records, Response, and Resolution of Reports of Persons Allegedly Involved in Compliance Violations-VA.

SYSTEM LOCATION:

All computerized and paper records are located at: Department of Veterans Affairs (VA) Headquarters, 810 Vermont Avenue, NW, Washington, DC 20420;

Veterans Integrated Services Networks (VISN); and, VA health care facilities. Address locations for VA facilities are listed in VA Appendix 1 of the biennial publication of the Privacy Act Issuances.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

The following categories of individuals will be covered by the system: (1) Employees, (2) veterans, (3) third parties such as contractors who conduct official business with the Veterans Health Administration (VHA), and (4) subjects of complaints and complainants. Complainants are individuals who have reported a possible violation of law, rules, policies, regulations, or external program requirements, such as third-party payor billing guidelines.

CATEGORIES OF RECORDS IN THE SYSTEM:

Records (or information contained in records) in this system include allegations made by individuals calling VHA's Compliance Line, or through another source, to report a possible violation of law, rules, policies, regulations, or external program requirements such as third-party payor billing guidelines. Records also may contain reports of the reviews or investigations conducted at the medical center, VISN, or Headquarters level to verify the reported allegations and take remedial action as needed. The VHA Compliance Office will maintain a copy of these reports. Information in this system regarding reports of suspected non-compliance may include: (1) The name, home and work address and phone number of the complainant; (2) the name of the subject of the complaint; (3) the name and/or patient number of veteran patient who received services associated with the complaint; (4) the date when the allegation was reported; (5) the date, location and nature of the alleged wrongdoing; and (6) the Compliance Office's identification number assigned to the case. The records may also include correspondence between the Compliance Office and the Compliance Line contractor as to the status of each case (open or closed).

Information in the investigation records may include: (1) The name of the subject of an investigation; (2) the names of individuals whose work was reviewed as part of the investigation; (3) the names and/or patient numbers of veteran patients whose medical records were reviewed in order to investigate the allegation; (4) the station at which an investigation took place; (5) the time period when the investigation took place; (6) the nature of the allegation; (7) the outcome of the investigation; (8) the recommended action; and, (9) the Compliance Office's identification number assigned to the case. Information may be in the form of a narrative summary or synopsis, exhibits, or internal documentation and memoranda.

Records in the system will be a combination of computerized files and paper files. Both paper and electronic records may contain the information listed above, and may relate to complainants and subjects of complaints.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

Title 38 United States Code, section 501.

PURPOSE(S):

The purpose is to establish a process to receive reports of suspected compliance violations, and to maintain a system to respond to such allegations.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

1. The record of an individual who is covered by this system may be disclosed to a Member of Congress or staff person acting for the member when the member or staff person requests the records on behalf of and at the request of that individual.

2. Any information in this system may be disclosed to a Federal agency, upon its official request, to the extent that it is relevant and necessary to that agency's decision regarding: the hiring, retention or transfer of an employee, the issuance of a security clearance, the letting of a contract, or the issuance or continuance of a license, grant or other benefit given by that agency. However, in accordance with an agreement with the U.S. Postal Service, disclosures to the U.S. Postal Service for decisions concerning the employment of veterans will only be made with the veteran's prior written consent.

3. Any information in this system may be disclosed to a State or local agency, upon its official request, to the extent that it is relevant and necessary to that agency's decision on: The hiring, transfer or retention of an employee, the issuance of a security clearance, the letting of a contract, or the issuance or continuance of a license, grant or other benefit by the agency; provided, that if the information pertains to a veteran, the name and address of the veteran will not be disclosed unless the name and address is provided first by the requesting State or local agency.

4. Any information in this system, except the name and address of a veteran, may be disclosed to a Federal, State or local agency maintaining civil or criminal violation records, or other pertinent information such as prior employment history, prior Federal employment background investigations, and/or personal or educational background in order for VA to obtain information relevant to the hiring, transfer or retention of an employee, the letting of a contract, the granting of a security clearance, or the issuance of a grant or other benefit. The name and address of a veteran may be disclosed to a Federal agency under this routine use if this information has been requested by the Federal agency in order to respond to the VA inquiry.

5. Any information in this system, except the name and address of a veteran, which is relevant to a suspected violation or reasonably imminent violation of law, whether civil, criminal or regulatory in nature and whether arising by general or program statute or by regulation, rule or order issued pursuant thereto, may be disclosed to a Federal, State, local or foreign agency charged with the responsibility of investigating or prosecuting such violation, or charged with enforcing or implementing the statute, regulation, rule or order issued pursuant thereto.

6. The name and address of a veteran, which is relevant to a suspected violation or reasonably imminent violation of law, whether civil, criminal or regulatory in nature and whether arising by general or program statute or by regulation, rule or order issued pursuant thereto, may be disclosed to a Federal agency charged with the responsibility of investigating or prosecuting such violation, or charged with enforcing or implementing the statute, regulation, rule or order issued pursuant thereto, in response to its official request.

7. The name and address of a veteran, which is relevant to a suspected violation or reasonably imminent violation of law concerning public health or safety, whether civil, criminal or regulatory in nature and whether arising by general or program statute or by regulation, rule or order issued pursuant thereto, may be disclosed to any foreign, State or local governmental agency or instrumentality charged under applicable law with the protection of the public health or safety if a qualified representative of such organization, agency or instrumentality has made a written request that such name and address be provided for a purpose authorized by law.

8. Any information in this system may be disclosed to the U.S. Office of Special Counsel, upon its official request, when

required for the Special Counsel's review of the complainant's allegations of prohibited personnel practices.

9. The name, address, and other identifying data, including title, date and place of birth, social security number, and summary information concerning an individual who, for fraudulent or deceitful conduct either as an employee or while conducting or seeking to conduct business with the Agency, has been convicted of violating Federal or State law or has been debarred or suspended from doing business with VA, may be furnished to other Federal agencies to assist such agencies in preventing and detecting possible fraud or abuse by such individual in their operations and programs. This routine use applies to all information in this system of records which can be retrieved by name or by some identifier assigned to an individual, regardless of whether the information concerns the individual in a personal or in an entrepreneurial capacity.

10. Records from this system of records may be disclosed to a Federal agency or to a State or local government licensing board and/or to the Federation of State Medical Boards or a similar non-government entity which maintains records concerning individuals' employment histories or concerning the issuance, retention or revocation of licenses, certifications, or registration necessary to practice an occupation, profession or specialty, in order for the agency to obtain information relevant to an agency decision concerning the hiring, retention or termination of an employee or to inform a Federal agency or licensing boards or the appropriate non-government entities about the health care practices of a terminated, resigned or retired health care employee whose professional health care activity so significantly failed to conform to generally accepted standards of professional medical practice as to raise reasonable concern for the health and safety of patients in the private sector or from another Federal agency. These records may also be disclosed as part of an ongoing computer matching program to accomplish these purposes.

11. Relevant information from this system of records related to final adverse actions taken against a health care provider, supplier, or practitioner may be disclosed to the Health Integrity and Protection Data Bank (HIPDB) (45 CFR part 61). The information to be reported includes: (1) The name and Taxpayer Identification Number (as defined in section 7701 (a)(41) of the Internal Revenue Code of 1986) of any health care provider, supplier, or practitioner who is the subject of a final adverse action; (2) the name of any health care entity, if known, with which a health care provider, supplier, or practitioner, who is the subject of a final adverse action, is affiliated or associated; (3) the nature of the final adverse action and whether such action is on appeal; and (4) a description of the acts or omissions and injuries upon which the final adverse action was based, and such other information as the Secretary, Department of Health and Human Services, determines by regulation is required for appropriate interpretation of information reported. Information reported will be considered confidential and shall not be disclosed except as specified in the HIPDB regulations.

12. Disclosure of relevant information may be made to individuals, organizations, private or public agencies, etc., with whom VA has a contract or agreement to perform such services as VA may deem practicable for the purposes of laws administered by VA, in order for the contractor or subcontractor to perform the services of the contract or agreement.

13. For program review purposes and the seeking of accreditation and/or certification, disclosure may be made to survey teams of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), College of American Pathologists, American Association of Blood Banks, and similar national accreditation agencies or boards with which VA has a contract or agreement to conduct such reviews but only to the extent that the information is necessary and relevant to the review.

14. Disclosure may be made to the National Archives and Records Administration (NARA) in records management inspections conducted under authority of Title 44 United States Code.

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

All reports of suspected noncompliance will be documented in a computerized database and assigned a unique identification number. Paper files may also be maintained which contain documents collected in association with reviewing the case, such as memoranda, policies, or examples of work produced as a result of the complaint.

RETRIEVABILITY:

Both electronic and paper case files will be stored and individually retrieved by the unique identification number, not by name.

SAFEGUARDS:

Access to computerized information in the database is restricted to authorized personnel on a need-to-know basis by means of passwords and authorized user identification codes. Computer system documentation will be maintained in a secure environment in the VHA Office of the Chief Financial Officer (CFO) Compliance Office, and in the Compliance Offices at the network and medical center locations. Physical access to printouts and data terminals will be limited to authorized personnel in the Compliance Program.

Access to file folders is restricted to authorized personnel on a need-to-know basis. Paper files are maintained in file cabinets or closets and are locked after duty hours. These files are under the control of the Compliance Officer or his/her designees. Buildings are protected from unauthorized access by a protective service.

RETENTION AND DISPOSAL:

Computerized records will be retained indefinitely. Periodic system back-ups will be employed for record protection. If disk space is limited, the records will be archived to tape or disk in accordance with established practice. Paper records will be maintained and disposed of in accordance with records disposition authority approved by the Archivist of the United States.

SYSTEM MANAGER(S) AND ADDRESS:

VHA Chief Financial Officer (17), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420.

NOTIFICATION PROCEDURE:

An individual who wishes to know if a record is being maintained by the VHA CFO Compliance Office under his or her name in this system or wants to determine the contents of such records should submit a written request or apply in person to the VHA CFO (17).

RECORD ACCESS PROCEDURES:

An individual who seeks access to or wishes to contest records maintained under his or her name in this system may write, call or visit the VHA CFO (17).

CONTESTING RECORD PROCEDURES:

(See Record Access Procedures above.)

RECORD SOURCE CATEGORIES:

The information in this system will be obtained from calls that are received on the Compliance Line and reports

received through other sources. Information is obtained from VHA employees, veterans, third parties such as contractors, and VHA records which may include billing data, patient medical records, policies and procedures, and memoranda.

[FR Doc. 01–29735 Filed 11–29–01; 8:45 am]

BILLING CODE 8320–01–P

Corrections

Federal Register

Vol. 66, No. 231

Friday, November 30, 2001

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 STATE

Office of the Secretary

[Public Notice 3844]

Extension of the Restriction on the Use of United States Passports for Travel To, In, or Through Libya

Correction

In notice document 01–29156 appearing on page 58546 in the issue of Wednesday, November 21, 2001, make the following correction:

On the same page, in column three, ''Dated: December 13, 2001'' should read ''Dated: November 13, 2001''.

[FR Doc. C1–29156 Filed 11–29–01; 8:45 am]

BILLING CODE 1505–01–D

Federal Register

Friday,
November 30, 2001

Part II

The President

Executive Order 13237—Creation of the President's Council on Bioethics

Federal Register
Vol. 66, No. 231
Friday, November 30, 2001

Presidential Documents

Title 3—

The President

Executive Order 13237 of November 28, 2001

Creation of the President's Council on Bioethics

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

Section 1. *Establishment.* There is established the President's Council on Bioethics (the ''Council'').

Sec. 2. *Mission.*

(a) The Council shall advise the President on bioethical issues that may emerge as a consequence of advances in biomedical science and technology. In connection with its advisory role, the mission of the Council includes the following functions:

(1) to undertake fundamental inquiry into the human and moral significance of developments in biomedical and behavioral science and technology;

(2) to explore specific ethical and policy questions related to these developments;

(3) to provide a forum for a national discussion of bioethical issues;

(4) to facilitate a greater understanding of bioethical issues; and

(5) to explore possibilities for useful international collaboration on bioethical issues.

(b) In support of its mission, the Council may study ethical issues connected with specific technological activities, such as embryo and stem cell research, assisted reproduction, cloning, uses of knowledge and techniques derived from human genetics or the neurosciences, and end of life issues. The Council may also study broader ethical and social issues not tied to a specific technology, such as questions regarding the protection of human subjects in research, the appropriate uses of biomedical technologies, the moral implications of biomedical technologies, and the consequences of limiting scientific research.

(c) The Council shall strive to develop a deep and comprehensive understanding of the issues that it considers. In pursuit of this goal, the Council shall be guided by the need to articulate fully the complex and often competing moral positions on any given issue, rather than by an overriding concern to find consensus. The Council may therefore choose to proceed by offering a variety of views on a particular issue, rather than attempt to reach a single consensus position.

(d) The Council shall not be responsible for the review and approval of specific projects or for devising and overseeing regulations for specific government agencies.

(e) In support of its mission, the Council may accept suggestions of issues for consideration from the heads of other Government agencies and other sources, as it deems appropriate.

(f) In establishing priorities for its activities, the Council shall consider the urgency and gravity of the particular issue; the need for policy guidance and public education on the particular issue; the connection of the bioethical issue to the goal of Federal advancement of science and technology; and the existence of another entity available to deliberate appropriately on the bioethical issue.

Sec. 3. *Membership.*

(a) The Council shall be composed of not more than 18 members appointed by the President from among individuals who are not officers or employees of the Federal Government. The Council shall include members drawn from the fields of science and medicine, law and government, philosophy and theology, and other areas of the humanities and social sciences.

(b) The President shall designate a member of the Council to serve as Chairperson.

(c) The term of office of a member shall be 2 years, and members shall be eligible for reappointment. Members may continue to serve after the expiration of their terms until the President appoints a successor. A member appointed to fill a vacancy shall serve only for the unexpired term of such vacancy.

Sec. 4. *Administration.*

(a) Upon the request of the Chairperson, the heads of executive departments and agencies shall, to the extent permitted by law, provide the Council with information it needs for purposes of carrying out its functions.

(b) The Council may conduct inquiries, hold hearings, and establish subcommittees, as necessary.

(c) The Council is authorized to conduct analyses and develop reports or other materials.

(d) Members of the Council may be compensated to the extent permitted by Federal law for their work on the Council. Members may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law for persons serving intermittently in Government service (5 U.S.C. 5701–5707), to the extent funds are available.

(e) To the extent permitted by law, and subject to the availability of appropriations, the Department of Health and Human Services shall provide the Council with administrative support and with such funds as may be necessary for the performance of the Council's functions.

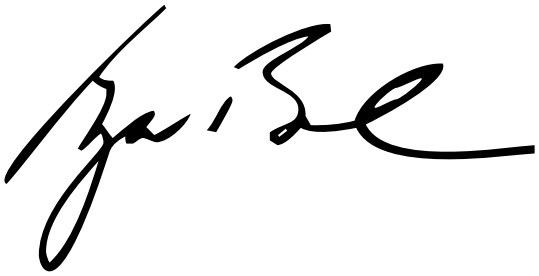
(f) The Council shall have a staff headed by an Executive Director, who shall be appointed by the Secretary of Health and Human Services in consultation with the Chairperson. To the extent permitted by law, office space, analytical support, and additional staff support for the Council shall be provided by the Department of Health and Human Services or other executive branch departments and agencies as directed by the President.

Sec. 5. *General Provisions.*

(a) Insofar as the Federal Advisory Committee Act, as amended (5 U.S.C. App.), may apply to the Council, any functions of the President under that Act, except that of reporting to the Congress, shall be performed by the Secretary of Health and Human Services in accordance with the guidelines that have been issued by the Administrator of General Services.

(b) The Council shall terminate 2 years from the date of this order unless extended by the President prior to that date.

(c) This order is intended only to improve the internal management of the executive branch and it is not intended to create any right, benefit, trust, or responsibility, substantive or procedural, enforceable at law or equity by a party against the United States, its agencies, its officers, or any person.



THE WHITE HOUSE,
November 28, 2001.

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Federal Register

Friday,
November 30, 2001

Part III

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 413, 419, and 489

Medicare Program; Changes to the Hospital Outpatient Prospective Payment System for Calendar Year 2002; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 413, 419, and 489

[CMS–1159–F2]

RIN 0938–AK54

Medicare Program; Changes to the Hospital Outpatient Prospective Payment System for Calendar Year 2002

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

ACTION: Final rule.

SUMMARY: This final rule revises the Medicare hospital outpatient prospective payment system to implement applicable statutory requirements, including relevant provisions of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, 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. This final rule also announces a uniform reduction of 68.9 percent to be applied to each of the transitional pass-through payments. These changes are applicable to services furnished on or after January 1, 2002.

EFFECTIVE DATE: This final rule is effective January 1, 2002 and is applicable to services furnished on or after January 1, 2002.

FOR FURTHER INFORMATION CONTACT: George Morey (410) 786–4653, for provider-based issues; and Nancy Edwards (410) 786–0378, for all other issues.

SUPPLEMENTARY INFORMATION:

Availability of Copies and Electronic Access

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 $9. 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.*

Information on the outpatient prospective payment system can be found on our homepage. You can access these data by using the following directions:

1. Go to CMS homepage (*http://www.cms.hhs.gov*).
2. Click on ''Professionals.''
3. Under the heading ''Physicians and Health Care Professionals,'' click on ''Medicare Coding and Payment Systems.''
4. Select Hospital Outpatient Prospective Payment System.

Or, you can go directly to the Hospital Outpatient Prospective Payment System page by typing the following: *http://www.hcfa.gov/medicare/hopsmain.htm.*

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Alphabetical List of Acronyms Appearing in the Proposed Rule

APC Ambulatory payment classification
APG Ambulatory patient group
ASC Ambulatory surgical center
AWP Average wholesale price
BBA 1997 Balanced Budget Act of 1997
BBRA 1999 Balanced Budget Refinement Act of 1999
BIPA 2000 Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
CAH Critical access hospital
CAT Computerized axial tomography
CCI Correct Coding Initiative
CCR Cost-to-charge ratio
CMHC Community mental health center
CMS Centers for Medicare & Medicaid Services (Formerly known as the Health Care Financing Administration)
CORF Comprehensive outpatient rehabilitation facility
CPI Consumer Price Index
CPT (Physician's) Current Procedural Terminology, Fourth Edition, 2001, copyrighted by the American Medical Association
DME Durable medical equipment
DMEPOS DME, prosthetics (which include prosthetic devices and implants), orthotics, and supplies
DRG Diagnosis-related group
EMTALA Emergency Medical Treatment and Active Labor Act
FDA Food and Drug Administration
FQHC Federally qualified health center
HCPCS Healthcare Common Procedure Coding System
HHA Home health agency
ICD–9–CM International Classification of Diseases, Ninth Edition, Clinical Modification
IME Indirect medical education
JCAHO Joint Commission on Accreditation of Healthcare Organizations
MRI Magnetic resonance imaging
MSA Metropolitan statistical area
NECMA New England County Metropolitan Area
OPPS Hospital outpatient prospective payment system
PPS Prospective payment system
RFA Regulatory Flexibility Act
RHC Rural health clinic
RRC Rural referral center
SCH Sole community hospital
SNF Skilled nursing facility

I. Background

A. Authority

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 BIPA provisions that affect the OPPS are summarized below, in section I.C. The OPPS was first implemented for services furnished on or after August 1, 2000.

B. Summary of Rulemaking

- 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 June 30, 1999, we published a correction notice (64 FR 35258) to correct a number of technical and typographic errors in the September 1998 proposed rule including the proposed amounts and factors used to determine the payment rates.
- On April 7, 2000, we published a final rule with comment period (65 FR 18438) 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 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 of 1997 and amended by the BBRA of 1999. Medicare regulations governing the hospital OPPS are set forth at 42 CFR 419.
- On June 30, 2000, we published a notice (65 FR 40535) announcing 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 August 3, 2000 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). This rule provided for the annual update to the amounts and factors for OPPS payment rates effective for services furnished on or after 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 August 24, 2001, we published a proposed rule (66 FR 44672) that set forth proposed changes to the Medicare hospital OPPS and calendar year (CY) 2002 payment rates. It also set forth proposed changes to the amounts and factors used to determine these payment rates.

C. Summary of Changes in the August 24, 2001 Proposed Rule

On August 24, 2001, we published a proposed rule (66 FR 44672) that set forth proposed changes to the Medicare hospital OPPS and CY 2002 payment rates including changes to the amounts and factors 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 24, 2001 proposed rule.

1. Changes Required by BIPA 2000

We proposed the following changes to the OPPS, to implement the provisions of BIPA 2000:

- Limit coinsurance to a specified percentage of APC payment amounts.
- Provide hold-harmless payments to children's hospitals.
- Provide separate APCs for services that use contrast agents and those that do not.
- Payment for glaucoma screening as a covered service.
- Payment for certain new technology used in diagnostic mammograms.

2. Additional Changes

We proposed the following additional changes to the OPPS:

- Add APCs, delete APCs, and modify the composition of services within some existing APCs.
- Add an APC group that would provide separate payment for observation services in limited circumstances to patients having specific diagnoses.
- Recalibrate the relative payment weights of the APCs.
- Update the conversion factor and wage index.
- Revise the APC payment amounts to reflect the APC reclassifications, the recalibration of payment weights and the other required updates and adjustments.
- Make reductions in pass-through payments for specific drugs and categories of devices to account for the drug and device costs that are included in the APC payment for associated procedures and services.
- Apply a standard procedure to calculate copayment amounts when new APCs are created or when APC payment rates are increased or decreased as a result of recalibrated relative weights.
- Calculate outlier payments on a service-by-service basis beginning in 2002. We also proposed a methodology for allocating packaged services to individual APCs in determining costs of a service and we proposed to use a hospital's overall outpatient cost-to-charge ratio to convert charges to costs.
- Set the threshold for outlier payments to require costs to exceed 3 times the APC payment amount and payment at 50 percent of any excess costs above the threshold.
- Exclude hospitals located outside the 50 states, the District of Columbia and Puerto Rico from the OPPS.
- Exclude from payment under the OPPS certain services that are furnished to inpatients of hospitals that do not submit claims for outpatient services under Medicare Part B.
- Make conforming changes to regulations text to reflect the exclusion from the OPPS of certain items and services (for example, bad debts, direct medical education and certain certified registered nurse anesthetists services) that are paid on a cost basis.
- Update the payments for pass-through radiopharmaceuticals, drugs, and biologicals on a calendar year basis to reflect increases in AWP.
- Allow reprocessed single use devices to be considered eligible for pass-through payments if the reprocessing process for single use devices meets the FDA's most recent criteria.
- Revise the criteria we will use to determine whether a procedure or service is eligible to be assigned to a new technology APC.
- Revise the list of information that must be submitted to request assignment of a service or procedure to a new technology APC.
- Provide more flexibility in the amount of time a service may be paid under a new technology APC.
- A description of the Secretary's estimate of the total amount of pass-through payments for CY 2002 and the need for a pro rata reduction to those payments in that year.

3. Provider-Based Changes

We proposed to make changes to the provider-based regulations to reflect the provisions of section 404 of BIPA and to codify certain clarifications on provider-based status that were posted on the CMS Web site.

D. Public Comments Received in Response to the August 24, 2001 Proposed Rule

We received approximately 400 timely items of correspondence containing multiple comments on the proposed rule. Major issues addressed by the commenters included the following:

- The implementation of a uniform reduction in the transitional pass-through payments for CY 2002.
- Changes to APC classifications and weights for certain outpatient services including mammography, stereotactic radiosurgery and intensity modulated radiation therapy, and positive emission tomography (PET) scans.
- Changes to the eligibility criteria for payment as a new technology service.

On November 2, 2001, we published a final rule (66 FR 55857) that responded to the comments on the Secretary's estimate of the total amount of transitional pass-through payments for CY 2002 and the need for a uniform reduction in the pass-through payments for that year as well as comments on the proposed conversion factor for CY 2002. That final rule announced that the conversion factor for CY 2002 is $50.904 and that the Secretary is implementing a pro rata reduction in 2002 (expected to be between 65 and 70 percent) to each pass-through payment (we stated that we would announce the exact amount of the reduction before the beginning of 2002).

Summaries of the remaining public comments received and our responses to those comments are set forth below under the appropriate heading. In addition, we are announcing that the pro rata reduction is 68.9 percent.

II. Changes to the 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. As described in the April 7, 2000 final rule (65 FR 18484), 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 and related payment adjustment factors to take into account changes in medical practice, changes in technology, and the addition of the new services, new cost data, and other relevant information. Section 1833(t)(9)(A) of the Act requires the Secretary, beginning in 2001, to consult with an outside panel of experts when annually reviewing and updating the APC groups and the relative 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 item or service in the group is more than 2 times greater than the lowest median or mean cost 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 the proposed rule and for 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

Section 1833(t)(9)(A) of the Act, which requires that we consult with an outside panel of experts when annually reviewing and updating the APC groups and the relative weights, specifies that the panel will act in an advisory capacity. The expert panel, which is to be composed of representatives of providers, is to review and advise 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). The Panel is technical in nature and is governed by the provisions of the Federal Advisory Committee Act (FACA) as amended (Public Law 92–463). 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 themselves or a colleague. After carefully reviewing the applications, CMS chose 15 highly qualified individuals to serve on the Panel. The Panel was convened for the first time on February 27, February 28, and March 1, 2001. We published a notice in the **Federal Register** on February 12, 2001 (66 FR 9857) to announce the location and time of the Panel meeting, a list of agenda items, and that the meeting was open to the public. We also provided additional information through a press release and our website.

2. Specific Recommendations of the Advisory Panel and Our Responses

In the proposed rule, we summarized the issues considered by the Panel, the Panel's APC recommendations, and our subsequent action with regard to the Panel's recommendations. The data used by the Panel in making its recommendation are the 1996 claims that were used to set the APC weights and payment rates for CY 2000 and 2001. In the proposed rule, we provided a detailed summary of the Panel discussion and recommendations (66 FR 44675–44686). See the proposed rule for more details regarding these discussions.

As discussed below, the Panel sometimes declined to recommend a change in an APC even though the APC violated the 2 times rule. In section II.C.3 of this preamble, we discuss our policies regarding the 2 times rule based on the data we are using to recalibrate the 2002 APC relative weights (that is, claims for services furnished on or after July 1, 1999 and before July 1, 2000). That section also details the criteria we use in deciding to make an exception to the 2 times rule. We asked the Panel to review many of the exceptions we implemented in 2000 and 2001. The exceptions are referred to as ''violations of the 2 times'' rule in the following discussion.

We did not receive comments on the APC changes we proposed based on the recommendations of the Panel except for our proposal regarding stereotactic radiosurgery (APCs 0300 and 0302). We discuss that proposal in detail below along with the comments and our responses. For all other APC Panel proposed changes, we briefly discuss the Panel's recommendation, our proposal, and the final changes we have made. We also received comments on APCs and the assignment of codes to APCs for which we made no specific proposal in the proposed rule. We address those comments below in section II.A.3. of this preamble.

APC 0016: Level V Debridement & Destruction

APC 0017: Level VI Debridement & Destruction

We asked the Panel to review the current placement of CPT code 56501, Destruction of lesion(s), vulva; simple, any method, in APC 0016 because the APC violates the 2 times rule. Because the procedure is a simple destruction of skin and superficial subcutaneous tissues, we will not expect it to have a median cost of $500. Thus, we believe that the higher costs associated with this code were the result of incorrect coding. To ensure that procedures in APC 0016 comply with the 2 times rule, we asked the Panel to consider one of the following clinical options:

- Move CPT code 56501 to APC 0017.
- Retain CPT code 56501 in APC 0016 but split APC 0016 into three APCs to distinguish simple destruction lesions from extensive destruction lesions.

The Panel recommended the following:

- Move CPT code 56501 from APC 0016 to APC 0017.
- Move CPT code 46917 from APC 0014 to APC 0017.

After considerable discussion the Panel recommended these changes to achieve clinical coherence and resource similarity among the procedures assigned to these APCs. Because CPT code 46917 is performed using laser equipment and requires anesthesia, the Panel believed it appropriate to move this procedure to APC 0017. Although the Panel considered the reassignment of CPT code 54055 to APC 0017, it did not recommend this change. The Panel's recommended changes will group in APC 0017 simple destruction of lesion procedures that use laser or surgical techniques with extensive destruction of lesion procedures.

We proposed to accept the Panel's recommendation regarding CPT code 56501 and to revise the APC accordingly. We are adopting these changes in final; however, as shown below in Table 3, we are making additional changes to these APCs because of the 2 times rule.

APC 0024: Level I Skin Repair

APC 0025: Level II Skin Repair

APC 0026: Level III Skin Repair

APC 0027: Level IV Skin Repair

The composition of procedures in APCs 0025 and 0027 results in these APCs violating the 2 times rule. Therefore, we requested the Panel's advice in exploring other clinical options for reconfiguring the four skin repair APCs to achieve clinical and resource homogeneity among the procedures assigned to APCs 0025 and 0027 while retaining clinical and resource homogeneity for APCs 0024 and 0026. We asked the Panel to consider the following clinical options to achieve this result:

- Rearrange the procedures assigned to APCs 0024 through 0027 based on the size or the length of the skin incision.
- Rearrange the procedures assigned to APCs 0024 through 0027 based on the complexity of the repair, such as distinguishing repairs that involve layers of skin, flaps, or grafts from those that do not.

The Panel reviewed the various options presented, which were modeled based on the 1996 claims data used in constructing the current APC groups and payment rates. The Panel recommended the following:

- Make no changes to APCs 0024 and 0027.
- Reevaluate these APCs with new data when the Panel meets in 2002.
- The Panel, in preparation for the 2002 meeting, will discuss options with and gather clinical and utilization information from their respective hospitals regarding these procedures.

We proposed to accept the Panel's recommendations. We are adopting these recommendations as final; however, as discussed below in section II.C., we are making additional changes to these APCs based on the use of new data and application of the 2 times rule.

APC 0058: Level I Strapping and Casting Application

APC 0059: Level II Strapping and Casting Application

APC 0058 (which consists of the simpler casting, splinting, and strapping procedures) violates the 2 times rule. The median costs for high volume procedures in APC 0058 vary widely, ranging from $27 to $83. The median costs associated with presumably more resource-intensive procedures in APC 0059 are fairly uniform, ranging from $69 to $119. To limit the cost variation in APC 0058, we asked the Panel to consider the following options:

- Move the following four codes from APC 0058 to APC 0059: CPT code 29515, Application of short splint (calf to foot); CPT code 29520, Strapping; hip; CPT code 29530, Strapping; knee; and CPT code 29590, Denis-Brown splint strapping.
- Create a new APC to include a third level of strapping and casting application procedures by regrouping all procedures assigned to both APCs 0058 and 0059 based on the following clinical distinctions: removal/revision, strapping/splinting, and casting.
- Package certain CPT codes assigned to APC 0058 with relevant procedures.

The Panel recommended that we do the following:

- Make no changes to APC 0058.
- Provide appropriate education and guidance to hospitals regarding appropriate use and billing of codes in APC 0058.
- Resubmit APC 0058 to the Panel for reevaluation when later data are available.

We proposed to accept the Panel's recommendations except that we proposed to move CPT code 29515 to APC 0059 due to the 2 times rule and the newer data we are using for this rule. These changes have been adopted as final in this document.

APC 0079: Ventilation Initiation and Management

The codes in APC 0079 represent respiratory treatment and support provided in the outpatient setting. The cost variation among the assigned procedures in this APC raises concern about hospital coding practices. The median costs for these procedures range from $40 to $315. We asked the Panel to clarify whether these procedures are performed on outpatients or if they are performed on patients who come to the emergency room and are later admitted to the hospital as inpatients.

The Panel recommended the following:

- Remove CPT code 94660 from APC 0079 and create a new APC for this one procedure.

We proposed to accept the Panel's recommendation by creating a new APC 0065, CPAP Initiation. We have adopted this change in this final rule.

APC 0094: Resuscitation and Cardioversion

We requested the Panel's assistance in determining whether it is clinically appropriate to remove the cardioversion procedures from APC 0094 because the rest of the procedures assigned to APC 0094 are emergency procedures rather than elective. We proposed that the Panel consider the creation of a new APC for the cardioversion procedures or reassignment of the procedures to another APC that would be more appropriate in terms of clinical coherence and resource similarity. Splitting APC 0094 into two distinct groups, one for resuscitation procedures and the other for internal and external electrical cardioversion procedures, would not result in a significant difference in the APC payment rate for either of the new APCs.

The Panel recommended that the only action we take would be to move CPT code 92961, Cardioversion, elective, electrical conversion of arrhythmia; internal (separate procedure) from APC 0094 to APC 0087, Cardiac Electrophysiology Recording/Mapping.

We proposed to accept the APC Panel recommendation. We are adopting this change as final.

APC 0102: Electronic Analysis of Pacemakers/Other Devices

The neurologic procedures included in APC 0102 (CPT codes 95970 through 95975), are significantly more complex than the routine cardiac pacemaker programming codes also assigned to this APC. Because we believe these codes are clinically different, we asked the Panel to consider the following:

- Create a new APC for the neurologic codes.
- Move the neurologic codes to APC 0215, Level I Nerve and Muscle Tests.

The Panel recommended the following reorganization of APC 0102 to better reflect clinical coherence:

- Split APC 0102 into four new APCs: one APC for analysis and programming of infusion pumps and CSF shunts; a second for analysis and programming of neurostimulators; a third for analysis and programming of pacemakers and internal loop recorders; and a fourth for analysis and programming of cardioverter-defibrillators.

We proposed to accept the Panel's recommendations and proposed to create four new APCs as follows:

APC 0689: Electronic Analysis of Cardioverter-Defibrillator
APC 0690: Electronic Analysis of Pacemakers and Other Cardiac Devices
APC 0691: Electronic Analysis of Programmable Shunts/Pumps
APC 0692: Electronic Analysis of Neurostimulator Pulse Generators.

We have made these changes final in this rule.

APC 0110: Transfusion

APC 0111: Blood Product Exchange

APC 0112: Extracorporeal Photopheresis

The procedures included in APC 0110 are those related only to the services associated with performing the blood transfusion and monitoring the patient during the transfusion; the costs associated with the blood products themselves are not included in APC 0110. We advised the Panel that we were not certain that cost data for blood transfusions excluded the costs of the blood products because the APC 0110 median cost of $289 seemed excessive. We expressed concern about hospital coding and billing practices for blood products, blood processing, storage, and transportation charges as represented in the 1996 data. We asked the Panel to advise us on how to clarify hospital billing and coding practices for blood transfusions; we also asked if the Panel members believe that the median costs for transfusion procedures include the costs for blood products and, if so, how the procedures should be adjusted to eliminate these costs.

After considerable discussion, the Panel recommended the following:

- Take no action on APC 0110.
- Move CPT code 36521 from APC 0111 to APC 0112 to achieve clinical coherence and resource similarity with photopheresis procedures included in APC 0112. However, the Panel cautioned that the payment for APC 0112 captured the cost of the entire procedure including the cost of the adsorption column. For this reason, any additional payment for the adsorption column through the transitional pass-through payment mechanism will be a duplicate payment. Therefore, the Panel asked that CMS address this problem when considering their recommendation.

We proposed to accept the Panel's recommendations. We noted that effective April 1, 2001, the Prosorba column is no longer eligible for a transitional pass-through payment (see PMA–01–40 issued on March 27, 2001).

We have adopted the proposed changes in final in this document.

APC 0116: Chemotherapy Administration by Other Technique Except Infusion

APC 0117: Chemotherapy Administration by Infusion Only

APC 0118: Chemotherapy Administration by Both Infusion and Other Technique

Based on previous comments we had received, we asked the Panel to review whether oral delivery of chemotherapy and delivery of chemotherapy by infusion pumps and reservoirs should be recognized for payment under the OPPS.

In summary, the Panel recommended the following:

- Allow hospitals to bill for patient education on the administration of oral anticancer agents under the appropriate clinic codes.
- Assign CPT codes 96520 and 96530 to a new APC.
- Continue to use the current HCPCS Level II Q codes for chemotherapy administration.
- There is no need to develop a new HCPCS code for ''extended chemotherapy infusions.''
- CMS should consider developing a new HCPCS code for flushing of ports and reservoirs.

We proposed to accept all the Panel's recommendations except for the recommendation regarding flushing of ports and reservoirs. Flushing is performed in conjunction with either a chemotherapy administration service or an outpatient clinic visit. In the first case, flushing is part of the chemotherapy administration and its costs are adequately captured in the costs of the chemotherapy administration code. In the second case, we believe that the costs of flushing are adequately captured in the costs of the clinic visit and need not be paid separately. We proposed to create a new APC 0125, Refilling of Infusion Pump.

We are adopting these changes as final in this rule.

APC 0123: Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant

In APC 0123, the 1996 median cost for CPT code 38230, Bone marrow harvesting for transplantation, was only $15. We believe that this cost is lower than the actual cost of the procedure. Further, we do not have sufficient data to determine how often bone marrow and stem cell transplant procedures are performed on an outpatient basis. For these reasons, we requested the Panel's advice in clarifying the resources used in performing the procedures assigned to APC 0123, and the extent to which these procedures are performed on an outpatient basis.

The Panel recommended the following:

- Make no changes in the procedures assigned to APC 0123 in the absence of sufficient data to support such modifications.
- The two presenters on this APC issue should submit cost data for the Panel to use in reevaluating this issue at its 2002 meeting.

We noted in the proposed rule that our analysis of the more recent claims data we are using to reclassify and recalibrate the APCs reveals a significant increase in costs for this APC resulting in a payment rate that is double the current rate. However, very few procedures (fewer than 20) were billed on an outpatient basis. As we indicated in the proposed rule, we will have the Panel review this APC again at their next meeting.

APC 0142: Small Intestine Endoscopy

APC 0143: Lower GI Endoscopy

APC 0145: Therapeutic Anoscopy

APC 0147: Level II Sigmoidoscopy

APC 0148: Level I Anal/Rectal Procedures

APC 0149: Level II Anal/Rectal Procedures

APC 0150: Level III Anal/Rectal Procedures

We presented these seven APCs to the Panel because of the inconsistencies in the median costs for some procedures included in APCs 0142, 0143, 0145, and 0147. We advised the Panel that our cost data do not show a progression of median costs proportional to increases in clinical complexity as we would expect. For example, the data indicate that a therapeutic anoscopy assigned to APC 0145 costs more than twice as much as a flexible or rigid sigmoidoscopy assigned to APC 0147. We stated our concern that cost disparity could provide incentives to use inappropriate procedures. Because of these concerns, we asked the Panel's advice in determining whether one of the following actions should be taken:

- Divide the codes in APC 0142 into separate APCs representing ileoscopy and small intestine procedures.
- Combine diagnostic anoscopy and Level I sigmoidoscopy.
- Merge APCs 0143, 0145, and 0147 into one APC.

We also asked the Panel whether the costs associated with codes in APC 0145 appeared to be valid.

The Panel recommended that we do the following:

- Make no changes to APCs 0142, 0143, 0145, and 0147.
- Provide information and guidance to better assist hospitals in understanding how to bill appropriately for services included in APCs 0142, 0143, 0145, and 0147.
- Resubmit these APCs to the Panel for review when newer data are available.

We proposed to accept the Panel's recommendations.

We have adopted these recommendations in this final rule.

APC 0151: Endoscopic Retrograde Cholangio-Pancreatography (ERCP)

We advised the Panel that we have received comments that indicate that it is inappropriate to assign both diagnostic and therapeutic ERCP procedures to the same APC. The commenters allege that virtually every hospital performs diagnostic ERCPs but only teaching hospitals perform therapeutic ERCPs. Based on our current data, if we created two APCs for ERCP procedures, the APC payment rate for therapeutic ERCPs would be lower than that for diagnostic ERCPs (approximately $526 and $535, respectively). Therefore, we requested the Panel's advice to help us determine whether to create separate APCs for diagnostic and therapeutic ERCP procedures.

The Panel recommended that we do the following:

- Do not reconfigure the ERCP procedures in APC 0151.
- Resubmit this issue to the Panel for review when more recent data are available.
- Explore the feasibility of using multiple claims rather than single claims to calculate appropriate APC payment rates for ERCP procedures.

We proposed to accept the Panel's recommendations. As we stated in the proposed rule, we are reviewing the potential for using multiple claims data for determining payment rates for ERCP procedures. As a first step in the process, in the proposed rule, we determined a payment rate for ERCP procedures based on both single claims for ERCP procedures and, because ERCP procedures are typically done under radiologic guidance, on claims that included both an ERCP procedure and a radiologic supervision or guidance procedure in this APC. We

accomplished this by changing the status indicator for radiologic guidance and supervision codes to ''N'', which results in these codes being packaged. Using these additional claims resulted in significantly increasing the number of claims used to determine the payment rate for this APC and in a much higher payment rate (about $780 in this final rule).

We will be presenting this issue again to the APC Panel at their next meeting.

APC 0160: Level I Cystourethroscopy and other Genitourinary Procedures

APC 0161: Level II Cystourethroscopy and other Genitourinary Procedures

APC 0162: Level III Cystourethroscopy and Other Genitourinary Procedures

APC 0163: Level IV Cystourethroscopy and Other Genitourinary Procedures
APC 0169: Lithotripsy

We advised the Panel that we had previously received a number of comments that advocated moving CPT code 52337, Cystoscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included), from APC 0162 to APC 0163. (We note that CPT code 52337 was deleted for 2001 and replaced with an identical CPT code, 52353. We will use the new code in the following discussion.) Because of these comments, we sought the Panel's advice in examining the clinical and resource distinctions between CPT code 52353 and other procedures assigned to APC 0162. Other information shared with the Panel noted that most of the procedures included in APC 0162 are complicated cystourethroscopies while those assigned to APC 0163 are largely prostate procedures.

The Panel recommended that we move CPT code 52353 from APC 0162 to APC 0169 because both codes 52353 and 50590 are lithotripsy procedures.

We reviewed the Panel discussion very carefully and noted the close vote. After careful consideration, we proposed to disagree with the Panel's recommendation and move code 52353 to APC 0163. The 1999–2000 cost data used for the proposed rule, which contained over 400 single claims for code 52353 (reported under code 52337) and over 6,000 single claims for code 50590, showed that the median cost for code 52353 is much more similar to the median cost of other procedures in APC 0163 than it is to the median cost of APC 0169. Although both codes involve lithotripsy, the type of equipment used in the two procedures is very different. Clinically, the surgical approach used for code 52353 and the resources used (e.g., anesthesia and operating room costs) are much more similar to other procedures in APC 0163 than to those for code 50590. Additionally, the median cost for code 50590, which was $700 higher than that of code 52353, is dependent on the widely variable arrangements hospitals make for use of the extracorporeal lithotriptor. Therefore, we believe that placing code 52353 in APC 0163 maintains its clinical coherence and similar use of resources.

Based on the updated 1999–2000 data base available for the final rule, we find that the cost relationship between codes 52353 and 50590 continues to reflect a difference. There are now almost 500 single claims for code 52353 and almost 7,000 single claims for code 50590. The median cost for 50590 remains about $700 higher than the median cost for code 52353. Therefore, we are adopting as final our proposal to move code 52353 to APC 0163.

APC 0191: Level I Female Reproductive Procedures

APC 0192: Level II Female Reproductive Procedures

APC 0193: Level III Female Reproductive Procedures

APC 0194: Level IV Female Reproductive Procedures

APC 0195: Level V Female Reproductive Procedures

This group of APCs was presented to the Panel because APC 0195 violates the 2 times rule. To facilitate the Panel's review of this issue, we distributed cost data on all the female reproductive procedures assigned to these five APCs. These data showed that the median costs for procedures assigned to APC 0195 ranged from a low of $365 to a high of $1,817. The CPT code 57288, Sling operation for stress incontinence (e.g., fascia or synthetic), which is assigned to APC 0195, has the highest median cost of the procedures in this group. We discussed with the Panel two clinical options for rearranging the procedures assigned to APC 0195 to comply with the 2 times rule. The first option would split APC 0195 into two separate APCs by separating vaginal procedures from abdominal procedures. The second option would split APC 0195 into three distinct APCs by retaining the separate APCs for abdominal and vaginal procedures and further distinguishing vaginal procedures based on whether they are simple or complex.

The Panel closely reviewed the four APCs for female reproductive procedures (APCs 0191, 0192, 0193, and 0194) to ensure each was clinically homogeneous. As a result of this review, the Panel recommended a number of changes for these APCs. These recommendations and those for APC 0195 are as follows:

- Move CPT codes 56350, Hysteroscopy, diagnostic, and 58555, Hysterosocopy, diagnostic/separate procedure, from APC 0191 to APC 0194 (In 2001, CPT code 56350 was replaced with CPT code 58555.)
- Divide APC 0195 into two APCs to distinguish vaginal procedures from abdominal procedures.
- Retain the following vaginal procedures in APC 0195:

CPT code	Descriptor
57555 ..	Excision of cervical stump, vaginal approach: with anterior and/or posterior repair.
58800 ..	Drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure); vaginal approach.
58820 ..	Drainage of ovarian abscess; vaginal approach, open.
57310 ..	Closure of urethrovaginal fistula;
57320 ..	Closure of vesicovaginal fistula; vaginal approach
57530 ..	Trachelectomy (cervicectomy), amputation of cervix (separate procedure).
57291 ..	Construction of artificial vagina; without graft.
57220 ..	Plastic operation on urethral sphincter, vaginal approach (e.g., Kelly urethral plication).
57550 ..	Excision of cervical stump, vaginal approach.
57556 ..	Excision of cervical stump, vaginal approach; with repair of enterocele.
57289 ..	Pereyra procedure, including anterior colporrhapy.
57300 ..	Closure of rectovaginal fistula; vaginal or transanal approach.

CPT code	Descriptor
57284 ..	Paravaginal defect repair (including repair of cystocele, stress urinary incontinence, and/or incomplete vaginal prolapse).
57265 ..	Combined anteroposterior colporrhaphy; with enterocele repair.
57268 ..	Repair of enterocele vaginal approach (separate procedure).
56625 ..	Vulvectomy simple; complete.
58145 ..	Myomectomy excision of fibroid tumor of uterus, single or multiple (separate procedure); vaginal approach.
57260 ..	Combined anteroposterior colporrhaphy;
57240 ..	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele.
57250 ..	Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy.
56620 ..	Vulvectomy simple; partial.
57522 ..	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision.

• Include the following abdominal procedures in a new APC titled ''Level VI Female Reproductive Procedures.''

CPT code	Descriptor
58920 ..	Wedge resection or bisection of ovary, unilateral or bilateral.
58900 ..	Biopsy of ovary, unilateral or bilateral (separate procedure).
58925 ..	Ovarian cystectomy, unilateral or bilateral.
57288 ..	Sling operation for stress incontinence (e.g., fascia or synthetic).
57287 ..	Removal or revision of sling for stress incontinence (e.g., fascia or synthetic).

• Move CPT code 57107 from APC 0194 to APC 0195, Level V Female Reproductive Procedures.

• Move CPT code 57109, Vaginectomy with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), from APC 0194 to the new APC, Level VI Female Reproductive Procedures.

We proposed to accept all of these Panel recommendations. These APCs would be reconfigured and renumbered as APCs 0188 to 0194. We also proposed to add new APCs for Level VII and Level VIII Female Reproductive Procedures (APCs 0195 and 0202, respectively) based on the 1999–2000 claims data and the 2 times rule. These proposed changes have been adopted as final in this document.

APC 0210: Spinal Tap

APC 0211: Level I Nervous System Injections

APC 0212: Level II Nervous System Injections

The Panel heard testimony from two presenters regarding the merits of modifying these three APCs. The first presenter, speaking on behalf of a manufacturer, discussed a new code for 2001, CPT code 64614, Chemodenervation of muscles; extremities and/or trunk muscles (e.g., for dystonia, cerebral palsy, multiple sclerosis).

The second presenter, representing a specialty society, proposed regrouping the procedures assigned to APCs 0210, 0211, and 0212 based on similar levels of complexity and median costs. The presenter's proposal also included reassignment to these APCs of interventional pain procedures currently assigned to APCs 040, Arthrocentesis and Ligament/Tendon Injection, 0105, Revision/Removal of Pacemakers, AICD, or Vascular Device, and 0971. The presenter proposed establishing the following five levels of interventional pain procedures by regrouping the procedures into new APCs as stated below:

• Level I Nerve Injections (to include Trigger Point, Joint, Other Injections, and Lower Complexity Nerve Blocks):

CPT code	Reassigned from APC
20550	040
20600	040
20605	040
20610	040
64612	0211
64613	0211
64614	0971
64400–64418	0211
64425	0211
64430	0211
64435	0211
64445	0211
64450	0211
64505	0211
64508	0211

• Level II Nerve Injections (to include Moderate Complexity Nerve Blocks and Epidurals):

CPT Code	Reassigned from APC
27096	0210
62270	0210
62272	0210
62273	0212
62310–62319	0212

• Level III Nerve Injections (to include Moderately High Complexity Epidurals, Facet Blocks, and Disk Injections):

CPT Code	Reassigned from APC
62280–62282	0212
62290	([1])
62291	([1])
64420–64421	0211
64470	0211
64472	0211
64475–64476	0211
64479	0211
64480	0211
64483–64484	0211
64510	0211
64520	0211
64530	0211
64630	0211
64640	0211

[1] Currently packaged.

• Level IV Nerve Injections (to include High Complexity Lysis of Adhesions, Neurolytic Procedures, Removal of Implantable Pumps and Stimulators):

CPT Code	Reassigned from APC
62263	0212
64600	0211
64605	0211
64610	0211
64620	0211
64622–64623	0211
64626–64627	0211
64680	0211
62355	0105
62365	0105

• Level V Nerve Injections (to include Highest Complexity Disk and Spinal Endoscopies): CPT code 62287, Aspiration or decompression procedure, percutaneous, of nucleus pulposus of invertebral disk, any method, single or multiple levels, lumbar (e.g., manual or automated percutaneous diskectomy, percutaneous laser diskectomy), reassigned from APC 0220, Level I Nerve Procedures.

The Panel recommended reassignment of CPT code 64614 from APC 0971 to APC 0211.

Concerning the suggested regrouping of interventional pain procedures, the Panel agreed that the recommended division of these procedures by clinical complexity would reflect resource use and was a reasonable approach to take. It was pointed out to the Panel that the costs for CPT codes 62290, Injection procedure for diskography, each level; lumbar, and 62291, Injection procedure for diskography, each level; cervical or thoracic, were packaged into the procedures with which they were billed. Therefore, the Panel concurred with the regrouping of procedures to establish

Levels I, II, III, and IV with the following exceptions:

- The Panel recommended that we not include CPT codes 62290 and 62291 in Level III because they are packaged injections and should not be unpackaged and paid separately.
- The Panel opposed moving CPT codes 62355, Removal of previously implanted intrathecal or epidural catheter, and 62365, Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion, from APC 0105 to Level IV Nerve Injections because they were neither clinically similar nor similar in resource use to the other codes assigned to this APC.
- The Panel opposed the creation of Level V Nerve Tests as it included only one code and recommended that CPT code 62287 remain in APC 220.
- We proposed to accept the Panel's recommendations for these services and we proposed to create new APCs 0203, 0204, 0206, and 0207 to accommodate these changes. We are adopting these proposed changes as final.

APC 0215: Level I Nerve and Muscle Tests

APC 0216: Level II Nerve and Muscle Tests

APC 0217: Level III Nerve and Muscle Tests

We advised the Panel that we had received a comment contending that assignment of CPT code 95863, Needle electromyography, three extremities with or without related paraspinal areas, to APC 0216 created an inappropriate incentive to perform tests on three extremities rather than two or four extremities. The payment of about $144 for APC 0216 is greater than the payment of about $58 for the same tests when performed on one, two, or four extremities. This is because CPT codes 95860, 95861, and 95864, Needle electromyography, one, two, and four extremities with or without related paraspinal areas, respectively, are assigned to APC 0215. We distributed data to the Panel that showed a median cost of about $141 for CPT code 95863, which is more than 3 times that of the median cost of $41 for CPT code 95864. We asked the Panel to consider the reassignment of CPT code 95863 from APC 0216 to APC 0215 and advised the Panel that, based on cost data available at the time of our meeting, this change could potentially reduce the payment for APC 0216. It was also noted that this change could result in a payment increase for APC 0215.

The Panel reviewed the cost data for APCs 0215 and 0216 and noted that the median costs for both CPT codes 95863 and 95864 appeared aberrant. Based on the information presented, the Panel recommended that we move CPT code 95863 from APC 0216 to APC 0215. We proposed to accept the Panel's recommendation with one exception. We proposed to revise these APCs based on the 1999–2000 cost data and the 2 times rule, and CPT code 95863 would be assigned to a reconfigured APC for Level II Nerve and Muscle Tests (APC 0218).

The changes we proposed to APCs 0215, 0216, and 0217 have been adopted as final in this document.

APC 0237: Level III Posterior Segment Eye Procedures

We advised the Panel that procedures assigned to APC 0237 are high volume procedures and rank among the top outpatient procedures billed under Medicare. We have received a number of comments disagreeing with the assignment of CPT code 67027, Implantation of intravitreal drug delivery system (e.g., ganciclovir implant), includes concomitant removal of vitreous, to APC 0237. This procedure was added to the CPT coding system after 1996 and, therefore, was not included in the 1996 data. We advised the Panel that ganciclovir, the drug implanted during this procedure, is paid separately as a transitional pass-through item. Because the drug is paid separately, it should not be included in determining whether the resources associated with the surgical procedure are similar to the resources required to perform the other procedures assigned to APC 0237. We advised the Panel that, of the procedures assigned to APC 0237, we believe that CPT code 67027 is related to codes 65260, 65265, and 67005, all of which involve removal of foreign bodies and vitreous from the eye. To ensure that CPT code 67027 is assigned to the appropriate APC, we asked the Panel to consider creation of a new APC, Level IV Posterior Segment Eye Procedures, for CPT codes 65260, 65265, 67005, and 67027. Based on the APC rates effective January 1, 2001, the suggested change could lower the APC rate for the four procedures by $400.

The Panel reviewed the data and did not believe it was sufficient to support the creation of a new APC for these four procedures. Therefore, the Panel recommended that APC 0237 remain intact and that more recent claims data be analyzed to determine whether CPT code 67027 is similar to the other procedures assigned to APC 0237.

Based on the 1999–2000 claims data, we have determined that the resources used for code 67027 are similar to other procedures in APC 0237. However, we will present APCs 0235, 0236, and 0237 to the Panel at their next meeting to determine whether any further changes should be made. We proposed to make various other changes to these APCs based on the new data and the 2 times rule, which we are incorporating as final in this document.

APC 0251: Level I ENT Procedures

This APC violates the 2 times rule because it consists of a wide variety of minor ENT procedures, many of which are low volume services or codes for nonspecific procedures. In order to correct this problem, we recommended to the Panel that this APC be split by surgical site (for example, nasal and oral). After reviewing cost data, the Panel agreed that the APC should be split but that current data were insufficient to determine how that split should be made. Therefore, the Panel asked that this APC, along with more recent cost data, be placed on the agenda at the next meeting.

We agree that this APC should be reviewed by the Panel at its next meeting. However, our review of the more recent cost data indicates that significant violations of the 2 times rule still exist. In order to correct this problem, but keep the APC as intact as possible, we proposed to move CPT codes 30300, Remove foreign body, intranasal; office type procedure, 40804, Removal of embedded foreign body, vestibule of mouth; simple, and 42809, Removal of foreign body from pharynx, to APC 0340, Minor Ancillary Procedures. This APC consists of procedures such as removal of earwax that require similar resources. Based on the latest 1999–2000 data, we find that the reasons for our proposed revision are still valid, therefore, we have incorporated those changes as final in this rule.

APC 0264: Level II Miscellaneous Radiology Procedures

We asked the Panel to review this APC because it violated the 2 times rule and consisted of a wide variety of unrelated procedures. Specifically, we believe that the costs associated with CPT codes 74740, Hysterosalpingography, radiological supervision and interpretation, and 76102, Radiologic examination, complex motion (e.g., hypercycloidal) body section (e.g., mastoid polytomography), other than with urography; bilateral, were aberrant and that we would significantly underpay these procedures if we moved them into a lower paying APC. We also asked the Panel to determine whether this APC

and APC 0263, Level I Miscellaneous Radiology Procedures, should be reconfigured by body system.

After considerable discussion, the Panel agreed that the procedures in these APCs were not clinically homogeneous; however, it recommended that we leave these APCs intact because the data do not support any more coherent reorganization. The Panel requested that this APC be placed on the agenda for the 2002 meeting.

We stated in the proposed rule that we agreed with the Panel's recommendations with the following revisions. First, BIPA requires us to assign procedures requiring contrast into different APCs from procedures not requiring contrast. This required changes to a number of radiologic APCs including APCs 0263 and 0264. In addition, we proposed to move CPT code 75940, Percutaneous Placement of IVC filter, radiologic supervision and interpretation, to a new APC 0187, Placement/Reposition Miscellaneous Catheters, because its costs were significantly higher than the costs of the procedures remaining in APC 0264.

We are adopting the changes discussed in the proposed rule as final. However, as discussed in a comment and response below in section II.A.3 of this preamble, we are revising the title and status indicator for APC 0187.

APC 0269: Echocardiogram Except Transesophageal

APC 0270: Transesophageal Echocardiogram

We asked the Panel to consider splitting these APCs based on whether or not 2D imaging is employed. After review of the data, the Panel recommended that we leave these APCs intact.

We proposed to leave APC 0270 intact except for the addition of two new codes for transesophageal echocardiography. We also proposed to split APC 0269 into two APCs, APC 0269, Level I Echocardiogram Except Transesophageal and APC 0697, Level II Echocardiogram Except Transesophageal. One APC (0269) would include comprehensive echocardiograms and the other APC (0697) would include limited/follow-up echocardiograms and doppler add-on procedures.

We have included these proposed changes in the APCs set forth in this final rule.

APC 0274: Myelography

We advised the Panel that APC 0274 is clinically homogeneous but that it violates the 2 times rule. Procedures assigned to this APC include radiological supervision and interpretation of diagnostic studies of central nervous system structures (e.g., spinal cord and spinal nerves) performed after injection of contrast material. We shared data with the Panel that showed the median costs for the procedures assigned to this APC ranged from a low of about $109 to a high of about $295. We asked the Panel's recommendation for reconfiguring APC 0274 to comply with the 2 times rule.

We informed the Panel members that we packaged the costs associated with radiologic injection codes into the radiological supervision and interpretation codes with which they were reported. The reason for doing this is that hospitals incur expenses for providing both services and they typically perform both an injection and a supervision and interpretation procedure on the same patient. Therefore, since neither an injection code nor a supervision and interpretation code should be billed alone, it would not be appropriate for us to use single claims data to determine the costs of performing these procedures. However, we are using single claims data in order to accurately determine the costs of performing procedures. Therefore, in order to accurately determine the costs of a complete radiologic procedure, we had to package the costs of the injection component into the cost of the supervision and interpretation component with which it was billed.

The Panel recommended the following:

- Make no changes to APC 0274.
- Review new cost data to determine whether payment would increase for APC 0274.

We proposed to accept the Panel's recommendation. We have made no further changes in this APC.

APC 0279: Level I Diagnostic Angiography and Venography

APC 0280: Level II Diagnostic Angiography and Venography

We presented these codes to the Panel for several reasons. APC 0279 violates the 2 times rule, there are numerous codes in these APCs with no cost data, there are numerous ''add on'' codes in these APCs, and many of these procedures were performed infrequently in the outpatient setting in 1996.

The Panel recommended the following:

- Create a new APC (APC 0287, Complex Venography) with the following CPT codes: 75831, 75840, 75842, 75860, 75870, 75872, and 75880.
- Move CPT codes 75960, 75961, 75964, 75968, 75970, 75978, 75992, and 75995 from APC 0279 to APC 0280.

We proposed to accept the Panel's recommendations. We noted that, as proposed, APC 0279 violated the 2 times rule because of the low cost data for CPT code 75660, Angiography, external carotid, unilateral selective, radiological supervision and interpretation. We believe that, for these procedures, these cost data are aberrant. This code is clinically similar to the other codes in APC 0279 and moving code 75660 to an APC with a lower weight could be an inappropriate APC assignment. Therefore, we stated in the proposed rule that we believe that an exception to the 2 times rule is warranted.

We are adopting the proposed changes as final. We note that APC 0279 continues to violate the 2 times rule due to the median cost of CPT code 75660. However, we continue to believe an exception is warranted.

APC 0300: Level I Radiation Therapy

APC 0302: Level III Radiation Therapy

As discussed in the proposed rule, we presented this APC to the technical advisory Panel because we had received comments that the assignment of CPT code 61793, Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator), one or more sessions, to APC 0302 would result in inappropriate payment for this service. Many commenters wrote that stereotactic radiosurgery and intensity modulated radiation therapy (IMRT) required significantly more staff time, treatment time, and resources than other types of radiation therapy. Other commenters disagreed with our decision, effective January 1, 2001, to discontinue recognizing CPT code 61793, and to create two HCPCS level 2 codes, G0173, Stereotactic radiosurgery, complete course of therapy in one session, and G0174, Intensity modulated radiation therapy (IMRT) plan, per session, to report both stereotactic radiosurgery and IMRT.

We reported to the Panel that the APC assignment of these G codes and their payment rate was based on our understanding that stereotactic radiosurgery was generally performed on an inpatient basis and delivered a complete course of treatment in a single session, while IMRT was performed on an outpatient basis and required several sessions to deliver a complete course of treatment. We also explained to the Panel that it was our understanding that multiple CPT codes were billed for each session of stereotactic radiosurgery and

IMRT. Therefore, we believed that the payment for APC 0302 was only a fraction of the total payment a hospital received for performing stereotactic radiosurgery or IMRT on an outpatient basis.

Radiosurgery equipment manufacturers, physician groups, and patient advocacy groups submitted comments and provided testimony to the APC Panel on these issues. These comments convinced us that we did not clearly understand either the relationship of IMRT to stereotactic radiosurgery or the various types of equipment used to perform these services.

We proposed a new coding structure to more accurately reflect the clinical use of these services and the resources required to perform them. In the proposed rule, we stated that there are essentially two services required to deliver stereotactic radiosurgery and IMRT. First, there is ''treatment planning,'' which includes such activities as determining the location of all normal and abnormal tissues, determining the amount of radiation to be delivered to the abnormal tissue, determining the dose tolerances of normal tissues, and determining how to deliver the required dose to abnormal tissue while delivering a dose to adjacent normal tissues within their range of tolerance. We noted that planning activities include the ability to manufacture various treatment devices for protection of normal tissue as well as the ability to ensure that the plan will deliver the intended doses to normal and abnormal tissue by simulating the treatment. Second, there is ''treatment delivery,'' which is the actual delivery of radiation to the patient in accordance with the treatment plan and includes such activities as adjusting the collimator (a device that filters the radiation beams), doing setup and verification images, treating one or more areas, and performing quality control.

We noted that treatment planning for IMRT requires specialized equipment including a duplicate of the actual equipment used to deliver the treatment, the ability to perform a CT scan, various disposable supplies, and involvement of various staff such as the physician, the physicist, the dosimetrist, and the radiation technologist. Treatment delivery requires specialized equipment to deliver the treatment and the involvement of the radiation technologist. The physician and physicist provide general oversight of this process.

Our proposal stated that although there are several types of equipment, produced by several manufacturers, used to accomplish this treatment, it was the consensus of the commenters and the Panel that the most useful way to categorize stereotactic radiosurgery and IMRT is by the source of radiation used for the treatment and not by the type of equipment used. One reason for this is that the clinical indications for stereotactic radiosurgery and IMRT overlap. Therefore, a single disease process can be treated by either modality but the cost of treatment varies by source of radiation used for the treatment. Second, while both stereotactic radiosurgery and IMRT can deliver a complete course of treatment in either one or multiple sessions, the cost of treatment delivery per session is relatively fixed, and is closely related to the source of radiation used for the treatment. On the basis of this understanding we made the following proposal: Appropriate APC assignment and payment were to be made by creating four HCPCS codes to describe these services.

The proposed codes are as follows:

- GXXX1 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.
- GXXX2 Multi-source photon stereotactic radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment, per lesion.
- G0174 Intensity modulated radiation therapy (IMRT) delivery to one or more treatment areas, multiple couch angles/fields/arcs custom collimated pencil-beams with treatment setup and verification images, complete course of therapy requiring more than one session, per session.
- G0178 Intensity modulated radiation therapy (IMRT) plan, including dose volume histograms for target and critical structure partial tolerances, inverse plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, per course of treatment.

We also proposed that HCPCS codes GXXX1, G0174, and G0178 have status indicators of S, while GXXX2 has a status indicator of T. We believe these are the correct status indicators because G0178 has a ''per session'' designation, while GXXX2 has a ''per lesion'' designation. This was based on our understanding that GXXX1 would not be billed on a ''per lesion'' basis as the planning process would take into account all lesions being treated and it would be extremely difficult to determine resource utilization for planning on a ''per lesion'' basis. Because the costs of performing GXXX1 will vary based on the number of lesions treated, payment would reflect a weighted average.

We based our proposal on our understanding that single-source photon stereotactic radiosurgery (or linear accelerator) planning and delivery are similar to IMRT planning and delivery in terms of clinical use and resource requirements. Therefore, we proposed to require coding for single-source photon stereotactic radiosurgery under HCPCS codes G0174 and G0178.

We also noted that the AMA is establishing codes for IMRT planning and treatment delivery for 2002 and we proposed to retire G0174 and G0178 (with the usual 90-day phase out) and recognize the applicable CPT codes when they are established in January 2002.

Because all activities required to perform stereotactic radiosurgery and IMRT were to be included in the codes described above, we proposed to discontinue the use of any other radiation therapy codes for activities involved with planning and delivery of stereotactic radiosurgery and IMRT for purposes of hospital billing in OPPS. Therefore, we also proposed continuing to not recognize CPT code 61793 for hospital billing purposes.

We believed that our proposal would not only simplify the reporting process for hospitals, but also appropriately recognize the clinical practice and resource requirements for stereotactic radiosurgery and IMRT.

We sought comments on our proposal, including the code titles, descriptors, and coding requirements discussed above. We also requested information regarding appropriate APC assignment and payment rates to inform our decision-making. We specifically asked for information regarding the costs of treatment delivery including any differences between the cost of a complete treatment in single versus multiple sessions.

Finally, we noted that several commenters had requested placement of the stereotactic delivery codes in surgical APCs, therefore, we requested clarification and support for these comments within the context of our coding proposal. Specifically, we were concerned that appropriate payment be made for GXXX2, which has a ''per lesion'' descriptor.

We received numerous comments on our proposal. These comments concerned our proposed coding scheme

and payment amounts as well as the need for separate codes recognizing linear accelerator-based radiosurgery. Many of the comments were part of a write-in campaign asking us to categorize radiosurgery as a surgical procedure and not a radiologic procedure. These letters also asserted that our payment amount for stereotactic radiosurgery should be $15,000. Below, we address each major issue raised by the commenters.

Comment: We received several comments regarding our coding proposal. The commenters indicated the following:

- Our proposed codes are duplicative of currently existing codes.
- We should recognize CPT code 61793 in the APC system.
- Our proposed codes would not allow billing for single session and fractionated linear accelerator-based radiosurgery.
- We incorrectly believe that multisession radiosurgery is similar in resource use to IMRT.
- We should delete our proposed codes for stereotactic radiosurgery planning and recognize CPT code 77295 for this purpose.
- CMS should clarify the other codes that would be billable with our proposed codes.
- Conflicting comments on whether the proposed code for stereotactic radiosurgery delivery should be ''per lesion'' or ''per session'' or ''per course of treatment.''

Commenters were also concerned about our ability to establish APC weights using claims that contained two significant procedures (e.g., stereotactic radiosurgery planning and stereotactic radiosurgery delivery).

Response: We reviewed all these comments very carefully. After completing our review, we have decided to make the following modifications to our proposed coding scheme:

- IMRT—We are not making any changes to our proposal for IMRT coding. We will delete the applicable G codes (G0174 and G0178) and recognize the new CPT codes for IMRT planning (code 77301) and IMRT delivery (code 77418) as established by the AMA.
- GXXX1—Under our proposal, GXXX1 (now G0242) would have been used only for Cobalt-based radiosurgery. After review of the comments, we believe that the planning for Cobalt-based and linear accelerator-based radiosurgery is similar both clinically and in terms of resource consumption. Therefore, at the next coding update, we will change the descriptor for this code to include linear accelerator-based radiosurgery planning. We do not know whether radiosurgery planning is similar clinically and in terms of resource consumption to CPT code 77295 (therapeutic radiology simulation-added field setting; three-dimensional). Use of G0242 will allow us to collect claims data and cost information that will aid us in determining whether G0242 is similar in resource use to 77295. However, we believe that tracking the utilization of G0242 as well as the codes with which it is submitted is very important for future APC reclassification and recalibration purposes, therefore, at this time, we do not intend to discontinue use of this code.
- GXXX2—Most of the comments concerned whether this code (now G0243) should be ''per lesion.'' After extensive review of the comments, we have determined that it is more appropriate for this code to be used ''per session'' or ''per course of treatment.'' We have concluded that the resource consumption for stereotactic treatment delivery varies significantly depending on the size, shape, and depth of the lesion(s) being treated. It is quite possible for the treatment of two superficial, spherical lesions to be less resource intensive than the treatment of a single, large, irregular lesion deep within the brain. Furthermore, the method of treatment and the manner in which the resources are used make a ''per lesion'' description inappropriate. For example, in Cobalt-based treatment, patients are administered ''spheres of dose'' and moved in and out of the machine after each ''sphere of dose.'' The number of ''spheres of dose'' per lesion varies widely so therefore ''per sphere of dose'' might be an alternative description for this service. However, we have concluded that any descriptor other than ''per session'' or ''per course of treatment'' will result in, or create the incentive to bill for, inappropriate payments for this service. Furthermore, it is our understanding that hospitals usually have a single charge for this service and that charge is based on the average resource use for all patients undergoing the procedure whether those patients have one, two, or more lesions treated. Because of the variability of treatment delivery per lesion, hospitals would be overpaid for multi-lesion patients if their charge is based on the average resource use over all patients. Finally, a ''per session'' description is more consistent with a prospective payment system. Because a ''per session'' payment reflects an average that includes all patients, unless a hospital specializes in treatment of multi-lesion patients, the OPPS payment is likely to be appropriate across all patient types. That is, the payment will be slightly higher than costs for single lesion treatments, and slightly lower than costs for multiple lesion treatments, averaging out over all patients.
- Linear accelerator-based radiosurgery—This treatment poses an especially difficult problem because linear accelerator-based radiosurgery can be delivered in a single dose like Cobalt-based treatment, or it can be delivered in fractions, with a maximum of five fractions. We do not have any cost information concerning the resource use of linear accelerator-based treatment delivery, but we do understand that there are two types of linear accelerator-based delivery of radiosurgery: ''gantry-based'' and ''image-directed.'' We do not know if the resource use of these two subtypes of linear accelerator based-radiosurgery is similar. Furthermore, we do not know whether the total resource consumption of fractionated radiosurgery delivered from a linear accelerator is different from the resource consumption of single dose radiosurgery delivered by a linear accelerator.

Therefore, in order to collect data on this procedure, we will designate current code G0173 for reporting single session radiosurgery delivered by a linear accelerator, either gantry-based or image-directed. At the next coding update, we will revise the descriptor for G0173 to reflect this change. Additionally, at the next coding update, we will create a new G code for use by facilities for fractionated radiosurgery delivered by a linear accelerator (either gantry-based or image-directed). The number of fractions will be limited to no more than five. Both G0173 and the new code for fractionated linear accelerator-based radiosurgery will be temporary while we collect cost and utilization data for these services. Once we have collected these data, we will determine whether permanent codes are needed.

In general, we have tried to strike a balance between recognizing clinically dissimilar treatments with individual codes and avoiding the creation of equipment-specific codes for purposes of the OPPS. We believe that the codes established in this final rule reflect this balance.

For multiple procedure claims, we do not believe there is a problem recognizing claims with more than one significant procedure to assist us in determining appropriate APC weights. We have analyzed all the claims in the 1999–2000 data base for CPT code 61793 to determine the codes with which it was billed and in what

frequencies. We have developed coding edits based on this claims analysis and, as discussed below, the payments for stereotactic radiosurgery reflect the median costs for all services that will be included in the payment for stereotactic radiosurgery planning and delivery. We have discussed these coding edits in great detail with the American Society for Therapeutic Radiology and Oncology (ASTRO) and they concur with the edits.

Comment: Many commenters asked us to place stereotactic radiosurgery in a ''surgical'' APC.

Response: We do not understand these comments. We realize that a neurosurgeon is present during stereotactic radiosurgery but, unlike the hospital inpatient PPS, we have no APC designation of ''surgical.'' We have interpreted this comment to mean that commenters do not want stereotactic radiosurgery to be in the same APC as IMRT or fractionated stereotactic radiosurgery. As discussed below, our new assignments of the codes to APCs will effectively create this change.

Comment: We received numerous comments concerning the status indicators we had proposed for the various radiosurgery procedures.

Response: In view of the change in the descriptor for G0243, we will be changing the status indicator for G0243 to ''S.'' This is because there will not be multiple units of this service billed and the costs for providing single dose stereotactic radiosurgery is relatively fixed and it would be inappropriate to give this procedure, as finalized, a ''T'' designation (that is, the multiple procedure reduction is not applicable).

Comment: Many comments addressed the payment rate for stereotactic radiosurgery and IMRT. Suggested amounts for payment of IMRT treatment planning and delivery varied from less than $300 to over $2,000 and suggested amounts for radiosurgery planning and treatment ranged from less than $1,000 to $15,000.

Response: We have no cost data specifically associated with IMRT upon which to base payment for IMRT. Therefore, we used information that provided the basis for IMRT payment under the physician fee schedule and we have established APC assignments that result in payment rates for IMRT planning and treatment delivery similar to payment under the physician fee schedule. We believe this is appropriate because the resource use for these procedures is similar in freestanding facilities and in hospitals. Because we have no claims data on the costs of IMRT, these procedures will be assigned to new technology APCs. As cost data are incorporated in the OPPS claims data base, they will be used to recalibrate the payment for these services and determine their future APC assignment. We would note that payment for IMRT planning includes payment for the following CPT codes: 77300, 77280–77295, 77305–77321. The only CPT codes that may be billed in addition to G0242 (IMRT planning) are the CPT codes 72332–72334 for treatment devices. We plan to incorporate the costs of those codes into IMRT planning when we have collected the cost data. The APC assignment for G0242 is APC 0714, New Technology—IX ($1250–$1500).

In order to determine appropriate payment amounts for both planning and treatment of stereotactic radiosurgery, we did an extensive analysis of our claims data base for code 61793 because that was the code used for stereotactic radiosurgery during 1999–2000. We collected all claims for 61793 and determined which CPT codes were billed with 61793 and the frequency with which each of those codes was billed with 61793. Within the subset of claims including CPT code 61793, we determined the median costs for 61793 and for each CPT code billed with 61793. In analyzing these claims, it was clear that 61793 was generally used to bill for treatment delivery and other codes were used, in combination, to bill for treatment planning. For example, 61793 was billed with 77300 on 57 percent of the claims, with either 77295 or 77290 on 62 percent of the claims, with either 77370 or 77336 on 77 percent of the claims (occasionally both of these codes were on the same claim), and with either 77305, 77315, or 77321 on 59 percent of the claims.

Based on these data, we have determined the total cost for stereotactic radiosurgery as follows: For stereotactic radiosurgery planning, we added the median costs (when billed with 61793) of 77295 (the most typical simulation code billed with 61793), 77300, 77370 (the most common physics consult billed with 61793), and 77315 (the most common dose plan billed with 61793) and will use the sum of these medians as the basis for our APC assignment for 2002. The medians of these codes are: $134.06 for 77300; $146.97 for 77370; $955.88 for 77295; and $206.56 for 77315. The total median cost for these codes is $1,443.47. Effective for services furnished on or after January 1, 2002, we will no longer allow these codes to be billed with stereotactic radiosurgery. No other codes were billed frequently enough with 61793 to justify including their costs in our stereotactic radiosurgery planning code. However, treatment device codes (77332–77334) were billed with 61793 on 42 percent of the claims, so we will allow one of those codes to be billed with each claim for stereotactic radiosurgery. We will consider incorporating their costs into the payment for stereotactic radiosurgery in the future. We note that the median cost of 77334 (the most common treatment device code billed with 61793) was $174.27 when it was billed with 61793.

CPT Code 20660, application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure), was billed with 61793 on only 23 percent of the claims. Because 20660 is required in order to perform stereotactic radiosurgery treatment, we will package the costs associated with 20660 into G0243, the radiosurgery treatment delivery code. We also note that 61793 was billed with an MRI of the brain on 71 percent of the claims. We will allow CTs and MRIs to be billed in addition to stereotactic radiosurgery planning.

For stereotactic radiosurgery delivery, we determined that the median cost of 61793 (using all claims) was $5,734.22 and will use that amount as the basis for our APC assignment for stereotactic radiosurgery for 2002. No other radiotherapy treatment code was billed frequently enough with 61793 to justify incorporation of its cost into our payment (that is, the treatment code most commonly billed with 61793 was 77470 (33 percent of the claims) and the next most common was 77412 (6 percent of the claims)). We will not allow billing of any other radiation treatment delivery codes with stereotactic radiosurgery treatment.

Therefore, we are assigning G0243 to APC 0721, New Technology—XVI ($5,000 to $6,000).

We will pay the same amount for linear accelerator-based stereotactic radiosurgery as for multiple source-based radiosurgery. For fractionated linear accelerator-based radiosurgery, we will divide the payment for single session radiosurgery by five and allow up to five payments. This will make total payment for fractionated linear accelerator based radiosurgery similar to linear accelerator-based single dose radiosurgery while allowing us to collect cost and utilization data for setting payments in 2003. Note that because application of a stereotactic frame is not required for linear accelerator-based radiosurgery, we will not be packaging the costs of code 20660 into the costs for linear accelerator-based radiosurgery.

Linear accelerator-based radiosurgery planning will be coded with the same

code as multiple source-based radiosurgery; therefore, the APC assignment will be the same as well. We note that all of these codes associated with radiosurgery are assigned to new technology APCs as we have no claim data on the procedures. Once we have collected data, the procedures will be assigned to other APCs.

The final APC assignments are as follows:

- 77301 is assigned to APC 0712
- 77418 is assigned to APC 0710
- G0173 is assigned to APC 0721
- G0242 is assigned to APC 0714
- G0243 is assigned to APC 0721.

APC 0311: Radiation Physics Services

APC 0312: Radio Element Application

APC 0313: Brachytherapy

We presented APC 0311 to the Panel because we believed our cost data for CPT codes 77336, Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy; 77370, Special medical radiation physics consultation; and 77399, Unlisted procedure, medical radiation physics, dosimetry, and treatment devices, and special services, were inaccurate. We were concerned that these procedures, particularly code 77370, were not being paid appropriately in APC 0311.

Presenters pointed out that, as with all radiation oncology services, the usual practice is to bill multiple CPT codes on the same date of service. Therefore, single claims were likely to be inaccurate bills and did not represent the true costs of the procedure. For this reason, presenters believed that using single claims to set payment rates for radiation oncology procedures was inappropriate and that we needed to develop a methodology that allowed the use of multiple claims data to set payment rates for these services.

For radiation physics consultation, presenters stated that the staff costs associated with CPT code 77370 were significantly greater than the costs of CPT codes 77336 and 77399. Therefore, they recommended that CPT codes 77336 and 77399 be moved from APC 0311 to APC 0304, Level I Therapeutic Radiation Treatment Preparation, and CPT code 77370 be moved from APC 0311 to APC 0305, Level II Therapeutic Radiation Treatment Preparation. The Panel agreed with this recommendation and we proposed to accept the Panel's recommendation. We also agreed that we should review the use of single claims to set payment rates for radiation oncology services. We plan to present this issue again at the 2002 Panel meeting.

We presented APCs 0312 and 0313 to the Panel because commenters were concerned that the payment rates were too low for the procedures assigned to the APCs and that there were insufficient data to set payment rates for these APCs. The Panel agreed that the issue regarding the use of single claim data affected the payment rates for these services. However, there were insufficient data for the Panel to make any recommendations regarding these APCs. The Panel did request to look at the issue of radiation oncology at its 2002 meeting.

Therefore, we proposed to make no changes to APCs 0312 and 0313 but will address radiation oncology issues at the Panel's 2002 meeting. We note that our updated claims data show very few single claims for procedures in these APCs. However, moving any of these procedures into other radiation oncology APCs would lower their payment rates. We are making no further changes to these APCs.

APC 0371: Allergy Injections

We presented this APC to the Panel because it violates the 2 times rule. The median costs for CPT codes 95115, Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection, and 95117, Professional services for allergen immunotherapy not including provision of allergenic extracts; two or more injections, were lower than the median costs for the other services in this APC.

The Panel agreed that because codes 95115 and 95117 included administration of an injection only, the resource utilization for these services was lower than for the other services. The other services involve preparation of antigen and require more staff time and hospital resources to perform.

In order to create clinical and resource homogeneity, the Panel recommended that we create a new APC for codes 95115 and 95117 and that we leave the other services in APC 0371. We proposed to accept the Panel recommendation and create a new APC 0353, Level II Allergy Injections, and revise the title of APC 0371 to Level I Allergy Injections. These proposed changes are incorporated as final in this rule.

Observation Services

See the discussion on observation services in section II.C.4 of this preamble for the Panel's recommendations and our proposal as well as a discussion of the comments we received.

Inpatient Procedure List

See the discussion of the inpatient procedures list in section II.C.5 of this preamble for the Panel's recommendations and our proposal and a discussion of the comments we received on the list.

3. Other APC Issues

APC 0285: Positron Emission Tomography (PET)

Comment: Commenters expressed concern about the calculation of the payment rate for APC 0285, Positron Emission Tomography (PET), which includes PET for myocardial perfusion imaging. One specific concern is that single service claims are used to calculate relative weights although the applicable procedure codes for these studies are always linked to another diagnostic study and, therefore, they should not appear on single service claims. Second, the commenters are concerned that it is not appropriate to place both single study and multiple study PET procedures in the same APC.

Response: While the PET procedures are linked with a previous diagnostic procedure, the latter need not have been performed on the same day or in the same facility. Upon review of our claims data base, we find that nearly 50 percent of all claims for PET myocardial perfusion imaging studies are single service claims. We believe this to be a sufficient frequency for setting payment rates consistent with the overall methodology for setting rates in the OPPS. With regard to the second concern, after further analysis of claims, we concluded that there is not sufficient variation in the cost among the relevant codes, whether single or multiple studies, to warrant a change in the APC structure.

PET Scans Assigned to APC 0976: New Technology—Level VII ($750–$1000)

In the April 7, 2000 final rule, we assigned PET scans that use 18-flurodeoxyglucose (FDG) to APC 0980, New Technology—Level XII ($2000–$2500) because there were no claims for these procedures in the 1996 data used to establish the APC relative weights for 2000. However, based on the data from over 4,000 claims for services furnished between July 1, 1999 through June 30, 2000, the data base that was used to set the proposed APC weights, we found that the reported median costs for these procedures was closer to $900. Therefore, in the proposed rule, we

assigned the FDG PET scans to APC 0976, New Technology—Level VII ($750–$1000). We received a large number of comments on this proposed change.

Comment: Commenters expressed concern that the proposed APC assignment resulted in a much reduced payment rate for FDG PET scans. Many of these commenters expressed particular concern that the proposed rate of about $850 would not cover the cost of purchasing FDG in addition to the direct and indirect costs of a PET scan. The commenters requested that we review our data and the data they submitted and assign these procedures to a higher level new technology APC.

Response: As we discussed in detail in the April 7, 2002 final rule (65 FR 18476–78), the purpose of assigning a service to a new technology APC is to pay for a new technology based on its expected costs (as evidenced by data collected by us from various external sources) while we collect claims data that would allow assignment of the service to a clinically appropriate APC based on the actual resource use of the service. Our current policy is that a service remains in a new technology APC for 2 to 3 years while we collect the necessary claims data. (See section VI.G of this preamble for a discussion of changes we are making to this policy effective CY 2002.) Because FDG PET scans were assigned to a new technology APC at the implementation of the OPPS in August 2000, they will continue to be assigned to a new technology APC through 2002. However, when we reviewed the claims data in our 1999–2000 data base, there were about 5,000 single claims for these PET scans, with a median cost of about $900. Therefore, we proposed to move these procedures from APC 0980 to APC 0976.

As requested by the commenters and consistent with our policy on pricing services for assignment to new technology APCs, we reviewed the external data provided by the commenters as well as our claims data. These data suggest that our claims cost data may not have accurately captured the entire costs of the procedure, particularly the cost of the FDG. Based on our analysis, we believe that the cost of an FDG PET scan is between $1,200 and $1,800, with a midpoint of $1,500. According to our methodology for pricing new technology services, these services will be reassigned to APC 0978, New Technology—Level IX ($1250–$1500), which results in a payment rate of $1,375.

Cryoablation of the Prostate

Comment: We received several comments concerning our proposal to place CPT code 55873, cryosurgical ablation of the prostate, into APC 0163, Level IV Cystourethroscopy and other Genitourinary Procedures. Commenters believe that we had insufficient cost data to justify moving this code from its current assignment, APC 0980, New Technology—XI ($1750–$2000). They also believe that cryoablation of the prostate is not clinically similar to other procedures in APC 0163. One commenter requested moving code 55873 into either APC 0984, New Technology—XV ($3500–$5000) or 0132, Level III Laparoscopy.

Response: We have reviewed our 1999–2000 cost data for code 55873, and have 4 claims that show a median cost of just over $4,000, which includes the cost of the procedure as well as the associated devices. The devices associated with this procedure are eligible for transitional pass-through payments. After subtracting the estimated cost of the pass-through devices, we believe that the approximate expected cost of this procedure warrants its assignment to APC 0982 New Technology—XIII ($2500–$3000), with a status indicator of ''T.'' The devices associated with this procedure remain eligible for transitional pass-through payments in 2002 in addition to the APC payment amount.

Water-Induced Thermotherapy

Comment: We received a comment from the manufacturer of the equipment used for water-induced thermotherapy (a treatment for benign prostatic hyperplasia), CPT code 53853, that our proposal to assign this procedure in new technology APC 0977, New Technology—VIII ($1000–$1250) did not accurately reflect the costs and resources required to furnish this procedure. The commenter believes that 53853 should be placed in APC 0982, New Technology—XIII ($2500–$3000) with other minimally invasive thermotherapy treatments for benign prostatic hyperplasia.

Response: We disagree with the commenter and are finalizing our proposal. Based on the information provided by the commenters and our own clinical knowledge, we understand that the resources required to deliver water-induced thermotherapy are less than the resources required for the procedures assigned to APC 0982 (CPT codes 53850, transurethral destruction of prostate tissue; by microwave thermotherapy, and 53852, transurethral destruction of prostate tissue; by radiofrequency thermotherapy). Less intraoperative staff time and less equipment resources are required for 53853 than for the other procedures. In addition, unlike codes 53850 and 53852, which require sedation or regional anesthesia, code 53853 requires only local anesthesia. Finally, recovery time is shorter (in part because of the local anesthesia) and requires fewer facility resources. Therefore, we believe code 53853 is appropriately assigned to APC 0977.

Ultrasound Radiologic Guidance Codes

Comment: Several commenters inquired about a change in the proposed rule that resulted in the packaging of certain ultrasound and radiologic guidance codes. The commenters urged us to publish the data and rationale for these changes and recommended that the proposed changes not be made final, pending further review and a fuller discussion of the proposed changes. The commenters recommended separate rather than packaged payment for the guidance codes.

Response: As we explain above in section II.A.2 of this preamble under the discussion for APC 0151, we accepted the APC Panel's recommendation to consider the use of multiple claims data to determine payment rates for endoscopic retrograde cholangio-pancreatography (ERCP). The payment rate that we proposed for ERCP was based on both single claims for ERCP procedures and on claims that included both an ERCP procedure and a radiologic supervision or guidance procedure. That is, rather than making separate payment for the radiologic supervision and guidance furnished in connection with ERCP, we packaged those costs into the proposed rate for APC 0151.

Our experience using multiple procedure claims to price ERCP in accordance with the Panel's recommendation led us to consider other services that could be priced similarly. We believe that the following procedures assigned to APC 0268, Guidance Under Ultrasound, would never be performed alone, but would always be performed in connection with and be considered integral to the performance of another procedure: 76930, 76932, 76934, 76938, 76941, 76942, 76945, 76946, 76948, 76950, 76960, 76965, G0161. Therefore, if a claim listed one of the procedures in APC 0268 in addition to another procedure, we retained that claim in the pool of single-procedure bills used to calculate median costs for services within the various APCs. Costs

associated with the codes in APC 0268 were therefore packaged into the APCs of procedures with which they were billed between July 1, 1999 through June 30, 2000.

We continue to believe that the most appropriate way to pay for ultrasound guidance is to package its costs as part of the cost of performing the procedure for which the guidance is needed. Therefore, in the proposed rule, we assigned status indicator ''N'' to still active codes that had previously been in APC 0268. We applied the same principle to several radiologic guidance codes (76393, 19290, 19291, and 19295). We assigned status indicator ''N'' to these codes because they represent services that are always furnished in connection with another procedure. That is, they are integral to performing another procedure and would never be performed alone, as a single service. Therefore, costs associated with such radiologic guidance codes are more appropriately packaged than paid for separately.

It is crucial that hospitals bill charges for codes with status indicator ''N'' to ensure that costs for packaged services are appropriately captured in the APCs with which they are associated. For the 2003 OPPS update, we will consider proposing to package additional guidance services with whichever procedures they are billed, including the following:

76095, Stereotactic localization guidance for breast biopsy or needle placement.

76355, Computerized tomography guidance for stereotactic localization.

76360, Computerized tomography guidance for needle placement.

We will report to the Panel on our progress in treating bills with certain packaged services as single procedure claims. We will also include on the agenda of the next Panel meeting a follow-up discussion to review the services that we have packaged thus far and to consider other codes that would also be more appropriately paid as packaged rather than separate services. To identify all the procedures with which the ultrasound and radiologic guidance services are packaged would require a review of the raw outpatient claims that make up the 1999–2000 data that we are using to recalibrate the 2002 APC weights because we have previously packaged the guidance costs with whatever procedure they are billed in preparing the claims data base used for recalibration.

Breast Biopsy

Comment: A few commenters, including the manufacturer of a minimally invasive breast biopsy system, expressed concern that the higher APC relative weight for surgical breast biopsy procedures would discourage Medicare beneficiary access to less invasive procedures. The commenters were also concerned that the proposed payment for less invasive breast biopsy procedures was inadequate.

Response: As we discuss below in section II.D. of this preamble, the APC weights reflect hospital median costs (as determined from the charges reflected on claims submitted by hospitals) for a given procedure relative to the costs for other procedures. We expect that the costs for an open surgical procedure will be higher than those for less invasive procedures because open surgery is more resource intensive, especially in terms of recovery time, anesthesia, and nursing care. We do not agree that the higher relative weight for open surgical biopsy will serve as an incentive to perform this procedure rather than the less costly, less invasive options. The payment rate for the less invasive options are based on the costs of those procedures as reported by hospitals. We note that the payment rate for the breast biopsy procedure assigned to APC 0974, New Technology—Level V ($300–$500) (CPT code 19103, Percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance) is higher in this final rule relative to the proposed rule (see the discussion in section II.D. of this preamble, below).

Comment: Several commenters questioned why the proposed rule indicated that CPT code 76095, Stereotactic localization guidance for breast biopsy, would be moved from APC 0264, Level II Miscellaneous Radiology Procedures, with a status indicator of ''X'' (ancillary service) to APC 0187, Placement/Repositioning Miscellaneous Catheters, with a status indicator of ''T'' (significant procedure, multiple procedure reduction applies). The commenters were concerned that the ''T'' status indicator would result in a lower payment for the procedure when it is billed with other procedures.

Response: We agree with commenters that the title for APC 0187 in the proposed rule is misleading given the procedures that are included within the APC. Therefore, in the final rule, we are changing the name of APC 0187 to ''Miscellaneous Placement/Repositioning''. We are also changing the status indicator for APC 0187 from ''T'' to ''X''. We created APC 0187 to pay more appropriately for certain guidance codes, including code 76095.

Status Indicators

Comment: A commenter asserted that some hospitals believe that procedure codes designated with status indicators of ''S,'' ''T,'' ''V,'' and ''X'' mean that the procedure must be performed in the outpatient setting.

Response: This is not the case. These status indicators were developed to assist us with our pricing policy in OPPS, not to dictate where the procedures could be performed. Although a status indicator of ''C'' means that the procedure will not be paid if performed in the outpatient setting, the status indicators paid under the OPPS do not dictate where that service or procedure is covered. We pay for any covered service or procedure performed in the inpatient setting as an inpatient service as long as the patient's condition merits admission to the hospital as an inpatient.

B. Additional APC Changes Resulting from BIPA Provisions

1. Coverage of Glaucoma Screening

Section 102 of the BIPA amended section 1861(s)(2) of the Act to provide payment for glaucoma screening for eligible Medicare beneficiaries, specifically, those with diabetes mellitus or a family history of glaucoma, and certain other individuals found to be at high risk for glaucoma as specified by our rulemaking. The implementation of this provision is discussed in detail in a separate final rule concerning the revisions in the physician fee schedule payment policy for CY 2002, published in the **Federal Register** on November 1, 2001 (66 FR 55272).

In order to implement section 102 of BIPA, we have established two new HCPCS codes for glaucoma screening:

- G0117—Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist.
- G0118—Glaucoma screening for high risk patients furnished under the direct supervision of an optometrist or ophthalmologist.

We proposed to assign the glaucoma screening codes to APC 0230, Level I Eye Tests. We further proposed to instruct our fiscal intermediaries to make payment for glaucoma screening only if it is the sole ophthalmologic service for which the hospital submits a bill for a visit. That is, the services included in glaucoma screening (a dilated eye examination with an intraocular pressure measurement and direct opthalmoscopy or slit-lamp biomicroscopy) would generally be performed during the delivery of another opthalmologic service that is furnished on the same day. If the

beneficiary receives only a screening service, however, we would pay for it under APC 0230.

2. APCs for Contrast Enhanced Diagnostic Procedures

Section 430 of the BIPA amended section 1833(t)(2) of the Act to require the Secretary to create additional APC groups to classify procedures that utilize contrast agents separately from those that do not, effective for items and services furnished on or after July 1, 2001. On June 1, 2001, we issued a Program Memorandum, Transmittal A–01–73, in which we made numerous coding and grouping changes to implement this provision. (This transmittal can be found at *www.hcfa.gov/pubforms/transmit/AO173.pdf*) We removed the radiological procedures whose descriptors included either ''without contrast material'' or ''without contrast material followed by contrast material'' from APC groups 0282, Level I, Computerized Axial Tomography; APC 0283, Level II, Computerized Axial Tomography; and APC 0284, Magnetic Resonance Imaging. As a result, APCs 0283 and 0284 now include only imaging procedures that are performed with contrast materials. Additionally, reconfigured APC 0282 no longer includes radiological procedures that use contrast agents.

Effective for items or services furnished on or after July 1, 2001, we created six new APC groups for the procedures removed from APCs 0282, 0283, and 0284, as shown below. (Effective October 1, 2001, we eliminated APC 0338. Refer to Transmittal A–01–73 for a detailed description of this change.) For services furnished on or after July 1, 2001 and before January 1, 2002, the payment rates for the new imaging APCs are the same as those associated with the APCs from which the procedures were moved. For the proposed rule, we calculated separate weights for the new APCs based on the data available at the time for recalibration. In this final rule, we are establishing separate weights for the new APCs based on the final data used to recalibrate the weights for 2002.

TABLE 1.—APC GROUPS RECONFIGURED TO SEPARATE IMAGING PROCEDURES THAT USE CONTRAST MATERIAL FROM PROCEDURES THAT DO NOT USE CONTRAST MATERIAL

APC	SI	APC title
0282	S	Miscellaneous Computerized Axial Tomography.
0283	S	Computerized Axial Tomography with Contrast.
0284	S	Magnetic Resonance Imaging and Angiography with Contrast.
0332	S	Computerized Axial Tomography w/o Contrast.
0333	S	CT Angio and Computerized Axial Tomography w/o Contrast followed by with Contrast.
0335	S	Magnetic Resonance Imaging, Temporomandibular Joint.
0336	S	Magnetic Resonance Angiography and Imaging without Contrast.
0337	S	Magnetic Resonance Imaging and Angiography w/o Contrast followed by with Contrast.

The HCPCS codes that are reassigned to the new imaging APCs in this final rule are as follows:

APC	HCPCS	SI	Short descriptor
0282	76370	S	CAT scan for therapy guide.
	76375	S	3d/holograph reconstr add-on.
	76380	S	CAT scan for follow-up study.
	G0131	S	Ct scan, bone density study.
	G0132	S	Ct scan, bone density study.
0283	70460	S	Ct head/brain w/dye.
	70481	S	Ct orbit/ear/fossa w/dye.
	70487	S	Ct maxillofacial w/dye.
	70491	S	Ct soft tissue neck w/dye.
	71260	S	Ct thorax w/dye.
	72126	S	Ct neck spine w/dye.
	72129	S	Ct chest spine w/dye.
	72132	S	Ct lumbar spine w/dye.
	72193	S	Ct pelvis w/dye.
	73201	S	Ct upper extremity w/dye.
	73701	S	Ct lower extremity w/dye.
	74160	S	Ct abdomen w/dye.
	76355	S	CAT scan for localization
	76360	S	CAT scan for needle biopsy.
0284	70542	S	MRI orbit/face/neck w/dye.
	70545	S	Mr angiography head w/dye.
	70548	S	Mr angiography neck w/dye.
	70552	S	MRI brain w/dye.
	71551	S	MRI chest w/dye.
	72142	S	MRI neck spine w/dye.
	72147	S	MRI chest spine w/dye.
	72149	S	MRI lumbar spine w/dye.
	72196	S	MRI pelvis w/dye.
	73219	S	MRI upper extremity w/dye.
	73222	S	MRI joint upr extrem w/dye.
	73719	S	MRI lower extremity w/dye.
	73722	S	MRI joint of lwr extr w/dye.

APC	HCPCS	SI	Short descriptor
	74182	S	MRI abdomen w/dye.
	75553	S	Heart MRI for morph w/dye.
	C8900	S	MRA w/cont, abd.
	C8903	S	MRI w/cont, breast,uni.
	C8906	S	MRI w/cont, breast, bi.
	C8909	S	MRA w/cont, chest.
	C8912	S	MRA w/cont, lwr ext.
0332	70450	S	CAT scan of head or brain.
	70480	S	Ct orbit/ear/fossa w/o dye.
	70486	S	Ct maxillofacial w/o dye.
	70490	S	Ct soft tissue neck w/o dye.
	71250	S	Ct thorax w/o dye.
	72125	S	Ct neck spine w/o dye.
	72128	S	Ct chest spine w/o dye.
	72131	S	Ct lumbar spine w/o dye.
	72192	S	Ct pelvis w/o dye.
	73200	S	Ct upper extremity w/o dye.
	73700	S	Ct lower extremity w/o dye.
	74150	S	Ct abdomen w/o dye.
0333	70470	S	Ct head/brain w/o&w dye.
	70482	S	Ct orbit/ear/fossa w/o&w dye.
	70488	S	Ct maxillofacial w/o&w dye.
	70492	S	Ct sft tsue nck w/o & w/dye.
	70496	S	Ct angiography, head.
	70498	S	Ct angiography, neck.
	71270	S	Ct thorax w/o&w dye.
	71275	S	Ct angiography, chest.
	72127	S	Ct neck spine w/o&w dye.
	72130	S	Ct chest spine w/o&w dye.
	72133	S	Ct lumbar spine w/o&w dye.
	72191	S	Ct angiograph pelv w/o&w dye.
	72194	S	Ct pelvis w/o&w dye.
	73202	S	Ct uppr extremity w/o&w dye.
	73206	S	Ct angio upr extrm w/o&w dye.
	73702	S	Ct lwr extremity w/o&w dye.
	73706	S	Ct angio lwr extr w/o&w dye.
	74170	S	Ct abdomen w/o&w dye.
	74175	S	Ct angio abdom w/o&w dye.
	75635	S	Ct angio abdominal arteries.
0335	70336	S	Magnetic image, jaw joint.
	75554	S	Cardiac mri/function.
	75555	S	Cardiac mri/limited study.
	76390	S	Mr spectroscopy.
	76400	S	Magnetic image, bone marrow.
0336	70540	S	MRI orbit/face/neck w/o dye.
	70544	S	Mr angiography head w/o dye.
	70547	S	Mr angiography neck w/o dye.
	70551	S	MRI brain w/o dye.
	71550	S	MRI chest w/o dye.
	72141	S	MRI neck spine w/o dye.
	72146	S	MRI chest spine w/o dye.
	72148	S	MRI lumbar spine w/o dye.
	72195	S	MRI pelvis w/o dye.
	73218	S	MRI upper extremity w/o dye.
	73221	S	MRI joint upr extrem w/o dye.
	73718	S	MRI lower extremity w/o dye.
	73721	S	MRI joint of lwr extre w/o d.
	74181	S	MRI abdomen w/o dye.
	75552	S	Heart MRI for morph w/o dye.
	C8901	S	MRA w/o cont, abd.
	C8904	S	MRI w/o cont, breast, uni.
	C8910	S	MRA w/o cont, chest.
	C8913	S	MRA w/o cont, lwr ext.
0337	70543	S	MRI orbt/fac/nck w/o&w dye.
	70546	S	Mr angiograph head w/o&w dye.
	70549	S	Mr angiograph neck w/o&w dye.
	70553	S	MRI brain w/o&w dye.
	71552	S	MRI chest w/o&w dye.
	72156	S	MRI neck spine w/o&w dye.
	72157	S	MRI chest spine w/o&w dye.
	72158	S	MRI lumbar spine w/o&w dye.
	72197	S	MRI pelvis w/o&w dye.
	73220	S	MRI uppr extremity w/o&w dye.
	73223	S	MRI joint upr extr w/o&w dye.

APC	HCPCS	SI	Short descriptor
	73720	S	MRI lwr extremity w/o&w dye.
	73723	S	MRI joint lwr extr w/o&w dye.
	74183	S	MRI abdomen w/o&w dye.
	C8902	S	MRA w/o fol w/cont, abd.
	C8905	S	MRI w/o fol w/cont, brst, uni.
	C8908	S	MRI w/o fol w/cont, breast, bi.
	C8911	S	MRA w/o fol w/cont, chest.
	C8914	S	MRA w/o fol w/cont, lwr ext.

Refer to Addendum A or Addendum B of this final rule for the updated weights, payment rates, national unadjusted copayment, and minimum unadjusted copayment for all of the procedures listed above.

3. Coding and Payment for Mammography Services

a. Screening Mammography. Screening mammography means a radiologic procedure provided to a woman without signs or symptoms of breast disease for the purpose of early detection of breast cancer. Under Medicare, screening mammography services can be billed in three ways: (1) For the physician's interpretation of the results of the screening mammogram (that is, the professional component of mammography services); (2) for all services other than the physician's interpretation (that is, the technical component); or (3) for both the professional and technical components (global billing), although global billing is not permitted for services furnished in the hospital outpatient setting.

Section 4163 of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101–508) added section 1834(c) of the Act to provide for Part B coverage of screening mammography performed on or after January 1, 1991. Section 1834(c) of the Act governing those screenings did not include screening mammography under the physician fee schedule; it provided for payment under a separate statutory methodology. Payment for screening mammography services furnished in the hospital outpatient setting before January 1, 2002 is subject to the payment method set by the statute at section 1834(c) of the Act. When Medicare implemented the OPPS for services furnished beginning August 1, 2000, payment for screening mammography services continued to be based on the payment method set by the statute at section 1834(c) (the lower of hospital charges or the national payment limitation) of the Act and was not made under the OPPS.

Section 104 of BIPA amended section 1848(j)(3) of the Act to include screening mammography as a physician service. As a result of this amendment, the payment limit that is currently the basis for payment is replaced beginning January 1, 2002 by payment under the Medicare physician fee schedule. Payments for all services under the physician fee schedule are resource-based and have geographic adjustments that reflect cost differences among areas. A discussion of how payment for screening mammography services is determined under the physician fee schedule can be found in the final rule, ''Revisions to Payment Policies and Five-Year Review of and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 2002,'' published in the November 1, 2001 **Federal Register** (66 FR 55246). Beginning January 1, 2002, Medicare payment for screening mammography services furnished in a hospital outpatient setting is no longer the lower of hospital charges or the national payment limitation; however, payment will continue to be excluded from the OPPS. For screening mammography furnished in the outpatient setting, Medicare will pay hospitals the technical component amount established under the Medicare physician fee schedule.

Comment: A few commenters questioned why we had not established an APC or a payment rate for screening mammography in the proposed rule. One commenter expressed grave concern that our failure to include an APC for screening mammography in the proposed rule meant that Medicare beneficiaries would not be able to receive screening mammography services in the hospital outpatient setting. These commenters urged that we establish an APC for screening mammography services and that the payment rate be consistent with the cost of taking a screening mammogram in the hospital outpatient setting rather than the payment rate proposed for diagnostic mammograms in APC 0271, Mammography. One commenter, citing a survey conducted by a professional society, reported the average cost of doing a screening mammogram in a hospital to be about $97. Several commenters supported the physician fee schedule payment rate for screening mammography services as a more reasonable recognition of associated costs than the payment rate proposed for diagnostic mammography under APC 0271.

Response: The fact that we have not assigned the HCPCS codes for screening mammography services to an APC does not mean that Medicare does not pay hospitals for these services when they are furnished in the outpatient setting. Rather, as we explain in the April 7, 2000 final rule, we excluded screening mammography services from payment under the OPPS because they were already subject to an existing fee schedule or other prospectively determined payment rate (65 FR 18442). When the OPPS was implemented on August 1, 2000, screening mammography services were assigned payment status indicator ''A'' to specify that payment would be the ''lower of charge or national rate,'' consistent with section 1834(c)(3) of the Act (65 FR 18445).

As a result of section 104 of BIPA, which amended section 1848(j)(3) of the Act to define screening mammography as a physician service, Medicare payment for screening mammography services furnished on or after January 1, 2002 is no longer subject to the payment methodology established under section 1834(c) of the Act. Therefore, payment for both the professional and technical components of screening mammography services furnished on or after January 1, 2002 is made under the physician fee schedule. This means that, effective for services furnished on or after January 1, 2002, the payment amount to hospitals for screening mammography services furnished in the outpatient setting will be based on the amount established for the technical component of screening mammography under the physician fee schedule.

Hospitals are to use the following codes to bill for screening mammography services effective January 1, 2002:

- CPT code 76092, Screening mammography, bilateral (two view film study of each breast)

• HCPCS code G0202, Screening mammography, direct digital image, bilateral, all views

• CPT code 76085, Computer-aided detection add-on code for screening mammography (can only be billed with CPT code 76092)

We further discuss in section II.B.3.c, below, coding and payment for screening and diagnostic mammograms that use advanced new technologies.

Payment for screening mammography services furnished in a hospital outpatient department beginning January 1, 2002 is equal to 80 percent of the lower of the hospital's actual charge or the locality specific technical component payment amount under the physician fee schedule. Coinsurance equals 20 percent of the lower of the actual charge or the physician fee schedule amount. The Medicare Part B deductible does not apply to screening mammography. The November 1 physician fee schedule final rule lists the relative value units for screening mammography services and the physician fee schedule conversion factor for CY 2002 (66 FR 55334). In addition to the technical component payment made to the hospital, physicians are paid an additional amount for professional services furnished in connection with these procedures.

In this final rule, we are changing the descriptor of payment status indicator ''A'' for the screening mammography codes to ''Physician Fee Schedule'' to conform with the BIPA change.

b. Diagnostic Mammography. Medicare covers a radiological mammogram as a diagnostic test under the following conditions:

• A patient has distinct signs and symptoms for which a mammogram is indicated;

• A patient has a history of breast cancer; or

• A patient is asymptomatic, but on the basis of the patient's history and other factors the physician considers significant, the physician's judgment is that a mammogram is appropriate.

Payment for a diagnostic mammogram furnished in a hospital outpatient setting is made under the OPPS. The following codes are used to report diagnostic mammography: CPT code 76090, Mammography; unilateral, and CPT code 76091, Mammography, bilateral are used to report a diagnostic mammogram. These two codes are assigned to APC 0271, Mammography, and we proposed no changes to the assignment of these codes in the proposed rule. (We discuss in section III.B.3.c, below, coding changes for the CY 2002 related to new technology mammography.)

In the proposed rule, the relative weight for APC 0271 was equal to 0.64. We recalibrated all the APC relative weights, including that for APC 0271, using claims data for services furnished beginning July 1, 1999 through June 30, 2000 in accordance with the process explained in the proposed rule (66 FR 44695).

Comment: We received numerous comments, many of which were the product of a ''write-in'' campaign, regarding the relative weight and payment rate proposed for APC 0271. The commenters asserted that the current payment rate for APC 0271 is inadequate to support the provision of mammography services in the hospital outpatient setting, and they expressed disbelief that the proposed payment rate for 2002 is lower than the current rate. Commenters expressed grave concern that the proposed payment rate for diagnostic mammography would have a generally negative impact on beneficiary access to mammography services. Many commenters cited a practice cost survey conducted by the American College of Radiology that indicated the average cost for performing a screening mammogram in a hospital outpatient setting to be $97. The commenters argued that diagnostic mammography is more complex technically and more resource intensive, requiring more than double the clinical labor, supply, and equipment inputs than those required for screening mammography. One commenter stated that the technical cost of providing screening mammography in the hospital setting is nearly twice the cost of providing the same service in a physician office setting.

Other commenters recommended that payment for all mammography services furnished in the outpatient setting, both screening and diagnostic, be paid under the physician fee schedule to eliminate the significant payment disparity that will result if the proposed OPPS rates for diagnostic mammography are implemented in 2002. Several commenters complained that we provided no rationale or data to show how the proposed payment rate for APC 0271 was calculated nor did we explain why the proposed payment for these services is lower than the current payment. Commenters urged that we recalculate the payment rate for APC 0271 to represent a payment rate that is reflective of the resources used to perform the procedure.

Response: We calculated the relative weight for APC 0271 in the April 7, 2000 final rule in accordance with the process we described in that rule (65 FR 18482), using, as required by the statute, claims from 1996 and data from the most recent available hospital cost reports. Because we did not recalibrate the relative weights for any APC groups in the November 13, 2000 final rule, the relative weight (0.70) for APC 0271 as well as the relative weights for the other APC groups have not changed since August 1, 2000.

Using 1999–2000 claims data, we recalibrated all the APC weights in the proposed rule in accordance with the process that we explained in that rule (66 FR 44695). The relative weight for every APC group changed for two reasons: the use of more recent claims data, and the statutory requirements for budget neutrality. Section 1833(t)(9)(B) of the Act requires that estimated spending for services covered under the OPPS be neither greater nor less than it would have been had the recalibration and reclassification changes not been made. Because of this, the weights and, therefore, the payment rates for a specific service may increase or decrease depending on the change in charges hospitals report for that service relative to the change in charges hospitals report for other outpatient services. The decrease in the relative weight for diagnostic mammography proposed for 2002 can be attributed to a decrease in the relative level of charges for diagnostic mammography that hospitals reported for services furnished from July 1, 1999 through June 30, 2000 compared to the relative level of charges hospitals reported for all other outpatient services furnished during the same period. However, that weight does reflect the hospital resources used to perform mammograms. We note that the weight for APC 0271 in both the proposed and final rules is calculated from the median cost of almost 900,000 single-procedure claims.

The weight for APC 0271 in this final rule is 0.60. This weight was recalibrated, like all of the APC weights in this final rule, in accordance with the methodology described in section II.D. of this preamble. We note that the weight for APC 0271, like the weights for all of the nondevice-related APCs, has decreased from the proposed weight. This decrease is the result of our incorporating a portion of the cost of pass-through devices into the base costs of the APCs with which the devices are associated. As we explained in the final rule published on November 2, 2001, the additional pass-through device costs that were incorporated into the base APC costs are not evenly distributed among the APCs, but rather are concentrated in a relatively small

number of APCs that include the procedures that use pass-through devices (66 FR 55862). Whereas the weights of these APCs increased as a result of the added device costs, in general, the weights for APCs that do not include device costs, such as APC 0271, decreased by approximately 8 percent. For a more detailed discussion of how the incorporation of device costs into the base APCs affects the relative weights, see sections II.D. and VII, below.

Unlike screening mammography, the statute makes no specific designation for the technical component of diagnostic mammography services furnished in the hospital outpatient setting to be defined as a physicians' service. Therefore, we believe that the payment for diagnostic mammography should be included in the OPPS.

Comment: Several commenters expressed concern that the reduced payment rate for diagnostic mammography would have an especially onerous and negative impact on small, low volume hospitals, most of which are located in rural areas. The commenters noted that although these small rural hospitals are generally the sole providers of mammography and radiology services to the surrounding communities, volume in these hospitals is nonetheless too low to offset the fixed costs incurred for certified staff and equipment.

Response: In order to limit potential reductions in payment to hospitals under the OPPS, section 1833(t)(7) of the Act requires us to provide transitional payment adjustments for hospitals whose OPPS payments are less than our estimate of the hospital's pre-BBA payments. Section 1833(t)(7)(D)(i) of the Act includes a special ''hold harmless'' provision, which applies to hospital outpatient services furnished before 2004 by hospitals that are located in a rural area and that have no more than 100 beds. Under section 1833(t)(7)(D)(i) of the Act, small rural hospitals will be paid a predetermined pre-BBA amount for services covered under the OPPS if payment under the OPPS would be less than the pre-BBA amount. This hold harmless provision establishes a payment floor until January 1, 2004 for small rural hospitals. These provisions should provide some measure of protection to small hospitals in rural areas to the extent that the reduced payment for diagnostic mammography services results in overall payment reductions.

c. Coding and Payment for New Technology Mammography Services. Section 104(d) of BIPA prescribes a payment methodology for both diagnostic and screening mammography furnished during the period April 1, 2001 through December 31, 2001 that use a new technology, as defined in section 104(d)(3) of BIPA. Section 104(d)(2) of BIPA directs the Secretary to determine, for mammography performed after 2001, whether the assignment of a new HCPCS code is appropriate for mammography that uses a new technology. The following codes have been established to identify the new technology mammography services and will be used effective January 1, 2002:

- *HCPCS code G0202,* Screening mammography producing direct digital image, bilateral, all views.
- *CPT code 76085,* Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography. (This code can only be billed with CPT code 76092, Screening mammography, bilateral.)
- *HCPCS code G0204,* Diagnostic mammography, direct digital image, bilateral, all views.
- *HCPCS code G0206,* Diagnostic mammography, direct digital image, unilateral, all views.
- *HCPCS code G0236,* Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography. (This code can only be billed with code CPT code 76090, Diagnostic mammography, unilateral, or CPT code 76091, Diagnostic mammography, bilateral.)

In the proposed rule, we assigned computer-aided detection (CAD) and full field digital mammography (FFDM) services used for diagnostic mammography to APC 0271. We proposed to assign payment status indicator ''A,'' designating that payment would be ''lower of charges or national rate,'' to the CAD and FFDM codes for screening mammography. Numerous commenters addressed our proposed payment for CAD and FFDM new technology mammography services. Their comments are summarized below.

Comment: One commenter recommended that CAD used in conjunction with film screening mammography be assigned to a new technology APC under the OPPS rather than being paid under the physician fee schedule. The commenter argued that although section 104(a) of BIPA provided for payment for screening mammography under the physician fee schedule, payment for a new technology such as CAD is provided under a separate BIPA provision, section 104(d)(3), and therefore is not linked to the physician fee schedule.

Response: We do not agree with the commenter's recommendation that CPT code 76085 for CAD used with screening mammography be assigned for payment to a new technology APC under the OPPS. Because CPT code 76085 is an add-on code that can be paid only when it is billed with CPT code 76092 for screening mammography, we believe it is more appropriate to pay for both CPT codes 76085 and 76092 under the physician fee schedule than to pay for them separately under two different payment systems.

Comment: Most commenters recommended assignment of CAD and FFDM services used with diagnostic mammography to a new technology APC on the grounds that no existing APC would be appropriate both clinically and in terms of payment for these services. Commenters were unanimous in opposing assignment of the CAD and FFDM services used for diagnostic mammography to APC 0271. Several commenters were concerned that payment for these services under the physician fee schedule was so much higher than that proposed under the OPPS.

Response: We agree that the new technology procedures associated with diagnostic mammography should be assigned to a new technology APC until we have collected cost data to make a more clinically and resource use appropriate APC assignment. Therefore, effective for services furnished on or after January 1, 2002, HCPCS codes G0204 and G0206 will be assigned to APC 0971 and HCPCS code G0236 will be assigned to APC 0970.

The difference in payment amounts for the new technology mammography services between the physician fee schedule and the OPPS is attributable to differences in the payment methodology required under the statute.

Final Action: See section II.B.3.a. for the codes used to bill for new technology screening mammography services. The following codes and APC groups are effective for new technology services used for diagnostic mammography beginning January 1, 2002:

HCPCS codes G0205 and G0207 are deleted.

Use HCPCS codes G0204 and G0206 for full field digital diagnostic mammography services; assigned to APC 0707.

Use HCPCS code G0236 for computer-assisted detection with CPT code 76090 and CPT code 76091 for diagnostic mammography; assigned to APC 0706.

C. Other Changes Affecting the APCs

1. Changes in Revenue Code Packaging

In the April 7, 2000 final rule, we described how, in calculating the per procedure and per visit costs to determine the median cost of an APC (and therefore its relative weight), we used the charges billed using the revenue codes that contained items that were integral to performing the procedure or visit (65 FR 18483). The complete list of the revenue centers by type of APC group was printed in the April 7, 2000 rule (65 FR 18484).

In the November 13, 2000 interim final rule, we made some changes to the list of revenue codes to reflect the charges associated with implantable devices (65 FR 67806 and 67825). We were later able to incorporate revenue codes 274 (prosthetic/orthotic devices), 275 (pacemaker), and 278 (other implants) in our database, and effective January 1, 2001, we updated the APC payment rates to reflect inclusion of this information.

As discussed in the proposed rule, we have continued to review and revise the list of revenue codes to be included in the database and we proposed several changes to the list of revenue codes that are packaged with the costs used to calculate the proposed APC rates. Some of these changes reflect the addition of revenue codes and others are a further refinement of our methodology. The following are the specific changes we proposed:

- Package additional revenue centers that may be used to bill for implantable devices (including durable medical equipment (DME) and brachytherapy seeds) with surgical procedures. These additional centers are revenue codes 280 (oncology), 289 (other oncology), 290 (DME), and 624 (investigational devices).
- Package revenue codes 280, 289, and 624 with other diagnostic and radiology services.
- Package the revenue codes for medical social services, 560 (medical social services) and 569 (other medical social services). These services are not paid separately in the hospital outpatient setting but often constitute discharge-planning services if provided with an outpatient service.
- Package revenue code 637 (self-administered drug (insulin administered in an emergency diabetic coma)) with medical visits. Although this is a self-administrable drug, it is covered when administered as described.
- Remove revenue code 723 (circumcision) from the list of packaged revenue codes because circumcision is a payable procedure under OPPS and should not be packaged.
- Package revenue code 942 (education/training) with medical visits and the category of ''All Other APC Groups.'' Patient training and education are generally not paid as a separate service under Medicare, but may be included as part of an otherwise payable service such as a medical visit. We believe that training and education services generally occur as part of a medical visit or psychiatric service.
- Remove the revenue codes in the range of 890 through 899 (donor bank), as these are no longer valid revenue codes.

Comment: One commenter disagreed with our proposal to package revenue code 942 (education/training). The commenter stated that such a policy would be inappropriate because revenue code 942 is the proper revenue code to use when billing diabetes training with HCPCS codes G0108 and G0109. If CMS does package that revenue code, the commenter wanted to know what revenue code should be billed for diabetes education.

Response: Although under OPPS we will package charges for education and training when billed with revenue code 942, training and education associated with diabetes management, identified by HCPCS codes G0108 and G0109, is not paid under the OPPS and, therefore, is not a packaged service. The list of packaged revenue codes contained in the proposed rule represents revenue codes that are packaged when they appear on a bill with an OPPS service and are not billed with a HCPCS code for a service, like diabetes education, which is paid by Medicare but paid outside of the OPPS.

Comment: One commenter questioned our proposal to package additional revenue centers that may be used to bill for implantable devices (including brachytherapy seeds) with surgical procedures. The commenter asked for details on how such packaging would be accomplished and specifically how we would account for the varying number of costly brachytherapy seeds used in each procedure.

Response: In determining the median cost of a procedure or service, we take into account the costs associated with any packaged revenue center that appears on a bill as well as the cost associated with the specific line item that reflects the HCPCS code for the procedure or service. Thus, when a hospital bills a charge for brachytherapy seeds using one of the revenue codes that are identified as a packaged revenue code, we convert that charge to a cost by multiplying the billed charge by the hospital-specific cost-to-charge ratio for the related cost center. The cost of the brachytherapy seeds is then added to all other costs on the bill that are attributable to the procedure to arrive at the cost of the bill. Under this methodology, the varying numbers of brachytherapy seeds used and the varying costs of the seeds are accurately captured in the median cost data we use to calculate median cost for the APC. That is, we would expect that the cost associated with a bill would reflect the number of seeds used in a particular procedure and the median cost for that procedure overall would be an average of the varying numbers of seeds used by hospitals.

2. Special Revenue Code Packaging for Specific Types of Procedures

We proposed that the same packaging used for surgical procedures be used for corneal tissue implant procedures in APC 0244, Corneal Transplant, except that organ acquisition revenue codes and the revenue codes used to bill implantable devices are not packaged with corneal implants.

There are certain other diagnostic procedures with CPT codes that are similar to surgical procedures. The cost of these procedures (HCPCS codes 92980–92996, 93501–93505, and 93510–93536) reflects both the revenue code packaging for ambulatory surgical center (ASC) and other surgery, as well as the revenue code packaging for other diagnostic services.

A complete listing of the revenue codes that we used for purposes of calculating median costs of services are shown below in Table 2.

Table 2.—Packaged Services by Revenue Code

Surgery

250	Pharmacy
251	Generic
252	Nongeneric
257	Nonprescription Drugs
258	IV Solutions
259	Other Pharmacy
260	IV Therapy, general class
262	IV Therapy/pharmacy services
263	IV Therapy/drug 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

762 Observation room
810 Organ acquisition
290 Durable medical equipment
370 Anesthesia
379 Other anesthesia
390 Blood storage and processing
399 Other blood storage and processing
560 Medical social services
569 Other medical social services
624 Investigational device (IDE)
630 Drugs requiring specific identification, general class
631 Single source
632 Multiple
633 Restrictive prescription
700 Cast room
709 Other cast room
710 Recovery room
719 Other recovery room
720 Labor room
721 Labor
819 Other organ acquisition

Medical Visit

250 Pharmacy
251 Generic
252 Nongeneric
257 Nonprescription drugs
258 IV solutions
259 Other pharmacy
270 M&S supplies
271 Nonsterile supplies
272 Sterile supplies
279 Other M&S supplies
560 Medical social services
569 Other medical social services
630 Drugs requiring specific identification, general class
631 Single source drug
632 Multiple source drug
633 Restrictive prescription
637 Self-administered drug (insulin admin. in emergency diabetic coma)
700 Cast room
709 Other cast room
762 Observation room
942 Education/training

Other Diagnostic

254 Pharmacy incident to other diagnostic
280 Oncology
289 Other oncology
372 Anesthesia incident to other diagnostic
560 Medical social services
569 Other medical social services
622 Supplies incident to other diagnostic
624 Investigational device (IDE)
710 Recovery room
719 Other recovery room
762 Observation room

Radiology

255 Pharmacy incident to radiology
280 Oncology
289 Other oncology
371 Anesthesia incident to radiology
560 Medical social services
569 Other medical social services
621 Supplies incident to radiology
624 Investigational device (IDE)
710 Recovery room
719 Other recovery room
762 Observation room

All Other APC Groups

250 Pharmacy
251 Generic
252 Nongeneric
257 Nonprescription drugs
258 IV Solutions
259 Other pharmacy
260 IV Therapy, general class
262 IV Therapy pharmacy services
263 IV Therapy drug/supply/delivery
264 IV Therapy supplies
269 Other IV therapy
270 M&S supplies
271 Nonsterile supplies
272 Sterile supplies
279 Other M&S supplies
560 Medical social services
569 Other medical social services
630 Drugs requiring specific identification, general class
631 Single source drug
632 Multiple source drug
633 Restrictive prescription
762 Observation room
942 Education/training

3. Limit on Variation of Costs of Services Classified Within a 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 a group is more than 2 times greater than the lowest cost item or service within the same group. However, the Secretary may make exceptions to this limit on the variation of costs within each group in unusual cases such as low volume items and services. No exception may be made, however, 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.

Based on the APC changes discussed above in this section of this preamble and our use of more current 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 proposed rule set forth a list of APCs that we proposed to exempt from the 2 times rule based on the criteria cited above (66 FR 44690). In cases in which compliance with the 2 times rule appeared to conflict with a recommendation of the APC Advisory Panel, we generally proposed to accept the Panel recommendation. This was 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.

We received no comments on our proposal. The following is the final list of APCs we exempted from the 2 times rule. This list reflects the final APCs as recalibrated based on the updated 1999–2000 data base as well as the incorporation of 75 percent of the estimated cost of the pass-through devices (See section II.D).

List of APCs exempted from the ''two times'' requirement:

0001 Photochemotherapy
0004 Level I Needle Biopsy/Aspiration Except Bone Marrow
0043 Closed Treatment Fracture Finger/Toe/Trunk
0044 Closed Treatment Fracture/Dislocation Except Finger
0047 Arthroscopy without Prosthesis
0058 Level I Strapping and Cast Application
0060 Manipulation Therapy
0077 Level I Pulmonary Treatment
0093 Vascular Repair/Fistula Construction
0096 Non-Invasive Vascular Studies
0097 Cardiac Monitoring for 30 Days
0115 Cannula/Access Device Procedures
0121 Level I Tube Changes and Repositioning
0140 Esophageal Dilation without Endoscopy
0141 Upper GI Procedures
0142 Small Intestine Endoscopy
0147 Level II Sigmoidoscopy
0164 Level I Urinary and Anal Procedures
0165 Level III Urinary and Anal Procedures
0182 Insertion of Penile Prosthesis
0187 Placement/Repositioning Misc Catheters
0198 Pregnancy and Neonatal Care Procedures
0203 Level V Nerve Injections
0204 Level VI Nerve Injections
0207 Level IV Nerve Injections
0213 Extended EEG Studies and Sleep Studies, Level I

0215 Level I Nerve and Muscle Tests
0218 Level II Nerve and Muscle Tests
0233 Level II Anterior Segment Eye Procedures
0234 Level III Anterior Segment Eye Procedures
0237 Level III Posterior Segment Eye Procedures
0247 Laser Eye Procedures Except Retinal
0251 Level I ENT Procedures
0252 Level II ENT Procedures
0260 Level I Plain Film Except Teeth
0263 Level I Miscellaneous Radiology Procedures
0264 Level II Miscellaneous Radiology Procedures
0265 Level I Diagnostic Ultrasound Except Vascular
0279 Level I Angiography and Venography Except Extremity
0285 Positron Emission Tomography (PET)
0294 Level I Therapeutic Nuclear Medicine
0296 Level I Therapeutic Radiologic Procedures
0305 Level II Therapeutic Radiation Treatment Preparation
0322 Brief Individual Psychotherapy
0345 Level I Transfusion Laboratory Procedures
0354 Administration of Influenza/Pneumonia Vaccine
0355 Level I Immunizations
0356 Level II Immunizations
0363 Otorhyinolaryngologic Function Tests
0364 Level I Audiometry
0373 Neuropsychological Testing
0600 Low Level Clinic Visits
0601 Mid Level Clinic Visits
0602 High Level Clinic Visits
0694 Level III Excision/Biopsy

4. Observation Services

Frequently, beneficiaries are placed in ''observation status'' in order to receive treatment or be monitored before making a decision concerning their next placement (that is, admit to the hospital or discharge to home). This occurs most frequently after surgery or a visit to the emergency department. In the proposed rule, we discussed the clinical and payment history of observation services. We also discussed at length the issues we considered in determining whether to make separate payment for observation services. For a more detailed discussion of our deliberations, see 66 FR 44690–91. After careful consideration, we proposed the following:

• To continue to package observation services into surgical procedures and most clinic and emergency visits.

• To create a single APC, APC 0339, Observation, to make separate payment for observation services for three medical conditions, chest pain, asthma, and congestive heart failure, when certain criteria (as described below) are met.

We also proposed to instruct hospitals that payment under APC 0339 for observation services would be subject to the following billing requirements and conditions:

• An emergency department visit (APC 0610, 0611, or 0612) or a clinic visit (APC 0600, 0601, or 0602) is billed in conjunction with each bill for observation services.

• Observation care is billed hourly for a minimum of 8 hours up to a maximum of 48 hours. We would not pay separately for any hours a beneficiary spends in observation over 24 hours, but all costs beyond 24 hours would be packaged into the APC payment for observation services.

• Observation time begins at the clock time appearing on the nurse's observation admission note. (We note that this coincides with the initiation of observation care or with the time of the patient's arrival in the observation unit.)

• Observation time ends at the clock time documented in the physician's discharge orders, or, in the absence of such a documented time, the clock time when the nurse or other appropriate person signs off on the physician's discharge order. (This time coincides with the end of the patient's period of monitoring or treatment in observation.)

• The beneficiary is under the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes, timed, written, and signed by the physician.

• The medical record includes documentation that the physician used risk stratification criteria to determine that the beneficiary would benefit from observation care. (These criteria may be either published generally accepted medical standards or established hospital-specific standards.)

• The hospital furnishes certain other diagnostic services along with observation services to ensure that separate payment is made only for those beneficiaries truly requiring observation care. We believe that these tests are typically performed on beneficiaries requiring observation care for the three specified conditions and they are medically necessary to determine whether a beneficiary will benefit from being admitted to observation care and the appropriate disposition of a patient in observation care. The diagnostic tests are as follows:

• For chest pain, at least two sets of cardiac enzymes and two sequential electrocardiograms.

• For asthma, a peak expiratory flow rate (PEFR) (CPT code 94010) and nebulizer treatments.

• For congestive heart failure, a chest x-ray, an electrocardiogram, and pulse oximetry.

We proposed to make payment for APC 0339 only if the tests described above are billed on the same claim as the observation service. (We did not propose to require telemetry and other ongoing monitoring services as criteria to make separate payment for observation services. Although these services are often medically necessary to ensure prompt diagnosis of cardiac arrhythmias and other disorders, we do not believe they are necessary to support separate payment for observation services.) In the proposed rule, we listed the following ICD–9–CM diagnosis codes that hospitals would be required to bill to receive payment for APC 0339:

For Chest Pain:

411.1 Intermediate coronary syndrome
411.81 Coronary occlusion without myocardial infarction
411.0 Postmyocardial infarction syndrome
411.89 Other acute ischemic heart disease
413.0 Angina decubitus
413.1 Prinzmetal angina
413.9 Other and unspecified angina pectoris
786.05 Shortness of breath
786.50 Chest pain, unspecified
786.51 Precordial pain
786.52 Painful respiration
786.59 Other chest pain

For Asthma:

493.01 Extrinsic asthma with status asthmaticus
493.02 Extrinsic asthma with acute exacerbation
493.11 Intrinsic asthma with status asthmaticus
493.12 Intrinsic asthma with acute exacerbation
493.21 Chronic obstructive asthma with status asthmaticus
493.22 Chronic obstructive asthma with acute exacerbation
493.91 Asthma, unspecified with status asthmaticus
493.92 Asthma, unspecified with acute exacerbation

For Congestive Heart Failure:

428.0 Congestive heart failure
428.1 Left heart failure
428.9 Heart failure, unspecified

In the proposed rule, we specified the following process to identify the appropriate median cost for APC 0339 (66 FR 44692). First, we identified in the 1999–2000 claims data all hospital outpatient claims for observation using revenue codes 760, 761, 762, and 769. We then selected the subset of these claims that were billed for patients with chest pain, asthma, and congestive heart failure. Because no standard method for coding these claims was in place in 1996, we identified all diagnosis codes that could reasonably have been used to classify beneficiaries as having chest pain, asthma, and congestive heart failure. We then verified that these beneficiaries received appropriate observation care for chest pain, asthma, or congestive heart failure by identifying the claims in which one or more of the tests identified above were performed. The median costs of these claims were used to establish the median costs of APC 0339.

Finally, we stated that we would consider medical research submitted to support the benefits of observation services for conditions other than those we had proposed. This information will assist us in determining whether these other conditions meet the criteria we used to select the three conditions we proposed to include in APC 0339.

We received a large number of comments on this proposal. Many commenters commended our proposal to pay separately for observation services. However, other commenters either had questions about or suggestions on revising our proposal. Those comments and our responses appear below.

Comment: We received comments requesting that we expand the list of conditions for which we would make a separate payment for observation services. Some commenters listed specific conditions that should be added to the list (for example, abdominal pain, atrial fibrillation, or pyelonephritis) while others asserted that any condition a physician thought required observation should qualify for separate payment. One commenter submitted medical literature as supportive evidence that we should expand our list of conditions. One commenter argued that developing a restrictive list of conditions for which separate payment would be made is inconsistent with the medical literature and with InterQual, which publishes the criteria used by Peer Review Organizations to assess whether admission to the hospital as an inpatient is necessary.

Response: We wish to clarify that our proposal merely specified a list of conditions for which we would make separate payment for observation services. For all other conditions, payment for observation services would be packaged into the APC in which those services were provided. For example, if a patient with syncope goes to the emergency room and receives emergency services and observation services, the payment to the hospital for the emergency visit includes payment for the observation service. The payment rate calculated for clinic and emergency visits includes the packaged costs of observation services to the extent that those costs were included on the visit bills.

We have reviewed the commenters' suggestions for additional conditions and the medical literature that they submitted in support of their requests. At this time, we are finalizing our proposal without expanding the list of conditions for which separate observation payment will be made. As noted in the proposed rule, we believe that chest pain, asthma, and congestive heart failure are the only conditions that require a well-defined set of hospital services that are distinctly different from the services provided in a clinic or emergency service. Thus, they are the services for which a separately payable observation period is clinically appropriate. Given the clinically improper use of observation care by hospitals in the recent past, we want to minimize the risk of future improper use while ensuring a valid medical benefit to the patient for appropriate medical care. Therefore, we believe it is premature to expand the conditions for which we will separately pay for observation services. We want to observe the effect of separate payment for this limited set of conditions to determine what clinical and payment issues arise before expanding the list of conditions. Furthermore, an essential issue for Medicare is that separate payment for observation be made only when those services are clearly distinct and separate from prolonged clinic or emergency department care and when observation provides a distinct clinical benefit that cannot be obtained by sending the patient home or admitting the patient to the hospital. We believe that the medical literature demonstrates such a benefit exists for patients with chest pain, congestive heart failure, and asthma.

We will continue to review this issue and any information that is provided to us. If we believe an expansion of the list of conditions is appropriate, we will include such a proposal in a future proposed rule.

Comment: An association of hospitals provided an explanation of their concept of ''rapid treatment,'' which they distinguished from observation. They defined observation as a service required by managed care contracts that involves only physiologic monitoring, frequent nursing assessment, and the patient's routine daily medication.

Response: This level of care would not qualify as an observation service, either packaged or separately paid, under Medicare. We require that during observation, patients be actively assessed and, if necessary, treated in order to determine if they should be admitted or may be safely discharged.

Comment: Several commenters pointed out that correct coding guidelines allow hospitals to code the reason for a patient's visit in any one of several fields on the claim including the principal diagnosis field, the secondary diagnosis field, and the admitting diagnosis field. These commenters suggested that facilities be allowed to report the appropriate diagnosis code supporting the provision of observation services in the admitting, principal, or secondary diagnosis field.

Response: We agree with the commenters and will ensure that our software is designed to allow this.

Comment: Commenters argued that additional ICD–9–CM diagnosis codes for chest pain, congestive heart failure, and asthma be added to the proposed list of diagnoses qualifying observation care for separate payment. These included: for asthma: 493.00, 493.10, 493.20, 493.90; for congestive heart failure: 391.8, 398.91, 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93; for chest pain: codes for weakness, shortness of breath, palpitations, rapid heart beat, and syncope. One commenter asked that we include codes for chronic obstructive pulmonary disease (COPD) on the list of qualifying diagnoses. One commenter believes that 428.1 and 428.9 are not to be used for congestive heart failure and should be deleted from the list.

Response: With regard to the comments to add diagnosis codes for asthma, our proposal included codes for status asthmaticus and acute exacerbations of asthma. The codes suggested by the commenters are used for chronic, stable asthma, or unspecified asthma. Our clinical judgment is that these patients do not require active observation care that meets our definition and, thus, a separate payment is not warranted. Therefore, we have not revised our list of qualifying diagnoses for asthma.

With regard to the suggested codes to be added for congestive heart failure, we agree with the commenters and are adding the codes to the list.

With regard to the suggested codes for chest pain, we note that 786.05, Shortness of breath, was included on our proposed list of qualifying codes. If a patient has one of the other suggested symptoms (weakness, palpitations, rapid heartbeat, and syncope), it would be appropriate to use one of the proposed codes as the diagnosis (for example, 413.9, other and unspecified angina). Therefore, we believe the list we proposed covers the additions suggested by the commenter.

With regard to the requested deletions of codes 428.1 and 428.9, we disagree. Code 428.1 is specified for use in patients with acute pulmonary edema and 428.9 is used for patients with congestive heart failure without a specific diagnosis and both codes are therefore appropriately included on the list.

Comment: Several commenters believe that dedicated observation units would not be financially viable if only three conditions qualified for payment.

Response: We want to emphasize that we are making payment for all observation services provided in the outpatient setting. Payment for observation services not meeting the requirements for separate payment in APC 0339 is included in the payment for the clinic or emergency department visit. That is, the payment for each clinic or emergency department visit contains a payment for packaged observation services. This means that hospitals are being paid for observation every time a clinic or emergency visit is billed.

Our policy of separate payment for certain observation services is not intended to increase the total amount of money paid for observation services. Instead, our policy redistributes payments into a separate APC; the relative weight of the new APC for observation services reflects costs that would otherwise be reflected in the relative weights for other relevant APCs. Thus, the payments for clinic and emergency visits are slightly lower than would have been the case had we not created a separate payment for observation. The only hospitals that could be disadvantaged are those that provided observation care for packaged conditions to an unusually large number of patients. Hospitals with large numbers of observation cases for chest pain, asthma, and congestive heart failure will benefit from our new policy. Hospitals with an average number of observation cases will be neither advantaged nor disadvantaged by our new policy.

Comment: Some commenters believe it is inappropriate ''not to pay for observation'' for other conditions. Others argued that because pulse oximetry, one of the diagnostic tests we identified as a condition of separate payment for congestive heart failure, is a packaged service, it is not paid for and therefore cannot be reported on the bill. This would place hospitals in a ''Catch-22'' situation because they would be required to report pulse oximetry to be paid separately for observation but could not report pulse oximetry because it is packaged.

Response: These comments reflect a misunderstanding of what it means for a service to be ''packaged.'' The concept is perhaps most clearly understood in terms of the anesthesia used during surgery. The costs of the anesthesia drugs and administration are associated with the surgery with which they were billed, and become part of the payment for the surgery. It is understood that anesthesia is paid for, but not paid for separately from the surgical procedure. Similarly, we packaged the cost of observation whenever it was billed. It is packaged into surgical procedures as well as clinic and emergency visits. Each time a hospital bills for a procedure or visit, any associated observation cost is recognized. Because, according to the literature, observation is billed in fewer than 6 percent of emergency room visits, the cost is not always readily identifiable. However, we wish to emphasize that it is important for hospital bills to show that observation was provided and the charges associated with it. This is because the charges for packaged services might affect outlier and transitional corridor payments, and are used to update the APC weights. Thus, hospitals should report pulse oximetry on the bill even though it is not separately payable.

Comment: Surgeons reported that hospitals, believing that observation is not payable, would not allow postoperative observation for patients such as those who have undergone mastectomy or thyroidectomy.

Response: Surgery performed in the outpatient setting should not, as a rule, require a period of postoperative observation. As provided in section 230.6E of the Medicare Hospital Manual, standing orders for observation following outpatient surgery is not a covered service. In addition, that section states that the availability of an outpatient observation unit at a hospital is not a reason to perform, on an outpatient basis, surgeries for which an overnight stay is anticipated.

Although an occasional surgical case may require a longer recovery period, as a rule, surgical outpatients should not require observation. We note, however, that to the extent that observation care is provided to surgical patients, the cost of that care is packaged into the payment for the surgical APC.

Comment: There were many comments on the list of diagnostic tests required for separate payment for observation services. Several commenters pointed out that nebulizer treatments, by definition, are not diagnostic. These commenters also noted that observation of asthma patients need not involve nebulizer treatments (that is, some patients are treated with intravenous steroids or inhalers). Others indicated that pulse oximetry is a routine test and is not usually coded. Other commenters were concerned that the required tests would not all be performed within the period of observation; that is, some tests might be performed in the emergency department before admission to observation status.

Response: The requirement that certain diagnostic tests be performed in order to receive separate payment for observation services reflects our concern that observation not be considered a way to keep a patient in a ''holding pattern.'' We are aware that some patients are considered to be in observation overnight when they are placed in a bed on a nursing unit, with vital signs taken every 4 hours. This is not the service we recognize as observation, which we define as an active treatment to determine if a patient's condition is going to require that he or she be admitted as an inpatient, or if it resolves itself so that the patient may be discharged. The services we included on the list of required treatment were designed to indicate that an active assessment of the patient was being undertaken. We believe this is consistent with the clinical practice of observation.

We agree that nebulizer treatments are not diagnostic, and, although, based on the experience of our clinical staff, are frequently used in acute asthma, they need not be used for every asthma patient receiving observation services. We agree that occasionally patients may use their own inhaler or be given intravenous medications without nebulizer treatments. Thus, we are not including this treatment on the final list of services required for separate payment of observation. As discussed above, pulse oximetry, although packaged, should be reported on the bill when furnished.

We agree that some of the required diagnostic testing (for example, cardiac enzymes) may be performed as part of the emergency or clinic visit before the

beneficiary is admitted to observation status. We will ensure that our software identifies when the required diagnostic tests were performed in the clinic or emergency department as well as diagnostic tests performed during the period of observation.

Comment: Several commenters claimed that requiring specific clinical interventions for observation care was an intrusion into the practice of medicine.

Response: We disagree with the commenters. We are setting conditions only for separate payment for observation. All observation care that does not meet the criteria for classification into APC 0339 will continue to be paid as part of the service into which it is packaged. In order to ensure that we are making separate payment only when it is warranted, we are providing as a condition for separate payment that a minimal number of appropriate diagnostic tests must be performed. The hospital will continue to receive packaged payment for observation care for beneficiaries who require such care but for whom the required tests were not performed.

As stated above, we are withdrawing the proposed condition of administering nebulizer treatments. We will allow either pulse oximetry or peak expiratory flow rate to be performed as a requirement to receive separate payment for observation of asthma patients. We are finalizing our requirements for chest pain and congestive heart failure. We note that none of the commenters had any clinical disagreement with the designation of these specific tests. Their only concern stemmed from the misconception that these tests would be required to be performed in order to receive payment for observation care. We will closely follow the impact of these requirements and, if we believe that changes are necessary, we will propose them in a future rule.

Comment: Several commenters argued that packaging the first 8 hours of observation was arbitrary and would be difficult to document. We also received comments that we should eliminate our minimum time requirement for observation or reduce it to 6 hours. The following reasons were given for these comments: asthma patients do not require 8 hours of observation; no evaluation and management (E/M) service lasts for more than 1 hour and 45 minutes; and emergency visits typically last 3–4 hours so any potential for abuse of observation would be reduced with a minimum time requirement of 6 hours because 6 hours does not overlap with the length of a typical emergency visit.

Response: We believe it is important to ensure that payment for clinic and emergency department services does not duplicate payments for observation. We also want to make clear that we do not consider a long emergency room visit to be ''observation.'' We believe that observation is a specific type of service that should be specifically ordered by a physician and should involve specific goals and a plan of care that is distinct from the goals and plan of care for an emergency or clinic visit. We believe that requiring 8 hours of care as a condition for separate payment of observation is reasonable and will minimize confusion for hospitals. We will be including the first 8 hours of observation care as a packaged service and make payment as part of the clinic or emergency visit with which it occurs. Therefore, the payment rate for emergency and clinic visit will reflect the extent to which patients are observed for less than 8 hours. Although occasionally patients with asthma may require less than 8 hours of observation, we believe that intensity and variety of services provided to patients with an acute asthma exacerbation or status asthmaticus who require 8 or more hours of observation is different from the service provided when they require less than 8 hours of observation. The less intensive services provided to asthma patients who require less than 8 hours of observation is appropriately paid for as part of an emergency or clinic visit. We note that we received no comments disagreeing with our minimum time requirement for patients with chest pain and congestive heart failure. Finally, we believe that a clear requirement of 8 hours will allow hospitals to prospectively develop clinical protocols and plans of care facilitating the appropriate use of observation services. However, we will closely monitor the impact of the 8-hour time requirement and, if appropriate, consider changes for a future proposed rule.

Comment: Commenters raised concerns about our requirement that physicians write progress notes in the medical record. They believe that admission and discharge notes are generally sufficient to document observation care. The commenters also raised questions about determining when observation starts and ends, with one commenter describing the proposed documentation requirement as ''rigid and inflexible.'' Others expected documentation to be difficult in hospitals without emergency department staff or house staff. One commenter stated that specific requirements for determining the time observation stops would not reflect the variety of methods hospitals and physicians have to document time in the medical record. Commenters asserted that the period of treatment and monitoring can continue beyond the time that a discharge order is written by the physician or taken off by the nurse.

One commenter discussed the difficulty in determining when a patient is ''moved to observation status'' and the need for physicians to be able to write orders specifying discharge at a ''future time.'' Several commenters expressed concerns about requiring documentation that the physician used risk stratification criteria to determine that the beneficiary would benefit from observation care because documenting use of risk stratification criteria would be burdensome and is not required for any other services.

Response: We appreciate these concerns and, although we are finalizing our proposal, we wish to clarify several aspects of these requirements to reassure commenters. With regard to writing progress notes, we wish to emphasize that the requirement is only to write ''appropriate'' progress notes. We understand that, in many cases, writing a progress note is unnecessary (because the admission and discharge notes are sufficient), while in other cases it is necessary to write progress notes because of the length and complexity of care provided or because of a change in the patient's condition. We wish to clarify that progress notes are not required in every case but only in those cases in which the physician deems it appropriate to write a progress note.

With regard to documenting the times that observation starts and ends, we have to balance the potential for improper billing of observation status against creating burdens for hospitals that will have to support their claims for observation treatment in the medical record. We believe that our policy strikes this balance appropriately. Typically both physicians' orders and nurses' removal of those orders are timed; therefore, we do not believe this requirement places a significant burden on physicians or hospitals because no change in the processes of care will be required. We do not believe that for chest pain, congestive heart failure, and asthma, orders are written for a future discharge time because those patients may not be discharged until treatment goals are met, and determining this requires current (not future) physician intervention (for example, to review lab tests or examine the patient).

An important reason we are requiring clocked time to determine the period of observation is because we want to minimize confusion and separate observation care from prolonged emergency or clinic visits. Our requirements will assist hospitals to prospectively ensure that observation is appropriately billed. Although it is possible that treatment and monitoring may continue for a significant period of time after a discharge order is written or taken off, we believe such an occurrence is the exception rather than the rule; additionally, it is frequently difficult to determine exactly when facility services are discontinued. One problem is that it is typical for those patients to remain in the observation area for a significant period of time after treatment is finished, most commonly because the patient is waiting for transportation home. As stated above, we need a bright line rule with regard to the stop time for observation.

With regard to documenting the use of risk stratification, we did not mean to require any extra documentation in the medical record. We just wish to put physicians and hospitals on notice as to what type of medical record evidence reviewers will use when reviewing claims for observation. We believe that a well-documented observation record will satisfy this requirement without any extra documentation. Therefore, we are clarifying that the manner in which documentation of risk stratification is made is at the discretion of the physician. As with all the criteria we are establishing for payment of APC 0339, we will monitor the effects of these requirements on the provision of observation care and consider making changes if appropriate.

Comment: We received a variety of comments asking for clarification as to how observation services should be reported; whether notes may be written by house staff or fellows; whether orders may be phoned in; whether additional diagnostic tests during observation would be paid for; how observation would be treated by local medical review policies; whether short inpatient stays for congestive heart failure and asthma would no longer be allowed; how billing would occur for patients who are admitted directly to a chest pain center without being seen in the emergency department; and whether payment for observation is made per hour or per day.

Response: Observation services should be tracked by the hour. If the number of hours is less than 8, then payment is packaged into the associated clinic or emergency visit. If more than 24 hours of observation are billed, payment for any time over 24 hours is packaged into the payment for 8 to 24 hours of observation. Therefore, the payment rate for observation will reflect those cases in which observation actually occurs for more than 24 hours. That is, just as the payment for emergency visits reflects payment for observation of up to 8 hours, so will payment for APC 0339 reflect payment for observation care up to 48 hours. Effective for services furnished on or after January 1, 2001, we have created a new HCPCS code for use with our new APC 0339 to help distinguish packaged observation form separately payable observation. The code is G0224, Observation care provided by a facility to a patient with CHF, chest pain, or asthma, minimum eight hours, maximum forty-eight hours. The previously available CPT codes for observation, 99234–99236, should continue to be used for packaged observation services.

With regard to house staff writing notes and orders, teaching physician rules apply to Part B payments for observation care. With regard to facility payments, observation may be billed if the notes are written by house staff. Physicians may phone in orders but if those orders are for admission or discharge to observation, they must be timed. Moreover, the physician must write admission and discharge notes in the medical record.

We note that we will pay separately for all nonpackaged diagnostic tests furnished to observation patients.

We will continue pay for inpatient admissions for chest pain, asthma, and congestive heart failure when appropriate and our observation payment policy is subject to local medical review policies.

With regard to direct admissions from physician offices, separate payment for observation will not be made unless a physician is present to order the initiation of observation services and to monitor the patient as clinically appropriate.

The following are the final requirements for billing G0244 and assignment to APC 0339.

The acceptable diagnosis codes are:

For Chest Pain

- 391.8 Other acute rheumatic heart disease
- 398.91 Rheumatic heart failure (congestive)
- 402.01 Malignant hypertensive heart disease with congestive heart failure
- 402.11 Benign hypertensive heart disease with congestive heart failure
- 402.91 Unspecified hypertensive heart disease with congestive heart failure
- 404.01 Malignant hypertensive heart and renal disease with congestive heart failure
- 404.03 Malignant hypertensive heart and renal disease with congestive heart and renal failure
- 404.11 Benign hypertensive heart and renal disease with congestive heart failure
- 404.13 Benign hypertensive heart and renal disease with congestive heart and renal failure
- 404.91 Unspecified hypertensive heart and renal disease with congestive heart failure
- 404.93 Unspecified hypertensive heart and renal disease with congestive heart and renal failure
- 411.1 Intermediate coronary syndrome
- 411.81 Coronary occlusion without myocardial infarction
- 411.0 Postmyocardial infarction syndrome
- 411.89 Other acute ischemic heart disease
- 413.0 Angina decubitus
- 413.1 Prinzmetal angina
- 413.9 Other and unspecified angina pectoris
- 786.05 Shortness of breath
- 786.50 Chest pain, unspecified
- 786.51 Precordial pain
- 786.52 Painful respiration
- 786.59 Other chest pain

For Asthma

- 493.01 Extrinsic asthma with status asthmaticus
- 493.02 Extrinsic asthma with acute exacerbation
- 493.11 Intrinsic asthma with status asthmaticus
- 493.12 Intrinsic asthma with acute exacerbation
- 493.21 Chronic obstructive asthma with status asthmaticus
- 493.22 Chronic obstructive asthma with acute exacerbation
- 493.91 Asthma, unspecified with status asthmaticus
- 493.92 Asthma, unspecified with acute exacerbation

For Congestive Heart Failure

- 428.0 Congestive heart failure
- 428.1 Left heart failure
- 428.9 Heart failure, unspecified

The required tests are as follows:

For chest pain, at least two sets of cardiac enzymes and two sequential electrocardiograms.

For asthma, a peak expiratory flow rate (PEFR) (CPT code 94010).

For congestive heart failure, a chest x-ray, an electrocardiogram, and pulse oximetry.

5. List of Procedures That Will Be Paid Only As Inpatient Procedures

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 OPPS. In the April 7, 2000 final rule, we defined a set of services that are typically provided only in an inpatient setting and, hence, would not be paid by Medicare under the OPPS (65 FR 18455). This set of services is referred to as the ''inpatient list.'' The inpatient list specifies those services that are appropriate to provide only in an inpatient setting and that, therefore, are only paid when provided in an inpatient setting. These are services that require inpatient care because of the invasive nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient.

At its February 2001 meeting, the APC Advisory Panel generally favored the elimination of the inpatient list. In the proposed rule, we stated that we disagreed with the position taken by the Panel and we proposed to continue the current policy of reviewing the HCPCS codes on the inpatient list and eliminating procedures from the list if they can be appropriately performed on the Medicare population in the outpatient setting. Our medical and policy staff, supplemented as appropriate by the APC Advisory Panel, would review comments submitted by the public and consider advances in medical practice in making decisions to remove codes from the list. We stated that we would continue to use the following criteria, which we discussed in the April 7, 2000 final rule, when deciding to remove codes from the list:

- 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 we have already moved off the inpatient list (for example, the radiologic part of an interventional cardiology procedure).

In the proposed rule, we indicated that we would continue to update the list in response to comments as often as quarterly through program memoranda to reflect current advances in medical practice. We proposed no further changes to the inpatient list, which we set forth in Addendum E to the proposed rule.

Comment: Several specialty organizations, hospitals, and device manufacturers recommended that we remove certain procedures from the inpatient only list and assign them to APCs.

Response: We reviewed these requests in accordance with our previously published criteria and moved several of the procedures from the list. However, in our clinical judgment, the remainder of the procedures should not be moved. We are referring some of them to the APC Advisory Panel for review and further discussion at the next meeting. As noted in the proposed rule, we plan to continue updating the list on a quarterly basis, as needed. Set forth below is the list of procedures that commenters requested be moved off the inpatient list and the final action that we are taking in this rule.

Procedures That Remain Inpatient

- 34800—Endovascular repair of infrarenal abdominal aortic aneurysm or dissection
- 34802—Endovascular repair of infrarenal abdominal aortic aneurysm or dissection
- 34804—Endovascular repair of infrarenal abdominal aortic aneurysm or dissection
- 34808—Endovascular placement of iliac artery occlusion device
- 34812—Open femoral artery exposure for delivery of aortic endovascular prosthesis
- 34813—Placement of femoral-femoral prosthetic graft
- 34820—Occlusion during endovascular therapy
- 34825—Placement of proximal or distal extension prosthesis
- 34826—Infrarenal abdominal aortic aneurysm
- 33968—Removal of intra-aortic balloon assist device, percutaneous
- 44901—Incision and drainage of appendiceal abscess; percutaneous
- 49021—Drainage of peritoneal abscess or localized peritonitis; percutaneous
- 49041—Drainage of subdiaphragmatic or subphrenic abscess; percutaneous
- 49061—Drainage of retroperitoneal abscess; percutaneous
- 61624—Transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)

Procedures Referred to the APC Advisory Panel

- 21390—Open treatment of orbital floor blowout fracture
- 27216—Percutaneous skeletal fixation of posterior pelvic ring fracture and/or dislocation
- 27235—Percutaneous skeletal fixation of femoral fracture, proximal end, neck
- 32201—Pneumonostomy; with percutaneous drainage of abscess or cyst
- 47490—Percutaneous cholecystostomy
- 64820—Sympathectomy, digital arteries, with magnification, each digit
- 92986—Percutaneous balloon valvuloplasty; aortic valve
- 92987—Percutaneous balloon valvuloplasty; mitral valve
- 92990—Percutaneous balloon valvuloplasty; pulmonary valve
- 92997—Percutaneous transluminal pulmonary artery balloon angioplasty; single vessel
- 92998—Percutaneous transluminal pulmonary artery balloon angioplasty; each additional vessel (list separately in addition to code for primary procedure)

Procedures Moved to APCs

- 23440—Resection or transplantation of long tendon of biceps (APC 0052)
- 23470—Arthroplasty, glenohumeral joint; hemiarthroplasty (APC 0048)
- 47011—Hepatotomy; for percutaneous drainage of abscess or cyst, one or two stages (APC 0005)
- 48511—External drainage, pseudocyst of pancreas; percutaneous (APC 0005)
- 49200—Excision or destruction by any method of intra-abdominal or retroperitoneal tumors or cysts or endometriomas (APC 0130)
- 50021—Drainage of perirenal or renal abscess; percutaneous (APC 0005)
- 58823—Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous (APC 0193)
- 61626—Transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; non-central nervous system, head or neck extracranial, brachiocephalic branch) (APC 0081)
- 61791—Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (e.g., alcohol, thermal, electrical, radiofrequency); trigeminal medullary tract (APC 0204)
- 63655—Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural (APC 0225)

6. Additional New Technology APC Groups

In the April 7, 2000 final rule, we created 15 new technology APC groups to pay for new technologies that do not meet the statutory requirements for

transitional pass-through payments and for which we have little or no data upon which to base assignment to an appropriate APC. APC groups 0970 through 0984 are the current new technology APCs. We currently assign services to a new technology APC for 2 to 3 years based solely on costs, without regard to clinical factors. This method of paying for new technologies allows us to gather data on their use for subsequent assignment to a clinically-based APC. Payment rates for the new technology APCs are based on the midpoint of ranges of possible costs.

After evaluating the costs of services in the new technology APCs, we proposed that APC 0982, which covers a range of costs from $2500 to $3500, be split into two APCs, as follows: APC 0982, which would encompass services whose costs fall between $2500 and $3000, and APC 0983, which would encompass those services whose costs fall between $3000 and $3500. APC 0984 would then encompass services whose costs fall between $3500 and $5000 and we would create a new APC, 0985, for services whose costs fall between $5000 and $6000. We believe that subdividing the current range of costs within APC 0982 would allow us to pay more accurately for the services in that cost range.

In section VI.G of this preamble, we describe several modifications and refinements to the criteria and process for assigning services to new technology APCs that we are implementing in this final rule.

We received no comments on adding a new technology APC group and have included this change in the final APCs. However, we note that in this final rule, we are making additional changes to the new technology APCs to improve our ability to pay appropriately for new technology services.

We are designating 16 additional APC groups, APCs 0706 through 0721, as new technology APCs and reassigning some services currently assigned to APC groups 0970 through 0985 so that, beginning with services furnished on or after January 1, 2002, there will be two parallel sets of new technology APCs. This is an administrative adjustment to distinguish between those new technology services designated with a status indicator of ''S'' and those designated ''T.'' The new APCs will allow us to assign to the same APC group procedures that are appropriately subject to a multiple procedure payment reduction (T) with those that should not be so discounted (S). Each set of new technology APC groups will have identical group titles, payment rates, and minimum unadjusted copayments, but a different status indicator. That is, the new technology APC groups 0970 through 0985 will, effective January 1, 2002, be assigned status indicator ''T'' and all services grouped in APCs 970 through 985 will be subject to the multiple procedure reduction. Each of the new technology APC groups 0706 through 0721 will be assigned status indicator ''S.'' Therefore, effective January 1, 2002, new technology services currently grouped under APC 0971, 0974, 0976, and 0981 are reassigned to APC 0707, 0710, 0712, and 0717, respectively, in order to retain the payment status indicator ''S.''

D. Recalibration of APC Weights for CY 2002

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 for application in 2002. 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 2001. (See the November 13, 2000 interim final rule (65 FR 67824–67827).)

To recalibrate the relative APC weights for services furnished on or after January 1, 2002 and before January 1, 2003, we proposed to use the same basic methodology that we described in the April 7, 2000 final rule to recalibrate the relative weights for 2002. That is, we would recalibrate the weights based on claims and cost report data for outpatient services. We proposed to use the most recent available data to construct the database for calculating APC group weights. For the purpose of recalibrating the proposed APC relative weights for 2002, the most recent available claims data are the approximately 98 million final action claims for hospital outpatient department services furnished on or after July 1, 1999 and before July 1, 2000. We matched these claims to the most recent cost report filed by the individual hospitals represented in our claims data. The APC relative weights would continue to be based on the median hospital costs for services in the APC groups.

The methodology we followed to calculate the final APC relative weights for CY 2002 is similar to the proposed except that there are now over 107 million final action claims and as discussed below in section VII of this preamble, we have incorporated a portion of pass-through device costs into device-related procedures. That action has increased the median costs for those procedures. The methodology for calculating the final APC relative weights is as follows:

- We excluded from the data approximately 16.2 million 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 ESRD).
- 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 1999–2000 outpatient bills. The CCRs included operating and capital costs but excluded costs paid on a reasonable cost basis that are described elsewhere in this preamble.
- We eliminated from the hospital CCR data 283 hospitals that we identified as having reported charges on their cost reports that were not actual charges (for example, they make uniform charges for all services).
- We calculated the geometric mean of the total operating CCRs of hospitals remaining in the CCR data. We removed from the CCR data 67 hospitals whose total operating CCR exceeded the geometric mean by more than 3 standard deviations.
- We excluded from our data approximately 2.1 million claims from the hospitals that we removed or trimmed from the hospital CCR data.
- We matched revenue centers from the remaining universe of approximately 89.1 million claims to CCRs of 5,672 hospitals.
- We separated the 89.1 million claims that we had matched with a cost report into two distinct groups: single-procedure claims and multiple-procedure claims. Single-procedure claims were those that included 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 included more than one HCPCS code that could be mapped to an APC. There were approximately 39.9 million single-procedure claims and 49.2 million multiple-procedure claims.
- To calculate median costs for services within an APC, we used only single-procedure bills. We did not use multiple-procedure claims because we are not able to specifically allocate charges or costs for packaged items and services such as anesthesia, recovery room, drugs, or supplies to a particular

procedure when more than one significant procedure or medical visit is billed on a claim. Use of the single-procedure bills minimizes the risk of improperly assigning costs to the wrong procedure or visit.

• 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. If the appropriate cost center did not exist for a given hospital, we crosswalked the revenue center to a secondary cost center when possible, or to the hospital's overall cost-to-charge ratio 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).

• To calculate the per-service costs, we used the charges shown in the revenue centers that contained items integral to performing the service. These included those items that we previously discussed as being subject to our proposed packaging provision. For instance, in calculating the surgical procedure cost, we included charges for the operating room, treatment rooms, recovery, observation, medical and surgical supplies, pharmacy, anesthesia, and donor tissue, bone, and organ. For medical visit cost estimates, we included charges for items such as medical and surgical supplies, drugs, and observation in those instances in which it is still packaged. See sections II.C.1 and II.C.2 of this preamble for a discussion and complete listing of the revenue centers that we used to calculate per-service costs. In addition, for device-related procedures, we incorporated 75 percent of the estimated cost of the pass-through device into the per-service costs.

• 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 current FY 2002 hospital inpatient prospective payment system wage index published in the **Federal Register** on August 1, 2001 (65 FR 40038). We used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. A more detailed discussion of wage index adjustments is found in section III of this preamble.

• 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 DRG weights for the hospital inpatient PPS. That is, we eliminated any bills with costs outside of 3 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 described elsewhere in this preamble.

• We calculated the median cost, weighted by procedure volume, for each APC.

• Using the weighted median APC costs, we calculated the relative payment weights for each APC. 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. This approach is consistent with that used in developing relative value units for the Medicare physician fee schedule. 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. The median cost for APC 0601 is $54.00.

Section 1833(t)(9)(B) of the Act requires that APC reclassification and recalibration changes and wage index changes be made in a manner that ensures that aggregate payments under the OPPS for 2002 are neither greater than nor less than the aggregate payments that would have been made without the changes. To comply with this requirement concerning the APC changes, we compared aggregate payments using the CY 2001 relative weights to aggregate payments using the CY 2002 final weights. Based on this comparison, in this final rule we are making an adjustment of 0.945 to the weights; that is, each weight is reduced by this factor (the scaler). The final weights for 2002, which incorporate the recalibration adjustments explained in this section, are listed in Addendum A and Addendum B of the final rule.

We note that in the proposed rule, we inadvertently applied the weight adjustment factor of 1.022 to the relative weights of the new technology APCs. This was incorrect. The payment rates for the new technology APCs are based on the mid-point of the cost range represented by the APC. Therefore the payment rates should be static from year to year. In this final rule, the payment rates for APCs 0970–0985 correctly reflect no adjustment.

Comment: We received numerous comments regarding HCPCS codes and APC groups for which the payment rate proposed for 2002 is lower than the current payment rate. Commenters expressed concern that the proposed decrease in payment would have adverse effects both on beneficiary access to services and hospital solvency. Many commenters suggested that a lower rate was a data or a calculation error and requested that a particular weight be confirmed. Many commenters stated that because the lower proposed payment rate was inadequate to pay hospital costs for the service, we should adjust the rate to a more appropriate level.

Response: As explained above, the methodology we used to recalibrate the final 2002 relative weights is essentially the same methodology that we followed to recalibrate the weights in the August 24, 2001 proposed rule, with the exception of the additional step of folding pass-through device costs into certain base APC costs. (We discuss the reason for this additional step in the November 2, 2001 OPPS final rule (66 FR 55857).)

In both the proposed rule and this final rule, the relative weights for the APC groups change for two reasons: The use of more recent claims data, and the statutory requirements governing how payment for all services under the OPPS must be determined.

The use of more recent claims data: We calibrated the relative weights published in the April 7, 2000 final rule using, as required by the statute, claims from 1996 and data from the most recent available hospital cost reports. These relative payment weights were implemented on August 1, 2000 and they have remained largely unchanged throughout 2001. In the August 24 proposed rule, we proposed to use the same basic methodology to recalibrate the weights that we described in the April 7, 2000 final rule (65 FR 18482). But we also proposed to use the most recent available data, rather than 1996 data, to construct the database for calculating APC group weights. For 2002, the most recent data are from final action claims for hospital outpatient services furnished beginning July 1, 1999 through June 30, 2000. In recalibrating the final weights for 2002, we had the benefit of data from additional claims that had not been received when we recalibrated the relative payment weights for the August 24, 2001 proposed rule. We matched these claims to the most recent cost report filed by the various hospitals represented in the claims data. Hospital costs reflected in claims for the period July 1, 1999 through June 30, 2000 have

changed from those taken from 1996 claims.

Statutory requirements governing how payment for OPPS services is to be determined. Section 1833(t)(9)(B) of the Act requires that estimated spending for services covered under the OPPS be neither greater nor less than it would have been had we not recalibrated the APC weights nor made changes in the APC groups. Because of this, the weights and, therefore, the payment rates for a specific service may increase or decrease depending on the change in charges hospitals report for that service relative to the change in charges hospitals report for other outpatient services.

Under any prospective payment system or fee schedule that bases rates on a system of relative weights within limits imposed by a budget neutrality requirement, some weights will increase and others will decrease from year to year. A decrease in the relative weight for an APC is the result of a decrease in the relative level of charges for the services in that APC that hospitals reported for the period from July 1, 1999 through June 30, 2000, compared to the relative level of charges the same hospitals reported for all other outpatient services furnished during the same period. In addition, the application of the budget neutrality adjustment required by section 1833(t)(9)(B) of the Act will further decrease a relative weight if the adjustment is less than 1.000.

In this final rule, some weights are lower than what we had proposed. The further lowering of weights for some APCs is the result of our incorporating a portion of the cost of pass-through devices into the basic costs of the APCs with which the devices are associated. As we explained in the final rule published on November 2, 2001 (66 FR 55857), the portion of the pass-through device costs that were incorporated into APC costs are not evenly distributed among the APCs, but rather are concentrated in a relatively small number of APCs that include the procedures that use pass-through devices. Whereas the weights of these APCs have increased as a result of the added device costs, the weights for all APCs that do not include device costs have decreased.

In preparing the weights for this final rule, we were particularly attentive to APCs such as APC 0169, Lithotripsy, APC 0245, Level I Cataract Procedures without IOL Insert, and APC 0246, Cataract Procedures with IOL Insert, about which commenters had expressed concern. As a result, we have a high level of confidence in the appropriateness of the weights that are in this final rule. Therefore, we are not increasing the relative weight or payment rate for an APC group simply because its payment is lower in 2002 than it was in 2001 nor are we reducing the relative weight or payment rate for an APC group simply because its payment is higher in 2002 than it was in 2001.

III. Wage Index Changes

Under section 1833(t)(2)(D) of the Act, we are required to 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 May 4, 2001 proposed Federal fiscal year (FY) 2002 hospital inpatient PPS wage index (66 FR 22646) to make wage adjustments in determining the proposed payment rates set forth in the proposed rule. We also proposed to use the final FY 2002 hospital inpatient wage index to calculate the final CY 2002 payment rates and coinsurance amounts for OPPS. We received no comments on this issue and are implementing our proposed policy in final.

The final FY 2002 hospital inpatient wage index published in the August 1, 2001 **Federal Register** (66 FR 39828) 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. Those wage index values will be used to calculate the OPPS payment rates and coinsurance amounts for calendar year (CY) 2002.

IV. Copayment Changes

We note that in section 1833(t) of the Act, the terms ''*copayment*'' and ''*coinsurance*'' appear to be used interchangeably. To be consistent with CMS usage, we make a distinction between the two terms throughout this preamble. We are making conforming changes to part 419 of the regulations to reflect the following usage:

- ''*Coinsurance*'' means the percent of the Medicare-approved amount that beneficiaries pay for a service furnished in the hospital outpatient department (after they meet the Part B deductible).
- ''*Copayment*'' means the set dollar amount that beneficiaries pay under the OPPS. For example, if the payment rate for an APC is $200 and the beneficiary is responsible for paying $50, the copayment is $50 and the coinsurance is 25 percent.

A. BIPA 2000 Coinsurance Limit

As discussed in section I.C of this preamble, certain provisions of BIPA 2000 affect beneficiary copayment amounts under the OPPS. Section 111 of the BIPA added section 1833(t)(8)(C)(ii) of the Act, to accelerate the reduction of beneficiary copayment amounts, providing that, for services furnished on or after April 1, 2001 and before January 1, 2002, the national unadjusted coinsurance for an APC cannot exceed 57 percent of the APC payment rate. The statute provides for further reductions in future years so that the national unadjusted coinsurance for an APC cannot exceed 55 percent in 2002 and 2003, 50 percent in 2004, 45 percent in 2005, and 40 percent in 2006 and thereafter.

We implemented the reduction in beneficiary copayments for 2001 effective April 1, 2001 through changes to the OPPS PRICER software used to calculate OPPS payments to hospitals from the Medicare Program and beneficiary copayments.

We proposed to revise § 419.41 to conform the regulations text to this provision.

We received no comments on this proposal and are implementing the required 55 percent limit on the national unadjusted coinsurance rate of the final APCs. We are also adopting as final the proposed changes to the regulations text.

B. Impact of BIPA 2000 Payment Rate Increase on Coinsurance

Under the statute as enacted by BBA 1997, APC payment rates for 2001 were to be based on the payment rates for 2000 increased by the inpatient hospital market basket percentage increase minus 1 percentage point; however, section 401 of the BIPA 2000 increased APC payment rates for 2001 to reflect an update based on the full market basket percentage increase. The Congress intended for the increased payment to be in effect for the entire calendar year 2001; however, to provide us sufficient time to make the change, the Congress adopted a special payment rule for 2001. Under section 401(c) of the BIPA, the payment rates in effect for services furnished on or after January 1, 2001 and before April 1, 2001 are the rates as determined under the statute prior to the enactment of BIPA. For services furnished on or after April 1, 2001 and before January 1, 2002 the payment rates reflect the full market basket update and are further increased by 0.32 percent to account for the timing delay in implementing the full market basket update for 2001. The 0.32 percent

increase is a temporary increase that applies only to the period April 1 through December 31, 2001 and is not considered in updating the OPPS conversion factor for 2002. The increase in APC payment rates for 2001 was implemented effective April 1, 2001 through changes to the OPPS PRICER software. We proposed to revise § 419.32 to conform to the statute.

The section 401 increase to the APC payment rates affected beneficiary copayments in several ways. In cases for which the beneficiary coinsurance was already based on 20 percent of the APC payment rate, the increase in the APC payment rate caused a corresponding increase in the copayment for the APC. For all other APCs, the copayment amount remained at the same level. In addition, because the minimum copayment amount for an APC, which is the lowest amount a provider may elect to charge if it chooses to reduce copayments for an APC, is based on 20 percent of the APC amount, the increase to an APC payment rate under section 401 of BIPA resulted in an increase to the minimum copayment amount for each APC.

We received no comments on this issue, and we are implementing the changes to the regulations text in final.

C. Coinsurance and Copayment Changes Resulting From Change in an APC Group

National unadjusted copayment amounts for the original APCs that went into effect on August 1, 2000 were, by statute, based on 20 percent of the national median charge billed for services in the APC group during calendar year 1996, trended forward to 1999, but could be no lower than 20 percent of the APC payment rate. Although the BBA 1997 specified how copayments were to be determined initially, the statute does not specify how copayments are to be determined in the future as the APC groups are recalibrated or as individual services are reclassified from one APC group to another. In the proposed rule, we provided the method we intend to apply in determining copayments for new APCs (that is, those created after 2001) and for APCs that are revised because of recalibration and reclassification. We also discussed the issues we considered in developing a proposed approach to be used in determining copayments for new or revised APCs.

The following describes how we proposed to determine copayment amounts for new and revised APCs for 2002 and subsequent years:

1. If a newly created APC group consists of services that were not included in the 1996 data base or whose charges were not separately calculated in that data base (that is, the services were excluded or packaged) the unadjusted copayment amount would be 20 percent of the APC payment rate.

2. If recalibrating the relative payment weights results in an APC having a decrease in its payment rate for a subsequent year, the unadjusted copayment amount will be calculated so that the coinsurance percentage for the APC remains the same as it was before the payment rate decrease. For example, assume the APC had a payment rate of $100 and an unadjusted copayment amount of $50, resulting in a coinsurance percentage of 50 percent. If the new payment rate for the APC is lowered to $80, the copayment amount is calculated using the prior coinsurance percentage of 50 percent; therefore, the new copayment amount would be 50 percent of $80 or $40.

3. If recalibrating the relative payment weights results in an APC having an increase in its payment rate for a subsequent year, the unadjusted copayment amount would be calculated so that the copayment dollar amount for the APC remains the same as it was before the payment rate increase. That is, the unadjusted copayment amount would not change. For example, assume the APC had a payment rate of $100 and an unadjusted copayment amount of $60 (a coinsurance percentage of 60 percent). If the new payment rate for the APC is increased to $150, the unadjusted copayment amount would remain at $60 (a coinsurance percentage of 40 percent).

4. If a newly created APC group consists of services from two or more existing APCs, the unadjusted copayment amount would be calculated based on the lowest coinsurance percentage of the contributing APCs. For example, a new APC is created by moving some or all of the services from two existing APCs into the new APC. Assume that one contributing APC had a payment rate of $100 and an unadjusted copayment amount of $40, a coinsurance percentage of 40 percent. Assume the other contributing APC had a payment rate of $150 and an unadjusted copayment amount of $75, a coinsurance percentage of 50 percent. If the new APC had a payment rate of $130, the unadjusted copayment amount for the new APC would be based on a coinsurance percentage of 40. The unadjusted copayment amount for the new APC would be 40 percent of $130, or $52.

These changes will in general reduce beneficiary copayment for services in affected APCs. For 2002, we believe the size of these changes will be modest. If in the future the size of such changes appears likely to be large, we may revisit this policy.

5. If an APC payment rate is increased due to a conversion factor update, the unadjusted copayment amount for the APC would not change.

We received no comments on this proposal. Therefore, we are implementing the proposed methodology for calculating copayment amounts in this final rule.

V. Outlier Policy Changes

For OPPS services furnished before January 1, 2002, section 1833(t)(5)(D) of the Act explicitly authorizes the Secretary to apply the outlier payment provision based upon all of the OPPS services on a bill. We exercised that authority and, since the beginning of the OPPS on August 1, 2000, we have calculated outlier payments in the aggregate for all OPPS services that appear on a bill. However, beginning January 1, 2002, we proposed to calculate outlier payments based on each individual OPPS service. That is, we proposed to revise the aggregate method that we are currently using to calculate outlier payments and begin to determine outliers on a service-by-service basis for OPPS services furnished on or after January 1, 2002.

In the proposed rule, we discussed in detail the difficulties we faced with calculating outliers based on individual services. We also discussed possible solutions to those problems including requiring hospitals to submit separate bills for each OPPS service and allocating the charges for any packaged service among the individual OPPS services that appear on the bill. We stated that we prefer using one of the approaches that would allocate packaged charges among the APCs on a bill to avoid disruptive billing changes. We proposed that charges be allocated to each OPPS service based on the percent the APC payment rate for that service bears to the total APC rates for all OPPS services on the bill.

We also proposed to convert charges to costs for calculating outlier payments by continuing to apply a single overall hospital-specific cost-to-charge ratio instead of applying hospital-specific departmental cost-to-charge ratios. In the proposed rule, we explained that, for purposes of calculating outlier payments under the OPPS, the use of departmental cost-to-charge ratios is not feasible given currently available information because we do not have a way of defining, in a uniform manner that is accurate for all hospitals, which departmental cost-to charge ratio to

apply to a revenue code billed by a hospital. We also explained that collecting the data necessary to make it feasible to use departmental cost-to-charge ratios would impose significant burden and administrative costs on hospitals and our contractors. We then stated that given that outliers represent only 2 to 3 percent of total OPPS expenditures, we believe that the increased accuracy in calculating outlier payments that we could gain would not be sufficient to justify the significant additional administrative burden and cost that would be required. For this reason, we proposed to continue to apply a single hospital-specific outpatient cost-to-charge ratio to convert billed charges to costs for calculating outlier payments.

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. We also explained that, for purposes of simulating payments to calculate outlier thresholds, we set the parameters for determining outlier payments as if the target were 2.5 percent. We believed that it would be likely that using simulation 1996 claims data would overstate the percentage of payments that would be made. Based on the simulations, we set a threshold for outlier payments at 2.5 times the claim cost and a payment percent of 75 percent of the cost above the threshold for both 2000 and 2001.

In setting the proposed CY 2002 outlier threshold and payment percentage, we accounted for the change to service level rather than claim level outlier calculation. We proposed to set the target for outlier payment at 2.0 percent as we had for CY 2001. We believe that the claims data we are using to set the 2002 payment rates reflect much better coding of services than did the 1996 data so we set the proposed threshold and proposed payment percentage based on simulations of payments so that the percentage of outlier payments under the simulations was 2.0 percent, rather than 2.5 percent as we did in simulating payments to set the outlier criteria for the April 7, 2000 final rule. Based on our simulations, the proposed threshold for 2002 is 3 times the service costs and the proposed payment percentage for costs above that threshold is set at 50 percent. Based on the simulations using the updated claims data from July 1, 1999 to June 30, 2000, the final threshold for 2002 is 3 times the service costs and the final payment percentage for costs above that threshold is set at 50 percent (the same as the proposed thresholds).

We received many comments on our proposed changes to the outlier policy, which are summarized below along with our responses.

Comment: Several commenters expressed concern that we proposed to increase the outlier threshold while lowering the payment percentage without providing sufficient analysis in the proposed rule to document and justify these changes. A number of commenters contended that the quality of the data is not sufficient to justify these dramatic changes and urged us to maintain the current threshold and payment percentage until better data become available. One commenter recommended that we either furnish hospitals with the information that explains the significant changes, providing an additional opportunity to comment, or maintain the current threshold and payment percentage amounts. Another commenter stated that, in the annual proposed and final rules for hospital inpatient PPS, the data to support any modifications to outlier payments are presented in detail and the commenter believes we should include similar information in the annual proposed and final OPPS rules.

Response: In the April 7, 2000 final rule (65 FR 18498), we described the general methodology that we use to set the outlier threshold and payment percentage. We use historical claims data and simulate payments for those claims by applying the payment rates and policies for the upcoming year. We calibrate the threshold and payment percentage by applying an iterative process in which we try different combinations of thresholds and payment percentages until an appropriate combination results in outlier payments under the simulation equal to the target percentage (for purposes of the simulation) of total OPPS payments under the simulation.

There are two major sources of the changes between the threshold and payment percentage for 2001 and these proposed 2002. First, the outlier payment simulations for the proposed rule reflected the proposed change in the outlier payment policy from a bill-level calculation to service-level calculation. Second, the outlier payment simulations for the proposed rule were based on updated claims data which were considerably more recent than the 1996 claims we used previously. We believe that the updated data reflect more accurate coding of the outpatient services hospitals furnished compared to the 1996 data.

When updated data or a change in policy (or, as in this case, both) dictate a significant change in the outlier parameters, we believe it is, in general, a better policy to adjust both the threshold and the outlier payment percentage. For 2002, an adjustment made only to the threshold amount would greatly limit the number of services that would qualify for an outlier payment. Conversely, an adjustment only to the outlier payment percentage would have significantly decreased the amount of the outlier payment made for the services that do qualify. By adjusting both of the parameters, we hope to strike a balance. That is, for 2002 as compared to 2001, we do not wish to drastically lower the number of services qualifying for outlier payment nor do we wish to significantly decrease the amount of payment hospitals may receive for services that qualify as outliers. Based on this premise, we both raised the outlier threshold and decreased the payment percentage in order to prevent, to the extent possible, large changes in the outlier payments made to hospitals.

Comment: One commenter stated that, because we provided no data to demonstrate that the target for CY 2001 would be exceeded, we should provide that if the proposed changes are put into place and actual outlier payments in 2002 are significantly less than the 2002 outlier target, the ''shortfall'' from 2001 and 2002 will be made up by increased outlier payments in subsequent years.

Response: The outlier threshold and payment percentage are determined each year based on our best estimate of what threshold and payment percentage are needed to achieve a certain level of outlier payments. For example, for CY 2002, we set the threshold and payment percentage based on estimates so that outlier payments are projected to equal 2.0 percent of total OPPS payments.

Section 1833(t)(5)(C) of the Act requires that the outlier payment estimate for a year be made by the Secretary before the beginning of the year. Consistent with our outlier policies in other prospective payment systems, we will not adjust outlier payments in subsequent years to account for an underestimation (or overestimation) of outlier payments in a previous year. The statute does not provide for such an adjustment. We set the outlier policies prospectively, using the best available data. Outlier payments, like many aspects of a prospective payment system, reflect estimates, and we believe it would be inappropriate to adjust the outlier payments (upward or downward) for a given year simply because an estimate for a previous year ultimately turned out to be inaccurate. If we underestimate or overestimate the percentage of outlier payments, the divergence of our estimate from actual experience may

provide information that might help us improve future estimates, but it would have no direct effect on the amount of outlier payments for any following year.

Comment: One commenter suggested that we lack reliable data on actual claims experience that are critical in determining which hospitals are receiving outlier payments and for which specific services. The commenter believes that once such data become available, they can be used to improve the APC system, reducing the overall need for outliers and to refine the outlier methodology to target outlier payments as most appropriate.

Response: As coding on outpatient claims improves, the median costs we use to calculate APC weights and, ultimately, APC payment rates will also more accurately reflect the resources associated with furnishing the services within each APC. It is possible that this may reduce the incidence of outlier payments for specific services as well as decrease the need for outlier payments across all services.

Comment: One commenter pointed out that the increase in the outlier threshold and the decrease in the percent of the excess costs that will be paid as an outlier payment are based on an outlier target of 2.0 percent of estimated total OPPS payments. In order to not penalize hospitals that treat high cost cases, the commenter recommended that the outlier target be set at 3.0 percent of estimated total OPPS payments.

Response: Section 1833(t)(5)(C) of the Act limits projected outlier payments for years prior to 2004 to no more than 2.5 percent of projected total OPPS payments. For CY 2002, we proposed to set the target for outlier payments at 2.0 percent. Although we could increase that amount to 2.5 percent, we have chosen not to do so because increasing the outlier target percentage would require a corresponding decrease to APC payment amounts due to budget neutrality. Given the decrease in many of the APC payment rates that results from the incorporation of 75 percent of device pass-through costs into the APCs (see section II.D. of this preamble), we believe it is appropriate not to increase the outlier target percentage so that there is no additional reduction in the APC payments. Once we have claims data that reflect payments made under the OPPS, our analysis of those data may lead us to revise our policy of setting the outlier target below the limit allowed.

Comment: One commenter estimated that the proposed changes in the threshold and the payment percentage would reduce outlier payments by as much as 50 percent. Several other commenters claimed that the proposed changes would result in drastic cuts in outlier payments to certain community mental health centers (CMHCs) in Louisiana and Mississippi. These commenters contended that the payment reductions would be so severe that CMHCs would be forced to close, thereby eliminating services for the seriously and persistently mentally ill. These commenters requested that the CY 2002 outlier payments for CMHCs continue to be calculated using the CY 2001 outlier threshold and payment percentage.

Another commenter asked that we provide data on outlier payments made since the implementation of the OPPS to provide greater information about the impact of outliers on cancer care. The commenter stated that, in the area of cancer care, hospital outpatient departments often provide the only access point for patients needing complex therapies or new therapies not yet specifically recognized by the coding system and outlier payments provide an important safeguard against any adverse impact of providing this care. The commenter specifically requested information on how the outlier payments have been applied to cancer patients across the country. If actual outlier payments are less than the 2.0 percent target, the commenter urged us to direct more of the outlier monies to cancer care or apply any difference between projected and actual outlier amounts to the transitional pass-through payments for drugs and devices.

Response: As discussed above, the difference between the 2001 and proposed 2002 outlier threshold and payment percentage arises from the use of newer claims data and the change to a service-level rather than claim-level outlier payment calculation. In accordance with section 1833(t)(5) of the act, we set a ''fixed'' threshold that applies to all OPPS services. Thus, we apply a uniform threshold to all OPPS services in a given calendar year; the statute does not provide for different thresholds for different classes of providers or different types of OPPS services. Similarly, we set the payment percentage prospectively before the beginning of each year and apply it to all OPPS services qualifying for outlier payments in that year.

Currently, we do not have adequate data for OPPS claims to perform a useful analysis of actual outlier payments under the OPPS, but we expect to discuss information on actual outlier payments in future regulation documents after sufficient information becomes available.

For the suggestion concerning the redistribution of outlier payments to pass-through drugs and devices, we note that the statute provides for both the outlier and transitional pass-through payments and establishes the 2.5 percent limits on those payments for the years before 2004 (when the limit for outliers increases to 3.0 percent and the limit for transitional pass-throughs decreases to 2.0 percent). Thus, we do not have the administrative authority to make the change that this commenter has recommended. Rather, legislative action would be required to make any of these changes.

Comment: Although some commenters were in favor of calculating outlier payments on an individual service basis, several commenters requested that we reconsider our proposal and recommended that we continue to use the aggregate bill method. Another commenter believes that the increased specificity gained under the proposed outlier methodology would not offset the additional costs and administrative burden to hospitals of making information system changes necessary to calculate and verify outlier payments. One commenter asserted that multiple service claims are not used in calculating the APC relative weights because we are unable to accurately allocate packaged items and services when more than one service is billed on a claim. The commenter is concerned that the same problem would occur with the proposed methodology for paying outliers and recommends that, to avoid inappropriate outlier payments, we should continue to calculate outliers on a claim-level basis until an equitable method of assigning packaged costs is developed.

Another commenter believes that the current methodology more accurately meets the intent of outlier payments, which is to pay facilities for unusual expenses incurred on behalf of patients, not specific line items or individual services. The commenter stated that the allocation of charges to develop service-by-service outliers presents an administrative problem to those hospitals that must significantly alter their systems in order to monitor and audit their payments.

Several commenters expressed concern that the proposed service-level approach could result in very few services qualifying for additional payment and asked for a delay in the policy. One hospital association requested a delay so it would have an opportunity to evaluate CYs 2000 and 2001 data to better understand the impact the change would have on its member hospitals. Another hospital

association believes that the data that are currently available (that is, data for services furnished prior to implementation of the OPPS) may not accurately reflect the financial impact of the proposed change and asked for a delay in calculating service-level outliers until OPPS data are available and can be provided to the hospital industry for analysis. Several commenters urged us to delay implementation of service-level outlier calculations until hospitals and fiscal intermediaries had adequate time to perform systems testing related to the change.

Response: We believe that calculating outliers on a service-by-service basis is the most appropriate way to calculate outliers for outpatient services. Outliers on a bill basis requires both the aggregation of costs and the aggregation of OPPS payments thereby introducing some degree of offset among services; that is, the aggregation of low cost services and high cost services on a bill may result in no outlier payment being made. While service-based outliers are somewhat more complex to administer, under this method, outlier payments will be more appropriately directed to those specific services for which a hospital incurs significantly increased costs. We are revising the outpatient PRICER program to calculate outliers on a service-by-service basis, and we do not anticipate that our contractors will have any significant problems being able to calculate outlier payments under this revised policy.

Comment: Two commenters requested clarification concerning how outlier payments would be calculated on a service-by-service basis in the case of multiple surgical procedures appearing on the same claim when all of the surgical charges are combined into a single line on the claim. One commenter stated that if hospitals will be required to change the practice of combining surgical charges for all procedures on a single line item, they may require significant resources to comply with such a change.

Response: The commenters raise a valid concern. When a hospital performs several surgical procedures during the same operative session, it is an acceptable billing practice to show the entire charge for use of the operating room or treatment room on the line with one of the surgical HCPCS codes and zero charges on the lines with the remaining surgical HCPCS codes. We do not intend to require that hospitals change this practice. Hospitals will continue to have the option of splitting out the charges among the individual surgical procedures based on the resources that are attributable to each procedure or they may show a single combined charge with one of the surgical HCPCS codes and zero charges with the others. If the hospital chooses the latter option, in calculating outliers on a service-by-service basis, we will allocate the combined operating or treatment room charge among all of the surgical procedures on the bill. The charges will be allocated to each surgical procedure based on the proportion that the APC payment for the procedure bears to the total APC payments for all surgical procedures performed on that day.

Comment: One commenter supported calculating outliers on a service-by-service basis and agreed with using an overall cost-to-charge ratio, but disagreed with the proposal to allocate packaged services. Several commenters asserted that while it is not possible to directly assign packaged services to a payable procedure in all cases, it is possible in some cases. As an example, the commenters stated that on a claim with a surgical procedure and a visit or diagnostic service, it would be logical and reasonable to assign anesthesia, recovery room, and device charges completely to the surgical procedure, instead of allocating a portion to the visit or diagnostic service.

Another commenter recommended that we modify our proposal for allocating packaged services and develop a set of rules to directly assign the packaged services for those obvious situations when there is a clear relationship of the packaged item or service to the payable service or procedure.

Response: We believe that the policy the commenters are recommending is problematic. For example, anesthesia and recovery room services are not limited to surgical procedures but may also be billed with certain diagnostic procedures. Although we agree that we may in the future be able to improve the allocation of packaged services for a service-level outlier calculation, we also must be careful that the calculation does not become so complex that hospitals are unable to understand how their outlier payments have been determined. Therefore, we are not adopting the commenter's suggestion. We will however continue to analyze possible refinements to this policy.

Comment: One commenter acknowledged the complexities we would face in using a cost report line-specific method of calculating the cost-to-charge ratios (CCRs) for outlier payments but believes the issue warrants further study. The commenter contends that using line-specific CCRs is the only way to ensure that outlier payments are equitable on a service level.

Response: We agree with the commenter that applying appropriate departmental cost-to-charge ratios (CCRs) would generally be more accurate than using an overall outpatient CCR. However, as discussed above and in the proposed rule, it is currently unfeasible to use departmental cost-to-charge ratios for purposes of outlier payments under the OPPS because we currently do not have the necessary information. We continue to believe that the increased accuracy that would be achieved by use of departmental CCRs would not justify the significant administrative burden that would be placed on both hospitals and fiscal intermediaries.

Comment: A number of commenters raised concerns about the hospital-specific CCRs we have used since the beginning of OPPS to calculate outlier payments as well as transitional pass-through payments and interim transitional corridor payments. The commenters raised issues relating to the accuracy of CCR calculations, the basis of future CCR updates, and the timing of CCR updates.

Response: We are working on instructions to our fiscal intermediaries that will address both how and when the CCRs will be revised and updated and those instructions will be published in a forthcoming program memorandum.

VI. Other Policy Decisions and Proposed Changes

A. Change in Services Covered Within the Scope of the OPPS

Section 1833(t)(1)(B) of the Act defines the term ''covered OPD services'' that are to be paid under the OPPS. ''Covered OPD services'' are ''hospital outpatient services designated by the Secretary'' and include ''inpatient hospital services designated by the Secretary that are covered under this part and furnished to a hospital inpatient who (1) is entitled to benefits under Part A but has exhausted benefits for inpatient hospital services during a spell of illness, or (2) is not so entitled'' (that is, ''Part B-only'' services). ''Part B-only'' services are certain ancillary services furnished to inpatients for which the hospital receives payment under Medicare Part B. These services, which are specified in section 3110 of the Medicare Intermediary Manual and section 2255C of the Medicare Carriers Manual include diagnostic tests; X-ray and radioactive isotope therapy; surgical dressings, splints and casts; prosthetic

devices; and limb braces and trusses and artificial limbs and eyes.

In the April 7, 2000 final rule, we included inpatient ''Part B-only'' services within the definition of services payable under the OPPS (68 FR 18543). In the proposed rule, we discussed some hospitals' concerns about the administrative burden and prohibitive costs they would incur if they were to change their billing systems to accommodate OPPS requirements solely to receive payment for ''Part B-only'' services. We proposed to revise § 419.22 by adding paragraph (r) to exclude Part B-only services that are furnished to inpatients of hospitals that do no other billing for hospital outpatient services under Part B from payment under the OPPS.

We noted that under this proposed revision of the regulations, hospitals with outpatient departments would continue to bill under the OPPS for Part B-only services that they furnish to their inpatients. However, a hospital that does not have an outpatient department would be unable to bill under the OPPS for any Part B-only service the hospital furnished to its inpatients because those services would not fall within the scope of covered OPD services. If a hospital with no outpatient department is currently billing under the OPPS, the hospital would have to revert to its previous payment methodology for services furnished on or after January 1, 2002. That methodology would be an all-inclusive rate for hospitals paid that way prior to the implementation of OPPS and reasonable cost for other hospitals.

We received several comments on this proposal, which are summarized below.

Comment: Several commenters requested that the proposed change be made retroactive to the implementation of OPPS on August 1, 2000. These commenters observed that, without retroactive effect, the hospitals would be unable to bill for inpatient ancillary services provided to beneficiaries with Part B-only coverage during the period from August 1, 2000 until January 1, 2002. Another commenter contended that the proposed policy should have retroactive effect. The commenter raised two alternative reasons for this contention. One was that section 1833(t)(1)(B)(ii) of the Act should not have been interpreted to apply to inpatients who have exhausted their Part A coverage because of the 190-day lifetime limit on inpatient psychiatric days, because the statutory language refers only to hospital inpatients who have ''exhausted benefits for inpatient hospital services during a spell of illness.'' The other was that, allegedly, CMS had never designated through formal regulations those Part B services that are subject to the OPPS. Until such a rule is adopted, the commenter contended, no service provided on an inpatient basis to beneficiaries with Part B-only coverage can be subject to OPPS.

Response: Contrary to the assertion of the commenter, we have in fact designated those Part B services to be covered under the OPPS through formal regulations. In the April 7, 2000, final rule, we specifically included services furnished to inpatients who have exhausted their Part A benefits in the list of ''Services Included Within the Scope of the Hospital Outpatient PPS,'' and provided examples of those services (65 FR 18444). The statutory language gives the agency broad authority to define the services that are to be included under the OPPS. The statute broadly includes both ''hospital outpatient services designated by the Secretary'' and ''inpatient hospital services designated by the Secretary that are covered under this part and furnished to a hospital inpatient who (1) is entitled to benefits under Part A but has exhausted benefits for inpatient hospital services during a spell of illness, or (2) is not so entitled'' within the definition.

We designated Part B-only services as OPPS services through notice and comment rulemaking, and the policy has been in effect since the inception of OPPS. As discussed in the proposed rule, representatives of hospitals approached us *after* publication of the April 7, 2000 final rule to express concerns about the policy. We have considered those concerns, and we are changing the policy prospectively. We believe not only that applying the policy change on a prospective basis only is fair (particularly given that the current policy was established through notice and comment rulemaking) but also that applying the policy change on a retroactive basis would constitute impermissible retroactive rulemaking.

Comment: Several commenters requested that CMS clarify that those hospitals to which this change applies may resume billing under the per diem based methodology that they employed prior to the implementation of OPPS.

Response: As we stated in the proposed rule (66 FR 44699), ''If a hospital with no outpatient department is currently billing under the OPPS, the hospital would have to revert to its previous payment methodology for services furnished on or after January 1, 2002. That methodology would be an all-inclusive rate for hospitals paid that way prior to the implementation of OPPS and reasonable cost for other hospitals.'' The hospitals to which this change applies may therefore resume billing under the per diem or reasonable cost methodology that was applicable to them prior to the implementation of the OPPS.

Comment: One commenter asked that we recognize the situation of two other classes of hospitals. Some hospitals that have outpatient departments submit claims for only a limited range of outpatient services under Part B. Other hospitals have outpatient departments (for example, for children's psychiatric services) but submit no claims under Medicare Part B. The commenter contended that these hospitals do not have the capacity to bill for the full range of inpatient ancillary services under the OPPS.

Response: We believe that it is very important to restrict this exception to those hospitals that do not provide Medicare Part B services through an outpatient department. As stated in the April 7, 2000 final rule, in developing a hospital OPPS, we ''wanted to ensure that all services furnished in a hospital outpatient setting will be paid on a prospective basis.'' (65 FR 18442.) We believe that hospitals that have outpatient departments and that bill for some outpatient services under Part B should also be paid for the services in question under the OPPS. Therefore, those hospitals will not be excluded from billing under the OPPS. On the other hand, the exception will apply to those hospitals that do not bill under Medicare Part B, even if they have outpatient departments; that is, they do not treat Medicare beneficiaries in their outpatient departments.

Comment: Several commenters requested that CMS clarify whether the proposed provision in § 419.22(r) of the regulations would include therapy services (for example, physical therapy) so that the State psychiatric hospitals included in the exception could resume billing therapies at the per diem all-inclusive rate. The commenters pointed out that these services are currently included in the list of ancillary services under section 3110 of the Medicare Intermediary Manual and section 2255C of the Medicare Carrier Manual. In the proposed rule, CMS specified that the Part B-only services to which the proposed exception would apply were ancillary services listed in those manual sections, but did not specifically list the therapy services in the proposed rule. Some of these commenters raised the same question about diagnostic laboratory services, which CMS had also not specifically listed in the preamble text, but which are included in the list of ancillary services under section 3110

of the Medicare Intermediary Manual and section 2255C of the Medicare Carrier Manual.

Response: Section 1833(t)(1)(B)(iv) of the Act specifically excludes outpatient physical therapy, outpatient speech-language pathology, and outpatient occupational therapy from the definition of services payable under the OPPS. Therefore, we specifically did not include them in the list of Part-B only services to which the exception would apply in the proposed rule. These services are subject to fee schedules that were established prior to the OPPS.

We agree with the commenters that diagnostic laboratory services are included in the list of ancillary services that are excluded from the OPPS under this policy.

B. Categories of Hospitals Subject To and Excluded from the OPPS

Under § 419.20(b), certain hospitals in Maryland that qualify under section 1814(b)(3) of the Act for payment under the State's payment system are excluded from the OPPS. Critical access hospitals (CAHs), which are paid under a reasonable cost-based system as required under section 1834(g) of the Act, are also excluded. In addition, we stated in the April 7, 2000 final rule that the outpatient services provided by the hospitals of the Indian Health Services (IHS) will continue to be paid under separately established rates. We also noted that we intended to consult with the IHS and develop a plan to transition these hospitals into OPPS. With these exceptions, the OPPS applies to all other hospitals that participate in the Medicare program.

In the proposed rule, we noted that under the statute, hospitals located in Guam, Saipan, American Samoa, and the Virgin Islands are excluded from the hospital inpatient PPS. We proposed to revise § 419.20 of the regulations by adding paragraph (b)(3) to exclude these hospitals from OPPS consistent with their treatment under inpatient PPS. In addition, we proposed to revise paragraph (b)(4) of that section to include the hospitals of the IHS to clarify that they are excluded from OPPS until we develop a plan to include them. We noted that it might also be possible to include the hospitals in the territories in the OPPS in the future.

We received one comment on this proposal, as set forth below.

Comment: A commenter asked for clarification about the meaning of ''hospital of the Indian Health Service'' in the context of our proposal. The commenter requested that CMS define the term to include several classes of hospitals, not only those owned and operated by the IHS, but also those that are operated by Tribes and Tribal organizations, but owned or leased by the IHS.

Response: We agree with the commenter that clarification of the term ''hospital of the Indian Health Service'' is appropriate, and we are taking this opportunity to do so. Specifically, we will use here the definition at 42 CFR 413.65(l), where the term is defined to include facilities and organizations that, on or before April 7, 2000, furnished only services that were billed as if they were furnished by a hospital operated by the IHS or by a Tribe and that are: owned and operated by the Indian Health Service; owned by a Tribe or Tribal organization but leased from the Tribe or Tribal organization by the IHS under the Indian Self-Determination Act (Pub. L. 93–638) in accordance with applicable regulations and policies of the Indian Health Service in consultation with Tribes; or owned by the Indian Health Service but leased and operated by the Tribe or Tribal organization under the Indian Self-Determination Act (Pub. L. 93–638) in accordance with applicable regulations and policies of the Indian Health Service in consultation with Tribes.

C. Conforming Changes: Additional Payments on a Reasonable Cost Basis

Hospitals subject to the OPPS are paid for certain items and services that are outside the scope of the OPPS on a reasonable cost or other basis. Payments for the following services are made on a reasonable cost basis or otherwise applicable methodology:

a. The direct costs of medical education as described in § 413.86.

b. The costs of nursing and allied health programs as described in § 413.85.

c. The costs associated with interns and residents not in approved teaching programs as described in § 415.202.

d. The costs of teaching physicians attributable to Part B services for hospitals that elect cost-based payment for teaching physicians under § 415.160.

e. The costs of anesthesia services furnished to hospital outpatients by qualified nonphysician anesthetists (certified registered nurse anesthetists and anesthesiologists' assistants) employed by the hospital or obtained under arrangements, for hospitals that meet the requirements under § 412.113(c).

f. Bad debts for uncollectible deductible and coinsurance amounts as described in § 413.80(b).

g. Organ acquisition costs paid under Part B.

Interim payments for these services are made on a biweekly basis and final payments are determined at cost report settlement.

We proposed to revise § 419.2(c) to make conforming changes that reflect the exclusion of these costs from the OPPS rates.

We received one comment on this proposal, as follows.

Comment: The commenter supported the clarification, but requested a statement concerning how CMS will ensure that the appropriate interim biweekly payments for these services are made.

Response: We are working on appropriate operating instructions to our intermediaries with directions to ensure that the appropriate interim payments for these items and services are made.

D. Hospital Coding for Evaluation and Management Services

In the April 7, 2000 final rule, we emphasized the importance of each facility accurately assessing the intensity, resource use, and charges for evaluation and management (E/M) services, in order to ensure proper reporting of the service provided. In the proposed rule, we stated that we understand that facilities have developed several different systems for determining resource consumption to assign proper E/M codes. Some of these systems are based on clinical (''condition'') criteria, and others are based on weighted scoring criteria. We continue to believe that proper facility coding of E/M services is critical for assuring appropriate payments. In order to achieve this, we are interested in developing and implementing a standardized coding process for facility reporting of E/M services. This process could include the use of current HCPCS codes or the establishment of new HCPCS codes in conjunction with guidelines for facility coding.

In the proposed rule, we solicited comments from hospitals and other interested parties on this issue. We stated that we would submit these comments to the APC Advisory Panel and ask for the Panel's recommendations regarding the development and implementation of a facility coding process for E/M services. We will review both the public comments and the recommendations from the Panel and propose a coding process in the proposed rule for 2003.

E. Annual Drug Pricing Update

1. Payment for Drugs and Biologicals

Under the OPPS, we pay for drugs and biologicals in one of three ways.

a. Packaged Payment. As we explained in the April 7, 2000 final rule, we generally package the cost of drugs, biologicals, and pharmaceuticals into the APC payment rate for the primary procedure or treatment with which the drugs are usually furnished (65 FR 18450). No separate payment is made under the OPPS for drugs, biologicals, and pharmaceuticals whose costs are packaged into the APCs with which they are associated.

b. Transitional Pass-Through Payments for Eligible Drugs and Biologicals. As we also explained in the April 7, 2000 final rule and in section VII of this preamble, the BBRA 1999 provided for special transitional pass-through payments for a period of 2 to 3 years for the following drugs and biologicals:

- Current orphan drugs, as designated under section 526 of the Federal Food, Drug, and Cosmetic Act;
- Current drugs and biologic agents used for treatment of cancer;
- Current radiopharmaceutical drugs and biological products; and
- New drugs and biologic agents in instances where the item was not being paid for as a hospital outpatient service as of December 31, 1996, and where the cost of the item is ''not insignificant'' in relation to the hospital outpatient PPS payment amount.

In this context, ''current'' refers to those items for which hospital outpatient payment was being made on August 1, 2000, the date on which the OPPS was implemented. A ''new'' drug or biological is a product that was not paid as a hospital outpatient service before January 1, 1997 and for which the cost is not insignificant in relation to the payment for the APC to which it is assigned. In the proposed rule, we discussed in detail the statutory basis and payment methodology for transitional pass-through payments for drugs and biologicals. In addition, we included an illustration of the payment methodology.

Section 1833(t)(6)(D)(i) of the Act sets the payment rate for pass-through eligible drugs (assuming that no pro rata reduction in pass-through payment is necessary) as the amount determined under section 1842(o) of the Act, that is, 95 percent of the applicable average wholesale price (AWP). Section 1833(t)(6)(D)(i) of the Act also sets the amount of additional payment for pass-through-eligible drugs and biologicals (the pass-through payment amount). The pass-through payment amount is the difference between 95 percent of the applicable AWP and the portion of the otherwise applicable fee schedule amount (that is, the APC payment rate) that the Secretary determines is associated with the drug or biological. Therefore, as we explained in the April 7, 2000 final rule (65 FR 18481), in order to determine the correct pass-through payment amount, we first had to determine the cost that was packaged for the drug or biological within its related APC. In order to determine this amount, we used the following methodology, which we also explained in the April 7, 2000 final rule.

When we implemented the OPPS on August 1, 2000, costs for drugs and biologicals eligible for transitional pass-through payment were, to the extent possible, not included in the payment rates for the APC groups into which they had been packaged prior to enactment of the BBRA 1999. That is, to the extent feasible, we removed from the APC groups into which they were packaged, the costs of as many of the pass-through eligible drugs and biologicals as we could identify in the 1996 claims data. Then, we assigned each drug and biological eligible for a pass-through payment to its own, separate APC group, the total payment rate for which was set at 95 percent of the applicable AWP.

Next, in order to establish the applicable beneficiary copayment amount and pass-through payment amount, we had to determine the cost of the pass-through eligible drug or biological that would have been included in the payment rate for its associated APC had the drug or biological been packaged. We used hospital acquisition costs as a proxy for the amount that would have been packaged, based on data taken from an external survey of hospital drug costs. (See the April 7, 2000 final rule (65 FR 18481).) We imputed the acquisition cost for the various drugs and biologicals in pass-through APCs by multiplying their applicable AWP by one of the following ratios. The following ratios are based on the survey data, and they represent, on average, hospital drug acquisition cost relative to AWP:

- For drugs with one manufacturer (sole-source), the ratio of acquisition cost to AWP equals 0.68.
- For drugs with more than one manufacturer (multi-source), the ratio of acquisition cost to AWP equals 0.61.
- For drugs with more than one manufacturer and with generic competitors, the ratio of acquisition cost to AWP equals 0.43.

In accordance with section 1833(t)(7) of the Act, we base beneficiary copayment amounts for pass-through drugs only on that portion of the drug's cost that would have been included in the payment amount for an associated APC had the drug been packaged. Therefore, having determined the hospital acquisition cost of the drug based on the ratios described above, we multiply the acquisition cost by 20 percent to calculate the beneficiary copayment for the pass-through drug or biological APCs. Finally, to calculate the actual pass-through payment amount, we subtract the hospital acquisition cost from the applicable 95 percent of AWP. The Medicare program payment is the sum of the acquisition cost and the pass-through amount, less the beneficiary copayment amount.

To illustrate this payment methodology, consider a current sole source drug with an average wholesale price (AWP) of $100 per dose. Under section 1842(o) of the Act, the total allowed payment for the drug is $95, that is, 95 percent of AWP. We impute the cost of the drug based on survey data, which indicate hospital acquisition costs for this type of drug on average to be 68 percent of its AWP (or $68). In the absence of the pass-through provisions, this cost would be packaged into the APC payment for the procedure or service with which the drug or biological is furnished. Therefore, we define the beneficiary coinsurance as 20 percent of the imputed cost of $68, resulting in a copayment amount of $13.60. The pass-through payment amount is $27 (the difference between 95 percent of AWP ($95) and the portion of the APC payment that is based on the cost of the drug ($68)). The total Medicare program payment in this example equals $81.40 (cost of the drug in the APC ($68) less beneficiary copayment ($13.60), plus pass-through payment ($27)). In the proposed rule, we clarified that, for purposes of calculating transitional pass-through payment amounts, we make no distinction between new and current drugs and biologicals. Rather, we assume that drugs and biologicals defined as ''new'' under section 1833(t)(6)(A)(iv)(I) of the Act, that is, for which payment was not being made as of December 31, 1996, nonetheless replace or are alternatives to drugs, biologicals, or therapies whose costs would have been reflected in our 1996 claims data and, thus, have been packaged into an associated APC. Therefore, we assume that our imputed acquisition cost, based on the external survey data, represents that portion of the APC payment attributable to new as well as current drugs and biologicals. For that reason, we are discontinuing use of the payment status indicator ''J'' that we introduced in the November 13,

2000 final rule to designate a ''new'' drug/biological pass-through. Instead, we stated that we would assign payment status indicator ''G'' to both current and new drugs that are eligible for pass-through payment under the OPPS. (Addendum D of this final rule lists the definition of the OPPS payment status indicators.)

c. Separate APCs for Drugs Not Eligible for Transitional Pass-Through Payment. There are some drugs and biologicals for which we did not yet have adequate cost data that are not eligible for transitional pass-through payments. Beginning with the April 7, 2000 final rule, we created separate APCs for these drugs and biologicals to allow separate payment so as not to discourage their use where appropriate.

We based the payment rate for these APCs on median hospital acquisition costs. To determine the hospital acquisition cost for the drugs, we imputed a cost using the same ratios of drug acquisition cost to AWP used in connection with calculating acquisition costs for transitional pass-through drug payments. That is, we multiplied the AWP for the drug by the applicable ratio (sole, multi, or generic source) based on data collected in an external survey of hospital drug acquisition costs.

We set beneficiary copayment amounts for these drugs APCs at 20 percent of the imputed acquisition cost. We use status indicator ''K'' to denote the APCs for drugs, biologicals, and pharmaceuticals that are paid separately from and in addition to the procedure or treatment with which they are associated yet are not eligible for transitional pass-through payment. Refer to Addendum A of this final rule to identify these APCs.

2. Annual Drug Pricing Update

a. Drugs Eligible for Pass-Through Payments. We used the AWPs reported in the Drug Topics Red Book to determine the payment rates for the pass-through drugs and biologicals. In the proposed rule we referred to a discussion in the November 13, 2000 interim final rule. When we developed that interim final rule, it was our understanding that, although there are quarterly updates to the AWPs in the Red Book, the annual update is published in April of each year. It was our intention to update the AWPs for drugs each July 1, the quarter following the annual publication, and we did use the April 2001 version of the Red Book to update the APC rates for drugs eligible for pass-through payments. The pass-through payment rates for drugs and biologicals updated for 2001 went into effect July 1, 2001 (Program Memorandum A–01–73, issued on June 1, 2001).

We found that doing an update for all the pass-through drugs and biologicals at mid-year was disruptive to both our computer systems and pricing software. Thus, we proposed to update the APC rates for drugs that are eligible for pass-through payments in 2002 using the July 2001 or October 2001 version of Red Book. The updated rates effective January 1, 2002 would remain in effect until we implement the next annual update in 2003, when we would again update the AWPs based on the latest quarterly version of the Red Book. This would place the update of pass-through drug prices on the same calendar year schedule as the other annual OPPS updates.

b. Drugs in Separate APCs Not Eligible for Pass-Through Payments. We used the conversion factor published in the November 13, 2000 final rule (65 FR 67827) to update, effective January 1, 2001, the APC rates for the drugs that are not eligible for pass-through payments that are in separate APCs. We also made payment adjustments to these APC groups effective April 1, 2001, as required by section 401(c) of the BIPA, which sets forth a special payment rule that had the effect of providing a full market basket update in 2001.

For 2002, we proposed to recalibrate the weights for the APCs for drugs that are not pass-through items and make the other adjustments applicable to the APC groups that we discuss in sections III, IV, and VIII of this preamble.

We received several comments on our discussion of the payment for drugs under the OPPS. These comments are summarized below.

Comment: One commenter expressed concern that the ''three methodologies for drug payment reductions in the proposed rule'' may not take into account the most recent data. The commenter requested an estimate of the magnitude of the expected reduction, and the data used to develop the estimate.

Response: We did not propose three methodologies for drug payment reductions in the proposed rule. Rather we described, in greater detail than we have previously, the three methods by which drug costs are paid under the OPPS. In the final rule that we published on November 2, 2001 (66 FR 55857), we announced that we would be implementing a reduction in the payments made for one category of drugs, namely those drugs that qualify for transitional pass-through payments. As we described in that final rule, this reduction is applied on a uniform basis to all pass-through payments (including payments for devices) and is required to enforce a statutory limit on the size of those estimated payments relative to the estimate of all spending under the OPPS.

Comment: One commenter was confused by an apparent discrepancy between our description of how the pass-through payment amount for a drug is calculated and our example of how the amount is calculated. The description indicated that the beneficiary coinsurance is subtracted from the applicable 95 percent of AWP and imputed acquisition cost, but the example did not include this subtraction.

Response: We regret that the written description was not entirely clear. The example was accurate. The pass-through payment is the difference between 95 percent of AWP and imputed acquisition cost. The beneficiary coinsurance is 20 percent of the imputed acquisition cost. The Medicare program payment is the pass-through amount, plus the imputed acquisition cost, minus the beneficiary copayment. Total payment to the hospital is the pass-through amount, plus the imputed acquisition cost, plus the beneficiary copayment. In our example (see above), the AWP for the drug was $100, and 95 percent of AWP was thus $95. The imputed acquisition cost for the drug was 68 percent of AWP, or $68. Beneficiary coinsurance was 20 percent of $68, or $13.60. The Medicare program payment is $27 (the pass-through amount), plus $68 (the imputed acquisition cost), minus $13.60 (the beneficiary copayment), for a total of $81.40. Total payment to the hospital is $81.40 (the Medicare program payment) plus $13.60 (the beneficiary copayment), for a total of $95.

Comment: Several commenters objected that our drug pricing is based on annual updates using 6-month old data and on ratios of drug acquisition costs to AWP that derive from outdated and limited data. Some of these commenters objected to the use of the acquisition cost study to establish the ratios of drug acquisition costs to AWP. One commenter asked that CMS clarify why the new system is too complex to undertake quarterly updates of drug prices.

Response: We are placing the updates for the drugs that are eligible for pass-through payments on the same annual update schedule as the rest of the OPPS. We will always use the most recent available version of the Red Book in doing this update. Assuming that the October Red Book becomes available in time for use in the final rule establishing the annual OPPS updates, our drug

pricing may be based on data that are only 3 months old when it becomes effective. In any event, it is not unusual for updates to prospective payment systems to reflect data that are 6 months old or older. We have always considered the use of the study-derived ratios of drug costs to AWP to be an interim measure until we are able to obtain data on hospitals' actual costs for drugs from claims. We anticipate having this data available for use in setting payment rates for 2003. Revisions to our payment systems require a long lead-time, and thus it would be very difficult to implement more than one update in a year. We note that rate-based payment systems are commonly updated annually, and we see no compelling reason why the update of drug prices under the OPPS should be updated more frequently than the other payment rates under the system.

Comment: Several commenters requested more information about the methodology that CMS uses to compute payment rates for drugs, radiopharmaceuticals, and biologicals, particularly those that are not sole source.

Response: We employ the methodology provided in 42 CFR § 405.517(c) to determine the payment rates. Specifically, we compute the median price of each drug, radiopharmaceutical, or biological, using the median price of the generic versions or the lowest of the prices of the brand versions from the Red Book. (For drugs with both generic and brand manufacturers, we use the lower cost of the two.) For the denominator, we employ measures of dosage and concentration that are compatible with the HCPCS code descriptor. We also consider route of administration (for example, intravenous or perenteral) and dose. As an example, if drug A has a descriptor of 10 mg As the dose, we usually utilize the AWP for 5 mg and 10 mg doses, but not for 25 mg or 50 mg doses. This is because the latter two doses could not be administered to provide a 10 mg dose. If drug B has a descriptor for 25 mg injection and the drug is manufactured in 5 mg per ml, 25 mg per ml, and 50 mg per ml concentrations, we would utilize the AWP for the 25 and 50 mg per ml concentrations, but not the 5 mg per ml concentration. This is because we would not expect a beneficiary to receive a 5 ml injection, which would be necessary to utilize the lowest concentration dose to provide 25 mg of the drug at the 5 mg per ml concentration.

However, we lack precise information for many drugs in the Red Book concerning the size of vials/ampules and the numbers of vials/ampules per packaging. In these cases, we are unable to employ this methodology, and we simply use the list price. We are continuously seeking further information on these drugs, and we will revise the pricing as we obtain additional information.

Comment: Several commenters called our attention to instances in which the Medicare payment is higher than the cost for certain drugs, especially radiopharmaceuticals.

Response: We thank the commenters for bringing these cases to our attention. We have experienced some difficulty in determining appropriate payment rates for radiopharmaceuticals due to several factors. First, the Red Book lacks information concerning the dosage per vial after the elements are compounded to create the radioactive substance, the numbers of doses that can be obtained per vial, and the cost per vial when more than one dose may be given from the vial. Nuclear medicine experts have informed us that multiple doses for multiple patients can often be obtained with one vial and that we have often unnecessarily assumed the cost for the entire vial. At the same time, there are circumstances in which an entire vial is appropriately charged for one patient. We have made the appropriate modifications for those agents that have been identified to us. We welcome any additional information that would help us to ensure that payment rates reflect as accurately as possible the cost and usage of these agents.

Comment: One commenter requested that CMS clarify whether repackaged products are included in its calculations.

Response: There is no separate calculation for any repackaging process. We use only AWPs to calculate drugs and biological prices.

Comment: One commenter asked us to clarify how we pay for the pharmacy overhead costs associated with administering drugs. The commenter expressed concern that the data in the survey of drug costs did not capture these costs.

Response: For the drugs paid for under the OPPS, hospitals can bill both for the drug and for the administration of the drug. The overhead cost is captured in the administration codes, along with the costs of all drugs that are not paid for separately. Each time a drug is billed with an administration code, the total payment thus includes the acquisition cost for the billed drug, the packaged cost of all other drugs, and the overhead costs.

F. Definition of Single-Use Devices

Our definition of a device eligible for pass-through payment includes a criterion whereby eligible devices are used for one patient only and are single use (65 FR 47674, August 3, 2000). In the November 13, 2000 interim final rule, we stated, in response to a comment, that additional pass-through payments would not be made for devices that are reprocessed or reused because they are not single-use items. We further indicated that hospitals submitting pass-through claims for these devices might be considered to be engaging in fraudulent billing practices (65 FR 67822).

In the proposed rule, we discussed issues that have come to our attention regarding reprocessed single-use devices. We noted that the FDA published guidance for the reprocessing of single-use devices (FDA's ''Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals,'' issued August 14, 2000). This document presents a phased-in regulatory scheme for reprocessed devices. We proposed to follow FDA's guidance on reprocessed single-use devices. We stated that we would consider reprocessed single-use devices that are otherwise eligible for pass-through payment as part of a category of devices to be eligible for that payment if they meet FDA's most recent regulatory criteria on single-use devices. Also, reprocessed devices must meet any FDA guidance or other regulatory requirements in the future regarding single use. We proposed to consider reprocessed devices adhering to these guidelines as having met our criterion of approval or clearance by the FDA. We have met with and will continue to meet and coordinate with the FDA concerning that Federal agency's definition and regulation of single-use devices. We also stated our expectation that hospital charges on claims submitted for pass-through payments for reprocessed single-use devices would reflect the lower cost of these devices.

We received several comments on this proposal, which are summarized below.

Comment: One commenter expressed agreement with our decision to allow hospitals to submit claims for pass-through payment for reprocessed devices, as long as the device is reprocessed in accordance with FDA policy on reprocessing.

Response: We appreciate the comment. It is important to emphasize that, in order to qualify for pass-through payment, a reprocessed device must clearly fit into one of the currently open device categories established for pass-

through payment. We also expect that the charges for the reprocessed device will accurately reflect any lower cost of reprocessed devices.

Comment: One commenter recommended that CMS not expect hospitals to charge less for reprocessed devices, claiming that paying hospitals less for reprocessed devices would perpetuate an incentive to use new devices instead of reprocessed devices.

Response: We disagree. Hospitals would not necessarily have a greater incentive to use new devices if their charges for reprocessed devices are in accordance with their costs. If the charges reflect the lower costs of the reprocessed devices to the hospital, the margins for reprocessed versus new devices should remain relatively constant. This would not create an incentive for hospitals to use either new or reprocessed devices. On the other hand, if hospitals to charge the same amount for reprocessed and original devices, this would inflate the margins of pass-through payment for reprocessed devices and create an incentive to use reprocessed over new devices.

Comment: Several commenters asked that CMS clarify how we will implement and enforce our pass-through payment policy for reprocessed single-use devices. A device manufacturer pointed out that Pre-Market Approval and 510k submissions for approval of reprocessed single-use devices are still pending with the FDA, awaiting final decisions. These commenters also asked how CMS would prohibit noncompliant single-use devices from receiving Medicare payment.

Response: As we indicated in the proposed rule, we will follow the most recent FDA guidance or regulatory criteria on the issue of reprocessed single-use devices. When the FDA requires reprocessors, including hospitals, to have FDA approval or clearance regarding safety and effectiveness, prior to use in a health setting. Hospitals must adhere to these requirements, and will not be entitled to receive a pass-though payment if they do not comply. We will employ our standard procedures for claims reviews to enforce these requirements.

Comment: One commenter recommended that CMS develop and implement a tracking mechanism to differentiate and collect data on reprocessed versus original device costs and use. This commenter also recommended either creating a modifier or establishing pairs of categories for original and reprocessed devices.

Response: Reprocessed devices will be subsumed under the same categories as the original devices, and the average cost for the category will accurately reflect the cost of reprocessed and new devices. We do not believe that it is practical or advisable to create special modifiers or categories for items that will be receiving pass-though payments for only a limited period of time.

Comment: One commenter recommended that CMS provide hospitals with guidance on how to adjust their charges for reprocessed devices eligible for pass-through payment, taking into account the costs of reprocessing and amortization of the initial cost of the device.

Response: We expect those hospitals' charges for reprocessed single-use devices will reflect their costs, just as in the case of the first-use devices. The device's full cost to the hospital is reflected in the payment the first time it is used for a Medicare patient. The cost of the reprocessed device to the hospital will already include the cost of reprocessing. No amortization of the initial cost of the device will apply for single use devices, since they are intended for one time use only.

G. Criteria for New Technology APCs

1. Background

In the April 7, 2000 final rule (68 FR 18477), we created a set of new technology APCs to pay for certain new technology services under the OPPS. New technology APCs are intended to pay for new technology services that are not addressed by the transitional pass-through provisions of the BBRA 1999 and BIPA 2000. New technology APCs are defined on the basis of costs and not the clinical characteristics of a service. The payment rate for each new technology APC is based on the midpoint of a range of costs.

The new technology APCs that were implemented on August 1, 2000 were populated with 11 new technology services. We stated in the April 7, 2000 rule that we will pay for an item or service under a new technology APC for at least 2 years but no more than 3 years, consistent with the term of transitional pass-through payments. After that period of time, during the annual APC update cycle, we stated that we will move the item or service into the existing APC structure based on its clinical attributes and, based on claims data, its resource costs. For a new technology APC, the beneficiary coinsurance is 20 percent of the APC payment rate.

In the April 7, 2000 rule, we specified an application process and the information that must be supplied for us to consider a request for payment under the new technology APCs (65 FR 18478). We also described the five criteria we would use to determine whether a service is eligible for assignment to a new technology APC group. These criteria, which we are currently using, are as follows:

- The item or service is one that could not have been billed to the Medicare program in 1996 or, if it was available in 1996, the costs of the service could not have been adequately represented in 1996 data.
- The item or service does not qualify for an additional payment under the transitional pass-through payments provided for by section 1833(t)(6) of the Act as a current orphan drug, as a current cancer therapy drug or biological or brachytherapy, as a current radiopharmaceutical drug or biological product, or as a new medical device, drug, or biological.
- The item or service has a HCPCS code.
- The item or service falls within the scope of Medicare benefits under section 1832(a) of the Act.
- The item or service is determined to be reasonable and necessary in accordance with section 1862(a)(1)(A) of the Act.

2. Modifications to the Criteria and Process for Assigning Services to New Technology APCs

Based on the experience we have gained and data we have collected since publication of the April 7, 2000 final rule, we proposed in the August 24 proposed rule to revise—(1) the definition of what is appropriately paid for under the new technology APCs; (2) the criteria for determining whether a service may be paid under the new technology APCs; (3) the information that we will require to determine eligibility for assignment to a new technology APC; and 4) the length of time we will pay for a service in a new technology APC.

We invited comment on the changes to the definition, criteria, application process, and timeframe that we proposed for services and procedures that may qualify for assignment to a new technology APC under the OPPS. We received numerous comments on the proposed changes, primarily from drug and device manufacturers and their trade associations, but also from medical specialty societies and hospital associations. Although several commenters supported the changes that we proposed, most commenters expressed concern that the new requirements might make it extremely difficult or virtually impossible for any new technology to qualify for

assignment to a new technology APC. Many commenters urged us to maintain flexibility in approving services and products for new technology APCs rather than adhering to rigid criteria. The comments are summarized below.

a. Services Paid Under New Technology APCs. We proposed to limit eligibility for placement in new technology APCs to complete services or procedures. That is, items, materials, supplies, apparatuses, instruments, implements, or equipment that are used to accomplish a more comprehensive service or procedure would not be eligible for placement in a new technology APC. Devices or any drug, biologic, radiopharmaceutical, product, or commodity for which payment could be made under the transitional pass-through provisions would continue to be excluded from assignment to a new technology APC. We proposed to limit new technology APCs to comprehensive services or procedures that are truly new. In addition, we clarified that we do not consider a different approach to an existing treatment or procedure to qualify a service for assignment to a new technology APC.

A few commenters supported our proposal to limit eligibility to complete services and procedures, and to exclude changes to an existing service or procedure from new technology APCs. They cited this approach as a means of better controlling and managing payment and improving the predictability of cost estimates for new services or procedures under the OPPS. However, most commenters were opposed to these proposals. (In our responses to comments in this section VI.G., we use ''HCPCS code'' to mean a Level II HCPCS/National Code and ''CPT code'' to mean a Level I HCPCS code.)

Comment: One commenter was concerned that the new criteria for identifying devices that will be eligible for assignment to a new technology APC will make it more difficult for new devices to qualify.

Response: The commenter is correct. The changes that we proposed are intended to clarify, sharpen, and refine the scope of what we assign and pay for under a new technology APC. We want to clarify that new technology APCs are *not* meant to be the payment vehicle for items that can be paid under a transitional pass-through device category. Nor are new technology APCs meant to be a means of paying for drugs, biologicals, or radiopharmaceutical drugs that are otherwise eligible for transitional pass-through payments. The cost of a device that is not eligible for transitional pass-through payment and that is not associated with a comprehensive service or treatment eligible for assignment to a new technology APC will become incorporated into the weight of the APC or APCs associated with its use as hospitals begin to use it. The same is true for other items, supplies, and equipment that are furnished incident to a service or procedure and are used as a tool or serve as an aid in performing a variety of procedures.

Comment: A number of commenters were opposed to limiting new technology APCs to services and procedures that are ''truly new'' because what constitutes ''truly new'' is vague and difficult to define and does not reflect the significant advances in medical technology that are incremental and build on existing technology or procedures. One commenter argued that transformational technology often changes significantly the *way* that a procedure is done, for example, changing a traditionally human resource (for example, labor) or time intensive procedure to one that is technology intensive. Commenters were concerned that the requirement that a new technology be ''truly new'' could result in lack of adequate payment for important new therapies and severely limit patient access to such therapies. For example, a new interventional radiology or other minimally invasive procedure such as the recent advances in endovascular techniques and device technology that replace traditional open surgery could be viewed as a ''different approach to an existing treatment'' and therefore not qualify for assignment to a new technology APC. One commenter concluded that this requirement would limit new technology APCs to inpatient procedures that move to an outpatient setting or procedures that are fundamentally different enough to qualify for a new CPT code. Many commenters recommended that innovation that improves current procedures be recognized and paid for in addition to ''truly new'' services. Several commenters stated that we should publish the definition of ''truly new'' in the **Federal Register** for public comment before implementing this criterion.

Response: In fact, we do want to limit new technology APCs to those services that would be eligible for a new HCPCS code. For example, there are existing codes for wound repair which hospitals have been using to bill for Medicare services for many years. The use of a new, expensive instrument for tissue debridement or a new, expensive wound dressing does not in and of itself warrant creation of a new HCPCS code to describe the instrument or dressing; rather, the existing wound repair code appropriately describes the service that is being furnished, that is, the service is a wound repair, regardless of whether or not a new instrument or a new wound dressing is involved. We would consider it inappropriate to pay for the wound repair performed with the new, expensive dressing or instrument under a new technology APC because an APC group that includes the wound repair procedure already exists. (However, we note that the dressing or instrument could qualify for transitional pass-through payments.) Similarly, the invention of a new endoscope or new suturing material would not qualify for a new technology APC unless the procedure in which it is used cannot be appropriately billed under an existing code.

By contrast, new services such as cryosurgery of the prostate, coronary artery brachytherapy, and 3-D electrophysiologic mapping of the heart are not adequately described with current codes, and they do not fit appropriately within an existing APC group. The new technology APCs are intended to address appropriate payment for these latter types of services, which cannot be accurately described by existing codes and are not similar either clinically or in terms of resource use with an existing APC group.

We want to ensure appropriate allocation of Medicare expenditures and access for our beneficiaries to breakthrough technologies. The appropriate method of reflecting changes in the costs of supplies and equipment used to provide existing services is to incorporate those changes into the payment for such services during the yearly reclassification and recalibration of the APCs. We believe it is appropriate for those new technologies that can be appropriately reported by existing codes and do not qualify for transitional pass-through payments to be grouped with older technologies, and have their costs gradually incorporated into APCs when APC weights are adjusted.

In summary, the most important criterion that will determine whether a technology is ''truly new'' and appropriate for a new technology APC is the inability to appropriately, and without redundancy, describe the new, complete (or comprehensive) service with any combination of existing HCPCS and CPT codes. We acknowledge the need to critically evaluate, on an ongoing basis, our criteria for new technology APCs. We remind interested parties that eligibility

of a procedure for a temporary HCPCS code and assignment to a new technology APC does not guarantee that a permanent code will ultimately be approved for the service or procedure. Conversely, the fact that a new CPT or HCPCS code has been assigned to a service or procedure does not automatically qualify it for placement in a new technology APC unless it meets the criteria we have established for this purpose.

Comment: A few commenters indicated that we need to better define ''complete services or procedures'' and ''a more comprehensive service'' with a clearer explanation of the underlying intent and examples to clarify when assignment to a new technology APC would be appropriate and when it would not. A couple of commenters stated that our proposal to permit only ''complete'' or ''comprehensive'' services or procedures to qualify for assignment to a new technology APC is contrary to the underlying concepts of the OPPS. These commenters argued that hospital outpatient departments, in order to provide a ''complete'' or ''comprehensive'' service, are allowed and expected to bill the appropriate set of CPT and HCPCS codes that combine to describe a particular service, often resulting in claims with multiple codes matched to multiple APCs. The same commenters asserted that a new technology or procedure will likely consist of multiple codes and multiple APCs and that this can be most effectively evaluated as part of the data collection during the period that the technology or procedure is assigned to a new technology APC. One commenter stated that medical technologies, even when considered transformational, are not usually ''complete services and procedures.''

Response: These comments focus on our concept of the type of services appropriate for assignment to new technology APCs under the OPPS. A service that qualifies for a new technology APC may be a complete, stand-alone service (for example, water-induced thermotherapy of the prostate or cryosurgery of the prostate) or it may be a service that would always be billed in combination with other services (for example, coronary artery brachytherapy). In the latter case, the new technology procedure, even though billed in combination with other, previously existing procedures, describes a distinct procedure with a beginning, middle, and end. Drugs, supplies, devices, and equipment in and of themselves are not a distinct procedure with a beginning, middle, and end. Rather, drugs, supplies, devices, and equipment are used in the performance of a procedure. Therefore, taken individually and apart from the procedure or service with which they are used, these items will not be eligible for new technology APCs. (As noted above, these items may qualify for transitional pass-through payments.) Furthermore, unbundled components that are integral to a service or procedure (for example, preparing a patient for surgery or preparation and application of a wound dressing for wound care) are not eligible for consideration for a new technology APC.

We understand that hospitals frequently bill multiple codes to describe multiple services furnished to a given patient. Therefore, we are not making eligibility for new technology APCs contingent on whether hospitals would bill other HCPCS codes in conjunction with a proposed new technology procedure. However, we reiterate that the inability to describe appropriately, and without redundancy, a complete (or comprehensive) service with any combination of current CPT or HCPCS codes is crucial to determining eligibility for a new technology APC. It is possible that a procedure for which assignment to a new technology APC is sought can only be described by several current codes and the applicant believes it is important to establish a single HCPCS code to describe the procedure in a more comprehensive manner (for example, stereotactic radiosurgery or intensity modulated radiotherapy). We agree with this and will consider creating such new HCPCS codes if reporting a combination of current codes does not adequately describe the service or does not properly account for the resources used to deliver the comprehensive service.

In short, we consider that a ''truly new'' service is one that cannot be appropriately described by existing HCPCS codes and that a new HCPCS code needs to be established in order to describe the new procedure.

Claims for services assigned to new technology APCs should include, in addition to other HCPCS codes billed, the appropriate revenue codes and charges for the resources required to deliver the service. We evaluate these data to identify the complete package of resources required to perform the new technology service, the cost of this package of services, and, subsequently, the extent to which the new technology service is, or is not, consistent with services in an existing APC. If, over time, our claims data indicate that the package of resources and the clinical components of the new technology are unique and bear no similarity to services in any existing APC, we may create a separate APC for the new technology service when it is reassigned from a new technology APC. Examples of services that are currently in new technology APCs due to lack of data include water-induced thermotherapy, coronary artery thrombectomy, and coronary artery brachytherapy.

Comment: Several commenters stated that we should eliminate the proposed criteria for defining services eligible for new technology APCs and suggested, instead, that we be flexible and work closely with manufacturers, providers, the APC Panel, and other experts ''to consider circumstances unique to the individual technology'' when determining whether a new technology APC is appropriate.

Response: We will continue to work with manufacturers and their representative associations, with hospitals, with the APC Panel, with other experts, and with applicants as we evaluate requests for new technology APC assignments and determine which are appropriate for new technology APCs. The review of an application for new technology APC assignment by our medical officers and clinical experts is a dynamic, interactive process that involves ongoing consultation with the applicant, with hospitals and physicians who are furnishing the service or who participated in clinical trials, with the manufacturers of the new technology, and with other agencies such as the FDA that may have pertinent information. We believe that the criteria that we proposed serve to inform, guide, and expedite the review process and help to guard against inappropriate assignment of services to a new technology APC simply on the basis of those services being characterized as ''new.''

Comment: One commenter recommended that an applicant be the one to determine whether to seek pass-through payment for a drug used as part of the service or new technology APC status for the entire service, including the drug.

Response: We agree. Application for pass-through payment or new technology APC status is voluntary and the determination of which application(s) to submit is left solely to the interested party. However, as part of the review process, we would expect to work with the applicant to arrive at the most appropriate classification for the service under consideration.

Comment: Several commenters recommended that we further clarify the proposed criteria to ensure that all new technologies and services that do not

qualify for pass-through status and that would not be adequately paid under existing APCs can be assigned to new technology APCs. These commenters also recommended that, when a pass-through category expires, we consider reclassifying medical devices in the expired category into a new technology APC to give beneficiaries seamless access to expensive new medical technology.

Response: As we discussed above, devices eligible for pass-through payments fall outside the scope of services appropriate for new technology APCs. As data associated with pass-through items are collected and incorporated into the APCs with which they are associated, they will be reflected in the weight of the APC. The services assigned to the new technology APCs are those for which we do not have adequate data to make an appropriate APC assignment. Thus, it would not be appropriate to assign a pass-through device for which we have collected data to a new technology APC.

b. Criteria for Assignment to New Technology APC. In the proposed rule, we proposed that the following criteria be used to determine whether a service be assigned to a new technology APC. These proposals represent modifications to criteria that are based on changes in data (we are no longer using 1996 data to set payment rates) and our continuing experience with the system of assigning new technology APCs.

- The service is one that could not have been adequately represented in the claims data being used for the most current annual payment update. (Current criterion based on 1996 data.)
- The service does not qualify for an additional payment under the transitional pass-through provisions. (This criterion is unchanged.)
- The service cannot reasonably be placed in an existing APC group that is appropriate in terms of clinical characteristics and resource costs. We believe it is unnecessary to assign a new service to a new technology APC if it may be appropriately placed in a current APC. (This criterion for assignment to a new technology APC is implied but not explicitly stated in the April 7, 2000 final rule.)
- The service falls within the scope of Medicare benefits under section 1832(a) of the Act. (This criterion is unchanged.)
- The service is determined to be reasonable and necessary in accordance with section 1862(a)(1)(A) of the Act. (This criterion is unchanged.)

We further proposed to delete the criterion that the service must have a HCPCS code in order to be assigned to a new technology APC. We wish to clarify that our proposal to delete the criterion that a service must have a HCPCS code refers to the discussion in the April 7, 2000 final rule which implied that assignment of a HCPCS code through the annual HCPCS cycle is required. On the contrary, as we state throughout this section, in order to be considered for a new technology APC, a truly new service cannot be adequately described by existing codes. Therefore, in the absence of an appropriate HCPCS code, we would consider creating a HCPCS code that describes the new technology service. These HCPCS codes would be solely for hospitals to use when billing under the OPPS.

Most commenters supported the proposal not to require a HCPCS code for products or services in order to be considered for assignment to a new technology APC. The few commenters that addressed the proposed criterion that would define a new technology APC service as one that could not have been adequately represented in the claims data being used for the most current annual payment update (rather than on 1996 claims data) concurred with the proposed change; no one opposed the change. The remaining comments on these proposed criteria are summarized below.

Comment: One commenter wanted to confirm our intention to assign a new service or procedure to an existing APC only in those instances where a clinically similar APC exists and the associated APC payment rate meets or exceeds the cost of furnishing the new technology service as itemized in the application for a new technology APC.

Response: Our experience to date in evaluating requests for new technology APC classification prompted us to propose changes regarding the information that would be required in an application. One of the principal reasons that we proposed to require submission of a clinical vignette, including a detailed description of the resources used to furnish the service, was to enable us to determine whether a clinically similar APC exists and whether the APC payment rate adequately addresses the costs associated with the nominated new technology service. However, we will not limit our determination of the cost of the procedure to information submitted by the applicant. Our staff will obtain information on cost from other appropriate sources before making a determination of the cost of the procedure to hospitals.

Comment: A number of commenters strongly opposed the criterion excluding any service involving a new drug or biological that qualifies for transitional pass-through payment from possible eligibility as a new technology APC. Commenters stated that continuing to exclude drugs or biologicals eligible for pass-through payments from being eligible for a new technology APC seems to suggest that an entirely new service that includes a new drug would only be eligible for pass-through payments for the drug, rather than the entire service being eligible for payment under a new technology APC. Under this criterion, novel treatments such as those in the growing field of radioimmunotherapy that involve both a new drug and new procedures for both calculating appropriate dosages and administering treatment would not be paid as a new technology APC. Instead, the hospital would be paid for the cost of the drug through the applicable pass-through payment, which may result in underpaying hospitals for the total package of items and services associated with the treatment.

Commenters requested that we clarify that a brand new service in which a pass-through drug or device is used could be eligible for either a pass-through payment for the drug or device or for a new technology APC for the entire service and that we permit a new technology that includes the provision of a new drug or biological to be eligible for payments under a new technology APC. A few commenters recommended that we eliminate this requirement altogether and allow new medical device technology to be included in new tech APCs.

Response: In the April 7, 2000 final rule we adopted a criterion that provided that an item or service that qualifies as a transitional pass-through item would not be considered for assignment to a new technology APC. We proposed to retain that criterion without modification. We have *never* intended new technology APCs to be a substitute payment vehicle for individual items that qualify for payment under a transitional pass-through device category. Nor are new technology APCs meant to be the means of payment for drugs, biologicals, or radiopharmaceutical drugs that are otherwise eligible for transitional pass-through payments. From the outset of the OPPS, our policy regarding payment for devices, drugs, and biologicals that do not qualify for transitional pass-through payment has been to package payment with the items' associated APCs, with the exception of a few drugs for which we had insufficient data.

Many commenters expressed concern and disagreement with this criterion. We believe the commenters misunderstood our explanation of this

criterion. Therefore, we reiterate that we have never intended to disqualify from assignment to a new technology APC a truly new, comprehensive service, procedure, or therapy that involves the use of a drug or device which, on its own, might also qualify for a transitional pass-through payment. That is, a truly new, comprehensive service could qualify for assignment to a new technology APC even if it involves a device or drug that could, on its own, qualify for a pass-through payment.

Take, for example, a case in which a drug that qualifies for a pass-through payment is integral to a service that may be considered a new, comprehensive procedure or service appropriate for a new technology APC. In this case, an interested party has several options. The first option is to simply submit a request for the drug pass-through payment. Under this option, the therapy or procedure or service associated with administration of the drug would be paid through an existing APC that most closely approximates the service clinically and in terms of resources. (In this option, if the new service associated with the drug can be appropriately described by one or more existing HCPCS codes, it is possible that the new service might not qualify for a new technology APC.) A second option would be for the interested party to apply for a pass-through payment for the drug and submit a separate application for assignment of the therapy or procedure associated with administration of the drug to a new technology APC. A third option is to submit an application to have the *entire* service, *including* the potential pass-through drug, which is an integral part of the service, assigned to a new technology APC. In that case, the cost of the drug would be taken into account and packaged with the other costs associated with the service so that the drug cost is reflected and accounted for within the new technology APC payment rate for the service. We believe the third option represents a simple, unburdensome approach that would ensure timely and appropriate payment in a new technology APC for a new service that includes administration of a new drug or biological and that meets the other criteria for a new technology APC. For both options two and three, we would first consider whether assigning a new HCPCS code is appropriate and, if it is, we would then determine whether the new code should be assigned to an existing APC. If not, we would assign it to a new technology APC.

c. Revision of Application for New Technology Status. In the August 24 proposed rule we proposed to change the information that interested parties must submit to have a service or procedure considered for assignment to a new technology APC. Specifically, to be considered, we proposed to require that requests include the following information:

- The name by which the service is most commonly known. We currently require only the trade/brand name.
- A clinical vignette, including patient diagnoses that the service is intended to treat, the typical patient, and a description of what resources are used to furnish the service by both the facility and the physician. For example, for a surgical procedure this would include staff, operating room, and recovery room services as well as equipment, supplies, and devices, etc. This criterion would replace the criterion that requires a detailed description of the clinical application of the service.
- A list of any drugs or devices used as part of the service that require approval from the Food and Drug Administration (FDA) and information to document receipt of FDA approval/clearances and the date obtained.
- A description of where the service is currently being performed (by location) and the approximate number of patients receiving the service in each location.
- An estimate of the number of physicians who are furnishing the service nationally and the specialties they represent.
- Information about the clinical use and efficacy of the service such as peer-reviewed articles.
- The CPT or HCPCS Level II code(s) that are currently being used to report the service and an explanation of why use of these HCPCS codes is inadequate to report the service under the OPPS.
- A list of the CPT or HCPCS Level II codes for all items and procedures that are an integral part of the service. This list should include codes for all procedures and services that, if coded in addition to the code for the service under consideration for new technology status, would represent unbundling.
- A list of all CPT and HCPCS Level II codes that would typically be reported in addition to the service.
- A proposal for a new HCPCS code, including a descriptor and rationale for why the descriptor is appropriate. The proposal should include the reason why the service does not have a CPT or HCPCS Level II code, and why the CPT or HCPCS Level II code or codes currently used to describe the service are inadequate.
- An itemized list of the costs incurred by a hospital to furnish the new technology service, including labor, equipment, supplies, overhead, etc. (This criterion is unchanged.)
- The name, address, and telephone number of the party making the request. (This criterion is unchanged.)
- Other information as CMS may require to evaluate specific requests. (This criterion is unchanged.)

One commenter stated that, on the whole, the proposed changes to the information that interested parties must submit to have a service or procedures considered for assignment to a new technology APC seem reasonable and designed to minimize the need for time-consuming requests for supplemental information from applicants. Other comments on the proposed changes are summarized below.

Comment: A few commenters stated that the significant amount of additional data required to file an application is unnecessarily burdensome, and, in some cases, may not be available when new products are launched. In particular, one commenter was concerned that the information needed to provide a clinical vignette (patient diagnoses that the service is intended to treat, the typical patient, a description of resources used to furnish the service such as staff, equipment, supplies, and similar facility and professional resources) may not always be available when a new product is launched. The commenter was also concerned that upcoming implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will make providers reluctant to furnish necessary data to manufacturers. The need for consent releases and storage retention required by the HIPAA regulations are added administrative costs that will have to be incurred. Instead, the commenter recommended that we request a detailed description of the service which, if possible, includes the resources used during the procedure.

Response: Our experience with new technology applications has revealed the critical need for the information on clinical factors and resource utilization that is described as part of a ''clinical vignette.'' Without this information, it is difficult to understand what the nominated service involves in both clinical and resource terms. We need the fullest possible description of every aspect of the service to help us understand how it is being furnished in hospitals and the costs associated with the service. This information is indispensable in assessing the appropriate payment rate for the

nominated service. We believe that those seeking to apply for new technology APC status for a service will have sufficient expertise and experience with the service to enable them to furnish the full and detailed description of the service that is required as part of the clinical vignette. Based on our experience to date in reviewing applications for new technology APCs, there is strong evidence that close cooperative working relationships exist among manufacturers, hospitals, and clinicians who seek to have a service assigned to a new technology APC. When we have had to ask for additional information of the type we proposed to require for future applications, this information has been readily available and promptly supplied.

Comment: One commenter stated that the requirement for ''a description of where the service is currently being performed (by location) and the approximate number of patients receiving the service in each location'' appears excessive if all that is sought through this requirement is the identification of medical contacts. A commenter expressed concern that having to identify all facilities or physicians performing the procedure would in many cases appear to be administratively excessive and a potential breach of confidentiality. A commenter recommended that, if medical contacts are desired, the requirement should be for the names, contact information and approximate number of patients treated for a ''representative'' sample of facilities and/or physicians performing the procedure or service who are willing to serve as such contacts.

Response: While this requirement would furnish us with medical contacts, it also provides us with other significant information. For example, knowing the locations where the service is being performed and the approximate number of patients receiving the service provides insight into the extent to which the service is being performed (rarely, occasionally, or frequently); the types of hospitals where it is being performed (small rural or suburban hospitals, large urban teaching hospitals); and a geographic profile of where the service is currently available. We believe it is crucial to our evaluation of nominated procedures that we have a detailed understanding of, among other things, the indications and contraindications for the procedure, the current utilization of the procedure, the patient populations for which the procedure is performed, the types of hospitals where it is performed, the sites (for example, inpatient hospital, physician office) and locations (for example, teaching hospitals, community hospitals) where the procedure is performed. Without such information, we cannot make an appropriate determination as to whether the procedure is ''truly new''. This information, along with information about the specialties of physicians performing the service, assists our medical advisors and clinicians in their evaluation of whether or not the service should be assigned to a new technology APC.

Comment: One commenter wanted assurance that ''information about the clinical use and efficacy of the service such as peer-reviewed articles' would be referred to the Office of Clinical Standards and Quality if the intent of this new requirement were to determine whether the new technology should be ''covered.''

Response: The purpose of this requirement is to help us better understand the clinical dimensions of the service. Neither assignment of one or more new HCPCS code(s) to a procedure or assignment of a procedure to a new technology APC assures that Medicare will cover the procedure. In order for a procedure to be covered by Medicare, it must be determined, either locally, or nationally, that the procedure is medically reasonable and necessary. Information about how to obtain a national coverage decision is posted on the CMS website at http://www.hcfa.gov/coverage. To receive Medicare payment, services must be considered reasonable and necessary and each use of a service is subject to medical review for determination of whether its use was reasonable and necessary.

d. Length of Time in a New Technology APC. We proposed to change the period of time during which a service may be paid under a new technology APC. We noted that although section 1833(t)(6)(B) of the Act, as amended by section 201 of BBRA 1999, sets a 2 to 3 year period of payment for transitional pass-through payments, this requirement does not extend to new technology APCs. We proposed to modify the time frame that we established for new technology APCs in the April 7, 2000 final rule and 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 would allow us to move a service from a new technology APC in less than 2 years if sufficient data were available and would also allow us to retain a service in a new technology APC for more than 3 years if sufficient data upon which to base a decision had not been collected.

Comment: One commenter supported eliminating the 2 to 3 year assignment to a new tech APC, which would give CMS greater flexibility to base future payment on adequate pricing data that could take less than 2 or more than 3 years to collect.

Several commenters stated that we should clarify at the time of the assignment to the new technology APC how the decision will be made to move it into a permanent APC. Specifically, these commenters indicated that we should publish the methodology used to reassign services from new technology APCs into existing APC categories, including how we will evaluate clinical and cost data to determine whether or not a service in a new technology APC should be reassigned to an existing APC.

Most commenters supported keeping a procedure in a new technology APC for a minimum of 2 years of data collection to ensure that an adequate claims database is available to make appropriate decisions about ultimate APC assignment, structuring, packaging, and payment. These commenters noted that limited procedure volume and coding confusion immediately following market release of a new technology could limit the amount of useful data that would be available in the first year.

Response: We agree with commenters that adequate claims data is more important than completion of a fixed time span for determining when to reassign a new technology APC service. We expect that, practically speaking, we will need a full year of available claims data. We use the same methodology to reassign services from a new technology APC to an existing APC group, or to a new APC group if that is indicated, that we use in our annual review of all APC weights and assignments. That is, we review claims-based charge and utilization data and the most recent available cost report data. This process may include consulting the APC Advisory Panel for its recommendations regarding appropriate APC assignments.

Comment: Several commenters urged us not to reassign new medical procedures from one new technology APC to another during the yearly updates to the APC system absent current and complete data. These commenters asserted that during the period when a new procedure is assigned to a new technology APC, there may be reasons why claims data used for the annual updates to the APC system are not representative of actual hospital experience in providing the service. Therefore, we should recognize that the reasons that support a multi-

year assignment to a new technology APC, that is, the need to gather data, also argue for caution in moving services from one new technology APC (and payment rate) to another.

Response: In general, we agree that once a device has been assigned to a new technology APC, it will remain there until we have collected the data necessary to move it to a clinically appropriate APC. However, we have on occasion, made an assignment to a new technology APC based on information that later was found to have been inaccurate. In those cases, we believe that it is appropriate to move the service to the new technology APC that better reflects the cost. We note that when we have made these changes in the past, services were moved to higher-paying APCs as well as lower-paying APCs.

Comment: One commenter urged that any new criteria that we adopt be applied prospectively to those applications submitted after the effective date of the final rules.

Response: Changes in the criteria and application process for assigning services to a new technology APC will be made prospectively, effective upon implementation of this final rule.

Comment: Although the new technology APCs and pass-through device categories were to be updated on a quarterly basis, many applications have taken much longer to process. CMS should establish a mechanism to process applications in a timely manner. One commenter suggested monthly updates.

Response: The volume of applications and changes we have had to make in the OPPS following enactment of BIPA have combined to stretch our resources to the maximum. Also, the need to seek additional information to enable us to complete a thorough and rigorous evaluation of applications for new technology APC assignments has often caused delays in making a final determination. We believe the additional information that we proposed to require in an application for new technology APC status will assist us in completing our reviews and making final determinations in a timely manner. CMS and our fiscal intermediaries' systems constraints preclude making updates more frequently than quarterly.

Comment: One commenter stated that the amount of information provided in the proposed rule does not satisfy the requirement of the Administrative Procedures Act that the public be informed and allowed to comment on major regulatory changes. The commenter requested full disclosure of data, methodology and options considered prior to implementation of the methodology with a suitable time of at least 60 days for public comment. The commenter requested that we retain the criteria established in the April 2000 final rule but that we eliminate the need for a HCPCS code.

Response: We believe that our description of the proposed changes to the criteria and application process for new technology APCs allowed ample opportunity for substantive comment, and we did receive numerous substantive comments on the proposed changes. In addition, changes in the process and information required to apply for new technology APC status under the OPPS are subject to provisions of the Paperwork Reduction Act (PRA) of 1995, as further explained in section XII of this final rule.

Final Action: We are making final the changes we proposed regarding the definition of what is appropriately paid for under a new technology APC, the criteria for determining assignment to a new APC, the information that must be supplied for a request to be considered, and the period of time during which payment in a new technology APC can be made. The schedule for submission of applications and the process and information required for a new technology APC designation is posted on the CMS website at http://www.hcfa.gov/medlearn.

VII. Transitional Pass-Through Payment Issues

A. Background

Section 1833(t)(6) of the Act provides for temporary additional payments or ''transitional pass-through payments'' for certain innovative medical devices, drugs, and biologicals. 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; current drugs, biologic agents, and brachytherapy devices used for the treatment of cancer; and current radiopharmaceutical drugs and biological products. Transitional pass-through payments are also required for new medical devices, drugs, and biologic 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 are to be made for at least 2 years but not more than 3 years.

Section 402 of BIPA, which was enacted on December 21, 2000, made several changes to section 1833(t)(6) of the Act. First, section 1833(t)(6)(B)(i) of the Act, as amended, requires us to establish by April 1, 2001, initial categories to be used for purposes of determining which medical devices are eligible for transitional pass-through payments. We fulfilled this requirement through the issuance on March 22, 2001 of two Program Memoranda, Transmittals A–01–40 and A–01–41. These Program Memoranda can be found on the CMS homepage at *www.hcfa.gov/pubforms/transmit/A0140.pdf* and *www.hcfa.gov/pubforms/transmit/A0141.pdf,* respectively. We note that section 1833(t)(6)(B)(i)(II) of the Act explicitly authorizes the Secretary to establish initial categories by program memorandum.

Transmittal A–01–41 includes a list of the initial device categories and a crosswalk of all the item-specific C-codes for individual devices that were approved for transitional pass-through payments as of January 20, 2001 to the initial category code by which the device is to be billed beginning April 1, 2001.

Section 1833(t)(6)(B)(ii) of the Act also requires us to establish, through rulemaking, criteria that will be used to create additional categories, other than those established initially. On November 2, 2001, we published an interim final rule with comment that established the criteria for new categories (66 FR 55850).

Transitional pass-through categories are for devices only; they do not apply to drugs or biologicals. The regulations governing transitional pass-through payments for eligible drugs and biologicals remain unchanged. The process to apply for transitional pass-through payment for eligible drugs and biological agents, including radiopharmaceuticals, can be found in the April 7, 2000 **Federal Register** (65 FR 18481) and on the CMS web site at *http://www.hcfa.gov/medlearn/appdead.htm.* If we revise the application instructions in any way, we will post the revisions on our web site and submit the changes for the Office of Management and Budget (OMB) review under the Paperwork Reduction Act. The application process for new categories can be found on the CMS web site at http://www.hcfa.gov//medicare/newcatapp1030f.rtf.

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 payments under the hospital OPPS. For a year before 2004,

the applicable percentage is 2.5 percent; for 2004 and subsequent years, the applicable percentage is specified by the Secretary up to 2.0 percent. If the Secretary estimates 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.

As discussed above, on November 2, 2001, we published a final rule that announced the implementation of a pro rata reduction for CY 2002. That document describes the methodology for estimating pass-through payments and indicates that we expected the reduction would be between 65 and 70 percent. Based on the final APC weights, which incorporate 75 percent of the estimated device pass-through costs, the final pro rata reduction is 68.9 percent.

C. Reducing Transitional Pass-Through Payments To Offset Costs Packaged Into APC Groups

As discussed in the proposed rule, in the November 13, 2000 interim final rule (65 FR 67806 and 67825), we had excluded costs in revenue codes 274 (Prosthetic/orthotic devices), 275 (Pacemaker), and 278 (Other implants) from the calculation of APC payment rates. This was because, before enactment of the BBRA 1999, we had proposed to pay for implantable devices outside of the OPPS. After the enactment of the BBRA, it was not feasible to revise our database to include these revenue codes in developing the April 7, 2000 final rule. We were able to make the necessary revisions and adjustments in time for implementation on January 1, 2001. When we packaged costs from these revenue codes to recalculate APC rates for 2001, to comply with the BBRA 1999 requirement, the median costs for a handful of procedures related to pacemakers and neurostimulators significantly increased. Therefore, we restructured the affected APCs to account for these changes in procedure level median costs.

Under section 1833(t)(6)(D)(ii) of the Act, as added by the BBRA 1999 and redesignated by BIPA, the amount of additional payment for an eligible device is the amount by which the hospital's cost exceeds the portion of the otherwise applicable APC payment amount that the Secretary determines is associated with the device. Thus, beginning January 1, 2001, for eligible devices, we deducted from transitional pass-through payments the dollar increase in the rates for the new APCs for procedures associated with the devices. Effective April 1, 2001, we revised our policy to subtract the dollar amount from the otherwise applicable pass-through payment for each category of device. The dollar amount subtracted in 2001 from transitional pass-through payments for affected categories of devices is as follows:

TABLE 4.—CY 2001 REDUCTIONS TO PASS-THROUGH PAYMENTS TO OFFSET DEVICE-RELATED COSTS PACKAGED IN ASSOCIATED APC GROUPS

For item billed under HCPCS code. * * *	Subtract from the pass-through payment the following amount:
C1767 Generator, neurostimulator (implantable)	$643.73
C1778 Lead, neurostimulator (implantable)	501.27
C1785 Pacemaker, dual chamber, rate-responsive (implantable)	2,843.00
C1786 Pacemaker, single chamber, rate-responsive (implantable)	2,843.00
C1816 Receiver and/or transmitter, neurostimulator (implantable)	537.83
C2619 Pacemaker, dual chamber, non rate-responsive (implantable)	2,843.00
C2620 Pacemaker, single chamber, non rate-responsive (implantable)	2,843.00

The increase in certain APC rates for device costs on January 1, 2001 was offset by the simultaneous reduction of the associated pass-through payments. Payments for the procedures in the affected APCs that did not include a pass-through device increased for 2001 and for procedures that did include devices, total payment for the procedure plus the device or devices did not change.

For 2002, we estimated in the proposed rule the portion of each APC rate that could reasonably be attributed to the cost of associated devices that are eligible for pass-through payments. This amount will be deducted from the pass-through payments for those devices as required by the statute. Since the deductions to the pass-through payments for costs included in APCs for 2002 are included in the recalibration of the weights and the ''fixed pool'' of dollars for outpatient services, the total payment for the procedure plus device or devices will be reduced rather than remain constant as they did in 2001.

We described our methodology for calculating these reductions for the proposed rule. First, we reviewed the APCs to determine which of them contained services that are associated with a category of devices eligible for a transitional pass-through payment. We then estimated the portion of the costs in those APCs that could reasonably be attributed to the cost of pass-through devices as follows:

- For each procedure associated with a pass-through device or devices, we examined all single-service bills (that is, bills that include services payable only under one APC) to determine utilization patterns for specific revenue centers that would reasonably be used for device-related charges in revenue codes 272 (sterile supplies), 275 (pacemakers), and 278 (other implants).
- We removed the costs in those revenue codes to calculate a cost for the bill net of device-related costs (reduced cost). For example, the average bill cost (in 1999–2000 dollars) for insertion of a cardiac pacemaker (CPT 33208) was $5,733. The average cost associated with revenue code 275 was $4,163, so the reduced cost for the procedure was $1,570. We calculated the ratio of the reduced cost ($1,570) to the full bill costs ($5,733), and we applied that ratio to the costs on any bills for CPT 33208 that did not use revenue code 275 to establish reduced cost at the procedure code level across all claims.
- To determine the reduced cost at the APC level and that portion of the APC payment rate associated with device costs, we calculated the median cost of the reduced cost bills for each relevant APC. For this calculation of the median, we allowed the full costs of bills for services in the APC that were not associated with pass-through devices.
- We calculated, for the APC, the percentage difference between the APC median of full cost or unreduced bills and the APC median where some or all of the bills had reduced costs. We applied this percent difference to the proposed APC payment rate in order to calculate the share of that rate attributable to the device or devices associated with procedures in the APC.

In column 3 of Table 5, we show the amount of the offset that we have computed with this methodology for each of the 25 APCs that we determined to have device costs represented in their rates. We note that the list of 25 APCs with device costs in their rates has changed slightly since the publication of the proposed rule. Specifically, APC 0185, Removal or Repair of Penile

Prosthesis, is no longer on the list, and APC 0259, Level VI ENT Procedures, has been added to the list. These changes result from the application of the limit on the variation of costs of services classified within a group (the ''two-times'' rule). APC 0185 has been deleted due to the application of this rule. The device-related procedures that had been included with APC 0185 have been incorporated into APC 0259. As a result, APC 0259 has been added to the list of APCs with device costs reflected in their rates, on the basis of the same costs that had been included in APC 0185.

We received several comments on this proposal, which are summarized below.

Comment: Several commenters asked for clarification of the methodology used in selecting the 25 APCs for which we calculated reductions.

Response: We described our methodology for selecting the 25 APCs in some detail in the proposed rule (66 FR 44706). As we stated there, we reviewed the APCs to determine which of them contained services that are associated with a category of devices eligible for a transitional pass-through payment. We carefully examined those APCs with a high frequency of claims in the data, and those that were associated with high-cost devices. We selected those APCs with patterns of billing that could be reasonably associated with devices, that is, with charges in revenue centers that are likely to be used for devices (revenue codes 272 (sterile supplies), 275 (pacemakers), and 278 (other implants)).

Comment: Several commenters noted that for 11 of the 25 APCs for which we have identified offsets, the amount of the proposed APC payment for 2002 has either decreased or increased by less than the amount of the offset. For these 11 APCs, Medicare's combined payments for the device and procedure would thus be reduced effective January 1, 2002.

Response: The estimate of the offset did not affect the APC rates. Any changes in the APC rates were due to the recalibration of the relative weights using the 1999–2000 data. The offset amount will be subtracted from the pass-through payment amount that would have been made otherwise. Thus, the combined payment for the device and procedure is necessarily reduced for all 25 APCs relative to what the payment would have been in 2002 without the offset. In other words, payments for all 25 device/procedure combinations would have been higher in 2002 by the amount of the offset if we had not identified the packaged costs and applied the offset. We assume, however, that the commenter means that payments for the device/procedure combinations associated with 11 of the 25 APCs will decrease in 2002 relative to the combined payments in 2001. Relative to the payments for 2001, the combined payment for the device and procedure could increase or decrease due to a number of factors affecting the relative weights for the APCs and the costs of the devices themselves. In the cases identified by the commenter, these factors decreased the proposed rates, or increased those rates by less than the amount of the offset, and thus decreased the payment in 2002 for the device/procedure combination relative to the payment for the combination in 2001.

Comment: One commenter endorsed the idea of making a reduction in pass-through payments for the costs already represented in the APC rates. However, the commenter expressed concern that reducing the pass-through payment will likely result in underpayments to hospitals that are using the associated devices with procedures, and overpayments to hospitals performing procedures without using the associated devices.

Response: We are not certain that the commenter understands how the pass-through offset works. The purpose of this measure is to ensure that the Medicare program pays only for the incremental costs of the new technology, over and above what is already represented in the APC rate for the associated procedure. The offset is applied only when a hospital bills for a device or other pass-through item in conjunction with billing for a procedure in an associated APC. When a hospital bills for a pass-through item along with a procedure, the hospital receives the full APC payment for the procedure. The offset is subtracted from the cost of the pass-through item. The hospital thus receives payment for the cost of the pass-through item over and above the offset amount. Without applying the offset, hospitals would be paid twice for the same costs. There is thus no underpayment for hospitals that are using pass-through items. When a hospital does not bill for a pass-through item with an APC, the hospital receives the full APC payment but no pass-through payment. The offset is not applied in the absence of a bill for a pass-through item. There is thus no overpayment for hospitals that are not using pass-through items. The hospital is paid only for the technology costs incorporated into the base APC rate, not for the incremental costs of new technologies.

Comment: One commenter raised a question about a possible consequence of applying predetermined amounts to subtract from pass-through payments as offsets for the device-related costs already included in the APC rates. The commenter observed that use of a hospital-wide cost-to-charge ratio in determining the amount of a pass-through payment makes it possible for the predetermined offset amount to exceed the calculated cost of a device to the hospital. The commenter therefore recommended that the reduction for the costs included in the APC rates never exceed the amount of the pass-through payment.

Response: We agree that the application of the pass-through offset should never result in a negative payment amount to the hospital. Our systems do not in fact compute pass-through payment amounts of less than zero.

Comment: One commenter recommended that, if we implement a pro rata reduction in the transitional pass-through payments, the same percentage reduction should be applied to the offsets for the technology costs already represented in the APCs associated with pass-through items. Such a reduction in the offset would help hospitals to maintain beneficiary access to new technology services in the event of a substantial pro rata reduction.

Response: The statute provides for applying a pro rata reduction only to the pass-through payments themselves, not to the offsets that are required to account for the costs that are represented in the payment rates for associated APCs. Reducing the offset would also increase the estimate of pass-through spending and require a larger pro rata reduction. We are therefore unable to accept the commenter's recommendation. We note, however, that the pro rata reduction is applied to the pass-through payment amount only *after* the offset.

Comment: One commenter endorsed the concept of incorporating pass-through device costs into their associated APCs, but raised a specific question about the device costs associated with APC 0182, Insertion of Penile Prosthesis. The commenter contended that a review of the median cost files suggests that numerous claims could not have included device costs, even though the whole point of the procedure is to implant a device. As a result, the commenter contended that both the pass-through offset for the device and any upward adjustment to incorporate device costs into the APC can only be understated. Two commenters inquired about APC 0108, Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads. The

commenter contended that the $5,768 that we have determined as representing device costs in that APC is far too low, since the average device costs between $22,000 and $23,000 in 1996.

Response: The first commenter is mistaken in thinking that we published a methodology for incorporating device costs into the APCs in the proposed rule. Rather, we published a methodology for identifying device costs that are *already* represented in the rates. (We published a methodology for incorporating device costs into the APCs in the November 2, 2001 final rule announcing the CY 2002 conversion factor and the pro rata reduction of transitional pass-through payments (66 FR 55857).) In developing our estimate of the device costs included in the APC rates, we used that portion of hospital costs that were allocated to those revenue centers in which device charges were likely to be billed. Hospitals have considerable flexibility in determining which revenue centers to assign charges, and we believe that in many cases they have allocated device charges to general supply centers. We are unable to separate the device charges from the other charges assigned to those revenue centers. We were thus unable to use costs from those centers in developing our estimates of the device costs associated with the APC rates. As a result, our estimate of the device costs in the APC rates might conceivably be understated. We believe that it does represent, however, a reasonably conservative estimate. We do not know the source of the other commenter's information about the cost for a specific device, but we believe that our offsets accurately capture the costs for device costs that are included in the current APC rates, net of all discounts, rebates, etc.

Comment: Several commenters questioned whether we would deduct from pass-through payments the full amount of the offset for the device costs reflected in associated APCs in cases where the payment for the associated APC is reduced due to the multiple procedures discount. Some of these commenters also recommended a methodology for making an appropriate adjustment. Specifically, they recommended that the multiple procedure discount be applied only to the nondevice-related portion of the APC payment amount.

Response: We agree with the commenters that the full pass-through offset should not be applied when the APC associated with the use of the device is subject to the multiple procedure discount of 50 percent. The purpose of the offset is to ensure that the program is not making double payment for any portion of the cost associated with the use of a pass-through item. The offset should therefore reflect that portion of the cost for the pass-through item actually reflected in the payment that is received for the associated APC. We believe that the most straightforward methodology for applying this principle is simply to reduce the offset amount by 50 percent whenever the multiple procedure discount applies to the associated APC.

Comment: One commenter asked how the offset is applied when one pass-through device is billed with more than one of the 25 APCs in which we have identified costs associated with pass-through items. And conversely, the commenter wondered what happens when two or more devices are billed with only one of the 25 APCs with offsets.

Response: The purpose of the offset is to avoid paying twice for costs that are represented both in the APC rates and in the costs of pass-through items. When one pass-through device is billed with two or more APCs with device-related costs, we would be double paying for some costs if we applied only one offset to the pass-through payment. We therefore apply all the offsets for the APCs on a bill when only one device is billed. As we have discussed above, however, the offset for the second APC would be reduced by 50 percent when the multiple service discount applies to that APC. Conversely, the offset is applied only once when one APC is billed, no matter how many devices are billed along with the APC. To apply the offset more than once would be to double-count the pass-through costs represented in that APC.

We employed the following methodology in incorporating 75 percent of the device pass-through costs into the costs that are used to establish the APC relative weights. We used a crosswalk that we developed as part of the methodology for estimating total pass-through spending as the basis for determining the device costs that are to be included in setting the relative weight for each APC. This crosswalk matches devices to the primary procedures in which they are used. In developing the total pass-through estimate, we used this crosswalk to produce a device package for each APC associated with device use, based on the one or more devices used in the procedures included in the APC. We then adjusted the costs of each package by subtracting the costs already represented in the payment amount for the APC. (These are the costs that are shown in column 3 of Table 5 below.) In order to account for these costs in determining the new relative weights, we added 75 percent of the costs in this adjusted package to the costs at the claim level for each procedure that uses the package of devices in the APC. At this point, we determined a revised median cost for the APC. That new median cost in turn was used as the basis for calculating the APC's new relative weight.

It is important to note that the median cost of an APC will not necessarily increase by the same amount as the costs that are folded into the APC. The middle number (that is, the median) in the ordered sequence of the costs for services in an APC would only vary by the same amount as the folded-in costs if every number in the sequence were increased by the amount of those folded-in costs. However, as we explained in the November 2, 2001 final rule concerning the pro rata reduction on transitional pass-through payments (FR 66 55862–5863), the device costs folded into an APC will not be uniformly distributed among the procedures in that APC. This is because procedures in an APC may require different types or numbers of devices, and some procedures may not require devices at all. Therefore, the increase in median cost for an APC is unlikely to exactly equal the amount of the costs folded into the APC. In the November 2, 2001 final rule, we also discuss in detail how the increase in APC rates due to the incorporation of these pass-through costs will be offset against the 2002 pass-through payments.

Table 5 shows the amount of the offsets that we will apply for each APC that contains device costs. Column 4 of Table 5 shows the amount of the offset for each APC into which costs have been folded employing the methodology we have just described. Column 5 then shows the total offset that is to be applied for each APC. For the 25 APCs in which we had previously identified device costs, the amount of the offset in column 5 is the sum of the amount in column 3 (the amount of the offset due to the device costs that we had previously identified in the APC) and the amount in column 4 (the amount of the offset due to the costs that have just been folded in). For all the other APCs listed in the table, the amounts in column 4 and column 5 are identical (and there is no entry in column 3). This is because we had not previously identified device costs that were already represented in the payment amounts for these APCs.

TABLE 5.—OFFSETS TO BE APPLIED FOR EACH APC THAT CONTAINS DEVICE COSTS

APC	Description	Device costs already reflected in APC rate	Additional device costs folded into APC rate	Total office for device costs
1	2	3	4	5
0032	Insertion of Central Venous/Arterial Catheter	$73.79	$276.41	$350.20
0046	Open/Percutaneous Treatment Fracture or Dislocation	NA	91.63	91.63
0048	Arthroplasty with Prosthesis	NA	501.91	501.91
0057	Bunion Procedures	NA	155.76	155.76
0070	Thoracentesis/Lavage Procedures	NA	24.94	24.94
0080	Diagnostic Cardiac Catheterization	164.27	124.21	288.48
0081	Non-Coronary Angioplasty or Atherectomy	307.06	353.78	660.84
0082	Coronary Atherectomy	242.95	1,187.08	1,430.03
0083	Coronary Angioplasty	528.64	365.49	894.13
0084	Level I Electrophysiologic Evaluation	NA	9,783.24	9,783.24
0085	Level II Electrophysiologic Evaluation	NA	580.82	580.82
0086	Ablate Heart Dysrhythm Focus	NA	1,299.58	1,299.58
0087	Cardiac Electrophysiologic Recording/Mapping	NA	1,964.38	1,964.38
0088	Thrombectomy	162.72	251.47	414.19
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	3,175.70	3,242.08	6,417.78
0090	Insertion/Replacement of Pacemaker Pulse Generator	2,921.06	2,196.00	5,117.06
0094	Resuscitation and Cardioversion	NA	17.31	17.31
0103	Miscellaneous Vascular Procedures	NA	202.60	202.60
0104	Transcatheter Placement of Intracoronary Stents	428.16	798.68	1,226.84
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	657.59	1,038.44	1,696.03
0107	Insertion of Cardioverter-Defibrillator	6,803.85	10,987.63	17,791.48
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	6,940.27	19,438.20	26,378.47
0111	Blood Product Exchange	NA	203.11	203.11
0115	Cannula/Access Device Procedures	NA	121.15	121.15
0117	Chemotherapy Administration by Infusion Only	NA	29.02	29.02
0118	Chemotherapy Administration by Both Infusion and Other Technique	NA	27.49	27.49
0119	Implantation of Devices	NA	3,325.05	3,325.05
0120	Infusion Therapy Except Chemotherapy	NA	34.10	34.10
0121	Level I Tube Changes and Repositioning	NA	5.09	5.09
0122	Level II Tube Changes and Repositioning	72.55	212.27	284.82
0124	Revision of Implanted Infusion Pump	NA	3,282.80	3,282.80
0144	Diagnostic Anoscopy	NA	126.75	126.75
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	60.92	0.00	60.92
0152	Percutaneous Biliary Endoscopic Procedures	107.61	0.00	107.61
0153	Peritoneal and Abdominal Procedures	NA	33.60	33.60
0154	Hernia/Hydrocele Procedures	108.11	369.57	477.68
0161	Level II Cystourethroscopy and other Genitourinary Procedures	NA	7.12	7.12
0162	Level III Cystourethroscopy and other Genitourinary Procedures	NA	312.55	312.55
0163	Level IV Cystourethroscopy and other Genitourinary Procedures	NA	889.80	889.80
0179	Urinary Incontinence Procedures	NA	3,359.66	3,359.66
0182	Insertion of Penile Prosthesis	2,238.90	543.66	2,782.56
0202	Level VIII Female Reproductive Proc	505.32	1,215.08	1,720.40
0203	Level V Nerve Injections	NA	416.39	416.39
0207	Level IV Nerve Injections	NA	61.60	61.60
0222	Implantation of Neurological Device	4,458.57	9,510.40	13,968.97
0223	Implantation of Pain Management Device	421.33	3,307.74	3,729.07
0225	Implantation of Neurostimulator Electrodes	1,182.00	11,862.15	13,044.15
0226	Implantation of Drug Infusion Reservoir	NA	3,341.85	3,341.85
0227	Implantation of Drug Infusion Device	3,810.46	2,354.31	6,164.77
0229	Transcatherter Placement of Intravascular Shunts	1,074.41	391.45	1,465.86
0237	Level III Posterior Segment Eye Procedures	NA	138.46	138.46
0246	Cataract Procedures with IOL Insert	146.82	0.00	146.82
0248	Laser Retinal Procedures	NA	1,262.93	1,262.93
0259	Level VI ENT Procedures	12,407.52	3,724.65	16,132.17
0264	Level II Miscellaneous Radiology Procedures	NA	60.06	60.06
0312	Radioelement Applications	NA	1,201.84	1,201.84
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	NA	208.20	208.20
0686	Level V Skin Repair	NA	458.65	458.65
0687	Revision/Removal of Neurostimulator Electrodes	NA	1,432.44	1,432.44
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	NA	6,195.52	6,195.52
0692	Electronic Analysis of Neurostimulator Pulse Generators	NA	639.86	639.86

VIII. Conversion Factor Update for CY 2002

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, as redesignated by section 401 of the BIPA, provides that for 2002, 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, reduced by one percentage point. Further, section 401 of the BIPA increased the conversion factor for 2001 to reflect an update equal to the full market basket percentage increase amount.

In the November 2, 2001 final rule, we announced that the conversion factor for CY 2002 is $50.904 (66 FR 55864) based on an increase factor of 2.3 percent for 2002 and a wage index budget neutrality adjustment of 0.9936.

IX. Summary of and Responses to MedPAC Recommendations

On March 1, 2001 the Medicare Payment Advisory Commission (MedPAC) issued its annual report to Congress, including several recommendations related to the OPPS. In the August 24, 2001 proposed rule, we responded to these recommendations (66 FR 44707–44708).

MedPAC Recommendation: MedPAC has offered two recommendations regarding the update to the conversion factor in the OPPS. The first recommendation is that the Secretary should not use an expenditure target to update the conversion factor. The second recommendation is that Congress should require an annual update of the conversion factor in the OPPS that is based on the relevant factors influencing the costs of efficiently providing hospital outpatient care, and not just the change in input prices.

Response: Section 1833(t)(3)(C)(ii) of the Act requires the Secretary to update the conversion factor annually. Under section 1833(t)(3)(C)(iv) of the Act the update is equal to the hospital market basket percentage increase applicable under the hospital inpatient PPS, minus one percentage point for the years 2000 and 2002. The Secretary has the authority under section 1833(t)(3)(C)(iv) of the Act to substitute a market basket that is specific to hospital outpatient services. Finally, section 1833(t)(2)(F) of the Act requires the Secretary to develop a method for controlling unnecessary increases in the volume of covered hospital outpatient services, and section 1833(t)(9)(C) of the Act authorizes the Secretary to adjust the update to the conversion factor if the volume of services increased beyond the amount established under section 1833(t)(2)(F) of the Act.

In the September 8, 1998 proposed rule on the OPPS, we indicated that we were considering the option of developing an outpatient-specific market basket and invited comments on possible sources of data suitable for constructing one (63 FR 47579). We received no comments in response to this invitation, and we therefore announced in the April 7, 2000 final rule that we would update the conversion factor by the hospital inpatient market basket increase, minus one percentage point, for the years 2000, 2001, and 2002 (65 FR 18502). As required by section 401(c) of the BIPA, we made payment adjustments effective April 1, 2001 under a special payment rule that has had the effect of providing a full market basket update in 2001. We are, however, working with a contractor to study the option of developing an outpatient-specific market basket and would welcome comments and recommendations regarding appropriate data sources. We will also study the feasibility of developing appropriate adjustments for factors that influence the costs of efficiently providing hospital outpatient care, such as productivity increases and the introduction of new technologies, and the availability of appropriate sources of data for calculating the factors.

In the September 8, 1998 proposed rule on the OPPS, we proposed employing a modified version of the physicians' sustainable growth rate system (SGR) as an adjustment in the update framework to control for excess increases in the volume of covered outpatient services (63 FR 47586–47587). In response to comments on this proposal, we announced in the April 7, 2000 final rule that we had decided to delay implementation of a volume control mechanism, and to continue to study the options with a contractor (65 FR 18503). We will take MedPAC's recommendation into consideration in making a decision, and before implementing volume control mechanism we will publish a proposed rule with an opportunity for public comment.

MedPAC Recommendation: MedPAC recommends that the Secretary should develop formalized procedures in the OPPS for expeditiously assigning codes, updating relative weights, and investigating the need for service classification changes to recognize the costs of new and substantially improved technologies.

Response: Beginning with the April 7, 2000 final rule implementing the OPPS, we have outlined a comprehensive process to recognize the costs of new technology in the new system. One component of this process is the provision for pass-through payments for devices, drugs, and biologicals (see the discussion in conjunction with the next MedPAC recommendation). The other component is the creation of new APC groups to accommodate payment for new technology services that are not eligible for transitional pass-through payments. We assign new technology services that cannot be appropriately placed within existing APC groups to new technology APC groups, using costs alone (rather than costs plus clinical coherence) as the basis for the assignment. We describe revised criteria for assignment to a new technology group in section VI.G. of this preamble. When it is necessary, creation of new technology APC groups involves establishment of new codes. New codes are established through a well-ordered process that operates on an annual cycle. The cycle starts with submission of information by interested parties no later than April 1 of each year and ends with the announcement of new codes in October. As we stated previously, in the absence of an appropriate HCPCS code, we would consider creating a HCPCS code that describes the procedure or service. These codes would be solely for hospitals to use when billing under the OPPS.

We have also provided a mechanism for moving these services from the new technology APCs to clinically related APCs as part of the annual update of the APC groups. As described in section VI of this preamble, a service is retained within a new technology APC group until we have acquired adequate data that allow us to assign the service to an appropriate APC. We use the annual APC update cycle to assign the service to an existing APC that is similar both clinically and in terms of resource costs. If no such APC exists, we create a new APC for the service.

MedPAC Recommendation: MedPAC recommends that pass-through payments for specific technologies should be made in the OPPS only when a technology is new or substantially improved and adds substantially to the cost of care in an APC. MedPAC believes that the definition of ''new'' should not include items whose costs were included in the 1996 data used to set the OPPS payment rates.

Response: The statute requires that, under the OPPS, transitional pass-through payments are made for certain drugs, devices, and biologicals. The

items designated by the statute to receive these pass-through payments include the following:

- Current orphan drugs, as designated under section 526 of the Federal Food, Drug, and Cosmetic Act.
- Current drugs and biologicals used for the treatment of cancer, and brachytherapy and temperature monitored cryoablation devices used for the treatment of cancer.
- Current radiopharmaceutical drugs and biologicals.
- New drugs and biologicals in instances in which the item was not being paid as a hospital outpatient service as of December 31, 1996, and when the cost of the item is ''not insignificant'' in relation to the OPPS payment amount.
- Effective April 1, 2001, categories of Medical devices when the cost of the category is ''not insignificant'' in relation to the OPPS payment amount.

We are publishing a separate interim final rule in which we lay out the criteria for establishing categories of devices eligible for pass-through payments.

Section 1833(t)(6) of the Act provides that once a category is established, a specific device may receive a pass-through payment for 2 to 3 years if the device is described by an existing category, regardless of whether it was being paid as a hospital outpatient service as of December 31, 1996 or its cost meets the ''not insignificant'' criterion. Thus, the statute allows for certain devices that do not meet MedPAC's recommended limitation on a ''new'' device to receive transitional pass-through payments. However, no categories are created on the basis of devices that were paid for on or before December 31, 1996. That is, while devices paid for on or before December 31, 1996 can be included in a category, we would establish a category only on the basis of devices that were not being paid as hospital outpatient services as of December 31, 1996.

MedPAC Recommendation: MedPAC recommends that pass-through payments for specific technologies in the OPPS should be made on a budget-neutral basis and that the costs of new or substantially improved technologies should be factored into the update of the outpatient conversion factor.

Response: The statute requires that the transitional pass-through payments for drugs, devices, and biologicals be made on a budget neutral basis. Estimated pass-through payments are limited under the statute to 2.5 percent (and up to 2.0 percent for 2004 and thereafter) of estimated total program payments for covered hospital outpatient services. We adjust the conversion factor to account for the proportion of total program payments for covered hospital outpatient services, up to the statutory limit, that we estimate will be made in pass-through payments. As we have discussed in response to MedPAC's recommendation concerning an update framework for the OPPS conversion factor, we will study the feasibility of including appropriate adjustments for factors, including introduction of new technologies, that influence the costs of efficiently providing hospital outpatient care within such a framework.

MedPAC Recommendation: MedPAC recommends that the Congress should continue the reduction in outpatient coinsurance to achieve a 20 percent coinsurance rate by 2010.

Response: For most services that Medicare covers, the program is responsible for 80 percent of the total payment amount, and beneficiaries pay 20 percent. However, under the cost-based payment system in place for outpatient services before the OPPS, beneficiaries paid 20 percent of the hospital's charges for these services. As a result, coinsurance was often more than 20 percent of the total payment amount for the services.

The BBA established a formula under the OPPS that was designed to reduce coinsurance gradually to 20 percent of the total payment amount. Under this formula, a national copayment amount was set for each service category, and that amount is to remain frozen as payment rates increase until the coinsurance percentage falls to 20 percent for all services. On average, beneficiaries paid about 16 percent less in copayments for hospital outpatient services during 2000 under the OPPS than they would have paid under the previous system. However, it is true that the coinsurance remains higher than 20 percent of the Medicare payment amount for many services.

Subsequent legislation has placed caps on the coinsurance percentages to speed up this process. Specifically, section 111 of BIPA amended section 1833(t)(8)(C)(ii) of the Act to reduce beneficiary coinsurance liability by phasing in a cap on the coinsurance percentage for each service. Starting on April 1, 2001, coinsurance for a single service furnished in 2001 cannot exceed 57 percent of the total payment amount for the service. The cap will be 55 percent in 2002 and 2003, and will be reduced by 5 percentage points each year from 2004 to 2006 until coinsurance is limited to 40 percent of the total payment for each service. The underlying process for decreasing coinsurance will also continue during this period (see discussion in section IV.A. of this preamble). However, MedPAC projects that under current law, it would take until 2029 to reach the goal of 20 percent coinsurance for all services.

We agree with MedPAC's goal of continuing the reduction in outpatient coinsurance, and we would welcome enactment of a practical measure to do so.

We received no comments on our responses to the MedPAC recommendations.

X. Provider-Based Issues

A. Background and April 7, 2000 Regulations

On April 7, 2000, we published a final rule specifying the criteria that must be met for a determination regarding provider-based status (65 FR 18504). Since the beginning of the Medicare program, some providers, which we refer to as ''main providers,'' have functioned as a single entity while owning and operating multiple departments, locations, and facilities. Having clear criteria for provider-based status is important because this designation can result in additional Medicare payments for services furnished at the provider-based facility, and may also increase the coinsurance liability of Medicare for those services.

The regulations at § 413.65 define provider-based status as ''the relationship between a main provider and a provider-based entity or a department of a provider, remote location of a hospital, or satellite facility, that complies with the provisions of this section.'' Section 413.65(b)(2) states that before a main provider may bill for services of a facility as if the facility is provider-based, or before it includes costs of those services on its cost report, the facility must meet the criteria listed in the regulations at § 413.65(d). Among these criteria are the requirements that the main provider and the facility must have common licensure (when appropriate), the facility must operate under the ownership and control of the main provider, and the facility must be located in the immediate vicinity of the main provider.

The effective date of these regulations was originally set at October 10, 2000, but was subsequently delayed and is now in effect for cost reporting periods beginning on or after January 10, 2001. Program instructions on provider-based status issued before that date, found in Section 2446 of the Provider Reimbursement Manual—Part 1 (PRM–

1), Section 2004 of the Medicare State Operations Manual (SOM), and CMS Program Memorandum (PM) A–99–24, will apply to any facility for periods before the new regulations become applicable to it. (Some of these instructions will not be applied because they have been superseded by specific legislation on provider-based status, as described in item X.C below).

B. Provider-Based Issues/Frequently Asked Questions

Following publication of the April 7, 2000 final rule, we received many requests for clarification of policies on specific issues related to provider-based status. In response, we published a list of ''Frequently Asked Questions'' and the answers to them on the CMS web site at *www.hcfa.gov/medlearn/provqa.htm.* (This document can also be obtained by contacting the CMS (formerly, HCFA) Regional Office.) These Qs and As did not revise the regulatory criteria, but do provide subregulatory guidance for their implementation.

C. Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554)

On December 21, 2000, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (Pub. L. 106–554) was enacted. Section 404 of BIPA contains provisions that significantly affect the provider-based regulations at § 413.65. Section 404 includes a grandfathering provision for facilities treated as provider-based on October 1, 2000; alternative criteria for meeting the geographic location requirement; and criteria for temporary treatment as provider-based.

1. Two-Year ''Grandfathering''

Under section 404(a) of BIPA, any facilities or organizations that were ''treated'' as provider-based in relation to any hospital or CAH on October 1, 2000 will continue to be treated as such until October 1, 2002. For the purpose of this provision, we interpret ''treated as provider-based'' to include those facilities with formal CMS determinations, as well as those facilities without formal CMS determinations that were being paid as provider-based as of October 1, 2000. As a result, existing provider-based facilities and organizations may retain that status without meeting the criteria in the regulations under §§ 413.65(d), (e), (f), and (h) until October 1, 2002. These provisions concern provider-based status requirements, joint ventures, management contracts, and services under arrangement. Thus, the provider-based facilities and organizations affected under section 404(a) of BIPA are not required to submit an application for or obtain a provider-based status determination in order to continue receiving reimbursement as provider-based during this period.

These provider-based facilities and organizations will not be exempt from the Emergency Medical Treatment and Active Labor Act (EMTALA) responsibilities of provider-based facilities and organizations (revised § 489.24(b) and new § 489.24(i)) or from the obligations of hospital outpatient departments and hospital-based entities in § 413.65(g), such as the responsibility of off-campus facilities provide written notices to Medicare beneficiaries of coinsurance liability. These rules are not pre-empted by the grandfather provisions of BIPA section 404 because they do not set forth criteria that must be met for provider-based status as a department of a hospital, but instead identify responsibilities that flow from that status. These responsibilities become effective for hospitals on the first day of the hospital's cost reporting period beginning on or after January 10, 2001.

2. Geographic Location Criteria

Section 404(b) of BIPA provides that those facilities or organizations that are not included in the grandfathering provision at section 404(a) are deemed to comply with the ''immediate vicinity'' requirements of the new regulations under § 413.65(d)(7) if they are located not more than 35 miles from the main campus of the hospital or critical access hospital. Therefore, those facilities located within 35 miles of the main provider satisfy the immediate vicinity requirement as an alternative to meeting the ''75/75 test'' under § 413.65(d)(7).

In addition, BIPA provides that certain facilities or organizations are deemed to comply with the requirements for geographic proximity (either the ''75/75 test'' or the ''35-mile test'') if they are owned and operated by a main provider that is a hospital with a disproportionate share adjustment percentage greater than 11.75 percent and is (1) owned or operated by a unit of State or local government, (2) a public or private nonprofit corporation that is formally granted governmental powers by a unit of State or local government, or (3) a private hospital that has a contract with a State or local government that includes the operation of clinics of the hospital to ensure access in a well-defined service area to health care services for low-income individuals who are not entitled to benefits under Medicare or Medicaid.

These geographic location criteria are permanent. While those facilities or organizations treated as provider-based on October 1, 2000 are covered by the 2-year grandfathering provision noted above, the geographic location criteria at section 404(b) of BIPA and the regulations at § 413.65(d)(7) will apply to facilities or organizations not treated as provider-based as of that date, effective with the hospital's cost reporting period beginning on or after January 10, 2001. Beginning October 1, 2002, these criteria will also apply to the grandfathered facilities.

3. Criteria for Temporary Treatment as Provider-Based

Section 404(c) of BIPA also provides that a facility or organization that seeks a determination of provider-based status on or after October 1, 2000 and before October 1, 2002 shall be treated as having provider-based status for any period before a determination is made. Thus, recovery for overpayments will not be made retroactively for noncompliance with the provider-based criteria once a request for a determination during that time period has been made. For hospitals that do not qualify for grandfathering under section 404(a) of BIPA, a request for provider-based status should be submitted to the appropriate CMS Regional Office (RO). Until a uniform application is available, at a minimum, the request should include the identity of the main provider and the facility or organization for which provider-based status is being sought and supporting documentation to demonstrate compliance with the provider-based status criteria in effect at the time the application is submitted. Once such a request has been submitted on or after October 1, 2000, and before October 1, 2002, CMS will treat the facility or organization as being provider-based from the date it began operating as provider-based (as long as that date is on or after October 1, 2000) until the effective date of a CMS determination that the facility or organization is not provider-based.

Facilities requesting a provider-based status determination on or after October 1, 2002 will not be covered by the provision concerning temporary treatment as provider-based in section 404(c) of BIPA. Thus, as stated in § 413.65(n), CMS ROs will make provider-based status effective as of the earliest date on which a request for determination has been made and all requirements for provider-based status in effect as of the date of the request are shown to have been met, not on the date

of the formal CMS determination. If a facility or organization does not qualify for provider-based status and CMS learns that the provider has treated the facility or organization as provider-based without having obtained a provider-based determination under applicable regulations, CMS will review all payments and may seek recovery for overpayments in accordance with the regulations at § 413.65(j), including overpayments made for the period of time between submission of the request or application for provider-based status and the issuance of a formal CMS determination.

D. Commitment To Re-Examine EMTALA Applicability to Off-Campus Hospital Locations, and to Further Revise Provider-Based Regulations

As explained in the proposed rule published on August 24, 2001, (p. 44709) we are aware that many hospitals and physicians continue to have significant concerns with our policy on the applicability of EMTALA to provider-based facilities and organizations. We intend to re-examine these regulations and, in particular, reconsider the appropriateness of applying EMTALA to off-campus locations. We plan to review these regulations with a view toward ensuring that these locations are treated in ways that are appropriate to the responsibility for EMTALA compliance of the hospital as a whole. At the same time, we want to ensure that those departments that Medicare pays as hospital-based departments are appropriately integrated with the hospital as a whole. Because of these considerations, we stated in the preamble to our August 24, 2001 proposals that we intend to publish a proposed rule to address these issues more fully.

In response to our statements, we received several comments, which are summarized below.

Comment: Several commenters expressed approval of the statement, in the preamble to the August 24, 2001 proposed rule, that CMS plans to reconsider the appropriateness of applying EMTALA to off-campus hospital locations. The commenters offered to work with CMS in establishing further policy in this area.

Response: We appreciate the commenters' support, and look forward to working with them on these important issues.

Comment: One commenter stated that since CMS is planning to reconsider the appropriateness of applying EMTALA to off-campus hospital locations it should, while the review is taking place, either withdraw the regulations requiring EMTALA compliance at off-campus hospital facilities, or not implement those regulations.

Response: We agree that the issues need to be reviewed carefully. EMTALA affords important protections to individuals who come to hospitals to seek care for possible emergency medical conditions. Thus, any change in the scope of the EMTALA regulations must be considered very thoroughly before it is undertaken. At the same time, we are well aware that many hospitals continue to be concerned about what they view as the excessive financial and administrative burden of complying with EMTALA at off-campus locations. In view of the complexity of the issues under view, and in consideration of the very significant impact that any change could have on the health and safety of hospital patients, we remain convinced that it would not be appropriate to anticipate the conclusion of that review by withdrawing or rescinding the regulations at this time. For the same reason, we are not adopting the suggestion that we suspend implementation of the current regulations.

Comment: Several commenters recommended that CMS publish additional regulations clarifying various issues related to the criteria for provider-based status. The commenters offered to work with CMS in establishing further policy in this area.

Response: We appreciate the commenters' support, and look forward to working with them on these important issues.

E. Changes to Provider-Based Regulations

To fully implement the provisions of section 404 of BIPA and to codify the clarifications currently stated only in the Qs and As on provider-based status, as described above, we proposed to revise the regulations as follows.

1. Clarification of Requirements for Adequate Cost Data and Cost Finding (§ 413.24(d))

As part of the April 7, 2000, final rule implementing the prospective payment system for hospital outpatient services to Medicare beneficiaries, under § 413.24, Adequate Cost Data and Cost Finding, we added a new paragraph (d)(6), entitled ''Management Contracts.'' Since publication of the final rule, we have received several questions concerning the new paragraph.

In response to these questions, we proposed to revise that paragraph to clarify its meaning. In addition, for further clarity, we proposed to revise the coding and title of that material. We proposed to redesignate § 413.24(d)(6)(i) as § 413.24(d)(6) and § 413.24(d)(6)(ii) as § 413.24(d)(7). As revised, paragraph (d)(6) would address the situation when the main provider in a provider-based complex purchases services for a provider-based entity or for a department of the provider through a contract for services (for example, a management contract), directly assigning the costs to the provider-based entity or department and reporting the costs directly in the cost center for that entity or department. In any situation in which costs are directly assigned to a cost center, there is a risk of excess cost in that cost center resulting from the directly assigned costs plus a share of overhead improperly allocated to the cost center that duplicates the directly assigned costs. This duplication could result in improper Medicare payment to the provider. Therefore, when a provider has purchased services for a provider-based entity or for a provider department, like general service costs of the provider (for example, like costs in the administrative and general cost center) must be separately identified to ensure that they are not improperly allocated to the entity or the department. If the like costs of the provider cannot be separately identified, the costs of the services purchased through a contract for the provider-based entity or provider department must be reclassified to the main provider and allocated among the main provider's benefiting cost centers.

For costs of services furnished to free-standing entities, we proposed to clarify in revised § 413.24(d)(7), that the costs that a provider incurs to furnish services to free-standing entities with which it is associated are not allowable costs of that provider. Any costs of services furnished to a free-standing entity must be identified and eliminated from the allowable costs of the servicing provider, to prevent Medicare payment to that provider for those costs. This may be done by including the free-standing entity on the cost report as a nonreimbursable cost center for the purpose of allocating overhead costs to that entity. If this method would not result in an accurate allocation of costs to the entity, the provider must develop detailed work papers showing how the cost of services furnished by the provider to the entity were determined. These costs are removed from the applicable cost centers of the servicing provider.

This revision is not a change in the policy, but instead is a clarification to the policy set forth in the April 7, 2000

final rule. We received no comments on this proposal and are adopting it without change.

2. Scope and Definitions (§ 413.65(a))

In Q/A 9 published on the CMS (formerly, HCFA) web site at *www.hcfa.gov/medlearn/provqa.htm,*we identified specific types of facilities for which provider-based determinations would not be made, since their status would not affect either Medicare payment levels or beneficiary liability. (This document may also be obtained by contacting the CMS (formerly, HCFA) Regional Office.) The facilities identified in Q/A 9 are ambulatory surgical centers (ASCs); comprehensive outpatient rehabilitation facilities (CORFs); home health agencies (HHAs); skilled nursing facilities (SNFs); hospices; inpatient rehabilitation units that are excluded from the inpatient PPS for acute hospital services; independent diagnostic testing facilities and any other facilities that furnish only clinical diagnostic laboratory tests; facilities furnishing only physical, occupational or speech therapy to ambulatory patients, for as long as the $1500 annual cap on coverage of physical, occupational, and speech therapy, as described in section 1833(g)(2) of the Act, remains suspended by the action of subsequent legislation; and end-stage renal disease (ESRD) facilities. Determinations for ESRD facilities are made under § 413.174.

We proposed to revise the regulations at § 413.65(a) to clarify that these facilities are not subject to the provider-based requirements and that provider-based determinations will not be made for them.

We received a few comments on this proposal, which are summarized below.

Comment: One commenter expressed approval of the proposed revision, but suggested that we expand the list of facilities or organizations for which provider-based status is not required to include specific types of neonatal intensive care units and outpatient departments providing specialty pediatric care. The commenter believed such a change would permit these facilities to be treated as provider-based after the grandfather provisions of BIPA section 404 expire, even though they do not meet all criteria in 42 CFR 413.65(d).

Response: In Q/A 9 published on the CMS web site at *www.hcfa.gov/medlearn/provqa.htm* we identified specific types of facilities for which provider-based determinations will not be made because any determinations regarding their status would not affect either Medicare payment levels or beneficiary liability. In the August 24, 2001 proposed rule, we proposed to codify this list of facilities. Because the comment was submitted in response to this part of our proposal, we considered it in that context. However, the commenter did not succeed in establishing that the units and specialized outpatient departments meet the criteria for inclusion on a list of facilities for which a determination about provider-based status would not affect either Medicare payment levels or beneficiary liability. (On the contrary, the commenter argued that if determinations were made on such units and departments, payments would be reduced significantly.) Moreover, the primary focus of the comment is not to ask that no determinations be made for these units and departments, but instead that those facilities be treated as provider-based even though they do not meet some or all of the provider-based criteria in § 413.65(d). We did not propose to extend provider-based status to such facilities (except insofar as BIPA section 404 requires us to do so), nor can such a proposal be logically inferred from the provisions included in the proposed rule. Thus, while we reviewed this comment with interest, we did not adopt it. We received no other comments on this proposed revision and are adopting it without change.

3. BIPA Provisions on Grandfathering and Temporary Treatment as Provider-Based (§§ 413.65(b)(2) and (b)(5))

Currently, § 413.65(b)(2) states that a main provider or a facility must contact CMS (formerly, HCFA), and CMS must determine that the facility is provider-based before the main provider bills for services of the facility as if the facility were provider-based, or before it includes costs of those services on its cost report. However, as explained earlier, sections 404(a) and (c) of BIPA require that certain facilities be grandfathered for a 2-year period, and that facilities applying between October 1, 2000 and October 1, 2002 for provider-based status with respect to a hospital be given provider-based status on a temporary basis, pending a decision on their applications. To implement these provisions, we proposed to revise the regulations in § 413.65(b)(2) to state that if a facility was treated as provider-based in relation to a hospital or CAH on October 1, 2000, it will continue to be considered provider-based in relation to that hospital or CAH until October 1, 2002, and the requirements, limitations, and exclusions specified in paragraphs (d), (e), (f), and (h) of § 413.65 will not apply to that hospital or CAH with respect to that facility until October 1, 2002. We further proposed that for purposes of paragraph (b)(2), a facility would be considered to have been treated as provider-based on October 1, 2000, if on that date it either had a written determination from CMS (formerly, HCFA) that it was provider-based as of that date, or was billing and being paid as a provider-based department or entity of the hospital.

In addition, we proposed to add a new § 413.65(b)(2) to state that a facility for which a determination of provider-based status in relation to a hospital or CAH is requested on or after October 1, 2000 and before October 1, 2002 will be treated as provider-based in relation to the hospital or CAH from the first date on or after October 1, 2000 on which the facility was licensed (to the extent required by the State), staffed and equipped to treat patients until the date on which CMS (formerly, HCFA) determines that the facility does not qualify for provider-based status.

We received one comment on this proposal, which is summarized below.

Comment: One commenter stated that our proposed revision to these sections does not adequately implement section 404(c) of BIPA, in that it would require temporary treatment as provider-based for a facility or organization for which such status is requested on or before October 1, 2000 only from October 1, 2000 forward. The commenter believes this is inappropriate because section 404(c) of BIPA provides that such a facility or organization is to be treated as provider-based for ''any period before a determination is made.'' Under the commenter's recommended interpretation of the provision, such temporary treatment would also be available for any period before October 1, 2000.

Response: We believe this interpretation of the provision is overly literal, and does not accurately reflect the role of paragraph (c) in the total statutory scheme established by section 404 of BIPA. Section 404(a)(1) describes the treatment to be accorded to facilities treated as provider-based on October 1, 2000, by providing that such facilities will continue to be treated as provider-based until October 1, 2002. Thus, paragraph (a) of section 404 addresses the situation of facilities that existed and were treated as provider based on October 1, 2000. Section 404(c) of BIPA complements this provision by mandating a grace period for those facilities seeking provider-based status determinations on or after October 1, 2000 that either (i) existed on October 1, 2000 but were not treated as provider-based, or (ii) did not exist as of October

1, 2000 (that is, were opened after that date). Taken together, paragraphs (a) and (c) specify the treatment to be given to facilities treated as provider-based on the reference date of October 1, 2000 and to those facilities for which provider-based status is sought within 2 years after the reference date. However, we find no indication that the statute was intended to extend provider-based status for any period before the reference date. Such an extension would not be necessary to protect a provider from possible retroactive liability based on possible delay in considering a provider-based application, and could inappropriately prevent collection of overpayments incurred well before October 1, 2000. Thus, we did not adopt this comment.

We received no other comments on this proposal and we are adopting it without change.

4. Reporting (§ 413.65(c)(1))

Currently, § 413.65(c) states that a main provider that creates or acquires a facility or organization for which it wishes to claim provider-based status, including any physician offices that a hospital wishes to operate as a hospital outpatient department or clinic, must report its acquisition of the facility or organization to CMS (formerly, HCFA) if the facility or organization is located off the campus of the provider, or inclusion of the costs of the facility or organization in the provider's cost report would increase the total costs on the provider's cost report by at least 5 percent, and must furnish all information needed for a determination as to whether the facility or organization meets the requirements in paragraph (d) of this section for provider-based status. Concern has been expressed that such reporting would duplicate the requirement for obtaining approval of a facility as provider-based before billing its services that way or including its costs on the cost report of the main provider (current § 413.65(b)(2)). To prevent any unnecessary duplicate reporting, we proposed to delete the current requirement from § 413.65(c)(1). We proposed, however, to retain the requirement that a main provider that has had one or more facilities considered provider-based also report to CMS (formerly, HCFA) any material change in the relationship between it and any provider-based facility, such as a change in ownership of the facility or entry into a new or different management contract that could affect the provider-based status of the facility.

We received one comment on this proposal, which is summarized below.

Comment: A commenter stated that more guidance is needed on the rules regarding reporting to CMS any significant changes in the relationship between a main provider and its provider-based facilities. The commenter asked that we explain the meaning of ''significant changes,'' prescribe the format of such reporting, and specify to whom such reports are to be made.

Response: Although the commenter refers to reporting any significant changes, the regulations at § 413.65(c)(1) speak of reporting any ''material'' changes in the relationship between it and any provider-based facility. As explained in the August 24, 2001 proposed rule, we would consider a ''material'' change to be anything that may interfere with compliance with the provider-based rules. The August 24, 2001 document further explains that such a change may include but is not limited to a change of ownership, entry into a new or different management contract, or change in the financial operations of the facility or the main provider. The main provider may report such material changes in the form of a letter submitted to its CMS Regional Office with a copy to its fiscal intermediary. While we are responding in this preamble to the commenter's questions and hope that this information is helpful, we do not believe it is essential to include this level of detail in the Code of Federal Regulations. Therefore, we did not revise the regulations based on this comment.

We received no other comments on the proposal and are adopting it without change.

5. Geographic Location Criteria (§ 413.65(d)(7))

As explained earlier in X.C.2 of this preamble, section 404(b) of BIPA mandates that facilities seeking provider-based status be considered to meet any geographic location criteria if they are located not more than 35 miles from the main campus of the hospital or CAH to which they wish to be based, or meet other specific criteria relating to their ownership and operation. To implement this provision, we proposed to revise § 413.65(d)(7) to state that a facility will meet provider-based location criteria if it and the main provider are located on the same campus, or if one of the following three criteria are met:

- The facility or organization is located within a 35-mile radius of the main campus of the hospital or CAH that is the potential main provider.
- The facility or organization is owned and operated by a hospital or CAH that—

(A) Is owned or operated by a unit of State or local government;

(B) Is a public or nonprofit corporation that is formally granted governmental powers by a unit of State or local government; or

(C) Is a private hospital that has a contract with a State or local government that includes the operation of clinics located off the main campus of the hospital to ensure access in a well-defined service area to health care services to low-income individuals who are not entitled to benefits under Medicare (or medical assistance under a Medicaid State plan); and

(D) Has a disproportionate share adjustment (as determined under § 412.106 of this chapter) greater than 11.75 percent or is described in § 412.106(c)(2) of this chapter implementing section 1886(d)(5)(F)(i)(II) of the Act.

- The facility meets the criteria currently set forth in § 413.65(d)(7)(i) for service to the same patient population as the main provider.

We received no comments on this proposal and we are adopting it without change.

6. Notice to Beneficiaries of Coinsurance Liability (§ 413.65(g)(7))

Currently § 413.65(g)(7) states that when a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity (other than an RHC) that is not located on the main provider's campus, the hospital has a duty to provide written notice to the beneficiary, before the delivery of services, of the amount of the beneficiary's potential financial liability (that is, of the fact that the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital as well as for the physician service, and of the amount of that liability). The notice must be one that the beneficiary can read and understand.

We clarified in the preamble to an interim final rule with comment period published on August 3, 2000 (65 FR 47670) that if the exact type and extent of care needed is not known, the hospital may furnish a written notice to the patient that explains the fact that the beneficiary will incur a coinsurance liability to the hospital that they would not incur if the facility were not provider-based. The interim final rule further explained that the hospital may furnish an estimate based on typical or average charges for visits to the facility, while stating that the patient's actual liability will depend upon the actual

services furnished by the hospital if the beneficiary is unconscious, under great duress, or for any other reason unable to read a written notice and understand and act on his or her own rights, the notice must be provided, before the delivery of services, to the beneficiary's authorized representative.

We proposed to amend § 413.65(g)(7) to include this clarifying language. We received no comments on this proposal, and we are adopting it without change.

7. Clarification of Protocols for Off-Campus Departments (§ 489.24(i)(2)(ii))

Currently, § 489.24(i) specifies the anti-dumping obligations that hospitals have for individuals who come to off-campus hospital departments for the examination or treatment of a potential emergency medical condition. These obligations are sometimes known as EMTALA obligations, after the Emergency Medical Treatment and Labor Act, which is the legislation that first imposed the obligations. Currently, hospitals are responsible for ensuring that personnel at their off-campus departments are trained and given appropriate protocols for the handling of emergency cases.

In the case of off-campus departments not routinely staffed with physicians, RNs, or LPNs, the department's personnel must be given protocols that direct them to contact emergency personnel at the main hospital campus before arranging an appropriate transfer to a medical facility other than the main hospital.

Some concern had been expressed that taking the time needed to make such contacts might inappropriately delay the appropriate transfer of emergency patients in cases in which the patient's condition was deteriorating rapidly. In response to this concern, we clarified in the preamble to the interim final rule with comment period published on August 3, 2000 cited above (65 FR 47670) that in any case of the kind described in § 489.24(i)(2)(ii), the contact with emergency personnel at the main hospital campus should be made either concurrently with or after the actions needed to arrange an appropriate transfer, if, prior to transfer, contacting the main hospital campus would significantly jeopardize the individual's life or health. This does not relieve the off-campus department of the responsibility for making the contact, but only clarifies that the contact may be delayed in specific cases in which doing otherwise would endanger a patient subject to EMTALA protection.

We proposed to amend § 489.24(i)(2)(ii) to include this clarifying language. We received two comments on this proposal, which are summarized below.

Comment: Two commenters expressed approval of the change and recommended that it be adopted in the final rule. However, the commenter recommended that we further clarify the rule by spelling out the circumstances under which personnel at off-campus locations would be expected to call EMS before seeking guidance from the emergency department staff at the main campus delay.

Response: As noted above, we plan to reconsider the general issue of the appropriateness of applying EMTALA to off-campus hospital locations. We will consider the commenter's specific suggestion in the course of that more general review. Therefore, we have not made any change in the final rule based on this comment.

Comment: One commenter expressed approval of the proposed clarification at § 489.24(i)(2)(ii), under which personnel in off-campus departments that are not routinely staffed with physicians, RNs, or LPNs, may delay contacting the main hospital's emergency department according to protocols if, prior to transfer, contacting the main hospital campus would significantly jeopardize the individual's life or health. However, the commenter pointed out that the introductory paragraph of § 489.24(i)(2) applies the protocol requirement to all off-campus departments (whether or not staffed by physicians and nurses). Therefore, the commenter suggested that we move this provision to the introductory paragraph of § 489.24(i)(2), and so that it will apply to all off-campus departments. The commenter believes that this change would be consistent with the policy stated by CMS on its website (CMS EMTALA guidance, 7/20/01, Q/A ##7 and 13–16).

Response: We agree that it would be appropriate, and consistent with our policy in this area, to apply this provision concerning the delay of contact in certain situations to all off-campus departments. As the commeter suggested, we are amending § 489.24(i)(2) to include the clarifying language that had been proposed at § 489.24(i)(2)(ii).

8. Other Changes

In addition to the changes cited previously, we proposed to make the following conforming and clarifying changes:

- Correcting date references in §§ 413.65(i)(1)(i) and (i)(2), in order to take into account the effective date of the current regulations.
- Substituting ''CMS'' for ''HCFA'' throughout the revised sections of part 413, to reflect the renaming of the Health Care Financing Administration (HCFA) as the Centers for Medicare & Medicaid Services (CMS).

We received no comments on these proposals and are adopting them without change.

F. Comments on Other Issues

We also received a number of comments recommending various changes in the provider-based regulations that were not in our August 24, proposed rule and cannot logically be inferred from those proposals. While we read these comments with interest, we have not made any changes in the final rule based on them.

XI. Summary of the Final Rule

This final rule revises the Medicare hospital outpatient prospective payment system to implement applicable statutory requirements, including relevant provisions of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, 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. This final rule also announces a uniform reduction of 68.9 percent to be applied to each of the transitional pass-through payments.

This final rule finalizes a number of policies discussed in the August 24, 2001 proposed rule as follows:

- We are implementing BIPA provisions that affect the OPPS in 2002, including the following:
  + The national coinsurance rate for OPPS services is limited to 55 percent of the APC payment rate established for a procedure or service.
  + Children s hospitals receive the same hold-harmless protection accorded to cancer hospitals under BBRA.
  + Special payment provisions for certain services, including screening for glaucoma, payment for contrast agents, and new technology diagnostic mammography.
- We adjust payments to hospitals for geographic wage differences, as required by the statute, using the FY 2002 hospital inpatient PPS wage index. We have recalibrated the APC weights, also as required by the statute, using median costs drawn from claims data for hospital services furnished on or after July 1, 1999 through June 30, 2000.
- The methodology that we followed to calculate the final APC relative weights for CY 2002 is similar to the proposed methodology except that we have incorporated pass-through device

costs in device-related procedures. Specifically, we have incorporated 75 percent of the estimated cost for pass-through devices into the base APC costs.

• We have revised and updated the APC groups in accordance with several factors. These changes would affect more than half of the approximately 340 existing APC groups.

• As a result of consultations with the advisory panel on APC groups, we have reviewed and are accepting a number of the Panel's recommendations. In some cases, we have made additional changes to the APCs based on the use of new data and application of the 2 times rule.

• We have received recommendations from commenters and interested parties to establish separate APCs for observation services. As proposed, we are creating a new APC to make separate payment for observation services for patients with chest pain, asthma, and congestive heart failure, when certain clinical criteria are met. We have made some minor changes based on public comment.

• Based on public comment, we made several modifications to our proposed coding scheme for stereotactic radiosurgery.

• We have revised the criteria for the new technology APC groups that we created to allow payment at an appropriate level for new technologies that do not meet the statutory requirements for pass-through payments. These changes are intended to allow us to reserve these special new technology APC groups for services that are a new, ''complete'' procedure and not just modifications of existing technologies.

• We are changing the aggregate method currently used for calculating outlier payments and will begin determining outliers on an APC-by-APC basis rather than the entire bill. To do this, we allocate packaged items on a bill to APCs based on their relative weight.

• We are excluding from the OPPS the Part B-only services furnished to inpatients of hospitals that do no other billing for hospital outpatient services under Part B. This is in response to complaints we received from State psychiatric hospitals that did not have outpatient departments and, therefore, bill under OPPS only for inpatients. This policy would exempt them from having to make costly revisions to their billing systems.

• We are excluding from the OPPS hospitals that are located outside the 50 States or the District of Columbia or Puerto Rico, that is, hospitals in Guam, Saipan, American Samoa, and the Virgin Islands. This policy is consistent with their current exclusion from the inpatient PPS and will also save these hospitals from billing system revisions.

• We will continue to use a list of certain procedures that are designated as inpatient procedures and therefore are not paid by Medicare under the OPPS. Based on comments, we have made minor changes to this list.

• We are revising the regulations affecting provider-based entities to implement technical BIPA provisions on grandfathering, temporary treatment as provider-based, and certain geographic location criteria; and to clarify requirements for adequate cost data and cost finding, certain reporting requirements, requirements regarding notice to beneficiaries of coinsurance liability, and clarification of anti-patient dumping rules (EMTALA obligations) in off-campus departments.

• In response to public comments regarding provider-based issues, we are moving the provision concerning the delay of contact in certain situations to the introductory paragraph of § 489.24(i)(2) so that it will apply to all off-campus departments.

• In addition, we are making editorial and technical revisions to our regulations. We made minor editorial changes in paragraphs (b)(2), (b)(4), (b)(5), (c), (d)(7)(iv), and (g)(7) of § 413.65. In § 413.65(i)(2), we modified the presentation of our language to more clearly present our policy.

XII. 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 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.

Sections 413.65 and 419.42 of this final rule contain information collection requirements that are subject to review by OMB under the Paperwork Reduction Act of 1995. However, §§ 413.65 and 419.42 have been approved by OMB under approval number 0938–0798, with a current expiration date of August 31, 2003 and OMB approval number 0938–0802, with a current expiration date of December 31, 2001.

Process and Information Required To Apply for Transitional Pass-through Payment for Eligible Drugs and Biological Agents, Including Radiopharmaceuticals, Under the Hospital Outpatient Prospective Payment System

The application itself for Transitional Pass-Through Payment for Eligible Drugs and Biological Agents, Including Radiopharmaceuticals, may be found at <*www.hcfa.gov*>. Transitional pass-through categories are for devices only; they do not apply to drugs or biologicals. The regulations governing transitional pass-through payments for eligible drugs and biologicals remain unchanged. The process to apply for transitional pass-through payment for eligible drugs and biological agents, including radiopharmaceuticals, can be found in the April 7, 2000 **Federal Register** (65 FR 18481) and on the CMS web site at *http://www.hcfa.gov/medlearn/appdead.htm*. If we revise the application instructions in any way, we will post the revisions on our web site and submit the changes for the Office of Management and Budget (OMB) review under the Paperwork Reduction Act. The application process for new categories can be found on the CMS web site at http://www.hcfa.gov//medicare/newcatapp1030f.rtf.

We estimate that approximately 100 entities will file an application yearly. We believe it will take each of these entities around 16 hours to gather the necessary information and fill out the application.

We have submitted a copy of this final rule to OMB for its review of the information collection requirement described above. The requirement is not effective until it has been approved by OMB.

XIV. 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) and the Regulatory Flexibility Act (RFA) (September 19, 1980; Public Law 96–354). 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).

The provisions of this final rule do not result in impacts that exceed $100 million per year. The effects of the changes in this rule are redistributional and do not result in additional expenditures. The impacts discussed below reflect the effects of the final rule published on November 2, 2001. Therefore, this final rule is not an economically significant rule under Executive Order 12866, nor a major rule under 5 U.S.C. 804(2).

We note, however, that on November 2, 2001, we published a final rule that announced the updated conversion factor for payments under the OPPS (66 FR 55857). As discussed in more detail in that document, we estimated that the total impact of the changes for CY 2002 payments compared to CY 2001 payments as set forth in the November 2 rule would be approximately a $450 million increase (66 FR 55864).

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 $5 to $25 million or less annually (see 65 FR 69432). For purposes of the RFA, all providers of hospital outpatient services are considered small entities. 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 604 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we 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.

It is clear that the changes in this final rule 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.

Section 202 of the Unfunded Mandate 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 one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This final rule does not mandate any requirements for State, local, or tribal governments.

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes a proposed rule (and subsequent 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 any negative impact on the rights, roles, and responsibilities of State, local or tribal governments.

B. Changes in This Final Rule

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)(9)(A) of the Act to revise, not less often than annually, the wage index and other adjustments used to determine the APC payment rates. In addition, we must review the clinical integrity of payment groups and the relative weights at least annually. Accordingly, in this final rule, we are updating the wage index adjustment for hospital outpatient services furnished beginning January 1, 2002. We are also revising the relative APC payment weights based on claims data from July 1, 1999 through June 30, 2000. Finally, we are beginning to calculate outlier payments on an APC-specific basis rather than the current method of calculating outlier payments for each claim. In addition, as an administrative action, we have incorporated 75 percent of the estimated cost of the pass-through devices into the base APC rates.

As described in the preamble, budget neutrality adjustments are made to the weights to assure that the revisions in the wage index, APC groups, and relative weights do not affect aggregate payments. In addition, the parameters for outlier payments have been modified so that outlier payments for 2002 are projected to equal the established policy target of 2.0 percent of total payments. Because we are not revising the target percentage, there is no estimated aggregate impact from modifying the method of determining outlier payments.

The impact of the wage index, APC reclassification and recalibration, and outlier changes do vary somewhat by hospital group. Estimates of these impacts are displayed on Table 6.

We received no specific comments on the impact analysis. However, in commenting on certain proposed policies, commenters sometimes referred to the impact of a policy on hospitals or a specific group of hospitals. We have addressed these comments elsewhere in the preamble to this final rule. The following is a discussion of how the final policies set forth in this rule affect hospitals and beneficiaries. As an informational matter, the impact of changes set forth in Table 6 include the impact of the update to the conversion factor, which was implemented in the November 2 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 2002, 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. Finally, we do not model the impact of the transitional corridor payments, which protect hospitals from losses in 2002 compared to their 1996 payments. We are unable to model this impact because we do not yet have filed cost reports from hospitals for the services furnished under the PPS. The raw cost report data are generally not available until at least 7 months after the end of the cost reporting period.

D. Estimated Impacts of This Final Rule on Hospital Payments

Column 5 in Table 6 represents the full impact on each hospital group of all the changes for 2002. Columns 2 through 4 in the table reflect the independent effects of the change in the wage index, the APC reclassification and recalibration changes (including the incorporation of pass-through device

costs), and the change in outlier method, respectively.

In general, the wage index changes favor rural hospitals, particularly the largest in bed size and volume. The only rural hospitals that would experience a negative impact due to wage index changes are those in the Pacific Region, a decrease of 0.1 percent. Conversely, the urban hospitals are generally negatively affected by these changes, with the largest effect on those with 500 or more beds (a 0.5 percent decrease) and those in the Middle Atlantic (a 0.5 percent decrease) and West South Central (a 0.9 percent decrease) Regions.

We estimate that the APC reclassification and recalibration changes have generally an opposite impact from the wage index, causing increases in payments for all urban hospitals except those with fewer than 200 beds and volumes of fewer than 21,000 services per year and those located in the New England (a 0.6 percent decrease), Middle Atlantic (a 0.8 percent decrease), and Puerto Rico (an 8.1 percent decrease) Regions.

The incorporation of 75 percent of the estimated costs of pass-through devices into the base APC rates has a relatively large negative effect on rural hospitals. In the proposed rule, the estimated impact of the APC reclassification and recalibration changes on rural hospitals was a 1.5 percent decrease in payments. With the incorporation of the device costs, the impact is now estimated to be a 3.8 percent decrease. This impact does not include the effects of any additional transitional corridor payments to rural hospitals. The negative effect is particularly pronounced for rural hospitals with fewer than 100 beds (a decrease of 5.6 percent for hospitals with fewer than 50 beds and a 4.9 percent decrease for hospitals with 50–99 beds). This impact is due to the large increase in payment rates for device-related APCs and the corresponding decrease in nondevice-related APCs, as discussed in more detail above in section II.C. of this preamble. The decrease in the payment rates for clinic visits and diagnostic and preventive services affect rural hospitals disproportionately because they perform far more of these services as compared to the device-related APCs for which payment rates have increased. These impact estimates do not reflect the effects of the hold harmless transitional corridor payments in 2002 for the smallest rural hospitals.

We also note that it is not the large academic medical centers that are most positively affected by the incorporation of pass-through device costs. While the group of hospitals that receives the largest increase in payments is hospitals with 500 or more beds (a 3.4 percent increase), minor teaching hospitals will receive an increase of only 2.0 percent and major teaching hospitals, an increase of 0.5 percent.

Although teaching hospitals perform many device-related procedures, they also provide a very large number of clinic and emergency room visits, both of which will experience a projected decrease in payment rates of approximately 8 percent. In fact, teaching hospitals that do not also receive disproportionate share payments will experience a projected decrease of 2.1 percent. The largest negative impact for urban hospitals is for those with no teaching adjustment that also do not serve a disproportionate share of low-income patients. Even though this is a relatively small group of hospitals, their payments are projected to decrease by 15.5 percent.

The change in outlier policy to an APC-specific payment has a slight negative effect on rural hospitals as a group (a 0.1 percent decrease), no effect on urban hospitals as a group, and slight negative effects on all small hospitals (fewer than 100 beds) as well as those with lower volumes of services. For urban hospitals, other than a projected increase in payments of 0.3 percent for hospitals in the Middle Atlantic Region, no geographic group of hospitals is affected by more than 0.1 percent. For rural hospitals, the Middle Atlantic Region will also experience a positive impact, a 0.2 percent increase. For the rest of the regions, rural hospitals will experience no more than a 0.2 percent decrease, except for hospitals in the Pacific Region, where there is no impact.

The overall projected increase in payments for urban hospitals (3.0 percent) is greater than the average increase for all hospitals (2.3 percent). However, due to the large decrease in payments attributable to the APC changes, rural hospitals will experience an average decrease in payments of 0.7 percent. While rural hospitals gain 1.0 percent from the wage index change, they lose a combined 3.9 percent from the APC changes (–3.8 percent) and the change in method of determining outlier payments (a slight decrease of 0.1 percent). These impacts do not include the effects of any additional transitional corridor payments to rural hospitals. Rural hospitals with 100 or more beds will experience an overall increase in payments, however, those with fewer than 100 beds are projected to receive large decreases in payments (–3.5 percent for hospitals with fewer than 50 beds and –2.4 percent for those with 50 to 99 beds). We note that these smallest rural hospitals will be protected by the hold harmless transitional corridor payments for 2002. That is, their Medicare payment margin for services furnished under the OPPS cannot be less than their margin for the services in 1996.

In both urban and rural areas, hospitals that provide a higher volume of outpatient services are projected to receive a larger increase in payments than lower volume hospitals. In rural areas, hospitals with volumes of fewer than 5,000 services are projected to experience a relatively large decline in payments (–3.6 percent). The less favorable impact for the low volume hospitals is attributable to the APC changes and the change in outlier method. For example, rural hospitals providing fewer than 5000 services are projected to lose a combined 6 percent due to these changes.

Urban hospitals in all regions except Puerto Rico (with a decrease of 5.1 percent) receive an increase on overall payments. The lowest increase is in the Middle Atlantic Region, where hospitals are projected to receive a 1.2 percent increase in payments. Except for increases for hospitals in the South Atlantic (0.3 percent) and West South Central (0.5) Regions and no change in the Mountain Region, rural hospitals experience an overall loss in payments. Again, this is due to the decrease in payments as a result of the APC changes.

Major teaching hospitals are projected to experience a smaller increase in overall payments (2.4 percent) than do hospitals with the less intensive teaching programs due to the negative impacts of the wage index (–0.4 percent), a relatively small increase due to the APC recalibration (0.5 percent), and outlier changes (–0.2 percent). Among hospitals with varying shares of low-income patients, those with a DSH patient percentage of zero experience a large decrease in payments because of the APC changes (–7.6 percent) and the outlier changes (–0.3 percent). For hospitals with a greater than 0 percent of low-income patients, the impact on all hospitals is positive, with the lowest increase of 0.3 percent attributable to hospitals with the highest share.

E. Estimated Impacts of This Final Rule on Beneficiary Copayments

In general, the increase in the APC rates for procedures that use pass-through devices results in increased copayments for beneficiaries who receive those procedures. Many of the device-related APC rates (approximately 50 APCs) have increased by over 100

percent and a small number by over 750 percent. Under the statute, the copayment amount for an APC cannot be less than 20 percent of the payment rate. Therefore, beneficiaries will experience an increase in copayments for most of the device-related APCs. This increase is countered by small decreases in the copayments for some other APCs, particularly clinic and emergency room visits.

One important thing to note is that beneficiaries receive far more clinic and emergency visits in a year than they do device-related procedures. For example, in the 1999–2000 claims data base, there are almost 7 million low-level clinic visits, over 3 million mid-level clinic visits, and almost 2 million high-level clinic visits. However, for APC 0084, Level I Electrophysiologic Evaluation (the device-related APC with the largest increase), there were only about 7,000 procedures performed. Thus, the number of services received by beneficiaries with small decreases in copayments far outweighs the number of services for which they will incur some incremental costs.

In addition, we note that section 1833(t)(8)(C)(i) of the Act places a limit on the copayment amount for any procedure; that is, the copayment may not be more than the applicable inpatient hospital deductible for the year in which the procedure is performed. For CY 2002, the inpatient deductible is $812. We further note that the complete incorporation of the costs of the current pass-through devices into the base APCs must be done in CY 2003. Therefore, any increase in copayments that occur in 2002 are a transition to increases that must, by statute, occur in 2003. Finally, as discussed in section IV. C above, we have minimized the effects of changes in APC groupings on beneficiary coinsurance and copayments.

TABLE 6.—IMPACT OF CHANGES FOR CY 2002 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

[Percent change in total payment to hospitals (program and beneficiary); does not include the effects of additional transitional corridors payments]

	Number of hosps [1]	New wage index [2]	APC/WGTS/ 75% fold in [3]	New outlier policy [4]	All CY2002 changes [5]
	(1)	(2)	(3)	(4)	(5)
All Hospitals	5,084	0.0	0.0	0.0	2.3
Non-Tefra Hospitals	4,671	0.0	0.0	0.0	2.3
Urban Hosps	2,550	-0.2	1.0	0.0	3.0
Large Urban (GT 1 Mill.)	1,459	-0.4	0.8	0.1	2.7
Other Urban (LE 1 Mill.)	1,091	0.0	1.3	0.0	3.5
Rural Hosps	2,121	1.0	-3.8	-0.1	-0.7
Beds (Urban):					
0–99 Beds	646	-0.1	-3.2	-0.1	-1.2
100–199 Beds	908	-0.2	-1.2	0.0	0.9
200–299 Beds	490	-0.2	0.8	0.0	2.8
300–499 Beds	363	-0.2	2.9	0.0	5.0
500 + Beds	143	-0.5	3.4	0.1	5.3
Beds (Rural):					
0–49 Beds	1,278	0.2	-5.6	-0.2	-3.5
50–99 Beds	508	0.4	-4.9	-0.1	-2.4
100–149 Beds	196	1.5	-3.0	-0.1	0.6
150–199 Beds	73	1.5	-1.6	-0.1	2.0
200 + Beds	66	2.3	-1.7	0.0	2.8
Volume (Urban)					
LT 5,000	307	-0.4	0.7	-0.2	2.3
5,000–10,999	445	-0.3	-2.4	0.0	-0.5
11,000–20,999	570	-0.3	-0.9	0.0	1.1
21,000–42,999	739	-0.3	1.0	0.0	3.0
GT 42,999	489	-0.2	1.8	0.0	4.0
Volume (Rural):					
LT 5,000	945	0.3	-5.6	-0.4	-3.6
5,000–10,999	602	0.2	-5.7	-0.2	-3.5
11,000–20,999	332	0.7	-3.9	-0.1	-1.2
21,000–42,999	198	1.4	-2.5	0.0	1.1
GT 42,999	44	2.3	-2.2	0.0	2.3
Region (Urban):					
New England	135	0.6	-0.6	0.0	2.2
Middle Atlantic	379	-0.5	-0.8	0.3	1.2
South Atlantic	386	-0.1	2.8	0.0	5.0
East North Cent	441	-0.4	0.1	0.0	1.9
East South Cent	154	1.2	2.1	-0.1	5.5
West North Cent	181	-0.4	1.5	0.0	3.3
West South Cent	321	-0.9	2.1	-0.1	3.4
Mountain	128	-0.1	2.4	0.0	4.5
Pacific	386	-0.4	1.6	-0.1	3.5
Puerto Rico	39	1.0	-8.1	-0.1	-5.1
Region (Rural):					
New England	52	0.0	-4.1	-0.1	-2.1
Middle Atlantic	74	0.5	-4.9	0.2	-2.0
South Atlantic	270	1.4	-3.2	-0.1	0.3
East North Cent	279	1.1	-4.6	-0.1	-1.5
East South Cent	250	1.3	-3.8	-0.1	-0.4

TABLE 6.—IMPACT OF CHANGES FOR CY 2002 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent change in total payment to hospitals (program and beneficiary); does not include the effects of additional transitional corridors payments]

	Number of hosps [1] (1)	New wage index [2] (2)	APC/WGTS/ 75% fold in [3] (3)	New outlier policy [4] (4)	All CY2002 changes [5] (5)
West North Cent	506	1.2	-3.9	-0.2	-0.9
West South Cent	328	1.5	-3.0	-0.1	0.5
Mountain	215	1.3	-3.2	-0.2	0.0
Pacific	142	-0.8	-2.8	0.0	-1.5
Puerto Rico	5	4.5	-6.8	-0.1	-0.5
Teaching Status:					
Non-Teaching	3,576	0.2	-1.4	0.0	0.9
Minor	803	0.0	2.0	0.0	4.4
Major	291	-0.4	0.5	0.0	2.4
DSH Patient Percent:					
0	32	0.7	-7.6	-1.3	-6.4
GT 0–0.10	1,261	0.0	0.2	0.0	2.5
0.10–0.16	1,035	0.1	-0.1	0.1	2.4
0.16–0.23	869	-0.1	0.6	0.0	2.7
0.23–0.35	786	0.1	0.3	-0.1	2.6
GE 0.35	688	-0.2	-1.6	-0.1	0.3
Urban IME/DSH:					
IME & DSH	1,000	-0.3	1.8	0.1	3.8
IME/No DSH	3	0.0	-2.1	-2.0	-2.3
No IME/DSH	1,531	-0.2	-0.1	0.0	2.0
No IME/No DSH	16	0.8	-15.5	-0.3	-13.2
Rural Hosp. Types:					
No Special Status	794	0.2	-4.8	-0.1	-2.6
RRC	172	2.1	-2.0	0.0	2.3
SCH/Each	666	0.4	-4.8	-0.1	-2.4
MDH	329	0.2	-6.2	-0.3	-4.2
SCH and RRC	71	2.0	-2.1	-0.1	2.0
Type of Ownership:					
Voluntary	2,774	0.0	0.2	0.0	2.4
Proprietary	757	0.0	1.0	0.0	3.3
Government	1,140	0.3	-1.7	-0.1	0.6
Specialty Hospitals:					
Eye and Ear	12	0.8	-4.8	0.0	-1.8
Trauma	151	-0.1	1.5	0.0	3.7
Cancer	10	-1.3	-0.4	0.4	0.7
Tefra Hospitals (Not Included on Other Lines):					
Rehab	169	0.3	7.5	-0.3	9.2
Psych	103	-0.7	-7.4	-1.7	-7.8
LTC	99	-0.7	-4.3	-0.4	-3.3
Children	42	-0.6	-0.9	-1.0	-0.5

Note: For CY 2002, under the OPPS transitional corridor policy cancer, children's, and rural hospitals with 100 or fewer beds are held harmless compared to their 1996 payment margin for these services. All other hospitals are protected to some extent when their payment margins are less than they were in 1996 (see § 419.70(b)). These additional payments are not reflected below.

[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 using the final FY 2002 hospital inpatient wage index after geographic reclassification by the Medicare Geographic Classification Review Board. The hospital inpatient final rule for FY 2002 was published in the **Federal Register** on September 1, 2001.

[3] This column shows the impact of recalibrating the APC weights based on the 1999–2000 hospital claims data and on the reassignment of some HCPCs to APCs as well as the incorporation of the device costs discussed in this rule.

[4] This column shows the difference in calculating outliers on an APC-specific rather than bill basis and with the final thresholds.

[5] This column shows changes in total payment from CY2001 to CY 2002. It incorporates all of the changes reflected in columns 2, 3, and 4. In addition, it shows the impact of the CY 2002 payment update. The sum of the columns may be different from the percentage changes shown here due to rounding.

In accordance with the provisions of Executive Order 12866, this final rule was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 419

Hospitals, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare &

Medicaid Services amends 42 CFR chapter IV as follows:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

A. Part 413 is amended as set forth below:

1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 1395l, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

Subpart B—Accounting Records and Reports

2. In § 413.24, the heading to paragraph (d) is republished, paragraph (d)(6) is revised, and a new paragraph (d)(7) is added, to read as follows:

§ 413.24 Adequate cost data and cost finding.

* * * * *

(d) *Cost finding methods.* * * *

(6) *Provider-based entities and departments: Preventing duplication of cost.* In some situations, the main provider in a provider-based complex may purchase services for a provider-based entity or for a department of the provider through a contract for services (for example, a management contract), directly assigning the costs to the provider-based entity or department and reporting the costs directly in the cost center for that entity or department. In any situation in which costs are directly assigned to a cost center, there is a risk of excess cost in that cost center resulting from the directly assigned costs plus a share of overhead improperly allocated to the cost center which duplicates the directly assigned costs. This duplication could result in improper Medicare payment to the provider. Where a provider has purchased services for a provider-based entity or for a provider department, like general service costs of the provider (for example, like costs in the administrative and general cost center) must be separately identified to ensure that they are not improperly allocated to the entity or the department. If the like costs of the main provider cannot be separately identified, the costs of the services purchased through a contract must be reclassified to the main provider and allocated among the main provider's benefiting cost centers.

Example: A provider-based complex is composed of a hospital and a hospital-based rural health clinic (RHC). The hospital furnishes the entirety of its own administrative and general costs internally. The RHC, however, is managed by an independent contractor through a management contract. The management contract provides a full array of administrative and general services, with the exception of patient billing. The hospital directly assigns the costs of the RHC's management contract to the RHC cost center (for example, Form HCFA 2552–96, Worksheet A, Line 71). A full allocation of the hospital's administrative and general costs to the RHC cost center would duplicate most of the RHC's administrative and general costs. However, an allocation of the hospital's cost (included in hospital administrative and general costs) of its patient billing function to the RHC would be appropriate. Therefore, the hospital must include the costs of the patient billing function in a separate cost center to be allocated to the benefiting cost centers, including the RHC cost center. The remaining hospital administrative and general costs would be allocated to all cost centers, excluding the RHC cost center. If the hospital is unable to isolate the costs of the patient billing function, the costs of the RHC's management contract must be reclassified to the hospital administrative and general cost center to be allocated among all cost centers, as appropriate.

(7) *Costs of services furnished to free-standing entities.* The costs that a provider incurs to furnish services to free-standing entities with which it is associated are not allowable costs of that provider. Any costs of services furnished to a free-standing entity must be identified and eliminated from the allowable costs of the servicing provider, to prevent Medicare payment to that provider for those costs. This may be done by including the free-standing entity on the cost report as a nonreimbursable cost center for the purpose of allocating overhead costs to that entity. If this method would not result in an accurate allocation of costs to the entity, the provider must develop detailed work papers showing how the cost of services furnished by the provider to the entity were determined. These costs are removed from the applicable cost centers of the servicing provider.

* * * * *

Subpart E—Payments to Providers

3. Section 413.65 is amended as follows:

A. Revising paragraph (a)(1).

B. Revising the definition of ''Provider-based entity'' in paragraph (a)(2).

C. Revising paragraph (b).

D. Revising paragraph (c).

E. Revising the introductory text to paragraph (d).

F. Revising paragraph (d)(7).

G. Revising paragraph (g)(7).

H. Revising the introductory text to paragraph (i)(1).

I. Revising paragraph (i)(1)(ii).

J. Revising paragraph (i)(2).

The revisions read as follows:

§ 413.65 Requirements for a determination that a facility or an organization has provider-based status.

(a) *Scope and definitions.* (1) *Scope.* (i) This section applies to all facilities for which provider-based status is sought, including remote locations of hospitals, as defined in paragraph (a)(2) of this section and satellite facilities as defined in § 412.22(h)(1) and § 412.25(e)(1) of this chapter, other than facilities described in paragraph (a)(1)(ii) of this section.

(ii) This section does not apply to the following facilities:

(A) Ambulatory surgical centers (ASCs).

(B) Comprehensive outpatient rehabilitation facilities (CORFs).

(C) Home health agencies (HHAs).

(D) Skilled nursing facilities (SNFs).

(E) Hospices.

(F) Inpatient rehabilitation units that are excluded from the inpatient PPS for acute hospital services.

(G) Independent diagnostic testing facilities and any other facilities that furnish only clinical diagnostic laboratory tests.

(H) Facilities furnishing only physical, occupational, or speech therapy to ambulatory patients, for as long as the $1,500 annual cap on coverage of physical, occupational, and speech therapy, as described in section 1833(g)(2) of the Act, remains suspended by the action of subsequent legislation.

(I) ESRD facilities (determinations for ESRD facilities are made under § 413.174 of this chapter).

(2) *Definitions.* * * *

* * * * *

Provider-based entity means a provider of health care services, or an RHC as defined in § 405.2401(b) of this chapter, that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the name, ownership, and administrative and financial control of the main provider, in accordance with the provisions of this section.

* * * * *

(b) *Provider-based determinations.* (1) A facility or organization is not entitled to be treated as provider-based simply

because it or the main provider believe it is provider-based.

(2) If a facility was treated as provider-based in relation to a hospital or CAH on October 1, 2000, it will continue to be considered provider-based in relation to that hospital or CAH until October 1, 2002. The requirements, limitations, and exclusions specified in paragraphs (d), (e), (f), and (h) of this section will not apply to that hospital or CAH for that facility until October 1, 2002. For purposes of this paragraph, a facility is considered as provider-based on October 1, 2000, if on that date it either had a written determination from CMS that it was provider-based, or was billing and being paid as a provider-based department or entity of the hospital.

(3) Except as specified in paragraphs (b)(2) and (b)(5) of this section, a main provider or a facility must contact CMS, and the facility must be determined by CMS to be provider-based, before the main provider bills for services of the facility as if the facility were provider based, or before it includes costs of those services on its cost report.

(4) A facility that is not located on the campus of a hospital and that is used as a site where physician services of the kind ordinarily furnished in physician offices are furnished is presumed as a free-standing facility, unless CMS determines the facility has provider-based status.

(5) A facility that has requested provider-based status in relation to a hospital or CAH on or after October 1, 2000 and before October 1, 2002 will be treated as provider-based in relation to the hospital or CAH from the first date on or after October 1, 2000 on which the facility was licensed (to the extent required by the State), staffed and equipped to treat patients until the date on which CMS determines that the facility does not qualify for provider-based status.

(c) *Reporting.* A main provider that has had one or more facilities considered provider-based also must report to CMS any material change in the relationship between it and any provider-based facility, such as a change in ownership of the facility or entry into a new or different management contract that would affect the provider-based status of the facility.

(d) *Requirements.* An entity must meet all of the following requirements to be determined by CMS to have provider-based status.

* * * * *

(7) *Location in immediate vicinity.* The facility or organization and the main provider are located on the same campus, except when the requirements in paragraphs (d)(7)(i), (d)(7)(ii), or (d)(7)(iii) of this section are met:

(i) The facility or organization is located within a 35-mile radius of the main campus of the hospital or CAH that is the potential main provider;

(ii) The facility or organization is owned and operated by a hospital or CAH that has a disproportionate share adjustment (as determined under § 412.106 of this chapter) greater than 11.75 percent or is described in § 412.106(c)(2) of this chapter implementing section 1886(d)(5)(F)(i)(II) of the Act and is—

(A) Owned or operated by a unit of State or local government;

(B) A public or nonprofit corporation that is formally granted governmental powers by a unit of State or local government; or

(C) A private hospital that has a contract with a State or local government that includes the operation of clinics located off the main campus of the hospital to assure access in a well-defined service area to health care services to low-income individuals who are not entitled to benefits under Medicare (or medical assistance under a Medicaid State plan).

(iii) The facility or organization demonstrates a high level of integration with the main provider by showing that it meets all of the other provider-based criteria and demonstrates that it serves the same patient population as the main provider, by submitting records showing that, during the 12-month period immediately preceding the first day of the month in which the application for provider-based status is filed with CMS, and for each subsequent 12-month period—

(A) At least 75 percent of the patients served by the facility or organization reside in the same zip code areas as at least 75 percent of the patients served by the main provider;

(B) At least 75 percent of the patients served by the facility or organization who required the type of care furnished by the main provider received that care from that provider (for example, at least 75 percent of the patients of an RHC seeking provider-based status received inpatient hospital services from the hospital that is the main provider); or

(C) If the facility or organization is unable to meet the criteria in paragraph (d)(7)(i)(A) or (d)(7)(i)(B) of this section because it was not in operation during all of the 12-month period described in the previous sentence, the facility or organization is located in a zip code area included among those that, during all of the 12-month period described in the previous sentence, accounted for at least 75 percent of the patients served by the main provider.

(iv) A facility or organization is not considered in the ''immediate vicinity'' of the main provider unless the facility or organization and the main provider are located in the same State or, when consistent with the laws of both States, or adjacent States.

(v) An RHC that is otherwise qualified as a provider-based entity of a hospital that is located in a rural area, as defined in § 412.62(f)(1)(iii) of this chapter, and has fewer than 50 beds, as determined under § 412.105(b) of this chapter, is not subject to the criteria in paragraphs (d)(7)(i) through (d)(7)(iv) of this section.

* * * * *

(g) *Obligations of hospital outpatient departments and hospital-based entities.* * * *

* * * * *

(7) When a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity (other than an RHC) that is not located on the main provider's campus, the hospital must provide written notice to the beneficiary, before the delivery of services, of the amount of the beneficiary's potential financial liability (that is, that the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital as well as for the physician service, and of the amount of that liability). The notice must be one that the beneficiary can read and understand. If the exact type and extent of care needed is not known, the hospital may furnish a written notice to the patient that explains that the beneficiary will incur a coinsurance liability to the hospital that he or she would not incur if the facility were not provider-based. The hospital may furnish an estimate based on typical or average charges for visits to the facility, while stating that the patient's actual liability will depend upon the actual services furnished by the hospital. If the beneficiary is unconscious, under great duress, or for any other reason unable to read a written notice and understand and act on his or her own rights, the notice must be provided, before the delivery of services, to the beneficiary's authorized representative.

* * * * *

(i) *Inappropriate treatment of a facility or organization as provider-based*—(1) *Determination and review.* If CMS learns that a provider has treated a facility or organization as provider-based and the provider had not obtained a determination of provider-based status under this section, CMS will—

* * * * *

(ii) Investigate and determine whether the requirements in paragraph (d) of this section (or, for periods before the beginning of the hospital's first cost reporting period beginning or or after January 10, 2001, the requirements in applicable program instructions) were met; and

* * * * *

(2) *Recovery of overpayments.* If CMS finds that payments for services at the facility or organization were made as if the facility or organization were provider-based, even though CMS had not previously determined that the facility or organization qualified for provider-based status—

(i) CMS will recover the difference between the amount of payments that actually were made and the amount of payments that CMS estimates would have been made in the absence of a determination of provider-based status.

(ii) CMS will not make recovery payments for any period before the beginning of the hospital's first cost reporting period beginning on or after January 10, 2001 if during all of that period the management of the entity made a good faith effort to operate it as a provider-based facility or organization, as described in paragraph (h)(3) of this section.

* * * * *

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

B. Part 419 is amended as set forth below:

1. The authority citation for part 419 continues to read as follows:

Authority: Secs. 1102, 1833(t), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395l(t), and 1395hh).

Subpart A—General Provisions

2. In § 419.2, paragraph (c) is revised to read as follows:

§ 419.2 Basis of payment.

* * * * *

(c) *Determination of hospital outpatient prospective payment rates: Excluded costs.* The following costs are excluded from the hospital outpatient prospective payment system.

(1) The costs of direct graduate medical education activities as described in § 413.86 of this chapter.

(2) The costs of nursing and allied health programs as described in § 413.85 of this chapter.

(3) The costs associated with interns and residents not in approved teaching programs as described in § 415.202 of this chapter.

(4) The costs of teaching physicians attributable to Part B services for hospitals that elect cost-based reimbursement for teaching physicians under § 415.160.

(5) The reasonable costs of anesthesia services furnished to hospital outpatients by qualified nonphysician anesthetists (certified registered nurse anesthetists and anesthesiologists' assistants) employed by the hospital or obtained under arrangements, for hospitals that meet the requirements under § 412.113(c) of this chapter.

(6) Bad debts for uncollectible deductibles and coinsurances as described in § 413.80(b) of this chapter.

(7) Organ acquisition costs paid under Part B.

(8) Corneal tissue acquisition costs.

Subpart B—Categories of Hospitals and Services Subject to and Excluded from the Hospital Outpatient Prospective Payment System

3. In § 419.20, paragraph (a) is revised, and paragraphs (b)(3) and (b)(4) are added to read as follows:

§ 419.20 Hospitals subject to the hospital outpatient prospective payment system.

(a) *Applicability.* The hospital outpatient prospective payment system is applicable to any hospital participating in the Medicare program, except those specified in paragraph (b) of this section, for services furnished on or after August 1, 2000.

(b) *Hospitals excluded from the outpatient prospective payment system.*

* * * * *

(3) A hospital located outside one of the 50 States, the District of Columbia, and Puerto Rico is excluded from the hospital outpatient prospective payment system.

(4) A hospital of the Indian Health Service.

4. In § 419.22, the introductory text is republished, and paragraph (r) is added to read as follows:

§ 419.22 Hospital outpatient services excluded from payment under the hospital outpatient prospective payment system.

The following services are not paid for under the hospital outpatient prospective payment system:

* * * * *

(r) Services defined in § 419.21(b) that are furnished to inpatients of hospitals that do not submit claims for outpatient services under Medicare Part B.

Subpart C—Basic Methodology for Determining Prospective Payment Rates for Hospital Outpatient Services

5. In § 419.32, paragraph (b)(1) is revised to read as follows:

§ 419.32 Calculation of prospective payment rates for hospital outpatient services.

* * * * *

(b) *Conversion factor for calendar year 2000 and subsequent years.* (1) Subject to paragraph (b)(2) of this section, the conversion factor for a calendar year is equal to the conversion factor calculated for the previous year adjusted as follows:

(i) For calendar year 2000, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act reduced by one percentage point.

(ii) For calendar year 2001—

(A) For services furnished on or after January 1, 2001 and before April 1, 2001, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act reduced by one percentage point; and

(B) For services furnished on or after April 1, 2001 and before January 1, 2002, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act, and increased by a transitional percentage allowance equal to 0.32 percent.

(iii) For calendar year 2002, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act reduced by one percentage point, without taking into account the transitional percentage allowance referenced in § 419.32(b)(ii)(B).

(iv) For calendar year 2003 and subsequent years, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act.

* * * * *

Subpart D—Payments to Hospitals

6. In § 419.40, the word ''coinsurance'' is removed and the word ''copayment'' is added in its place as follows. As revised, § 419.40 reads as follows:

§ 419.40 Payment concepts.

(a) In addition to the payment rate described in § 419.32, for each APC group there is a predetermined beneficiary copayment amount as described in § 419.41(a). The Medicare program payment amount for each APC group is calculated by applying the

program payment percentage as described in § 419.41(b).

(b) For purposes of this section—

(1) Coinsurance percentage is calculated as the difference between the program payment percentage and 100 percent. The coinsurance percentage in any year is thus defined for each APC group as the greater of the following: the ratio of the APC group unadjusted copayment amount to the annual APC group payment rate, or 20 percent.

(2) Program payment percentage is calculated as the lower of the following: the ratio of the APC group payment rate minus the APC group unadjusted copayment amount, to the APC group payment rate, or 80 percent.

(3) Unadjusted copayment amount is calculated as 20 percent of the wage-adjusted national median of charges for services within an APC group furnished during 1996, updated to 1999 using an actuarial projection of charge increases for hospital outpatient department services during the period 1996 to 1999.

(c) *Limitation of copayment amount to inpatient hospital deductible amount.* The copayment amount for a procedure performed in a year cannot exceed the amount of the inpatient hospital deductible established under section 1813(b) of the Act for that year.

7. Amend § 419.41 as follows:

A. The section heading is revised.

B. The word ''coinsurance'' is removed each time it appears, and the word ''copayment'' is added in its place.

C. Paragraph (c)(4)(ii) is redesignated as paragraph (c)(4)(iv).

D. Paragraphs (c)(4)(ii) and (c)(4)(iii) are added as follows:

§ 419.41 Calculation of national beneficiary copayment amounts and national Medicare program payment amounts.

* * * * *

(c) * * *

(4) * * *

(ii) Effective for services furnished from April 1, 2001 through December 31, 2001, the national unadjusted coinsurance rate for an APC cannot exceed 57 percent of the prospective payment rate for that APC.

(iii) The national unadjusted coinsurance rate for an APC cannot exceed 55 percent in calendar years 2002 and 2003; 50 percent in calendar year 2004; 45 percent in calendar year 2005; and 40 percent in calendar year 2006 and thereafter.

* * * * *

8. In § 419.42 paragraph (a), (c), and (e) are revised to read as follows:

§ 419.42 Hospital election to reduce coinsurance.

(a) A hospital may elect to reduce coinsurance for any or all APC groups on a calendar year basis. A hospital may not elect to reduce copayment amounts for some, but not all, services within the same group.

* * * * *

(c) The hospital's election must be properly documented. It must specifically identify the APCs to which it applies and the copayment amount (within the limits identified below) that the hospital has selected for each group.

* * * * *

(e) In electing reduced coinsurance, a hospital may elect a copayment amount that is less than that year's wage-adjusted copayment amount for the group but not less than 20 percent of the APC payment rate as determined in § 419.32.

* * * * *

§ 419.43 [Amended]

9. Section 419.43 is amended by removing the word ''coinsurance'' from the section heading and from paragraph (a), and adding the word ''copayment'' in its place.

Subpart H—Transitional Corridors

10. In § 419.70, paragraph (d)(2) is revised to read as follows:

§ 419.70 Transitional adjustment to limit decline in payment.

* * * * *

(d) *Hold harmless provisions* * * *

* * * * *

(2) *Permanent treatment for cancer hospitals and children's hospitals.* In the case of a hospital described in § 412.23(d) or § 412.23(f) of this chapter for which the prospective payment system amount is less than the pre-BBA amount for covered hospital outpatient services, the amount of payment under this part is increased by the amount of this difference.

* * * * *

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

C. Part 489 is amended as set forth below:

1. The authority citation to part 489 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart B—Essentials of Provider Agreements

2. In § 489.24, paragraphs (i)(2) introductory text and (i)(2)(ii) are revised to read as follows:

§ 489.24 Special responsibilities of Medicare hospitals in emergency cases.

* * * * *

(i) *Off-campus departments.* * * *

(2) *Protocols for off-campus departments.* The hospital must establish protocols for the handling of individuals with potential emergency conditions at off-campus departments. These protocols must provide for direct contact between personnel at the off-campus department and emergency personnel at the main hospital campus and may provide for dispatch of practitioners, when appropriate, from the main hospital campus to the off-campus department to provide screening or stabilization services. Any contact with emergency personnel at the main hospital campus should either be made after or concurrently with the actions needed to arrange an appropriate transfer under paragraph (i)(3)(ii) of this section if contacting the main hospital campus prior to transfer would significantly jeopardize the life or health of the individual.

* * * * *

(ii) If the off-campus department is a physical therapy, radiology, or other facility not routinely staffed with physicians, RNs, or LPNs, the department's personnel must be given protocols that direct them to contact emergency personnel at the main hospital campus for direction. Under this direction, and in accordance with protocols established in advance by the hospital, the personnel at the off-campus department must describe patient appearance and report symptoms and, if appropriate, either arrange transportation of the individual to the main hospital campus in accordance with paragraph (i)(3)(i) of this section or assist in an appropriate transfer as described in paragraphs (i)(3)(ii) and (d)(2) of this section.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: November 20, 2001.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: November 23, 2001.

Tommy G. Thompson,

Secretary.

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS

[Calendar Year 2002]

APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0001	Photochemotherapy	S	0.43	$21.89	$7.88	$4.38
0002	Fine needle Biopsy/Aspiration	T	0.42	$21.38	$11.76	$4.28
0003	Bone Marrow Biopsy/Aspiration	T	1.03	$52.43	$27.99	$10.49
0004	Level I Needle Biopsy/ Aspiration Except Bone Marrow	T	2.47	$125.73	$32.57	$25.15
0005	Level II Needle Biopsy /Aspiration Except Bone Marrow	T	4.03	$205.14	$90.26	$41.03
0006	Level I Incision & Drainage	T	2.18	$110.97	$33.95	$22.19
0007	Level II Incision & Drainage	T	6.75	$343.60	$72.03	$68.72
0008	Level III Incision and Drainage	T	10.93	$556.38	$113.67	$111.28
0009	Nail Procedures	T	0.63	$32.07	$8.34	$6.41
0010	Level I Destruction of Lesion	T	0.66	$33.60	$9.86	$6.72
0011	Level II Destruction of Lesion	T	1.47	$74.83	$27.69	$14.97
0012	Level I Debridement & Destruction	T	0.66	$33.60	$9.18	$6.72
0013	Level II Debridement & Destruction	T	1.36	$69.23	$17.66	$13.85
0015	Level IV Debridement & Destruction	T	2.07	$105.37	$31.20	$21.07
0016	Level V Debridement & Destruction	T	3.02	$153.73	$64.57	$30.75
0017	Level VI Debridement & Destruction	T	9.68	$492.75	$226.67	$98.55
0018	Biopsy of Skin/Puncture of Lesion	T	1.05	$53.45	$17.66	$10.69
0019	Level I Excision/ Biopsy	T	4.22	$214.81	$78.91	$42.96
0020	Level II Excision/ Biopsy	T	8.44	$429.63	$130.53	$85.93
0021	Level IV Excision/ Biopsy	T	11.82	$601.69	$236.51	$120.34
0022	Level V Excision/ Biopsy	T	13.91	$708.07	$292.94	$141.61
0023	Exploration Penetrating Wound	T	2.08	$105.88	$40.37	$21.18
0024	Level I Skin Repair	T	2.28	$116.06	$41.78	$23.21
0025	Level II Skin Repair	T	3.39	$172.56	$65.57	$34.51
0026	Level III Skin Repair	T	12.62	$642.41	$277.92	$128.48
0027	Level IV Skin Repair	T	18.02	$917.29	$383.10	$183.46
0028	Level I Breast Surgery	T	14.00	$712.66	$303.74	$142.53
0029	Level II Breast Surgery	T	23.76	$1,209.48	$628.93	$241.90
0030	Level III Breast Surgery	T	34.20	$1,740.92	$763.55	$348.18
0032	Insertion of Central Venous/Arterial Catheter	T	12.64	$643.43	.....	$128.69
0033	Partial Hospitalization	P	4.17	$212.27	$48.17	$42.45
0035	Placement of Arterial or Central Venous Catheter	T	0.12	$6.11	$2.69	$1.22
0041	Level I Arthroscopy	T	23.61	$1,201.84	$576.88	$240.37
0042	Level II Arthroscopy	T	35.76	$1,820.33	$804.74	$364.07
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	4.05	$206.16	.....	$41.23
0044	Closed Treatment Fracture/Dislocation Except Finger/Toe/Trunk	T	2.52	$128.28	$38.08	$25.66
0045	Bone/Joint Manipulation Under Anesthesia	T	11.67	$594.05	$277.12	$118.81
0046	Open/Percutaneous Treatment Fracture or Dislocation	T	27.69	$1,409.53	$535.76	$281.91
0047	Arthroplasty without Prosthesis	T	26.36	$1,341.83	$537.03	$268.37
0048	Arthroplasty with Prosthesis	T	43.19	$2,198.54	$725.94	$439.71
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	15.84	$806.32	$356.95	$161.26
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	20.63	$1,050.15	$504.07	$210.03
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	28.56	$1,453.82	$675.24	$290.76
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	35.94	$1,829.49	$930.91	$365.90
0053	Level I Hand Musculoskeletal Procedures	T	11.69	$595.07	$253.49	$119.01
0054	Level II Hand Musculoskeletal Procedures	T	19.83	$1,009.43	$472.33	$201.89
0055	Level I Foot Musculoskeletal Procedures	T	15.44	$785.96	$355.34	$157.19
0056	Level II Foot Musculoskeletal Procedures	T	18.85	$959.54	$405.81	$191.91
0057	Bunion Procedures	T	24.35	$1,239.51	$496.65	$247.90
0058	Level I Strapping and Cast Application	S	1.28	$65.16	$19.27	$13.03
0059	Level II Strapping and Cast Application	S	2.22	$113.01	$29.59	$22.60
0060	Manipulation Therapy	S	0.23	$11.71	.....	$2.34
0068	CPAP Initiation	S	3.02	$153.73	$84.55	$30.75
0069	Thoracoscopy	T	23.57	$1,199.81	.....	$239.96
0070	Thoracentesis/Lavage Procedures	T	4.58	$233.14	$79.60	$46.63
0071	Level I Endoscopy Upper Airway	T	1.03	$52.43	$14.22	$10.49
0072	Level II Endoscopy Upper Airway	T	1.21	$61.59	$33.87	$12.32
0073	Level III Endoscopy Upper Airway	T	3.29	$167.47	$73.69	$33.49
0074	Level IV Endoscopy Upper Airway	T	11.32	$576.23	$293.88	$115.25
0075	Level V Endoscopy Upper Airway	T	17.42	$886.75	$443.38	$177.35
0076	Endoscopy Lower Airway	T	7.56	$384.83	$188.57	$76.97
0077	Level I Pulmonary Treatment	S	0.39	$19.85	$10.92	$3.97
0078	Level II Pulmonary Treatment	S	0.86	$43.78	$18.83	$8.76
0079	Ventilation Initiation and Management	S	0.60	$30.54	$16.80	$6.11
0080	Diagnostic Cardiac Catheterization	T	34.73	$1,767.90	$838.92	$353.58
0081	Non-Coronary Angioplasty or Atherectomy	T	29.24	$1,488.43	$710.91	$297.69
0082	Coronary Atherectomy	T	92.00	$4,683.17	$1,351.74	$936.63

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS—Continued

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APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0083	Coronary Angioplasty	T	59.49	$3,028.28	$794.30	$605.66
0084	Level I Electrophysiologic Evaluation	S	199.65	$10,162.98	.....	$2,032.60
0085	Level II Electrophysiologic Evaluation	T	38.69	$1,969.48	$654.48	$393.90
0086	Ablate Heart Dysrhythm Focus	T	72.72	$3,701.74	$1,265.37	$740.35
0087	Cardiac Electrophysiologic Recording/Mapping	T	52.46	$2,670.42	.....	$534.08
0088	Thrombectomy	T	34.38	$1,750.08	$678.68	$350.02
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	T	149.52	$7,611.17	$2,246.59	$1,522.23
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	117.54	$5,983.26	$2,133.88	$1,196.65
0091	Level I Vascular Ligation	T	20.34	$1,035.39	$348.23	$207.08
0092	Level II Vascular Ligation	T	19.91	$1,013.50	$503.71	$202.70
0093	Vascular Repair/Fistula Construction	T	14.16	$720.80	$277.34	$144.16
0094	Resuscitation and Cardioversion	S	6.08	$309.50	$105.29	$61.90
0095	Cardiac Rehabilitation	S	0.61	$31.05	$16.46	$6.21
0096	Non-Invasive Vascular Studies	S	1.71	$87.05	$47.88	$17.41
0097	Cardiac Monitoring for 30 days	X	0.84	$42.76	$23.52	$8.55
0098	Injection of Sclerosing Solution	T	1.24	$63.12	$20.88	$12.62
0099	Electrocardiograms	S	0.35	$17.82	$9.80	$3.56
0100	Stress Tests and Continuous ECG	X	1.47	$74.83	$41.16	$14.97
0101	Tilt Table Evaluation	S	3.74	$190.38	$104.71	$38.08
0103	Miscellaneous Vascular Procedures	T	15.95	$811.92	$295.70	$162.38
0104	Transcatheter Placement of Intracoronary Stents	T	87.98	$4,478.53	.....	$895.71
0105	Revision/Removal of Pacemakers, AICD, or Vascular	T	14.76	$751.34	$368.16	$150.27
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	T	36.64	$1,865.12	$503.07	$373.02
0107	Insertion of Cardioverter-Defibrillator	T	379.46	$19,316.03	$4,224.27	$3,863.21
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T	573.46	$29,191.41	.....	$5,838.28
0109	Removal of Implanted Devices	T	6.27	$319.17	$130.86	$63.83
0110	Transfusion	S	5.30	$269.79	$113.31	$53.96
0111	Blood Product Exchange	S	21.08	$1,073.06	$300.74	$214.61
0112	Apheresis, Photopheresis, and Plasmapheresis	S	36.25	$1,845.27	$608.94	$369.05
0113	Excision Lymphatic System	T	15.53	$790.54	$326.55	$158.11
0114	Thyroid/Lymphadenectomy Procedures	T	29.28	$1,490.47	$493.78	$298.09
0115	Cannula/Access Device Procedures	T	21.35	$1,086.80	$506.74	$217.36
0116	Chemotherapy Administration by Other Technique Except Infusion	S	0.91	$46.32	.....	$9.26
0117	Chemotherapy Administration by Infusion Only	S	4.01	$204.13	$52.69	$40.83
0118	Chemotherapy Administration by Both Infusion and Other Technique	S	4.20	$213.80	$72.03	$42.76
0119	Implantation of Devices	T	79.67	$4,055.52	.....	$811.10
0120	Infusion Therapy Except Chemotherapy	T	3.08	$156.78	$42.67	$31.36
0121	Level I Tube changes and Repositioning	T	2.54	$129.30	$52.53	$25.86
0122	Level II Tube changes and Repositioning	T	9.89	$503.44	$114.93	$100.69
0123	Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant	S	8.56	$435.74	.....	$87.15
0124	Revision of Implanted Infusion Pump	T	89.07	$4,534.02	.....	$906.80
0125	Refilling of Infusion Pump	T	3.00	$152.71	.....	$30.54
0130	Level I Laparoscopy	T	25.91	$1,318.92	$659.53	$263.78
0131	Level II Laparoscopy	T	37.63	$1,915.52	$996.07	$383.10
0132	Level III Laparoscopy	T	56.06	$2,853.68	$1,239.22	$570.74
0140	Esophageal Dilation without Endoscopy	T	5.65	$287.61	$107.24	$57.52
0141	Upper GI Procedures	T	7.21	$367.02	$184.67	$73.40
0142	Small Intestine Endoscopy	T	6.94	$353.27	$151.91	$70.65
0143	Lower GI Endoscopy	T	7.27	$370.07	$185.04	$74.01
0144	Diagnostic Anoscopy	T	4.43	$225.50	$49.32	$45.10
0145	Therapeutic Anoscopy	T	10.81	$550.27	$179.39	$110.05
0146	Level I Sigmoidoscopy	T	2.73	$138.97	$63.93	$27.79
0147	Level II Sigmoidoscopy	T	5.71	$290.66	$136.61	$58.13
0148	Level I Anal/Rectal Procedure	T	2.40	$122.17	$43.59	$24.43
0149	Level III Anal/Rectal Procedure	T	13.53	$688.73	$293.06	$137.75
0150	Level IV Anal/Rectal Procedure	T	18.08	$920.34	$437.12	$184.07
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	T	15.29	$778.32	$245.46	$155.66
0152	Percutaneous Biliary Endoscopic Procedures	T	16.13	$821.08	$207.38	$164.22
0153	Peritoneal and Abdominal Procedures	T	23.55	$1,198.79	$496.31	$239.76
0154	Hernia/Hydrocele Procedures	T	31.40	$1,598.39	$556.98	$319.68
0155	Level II Anal/Rectal Procedure	T	5.26	$267.76	.....	$53.55
0156	Level II Urinary and Anal Procedures	T	2.45	$124.71	$37.41	$24.94
0157	Colorectal Cancer Screening: Barium Enema	S	1.98	$100.79	$22.19	$20.16
0158	Colorectal Cancer Screening: Colonoscopy	T	6.55	$333.42	$83.36	$66.68
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	2.33	$118.61	$29.65	$23.72
0160	Level I Cystourethroscopy and other Genitourinary Procedures	T	5.13	$261.14	$104.46	$52.23
0161	Level II Cystourethroscopy and other Genitourinary Procedures	T	13.72	$698.40	$249.36	$139.68
0162	Level III Cystourethroscopy and other Genitourinary Procedures	T	25.09	$1,277.18	$427.49	$255.44
0163	Level IV Cystourethroscopy and other Genitourinary Procedures	T	40.40	$2,056.52	$792.58	$411.30
0164	Level I Urinary and Anal Procedures	T	1.01	$51.41	$15.42	$10.28
0165	Level III Urinary and Anal Procedures	T	5.22	$265.72	$91.76	$53.14
0166	Level I Urethral Procedures	T	12.20	$621.03	$218.73	$124.21
0167	Level II Urethral Procedures	T	22.28	$1,134.14	$555.84	$226.83
0168	Level III Urethral Procedures	T	18.42	$937.65	$403.19	$187.53
0169	Lithotripsy	T	39.62	$2,016.82	$1,109.25	$403.36
0170	Dialysis for Other Than ESRD Patients	S	0.28	$14.25	$3.14	$2.85
0179	Urinary Incontinence Procedures	T	139.33	$7,092.45	$2,340.51	$1,418.49

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS—Continued

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APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0180	Circumcision	T	15.02	$764.58	$304.87	$152.92
0181	Penile Procedures	T	22.09	$1,124.47	$618.46	$224.89
0182	Insertion of Penile Prosthesis	T	87.54	$4,456.14	$1,492.28	$891.23
0183	Testes/Epididymis Procedures	T	18.87	$960.56	$448.94	$192.11
0184	Prostate Biopsy	T	4.83	$245.87	$122.94	$49.17
0187	Miscellaneous Placement/Repositioning	X	4.22	$214.81	.....	$42.96
0188	Level II Female Reproductive Proc	T	0.80	$40.72	$11.81	$8.14
0189	Level III Female Reproductive Proc	T	1.26	$64.14	$17.96	$12.83
0190	Surgical Hysteroscopy	T	16.91	$860.79	$421.79	$172.16
0191	Level I Female Reproductive Proc	T	0.23	$11.71	$3.40	$2.34
0192	Level IV Female Reproductive Proc	T	2.50	$127.26	$35.33	$25.45
0193	Level V Female Reproductive Proc	T	11.16	$568.09	$171.13	$113.62
0194	Level VI Female Reproductive Proc	T	15.86	$807.34	$395.60	$161.47
0195	Level VII Female Reproductive Proc	T	20.62	$1,049.64	$483.80	$209.93
0196	Dilation and Curettage	T	13.48	$686.19	$336.23	$137.24
0197	Infertility Procedures	T	2.40	$122.17	$49.55	$24.43
0198	Pregnancy and Neonatal Care Procedures	T	1.31	$66.68	$32.67	$13.34
0199	Vaginal Delivery	T	5.09	$259.10	$72.55	$51.82
0200	Therapeutic Abortion	T	11.34	$577.25	$305.94	$115.45
0201	Spontaneous Abortion	T	14.33	$729.45	$329.65	$145.89
0202	Level VIII Female Reproductive Proc	T	63.54	$3,234.44	$1,487.84	$646.89
0203	Level V Nerve Injections	T	15.79	$803.77	$369.73	$160.75
0204	Level VI Nerve Injections	T	2.24	$114.02	$43.33	$22.80
0206	Level III Nerve Injections	T	3.59	$182.75	$74.93	$36.55
0207	Level IV Nerve Injections	T	5.36	$272.85	$122.78	$54.57
0208	Laminotomies and Laminectomies	T	29.12	$1,482.32	.....	$296.46
0209	Extended EEG Studies and Sleep Studies, Level II	S	10.54	$536.53	$279.00	$107.31
0212	Level II Nervous System Injections	T	3.77	$191.91	$88.78	$38.38
0213	Extended EEG Studies and Sleep Studies, Level I	S	2.65	$134.90	$70.15	$26.98
0214	Electroencephalogram	S	2.10	$106.90	$53.45	$21.38
0215	Level I Nerve and Muscle Tests	S	0.66	$33.60	$17.47	$6.72
0216	Level III Nerve and Muscle Tests	S	2.61	$132.86	$59.79	$26.57
0218	Level II Nerve and Muscle Tests	S	1.03	$52.43	$23.59	$10.49
0220	Level I Nerve Procedures	T	13.60	$692.29	$325.38	$138.46
0221	Level II Nerve Procedures	T	21.43	$1,090.87	$463.62	$218.17
0222	Implantation of Neurological Device	T	302.53	$15,399.99	.....	$3,080.00
0223	Implantation of Pain Management Device	T	75.39	$3,837.65	.....	$767.53
0224	Implantation of Reservoir/Pump/Shunt	T	28.48	$1,449.75	$453.41	$289.95
0225	Implantation of Neurostimulator Electrodes	T	267.56	$13,619.87	.....	$2,723.97
0226	Implantation of Drug Infusion Reservoir	T	75.81	$3,859.03	.....	$771.81
0227	Implantation of Drug Infusion Device	T	139.55	$7,103.65	.....	$1,420.73
0228	Creation of Lumbar Subarachnoid Shunt	T	53.77	$2,737.11	$696.46	$547.42
0229	Transcatherter Placement of Intravascular Shunts	T	67.22	$3,421.77	$996.86	$684.35
0230	Level I Eye Tests & Treatments	S	0.61	$31.05	$14.28	$6.21
0231	Level III Eye Tests & Treatments	S	2.03	$103.34	$46.50	$20.67
0232	Level I Anterior Segment Eye Procedures	T	3.50	$178.16	$78.39	$35.63
0233	Level II Anterior Segment Eye Procedures	T	10.83	$551.29	$264.62	$110.26
0234	Level III Anterior Segment Eye Procedures	T	19.08	$971.25	$466.20	$194.25
0235	Level I Posterior Segment Eye Procedures	T	5.57	$283.54	$78.91	$56.71
0236	Level II Posterior Segment Eye Procedures	T	16.21	$825.15	.....	$165.03
0237	Level III Posterior Segment Eye Procedures	T	36.32	$1,848.83	.....	$369.77
0238	Level I Repair and Plastic Eye Procedures	T	3.01	$153.22	$58.96	$30.64
0239	Level II Repair and Plastic Eye Procedures	T	5.80	$295.24	$115.14	$59.05
0240	Level III Repair and Plastic Eye Procedures	T	13.83	$704.00	$315.34	$140.80
0241	Level IV Repair and Plastic Eye Procedures	T	18.12	$922.38	$384.47	$184.48
0242	Level V Repair and Plastic Eye Procedures	T	23.72	$1,207.44	$597.36	$241.49
0243	Strabismus/Muscle Procedures	T	17.70	$901.00	$429.78	$180.20
0244	Corneal Transplant	T	38.46	$1,957.77	$851.42	$391.55
0245	Level I Cataract Procedures without IOL Insert	T	10.44	$531.44	$249.78	$106.29
0246	Cataract Procedures with IOL Insert	T	21.20	$1,079.16	$507.21	$215.83
0247	Laser Eye Procedures Except Retinal	T	4.03	$205.14	$94.36	$41.03
0248	Laser Retinal Procedures	T	29.51	$1,502.18	.....	$300.44
0249	Level II Cataract Procedures without IOL Insert	T	21.80	$1,109.71	$521.56	$221.94
0250	Nasal Cauterization/Packing	T	2.10	$106.90	$37.42	$21.38
0251	Level I ENT Procedures	T	2.43	$123.70	$27.99	$24.74
0252	Level II ENT Procedures	T	5.95	$302.88	$114.24	$60.58
0253	Level III ENT Procedures	T	12.33	$627.65	$284.00	$125.53
0254	Level IV ENT Procedures	T	17.37	$884.20	$272.41	$176.84
0256	Level V ENT Procedures	T	26.61	$1,354.56	$623.05	$270.91
0258	Tonsil and Adenoid Procedures	T	17.43	$887.26	$434.76	$177.45
0259	Level VI ENT Procedures	T	376.56	$19,168.41	$8,798.30	$3,833.68
0260	Level I Plain Film Except Teeth	X	0.70	$35.63	$19.60	$7.13
0261	Level II Plain Film Except Teeth Including Bone Density Measurement	X	1.21	$61.59	$33.87	$12.32
0262	Plain Film of Teeth	X	0.65	$33.09	$10.90	$6.62
0263	Level I Miscellaneous Radiology Procedures	X	1.61	$81.96	$44.26	$16.39
0264	Level II Miscellaneous Radiology Procedures	X	3.71	$188.85	$103.87	$37.77
0265	Level I Diagnostic Ultrasound Except Vascular	S	0.95	$48.36	$26.60	$9.67

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS—Continued

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APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0266	Level II Diagnostic Ultrasound Except Vascular	S	1.54	$78.39	$43.11	$15.68
0267	Vascular Ultrasound	S	2.33	$118.61	$65.24	$23.72
0269	Level I Echocardiogram Except Transesophageal	S	3.85	$195.98	$101.91	$39.20
0270	Transesophageal Echocardiogram	S	5.30	$269.79	$145.69	$53.96
0271	Mammography	S	0.60	$30.54	$16.80	$6.11
0272	Level I Fluoroscopy	X	1.38	$70.25	$38.64	$14.05
0274	Myelography	S	5.24	$266.74	$128.12	$53.35
0275	Arthrography	S	2.59	$131.84	$68.56	$26.37
0276	Level I Digestive Radiology	S	1.48	$75.34	$41.44	$15.07
0277	Level II Digestive Radiology	S	2.16	$109.95	$60.47	$21.99
0278	Diagnostic Urography	S	2.34	$119.12	$65.52	$23.82
0279	Level I Angiography and Venography except Extremity	S	7.72	$392.98	$174.57	$78.60
0280	Level II Angiography and Venography except Extremity	S	13.54	$689.24	$351.51	$137.85
0281	Venography of Extremity	S	4.32	$219.91	$114.35	$43.98
0282	Miscellaneous Computerized Axial Tomography	S	1.58	$80.43	$44.24	$16.09
0283	Computerized Axial Tomography with Contrast Material	S	4.48	$228.05	$125.43	$45.61
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast Material.	S	7.15	$363.96	$200.18	$72.79
0285	Positron Emission Tomography (PET)	S	18.72	$952.92	$415.21	$190.58
0286	Myocardial Scans	S	5.41	$275.39	$151.46	$55.08
0287	Complex Venography	S	4.06	$206.67	$90.93	$41.33
0288	CT, Bone Density	S	1.17	$59.56	$32.76	$11.91
0289	Needle Localization for Breast Biopsy	X	1.63	$82.97	$44.80	$16.59
0290	Standard Non-Imaging Nuclear Medicine	S	1.75	$89.08	$48.99	$17.82
0291	Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans	S	3.50	$178.16	$90.20	$35.63
0292	Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans	S	4.20	$213.80	$117.59	$42.76
0294	Level I Therapeutic Nuclear Medicine	S	5.01	$255.03	$140.27	$51.01
0295	Level II Therapeutic Nuclear Medicine	S	12.10	$615.94	$338.77	$123.19
0296	Level I Therapeutic Radiologic Procedures	S	3.39	$172.56	$94.91	$34.51
0297	Level II Therapeutic Radiologic Procedures	S	7.07	$359.89	$172.51	$71.98
0299	Miscellaneous Radiation Treatment	S	0.21	$10.69	$4.06	$2.14
0300	Level I Radiation Therapy	S	2.07	$105.37	$47.72	$21.07
0301	Level II Radiation Therapy	S	5.15	$262.16	$52.53	$52.43
0302	Level III Radiation Therapy	S	11.16	$568.09	$216.55	$113.62
0303	Treatment Device Construction	X	3.00	$152.71	$69.28	$30.54
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.63	$82.97	$41.52	$16.59
0305	Level II Therapeutic Radiation Treatment Preparation	X	3.71	$188.85	$90.65	$37.77
0310	Level III Therapeutic Radiation Treatment Preparation	X	14.51	$738.62	$339.05	$147.72
0312	Radioelement Applications	S	32.40	$1,649.29	.....	$329.86
0313	Brachytherapy	S	14.84	$755.42	$164.02	$151.08
0314	Hyperthermic Therapies	S	3.90	$198.53	$101.25	$39.71
0320	Electroconvulsive Therapy	S	3.88	$197.51	$80.06	$39.50
0321	Biofeedback and Other Training	S	0.93	$47.34	$21.78	$9.47
0322	Brief Individual Psychotherapy	S	1.15	$58.54	$12.29	$11.71
0323	Extended Individual Psychotherapy	S	1.73	$88.06	$21.13	$17.61
0324	Family Psychotherapy	S	2.69	$136.93	$20.19	$27.39
0325	Group Psychotherapy	S	1.38	$70.25	$18.27	$14.05
0330	Dental Procedures	S	10.97	$558.42	.....	$111.68
0332	Computerized Axial Tomography and Computerized Angiography without Contrast Material.	S	3.24	$164.93	$90.71	$32.99
0333	Computerized Axial Tomography and Computerized Angio w/o Contrast Material followed by Contrast.	S	5.22	$265.72	$146.15	$53.14
0335	Magnetic Resonance Imaging, Miscellaneous	S	5.39	$274.37	$150.90	$54.87
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast.	S	6.29	$320.19	$176.10	$64.04
0337	MRI and Magnetic Resonance Angiography without Contrast Material followed by Contrast Material.	S	8.54	$434.72	$239.10	$86.94
0339	Observation	X	6.85	$348.69	.....	$69.74
0340	Minor Ancillary Procedures	X	0.84	$42.76	$10.69	$8.55
0341	Skin Tests and Miscellaneous Red Blood Cell Tests	X	0.10	$5.09	$2.80	$1.02
0342	Level I Pathology	X	0.21	$10.69	$5.88	$2.14
0343	Level II Pathology	X	0.39	$19.85	$10.72	$3.97
0344	Level III Pathology	X	0.56	$28.51	$15.68	$5.70
0345	Level I Transfusion Laboratory Procedures	X	0.26	$13.24	$5.37	$2.65
0346	Level II Transfusion Laboratory Procedures	X	0.77	$39.20	$12.03	$7.84
0347	Level III Transfusion Laboratory Procedures	X	1.56	$79.41	$20.13	$15.88
0348	Fertility Laboratory Procedures	X	0.77	$39.20	.....	$7.84
0352	Level II Injections	X	0.41	$20.87	.....	$4.17
0353	Level II Allergy Injections	X	0.25	$12.73	.....	$2.55
0354	Administration of Influenza/Pneumonia Vaccine	K	0.10	$5.09	.....	.....
0355	Level I Immunizations	K	0.19	$9.67	.....	$1.93
0356	Level II Immunizations	K	1.11	$56.50	.....	$11.30
0359	Level II Injections	X	1.79	$91.12	.....	$18.22
0360	Level I Alimentary Tests	X	1.35	$68.72	$34.36	$13.74
0361	Level II Alimentary Tests	X	3.25	$165.44	$82.72	$33.09
0362	Fitting of Vision Aids	X	0.86	$43.78	$9.63	$8.76
0363	Otorhinolaryngologic Function Tests	X	1.73	$88.06	$32.58	$17.61

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS—Continued

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APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0364	Level I Audiometry	X	0.58	$29.52	$11.51	$5.90
0365	Level II Audiometry	X	1.31	$66.68	$20.00	$13.34
0367	Level I Pulmonary Test	X	0.70	$35.63	$17.82	$7.13
0368	Level II Pulmonary Tests	X	1.47	$74.83	$38.16	$14.97
0369	Level III Pulmonary Tests	X	3.49	$177.65	$58.50	$35.53
0370	Allergy Tests	X	0.80	$40.72	$11.81	$8.14
0371	Level I Allergy Injections	X	0.70	$35.63		$7.13
0372	Therapeutic Phlebotomy	X	0.53	$26.98	$10.09	$5.40
0373	Neuropsychological Testing	X	1.00	$50.90	$14.25	$10.18
0374	Monitoring Psychiatric Drugs	X	0.89	$45.30	$9.97	$9.06
0600	Low Level Clinic Visits	V	0.86	$43.78		$8.76
0601	Mid Level Clinic Visits	V	0.95	$48.36		$9.67
0602	High Level Clinic Visits	V	1.38	$70.25		$14.05
0610	Low Level Emergency Visits	V	1.23	$62.61	$19.41	$12.52
0611	Mid Level Emergency Visits	V	2.16	$109.95	$36.47	$21.99
0612	High Level Emergency Visits	V	3.49	$177.65	$54.14	$35.53
0620	Critical Care	S	8.40	$427.59	$149.66	$85.52
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	9.16	$466.28	$205.16	$93.26
0686	Level V Skin Repair	T	24.01	$1,222.21	$277.92	$244.44
0687	Revision/Removal of Neurostimulator Electrodes	T	42.34	$2,155.28		$431.06
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	T	145.27	$7,394.82		$1,478.96
0689	Electronic Analysis of Cardioverter-defibrillators	S	0.43	$21.89	$12.04	$4.38
0690	Electronic Analysis of Pacemakers and other Cardiac Devices	S	0.37	$18.83	$10.36	$3.77
0691	Electronic Analysis of Programmable Shunts/Pumps	S	3.17	$161.37	$88.75	$32.27
0692	Electronic Analysis of Neurostimulator Pulse Generators	S	14.34	$729.96	$401.48	$145.99
0693	Level II Breast Reconstruction	T	31.81	$1,619.26	$712.47	$323.85
0694	Level III Excision/Biopsy	T	3.99	$203.11	$60.93	$40.62
0695	Level VII Debridement & Destruction	T	15.78	$803.27	$369.50	$160.65
0697	Level II Echocardiogram Except Transesophageal	S	2.08	$105.88	$55.06	$21.18
0698	Level II Eye Tests & Treatments	S	1.03	$52.43	$19.92	$10.49
0699	Level IV Eye Tests & Treatment	T	6.46	$328.84	$147.98	$65.77
0701	SR 89 chloride, per mCi	G		$963.42		$137.92
0702	SM 153 lexidronam, 50 mCi	G		$1,020.00		$146.02
0704	IN 111 Satumomab pendetide per dose	G		$1,591.25		$227.80
0705	TC 99M tetrofosmin, per dose	G		$114.00		$16.32
0706	New Technology—Level I ($0–$50)	S		$25.00		$5.00
0707	New Technology—Level II ($50–$100)	S		$75.00		$15.00
0708	New Technology—Level III ($100–$200)	S		$150.00		$30.00
0709	New Technology—Level IV ($200–$300)	S		$250.00		$50.00
0710	New Technology—Level V ($300–$500)	S		$400.00		$80.00
0711	New Technology—Level VI ($500–$750)	S		$625.00		$125.00
0712	New Technology—Level VII ($750–$1000)	S		$875.00		$175.00
0713	New Technology—Level VIII ($1000–$1250)	S		$1,125.00		$225.00
0714	New Technology—Level IX ($1250–$1500)	S		$1,375.00		$275.00
0715	New Technology—Level X ($1500–$1750)	S		$1,625.00		$325.00
0716	New Technology—Level XI ($1750–$2000)	S		$1,875.00		$375.00
0717	New Technology—Level XII ($2000–$2500)	S		$2,250.00		$450.00
0718	New Technology—Level XIII ($2500–$3000)	S		$2,750.00		$550.00
0719	New Technology—Level XIV ($3000–$3500)	S		$3,250.00		$650.00
0720	New Technology—Level XV ($3500–$5000)	S		$4,250.00		$850.00
0721	New Technology—Level XVI ($5000–$6000)	S		$5,500.00		$1,100.00
0725	Leucovorin calcium inj, 50 mg	G		$4.15		$.38
0726	Dexrazoxane hcl injection, 250 mg	G		$194.52		$24.98
0727	Etidronate disodium inj 300 mg	G		$63.65		$9.11
0728	Filgrastim 300 mcg injection	G		$179.08		$23.00
0730	Pamidronate disodium , 30 mg	G		$265.87		$38.06
0731	Sargramostim injection 50 mcg	G		$29.06		$4.16
0732	Mesna injection 200 mg	G		$36.48		$3.30
0733	Non esrd epoetin alpha inj, 1000 u	G		$12.26		$1.57
0750	Dolasetron mesylate, 10 mg	G		$16.45		$2.11
0754	Metoclopramide hcl injection up to 10 mg	G		$1.17		$.11
0755	Thiethylperazine maleate inj up to 10 mg	G		$4.60		$.66
0762	Dronabinol 2.5mg oral	G		$3.28		$.42
0763	Dolasetron mesylate oral, 100 mg	G		$69.64		$8.94
0764	Granisetron hcl injection 10 mcg	G		$18.54		$2.65
0765	Granisetron hcl 1 mg oral	G		$44.69		$6.40
0768	Ondansetron hcl injection 1 mg	G		$6.09		$.78
0769	Ondansetron hcl 8mg oral	G		$26.41		$3.39
0800	Leuprolide acetate, 3.75 mg	G		$93.47		$12.00
0801	Cyclophosphamide oral 25 mg	G		$2.03		$.18
0802	Etoposide oral 50 mg	G		$52.43		$6.73
0803	Melphalan oral 2 mg	G		$2.29		$.33
0807	Aldesleukin/single use vial	G		$672.60		$96.29
0809	Bcg live intravesical vac	G		$166.49		$21.38
0810	Goserelin acetate implant 3.6 mg	G		$446.49		$63.92
0811	Carboplatin injection 50 mg	G		$114.46		$16.39
0812	Carmus bischl nitro inj 100 mg	G		$117.84		$16.87

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS—Continued

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APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0813	Cisplatin 10 mg injection	G		$42.18		$3.82
0814	Asparaginase injection 10,000 u	G		$62.61		$8.96
0815	Cyclophosphamide 100 mg inj	G		$5.82		$.75
0816	Cyclophosphamide lyophilized 100 mg	G		$4.89		$.63
0817	Cytarabine hcl 100 mg inj	G		$6.10		$.55
0818	Dactinomycin 0.5 mg	G		$13.87		$1.99
0819	Dacarbazine 100 mg inj	G		$12.68		$1.15
0820	Daunorubicin 10 mg	G		$76.62		$6.94
0821	Daunorubicin citrate liposom 10 mg	G		$64.60		$9.25
0822	Diethylstilbestrol injection 250 mg	G		$14.41		$1.30
0823	Docetaxel, 20 mg	G		$297.83		$42.64
0824	Etoposide 10 mg inj	G		$10.45		$.95
0826	Methotrexate Oral 2.5 mg	G		$3.45		$.31
0827	Floxuridine injection 500 mg	G		$129.56		$16.64
0828	Gemcitabine HCL 200 mg	G		$106.72		$15.28
0830	Irinotecan injection 20 mg	G		$134.25		$19.22
0831	Ifosfomide injection 1 gm	G		$156.64		$22.42
0832	Idarubicin hcl injection 5 mg	G		$412.21		$59.01
0833	Interferon alfacon-1, 1 mcg	G		$4.10		$.59
0834	Interferon alfa-2a inj recombinant 3 million u	G		$34.86		$4.99
0836	Interferon alfa-2b inj recombinant, 1 million	G		$11.28		$1.45
0838	Interferon gamma 1–b inj, 3 million u	G		$285.65		$40.89
0839	Mechlorethamine hcl inj 10 mg	G		$12.01		$1.72
0840	Melphalan hydrochl 50 mg	G		$400.74		$57.37
0841	Methotrexate sodium inj 5 mg	G		$.45		$.04
0842	Fludarabine phosphate inj 50 mg	G		$271.82		$38.91
0844	Pentostatin injection, 10 mg	G		$1,654.14		$236.80
0847	Doxorubicin hcl 10 mg vl chemo	G		$37.46		$4.81
0849	Rituximab, 100 mg	G		$454.55		$65.07
0850	Streptozocin injection, 1 gm	G		$117.64		$16.84
0851	Thiotepa injection, 15 mg	G		$116.97		$10.59
0852	Topotecan, 4 mg	G		$664.19		$95.08
0853	Vinblastine sulfate inj, 1 mg	G		$4.11		$.37
0854	Vincristine sulfate 1 mg inj	G		$30.16		$3.87
0855	Vinorelbine tartrate, 10 mg	G		$88.83		$12.72
0856	Porfimer sodium, 75 mg	G		$2,603.67		$372.74
0857	Bleomycin sulfate injection 15 u	G		$289.37		$37.16
0858	Cladribine, 1mg	G		$53.39		$4.83
0859	Fluorouracil injection 500 mg	G		$2.73		$.25
0860	Plicamycin (mithramycin) inj 2.5 mg	G		$93.80		$13.43
0861	Leuprolide acetate injection 1 mg	G		$69.79		$6.32
0862	Mitomycin 5 mg inj	G		$121.65		$11.01
0863	Paclitaxel injection, 30 mg	G		$173.50		$22.28
0864	Mitoxantrone hcl, 5 mg	G		$244.21		$34.96
0865	Interferon alfa-n3 inj, human leukocyte derived, 2	G		$7.86		$1.12
0884	Rho d immune globulin inj, 1 dose pkg	G		$34.11		$4.38
0886	Azathioprine oral 50mg	G		$1.25		$.11
0887	Azathioprine parenteral 100 mg	G		$1.06		$.10
0888	Cyclosporine oral 100 mg	G		$5.22		$.67
0889	Cyclosporin parenteral 250mg	G		$25.08		$3.22
0890	Lymphocyte immune globulin 250 mg	G		$269.06		$38.52
0891	Tacrolimus oral per 1 mg	G		$2.91		$.42
0900	Alglucerase injection, per 10 u	G		$37.53		$5.37
0901	Alpha 1 proteinase inhibitor, 10 mg	G		$2.09		$.30
0902	Botulinum toxin a, per unit	G		$4.39		$.63
0903	Cytomegalovirus imm IV/vial	G		$370.50		$47.58
0905	Immune globulin 500 mg	G		$35.63		$3.23
0906	RSV-ivig, 50 mg	G		$15.51		$1.99
0907	Ganciclovir Sodium 500 mg injection	K	0.42	$21.38		$4.28
0908	Tetanus immune globulin inj up to 250 u	G		$102.60		$13.18
0909	Interferon beta-1a, 33 mcg	G		$225.22		$32.24
0910	Interferon beta-1b /0.25 mg	G		$68.40		$9.79
0911	Streptokinase per 250,000 iu	K	1.66	$84.50		$16.90
0913	Ganciclovir long act implant 4.5 mg	G		$4,750.00		$680.00
0916	Injection imiglucerase /unit	G		$3.75		$.54
0917	Pharmacologic stressors	K	0.34	$17.31		$3.46
0925	Factor viii per iu	G		$.87		$.08
0926	Factor VIII (porcine) per iu	G		$2.09		$.30
0927	Factor viii recombinant per iu	G		$1.12		$.14
0928	Factor ix complex per iu	G		$.48		$.04
0929	Anti-inhibitor per iu	G		$1.43		$.18
0930	Antithrombin iii injection per iu	G		$1.05		$.15
0931	Factor IX non-recombinant, per iu	G		$26.13		$3.74
0932	Factor IX recombinant, per iu	G		$1.12		$.16
0949	Plasma, Pooled Multiple Donor, Solvent/Detergent T	K	2.78	$141.51		$28.30
0950	Blood (Whole) For Transfusion	K	1.97	$100.28		$20.06
0952	Cryoprecipitate	K	0.66	$33.60		$6.72

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS—Continued

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APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0954	RBC leukocytes reduced	K	2.67	$135.91		$27.18
0955	Plasma, Fresh Frozen	K	2.13	$108.43		$21.69
0956	Plasma Protein Fraction	K	1.19	$60.58		$12.12
0957	Platelet Concentrate	K	0.93	$47.34		$9.47
0958	Platelet Rich Plasma	K	1.10	$55.99		$11.20
0959	Red Blood Cells	K	1.93	$98.24		$19.65
0960	Washed Red Blood Cells	K	3.60	$183.25		$36.65
0961	Infusion, Albumin (Human) 5%, 50 ml	K	2.07	$105.37		$21.07
0962	Infusion, Albumin (Human) 25%, 50 ml	K	1.04	$52.94		$10.59
0963	Albumin (human), 5%, 250 ml	K	10.35	$526.86		$105.37
0964	Albumin (human), 25%, 20 ml	K	2.08	$105.88		$21.18
0965	Albumin (human), 25%, 50ml	K	5.20	$264.70		$52.94
0966	Plasmaprotein fract,5%,250ml	K	5.95	$302.88		$60.58
0970	New Technology—Level I ($0–$50)	T		$25.00		$5.00
0971	New Technology—Level II ($50–$100)	T		$75.00		$15.00
0972	New Technology—Level III ($100–$200)	T		$150.00		$30.00
0973	New Technology—Level IV ($200–$300)	T		$250.00		$50.00
0974	New Technology—Level V ($300–$500)	T		$400.00		$80.00
0975	New Technology—Level VI ($500–$750)	T		$625.00		$125.00
0976	New Technology—Level VII ($750–$1000)	T		$875.00		$175.00
0977	New Technology—Level VIII ($1000–$1250)	T		$1,125.00		$225.00
0978	New Technology—Level IX ($1250–$1500)	T		$1,375.00		$275.00
0979	New Technology—Level X ($1500–$1750)	T		$1,625.00		$325.00
0980	New Technology—Level XI ($1750–$2000)	T		$1,875.00		$375.00
0981	New Technology—Level XII ($2000–$2500)	T		$2,250.00		$450.00
0982	New Technology—Level XIII ($2500–$3000)	T		$2,750.00		$550.00
0983	New Technology—Level XIV ($3000– $3500)	T		$3,250.00		$650.00
0984	New Technology—Level XV ($3500–$5000)	T		$4,250.00		$850.00
0985	New Technology—Level XVI ($5000–$6000)	T		$5,500.00		$1,100.00
1009	Cryoprecip reduced plasma	K	0.82	$41.74		$8.35
1010	Blood, L/R, CMV-neg	K	2.72	$138.46		$27.69
1011	Platelets, HLA-m, L/R, unit	K	11.21	$570.63		$114.13
1012	Platelet concentrate, L/R, irradiated, unit	K	1.81	$92.14		$18.43
1013	Platelet concentrate, L/R, unit	K	1.11	$56.50		$11.30
1014	Platelets, aph/pher, L/R, unit	K	8.45	$430.14		$86.03
1016	Blood, L/R, froz/deglycerol/washed	K	6.76	$344.11		$68.82
1017	Platelets, aph/pher, L/R, CMV-neg, unit	K	8.82	$448.97		$89.79
1018	Blood, L/R, irradiated	K	2.96	$150.68		$30.14
1019	Platelets, aph/pher, L/R, irradiated, unit	K	9.11	$463.74		$92.75
1024	Quinupristin/dalfopristin 500 mg (150/350)	G		$102.05		$13.11
1045	Iobenguane sulfate I–131	G		$495.65		$70.96
1058	TC 99M oxidronate, per vial	G		$36.74		$5.26
1059	Cultured chondrocytes implnt	G		$14,250.00		$2,040.00
1064	I–131 cap, each add mCi	G		$5.86		$.75
1065	I–131 sol, each add mCi	G		$15.81		$2.03
1066	IN 111 satumomab pendetide	G		$1,591.25		$227.80
1079	CO 57/58 0.5 mCi	G		$253.84		$36.34
1084	Denileukin diftitox, 300 MCG	G		$999.88		$143.14
1086	Temozolomide,oral 5 mg	G		$6.05		$.87
1087	I–123 per 100 uci	G		$.65		$.06
1089	Coo 57, 0.5 Mci	G		$81.10		$10.41
1091	IN 111 Oxyquinoline, per .5 mCi	G		$427.50		$61.20
1092	IN 111 Pentetate, per 0.5 mCi	G		$256.50		$23.22
1094	TC 99M Albumin aggr,1.0 cmCi	G		$33.09		$4.25
1095	Technetium TC 99M Depreotide	G		$38.00		$5.44
1096	TC 99M Exametazime, per dose	G		$445.31		$63.75
1097	TC 99M Mebrofenin, per vial	G		$51.44		$7.36
1098	TC 99M Pentetate, per vial	G		$22.43		$2.88
1099	TC 99M Pyrophosphate, per vial	G		$39.11		$5.60
1122	TC 99M arcitumomab, per vial	G		$1,235.00		$176.80
1166	Cytarabine liposomal, 10 mg	G		$371.45		$53.18
1167	Epirubicin hcl, 2 mg	G		$24.94		$3.57
1178	Busulfan IV, 6 mg	G		$26.48		$3.79
1188	I–131 cap, per 1–5 mCi	G		$117.25		$15.06
1200	TC 99M Sodium Glucoheptonate	G		$22.61		$3.24
1201	TC 99M succimer, per vial	G		$135.66		$19.42
1202	TC 99M Sulfur Colloid, per dose	G		$76.00		$9.76
1203	Verteporfin for injection	G		$1,458.25		$208.76
1205	Technetium Tc 99m disofenin	G		$79.17		$11.33
1207	Octreotide acetate depot 1mg	G		$138.08		$19.77
1305	Apligraf	G		$1,157.81		$165.75
1348	I–131 sol, per 1–6 mCi	G		$146.57		$18.82
1400	Diphenhydramine hcl 50mg	G		$.23		$.02
1401	Prochlorperazine maleate 5mg	G		$.65		$.06
1402	Promethazine hcl 12.5mg oral	G		$.01		$.00
1403	Chlorpromazine hcl 10mg oral	G		$.27		$.02
1404	Trimethobenzamide hcl 250mg	G		$.38		$.03

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS—Continued

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APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1405	Thiethylperazine maleate10mg	G		$.56		$.08
1406	Perphenazine 4mg oral	G		$.62		$.06
1407	Hydroxyzine pamoate 25mg	G		$.28		$.03
1409	Factor viia recombinant, per 1.2 mg	G		$1,596.00		$228.48
1600	Technetium TC 99M sestamibi	G		$121.70		$17.42
1601	Technetium TC 99M medronate	G		$42.18		$5.42
1602	Technetium TC 99M apcitide	G		$475.00		$68.00
1603	Thallous chloride TL 201, per mCi	G		$78.16		$7.08
1604	IN 111 capromab pendetide, per dose	G		$2,192.13		$313.82
1605	Abciximab injection, 10 mg	G		$513.02		$73.44
1606	Anistreplase, 30 u	G		$2,693.80		$385.64
1607	Eptifibatide injection, 5 mg	G		$11.31		$1.45
1608	Etanercept injection, 25 mg	G		$141.01		$20.19
1609	Rho(D) immune globulin h, sd, 100 iu	G		$20.55		$2.64
1611	Hylan G–F 20 injection, 16 mg	G		$213.87		$27.47
1612	Daclizumab, parenteral, 25 mg	G		$397.29		$56.88
1613	Trastuzumab, 10 mg	G		$52.83		$7.56
1614	Valrubicin, 200 mg	G		$423.23		$60.59
1615	Basiliximab, 20 mg	G		$1,437.78		$205.83
1617	Lepirudin	G		$131.96		$18.89
1618	Vonwillebrandfactrcmplx, per iu	G		$.95		$.14
1619	Ga 67, per mCi	G		$25.62		$2.32
1620	Technetium tc99m bicisate	G		$403.99		$57.83
1621	Xenin xe 133	G		$29.93		$2.71
1622	Technetium tc99m mertiatide	G		$137.75		$19.72
1623	Technetium tc99m glucepatate	G		$22.61		$3.24
1624	Sodium phosphate p32	G		$54.34		$7.78
1625	Indium 111-in pentetreotide	G		$935.75		$133.96
1626	Technetium tc99m oxidronate	G		$1.47		$.21
1627	Technetium tc99mlabeled rbcs	G		$40.90		$5.85
1628	Chromic phosphate p32	G		$150.86		$21.60
1713	Anchor/screw bn/bn,tis/bn	H				
1714	Cath, trans atherectomy, dir	H				
1715	Brachytherapy needle	H				
1716	Brachytx seed, Gold 198	H				
1717	Brachytx seed, HDR Ir-192	H				
1718	Brachytx seed, Iodine 125	H				
1719	Brachytxseed, Non-HDR Ir-192	H				
1720	Brachytx seed, Palladium 103	H				
1721	AICD, dual chamber	H				
1722	AICD, single chamber	H				
1724	Cath, trans atherec,rotation	H				
1725	Cath, translumin non-laser	H				
1726	Cath, bal dil, non-vascular	H				
1727	Cath, bal tis dis, non-vas	H				
1728	Cath, brachytx seed adm	H				
1729	Cath, drainage	H				
1730	Cath, EP, 19 or fewer elect	H				
1731	Cath, EP, 20 or more elec	H				
1732	Cath, EP, diag/abl, 3D/vect	H				
1733	Cath, EP, othr than cool-tip	H				
1750	Cath, hemodialysis,long-term	H				
1751	Cath, inf, per/cent/midline	H				
1752	Cath, hemodialysis,short-term	H				
1753	Cath, intravas ultrasound	H				
1754	Catheter, intradiscal	H				
1755	Catheter, intraspinal	H				
1756	Cath, pacing, transesoph	H				
1757	Cath, thrombectomy/embolect	H				
1758	Cath, ureteral	H				
1759	Cath, intra echocardiography	H				
1760	Closure dev, vasc, imp/insert	H				
1762	Conn tiss, human (inc fascia)	H				
1763	Conn tiss, non-human	H				
1764	Event recorder, cardiac	H				
1765	Adhesion barrier	H				
1766	Intro/sheath,strble,non-peel	H				
1767	Generator, neurostim, imp	H				
1768	Graft, vascular	H				
1769	Guide wire	H				
1770	Imaging coil, MR, insertable	H				
1771	Rep dev, urinary, w/sling	H				
1772	Infusion pump, programmable	H				
1773	Retrieval dev, insert	H				
1776	Joint device (implantable)	H				
1777	Lead, AICD, endo single coil	H				
1778	Lead, neurostimulator	H				

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS—Continued

[Calendar Year 2002]

APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1779	Lead, pmkr, transvenous VDD	H				
1780	Lens, intraocular	H				
1781	Mesh (implantable)	H				
1782	Morcellator	H				
1784	Ocular dev, intraop, det ret	H				
1785	Pmkr, dual, rate-resp	H				
1786	Pmkr, single, rate-resp	H				
1787	Patient progr, neurostim	H				
1788	Port, indwelling, imp	H				
1789	Prosthesis, breast, imp	H				
1813	Prosthesis, penile, inflatab	H				
1815	Pros, urinary sph, imp	H				
1816	Receiver/transmitter, neuro	H				
1817	Septal defect imp sys	H				
1874	Stent, coated/cov w/del sys	H				
1875	Stent, coated/cov w/o del sy	H				
1876	Stent, non-coa/no-cov w/del	H				
1877	Stent, non-coat/cov w/o del	H				
1878	Matrl for vocal cord	H				
1879	Tissue marker, imp	H				
1880	Vena cava filter	H				
1881	Dialysis access system	H				
1882	AICD, other than sing/dual	H				
1883	Adapt/ext, pacing/neuro lead	H				
1885	Cath, translumin angio laser	H				
1887	Catheter, guiding	H				
1891	Infusion pump,non-prog,perm	H				
1892	Intro/sheath,fixed,peel-away	H				
1893	Intro/sheath,fixed,non-peel	H				
1894	Intro/sheath, non-laser	H				
1895	Lead, AICD, endo dual coil	H				
1896	Lead, AICD, non sing/dual	H				
1897	Lead, neurostim test kit	H				
1898	Lead, pmkr, other than trans	H				
1899	Lead, pmkr/AICD combination	H				
2615	Sealant, pulmonary, liquid	H				
2616	Brachytx seed, Yttrium-90	H				
2617	Stent, non-cor, tem w/o del	H				
2618	Probe, cryoablation	H				
2619	Pmkr, dual, non rate-resp	H				
2620	Pmkr, single, non rate-resp	H				
2621	Pmkr, other than sing/dual	H				
2622	Prosthesis, penile, non-inf	H				
2625	Stent, non-cor, tem w/del sys	H				
2626	Infusion pump, non-prog,temp	H				
2627	Cath, suprapubic/cystoscopic	H				
2628	Catheter, occlusion	H				
2629	Intro/sheath, laser	H				
2630	Cath, EP, cool-tip	H				
2631	Rep dev, urinary, w/o sling	H				
7000	Amifostine, 500 mg	G		$392.06		$56.13
7001	Amphotericin B lipid complex, 50 mg	G		$109.25		$15.64
7003	Epoprostenol injection 0.5 mg	G		$12.04		$1.72
7005	Gonadorelin hydroch, 100 mcg	G		$192.37		$27.54
7007	Milrinone lactate, per 5 ml, inj	K	0.44	$22.40		$4.48
7010	Morphine sulfate (preservative free) 10 mg	G		$1.02		$.09
7011	Oprelvekin injection, 5 mg	G		$245.81		$35.19
7014	Fentanyl citrate injection	G		$1.23		$.11
7015	Busulfan, oral, 2 mg	G		$1.91		$.27
7019	Aprotinin, 10,000 kiu	G		$2.16		$.31
7022	Elliot's B solution, per ml	G		$1.43		$.20
7023	Bladder calculi irrig sol	G		$24.70		$3.54
7024	Corticorelin ovine triflutat	G		$368.03		$52.69
7025	Digoxin immune FAB (ovine)	G		$551.66		$78.97
7026	Ethanolamine oleate, 100 mg	G		$39.73		$5.69
7027	Fomepizole, 15 mg	G		$10.93		$1.56
7028	Fosphenytoin, 50 mg	G		$5.73		$.82
7029	Glatiramer acetate, per dose	G		$30.07		$4.30
7030	Hemin, per 1 mg	G		$.99		$.14
7031	Octreotide acetate injection	G		$138.08		$19.77
7032	Sermorelin acetate, 0.5 mg	G		$13.60		$1.95
7033	Somatrem, 5mg	G		$209.48		$29.99
7034	Somatropin injection	G		$39.90		$5.12
7035	Teniposide, 50 mg	G		$222.80		$31.90
7036	Urokinase 250,000 iu inj	K	6.41	$326.29		$65.26
7037	Urofollitropin, 75 iu	G		$73.29		$10.49
7038	Muromonab-CD3, 5 mg	G		$269.06		$38.52

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS—Continued

[Calendar Year 2002]

APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
7039	Pegademase bovine inj 25 I.U	G		$139.33		$19.95
7040	Pentastarch 10% solution	G		$15.11		$2.16
7041	Tirofiban hydrochloride 12.5 mg	G		$436.41		$62.48
7042	Capecitabine, oral, 150 mg	G		$2.43		$.35
7043	Infliximab injection 10 mg	G		$63.24		$9.05
7045	Trimetrexate glucoronate	G		$118.75		$17.00
7046	Doxorubicin hcl liposome inj 10 mg	G		$358.95		$51.39
7048	Alteplase recombinant	K	0.36	$18.33		$3.67
7049	Filgrastim 480 mcg injection	G		$285.38		$36.65
7050	Prednisone oral	G		$.07		$.01
7051	Leuprolide acetate implant, 65 mg	G		$5,399.80		$773.02
7315	Sodium hyaluronate injection, 5mg	G		$26.13		$3.74
9000	Na chromate Cr51, per 0.25mCi	G		$.52		$.07
9001	Linezolid inj, 200mg	G		$24.13		$3.45
9002	Tenecteplase, 50mg/vial	G		$2,612.50		$374.00
9003	Palivizumab, per 50mg	G		$664.49		$95.13
9004	Gemtuzumab ozogamicin inj,5mg	G		$1,929.69		$276.25
9005	Reteplase injection	G		$1,306.25		$187.00
9006	Tacrolimus inj	G		$113.15		$16.20
9007	Baclofen Intrathecal kit-1amp	G		$79.80		$11.42
9008	Baclofen refill kit—per 500 mcg	G		$11.69		$1.67
9009	Baclofen refill kit—per 2000 mcg	G		$49.12		$7.03
9010	Baclofen refill kit—per 4000 mcg	G		$43.08		$6.17
9011	Caffeine Citrate, inj,	G		$3.05		$.44
9012	Arsenic Trioxide	G		$23.75		$3.40
9013	Co 57 Cobaltous Cl	G		$81.10		$10.41
9015	Mycophenolate mofetil oral 250 mg	G		$2.40		$.34
9016	Echocardiography contrast	G		$118.75		$17.00
9018	Botulinum tox B, per 100 u	G		$8.79		$1.26
9019	Caspofungin acetate, 5 mg	G		$34.20		$4.90
9020	Sirolimus tablet, 1 mg	G		$6.51		$.93
9100	Iodinated I–131 albumin	G		$10.34		$1.48
9102	51 na chromate, per 50mCi	G		$64.84		$9.28
9103	Na iothalamate I–125, per 10 uci	G		$17.18		$2.46
9104	Anti-thymocycte globulin rabbit	G		$325.09		$46.54
9105	Hep B imm glob, per 1 ml	G		$133.00		$17.08
9106	Sirolimus, 1 mg	G		$6.51		$.93
9108	Thyrotropin alfa, per 1.1 mg	G		$531.05		$76.02
9109	Tirofliban hcl, per 6.25 mg	G		$207.81		$29.75
9110	Alemtuzumab, per ml	G		$486.88		$69.70
9111	Inj, bivalirudin, per 250mg vial	G		$397.81		$56.95
9112	Perflutren lipid micro, per 2ml	G		$148.20		$21.22
9113	Inj pantoprazole sodium, vial	G		$22.80		$3.26
9114	Nesiritide, per 1.5 mg vial	G		$433.20		$62.02
9115	Inj, zoledronic acid, per 2 mg	G		$406.78		$58.23
9200	Orcel, per 36 cm2	G		$1,135.25		$162.52
9201	Dermagraft, per 37.5 sq cm	G		$577.60		$82.69
9217	Leuprolide acetate suspnsion, 7.5 mg	G		$592.60		$84.84
9500	Platelets, irradiated	K	1.68	$85.52		$17.10
9501	Platelets, pheresis	K	9.16	$466.28		$93.26
9502	Platelet pheresis irradiated	K	9.94	$505.99		$101.20
9503	Fresh frozen plasma, ea unit	K	1.56	$79.41		$15.88
9504	RBC deglycerolized	K	4.11	$209.22		$41.84
9505	RBC irradiated	K	2.44	$124.21		$24.84
9506	Granulocytes, pheresis	K	27.75	$1,412.59		$282.52

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
*0001T	C	Endovas repr abdo ao aneurys					
*0002T	C	Endovas repr abdo ao aneurys					
*0003T	N	Cervicography					
*0005T	C	Perc cath stent/brain cv art					
*0006T	C	Perc cath stent/brain cv art					
*0007T	C	Perc cath stent/brain cv art					
*0008T	E	Upper gi endoscopy w/suture					
*0009T	T	Endometrial cryoablation	0193	11.16	$568.09	$171.13	$113.62

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00100	N	Anesth, salivary gland					
00102	N	Anesth, repair of cleft lip					
00103	N	Anesth, blepharoplasty					
00104	N	Anesth, electroshock					
*0010T	A	Tb test, gamma interferon					
00120	N	Anesth, ear surgery					
00124	N	Anesth, ear exam					
00126	N	Anesth, tympanotomy					
*0012T	T	Osteochondral knee autograft	0041	23.61	$1,201.84	$576.88	$240.37
*0013T	T	Osteochondral knee allograft	0041	23.61	$1,201.84	$576.88	$240.37
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	23.61	$1,201.84	$576.88	$240.37
00160	N	Anesth, nose/sinus surgery					
00162	N	Anesth, nose/sinus surgery					
00164	N	Anesth, biopsy of nose					
*0016T	E	Thermotx choroid vasc lesion					
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	0.66	$33.60	$17.47	$6.72
00190	N	Anesth, face/skull bone surg					
00192	C	Anesth, facial bone surgery					
*0019T	A	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, trnsvag/cerv					
00220	N	Anesth, spinal fluid shunt					
00222	N	Anesth, head nerve surgery					
*0023T	A	Phenotype drug test, hiv 1					
*0024T	C	Transcath cardiac reduction					
*0025T	S	Ultrasonic pachymetry	0230	0.61	$31.05	$14.28	$6.21
*0026T	A	Measure remnant lipoproteins					
00300	N	Anesth, head/neck/ptrunk					
00320	N	Anesth, neck organ surgery					
00322	N	Anesth, biopsy of thyroid					
00350	N	Anesth, neck vessel surgery					
00352	N	Anesth, neck vessel surgery					
00400	N	Anesth, skin, ext/per/atrunk					
00402	N	Anesth, surgery of breast					
00404	C	Anesth, surgery of breast					
00406	C	Anesth, surgery of breast					
00410	N	Anesth, correct heart rhythm					
00450	N	Anesth, surgery of shoulder					
00452	C	Anesth, surgery of shoulder					
00454	N	Anesth, collar bone biopsy					
00470	N	Anesth, removal of rib					
00472	N	Anesth, chest wall repair					
00474	C	Anesth, surgery of rib(s)					
00500	N	Anesth, esophageal surgery					
00520	N	Anesth, chest procedure					
00522	N	Anesth, chest lining biopsy					
00524	C	Anesth, chest drainage					
00528	N	Anesth, chest partition view					
00530	N	Anesth, pacemaker insertion					
00532	N	Anesth, vascular access					
00534	N	Anesth, cardioverter/defib					
00537	N	Anesth, cardiac electrophys					
00540	C	Anesth, chest surgery					
00542	C	Anesth, release of lung					
00544	C	Anesth, chest lining removal					
00546	C	Anesth, lung,chest wall surg					
00548	N	Anesth, trachea,bronchi surg					
00550	N	Anesth, sternal debridement					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00560	C	Anesth, open heart surgery					
00562	C	Anesth, open heart surgery					
00563	N	Anesth, heart proc w/pump					
00566	N	Anesth, cabg w/o pump					
00580	C	Anesth heart/lung transplant					
00600	N	Anesth, spine, cord surgery					
00604	C	Anesth, sitting procedure					
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					
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					
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					
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					
00850	D	Anesth, cesarean section					
*00851	N	Anesth, tubal ligation					
00855	D	Anesth, hysterectomy					
00857	D	Analgesia, labor & c-section					
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					
*00869	N	Anesth, vasectomy					
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					
00884	D	Anesth, major vein revision					
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					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00940	N	Anesth, vaginal procedures					
00942	N	Anesth, surg on vag/urethal					
00944	C	Anesth, vaginal hysterectomy					
00946	D	Anesth, vaginal delivery					
00948	N	Anesth, repair of cervix					
00950	N	Anesth, vaginal endoscopy					
00952	N	Anesth, hysteroscope/graph					
00955	D	Analgesia, vaginal delivery					
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					
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, replacement of hip					
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					
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, knee arthroscopy					
01390	N	Anesth, knee area procedure					
01392	N	Anesth, knee area surgery					
01400	N	Anesth, knee joint surgery					
01402	C	Anesth, replacement of knee					
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 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	Anesth, 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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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, 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					
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					
01860	N	Anesth, lower arm casting					
01904	D	Anesth, skull x-ray inject					
*01905	N	Anes, spine inject, x-ray/re					
01906	D	Anesth, lumbar myelography					
01908	D	Anesth, cervical myelography					
01910	D	Anesth, skull myelography					
01912	D	Anesth, lumbar diskography					
01914	D	Anesth, cervical diskography					
01916	N	Anesth, head arteriogram					
01918	D	Anesth, limb arteriogram					
01920	N	Anesth, catheterize heart					
01921	D	Anesth, vessel surgery					
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 1 percent					
01952	N	Anesth, burn, 1–9 percent					
01953	N	Anesth, burn, each 9 percent					
*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					
01995	N	Regional anesthesia, limb					
01996	N	Manage daily drug therapy					
01999	N	Unlisted anesth procedure					
*10021	T	Fna w/o image	0002	0.42	$21.38	$11.75	$4.28
*10022	T	Fna w/image	0002	0.42	$21.38	$11.75	$4.28
10040	T	Acne surgery of skin abscess	0006	2.18	$110.97	$33.95	$22.19
10060	T	Drainage of skin abscess	0006	2.18	$110.97	$33.95	$22.19
10061	T	Drainage of skin abscess	0006	2.18	$110.97	$33.95	$22.19
10080	T	Drainage of pilonidal cyst	0006	2.18	$110.97	$33.95	$22.19
10081	T	Drainage of pilonidal cyst	0007	6.75	$343.60	$72.03	$68.72
10120	T	Remove foreign body	0006	2.18	$110.97	$33.95	$22.19
10121	T	Remove foreign body	0020	8.44	$429.63	$130.53	$85.93
10140	T	Drainage of hematoma/fluid	0007	6.75	$343.60	$72.03	$68.72
10160	T	Puncture drainage of lesion	0018	1.05	$53.45	$17.66	$10.69
10180	T	Complex drainage, wound	0007	6.75	$343.60	$72.03	$68.72
11000	T	Debride infected skin	0015	2.07	$105.37	$31.20	$21.07

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
11001	T	Debride infected skin add-on	0013	1.36	$69.23	$17.66	$13.85
11010	T	Debride skin, fx	0022	13.91	$708.07	$292.94	$141.61
11011	T	Debride skin/muscle, fx	0022	13.91	$708.07	$292.94	$141.61
11012	T	Debride skin/muscle/bone, fx	0022	13.91	$708.07	$292.94	$141.61
11040	T	Debride skin, partial	0015	2.07	$105.37	$31.20	$21.07
11041	T	Debride skin, full	0015	2.07	$105.37	$31.20	$21.07
11042	T	Debride skin/tissue	0016	3.02	$153.73	$64.57	$30.75
11043	T	Debride tissue/muscle	0016	3.02	$153.73	$64.57	$30.75
11044	T	Debride tissue/muscle/bone	0017	9.68	$492.75	$226.67	$98.55
11055	T	Trim skin lesion	0012	0.66	$33.60	$9.18	$6.72
11056	T	Trim skin lesions, 2 to 4	0012	0.66	$33.60	$9.18	$6.72
11057	T	Trim skin lesions, over 4	0012	0.66	$33.60	$9.18	$6.72
11100	T	Biopsy of skin lesion	0018	1.05	$53.45	$17.66	$10.69
11101	T	Biopsy, skin add-on	0018	1.05	$53.45	$17.66	$10.69
11200	T	Removal of skin tags	0013	1.36	$69.23	$17.66	$13.85
11201	T	Remove skin tags add-on	0015	2.07	$105.37	$31.20	$21.07
11300	T	Shave skin lesion	0012	0.66	$33.60	$9.18	$6.72
11301	T	Shave skin lesion	0012	0.66	$33.60	$9.18	$6.72
11302	T	Shave skin lesion	0013	1.36	$69.23	$17.66	$13.85
11303	T	Shave skin lesion	0015	2.07	$105.37	$31.20	$21.07
11305	T	Shave skin lesion	0013	1.36	$69.23	$17.66	$13.85
11306	T	Shave skin lesion	0013	1.36	$69.23	$17.66	$13.85
11307	T	Shave skin lesion	0013	1.36	$69.23	$17.66	$13.85
11308	T	Shave skin lesion	0013	1.36	$69.23	$17.66	$13.85
11310	T	Shave skin lesion	0013	1.36	$69.23	$17.66	$13.85
11311	T	Shave skin lesion	0013	1.36	$69.23	$17.66	$13.85
11312	T	Shave skin lesion	0013	1.36	$69.23	$17.66	$13.85
11313	T	Shave skin lesion	0016	3.02	$153.73	$64.57	$30.75
11400	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11401	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11402	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11403	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11404	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11406	T	Removal of skin lesion	0021	11.82	$601.69	$236.51	$120.34
11420	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11421	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11422	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11423	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11424	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11426	T	Removal of skin lesion	0022	13.91	$708.07	$292.94	$141.61
11440	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11441	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11442	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11443	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11444	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11446	T	Removal of skin lesion	0022	13.91	$708.07	$292.94	$141.61
11450	T	Removal, sweat gland lesion	0022	13.91	$708.07	$292.94	$141.61
11451	T	Removal, sweat gland lesion	0022	13.91	$708.07	$292.94	$141.61
11462	T	Removal, sweat gland lesion	0022	13.91	$708.07	$292.94	$141.61
11463	T	Removal, sweat gland lesion	0022	13.91	$708.07	$292.94	$141.61
11470	T	Removal, sweat gland lesion	0022	13.91	$708.07	$292.94	$141.61
11471	T	Removal, sweat gland lesion	0022	13.91	$708.07	$292.94	$141.61
11600	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11601	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11602	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11603	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11604	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11606	T	Removal of skin lesion	0021	11.82	$601.69	$236.51	$120.34
11620	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11621	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11622	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11623	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11624	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11626	T	Removal of skin lesion	0022	13.91	$708.07	$292.94	$141.61
11640	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11641	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11642	T	Removal of skin lesion	0019	4.22	$214.81	$78.91	$42.96
11643	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11644	T	Removal of skin lesion	0020	8.44	$429.63	$130.53	$85.93
11646	T	Removal of skin lesion	0022	13.91	$708.07	$292.94	$141.61
11719	T	Trim nail(s)	0009	0.63	$32.07	$8.34	$6.41
11720	T	Debride nail, 1–5	0009	0.63	$32.07	$8.34	$6.41
11721	T	Debride nail, 6 or more	0009	0.63	$32.07	$8.34	$6.41
11730	T	Removal of nail plate	0013	1.36	$69.23	$17.66	$13.85
11732	T	Remove nail plate, add-on	0012	0.66	$33.60	$9.18	$6.72

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
11740	T	Drain blood from under nail	0009	0.63	$32.07	$8.34	$6.41
11750	T	Removal of nail bed	0019	4.22	$214.81	$78.91	$42.96
11752	T	Remove nail bed/finger tip	0022	13.91	$708.07	$292.94	$141.61
11755	T	Biopsy, nail unit	0019	4.22	$214.81	$78.91	$42.96
11760	T	Repair of nail bed	0024	2.28	$116.06	$41.78	$23.21
11762	T	Reconstruction of nail bed	0024	2.28	$116.06	$41.78	$23.21
11765	T	Excision of nail fold, toe	0015	2.07	$105.37	$31.20	$21.07
11770	T	Removal of pilonidal lesion	0021	11.82	$601.69	$236.51	$120.34
11771	T	Removal of pilonidal lesion	0022	13.91	$708.07	$292.94	$141.61
11772	T	Removal of pilonidal lesion	0022	13.91	$708.07	$292.94	$141.61
11900	T	Injection into skin lesions	0012	0.66	$33.60	$9.18	$6.72
11901	T	Added skin lesions injection	0012	0.66	$33.60	$9.18	$6.72
11920	T	Correct skin color defects	0024	2.28	$116.06	$41.78	$23.21
11921	T	Correct skin color defects	0024	2.28	$116.06	$41.78	$23.21
11922	T	Correct skin color defects	0024	2.28	$116.06	$41.78	$23.21
11950	T	Therapy for contour defects	0024	2.28	$116.06	$41.78	$23.21
11951	T	Therapy for contour defects	0024	2.28	$116.06	$41.78	$23.21
11952	T	Therapy for contour defects	0024	2.28	$116.06	$41.78	$23.21
11954	T	Therapy for contour defects	0024	2.28	$116.06	$41.78	$23.21
11960	T	Insert tissue expander(s)	0026	12.62	$642.41	$277.92	$128.48
11970	T	Replace tissue expander	0026	12.62	$642.41	$277.92	$128.48
11971	T	Remove tissue expander(s)	0022	13.91	$708.07	$292.94	$141.61
11975	E	Insert contraceptive cap					
11976	T	Removal of contraceptive cap	0019	4.22	$214.81	$78.91	$42.96
11977	E	Removal/reinsert contra cap					
11980	X	Implant hormone pellet(s)	0340	0.84	$42.76	$10.69	$8.55
*11981	X	Insert drug implant device	0340	0.84	$42.76	$10.69	$8.55
*11982	X	Remove drug implant device	0340	0.84	$42.76	$10.69	$8.55
*11983	X	Remove/insert drug implant	0340	0.84	$42.76	$10.69	$8.55
12001	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12002	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12004	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12005	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12006	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12007	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12011	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12013	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12014	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12015	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12016	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12017	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12018	T	Repair superficial wound(s)	0024	2.28	$116.06	$41.78	$23.21
12020	T	Closure of split wound	0024	2.28	$116.06	$41.78	$23.21
12021	T	Closure of split wound	0024	2.28	$116.06	$41.78	$23.21
12031	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12032	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12034	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12035	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12036	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12037	T	Layer closure of wound(s)	0026	12.62	$642.41	$277.92	$128.48
12041	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12042	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12044	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12045	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12046	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12047	T	Layer closure of wound(s)	0026	12.62	$642.41	$277.92	$128.48
12051	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12052	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12053	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12054	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12055	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12056	T	Layer closure of wound(s)	0024	2.28	$116.06	$41.78	$23.21
12057	T	Layer closure of wound(s)	0026	12.62	$642.41	$277.92	$128.48
13100	T	Repair of wound or lesion	0025	3.39	$172.56	$65.57	$34.51
13101	T	Repair of wound or lesion	0025	3.39	$172.56	$65.57	$34.51
13102	T	Repair wound/lesion add-on	0025	3.39	$172.56	$65.57	$34.51
13120	T	Repair of wound or lesion	0025	3.39	$172.56	$65.57	$34.51
13121	T	Repair of wound or lesion	0025	3.39	$172.56	$65.57	$34.51
13122	T	Repair wound/lesion add-on	0025	3.39	$172.56	$65.57	$34.51
13131	T	Repair of wound or lesion	0025	3.39	$172.56	$65.57	$34.51
13132	T	Repair of wound or lesion	0025	3.39	$172.56	$65.57	$34.51
13133	T	Repair wound/lesion add-on	0025	3.39	$172.56	$65.57	$34.51
13150	T	Repair of wound or lesion	0026	12.62	$642.41	$277.92	$128.48
13151	T	Repair of wound or lesion	0025	3.39	$172.56	$65.57	$34.51
13152	T	Repair of wound or lesion	0025	3.39	$172.56	$65.57	$34.51

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
13153	T	Repair wound/lesion add-on	0025	3.39	$172.56	$65.57	$34.51
13160	T	Late closure of wound	0026	12.62	$642.41	$277.92	$128.48
14000	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14001	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14020	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14021	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14040	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14041	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14060	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14061	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14300	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
14350	T	Skin tissue rearrangement	0026	12.62	$642.41	$277.92	$128.48
15000	T	Skin graft	0026	12.62	$642.41	$277.92	$128.48
15001	T	Skin graft add-on	0026	12.62	$642.41	$277.92	$128.48
15050	T	Skin pinch graft	0026	12.62	$642.41	$277.92	$128.48
15100	T	Skin split graft	0026	12.62	$642.41	$277.92	$128.48
15101	T	Skin split graft add-on	0026	12.62	$642.41	$277.92	$128.48
15120	T	Skin split graft	0026	12.62	$642.41	$277.92	$128.48
15121	T	Skin split graft add-on	0026	12.62	$642.41	$277.92	$128.48
15200	T	Skin full graft	0026	12.62	$642.41	$277.92	$128.48
15201	T	Skin full graft add-on	0026	12.62	$642.41	$277.92	$128.48
15220	T	Skin full graft	0026	12.62	$642.41	$277.92	$128.48
15221	T	Skin full graft add-on	0026	12.62	$642.41	$277.92	$128.48
15240	T	Skin full graft	0026	12.62	$642.41	$277.92	$128.48
15241	T	Skin full graft add-on	0026	12.62	$642.41	$277.92	$128.48
15260	T	Skin full graft	0026	12.62	$642.41	$277.92	$128.48
15261	T	Skin full graft add-on	0026	12.62	$642.41	$277.92	$128.48
15342	T	Cultured skin graft, 25 cm	0025	3.39	$172.56	$65.57	$34.51
15343	T	Culture skn graft addl 25 cm	0025	3.39	$172.56	$65.57	$34.51
15350	T	Skin homograft	0686	24.01	$1,222.21	$277.92	$244.44
15351	T	Skin homograft add-on	0026	12.62	$642.41	$277.92	$128.48
15400	T	Skin heterograft	0026	12.62	$642.41	$277.92	$128.48
15401	T	Skin heterograft add-on	0026	12.62	$642.41	$277.92	$128.48
15570	T	Form skin pedicle flap	0026	12.62	$642.41	$277.92	$128.48
15572	T	Form skin pedicle flap	0026	12.62	$642.41	$277.92	$128.48
15574	T	Form skin pedicle flap	0026	12.62	$642.41	$277.92	$128.48
15576	T	Form skin pedicle flap	0026	12.62	$642.41	$277.92	$128.48
15600	T	Skin graft	0026	12.62	$642.41	$277.92	$128.48
15610	T	Skin graft	0026	12.62	$642.41	$277.92	$128.48
15620	T	Skin graft	0026	12.62	$642.41	$277.92	$128.48
15630	T	Skin graft	0026	12.62	$642.41	$277.92	$128.48
15650	T	Transfer skin pedicle flap	0026	12.62	$642.41	$277.92	$128.48
15732	T	Muscle-skin graft, head/neck	0027	18.02	$917.29	$383.10	$183.46
15734	T	Muscle-skin graft, trunk	0027	18.02	$917.29	$383.10	$183.46
15736	T	Muscle-skin graft, arm	0027	18.02	$917.29	$383.10	$183.46
15738	T	Muscle-skin graft, leg	0027	18.02	$917.29	$383.10	$183.46
15740	T	Island pedicle flap graft	0027	18.02	$917.29	$383.10	$183.46
15750	T	Neurovascular pedicle graft	0027	18.02	$917.29	$383.10	$183.46
15756	C	Free muscle flap, microvasc					
15757	C	Free skin flap, microvasc					
15758	C	Free fascial flap, microvasc					
15760	T	Composite skin graft	0027	18.02	$917.29	$383.10	$183.46
15770	T	Derma-fat-fascia graft	0027	18.02	$917.29	$383.10	$183.46
15775	T	Hair transplant punch grafts	0026	12.62	$642.41	$277.92	$128.48
15776	T	Hair transplant punch grafts	0026	12.62	$642.41	$277.92	$128.48
15780	T	Abrasion treatment of skin	0022	13.91	$708.07	$292.94	$141.61
15781	T	Abrasion treatment of skin	0022	13.91	$708.07	$292.94	$141.61
15782	T	Abrasion treatment of skin	0022	13.91	$708.07	$292.94	$141.61
15783	T	Abrasion treatment of skin	0016	3.02	$153.73	$64.57	$30.75
15786	T	Abrasion, lesion, single	0013	1.36	$69.23	$17.66	$13.85
15787	T	Abrasion, lesions, add-on	0013	1.36	$69.23	$17.66	$13.85
15788	T	Chemical peel, face, epiderm	0012	0.66	$33.60	$9.18	$6.72
15789	T	Chemical peel, face, dermal	0015	2.07	$105.37	$31.20	$21.07
15792	T	Chemical peel, nonfacial	0012	0.66	$33.60	$9.18	$6.72
15793	T	Chemical peel, nonfacial	0013	1.36	$69.23	$17.66	$13.85
15810	T	Salabrasion	0016	3.02	$153.73	$64.57	$30.75
15811	T	Salabrasion	0016	3.02	$153.73	$64.57	$30.75
15819	T	Plastic surgery, neck	0026	12.62	$642.41	$277.92	$128.48
15820	T	Revision of lower eyelid	0026	12.62	$642.41	$277.92	$128.48
15821	T	Revision of lower eyelid	0026	12.62	$642.41	$277.92	$128.48
15822	T	Revision of upper eyelid	0026	12.62	$642.41	$277.92	$128.48
15823	T	Revision of upper eyelid	0026	12.62	$642.41	$277.92	$128.48
15824	T	Removal of forehead wrinkles	0027	18.02	$917.29	$383.10	$183.46
15825	T	Removal of neck wrinkles	0026	12.62	$642.41	$277.92	$128.48
15826	T	Removal of brow wrinkles	0026	12.62	$642.41	$277.92	$128.48

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15828	T	Removal of face wrinkles	0027	18.02	$917.29	$383.10	$183.46
15829	T	Removal of skin wrinkles	0026	12.62	$642.41	$277.92	$128.48
15831	T	Excise excessive skin tissue	0022	13.91	$708.07	$292.94	$141.61
15832	T	Excise excessive skin tissue	0022	13.91	$708.07	$292.94	$141.61
15833	T	Excise excessive skin tissue	0022	13.91	$708.07	$292.94	$141.61
15834	T	Excise excessive skin tissue	0022	13.91	$708.07	$292.94	$141.61
15835	T	Excise excessive skin tissue	0026	12.62	$642.41	$277.92	$128.48
15836	T	Excise excessive skin tissue	0019	4.22	$214.81	$78.91	$42.96
15837	T	Excise excessive skin tissue	0019	4.22	$214.81	$78.91	$42.96
15838	T	Excise excessive skin tissue	0019	4.22	$214.81	$78.91	$42.96
15839	T	Excise excessive skin tissue	0019	4.22	$214.81	$78.91	$42.96
15840	T	Graft for face nerve palsy	0027	18.02	$917.29	$383.10	$183.46
15841	T	Graft for face nerve palsy	0027	18.02	$917.29	$383.10	$183.46
15842	T	Flap for face nerve palsy	0027	18.02	$917.29	$383.10	$183.46
15845	T	Skin and muscle repair, face	0027	18.02	$917.29	$383.10	$183.46
15850	T	Removal of sutures	0016	3.02	$153.73	$64.57	$30.75
15851	T	Removal of sutures	0013	1.36	$69.23	$17.66	$13.85
15852	T	Dressing change, not for burn	0013	1.36	$69.23	$17.66	$13.85
15860	N	Test for blood flow in graft					
15876	T	Suction assisted lipectomy	0027	18.02	$917.29	$383.10	$183.46
15877	T	Suction assisted lipectomy	0027	18.02	$917.29	$383.10	$183.46
15878	T	Suction assisted lipectomy	0027	18.02	$917.29	$383.10	$183.46
15879	T	Suction assisted lipectomy	0027	18.02	$917.29	$383.10	$183.46
15920	T	Removal of tail bone ulcer	0022	13.91	$708.07	$292.94	$141.61
15922	T	Removal of tail bone ulcer	0027	18.02	$917.29	$383.10	$183.46
15931	T	Remove sacrum pressure sore	0022	13.91	$708.07	$292.94	$141.61
15933	T	Remove sacrum pressure sore	0022	13.91	$708.07	$292.94	$141.61
15934	T	Remove sacrum pressure sore	0027	18.02	$917.29	$383.10	$183.46
15935	T	Remove sacrum pressure sore	0027	18.02	$917.29	$383.10	$183.46
15936	T	Remove sacrum pressure sore	0027	18.02	$917.29	$383.10	$183.46
15937	T	Remove sacrum pressure sore	0027	18.02	$917.29	$383.10	$183.46
15940	T	Remove hip pressure sore	0022	13.91	$708.07	$292.94	$141.61
15941	T	Remove hip pressure sore	0022	13.91	$708.07	$292.94	$141.61
15944	T	Remove hip pressure sore	0027	18.02	$917.29	$383.10	$183.46
15945	T	Remove hip pressure sore	0027	18.02	$917.29	$383.10	$183.46
15946	T	Remove hip pressure sore	0027	18.02	$917.29	$383.10	$183.46
15950	T	Remove thigh pressure sore	0022	13.91	$708.07	$292.94	$141.61
15951	T	Remove thigh pressure sore	0022	13.91	$708.07	$292.94	$141.61
15952	T	Remove thigh pressure sore	0027	18.02	$917.29	$383.10	$183.46
15953	T	Remove thigh pressure sore	0027	18.02	$917.29	$383.10	$183.46
15956	T	Remove thigh pressure sore	0027	18.02	$917.29	$383.10	$183.46
15958	T	Remove thigh pressure sore	0027	18.02	$917.29	$383.10	$183.46
15999	T	Removal of pressure sore	0022	13.91	$708.07	$292.94	$141.61
16000	T	Initial treatment of burn(s)	0013	1.36	$69.23	$17.66	$13.85
16010	T	Treatment of burn(s)	0016	3.02	$153.73	$64.57	$30.75
16015	T	Treatment of burn(s)	0017	9.68	$492.75	$226.67	$98.55
16020	T	Treatment of burn(s)	0013	1.36	$69.23	$17.66	$13.85
16025	T	Treatment of burn(s)	0013	1.36	$69.23	$17.66	$13.85
16030	T	Treatment of burn(s)	0015	2.07	$105.37	$31.20	$21.07
16035	C	Incision of burn scab, initi					
16036	C	Incise burn scab, addl incis					
17000	T	Destroy benign/premal lesion	0010	0.66	$33.60	$9.86	$6.72
17003	T	Destroy lesions, 2–14	0010	0.66	$33.60	$9.86	$6.72
17004	T	Destroy lesions, 15 or more	0011	1.47	$74.83	$27.69	$14.97
17106	T	Destruction of skin lesions	0011	1.47	$74.83	$27.69	$14.97
17107	T	Destruction of skin lesions	0011	1.47	$74.83	$27.69	$14.97
17108	T	Destruction of skin lesions	0011	1.47	$74.83	$27.69	$14.97
17110	T	Destruct lesion, 1–14	0010	0.66	$33.60	$9.86	$6.72
17111	T	Destruct lesion, 15 or more	0011	1.47	$74.83	$27.69	$14.97
17250	T	Chemical cautery, tissue	0013	1.36	$69.23	$17.66	$13.85
17260	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17261	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17262	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17263	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17264	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17266	T	Destruction of skin lesions	0016	3.02	$153.73	$64.57	$30.75
17270	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17271	T	Destruction of skin lesions	0012	0.66	$33.60	$9.18	$6.72
17272	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17273	T	Destruction of skin lesions	0015	2.07	$105.37	$31.20	$21.07
17274	T	Destruction of skin lesions	0016	3.02	$153.73	$64.57	$30.75
17276	T	Destruction of skin lesions	0016	3.02	$153.73	$64.57	$30.75
17280	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17281	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17282	T	Destruction of skin lesions	0015	2.07	$105.37	$31.20	$21.07

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
17283	T	Destruction of skin lesions	0015	2.07	$105.37	$31.20	$21.07
17284	T	Destruction of skin lesions	0016	3.02	$153.73	$64.57	$30.75
17286	T	Destruction of skin lesions	0013	1.36	$69.23	$17.66	$13.85
17304	T	Chemosurgery of skin lesion	0694	3.99	$203.11	$60.93	$40.62
17305	T	2nd stage chemosurgery	0694	3.99	$203.11	$60.93	$40.62
17306	T	3rd stage chemosurgery	0694	3.99	$203.11	$60.93	$40.62
17307	T	Followup skin lesion therapy	0694	3.99	$203.11	$60.93	$40.62
17310	T	Extensive skin chemosurgery	0694	3.99	$203.11	$60.93	$40.62
17340	T	Cryotherapy of skin	0012	0.66	$33.60	$9.18	$6.72
17360	T	Skin peel therapy	0012	0.66	$33.60	$9.18	$6.72
17380	T	Hair removal by electrolysis	0017	9.68	$492.75	$226.67	$98.55
17999	T	Skin tissue procedure	0004	2.47	$125.73	$32.57	$25.15
19000	T	Drainage of breast lesion	0004	2.47	$125.73	$32.57	$25.15
19001	T	Drain breast lesion add-on	0004	2.47	$125.73	$32.57	$25.15
19020	T	Incision of breast lesion	0008	10.93	$556.38	$113.67	$111.28
19030	N	Injection for breast x-ray					
19100	T	Bx breast percut w/o image	0005	4.03	$205.14	$90.26	$41.03
19101	T	Biopsy of breast, open	0028	14.00	$712.66	$303.74	$142.53
19102	T	Bx breast percut w/image	0005	4.03	$205.14	$90.26	$41.03
19103	S	Bx breast percut w/device	0710		$400.00		$80.00
19110	T	Nipple exploration	0028	14.00	$712.66	$303.74	$142.53
19112	T	Excise breast duct fistula	0028	14.00	$712.66	$303.74	$142.53
19120	T	Removal of breast lesion	0028	14.00	$712.66	$303.74	$142.53
19125	T	Excision, breast lesion	0028	14.00	$712.66	$303.74	$142.53
19126	T	Excision, addl breast lesion	0028	14.00	$712.66	$303.74	$142.53
19140	T	Removal of breast tissue	0028	14.00	$712.66	$303.74	$142.53
19160	T	Removal of breast tissue	0028	14.00	$712.66	$303.74	$142.53
19162	T	Remove breast tissue, nodes	0693	31.81	$1,619.26	$712.47	$323.85
19180	T	Removal of breast	0029	23.76	$1,209.48	$628.93	$241.90
19182	T	Removal of breast	0029	23.76	$1,209.48	$628.93	$241.90
19200	C	Removal of breast					
19220	C	Removal of breast					
19240	T	Removal of breast	0030	34.20	$1,740.92	$763.55	$348.18
19260	T	Removal of chest wall lesion	0021	11.82	$601.69	$236.51	$120.34
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	N	Place breast clip, percut					
19316	T	Suspension of breast	0029	23.76	$1,209.48	$628.93	$241.90
19318	T	Reduction of large breast	0693	31.81	$1,619.26	$712.47	$323.85
19324	T	Enlarge breast	0693	31.81	$1,619.26	$712.47	$323.85
19325	T	Enlarge breast with implant	0693	31.81	$1,619.26	$712.47	$323.85
19328	T	Removal of breast implant	0029	23.76	$1,209.48	$628.93	$241.90
19330	T	Removal of implant material	0029	23.76	$1,209.48	$628.93	$241.90
19340	T	Immediate breast prosthesis	0030	34.20	$1,740.92	$763.55	$348.18
19342	T	Delayed breast prosthesis	0693	31.81	$1,619.26	$712.47	$323.85
19350	T	Breast reconstruction	0029	23.76	$1,209.48	$628.93	$241.90
19355	T	Correct inverted nipple(s)	0029	23.76	$1,209.48	$628.93	$241.90
19357	T	Breast reconstruction	0693	31.81	$1,619.26	$712.47	$323.85
19361	C	Breast reconstruction					
19364	C	Breast reconstruction					
19366	T	Breast reconstruction	0029	23.76	$1,209.48	$628.93	$241.90
19367	C	Breast reconstruction					
19368	C	Breast reconstruction					
19369	C	Breast reconstruction					
19370	T	Surgery of breast capsule	0029	23.76	$1,209.48	$628.93	$241.90
19371	T	Removal of breast capsule	0029	23.76	$1,209.48	$628.93	$241.90
19380	T	Revise breast reconstruction	0030	34.20	$1,740.92	$763.55	$348.18
19396	T	Design custom breast implant	0029	23.76	$1,209.48	$628.93	$241.90
19499	T	Breast surgery procedure	0028	14.00	$712.66	$303.74	$142.53
20000	T	Incision of abscess	0006	2.18	$110.97	$33.95	$22.19
20005	T	Incision of deep abscess	0049	15.84	$806.32	$356.95	$161.26
20100	T	Explore wound, neck	0023	2.08	$105.88	$40.37	$21.18
20101	T	Explore wound, chest	0026	12.62	$642.41	$277.92	$128.48
20102	T	Explore wound, abdomen	0026	12.62	$642.41	$277.92	$128.48
20103	T	Explore wound, extremity	0023	2.08	$105.88	$40.37	$21.18
20150	T	Excise epiphyseal bar	0051	28.56	$1,453.82	$675.24	$290.76
20200	T	Muscle biopsy	0020	8.44	$429.63	$130.53	$85.93
20205	T	Deep muscle biopsy	0021	11.82	$601.69	$236.51	$120.34
20206	T	Needle biopsy, muscle	0005	4.03	$205.14	$90.26	$41.03
20220	T	Bone biopsy, trocar/needle	0019	4.22	$214.81	$78.91	$42.96
20225	T	Bone biopsy, trocar/needle	0019	4.22	$214.81	$78.91	$42.96
20240	T	Bone biopsy, excisional	0022	13.91	$708.07	$292.94	$141.61
20245	T	Bone biopsy, excisional	0022	13.91	$708.07	$292.94	$141.61

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
20250	T	Open bone biopsy	0049	15.84	$806.32	$356.95	$161.26
20251	T	Open bone biopsy	0049	15.84	$806.32	$356.95	$161.26
20500	T	Injection of sinus tract	0251	2.43	$123.70	$27.99	$24.74
20501	N	Inject sinus tract for x-ray					
20520	T	Removal of foreign body	0019	4.22	$214.81	$78.91	$42.96
20525	T	Removal of foreign body	0022	13.91	$708.07	$292.94	$141.61
*20526	T	Ther injection carpal tunnel	0204	2.24	$114.02	$43.33	$22.80
20550	T	Inject tendon/ligament/cyst	0204	2.24	$114.02	$43.33	$22.80
*20551	T	Inject tendon origin/insert	0204	2.24	$114.02	$43.33	$22.80
*20552	T	Inject trigger point, 1 or 2	0204	2.24	$114.02	$43.33	$22.80
*20553	T	Inject trigger points, > 3	0204	2.24	$114.02	$43.33	$22.80
20600	T	Drain/inject, joint/bursa	0204	2.24	$114.02	$43.33	$22.80
20605	T	Drain/inject, joint/bursa	0204	2.24	$114.02	$43.33	$22.80
20610	T	Drain/inject, joint/bursa	0204	2.24	$114.02	$43.33	$22.80
20615	T	Treatment of bone cyst	0004	2.47	$125.73	$32.57	$25.15
20650	T	Insert and remove bone pin	0049	15.84	$806.32	$356.95	$161.26
20660	C	Apply,remove 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	N	Removal of fixation device					
20670	T	Removal of support implant	0021	11.82	$601.69	$236.51	$120.34
20680	T	Removal of support implant	0022	13.91	$708.07	$292.94	$141.61
20690	T	Apply bone fixation device	0050	20.63	$1,050.15	$504.07	$210.03
20692	T	Apply bone fixation device	0050	20.63	$1,050.15	$504.07	$210.03
20693	T	Adjust bone fixation device	0049	15.84	$806.32	$356.95	$161.26
20694	T	Remove bone fixation device	0049	15.84	$806.32	$356.95	$161.26
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					
20900	T	Removal of bone for graft	0050	20.63	$1,050.15	$504.07	$210.03
20902	T	Removal of bone for graft	0050	20.63	$1,050.15	$504.07	$210.03
20910	T	Remove cartilage for graft	0026	12.62	$642.41	$277.92	$128.48
20912	T	Remove cartilage for graft	0026	12.62	$642.41	$277.92	$128.48
20920	T	Removal of fascia for graft	0026	12.62	$642.41	$277.92	$128.48
20922	T	Removal of fascia for graft	0026	12.62	$642.41	$277.92	$128.48
20924	T	Removal of tendon for graft	0050	20.63	$1,050.15	$504.07	$210.03
20926	T	Removal of tissue for graft	0026	12.62	$642.41	$277.92	$128.48
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	2.18	$110.97	$33.95	$22.19
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	15.84	$806.32	$356.95	$161.26
20979	A	Us bone stimulation					
20999	N	Musculoskeletal surgery					
21010	T	Incision of jaw joint	0254	17.37	$884.20	$272.41	$176.84
21015	T	Resection of facial tumor	0252	5.95	$302.88	$114.24	$60.58
21025	T	Excision of bone, lower jaw	0256	26.61	$1,354.56	$623.05	$270.91
21026	T	Excision of facial bone(s)	0256	26.61	$1,354.56	$623.05	$270.91
21029	T	Contour of face bone lesion	0256	26.61	$1,354.56	$623.05	$270.91
21030	T	Removal of face bone lesion	0254	17.37	$884.20	$272.41	$176.84
21031	T	Remove exostosis, mandible	0254	17.37	$884.20	$272.41	$176.84
21032	T	Remove exostosis, maxilla	0254	17.37	$884.20	$272.41	$176.84
21034	T	Removal of face bone lesion	0256	26.61	$1,354.56	$623.05	$270.91
21040	T	Removal of jaw bone lesion	0254	17.37	$884.20	$272.41	$176.84
21041	T	Removal of jaw bone lesion	0256	26.61	$1,354.56	$623.05	$270.91
21044	T	Removal of jaw bone lesion	0256	26.61	$1,354.56	$623.05	$270.91
21045	C	Extensive jaw surgery					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21050	T	Removal of jaw joint	0256	26.61	$1,354.56	$623.05	$270.91
21060	T	Remove jaw joint cartilage	0256	26.61	$1,354.56	$623.05	$270.91
21070	T	Remove coronoid process	0256	26.61	$1,354.56	$623.05	$270.91
21076	T	Prepare face/oral prosthesis	0254	17.37	$884.20	$272.41	$176.84
21077	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21079	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21080	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21081	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21082	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21083	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21084	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21085	T	Prepare face/oral prosthesis	0253	12.33	$627.65	$284.00	$125.53
21086	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21087	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21088	T	Prepare face/oral prosthesis	0256	26.61	$1,354.56	$623.05	$270.91
21089	T	Prepare face/oral prosthesis	0253	12.33	$627.65	$284.00	$125.53
21100	T	Maxillofacial fixation	0256	26.61	$1,354.56	$623.05	$270.91
21110	T	Interdental fixation	0252	5.95	$302.88	$114.24	$60.58
21116	N	Injection, jaw joint x-ray					
21120	T	Reconstruction of chin	0254	17.37	$884.20	$272.41	$176.84
21121	T	Reconstruction of chin	0254	17.37	$884.20	$272.41	$176.84
21122	T	Reconstruction of chin	0254	17.37	$884.20	$272.41	$176.84
21123	T	Reconstruction of chin	0254	17.37	$884.20	$272.41	$176.84
21125	T	Augmentation, lower jaw bone	0254	17.37	$884.20	$272.41	$176.84
21127	T	Augmentation, lower jaw bone	0256	26.61	$1,354.56	$623.05	$270.91
21137	T	Reduction of forehead	0254	17.37	$884.20	$272.41	$176.84
21138	T	Reduction of forehead	0256	26.61	$1,354.56	$623.05	$270.91
21139	T	Reduction of forehead	0256	26.61	$1,354.56	$623.05	$270.91
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	17.37	$884.20	$272.41	$176.84
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	26.61	$1,354.56	$623.05	$270.91
21199	T	Reconstr lwr jaw w/advance	0256	26.61	$1,354.56	$623.05	$270.91
21206	T	Reconstruct upper jaw bone	0256	26.61	$1,354.56	$623.05	$270.91
21208	T	Augmentation of facial bones	0256	26.61	$1,354.56	$623.05	$270.91
21209	T	Reduction of facial bones	0256	26.61	$1,354.56	$623.05	$270.91
21210	T	Face bone graft	0256	26.61	$1,354.56	$623.05	$270.91
21215	T	Lower jaw bone graft	0256	26.61	$1,354.56	$623.05	$270.91
21230	T	Rib cartilage graft	0256	26.61	$1,354.56	$623.05	$270.91
21235	T	Ear cartilage graft	0254	17.37	$884.20	$272.41	$176.84
21240	T	Reconstruction of jaw joint	0256	26.61	$1,354.56	$623.05	$270.91
21242	T	Reconstruction of jaw joint	0256	26.61	$1,354.56	$623.05	$270.91
21243	T	Reconstruction of jaw joint	0256	26.61	$1,354.56	$623.05	$270.91
21244	T	Reconstruction of lower jaw	0256	26.61	$1,354.56	$623.05	$270.91
21245	T	Reconstruction of jaw	0256	26.61	$1,354.56	$623.05	$270.91
21246	T	Reconstruction of jaw	0256	26.61	$1,354.56	$623.05	$270.91
21247	C	Reconstruct lower jaw bone					
21248	T	Reconstruction of jaw	0256	26.61	$1,354.56	$623.05	$270.91
21249	T	Reconstruction of jaw	0256	26.61	$1,354.56	$623.05	$270.91
21255	C	Reconstruct lower jaw bone					
21256	C	Reconstruction of orbit					
21260	T	Revise eye sockets	0256	26.61	$1,354.56	$623.05	$270.91
21261	T	Revise eye sockets	0256	26.61	$1,354.56	$623.05	$270.91

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21263	T	Revise eye sockets	0256	26.61	$1,354.56	$623.05	$270.91
21267	T	Revise eye sockets	0256	26.61	$1,354.56	$623.05	$270.91
21268	C	Revise eye sockets					
21270	T	Augmentation, cheek bone	0256	26.61	$1,354.56	$623.05	$270.91
21275	T	Revision, orbitofacial bones	0256	26.61	$1,354.56	$623.05	$270.91
21280	T	Revision of eyelid	0256	26.61	$1,354.56	$623.05	$270.91
21282	T	Revision of eyelid	0253	12.33	$627.65	$284.00	$125.53
21295	T	Revision of jaw muscle/bone	0252	5.95	$302.88	$114.24	$60.58
21296	T	Revision of jaw muscle/bone	0254	17.37	$884.20	$272.41	$176.84
21299	T	Cranio/maxillofacial surgery	0253	12.33	$627.65	$284.00	$125.53
21300	T	Treatment of skull fracture	0253	12.33	$627.65	$284.00	$125.53
21310	X	Treatment of nose fracture	0340	0.84	$42.76	$10.69	$8.55
21315	X	Treatment of nose fracture	0340	0.84	$42.76	$10.69	$8.55
21320	X	Treatment of nose fracture	0340	0.84	$42.76	$10.69	$8.55
21325	T	Treatment of nose fracture	0254	17.37	$884.20	$272.41	$176.84
21330	T	Treatment of nose fracture	0254	17.37	$884.20	$272.41	$176.84
21335	T	Treatment of nose fracture	0254	17.37	$884.20	$272.41	$176.84
21336	T	Treat nasal septal fracture	0046	27.69	$1,409.53	$535.76	$281.91
21337	T	Treat nasal septal fracture	0253	12.33	$627.65	$284.00	$125.53
21338	T	Treat nasoethmoid fracture	0254	17.37	$884.20	$272.41	$176.84
21339	T	Treat nasoethmoid fracture	0254	17.37	$884.20	$272.41	$176.84
21340	T	Treatment of nose fracture	0256	26.61	$1,354.56	$623.05	$270.91
21343	C	Treatment of sinus fracture					
21344	C	Treatment of sinus fracture					
21345	T	Treat nose/jaw fracture	0254	17.37	$884.20	$272.41	$176.84
21346	C	Treat nose/jaw fracture					
21347	C	Treat nose/jaw fracture					
21348	C	Treat nose/jaw fracture					
21355	T	Treat cheek bone fracture	0256	26.61	$1,354.56	$623.05	$270.91
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	C	Treat eye socket fracture					
21395	C	Treat eye socket fracture					
21400	T	Treat eye socket fracture	0252	5.95	$302.88	$114.24	$60.58
21401	T	Treat eye socket fracture	0253	12.33	$627.65	$284.00	$125.53
21406	T	Treat eye socket fracture	0256	26.61	$1,354.56	$623.05	$270.91
21407	T	Treat eye socket fracture	0256	26.61	$1,354.56	$623.05	$270.91
21408	C	Treat eye socket fracture					
21421	T	Treat mouth roof fracture	0254	17.37	$884.20	$272.41	$176.84
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	17.37	$884.20	$272.41	$176.84
21445	T	Treat dental ridge fracture	0254	17.37	$884.20	$272.41	$176.84
21450	T	Treat lower jaw fracture	0251	2.43	$123.70	$27.99	$24.74
21451	T	Treat lower jaw fracture	0252	5.95	$302.88	$114.24	$60.58
21452	T	Treat lower jaw fracture	0253	12.33	$627.65	$284.00	$125.53
21453	T	Treat lower jaw fracture	0256	26.61	$1,354.56	$623.05	$270.91
21454	T	Treat lower jaw fracture	0254	17.37	$884.20	$272.41	$176.84
21461	T	Treat lower jaw fracture	0256	26.61	$1,354.56	$623.05	$270.91
21462	T	Treat lower jaw fracture	0256	26.61	$1,354.56	$623.05	$270.91
21465	T	Treat lower jaw fracture	0256	26.61	$1,354.56	$623.05	$270.91
21470	T	Treat lower jaw fracture	0256	26.61	$1,354.56	$623.05	$270.91
21480	T	Reset dislocated jaw	0251	2.43	$123.70	$27.99	$24.74
21485	T	Reset dislocated jaw	0253	12.33	$627.65	$284.00	$125.53
21490	T	Repair dislocated jaw	0256	26.61	$1,354.56	$623.05	$270.91
21493	T	Treat hyoid bone fracture	0252	5.95	$302.88	$114.24	$60.58
21494	T	Treat hyoid bone fracture	0252	5.95	$302.88	$114.24	$60.58
21495	C	Treat hyoid bone fracture					
21497	T	Interdental wiring	0253	12.33	$627.65	$284.00	$125.53
21499	T	Head surgery procedure	0253	12.33	$627.65	$284.00	$125.53
21501	T	Drain neck/chest lesion	0008	10.93	$556.38	$113.67	$111.28
21502	T	Drain chest lesion	0049	15.84	$806.32	$356.95	$161.26
21510	C	Drainage of bone lesion					
21550	T	Biopsy of neck/chest	0019	4.22	$214.81	$78.91	$42.96
21555	T	Remove lesion, neck/chest	0022	13.91	$708.07	$292.94	$141.61

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21556	T	Remove lesion, neck/chest	0022	13.91	$708.07	$292.94	$141.61
21557	C	Remove tumor, neck/chest					
21600	T	Partial removal of rib	0050	20.63	$1,050.15	$504.07	$210.03
21610	T	Partial removal of rib	0050	20.63	$1,050.15	$504.07	$210.03
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					
21700	T	Revision of neck muscle	0006	2.18	$110.97	$33.95	$22.19
21705	C	Revision of neck muscle/rib					
21720	T	Revision of neck muscle	0008	10.93	$556.38	$113.67	$111.28
21725	T	Revision of neck muscle	0006	2.18	$110.97	$33.95	$22.19
21740	C	Reconstruction of sternum					
21750	C	Repair of sternum separation					
21800	T	Treatment of rib fracture	0043	4.05	$206.16		$41.23
21805	T	Treatment of rib fracture	0046	27.69	$1,409.53	$535.76	$281.91
21810	C	Treatment of rib fracture(s)					
21820	T	Treat sternum fracture	0044	2.52	$128.28	$38.08	$25.66
21825	C	Treat sternum fracture					
21899	T	Neck/chest surgery procedure	0252	5.95	$302.88	$114.24	$60.58
21920	T	Biopsy soft tissue of back	0019	4.22	$214.81	$78.91	$42.96
21925	T	Biopsy soft tissue of back	0022	13.91	$708.07	$292.94	$141.61
21930	T	Remove lesion, back or flank	0022	13.91	$708.07	$292.94	$141.61
21935	T	Remove tumor, back	0022	13.91	$708.07	$292.94	$141.61
22100	C	Remove part of neck vertebra					
22101	C	Remove part, thorax vertebra					
22102	C	Remove part, lumbar vertebra					
22103	C	Remove extra spine segment					
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	4.05	$206.16		$41.23
22310	T	Treat spine fracture	0043	4.05	$206.16		$41.23
22315	T	Treat spine fracture	0043	4.05	$206.16		$41.23
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	11.67	$594.05	$277.12	$118.81
22520	T	Percut vertebroplasty thor	0050	20.63	$1,050.15	$504.07	$210.03
22521	T	Percut vertebroplasty lumb	0050	20.63	$1,050.15	$504.07	$210.03
22522	T	Percut vertebroplasty addl	0050	20.63	$1,050.15	$504.07	$210.03
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	C	Lumbar spine fusion					
22614	C	Spine fusion, extra segment					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	4.05	$206.16		$41.23
22900	T	Remove abdominal wall lesion	0022	13.91	$708.07	$292.94	$141.61
22999	T	Abdomen surgery procedure	0022	13.91	$708.07	$292.94	$141.61
23000	T	Removal of calcium deposits	0021	11.82	$601.69	$236.51	$120.34
23020	T	Release shoulder joint	0051	28.56	$1,453.82	$675.24	$290.76
23030	T	Drain shoulder lesion	0008	10.93	$556.38	$113.67	$111.28
23031	T	Drain shoulder bursa	0008	10.93	$556.38	$113.67	$111.28
23035	C	Drain shoulder bone lesion					
23040	T	Exploratory shoulder surgery	0050	20.63	$1,050.15	$504.07	$210.03
23044	T	Exploratory shoulder surgery	0050	20.63	$1,050.15	$504.07	$210.03
23065	T	Biopsy shoulder tissues	0021	11.82	$601.69	$236.51	$120.34
23066	T	Biopsy shoulder tissues	0022	13.91	$708.07	$292.94	$141.61
23075	T	Removal of shoulder lesion	0021	11.82	$601.69	$236.51	$120.34
23076	T	Removal of shoulder lesion	0022	13.91	$708.07	$292.94	$141.61
23077	T	Remove tumor of shoulder	0022	13.91	$708.07	$292.94	$141.61
23100	T	Biopsy of shoulder joint	0049	15.84	$806.32	$356.95	$161.26
23101	T	Shoulder joint surgery	0050	20.63	$1,050.15	$504.07	$210.03
23105	T	Remove shoulder joint lining	0050	20.63	$1,050.15	$504.07	$210.03
23106	T	Incision of collarbone joint	0050	20.63	$1,050.15	$504.07	$210.03
23107	T	Explore treat shoulder joint	0050	20.63	$1,050.15	$504.07	$210.03
23120	T	Partial removal, collar bone	0051	28.56	$1,453.82	$675.24	$290.76
23125	C	Removal of collar bone					
23130	T	Remove shoulder bone, part	0051	28.56	$1,453.82	$675.24	$290.76
23140	T	Removal of bone lesion	0049	15.84	$806.32	$356.95	$161.26
23145	T	Removal of bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
23146	T	Removal of bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
23150	T	Removal of humerus lesion	0050	20.63	$1,050.15	$504.07	$210.03
23155	T	Removal of humerus lesion	0050	20.63	$1,050.15	$504.07	$210.03
23156	T	Removal of humerus lesion	0050	20.63	$1,050.15	$504.07	$210.03
23170	T	Remove collar bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
23172	T	Remove shoulder blade lesion	0050	20.63	$1,050.15	$504.07	$210.03
23174	T	Remove humerus lesion	0050	20.63	$1,050.15	$504.07	$210.03
23180	T	Remove collar bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
23182	T	Remove shoulder blade lesion	0050	20.63	$1,050.15	$504.07	$210.03
23184	T	Remove humerus lesion	0050	20.63	$1,050.15	$504.07	$210.03
23190	T	Partial removal of scapula	0050	20.63	$1,050.15	$504.07	$210.03
23195	C	Removal of head of humerus					
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	0019	4.22	$214.81	$78.91	$42.96
23331	T	Remove shoulder foreign body	0022	13.91	$708.07	$292.94	$141.61
23332	C	Remove shoulder foreign body					
23350	N	Injection for shoulder x-ray					
23395	C	Muscle transfer,shoulder/arm					
23397	C	Muscle transfers					
23400	C	Fixation of shoulder blade					
23405	T	Incision of tendon & muscle	0050	20.63	$1,050.15	$504.07	$210.03
23406	T	Incise tendon(s) & muscle(s)	0050	20.63	$1,050.15	$504.07	$210.03
23410	T	Repair of tendon(s)	0052	35.94	$1,829.49	$930.91	$365.90
23412	T	Repair of tendon(s)	0052	35.94	$1,829.49	$930.91	$365.90
23415	T	Release of shoulder ligament	0051	28.56	$1,453.82	$675.24	$290.76
23420	T	Repair of shoulder	0052	35.94	$1,829.49	$930.91	$365.90
23430	T	Repair biceps tendon	0052	35.94	$1,829.49	$930.91	$365.90
23440	T	Remove/transplant tendon	0052	35.94	$1,829.49	$930.91	$365.90
23450	T	Repair shoulder capsule	0052	35.94	$1,829.49	$930.91	$365.90
23455	T	Repair shoulder capsule	0052	35.94	$1,829.49	$930.91	$365.90

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
23460	T	Repair shoulder capsule	0052	35.94	$1,829.49	$930.91	$365.90
23462	T	Repair shoulder capsule	0052	35.94	$1,829.49	$930.91	$365.90
23465	T	Repair shoulder capsule	0052	35.94	$1,829.49	$930.91	$365.90
23466	T	Repair shoulder capsule	0052	35.94	$1,829.49	$930.91	$365.90
23470	T	Reconstruct shoulder joint	0048	43.19	$2,198.54	$725.94	$439.71
23472	C	Reconstruct shoulder joint					
23480	T	Revision of collar bone	0051	28.56	$1,453.82	$675.24	$290.76
23485	T	Revision of collar bone	0051	28.56	$1,453.82	$675.24	$290.76
23490	T	Reinforce clavicle	0051	28.56	$1,453.82	$675.24	$290.76
23491	T	Reinforce shoulder bones	0051	28.56	$1,453.82	$675.24	$290.76
23500	T	Treat clavicle fracture	0043	4.05	$206.16		$41.23
23505	T	Treat clavicle fracture	0043	4.05	$206.16		$41.23
23515	T	Treat clavicle fracture	0046	27.69	$1,409.53	$535.76	$281.91
23520	T	Treat clavicle dislocation	0044	2.52	$128.28	$38.08	$25.66
23525	T	Treat clavicle dislocation	0043	4.05	$206.16		$41.23
23530	T	Treat clavicle dislocation	0046	27.69	$1,409.53	$535.76	$281.91
23532	T	Treat clavicle dislocation	0046	27.69	$1,409.53	$535.76	$281.91
23540	T	Treat clavicle dislocation	0044	2.52	$128.28	$38.08	$25.66
23545	T	Treat clavicle dislocation	0043	4.05	$206.16		$41.23
23550	T	Treat clavicle dislocation	0046	27.69	$1,409.53	$535.76	$281.91
23552	T	Treat clavicle dislocation	0046	27.69	$1,409.53	$535.76	$281.91
23570	T	Treat shoulder blade fx	0043	4.05	$206.16		$41.23
23575	T	Treat shoulder blade fx	0044	2.52	$128.28	$38.08	$25.66
23585	T	Treat scapula fracture	0046	27.69	$1,409.53	$535.76	$281.91
23600	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
23605	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
23615	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
23616	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
23620	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
23625	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
23630	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
23650	T	Treat shoulder dislocation	0043	4.05	$206.16		$41.23
23655	T	Treat shoulder dislocation	0045	11.67	$594.05	$277.12	$118.81
23660	T	Treat shoulder dislocation	0046	27.69	$1,409.53	$535.76	$281.91
23665	T	Treat dislocation/fracture	0044	2.52	$128.28	$38.08	$25.66
23670	T	Treat dislocation/fracture	0046	27.69	$1,409.53	$535.76	$281.91
23675	T	Treat dislocation/fracture	0044	2.52	$128.28	$38.08	$25.66
23680	T	Treat dislocation/fracture	0046	27.69	$1,409.53	$535.76	$281.91
23700	T	Fixation of shoulder	0045	11.67	$594.05	$277.12	$118.81
23800	T	Fusion of shoulder joint	0051	28.56	$1,453.82	$675.24	$290.76
23802	T	Fusion of shoulder joint	0051	28.56	$1,453.82	$675.24	$290.76
23900	C	Amputation of arm & girdle					
23920	C	Amputation at shoulder joint					
23921	T	Amputation follow-up surgery	0026	12.62	$642.41	$277.92	$128.48
23929	T	Shoulder surgery procedure	0043	4.05	$206.16		$41.23
23930	T	Drainage of arm lesion	0008	10.93	$556.38	$113.67	$111.28
23931	T	Drainage of arm bursa	0006	2.18	$110.97	$33.95	$22.19
23935	T	Drain arm/elbow bone lesion	0049	15.84	$806.32	$356.95	$161.26
24000	T	Exploratory elbow surgery	0050	20.63	$1,050.15	$504.07	$210.03
24006	T	Release elbow joint	0050	20.63	$1,050.15	$504.07	$210.03
24065	T	Biopsy arm/elbow soft tissue	0020	8.44	$429.63	$130.53	$85.93
24066	T	Biopsy arm/elbow soft tissue	0021	11.82	$601.69	$236.51	$120.34
24075	T	Remove arm/elbow lesion	0021	11.82	$601.69	$236.51	$120.34
24076	T	Remove arm/elbow lesion	0022	13.91	$708.07	$292.94	$141.61
24077	T	Remove tumor of arm/elbow	0022	13.91	$708.07	$292.94	$141.61
24100	T	Biopsy elbow joint lining	0049	15.84	$806.32	$356.95	$161.26
24101	T	Explore/treat elbow joint	0050	20.63	$1,050.15	$504.07	$210.03
24102	T	Remove elbow joint lining	0050	20.63	$1,050.15	$504.07	$210.03
24105	T	Removal of elbow bursa	0049	15.84	$806.32	$356.95	$161.26
24110	T	Remove humerus lesion	0049	15.84	$806.32	$356.95	$161.26
24115	T	Remove/graft bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
24116	T	Remove/graft bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
24120	T	Remove elbow lesion	0049	15.84	$806.32	$356.95	$161.26
24125	T	Remove/graft bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
24126	T	Remove/graft bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
24130	T	Removal of head of radius	0050	20.63	$1,050.15	$504.07	$210.03
24134	T	Removal of arm bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
24136	T	Remove radius bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
24138	T	Remove elbow bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
24140	T	Partial removal of arm bone	0050	20.63	$1,050.15	$504.07	$210.03
24145	T	Partial removal of radius	0050	20.63	$1,050.15	$504.07	$210.03
24147	T	Partial removal of elbow	0050	20.63	$1,050.15	$504.07	$210.03
24149	C	Radical resection of elbow					
24150	C	Extensive humerus surgery					
24151	C	Extensive humerus surgery					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24152	C	Extensive radius surgery					
24153	C	Extensive radius surgery					
24155	T	Removal of elbow joint	0051	28.56	$1,453.82	$675.24	$290.76
24160	T	Remove elbow joint implant	0050	20.63	$1,050.15	$504.07	$210.03
24164	T	Remove radius head implant	0050	20.63	$1,050.15	$504.07	$210.03
24200	T	Removal of arm foreign body	0019	4.22	$214.81	$78.91	$42.96
24201	T	Removal of arm foreign body	0021	11.82	$601.69	$236.51	$120.34
24220	N	Injection for elbow x-ray					
*24300	T	Manipulate elbow w/anesth	0045	11.67	$594.05	$277.12	$118.81
24301	T	Muscle/tendon transfer	0050	20.63	$1,050.15	$504.07	$210.03
24305	T	Arm tendon lengthening	0050	20.63	$1,050.15	$504.07	$210.03
24310	T	Revision of arm tendon	0049	15.84	$806.32	$356.95	$161.26
24320	T	Repair of arm tendon	0051	28.56	$1,453.82	$675.24	$290.76
24330	T	Revision of arm muscles	0051	28.56	$1,453.82	$675.24	$290.76
24331	T	Revision of arm muscles	0051	28.56	$1,453.82	$675.24	$290.76
*24332	T	Tenolysis, triceps	0049	15.84	$806.32	$356.95	$161.26
24340	T	Repair of biceps tendon	0051	28.56	$1,453.82	$675.24	$290.76
24341	T	Repair arm tendon/muscle	0051	28.56	$1,453.82	$675.24	$290.76
24342	T	Repair of ruptured tendon	0051	28.56	$1,453.82	$675.24	$290.76
*24343	T	Repr elbow lat ligmnt w/tiss	0050	20.63	$1,050.15	$504.07	$210.03
*24344	T	Reconstruct elbow lat ligmnt	0051	28.56	$1,453.82	$675.24	$290.76
*24345	T	Repr elbw med ligmnt w/tiss	0050	20.63	$1,050.15	$504.07	$210.03
*24346	T	Reconstruct elbow med ligmnt	0051	28.56	$1,453.82	$675.24	$290.76
24350	T	Repair of tennis elbow	0050	20.63	$1,050.15	$504.07	$210.03
24351	T	Repair of tennis elbow	0050	20.63	$1,050.15	$504.07	$210.03
24352	T	Repair of tennis elbow	0050	20.63	$1,050.15	$504.07	$210.03
24354	T	Repair of tennis elbow	0050	20.63	$1,050.15	$504.07	$210.03
24356	T	Revision of tennis elbow	0050	20.63	$1,050.15	$504.07	$210.03
24360	T	Reconstruct elbow joint	0047	26.36	$1,341.83	$537.03	$268.37
24361	T	Reconstruct elbow joint	0048	43.19	$2,198.54	$725.94	$439.71
24362	T	Reconstruct elbow joint	0048	43.19	$2,198.54	$725.94	$439.71
24363	T	Replace elbow joint	0048	43.19	$2,198.54	$725.94	$439.71
24365	T	Reconstruct head of radius	0047	26.36	$1,341.83	$537.03	$268.37
24366	T	Reconstruct head of radius	0048	43.19	$2,198.54	$725.94	$439.71
24400	T	Revision of humerus	0050	20.63	$1,050.15	$504.07	$210.03
24410	T	Revision of humerus	0050	20.63	$1,050.15	$504.07	$210.03
24420	T	Revision of humerus	0051	28.56	$1,453.82	$675.24	$290.76
24430	T	Repair of humerus	0051	28.56	$1,453.82	$675.24	$290.76
24435	T	Repair humerus with graft	0051	28.56	$1,453.82	$675.24	$290.76
24470	T	Revision of elbow joint	0051	28.56	$1,453.82	$675.24	$290.76
24495	T	Decompression of forearm	0050	20.63	$1,050.15	$504.07	$210.03
24498	T	Reinforce humerus	0051	28.56	$1,453.82	$675.24	$290.76
24500	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
24505	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
24515	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24516	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24530	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
24535	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
24538	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24545	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24546	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24560	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
24565	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
24566	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24575	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24576	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
24577	T	Treat humerus fracture	0044	2.52	$128.28	$38.08	$25.66
24579	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24582	T	Treat humerus fracture	0046	27.69	$1,409.53	$535.76	$281.91
24586	T	Treat elbow fracture	0046	27.69	$1,409.53	$535.76	$281.91
24587	T	Treat elbow fracture	0046	27.69	$1,409.53	$535.76	$281.91
24600	T	Treat elbow dislocation	0044	2.52	$128.28	$38.08	$25.66
24605	T	Treat elbow dislocation	0045	11.67	$594.05	$277.12	$118.81
24615	T	Treat elbow dislocation	0046	27.69	$1,409.53	$535.76	$281.91
24620	T	Treat elbow fracture	0044	2.52	$128.28	$38.08	$25.66
24635	T	Treat elbow fracture	0046	27.69	$1,409.53	$535.76	$281.91
24640	T	Treat elbow dislocation	0044	2.52	$128.28	$38.08	$25.66
24650	T	Treat radius fracture	0044	2.52	$128.28	$38.08	$25.66
24655	T	Treat radius fracture	0044	2.52	$128.28	$38.08	$25.66
24665	T	Treat radius fracture	0046	27.69	$1,409.53	$535.76	$281.91
24666	T	Treat radius fracture	0046	27.69	$1,409.53	$535.76	$281.91
24670	T	Treat ulnar fracture	0044	2.52	$128.28	$38.08	$25.66
24675	T	Treat ulnar fracture	0044	2.52	$128.28	$38.08	$25.66
24685	T	Treat ulnar fracture	0046	27.69	$1,409.53	$535.76	$281.91
24800	T	Fusion of elbow joint	0051	28.56	$1,453.82	$675.24	$290.76

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24802	T	Fusion/graft of elbow joint	0051	28.56	$1,453.82	$675.24	$290.76
24900	C	Amputation of upper arm					
24920	C	Amputation of upper arm					
24925	T	Amputation follow-up surgery	0049	15.84	$806.32	$356.95	$161.26
24930	C	Amputation follow-up surgery					
24931	C	Amputate upper arm & implant					
24935	T	Revision of amputation	0052	35.94	$1,829.49	$930.91	$365.90
24940	C	Revision of upper arm					
24999	T	Upper arm/elbow surgery	0044	2.52	$128.28	$38.08	$25.66
25000	T	Incision of tendon sheath	0049	15.84	$806.32	$356.95	$161.26
*25001	T	Incise flexor carpi radialis	0049	15.84	$806.32	$356.95	$161.26
25020	T	Decompression of forearm	0049	15.84	$806.32	$356.95	$161.26
25023	T	Decompression of forearm	0050	20.63	$1,050.15	$504.07	$210.03
*25024	T	Decompress forearm 2 spaces	0050	20.63	$1,050.15	$504.07	$210.03
*25025	T	Decompress forarm 2 spaces	0050	20.63	$1,050.15	$504.07	$210.03
25028	T	Drainage of forearm lesion	0049	15.84	$806.32	$356.95	$161.26
25031	T	Drainage of forearm bursa	0049	15.84	$806.32	$356.95	$161.26
25035	T	Treat forearm bone lesion	0049	15.84	$806.32	$356.95	$161.26
25040	T	Explore/treat wrist joint	0050	20.63	$1,050.15	$504.07	$210.03
25065	T	Biopsy forearm soft tissues	0021	11.82	$601.69	$236.51	$120.34
25066	T	Biopsy forearm soft tissues	0022	13.91	$708.07	$292.94	$141.61
25075	T	Removal of forearm lesion	0020	8.44	$429.63	$130.53	$85.93
25076	T	Removal of forearm lesion	0022	13.91	$708.07	$292.94	$141.61
25077	T	Remove tumor, forearm/wrist	0022	13.91	$708.07	$292.94	$141.61
25085	T	Incision of wrist capsule	0049	15.84	$806.32	$356.95	$161.26
25100	T	Biopsy of wrist joint	0049	15.84	$806.32	$356.95	$161.26
25101	T	Explore/treat wrist joint	0050	20.63	$1,050.15	$504.07	$210.03
25105	T	Remove wrist joint lining	0050	20.63	$1,050.15	$504.07	$210.03
25107	T	Remove wrist joint cartilage	0050	20.63	$1,050.15	$504.07	$210.03
25110	T	Remove wrist tendon lesion	0049	15.84	$806.32	$356.95	$161.26
25111	T	Remove wrist tendon lesion	0053	11.69	$595.07	$253.49	$119.01
25112	T	Reremove wrist tendon lesion	0053	11.69	$595.07	$253.49	$119.01
25115	T	Remove wrist/forearm lesion	0049	15.84	$806.32	$356.95	$161.26
25116	T	Remove wrist/forearm lesion	0049	15.84	$806.32	$356.95	$161.26
25118	T	Excise wrist tendon sheath	0050	20.63	$1,050.15	$504.07	$210.03
25119	T	Partial removal of ulna	0050	20.63	$1,050.15	$504.07	$210.03
25120	T	Removal of forearm lesion	0050	20.63	$1,050.15	$504.07	$210.03
25125	T	Remove/graft forearm lesion	0050	20.63	$1,050.15	$504.07	$210.03
25126	T	Remove/graft forearm lesion	0050	20.63	$1,050.15	$504.07	$210.03
25130	T	Removal of wrist lesion	0050	20.63	$1,050.15	$504.07	$210.03
25135	T	Remove & graft wrist lesion	0050	20.63	$1,050.15	$504.07	$210.03
25136	T	Remove & graft wrist lesion	0050	20.63	$1,050.15	$504.07	$210.03
25145	T	Remove forearm bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
25150	T	Partial removal of ulna	0050	20.63	$1,050.15	$504.07	$210.03
25151	T	Partial removal of radius	0050	20.63	$1,050.15	$504.07	$210.03
25170	C	Extensive forearm surgery					
25210	T	Removal of wrist bone	0054	19.83	$1,009.43	$472.33	$201.89
25215	T	Removal of wrist bones	0054	19.83	$1,009.43	$472.33	$201.89
25230	T	Partial removal of radius	0050	20.63	$1,050.15	$504.07	$210.03
25240	T	Partial removal of ulna	0050	20.63	$1,050.15	$504.07	$210.03
25246	N	Injection for wrist x-ray					
25248	T	Remove forearm foreign body	0049	15.84	$806.32	$356.95	$161.26
25250	T	Removal of wrist prosthesis	0050	20.63	$1,050.15	$504.07	$210.03
25251	T	Removal of wrist prosthesis	0050	20.63	$1,050.15	$504.07	$210.03
*25259	T	Manipulate wrist w/anesthes	0044	2.52	$128.28	$38.08	$25.66
25260	T	Repair forearm tendon/muscle	0050	20.63	$1,050.15	$504.07	$210.03
25263	T	Repair forearm tendon/muscle	0050	20.63	$1,050.15	$504.07	$210.03
25265	T	Repair forearm tendon/muscle	0050	20.63	$1,050.15	$504.07	$210.03
25270	T	Repair forearm tendon/muscle	0050	20.63	$1,050.15	$504.07	$210.03
25272	T	Repair forearm tendon/muscle	0050	20.63	$1,050.15	$504.07	$210.03
25274	T	Repair forearm tendon/muscle	0050	20.63	$1,050.15	$504.07	$210.03
*25275	T	Repair forearm tendon sheath	0050	20.63	$1,050.15	$504.07	$210.03
25280	T	Revise wrist/forearm tendon	0050	20.63	$1,050.15	$504.07	$210.03
25290	T	Incise wrist/forearm tendon	0050	20.63	$1,050.15	$504.07	$210.03
25295	T	Release wrist/forearm tendon	0049	15.84	$806.32	$356.95	$161.26
25300	T	Fusion of tendons at wrist	0050	20.63	$1,050.15	$504.07	$210.03
25301	T	Fusion of tendons at wrist	0050	20.63	$1,050.15	$504.07	$210.03
25310	T	Transplant forearm tendon	0051	28.56	$1,453.82	$675.24	$290.76
25312	T	Transplant forearm tendon	0051	28.56	$1,453.82	$675.24	$290.76
25315	T	Revise palsy hand tendon(s)	0051	28.56	$1,453.82	$675.24	$290.76
25316	T	Revise palsy hand tendon(s)	0051	28.56	$1,453.82	$675.24	$290.76
25320	T	Repair/revise wrist joint	0051	28.56	$1,453.82	$675.24	$290.76
25332	T	Revise wrist joint	0047	26.36	$1,341.83	$537.03	$268.37
25335	T	Realignment of hand	0051	28.56	$1,453.82	$675.24	$290.76
25337	T	Reconstruct ulna/radioulnar	0051	28.56	$1,453.82	$675.24	$290.76

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25350	T	Revision of radius	0051	28.56	$1,453.82	$675.24	$290.76
25355	T	Revision of radius	0051	28.56	$1,453.82	$675.24	$290.76
25360	T	Revision of ulna	0050	20.63	$1,050.15	$504.07	$210.03
25365	T	Revise radius & ulna	0050	20.63	$1,050.15	$504.07	$210.03
25370	T	Revise radius or ulna	0051	28.56	$1,453.82	$675.24	$290.76
25375	T	Revise radius & ulna	0051	28.56	$1,453.82	$675.24	$290.76
25390	C	Shorten radius or ulna					
25391	C	Lengthen radius or ulna					
25392	C	Shorten radius & ulna					
25393	C	Lengthen radius & ulna					
*25394	T	Repair carpal bone, shorten	0053	11.69	$595.07	$253.49	$119.01
25400	T	Repair radius or ulna	0050	20.63	$1,050.15	$504.07	$210.03
25405	T	Repair/graft radius or ulna	0050	20.63	$1,050.15	$504.07	$210.03
25415	T	Repair radius & ulna	0050	20.63	$1,050.15	$504.07	$210.03
25420	C	Repair/graft radius & ulna					
25425	T	Repair/graft radius or ulna	0051	28.56	$1,453.82	$675.24	$290.76
25426	T	Repair/graft radius & ulna	0051	28.56	$1,453.82	$675.24	$290.76
*25430	T	Vasc graft into carpal bone	0054	19.83	$1,009.43	$472.33	$201.89
*25431	T	Repair nonunion carpal bone	0054	19.83	$1,009.43	$472.33	$201.89
25440	T	Repair/graft wrist bone	0051	28.56	$1,453.82	$675.24	$290.76
25441	T	Reconstruct wrist joint	0048	43.19	$2,198.54	$725.94	$439.71
25442	T	Reconstruct wrist joint	0048	43.19	$2,198.54	$725.94	$439.71
25443	T	Reconstruct wrist joint	0048	43.19	$2,198.54	$725.94	$439.71
25444	T	Reconstruct wrist joint	0048	43.19	$2,198.54	$725.94	$439.71
25445	T	Reconstruct wrist joint	0048	43.19	$2,198.54	$725.94	$439.71
25446	T	Wrist replacement	0048	43.19	$2,198.54	$725.94	$439.71
25447	T	Repair wrist joint(s)	0047	26.36	$1,341.83	$537.03	$268.37
25449	T	Remove wrist joint implant	0047	26.36	$1,341.83	$537.03	$268.37
25450	T	Revision of wrist joint	0051	28.56	$1,453.82	$675.24	$290.76
25455	T	Revision of wrist joint	0051	28.56	$1,453.82	$675.24	$290.76
25490	T	Reinforce radius	0051	28.56	$1,453.82	$675.24	$290.76
25491	T	Reinforce ulna	0051	28.56	$1,453.82	$675.24	$290.76
25492	T	Reinforce radius and ulna	0051	28.56	$1,453.82	$675.24	$290.76
25500	T	Treat fracture of radius	0044	2.52	$128.28	$38.08	$25.66
25505	T	Treat fracture of radius	0044	2.52	$128.28	$38.08	$25.66
25515	T	Treat fracture of radius	0046	27.69	$1,409.53	$535.76	$281.91
25520	T	Treat fracture of radius	0044	2.52	$128.28	$38.08	$25.66
25525	T	Treat fracture of radius	0046	27.69	$1,409.53	$535.76	$281.91
25526	T	Treat fracture of radius	0046	27.69	$1,409.53	$535.76	$281.91
25530	T	Treat fracture of ulna	0044	2.52	$128.28	$38.08	$25.66
25535	T	Treat fracture of ulna	0044	2.52	$128.28	$38.08	$25.66
25545	T	Treat fracture of ulna	0046	27.69	$1,409.53	$535.76	$281.91
25560	T	Treat fracture radius & ulna	0044	2.52	$128.28	$38.08	$25.66
25565	T	Treat fracture radius & ulna	0044	2.52	$128.28	$38.08	$25.66
25574	T	Treat fracture radius & ulna	0046	27.69	$1,409.53	$535.76	$281.91
25575	T	Treat fracture radius/ulna	0046	27.69	$1,409.53	$535.76	$281.91
25600	T	Treat fracture radius/ulna	0044	2.52	$128.28	$38.08	$25.66
25605	T	Treat fracture radius/ulna	0044	2.52	$128.28	$38.08	$25.66
25611	T	Treat fracture radius/ulna	0046	27.69	$1,409.53	$535.76	$281.91
25620	T	Treat fracture radius/ulna	0046	27.69	$1,409.53	$535.76	$281.91
25622	T	Treat wrist bone fracture	0044	2.52	$128.28	$38.08	$25.66
25624	T	Treat wrist bone fracture	0044	2.52	$128.28	$38.08	$25.66
25628	T	Treat wrist bone fracture	0046	27.69	$1,409.53	$535.76	$281.91
25630	T	Treat wrist bone fracture	0044	2.52	$128.28	$38.08	$25.66
25635	T	Treat wrist bone fracture	0044	2.52	$128.28	$38.08	$25.66
25645	T	Treat wrist bone fracture	0046	27.69	$1,409.53	$535.76	$281.91
25650	T	Treat wrist bone fracture	0044	2.52	$128.28	$38.08	$25.66
*25651	T	Pin ulnar styloid fracture	0046	27.69	$1,409.53	$535.76	$281.91
*25652	T	Treat fracture ulnar styloid	0046	27.69	$1,409.53	$535.76	$281.91
25660	T	Treat wrist dislocation	0044	2.52	$128.28	$38.08	$25.66
25670	T	Treat wrist dislocation	0046	27.69	$1,409.53	$535.76	$281.91
*25671	T	Pin radioulnar dislocation	0046	27.69	$1,409.53	$535.76	$281.91
25675	T	Treat wrist dislocation	0044	2.52	$128.28	$38.08	$25.66
25676	T	Treat wrist dislocation	0046	27.69	$1,409.53	$535.76	$281.91
25680	T	Treat wrist fracture	0044	2.52	$128.28	$38.08	$25.66
25685	T	Treat wrist fracture	0046	27.69	$1,409.53	$535.76	$281.91
25690	T	Treat wrist dislocation	0044	2.52	$128.28	$38.08	$25.66
25695	T	Treat wrist dislocation	0046	27.69	$1,409.53	$535.76	$281.91
25800	T	Fusion of wrist joint	0051	28.56	$1,453.82	$675.24	$290.76
25805	T	Fusion/graft of wrist joint	0051	28.56	$1,453.82	$675.24	$290.76
25810	T	Fusion/graft of wrist joint	0051	28.56	$1,453.82	$675.24	$290.76
25820	T	Fusion of hand bones	0053	11.69	$595.07	$253.49	$119.01
25825	T	Fuse hand bones with graft	0054	19.83	$1,009.43	$472.33	$201.89
25830	T	Fusion, radioulnar jnt/ulna	0051	28.56	$1,453.82	$675.24	$290.76
25900	C	Amputation of forearm					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25905	C	Amputation of forearm					
25907	T	Amputation follow-up surgery	0049	15.84	$806.32	$356.95	$161.26
25909	C	Amputation follow-up surgery					
25915	C	Amputation of forearm					
25920	C	Amputate hand at wrist					
25922	T	Amputate hand at wrist	0049	15.84	$806.32	$356.95	$161.26
25924	C	Amputation follow-up surgery					
25927	C	Amputation of hand					
25929	T	Amputation follow-up surgery	0026	12.62	$642.41	$277.92	$128.48
25931	C	Amputation follow-up surgery					
25999	T	Forearm or wrist surgery	0044	2.52	$128.28	$38.08	$25.66
26010	T	Drainage of finger abscess	0006	2.18	$110.97	$33.95	$22.19
26011	T	Drainage of finger abscess	0007	6.75	$343.60	$72.03	$68.72
26020	T	Drain hand tendon sheath	0053	11.69	$595.07	$253.49	$119.01
26025	T	Drainage of palm bursa	0053	11.69	$595.07	$253.49	$119.01
26030	T	Drainage of palm bursa(s)	0053	11.69	$595.07	$253.49	$119.01
26034	T	Treat hand bone lesion	0053	11.69	$595.07	$253.49	$119.01
26035	T	Decompress fingers/hand	0053	11.69	$595.07	$253.49	$119.01
26037	T	Decompress fingers/hand	0053	11.69	$595.07	$253.49	$119.01
26040	T	Release palm contracture	0054	19.83	$1,009.43	$472.33	$201.89
26045	T	Release palm contracture	0054	19.83	$1,009.43	$472.33	$201.89
26055	T	Incise finger tendon sheath	0053	11.69	$595.07	$253.49	$119.01
26060	T	Incision of finger tendon	0053	11.69	$595.07	$253.49	$119.01
26070	T	Explore/treat hand joint	0053	11.69	$595.07	$253.49	$119.01
26075	T	Explore/treat finger joint	0053	11.69	$595.07	$253.49	$119.01
26080	T	Explore/treat finger joint	0053	11.69	$595.07	$253.49	$119.01
26100	T	Biopsy hand joint lining	0053	11.69	$595.07	$253.49	$119.01
26105	T	Biopsy finger joint lining	0053	11.69	$595.07	$253.49	$119.01
26110	T	Biopsy finger joint lining	0053	11.69	$595.07	$253.49	$119.01
26115	T	Removal of hand lesion	0022	13.91	$708.07	$292.94	$141.61
26116	T	Removal of hand lesion	0022	13.91	$708.07	$292.94	$141.61
26117	T	Remove tumor, hand/finger	0022	13.91	$708.07	$292.94	$141.61
26121	T	Release palm contracture	0054	19.83	$1,009.43	$472.33	$201.89
26123	T	Release palm contracture	0054	19.83	$1,009.43	$472.33	$201.89
26125	T	Release palm contracture	0054	19.83	$1,009.43	$472.33	$201.89
26130	T	Remove wrist joint lining	0053	11.69	$595.07	$253.49	$119.01
26135	T	Revise finger joint, each	0054	19.83	$1,009.43	$472.33	$201.89
26140	T	Revise finger joint, each	0053	11.69	$595.07	$253.49	$119.01
26145	T	Tendon excision, palm/finger	0053	11.69	$595.07	$253.49	$119.01
26160	T	Remove tendon sheath lesion	0053	11.69	$595.07	$253.49	$119.01
26170	T	Removal of palm tendon, each	0053	11.69	$595.07	$253.49	$119.01
26180	T	Removal of finger tendon	0053	11.69	$595.07	$253.49	$119.01
26185	T	Remove finger bone	0053	11.69	$595.07	$253.49	$119.01
26200	T	Remove hand bone lesion	0053	11.69	$595.07	$253.49	$119.01
26205	T	Remove/graft bone lesion	0054	19.83	$1,009.43	$472.33	$201.89
26210	T	Removal of finger lesion	0053	11.69	$595.07	$253.49	$119.01
26215	T	Remove/graft finger lesion	0053	11.69	$595.07	$253.49	$119.01
26230	T	Partial removal of hand bone	0053	11.69	$595.07	$253.49	$119.01
26235	T	Partial removal, finger bone	0053	11.69	$595.07	$253.49	$119.01
26236	T	Partial removal, finger bone	0053	11.69	$595.07	$253.49	$119.01
26250	T	Extensive hand surgery	0053	11.69	$595.07	$253.49	$119.01
26255	T	Extensive hand surgery	0054	19.83	$1,009.43	$472.33	$201.89
26260	T	Extensive finger surgery	0053	11.69	$595.07	$253.49	$119.01
26261	T	Extensive finger surgery	0053	11.69	$595.07	$253.49	$119.01
26262	T	Partial removal of finger	0053	11.69	$595.07	$253.49	$119.01
26320	T	Removal of implant from hand	0020	8.44	$429.63	$130.53	$85.93
*26340	T	Manipulate finger w/anesth	0043	4.05	$206.16		$41.23
26350	T	Repair finger/hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26352	T	Repair/graft hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26356	T	Repair finger/hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26357	T	Repair finger/hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26358	T	Repair/graft hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26370	T	Repair finger/hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26372	T	Repair/graft hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26373	T	Repair finger/hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26390	T	Revise hand/finger tendon	0054	19.83	$1,009.43	$472.33	$201.89
26392	T	Repair/graft hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26410	T	Repair hand tendon	0053	11.69	$595.07	$253.49	$119.01
26412	T	Repair/graft hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26415	T	Excision, hand/finger tendon	0054	19.83	$1,009.43	$472.33	$201.89
26416	T	Graft hand or finger tendon	0054	19.83	$1,009.43	$472.33	$201.89
26418	T	Repair finger tendon	0053	11.69	$595.07	$253.49	$119.01
26420	T	Repair/graft finger tendon	0054	19.83	$1,009.43	$472.33	$201.89
26426	T	Repair finger/hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26428	T	Repair/graft finger tendon	0054	19.83	$1,009.43	$472.33	$201.89

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26432	T	Repair finger tendon	0053	11.69	$595.07	$253.49	$119.01
26433	T	Repair finger tendon	0053	11.69	$595.07	$253.49	$119.01
26434	T	Repair/graft finger tendon	0054	19.83	$1,009.43	$472.33	$201.89
26437	T	Realignment of tendons	0053	11.69	$595.07	$253.49	$119.01
26440	T	Release palm/finger tendon	0053	11.69	$595.07	$253.49	$119.01
26442	T	Release palm & finger tendon	0054	19.83	$1,009.43	$472.33	$201.89
26445	T	Release hand/finger tendon	0053	11.69	$595.07	$253.49	$119.01
26449	T	Release forearm/hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26450	T	Incision of palm tendon	0053	11.69	$595.07	$253.49	$119.01
26455	T	Incision of finger tendon	0053	11.69	$595.07	$253.49	$119.01
26460	T	Incise hand/finger tendon	0053	11.69	$595.07	$253.49	$119.01
26471	T	Fusion of finger tendons	0053	11.69	$595.07	$253.49	$119.01
26474	T	Fusion of finger tendons	0053	11.69	$595.07	$253.49	$119.01
26476	T	Tendon lengthening	0053	11.69	$595.07	$253.49	$119.01
26477	T	Tendon shortening	0053	11.69	$595.07	$253.49	$119.01
26478	T	Lengthening of hand tendon	0053	11.69	$595.07	$253.49	$119.01
26479	T	Shortening of hand tendon	0053	11.69	$595.07	$253.49	$119.01
26480	T	Transplant hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26483	T	Transplant/graft hand tendon	0054	19.83	$1,009.43	$472.33	$201.89
26485	T	Transplant palm tendon	0054	19.83	$1,009.43	$472.33	$201.89
26489	T	Transplant/graft palm tendon	0054	19.83	$1,009.43	$472.33	$201.89
26490	T	Revise thumb tendon	0054	19.83	$1,009.43	$472.33	$201.89
26492	T	Tendon transfer with graft	0054	19.83	$1,009.43	$472.33	$201.89
26494	T	Hand tendon/muscle transfer	0054	19.83	$1,009.43	$472.33	$201.89
26496	T	Revise thumb tendon	0054	19.83	$1,009.43	$472.33	$201.89
26497	T	Finger tendon transfer	0054	19.83	$1,009.43	$472.33	$201.89
26498	T	Finger tendon transfer	0054	19.83	$1,009.43	$472.33	$201.89
26499	T	Revision of finger	0054	19.83	$1,009.43	$472.33	$201.89
26500	T	Hand tendon reconstruction	0053	11.69	$595.07	$253.49	$119.01
26502	T	Hand tendon reconstruction	0054	19.83	$1,009.43	$472.33	$201.89
26504	T	Hand tendon reconstruction	0054	19.83	$1,009.43	$472.33	$201.89
26508	T	Release thumb contracture	0053	11.69	$595.07	$253.49	$119.01
26510	T	Thumb tendon transfer	0054	19.83	$1,009.43	$472.33	$201.89
26516	T	Fusion of knuckle joint	0054	19.83	$1,009.43	$472.33	$201.89
26517	T	Fusion of knuckle joints	0054	19.83	$1,009.43	$472.33	$201.89
26518	T	Fusion of knuckle joints	0054	19.83	$1,009.43	$472.33	$201.89
26520	T	Release knuckle contracture	0053	11.69	$595.07	$253.49	$119.01
26525	T	Release finger contracture	0053	11.69	$595.07	$253.49	$119.01
26530	T	Revise knuckle joint	0047	26.36	$1,341.83	$537.03	$268.37
26531	T	Revise knuckle with implant	0048	43.19	$2,198.54	$725.94	$439.71
26535	T	Revise finger joint	0047	26.36	$1,341.83	$537.03	$268.37
26536	T	Revise/implant finger joint	0048	43.19	$2,198.54	$725.94	$439.71
26540	T	Repair hand joint	0053	11.69	$595.07	$253.49	$119.01
26541	T	Repair hand joint with graft	0054	19.83	$1,009.43	$472.33	$201.89
26542	T	Repair hand joint with graft	0053	11.69	$595.07	$253.49	$119.01
26545	T	Reconstruct finger joint	0054	19.83	$1,009.43	$472.33	$201.89
26546	T	Repair nonunion hand	0054	19.83	$1,009.43	$472.33	$201.89
26548	T	Reconstruct finger joint	0054	19.83	$1,009.43	$472.33	$201.89
26550	T	Construct thumb replacement	0054	19.83	$1,009.43	$472.33	$201.89
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	19.83	$1,009.43	$472.33	$201.89
26556	C	Toe joint transfer					
26560	T	Repair of web finger	0053	11.69	$595.07	$253.49	$119.01
26561	T	Repair of web finger	0054	19.83	$1,009.43	$472.33	$201.89
26562	T	Repair of web finger	0054	19.83	$1,009.43	$472.33	$201.89
26565	T	Correct metacarpal flaw	0054	19.83	$1,009.43	$472.33	$201.89
26567	T	Correct finger deformity	0054	19.83	$1,009.43	$472.33	$201.89
26568	T	Lengthen metacarpal/finger	0054	19.83	$1,009.43	$472.33	$201.89
26580	T	Repair hand deformity	0054	19.83	$1,009.43	$472.33	$201.89
26585	D	Repair finger deformity	0054	19.83	$1,009.43	$472.33	$201.89
26587	T	Reconstruct extra finger	0053	11.69	$595.07	$253.49	$119.01
26590	T	Repair finger deformity	0054	19.83	$1,009.43	$472.33	$201.89
26591	T	Repair muscles of hand	0054	19.83	$1,009.43	$472.33	$201.89
26593	T	Release muscles of hand	0053	11.69	$595.07	$253.49	$119.01
26596	T	Excision constricting tissue	0054	19.83	$1,009.43	$472.33	$201.89
26597	D	Release of scar contracture	0054	19.83	$1,009.43	$472.33	$201.89
26600	T	Treat metacarpal fracture	0044	2.52	$128.28	$38.08	$25.66
26605	T	Treat metacarpal fracture	0044	2.52	$128.28	$38.08	$25.66
26607	T	Treat metacarpal fracture	0044	2.52	$128.28	$38.08	$25.66
26608	T	Treat metacarpal fracture	0046	27.69	$1,409.53	$535.76	$281.91
26615	T	Treat metacarpal fracture	0046	27.69	$1,409.53	$535.76	$281.91
26641	T	Treat thumb dislocation	0044	2.52	$128.28	$38.08	$25.66
26645	T	Treat thumb fracture	0044	2.52	$128.28	$38.08	$25.66

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26650	T	Treat thumb fracture	0046	27.69	$1,409.53	$535.76	$281.91
26665	T	Treat thumb fracture	0046	27.69	$1,409.53	$535.76	$281.91
26670	T	Treat hand dislocation	0044	2.52	$128.28	$38.08	$25.66
26675	T	Treat hand dislocation	0044	2.52	$128.28	$38.08	$25.66
26676	T	Pin hand dislocation	0046	27.69	$1,409.53	$535.76	$281.91
26685	T	Treat hand dislocation	0046	27.69	$1,409.53	$535.76	$281.91
26686	T	Treat hand dislocation	0046	27.69	$1,409.53	$535.76	$281.91
26700	T	Treat knuckle dislocation	0043	4.05	$206.16		$41.23
26705	T	Treat knuckle dislocation	0044	2.52	$128.28	$38.08	$25.66
26706	T	Pin knuckle dislocation	0044	2.52	$128.28	$38.08	$25.66
26715	T	Treat knuckle dislocation	0046	27.69	$1,409.53	$535.76	$281.91
26720	T	Treat finger fracture, each	0043	4.05	$206.16		$41.23
26725	T	Treat finger fracture, each	0043	4.05	$206.16		$41.23
26727	T	Treat finger fracture, each	0046	27.69	$1,409.53	$535.76	$281.91
26735	T	Treat finger fracture, each	0046	27.69	$1,409.53	$535.76	$281.91
26740	T	Treat finger fracture, each	0043	4.05	$206.16		$41.23
26742	T	Treat finger fracture, each	0044	2.52	$128.28	$38.08	$25.66
26746	T	Treat finger fracture, each	0046	27.69	$1,409.53	$535.76	$281.91
26750	T	Treat finger fracture, each	0043	4.05	$206.16		$41.23
26755	T	Treat finger fracture, each	0043	4.05	$206.16		$41.23
26756	T	Pin finger fracture, each	0046	27.69	$1,409.53	$535.76	$281.91
26765	T	Treat finger fracture, each	0046	27.69	$1,409.53	$535.76	$281.91
26770	T	Treat finger dislocation	0043	4.05	$206.16		$41.23
26775	T	Treat finger dislocation	0045	11.67	$594.05	$277.12	$118.81
26776	T	Pin finger dislocation	0046	27.69	$1,409.53	$535.76	$281.91
26785	T	Treat finger dislocation	0046	27.69	$1,409.53	$535.76	$281.91
26820	T	Thumb fusion with graft	0054	19.83	$1,009.43	$472.33	$201.89
26841	T	Fusion of thumb	0054	19.83	$1,009.43	$472.33	$201.89
26842	T	Thumb fusion with graft	0054	19.83	$1,009.43	$472.33	$201.89
26843	T	Fusion of hand joint	0054	19.83	$1,009.43	$472.33	$201.89
26844	T	Fusion/graft of hand joint	0054	19.83	$1,009.43	$472.33	$201.89
26850	T	Fusion of knuckle	0054	19.83	$1,009.43	$472.33	$201.89
26852	T	Fusion of knuckle with graft	0054	19.83	$1,009.43	$472.33	$201.89
26860	T	Fusion of finger joint	0054	19.83	$1,009.43	$472.33	$201.89
26861	T	Fusion of finger jnt, add-on	0054	19.83	$1,009.43	$472.33	$201.89
26862	T	Fusion/graft of finger joint	0054	19.83	$1,009.43	$472.33	$201.89
26863	T	Fuse/graft added joint	0054	19.83	$1,009.43	$472.33	$201.89
26910	T	Amputate metacarpal bone	0054	19.83	$1,009.43	$472.33	$201.89
26951	T	Amputation of finger/thumb	0053	11.69	$595.07	$253.49	$119.01
26952	T	Amputation of finger/thumb	0053	11.69	$595.07	$253.49	$119.01
26989	T	Hand/finger surgery	0043	4.05	$206.16		$41.23
26990	T	Drainage of pelvis lesion	0049	15.84	$806.32	$356.95	$161.26
26991	T	Drainage of pelvis bursa	0049	15.84	$806.32	$356.95	$161.26
26992	C	Drainage of bone lesion					
27000	T	Incision of hip tendon	0049	15.84	$806.32	$356.95	$161.26
27001	T	Incision of hip tendon	0050	20.63	$1,050.15	$504.07	$210.03
27003	T	Incision of hip tendon	0050	20.63	$1,050.15	$504.07	$210.03
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	28.56	$1,453.82	$675.24	$290.76
27035	C	Denervation of hip joint					
27036	C	Excision of hip joint/muscle					
27040	T	Biopsy of soft tissues	0021	11.82	$601.69	$236.51	$120.34
27041	T	Biopsy of soft tissues	0022	13.91	$708.07	$292.94	$141.61
27047	T	Remove hip/pelvis lesion	0022	13.91	$708.07	$292.94	$141.61
27048	T	Remove hip/pelvis lesion	0022	13.91	$708.07	$292.94	$141.61
27049	T	Remove tumor, hip/pelvis	0022	13.91	$708.07	$292.94	$141.61
27050	T	Biopsy of sacroiliac joint	0049	15.84	$806.32	$356.95	$161.26
27052	T	Biopsy of hip joint	0049	15.84	$806.32	$356.95	$161.26
27054	C	Removal of hip joint lining					
27060	T	Removal of ischial bursa	0049	15.84	$806.32	$356.95	$161.26
27062	T	Remove femur lesion/bursa	0049	15.84	$806.32	$356.95	$161.26
27065	T	Removal of hip bone lesion	0049	15.84	$806.32	$356.95	$161.26
27066	T	Removal of hip bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
27067	T	Remove/graft hip bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
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	20.63	$1,050.15	$504.07	$210.03

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27086	T	Remove hip foreign body	0019	4.22	$214.81	$78.91	$42.96
27087	T	Remove hip foreign body	0049	15.84	$806.32	$356.95	$161.26
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	N	Inject sacroiliac joint					
27097	T	Revision of hip tendon	0050	20.63	$1,050.15	$504.07	$210.03
27098	T	Transfer tendon to pelvis	0050	20.63	$1,050.15	$504.07	$210.03
27100	T	Transfer of abdominal muscle	0051	28.56	$1,453.82	$675.24	$290.76
27105	T	Transfer of spinal muscle	0051	28.56	$1,453.82	$675.24	$290.76
27110	T	Transfer of iliopsoas muscle	0051	28.56	$1,453.82	$675.24	$290.76
27111	T	Transfer of iliopsoas muscle	0051	28.56	$1,453.82	$675.24	$290.76
27120	C	Reconstruction of hip socket					
27122	C	Reconstruction of hip socket					
27125	C	Partial hip replacement					
27130	C	Total hip replacement					
27132	C	Total hip replacement					
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					
27193	T	Treat pelvic ring fracture	0044	2.52	$128.28	$38.08	$25.66
27194	T	Treat pelvic ring fracture	0045	11.67	$594.05	$277.12	$118.81
27200	T	Treat tail bone fracture	0044	2.52	$128.28	$38.08	$25.66
27202	T	Treat tail bone fracture	0046	27.69	$1,409.53	$535.76	$281.91
27215	C	Treat pelvic fracture(s)					
27216	C	Treat pelvic ring fracture					
27217	C	Treat pelvic ring fracture					
27218	C	Treat pelvic ring fracture					
27220	T	Treat hip socket fracture	0044	2.52	$128.28	$38.08	$25.66
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	0044	2.52	$128.28	$38.08	$25.66
27232	C	Treat thigh fracture					
27235	C	Treat thigh fracture					
27236	C	Treat thigh fracture					
27238	T	Treat thigh fracture	0044	2.52	$128.28	$38.08	$25.66
27240	C	Treat thigh fracture					
27244	C	Treat thigh fracture					
27245	C	Treat thigh fracture					
27246	T	Treat thigh fracture	0043	4.05	$206.16		$41.23
27248	C	Treat thigh fracture					
27250	T	Treat hip dislocation	0044	2.52	$128.28	$38.08	$25.66
27252	T	Treat hip dislocation	0045	11.67	$594.05	$277.12	$118.81
27253	C	Treat hip dislocation					
27254	C	Treat hip dislocation					
27256	T	Treat hip dislocation	0043	4.05	$206.16		$41.23
27257	T	Treat hip dislocation	0045	11.67	$594.05	$277.12	$118.81
27258	C	Treat hip dislocation					
27259	C	Treat hip dislocation					
27265	T	Treat hip dislocation	0044	2.52	$128.28	$38.08	$25.66
27266	T	Treat hip dislocation	0047	26.36	$1,341.83	$537.03	$268.37
27275	T	Manipulation of hip joint	0045	11.67	$594.05	$277.12	$118.81
27280	C	Fusion of sacroiliac joint					
27282	C	Fusion of pubic bones					
27284	C	Fusion of hip joint					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	4.05	$206.16		$41.23
27301	T	Drain thigh/knee lesion	0008	10.93	$556.38	$113.67	$111.28
27303	C	Drainage of bone lesion					
27305	T	Incise thigh tendon & fascia	0049	15.84	$806.32	$356.95	$161.26
27306	T	Incision of thigh tendon	0049	15.84	$806.32	$356.95	$161.26
27307	T	Incision of thigh tendons	0049	15.84	$806.32	$356.95	$161.26
27310	T	Exploration of knee joint	0050	20.63	$1,050.15	$504.07	$210.03
27315	T	Partial removal, thigh nerve	0220	13.60	$692.29	$325.38	$138.46
27320	T	Partial removal, thigh nerve	0220	13.60	$692.29	$325.38	$138.46
27323	T	Biopsy, thigh soft tissues	0021	11.82	$601.69	$236.51	$120.34
27324	T	Biopsy, thigh soft tissues	0022	13.91	$708.07	$292.94	$141.61
27327	T	Removal of thigh lesion	0022	13.91	$708.07	$292.94	$141.61
27328	T	Removal of thigh lesion	0022	13.91	$708.07	$292.94	$141.61
27329	T	Remove tumor, thigh/knee	0022	13.91	$708.07	$292.94	$141.61
27330	T	Biopsy, knee joint lining	0050	20.63	$1,050.15	$504.07	$210.03
27331	T	Explore/treat knee joint	0050	20.63	$1,050.15	$504.07	$210.03
27332	T	Removal of knee cartilage	0050	20.63	$1,050.15	$504.07	$210.03
27333	T	Removal of knee cartilage	0050	20.63	$1,050.15	$504.07	$210.03
27334	T	Remove knee joint lining	0050	20.63	$1,050.15	$504.07	$210.03
27335	T	Remove knee joint lining	0050	20.63	$1,050.15	$504.07	$210.03
27340	T	Removal of kneecap bursa	0049	15.84	$806.32	$356.95	$161.26
27345	T	Removal of knee cyst	0049	15.84	$806.32	$356.95	$161.26
27347	T	Remove knee cyst	0049	15.84	$806.32	$356.95	$161.26
27350	T	Removal of kneecap	0050	20.63	$1,050.15	$504.07	$210.03
27355	T	Remove femur lesion	0050	20.63	$1,050.15	$504.07	$210.03
27356	T	Remove femur lesion/graft	0050	20.63	$1,050.15	$504.07	$210.03
27357	T	Remove femur lesion/graft	0050	20.63	$1,050.15	$504.07	$210.03
27358	T	Remove femur lesion/fixation	0050	20.63	$1,050.15	$504.07	$210.03
27360	T	Partial removal, leg bone(s)	0050	20.63	$1,050.15	$504.07	$210.03
27365	C	Extensive leg surgery					
27370	N	Injection for knee x-ray					
27372	T	Removal of foreign body	0022	13.91	$708.07	$292.94	$141.61
27380	T	Repair of kneecap tendon	0049	15.84	$806.32	$356.95	$161.26
27381	T	Repair/graft kneecap tendon	0049	15.84	$806.32	$356.95	$161.26
27385	T	Repair of thigh muscle	0049	15.84	$806.32	$356.95	$161.26
27386	T	Repair/graft of thigh muscle	0049	15.84	$806.32	$356.95	$161.26
27390	T	Incision of thigh tendon	0049	15.84	$806.32	$356.95	$161.26
27391	T	Incision of thigh tendons	0049	15.84	$806.32	$356.95	$161.26
27392	T	Incision of thigh tendons	0049	15.84	$806.32	$356.95	$161.26
27393	T	Lengthening of thigh tendon	0050	20.63	$1,050.15	$504.07	$210.03
27394	T	Lengthening of thigh tendons	0050	20.63	$1,050.15	$504.07	$210.03
27395	T	Lengthening of thigh tendons	0051	28.56	$1,453.82	$675.24	$290.76
27396	T	Transplant of thigh tendon	0050	20.63	$1,050.15	$504.07	$210.03
27397	T	Transplants of thigh tendons	0051	28.56	$1,453.82	$675.24	$290.76
27400	T	Revise thigh muscles/tendons	0051	28.56	$1,453.82	$675.24	$290.76
27403	T	Repair of knee cartilage	0050	20.63	$1,050.15	$504.07	$210.03
27405	T	Repair of knee ligament	0051	28.56	$1,453.82	$675.24	$290.76
27407	T	Repair of knee ligament	0051	28.56	$1,453.82	$675.24	$290.76
27409	T	Repair of knee ligaments	0051	28.56	$1,453.82	$675.24	$290.76
27418	T	Repair degenerated kneecap	0051	28.56	$1,453.82	$675.24	$290.76
27420	T	Revision of unstable kneecap	0051	28.56	$1,453.82	$675.24	$290.76
27422	T	Revision of unstable kneecap	0051	28.56	$1,453.82	$675.24	$290.76
27424	T	Revision/removal of kneecap	0051	28.56	$1,453.82	$675.24	$290.76
27425	T	Lateral retinacular release	0050	20.63	$1,050.15	$504.07	$210.03
27427	T	Reconstruction, knee	0052	35.94	$1,829.49	$930.91	$365.90
27428	T	Reconstruction, knee	0052	35.94	$1,829.49	$930.91	$365.90
27429	T	Reconstruction, knee	0052	35.94	$1,829.49	$930.91	$365.90
27430	T	Revision of thigh muscles	0051	28.56	$1,453.82	$675.24	$290.76
27435	T	Incision of knee joint	0051	28.56	$1,453.82	$675.24	$290.76
27437	T	Revise kneecap	0047	26.36	$1,341.83	$537.03	$268.37
27438	T	Revise kneecap with implant	0048	43.19	$2,198.54	$725.94	$439.71
27440	T	Revision of knee joint	0047	26.36	$1,341.83	$537.03	$268.37
27441	T	Revision of knee joint	0047	26.36	$1,341.83	$537.03	$268.37
27442	T	Revision of knee joint	0047	26.36	$1,341.83	$537.03	$268.37
27443	T	Revision of knee joint	0047	26.36	$1,341.83	$537.03	$268.37
27445	C	Revision of knee joint					
27446	T	Revision of knee joint	0047	26.36	$1,341.83	$537.03	$268.37
27447	C	Total knee replacement					
27448	C	Incision of thigh					
27450	C	Incision of thigh					
27454	C	Realignment of thigh bone					
27455	C	Realignment of knee					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	15.84	$806.32	$356.95	$161.26
27497	T	Decompression of thigh/knee	0049	15.84	$806.32	$356.95	$161.26
27498	T	Decompression of thigh/knee	0049	15.84	$806.32	$356.95	$161.26
27499	T	Decompression of thigh/knee	0049	15.84	$806.32	$356.95	$161.26
27500	T	Treatment of thigh fracture	0044	2.52	$128.28	$38.08	$25.66
27501	T	Treatment of thigh fracture	0044	2.52	$128.28	$38.08	$25.66
27502	T	Treatment of thigh fracture	0044	2.52	$128.28	$38.08	$25.66
27503	T	Treatment of thigh fracture	0044	2.52	$128.28	$38.08	$25.66
27506	C	Treatment of thigh fracture					
27507	C	Treatment of thigh fracture					
27508	T	Treatment of thigh fracture	0044	2.52	$128.28	$38.08	$25.66
27509	T	Treatment of thigh fracture	0046	27.69	$1,409.53	$535.76	$281.91
27510	T	Treatment of thigh fracture	0044	2.52	$128.28	$38.08	$25.66
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	0044	2.52	$128.28	$38.08	$25.66
27517	T	Treat thigh fx growth plate	0043	4.05	$206.16		$41.23
27519	C	Treat thigh fx growth plate					
27520	T	Treat kneecap fracture	0044	2.52	$128.28	$38.08	$25.66
27524	T	Treat kneecap fracture	0046	27.69	$1,409.53	$535.76	$281.91
27530	T	Treat knee fracture	0044	2.52	$128.28	$38.08	$25.66
27532	T	Treat knee fracture	0044	2.52	$128.28	$38.08	$25.66
27535	C	Treat knee fracture					
27536	C	Treat knee fracture					
27538	T	Treat knee fracture(s)	0043	4.05	$206.16		$41.23
27540	C	Treat knee fracture					
27550	T	Treat knee dislocation	0044	2.52	$128.28	$38.08	$25.66
27552	T	Treat knee dislocation	0045	11.67	$594.05	$277.12	$118.81
27556	C	Treat knee dislocation					
27557	C	Treat knee dislocation					
27558	C	Treat knee dislocation					
27560	T	Treat kneecap dislocation	0044	2.52	$128.28	$38.08	$25.66
27562	T	Treat kneecap dislocation	0045	11.67	$594.05	$277.12	$118.81
27566	T	Treat kneecap dislocation	0046	27.69	$1,409.53	$535.76	$281.91
27570	T	Fixation of knee joint	0045	11.67	$594.05	$277.12	$118.81
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	15.84	$806.32	$356.95	$161.26
27596	C	Amputation follow-up surgery					
27598	C	Amputate lower leg at knee					
27599	T	Leg surgery procedure	0044	2.52	$128.28	$38.08	$25.66
27600	T	Decompression of lower leg	0049	15.84	$806.32	$356.95	$161.26
27601	T	Decompression of lower leg	0049	15.84	$806.32	$356.95	$161.26
27602	T	Decompression of lower leg	0049	15.84	$806.32	$356.95	$161.26
27603	T	Drain lower leg lesion	0008	10.93	$556.38	$113.67	$111.28
27604	T	Drain lower leg bursa	0049	15.84	$806.32	$356.95	$161.26
27605	T	Incision of achilles tendon	0055	15.44	$785.96	$355.34	$157.19
27606	T	Incision of achilles tendon	0049	15.84	$806.32	$356.95	$161.26
27607	T	Treat lower leg bone lesion	0049	15.84	$806.32	$356.95	$161.26
27610	T	Explore/treat ankle joint	0050	20.63	$1,050.15	$504.07	$210.03
27612	T	Exploration of ankle joint	0050	20.63	$1,050.15	$504.07	$210.03
27613	T	Biopsy lower leg soft tissue	0019	4.22	$214.81	$78.91	$42.96
27614	T	Biopsy lower leg soft tissue	0022	13.91	$708.07	$292.94	$141.61
27615	T	Remove tumor, lower leg	0046	27.69	$1,409.53	$535.76	$281.91
27618	T	Remove lower leg lesion	0021	11.82	$601.69	$236.51	$120.34
27619	T	Remove lower leg lesion	0022	13.91	$708.07	$292.94	$141.61
27620	T	Explore/treat ankle joint	0050	20.63	$1,050.15	$504.07	$210.03
27625	T	Remove ankle joint lining	0050	20.63	$1,050.15	$504.07	$210.03

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27626	T	Remove ankle joint lining	0050	20.63	$1,050.15	$504.07	$210.03
27630	T	Removal of tendon lesion	0049	15.84	$806.32	$356.95	$161.26
27635	T	Remove lower leg bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
27637	T	Remove/graft leg bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
27638	T	Remove/graft leg bone lesion	0050	20.63	$1,050.15	$504.07	$210.03
27640	T	Partial removal of tibia	0051	28.56	$1,453.82	$675.24	$290.76
27641	T	Partial removal of fibula	0050	20.63	$1,050.15	$504.07	$210.03
27645	C	Extensive lower leg surgery					
27646	C	Extensive lower leg surgery					
27647	T	Extensive ankle/heel surgery	0051	28.56	$1,453.82	$675.24	$290.76
27648	N	Injection for ankle x-ray					
27650	T	Repair achilles tendon	0051	28.56	$1,453.82	$675.24	$290.76
27652	T	Repair/graft achilles tendon	0051	28.56	$1,453.82	$675.24	$290.76
27654	T	Repair of achilles tendon	0051	28.56	$1,453.82	$675.24	$290.76
27656	T	Repair leg fascia defect	0049	15.84	$806.32	$356.95	$161.26
27658	T	Repair of leg tendon, each	0049	15.84	$806.32	$356.95	$161.26
27659	T	Repair of leg tendon, each	0049	15.84	$806.32	$356.95	$161.26
27664	T	Repair of leg tendon, each	0049	15.84	$806.32	$356.95	$161.26
27665	T	Repair of leg tendon, each	0050	20.63	$1,050.15	$504.07	$210.03
27675	T	Repair lower leg tendons	0049	15.84	$806.32	$356.95	$161.26
27676	T	Repair lower leg tendons	0050	20.63	$1,050.15	$504.07	$210.03
27680	T	Release of lower leg tendon	0050	20.63	$1,050.15	$504.07	$210.03
27681	T	Release of lower leg tendons	0050	20.63	$1,050.15	$504.07	$210.03
27685	T	Revision of lower leg tendon	0050	20.63	$1,050.15	$504.07	$210.03
27686	T	Revise lower leg tendons	0050	20.63	$1,050.15	$504.07	$210.03
27687	T	Revision of calf tendon	0050	20.63	$1,050.15	$504.07	$210.03
27690	T	Revise lower leg tendon	0051	28.56	$1,453.82	$675.24	$290.76
27691	T	Revise lower leg tendon	0051	28.56	$1,453.82	$675.24	$290.76
27692	T	Revise additional leg tendon	0051	28.56	$1,453.82	$675.24	$290.76
27695	T	Repair of ankle ligament	0050	20.63	$1,050.15	$504.07	$210.03
27696	T	Repair of ankle ligaments	0050	20.63	$1,050.15	$504.07	$210.03
27698	T	Repair of ankle ligament	0050	20.63	$1,050.15	$504.07	$210.03
27700	T	Revision of ankle joint	0047	26.36	$1,341.83	$537.03	$268.37
27702	C	Reconstruct ankle joint					
27703	C	Reconstruction, ankle joint					
27704	T	Removal of ankle implant	0049	15.84	$806.32	$356.95	$161.26
27705	T	Incision of tibia	0051	28.56	$1,453.82	$675.24	$290.76
27707	T	Incision of fibula	0049	15.84	$806.32	$356.95	$161.26
27709	T	Incision of tibia & fibula	0050	20.63	$1,050.15	$504.07	$210.03
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	20.63	$1,050.15	$504.07	$210.03
27732	T	Repair of fibula epiphysis	0050	20.63	$1,050.15	$504.07	$210.03
27734	T	Repair lower leg epiphyses	0050	20.63	$1,050.15	$504.07	$210.03
27740	T	Repair of leg epiphyses	0050	20.63	$1,050.15	$504.07	$210.03
27742	T	Repair of leg epiphyses	0051	28.56	$1,453.82	$675.24	$290.76
27745	T	Reinforce tibia	0051	28.56	$1,453.82	$675.24	$290.76
27750	T	Treatment of tibia fracture	0044	2.52	$128.28	$38.08	$25.66
27752	T	Treatment of tibia fracture	0044	2.52	$128.28	$38.08	$25.66
27756	T	Treatment of tibia fracture	0046	27.69	$1,409.53	$535.76	$281.91
27758	T	Treatment of tibia fracture	0046	27.69	$1,409.53	$535.76	$281.91
27759	T	Treatment of tibia fracture	0046	27.69	$1,409.53	$535.76	$281.91
27760	T	Treatment of ankle fracture	0044	2.52	$128.28	$38.08	$25.66
27762	T	Treatment of ankle fracture	0044	2.52	$128.28	$38.08	$25.66
27766	T	Treatment of ankle fracture	0046	27.69	$1,409.53	$535.76	$281.91
27780	T	Treatment of fibula fracture	0044	2.52	$128.28	$38.08	$25.66
27781	T	Treatment of fibula fracture	0044	2.52	$128.28	$38.08	$25.66
27784	T	Treatment of fibula fracture	0046	27.69	$1,409.53	$535.76	$281.91
27786	T	Treatment of ankle fracture	0044	2.52	$128.28	$38.08	$25.66
27788	T	Treatment of ankle fracture	0044	2.52	$128.28	$38.08	$25.66
27792	T	Treatment of ankle fracture	0046	27.69	$1,409.53	$535.76	$281.91
27808	T	Treatment of ankle fracture	0044	2.52	$128.28	$38.08	$25.66
27810	T	Treatment of ankle fracture	0044	2.52	$128.28	$38.08	$25.66
27814	T	Treatment of ankle fracture	0046	27.69	$1,409.53	$535.76	$281.91
27816	T	Treatment of ankle fracture	0044	2.52	$128.28	$38.08	$25.66
27818	T	Treatment of ankle fracture	0044	2.52	$128.28	$38.08	$25.66
27822	T	Treatment of ankle fracture	0046	27.69	$1,409.53	$535.76	$281.91
27823	T	Treatment of ankle fracture	0046	27.69	$1,409.53	$535.76	$281.91
27824	T	Treat lower leg fracture	0044	2.52	$128.28	$38.08	$25.66
27825	T	Treat lower leg fracture	0044	2.52	$128.28	$38.08	$25.66

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27826	T	Treat lower leg fracture	0046	27.69	$1,409.53	$535.76	$281.91
27827	T	Treat lower leg fracture	0046	27.69	$1,409.53	$535.76	$281.91
27828	T	Treat lower leg fracture	0046	27.69	$1,409.53	$535.76	$281.91
27829	T	Treat lower leg joint	0046	27.69	$1,409.53	$535.76	$281.91
27830	T	Treat lower leg dislocation	0044	2.52	$128.28	$38.08	$25.66
27831	T	Treat lower leg dislocation	0044	2.52	$128.28	$38.08	$25.66
27832	T	Treat lower leg dislocation	0046	27.69	$1,409.53	$535.76	$281.91
27840	T	Treat ankle dislocation	0044	2.52	$128.28	$38.08	$25.66
27842	T	Treat ankle dislocation	0045	11.67	$594.05	$277.12	$118.81
27846	T	Treat ankle dislocation	0046	27.69	$1,409.53	$535.76	$281.91
27848	T	Treat ankle dislocation	0046	27.69	$1,409.53	$535.76	$281.91
27860	T	Fixation of ankle joint	0045	11.67	$594.05	$277.12	$118.81
27870	T	Fusion of ankle joint	0051	28.56	$1,453.82	$675.24	$290.76
27871	T	Fusion of tibiofibular joint	0051	28.56	$1,453.82	$675.24	$290.76
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	15.84	$806.32	$356.95	$161.26
27886	C	Amputation follow-up surgery					
27888	C	Amputation of foot at ankle					
27889	T	Amputation of foot at ankle	0050	20.63	$1,050.15	$504.07	$210.03
27892	T	Decompression of leg	0049	15.84	$806.32	$356.95	$161.26
27893	T	Decompression of leg	0049	15.84	$806.32	$356.95	$161.26
27894	T	Decompression of leg	0049	15.84	$806.32	$356.95	$161.26
27899	T	Leg/ankle surgery procedure	0044	2.52	$128.28	$38.08	$25.66
28001	T	Drainage of bursa of foot	0008	10.93	$556.38	$113.67	$111.28
28002	T	Treatment of foot infection	0049	15.84	$806.32	$356.95	$161.26
28003	T	Treatment of foot infection	0049	15.84	$806.32	$356.95	$161.26
28005	T	Treat foot bone lesion	0055	15.44	$785.96	$355.34	$157.19
28008	T	Incision of foot fascia	0055	15.44	$785.96	$355.34	$157.19
28010	T	Incision of toe tendon	0055	15.44	$785.96	$355.34	$157.19
28011	T	Incision of toe tendons	0055	15.44	$785.96	$355.34	$157.19
28020	T	Exploration of foot joint	0055	15.44	$785.96	$355.34	$157.19
28022	T	Exploration of foot joint	0055	15.44	$785.96	$355.34	$157.19
28024	T	Exploration of toe joint	0055	15.44	$785.96	$355.34	$157.19
28030	T	Removal of foot nerve	0220	13.60	$692.29	$325.38	$138.46
28035	T	Decompression of tibia nerve	0220	13.60	$692.29	$325.38	$138.46
28043	T	Excision of foot lesion	0021	11.82	$601.69	$236.51	$120.34
28045	T	Excision of foot lesion	0055	15.44	$785.96	$355.34	$157.19
28046	T	Resection of tumor, foot	0055	15.44	$785.96	$355.34	$157.19
28050	T	Biopsy of foot joint lining	0055	15.44	$785.96	$355.34	$157.19
28052	T	Biopsy of foot joint lining	0055	15.44	$785.96	$355.34	$157.19
28054	T	Biopsy of toe joint lining	0055	15.44	$785.96	$355.34	$157.19
28060	T	Partial removal, foot fascia	0056	18.85	$959.54	$405.81	$191.91
28062	T	Removal of foot fascia	0056	18.85	$959.54	$405.81	$191.91
28070	T	Removal of foot joint lining	0056	18.85	$959.54	$405.81	$191.91
28072	T	Removal of foot joint lining	0056	18.85	$959.54	$405.81	$191.91
28080	T	Removal of foot lesion	0055	15.44	$785.96	$355.34	$157.19
28086	T	Excise foot tendon sheath	0055	15.44	$785.96	$355.34	$157.19
28088	T	Excise foot tendon sheath	0055	15.44	$785.96	$355.34	$157.19
28090	T	Removal of foot lesion	0055	15.44	$785.96	$355.34	$157.19
28092	T	Removal of toe lesions	0055	15.44	$785.96	$355.34	$157.19
28100	T	Removal of ankle/heel lesion	0055	15.44	$785.96	$355.34	$157.19
28102	T	Remove/graft foot lesion	0056	18.85	$959.54	$405.81	$191.91
28103	T	Remove/graft foot lesion	0056	18.85	$959.54	$405.81	$191.91
28104	T	Removal of foot lesion	0055	15.44	$785.96	$355.34	$157.19
28106	T	Remove/graft foot lesion	0056	18.85	$959.54	$405.81	$191.91
28107	T	Remove/graft foot lesion	0056	18.85	$959.54	$405.81	$191.91
28108	T	Removal of toe lesions	0055	15.44	$785.96	$355.34	$157.19
28110	T	Part removal of metatarsal	0056	18.85	$959.54	$405.81	$191.91
28111	T	Part removal of metatarsal	0055	15.44	$785.96	$355.34	$157.19
28112	T	Part removal of metatarsal	0055	15.44	$785.96	$355.34	$157.19
28113	T	Part removal of metatarsal	0055	15.44	$785.96	$355.34	$157.19
28114	T	Removal of metatarsal heads	0055	15.44	$785.96	$355.34	$157.19
28116	T	Revision of foot	0055	15.44	$785.96	$355.34	$157.19
28118	T	Removal of heel bone	0055	15.44	$785.96	$355.34	$157.19
28119	T	Removal of heel spur	0055	15.44	$785.96	$355.34	$157.19
28120	T	Part removal of ankle/heel	0055	15.44	$785.96	$355.34	$157.19
28122	T	Partial removal of foot bone	0055	15.44	$785.96	$355.34	$157.19
28124	T	Partial removal of toe	0055	15.44	$785.96	$355.34	$157.19
28126	T	Partial removal of toe	0055	15.44	$785.96	$355.34	$157.19
28130	T	Removal of ankle bone	0055	15.44	$785.96	$355.34	$157.19
28140	T	Removal of metatarsal	0055	15.44	$785.96	$355.34	$157.19
28150	T	Removal of toe	0055	15.44	$785.96	$355.34	$157.19
28153	T	Partial removal of toe	0055	15.44	$785.96	$355.34	$157.19

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28160	T	Partial removal of toe	0055	15.44	$785.96	$355.34	$157.19
28171	T	Extensive foot surgery	0055	15.44	$785.96	$355.34	$157.19
28173	T	Extensive foot surgery	0055	15.44	$785.96	$355.34	$157.19
28175	T	Extensive foot surgery	0055	15.44	$785.96	$355.34	$157.19
28190	T	Removal of foot foreign body	0019	4.22	$214.81	$78.91	$42.96
28192	T	Removal of foot foreign body	0021	11.82	$601.69	$236.51	$120.34
28193	T	Removal of foot foreign body	0021	11.82	$601.69	$236.51	$120.34
28200	T	Repair of foot tendon	0055	15.44	$785.96	$355.34	$157.19
28202	T	Repair/graft of foot tendon	0056	18.85	$959.54	$405.81	$191.91
28208	T	Repair of foot tendon	0055	15.44	$785.96	$355.34	$157.19
28210	T	Repair/graft of foot tendon	0055	15.44	$785.96	$355.34	$157.19
28220	T	Release of foot tendon	0055	15.44	$785.96	$355.34	$157.19
28222	T	Release of foot tendons	0055	15.44	$785.96	$355.34	$157.19
28225	T	Release of foot tendon	0055	15.44	$785.96	$355.34	$157.19
28226	T	Release of foot tendons	0055	15.44	$785.96	$355.34	$157.19
28230	T	Incision of foot tendon(s)	0055	15.44	$785.96	$355.34	$157.19
28232	T	Incision of toe tendon	0055	15.44	$785.96	$355.34	$157.19
28234	T	Incision of foot tendon	0055	15.44	$785.96	$355.34	$157.19
28238	T	Revision of foot tendon	0056	18.85	$959.54	$405.81	$191.91
28240	T	Release of big toe	0055	15.44	$785.96	$355.34	$157.19
28250	T	Revision of foot fascia	0056	18.85	$959.54	$405.81	$191.91
28260	T	Release of midfoot joint	0056	18.85	$959.54	$405.81	$191.91
28261	T	Revision of foot tendon	0056	18.85	$959.54	$405.81	$191.91
28262	T	Revision of foot and ankle	0056	18.85	$959.54	$405.81	$191.91
28264	T	Release of midfoot joint	0056	18.85	$959.54	$405.81	$191.91
28270	T	Release of foot contracture	0055	15.44	$785.96	$355.34	$157.19
28272	T	Release of toe joint, each	0055	15.44	$785.96	$355.34	$157.19
28280	T	Fusion of toes	0055	15.44	$785.96	$355.34	$157.19
28285	T	Repair of hammertoe	0055	15.44	$785.96	$355.34	$157.19
28286	T	Repair of hammertoe	0055	15.44	$785.96	$355.34	$157.19
28288	T	Partial removal of foot bone	0056	18.85	$959.54	$405.81	$191.91
28289	T	Repair hallux rigidus	0056	18.85	$959.54	$405.81	$191.91
28290	T	Correction of bunion	0056	18.85	$959.54	$405.81	$191.91
28292	T	Correction of bunion	0057	24.35	$1,239.51	$496.65	$247.90
28293	T	Correction of bunion	0057	24.35	$1,239.51	$496.65	$247.90
28294	T	Correction of bunion	0056	18.85	$959.54	$405.81	$191.91
28296	T	Correction of bunion	0056	18.85	$959.54	$405.81	$191.91
28297	T	Correction of bunion	0057	24.35	$1,239.51	$496.65	$247.90
28298	T	Correction of bunion	0056	18.85	$959.54	$405.81	$191.91
28299	T	Correction of bunion	0057	24.35	$1,239.51	$496.65	$247.90
28300	T	Incision of heel bone	0056	18.85	$959.54	$405.81	$191.91
28302	T	Incision of ankle bone	0056	18.85	$959.54	$405.81	$191.91
28304	T	Incision of midfoot bones	0056	18.85	$959.54	$405.81	$191.91
28305	T	Incise/graft midfoot bones	0056	18.85	$959.54	$405.81	$191.91
28306	T	Incision of metatarsal	0056	18.85	$959.54	$405.81	$191.91
28307	T	Incision of metatarsal	0056	18.85	$959.54	$405.81	$191.91
28308	T	Incision of metatarsal	0056	18.85	$959.54	$405.81	$191.91
28309	T	Incision of metatarsals	0056	18.85	$959.54	$405.81	$191.91
28310	T	Revision of big toe	0055	15.44	$785.96	$355.34	$157.19
28312	T	Revision of toe	0055	15.44	$785.96	$355.34	$157.19
28313	T	Repair deformity of toe	0055	15.44	$785.96	$355.34	$157.19
28315	T	Removal of sesamoid bone	0055	15.44	$785.96	$355.34	$157.19
28320	T	Repair of foot bones	0056	18.85	$959.54	$405.81	$191.91
28322	T	Repair of metatarsals	0056	18.85	$959.54	$405.81	$191.91
28340	T	Resect enlarged toe tissue	0055	15.44	$785.96	$355.34	$157.19
28341	T	Resect enlarged toe	0055	15.44	$785.96	$355.34	$157.19
28344	T	Repair extra toe(s)	0056	18.85	$959.54	$405.81	$191.91
28345	T	Repair webbed toe(s)	0056	18.85	$959.54	$405.81	$191.91
28360	T	Reconstruct cleft foot	0056	18.85	$959.54	$405.81	$191.91
28400	T	Treatment of heel fracture	0044	2.52	$128.28	$38.08	$25.66
28405	T	Treatment of heel fracture	0044	2.52	$128.28	$38.08	$25.66
28406	T	Treatment of heel fracture	0046	27.69	$1,409.53	$535.76	$281.91
28415	T	Treat heel fracture	0046	27.69	$1,409.53	$535.76	$281.91
28420	T	Treat/graft heel fracture	0046	27.69	$1,409.53	$535.76	$281.91
28430	T	Treatment of ankle fracture	0044	2.52	$128.28	$38.08	$25.66
28435	T	Treatment of ankle fracture	0044	2.52	$128.28	$38.08	$25.66
28436	T	Treatment of ankle fracture	0046	27.69	$1,409.53	$535.76	$281.91
28445	T	Treat ankle fracture	0046	27.69	$1,409.53	$535.76	$281.91
28450	T	Treat midfoot fracture, each	0044	2.52	$128.28	$38.08	$25.66
28455	T	Treat midfoot fracture, each	0044	2.52	$128.28	$38.08	$25.66
28456	T	Treat midfoot fracture	0046	27.69	$1,409.53	$535.76	$281.91
28465	T	Treat midfoot fracture, each	0046	27.69	$1,409.53	$535.76	$281.91
28470	T	Treat metatarsal fracture	0044	2.52	$128.28	$38.08	$25.66
28475	T	Treat metatarsal fracture	0044	2.52	$128.28	$38.08	$25.66
28476	T	Treat metatarsal fracture	0046	27.69	$1,409.53	$535.76	$281.91

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28485	T	Treat metatarsal fracture	0046	27.69	$1,409.53	$535.76	$281.91
28490	T	Treat big toe fracture	0044	2.52	$128.28	$38.08	$25.66
28495	T	Treat big toe fracture	0044	2.52	$128.28	$38.08	$25.66
28496	T	Treat big toe fracture	0046	27.69	$1,409.53	$535.76	$281.91
28505	T	Treat big toe fracture	0046	27.69	$1,409.53	$535.76	$281.91
28510	T	Treatment of toe fracture	0043	4.05	$206.16		$41.23
28515	T	Treatment of toe fracture	0043	4.05	$206.16		$41.23
28525	T	Treat toe fracture	0046	27.69	$1,409.53	$535.76	$281.91
28530	T	Treat sesamoid bone fracture	0044	2.52	$128.28	$38.08	$25.66
28531	T	Treat sesamoid bone fracture	0046	27.69	$1,409.53	$535.76	$281.91
28540	T	Treat foot dislocation	0044	2.52	$128.28	$38.08	$25.66
28545	T	Treat foot dislocation	0045	11.67	$594.05	$277.12	$118.81
28546	T	Treat foot dislocation	0046	27.69	$1,409.53	$535.76	$281.91
28555	T	Repair foot dislocation	0046	27.69	$1,409.53	$535.76	$281.91
28570	T	Treat foot dislocation	0044	2.52	$128.28	$38.08	$25.66
28575	T	Treat foot dislocation	0043	4.05	$206.16		$41.23
28576	T	Treat foot dislocation	0046	27.69	$1,409.53	$535.76	$281.91
28585	T	Repair foot dislocation	0046	27.69	$1,409.53	$535.76	$281.91
28600	T	Treat foot dislocation	0044	2.52	$128.28	$38.08	$25.66
28605	T	Treat foot dislocation	0043	4.05	$206.16		$41.23
28606	T	Treat foot dislocation	0046	27.69	$1,409.53	$535.76	$281.91
28615	T	Repair foot dislocation	0046	27.69	$1,409.53	$535.76	$281.91
28630	T	Treat toe dislocation	0044	2.52	$128.28	$38.08	$25.66
28635	T	Treat toe dislocation	0045	11.67	$594.05	$277.12	$118.81
28636	T	Treat toe dislocation	0046	27.69	$1,409.53	$535.76	$281.91
28645	T	Repair toe dislocation	0046	27.69	$1,409.53	$535.76	$281.91
28660	T	Treat toe dislocation	0043	4.05	$206.16		$41.23
28665	T	Treat toe dislocation	0045	11.67	$594.05	$277.12	$118.81
28666	T	Treat toe dislocation	0046	27.69	$1,409.53	$535.76	$281.91
28675	T	Repair of toe dislocation	0046	27.69	$1,409.53	$535.76	$281.91
28705	T	Fusion of foot bones	0056	18.85	$959.54	$405.81	$191.91
28715	T	Fusion of foot bones	0056	18.85	$959.54	$405.81	$191.91
28725	T	Fusion of foot bones	0056	18.85	$959.54	$405.81	$191.91
28730	T	Fusion of foot bones	0056	18.85	$959.54	$405.81	$191.91
28735	T	Fusion of foot bones	0056	18.85	$959.54	$405.81	$191.91
28737	T	Revision of foot bones	0055	15.44	$785.96	$355.34	$157.19
28740	T	Fusion of foot bones	0056	18.85	$959.54	$405.81	$191.91
28750	T	Fusion of big toe joint	0055	15.44	$785.96	$355.34	$157.19
28755	T	Fusion of big toe joint	0055	15.44	$785.96	$355.34	$157.19
28760	T	Fusion of big toe joint	0056	18.85	$959.54	$405.81	$191.91
28800	C	Amputation of midfoot					
28805	C	Amputation thru metatarsal					
28810	T	Amputation toe & metatarsal	0055	15.44	$785.96	$355.34	$157.19
28820	T	Amputation of toe	0055	15.44	$785.96	$355.34	$157.19
28825	T	Partial amputation of toe	0055	15.44	$785.96	$355.34	$157.19
28899	T	Foot/toes surgery procedure	0043	4.05	$206.16		$41.23
29000	S	Application of body cast	0059	2.22	$113.01	$29.59	$22.60
29010	S	Application of body cast	0059	2.22	$113.01	$29.59	$22.60
29015	S	Application of body cast	0059	2.22	$113.01	$29.59	$22.60
29020	S	Application of body cast	0059	2.22	$113.01	$29.59	$22.60
29025	S	Application of body cast	0059	2.22	$113.01	$29.59	$22.60
29035	S	Application of body cast	0058	1.28	$65.16	$19.27	$13.03
29040	S	Application of body cast	0059	2.22	$113.01	$29.59	$22.60
29044	S	Application of body cast	0059	2.22	$113.01	$29.59	$22.60
29046	S	Application of body cast	0059	2.22	$113.01	$29.59	$22.60
29049	S	Application of figure eight	0059	2.22	$113.01	$29.59	$22.60
29055	S	Application of shoulder cast	0059	2.22	$113.01	$29.59	$22.60
29058	S	Application of shoulder cast	0059	2.22	$113.01	$29.59	$22.60
29065	S	Application of long arm cast	0059	2.22	$113.01	$29.59	$22.60
29075	S	Application of forearm cast	0058	1.28	$65.16	$19.27	$13.03
29085	S	Apply hand/wrist cast	0058	1.28	$65.16	$19.27	$13.03
*29086	S	Apply finger cast	0058	1.28	$65.16	$19.27	$13.03
29105	S	Apply long arm splint	0058	1.28	$65.16	$19.27	$13.03
29125	S	Apply forearm splint	0058	1.28	$65.16	$19.27	$13.03
29126	S	Apply forearm splint	0058	1.28	$65.16	$19.27	$13.03
29130	S	Application of finger splint	0058	1.28	$65.16	$19.27	$13.03
29131	S	Application of finger splint	0058	1.28	$65.16	$19.27	$13.03
29200	S	Strapping of chest	0058	1.28	$65.16	$19.27	$13.03
29220	S	Strapping of low back	0059	2.22	$113.01	$29.59	$22.60
29240	S	Strapping of shoulder	0058	1.28	$65.16	$19.27	$13.03
29260	S	Strapping of elbow or wrist	0058	1.28	$65.16	$19.27	$13.03
29280	S	Strapping of hand or finger	0058	1.28	$65.16	$19.27	$13.03
29305	S	Application of hip cast	0058	1.28	$65.16	$19.27	$13.03
29325	S	Application of hip casts	0059	2.22	$113.01	$29.59	$22.60
29345	S	Application of long leg cast	0059	2.22	$113.01	$29.59	$22.60

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
29355	S	Application of long leg cast	0059	2.22	$113.01	$29.59	$22.60
29358	S	Apply long leg cast brace	0059	2.22	$113.01	$29.59	$22.60
29365	S	Application of long leg cast	0059	2.22	$113.01	$29.59	$22.60
29405	S	Apply short leg cast	0058	1.28	$65.16	$19.27	$13.03
29425	S	Apply short leg cast	0059	2.22	$113.01	$29.59	$22.60
29435	S	Apply short leg cast	0058	1.28	$65.16	$19.27	$13.03
29440	S	Addition of walker to cast	0059	2.22	$113.01	$29.59	$22.60
29445	S	Apply rigid leg cast	0059	2.22	$113.01	$29.59	$22.60
29450	S	Application of leg cast	0059	2.22	$113.01	$29.59	$22.60
29505	S	Application, long leg splint	0059	2.22	$113.01	$29.59	$22.60
29515	S	Application lower leg splint	0059	2.22	$113.01	$29.59	$22.60
29520	S	Strapping of hip	0058	1.28	$65.16	$19.27	$13.03
29530	S	Strapping of knee	0058	1.28	$65.16	$19.27	$13.03
29540	S	Strapping of ankle	0058	1.28	$65.16	$19.27	$13.03
29550	S	Strapping of toes	0058	1.28	$65.16	$19.27	$13.03
29580	S	Application of paste boot	0058	1.28	$65.16	$19.27	$13.03
29590	S	Application of foot splint	0058	1.28	$65.16	$19.27	$13.03
29700	S	Removal/revision of cast	0058	1.28	$65.16	$19.27	$13.03
29705	S	Removal/revision of cast	0058	1.28	$65.16	$19.27	$13.03
29710	S	Removal/revision of cast	0058	1.28	$65.16	$19.27	$13.03
29715	S	Removal/revision of cast	0058	1.28	$65.16	$19.27	$13.03
29720	S	Repair of body cast	0058	1.28	$65.16	$19.27	$13.03
29730	S	Windowing of cast	0058	1.28	$65.16	$19.27	$13.03
29740	S	Wedging of cast	0058	1.28	$65.16	$19.27	$13.03
29750	S	Wedging of clubfoot cast	0058	1.28	$65.16	$19.27	$13.03
29799	N	Casting/strapping procedure					
29800	T	Jaw arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29804	T	Jaw arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
*29805	T	Shoulder arthroscopy, dx	0041	23.61	$1,201.84	$576.88	$240.37
*29806	T	Shoulder arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
*29807	T	Shoulder arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29815	D	Shoulder arthroscopy	0041	23.61	$1,201.84	$576.88	$240.37
29819	T	Shoulder arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29820	T	Shoulder arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29821	T	Shoulder arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29822	T	Shoulder arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29823	T	Shoulder arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
*29824	T	Shoulder arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29825	T	Shoulder arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29826	T	Shoulder arthroscopy/surgery	0042	35.76	$1,820.33	$804.74	$364.07
29830	T	Elbow arthroscopy	0041	23.61	$1,201.84	$576.88	$240.37
29834	T	Elbow arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29835	T	Elbow arthroscopy/surgery	0042	35.76	$1,820.33	$804.74	$364.07
29836	T	Elbow arthroscopy/surgery	0042	35.76	$1,820.33	$804.74	$364.07
29837	T	Elbow arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29838	T	Elbow arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29840	T	Wrist arthroscopy	0041	23.61	$1,201.84	$576.88	$240.37
29843	T	Wrist arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29844	T	Wrist arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29845	T	Wrist arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29846	T	Wrist arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29847	T	Wrist arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29848	T	Wrist endoscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29850	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29851	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29855	T	Tibial arthroscopy/surgery	0042	35.76	$1,820.33	$804.74	$364.07
29856	T	Tibial arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29860	T	Hip arthroscopy, dx	0041	23.61	$1,201.84	$576.88	$240.37
29861	T	Hip arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29862	T	Hip arthroscopy/surgery	0042	35.76	$1,820.33	$804.74	$364.07
29863	T	Hip arthroscopy/surgery	0042	35.76	$1,820.33	$804.74	$364.07
29870	T	Knee arthroscopy, dx	0041	23.61	$1,201.84	$576.88	$240.37
29871	T	Knee arthroscopy/drainage	0041	23.61	$1,201.84	$576.88	$240.37
29874	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29875	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29876	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29877	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29879	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29880	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29881	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29882	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29883	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29884	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29885	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29886	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
29887	T	Knee arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29888	T	Knee arthroscopy/surgery	0042	35.76	$1,820.33	$804.74	$364.07
29889	T	Knee arthroscopy/surgery	0042	35.76	$1,820.33	$804.74	$364.07
29891	T	Ankle arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29892	T	Ankle arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29893	T	Scope, plantar fasciotomy	0055	15.44	$785.96	$355.34	$157.19
29894	T	Ankle arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29895	T	Ankle arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29897	T	Ankle arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
29898	T	Ankle arthroscopy/surgery	0041	23.61	$1,201.84	$576.88	$240.37
*29900	T	Mcp joint arthroscopy, dx	0053	11.69	$595.07	$253.49	$119.01
*29901	T	Mcp joint arthroscopy, surg	0053	11.69	$595.07	$253.49	$119.01
*29902	T	Mcp joint arthroscopy, surg	0053	11.69	$595.07	$253.49	$119.01
29909	D	Arthroscopy of joint	0041	23.61	$1,201.84	$576.88	$240.37
*29999	T	Arthroscopy of joint	0041	23.61	$1,201.84	$576.88	$240.37
30000	T	Drainage of nose lesion	0251	2.43	$123.70	$27.99	$24.74
30020	T	Drainage of nose lesion	0251	2.43	$123.70	$27.99	$24.74
30100	T	Intranasal biopsy	0252	5.95	$302.88	$114.24	$60.58
30110	T	Removal of nose polyp(s)	0253	12.33	$627.65	$284.00	$125.53
30115	T	Removal of nose polyp(s)	0253	12.33	$627.65	$284.00	$125.53
30117	T	Removal of intranasal lesion	0253	12.33	$627.65	$284.00	$125.53
30118	T	Removal of intranasal lesion	0254	17.37	$884.20	$272.41	$176.84
30120	T	Revision of nose	0253	12.33	$627.65	$284.00	$125.53
30124	T	Removal of nose lesion	0252	5.95	$302.88	$114.24	$60.58
30125	T	Removal of nose lesion	0256	26.61	$1,354.56	$623.05	$270.91
30130	T	Removal of turbinate bones	0253	12.33	$627.65	$284.00	$125.53
30140	T	Removal of turbinate bones	0254	17.37	$884.20	$272.41	$176.84
30150	T	Partial removal of nose	0256	26.61	$1,354.56	$623.05	$270.91
30160	T	Removal of nose	0256	26.61	$1,354.56	$623.05	$270.91
30200	T	Injection treatment of nose	0253	12.33	$627.65	$284.00	$125.53
30210	T	Nasal sinus therapy	0252	5.95	$302.88	$114.24	$60.58
30220	T	Insert nasal septal button	0252	5.95	$302.88	$114.24	$60.58
30300	X	Remove nasal foreign body	0340	0.84	$42.76	$10.69	$8.55
30310	T	Remove nasal foreign body	0253	12.33	$627.65	$284.00	$125.53
30320	T	Remove nasal foreign body	0253	12.33	$627.65	$284.00	$125.53
30400	T	Reconstruction of nose	0256	26.61	$1,354.56	$623.05	$270.91
30410	T	Reconstruction of nose	0256	26.61	$1,354.56	$623.05	$270.91
30420	T	Reconstruction of nose	0256	26.61	$1,354.56	$623.05	$270.91
30430	T	Revision of nose	0254	17.37	$884.20	$272.41	$176.84
30435	T	Revision of nose	0256	26.61	$1,354.56	$623.05	$270.91
30450	T	Revision of nose	0256	26.61	$1,354.56	$623.05	$270.91
30460	T	Revision of nose	0256	26.61	$1,354.56	$623.05	$270.91
30462	T	Revision of nose	0256	26.61	$1,354.56	$623.05	$270.91
30465	T	Repair nasal stenosis	0256	26.61	$1,354.56	$623.05	$270.91
30520	T	Repair of nasal septum	0256	26.61	$1,354.56	$623.05	$270.91
30540	T	Repair nasal defect	0256	26.61	$1,354.56	$623.05	$270.91
30545	T	Repair nasal defect	0256	26.61	$1,354.56	$623.05	$270.91
30560	T	Release of nasal adhesions	0251	2.43	$123.70	$27.99	$24.74
30580	T	Repair upper jaw fistula	0256	26.61	$1,354.56	$623.05	$270.91
30600	T	Repair mouth/nose fistula	0256	26.61	$1,354.56	$623.05	$270.91
30620	T	Intranasal reconstruction	0256	26.61	$1,354.56	$623.05	$270.91
30630	T	Repair nasal septum defect	0254	17.37	$884.20	$272.41	$176.84
30801	T	Cauterization, inner nose	0252	5.95	$302.88	$114.24	$60.58
30802	T	Cauterization, inner nose	0253	12.33	$627.65	$284.00	$125.53
30901	T	Control of nosebleed	0250	2.10	$106.90	$37.42	$21.38
30903	T	Control of nosebleed	0250	2.10	$106.90	$37.42	$21.38
30905	T	Control of nosebleed	0250	2.10	$106.90	$37.42	$21.38
30906	T	Repeat control of nosebleed	0250	2.10	$106.90	$37.42	$21.38
30915	T	Ligation, nasal sinus artery	0091	20.34	$1,035.39	$348.23	$207.08
30920	T	Ligation, upper jaw artery	0092	19.91	$1,013.50	$503.71	$202.70
30930	T	Therapy, fracture of nose	0253	12.33	$627.65	$284.00	$125.53
30999	T	Nasal surgery procedure	0251	2.43	$123.70	$27.99	$24.74
31000	T	Irrigation, maxillary sinus	0251	2.43	$123.70	$27.99	$24.74
31002	T	Irrigation, sphenoid sinus	0252	5.95	$302.88	$114.24	$60.58
31020	T	Exploration, maxillary sinus	0254	17.37	$884.20	$272.41	$176.84
31030	T	Exploration, maxillary sinus	0256	26.61	$1,354.56	$623.05	$270.91
31032	T	Explore sinus,remove polyps	0256	26.61	$1,354.56	$623.05	$270.91
31040	T	Exploration behind upper jaw	0254	17.37	$884.20	$272.41	$176.84
31050	T	Exploration, sphenoid sinus	0256	26.61	$1,354.56	$623.05	$270.91
31051	T	Sphenoid sinus surgery	0256	26.61	$1,354.56	$623.05	$270.91
31070	T	Exploration of frontal sinus	0254	17.37	$884.20	$272.41	$176.84
31075	T	Exploration of frontal sinus	0256	26.61	$1,354.56	$623.05	$270.91
31080	T	Removal of frontal sinus	0256	26.61	$1,354.56	$623.05	$270.91
31081	T	Removal of frontal sinus	0256	26.61	$1,354.56	$623.05	$270.91
31084	T	Removal of frontal sinus	0256	26.61	$1,354.56	$623.05	$270.91

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31085	T	Removal of frontal sinus	0256	26.61	$1,354.56	$623.05	$270.91
31086	T	Removal of frontal sinus	0256	26.61	$1,354.56	$623.05	$270.91
31087	T	Removal of frontal sinus	0256	26.61	$1,354.56	$623.05	$270.91
31090	T	Exploration of sinuses	0256	26.61	$1,354.56	$623.05	$270.91
31200	T	Removal of ethmoid sinus	0256	26.61	$1,354.56	$623.05	$270.91
31201	T	Removal of ethmoid sinus	0256	26.61	$1,354.56	$623.05	$270.91
31205	T	Removal of ethmoid sinus	0256	26.61	$1,354.56	$623.05	$270.91
31225	C	Removal of upper jaw					
31230	C	Removal of upper jaw					
31231	T	Nasal endoscopy, dx	0071	1.03	$52.43	$14.22	$10.49
31233	T	Nasal/sinus endoscopy, dx	0072	1.21	$61.59	$33.87	$12.32
31235	T	Nasal/sinus endoscopy, dx	0074	11.32	$576.23	$293.88	$115.25
31237	T	Nasal/sinus endoscopy, surg	0075	17.42	$886.75	$443.38	$177.35
31238	T	Nasal/sinus endoscopy, surg	0074	11.32	$576.23	$293.88	$115.25
31239	T	Nasal/sinus endoscopy, surg	0075	17.42	$886.75	$443.38	$177.35
31240	T	Nasal/sinus endoscopy, surg	0074	11.32	$576.23	$293.88	$115.25
31254	T	Revision of ethmoid sinus	0075	17.42	$886.75	$443.38	$177.35
31255	T	Removal of ethmoid sinus	0075	17.42	$886.75	$443.38	$177.35
31256	T	Exploration maxillary sinus	0075	17.42	$886.75	$443.38	$177.35
31267	T	Endoscopy, maxillary sinus	0075	17.42	$886.75	$443.38	$177.35
31276	T	Sinus endoscopy, surgical	0075	17.42	$886.75	$443.38	$177.35
31287	T	Nasal/sinus endoscopy, surg	0075	17.42	$886.75	$443.38	$177.35
31288	T	Nasal/sinus endoscopy, surg	0075	17.42	$886.75	$443.38	$177.35
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	5.95	$302.88	$114.24	$60.58
31300	T	Removal of larynx lesion	0256	26.61	$1,354.56	$623.05	$270.91
31320	T	Diagnostic incision, larynx	0256	26.61	$1,354.56	$623.05	$270.91
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	26.61	$1,354.56	$623.05	$270.91
31420	T	Removal of epiglottis	0256	26.61	$1,354.56	$623.05	$270.91
31500	S	Insert emergency airway	0094	6.08	$309.50	$105.29	$61.90
31502	T	Change of windpipe airway	0121	2.54	$129.30	$52.53	$25.86
31505	T	Diagnostic laryngoscopy	0072	1.21	$61.59	$33.87	$12.32
31510	T	Laryngoscopy with biopsy	0074	11.32	$576.23	$293.88	$115.25
31511	T	Remove foreign body, larynx	0072	1.21	$61.59	$33.87	$12.32
31512	T	Removal of larynx lesion	0074	11.32	$576.23	$293.88	$115.25
31513	T	Injection into vocal cord	0073	3.29	$167.47	$73.69	$33.49
31515	T	Laryngoscopy for aspiration	0074	11.32	$576.23	$293.88	$115.25
31520	T	Diagnostic laryngoscopy	0072	1.21	$61.59	$33.87	$12.32
31525	T	Diagnostic laryngoscopy	0074	11.32	$576.23	$293.88	$115.25
31526	T	Diagnostic laryngoscopy	0075	17.42	$886.75	$443.38	$177.35
31527	T	Laryngoscopy for treatment	0075	17.42	$886.75	$443.38	$177.35
31528	T	Laryngoscopy and dilatation	0074	11.32	$576.23	$293.88	$115.25
31529	T	Laryngoscopy and dilatation	0074	11.32	$576.23	$293.88	$115.25
31530	T	Operative laryngoscopy	0075	17.42	$886.75	$443.38	$177.35
31531	T	Operative laryngoscopy	0075	17.42	$886.75	$443.38	$177.35
31535	T	Operative laryngoscopy	0075	17.42	$886.75	$443.38	$177.35
31536	T	Operative laryngoscopy	0075	17.42	$886.75	$443.38	$177.35
31540	T	Operative laryngoscopy	0075	17.42	$886.75	$443.38	$177.35
31541	T	Operative laryngoscopy	0075	17.42	$886.75	$443.38	$177.35
31560	T	Operative laryngoscopy	0075	17.42	$886.75	$443.38	$177.35
31561	T	Operative laryngoscopy	0075	17.42	$886.75	$443.38	$177.35
31570	T	Laryngoscopy with injection	0074	11.32	$576.23	$293.88	$115.25
31571	T	Laryngoscopy with injection	0075	17.42	$886.75	$443.38	$177.35
31575	T	Diagnostic laryngoscopy	0071	1.03	$52.43	$14.22	$10.49
31576	T	Laryngoscopy with biopsy	0075	17.42	$886.75	$443.38	$177.35
31577	T	Remove foreign body, larynx	0073	3.29	$167.47	$73.69	$33.49
31578	T	Removal of larynx lesion	0075	17.42	$886.75	$443.38	$177.35
31579	T	Diagnostic laryngoscopy	0073	3.29	$167.47	$73.69	$33.49
31580	T	Revision of larynx	0256	26.61	$1,354.56	$623.05	$270.91
31582	C	Revision of larynx					
31584	C	Treat larynx fracture					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31585	T	Treat larynx fracture	0253	12.33	$627.65	$284.00	$125.53
31586	T	Treat larynx fracture	0256	26.61	$1,354.56	$623.05	$270.91
31587	C	Revision of larynx					
31588	T	Revision of larynx	0256	26.61	$1,354.56	$623.05	$270.91
31590	T	Reinnervate larynx	0256	26.61	$1,354.56	$623.05	$270.91
31595	T	Larynx nerve surgery	0256	26.61	$1,354.56	$623.05	$270.91
31599	T	Larynx surgery procedure	0254	17.37	$884.20	$272.41	$176.84
31600	T	Incision of windpipe	0254	17.37	$884.20	$272.41	$176.84
31601	T	Incision of windpipe	0254	17.37	$884.20	$272.41	$176.84
31603	T	Incision of windpipe	0252	5.95	$302.88	$114.24	$60.58
31605	T	Incision of windpipe	0253	12.33	$627.65	$284.00	$125.53
31610	T	Incision of windpipe	0254	17.37	$884.20	$272.41	$176.84
31611	T	Surgery/speech prosthesis	0254	17.37	$884.20	$272.41	$176.84
31612	T	Puncture/clear windpipe	0254	17.37	$884.20	$272.41	$176.84
31613	T	Repair windpipe opening	0254	17.37	$884.20	$272.41	$176.84
31614	T	Repair windpipe opening	0256	26.61	$1,354.56	$623.05	$270.91
31615	T	Visualization of windpipe	0076	7.56	$384.83	$188.57	$76.97
31622	T	Dx bronchoscope/wash	0076	7.56	$384.83	$188.57	$76.97
31623	T	Dx bronchoscope/brush	0076	7.56	$384.83	$188.57	$76.97
31624	T	Dx bronchoscope/lavage	0076	7.56	$384.83	$188.57	$76.97
31625	T	Bronchoscopy with biopsy	0076	7.56	$384.83	$188.57	$76.97
31628	T	Bronchoscopy with biopsy	0076	7.56	$384.83	$188.57	$76.97
31629	T	Bronchoscopy with biopsy	0076	7.56	$384.83	$188.57	$76.97
31630	T	Bronchoscopy with repair	0076	7.56	$384.83	$188.57	$76.97
31631	T	Bronchoscopy with dilation	0076	7.56	$384.83	$188.57	$76.97
31635	T	Remove foreign body, airway	0076	7.56	$384.83	$188.57	$76.97
31640	T	Bronchoscopy & remove lesion	0076	7.56	$384.83	$188.57	$76.97
31641	T	Bronchoscopy, treat blockage	0076	7.56	$384.83	$188.57	$76.97
31643	T	Diag bronchoscope/catheter	0076	7.56	$384.83	$188.57	$76.97
31645	T	Bronchoscopy, clear airways	0076	7.56	$384.83	$188.57	$76.97
31646	T	Bronchoscopy, reclear airway	0076	7.56	$384.83	$188.57	$76.97
31656	T	Bronchoscopy, inj for xray	0076	7.56	$384.83	$188.57	$76.97
31700	T	Insertion of airway catheter	0072	1.21	$61.59	$33.87	$12.32
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	3.29	$167.47	$73.69	$33.49
31720	T	Clearance of airways	0072	1.21	$61.59	$33.87	$12.32
31725	C	Clearance of airways					
31730	T	Intro, windpipe wire/tube	0073	3.29	$167.47	$73.69	$33.49
31750	T	Repair of windpipe	0256	26.61	$1,354.56	$623.05	$270.91
31755	T	Repair of windpipe	0256	26.61	$1,354.56	$623.05	$270.91
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	C	Remove windpipe lesion					
31786	C	Remove windpipe lesion					
31800	C	Repair of windpipe injury					
31805	C	Repair of windpipe injury					
31820	T	Closure of windpipe lesion	0253	12.33	$627.65	$284.00	$125.53
31825	T	Repair of windpipe defect	0254	17.37	$884.20	$272.41	$176.84
31830	T	Revise windpipe scar	0254	17.37	$884.20	$272.41	$176.84
31899	T	Airways surgical procedure	0076	7.56	$384.83	$188.57	$76.97
32000	T	Drainage of chest	0070	4.58	$233.14	$79.60	$46.63
32002	T	Treatment of collapsed lung	0070	4.58	$233.14	$79.60	$46.63
32005	T	Treat lung lining chemically	0070	4.58	$233.14	$79.60	$46.63
32020	T	Insertion of chest tube	0070	4.58	$233.14	$79.60	$46.63
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	C	Drain, percut, lung lesion					
32215	C	Treat chest lining					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	4.03	$205.14	$90.26	$41.03
32402	C	Open biopsy chest lining					
32405	T	Biopsy, lung or mediastinum	0685	9.16	$466.28	$205.16	$93.26
32420	T	Puncture/clear lung	0070	4.58	$233.14	$79.60	$46.63
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					
32601	T	Thoracoscopy, diagnostic	0069	23.57	$1,199.81		$239.96
32602	T	Thoracoscopy, diagnostic	0069	23.57	$1,199.81		$239.96
32603	T	Thoracoscopy, diagnostic	0069	23.57	$1,199.81		$239.96
32604	T	Thoracoscopy, diagnostic	0069	23.57	$1,199.81		$239.96
32605	T	Thoracoscopy, diagnostic	0069	23.57	$1,199.81		$239.96
32606	T	Thoracoscopy, diagnostic	0069	23.57	$1,199.81		$239.96
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	4.58	$233.14	$79.60	$46.63
32997	C	Total lung lavage					
32999	T	Chest surgery procedure	0070	4.58	$233.14	$79.60	$46.63
33010	T	Drainage of heart sac	0070	4.58	$233.14	$79.60	$46.63
33011	T	Repeat drainage of heart sac	0070	4.58	$233.14	$79.60	$46.63
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33206	T	Insertion of heart pacemaker	0089	149.52	$7,611.17	$2,246.59	$1,522.23
33207	T	Insertion of heart pacemaker	0089	149.52	$7,611.17	$2,246.59	$1,522.23
33208	T	Insertion of heart pacemaker	0089	149.52	$7,611.17	$2,246.59	$1,522.23
33210	T	Insertion of heart electrode	0106	36.64	$1,865.12	$503.07	$373.02
33211	T	Insertion of heart electrode	0106	36.64	$1,865.12	$503.07	$373.02
33212	T	Insertion of pulse generator	0090	117.54	$5,983.26	$2,133.88	$1,196.65
33213	T	Insertion of pulse generator	0090	117.54	$5,983.26	$2,133.88	$1,196.65
33214	T	Upgrade of pacemaker system	0089	149.52	$7,611.17	$2,246.59	$1,522.23
33216	T	Revise eltrd pacing-defib	0106	36.64	$1,865.12	$503.07	$373.02
33217	T	Revise eltrd pacing-defib	0106	36.64	$1,865.12	$503.07	$373.02
33218	T	Revise eltrd pacing-defib	0106	36.64	$1,865.12	$503.07	$373.02
33220	T	Revise eltrd pacing-defib	0106	36.64	$1,865.12	$503.07	$373.02
33222	T	Revise pocket, pacemaker	0026	12.62	$642.41	$277.92	$128.48
33223	T	Revise pocket, pacing-defib	0026	12.62	$642.41	$277.92	$128.48
33233	T	Removal of pacemaker system	0105	14.76	$751.34	$368.16	$150.27
33234	T	Removal of pacemaker system	0105	14.76	$751.34	$368.16	$150.27
33235	T	Removal pacemaker electrode	0105	14.76	$751.34	$368.16	$150.27
33236	C	Remove electrode/thoracotomy					
33237	C	Remove electrode/thoracotomy					
33238	C	Remove electrode/thoracotomy					
33240	T	Insert pulse generator	0107	379.46	$19,316.03	$4,224.27	$3,863.21
33241	T	Remove pulse generator	0105	14.76	$751.34	$368.16	$150.27
33243	C	Remove eltrd/thoracotomy					
33244	T	Remove eltrd, transven	0105	14.76	$751.34	$368.16	$150.27
33245	C	Insert epic eltrd pace-defib					
33246	C	Insert epic eltrd/generator					
33249	T	Eltrd/insert pace-defib	0108	573.46	$29,191.41		$5,838.28
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	0710		$400.00		$80.00
33284	T	Remove pat-active ht record	0109	6.27	$319.17	$130.86	$63.83
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
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	4.58	$233.14	$79.60	$46.63
34001	C	Removal of artery clot					
34051	C	Removal of artery clot					
34101	T	Removal of artery clot	0088	34.38	$1,750.08	$678.68	$350.02
34111	T	Removal of arm artery clot	0088	34.38	$1,750.08	$678.68	$350.02
34151	C	Removal of artery clot					
34201	T	Removal of artery clot	0088	34.38	$1,750.08	$678.68	$350.02
34203	T	Removal of leg artery clot	0088	34.38	$1,750.08	$678.68	$350.02
34401	C	Removal of vein clot					
34421	T	Removal of vein clot	0088	34.38	$1,750.08	$678.68	$350.02
34451	C	Removal of vein clot					
34471	T	Removal of vein clot	0088	34.38	$1,750.08	$678.68	$350.02
34490	T	Removal of vein clot	0088	34.38	$1,750.08	$678.68	$350.02
34501	T	Repair valve, femoral vein	0088	34.38	$1,750.08	$678.68	$350.02
34502	C	Reconstruct vena cava					
34510	T	Transposition of vein valve	0088	34.38	$1,750.08	$678.68	$350.02
34520	T	Cross-over vein graft	0088	34.38	$1,750.08	$678.68	$350.02
34530	T	Leg vein fusion	0088	34.38	$1,750.08	$678.68	$350.02
34800	C	Endovasc abdo repair w/tube					
34802	C	Endovasc abdo repr w/device					
34804	C	Endovasc abdo repr w/device					
34808	C	Endovasc abdo occlud device					
34812	C	Xpose for endoprosth, aortic					
34813	C	Xpose for endoprosth, femorl					
34820	C	Xpose for endoprosth, iliac					
34825	C	Endovasc extend prosth, init					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
35001	C	Repair defect of artery					
35002	C	Repair artery rupture, neck					
35005	C	Repair defect of artery					
35011	T	Repair defect of artery	0093	14.16	$720.80	$277.34	$144.16
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					
35180	T	Repair blood vessel lesion	0093	14.16	$720.80	$277.34	$144.16
35182	C	Repair blood vessel lesion					
35184	T	Repair blood vessel lesion	0093	14.16	$720.80	$277.34	$144.16
35188	T	Repair blood vessel lesion	0088	34.38	$1,750.08	$678.68	$350.02
35189	C	Repair blood vessel lesion					
35190	T	Repair blood vessel lesion	0093	14.16	$720.80	$277.34	$144.16
35201	T	Repair blood vessel lesion	0093	14.16	$720.80	$277.34	$144.16
35206	T	Repair blood vessel lesion	0093	14.16	$720.80	$277.34	$144.16
35207	T	Repair blood vessel lesion	0088	34.38	$1,750.08	$678.68	$350.02
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	14.16	$720.80	$277.34	$144.16
35231	T	Repair blood vessel lesion	0093	14.16	$720.80	$277.34	$144.16
35236	T	Repair blood vessel lesion	0093	14.16	$720.80	$277.34	$144.16
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	14.16	$720.80	$277.34	$144.16
35261	T	Repair blood vessel lesion	0093	14.16	$720.80	$277.34	$144.16
35266	T	Repair blood vessel lesion	0093	14.16	$720.80	$277.34	$144.16
35271	C	Repair blood vessel lesion					
35276	C	Repair blood vessel lesion					
35281	C	Repair blood vessel lesion					
35286	T	Repair blood vessel lesion	0093	14.16	$720.80	$277.34	$144.16
35301	C	Rechanneling of artery					
35311	C	Rechanneling of artery					
35321	T	Rechanneling of artery	0093	14.16	$720.80	$277.34	$144.16
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	29.24	$1,488.43	$710.91	$297.69
35459	T	Repair arterial blockage	0081	29.24	$1,488.43	$710.91	$297.69

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35460	T	Repair venous blockage	0081	29.24	$1,488.43	$710.91	$297.69
35470	T	Repair arterial blockage	0081	29.24	$1,488.43	$710.91	$297.69
35471	T	Repair arterial blockage	0081	29.24	$1,488.43	$710.91	$297.69
35472	T	Repair arterial blockage	0081	29.24	$1,488.43	$710.91	$297.69
35473	T	Repair arterial blockage	0081	29.24	$1,488.43	$710.91	$297.69
35474	T	Repair arterial blockage	0081	29.24	$1,488.43	$710.91	$297.69
35475	T	Repair arterial blockage	0081	29.24	$1,488.43	$710.91	$297.69
35476	T	Repair venous blockage	0081	29.24	$1,488.43	$710.91	$297.69
35480	C	Atherectomy, open					
35481	C	Atherectomy, open					
35482	C	Atherectomy, open					
35483	C	Atherectomy, open					
35484	T	Atherectomy, open	0081	29.24	$1,488.43	$710.91	$297.69
35485	T	Atherectomy, open	0081	29.24	$1,488.43	$710.91	$297.69
35490	T	Atherectomy, percutaneous	0081	29.24	$1,488.43	$710.91	$297.69
35491	T	Atherectomy, percutaneous	0081	29.24	$1,488.43	$710.91	$297.69
35492	T	Atherectomy, percutaneous	0081	29.24	$1,488.43	$710.91	$297.69
35493	T	Atherectomy, percutaneous	0081	29.24	$1,488.43	$710.91	$297.69
35494	T	Atherectomy, percutaneous	0081	29.24	$1,488.43	$710.91	$297.69
35495	T	Atherectomy, percutaneous	0081	29.24	$1,488.43	$710.91	$297.69
35500	T	Harvest vein for bypass	0081	29.24	$1,488.43	$710.91	$297.69
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					
35511	C	Artery bypass graft					
35515	C	Artery bypass graft					
35516	C	Artery bypass graft					
35518	C	Artery bypass graft					
35521	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					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35681	C	Composite bypass graft					
35682	C	Composite bypass graft					
35683	C	Composite bypass graft					
*35685	T	Bypass graft patency/patch	0093	14.16	$720.80	$277.34	$144.16
*35686	T	Bypass graft/av fist patency	0093	14.16	$720.80	$277.34	$144.16
35691	C	Arterial transposition					
35693	C	Arterial transposition					
35694	C	Arterial transposition					
35695	C	Arterial transposition					
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	21.35	$1,086.80	$506.74	$217.36
35800	C	Explore neck vessels					
35820	C	Explore chest vessels					
35840	C	Explore abdominal vessels					
35860	T	Explore limb vessels	0093	14.16	$720.80	$277.34	$144.16
35870	C	Repair vessel graft defect					
35875	T	Removal of clot in graft	0088	34.38	$1,750.08	$678.68	$350.02
35876	T	Removal of clot in graft	0088	34.38	$1,750.08	$678.68	$350.02
35879	T	Revise graft w/vein	0088	34.38	$1,750.08	$678.68	$350.02
35881	T	Revise graft w/vein	0088	34.38	$1,750.08	$678.68	$350.02
35901	C	Excision, graft, neck					
35903	T	Excision, graft, extremity	0115	21.35	$1,086.80	$506.74	$217.36
35905	C	Excision, graft, thorax					
35907	C	Excision, graft, abdomen					
36000	N	Place needle in vein					
*36002	S	Pseudoaneurysm injection trt	0267	2.33	$118.61	$65.23	$23.72
36005	N	Injection, 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	79.67	$4,055.52		$811.10
36261	T	Revision of infusion pump	0124	89.07	$4,534.02		$906.80
36262	T	Removal of infusion pump	0109	6.27	$319.17	$130.86	$63.83
36299	N	Vessel injection procedure					
36400	N	Drawing blood					
36405	N	Drawing blood					
36406	N	Drawing blood					
36410	N	Drawing blood					
36415	E	Drawing blood					
36420	T	Establish access to vein	0035	0.12	$6.11	$2.69	$1.22
36425	T	Establish access to vein	0035	0.12	$6.11	$2.69	$1.22
36430	S	Blood transfusion service	0110	5.30	$269.79	$113.31	$53.96
36440	S	Blood transfusion service	0110	5.30	$269.79	$113.31	$53.96
36450	S	Exchange transfusion service	0110	5.30	$269.79	$113.31	$53.96
36455	S	Exchange transfusion service	0110	5.30	$269.79	$113.31	$53.96
36460	S	Transfusion service, fetal	0110	5.30	$269.79	$113.31	$53.96
36468	T	Injection(s), spider veins	0098	1.24	$63.12	$20.88	$12.62
36469	T	Injection(s), spider veins	0098	1.24	$63.12	$20.88	$12.62
36470	T	Injection therapy of vein	0098	1.24	$63.12	$20.88	$12.62
36471	T	Injection therapy of veins	0098	1.24	$63.12	$20.88	$12.62
36481	N	Insertion of catheter, vein					
36488	T	Insertion of catheter, vein	0032	12.64	$643.43		$128.69
36489	T	Insertion of catheter, vein	0032	12.64	$643.43		$128.69
36490	T	Insertion of catheter, vein	0032	12.64	$643.43		$128.69
36491	T	Insertion of catheter, vein	0032	12.64	$643.43		$128.69

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
36493	X	Repositioning of cvc	0187	4.22	$214.81		$42.96
36500	N	Insertion of catheter, vein					
36510	C	Insertion of catheter, vein					
36520	S	Plasma and/or cell exchange	0111	21.08	$1,073.06	$300.74	$214.61
36521	S	Apheresis w/ adsorp/reinfuse	0112	36.25	$1,845.27	$608.94	$369.05
36522	S	Photopheresis	0112	36.25	$1,845.27	$608.94	$369.05
36530	T	Insertion of infusion pump	0119	79.67	$4,055.52		$811.10
36531	T	Revision of infusion pump	0124	89.07	$4,534.02		$906.80
36532	T	Removal of infusion pump	0109	6.27	$319.17	$130.86	$63.83
36533	T	Insertion of access device	0115	21.35	$1,086.80	$506.74	$217.36
36534	T	Revision of access device	0109	6.27	$319.17	$130.86	$63.83
36535	T	Removal of access device	0109	6.27	$319.17	$130.86	$63.83
36540	N	Collect blood venous device					
36550	T	Declot vascular device	0972		$150.00		$30.00
36600	N	Withdrawal of arterial blood					
36620	N	Insertion catheter, artery					
36625	N	Insertion catheter, artery					
36640	T	Insertion catheter, artery	0032	12.64	$643.43		$128.69
36660	C	Insertion catheter, artery					
36680	T	Insert needle, bone cavity	0120	3.08	$156.78	$42.67	$31.36
36800	T	Insertion of cannula	0115	21.35	$1,086.80	$506.74	$217.36
36810	T	Insertion of cannula	0115	21.35	$1,086.80	$506.74	$217.36
36815	T	Insertion of cannula	0115	21.35	$1,086.80	$506.74	$217.36
36819	T	Av fusion by basilic vein	0088	34.38	$1,750.08	$678.68	$350.02
*36820	T	Av fusion/forearm vein	0088	34.38	$1,750.08	$678.68	$350.02
36821	T	Av fusion direct any site	0088	34.38	$1,750.08	$678.68	$350.02
36822	C	Insertion of cannula(s)					
36823	C	Insertion of cannula(s)					
36825	T	Artery-vein graft	0088	34.38	$1,750.08	$678.68	$350.02
36830	T	Artery-vein graft	0088	34.38	$1,750.08	$678.68	$350.02
36831	T	Av fistula excision, open	0088	34.38	$1,750.08	$678.68	$350.02
36832	T	Av fistula revision, open	0088	34.38	$1,750.08	$678.68	$350.02
36833	T	Av fistula revision	0088	34.38	$1,750.08	$678.68	$350.02
36834	T	Repair A-V aneurysm	0088	34.38	$1,750.08	$678.68	$350.02
36835	T	Artery to vein shunt	0115	21.35	$1,086.80	$506.74	$217.36
36860	T	External cannula declotting	0115	21.35	$1,086.80	$506.74	$217.36
36861	T	Cannula declotting	0115	21.35	$1,086.80	$506.74	$217.36
36870	T	Av fistula revision, open	0093	14.16	$720.80	$277.34	$144.16
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					
37195	C	Thrombolytic therapy, stroke					
37200	T	Transcatheter biopsy	0685	9.16	$466.28	$205.16	$93.26
37201	T	Transcatheter therapy infuse	0120	3.08	$156.78	$42.67	$31.36
37202	T	Transcatheter therapy infuse	0120	3.08	$156.78	$42.67	$31.36
37203	T	Transcatheter retrieval	0103	15.95	$811.92	$295.70	$162.38
37204	T	Transcatheter occlusion	0103	15.95	$811.92	$295.70	$162.38
37205	T	Transcatheter stent	0229	67.22	$3,421.77	$996.86	$684.35
37206	T	Transcatheter stent add-on	0229	67.22	$3,421.77	$996.86	$684.35
37207	T	Transcatheter stent	0229	67.22	$3,421.77	$996.86	$684.35
37208	T	Transcatheter stent add-on	0229	67.22	$3,421.77	$996.86	$684.35
37209	T	Exchange arterial catheter	0103	15.95	$811.92	$295.70	$162.38
37250	T	Iv us first vessel add-on	0103	15.95	$811.92	$295.70	$162.38
37251	T	Iv us each add vessel add-on	0103	15.95	$811.92	$295.70	$162.38
37565	T	Ligation of neck vein	0093	14.16	$720.80	$277.34	$144.16
37600	T	Ligation of neck artery	0093	14.16	$720.80	$277.34	$144.16
37605	T	Ligation of neck artery	0091	20.34	$1,035.39	$348.23	$207.08
37606	T	Ligation of neck artery	0091	20.34	$1,035.39	$348.23	$207.08
37607	T	Ligation of a-v fistula	0092	19.91	$1,013.50	$503.71	$202.70
37609	T	Temporal artery procedure	0020	8.44	$429.63	$130.53	$85.93
37615	T	Ligation of neck artery	0091	20.34	$1,035.39	$348.23	$207.08
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	20.34	$1,035.39	$348.23	$207.08
37650	T	Revision of major vein	0091	20.34	$1,035.39	$348.23	$207.08
37660	C	Revision of major vein					
37700	T	Revise leg vein	0091	20.34	$1,035.39	$348.23	$207.08
37720	T	Removal of leg vein	0092	19.91	$1,013.50	$503.71	$202.70
37730	T	Removal of leg veins	0092	19.91	$1,013.50	$503.71	$202.70
37735	T	Removal of leg veins/lesion	0092	19.91	$1,013.50	$503.71	$202.70
37760	T	Revision of leg veins	0091	20.34	$1,035.39	$348.23	$207.08
37780	T	Revision of leg vein	0091	20.34	$1,035.39	$348.23	$207.08

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
37785	T	Revise secondary varicosity	0091	20.34	$1,035.39	$348.23	$207.08
37788	C	Revascularization, penis					
37790	T	Penile venous occlusion	0181	22.09	$1,124.47	$618.45	$224.89
37799	T	Vascular surgery procedure	0020	8.44	$429.63	$130.53	$85.93
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	37.63	$1,915.52	$996.07	$383.10
38129	T	Laparoscope proc, spleen	0130	25.91	$1,318.92	$659.53	$263.78
38200	N	Injection for spleen x-ray					
*38220	T	Bone marrow aspiration	0003	1.03	$52.43	$27.99	$10.49
*38221	T	Bone marrow biopsy	0003	1.03	$52.43	$27.99	$10.49
38230	S	Bone marrow collection	0123	8.56	$435.74		$87.15
38231	S	Stem cell collection	0111	21.08	$1,073.06	$300.74	$214.61
38240	S	Bone marrow/stem transplant	0123	8.56	$435.74		$87.15
38241	S	Bone marrow/stem transplant	0123	8.56	$435.74		$87.15
38300	T	Drainage, lymph node lesion	0008	10.93	$556.38	$113.67	$111.28
38305	T	Drainage, lymph node lesion	0008	10.93	$556.38	$113.67	$111.28
38308	T	Incision of lymph channels	0113	15.53	$790.54	$326.55	$158.11
38380	C	Thoracic duct procedure					
38381	C	Thoracic duct procedure					
38382	C	Thoracic duct procedure					
38500	T	Biopsy/removal, lymph nodes	0113	15.53	$790.54	$326.55	$158.11
38505	T	Needle biopsy, lymph nodes	0005	4.03	$205.14	$90.26	$41.03
38510	T	Biopsy/removal, lymph nodes	0113	15.53	$790.54	$326.55	$158.11
38520	T	Biopsy/removal, lymph nodes	0113	15.53	$790.54	$326.55	$158.11
38525	T	Biopsy/removal, lymph nodes	0113	15.53	$790.54	$326.55	$158.11
38530	T	Biopsy/removal, lymph nodes	0113	15.53	$790.54	$326.55	$158.11
38542	T	Explore deep node(s), neck	0114	29.28	$1,490.47	$493.78	$298.09
38550	T	Removal, neck/armpit lesion	0113	15.53	$790.54	$326.55	$158.11
38555	T	Removal, neck/armpit lesion	0113	15.53	$790.54	$326.55	$158.11
38562	C	Removal, pelvic lymph nodes					
38564	C	Removal, abdomen lymph nodes					
38570	T	Laparoscopy, lymph node biop	0131	37.63	$1,915.52	$996.07	$383.10
38571	T	Laparoscopy, lymphadenectomy	0132	56.06	$2,853.68	$1,239.22	$570.74
38572	T	Laparoscopy, lymphadenectomy	0131	37.63	$1,915.52	$996.07	$383.10
38589	T	Laparoscope proc, lymphatic	0130	25.91	$1,318.92	$659.53	$263.78
38700	C	Removal of lymph nodes, neck					
38720	T	Removal of lymph nodes, neck	0113	15.53	$790.54	$326.55	$158.11
38724	C	Removal of lymph nodes, neck					
38740	T	Remove armpit lymph nodes	0114	29.28	$1,490.47	$493.78	$298.09
38745	T	Remove armpit lymph nodes	0114	29.28	$1,490.47	$493.78	$298.09
38746	C	Remove thoracic lymph nodes					
38747	C	Remove abdominal lymph nodes					
38760	T	Remove groin lymph nodes	0113	15.53	$790.54	$326.55	$158.11
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	T	Blood/lymph system procedure	0008	10.93	$556.38	$113.67	$111.28
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	23.57	$1,199.81		$239.96
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	2.43	$123.70	$27.99	$24.74
40500	T	Partial excision of lip	0253	12.33	$627.65	$284.00	$125.53
40510	T	Partial excision of lip	0254	17.37	$884.20	$272.41	$176.84
40520	T	Partial excision of lip	0253	12.33	$627.65	$284.00	$125.53

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
40525	T	Reconstruct lip with flap	0254	17.37	$884.20	$272.41	$176.84
40527	T	Reconstruct lip with flap	0254	17.37	$884.20	$272.41	$176.84
40530	T	Partial removal of lip	0254	17.37	$884.20	$272.41	$176.84
40650	T	Repair lip	0252	5.95	$302.88	$114.24	$60.58
40652	T	Repair lip	0252	5.95	$302.88	$114.24	$60.58
40654	T	Repair lip	0252	5.95	$302.88	$114.24	$60.58
40700	T	Repair cleft lip/nasal	0256	26.61	$1,354.56	$623.05	$270.91
40701	T	Repair cleft lip/nasal	0256	26.61	$1,354.56	$623.05	$270.91
40702	T	Repair cleft lip/nasal	0256	26.61	$1,354.56	$623.05	$270.91
40720	T	Repair cleft lip/nasal	0256	26.61	$1,354.56	$623.05	$270.91
40761	T	Repair cleft lip/nasal	0256	26.61	$1,354.56	$623.05	$270.91
40799	T	Lip surgery procedure	0253	12.33	$627.65	$284.00	$125.53
40800	T	Drainage of mouth lesion	0251	2.43	$123.70	$27.99	$24.74
40801	T	Drainage of mouth lesion	0252	5.95	$302.88	$114.24	$60.58
40804	X	Removal, foreign body, mouth	0340	0.84	$42.76	$10.69	$8.55
40805	T	Removal, foreign body, mouth	0252	5.95	$302.88	$114.24	$60.58
40806	T	Incision of lip fold	0251	2.43	$123.70	$27.99	$24.74
40808	T	Biopsy of mouth lesion	0251	2.43	$123.70	$27.99	$24.74
40810	T	Excision of mouth lesion	0253	12.33	$627.65	$284.00	$125.53
40812	T	Excise/repair mouth lesion	0252	5.95	$302.88	$114.24	$60.58
40814	T	Excise/repair mouth lesion	0253	12.33	$627.65	$284.00	$125.53
40816	T	Excision of mouth lesion	0254	17.37	$884.20	$272.41	$176.84
40818	T	Excise oral mucosa for graft	0251	2.43	$123.70	$27.99	$24.74
40819	T	Excise lip or cheek fold	0252	5.95	$302.88	$114.24	$60.58
40820	T	Treatment of mouth lesion	0253	12.33	$627.65	$284.00	$125.53
40830	T	Repair mouth laceration	0251	2.43	$123.70	$27.99	$24.74
40831	T	Repair mouth laceration	0252	5.95	$302.88	$114.24	$60.58
40840	T	Reconstruction of mouth	0254	17.37	$884.20	$272.41	$176.84
40842	T	Reconstruction of mouth	0254	17.37	$884.20	$272.41	$176.84
40843	T	Reconstruction of mouth	0254	17.37	$884.20	$272.41	$176.84
40844	T	Reconstruction of mouth	0256	26.61	$1,354.56	$623.05	$270.91
40845	T	Reconstruction of mouth	0256	26.61	$1,354.56	$623.05	$270.91
40899	T	Mouth surgery procedure	0252	5.95	$302.88	$114.24	$60.58
41000	T	Drainage of mouth lesion	0253	12.33	$627.65	$284.00	$125.53
41005	T	Drainage of mouth lesion	0251	2.43	$123.70	$27.99	$24.74
41006	T	Drainage of mouth lesion	0254	17.37	$884.20	$272.41	$176.84
41007	T	Drainage of mouth lesion	0253	12.33	$627.65	$284.00	$125.53
41008	T	Drainage of mouth lesion	0253	12.33	$627.65	$284.00	$125.53
41009	T	Drainage of mouth lesion	0251	2.43	$123.70	$27.99	$24.74
41010	T	Incision of tongue fold	0253	12.33	$627.65	$284.00	$125.53
41015	T	Drainage of mouth lesion	0251	2.43	$123.70	$27.99	$24.74
41016	T	Drainage of mouth lesion	0252	5.95	$302.88	$114.24	$60.58
41017	T	Drainage of mouth lesion	0252	5.95	$302.88	$114.24	$60.58
41018	T	Drainage of mouth lesion	0252	5.95	$302.88	$114.24	$60.58
41100	T	Biopsy of tongue	0252	5.95	$302.88	$114.24	$60.58
41105	T	Biopsy of tongue	0253	12.33	$627.65	$284.00	$125.53
41108	T	Biopsy of floor of mouth	0252	5.95	$302.88	$114.24	$60.58
41110	T	Excision of tongue lesion	0253	12.33	$627.65	$284.00	$125.53
41112	T	Excision of tongue lesion	0253	12.33	$627.65	$284.00	$125.53
41113	T	Excision of tongue lesion	0253	12.33	$627.65	$284.00	$125.53
41114	T	Excision of tongue lesion	0254	17.37	$884.20	$272.41	$176.84
41115	T	Excision of tongue fold	0252	5.95	$302.88	$114.24	$60.58
41116	T	Excision of mouth lesion	0253	12.33	$627.65	$284.00	$125.53
41120	T	Partial removal of tongue	0256	26.61	$1,354.56	$623.05	$270.91
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	2.43	$123.70	$27.99	$24.74
41251	T	Repair tongue laceration	0252	5.95	$302.88	$114.24	$60.58
41252	T	Repair tongue laceration	0252	5.95	$302.88	$114.24	$60.58
41500	T	Fixation of tongue	0254	17.37	$884.20	$272.41	$176.84
41510	T	Tongue to lip surgery	0253	12.33	$627.65	$284.00	$125.53
41520	T	Reconstruction, tongue fold	0252	5.95	$302.88	$114.24	$60.58
41599	T	Tongue and mouth surgery	0251	2.43	$123.70	$27.99	$24.74
41800	T	Drainage of gum lesion	0251	2.43	$123.70	$27.99	$24.74
41805	T	Removal foreign body, gum	0254	17.37	$884.20	$272.41	$176.84
41806	T	Removal foreign body, jawbone	0253	12.33	$627.65	$284.00	$125.53
41820	T	Excision, gum, each quadrant	0252	5.95	$302.88	$114.24	$60.58
41821	T	Excision of gum flap	0252	5.95	$302.88	$114.24	$60.58
41822	T	Excision of gum lesion	0253	12.33	$627.65	$284.00	$125.53
41823	T	Excision of gum lesion	0254	17.37	$884.20	$272.41	$176.84

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
41825	T	Excision of gum lesion	0253	12.33	$627.65	$284.00	$125.53
41826	T	Excision of gum lesion	0253	12.33	$627.65	$284.00	$125.53
41827	T	Excision of gum lesion	0254	17.37	$884.20	$272.41	$176.84
41828	T	Excision of gum lesion	0253	12.33	$627.65	$284.00	$125.53
41830	T	Removal of gum tissue	0253	12.33	$627.65	$284.00	$125.53
41850	T	Treatment of gum lesion	0253	12.33	$627.65	$284.00	$125.53
41870	T	Gum graft	0254	17.37	$884.20	$272.41	$176.84
41872	T	Repair gum	0253	12.33	$627.65	$284.00	$125.53
41874	T	Repair tooth socket	0254	17.37	$884.20	$272.41	$176.84
41899	T	Dental surgery procedure	0253	12.33	$627.65	$284.00	$125.53
42000	T	Drainage mouth roof lesion	0251	2.43	$123.70	$27.99	$24.74
42100	T	Biopsy roof of mouth	0252	5.95	$302.88	$114.24	$60.58
42104	T	Excision lesion, mouth roof	0253	12.33	$627.65	$284.00	$125.53
42106	T	Excision lesion, mouth roof	0253	12.33	$627.65	$284.00	$125.53
42107	T	Excision lesion, mouth roof	0254	17.37	$884.20	$272.41	$176.84
42120	T	Remove palate/lesion	0256	26.61	$1,354.56	$623.05	$270.91
42140	T	Excision of uvula	0252	5.95	$302.88	$114.24	$60.58
42145	T	Repair palate, pharynx/uvula	0254	17.37	$884.20	$272.41	$176.84
42160	T	Treatment mouth roof lesion	0253	12.33	$627.65	$284.00	$125.53
42180	T	Repair palate	0251	2.43	$123.70	$27.99	$24.74
42182	T	Repair palate	0256	26.61	$1,354.56	$623.05	$270.91
42200	T	Reconstruct cleft palate	0256	26.61	$1,354.56	$623.05	$270.91
42205	T	Reconstruct cleft palate	0256	26.61	$1,354.56	$623.05	$270.91
42210	T	Reconstruct cleft palate	0256	26.61	$1,354.56	$623.05	$270.91
42215	T	Reconstruct cleft palate	0256	26.61	$1,354.56	$623.05	$270.91
42220	T	Reconstruct cleft palate	0256	26.61	$1,354.56	$623.05	$270.91
42225	T	Reconstruct cleft palate	0256	26.61	$1,354.56	$623.05	$270.91
42226	T	Lengthening of palate	0256	26.61	$1,354.56	$623.05	$270.91
42227	T	Lengthening of palate	0256	26.61	$1,354.56	$623.05	$270.91
42235	T	Repair palate	0253	12.33	$627.65	$284.00	$125.53
42260	T	Repair nose to lip fistula	0254	17.37	$884.20	$272.41	$176.84
42280	T	Preparation, palate mold	0251	2.43	$123.70	$27.99	$24.74
42281	T	Insertion, palate prosthesis	0253	12.33	$627.65	$284.00	$125.53
42299	T	Palate/uvula surgery	0251	2.43	$123.70	$27.99	$24.74
42300	T	Drainage of salivary gland	0253	12.33	$627.65	$284.00	$125.53
42305	T	Drainage of salivary gland	0253	12.33	$627.65	$284.00	$125.53
42310	T	Drainage of salivary gland	0251	2.43	$123.70	$27.99	$24.74
42320	T	Drainage of salivary gland	0251	2.43	$123.70	$27.99	$24.74
42325	T	Create salivary cyst drain	0251	2.43	$123.70	$27.99	$24.74
42326	T	Create salivary cyst drain	0252	5.95	$302.88	$114.24	$60.58
42330	T	Removal of salivary stone	0252	5.95	$302.88	$114.24	$60.58
42335	T	Removal of salivary stone	0253	12.33	$627.65	$284.00	$125.53
42340	T	Removal of salivary stone	0253	12.33	$627.65	$284.00	$125.53
42400	T	Biopsy of salivary gland	0004	2.47	$125.73	$32.57	$25.15
42405	T	Biopsy of salivary gland	0253	12.33	$627.65	$284.00	$125.53
42408	T	Excision of salivary cyst	0253	12.33	$627.65	$284.00	$125.53
42409	T	Drainage of salivary cyst	0253	12.33	$627.65	$284.00	$125.53
42410	T	Excise parotid gland/lesion	0256	26.61	$1,354.56	$623.05	$270.91
42415	T	Excise parotid gland/lesion	0256	26.61	$1,354.56	$623.05	$270.91
42420	T	Excise parotid gland/lesion	0256	26.61	$1,354.56	$623.05	$270.91
42425	T	Excise parotid gland/lesion	0256	26.61	$1,354.56	$623.05	$270.91
42426	C	Excise parotid gland/lesion					
42440	T	Excise submaxillary gland	0256	26.61	$1,354.56	$623.05	$270.91
42450	T	Excise sublingual gland	0254	17.37	$884.20	$272.41	$176.84
42500	T	Repair salivary duct	0254	17.37	$884.20	$272.41	$176.84
42505	T	Repair salivary duct	0256	26.61	$1,354.56	$623.05	$270.91
42507	T	Parotid duct diversion	0256	26.61	$1,354.56	$623.05	$270.91
42508	T	Parotid duct diversion	0256	26.61	$1,354.56	$623.05	$270.91
42509	T	Parotid duct diversion	0256	26.61	$1,354.56	$623.05	$270.91
42510	T	Parotid duct diversion	0256	26.61	$1,354.56	$623.05	$270.91
42550	N	Injection for salivary x-ray					
42600	T	Closure of salivary fistula	0253	12.33	$627.65	$284.00	$125.53
42650	T	Dilation of salivary duct	0252	5.95	$302.88	$114.24	$60.58
42660	T	Dilation of salivary duct	0252	5.95	$302.88	$114.24	$60.58
42665	T	Ligation of salivary duct	0254	17.37	$884.20	$272.41	$176.84
42699	T	Salivary surgery procedure	0253	12.33	$627.65	$284.00	$125.53
42700	T	Drainage of tonsil abscess	0251	2.43	$123.70	$27.99	$24.74
42720	T	Drainage of throat abscess	0253	12.33	$627.65	$284.00	$125.53
42725	T	Drainage of throat abscess	0256	26.61	$1,354.56	$623.05	$270.91
42800	T	Biopsy of throat	0252	5.95	$302.88	$114.24	$60.58
42802	T	Biopsy of throat	0253	12.33	$627.65	$284.00	$125.53
42804	T	Biopsy of upper nose/throat	0253	12.33	$627.65	$284.00	$125.53
42806	T	Biopsy of upper nose/throat	0254	17.37	$884.20	$272.41	$176.84
42808	T	Excise pharynx lesion	0253	12.33	$627.65	$284.00	$125.53
42809	X	Remove pharynx foreign body	0340	0.84	$42.76	$10.69	$8.55

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
42810	T	Excision of neck cyst	0254	17.37	$884.20	$272.41	$176.84
42815	T	Excision of neck cyst	0256	26.61	$1,354.56	$623.05	$270.91
42820	T	Remove tonsils and adenoids	0258	17.43	$887.26	$434.76	$177.45
42821	T	Remove tonsils and adenoids	0258	17.43	$887.26	$434.76	$177.45
42825	T	Removal of tonsils	0258	17.43	$887.26	$434.76	$177.45
42826	T	Removal of tonsils	0258	17.43	$887.26	$434.76	$177.45
42830	T	Removal of adenoids	0258	17.43	$887.26	$434.76	$177.45
42831	T	Removal of adenoids	0258	17.43	$887.26	$434.76	$177.45
42835	T	Removal of adenoids	0258	17.43	$887.26	$434.76	$177.45
42836	T	Removal of adenoids	0258	17.43	$887.26	$434.76	$177.45
42842	C	Extensive surgery of throat					
42844	T	Extensive surgery of throat	0256	26.61	$1,354.56	$623.05	$270.91
42845	C	Extensive surgery of throat					
42860	T	Excision of tonsil tags	0258	17.43	$887.26	$434.76	$177.45
42870	T	Excision of lingual tonsil	0258	17.43	$887.26	$434.76	$177.45
42890	T	Partial removal of pharynx	0256	26.61	$1,354.56	$623.05	$270.91
42892	T	Revision of pharyngeal walls	0256	26.61	$1,354.56	$623.05	$270.91
42894	C	Revision of pharyngeal walls					
42900	T	Repair throat wound	0252	5.95	$302.88	$114.24	$60.58
42950	T	Reconstruction of throat	0254	17.37	$884.20	$272.41	$176.84
42953	C	Repair throat, esophagus					
42955	T	Surgical opening of throat	0254	17.37	$884.20	$272.41	$176.84
42960	T	Control throat bleeding	0250	2.10	$106.90	$37.42	$21.38
42961	C	Control throat bleeding					
42962	T	Control throat bleeding	0256	26.61	$1,354.56	$623.05	$270.91
42970	T	Control nose/throat bleeding	0250	2.10	$106.90	$37.42	$21.38
42971	C	Control nose/throat bleeding					
42972	T	Control nose/throat bleeding	0253	12.33	$627.65	$284.00	$125.53
42999	T	Throat surgery procedure	0252	5.95	$302.88	$114.24	$60.58
43020	T	Incision of esophagus	0252	5.95	$302.88	$114.24	$60.58
43030	C	Throat muscle surgery					
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	Parital removal of esophagus					
43123	C	Partial removal of esophagus					
43124	C	Removal of esophagus					
43130	T	Removal of esophagus pouch	0254	17.37	$884.20	$272.41	$176.84
43135	C	Removal of esophagus pouch					
43200	T	Esophagus endoscopy	0141	7.21	$367.02	$184.67	$73.40
43202	T	Esophagus endoscopy, biopsy	0141	7.21	$367.02	$184.67	$73.40
43204	T	Esophagus endoscopy & inject	0141	7.21	$367.02	$184.67	$73.40
43205	T	Esophagus endoscopy/ligation	0141	7.21	$367.02	$184.67	$73.40
43215	T	Esophagus endoscopy	0141	7.21	$367.02	$184.67	$73.40
43216	T	Esophagus endoscopy/lesion	0141	7.21	$367.02	$184.67	$73.40
43217	T	Esophagus endoscopy	0141	7.21	$367.02	$184.67	$73.40
43219	T	Esophagus endoscopy	0141	7.21	$367.02	$184.67	$73.40
43220	T	Esoph endoscopy, dilation	0141	7.21	$367.02	$184.67	$73.40
43226	T	Esoph endoscopy, dilation	0141	7.21	$367.02	$184.67	$73.40
43227	T	Esoph endoscopy, repair	0141	7.21	$367.02	$184.67	$73.40
43228	T	Esoph endoscopy, ablation	0141	7.21	$367.02	$184.67	$73.40
43231	T	Esoph endoscopy w/us exam	0141	7.21	$367.02	$184.67	$73.40
43232	T	Esoph endoscopy w/us fn bx	0141	7.21	$367.02	$184.67	$73.40
43234	T	Upper GI endoscopy, exam	0141	7.21	$367.02	$184.67	$73.40
43235	T	Uppr gi endoscopy, diagnosis	0141	7.21	$367.02	$184.67	$73.40
43239	T	Upper GI endoscopy, biopsy	0141	7.21	$367.02	$184.67	$73.40
43240	T	Esoph endoscope w/drain cyst	0141	7.21	$367.02	$184.67	$73.40
43241	T	Upper GI endoscopy with tube	0141	7.21	$367.02	$184.67	$73.40
43242	T	Uppr gi endoscopy w/us fn bx	0141	7.21	$367.02	$184.67	$73.40
43243	T	Upper gi endoscopy & inject	0141	7.21	$367.02	$184.67	$73.40
43244	T	Upper GI endoscopy/ligation	0141	7.21	$367.02	$184.67	$73.40
43245	T	Operative upper GI endoscopy	0141	7.21	$367.02	$184.67	$73.40
43246	T	Place gastrostomy tube	0141	7.21	$367.02	$184.67	$73.40
43247	T	Operative upper GI endoscopy	0141	7.21	$367.02	$184.67	$73.40
43248	T	Uppr gi endoscopy/guide wire	0141	7.21	$367.02	$184.67	$73.40
43249	T	Esoph endoscopy, dilation	0141	7.21	$367.02	$184.67	$73.40
43250	T	Upper GI endoscopy/tumor	0141	7.21	$367.02	$184.67	$73.40

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43251	T	Operative upper GI endoscopy	0141	7.21	$367.02	$184.67	$73.40
43255	T	Operative upper GI endoscopy	0141	7.21	$367.02	$184.67	$73.40
43256	T	Uppr gi endoscopy w stent	0141	7.21	$367.02	$184.67	$73.40
43258	T	Operative upper GI endoscopy	0141	7.21	$367.02	$184.67	$73.40
43259	T	Endoscopic ultrasound exam	0141	7.21	$367.02	$184.67	$73.40
43260	T	Endo cholangiopancreatograph	0151	15.29	$778.32	$245.46	$155.66
43261	T	Endo cholangiopancreatograph	0151	15.29	$778.32	$245.46	$155.66
43262	T	Endo cholangiopancreatograph	0151	15.29	$778.32	$245.46	$155.66
43263	T	Endo cholangiopancreatograph	0151	15.29	$778.32	$245.46	$155.66
43264	T	Endo cholangiopancreatograph	0151	15.29	$778.32	$245.46	$155.66
43265	T	Endo cholangiopancreatograph	0151	15.29	$778.32	$245.46	$155.66
43267	T	Endo cholangiopancreatograph	0151	15.29	$778.32	$245.46	$155.66
43268	T	Endo cholangiopancreatograph	0151	15.29	$778.32	$245.46	$155.66
43269	T	Endo cholangiopancreatograph	0151	15.29	$778.32	$245.46	$155.66
43271	T	Endo cholangiopancreatograph	0151	15.29	$778.32	$245.46	$155.66
43272	T	Endo cholangiopancreatograph	0151	15.29	$778.32	$245.46	$155.66
43280	T	Laparoscopy, fundoplasty	0132	56.06	$2,853.68	$1,239.22	$570.74
43289	T	Laparoscope proc, esoph	0130	25.91	$1,318.92	$659.53	$263.78
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 congential					
*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	5.65	$287.61	$107.24	$57.52
43453	T	Dilate esophagus	0140	5.65	$287.61	$107.24	$57.52
43456	T	Dilate esophagus	0140	5.65	$287.61	$107.24	$57.52
43458	T	Dilate esophagus	0140	5.65	$287.61	$107.24	$57.52
43460	C	Pressure treatment esophagus					
43496	C	Free jejunum flap, microvasc					
43499	T	Esophagus surgery procedure	0140	5.65	$287.61	$107.24	$57.52
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	7.21	$367.02	$184.67	$73.40
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	56.06	$2,853.68	$1,239.22	$570.74
43652	T	Laparoscopy, vagus nerve	0132	56.06	$2,853.68	$1,239.22	$570.74
43653	T	Laparoscopy, gastrostomy	0131	37.63	$1,915.52	$996.07	$383.10

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43659	T	Laparoscope proc, stom	0130	25.91	$1,318.92	$659.53	$263.78
43750	T	Place gastrostomy tube	0141	7.21	$367.02	$184.67	$73.40
43752	E	Nasal/orogastric w/stent					
43760	T	Change gastrostomy tube	0121	2.54	$129.30	$52.53	$25.86
43761	T	Reposition gastrostomy tube	0121	2.54	$129.30	$52.53	$25.86
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	7.21	$367.02	$184.67	$73.40
43831	T	Place gastrostomy tube	0141	7.21	$367.02	$184.67	$73.40
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	0025	3.39	$172.56	$65.57	$34.51
43880	C	Repair stomach-bowel fistula					
43999	T	Stomach surgery procedure	0121	2.54	$129.30	$52.53	$25.86
44005	C	Freeing of bowel adhesion					
44010	C	Incision of small bowel					
44015	C	Insert needle cath bowel					
44020	C	Exploration of small bowel					
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	7.21	$367.02	$184.67	$73.40
44110	C	Excision of bowel 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/taper, cong					
*44127	C	Enterectomy w/o 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	37.63	$1,915.52	$996.07	$383.10
44201	T	Laparoscopy, jejunostomy	0131	37.63	$1,915.52	$996.07	$383.10
44202	C	Laparo, resect intestine					
*44203	C	Lap resect s/intestine, addl					
*44204	C	Laparo partial colectomy					
*44205	C	Lap colectomy part w/ileum					
44209	T	Laparoscope proc, intestine	0130	25.91	$1,318.92	$659.53	$263.78
44300	C	Open bowel to skin					
44310	C	Ileostomy/jejunostomy					
44312	T	Revision of ileostomy	0026	12.62	$642.41	$277.92	$128.48
44314	C	Revision of ileostomy					
44316	C	Devise bowel pouch					
44320	C	Colostomy					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
44322	C	Colostomy with biopsies					
44340	T	Revision of colostomy	0026	12.62	$642.41	$277.92	$128.48
44345	C	Revision of colostomy					
44346	C	Revision of colostomy					
44360	T	Small bowel endoscopy	0142	6.94	$353.27	$151.91	$70.65
44361	T	Small bowel endoscopy/biopsy	0142	6.94	$353.27	$151.91	$70.65
44363	T	Small bowel endoscopy	0142	6.94	$353.27	$151.91	$70.65
44364	T	Small bowel endoscopy	0142	6.94	$353.27	$151.91	$70.65
44365	T	Small bowel endoscopy	0142	6.94	$353.27	$151.91	$70.65
44366	T	Small bowel endoscopy	0142	6.94	$353.27	$151.91	$70.65
44369	T	Small bowel endoscopy	0142	6.94	$353.27	$151.91	$70.65
44370	T	Small bowel endoscopy/stent	0142	6.94	$353.27	$151.91	$70.65
44372	T	Small bowel endoscopy	0142	6.94	$353.27	$151.91	$70.65
44373	T	Small bowel endoscopy	0142	6.94	$353.27	$151.91	$70.65
44376	T	Small bowel endoscopy	0142	6.94	$353.27	$151.91	$70.65
44377	T	Small bowel endoscopy/biopsy	0142	6.94	$353.27	$151.91	$70.65
44378	T	Small bowel endoscopy	0142	6.94	$353.27	$151.91	$70.65
44379	T	S bowel endoscope w/stent	0142	6.94	$353.27	$151.91	$70.65
44380	T	Small bowel endoscopy	0142	6.94	$353.27	$151.91	$70.65
44382	T	Small bowel endoscopy	0142	6.94	$353.27	$151.91	$70.65
44383	T	Ileoscopy w/stent	0142	6.94	$353.27	$151.91	$70.65
44385	T	Endoscopy of bowel pouch	0143	7.27	$370.07	$185.04	$74.01
44386	T	Endoscopy, bowel pouch/biop	0143	7.27	$370.07	$185.04	$74.01
44388	T	Colon endoscopy	0143	7.27	$370.07	$185.04	$74.01
44389	T	Colonoscopy with biopsy	0143	7.27	$370.07	$185.04	$74.01
44390	T	Colonoscopy for foreign body	0143	7.27	$370.07	$185.04	$74.01
44391	T	Colonoscopy for bleeding	0143	7.27	$370.07	$185.04	$74.01
44392	T	Colonoscopy & polypectomy	0143	7.27	$370.07	$185.04	$74.01
44393	T	Colonoscopy, lesion removal	0143	7.27	$370.07	$185.04	$74.01
44394	T	Colonoscopy w/snare	0143	7.27	$370.07	$185.04	$74.01
44397	T	Colonoscopy w stent	0143	7.27	$370.07	$185.04	$74.01
44500	T	Intro, gastrointestinal tube	0121	2.54	$129.30	$52.53	$25.86
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					
44799	T	Intestine surgery procedure	0142	6.94	$353.27	$151.91	$70.65
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	25.91	$1,318.92	$659.53	$263.78
44979	T	Laparoscope proc, app	0130	25.91	$1,318.92	$659.53	$263.78
45000	T	Drainage of pelvic abscess	0149	13.53	$688.73	$293.06	$137.75
45005	T	Drainage of rectal abscess	0148	2.40	$122.17	$43.59	$24.43
45020	T	Drainage of rectal abscess	0149	13.53	$688.73	$293.06	$137.75
45100	T	Biopsy of rectum	0149	13.53	$688.73	$293.06	$137.75
45108	T	Removal of anorectal lesion	0150	18.08	$920.34	$437.12	$184.07
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
45135	C	Excision of rectal prolapse					
*45136	C	Excise ileoanal reservoir					
45150	T	Excision of rectal stricture	0150	18.08	$920.34	$437.12	$184.07
45160	T	Excision of rectal lesion	0150	18.08	$920.34	$437.12	$184.07
45170	T	Excision of rectal lesion	0150	18.08	$920.34	$437.12	$184.07
45190	T	Destruction, rectal tumor	0150	18.08	$920.34	$437.12	$184.07
45300	T	Proctosigmoidoscopy dx	0146	2.73	$138.97	$63.93	$27.79
45303	T	Proctosigmoidoscopy dilate	0146	2.73	$138.97	$63.93	$27.79
45305	T	Protosigmoidoscopy w/bx	0146	2.73	$138.97	$63.93	$27.79
45307	T	Protosigmoidoscopy fb	0146	2.73	$138.97	$63.93	$27.79
45308	T	Protosigmoidoscopy removal	0147	5.71	$290.66	$136.61	$58.13
45309	T	Protosigmoidoscopy removal	0147	5.71	$290.66	$136.61	$58.13
45315	T	Protosigmoidoscopy removal	0147	5.71	$290.66	$136.61	$58.13
45317	T	Protosigmoidoscopy bleed	0146	2.73	$138.97	$63.93	$27.79
45320	T	Protosigmoidoscopy ablate	0147	5.71	$290.66	$136.61	$58.13
45321	T	Protosigmoidoscopy volvul	0147	5.71	$290.66	$136.61	$58.13
45327	T	Proctosigmoidoscopy w/stent	0147	5.71	$290.66	$136.61	$58.13
45330	T	Diagnostic sigmoidoscopy	0146	2.73	$138.97	$63.93	$27.79
45331	T	Sigmoidoscopy and biopsy	0146	2.73	$138.97	$63.93	$27.79
45332	T	Sigmoidoscopy w/fb removal	0146	2.73	$138.97	$63.93	$27.79
45333	T	Sigmoidoscopy & polypectomy	0147	5.71	$290.66	$136.61	$58.13
45334	T	Sigmoidoscopy for bleeding	0147	5.71	$290.66	$136.61	$58.13
45337	T	Sigmoidoscopy & decompress	0147	5.71	$290.66	$136.61	$58.13
45338	T	Sigmoidoscpy w/tumr remove	0147	5.71	$290.66	$136.61	$58.13
45339	T	Sigmoidoscopy w/ablate tumr	0147	5.71	$290.66	$136.61	$58.13
45341	T	Sigmoidoscopy w/ultrasound	0147	5.71	$290.66	$136.61	$58.13
45342	T	Sigmoidoscopy w/us guide bx	0147	5.71	$290.66	$136.61	$58.13
45345	T	Sigmodoscopy w/stent	0147	5.71	$290.66	$136.61	$58.13
45355	T	Surgical colonoscopy	0143	7.27	$370.07	$185.04	$74.01
45378	T	Diagnostic colonoscopy	0143	7.27	$370.07	$185.04	$74.01
45379	T	Colonoscopy w/fb removal	0143	7.27	$370.07	$185.04	$74.01
45380	T	Colonoscopy and biopsy	0143	7.27	$370.07	$185.04	$74.01
45382	T	Colonoscopy/control bleeding	0143	7.27	$370.07	$185.04	$74.01
45383	T	Lesion removal colonoscopy	0143	7.27	$370.07	$185.04	$74.01
45384	T	Lesion remove colonoscopy	0143	7.27	$370.07	$185.04	$74.01
45385	T	Lesion removal colonoscopy	0143	7.27	$370.07	$185.04	$74.01
45387	T	Colonoscopy w/stent	0143	7.27	$370.07	$185.04	$74.01
45500	T	Repair of rectum	0150	18.08	$920.34	$437.12	$184.07
45505	T	Repair of rectum	0150	18.08	$920.34	$437.12	$184.07
45520	T	Treatment of rectal prolapse	0098	1.24	$63.12	$20.88	$12.62
45540	C	Correct rectal prolapse					
45541	C	Correct rectal prolapse					
45550	C	Repair rectum/remove sigmoid					
45560	T	Repair of rectocele	0150	18.08	$920.34	$437.12	$184.07
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	2.40	$122.17	$43.59	$24.43
45905	T	Dilation of anal sphincter	0149	13.53	$688.73	$293.06	$137.75
45910	T	Dilation of rectal narrowing	0149	13.53	$688.73	$293.06	$137.75
45915	T	Remove rectal obstruction	0148	2.40	$122.17	$43.59	$24.43
45999	T	Rectum surgery procedure	0148	2.40	$122.17	$43.59	$24.43
*46020	T	Placement of seton	0148	2.40	$122.17	$43.59	$24.43
46030	N	Removal of rectal marker					
46040	T	Incision of rectal abscess	0155	5.26	$267.76		$53.55
46045	T	Incision of rectal abscess	0150	18.08	$920.34	$437.12	$184.07
46050	T	Incision of anal abscess	0148	2.40	$122.17	$43.59	$24.43
46060	T	Incision of rectal abscess	0150	18.08	$920.34	$437.12	$184.07
46070	T	Incision of anal septum	0155	5.26	$267.76		$53.55
46080	T	Incision of anal sphincter	0149	13.53	$688.73	$293.06	$137.75
46083	T	Incise external hemorrhoid	0148	2.40	$122.17	$43.59	$24.43
46200	T	Removal of anal fissure	0150	18.08	$920.34	$437.12	$184.07
46210	T	Removal of anal crypt	0149	13.53	$688.73	$293.06	$137.75
46211	T	Removal of anal crypts	0150	18.08	$920.34	$437.12	$184.07
46220	T	Removal of anal tab	0149	13.53	$688.73	$293.06	$137.75
46221	T	Ligation of hemorrhoid(s)	0155	5.26	$267.76		$53.55
46230	T	Removal of anal tabs	0149	13.53	$688.73	$293.06	$137.75
46250	T	Hemorrhoidectomy	0150	18.08	$920.34	$437.12	$184.07
46255	T	Hemorrhoidectomy	0150	18.08	$920.34	$437.12	$184.07
46257	T	Remove hemorrhoids & fissure	0150	18.08	$920.34	$437.12	$184.07
46258	T	Remove hemorrhoids & fistula	0150	18.08	$920.34	$437.12	$184.07
46260	T	Hemorrhoidectomy	0150	18.08	$920.34	$437.12	$184.07

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
46261	T	Remove hemorrhoids & fissure	0150	18.08	$920.34	$437.12	$184.07
46262	T	Remove hemorrhoids & fistula	0150	18.08	$920.34	$437.12	$184.07
46270	T	Removal of anal fistula	0150	18.08	$920.34	$437.12	$184.07
46275	T	Removal of anal fistula	0150	18.08	$920.34	$437.12	$184.07
46280	T	Removal of anal fistula	0150	18.08	$920.34	$437.12	$184.07
46285	T	Removal of anal fistula	0150	18.08	$920.34	$437.12	$184.07
46288	T	Repair anal fistula	0150	18.08	$920.34	$437.12	$184.07
46320	T	Removal of hemorrhoid clot	0155	5.26	$267.76		$53.55
46500	T	Injection into hemorrhoids	0155	5.26	$267.76		$53.55
46600	N	Diagnostic anoscopy					
46604	T	Anoscopy and dilation	0144	4.43	$225.50	$49.32	$45.10
46606	T	Anoscopy and biopsy	0145	10.81	$550.27	$179.39	$110.05
46608	T	Anoscopy/ remove for body	0144	4.43	$225.50	$49.32	$45.10
46610	T	Anoscopy/remove lesion	0145	10.81	$550.27	$179.39	$110.05
46611	T	Anoscopy	0145	10.81	$550.27	$179.39	$110.05
46612	T	Anoscopy/ remove lesions	0145	10.81	$550.27	$179.39	$110.05
46614	T	Anoscopy/control bleeding	0145	10.81	$550.27	$179.39	$110.05
46615	T	Anoscopy	0145	10.81	$550.27	$179.39	$110.05
46700	T	Repair of anal stricture	0150	18.08	$920.34	$437.12	$184.07
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					
46750	T	Repair of anal sphincter	0150	18.08	$920.34	$437.12	$184.07
46751	C	Repair of anal sphincter					
46753	T	Reconstruction of anus	0150	18.08	$920.34	$437.12	$184.07
46754	T	Removal of suture from anus	0149	13.53	$688.73	$293.06	$137.75
46760	T	Repair of anal sphincter	0150	18.08	$920.34	$437.12	$184.07
46761	T	Repair of anal sphincter	0150	18.08	$920.34	$437.12	$184.07
46762	T	Implant artificial sphincter	0150	18.08	$920.34	$437.12	$184.07
46900	T	Destruction, anal lesion(s)	0016	3.02	$153.73	$64.57	$30.75
46910	T	Destruction, anal lesion(s)	0017	9.68	$492.75	$226.67	$98.55
46916	T	Cryosurgery, anal lesion(s)	0013	1.36	$69.23	$17.66	$13.85
46917	T	Laser surgery, anal lesions	0695	15.78	$803.27	$369.50	$160.65
46922	T	Excision of anal lesion(s)	0695	15.78	$803.27	$369.50	$160.65
46924	T	Destruction, anal lesion(s)	0695	15.78	$803.27	$369.50	$160.65
46934	T	Destruction of hemorrhoids	0155	5.26	$267.76		$53.55
46935	T	Destruction of hemorrhoids	0155	5.26	$267.76		$53.55
46936	T	Destruction of hemorrhoids	0149	13.53	$688.73	$293.06	$137.75
46937	T	Cryotherapy of rectal lesion	0149	13.53	$688.73	$293.06	$137.75
46938	T	Cryotherapy of rectal lesion	0150	18.08	$920.34	$437.12	$184.07
46940	T	Treatment of anal fissure	0149	13.53	$688.73	$293.06	$137.75
46942	T	Treatment of anal fissure	0149	13.53	$688.73	$293.06	$137.75
46945	T	Ligation of hemorrhoids	0155	5.26	$267.76		$53.55
46946	T	Ligation of hemorrhoids	0155	5.26	$267.76		$53.55
46999	T	Anus surgery procedure	0149	13.53	$688.73	$293.06	$137.75
47000	T	Needle biopsy of liver	0685	9.16	$466.28	$205.16	$93.26
47001	C	Needle biopsy, liver add-on					
47010	C	Open drainage, liver lesion					
47011	T	Percut drain, liver lesion	0005	4.03	$205.14	$90.26	$41.03
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	Partial removal, donor liver					
47135	C	Transplantation of liver					
47136	C	Transplantation of liver					
47300	C	Surgery for liver lesion					
47350	C	Repair liver wound					
47360	C	Repair liver wound					
47361	C	Repair liver wound					
47362	C	Repair liver wound					
*47370	T	Laparo ablate liver tumor rf	0130	25.91	$1,318.92	$659.53	$263.78
*47371	T	Laparo ablate liver cryosug	0130	25.91	$1,318.92	$659.53	$263.78
47379	T	Laparoscope procedure, liver	0130	25.91	$1,318.92	$659.53	$263.78
*47380	C	Open ablate liver tumor rf					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
*47381	C	Open ablate liver tumor cryo					
*47382	T	Percut ablate liver rf	0152	16.13	$821.08	$207.38	$164.22
47399	T	Liver surgery procedure	0005	4.03	$205.14	$90.26	$41.03
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					
47490	C	Incision of gallbladder					
47500	N	Injection for liver x-rays					
47505	N	Injection for liver x-rays					
47510	T	Insert catheter, bile duct	0152	16.13	$821.08	$207.38	$164.22
47511	T	Insert bile duct drain	0152	16.13	$821.08	$207.38	$164.22
47525	T	Change bile duct catheter	0122	9.89	$503.44	$114.93	$100.69
47530	T	Revise/reinsert bile tube	0121	2.54	$129.30	$52.53	$25.86
47550	C	Bile duct endoscopy add-on					
47552	T	Biliary endoscopy thru skin	0152	16.13	$821.08	$207.38	$164.22
47553	T	Biliary endoscopy thru skin	0152	16.13	$821.08	$207.38	$164.22
47554	T	Biliary endoscopy thru skin	0152	16.13	$821.08	$207.38	$164.22
47555	T	Biliary endoscopy thru skin	0152	16.13	$821.08	$207.38	$164.22
47556	T	Biliary endoscopy thru skin	0152	16.13	$821.08	$207.38	$164.22
47560	T	Laparoscopy w/cholangio	0130	25.91	$1,318.92	$659.53	$263.78
47561	T	Laparo w/cholangio/biopsy	0130	25.91	$1,318.92	$659.53	$263.78
47562	T	Laparoscopic cholecystectomy	0131	37.63	$1,915.52	$996.07	$383.10
47563	T	Laparo cholecystectomy/graph	0131	37.63	$1,915.52	$996.07	$383.10
47564	T	Laparo cholecystectomy/explr	0131	37.63	$1,915.52	$996.07	$383.10
47570	C	Laparo cholecystoenterostomy					
47579	T	Laparoscope proc, biliary	0130	25.91	$1,318.92	$659.53	$263.78
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	16.13	$821.08	$207.38	$164.22
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	0121	2.54	$129.30	$52.53	$25.86
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					
48102	T	Needle biopsy, pancreas	0685	9.16	$466.28	$205.16	$93.26
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 pancreas cyst					
48510	C	Drain pancreatic pseudocyst					
48511	S	Drain pancreatic pseudocyst	0005	4.03	$205.14	$90.26	$41.03

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
48999	T	Pancreas surgery procedure	0005	4.03	$205.14	$90.26	$41.03
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	4.58	$233.14	$79.60	$46.63
49081	T	Removal of abdominal fluid	0070	4.58	$233.14	$79.60	$46.63
49085	T	Remove abdomen foreign body	0153	23.55	$1,198.79	$496.31	$239.76
49180	T	Biopsy, abdominal mass	0685	9.16	$466.28	$205.16	$93.26
49200	T	Removal of abdominal lesion	0130	25.91	$1,318.92	$659.53	$263.78
49201	C	Removal of abdominal lesion					
49215	C	Excise sacral spine tumor					
49220	C	Multiple surgery, abdomen					
49250	T	Excision of umbilicus	0153	23.55	$1,198.79	$496.31	$239.76
49255	C	Removal of omentum					
49320	T	Diag laparo separate proc	0130	25.91	$1,318.92	$659.53	$263.78
49321	T	Laparoscopy, biopsy	0130	25.91	$1,318.92	$659.53	$263.78
49322	T	Laparoscopy, aspiration	0130	25.91	$1,318.92	$659.53	$263.78
49323	T	Laparo drain lymphocele	0130	25.91	$1,318.92	$659.53	$263.78
49329	T	Laparo proc, abdm/per/oment	0130	25.91	$1,318.92	$659.53	$263.78
49400	N	Air injection into abdomen					
49420	T	Insert abdominal drain	0153	23.55	$1,198.79	$496.31	$239.76
49421	T	Insert abdominal drain	0153	23.55	$1,198.79	$496.31	$239.76
49422	T	Remove perm cannula/catheter	0105	14.76	$751.34	$368.16	$150.27
49423	T	Exchange drainage catheter	0153	23.55	$1,198.79	$496.31	$239.76
49424	N	Assess cyst, contrast inject					
49425	C	Insert abdomen-venous drain					
49426	T	Revise abdomen-venous shunt	0153	23.55	$1,198.79	$496.31	$239.76
49427	N	Injection, abdominal shunt					
49428	C	Ligation of shunt					
49429	T	Removal of shunt	0105	14.76	$751.34	$368.16	$150.27
*49491	T	Repairing hern premie reduc	0154	31.40	$1,598.39	$556.98	$319.68
*49492	T	Rpr ing hern premie, blocked	0154	31.40	$1,598.39	$556.98	$319.68
49495	T	Repair inguinal hernia, init	0154	31.40	$1,598.39	$556.98	$319.68
49496	T	Repair inguinal hernia, init	0154	31.40	$1,598.39	$556.98	$319.68
49500	T	Repair inguinal hernia	0154	31.40	$1,598.39	$556.98	$319.68
49501	T	Repair inguinal hernia, init	0154	31.40	$1,598.39	$556.98	$319.68
49505	T	Repair inguinal hernia	0154	31.40	$1,598.39	$556.98	$319.68
49507	T	Repair inguinal hernia	0154	31.40	$1,598.39	$556.98	$319.68
49520	T	Rerepair inguinal hernia	0154	31.40	$1,598.39	$556.98	$319.68
49521	T	Repair inguinal hernia, rec	0154	31.40	$1,598.39	$556.98	$319.68
49525	T	Repair inguinal hernia	0154	31.40	$1,598.39	$556.98	$319.68
49540	T	Repair lumbar hernia	0154	31.40	$1,598.39	$556.98	$319.68
49550	T	Repair femoral hernia	0154	31.40	$1,598.39	$556.98	$319.68
49553	T	Repair femoral hernia, init	0154	31.40	$1,598.39	$556.98	$319.68
49555	T	Repair femoral hernia	0154	31.40	$1,598.39	$556.98	$319.68
49557	T	Repair femoral hernia, recur	0154	31.40	$1,598.39	$556.98	$319.68
49560	T	Repair abdominal hernia	0154	31.40	$1,598.39	$556.98	$319.68
49561	T	Repair incisional hernia	0154	31.40	$1,598.39	$556.98	$319.68
49565	T	Rerepair abdominal hernia	0154	31.40	$1,598.39	$556.98	$319.68
49566	T	Repair incisional hernia	0154	31.40	$1,598.39	$556.98	$319.68
49568	T	Hernia repair w/mesh	0154	31.40	$1,598.39	$556.98	$319.68
49570	T	Repair epigastric hernia	0154	31.40	$1,598.39	$556.98	$319.68
49572	T	Repair epigastric hernia	0154	31.40	$1,598.39	$556.98	$319.68
49580	T	Repair umbilical hernia	0154	31.40	$1,598.39	$556.98	$319.68
49582	T	Repair umbilical hernia	0154	31.40	$1,598.39	$556.98	$319.68
49585	T	Repair umbilical hernia	0154	31.40	$1,598.39	$556.98	$319.68
49587	T	Repair umbilical hernia	0154	31.40	$1,598.39	$556.98	$319.68
49590	T	Repair abdominal hernia	0154	31.40	$1,598.39	$556.98	$319.68
49600	T	Repair umbilical lesion	0154	31.40	$1,598.39	$556.98	$319.68
49605	C	Repair umbilical lesion					
49606	C	Repair umbilical lesion					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
49610	C	Repair umbilical lesion					
49611	C	Repair umbilical lesion					
49650	T	Laparo hernia repair initial	0131	37.63	$1,915.52	$996.07	$383.10
49651	T	Laparo hernia repair recur	0131	37.63	$1,915.52	$996.07	$383.10
49659	T	Laparo proc, hernia repair	0131	37.63	$1,915.52	$996.07	$383.10
49900	C	Repair of abdominal wall					
49905	C	Omental flap					
49906	C	Free omental flap, microvasc					
49999	T	Abdomen surgery procedure	0121	2.54	$129.30	$52.53	$25.86
50010	C	Exploration of kidney					
50020	C	Renal abscess, open drain					
50021	S	Renal abscess, percut drain	0005	4.03	$205.14	$90.26	$41.03
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	40.40	$2,056.52	$792.58	$411.30
50081	T	Removal of kidney stone	0163	40.40	$2,056.52	$792.58	$411.30
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	9.16	$466.28	$205.16	$93.26
50205	C	Biopsy of kidney					
50220	C	Removal of kidney					
50225	C	Removal of kidney					
50230	C	Removal of kidney					
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	9.16	$466.28	$205.16	$93.26
50392	T	Insert kidney drain	0161	13.72	$698.40	$249.36	$139.68
50393	T	Insert ureteral tube	0161	13.72	$698.40	$249.36	$139.68
50394	N	Injection for kidney x-ray					
50395	T	Create passage to kidney	0161	13.72	$698.40	$249.36	$139.68
50396	T	Measure kidney pressure	0164	1.01	$51.41	$15.42	$10.28
50398	T	Change kidney tube	0122	9.89	$503.44	$114.93	$100.69
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	25.91	$1,318.92	$659.53	$263.78
50544	T	Laparoscopy, pyeloplasty	0130	25.91	$1,318.92	$659.53	$263.78
50545	C	Laparo radical nephrectomy					
50546	C	Laparoscopic nephrectomy					
50547	C	Laparo removal donor kidney					
50548	C	Laparo remove k/ureter					
50549	T	Laparoscope proc, renal	0130	25.91	$1,318.92	$659.53	$263.78
50551	T	Kidney endoscopy	0160	5.13	$261.14	$104.46	$52.23
50553	T	Kidney endoscopy	0161	13.72	$698.40	$249.36	$139.68
50555	T	Kidney endoscopy & biopsy	0160	5.13	$261.14	$104.46	$52.23
50557	T	Kidney endoscopy & treatment	0162	25.09	$1,277.18	$427.49	$255.44
50559	T	Renal endoscopy/radiotracer	0160	5.13	$261.14	$104.46	$52.23
50561	T	Kidney endoscopy & treatment	0161	13.72	$698.40	$249.36	$139.68
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
50580	C	Kidney endoscopy & treatment					
50590	T	Fragmenting of kidney stone	0169	39.62	$2,016.82	$1,109.25	$403.36
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	1.01	$51.41	$15.42	$10.28
50688	T	Change of ureter tube	0121	2.54	$129.30	$52.53	$25.86
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 bowel					
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	37.63	$1,915.52	$996.07	$383.10
50947	T	Laparo new ureter/bladder	0131	37.63	$1,915.52	$996.07	$383.10
50948	T	Laparo new ureter/bladder	0131	37.63	$1,915.52	$996.07	$383.10
50949	T	Laparoscope proc, ureter	0130	25.91	$1,318.92	$659.53	$263.78
50951	T	Endoscopy of ureter	0160	5.13	$261.14	$104.46	$52.23
50953	T	Endoscopy of ureter	0160	5.13	$261.14	$104.46	$52.23
50955	T	Ureter endoscopy & biopsy	0161	13.72	$698.40	$249.36	$139.68
50957	T	Ureter endoscopy & treatment	0161	13.72	$698.40	$249.36	$139.68
50959	T	Ureter endoscopy & tracer	0161	13.72	$698.40	$249.36	$139.68
50961	T	Ureter endoscopy & treatment	0161	13.72	$698.40	$249.36	$139.68
50970	T	Ureter endoscopy	0160	5.13	$261.14	$104.46	$52.23
50972	T	Ureter endoscopy & catheter	0160	5.13	$261.14	$104.46	$52.23
50974	T	Ureter endoscopy & biopsy	0161	13.72	$698.40	$249.36	$139.68
50976	T	Ureter endoscopy & treatment	0161	13.72	$698.40	$249.36	$139.68
50978	T	Ureter endoscopy & tracer	0161	13.72	$698.40	$249.36	$139.68
50980	T	Ureter endoscopy & treatment	0161	13.72	$698.40	$249.36	$139.68
51000	T	Drainage of bladder	0165	5.22	$265.72	$91.76	$53.14
51005	T	Drainage of bladder	0156	2.45	$124.71	$37.41	$24.94
51010	T	Drainage of bladder	0165	5.22	$265.72	$91.76	$53.14
51020	T	Incise & treat bladder	0162	25.09	$1,277.18	$427.49	$255.44
51030	T	Incise & treat bladder	0162	25.09	$1,277.18	$427.49	$255.44
51040	T	Incise & drain bladder	0162	25.09	$1,277.18	$427.49	$255.44
51045	T	Incise bladder/drain ureter	0160	5.13	$261.14	$104.46	$52.23
51050	T	Removal of bladder stone	0162	25.09	$1,277.18	$427.49	$255.44
51060	C	Removal of ureter stone					
51065	T	Removal of ureter stone	0162	25.09	$1,277.18	$427.49	$255.44
51080	T	Drainage of bladder abscess	0007	6.75	$343.60	$72.03	$68.72
51500	T	Removal of bladder cyst	0154	31.40	$1,598.39	$556.98	$319.68
51520	T	Removal of bladder lesion	0162	25.09	$1,277.18	$427.49	$255.44
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)					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
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	0156	2.45	$124.71	$37.41	$24.94
51705	T	Change of bladder tube	0121	2.54	$129.30	$52.53	$25.86
51710	T	Change of bladder tube	0121	2.54	$129.30	$52.53	$25.86
51715	T	Endoscopic injection/implant	0167	22.28	$1,134.14	$555.84	$226.83
51720	T	Treatment of bladder lesion	0156	2.45	$124.71	$37.41	$24.94
51725	T	Simple cystometrogram	0165	5.22	$265.72	$91.76	$53.14
51726	T	Complex cystometrogram	0165	5.22	$265.72	$91.76	$53.14
51736	T	Urine flow measurement	0164	1.01	$51.41	$15.42	$10.28
51741	T	Electro-uroflowmetry, first	0164	1.01	$51.41	$15.42	$10.28
51772	T	Urethra pressure profile	0165	5.22	$265.72	$91.76	$53.14
51784	T	Anal/urinary muscle study	0164	1.01	$51.41	$15.42	$10.28
51785	T	Anal/urinary muscle study	0156	2.45	$124.71	$37.41	$24.94
51792	T	Urinary reflex study	0156	2.45	$124.71	$37.41	$24.94
51795	T	Urine voiding pressure study	0165	5.22	$265.72	$91.76	$53.14
51797	T	Intraabdominal pressure test	0165	5.22	$265.72	$91.76	$53.14
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	25.09	$1,277.18	$427.49	$255.44
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	37.63	$1,915.52	$996.07	$383.10
51992	T	Laparo sling operation	0132	56.06	$2,853.68	$1,239.22	$570.74
52000	T	Cystoscopy	0160	5.13	$261.14	$104.46	$52.23
*52001	T	Cystoscopy, removal of clots	0160	5.13	$261.14	$104.46	$52.23
52005	T	Cystoscopy & ureter catheter	0161	13.72	$698.40	$249.36	$139.68
52007	T	Cystoscopy and biopsy	0161	13.72	$698.40	$249.36	$139.68
52010	T	Cystoscopy & duct catheter	0160	5.13	$261.14	$104.46	$52.23
52204	T	Cystoscopy	0161	13.72	$698.40	$249.36	$139.68
52214	T	Cystoscopy and treatment	0162	25.09	$1,277.18	$427.49	$255.44
52224	T	Cystoscopy and treatment	0162	25.09	$1,277.18	$427.49	$255.44
52234	T	Cystoscopy and treatment	0163	40.40	$2,056.52	$792.58	$411.30
52235	T	Cystoscopy and treatment	0163	40.40	$2,056.52	$792.58	$411.30
52240	T	Cystoscopy and treatment	0162	25.09	$1,277.18	$427.49	$255.44
52250	T	Cystoscopy and radiotracer	0162	25.09	$1,277.18	$427.49	$255.44
52260	T	Cystoscopy and treatment	0161	13.72	$698.40	$249.36	$139.68
52265	T	Cystoscopy and treatment	0160	5.13	$261.14	$104.46	$52.23
52270	T	Cystoscopy & revise urethra	0161	13.72	$698.40	$249.36	$139.68
52275	T	Cystoscopy & revise urethra	0161	13.72	$698.40	$249.36	$139.68
52276	T	Cystoscopy and treatment	0161	13.72	$698.40	$249.36	$139.68
52277	T	Cystoscopy and treatment	0162	25.09	$1,277.18	$427.49	$255.44
52281	T	Cystoscopy and treatment	0161	13.72	$698.40	$249.36	$139.68
52282	T	Cystoscopy, implant stent	0163	40.40	$2,056.52	$792.58	$411.30
52283	T	Cystoscopy and treatment	0161	13.72	$698.40	$249.36	$139.68
52285	T	Cystoscopy and treatment	0161	13.72	$698.40	$249.36	$139.68
52290	T	Cystoscopy and treatment	0161	13.72	$698.40	$249.36	$139.68
52300	T	Cystoscopy and treatment	0161	13.72	$698.40	$249.36	$139.68
52301	T	Cystoscopy and treatment	0161	13.72	$698.40	$249.36	$139.68
52305	T	Cystoscopy and treatment	0161	13.72	$698.40	$249.36	$139.68
52310	T	Cystoscopy and treatment	0160	5.13	$261.14	$104.46	$52.23
52315	T	Cystoscopy and treatment	0161	13.72	$698.40	$249.36	$139.68
52317	T	Remove bladder stone	0162	25.09	$1,277.18	$427.49	$255.44
52318	T	Remove bladder stone	0162	25.09	$1,277.18	$427.49	$255.44
52320	T	Cystoscopy and treatment	0162	25.09	$1,277.18	$427.49	$255.44
52325	T	Cystoscopy, stone removal	0162	25.09	$1,277.18	$427.49	$255.44
52327	T	Cystoscopy, inject material	0162	25.09	$1,277.18	$427.49	$255.44

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
52330	T	Cystoscopy and treatment	0162	25.09	$1,277.18	$427.49	$255.44
52332	T	Cystoscopy and treatment	0162	25.09	$1,277.18	$427.49	$255.44
52334	T	Create passage to kidney	0162	25.09	$1,277.18	$427.49	$255.44
52341	T	Cysto w/ureter stricture tx	0162	25.09	$1,277.18	$427.49	$255.44
52342	T	Cysto w/up stricture tx	0162	25.09	$1,277.18	$427.49	$255.44
52343	T	Cysto w/renal stricture tx	0162	25.09	$1,277.18	$427.49	$255.44
52344	T	Cysto/uretero, stone remove	0162	25.09	$1,277.18	$427.49	$255.44
52345	T	Cysto/uretero w/up stricture	0162	25.09	$1,277.18	$427.49	$255.44
52346	T	Cystouretero w/renal strict	0162	25.09	$1,277.18	$427.49	$255.44
*52347	T	Cystoscopy, resect ducts	0160	5.13	$261.14	$104.46	$52.23
52351	T	Cystouretro & or pyeloscope	0160	5.13	$261.14	$104.46	$52.23
52352	T	Cystouretro w/stone remove	0162	25.09	$1,277.18	$427.49	$255.44
52353	T	Cystouretero w/lithotripsy	0163	40.40	$2,056.52	$792.58	$411.30
52354	T	Cystouretero w/biopsy	0162	25.09	$1,277.18	$427.49	$255.44
52355	T	Cystouretero w/excise tumor	0162	25.09	$1,277.18	$427.49	$255.44
52400	T	Cystouretero w/congen repr	0162	25.09	$1,277.18	$427.49	$255.44
52450	T	Incision of prostate	0162	25.09	$1,277.18	$427.49	$255.44
52500	T	Revision of bladder neck	0162	25.09	$1,277.18	$427.49	$255.44
52510	T	Dilation prostatic urethra	0161	13.72	$698.40	$249.36	$139.68
52601	T	Prostatectomy (TURP)	0163	40.40	$2,056.52	$792.58	$411.30
52606	T	Control postop bleeding	0162	25.09	$1,277.18	$427.49	$255.44
52612	T	Prostatectomy, first stage	0163	40.40	$2,056.52	$792.58	$411.30
52614	T	Prostatectomy, second stage	0163	40.40	$2,056.52	$792.58	$411.30
52620	T	Remove residual prostate	0163	40.40	$2,056.52	$792.58	$411.30
52630	T	Remove prostate regrowth	0163	40.40	$2,056.52	$792.58	$411.30
52640	T	Relieve bladder contracture	0162	25.09	$1,277.18	$427.49	$255.44
52647	T	Laser surgery of prostate	0163	40.40	$2,056.52	$792.58	$411.30
52648	T	Laser surgery of prostate	0163	40.40	$2,056.52	$792.58	$411.30
52700	T	Drainage of prostate abscess	0162	25.09	$1,277.18	$427.49	$255.44
53000	T	Incision of urethra	0166	12.20	$621.03	$218.73	$124.21
53010	T	Incision of urethra	0166	12.20	$621.03	$218.73	$124.21
53020	T	Incision of urethra	0166	12.20	$621.03	$218.73	$124.21
53025	T	Incision of urethra	0166	12.20	$621.03	$218.73	$124.21
53040	T	Drainage of urethra abscess	0166	12.20	$621.03	$218.73	$124.21
53060	T	Drainage of urethra abscess	0166	12.20	$621.03	$218.73	$124.21
53080	T	Drainage of urinary leakage	0166	12.20	$621.03	$218.73	$124.21
53085	C	Drainage of urinary leakage					
53200	T	Biopsy of urethra	0166	12.20	$621.03	$218.73	$124.21
53210	T	Removal of urethra	0168	18.42	$937.65	$403.19	$187.53
53215	T	Removal of urethra	0168	18.42	$937.65	$403.19	$187.53
53220	T	Treatment of urethra lesion	0168	18.42	$937.65	$403.19	$187.53
53230	T	Removal of urethra lesion	0168	18.42	$937.65	$403.19	$187.53
53235	T	Removal of urethra lesion	0168	18.42	$937.65	$403.19	$187.53
53240	T	Surgery for urethra pouch	0168	18.42	$937.65	$403.19	$187.53
53250	T	Removal of urethra gland	0166	12.20	$621.03	$218.73	$124.21
53260	T	Treatment of urethra lesion	0166	12.20	$621.03	$218.73	$124.21
53265	T	Treatment of urethra lesion	0166	12.20	$621.03	$218.73	$124.21
53270	T	Removal of urethra gland	0167	22.28	$1,134.14	$555.84	$226.83
53275	T	Repair of urethra defect	0166	12.20	$621.03	$218.73	$124.21
53400	T	Revise urethra, stage 1	0168	18.42	$937.65	$403.19	$187.53
53405	T	Revise urethra, stage 2	0168	18.42	$937.65	$403.19	$187.53
53410	T	Reconstruction of urethra	0168	18.42	$937.65	$403.19	$187.53
53415	C	Reconstruction of urethra					
53420	T	Reconstruct urethra, stage 1	0168	18.42	$937.65	$403.19	$187.53
53425	T	Reconstruct urethra, stage 2	0168	18.42	$937.65	$403.19	$187.53
53430	T	Reconstruction of urethra	0168	18.42	$937.65	$403.19	$187.53
*53431	T	Reconstruct urethra/bladder	0168	18.42	$937.65	$403.19	$187.53
53440	T	Correct bladder function	0179	139.33	$7,092.45	$2,340.51	$1,418.49
53442	T	Remove perineal prosthesis	0166	12.20	$621.03	$218.73	$124.21
53443	D	Reconstruction of urethra					
*53444	T	Insert tandem cuff	0179	139.33	$7,092.45	$2,340.51	$1,418.49
53445	T	Correct urine flow control	0179	139.33	$7,092.45	$2,340.51	$1,418.49
*53446	T	Remove uro sphincter	0168	18.42	$937.65	$403.19	$187.53
53447	T	Remove artificial sphincter	0179	139.33	$7,092.45	$2,340.51	$1,418.49
*53448	C	Remov/replc ur sphinctr comp					
53449	T	Correct artificial sphincter	0168	18.42	$937.65	$403.19	$187.53
53450	T	Revision of urethra	0168	18.42	$937.65	$403.19	$187.53
53460	T	Revision of urethra	0168	18.42	$937.65	$403.19	$187.53
53502	T	Repair of urethra injury	0166	12.20	$621.03	$218.73	$124.21
53505	T	Repair of urethra injury	0167	22.28	$1,134.14	$555.84	$226.83
53510	T	Repair of urethra injury	0166	12.20	$621.03	$218.73	$124.21
53515	T	Repair of urethra injury	0168	18.42	$937.65	$403.19	$187.53
53520	T	Repair of urethra defect	0168	18.42	$937.65	$403.19	$187.53
53600	T	Dilate urethra stricture	0156	2.45	$124.71	$37.41	$24.94
53601	T	Dilate urethra stricture	0164	1.01	$51.41	$15.42	$10.28

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
53605	T	Dilate urethra stricture	0161	13.72	$698.40	$249.36	$139.68
53620	T	Dilate urethra stricture	0165	5.22	$265.72	$91.76	$53.14
53621	T	Dilate urethra stricture	0164	1.01	$51.41	$15.42	$10.28
53660	T	Dilation of urethra	0164	1.01	$51.41	$15.42	$10.28
53661	T	Dilation of urethra	0164	1.01	$51.41	$15.42	$10.28
53665	T	Dilation of urethra	0166	12.20	$621.03	$218.73	$124.21
53670	N	Insert urinary catheter					
53675	T	Insert urinary catheter	0156	2.45	$124.71	$37.41	$24.94
53850	T	Prostatic microwave thermotx	0982		$2,750.00		$550.00
53852	T	Prostatic rf thermotx	0982		$2,750.00		$550.00
*53853	T	Prostatic water thermother	0977		$1,125.00		$225.00
53899	T	Urology surgery procedure	0165	5.22	$265.72	$91.76	$53.14
54000	T	Slitting of prepuce	0166	12.20	$621.03	$218.73	$124.21
54001	T	Slitting of prepuce	0166	12.20	$621.03	$218.73	$124.21
54015	T	Drain penis lesion	0006	2.18	$110.97	$33.95	$22.19
54050	T	Destruction, penis lesion(s)	0013	1.36	$69.23	$17.66	$13.85
54055	T	Destruction, penis lesion(s)	0017	9.68	$492.75	$226.67	$98.55
54056	T	Cryosurgery, penis lesion(s)	0012	0.66	$33.60	$9.18	$6.72
54057	T	Laser surg, penis lesion(s)	0017	9.68	$492.75	$226.67	$98.55
54060	T	Excision of penis lesion(s)	0017	9.68	$492.75	$226.67	$98.55
54065	T	Destruction, penis lesion(s)	0695	15.78	$803.27	$369.50	$160.65
54100	T	Biopsy of penis	0020	8.44	$429.63	$130.53	$85.93
54105	T	Biopsy of penis	0021	11.82	$601.69	$236.51	$120.34
54110	T	Treatment of penis lesion	0181	22.09	$1,124.47	$618.45	$224.89
54111	T	Treat penis lesion, graft	0181	22.09	$1,124.47	$618.45	$224.89
54112	T	Treat penis lesion, graft	0181	22.09	$1,124.47	$618.45	$224.89
54115	T	Treatment of penis lesion	0008	10.93	$556.38	$113.67	$111.28
54120	T	Partial removal of penis	0181	22.09	$1,124.47	$618.45	$224.89
54125	C	Removal of penis					
54130	C	Remove penis & nodes					
54135	C	Remove penis & nodes					
54150	T	Circumcision	0180	15.02	$764.58	$304.87	$152.92
54152	T	Circumcision	0180	15.02	$764.58	$304.87	$152.92
54160	T	Circumcision	0180	15.02	$764.58	$304.87	$152.92
54161	T	Circumcision	0180	15.02	$764.58	$304.87	$152.92
*54162	T	Lysis penil circumcis lesion	0180	15.02	$764.58	$304.87	$152.92
*54163	T	Repair of circumcision	0180	15.02	$764.58	$304.87	$152.92
*54164	T	Frenulotomy of penis	0180	15.02	$764.58	$304.87	$152.92
54200	T	Treatment of penis lesion	0156	2.45	$124.71	$37.41	$24.94
54205	T	Treatment of penis lesion	0181	22.09	$1,124.47	$618.45	$224.89
54220	T	Treatment of penis lesion	0156	2.45	$124.71	$37.41	$24.94
54230	N	Prepare penis study					
54231	T	Dynamic cavernosometry	0165	5.22	$265.72	$91.76	$53.14
54235	T	Penile injection	0164	1.01	$51.41	$15.42	$10.28
54240	T	Penis study	0164	1.01	$51.41	$15.42	$10.28
54250	T	Penis study	0165	5.22	$265.72	$91.76	$53.14
54300	T	Revision of penis	0181	22.09	$1,124.47	$618.45	$224.89
54304	T	Revision of penis	0181	22.09	$1,124.47	$618.45	$224.89
54308	T	Reconstruction of urethra	0181	22.09	$1,124.47	$618.45	$224.89
54312	T	Reconstruction of urethra	0181	22.09	$1,124.47	$618.45	$224.89
54316	T	Reconstruction of urethra	0181	22.09	$1,124.47	$618.45	$224.89
54318	T	Reconstruction of urethra	0181	22.09	$1,124.47	$618.45	$224.89
54322	T	Reconstruction of urethra	0181	22.09	$1,124.47	$618.45	$224.89
54324	T	Reconstruction of urethra	0181	22.09	$1,124.47	$618.45	$224.89
54326	T	Reconstruction of urethra	0181	22.09	$1,124.47	$618.45	$224.89
54328	T	Revise penis/urethra	0181	22.09	$1,124.47	$618.45	$224.89
54332	C	Revise penis/urethra					
54336	C	Revise penis/urethra					
54340	T	Secondary urethral surgery	0181	22.09	$1,124.47	$618.45	$224.89
54344	T	Secondary urethral surgery	0181	22.09	$1,124.47	$618.45	$224.89
54348	T	Secondary urethral surgery	0181	22.09	$1,124.47	$618.45	$224.89
54352	T	Reconstruct urethra/penis	0181	22.09	$1,124.47	$618.45	$224.89
54360	T	Penis plastic surgery	0181	22.09	$1,124.47	$618.45	$224.89
54380	T	Repair penis	0181	22.09	$1,124.47	$618.45	$224.89
54385	T	Repair penis	0181	22.09	$1,124.47	$618.45	$224.89
54390	C	Repair penis and bladder					
54400	T	Insert semi-rigid prosthesis	0182	87.54	$4,456.14	$1,492.28	$891.23
54401	T	Insert self-contd prosthesis	0182	87.54	$4,456.14	$1,492.28	$891.23
54402	D	Remove penis prosthesis	0182	87.54	$4,456.14	$1,492.28	$891.23
54405	T	Insert multi-comp prosthesis	0182	87.54	$4,456.14	$1,492.28	$891.23
*54406	T	Remove multi-comp penis pros	0181	22.09	$1,124.47	$618.45	$224.89
54407	D	Remove multi-comp prosthesis	0182	87.54	$4,456.14	$1,492.28	$891.23
*54408	T	Repair multi-comp penis pros	0181	22.09	$1,124.47	$618.45	$224.89
54409	D	Revise penis prosthesis	0182	87.54	$4,456.14	$1,492.28	$891.23
*54410	T	Remove/replace penis prosth	0182	87.54	$4,456.14	$1,492.28	$891.23

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
*54411	C	Remv/replc penis pros, comp					
*54415	T	Remove self-contd penis pros	0181	22.09	$1,124.47	$618.45	$224.89
*54416	T	Remv/repl penis contain pros	0182	87.54	$4,456.14	$1,492.28	$891.23
*54417	C	Remv/replc penis pros, compl					
54420	T	Revision of penis	0181	22.09	$1,124.47	$618.45	$224.89
54430	C	Revision of penis					
54435	T	Revision of penis	0181	22.09	$1,124.47	$618.45	$224.89
54440	T	Repair of penis	0181	22.09	$1,124.47	$618.45	$224.89
54450	T	Preputial stretching	0156	2.45	$124.71	$37.41	$24.94
54500	T	Biopsy of testis	0005	4.03	$205.14	$90.26	$41.03
54505	T	Biopsy of testis	0183	18.87	$960.56	$448.94	$192.11
54510	D	Removal of testis lesion	0183	18.87	$960.56	$448.94	$192.11
54512	T	Excise lesion testis	0183	18.87	$960.56	$448.94	$192.11
54520	T	Removal of testis	0183	18.87	$960.56	$448.94	$192.11
54522	T	Orchiectomy, partial	0183	18.87	$960.56	$448.94	$192.11
54530	T	Removal of testis	0154	31.40	$1,598.39	$556.98	$319.68
54535	C	Extensive testis surgery					
54550	T	Exploration for testis	0154	31.40	$1,598.39	$556.98	$319.68
54560	C	Exploration for testis					
54600	T	Reduce testis torsion	0183	18.87	$960.56	$448.94	$192.11
54620	T	Suspension of testis	0183	18.87	$960.56	$448.94	$192.11
54640	T	Suspension of testis	0154	31.40	$1,598.39	$556.98	$319.68
54650	C	Orchiopexy (Fowler-Stephens)					
54660	T	Revision of testis	0183	18.87	$960.56	$448.94	$192.11
54670	T	Repair testis injury	0183	18.87	$960.56	$448.94	$192.11
54680	T	Relocation of testis(es)	0183	18.87	$960.56	$448.94	$192.11
54690	T	Laparoscopy, orchiectomy	0131	37.63	$1,915.52	$996.07	$383.10
54692	T	Laparoscopy, orchiopexy	0132	56.06	$2,853.68	$1,239.22	$570.74
54699	T	Laparoscope proc, testis	0130	25.91	$1,318.92	$659.53	$263.78
54700	T	Drainage of scrotum	0183	18.87	$960.56	$448.94	$192.11
54800	T	Biopsy of epididymis	0004	2.47	$125.73	$32.57	$25.15
54820	T	Exploration of epididymis	0183	18.87	$960.56	$448.94	$192.11
54830	T	Remove epididymis lesion	0183	18.87	$960.56	$448.94	$192.11
54840	T	Remove epididymis lesion	0183	18.87	$960.56	$448.94	$192.11
54860	T	Removal of epididymis	0183	18.87	$960.56	$448.94	$192.11
54861	T	Removal of epididymis	0183	18.87	$960.56	$448.94	$192.11
54900	T	Fusion of spermatic ducts	0183	18.87	$960.56	$448.94	$192.11
54901	T	Fusion of spermatic ducts	0183	18.87	$960.56	$448.94	$192.11
55000	T	Drainage of hydrocele	0004	2.47	$125.73	$32.57	$25.15
55040	T	Removal of hydrocele	0154	31.40	$1,598.39	$556.98	$319.68
55041	T	Removal of hydroceles	0154	31.40	$1,598.39	$556.98	$319.68
55060	T	Repair of hydrocele	0183	18.87	$960.56	$448.94	$192.11
55100	T	Drainage of scrotum abscess	0007	6.75	$343.60	$72.03	$68.72
55110	T	Explore scrotum	0183	18.87	$960.56	$448.94	$192.11
55120	T	Removal of scrotum lesion	0183	18.87	$960.56	$448.94	$192.11
55150	T	Removal of scrotum	0183	18.87	$960.56	$448.94	$192.11
55175	T	Revision of scrotum	0183	18.87	$960.56	$448.94	$192.11
55180	T	Revision of scrotum	0183	18.87	$960.56	$448.94	$192.11
55200	T	Incision of sperm duct	0183	18.87	$960.56	$448.94	$192.11
55250	T	Removal of sperm duct(s)	0183	18.87	$960.56	$448.94	$192.11
55300	N	Prepare, sperm duct x-ray					
55400	T	Repair of sperm duct	0183	18.87	$960.56	$448.94	$192.11
55450	T	Ligation of sperm duct	0183	18.87	$960.56	$448.94	$192.11
55500	T	Removal of hydrocele	0183	18.87	$960.56	$448.94	$192.11
55520	T	Removal of sperm cord lesion	0183	18.87	$960.56	$448.94	$192.11
55530	T	Revise spermatic cord veins	0183	18.87	$960.56	$448.94	$192.11
55535	T	Revise spermatic cord veins	0154	31.40	$1,598.39	$556.98	$319.68
55540	T	Revise hernia & sperm veins	0154	31.40	$1,598.39	$556.98	$319.68
55550	T	Laparo ligate spermatic vein	0131	37.63	$1,915.52	$996.07	$383.10
55559	T	Laparo proc, spermatic cord	0130	25.91	$1,318.92	$659.53	$263.78
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	18.87	$960.56	$448.94	$192.11
55700	T	Biopsy of prostate	0184	4.83	$245.87	$122.94	$49.17
55705	T	Biopsy of prostate	0184	4.83	$245.87	$122.94	$49.17
55720	T	Drainage of prostate abscess	0162	25.09	$1,277.18	$427.49	$255.44
55725	T	Drainage of prostate abscess	0162	25.09	$1,277.18	$427.49	$255.44
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
55842	C	Extensive prostate surgery					
55845	C	Extensive prostate surgery					
55859	T	Percut/needle insert, pros	0163	40.40	$2,056.52	$792.58	$411.30
55860	T	Surgical exposure, prostate	0165	5.22	$265.72	$91.76	$53.14
55862	C	Extensive prostate surgery					
55865	C	Extensive prostate surgery					
55870	T	Electroejaculation	0197	2.40	$122.17	$49.55	$24.43
55873	T	Cryoablate prostate	0982		$2,750.00		$550.00
55899	T	Genital surgery procedure	0164	1.01	$51.41	$15.42	$10.28
55970	E	Sex transformation, M to F					
55980	E	Sex transformation, F to M					
56405	T	I & D of vulva/perineum	0192	2.50	$127.26	$35.33	$25.45
56420	T	Drainage of gland abscess	0192	2.50	$127.26	$35.33	$25.45
56440	T	Surgery for vulva lesion	0194	15.86	$807.34	$395.60	$161.47
56441	T	Lysis of labial lesion(s)	0193	11.16	$568.09	$171.13	$113.62
56501	T	Destruction, vulva lesion(s)	0017	9.68	$492.75	$226.67	$98.55
56515	T	Destruction, vulva lesion(s)	0695	15.78	$803.27	$369.50	$160.65
56605	T	Biopsy of vulva/perineum	0019	4.22	$214.81	$78.91	$42.96
56606	T	Biopsy of vulva/perineum	0019	4.22	$214.81	$78.91	$42.96
56620	T	Partial removal of vulva	0195	20.62	$1,049.64	$483.80	$209.93
56625	T	Complete removal of vulva	0195	20.62	$1,049.64	$483.80	$209.93
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	15.86	$807.34	$395.60	$161.47
56720	T	Incision of hymen	0193	11.16	$568.09	$171.13	$113.62
56740	T	Remove vagina gland lesion	0194	15.86	$807.34	$395.60	$161.47
56800	T	Repair of vagina	0194	15.86	$807.34	$395.60	$161.47
56805	T	Repair clitoris	0194	15.86	$807.34	$395.60	$161.47
56810	T	Repair of perineum	0194	15.86	$807.34	$395.60	$161.47
57000	T	Exploration of vagina	0194	15.86	$807.34	$395.60	$161.47
57010	T	Drainage of pelvic abscess	0194	15.86	$807.34	$395.60	$161.47
57020	T	Drainage of pelvic fluid	0193	11.16	$568.09	$171.13	$113.62
57022	T	I &d vaginal hematoma, ob	0007	6.75	$343.60	$72.03	$68.72
57023	T	I &d vag hematoma, trauma	0007	6.75	$343.60	$72.03	$68.72
57061	T	Destruction vagina lesion(s)	0194	15.86	$807.34	$395.60	$161.47
57065	T	Destruction vagina lesion(s)	0194	15.86	$807.34	$395.60	$161.47
57100	T	Biopsy of vagina	0193	11.16	$568.09	$171.13	$113.62
57105	T	Biopsy of vagina	0194	15.86	$807.34	$395.60	$161.47
57106	T	Remove vagina wall, partial	0194	15.86	$807.34	$395.60	$161.47
57107	T	Remove vagina tissue, part	0195	20.62	$1,049.64	$483.80	$209.93
57109	T	Vaginectomy partial w/nodes	0202	63.54	$3,234.44	$1,487.84	$646.89
57110	C	Remove vagina wall, complete					
57111	C	Remove vagina tissue, compl					
57112	C	Vaginectomy w/nodes, compl					
57120	T	Closure of vagina	0194	15.86	$807.34	$395.60	$161.47
57130	T	Remove vagina lesion	0194	15.86	$807.34	$395.60	$161.47
57135	T	Remove vagina lesion	0194	15.86	$807.34	$395.60	$161.47
57150	T	Treat vagina infection	0191	0.23	$11.71	$3.40	$2.34
*57155	T	Insert uteri tandems/ovoids	0192	2.50	$127.26	$35.33	$25.45
57160	T	Insert pessary/other device	0188	0.80	$40.72	$11.81	$8.14
57170	T	Fitting of diaphragm/cap	0191	0.23	$11.71	$3.40	$2.34
57180	T	Treat vaginal bleeding	0192	2.50	$127.26	$35.33	$25.45
57200	T	Repair of vagina	0194	15.86	$807.34	$395.60	$161.47
57210	T	Repair vagina/perineum	0194	15.86	$807.34	$395.60	$161.47
57220	T	Revision of urethra	0195	20.62	$1,049.64	$483.80	$209.93
57230	T	Repair of urethral lesion	0194	15.86	$807.34	$395.60	$161.47
57240	T	Repair bladder & vagina	0195	20.62	$1,049.64	$483.80	$209.93
57250	T	Repair rectum & vagina	0195	20.62	$1,049.64	$483.80	$209.93
57260	T	Repair of vagina	0195	20.62	$1,049.64	$483.80	$209.93
57265	T	Extensive repair of vagina	0195	20.62	$1,049.64	$483.80	$209.93
57268	T	Repair of bowel bulge	0195	20.62	$1,049.64	$483.80	$209.93
57270	C	Repair of bowel pouch					
57280	C	Suspension of vagina					
57282	C	Repair of vaginal prolapse					
57284	T	Repair paravaginal defect	0195	20.62	$1,049.64	$483.80	$209.93
57287	T	Revise/remove sling repair	0202	63.54	$3,234.44	$1,487.84	$646.89
57288	T	Repair bladder defect	0202	63.54	$3,234.44	$1,487.84	$646.89
57289	T	Repair bladder & vagina	0195	20.62	$1,049.64	$483.80	$209.93
57291	T	Construction of vagina	0195	20.62	$1,049.64	$483.80	$209.93
57292	C	Construct vagina with graft					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
57300	T	Repair rectum-vagina fistula	0195	20.62	$1,049.64	$483.80	$209.93
57305	C	Repair rectum-vagina fistula					
57307	C	Fistula repair & colostomy					
57308	C	Fistula repair, transperine					
57310	T	Repair urethrovaginal lesion	0195	20.62	$1,049.64	$483.80	$209.93
57311	C	Repair urethrovaginal lesion					
57320	T	Repair bladder-vagina lesion	0195	20.62	$1,049.64	$483.80	$209.93
57330	T	Repair bladder-vagina lesion	0195	20.62	$1,049.64	$483.80	$209.93
57335	C	Repair vagina					
57400	T	Dilation of vagina	0194	15.86	$807.34	$395.60	$161.47
57410	T	Pelvic examination	0194	15.86	$807.34	$395.60	$161.47
57415	T	Remove vaginal foreign body	0194	15.86	$807.34	$395.60	$161.47
57452	T	Examination of vagina	0189	1.26	$64.14	$17.96	$12.83
57454	T	Vagina examination & biopsy	0192	2.50	$127.26	$35.33	$25.45
57460	T	Cervix excision	0193	11.16	$568.09	$171.13	$113.62
57500	T	Biopsy of cervix	0192	2.50	$127.26	$35.33	$25.45
57505	T	Endocervical curettage	0192	2.50	$127.26	$35.33	$25.45
57510	T	Cauterization of cervix	0193	11.16	$568.09	$171.13	$113.62
57511	T	Cryocautery of cervix	0189	1.26	$64.14	$17.96	$12.83
57513	T	Laser surgery of cervix	0193	11.16	$568.09	$171.13	$113.62
57520	T	Conization of cervix	0194	15.86	$807.34	$395.60	$161.47
57522	T	Conization of cervix	0195	20.62	$1,049.64	$483.80	$209.93
57530	T	Removal of cervix	0195	20.62	$1,049.64	$483.80	$209.93
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	20.62	$1,049.64	$483.80	$209.93
57555	T	Remove cervix/repair vagina	0195	20.62	$1,049.64	$483.80	$209.93
57556	T	Remove cervix, repair bowel	0195	20.62	$1,049.64	$483.80	$209.93
57700	T	Revision of cervix	0194	15.86	$807.34	$395.60	$161.47
57720	T	Revision of cervix	0194	15.86	$807.34	$395.60	$161.47
57800	T	Dilation of cervical canal	0192	2.50	$127.26	$35.33	$25.45
57820	T	D & c of residual cervix	0196	13.48	$686.19	$336.23	$137.24
58100	T	Biopsy of uterus lining	0188	0.80	$40.72	$11.81	$8.14
58120	T	Dilation and curettage	0196	13.48	$686.19	$336.23	$137.24
58140	C	Removal of uterus lesion					
58145	T	Removal of uterus lesion	0195	20.62	$1,049.64	$483.80	$209.93
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	Vaginal hysterectomy					
58263	C	Vaginal hysterectomy					
58267	C	Hysterectomy & vagina repair					
58270	C	Hysterectomy & vagina repair					
58275	C	Hysterectomy/revise vagina					
58280	C	Hysterectomy/revise vagina					
58285	C	Extensive hysterectomy					
58300	E	Insert intrauterine device					
58301	T	Remove intrauterine device	0189	1.26	$64.14	$17.96	$12.83
58321	T	Artificial insemination	0197	2.40	$122.17	$49.55	$24.43
58322	T	Artificial insemination	0197	2.40	$122.17	$49.55	$24.43
58323	T	Sperm washing	0197	2.40	$122.17	$49.55	$24.43
58340	N	Catheter for hysterography					
58345	T	Reopen fallopian tube	0194	15.86	$807.34	$395.60	$161.47
*58346	T	Insert heyman uteri capsule	0192	2.50	$127.26	$35.33	$25.45
58350	T	Reopen fallopian tube	0194	15.86	$807.34	$395.60	$161.47
58353	T	Endometr ablate, thermal	0193	11.16	$568.09	$171.13	$113.62
58400	C	Suspension of uterus					
58410	C	Suspension of uterus					
58520	C	Repair of ruptured uterus					
58540	C	Revision of uterus					
58550	T	Laparo-asst vag hysterectomy	0132	56.06	$2,853.68	$1,239.22	$570.74
58551	T	Laparoscopy, remove myoma	0131	37.63	$1,915.52	$996.07	$383.10
58555	T	Hysteroscopy, dx, sep proc	0194	15.86	$807.34	$395.60	$161.47
58558	T	Hysteroscopy, biopsy	0190	16.91	$860.79	$421.79	$172.16
58559	T	Hysteroscopy, lysis	0190	16.91	$860.79	$421.79	$172.16
58560	T	Hysteroscopy, resect septum	0190	16.91	$860.79	$421.79	$172.16
58561	T	Hysteroscopy, remove myoma	0190	16.91	$860.79	$421.79	$172.16
58562	T	Hysteroscopy, remove fb	0190	16.91	$860.79	$421.79	$172.16
58563	T	Hysteroscopy, ablation	0190	16.91	$860.79	$421.79	$172.16
58578	T	Laparo proc, uterus	0190	16.91	$860.79	$421.79	$172.16

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
58579	T	Hysteroscope procedure	0190	16.91	$860.79	$421.79	$172.16
58600	T	Division of fallopian tube	0194	15.86	$807.34	$395.60	$161.47
58605	C	Division of fallopian tube					
58611	C	Ligate oviduct(s) add-on					
58615	T	Occlude fallopian tube(s)	0194	15.86	$807.34	$395.60	$161.47
58660	T	Laparoscopy, lysis	0131	37.63	$1,915.52	$996.07	$383.10
58661	T	Laparoscopy, remove adnexa	0131	37.63	$1,915.52	$996.07	$383.10
58662	T	Laparoscopy, excise lesions	0131	37.63	$1,915.52	$996.07	$383.10
58670	T	Laparoscopy, tubal cautery	0131	37.63	$1,915.52	$996.07	$383.10
58671	T	Laparoscopy, tubal block	0131	37.63	$1,915.52	$996.07	$383.10
58672	T	Laparoscopy, fimbrioplasty	0131	37.63	$1,915.52	$996.07	$383.10
58673	T	Laparoscopy, salpingostomy	0131	37.63	$1,915.52	$996.07	$383.10
58679	T	Laparo proc, oviduct-ovary	0130	25.91	$1,318.92	$659.53	$263.78
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)	0195	20.62	$1,049.64	$483.80	$209.93
58805	C	Drainage of ovarian cyst(s)					
58820	T	Drain ovary abscess, open	0195	20.62	$1,049.64	$483.80	$209.93
58822	C	Drain ovary abscess, percut					
58823	T	Drain pelvic abscess, percut	0193	11.16	$568.09	$171.13	$113.62
58825	C	Transposition, ovary(s)					
58900	T	Biopsy of ovary(s)	0195	20.62	$1,049.64	$483.80	$209.93
58920	T	Partial removal of ovary(s)	0202	63.54	$3,234.44	$1,487.84	$646.89
58925	T	Removal of ovarian cyst(s)	0202	63.54	$3,234.44	$1,487.84	$646.89
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	15.86	$807.34	$395.60	$161.47
58974	T	Transfer of embryo	0197	2.40	$122.17	$49.55	$24.43
58976	T	Transfer of embryo	0197	2.40	$122.17	$49.55	$24.43
58999	T	Genital surgery procedure	0019	4.22	$214.81	$78.91	$42.96
59000	T	Amniocentesis	0198	1.31	$66.68	$32.67	$13.34
*59001	T	Amniocentesis, therapeutic	0198	1.31	$66.68	$32.67	$13.34
59012	T	Fetal cord puncture,prenatal	0198	1.31	$66.68	$32.67	$13.34
59015	T	Chorion biopsy	0198	1.31	$66.68	$32.67	$13.34
59020	T	Fetal contract stress test	0198	1.31	$66.68	$32.67	$13.34
59025	T	Fetal non-stress test	0198	1.31	$66.68	$32.67	$13.34
59030	T	Fetal scalp blood sample	0198	1.31	$66.68	$32.67	$13.34
59050	T	Fetal monitor w/report	0198	1.31	$66.68	$32.67	$13.34
59051	E	Fetal monitor/interpret only					
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					
59150	T	Treat ectopic pregnancy	0131	37.63	$1,915.52	$996.07	$383.10
59151	T	Treat ectopic pregnancy	0131	37.63	$1,915.52	$996.07	$383.10
59160	T	D & c after delivery	0196	13.48	$686.19	$336.23	$137.24
59200	T	Insert cervical dilator	0189	1.26	$64.14	$17.96	$12.83
59300	T	Episiotomy or vaginal repair	0193	11.16	$568.09	$171.13	$113.62
59320	T	Revision of cervix	0194	15.86	$807.34	$395.60	$161.47
59325	C	Revision of cervix					
59350	C	Repair of uterus					
59400	E	Obstetrical care					
59409	T	Obstetrical care	0199	5.09	$259.10	$72.55	$51.82
59410	E	Obstetrical care					
59412	T	Antepartum manipulation	0199	5.09	$259.10	$72.55	$51.82
59414	T	Deliver placenta	0199	5.09	$259.10	$72.55	$51.82
59425	E	Antepartum care only					
59426	E	Antepartum care only					
59430	E	Care after delivery					
59510	E	Cesarean delivery					
59514	C	Cesarean delivery only					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
59515	E	Cesarean delivery					
59525	C	Remove uterus after cesarean					
59610	E	Vbac delivery					
59612	T	Vbac delivery only	0199	5.09	$259.10	$72.55	$51.82
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	14.33	$729.45	$329.65	$145.89
59820	T	Care of miscarriage	0201	14.33	$729.45	$329.65	$145.89
59821	T	Treatment of miscarriage	0201	14.33	$729.45	$329.65	$145.89
59830	C	Treat uterus infection					
59840	T	Abortion	0200	11.34	$577.25	$305.94	$115.45
59841	T	Abortion	0200	11.34	$577.25	$305.94	$115.45
59850	C	Abortion					
59851	C	Abortion					
59852	C	Abortion					
59855	C	Abortion					
59856	C	Abortion					
59857	C	Abortion					
59866	T	Abortion (mpr)	0198	1.31	$66.68	$32.67	$13.34
59870	T	Evacuate mole of uterus	0201	14.33	$729.45	$329.65	$145.89
59871	T	Remove cerclage suture	0194	15.86	$807.34	$395.60	$161.47
59898	T	Laparo proc, ob care/deliver	0130	25.91	$1,318.92	$659.53	$263.78
59899	T	Maternity care procedure	0198	1.31	$66.68	$32.67	$13.34
60000	T	Drain thyroid/tongue cyst	0252	5.95	$302.88	$114.24	$60.58
60001	T	Aspirate/inject thyriod cyst	0004	2.47	$125.73	$32.57	$25.15
60100	T	Biopsy of thyroid	0004	2.47	$125.73	$32.57	$25.15
60200	T	Remove thyroid lesion	0114	29.28	$1,490.47	$493.78	$298.09
60210	T	Partial thyroid excision	0114	29.28	$1,490.47	$493.78	$298.09
60212	T	Parital thyroid excision	0114	29.28	$1,490.47	$493.78	$298.09
60220	T	Partial removal of thyroid	0114	29.28	$1,490.47	$493.78	$298.09
60225	T	Partial removal of thyroid	0114	29.28	$1,490.47	$493.78	$298.09
60240	T	Removal of thyroid	0114	29.28	$1,490.47	$493.78	$298.09
60252	T	Removal of thyroid	0256	26.61	$1,354.56	$623.05	$270.91
60254	C	Extensive thyroid surgery					
60260	T	Repeat thyroid surgery	0256	26.61	$1,354.56	$623.05	$270.91
60270	C	Removal of thyroid					
60271	C	Removal of thyroid					
60280	T	Remove thyroid duct lesion	0114	29.28	$1,490.47	$493.78	$298.09
60281	T	Remove thyroid duct lesion	0114	29.28	$1,490.47	$493.78	$298.09
60500	T	Explore parathyroid glands	0256	26.61	$1,354.56	$623.05	$270.91
60502	C	Re-explore parathyroids					
60505	C	Explore parathyroid glands					
60512	T	Autotransplant parathyroid	0021	11.82	$601.69	$236.51	$120.34
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	25.91	$1,318.92	$659.53	$263.78
60699	T	Endocrine surgery procedure	0004	2.47	$125.73	$32.57	$25.15
61000	T	Remove cranial cavity fluid	0212	3.77	$191.91	$88.78	$38.38
61001	T	Remove cranial cavity fluid	0212	3.77	$191.91	$88.78	$38.38
61020	T	Remove brain cavity fluid	0212	3.77	$191.91	$88.78	$38.38
61026	T	Injection into brain canal	0212	3.77	$191.91	$88.78	$38.38
61050	T	Remove brain canal fluid	0212	3.77	$191.91	$88.78	$38.38
61055	T	Injection into brain canal	0212	3.77	$191.91	$88.78	$38.38
61070	T	Brain canal shunt procedure	0212	3.77	$191.91	$88.78	$38.38
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	28.48	$1,449.75	$453.41	$289.95
61250	C	Pierce skull & explore					
61253	C	Pierce skull & explore					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
61320	C	Open skull for drainage					
61321	C	Open skull for drainage					
61330	T	Decompress eye socket	0256	26.61	$1,354.56	$623.05	$270.91
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					
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					
61538	C	Removal of brain tissue					
61539	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					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
61626	T	Occlusion/embolization cath	0081	29.24	$1,488.43	$710.91	$297.69
61680	C	Intracranial vessel surgery					
61682	C	Intracranial vessel surgery					
61684	C	Intracranial vessel surgery					
61686	C	Intracranial vessel surgery					
61690	C	Intracranial vessel surgery					
61692	C	Intracranial vessel surgery					
61697	C	Brain aneurysm repr, complx					
61698	C	Brain aneurysm repr, complx					
61700	C	Brain aneurysm repr , simple					
61702	C	Inner skull vessel surgery					
61703	C	Clamp neck artery					
61705	C	Revise circulation to head					
61708	C	Revise circulation to head					
61710	C	Revise circulation to head					
61711	C	Fusion of skull arteries					
61720	C	Incise skull/brain surgery					
61735	C	Incise skull/brain surgery					
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	13.60	$692.29	$325.38	$138.46
61791	T	Treat trigeminal tract	0204	2.24	$114.02	$43.33	$22.80
61793	S	Focus radiation beam	0302	11.16	$568.09	$216.55	$113.62
61795	S	Brain surgery using computer	0302	11.16	$568.09	$216.55	$113.62
61850	C	Implant neuroelectrodes					
61860	C	Implant neuroelectrodes					
61862	C	Implant neurostimul, subcort					
61870	C	Implant neuroelectrodes					
61875	C	Implant neuroelectrodes					
61880	T	Revise/remove neuroelectrode	0687	42.34	$2,155.28		$431.06
61885	T	Implant neurostim one array	0222	302.53	$15,399.99		$3,080.00
61886	T	Implant neurostim arrays	0222	302.53	$15,399.99		$3,080.00
61888	T	Revise/remove neuroreceiver	0688	145.27	$7,394.82		$1,478.96
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					
62180	C	Establish brain cavity shunt					
62190	C	Establish brain cavity shunt					
62192	C	Establish brain cavity shunt					
62194	T	Replace/irrigate catheter	0121	2.54	$129.30	$52.53	$25.86
62200	C	Establish brain cavity shunt					
62201	C	Establish brain cavity shunt					
62220	C	Establish brain cavity shunt					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
62223	C	Establish brain cavity shunt					
62225	T	Replace/irrigate catheter	0121	2.54	$129.30	$52.53	$25.86
62230	T	Replace/revise brain shunt	0224	28.48	$1,449.75	$453.41	$289.95
62252	S	Csf shunt reprogram	0691	3.17	$161.37	$88.75	$32.27
62256	C	Remove brain cavity shunt					
62258	C	Replace brain cavity shunt					
62263	T	Lysis epidural adhesions	0203	15.79	$803.77	$369.73	$160.75
62268	T	Drain spinal cord cyst	0212	3.77	$191.91	$88.78	$38.38
62269	T	Needle biopsy, spinal cord	0005	4.03	$205.14	$90.26	$41.03
62270	T	Spinal fluid tap, diagnostic	0206	3.59	$182.75	$74.93	$36.55
62272	T	Drain spinal fluid	0206	3.59	$182.75	$74.93	$36.55
62273	T	Treat epidural spine lesion	0206	3.59	$182.75	$74.93	$36.55
62280	T	Treat spinal cord lesion	0207	5.36	$272.85	$122.78	$54.57
62281	T	Treat spinal cord lesion	0207	5.36	$272.85	$122.78	$54.57
62282	T	Treat spinal canal lesion	0207	5.36	$272.85	$122.78	$54.57
62284	N	Injection for myelogram					
62287	T	Percutaneous diskectomy	0220	13.60	$692.29	$325.38	$138.46
62290	N	Inject for spine disk x-ray					
62291	N	Inject for spine disk x-ray					
62292	T	Injection into disk lesion	0212	3.77	$191.91	$88.78	$38.38
62294	T	Injection into spinal artery	0212	3.77	$191.91	$88.78	$38.38
62310	T	Inject spine c/t	0206	3.59	$182.75	$74.93	$36.55
62311	T	Inject spine l/s (cd)	0206	3.59	$182.75	$74.93	$36.55
62318	T	Inject spine w/cath, c/t	0206	3.59	$182.75	$74.93	$36.55
62319	T	Inject spine w/cath l/s (cd)	0206	3.59	$182.75	$74.93	$36.55
62350	T	Implant spinal canal cath	0223	75.39	$3,837.65		$767.53
62351	C	Implant spinal canal cath					
62355	T	Remove spinal canal catheter	0105	14.76	$751.34	$368.16	$150.27
62360	T	Insert spine infusion device	0226	75.81	$3,859.03		$771.81
62361	T	Implant spine infusion pump	0227	139.55	$7,103.65		$1,420.73
62362	T	Implant spine infusion pump	0227	139.55	$7,103.65		$1,420.73
62365	T	Remove spine infusion device	0105	14.76	$751.34	$368.16	$150.27
62367	S	Analyze spine infusion pump	0691	3.17	$161.37	$88.75	$32.27
62368	S	Analyze spine infusion pump	0691	3.17	$161.37	$88.75	$32.27
63001	T	Removal of spinal lamina	0208	29.12	$1,482.32		$296.46
63003	T	Removal of spinal lamina	0208	29.12	$1,482.32		$296.46
63005	T	Removal of spinal lamina	0208	29.12	$1,482.32		$296.46
63011	T	Removal of spinal lamina	0208	29.12	$1,482.32		$296.46
63012	T	Removal of spinal lamina	0208	29.12	$1,482.32		$296.46
63015	T	Removal of spinal lamina	0208	29.12	$1,482.32		$296.46
63016	T	Removal of spinal lamina	0208	29.12	$1,482.32		$296.46
63017	T	Removal of spinal lamina	0208	29.12	$1,482.32		$296.46
63020	T	Neck spine disk surgery	0208	29.12	$1,482.32		$296.46
63030	T	Low back disk surgery	0208	29.12	$1,482.32		$296.46
63035	T	Spinal disk surgery add-on	0208	29.12	$1,482.32		$296.46
63040	T	Laminotomy, single cervical	0208	29.12	$1,482.32		$296.46
63042	T	Laminotomy, single lumbar	0208	29.12	$1,482.32		$296.46
63043	C	Laminotomy, addl cervical					
63044	C	Laminotomy, addl lumbar					
63045	T	Removal of spinal lamina	0208	29.12	$1,482.32		$296.46
63046	T	Removal of spinal lamina	0208	29.12	$1,482.32		$296.46
63047	T	Removal of spinal lamina	0208	29.12	$1,482.32		$296.46
63048	T	Remove spinal lamina add-on	0208	29.12	$1,482.32		$296.46
63055	T	Decompress spinal cord	0208	29.12	$1,482.32		$296.46
63056	T	Decompress spinal cord	0208	29.12	$1,482.32		$296.46
63057	T	Decompress spine cord add-on	0208	29.12	$1,482.32		$296.46
63064	T	Decompress spinal cord	0208	29.12	$1,482.32		$296.46
63066	T	Decompress spine cord add-on	0208	29.12	$1,482.32		$296.46
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					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
63600	T	Remove spinal cord lesion	0220	13.60	$692.29	$325.38	$138.46
63610	T	Stimulation of spinal cord	0220	13.60	$692.29	$325.38	$138.46
63615	T	Remove lesion of spinal cord	0220	13.60	$692.29	$325.38	$138.46
63650	T	Implant neuroelectrodes	0225	267.56	$13,619.87		$2,723.97
63655	T	Implant neuroelectrodes	0225	267.56	$13,619.87		$2,723.97
63660	T	Revise/remove neuroelectrode	0687	42.34	$2,155.28		$431.06
63685	T	Implant neuroreceiver	0222	302.53	$15,399.99		$3,080.00
63688	T	Revise/remove neuroreceiver	0688	145.27	$7,394.82		$1,478.96
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	53.77	$2,737.11	$696.46	$547.42
63744	T	Revision of spinal shunt	0228	53.77	$2,737.11	$696.46	$547.42
63746	T	Removal of spinal shunt	0109	6.27	$319.17	$130.86	$63.83
64400	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64402	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64405	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64408	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64410	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64412	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64413	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64415	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64417	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64418	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64420	T	Injection for nerve block	0207	5.36	$272.85	$122.78	$54.57
64421	T	Injection for nerve block	0207	5.36	$272.85	$122.78	$54.57
64425	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64430	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64435	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64445	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64450	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64470	T	Inj paravertebral c/t	0207	5.36	$272.85	$122.78	$54.57
64472	T	Inj paravertebral c/t add-on	0207	5.36	$272.85	$122.78	$54.57
64475	T	Inj paravertebral l/s	0207	5.36	$272.85	$122.78	$54.57
64476	T	Inj paravertebral l/s add-on	0207	5.36	$272.85	$122.78	$54.57
64479	T	Inj foramen epidural c/t	0207	5.36	$272.85	$122.78	$54.57
64480	T	Inj foramen epidural add-on	0207	5.36	$272.85	$122.78	$54.57
64483	T	Inj foramen epidural l/s	0207	5.36	$272.85	$122.78	$54.57
64484	T	Inj foramen epidural add-on	0207	5.36	$272.85	$122.78	$54.57
64505	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64508	T	Injection for nerve block	0204	2.24	$114.02	$43.33	$22.80
64510	T	Injection for nerve block	0207	5.36	$272.85	$122.78	$54.57
64520	T	Injection for nerve block	0207	5.36	$272.85	$122.78	$54.57
64530	T	Injection for nerve block	0207	5.36	$272.85	$122.78	$54.57
64550	A	Apply neurostimulator					
64553	T	Implant neuroelectrodes	0225	267.56	$13,619.87		$2,723.97
64555	T	Implant neuroelectrodes	0225	267.56	$13,619.87		$2,723.97
64560	T	Implant neuroelectrodes	0225	267.56	$13,619.87		$2,723.97
*64561	T	Implant neuroelectrodes	0225	267.56	$13,619.87		$2,723.97
64565	T	Implant neuroelectrodes	0225	267.56	$13,619.87		$2,723.97
64573	T	Implant neuroelectrodes	0225	267.56	$13,619.87		$2,723.97
64575	T	Implant neuroelectrodes	0225	267.56	$13,619.87		$2,723.97
64577	T	Implant neuroelectrodes	0225	267.56	$13,619.87		$2,723.97
64580	T	Implant neuroelectrodes	0225	267.56	$13,619.87		$2,723.97
*64581	T	Implant neuroelectrodes	0225	267.56	$13,619.87		$2,723.97
64585	T	Revise/remove neuroelectrode	0687	42.34	$2,155.28		$431.06
64590	T	Implant neuroreceiver	0222	302.53	$15,399.99		$3,080.00
64595	T	Revise/remove neuroreceiver	0688	145.27	$7,394.82		$1,478.96
64600	T	Injection treatment of nerve	0203	15.79	$803.77	$369.73	$160.75
64605	T	Injection treatment of nerve	0203	15.79	$803.77	$369.73	$160.75
64610	T	Injection treatment of nerve	0203	15.79	$803.77	$369.73	$160.75
64612	T	Destroy nerve, face muscle	0204	2.24	$114.02	$43.33	$22.80
64613	T	Destroy nerve, spine muscle	0204	2.24	$114.02	$43.33	$22.80
64614	T	Destroy nerve, extrem musc	0206	3.59	$182.75	$74.93	$36.55
64620	T	Injection treatment of nerve	0203	15.79	$803.77	$369.73	$160.75
64622	T	Destr paravertebrl nerve l/s	0203	15.79	$803.77	$369.73	$160.75
64623	T	Destr paravertebral n add-on	0203	15.79	$803.77	$369.73	$160.75
64626	T	Destr paravertebrl nerve c/t	0203	15.79	$803.77	$369.73	$160.75
64627	T	Destr paravertebral n add-on	0203	15.79	$803.77	$369.73	$160.75
64630	T	Injection treatment of nerve	0207	5.36	$272.85	$122.78	$54.57
64640	T	Injection treatment of nerve	0207	5.36	$272.85	$122.78	$54.57
64680	T	Injection treatment of nerve	0203	15.79	$803.77	$369.73	$160.75
64702	T	Revise finger/toe nerve	0220	13.60	$692.29	$325.38	$138.46
64704	T	Revise hand/foot nerve	0220	13.60	$692.29	$325.38	$138.46
64708	T	Revise arm/leg nerve	0220	13.60	$692.29	$325.38	$138.46
64712	T	Revision of sciatic nerve	0220	13.60	$692.29	$325.38	$138.46
64713	T	Revision of arm nerve(s)	0220	13.60	$692.29	$325.38	$138.46
64714	T	Revise low back nerve(s)	0220	13.60	$692.29	$325.38	$138.46
64716	T	Revision of cranial nerve	0220	13.60	$692.29	$325.38	$138.46
64718	T	Revise ulnar nerve at elbow	0220	13.60	$692.29	$325.38	$138.46
64719	T	Revise ulnar nerve at wrist	0220	13.60	$692.29	$325.38	$138.46
64721	T	Carpal tunnel surgery	0220	13.60	$692.29	$325.38	$138.46
64722	T	Relieve pressure on nerve(s)	0220	13.60	$692.29	$325.38	$138.46
64726	T	Release foot/toe nerve	0220	13.60	$692.29	$325.38	$138.46
64727	T	Internal nerve revision	0220	13.60	$692.29	$325.38	$138.46
64732	T	Incision of brow nerve	0220	13.60	$692.29	$325.38	$138.46
64734	T	Incision of cheek nerve	0220	13.60	$692.29	$325.38	$138.46
64736	T	Incision of chin nerve	0220	13.60	$692.29	$325.38	$138.46
64738	T	Incision of jaw nerve	0220	13.60	$692.29	$325.38	$138.46
64740	T	Incision of tongue nerve	0220	13.60	$692.29	$325.38	$138.46
64742	T	Incision of facial nerve	0220	13.60	$692.29	$325.38	$138.46
64744	T	Incise nerve, back of head	0220	13.60	$692.29	$325.38	$138.46
64746	T	Incise diaphragm nerve	0220	13.60	$692.29	$325.38	$138.46
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	13.60	$692.29	$325.38	$138.46
64763	C	Incise hip/thigh nerve					
64766	C	Incise hip/thigh nerve					
64771	T	Sever cranial nerve	0220	13.60	$692.29	$325.38	$138.46
64772	T	Incision of spinal nerve	0220	13.60	$692.29	$325.38	$138.46
64774	T	Remove skin nerve lesion	0220	13.60	$692.29	$325.38	$138.46
64776	T	Remove digit nerve lesion	0220	13.60	$692.29	$325.38	$138.46

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64778	T	Digit nerve surgery add-on	0220	13.60	$692.29	$325.38	$138.46
64782	T	Remove limb nerve lesion	0220	13.60	$692.29	$325.38	$138.46
64783	T	Limb nerve surgery add-on	0220	13.60	$692.29	$325.38	$138.46
64784	T	Remove nerve lesion	0220	13.60	$692.29	$325.38	$138.46
64786	T	Remove sciatic nerve lesion	0221	21.43	$1,090.87	$463.62	$218.17
64787	T	Implant nerve end	0220	13.60	$692.29	$325.38	$138.46
64788	T	Remove skin nerve lesion	0220	13.60	$692.29	$325.38	$138.46
64790	T	Removal of nerve lesion	0220	13.60	$692.29	$325.38	$138.46
64792	T	Removal of nerve lesion	0221	21.43	$1,090.87	$463.62	$218.17
64795	T	Biopsy of nerve	0220	13.60	$692.29	$325.38	$138.46
64802	C	Remove sympathetic nerves					
64804	C	Remove sympathetic nerves					
64809	C	Remove sympathetic nerves					
64818	C	Remove sympathetic nerves					
64820	C	Remove sympathetic nerves					
*64821	T	Remove sympathetic nerves	0054	19.83	$1,009.43	$472.33	$201.89
*64822	T	Remove sympathetic nerves	0054	19.83	$1,009.43	$472.33	$201.89
*64823	T	Remove sympathetic nerves	0054	19.83	$1,009.43	$472.33	$201.89
64831	T	Repair of digit nerve	0221	21.43	$1,090.87	$463.62	$218.17
64832	T	Repair nerve add-on	0221	21.43	$1,090.87	$463.62	$218.17
64834	T	Repair of hand or foot nerve	0221	21.43	$1,090.87	$463.62	$218.17
64835	T	Repair of hand or foot nerve	0221	21.43	$1,090.87	$463.62	$218.17
64836	T	Repair of hand or foot nerve	0221	21.43	$1,090.87	$463.62	$218.17
64837	T	Repair nerve add-on	0221	21.43	$1,090.87	$463.62	$218.17
64840	T	Repair of leg nerve	0221	21.43	$1,090.87	$463.62	$218.17
64856	T	Repair/transpose nerve	0221	21.43	$1,090.87	$463.62	$218.17
64857	T	Repair arm/leg nerve	0221	21.43	$1,090.87	$463.62	$218.17
64858	T	Repair sciatic nerve	0221	21.43	$1,090.87	$463.62	$218.17
64859	T	Nerve surgery	0221	21.43	$1,090.87	$463.62	$218.17
64861	T	Repair of arm nerves	0221	21.43	$1,090.87	$463.62	$218.17
64862	T	Repair of low back nerves	0221	21.43	$1,090.87	$463.62	$218.17
64864	T	Repair of facial nerve	0221	21.43	$1,090.87	$463.62	$218.17
64865	T	Repair of facial nerve	0221	21.43	$1,090.87	$463.62	$218.17
64866	C	Fusion of facial/other nerve					
64868	C	Fusion of facial/other nerve					
64870	T	Fusion of facial/other nerve	0221	21.43	$1,090.87	$463.62	$218.17
64872	T	Subsequent repair of nerve	0221	21.43	$1,090.87	$463.62	$218.17
64874	T	Repair & revise nerve add-on	0221	21.43	$1,090.87	$463.62	$218.17
64876	T	Repair nerve/shorten bone	0221	21.43	$1,090.87	$463.62	$218.17
64885	T	Nerve graft, head or neck	0221	21.43	$1,090.87	$463.62	$218.17
64886	T	Nerve graft, head or neck	0221	21.43	$1,090.87	$463.62	$218.17
64890	T	Nerve graft, hand or foot	0221	21.43	$1,090.87	$463.62	$218.17
64891	T	Nerve graft, hand or foot	0221	21.43	$1,090.87	$463.62	$218.17
64892	T	Nerve graft, arm or leg	0221	21.43	$1,090.87	$463.62	$218.17
64893	T	Nerve graft, arm or leg	0221	21.43	$1,090.87	$463.62	$218.17
64895	T	Nerve graft, hand or foot	0221	21.43	$1,090.87	$463.62	$218.17
64896	T	Nerve graft, hand or foot	0221	21.43	$1,090.87	$463.62	$218.17
64897	T	Nerve graft, arm or leg	0221	21.43	$1,090.87	$463.62	$218.17
64898	T	Nerve graft, arm or leg	0221	21.43	$1,090.87	$463.62	$218.17
64901	T	Nerve graft add-on	0221	21.43	$1,090.87	$463.62	$218.17
64902	T	Nerve graft add-on	0221	21.43	$1,090.87	$463.62	$218.17
64905	T	Nerve pedicle transfer	0221	21.43	$1,090.87	$463.62	$218.17
64907	T	Nerve pedicle transfer	0221	21.43	$1,090.87	$463.62	$218.17
64999	T	Nervous system surgery	0204	2.24	$114.02	$43.33	$22.80
65091	T	Revise eye	0242	23.72	$1,207.44	$597.36	$241.49
65093	T	Revise eye with implant	0241	18.12	$922.38	$384.47	$184.48
65101	T	Removal of eye	0242	23.72	$1,207.44	$597.36	$241.49
65103	T	Remove eye/insert implant	0242	23.72	$1,207.44	$597.36	$241.49
65105	T	Remove eye/attach implant	0242	23.72	$1,207.44	$597.36	$241.49
65110	T	Removal of eye	0242	23.72	$1,207.44	$597.36	$241.49
65112	T	Remove eye/revise socket	0242	23.72	$1,207.44	$597.36	$241.49
65114	T	Remove eye/revise socket	0242	23.72	$1,207.44	$597.36	$241.49
65125	T	Revise ocular implant	0240	13.83	$704.00	$315.34	$140.80
65130	T	Insert ocular implant	0241	18.12	$922.38	$384.47	$184.48
65135	T	Insert ocular implant	0241	18.12	$922.38	$384.47	$184.48
65140	T	Attach ocular implant	0242	23.72	$1,207.44	$597.36	$241.49
65150	T	Revise ocular implant	0241	18.12	$922.38	$384.47	$184.48
65155	T	Reinsert ocular implant	0242	23.72	$1,207.44	$597.36	$241.49
65175	T	Removal of ocular implant	0240	13.83	$704.00	$315.34	$140.80
65205	S	Remove foreign body from eye	0231	2.03	$103.34	$46.50	$20.67
65210	S	Remove foreign body from eye	0231	2.03	$103.34	$46.50	$20.67
65220	S	Remove foreign body from eye	0231	2.03	$103.34	$46.50	$20.67
65222	S	Remove foreign body from eye	0231	2.03	$103.34	$46.50	$20.67
65235	T	Remove foreign body from eye	0233	10.83	$551.29	$264.62	$110.26
65260	T	Remove foreign body from eye	0237	36.32	$1,848.83		$369.77

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
65265	T	Remove foreign body from eye	0236	16.21	$825.15		$165.03
65270	T	Repair of eye wound	0240	13.83	$704.00	$315.34	$140.80
65272	T	Repair of eye wound	0233	10.83	$551.29	$264.62	$110.26
65273	C	Repair of eye wound					
65275	T	Repair of eye wound	0233	10.83	$551.29	$264.62	$110.26
65280	T	Repair of eye wound	0234	19.08	$971.25	$466.20	$194.25
65285	T	Repair of eye wound	0234	19.08	$971.25	$466.20	$194.25
65286	T	Repair of eye wound	0233	10.83	$551.29	$264.62	$110.26
65290	T	Repair of eye socket wound	0243	17.70	$901.00	$429.78	$180.20
65400	T	Removal of eye lesion	0233	10.83	$551.29	$264.62	$110.26
65410	T	Biopsy of cornea	0233	10.83	$551.29	$264.62	$110.26
65420	T	Removal of eye lesion	0233	10.83	$551.29	$264.62	$110.26
65426	T	Removal of eye lesion	0234	19.08	$971.25	$466.20	$194.25
65430	S	Corneal smear	0230	0.61	$31.05	$14.28	$6.21
65435	T	Curette/treat cornea	0239	5.80	$295.24	$115.14	$59.05
65436	T	Curette/treat cornea	0233	10.83	$551.29	$264.62	$110.26
65450	S	Treatment of corneal lesion	0231	2.03	$103.34	$46.50	$20.67
65600	T	Revision of cornea	0240	13.83	$704.00	$315.34	$140.80
65710	T	Corneal transplant	0244	38.46	$1,957.77	$851.42	$391.55
65730	T	Corneal transplant	0244	38.46	$1,957.77	$851.42	$391.55
65750	T	Corneal transplant	0244	38.46	$1,957.77	$851.42	$391.55
65755	T	Corneal transplant	0244	38.46	$1,957.77	$851.42	$391.55
65760	E	Revision of cornea					
65765	E	Revision of cornea					
65767	E	Corneal tissue transplant					
65770	T	Revise cornea with implant	0244	38.46	$1,957.77	$851.42	$391.55
65771	E	Radial keratotomy					
65772	T	Correction of astigmatism	0233	10.83	$551.29	$264.62	$110.26
65775	T	Correction of astigmatism	0233	10.83	$551.29	$264.62	$110.26
65800	T	Drainage of eye	0233	10.83	$551.29	$264.62	$110.26
65805	T	Drainage of eye	0233	10.83	$551.29	$264.62	$110.26
65810	T	Drainage of eye	0233	10.83	$551.29	$264.62	$110.26
65815	T	Drainage of eye	0234	19.08	$971.25	$466.20	$194.25
65820	T	Relieve inner eye pressure	0232	3.50	$178.16	$78.39	$35.63
65850	T	Incision of eye	0234	19.08	$971.25	$466.20	$194.25
65855	T	Laser surgery of eye	0248	29.51	$1,502.18		$300.44
65860	T	Incise inner eye adhesions	0247	4.03	$205.14	$94.36	$41.03
65865	T	Incise inner eye adhesions	0233	10.83	$551.29	$264.62	$110.26
65870	T	Incise inner eye adhesions	0234	19.08	$971.25	$466.20	$194.25
65875	T	Incise inner eye adhesions	0234	19.08	$971.25	$466.20	$194.25
65880	T	Incise inner eye adhesions	0233	10.83	$551.29	$264.62	$110.26
65900	T	Remove eye lesion	0233	10.83	$551.29	$264.62	$110.26
65920	T	Remove implant from eye	0233	10.83	$551.29	$264.62	$110.26
65930	T	Remove blood clot from eye	0234	19.08	$971.25	$466.20	$194.25
66020	T	Injection treatment of eye	0233	10.83	$551.29	$264.62	$110.26
66030	T	Injection treatment of eye	0233	10.83	$551.29	$264.62	$110.26
66130	T	Remove eye lesion	0234	19.08	$971.25	$466.20	$194.25
66150	T	Glaucoma surgery	0233	10.83	$551.29	$264.62	$110.26
66155	T	Glaucoma surgery	0234	19.08	$971.25	$466.20	$194.25
66160	T	Glaucoma surgery	0234	19.08	$971.25	$466.20	$194.25
66165	T	Glaucoma surgery	0234	19.08	$971.25	$466.20	$194.25
66170	T	Glaucoma surgery	0234	19.08	$971.25	$466.20	$194.25
66172	T	Incision of eye	0234	19.08	$971.25	$466.20	$194.25
66180	T	Implant eye shunt	0234	19.08	$971.25	$466.20	$194.25
66185	T	Revise eye shunt	0234	19.08	$971.25	$466.20	$194.25
66220	T	Repair eye lesion	0236	16.21	$825.15		$165.03
66225	T	Repair/graft eye lesion	0234	19.08	$971.25	$466.20	$194.25
66250	T	Follow-up surgery of eye	0233	10.83	$551.29	$264.62	$110.26
66500	T	Incision of iris	0232	3.50	$178.16	$78.39	$35.63
66505	T	Incision of iris	0232	3.50	$178.16	$78.39	$35.63
66600	T	Remove iris and lesion	0233	10.83	$551.29	$264.62	$110.26
66605	T	Removal of iris	0234	19.08	$971.25	$466.20	$194.25
66625	T	Removal of iris	0233	10.83	$551.29	$264.62	$110.26
66630	T	Removal of iris	0233	10.83	$551.29	$264.62	$110.26
66635	T	Removal of iris	0234	19.08	$971.25	$466.20	$194.25
66680	T	Repair iris & ciliary body	0234	19.08	$971.25	$466.20	$194.25
66682	T	Repair iris & ciliary body	0234	19.08	$971.25	$466.20	$194.25
66700	T	Destruction, ciliary body	0233	10.83	$551.29	$264.62	$110.26
66710	T	Destruction, ciliary body	0233	10.83	$551.29	$264.62	$110.26
66720	T	Destruction, ciliary body	0233	10.83	$551.29	$264.62	$110.26
66740	T	Destruction, ciliary body	0233	10.83	$551.29	$264.62	$110.26
66761	T	Revision of iris	0248	29.51	$1,502.18		$300.44
66762	T	Revision of iris	0247	4.03	$205.14	$94.36	$41.03
66770	T	Removal of inner eye lesion	0247	4.03	$205.14	$94.36	$41.03
66820	T	Incision, secondary cataract	0232	3.50	$178.16	$78.39	$35.63

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
66821	T	After cataract laser surgery	0248	29.51	$1,502.18	.....	$300.44
66825	T	Reposition intraocular lens	0234	19.08	$971.25	$466.20	$194.25
66830	T	Removal of lens lesion	0232	3.50	$178.16	$78.39	$35.63
66840	T	Removal of lens material	0245	10.44	$531.44	$249.78	$106.29
66850	T	Removal of lens material	0249	21.80	$1,109.71	$521.56	$221.94
66852	T	Removal of lens material	0249	21.80	$1,109.71	$521.56	$221.94
66920	T	Extraction of lens	0249	21.80	$1,109.71	$521.56	$221.94
66930	T	Extraction of lens	0249	21.80	$1,109.71	$521.56	$221.94
66940	T	Extraction of lens	0245	10.44	$531.44	$249.78	$106.29
66982	T	Cataract surgery, complex	0246	21.20	$1,079.16	$507.21	$215.83
66983	T	Cataract surg w/iol, 1 stage	0246	21.20	$1,079.16	$507.21	$215.83
66984	T	Cataract surg w/iol, i stage	0246	21.20	$1,079.16	$507.21	$215.83
66985	T	Insert lens prosthesis	0246	21.20	$1,079.16	$507.21	$215.83
66986	T	Exchange lens prosthesis	0246	21.20	$1,079.16	$507.21	$215.83
66999	T	Eye surgery procedure	0247	4.03	$205.14	$94.36	$41.03
67005	T	Partial removal of eye fluid	0237	36.32	$1,848.83	.....	$369.77
67010	T	Partial removal of eye fluid	0237	36.32	$1,848.83	.....	$369.77
67015	T	Release of eye fluid	0237	36.32	$1,848.83	.....	$369.77
67025	T	Replace eye fluid	0236	16.21	$825.15	.....	$165.03
67027	T	Implant eye drug system	0237	36.32	$1,848.83	.....	$369.77
67028	T	Injection eye drug	0235	5.57	$283.54	$78.91	$56.71
67030	T	Incise inner eye strands	0236	16.21	$825.15	.....	$165.03
67031	T	Laser surgery, eye strands	0247	4.03	$205.14	$94.36	$41.03
67036	T	Removal of inner eye fluid	0237	36.32	$1,848.83	.....	$369.77
67038	T	Strip retinal membrane	0237	36.32	$1,848.83	.....	$369.77
67039	T	Laser treatment of retina	0237	36.32	$1,848.83	.....	$369.77
67040	T	Laser treatment of retina	0237	36.32	$1,848.83	.....	$369.77
67101	T	Repair detached retina	0235	5.57	$283.54	$78.91	$56.71
67105	T	Repair detached retina	0247	4.03	$205.14	$94.36	$41.03
67107	T	Repair detached retina	0237	36.32	$1,848.83	.....	$369.77
67108	T	Repair detached retina	0237	36.32	$1,848.83	.....	$369.77
67110	T	Repair detached retina	0235	5.57	$283.54	$78.91	$56.71
67112	T	Rerepair detached retina	0237	36.32	$1,848.83	.....	$369.77
67115	T	Release encircling material	0236	16.21	$825.15	.....	$165.03
67120	T	Remove eye implant material	0236	16.21	$825.15	.....	$165.03
67121	T	Remove eye implant material	0237	36.32	$1,848.83	.....	$369.77
67141	T	Treatment of retina	0235	5.57	$283.54	$78.91	$56.71
67145	T	Treatment of retina	0247	4.03	$205.14	$94.36	$41.03
67208	S	Treatment of retinal lesion	0231	2.03	$103.34	$46.50	$20.67
67210	T	Treatment of retinal lesion	0247	4.03	$205.14	$94.36	$41.03
67218	T	Treatment of retinal lesion	0237	36.32	$1,848.83	.....	$369.77
67220	T	Treatment of choroid lesion	0235	5.57	$283.54	$78.91	$56.71
67221	T	Ocular photodynamic ther	0235	5.57	$283.54	$78.91	$56.71
*67225	T	Eye photodynamic ther add-on	0235	5.57	$283.54	$78.91	$56.71
67227	T	Treatment of retinal lesion	0235	5.57	$283.54	$78.91	$56.71
67228	T	Treatment of retinal lesion	0248	29.51	$1,502.18	.....	$300.44
67250	T	Reinforce eye wall	0240	13.83	$704.00	$315.34	$140.80
67255	T	Reinforce/graft eye wall	0237	36.32	$1,848.83	.....	$369.77
67299	T	Eye surgery procedure	0248	29.51	$1,502.18	.....	$300.44
67311	T	Revise eye muscle	0243	17.70	$901.00	$429.78	$180.20
67312	T	Revise two eye muscles	0243	17.70	$901.00	$429.78	$180.20
67314	T	Revise eye muscle	0243	17.70	$901.00	$429.78	$180.20
67316	T	Revise two eye muscles	0243	17.70	$901.00	$429.78	$180.20
67318	T	Revise eye muscle(s)	0243	17.70	$901.00	$429.78	$180.20
67320	T	Revise eye muscle(s) add-on	0243	17.70	$901.00	$429.78	$180.20
67331	T	Eye surgery follow-up add-on	0243	17.70	$901.00	$429.78	$180.20
67332	T	Rerevise eye muscles add-on	0243	17.70	$901.00	$429.78	$180.20
67334	T	Revise eye muscle w/suture	0243	17.70	$901.00	$429.78	$180.20
67335	T	Eye suture during surgery	0243	17.70	$901.00	$429.78	$180.20
67340	T	Revise eye muscle add-on	0243	17.70	$901.00	$429.78	$180.20
67343	T	Release eye tissue	0243	17.70	$901.00	$429.78	$180.20
67345	T	Destroy nerve of eye muscle	0238	3.01	$153.22	$58.96	$30.64
67350	T	Biopsy eye muscle	0699	6.46	$328.84	$147.98	$65.77
67399	T	Eye muscle surgery procedure	0243	17.70	$901.00	$429.78	$180.20
67400	T	Explore/biopsy eye socket	0241	18.12	$922.38	$384.47	$184.48
67405	T	Explore/drain eye socket	0241	18.12	$922.38	$384.47	$184.48
67412	T	Explore/treat eye socket	0241	18.12	$922.38	$384.47	$184.48
67413	T	Explore/treat eye socket	0241	18.12	$922.38	$384.47	$184.48
67414	T	Explr/decompress eye socket	0242	23.72	$1,207.44	$597.36	$241.49
67415	T	Aspiration, orbital contents	0239	5.80	$295.24	$115.14	$59.05
67420	T	Explore/treat eye socket	0242	23.72	$1,207.44	$597.36	$241.49
67430	T	Explore/treat eye socket	0242	23.72	$1,207.44	$597.36	$241.49
67440	T	Explore/drain eye socket	0242	23.72	$1,207.44	$597.36	$241.49
67445	T	Explr/decompress eye socket	0242	23.72	$1,207.44	$597.36	$241.49
67450	T	Explore/biopsy eye socket	0242	23.72	$1,207.44	$597.36	$241.49

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
67500	S	Inject/treat eye socket	0231	2.03	$103.34	$46.50	$20.67
67505	T	Inject/treat eye socket	0238	3.01	$153.22	$58.96	$30.64
67515	T	Inject/treat eye socket	0239	5.80	$295.24	$115.14	$59.05
67550	T	Insert eye socket implant	0242	23.72	$1,207.44	$597.36	$241.49
67560	T	Revise eye socket implant	0241	18.12	$922.38	$384.47	$184.48
67570	T	Decompress optic nerve	0242	23.72	$1,207.44	$597.36	$241.49
67599	T	Orbit surgery procedure	0239	5.80	$295.24	$115.14	$59.05
67700	T	Drainage of eyelid abscess	0238	3.01	$153.22	$58.96	$30.64
67710	T	Incision of eyelid	0239	5.80	$295.24	$115.14	$59.05
67715	T	Incision of eyelid fold	0240	13.83	$704.00	$315.34	$140.80
67800	T	Remove eyelid lesion	0238	3.01	$153.22	$58.96	$30.64
67801	T	Remove eyelid lesions	0239	5.80	$295.24	$115.14	$59.05
67805	T	Remove eyelid lesions	0238	3.01	$153.22	$58.96	$30.64
67808	T	Remove eyelid lesion(s)	0240	13.83	$704.00	$315.34	$140.80
67810	T	Biopsy of eyelid	0238	3.01	$153.22	$58.96	$30.64
67820	S	Revise eyelashes	0698	1.03	$52.43	$19.92	$10.49
67825	T	Revise eyelashes	0238	3.01	$153.22	$58.96	$30.64
67830	T	Revise eyelashes	0239	5.80	$295.24	$115.14	$59.05
67835	T	Revise eyelashes	0240	13.83	$704.00	$315.34	$140.80
67840	T	Remove eyelid lesion	0239	5.80	$295.24	$115.14	$59.05
67850	T	Treat eyelid lesion	0239	5.80	$295.24	$115.14	$59.05
67875	T	Closure of eyelid by suture	0239	5.80	$295.24	$115.14	$59.05
67880	T	Revision of eyelid	0233	10.83	$551.29	$264.62	$110.26
67882	T	Revision of eyelid	0240	13.83	$704.00	$315.34	$140.80
67900	T	Repair brow defect	0240	13.83	$704.00	$315.34	$140.80
67901	T	Repair eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67902	T	Repair eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67903	T	Repair eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67904	T	Repair eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67906	T	Repair eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67908	T	Repair eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67909	T	Revise eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67911	T	Revise eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67914	T	Repair eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67915	T	Repair eyelid defect	0239	5.80	$295.24	$115.14	$59.05
67916	T	Repair eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67917	T	Repair eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67921	T	Repair eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67922	T	Repair eyelid defect	0239	5.80	$295.24	$115.14	$59.05
67923	T	Repair eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67924	T	Repair eyelid defect	0240	13.83	$704.00	$315.34	$140.80
67930	T	Repair eyelid wound	0240	13.83	$704.00	$315.34	$140.80
67935	T	Repair eyelid wound	0240	13.83	$704.00	$315.34	$140.80
67938	S	Remove eyelid foreign body	0698	1.03	$52.43	$19.92	$10.49
67950	T	Revision of eyelid	0240	13.83	$704.00	$315.34	$140.80
67961	T	Revision of eyelid	0240	13.83	$704.00	$315.34	$140.80
67966	T	Revision of eyelid	0240	13.83	$704.00	$315.34	$140.80
67971	T	Reconstruction of eyelid	0241	18.12	$922.38	$384.47	$184.48
67973	T	Reconstruction of eyelid	0241	18.12	$922.38	$384.47	$184.48
67974	T	Reconstruction of eyelid	0241	18.12	$922.38	$384.47	$184.48
67975	T	Reconstruction of eyelid	0240	13.83	$704.00	$315.34	$140.80
67999	T	Revision of eyelid	0240	13.83	$704.00	$315.34	$140.80
68020	T	Incise/drain eyelid lining	0240	13.83	$704.00	$315.34	$140.80
68040	S	Treatment of eyelid lesions	0698	1.03	$52.43	$19.92	$10.49
68100	T	Biopsy of eyelid lining	0233	10.83	$551.29	$264.62	$110.26
68110	T	Remove eyelid lining lesion	0699	6.46	$328.84	$147.98	$65.77
68115	T	Remove eyelid lining lesion	0239	5.80	$295.24	$115.14	$59.05
68130	T	Remove eyelid lining lesion	0233	10.83	$551.29	$264.62	$110.26
68135	T	Remove eyelid lining lesion	0239	5.80	$295.24	$115.14	$59.05
68200	S	Treat eyelid by injection	0698	1.03	$52.43	$19.92	$10.49
68320	T	Revise/graft eyelid lining	0240	13.83	$704.00	$315.34	$140.80
68325	T	Revise/graft eyelid lining	0242	23.72	$1,207.44	$597.36	$241.49
68326	T	Revise/graft eyelid lining	0241	18.12	$922.38	$384.47	$184.48
68328	T	Revise/graft eyelid lining	0241	18.12	$922.38	$384.47	$184.48
68330	T	Revise eyelid lining	0233	10.83	$551.29	$264.62	$110.26
68335	T	Revise/graft eyelid lining	0241	18.12	$922.38	$384.47	$184.48
68340	T	Separate eyelid adhesions	0240	13.83	$704.00	$315.34	$140.80
68360	T	Revise eyelid lining	0234	19.08	$971.25	$466.20	$194.25
68362	T	Revise eyelid lining	0234	19.08	$971.25	$466.20	$194.25
68399	T	Eyelid lining surgery	0239	5.80	$295.24	$115.14	$59.05
68400	T	Incise/drain tear gland	0238	3.01	$153.22	$58.96	$30.64
68420	T	Incise/drain tear sac	0240	13.83	$704.00	$315.34	$140.80
68440	T	Incise tear duct opening	0238	3.01	$153.22	$58.96	$30.64
68500	T	Removal of tear gland	0241	18.12	$922.38	$384.47	$184.48
68505	T	Partial removal, tear gland	0241	18.12	$922.38	$384.47	$184.48

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
68510	T	Biopsy of tear gland	0240	13.83	$704.00	$315.34	$140.80
68520	T	Removal of tear sac	0241	18.12	$922.38	$384.47	$184.48
68525	T	Biopsy of tear sac	0240	13.83	$704.00	$315.34	$140.80
68530	T	Clearance of tear duct	0240	13.83	$704.00	$315.34	$140.80
68540	T	Remove tear gland lesion	0241	18.12	$922.38	$384.47	$184.48
68550	T	Remove tear gland lesion	0242	23.72	$1,207.44	$597.36	$241.49
68700	T	Repair tear ducts	0241	18.12	$922.38	$384.47	$184.48
68705	T	Revise tear duct opening	0238	3.01	$153.22	$58.96	$30.64
68720	T	Create tear sac drain	0242	23.72	$1,207.44	$597.36	$241.49
68745	T	Create tear duct drain	0241	18.12	$922.38	$384.47	$184.48
68750	T	Create tear duct drain	0242	23.72	$1,207.44	$597.36	$241.49
68760	S	Close tear duct opening	0698	1.03	$52.43	$19.92	$10.49
68761	S	Close tear duct opening	0231	2.03	$103.34	$46.50	$20.67
68770	T	Close tear system fistula	0240	13.83	$704.00	$315.34	$140.80
68801	S	Dilate tear duct opening	0231	2.03	$103.34	$46.50	$20.67
68810	T	Probe nasolacrimal duct	0699	6.46	$328.84	$147.98	$65.77
68811	T	Probe nasolacrimal duct	0240	13.83	$704.00	$315.34	$140.80
68815	T	Probe nasolacrimal duct	0240	13.83	$704.00	$315.34	$140.80
68840	T	Explore/irrigate tear ducts	0699	6.46	$328.84	$147.98	$65.77
68850	N	Injection for tear sac x-ray					
68899	T	Tear duct system surgery	0699	6.46	$328.84	$147.98	$65.77
69000	T	Drain external ear lesion	0006	2.18	$110.97	$33.95	$22.19
69005	T	Drain external ear lesion	0007	6.75	$343.60	$72.03	$68.72
69020	T	Drain outer ear canal lesion	0006	2.18	$110.97	$33.95	$22.19
69090	E	Pierce earlobes					
69100	T	Biopsy of external ear	0019	4.22	$214.81	$78.91	$42.96
69105	T	Biopsy of external ear canal	0253	12.33	$627.65	$284.00	$125.53
69110	T	Remove external ear, partial	0020	8.44	$429.63	$130.53	$85.93
69120	T	Removal of external ear	0254	17.37	$884.20	$272.41	$176.84
69140	T	Remove ear canal lesion(s)	0254	17.37	$884.20	$272.41	$176.84
69145	T	Remove ear canal lesion(s)	0020	8.44	$429.63	$130.53	$85.93
69150	C	Extensive ear canal surgery					
69155	C	Extensive ear/neck surgery					
69200	X	Clear outer ear canal	0340	0.84	$42.76	$10.69	$8.55
69205	T	Clear outer ear canal	0022	13.91	$708.07	$292.94	$141.61
69210	X	Remove impacted ear wax	0340	0.84	$42.76	$10.69	$8.55
69220	T	Clean out mastoid cavity	0012	0.66	$33.60	$9.18	$6.72
69222	T	Clean out mastoid cavity	0253	12.33	$627.65	$284.00	$125.53
69300	T	Revise external ear	0254	17.37	$884.20	$272.41	$176.84
69310	T	Rebuild outer ear canal	0256	26.61	$1,354.56	$623.05	$270.91
69320	T	Rebuild outer ear canal	0256	26.61	$1,354.56	$623.05	$270.91
69399	T	Outer ear surgery procedure	0251	2.43	$123.70	$27.99	$24.74
69400	T	Inflate middle ear canal	0251	2.43	$123.70	$27.99	$24.74
69401	N	Inflate middle ear canal					
69405	T	Catheterize middle ear canal	0252	5.95	$302.88	$114.24	$60.58
69410	T	Inset middle ear (baffle)	0252	5.95	$302.88	$114.24	$60.58
69420	T	Incision of eardrum	0251	2.43	$123.70	$27.99	$24.74
69421	T	Incision of eardrum	0253	12.33	$627.65	$284.00	$125.53
69424	T	Remove ventilating tube	0252	5.95	$302.88	$114.24	$60.58
69433	T	Create eardrum opening	0252	5.95	$302.88	$114.24	$60.58
69436	T	Create eardrum opening	0253	12.33	$627.65	$284.00	$125.53
69440	T	Exploration of middle ear	0254	17.37	$884.20	$272.41	$176.84
69450	T	Eardrum revision	0256	26.61	$1,354.56	$623.05	$270.91
69501	T	Mastoidectomy	0256	26.61	$1,354.56	$623.05	$270.91
69502	C	Mastoidectomy					
69505	T	Remove mastoid structures	0256	26.61	$1,354.56	$623.05	$270.91
69511	T	Extensive mastoid surgery	0256	26.61	$1,354.56	$623.05	$270.91
69530	T	Extensive mastoid surgery	0256	26.61	$1,354.56	$623.05	$270.91
69535	C	Remove part of temporal bone					
69540	T	Remove ear lesion	0253	12.33	$627.65	$284.00	$125.53
69550	T	Remove ear lesion	0256	26.61	$1,354.56	$623.05	$270.91
69552	T	Remove ear lesion	0256	26.61	$1,354.56	$623.05	$270.91
69554	C	Remove ear lesion					
69601	T	Mastoid surgery revision	0256	26.61	$1,354.56	$623.05	$270.91
69602	T	Mastoid surgery revision	0256	26.61	$1,354.56	$623.05	$270.91
69603	T	Mastoid surgery revision	0256	26.61	$1,354.56	$623.05	$270.91
69604	T	Mastoid surgery revision	0256	26.61	$1,354.56	$623.05	$270.91
69605	T	Mastoid surgery revision	0256	26.61	$1,354.56	$623.05	$270.91
69610	T	Repair of eardrum	0254	17.37	$884.20	$272.41	$176.84
69620	T	Repair of eardrum	0254	17.37	$884.20	$272.41	$176.84
69631	T	Repair eardrum structures	0256	26.61	$1,354.56	$623.05	$270.91
69632	T	Rebuild eardrum structures	0256	26.61	$1,354.56	$623.05	$270.91
69633	T	Rebuild eardrum structures	0256	26.61	$1,354.56	$623.05	$270.91
69635	T	Repair eardrum structures	0256	26.61	$1,354.56	$623.05	$270.91
69636	T	Rebuild eardrum structures	0256	26.61	$1,354.56	$623.05	$270.91

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
69637	T	Rebuild eardrum structures	0256	26.61	$1,354.56	$623.05	$270.91
69641	T	Revise middle ear & mastoid	0256	26.61	$1,354.56	$623.05	$270.91
69642	T	Revise middle ear & mastoid	0256	26.61	$1,354.56	$623.05	$270.91
69643	T	Revise middle ear & mastoid	0256	26.61	$1,354.56	$623.05	$270.91
69644	T	Revise middle ear & mastoid	0256	26.61	$1,354.56	$623.05	$270.91
69645	T	Revise middle ear & mastoid	0256	26.61	$1,354.56	$623.05	$270.91
69646	T	Revise middle ear & mastoid	0256	26.61	$1,354.56	$623.05	$270.91
69650	T	Release middle ear bone	0254	17.37	$884.20	$272.41	$176.84
69660	T	Revise middle ear bone	0256	26.61	$1,354.56	$623.05	$270.91
69661	T	Revise middle ear bone	0256	26.61	$1,354.56	$623.05	$270.91
69662	T	Revise middle ear bone	0256	26.61	$1,354.56	$623.05	$270.91
69666	T	Repair middle ear structures	0256	26.61	$1,354.56	$623.05	$270.91
69667	T	Repair middle ear structures	0256	26.61	$1,354.56	$623.05	$270.91
69670	T	Remove mastoid air cells	0256	26.61	$1,354.56	$623.05	$270.91
69676	T	Remove middle ear nerve	0256	26.61	$1,354.56	$623.05	$270.91
69700	T	Close mastoid fistula	0256	26.61	$1,354.56	$623.05	$270.91
69710	E	Implant/replace hearing aid					
69711	T	Remove/repair hearing aid	0256	26.61	$1,354.56	$623.05	$270.91
69714	T	Implant temple bone w/stimul	0256	26.61	$1,354.56	$623.05	$270.91
69715	T	Temple bne implnt w/stimulat	0256	26.61	$1,354.56	$623.05	$270.91
69717	T	Temple bone implant revision	0256	26.61	$1,354.56	$623.05	$270.91
69718	T	Revise temple bone implant	0256	26.61	$1,354.56	$623.05	$270.91
69720	T	Release facial nerve	0256	26.61	$1,354.56	$623.05	$270.91
69725	T	Release facial nerve	0256	26.61	$1,354.56	$623.05	$270.91
69740	T	Repair facial nerve	0256	26.61	$1,354.56	$623.05	$270.91
69745	T	Repair facial nerve	0256	26.61	$1,354.56	$623.05	$270.91
69799	T	Middle ear surgery procedure	0253	12.33	$627.65	$284.00	$125.53
69801	T	Incise inner ear	0256	26.61	$1,354.56	$623.05	$270.91
69802	T	Incise inner ear	0256	26.61	$1,354.56	$623.05	$270.91
69805	T	Explore inner ear	0256	26.61	$1,354.56	$623.05	$270.91
69806	T	Explore inner ear	0256	26.61	$1,354.56	$623.05	$270.91
69820	T	Establish inner ear window	0256	26.61	$1,354.56	$623.05	$270.91
69840	T	Revise inner ear window	0256	26.61	$1,354.56	$623.05	$270.91
69905	T	Remove inner ear	0256	26.61	$1,354.56	$623.05	$270.91
69910	T	Remove inner ear & mastoid	0256	26.61	$1,354.56	$623.05	$270.91
69915	T	Incise inner ear nerve	0256	26.61	$1,354.56	$623.05	$270.91
69930	T	Implant cochlear device	0259	376.56	$19,168.41	$8,798.30	$3,833.68
69949	T	Inner ear surgery procedure	0253	12.33	$627.65	$284.00	$125.53
69950	C	Incise inner ear nerve					
69955	T	Release facial nerve	0256	26.61	$1,354.56	$623.05	$270.91
69960	T	Release inner ear canal	0256	26.61	$1,354.56	$623.05	$270.91
69970	C	Remove inner ear lesion					
69979	T	Temporal bone surgery	0251	2.43	$123.70	$27.99	$24.74
69990	N	Microsurgery add-on					
70010	S	Contrast x-ray of brain	0274	5.24	$266.74	$128.12	$53.35
70015	S	Contrast x-ray of brain	0274	5.24	$266.74	$128.12	$53.35
70030	X	X-ray eye for foreign body	0260	0.70	$35.63	$19.59	$7.13
70100	X	X-ray exam of jaw	0260	0.70	$35.63	$19.59	$7.13
70110	X	X-ray exam of jaw	0260	0.70	$35.63	$19.59	$7.13
70120	X	X-ray exam of mastoids	0260	0.70	$35.63	$19.59	$7.13
70130	X	X-ray exam of mastoids	0260	0.70	$35.63	$19.59	$7.13
70134	X	X-ray exam of middle ear	0261	1.21	$61.59	$33.87	$12.32
70140	X	X-ray exam of facial bones	0260	0.70	$35.63	$19.59	$7.13
70150	X	X-ray exam of facial bones	0260	0.70	$35.63	$19.59	$7.13
70160	X	X-ray exam of nasal bones	0260	0.70	$35.63	$19.59	$7.13
70170	X	X-ray exam of tear duct	0263	1.61	$81.96	$44.26	$16.39
70190	X	X-ray exam of eye sockets	0260	0.70	$35.63	$19.59	$7.13
70200	X	X-ray exam of eye sockets	0260	0.70	$35.63	$19.59	$7.13
70210	X	X-ray exam of sinuses	0260	0.70	$35.63	$19.59	$7.13
70220	X	X-ray exam of sinuses	0260	0.70	$35.63	$19.59	$7.13
70240	X	X-ray exam, pituitary saddle	0260	0.70	$35.63	$19.59	$7.13
70250	X	X-ray exam of skull	0260	0.70	$35.63	$19.59	$7.13
70260	X	X-ray exam of skull	0261	1.21	$61.59	$33.87	$12.32
70300	X	X-ray exam of teeth	0262	0.65	$33.09	$10.90	$6.62
70310	X	X-ray exam of teeth	0262	0.65	$33.09	$10.90	$6.62
70320	X	Full mouth x-ray of teeth	0262	0.65	$33.09	$10.90	$6.62
70328	X	X-ray exam of jaw joint	0260	0.70	$35.63	$19.59	$7.13
70330	X	X-ray exam of jaw joints	0260	0.70	$35.63	$19.59	$7.13
70332	S	X-ray exam of jaw joint	0275	2.59	$131.84	$68.56	$26.37
70336	S	Magnetic image, jaw joint	0335	5.39	$274.37	$150.90	$54.87
70350	X	X-ray head for orthodontia	0260	0.70	$35.63	$19.59	$7.13
70355	X	Panoramic x-ray of jaws	0260	0.70	$35.63	$19.59	$7.13
70360	X	X-ray exam of neck	0260	0.70	$35.63	$19.59	$7.13
70370	X	Throat x-ray & fluoroscopy	0272	1.38	$70.25	$38.63	$14.05
70371	X	Speech evaluation, complex	0272	1.38	$70.25	$38.63	$14.05

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
70373	X	Contrast x-ray of larynx	0263	1.61	$81.96	$44.26	$16.39
70380	X	X-ray exam of salivary gland	0260	0.70	$35.63	$19.59	$7.13
70390	X	X-ray exam of salivary duct	0263	1.61	$81.96	$44.26	$16.39
70450	S	Ct head/brain w/o dye	0332	3.24	$164.93	$90.71	$32.99
70460	S	Ct head/brain w/dye	0283	4.48	$228.05	$125.42	$45.61
70470	S	Ct head/brain w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
70480	S	Ct orbit/ear/fossa w/o dye	0332	3.24	$164.93	$90.71	$32.99
70481	S	Ct orbit/ear/fossa w/dye	0283	4.48	$228.05	$125.42	$45.61
70482	S	Ct orbit/ear/fossa w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
70486	S	Ct maxillofacial w/o dye	0332	3.24	$164.93	$90.71	$32.99
70487	S	Ct maxillofacial w/dye	0283	4.48	$228.05	$125.42	$45.61
70488	S	Ct maxillofacial w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
70490	S	Ct soft tissue neck w/o dye	0332	3.24	$164.93	$90.71	$32.99
70491	S	Ct soft tissue neck w/dye	0283	4.48	$228.05	$125.42	$45.61
70492	S	Ct sft tsue nck w/o & w/dye	0333	5.22	$265.72	$146.14	$53.14
70496	S	Ct angiography, head	0333	5.22	$265.72	$146.14	$53.14
70498	S	Ct angiography, neck	0333	5.22	$265.72	$146.14	$53.14
70540	S	Mri orbit/face/neck w/o dye	0336	6.29	$320.19	$176.10	$64.04
70542	S	Mri orbit/face/neck w/dye	0284	7.15	$363.96	$200.17	$72.79
70543	S	Mri orbt/fac/nck w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
70544	S	Mr angiography head w/o dye	0336	6.29	$320.19	$176.10	$64.04
70545	S	Mr angiography head w/dye	0284	7.15	$363.96	$200.17	$72.79
70546	S	Mr angiograph head w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
70547	S	Mr angiography neck w/o dye	0336	6.29	$320.19	$176.10	$64.04
70548	S	Mr angiography neck w/dye	0284	7.15	$363.96	$200.17	$72.79
70549	S	Mr angiograph neck w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
70551	S	Mri brain w/o dye	0336	6.29	$320.19	$176.10	$64.04
70552	S	Mri brain w/dye	0284	7.15	$363.96	$200.17	$72.79
70553	S	Mri brain w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
71010	X	Chest x-ray	0260	0.70	$35.63	$19.59	$7.13
71015	X	Chest x-ray	0260	0.70	$35.63	$19.59	$7.13
71020	X	Chest x-ray	0260	0.70	$35.63	$19.59	$7.13
71021	X	Chest x-ray	0260	0.70	$35.63	$19.59	$7.13
71022	X	Chest x-ray	0260	0.70	$35.63	$19.59	$7.13
71023	X	Chest x-ray and fluoroscopy	0272	1.38	$70.25	$38.63	$14.05
71030	X	Chest x-ray	0260	0.70	$35.63	$19.59	$7.13
71034	X	Chest x-ray and fluoroscopy	0272	1.38	$70.25	$38.63	$14.05
71035	X	Chest x-ray	0260	0.70	$35.63	$19.59	$7.13
71040	X	Contrast x-ray of bronchi	0263	1.61	$81.96	$44.26	$16.39
71060	X	Contrast x-ray of bronchi	0263	1.61	$81.96	$44.26	$16.39
71090	X	X-ray & pacemaker insertion	0272	1.38	$70.25	$38.63	$14.05
71100	X	X-ray exam of ribs	0260	0.70	$35.63	$19.59	$7.13
71101	X	X-ray exam of ribs/chest	0260	0.70	$35.63	$19.59	$7.13
71110	X	X-ray exam of ribs	0260	0.70	$35.63	$19.59	$7.13
71111	X	X-ray exam of ribs/ chest	0261	1.21	$61.59	$33.87	$12.32
71120	X	X-ray exam of breastbone	0260	0.70	$35.63	$19.59	$7.13
71130	X	X-ray exam of breastbone	0260	0.70	$35.63	$19.59	$7.13
71250	S	Ct thorax w/o dye	0332	3.24	$164.93	$90.71	$32.99
71260	S	Ct thorax w/dye	0283	4.48	$228.05	$125.42	$45.61
71270	S	Ct thorax w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
71275	S	Ct angiography, chest	0333	5.22	$265.72	$146.14	$53.14
71550	S	Mri chest w/o dye	0336	6.29	$320.19	$176.10	$64.04
71551	S	Mri chest w/dye	0284	7.15	$363.96	$200.17	$72.79
71552	S	Mri chest w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
71555	E	Mri angio chest w or w/o dye					
72010	X	X-ray exam of spine	0261	1.21	$61.59	$33.87	$12.32
72020	X	X-ray exam of spine	0260	0.70	$35.63	$19.59	$7.13
72040	X	X-ray exam of neck spine	0260	0.70	$35.63	$19.59	$7.13
72050	X	X-ray exam of neck spine	0261	1.21	$61.59	$33.87	$12.32
72052	X	X-ray exam of neck spine	0261	1.21	$61.59	$33.87	$12.32
72069	X	X-ray exam of trunk spine	0260	0.70	$35.63	$19.59	$7.13
72070	X	X-ray exam of thoracic spine	0260	0.70	$35.63	$19.59	$7.13
72072	X	X-ray exam of thoracic spine	0260	0.70	$35.63	$19.59	$7.13
72074	X	X-ray exam of thoracic spine	0260	0.70	$35.63	$19.59	$7.13
72080	X	X-ray exam of trunk spine	0260	0.70	$35.63	$19.59	$7.13
72090	X	X-ray exam of trunk spine	0261	1.21	$61.59	$33.87	$12.32
72100	X	X-ray exam of lower spine	0260	0.70	$35.63	$19.59	$7.13
72110	X	X-ray exam of lower spine	0261	1.21	$61.59	$33.87	$12.32
72114	X	X-ray exam of lower spine	0261	1.21	$61.59	$33.87	$12.32
72120	X	X-ray exam of lower spine	0260	0.70	$35.63	$19.59	$7.13
72125	S	Ct neck spine w/o dye	0332	3.24	$164.93	$90.71	$32.99
72126	S	Ct neck spine w/dye	0283	4.48	$228.05	$125.42	$45.61
72127	S	Ct neck spine w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
72128	S	Ct chest spine w/o dye	0332	3.24	$164.93	$90.71	$32.99
72129	S	Ct chest spine w/dye	0283	4.48	$228.05	$125.42	$45.61

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
72130	S	Ct chest spine w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
72131	S	Ct lumbar spine w/o dye	0332	3.24	$164.93	$90.71	$32.99
72132	S	Ct lumbar spine w/dye	0283	4.48	$228.05	$125.42	$45.61
72133	S	Ct lumbar spine w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
72141	S	Mri neck spine w/o dye	0336	6.29	$320.19	$176.10	$64.04
72142	S	Mri neck spine w/dye	0284	7.15	$363.96	$200.17	$72.79
72146	S	Mri chest spine w/o dye	0336	6.29	$320.19	$176.10	$64.04
72147	S	Mri chest spine w/dye	0284	7.15	$363.96	$200.17	$72.79
72148	S	Mri lumbar spine w/o dye	0336	6.29	$320.19	$176.10	$64.04
72149	S	Mri lumbar spine w/dye	0284	7.15	$363.96	$200.17	$72.79
72156	S	Mri neck spine w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
72157	S	Mri chest spine w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
72158	S	Mri lumbar spine w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
72159	E	Mr angio spine w/o&w dye					
72170	X	X-ray exam of pelvis	0260	0.70	$35.63	$19.59	$7.13
72190	X	X-ray exam of pelvis	0260	0.70	$35.63	$19.59	$7.13
72191	S	Ct angiograph pelv w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
72192	S	Ct pelvis w/o dye	0332	3.24	$164.93	$90.71	$32.99
72193	S	Ct pelvis w/dye	0283	4.48	$228.05	$125.42	$45.61
72194	S	Ct pelvis w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
72195	S	Mri pelvis w/o dye	0336	6.29	$320.19	$176.10	$64.04
72196	S	Mri pelvis w/dye	0284	7.15	$363.96	$200.17	$72.79
72197	S	Mri pelvis w/o & w dye	0337	8.54	$434.72	$239.09	$86.94
72198	E	Mr angio pelvis w/o&w dye					
72200	X	X-ray exam sacroiliac joints	0260	0.70	$35.63	$19.59	$7.13
72202	X	X-ray exam sacroiliac joints	0260	0.70	$35.63	$19.59	$7.13
72220	X	X-ray exam of tailbone	0260	0.70	$35.63	$19.59	$7.13
72240	S	Contrast x-ray of neck spine	0274	5.24	$266.74	$128.12	$53.35
72255	S	Contrast x-ray, thorax spine	0274	5.24	$266.74	$128.12	$53.35
72265	S	Contrast x-ray, lower spine	0274	5.24	$266.74	$128.12	$53.35
72270	S	Contrast x-ray of spine	0274	5.24	$266.74	$128.12	$53.35
72275	S	Epidurography	0274	5.24	$266.74	$128.12	$53.35
72285	S	X-ray c/t spine disk	0274	5.24	$266.74	$128.12	$53.35
72295	S	X-ray of lower spine disk	0274	5.24	$266.74	$128.12	$53.35
73000	X	X-ray exam of collar bone	0260	0.70	$35.63	$19.59	$7.13
73010	X	X-ray exam of shoulder blade	0260	0.70	$35.63	$19.59	$7.13
73020	X	X-ray exam of shoulder	0260	0.70	$35.63	$19.59	$7.13
73030	X	X-ray exam of shoulder	0260	0.70	$35.63	$19.59	$7.13
73040	S	Contrast x-ray of shoulder	0275	2.59	$131.84	$68.56	$26.37
73050	X	X-ray exam of shoulders	0260	0.70	$35.63	$19.59	$7.13
73060	X	X-ray exam of humerus	0260	0.70	$35.63	$19.59	$7.13
73070	X	X-ray exam of elbow	0260	0.70	$35.63	$19.59	$7.13
73080	X	X-ray exam of elbow	0260	0.70	$35.63	$19.59	$7.13
73085	S	Contrast x-ray of elbow	0275	2.59	$131.84	$68.56	$26.37
73090	X	X-ray exam of forearm	0260	0.70	$35.63	$19.59	$7.13
73092	X	X-ray exam of arm, infant	0260	0.70	$35.63	$19.59	$7.13
73100	X	X-ray exam of wrist	0260	0.70	$35.63	$19.59	$7.13
73110	X	X-ray exam of wrist	0260	0.70	$35.63	$19.59	$7.13
73115	S	Contrast x-ray of wrist	0275	2.59	$131.84	$68.56	$26.37
73120	X	X-ray exam of hand	0260	0.70	$35.63	$19.59	$7.13
73130	X	X-ray exam of hand	0260	0.70	$35.63	$19.59	$7.13
73140	X	X-ray exam of finger(s)	0260	0.70	$35.63	$19.59	$7.13
73200	S	Ct upper extremity w/o dye	0332	3.24	$164.93	$90.71	$32.99
73201	S	Ct upper extremity w/dye	0283	4.48	$228.05	$125.42	$45.61
73202	S	Ct uppr extremity w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
73206	S	Ct angio upr extrm w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
73218	S	Mri upper extremity w/o dye	0336	6.29	$320.19	$176.10	$64.04
73219	S	Mri upper extremity w/dye	0284	7.15	$363.96	$200.17	$72.79
73220	S	Mri uppr extremity w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
73221	S	Mri joint upr extrem w/o dye	0336	6.29	$320.19	$176.10	$64.04
73222	S	Mri joint upr extrem w/ dye	0284	7.15	$363.96	$200.17	$72.79
73223	S	Mri joint upr extr w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
73225	E	Mr angio upr extr w/o&w dye					
73500	X	X-ray exam of hip	0260	0.70	$35.63	$19.59	$7.13
73510	X	X-ray exam of hip	0260	0.70	$35.63	$19.59	$7.13
73520	X	X-ray exam of hips	0260	0.70	$35.63	$19.59	$7.13
73525	S	Contrast x-ray of hip	0275	2.59	$131.84	$68.56	$26.37
73530	X	X-ray exam of hip	0261	1.21	$61.59	$33.87	$12.32
73540	X	X-ray exam of pelvis & hips	0260	0.70	$35.63	$19.59	$7.13
73542	S	X-ray exam, sacroiliac joint	0275	2.59	$131.84	$68.56	$26.37
73550	X	X-ray exam of thigh	0260	0.70	$35.63	$19.59	$7.13
73560	X	X-ray exam of knee, 1 or 2	0260	0.70	$35.63	$19.59	$7.13
73562	X	X-ray exam of knee, 3	0260	0.70	$35.63	$19.59	$7.13
73564	X	X-ray exam, knee, 4 or more	0260	0.70	$35.63	$19.59	$7.13
73565	X	X-ray exam of knees	0260	0.70	$35.63	$19.59	$7.13

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
73580	S	Contrast x-ray of knee joint	0275	2.59	$131.84	$68.56	$26.37
73590	X	X-ray exam of lower leg	0260	0.70	$35.63	$19.59	$7.13
73592	X	X-ray exam of leg, infant	0261	1.21	$61.59	$33.87	$12.32
73600	X	X-ray exam of ankle	0260	0.70	$35.63	$19.59	$7.13
73610	X	X-ray exam of ankle	0260	0.70	$35.63	$19.59	$7.13
73615	S	Contrast x-ray of ankle	0275	2.59	$131.84	$68.56	$26.37
73620	X	X-ray exam of foot	0260	0.70	$35.63	$19.59	$7.13
73630	X	X-ray exam of foot	0260	0.70	$35.63	$19.59	$7.13
73650	X	X-ray exam of heel	0260	0.70	$35.63	$19.59	$7.13
73660	X	X-ray exam of toe(s)	0260	0.70	$35.63	$19.59	$7.13
73700	S	Ct lower extremity w/o dye	0332	3.24	$164.93	$90.71	$32.99
73701	S	Ct lower extremity w/dye	0283	4.48	$228.05	$125.42	$45.61
73702	S	Ct lwr extremity w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
73706	S	Ct angio lwr extr w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
73718	S	Mri lower extremity w/o dye	0336	6.29	$320.19	$176.10	$64.04
73719	S	Mri lower extremity w/dye	0284	7.15	$363.96	$200.17	$72.79
73720	S	Mri lwr extremity w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
73721	S	Mri joint of lwr extre w/o d	0336	6.29	$320.19	$176.10	$64.04
73722	S	Mri joint of lwr extr w/dye	0284	7.15	$363.96	$200.17	$72.79
73723	S	Mri joint lwr extr w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
73725	E	Mr ang lwr ext w or w/o dye					
74000	X	X-ray exam of abdomen	0260	0.70	$35.63	$19.59	$7.13
74010	X	X-ray exam of abdomen	0260	0.70	$35.63	$19.59	$7.13
74020	X	X-ray exam of abdomen	0260	0.70	$35.63	$19.59	$7.13
74022	X	X-ray exam series, abdomen	0261	1.21	$61.59	$33.87	$12.32
74150	S	Ct abdomen w/o dye	0332	3.24	$164.93	$90.71	$32.99
74160	S	Ct abdomen w/dye	0283	4.48	$228.05	$125.42	$45.61
74170	S	Ct abdomen w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
74175	S	Ct angio abdom w/o&w dye	0333	5.22	$265.72	$146.14	$53.14
74181	S	Mri abdomen w/o dye	0336	6.29	$320.19	$176.10	$64.04
74182	S	Mri abdomen w/dye	0284	7.15	$363.96	$200.17	$72.79
74183	S	Mri abdomen w/o&w dye	0337	8.54	$434.72	$239.09	$86.94
74185	E	Mri angio, abdom w or w/o dy					
74190	X	X-ray exam of peritoneum	0263	1.61	$81.96	$44.26	$16.39
74210	S	Contrst x-ray exam of throat	0276	1.48	$75.34	$41.43	$15.07
74220	S	Contrast x-ray, esophagus	0276	1.48	$75.34	$41.43	$15.07
74230	S	Cinema x-ray, throat/esoph	0276	1.48	$75.34	$41.43	$15.07
74235	S	Remove esophagus obstruction	0296	3.39	$172.56	$94.90	$34.51
74240	S	X-ray exam, upper gi tract	0276	1.48	$75.34	$41.43	$15.07
74241	S	X-ray exam, upper gi tract	0276	1.48	$75.34	$41.43	$15.07
74245	S	X-ray exam, upper gi tract	0277	2.16	$109.95	$60.47	$21.99
74246	S	Contrst x-ray uppr gi tract	0276	1.48	$75.34	$41.43	$15.07
74247	S	Contrst x-ray uppr gi tract	0276	1.48	$75.34	$41.43	$15.07
74249	S	Contrst x-ray uppr gi tract	0277	2.16	$109.95	$60.47	$21.99
74250	S	X-ray exam of small bowel	0276	1.48	$75.34	$41.43	$15.07
74251	S	X-ray exam of small bowel	0277	2.16	$109.95	$60.47	$21.99
74260	S	X-ray exam of small bowel	0277	2.16	$109.95	$60.47	$21.99
74270	S	Contrast x-ray exam of colon	0276	1.48	$75.34	$41.43	$15.07
74280	S	Contrast x-ray exam of colon	0277	2.16	$109.95	$60.47	$21.99
74283	S	Contrast x-ray exam of colon	0276	1.48	$75.34	$41.43	$15.07
74290	S	Contrast x-ray, gallbladder	0276	1.48	$75.34	$41.43	$15.07
74291	S	Contrast x-rays, gallbladder	0276	1.48	$75.34	$41.43	$15.07
74300	X	X-ray bile ducts/pancreas	0263	1.61	$81.96	$44.26	$16.39
74301	X	X-rays at surgery add-on	0263	1.61	$81.96	$44.26	$16.39
74305	X	X-ray bile ducts/pancreas	0263	1.61	$81.96	$44.26	$16.39
74320	X	Contrast x-ray of bile ducts	0264	3.71	$188.85	$103.86	$37.77
74327	S	X-ray bile stone removal	0296	3.39	$172.56	$94.90	$34.51
74328	N	Xray 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	1.38	$70.25	$38.63	$14.05
74350	X	X-ray guide, stomach tube	0187	4.22	$214.81		$42.96
74355	X	X-ray guide, intestinal tube	0187	4.22	$214.81		$42.96
74360	S	X-ray guide, GI dilation	0296	3.39	$172.56	$94.90	$34.51
74363	S	X-ray, bile duct dilation	0297	7.07	$359.89	$172.51	$71.98
74400	S	Contrst x-ray, urinary tract	0278	2.34	$119.12	$65.51	$23.82
74410	S	Contrst x-ray, urinary tract	0278	2.34	$119.12	$65.51	$23.82
74415	S	Contrst x-ray, urinary tract	0278	2.34	$119.12	$65.51	$23.82
74420	S	Contrst x-ray, urinary tract	0278	2.34	$119.12	$65.51	$23.82
74425	S	Contrst x-ray, urinary tract	0278	2.34	$119.12	$65.51	$23.82
74430	S	Contrast x-ray, bladder	0278	2.34	$119.12	$65.51	$23.82
74440	S	X-ray, male genital tract	0278	2.34	$119.12	$65.51	$23.82
74445	S	X-ray exam of penis	0278	2.34	$119.12	$65.51	$23.82
74450	S	X-ray, urethra/bladder	0278	2.34	$119.12	$65.51	$23.82
74455	S	X-ray, urethra/bladder	0278	2.34	$119.12	$65.51	$23.82

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
74470	X	X-ray exam of kidney lesion	0264	3.71	$188.85	$103.86	$37.77
74475	S	X-ray control, cath insert	0297	7.07	$359.89	$172.51	$71.98
74480	S	X-ray control, cath insert	0297	7.07	$359.89	$172.51	$71.98
74485	S	X-ray guide, GU dilation	0296	3.39	$172.56	$94.90	$34.51
74710	X	X-ray measurement of pelvis	0260	0.70	$35.63	$19.59	$7.13
74740	X	X-ray, female genital tract	0264	3.71	$188.85	$103.86	$37.77
74742	X	X-ray, fallopian tube	0187	4.22	$214.81		$42.96
74775	S	X-ray exam of perineum	0278	2.34	$119.12	$65.51	$23.82
75552	S	Heart mri for morph w/o dye	0336	6.29	$320.19	$176.10	$64.04
75553	S	Heart mri for morph w/dye	0284	7.15	$363.96	$200.17	$72.79
75554	S	Cardiac MRI/function	0335	5.39	$274.37	$150.90	$54.87
75555	S	Cardiac MRI/limited study	0335	5.39	$274.37	$150.90	$54.87
75556	E	Cardiac MRI/flow mapping					
75600	S	Contrast x-ray exam of aorta	0280	13.54	$689.24	$351.51	$137.85
75605	S	Contrast x-ray exam of aorta	0280	13.54	$689.24	$351.51	$137.85
75625	S	Contrast x-ray exam of aorta	0280	13.54	$689.24	$351.51	$137.85
75630	S	X-ray aorta, leg arteries	0280	13.54	$689.24	$351.51	$137.85
75635	S	Ct angio abdominal arteries	0333	5.22	$265.72	$146.14	$53.14
75650	S	Artery x-rays, head & neck	0280	13.54	$689.24	$351.51	$137.85
75658	S	Artery x-rays, arm	0280	13.54	$689.24	$351.51	$137.85
75660	S	Artery x-rays, head & neck	0279	7.72	$392.98	$174.57	$78.60
75662	S	Artery x-rays, head & neck	0279	7.72	$392.98	$174.57	$78.60
75665	S	Artery x-rays, head & neck	0280	13.54	$689.24	$351.51	$137.85
75671	S	Artery x-rays, head & neck	0280	13.54	$689.24	$351.51	$137.85
75676	S	Artery x-rays, neck	0280	13.54	$689.24	$351.51	$137.85
75680	S	Artery x-rays, neck	0280	13.54	$689.24	$351.51	$137.85
75685	S	Artery x-rays, spine	0279	7.72	$392.98	$174.57	$78.60
75705	S	Artery x-rays, spine	0279	7.72	$392.98	$174.57	$78.60
75710	S	Artery x-rays, arm/leg	0280	13.54	$689.24	$351.51	$137.85
75716	S	Artery x-rays, arms/legs	0280	13.54	$689.24	$351.51	$137.85
75722	S	Artery x-rays, kidney	0280	13.54	$689.24	$351.51	$137.85
75724	S	Artery x-rays, kidneys	0280	13.54	$689.24	$351.51	$137.85
75726	S	Artery x-rays, abdomen	0280	13.54	$689.24	$351.51	$137.85
75731	S	Artery x-rays, adrenal gland	0280	13.54	$689.24	$351.51	$137.85
75733	S	Artery x-rays, adrenals	0280	13.54	$689.24	$351.51	$137.85
75736	S	Artery x-rays, pelvis	0280	13.54	$689.24	$351.51	$137.85
75741	S	Artery x-rays, lung	0279	7.72	$392.98	$174.57	$78.60
75743	S	Artery x-rays, lungs	0280	13.54	$689.24	$351.51	$137.85
75746	S	Artery x-rays, lung	0279	7.72	$392.98	$174.57	$78.60
75756	S	Artery x-rays, chest	0279	7.72	$392.98	$174.57	$78.60
75774	S	Artery x-ray, each vessel	0279	7.72	$392.98	$174.57	$78.60
75790	S	Visualize A-V shunt	0281	4.32	$219.91	$114.35	$43.98
75801	X	Lymph vessel x-ray, arm/leg	0264	3.71	$188.85	$103.86	$37.77
75803	X	Lymph vessel x-ray,arms/legs	0264	3.71	$188.85	$103.86	$37.77
75805	X	Lymph vessel x-ray, trunk	0264	3.71	$188.85	$103.86	$37.77
75807	X	Lymph vessel x-ray, trunk	0264	3.71	$188.85	$103.86	$37.77
75809	X	Nonvascular shunt, x-ray	0263	1.61	$81.96	$44.26	$16.39
75810	S	Vein x-ray, spleen/liver	0279	7.72	$392.98	$174.57	$78.60
75820	S	Vein x-ray, arm/leg	0281	4.32	$219.91	$114.35	$43.98
75822	S	Vein x-ray, arms/legs	0281	4.32	$219.91	$114.35	$43.98
75825	S	Vein x-ray, trunk	0279	7.72	$392.98	$174.57	$78.60
75827	S	Vein x-ray, chest	0279	7.72	$392.98	$174.57	$78.60
75831	S	Vein x-ray, kidney	0287	4.06	$206.67	$90.93	$41.33
75833	S	Vein x-ray, kidneys	0279	7.72	$392.98	$174.57	$78.60
75840	S	Vein x-ray, adrenal gland	0287	4.06	$206.67	$90.93	$41.33
75842	S	Vein x-ray, adrenal glands	0287	4.06	$206.67	$90.93	$41.33
75860	S	Vein x-ray, neck	0287	4.06	$206.67	$90.93	$41.33
75870	S	Vein x-ray, skull	0287	4.06	$206.67	$90.93	$41.33
75872	S	Vein x-ray, skull	0287	4.06	$206.67	$90.93	$41.33
75880	S	Vein x-ray, eye socket	0287	4.06	$206.67	$90.93	$41.33
75885	S	Vein x-ray, liver	0279	7.72	$392.98	$174.57	$78.60
75887	S	Vein x-ray, liver	0280	13.54	$689.24	$351.51	$137.85
75889	S	Vein x-ray, liver	0279	7.72	$392.98	$174.57	$78.60
75891	S	Vein x-ray, liver	0279	7.72	$392.98	$174.57	$78.60
75893	N	Venous sampling by catheter					
75894	S	X-rays, transcath therapy	0297	7.07	$359.89	$172.51	$71.98
75896	S	X-rays, transcath therapy	0297	7.07	$359.89	$172.51	$71.98
75898	X	Follow-up angiogram	0264	3.71	$188.85	$103.86	$37.77
75900	C	Arterial catheter exchange					
75940	X	X-ray placement, vein filter	0187	4.22	$214.81		$42.96
75945	S	Intravascular us	0267	2.33	$118.61	$65.23	$23.72
75946	S	Intravascular us add-on	0267	2.33	$118.61	$65.23	$23.72
75952	C	Endovasc repair abdom aorta					
75953	C	Abdom aneurysm endovas rpr					
75960	S	Transcatheter intro, stent	0280	13.54	$689.24	$351.51	$137.85

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
75961	S	Retrieval, broken catheter	0280	13.54	$689.24	$351.51	$137.85
75962	S	Repair arterial blockage	0280	13.54	$689.24	$351.51	$137.85
75964	S	Repair artery blockage, each	0280	13.54	$689.24	$351.51	$137.85
75966	S	Repair arterial blockage	0280	13.54	$689.24	$351.51	$137.85
75968	S	Repair artery blockage, each	0280	13.54	$689.24	$351.51	$137.85
75970	S	Vascular biopsy	0280	13.54	$689.24	$351.51	$137.85
75978	S	Repair venous blockage	0280	13.54	$689.24	$351.51	$137.85
75980	S	Contrast xray exam bile duct	0297	7.07	$359.89	$172.51	$71.98
75982	S	Contrast xray exam bile duct	0297	7.07	$359.89	$172.51	$71.98
75984	S	Xray control catheter change	0296	3.39	$172.56	$94.90	$34.51
75989	N	Abscess drainage under x-ray					
75992	S	Atherectomy, x-ray exam	0280	13.54	$689.24	$351.51	$137.85
75993	S	Atherectomy, x-ray exam	0280	13.54	$689.24	$351.51	$137.85
75994	S	Atherectomy, x-ray exam	0280	13.54	$689.24	$351.51	$137.85
75995	S	Atherectomy, x-ray exam	0280	13.54	$689.24	$351.51	$137.85
75996	S	Atherectomy, x-ray exam	0280	13.54	$689.24	$351.51	$137.85
76000	X	Fluoroscope examination	0272	1.38	$70.25	$38.63	$14.05
76001	N	Fluoroscope exam, extensive					
76003	N	Needle localization by x-ray					
76005	N	Fluoroguide for spine inject					
76006	X	X-ray stress view	0261	1.21	$61.59	$33.87	$12.32
76010	X	X-ray, nose to rectum	0260	0.70	$35.63	$19.59	$7.13
76012	S	Percut vertebroplasty fluor	0274	5.24	$266.74	$128.12	$53.35
76013	S	Percut vertebroplasty, ct	0274	5.24	$266.74	$128.12	$53.35
76020	X	X-rays for bone age	0261	1.21	$61.59	$33.87	$12.32
76040	X	X-rays, bone evaluation	0260	0.70	$35.63	$19.59	$7.13
76061	X	X-rays, bone survey	0261	1.21	$61.59	$33.87	$12.32
76062	X	X-rays, bone survey	0261	1.21	$61.59	$33.87	$12.32
76065	X	X-rays, bone evaluation	0261	1.21	$61.59	$33.87	$12.32
76066	X	Joint(s) survey, single film	0260	0.70	$35.63	$19.59	$7.13
76070	E	CT scan, bone density study					
76075	S	Dual energy x-ray study	0707		$75.00		$15.00
76076	S	Dual energy x-ray study	0707		$75.00		$15.00
76078	X	Photodensitometry	0261	1.21	$61.59	$33.87	$12.32
76080	X	X-ray exam of fistula	0263	1.61	$81.96	$44.26	$16.39
*76085	A	Computer mammogram add-on					
76086	X	X-ray of mammary duct	0263	1.61	$81.96	$44.26	$16.39
76088	X	X-ray of mammary ducts	0263	1.61	$81.96	$44.26	$16.39
76090	S	Mammogram, one breast	0271	0.60	$30.54	$16.79	$6.11
76091	S	Mammogram, both breasts	0271	0.60	$30.54	$16.79	$6.11
76092	A	Mammogram, screening					
76093	E	Magnetic image, breast					
76094	E	Magnetic image, both breasts					
76095	X	Stereotactic breast biopsy	0187	4.22	$214.81		$42.96
76096	X	X-ray of needle wire, breast	0289	1.63	$82.97	$44.80	$16.59
76098	X	X-ray exam, breast specimen	0260	0.70	$35.63	$19.59	$7.13
76100	X	X-ray exam of body section	0261	1.21	$61.59	$33.87	$12.32
76101	X	Complex body section x-ray	0263	1.61	$81.96	$44.26	$16.39
76102	X	Complex body section x-rays	0264	3.71	$188.85	$103.86	$37.77
76120	X	Cinematic x-rays	0261	1.21	$61.59	$33.87	$12.32
76125	X	Cinematic x-rays add-on	0261	1.21	$61.59	$33.87	$12.32
76140	E	X-ray consultation					
76150	X	X-ray exam, dry process	0260	0.70	$35.63	$19.59	$7.13
76350	N	Special x-ray contrast study					
76355	S	CAT scan for localization	0283	4.48	$228.05	$125.42	$45.61
76360	S	CAT scan for needle biopsy	0283	4.48	$228.05	$125.42	$45.61
*76362	N	Cat scan for tissue ablation					
76370	S	CAT scan for therapy guide	0282	1.58	$80.43	$44.23	$16.09
76375	S	3d/holograph reconstr add-on	0282	1.58	$80.43	$44.23	$16.09
76380	S	CAT scan follow-up study	0282	1.58	$80.43	$44.23	$16.09
76390	E	Mr spectroscopy					
76393	N	Mr guidance for needle place					
*76394	N	Mri for tissue ablation					
76400	S	Magnetic image, bone marrow	0335	5.39	$274.37	$150.90	$54.87
*76490	N	Us for tissue ablation					
76499	X	Radiographic procedure	0260	0.70	$35.63	$19.59	$7.13
76506	S	Echo exam of head	0266	1.54	$78.39	$43.11	$15.68
76511	S	Echo exam of eye	0266	1.54	$78.39	$43.11	$15.68
76512	S	Echo exam of eye	0266	1.54	$78.39	$43.11	$15.68
76513	S	Echo exam of eye, water bath	0265	0.95	$48.36	$26.59	$9.67
76516	S	Echo exam of eye	0266	1.54	$78.39	$43.11	$15.68
76519	S	Echo exam of eye	0266	1.54	$78.39	$43.11	$15.68
76529	S	Echo exam of eye	0265	0.95	$48.36	$26.59	$9.67
76536	S	Echo exam of head and neck	0266	1.54	$78.39	$43.11	$15.68
76604	S	Echo exam of chest	0266	1.54	$78.39	$43.11	$15.68

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
76645	S	Echo exam of breast(s)	0265	0.95	$48.36	$26.59	$9.67
76700	S	Echo exam of abdomen	0266	1.54	$78.39	$43.11	$15.68
76705	S	Echo exam of abdomen	0266	1.54	$78.39	$43.11	$15.68
76770	S	Echo exam abdomen back wall	0266	1.54	$78.39	$43.11	$15.68
76775	S	Echo exam abdomen back wall	0266	1.54	$78.39	$43.11	$15.68
76778	S	Echo exam kidney transplant	0266	1.54	$78.39	$43.11	$15.68
76800	S	Echo exam spinal canal	0266	1.54	$78.39	$43.11	$15.68
76805	S	Echo exam of pregnant uterus	0266	1.54	$78.39	$43.11	$15.68
76810	S	Echo exam of pregnant uterus	0265	0.95	$48.36	$26.59	$9.67
76815	S	Echo exam of pregnant uterus	0265	0.95	$48.36	$26.59	$9.67
76816	S	Echo exam follow-up/repeat	0265	0.95	$48.36	$26.59	$9.67
76818	S	Fetl biophys profil w/stress	0266	1.54	$78.39	$43.11	$15.68
76819	S	Fetl biophys profil w/o strs	0266	1.54	$78.39	$43.11	$15.68
76825	S	Echo exam of fetal heart	0269	3.85	$195.98	$101.91	$39.20
76826	S	Echo exam of fetal heart	0697	2.08	$105.88	$55.06	$21.18
76827	S	Echo exam of fetal heart	0269	3.85	$195.98	$101.91	$39.20
76828	S	Echo exam of fetal heart	0697	2.08	$105.88	$55.06	$21.18
76830	S	Echo exam, transvaginal	0266	1.54	$78.39	$43.11	$15.68
76831	S	Echo exam, uterus	0266	1.54	$78.39	$43.11	$15.68
76856	S	Echo exam of pelvis	0266	1.54	$78.39	$43.11	$15.68
76857	S	Echo exam of pelvis	0265	0.95	$48.36	$26.59	$9.67
76870	S	Echo exam of scrotum	0266	1.54	$78.39	$43.11	$15.68
76872	S	Echo exam, transrectal	0266	1.54	$78.39	$43.11	$15.68
76873	N	Echograp trans r, pros study					
76880	S	Echo exam of extremity	0266	1.54	$78.39	$43.11	$15.68
76885	S	Echo exam, infant hips	0266	1.54	$78.39	$43.11	$15.68
76886	S	Echo exam, infant hips	0266	1.54	$78.39	$43.11	$15.68
76930	N	Echo guide, cardiocentesis					
76932	N	Echo guide for heart biopsy					
76936	N	Echo guide for artery repair					
76941	N	Echo guide for transfusion					
76942	N	Echo guide for biopsy					
76945	N	Echo guide, villus sampling					
76946	N	Echo guide for amniocentesis					
76948	N	Echo guide, ova aspiration					
76950	N	Echo guidance radiotherapy					
76965	N	Echo guidance radiotherapy					
76970	S	Ultrasound exam follow-up	0265	0.95	$48.36	$26.59	$9.67
76975	S	GI endoscopic ultrasound	0266	1.54	$78.39	$43.11	$15.68
76977	S	Us bone density measure	0265	0.95	$48.36	$26.59	$9.67
76986	S	Ultrasound guide intraoper	0266	1.54	$78.39	$43.11	$15.68
76999	S	Echo examination procedure	0266	1.54	$78.39	$43.11	$15.68
77261	E	Radiation therapy planning					
77262	E	Radiation therapy planning					
77263	E	Radiation therapy planning					
77280	X	Set radiation therapy field	0304	1.63	$82.97	$41.52	$16.59
77285	X	Set radiation therapy field	0305	3.71	$188.85	$90.65	$37.77
77290	X	Set radiation therapy field	0305	3.71	$188.85	$90.65	$37.77
77295	X	Set radiation therapy field	0310	14.51	$738.62	$339.05	$147.72
77299	E	Radiation therapy planning					
77300	X	Radiation therapy dose plan	0304	1.63	$82.97	$41.52	$16.59
*77301	S	Radioltherapy dos plan, imrt	0712		$875.00		$175.00
77305	X	Radiation therapy dose plan	0304	1.63	$82.97	$41.52	$16.59
77310	X	Radiation therapy dose plan	0304	1.63	$82.97	$41.52	$16.59
77315	X	Radiation therapy dose plan	0305	3.71	$188.85	$90.65	$37.77
77321	X	Radiation therapy port plan	0305	3.71	$188.85	$90.65	$37.77
77326	X	Radiation therapy dose plan	0305	3.71	$188.85	$90.65	$37.77
77327	X	Radiation therapy dose plan	0305	3.71	$188.85	$90.65	$37.77
77328	X	Radiation therapy dose plan	0305	3.71	$188.85	$90.65	$37.77
77331	X	Special radiation dosimetry	0304	1.63	$82.97	$41.52	$16.59
77332	X	Radiation treatment aid(s)	0303	3.00	$152.71	$69.28	$30.54
77333	X	Radiation treatment aid(s)	0303	3.00	$152.71	$69.28	$30.54
77334	X	Radiation treatment aid(s)	0303	3.00	$152.71	$69.28	$30.54
77336	X	Radiation physics consult	0304	1.63	$82.97	$41.52	$16.59
77370	X	Radiation physics consult	0305	3.71	$188.85	$90.65	$37.77
77399	X	External radiation dosimetry	0304	1.63	$82.97	$41.52	$16.59
77401	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07
77402	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07
77403	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07
77404	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07
77406	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07
77407	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07
77408	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07
77409	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07
77411	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
77412	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07
77413	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07
77414	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07
77416	S	Radiation treatment delivery	0300	2.07	$105.37	$47.72	$21.07
77417	X	Radiology port film(s)	0260	0.70	$35.63	$19.59	$7.13
*77418	S	Radiation tx delivery, imrt	0710		$400.00		$80.00
77427	E	Radiation tx management, x5					
77431	E	Radiation therapy management					
77432	E	Stereotactic radiation trmt					
77470	S	Special radiation treatment	0299	0.21	$10.69	$4.06	$2.14
77499	E	Radiation therapy management					
77520	S	Proton trmt, simple w/o comp	0710		$400.00		$80.00
77522	S	Proton trmt, simple w/comp	0710		$400.00		$80.00
77523	S	Proton trmt, intermediate	0712		$875.00		$175.00
77525	S	Proton treatment, complex	0712		$875.00		$175.00
77600	S	Hyperthermia treatment	0314	3.90	$198.53	$101.25	$39.71
77605	S	Hyperthermia treatment	0314	3.90	$198.53	$101.25	$39.71
77610	S	Hyperthermia treatment	0314	3.90	$198.53	$101.25	$39.71
77615	S	Hyperthermia treatment	0314	3.90	$198.53	$101.25	$39.71
77620	S	Hyperthermia treatment	0314	3.90	$198.53	$101.25	$39.71
77750	S	Infuse radioactive materials	0301	5.15	$262.16	$52.53	$52.43
77761	S	Apply intrcav radiat simple	0312	32.40	$1,649.29		$329.86
77762	S	Apply intrcav radiat interm	0312	32.40	$1,649.29		$329.86
77763	S	Apply intrcav radiat compl	0312	32.40	$1,649.29		$329.86
77776	S	Apply interstit radiat simpl	0312	32.40	$1,649.29		$329.86
77777	S	Apply interstit radiat inter	0312	32.40	$1,649.29		$329.86
77778	S	Apply iterstit radiat compl	0312	32.40	$1,649.29		$329.86
77781	S	High intensity brachytherapy	0313	14.84	$755.42	$164.02	$151.08
77782	S	High intensity brachytherapy	0313	14.84	$755.42	$164.02	$151.08
77783	S	High intensity brachytherapy	0313	14.84	$755.42	$164.02	$151.08
77784	S	High intensity brachytherapy	0313	14.84	$755.42	$164.02	$151.08
77789	S	Apply surface radiation	0300	2.07	$105.37	$47.72	$21.07
77790	N	Radiation handling					
77799	S	Radium/radioisotope therapy	0313	14.84	$755.42	$164.02	$151.08
78000	S	Thyroid, single uptake	0290	1.75	$89.08	$48.99	$17.82
78001	S	Thyroid, multiple uptakes	0290	1.75	$89.08	$48.99	$17.82
78003	S	Thyroid suppress/stimul	0290	1.75	$89.08	$48.99	$17.82
78006	S	Thyroid imaging with uptake	0291	3.50	$178.16	$90.20	$35.63
78007	S	Thyroid image, mult uptakes	0291	3.50	$178.16	$90.20	$35.63
78010	S	Thyroid imaging	0290	1.75	$89.08	$48.99	$17.82
78011	S	Thyroid imaging with flow	0290	1.75	$89.08	$48.99	$17.82
78015	S	Thyroid met imaging	0291	3.50	$178.16	$90.20	$35.63
78016	S	Thyroid met imaging/studies	0291	3.50	$178.16	$90.20	$35.63
78018	S	Thyroid met imaging, body	0292	4.20	$213.80	$117.59	$42.76
78020	S	Thyroid met uptake	0291	3.50	$178.16	$90.20	$35.63
78070	S	Parathyroid nuclear imaging	0291	3.50	$178.16	$90.20	$35.63
78075	S	Adrenal nuclear imaging	0292	4.20	$213.80	$117.59	$42.76
78099	S	Endocrine nuclear procedure	0290	1.75	$89.08	$48.99	$17.82
78102	S	Bone marrow imaging, ltd	0291	3.50	$178.16	$90.20	$35.63
78103	S	Bone marrow imaging, mult	0292	4.20	$213.80	$117.59	$42.76
78104	S	Bone marrow imaging, body	0291	3.50	$178.16	$90.20	$35.63
78110	S	Plasma volume, single	0291	3.50	$178.16	$90.20	$35.63
78111	S	Plasma volume, multiple	0291	3.50	$178.16	$90.20	$35.63
78120	S	Red cell mass, single	0291	3.50	$178.16	$90.20	$35.63
78121	S	Red cell mass, multiple	0291	3.50	$178.16	$90.20	$35.63
78122	S	Blood volume	0292	4.20	$213.80	$117.59	$42.76
78130	S	Red cell survival study	0291	3.50	$178.16	$90.20	$35.63
78135	S	Red cell survival kinetics	0292	4.20	$213.80	$117.59	$42.76
78140	S	Red cell sequestration	0291	3.50	$178.16	$90.20	$35.63
78160	S	Plasma iron turnover	0291	3.50	$178.16	$90.20	$35.63
78162	S	Iron absorption exam	0291	3.50	$178.16	$90.20	$35.63
78170	S	Red cell iron utilization	0291	3.50	$178.16	$90.20	$35.63
78172	S	Total body iron estimation	0291	3.50	$178.16	$90.20	$35.63
78185	S	Spleen imaging	0291	3.50	$178.16	$90.20	$35.63
78190	S	Platelet survival, kinetics	0291	3.50	$178.16	$90.20	$35.63
78191	S	Platelet survival	0291	3.50	$178.16	$90.20	$35.63
78195	S	Lymph system imaging	0291	3.50	$178.16	$90.20	$35.63
78199	S	Blood/lymph nuclear exam	0290	1.75	$89.08	$48.99	$17.82
78201	S	Liver imaging	0291	3.50	$178.16	$90.20	$35.63
78202	S	Liver imaging with flow	0291	3.50	$178.16	$90.20	$35.63
78205	S	Liver imaging (3D)	0292	4.20	$213.80	$117.59	$42.76
78206	S	Liver image (3d) w/flow	0292	4.20	$213.80	$117.59	$42.76
78215	S	Liver and spleen imaging	0291	3.50	$178.16	$90.20	$35.63
78216	S	Liver & spleen image/flow	0291	3.50	$178.16	$90.20	$35.63
78220	S	Liver function study	0291	3.50	$178.16	$90.20	$35.63

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78223	S	Hepatobiliary imaging	0292	4.20	$213.80	$117.59	$42.76
78230	S	Salivary gland imaging	0291	3.50	$178.16	$90.20	$35.63
78231	S	Serial salivary imaging	0291	3.50	$178.16	$90.20	$35.63
78232	S	Salivary gland function exam	0291	3.50	$178.16	$90.20	$35.63
78258	S	Esophageal motility study	0291	3.50	$178.16	$90.20	$35.63
78261	S	Gastric mucosa imaging	0291	3.50	$178.16	$90.20	$35.63
78262	S	Gastroesophageal reflux exam	0291	3.50	$178.16	$90.20	$35.63
78264	S	Gastric emptying study	0291	3.50	$178.16	$90.20	$35.63
78267	A	Breath tst attain/anal c–14					
78268	A	Breath test analysis, c–14					
78270	S	Vit B–12 absorption exam	0290	1.75	$89.08	$48.99	$17.82
78271	S	Vit B–12 absorp exam, IF	0290	1.75	$89.08	$48.99	$17.82
78272	S	Vit B–12 absorp, combined	0291	3.50	$178.16	$90.20	$35.63
78278	S	Acute GI blood loss imaging	0291	3.50	$178.16	$90.20	$35.63
78282	S	GI protein loss exam	0290	1.75	$89.08	$48.99	$17.82
78290	S	Meckel's divert exam	0291	3.50	$178.16	$90.20	$35.63
78291	S	Leveen/shunt patency exam	0291	3.50	$178.16	$90.20	$35.63
78299	S	GI nuclear procedure	0290	1.75	$89.08	$48.99	$17.82
78300	S	Bone imaging, limited area	0291	3.50	$178.16	$90.20	$35.63
78305	S	Bone imaging, multiple areas	0291	3.50	$178.16	$90.20	$35.63
78306	S	Bone imaging, whole body	0291	3.50	$178.16	$90.20	$35.63
78315	S	Bone imaging, 3 phase	0292	4.20	$213.80	$117.59	$42.76
78320	S	Bone imaging (3D)	0292	4.20	$213.80	$117.59	$42.76
78350	X	Bone mineral, single photon	0261	1.21	$61.59	$33.87	$12.32
78351	E	Bone mineral, dual photon					
78399	S	Musculoskeletal nuclear exam	0290	1.75	$89.08	$48.99	$17.82
78414	S	Non-imaging heart function	0292	4.20	$213.80	$117.59	$42.76
78428	S	Cardiac shunt imaging	0292	4.20	$213.80	$117.59	$42.76
78445	S	Vascular flow imaging	0291	3.50	$178.16	$90.20	$35.63
78455	S	Venous thrombosis study	0291	3.50	$178.16	$90.20	$35.63
78456	S	Acute venous thrombus image	0291	3.50	$178.16	$90.20	$35.63
78457	S	Venous thrombosis imaging	0291	3.50	$178.16	$90.20	$35.63
78458	S	Ven thrombosis images, bilat	0291	3.50	$178.16	$90.20	$35.63
78459	E	Heart muscle imaging (PET)					
78460	S	Heart muscle blood, single	0286	5.41	$275.39	$151.46	$55.08
78461	S	Heart muscle blood, multiple	0286	5.41	$275.39	$151.46	$55.08
78464	S	Heart image (3d), single	0286	5.41	$275.39	$151.46	$55.08
78465	S	Heart image (3d), multiple	0286	5.41	$275.39	$151.46	$55.08
78466	S	Heart infarct image	0291	3.50	$178.16	$90.20	$35.63
78468	S	Heart infarct image (ef)	0292	4.20	$213.80	$117.59	$42.76
78469	S	Heart infarct image (3D)	0292	4.20	$213.80	$117.59	$42.76
78472	S	Gated heart, planar, single	0286	5.41	$275.39	$151.46	$55.08
78473	S	Gated heart, multiple	0286	5.41	$275.39	$151.46	$55.08
78478	S	Heart wall motion add-on	0286	5.41	$275.39	$151.46	$55.08
78480	S	Heart function add-on	0286	5.41	$275.39	$151.46	$55.08
78481	S	Heart first pass, single	0286	5.41	$275.39	$151.46	$55.08
78483	S	Heart first pass, multiple	0286	5.41	$275.39	$151.46	$55.08
78491	E	Heart image (pet), single					
78492	E	Heart image (pet), multiple					
78494	S	Heart image, spect	0296	3.39	$172.56	$94.90	$34.51
78496	S	Heart first pass add-on	0296	3.39	$172.56	$94.90	$34.51
78499	S	Cardiovascular nuclear exam	0291	3.50	$178.16	$90.20	$35.63
78580	S	Lung perfusion imaging	0291	3.50	$178.16	$90.20	$35.63
78584	S	Lung V/Q image single breath	0292	4.20	$213.80	$117.59	$42.76
78585	S	Lung V/Q imaging	0292	4.20	$213.80	$117.59	$42.76
78586	S	Aerosol lung image, single	0292	4.20	$213.80	$117.59	$42.76
78587	S	Aerosol lung image, multiple	0291	3.50	$178.16	$90.20	$35.63
78588	S	Perfusion lung image	0292	4.20	$213.80	$117.59	$42.76
78591	S	Vent image, 1 breath, 1 proj	0291	3.50	$178.16	$90.20	$35.63
78593	S	Vent image, 1 proj, gas	0292	4.20	$213.80	$117.59	$42.76
78594	S	Vent image, mult proj, gas	0292	4.20	$213.80	$117.59	$42.76
78596	S	Lung differential function	0292	4.20	$213.80	$117.59	$42.76
78599	S	Respiratory nuclear exam	0291	3.50	$178.16	$90.20	$35.63
78600	S	Brain imaging, ltd static	0292	4.20	$213.80	$117.59	$42.76
78601	S	Brain imaging, ltd w/ flow	0291	3.50	$178.16	$90.20	$35.63
78605	S	Brain imaging, complete	0291	3.50	$178.16	$90.20	$35.63
78606	S	Brain imaging, compl w/flow	0292	4.20	$213.80	$117.59	$42.76
78607	S	Brain imaging (3D)	0292	4.20	$213.80	$117.59	$42.76
78608	E	Brain imaging (PET)					
78609	E	Brain imaging (PET)					
78610	S	Brain flow imaging only	0291	3.50	$178.16	$90.20	$35.63
78615	S	Cerebral blood flow imaging	0291	3.50	$178.16	$90.20	$35.63
78630	S	Cerebrospinal fluid scan	0292	4.20	$213.80	$117.59	$42.76
78635	S	CSF ventriculography	0292	4.20	$213.80	$117.59	$42.76
78645	S	CSF shunt evaluation	0291	3.50	$178.16	$90.20	$35.63

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78647	S	Cerebrospinal fluid scan	0292	4.20	$213.80	$117.59	$42.76
78650	S	CSF leakage imaging	0292	4.20	$213.80	$117.59	$42.76
78660	S	Nuclear exam of tear flow	0291	3.50	$178.16	$90.20	$35.63
78699	S	Nervous system nuclear exam	0291	3.50	$178.16	$90.20	$35.63
78700	S	Kidney imaging, static	0291	3.50	$178.16	$90.20	$35.63
78701	S	Kidney imaging with flow	0291	3.50	$178.16	$90.20	$35.63
78704	S	Imaging renogram	0291	3.50	$178.16	$90.20	$35.63
78707	S	Kidney flow/function image	0292	4.20	$213.80	$117.59	$42.76
78708	S	Kidney flow/function image	0292	4.20	$213.80	$117.59	$42.76
78709	S	Kidney flow/function image	0292	4.20	$213.80	$117.59	$42.76
78710	S	Kidney imaging (3D)	0291	3.50	$178.16	$90.20	$35.63
78715	S	Renal vascular flow exam	0291	3.50	$178.16	$90.20	$35.63
78725	S	Kidney function study	0291	3.50	$178.16	$90.20	$35.63
78730	S	Urinary bladder retention	0291	3.50	$178.16	$90.20	$35.63
78740	S	Ureteral reflux study	0291	3.50	$178.16	$90.20	$35.63
78760	S	Testicular imaging	0291	3.50	$178.16	$90.20	$35.63
78761	S	Testicular imaging/flow	0291	3.50	$178.16	$90.20	$35.63
78799	S	Genitourinary nuclear exam	0292	4.20	$213.80	$117.59	$42.76
78800	S	Tumor imaging, limited area	0291	3.50	$178.16	$90.20	$35.63
78801	S	Tumor imaging, mult areas	0292	4.20	$213.80	$117.59	$42.76
78802	S	Tumor imaging, whole body	0292	4.20	$213.80	$117.59	$42.76
78803	S	Tumor imaging (3D)	0292	4.20	$213.80	$117.59	$42.76
78805	S	Abscess imaging, ltd area	0292	4.20	$213.80	$117.59	$42.76
78806	S	Abscess imaging, whole body	0292	4.20	$213.80	$117.59	$42.76
78807	S	Nuclear localization/abscess	0292	4.20	$213.80	$117.59	$42.76
78810	E	Tumor imaging (PET)					
78890	N	Nuclear medicine data proc					
78891	N	Nuclear med data proc					
78990	N	Provide diag radionuclide(s)					
78999	S	Nuclear diagnostic exam	0291	3.50	$178.16	$90.20	$35.63
79000	S	Init hyperthyroid therapy	0294	5.01	$255.03	$140.26	$51.01
79001	S	Repeat hyperthyroid therapy	0294	5.01	$255.03	$140.26	$51.01
79020	S	Thyroid ablation	0294	5.01	$255.03	$140.26	$51.01
79030	S	Thyroid ablation, carcinoma	0294	5.01	$255.03	$140.26	$51.01
79035	S	Thyroid metastatic therapy	0294	5.01	$255.03	$140.26	$51.01
79100	S	Hematopoetic nuclear therapy	0294	5.01	$255.03	$140.26	$51.01
79200	S	Intracavitary nuclear trmt	0295	12.10	$615.94	$338.76	$123.19
79300	S	Interstitial nuclear therapy	0294	5.01	$255.03	$140.26	$51.01
79400	S	Nonhemato nuclear therapy	0295	12.10	$615.94	$338.76	$123.19
79420	S	Intravascular nuclear ther	0295	12.10	$615.94	$338.76	$123.19
79440	S	Nuclear joint therapy	0294	5.01	$255.03	$140.26	$51.01
79900	N	Provide ther radiopharm(s)					
79999	S	Nuclear medicine therapy	0294	5.01	$255.03	$140.26	$51.01
80048	A	Basic metabolic panel					
80050	A	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					
80072	D	Arthritis panel					
80074	A	Acute hepatitis panel					
80076	A	Hepatic function panel					
80090	A	Torch antibody 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					
80174	A	Assay of imipramine					
80176	A	Assay of lidocaine					
80178	A	Assay of lithium					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	0.39	$19.85	$10.72	$3.97
80502	X	Lab pathology consultation	0342	0.21	$10.69	$5.87	$2.14
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					
82105	A	Alpha-fetoprotein, serum					
82106	A	Alpha-fetoprotein, amniotic					
82108	A	Assay of aluminum					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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 (stone) analysis					
82360	A	Calculus (stone) assay					
82365	A	Calculus (stone) assay					
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					
82495	A	Assay of chromium					
82507	A	Assay of citrate					
82520	A	Assay of cocaine					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	Blood gases, O2 sat only					
82820	A	Hemoglobin-oxygen affinity					
82926	A	Assay of gastric acid					
82928	A	Assay of gastric acid					
82938	A	Gastrin test					
82941	A	Assay of gastrin					
82943	A	Assay of glucagon					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
83633	A	Test urine for lactose					
83634	A	Assay of urine for lactose					
83655	A	Assay of lead					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
83661	A	L/s ratio, fetal lung					
83662	A	Foam stability, fetal lung					
83663	A	Fluoro polarize, 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					
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	Oncorprotein, 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					
84087	A	Assay phosphohexose enzymes					
84100	A	Assay of phosphorus					
84105	A	Assay of urine phosphorus					
84106	A	Test for porphobilinogen					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
84160	A	Assay of serum protein					
84165	A	Assay of serum 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					
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)					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
85007	A	Differential WBC count					
85008	A	Nondifferential WBC count					
85009	A	Differential WBC count					
85013	A	Hematocrit					
85014	A	Hematocrit					
85018	A	Hemoglobin					
85021	A	Automated hemogram					
85022	A	Automated hemogram					
85023	A	Automated hemogram					
85024	A	Automated hemogram					
85025	A	Automated hemogram					
85027	A	Automated hemogram					
85031	A	Manual hemogram, cbc					
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					
85060	X	Blood smear interpretation	0342	0.21	$10.69	$5.87	$2.14
85095	D	Bone marrow aspiration	0003	1.03	$52.43	$27.99	$10.49
85097	X	Bone marrow interpretation	0344	0.56	$28.51	$15.68	$5.70
85102	D	Bone marrow biopsy	0003	1.03	$52.43	$27.99	$10.49
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					
85300	A	Antithrombin III test					
85301	A	Antithrombin III test					
85302	A	Blood clot inhibitor antigen					
85303	A	Blood clot inhibitor test					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
85384	A	Fibrinogen					
85385	A	Fibrinogen					
85390	A	Fibrinolysins screen					
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					
85530	A	Heparin-protamine tolerance					
85535	D	Iron stain, blood cells					
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					
85585	A	Blood platelet estimation					
85590	A	Platelet count, manual					
85595	A	Platelet count, automated					
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	X	Physician blood bank service	0343	0.39	$19.85	$10.72	$3.97
86078	X	Physician blood bank service	0344	0.56	$28.51	$15.68	$5.70
86079	X	Physician blood bank service	0344	0.56	$28.51	$15.68	$5.70
86140	A	C-reactive protein					
*86141	A	C-reactive protein, hs					
86146	A	Glycoprotein antibody					
86147	A	Cardiolipin antibody					

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CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	0.10	$5.09	$2.79	$1.02
86490	X	Coccidioidomycosis skin test	0341	0.10	$5.09	$2.79	$1.02
86510	X	Histoplasmosis skin test	0341	0.10	$5.09	$2.79	$1.02
86580	X	TB intradermal test	0341	0.10	$5.09	$2.79	$1.02
86585	X	TB tine test	0341	0.10	$5.09	$2.79	$1.02
86586	X	Skin test, unlisted	0341	0.10	$5.09	$2.79	$1.02
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					
86625	A	Campylobacter antibody					
86628	A	Candida antibody					

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CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
86683	D	Hemoglobin, fecal 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					
86805	A	Lymphocytotoxicity assay					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	0.26	$13.24	$5.37	$2.65
86860	X	RBC antibody elution	0345	0.26	$13.24	$5.37	$2.65
86870	X	RBC antibody identification	0346	0.77	$39.20	$12.03	$7.84
86880	X	Coombs test	0341	0.10	$5.09	$2.79	$1.02
86885	X	Coombs test	0341	0.10	$5.09	$2.79	$1.02
86886	X	Coombs test	0341	0.10	$5.09	$2.79	$1.02
86890	X	Autologous blood process	0346	0.77	$39.20	$12.03	$7.84
86891	X	Autologous blood, op salvage	0345	0.26	$13.24	$5.37	$2.65
86900	X	Blood typing, ABO	0341	0.10	$5.09	$2.79	$1.02
86901	X	Blood typing, Rh (D)	0345	0.26	$13.24	$5.37	$2.65
86903	X	Blood typing, antigen screen	0345	0.26	$13.24	$5.37	$2.65
86904	X	Blood typing, patient serum	0345	0.26	$13.24	$5.37	$2.65
86905	X	Blood typing, RBC antigens	0345	0.26	$13.24	$5.37	$2.65
86906	X	Blood typing, Rh phenotype	0345	0.26	$13.24	$5.37	$2.65
86910	E	Blood typing, paternity test					
86911	E	Blood typing, antigen system					
86915	X	Bone marrow/stem cell prep	0346	0.77	$39.20	$12.03	$7.84
86920	X	Compatibility test	0346	0.77	$39.20	$12.03	$7.84
86921	X	Compatibility test	0345	0.26	$13.24	$5.37	$2.65
86922	X	Compatibility test	0346	0.77	$39.20	$12.03	$7.84
86927	X	Plasma, fresh frozen	0346	0.77	$39.20	$12.03	$7.84
86930	X	Frozen blood prep	0347	1.56	$79.41	$20.13	$15.88
86931	X	Frozen blood thaw	0347	1.56	$79.41	$20.13	$15.88
86932	X	Frozen blood freeze/thaw	0346	0.77	$39.20	$12.03	$7.84
86940	A	Hemolysins/agglutinins, auto					
86941	A	Hemolysins/agglutinins					
86945	X	Blood product/irradiation	0345	0.26	$13.24	$5.37	$2.65
86950	X	Leukacyte transfusion	0347	1.56	$79.41	$20.13	$15.88
86965	X	Pooling blood platelets	0347	1.56	$79.41	$20.13	$15.88
86970	X	RBC pretreatment	0345	0.26	$13.24	$5.37	$2.65
86971	X	RBC pretreatment	0345	0.26	$13.24	$5.37	$2.65
86972	X	RBC pretreatment	0345	0.26	$13.24	$5.37	$2.65
86975	X	RBC pretreatment, serum	0345	0.26	$13.24	$5.37	$2.65
86976	X	RBC pretreatment, serum	0345	0.26	$13.24	$5.37	$2.65
86977	X	RBC pretreatment, serum	0345	0.26	$13.24	$5.37	$2.65
86978	X	RBC pretreatment, serum	0345	0.26	$13.24	$5.37	$2.65
86985	X	Split blood or products	0347	1.56	$79.41	$20.13	$15.88
86999	X	Transfusion procedure	0346	0.77	$39.20	$12.03	$7.84
87001	A	Small animal inoculation					
87003	A	Small animal inoculation					
87015	A	Specimen concentration					
87040	A	Blood culture for bacteria					
87045	A	Stool 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	Culture bacteria anaerobic					
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	Cultur type immunofluoresc					
87143	A	Culture typing, glc/hplc					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	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	Macacroscopic 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, mlc					
87188	A	Microbe suscept, macrobroth					
87190	A	Microbe suscept, mycobacteri					
87197	A	Bactericidal level, serum					
*87198	A	Cytomegalovirus antibody dfa					
*87199	A	Enterovirus antibody, dfa					
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					
87260	A	Adenovirus ag, if					
87265	A	Pertussis ag, if					
87270	A	Chlamydia trachomatis ag, if					
87272	A	Cryptosporidum/gardia 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	Cryptospor 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	Hpylori 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					
87449	A	Ag detect nos, eia, mult					
87450	A	Ag detect nos, eia, single					
87451	A	Ag detect polyval, eia, mult					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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 , rna, dir probe					
87521	A	Hepatitis c , rna, amp probe					
87522	A	Hepatitis c, rna, 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					
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					
*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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	0.39	$19.85	$10.72	$3.97
88106	X	Cytopathology, fluids	0343	0.39	$19.85	$10.72	$3.97
88107	X	Cytopathology, fluids	0343	0.39	$19.85	$10.72	$3.97
88108	X	Cytopath, concentrate tech	0343	0.39	$19.85	$10.72	$3.97
88125	X	Forensic cytopathology	0342	0.21	$10.69	$5.87	$2.14
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					
88144	A	Cytopath, c/v thin lyr redo					
88145	A	Cytopath, c/v thin lyr sel					
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	0.21	$10.69	$5.87	$2.14
88161	X	Cytopath smear, other source	0343	0.39	$19.85	$10.72	$3.97
88162	X	Cytopath smear, other source	0343	0.39	$19.85	$10.72	$3.97
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					
88170	D	Fine needle aspiration	0002	0.42	$21.38	$11.75	$4.28
88171	D	Fine needle aspiration	0004	2.47	$125.73	$32.57	$25.15
88172	X	Cytopathology eval of fna	0343	0.39	$19.85	$10.72	$3.97
88173	X	Cytopath eval, fna, report	0343	0.39	$19.85	$10.72	$3.97
88180	X	Cell marker study	0344	0.56	$28.51	$15.68	$5.70
88182	X	Cell marker study	0344	0.56	$28.51	$15.68	$5.70
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					
88269	A	Chromosome analys, amniotic					
88271	A	Cytogenetics, dna probe					
88272	A	Cytogenetics, 3–5					

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CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	0.21	$10.69	$5.87	$2.14
88300	X	Surgical path, gross	0342	0.21	$10.69	$5.87	$2.14
88302	X	Tissue exam by pathologist	0342	0.21	$10.69	$5.87	$2.14
88304	X	Tissue exam by pathologist	0343	0.39	$19.85	$10.72	$3.97
88305	X	Tissue exam by pathologist	0343	0.39	$19.85	$10.72	$3.97
88307	X	Tissue exam by pathologist	0344	0.56	$28.51	$15.68	$5.70
88309	X	Tissue exam by pathologist	0344	0.56	$28.51	$15.68	$5.70
88311	X	Decalcify tissue	0342	0.21	$10.69	$5.87	$2.14
88312	X	Special stains	0342	0.21	$10.69	$5.87	$2.14
88313	X	Special stains	0342	0.21	$10.69	$5.87	$2.14
88314	X	Histochemical stain	0342	0.21	$10.69	$5.87	$2.14
88318	X	Chemical histochemistry	0342	0.21	$10.69	$5.87	$2.14
88319	X	Enzyme histochemistry	0342	0.21	$10.69	$5.87	$2.14
88321	X	Microslide consultation	0342	0.21	$10.69	$5.87	$2.14
88323	X	Microslide consultation	0343	0.39	$19.85	$10.72	$3.97
88325	X	Comprehensive review of data	0343	0.39	$19.85	$10.72	$3.97
88329	X	Path consult introp	0342	0.21	$10.69	$5.87	$2.14
88331	X	Path consult intraop, 1 bloc	0343	0.39	$19.85	$10.72	$3.97
88332	X	Path consult intraop, addl	0342	0.21	$10.69	$5.87	$2.14
88342	X	Immunocytochemistry	0344	0.56	$28.51	$15.68	$5.70
88346	X	Immunofluorescent study	0343	0.39	$19.85	$10.72	$3.97
88347	X	Immunofluorescent study	0344	0.56	$28.51	$15.68	$5.70
88348	X	Electron microscopy	0344	0.56	$28.51	$15.68	$5.70
88349	X	Scanning electron microscopy	0344	0.56	$28.51	$15.68	$5.70
88355	X	Analysis, skeletal muscle	0344	0.56	$28.51	$15.68	$5.70
88356	X	Analysis, nerve	0344	0.56	$28.51	$15.68	$5.70
88358	X	Analysis, tumor	0344	0.56	$28.51	$15.68	$5.70
88362	X	Nerve teasing preparations	0343	0.39	$19.85	$10.72	$3.97
88365	X	Tissue hybridization	0344	0.56	$28.51	$15.68	$5.70
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					
89060	A	Exam,synovial fluid crystals					
89100	X	Sample intestinal contents	0360	1.35	$68.72	$34.36	$13.74
89105	X	Sample intestinal contents	0360	1.35	$68.72	$34.36	$13.74
89125	A	Specimen fat stain					
89130	X	Sample stomach contents	0360	1.35	$68.72	$34.36	$13.74
89132	X	Sample stomach contents	0360	1.35	$68.72	$34.36	$13.74
89135	X	Sample stomach contents	0360	1.35	$68.72	$34.36	$13.74
89136	X	Sample stomach contents	0360	1.35	$68.72	$34.36	$13.74
89140	X	Sample stomach contents	0360	1.35	$68.72	$34.36	$13.74
89141	X	Sample stomach contents	0360	1.35	$68.72	$34.36	$13.74
89160	A	Exam feces for meat fibers					
89190	A	Nasal smear for eosinophils					
89250	X	Fertilization of oocyte	0348	0.77	$39.20		$7.84
89251	X	Culture oocyte w/embryos	0348	0.77	$39.20		$7.84
89252	X	Assist oocyte fertilization	0348	0.77	$39.20		$7.84
89253	X	Embryo hatching	0348	0.77	$39.20		$7.84
89254	X	Oocyte identification	0348	0.77	$39.20		$7.84
89255	X	Prepare embryo for transfer	0348	0.77	$39.20		$7.84
89256	X	Prepare cryopreserved embryo	0348	0.77	$39.20		$7.84
89257	X	Sperm identification	0348	0.77	$39.20		$7.84
89258	X	Cryopreservation, embryo	0348	0.77	$39.20		$7.84
89259	X	Cryopreservation, sperm	0348	0.77	$39.20		$7.84
89260	X	Sperm isolation, simple	0348	0.77	$39.20		$7.84
89261	X	Sperm isolation, complex	0348	0.77	$39.20		$7.84
89264	X	Identify sperm tissue	0348	0.77	$39.20		$7.84
89300	A	Semen analysis					
89310	A	Semen analysis					
89320	A	Semen analysis					
89321	A	Semen analysis					
89325	A	Sperm antibody test					
89329	A	Sperm evaluation test					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
89330	A	Evaluation, cervical mucus					
89350	X	Sputum specimen collection	0344	0.56	$28.51	$15.68	$5.70
89355	A	Exam feces for starch					
89360	X	Collect sweat for test	0344	0.56	$28.51	$15.68	$5.70
89365	A	Water load test					
89399	A	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	0356	1.11	$56.50		$11.30
90371	K	Hep b ig, im	0356	1.11	$56.50		$11.30
90375	K	Rabies ig, im/sc	0356	1.11	$56.50		$11.30
90376	K	Rabies ig, heat treated	0356	1.11	$56.50		$11.30
90378	K	Rsv ig, im, 50 mg	0356	1.11	$56.50		$11.30
90379	K	Rsv ig, iv	0356	1.11	$56.50		$11.30
90384	E	Rh ig, full-dose, im					
90385	K	Rh ig, minidose, im	0356	1.11	$56.50		$11.30
90386	E	Rh ig, iv					
90389	K	Tetanus ig, im	0356	1.11	$56.50		$11.30
90393	K	Vaccina ig, im	0356	1.11	$56.50		$11.30
90396	K	Varicella-zoster ig, im	0356	1.11	$56.50		$11.30
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	K	Adenovirus vaccine, type 4	0356	1.11	$56.50		$11.30
90477	K	Adenovirus vaccine, type 7	0356	1.11	$56.50		$11.30
90581	K	Anthrax vaccine, sc	0356	1.11	$56.50		$11.30
90585	K	Bcg vaccine, percut	0356	1.11	$56.50		$11.30
90586	K	Bcg vaccine, intravesical	0356	1.11	$56.50		$11.30
90632	K	Hep a vaccine, adult im	0356	1.11	$56.50		$11.30
90633	K	Hep a vacc, ped/adol, 2 dose	0356	1.11	$56.50		$11.30
90634	K	Hep a vacc, ped/adol, 3 dose	0356	1.11	$56.50		$11.30
90636	K	Hep a/hep b vacc, adult im	0355	0.19	$9.67		$1.93
90645	K	Hib vaccine, hboc, im	0355	0.19	$9.67		$1.93
90646	K	Hib vaccine, prp-d, im	0355	0.19	$9.67		$1.93
90647	K	Hib vaccine, prp-omp, im	0355	0.19	$9.67		$1.93
90648	K	Hib vaccine, prp-t, im	0355	0.19	$9.67		$1.93
90657	K	Flu vaccine, 6–35 mo, im	0354	0.10	$5.09		
90658	K	Flu vaccine, 3 yrs, im	0354	0.10	$5.09		
90659	K	Flu vaccine, whole, im	0354	0.10	$5.09		
90660	E	Flu vaccine, nasal					
90665	K	Lyme disease vaccine, im	0356	1.11	$56.50		$11.30
90669	E	Pneumococcal vacc, ped<5					
90675	K	Rabies vaccine, im	0356	1.11	$56.50		$11.30
90676	K	Rabies vaccine, id	0356	1.11	$56.50		$11.30
90680	K	Rotovirus vaccine, oral	0356	1.11	$56.50		$11.30
90690	K	Typhoid vaccine, oral	0356	1.11	$56.50		$11.30
90691	K	Typhoid vaccine, im	0356	1.11	$56.50		$11.30
90692	K	Typhoid vaccine, h-p, sc/id	0355	0.19	$9.67		$1.93
90693	K	Typhoid vaccine, akd, sc	0356	1.11	$56.50		$11.30
90700	K	Dtap vaccine, im	0355	0.19	$9.67		$1.93
90701	K	Dtp vaccine, im	0355	0.19	$9.67		$1.93
90702	K	Dt vaccine < 7, im	0355	0.19	$9.67		$1.93
90703	K	Tetanus vaccine, im	0355	0.19	$9.67		$1.93
90704	K	Mumps vaccine, sc	0355	0.19	$9.67		$1.93
90705	K	Measles vaccine, sc	0356	1.11	$56.50		$11.30
90706	K	Rubella vaccine, sc	0355	0.19	$9.67		$1.93
90707	K	Mmr vaccine, sc	0356	1.11	$56.50		$11.30
90708	K	Measles-rubella vaccine, sc	0356	1.11	$56.50		$11.30
90709	K	Rubella & mumps vaccine, sc	0356	1.11	$56.50		$11.30
90710	K	Mmrv vaccine, sc	0356	1.11	$56.50		$11.30
90712	K	Oral poliovirus vaccine	0355	0.19	$9.67		$1.93
90713	K	Poliovirus, ipv, sc	0355	0.19	$9.67		$1.93
90716	K	Chicken pox vaccine, sc	0355	0.19	$9.67		$1.93
90717	K	Yellow fever vaccine, sc	0356	1.11	$56.50		$11.30
90718	K	Td vaccine > 7, im	0355	0.19	$9.67		$1.93
90719	K	Diphtheria vaccine, im	0356	1.11	$56.50		$11.30
90720	K	Dtp/hib vaccine, im	0355	0.19	$9.67		$1.93
90721	K	Dtap/hib vaccine, im	0355	0.19	$9.67		$1.93
90723	K	Dtap-hep b-ipv vaccine, im	0356	1.11	$56.50		$11.30
90725	K	Cholera vaccine, injectable	0355	0.19	$9.67		$1.93

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90727	K	Plague vaccine, im	0355	0.19	$9.67		$1.93
90732	K	Pneumococcal vacc, adult/ill	0354	0.10	$5.09		
90733	K	Meningococcal vaccine, sc	0356	1.11	$56.50		$11.30
90735	K	Encephalitis vaccine, sc	0356	1.11	$56.50		$11.30
90740	K	Hepb vacc, ill pat 3 dose im	0356	1.11	$56.50		$11.30
90743	K	Hep b vacc, adol, 2 dose, im	0356	1.11	$56.50		$11.30
90744	K	Hepb vacc ped/adol 3 dose im	0356	1.11	$56.50		$11.30
90746	K	Hep b vaccine, adult, im	0356	1.11	$56.50		$11.30
90747	K	Hepb vacc, ill pat 4 dose im	0356	1.11	$56.50		$11.30
90748	K	Hep b/hib vaccine, im	0355	0.19	$9.67		$1.93
90749	K	Vaccine toxoid	0355	0.19	$9.67		$1.93
90780	E	IV infusion therapy, 1 hour					
90781	E	IV infusion, additional hour					
90782	X	Injection, sc/im	0352	0.41	$20.87		$4.17
90783	X	Injection, ia	0359	1.79	$91.12		$18.22
90784	X	Injection, iv	0359	1.79	$91.12		$18.22
90788	X	Injection of antibiotic	0359	1.79	$91.12		$18.22
90799	X	Ther/prophylactic/dx inject	0352	0.41	$20.87		$4.17
90801	S	Psy dx interview	0323	1.73	$88.06	$21.13	$17.61
90802	S	Intac psy dx interview	0323	1.73	$88.06	$21.13	$17.61
90804	S	Psytx, office, 20–30 min	0322	1.15	$58.54	$12.29	$11.71
90805	S	Psytx, off, 20–30 min w/e&m	0322	1.15	$58.54	$12.29	$11.71
90806	S	Psytx, off, 45–50 min	0323	1.73	$88.06	$21.13	$17.61
90807	S	Psytx, off, 45–50 min w/e&m	0323	1.73	$88.06	$21.13	$17.61
90808	S	Psytx, office, 75–80 min	0323	1.73	$88.06	$21.13	$17.61
90809	S	Psytx, off, 75–80, w/e&m	0323	1.73	$88.06	$21.13	$17.61
90810	S	Intac psytx, off, 20–30 min	0322	1.15	$58.54	$12.29	$11.71
90811	S	Intac psytx, 20–30, w/e&m	0322	1.15	$58.54	$12.29	$11.71
90812	S	Intac psytx, off, 45–50 min	0323	1.73	$88.06	$21.13	$17.61
90813	S	Intac psytx, 45–50 min w/e&m	0323	1.73	$88.06	$21.13	$17.61
90814	S	Intac psytx, off, 75–80 min	0323	1.73	$88.06	$21.13	$17.61
90815	S	Intac psytx, 75–80 w/e&m	0323	1.73	$88.06	$21.13	$17.61
90816	S	Psytx, hosp, 20–30 min	0322	1.15	$58.54	$12.29	$11.71
90817	S	Psytx, hosp, 20–30 min w/e&m	0322	1.15	$58.54	$12.29	$11.71
90818	S	Psytx, hosp, 45–50 min	0323	1.73	$88.06	$21.13	$17.61
90819	S	Psytx, hosp, 45–50 min w/e&m	0323	1.73	$88.06	$21.13	$17.61
90821	S	Psytx, hosp, 75–80 min	0323	1.73	$88.06	$21.13	$17.61
90822	S	Psytx, hosp, 75–80 min w/e&m	0323	1.73	$88.06	$21.13	$17.61
90823	S	Intac psytx, hosp, 20–30 min	0322	1.15	$58.54	$12.29	$11.71
90824	S	Intac psytx, hsp 20–30 w/e&m	0322	1.15	$58.54	$12.29	$11.71
90826	S	Intac psytx, hosp, 45–50 min	0323	1.73	$88.06	$21.13	$17.61
90827	S	Intac psytx, hsp 45–50 w/e&m	0323	1.73	$88.06	$21.13	$17.61
90828	S	Intac psytx, hosp, 75–80 min	0323	1.73	$88.06	$21.13	$17.61
90829	S	Intac psytx, hsp 75–80 w/e&m	0323	1.73	$88.06	$21.13	$17.61
90845	S	Psychoanalysis	0323	1.73	$88.06	$21.13	$17.61
90846	S	Family psytx w/o patient	0324	2.69	$136.93	$20.19	$27.39
90847	S	Family psytx w/patient	0324	2.69	$136.93	$20.19	$27.39
90849	S	Multiple family group psytx	0325	1.38	$70.25	$18.27	$14.05
90853	S	Group psychotherapy	0325	1.38	$70.25	$18.27	$14.05
90857	S	Intac group psytx	0325	1.38	$70.25	$18.27	$14.05
90862	X	Medication management	0374	0.89	$45.30	$9.97	$9.06
90865	S	Narcosynthesis	0323	1.73	$88.06	$21.13	$17.61
90870	S	Electroconvulsive therapy	0320	3.88	$197.51	$80.06	$39.50
90871	S	Electroconvulsive therapy	0320	3.88	$197.51	$80.06	$39.50
90875	E	Psychophysiological therapy					
90876	E	Psychophysiological therapy					
90880	S	Hypnotherapy	0323	1.73	$88.06	$21.13	$17.61
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	1.15	$58.54	$12.29	$11.71
90901	S	Biofeedback train, any meth	0321	0.93	$47.34	$21.78	$9.47
90911	S	Biofeedback peri/uro/rectal	0321	0.93	$47.34	$21.78	$9.47
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	0.28	$14.25	$3.14	$2.85
90937	E	Hemodialysis, repeated eval					
*90939	N	Hemodialysis study, transcut					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90940	N	Hemodialysis access study					
90945	S	Dialysis, one evaluation	0170	0.28	$14.25	$3.14	$2.85
90947	E	Dialysis, repeated eval					
90989	E	Dialysis training, complete					
90993	E	Dialysis training, incompl					
90997	E	Hemoperfusion					
90999	E	Dialysis procedure					
91000	X	Esophageal intubation	0361	3.25	$165.44	$82.72	$33.09
91010	X	Esophagus motility study	0361	3.25	$165.44	$82.72	$33.09
91011	X	Esophagus motility study	0361	3.25	$165.44	$82.72	$33.09
91012	X	Esophagus motility study	0361	3.25	$165.44	$82.72	$33.09
91020	X	Gastric motility	0361	3.25	$165.44	$82.72	$33.09
91030	X	Acid perfusion of esophagus	0361	3.25	$165.44	$82.72	$33.09
91032	X	Esophagus, acid reflux test	0361	3.25	$165.44	$82.72	$33.09
91033	X	Prolonged acid reflux test	0361	3.25	$165.44	$82.72	$33.09
91052	X	Gastric analysis test	0361	3.25	$165.44	$82.72	$33.09
91055	X	Gastric intubation for smear	0360	1.35	$68.72	$34.36	$13.74
91060	X	Gastric saline load test	0360	1.35	$68.72	$34.36	$13.74
91065	X	Breath hydrogen test	0360	1.35	$68.72	$34.36	$13.74
91100	X	Pass intestine bleeding tube	0360	1.35	$68.72	$34.36	$13.74
91105	X	Gastric intubation treatment	0361	3.25	$165.44	$82.72	$33.09
91122	T	Anal pressure record	0156	2.45	$124.71	$37.41	$24.94
*91123	N	Irrigate fecal impaction					
91132	X	Electrogastrography	0360	1.35	$68.72	$34.36	$13.74
91133	X	Electrogastrography w/test	0360	1.35	$68.72	$34.36	$13.74
91299	X	Gastroenterology procedure	0360	1.35	$68.72	$34.36	$13.74
92002	V	Eye exam, new patient	0601	0.95	$48.36		$9.67
92004	V	Eye exam, new patient	0602	1.38	$70.25		$14.05
92012	V	Eye exam established pat	0600	0.86	$43.78		$8.76
92014	V	Eye exam & treatment	0602	1.38	$70.25		$14.05
92015	E	Refraction					
92018	T	New eye exam & treatment	0699	6.46	$328.84	$147.98	$65.77
92019	S	Eye exam & treatment	0698	1.03	$52.43	$19.92	$10.49
92020	S	Special eye evaluation	0230	0.61	$31.05	$14.28	$6.21
92060	S	Special eye evaluation	0230	0.61	$31.05	$14.28	$6.21
92065	S	Orthoptic/pleoptic training	0230	0.61	$31.05	$14.28	$6.21
92070	N	Fitting of contact lens					
92081	S	Visual field examination(s)	0230	0.61	$31.05	$14.28	$6.21
92082	S	Visual field examination(s)	0698	1.03	$52.43	$19.92	$10.49
92083	S	Visual field examination(s)	0698	1.03	$52.43	$19.92	$10.49
92100	N	Serial tonometry exam(s)					
92120	S	Tonography & eye evaluation	0230	0.61	$31.05	$14.28	$6.21
92130	S	Water provocation tonography	0698	1.03	$52.43	$19.92	$10.49
92135	S	Opthalmic dx imaging	0230	0.61	$31.05	$14.28	$6.21
*92136	S	Ophthalmic biometry	0230	0.61	$31.05	$14.28	$6.21
92140	S	Glaucoma provocative tests	0231	2.03	$103.34	$46.50	$20.67
92225	S	Special eye exam, initial	0698	1.03	$52.43	$19.92	$10.49
92226	S	Special eye exam, subsequent	0231	2.03	$103.34	$46.50	$20.67
92230	T	Eye exam with photos	0699	6.46	$328.84	$147.98	$65.77
92235	S	Eye exam with photos	0231	2.03	$103.34	$46.50	$20.67
92240	S	Icg angiography	0231	2.03	$103.34	$46.50	$20.67
92250	S	Eye exam with photos	0230	0.61	$31.05	$14.28	$6.21
92260	S	Ophthalmoscopy/dynamometry	0230	0.61	$31.05	$14.28	$6.21
92265	S	Eye muscle evaluation	0231	2.03	$103.34	$46.50	$20.67
92270	S	Electro-oculography	0698	1.03	$52.43	$19.92	$10.49
92275	S	Electroretinography	0216	2.61	$132.86	$59.79	$26.57
92283	S	Color vision examination	0230	0.61	$31.05	$14.28	$6.21
92284	S	Dark adaptation eye exam	0231	2.03	$103.34	$46.50	$20.67
92285	S	Eye photography	0230	0.61	$31.05	$14.28	$6.21
92286	S	Internal eye photography	0698	1.03	$52.43	$19.92	$10.49
92287	S	Internal eye photography	0231	2.03	$103.34	$46.50	$20.67
92310	E	Contact lens fitting					
92311	X	Contact lens fitting	0362	0.86	$43.78	$9.63	$8.76
92312	X	Contact lens fitting	0362	0.86	$43.78	$9.63	$8.76
92313	X	Contact lens fitting	0362	0.86	$43.78	$9.63	$8.76
92314	E	Prescription of contact lens					
92315	X	Prescription of contact lens	0362	0.86	$43.78	$9.63	$8.76
92316	X	Prescription of contact lens	0362	0.86	$43.78	$9.63	$8.76
92317	X	Prescription of contact lens	0362	0.86	$43.78	$9.63	$8.76
92325	X	Modification of contact lens	0362	0.86	$43.78	$9.63	$8.76
92326	X	Replacement of contact lens	0362	0.86	$43.78	$9.63	$8.76
92330	S	Fitting of artificial eye	0230	0.61	$31.05	$14.28	$6.21
92335	N	Fitting of artificial eye					
92340	E	Fitting of spectacles					
92341	E	Fitting of spectacles					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92342	E	Fitting of spectacles					
92352	X	Special spectacles fitting	0362	0.86	$43.78	$9.63	$8.76
92353	X	Special spectacles fitting	0362	0.86	$43.78	$9.63	$8.76
92354	X	Special spectacles fitting	0362	0.86	$43.78	$9.63	$8.76
92355	X	Special spectacles fitting	0362	0.86	$43.78	$9.63	$8.76
92358	X	Eye prosthesis service	0362	0.86	$43.78	$9.63	$8.76
92370	E	Repair & adjust spectacles					
92371	X	Repair & adjust spectacles	0362	0.86	$43.78	$9.63	$8.76
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	0.61	$31.05	$14.28	$6.21
92502	T	Ear and throat examination	0251	2.43	$123.70	$27.99	$24.74
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	1.03	$52.43	$14.22	$10.49
92512	X	Nasal function studies	0363	1.73	$88.06	$32.58	$17.61
92516	X	Facial nerve function test	0363	1.73	$88.06	$32.58	$17.61
92520	X	Laryngeal function studies	0363	1.73	$88.06	$32.58	$17.61
92525	A	Oral function evaluation					
92526	A	Oral function therapy					
92531	N	Spontaneous nystagmus study					
92532	N	Positional nystagmus study					
92533	N	Caloric vestibular test					
92534	N	Optokinetic nystagmus					
92541	X	Spontaneous nystagmus test	0363	1.73	$88.06	$32.58	$17.61
92542	X	Positional nystagmus test	0363	1.73	$88.06	$32.58	$17.61
92543	X	Caloric vestibular test	0363	1.73	$88.06	$32.58	$17.61
92544	X	Optokinetic nystagmus test	0363	1.73	$88.06	$32.58	$17.61
92545	X	Oscillating tracking test	0363	1.73	$88.06	$32.58	$17.61
92546	X	Sinusoidal rotational test	0363	1.73	$88.06	$32.58	$17.61
92547	X	Supplemental electrical test	0363	1.73	$88.06	$32.58	$17.61
92548	X	Posturography	0363	1.73	$88.06	$32.58	$17.61
92551	E	Pure tone hearing test, air					
92552	X	Pure tone audiometry, air	0364	0.58	$29.52	$11.51	$5.90
92553	X	Audiometry, air & bone	0365	1.31	$66.68	$20.00	$13.34
92555	X	Speech threshold audiometry	0364	0.58	$29.52	$11.51	$5.90
92556	X	Speech audiometry, complete	0364	0.58	$29.52	$11.51	$5.90
92557	X	Comprehensive hearing test	0365	1.31	$66.68	$20.00	$13.34
92559	E	Group audiometric testing					
92560	E	Bekesy audiometry, screen					
92561	X	Bekesy audiometry, diagnosis	0365	1.31	$66.68	$20.00	$13.34
92562	X	Loudness balance test	0364	0.58	$29.52	$11.51	$5.90
92563	X	Tone decay hearing test	0364	0.58	$29.52	$11.51	$5.90
92564	X	Sisi hearing test	0364	0.58	$29.52	$11.51	$5.90
92565	X	Stenger test, pure tone	0364	0.58	$29.52	$11.51	$5.90
92567	X	Tympanometry	0364	0.58	$29.52	$11.51	$5.90
92568	X	Acoustic reflex testing	0364	0.58	$29.52	$11.51	$5.90
92569	X	Acoustic reflex decay test	0364	0.58	$29.52	$11.51	$5.90
92571	X	Filtered speech hearing test	0364	0.58	$29.52	$11.51	$5.90
92572	X	Staggered spondaic word test	0364	0.58	$29.52	$11.51	$5.90
92573	X	Lombard test	0364	0.58	$29.52	$11.51	$5.90
92575	X	Sensorineural acuity test	0365	1.31	$66.68	$20.00	$13.34
92576	X	Synthetic sentence test	0364	0.58	$29.52	$11.51	$5.90
92577	X	Stenger test, speech	0365	1.31	$66.68	$20.00	$13.34
92579	X	Visual audiometry (vra)	0365	1.31	$66.68	$20.00	$13.34
92582	X	Conditioning play audiometry	0365	1.31	$66.68	$20.00	$13.34
92583	X	Select picture audiometry	0364	0.58	$29.52	$11.51	$5.90
92584	X	Electrocochleography	0363	1.73	$88.06	$32.58	$17.61
92585	S	Auditor evoke potent, compre	0216	2.61	$132.86	$59.79	$26.57
92586	S	Auditor evoke potent, limit	0707		$75.00		$15.00
92587	X	Evoked auditory test	0363	1.73	$88.06	$32.58	$17.61
92588	X	Evoked auditory test	0363	1.73	$88.06	$32.58	$17.61
92589	X	Auditory function test(s)	0364	0.58	$29.52	$11.51	$5.90
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92595	E	Electro hearng aid tst, both					
92596	X	Ear protector evaluation	0365	1.31	$66.68	$20.00	$13.34
92599	X	ENT procedure/service	0364	0.58	$29.52	$11.51	$5.90
92950	S	Heart/lung resuscitation cpr	0094	6.08	$309.50	$105.29	$61.90
92953	S	Temporary external pacing	0094	6.08	$309.50	$105.29	$61.90
92960	S	Cardioversion electric, ext	0094	6.08	$309.50	$105.29	$61.90
92961	S	Cardioversion, electric, int	0094	6.08	$309.50	$105.29	$61.90
92970	C	Cardioassist, internal					
92971	C	Cardioassist, external					
*92973	T	Percut coronary thrombectomy	0973		$250.00		$50.00
*92974	T	Cath place, cardio brachytx	0981		$2,250.00		$450.00
92975	C	Dissolve clot, heart vessel					
92977	T	Dissolve clot, heart vessel	0120	3.08	$156.78	$42.67	$31.36
92978	S	Intravasc us, heart add-on	0267	2.33	$118.61	$65.23	$23.72
92979	S	Intravasc us, heart add-on	0267	2.33	$118.61	$65.23	$23.72
92980	T	Insert intracoronary stent	0104	87.98	$4,478.53		$895.71
92981	T	Insert intracoronary stent	0104	87.98	$4,478.53		$895.71
92982	T	Coronary artery dilation	0083	59.49	$3,028.28	$794.30	$605.66
92984	T	Coronary artery dilation	0083	59.49	$3,028.28	$794.30	$605.66
92986	C	Revision of aortic valve					
92987	C	Revision of mitral valve					
92990	C	Revision of pulmonary valve					
92992	C	Revision of heart chamber					
92993	C	Revision of heart chamber					
92995	T	Coronary atherectomy	0082	92.00	$4,683.17	$1,351.74	$936.63
92996	T	Coronary atherectomy add-on	0082	92.00	$4,683.17	$1,351.74	$936.63
92997	C	Pul art balloon repr, percut					
92998	C	Pul art balloon repr, percut					
93000	E	Electrocardiogram, complete					
93005	S	Electrocardiogram, tracing	0099	0.35	$17.82	$9.80	$3.56
93010	A	Electrocardiogram report					
93012	N	Transmission of ecg					
93014	E	Report on transmitted ecg					
93015	E	Cardiovascular stress test					
93016	E	Cardiovascular stress test					
93017	X	Cardiovascular stress test	0100	1.47	$74.83	$41.15	$14.97
93018	E	Cardiovascular stress test					
93024	X	Cardiac drug stress test	0100	1.47	$74.83	$41.15	$14.97
*93025	X	Microvolt t-wave assess	0100	1.47	$74.83	$41.15	$14.97
93040	E	Rhythm ECG with report					
93041	S	Rhythm ECG, tracing	0099	0.35	$17.82	$9.80	$3.56
93042	E	Rhythm ECG, report					
93224	E	ECG monitor/report, 24 hrs					
93225	X	ECG monitor/record, 24 hrs	0100	1.47	$74.83	$41.15	$14.97
93226	X	ECG monitor/report, 24 hrs	0100	1.47	$74.83	$41.15	$14.97
93227	E	ECG monitor/review, 24 hrs					
93230	E	ECG monitor/report, 24 hrs					
93231	X	Ecg monitor/record, 24 hrs	0100	1.47	$74.83	$41.15	$14.97
93232	X	ECG monitor/report, 24 hrs	0100	1.47	$74.83	$41.15	$14.97
93233	E	ECG monitor/review, 24 hrs					
93235	E	ECG monitor/report, 24 hrs					
93236	X	ECG monitor/report, 24 hrs	0100	1.47	$74.83	$41.15	$14.97
93237	E	ECG monitor/review, 24 hrs					
93268	E	ECG record/review					
93270	X	ECG recording	0097	0.84	$42.76	$23.51	$8.55
93271	X	Ecg/monitoring and analysis	0097	0.84	$42.76	$23.51	$8.55
93272	E	Ecg/review, interpret only					
93278	S	ECG/signal-averaged	0099	0.35	$17.82	$9.80	$3.56
93303	S	Echo transthoracic	0269	3.85	$195.98	$101.91	$39.20
93304	S	Echo transthoracic	0697	2.08	$105.88	$55.06	$21.18
93307	S	Echo exam of heart	0269	3.85	$195.98	$101.91	$39.20
93308	S	Echo exam of heart	0697	2.08	$105.88	$55.06	$21.18
93312	S	Echo transesophageal	0270	5.30	$269.79	$145.69	$53.96
93313	S	Echo transesophageal	0270	5.30	$269.79	$145.69	$53.96
93314	N	Echo transesophageal					
93315	S	Echo transesophageal	0270	5.30	$269.79	$145.69	$53.96
93316	S	Echo transesophageal	0270	5.30	$269.79	$145.69	$53.96
93317	N	Echo transesophageal					
93318	S	Echo transesophageal intraop	0270	5.30	$269.79	$145.69	$53.96
93320	S	Doppler echo exam, heart	0269	3.85	$195.98	$101.91	$39.20
93321	S	Doppler echo exam, heart	0697	2.08	$105.88	$55.06	$21.18
93325	S	Doppler color flow add-on	0697	2.08	$105.88	$55.06	$21.18
93350	S	Echo transthoracic	0269	3.85	$195.98	$101.91	$39.20
93501	T	Right heart catheterization	0080	34.73	$1,767.90	$838.92	$353.58
93503	T	Insert/place heart catheter	0103	15.95	$811.92	$295.70	$162.38

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
93505	T	Biopsy of heart lining	0103	15.95	$811.92	$295.70	$162.38
93508	T	Cath placement, angiography	0080	34.73	$1,767.90	$838.92	$353.58
93510	T	Left heart catheterization	0080	34.73	$1,767.90	$838.92	$353.58
93511	T	Left heart catheterization	0080	34.73	$1,767.90	$838.92	$353.58
93514	T	Left heart catheterization	0080	34.73	$1,767.90	$838.92	$353.58
93524	T	Left heart catheterization	0080	34.73	$1,767.90	$838.92	$353.58
93526	T	Rt & Lt heart catheters	0080	34.73	$1,767.90	$838.92	$353.58
93527	T	Rt & Lt heart catheters	0080	34.73	$1,767.90	$838.92	$353.58
93528	T	Rt & Lt heart catheters	0080	34.73	$1,767.90	$838.92	$353.58
93529	T	Rt, Lt heart catheterization	0080	34.73	$1,767.90	$838.92	$353.58
93530	T	Rt heart cath, congenital	0080	34.73	$1,767.90	$838.92	$353.58
93531	T	R & l heart cath, congenital	0080	34.73	$1,767.90	$838.92	$353.58
93532	T	R & l heart cath, congenital	0080	34.73	$1,767.90	$838.92	$353.58
93533	T	R & l heart cath, congenital	0080	34.73	$1,767.90	$838.92	$353.58
93536	D	Insert circulation assi	0103	15.95	$811.92	$295.70	$162.38
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					
93600	T	Bundle of His recording	0087	52.46	$2,670.42		$534.08
93602	T	Intra-atrial recording	0087	52.46	$2,670.42		$534.08
93603	T	Right ventricular recording	0087	52.46	$2,670.42		$534.08
93607	D	Left ventricular recording	0087	52.46	$2,670.42		$534.08
93609	T	Mapping of tachycardia	0087	52.46	$2,670.42		$534.08
93610	T	Intra-atrial pacing	0087	52.46	$2,670.42		$534.08
93612	T	Intraventricular pacing	0087	52.46	$2,670.42		$534.08
*93613	T	Electrophys map, 3d, add-on	0087	52.46	$2,670.42		$534.08
93615	T	Esophageal recording	0087	52.46	$2,670.42		$534.08
93616	T	Esophageal recording	0087	52.46	$2,670.42		$534.08
93618	T	Heart rhythm pacing	0087	52.46	$2,670.42		$534.08
93619	T	Electrophysiology evaluation	0085	38.69	$1,969.48	$654.48	$393.90
93620	T	Electrophysiology evaluation	0085	38.69	$1,969.48	$654.48	$393.90
93621	T	Electrophysiology evaluation	0085	38.69	$1,969.48	$654.48	$393.90
93622	T	Electrophysiology evaluation	0085	38.69	$1,969.48	$654.48	$393.90
93623	T	Stimulation, pacing heart	0087	52.46	$2,670.42		$534.08
93624	T	Electrophysiologic study	0087	52.46	$2,670.42		$534.08
93631	T	Heart pacing, mapping	0087	52.46	$2,670.42		$534.08
93640	S	Evaluation heart device	0084	199.65	$10,162.98		$2,032.60
93641	S	Electrophysiology evaluation	0084	199.65	$10,162.98		$2,032.60
93642	S	Electrophysiology evaluation	0084	199.65	$10,162.98		$2,032.60
93650	T	Ablate heart dysrhythm focus	0086	72.72	$3,701.74	$1,265.37	$740.35
93651	T	Ablate heart dysrhythm focus	0086	72.72	$3,701.74	$1,265.37	$740.35
93652	T	Ablate heart dysrhythm focus	0086	72.72	$3,701.74	$1,265.37	$740.35
93660	S	Tilt table evaluation	0101	3.74	$190.38	$104.70	$38.08
93662	S	Intracardiac ecg (ice)	0270	5.30	$269.79	$145.69	$53.96
93668	E	Peripheral vascular rehab					
*93701	T	Bioimpedance, thoracic	0970		$25.00		$5.00
93720	E	Total body plethysmography					
93721	S	Plethysmography tracing	0096	1.71	$87.05	$47.87	$17.41
93722	E	Plethysmography report					
93724	S	Analyze pacemaker system	0690	0.37	$18.83	$10.35	$3.77
93727	S	Analyze ilr system	0690	0.37	$18.83	$10.35	$3.77
93731	S	Analyze pacemaker system	0690	0.37	$18.83	$10.35	$3.77
93732	S	Analyze pacemaker system	0690	0.37	$18.83	$10.35	$3.77
93733	S	Telephone analy, pacemaker	0690	0.37	$18.83	$10.35	$3.77
93734	S	Analyze pacemaker system	0690	0.37	$18.83	$10.35	$3.77
93735	S	Analyze pacemaker system	0690	0.37	$18.83	$10.35	$3.77
93736	S	Telephone analy, pacemaker	0690	0.37	$18.83	$10.35	$3.77
93737	D	Analyze cardio/defibrillator	0689	0.43	$21.89	$12.03	$4.38
93738	D	Analyze cardio/defibrillator	0689	0.43	$21.89	$12.03	$4.38
93740	S	Temperature gradient studies	0096	1.71	$87.05	$47.87	$17.41
93741	S	Analyze ht pace device sngl	0689	0.43	$21.89	$12.03	$4.38
93742	S	Analyze ht pace device sngl	0689	0.43	$21.89	$12.03	$4.38
93743	S	Analyze ht pace device dual	0689	0.43	$21.89	$12.03	$4.38
93744	S	Analyze ht pace device dual	0689	0.43	$21.89	$12.03	$4.38
93760	E	Cephalic thermogram					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
93762	E	Peripheral thermogram					
93770	N	Measure venous pressure					
93784	E	Ambulatory BP monitoring					
93786	E	Ambulatory BP recording					
93788	E	Ambulatory BP analysis					
93790	E	Review/report BP recording					
93797	S	Cardiac rehab	0095	0.61	$31.05	$16.46	$6.21
93798	S	Cardiac rehab/monitor	0095	0.61	$31.05	$16.46	$6.21
93799	S	Cardiovascular procedure	0096	1.71	$87.05	$47.87	$17.41
93875	S	Extracranial study	0096	1.71	$87.05	$47.87	$17.41
93880	S	Extracranial study	0267	2.33	$118.61	$65.23	$23.72
93882	S	Extracranial study	0267	2.33	$118.61	$65.23	$23.72
93886	S	Intracranial study	0267	2.33	$118.61	$65.23	$23.72
93888	S	Intracranial study	0267	2.33	$118.61	$65.23	$23.72
93922	S	Extremity study	0096	1.71	$87.05	$47.87	$17.41
93923	S	Extremity study	0096	1.71	$87.05	$47.87	$17.41
93924	S	Extremity study	0096	1.71	$87.05	$47.87	$17.41
93925	S	Lower extremity study	0267	2.33	$118.61	$65.23	$23.72
93926	S	Lower extremity study	0267	2.33	$118.61	$65.23	$23.72
93930	S	Upper extremity study	0267	2.33	$118.61	$65.23	$23.72
93931	S	Upper extremity study	0267	2.33	$118.61	$65.23	$23.72
93965	S	Extremity study	0096	1.71	$87.05	$47.87	$17.41
93970	S	Extremity study	0267	2.33	$118.61	$65.23	$23.72
93971	S	Extremity study	0267	2.33	$118.61	$65.23	$23.72
93975	S	Vascular study	0267	2.33	$118.61	$65.23	$23.72
93976	S	Vascular study	0267	2.33	$118.61	$65.23	$23.72
93978	S	Vascular study	0267	2.33	$118.61	$65.23	$23.72
93979	S	Vascular study	0267	2.33	$118.61	$65.23	$23.72
93980	S	Penile vascular study	0267	2.33	$118.61	$65.23	$23.72
93981	S	Penile vascular study	0267	2.33	$118.61	$65.23	$23.72
93990	S	Doppler flow testing	0267	2.33	$118.61	$65.23	$23.72
94010	X	Breathing capacity test	0367	0.70	$35.63	$17.82	$7.13
94014	X	Patient recorded spirometry	0367	0.70	$35.63	$17.82	$7.13
94015	X	Patient recorded spirometry	0367	0.70	$35.63	$17.82	$7.13
94016	X	Review patient spirometry	0369	3.49	$177.65	$58.50	$35.53
94060	X	Evaluation of wheezing	0368	1.47	$74.83	$38.16	$14.97
94070	X	Evaluation of wheezing	0368	1.47	$74.83	$38.16	$14.97
94150	N	Vital capacity test					
94200	X	Lung function test (MBC/MVV)	0367	0.70	$35.63	$17.82	$7.13
94240	X	Residual lung capacity	0368	1.47	$74.83	$38.16	$14.97
94250	X	Expired gas collection	0367	0.70	$35.63	$17.82	$7.13
94260	X	Thoracic gas volume	0368	1.47	$74.83	$38.16	$14.97
94350	X	Lung nitrogen washout curve	0368	1.47	$74.83	$38.16	$14.97
94360	X	Measure airflow resistance	0368	1.47	$74.83	$38.16	$14.97
94370	X	Breath airway closing volume	0368	1.47	$74.83	$38.16	$14.97
94375	X	Respiratory flow volume loop	0367	0.70	$35.63	$17.82	$7.13
94400	X	CO2 breathing response curve	0368	1.47	$74.83	$38.16	$14.97
94450	X	Hypoxia response curve	0367	0.70	$35.63	$17.82	$7.13
94620	X	Pulmonary stress test/simple	0368	1.47	$74.83	$38.16	$14.97
94621	X	Pulm stress test/complex	0369	3.49	$177.65	$58.50	$35.53
94640	S	Airway inhalation treatment	0077	0.39	$19.85	$10.91	$3.97
94642	S	Aerosol inhalation treatment	0078	0.86	$43.78	$18.83	$8.76
94650	S	Pressure breathing (IPPB)	0077	0.39	$19.85	$10.91	$3.97
94651	S	Pressure breathing (IPPB)	0077	0.39	$19.85	$10.91	$3.97
94652	C	Pressure breathing (IPPB)					
94656	S	Initial ventilator mgmt	0079	0.60	$30.54	$16.79	$6.11
94657	S	Continued ventilator mgmt	0079	0.60	$30.54	$16.79	$6.11
94660	S	Pos airway pressure, CPAP	0068	3.02	$153.73	$84.55	$30.75
94662	S	Neg press ventilation, cnp	0079	0.60	$30.54	$16.79	$6.11
94664	S	Aerosol or vapor inhalations	0077	0.39	$19.85	$10.91	$3.97
94665	S	Aerosol or vapor inhalations	0077	0.39	$19.85	$10.91	$3.97
94667	S	Chest wall manipulation	0077	0.39	$19.85	$10.91	$3.97
94668	S	Chest wall manipulation	0077	0.39	$19.85	$10.91	$3.97
94680	X	Exhaled air analysis, o2	0368	1.47	$74.83	$38.16	$14.97
94681	X	Exhaled air analysis, o2/co2	0368	1.47	$74.83	$38.16	$14.97
94690	X	Exhaled air analysis	0367	0.70	$35.63	$17.82	$7.13
94720	X	Monoxide diffusing capacity	0367	0.70	$35.63	$17.82	$7.13
94725	X	Membrane diffusion capacity	0368	1.47	$74.83	$38.16	$14.97
94750	X	Pulmonary compliance study	0368	1.47	$74.83	$38.16	$14.97
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	0.70	$35.63	$17.82	$7.13
94772	X	Breath recording, infant	0369	3.49	$177.65	$58.50	$35.53
94799	X	Pulmonary service/procedure	0367	0.70	$35.63	$17.82	$7.13

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
95004	X	Allergy skin tests	0370	0.80	$40.72	$11.81	$8.14
95010	X	Sensitivity skin tests	0370	0.80	$40.72	$11.81	$8.14
95015	X	Sensitivity skin tests	0370	0.80	$40.72	$11.81	$8.14
95024	X	Allergy skin tests	0370	0.80	$40.72	$11.81	$8.14
95027	X	Skin end point titration	0370	0.80	$40.72	$11.81	$8.14
95028	X	Allergy skin tests	0370	0.80	$40.72	$11.81	$8.14
95044	X	Allergy patch tests	0370	0.80	$40.72	$11.81	$8.14
95052	X	Photo patch test	0370	0.80	$40.72	$11.81	$8.14
95056	X	Photosensitivity tests	0370	0.80	$40.72	$11.81	$8.14
95060	X	Eye allergy tests	0370	0.80	$40.72	$11.81	$8.14
95065	X	Nose allergy test	0370	0.80	$40.72	$11.81	$8.14
95070	X	Bronchial allergy tests	0369	3.49	$177.65	$58.50	$35.53
95071	X	Bronchial allergy tests	0369	3.49	$177.65	$58.50	$35.53
95075	X	Ingestion challenge test	0361	3.25	$165.44	$82.72	$33.09
95078	X	Provocative testing	0370	0.80	$40.72	$11.81	$8.14
95115	X	Immunotherapy, one injection	0353	0.25	$12.73		$2.55
95117	X	Immunotherapy injections	0353	0.25	$12.73		$2.55
95120	E	Immunotherapy, one injection					
95125	E	Immunotherapy, many antigens					
95130	E	Immunotherapy, insect venom					
95131	E	Immunotherapy, insect venoms					
95132	E	Immunotherapy, insect venoms					
95133	E	Immunotherapy, insect venoms					
95134	E	Immunotherapy, insect venoms					
95144	X	Antigen therapy services	0371	0.70	$35.63		$7.13
95145	X	Antigen therapy services	0371	0.70	$35.63		$7.13
95146	X	Antigen therapy services	0371	0.70	$35.63		$7.13
95147	X	Antigen therapy services	0371	0.70	$35.63		$7.13
95148	X	Antigen therapy services	0371	0.70	$35.63		$7.13
95149	X	Antigen therapy services	0371	0.70	$35.63		$7.13
95165	X	Antigen therapy services	0371	0.70	$35.63		$7.13
95170	X	Antigen therapy services	0371	0.70	$35.63		$7.13
95180	X	Rapid desensitization	0370	0.80	$40.72	$11.81	$8.14
95199	X	Allergy immunology services	0370	0.80	$40.72	$11.81	$8.14
*95250	T	Glucose monitoring, cont	0972		$150.00		$30.00
95805	S	Multiple sleep latency test	0209	10.54	$536.53	$279.00	$107.31
95806	S	Sleep study, unattended	0213	2.65	$134.90	$70.15	$26.98
95807	S	Sleep study, attended	0209	10.54	$536.53	$279.00	$107.31
95808	S	Polysomnography, 1–3	0209	10.54	$536.53	$279.00	$107.31
95810	S	Polysomnography, 4 or more	0209	10.54	$536.53	$279.00	$107.31
95811	S	Polysomnography w/cpap	0209	10.54	$536.53	$279.00	$107.31
95812	S	Electroencephalogram (EEG)	0213	2.65	$134.90	$70.15	$26.98
95813	S	Electroencephalogram (EEG)	0213	2.65	$134.90	$70.15	$26.98
95816	S	Electroencephalogram (EEG)	0214	2.10	$106.90	$53.45	$21.38
95819	S	Electroencephalogram (EEG)	0214	2.10	$106.90	$53.45	$21.38
95822	S	Sleep electroencephalogram	0214	2.10	$106.90	$53.45	$21.38
95824	S	Electroencephalography	0214	2.10	$106.90	$53.45	$21.38
95827	S	Night electroencephalogram	0209	10.54	$536.53	$279.00	$107.31
95829	S	Surgery electrocorticogram	0214	2.10	$106.90	$53.45	$21.38
95830	E	Insert electrodes for EEG					
95831	N	Limb muscle testing, manual					
95832	N	Hand muscle testing, manual					
95833	N	Body muscle testing, manual					
95834	N	Body muscle testing, manual					
95851	N	Range of motion measurements					
95852	N	Range of motion measurements					
95857	S	Tensilon test	0218	1.03	$52.43	$23.59	$10.49
95858	S	Tensilon test & myogram	0215	0.66	$33.60	$17.47	$6.72
95860	S	Muscle test, one limb	0218	1.03	$52.43	$23.59	$10.49
95861	S	Muscle test, two limbs	0218	1.03	$52.43	$23.59	$10.49
95863	S	Muscle test, 3 limbs	0218	1.03	$52.43	$23.59	$10.49
95864	S	Muscle test, 4 limbs	0218	1.03	$52.43	$23.59	$10.49
95867	S	Muscle test, head or neck	0218	1.03	$52.43	$23.59	$10.49
95868	S	Muscle test, head or neck	0218	1.03	$52.43	$23.59	$10.49
95869	S	Muscle test, thor paraspinal	0215	0.66	$33.60	$17.47	$6.72
95870	S	Muscle test, nonparaspinal	0218	1.03	$52.43	$23.59	$10.49
95872	S	Muscle test, one fiber	0215	0.66	$33.60	$17.47	$6.72
95875	S	Limb exercise test	0215	0.66	$33.60	$17.47	$6.72
95900	S	Motor nerve conduction test	0218	1.03	$52.43	$23.59	$10.49
95903	S	Motor nerve conduction test	0218	1.03	$52.43	$23.59	$10.49
95904	S	Sense/mixed n conduction tst	0215	0.66	$33.60	$17.47	$6.72
95920	S	Intraop nerve test add-on	0218	1.03	$52.43	$23.59	$10.49
95921	S	Autonomic nerv function test	0215	0.66	$33.60	$17.47	$6.72
95922	S	Autonomic nerv function test	0215	0.66	$33.60	$17.47	$6.72
95923	S	Autonomic nerv function test	0215	0.66	$33.60	$17.47	$6.72

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
95925	S	Somatosensory testing	0216	2.61	$132.86	$59.79	$26.57
95926	S	Somatosensory testing	0216	2.61	$132.86	$59.79	$26.57
95927	S	Somatosensory testing	0216	2.61	$132.86	$59.79	$26.57
95930	S	Visual evoked potential test	0216	2.61	$132.86	$59.79	$26.57
95933	S	Blink reflex test	0215	0.66	$33.60	$17.47	$6.72
95934	S	H-reflex test	0215	0.66	$33.60	$17.47	$6.72
95936	S	H-reflex test	0215	0.66	$33.60	$17.47	$6.72
95937	S	Neuromuscular junction test	0218	1.03	$52.43	$23.59	$10.49
95950	S	Ambulatory eeg monitoring	0213	2.65	$134.90	$70.15	$26.98
95951	S	EEG monitoring/videorecord	0209	10.54	$536.53	$279.00	$107.31
95953	S	EEG monitoring/computer	0209	10.54	$536.53	$279.00	$107.31
95954	S	EEG monitoring/giving drugs	0213	2.65	$134.90	$70.15	$26.98
95955	S	EEG during surgery	0214	2.10	$106.90	$53.45	$21.38
95956	N	Eeg monitoring, cable/radio					
95957	N	EEG digital analysis					
95958	S	EEG monitoring/function test	0213	2.65	$134.90	$70.15	$26.98
95961	S	Electrode stimulation, brain	0216	2.61	$132.86	$59.79	$26.57
95962	S	Electrode stim, brain add-on	0216	2.61	$132.86	$59.79	$26.57
*95965	T	Meg, spontaneous	0972		$150.00		$30.00
*95966	T	Meg, evoked, single	0972		$150.00		$30.00
*95967	T	Meg, evoked, each addl	0972		$150.00		$30.00
95970	S	Analyze neurostim, no prog	0692	14.34	$729.96	$401.47	$145.99
95971	S	Analyze neurostim, simple	0692	14.34	$729.96	$401.47	$145.99
95972	S	Analyze neurostim, complex	0692	14.34	$729.96	$401.47	$145.99
95973	S	Analyze neurostim, complex	0692	14.34	$729.96	$401.47	$145.99
95974	S	Cranial neurostim, complex	0692	14.34	$729.96	$401.47	$145.99
95975	S	Cranial neurostim, complex	0692	14.34	$729.96	$401.47	$145.99
95999	N	Neurological procedure					
*96000	T	Motion analysis, video/3d	0972		$150.00		$30.00
*96001	T	Motion test w/ft press meas	0972		$150.00		$30.00
*96002	T	Dynamic surface emg	0972		$150.00		$30.00
*96003	T	Dynamic fine wire emg	0972		$150.00		$30.00
*96004	E	Phys review of motion tests					
96100	X	Psychological testing	0373	1.00	$50.90	$14.25	$10.18
96105	X	Assessment of aphasia	0373	1.00	$50.90	$14.25	$10.18
96110	X	Developmental test, lim	0373	1.00	$50.90	$14.25	$10.18
96111	X	Developmental test, extend	0373	1.00	$50.90	$14.25	$10.18
96115	X	Neurobehavior status exam	0373	1.00	$50.90	$14.25	$10.18
96117	X	Neuropsych test battery	0373	1.00	$50.90	$14.25	$10.18
*96150	S	Assess hlth/behave, init	0322	1.15	$58.54	$12.29	$11.71
*96151	S	Assess hlth/behave, subseq	0322	1.15	$58.54	$12.29	$11.71
*96152	S	Intervene hlth/behave, indiv	0322	1.15	$58.54	$12.29	$11.71
*96153	S	Intervene hlth/behave, group	0322	1.15	$58.54	$12.29	$11.71
*96154	S	Interv hlth/behav, fam w/pt	0322	1.15	$58.54	$12.29	$11.71
*96155	S	Interv hlth/behav fam no pt	0322	1.15	$58.54	$12.29	$11.71
96400	E	Chemotherapy, sc/im					
96405	E	Intralesional chemo admin					
96406	E	Intralesional chemo admin					
96408	E	Chemotherapy, push technique					
96410	E	Chemotherapy,infusion method					
96412	E	Chemo, infuse method add-on					
96414	E	Chemo, infuse method add-on					
96420	E	Chemotherapy, push technique					
96422	E	Chemotherapy,infusion method					
96423	E	Chemo, infuse method add-on					
96425	E	Chemotherapy,infusion method					
96440	E	Chemotherapy, intracavitary					
96445	E	Chemotherapy, intracavitary					
96450	E	Chemotherapy, into CNS					
96520	T	Pump refilling, maintenance	0125	3.00	$152.71		$30.54
96530	T	Pump refilling, maintenance	0125	3.00	$152.71		$30.54
96542	E	Chemotherapy injection					
96545	E	Provide chemotherapy agent					
96549	E	Chemotherapy, unspecified					
*96567	T	Photodynamic tx, skin	0972		$150.00		$30.00
96570	T	Photodynamic tx, 30 min	0973		$250.00		$50.00
96571	T	Photodynamic tx, addl 15 min	0973		$250.00		$50.00
96900	S	Ultraviolet light therapy	0001	0.43	$21.89	$7.88	$4.38
96902	N	Trichogram					
96910	S	Photochemotherapy with UV–B	0001	0.43	$21.89	$7.88	$4.38
96912	S	Photochemotherapy with UV–A	0001	0.43	$21.89	$7.88	$4.38
96913	S	Photochemotherapy, UV–A or B	0001	0.43	$21.89	$7.88	$4.38
96999	S	Dermatological procedure	0001	0.43	$21.89	$7.88	$4.38
97001	A	Pt evaluation					
97002	A	Pt re-evaluation					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	A	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					
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 care selective					
97602	N	Wound care non-selective					
97703	A	Prosthetic checkout					
97750	A	Physical performance test					
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	0.23	$11.71		$2.34
98926	S	Osteopathic manipulation	0060	0.23	$11.71		$2.34
98927	S	Osteopathic manipulation	0060	0.23	$11.71		$2.34
98928	S	Osteopathic manipulation	0060	0.23	$11.71		$2.34
98929	S	Osteopathic manipulation	0060	0.23	$11.71		$2.34
98940	S	Chiropractic manipulation	0060	0.23	$11.71		$2.34
98941	S	Chiropractic manipulation	0060	0.23	$11.71		$2.34
98942	S	Chiropractic manipulation	0060	0.23	$11.71		$2.34
98943	E	Chiropractic manipulation					
99000	E	Specimen handling					
99001	E	Specimen handling					
99002	E	Device handling					
99024	E	Postop follow-up visit					
99025	E	Initial surgical evaluation					
99050	E	Medical services after hrs					
99052	E	Medical services at night					
99054	E	Medical servcs, unusual hrs					
99056	E	Non-office medical services					
99058	E	Office emergency care					
99070	E	Special supplies					
99071	E	Patient education materials					
99075	E	Medical testimony					
99078	N	Group health education					
99080	E	Special reports or forms					
99082	E	Unusual physician travel					
99090	E	Computer data analysis					
*99091	E	Collect/review data from pt					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99100	E	Special anesthesia service					
99116	E	Anesthesia with hypothermia					
99135	E	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	0.23	$11.71	$3.40	$2.34
99172	E	Ocular function screen					
99173	E	Visual acuity screen					
99175	N	Induction of vomiting					
99183	E	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	0.53	$26.98	$10.09	$5.40
99199	E	Special service/proc/report					
99201	V	Office/outpatient visit, new	0600	0.86	$43.78		$8.76
99202	V	Office/outpatient visit, new	0600	0.86	$43.78		$8.76
99203	V	Office/outpatient visit, new	0601	0.95	$48.36		$9.67
99204	V	Office/outpatient visit, new	0602	1.38	$70.25		$14.05
99205	V	Office/outpatient visit, new	0602	1.38	$70.25		$14.05
99211	V	Office/outpatient visit, est	0600	0.86	$43.78		$8.76
99212	V	Office/outpatient visit, est	0600	0.86	$43.78		$8.76
99213	V	Office/outpatient visit, est	0601	0.95	$48.36		$9.67
99214	V	Office/outpatient visit, est	0602	1.38	$70.25		$14.05
99215	V	Office/outpatient visit, est	0602	1.38	$70.25		$14.05
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	0.86	$43.78		$8.76
99242	V	Office consultation	0600	0.86	$43.78		$8.76
99243	V	Office consultation	0601	0.95	$48.36		$9.67
99244	V	Office consultation	0602	1.38	$70.25		$14.05
99245	V	Office consultation	0602	1.38	$70.25		$14.05
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	0.86	$43.78		$8.76
99272	V	Confirmatory consultation	0600	0.86	$43.78		$8.76
99273	V	Confirmatory consultation	0601	0.95	$48.36		$9.67
99274	V	Confirmatory consultation	0602	1.38	$70.25		$14.05
99275	V	Confirmatory consultation	0602	1.38	$70.25		$14.05
99281	V	Emergency dept visit	0610	1.23	$62.61	$19.41	$12.52
99282	V	Emergency dept visit	0610	1.23	$62.61	$19.41	$12.52
99283	V	Emergency dept visit	0611	2.16	$109.95	$36.47	$21.99
99284	V	Emergency dept visit	0612	3.49	$177.65	$54.14	$35.53
99285	V	Emergency dept visit	0612	3.49	$177.65	$54.14	$35.53
99288	E	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	8.40	$427.59	$149.66	$85.52
99292	N	Critical care, addl 30 min					
99295	C	Neonatal critical care					
99296	C	Neonatal critical care					
99297	C	Neonatal critical care					
99298	C	Neonatal critical care					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99301	E	Nursing facility care					
99302	E	Nursing facility care					
99303	E	Nursing facility care					
99311	E	Nursing fac care, subseq					
99312	E	Nursing fac care, subseq					
99313	E	Nursing fac care, subseq					
99315	E	Nursing fac discharge day					
99316	E	Nursing fac discharge day					
99321	E	Rest home visit, new patient					
99322	E	Rest home visit, new patient					
99323	E	Rest home visit, new patient					
99331	E	Rest home visit, est pat					
99332	E	Rest home visit, est pat					
99333	E	Rest home visit, est pat					
99341	E	Home visit, new patient					
99342	E	Home visit, new patient					
99343	E	Home visit, new patient					
99344	E	Home visit, new patient					
99345	E	Home visit, new patient					
99347	E	Home visit, est patient					
99348	E	Home visit, est patient					
99349	E	Home visit, est patient					
99350	E	Home visit, est patient					
99354	N	Prolonged service, office					
99355	N	Prolonged service, office					
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	E	Physician standby services					
99361	E	Physician/team conference					
99362	E	Physician/team conference					
99371	E	Physician phone consultation					
99372	E	Physician phone consultation					
99373	E	Physician phone consultation					
99374	E	Home health care supervision					
99377	E	Hospice care supervision					
99379	E	Nursing fac care supervision					
99380	E	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	N	Initial care, normal newborn					
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	6.08	$309.50	$105.29	$61.90
99450	E	Life/disability evaluation					
99455	E	Disability examination					
99456	E	Disability examination					
99499	E	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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
*99504	E	Home visit mech ventilator					
*99505	E	Home visit, stoma care					
*99506	E	Home visit, im injection					
*99507	E	Home visit, cath maintain					
*99508	E	Home visit, sleep studies					
*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, hemodialysis					
*99539	E	Home visit, nos					
*99551	E	Home infus, pain mgmt, iv/sc					
*99552	E	Hm infus pain mgmt, epid/ith					
*99553	E	Home infuse, tocolytic tx					
*99554	E	Home infus, hormone/platelet					
*99555	E	Home infuse, chemotheraphy					
*99556	E	Home infus, antibio/fung/vir					
*99557	E	Home infuse, anticoagulant					
*99558	E	Home infuse, immunotherapy					
*99559	E	Home infus, periton dialysis					
*99560	E	Home infus, entero nutrition					
*99561	E	Home infuse, hydration tx					
*99562	E	Home infus, parent nutrition					
*99563	E	Home admin, pentamidine					
*99564	E	Hme infus, antihemophil agnt					
*99565	E	Home infus, proteinase inhib					
*99566	E	Home infuse, iv therapy					
*99567	E	Home infuse, sympath agent					
*99568	E	Home infus, misc drug, daily					
*99569	E	Home infuse, each addl tx					
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 mileage					
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					
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	E	Supp for self-adm injections					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4212	E	Non coring needle or stylet					
A4213	E	20+ CC syringe only					
A4214	A	30 CC sterile water/saline					
A4215	E	Sterile needle					
A4220	A	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	A	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					
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					
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					
A4270	A	Disposable endoscope sheath					
A4280	A	Brst prsths adhsv attchmnt					
A4290	E	Sacral nerve stim test lead					
A4300	E	Cath impl vasc access portal					
A4301	E	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	Sterile H2O irrigation solut					
A4320	A	Irrigation tray					
A4321	A	Cath therapeutic irrig agent					
A4322	A	Irrigation syringe					
A4323	A	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					
A4329	D	External catheter start set					
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 bag					
A4359	A	Urinary suspensory w/o leg b					
*A4360	A	Adult incontinence garment					
A4361	A	Ostomy face plate					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4362	A	Solid skin barrier					
A4364	A	Adhesive, liquid or equal					
A4365	A	Adhesive remover wipes					
A4367	A	Ostomy belt					
A4368	A	Ostomy filter					
A4369	A	Skin barrier liquid per oz					
A4370	A	Skin barrier paste per oz					
A4371	A	Skin barrier powder per oz					
A4372	A	Skin barrier solid 4x4 equiv					
A4373	A	Skin barrier with flange					
A4374	A	Skin barrier extended wear					
A4375	A	Drainable plastic pch w fcpl					
A4376	A	Drainable rubber pch w fcplt					
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					
A4386	A	Ost skn barrier w flng ex wr					
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					
A4421	A	Ostomy supply misc					
A4454	A	Tape all types all sizes					
A4455	A	Adhesive remover per ounce					
A4460	A	Elastic compression bandage					
A4462	A	Abdmnl drssng holder/binder					
A4464	A	Joint support device/garment					
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					
A4550	E	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	N	Splint					
A4572	A	Rib belt					
A4575	E	Hyperbaric o2 chamber disps					
A4580	N	Cast supplies (plaster)					
A4590	N	Special casting material					
A4595	A	TENS suppl 2 lead per month					
A4608	A	Transtracheal oxygen cath					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4617	A	Mouth piece					
A4618	A	Breathing circuits					
A4619	A	Face tent					
A4620	A	Variable concentration mask					
A4621	A	Tracheotomy mask or collar					
A4622	A	Tracheostomy or larngectomy					
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	Wheelchair battery					
A4635	A	Underarm crutch pad					
A4636	A	Handgrip for cane etc					
A4637	A	Repl tip cane/crutch/walker					
A4640	A	Alternating pressure pad					
A4641	N	Diagnostic imaging agent					
A4642	G	Satumomab pendetide per dose	0704		$1,591.25		$227.80
A4643	N	High dose contrast MRI					
A4644	N	Contrast 100–199 MGs iodine					
A4645	N	Contrast 200–299 MGs iodine					
A4646	N	Contrast 300–399 MGs iodine					
A4647	N	Supp- paramagnetic contr mat					
A4649	A	Surgical supplies					
A4650	D	Supp esrd centrifuge					
*A4651	A	Calibrated microcap tube					
*A4652	A	Microcapillary tube sealant					
A4655	D	Esrd syringe/needle					
*A4656	A	Dialysis needle					
*A4657	A	Dialysis syringe w/wo needle					
A4660	A	Esrd blood pressure device					
A4663	A	Esrd blood pressure cuff					
A4670	E	Auto blood pressure monitor					
A4680	A	Activated carbon filters					
A4690	A	Dialyzers					
A4700	D	Standard dialysate solution					
A4705	D	Bicarb dialysate solution					
*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	Sterile water					
A4714	A	Treated water for dialysis					
*A4719	A	oY seto 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					
A4730	A	Fistula cannulation set dial					
A4735	D	Local/topical anesthetics					
*A4736	A	Topical anesthetic, per gram					
*A4737	A	Inj anesthetic per 10 ml					
A4740	A	Esrd shunt accessory					
A4750	A	Arterial or venous tubing					
A4755	A	Arterial and venous tubing					
A4760	A	Standard testing solution					
A4765	A	Dialysate concentrate					
*A4766	A	Dialysate conc sol add 10 ml					
A4770	A	Blood testing supplies					
A4771	A	Blood clotting time tube					
A4772	A	Dextrostick/glucose strips					
A4773	A	Hemostix					
A4774	A	Ammonia test paper					
A4780	D	Esrd sterilizing agent					
A4790	D	Esrd cleansing agents					
A4800	D	Heparin/antidote dialysis					
*A4801	A	Heparin per 1000 units					
*A4802	A	Protamine sulfate per 50 mg					
A4820	D	Supplies hemodialysis kit					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4850	D	Rubber tipped hemostats					
A4860	A	Disposable catheter caps					
A4870	A	Plumbing/electrical work					
A4880	D	Water storage tanks					
A4890	A	Contracts/repair/maintenance					
A4900	D	Capd supply kit					
A4901	D	Ccpd supply kit					
A4905	D	Ipd supply kit					
A4910	D	Esrd nonmedical supplies					
*A4911	A	Drain bag/bottle					
A4912	D	Gomco drain bottle					
A4913	A	Esrd supply					
A4914	D	Preparation kit					
A4918	A	Venous pressure clamp					
A4919	D	Supp dialysis dialyzer holde					
A4920	D	Harvard pressure clamp					
A4921	D	Measuring cylinder					
A4927	A	Gloves					
*A4928	A	Surgical mask					
*A4929	A	Tourniquet for dialysis, ea					
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	Drnble ostomy pouch w/o barr					
A5063	A	Drain ostomy pouch w/flange					
A5064	D	Drain ostomy pouch w/fceplte					
A5071	A	Urinary pouch w/barrier					
A5072	A	Urinary pouch w/o barrier					
A5073	A	Urinary pouch on barr w/flng					
A5074	D	Urinary pouch w/faceplate					
A5075	D	Urinary pouch on faceplate					
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					
A5123	A	Skin barrier with flange					
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					
A5502	D	Diabetic shoe density insert					
A5503	A	Diabetic shoe w/roller/rockr					
A5504	A	Diabetic shoe with wedge					
A5505	A	Diab shoe w/metatarsal bar					
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	A	Wound warming wound cover					
*A6010	A	Collagen based wound filler					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
A6260	A	Wound cleanser any type/size					
A6261	A	Wound filler gel/paste /oz					
A6262	A	Wound filler dry form / gram					
A6263	A	Non-sterile elastic gauze/yd					
A6264	A	Non-sterile no elastic gauze					
A6265	A	Tape per 18 sq inches					
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					
A6405	A	Sterile elastic gauze /yd					
A6406	A	Sterile non-elastic gauze/yd					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	Saline solution dispenser					
A7020	A	Sterile H2O or NSS w lgv neb					
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					
A9150	E	Misc/exper non-prescript dru					
A9160	D	Podiatrist non-covered servi					
A9170	D	Chiropractor non-covered ser					
A9190	D	Misc/expe personal comfort i					
A9270	E	Non-covered item or service					
A9300	E	Exercise equipment					
A9500	G	Technetium TC 99m sestamibi	1600		$121.70		$17.42
A9502	G	Technetium tc99m tetrofosmin, per unit dose	0705		$114.00		$16.32
A9503	G	Technetium TC 99m medronate	1601		$42.18		$5.42
A9504	G	Technetium tc 99m apcitide	1602		$475.00		$68.00
A9505	G	Thallous chloride TL 201/mci	1603		$78.16		$7.08
A9507	G	Indium/111 capromab pendetid, per dose	1604		$2,192.13		$313.82
A9508	G	Iobenguane sulfate I–31 per 0.5 mCi	1045		$495.65		$70.96
A9510	G	Technetium TC99m Disofenin	1205		$79.17		$11.33
*A9511	G	Technetium TC 99m depreotide	1095		$38.00		$5.44
A9600	G	Strontium-89 chloride per mCi	0701		$963.42		$137.92
A9605	G	Samarium sm153 lexidronamm 50 mCi	0702		$1,020.00		$146.02
A9700	G	Echocardiography contrast per study [per 3 ml]	9016		$118.75		$17.00
A9900	A	Supply/accessory/service					
A9901	A	Delivery/set up/dispensing					
B4034	A	Enter feed supkit syr by day					
B4035	A	Enteral feed supp pump per d					
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					
B4084	D	Gastrostomy/jejunostomy tubi					
B4085	D	Gastrostomy tube w/ring each					
*B4086	A	Gastrostomy/jejunostomy tube					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
B5200	A	Parenteral sol stres-brnch 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	Blood, L/R, CMV-neg	1010	2.72	$138.46		$27.69
C1011	K	Platelets, HLA-m, L/R, unit	1011	11.21	$570.63		$114.13
C1012	K	Platelet conc, L/R, irrad	1012	1.81	$92.14		$18.43
C1013	K	Platelet conc, L/R, unit	1013	1.11	$56.50		$11.30
C1014	K	Platelet,aph/pher, L/R, unit	1014	8.45	$430.14		$86.03
C1016	K	Blood,l/r,froz/degly/washed	1016	6.76	$344.11		$68.82
C1017	K	Plt, aph/pher,l/r,cmv-neg	1017	8.82	$448.97		$89.79
C1018	K	Blood, L/R, irradiated	1018	2.96	$150.68		$30.14
C1019	D	Plt, APH,PHER, L/R, IRRAD	1019	9.11	$463.74		$92.75
C1050	D	Prosorba Column	0976		$875.00		$175.00
*C1058	G	TC 99M oxidronate, per vial	1058		$36.74		$5.26
*C1064	G	I–131 cap, each add mCi	1064		$5.86		$.75
*C1065	G	I–131 sol, each add mCi	1065		$15.81		$2.03
*C1066	G	IN 111 satumomab pendetide	1066		$1,591.25		$227.80
C1079	G	Co 57/58 0.5 uCi	1079		$253.84		$36.34
C1087	G	I–123 per 100 uCi	1087		$.65		$.06
C1088	T	Laser optic tr sys	0980		$1,875.00		$375.00
C1090	D	IN 111 chloride, per mCi					
C1091	G	IN111 oxyquinoline,per0.5mCi	1091		$427.50		$61.20
C1092	G	IN 111 pentetate, per 0.5 mCi	1092		$256.50		$23.22
C1094	G	TC 99M albumin aggr, 1.0 mCi	1094		$33.09		$4.25
C1095	D	TC 99M Depreotide, per vial	1095		$38.00		$5.44
C1096	G	TC 99M exametazime, per dose	1096		$445.31		$63.75
C1097	G	TC 99M mebrofenin, per vial	1097		$51.44		$7.36
C1098	G	TC 99M pentetate, per vial	1098		$22.43		$2.88
C1099	G	TC 99M pyrophosphate,per vial	1099		$39.11		$5.60
C1122	G	TC 99M arcitumomab per vial	1122		$1,235.00		$176.80
C1166	G	Cytarabine liposomal, 10 mg	1166		$371.45		$53.18
C1167	G	Epirubicin hcl, 2 mg	1167		$24.94		$3.57
C1178	G	Busulfan IV, 6 mg	1178		$26.48		$3.79
C1188	G	I–131 cap, per 1–5 mCi	1188		$117.25		$15.06
C1200	G	TC 99M Sodium Glucoheptonat	1200		$22.61		$3.24
C1201	G	TC 99M succimer, per vial	1201		$135.66		$19.42
C1202	G	TC 99M sulfur colloid, dose	1202		$76.00		$9.76
C1207	G	Octreotide acetate depot 1 mg	1207		$138.08		$19.77
C1300	T	Hyperbaric oxygen	0971		$75.00		$15.00
C1305	G	Apligraf	1305		$1,157.81		$165.75
C1348	G	I–131 sol, per 1–6 mCi	1348		$146.57		$18.82
C1713	H	Anchor/screw bn/bn,tis/bn	1713				
C1714	H	Cath, trans atherectomy, dir	1714				
C1715	H	Brachytherapy needle	1715				
C1716	H	Brachytx seed, Gold 198	1716				
C1717	H	Brachytx seed, HDR Ir–192	1717				
C1718	H	Brachytx seed, Iodine 125	1718				
C1719	H	Brachytxseed, Non-HDR Ir–192	1719				
C1720	H	Brachytx seed, Palladium 103	1720				
C1721	H	AICD, dual chamber	1721				
C1722	H	AICD, single chamber	1722				
C1723	D	Cath, ablation, non-cardiac					
C1724	H	Cath, trans atherec,rotation	1724				
C1725	H	Cath, translumin non-laser	1725				
C1726	H	Cath, bal dil, non-vascular	1726				
C1727	H	Cath, bal tis dis, non-vas	1727				
C1728	H	Cath, brachytx seed adm	1728				
C1729	H	Cath, drainage	1729				
C1730	H	Cath, EP, 19 or fewer elect	1730				
C1731	H	Cath, EP, 20 or more elec	1731				
C1732	H	Cath, EP, diag/abl, 3D/vect	1732				
C1733	H	Cath, EP, othr than cool-tip	1733				
C1750	H	Cath, hemodialysis,long-term	1750				
C1751	H	Cath, inf, per/cent/midline	1751				
C1752	H	Cath, hemodialysis,short-term	1752				
C1753	H	Cath, intravas ultrasound	1753				
C1754	H	Catheter, intradiscal	1754				
C1755	H	Catheter, intraspinal	1755				
C1756	H	Cath, pacing, transesoph	1756				
C1757	H	Cath, thrombectomy/embolect	1757				
C1758	H	Cath, ureteral	1758				

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C1759	H	Cath, intra echocardiography	1759				
C1760	H	Closure dev, vasc, imp/insert	1760				
C1762	H	Conn tiss, human (inc fascia)	1762				
C1763	H	Conn tiss, non-human	1763				
C1764	H	Event recorder, cardiac	1764				
C1765	H	Adhesion barrier	1765				
C1766	H	Intro/sheath,strble,non-peel	1766				
C1767	H	Generator, neurostim, imp	1767				
C1768	H	Graft, vascular	1768				
C1769	H	Guide wire	1769				
C1770	H	Imaging coil, MR, insertable	1770				
C1771	H	Rep dev, urinary, w/sling	1771				
C1772	H	Infusion pump, programmable	1772				
C1773	H	Retrieval dev, insert	1773				
C1776	H	Joint device (implantable)	1776				
C1777	H	Lead, AICD, endo single coil	1777				
C1778	H	Lead, neurostimulator	1778				
C1779	H	Lead, pmkr, transvenous VDD	1779				
C1780	H	Lens, intraocular	1780				
C1781	H	Mesh (implantable)	1781				
C1782	H	Morcellator	1782				
C1784	H	Ocular dev, intraop, det ret	1784				
C1785	H	Pmkr, dual, rate-resp	1785				
C1786	H	Pmkr, single, rate-resp	1786				
C1787	H	Patient progr, neurostim	1787				
C1788	H	Port, indwelling, imp	1788				
C1789	H	Prosthesis, breast, imp	1789				
C1813	H	Prosthesis, penile, inflatab	1813				
C1815	H	Pros, urinary sph, imp	1815				
C1816	H	Receiver/transmitter, neuro	1816				
C1817	H	Septal defect imp sys	1817				
C1874	H	Stent, coated/cov w/del sys	1874				
C1875	H	Stent, coated/cov w/o del sy	1875				
C1876	H	Stent, non-coa/no-cov w/del	1876				
C1877	H	Stent, non-coat/cov w/o del	1877				
C1878	H	Matrl for vocal cord	1878				
C1879	H	Tissue marker, imp	1879				
C1880	H	Vena cava filter	1880				
C1881	H	Dialysis access system	1881				
C1882	H	AICD, other than sing/dual	1882				
C1883	H	Adapt/ext, pacing/neuro lead	1883				
C1885	H	Cath, translumin angio laser	1885				
C1887	H	Catheter, guiding	1887				
C1891	H	Infusion pump,non-prog,perm	1891				
C1892	H	Intro/sheath,fixed,peel-away	1892				
C1893	H	Intro/sheath,fixed,non-peel	1893				
C1894	H	Intro/sheath, non-laser	1894				
C1895	H	Lead, AICD, endo dual coil	1895				
C1896	H	Lead, AICD, non sing/dual	1896				
C1897	H	Lead, neurostim test kit	1897				
C1898	H	Lead, pmkr, other than trans	1898				
C1899	H	Lead, pmkr/AICD combination	1899				
C2615	H	Sealant, pulmonary, liquid	2615				
C2616	H	Brachytx seed, Yttrium-90	2616				
C2617	H	Stent, non-cor, tem w/o del	2617				
C2618	H	Probe, cryoablation	2618				
C2619	H	Pmkr, dual, non rate-resp	2619				
C2620	H	Pmkr, single, non rate-resp	2620				
C2621	H	Pmkr, other than sing/dual	2621				
C2622	H	Prosthesis, penile, non-inf	2622				
C2625	H	Stent, non-cor, tem w/del sys	2625				
C2626	H	Infusion pump, non-prog,temp	2626				
C2627	H	Cath, suprapubic/cystoscopic	2627				
C2628	H	Catheter, occlusion	2628				
C2629	H	Intro/sheath, laser	2629				
C2630	H	Cath, EP, cool-tip	2630				
C2631	H	Rep dev, urinary, w/o sling	2631				
C8900	S	MRA w/cont, abd	0284	7.15	$363.96	$200.17	$72.79
C8901	S	MRA w/o cont, abd	0336	6.29	$320.19	$176.10	$64.04
C8902	S	MRA w/o fol w/cont, abd	0337	8.54	$434.72	$239.09	$86.94
C8903	S	MRI w/cont, breast, uni	0284	7.15	$363.96	$200.17	$72.79
C8904	S	MRI w/o cont, breast, uni	0336	6.29	$320.19	$176.10	$64.04
C8905	S	MRI w/o fol w/cont, brst, uni	0337	8.54	$434.72	$239.09	$86.94
C8906	S	MRI w/cont, breast, bi	0284	7.15	$363.96	$200.17	$72.79
C8907	S	MRI w/o cont, breast, bi	0336	6.29	$320.19	$176.10	$64.04

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C8908	S	MRI w/o fol w/cont, breast, bi	0337	8.54	$434.72	$239.09	$86.94
C8909	S	MRA w/cont, chest	0284	7.15	$363.96	$200.17	$72.79
C8910	S	MRA w/o cont, chest	0336	6.29	$320.19	$176.10	$64.04
C8911	S	MRA w/o fol w/cont, chest	0337	8.54	$434.72	$239.09	$86.94
C8912	S	MRA w/cont, lwr ext	0284	7.15	$363.96	$200.17	$72.79
C8913	S	MRA w/o cont, lwr ext	0336	6.29	$320.19	$176.10	$64.04
C8914	S	MRA w/o fol w/cont, lwr ext	0337	8.54	$434.72	$239.09	$86.94
C9000	G	Na chromatecr51, per 0.25mCi	9000		$.52		$.07
C9001	D	Linezolid inj, 200 mg	9001		$24.13		$3.45
C9002	D	Tenecteplase, 50 mg/vial	9002		$2,612.50		$374.00
C9003	G	Palivizumab, per 50 mg	9003		$664.49		$95.13
C9004	D	Gemtuzumab ozogaminicin inj, 5m	9004		$1,929.69		$276.25
C9006	D	Tacrolimus inj, per 5 mg	9006		$113.15		$16.20
C9007	G	Baclofen intrathecal kit-1amp	9007		$79.80		$11.42
C9008	G	Baclofen Refill Kit-500 mcg	9008		$11.69		$1.67
C9009	G	Baclofen Refill Kit-2000 mcg	9009		$49.12		$7.03
C9010	G	Baclofen refill kitu per 4000 mcg	9010		$43.08		$6.17
C9011	D	Caffeine Citrate, inj, 1ml	9011		$3.05		$.44
C9012	D	Injection, arsenic trioxide	9012		$23.75		$3.40
C9013	G	Co 57 cobaltous chloride	9013		$81.10		$10.41
C9018	D	Botulinum tox B, per 100 u	9018		$8.79		$1.26
C9019	G	Caspofungin acetate, per 5 mg	9019		$34.20		$4.90
C9020	G	Sirolimus tablet, 1 mg	9020		$6.51		$.93
C9100	G	Iodinated I–131 Albumin	9100		$10.34		$1.48
C9102	G	51 Na Chromate, 50mCi	9102		$64.84		$9.28
C9103	G	Na Iothalamate I–125, 10 uCi	9103		$17.18		$2.46
C9104	D	Anti-thymocyct globulin, 25 mg	9104		$325.09		$46.54
C9105	G	Hep B imm glob, per 1 ml	9105		$133.00		$17.08
C9108	G	Thyrotropin alfa, 1.1 mg	9108		$531.05		$76.02
C9109	G	Tirofiban hcl, 6.25 mg	9109		$207.81		$29.75
C9110	G	Alemtuzumab, per 10 mg/ml	9110		$486.88		$69.70
*C9111	G	Inj, bivalirudin, 250 mg vial	9111		$397.81		$56.95
*C9112	G	Perflutren lipid micro, 2ml	9112		$148.20		$21.22
*C9113	G	Inj pantoprazole sodium, vial	9113		$22.80		$3.26
*C9114	G	Nesiritide, per 1.5 mg vial	9114		$433.20		$62.02
*C9115	G	Inj, zoledronic acid, 2 mg	9115		$406.78		$58.23
*C9200	G	Orcel, per 36 cm2	9200		$1,135.25		$162.52
*C9201	G	Dermagraft, per 37.5 sq cm	9201		$577.60		$82.69
C9503	K	Fresh frozen plasma, ea unit	9503	1.56	$79.41		$15.88
C9506	D	Granulocytes, pheresis	9506	27.75	$1,412.59		$282.52
C9700	D	Water induced thermo	0977		$1,125.00		$225.00
C9701	T	Stretta procedure	0980		$1,875.00		$375.00
C9702	D	Chkmate/Novost/Galileo Brach	0981		$2,250.00		$450.00
*C9703	T	Bard Endoscopic Suturing Sys	0979		$1,625.00		$325.00
C9708	T	Preview Tx Planning Software	0975		$625.00		$125.00
C9711	T	H.E.L.P. Apheresis System	0978		$1,375.00		$275.00
D0120	E	Periodic oral evaluation					
D0140	E	Limit oral eval problm focus					
D0150	S	Comprehensve oral evaluation	0330	10.97	$558.42		$111.68
D0160	E	Extensv oral eval prob focus					
D0170	E	Re-eval,est pt,problem focus					
D0210	E	Intraor complete film series					
D0220	E	Intraoral periapical first f					
D0230	E	Intraoral periapical ea add					
D0240	S	Intraoral occlusal film	0330	10.97	$558.42		$111.68
D0250	S	Extraoral first film	0330	10.97	$558.42		$111.68
D0260	S	Extraoral ea additional film	0330	10.97	$558.42		$111.68
D0270	S	Dental bitewing single film	0330	10.97	$558.42		$111.68
D0272	S	Dental bitewings two films	0330	10.97	$558.42		$111.68
D0274	S	Dental bitewings four films	0330	10.97	$558.42		$111.68
D0277	S	Vert bitewings-sev to eight	0330	10.97	$558.42		$111.68
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	10.97	$558.42		$111.68
D0470	E	Diagnostic casts					
D0472	S	Gross exam, prep & report	0330	10.97	$558.42		$111.68
D0473	S	Micro exam, prep & report	0330	10.97	$558.42		$111.68

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D0474	S	Micro w exam of surg margins	0330	10.97	$558.42		$111.68
D0480	S	Cytopath smear prep & report	0330	10.97	$558.42		$111.68
D0501	S	Histopathologic examinations	0330	10.97	$558.42		$111.68
D0502	S	Other oral pathology procedu	0330	10.97	$558.42		$111.68
D0999	S	Unspecified diagnostic proce	0330	10.97	$558.42		$111.68
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	10.97	$558.42		$111.68
D1515	S	Fixed bilat space maintainer	0330	10.97	$558.42		$111.68
D1520	S	Remove unilat space maintain	0330	10.97	$558.42		$111.68
D1525	S	Remove bilat space maintain	0330	10.97	$558.42		$111.68
D1550	S	Recement space maintainer	0330	10.97	$558.42		$111.68
D2110	E	Amalgam one surface primary					
D2120	E	Amalgam two surfaces primary					
D2130	E	Amalgam three surfaces prima					
D2131	E	Amalgam four/more surf prima					
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					
D2336	E	Composite resin crown					
D2337	E	Compo resin crown ant-perm					
D2380	E	Resin one surf poster primar					
D2381	E	Resin two surf poster primar					
D2382	E	Resin three/more surf post p					
D2385	E	Resin one surf poster perman					
D2386	E	Resin two surf poster perman					
D2387	E	Resin three/more surf post p					
D2388	E	Resin four/more, post perm					
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					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	10.97	$558.42		$111.68
D2980	E	Crown repair					
D2999	S	Dental unspec restorative pr	0330	10.97	$558.42		$111.68
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	10.97	$558.42		$111.68
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	10.97	$558.42		$111.68
D4210	E	Gingivectomy/plasty per quad					
D4211	E	Gingivectomy/plasty per toot					
D4220	E	Gingival curettage per quadr					
D4240	E	Gingival flap proc w/ planin					
D4245	E	Apically positioned flap					
D4249	E	Crown lengthen hard tissue					
D4260	S	Osseous surgery per quadrant	0330	10.97	$558.42		$111.68
D4263	S	Bone replce graft first site	0330	10.97	$558.42		$111.68
D4264	S	Bone replce graft each add	0330	10.97	$558.42		$111.68
D4266	E	Guided tiss regen resorble					
D4267	E	Guided tiss regen nonresorb					
D4268	S	Surgical revision procedure	0330	10.97	$558.42		$111.68
D4270	S	Pedicle soft tissue graft pr	0330	10.97	$558.42		$111.68
D4271	S	Free soft tissue graft proc	0330	10.97	$558.42		$111.68
D4273	S	Subepithelial tissue graft	0330	10.97	$558.42		$111.68
D4274	E	Distal/proximal wedge proc					
D4320	E	Provision splnt intracoronal					
D4321	E	Provisional splint extracoro					
D4341	E	Periodontal scaling & root					
D4355	S	Full mouth debridement	0330	10.97	$558.42		$111.68
D4381	S	Localized chemo delivery	0330	10.97	$558.42		$111.68
D4910	E	Periodontal maint procedures					

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CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
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					
D5899	E	Removable prosthodontic proc					
D5911	S	Facial moulage sectional	0330	10.97	$558.42		$111.68
D5912	S	Facial moulage complete	0330	10.97	$558.42		$111.68
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D5959	E	Intraoral con def mod palat					
D5960	E	Modify speech aid prosthesis					
D5982	E	Surgical stent					
D5983	S	Radiation applicator	0330	10.97	$558.42		$111.68
D5984	S	Radiation shield	0330	10.97	$558.42		$111.68
D5985	S	Radiation cone locator	0330	10.97	$558.42		$111.68
D5986	E	Fluoride applicator					
D5987	S	Commissure splint	0330	10.97	$558.42		$111.68
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					
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					
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					
D6519	E	Inlay/onlay porce/ceramic					
D6520	E	Dental retainer two surfaces					
D6530	E	Retainer metallic 3+ surface					
D6543	E	Dental retainr onlay 3 surf					
D6544	E	Dental retainr onlay 4/more					
D6545	E	Dental retainr cast metl					
D6548	E	Porcelain/ceramic retainer					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D6920	S	Dental connector bar	0330	10.97	$558.42		$111.68
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					
D6999	E	Fixed prosthodontic proc					
D7110	S	Oral surgery single tooth	0330	10.97	$558.42		$111.68
D7120	S	Each add tooth extraction	0330	10.97	$558.42		$111.68
D7130	S	Tooth root removal	0330	10.97	$558.42		$111.68
D7210	S	Rem imp tooth w mucoper flp	0330	10.97	$558.42		$111.68
D7220	S	Impact tooth remov soft tiss	0330	10.97	$558.42		$111.68
D7230	S	Impact tooth remov part bony	0330	10.97	$558.42		$111.68
D7240	S	Impact tooth remov comp bony	0330	10.97	$558.42		$111.68
D7241	S	Impact tooth rem bony w/comp	0330	10.97	$558.42		$111.68
D7250	S	Tooth root removal	0330	10.97	$558.42		$111.68
D7260	S	Oral antral fistula closure	0330	10.97	$558.42		$111.68
D7270	E	Tooth reimplantation					
D7272	E	Tooth transplantation					
D7280	E	Exposure impact tooth orthod					
D7281	E	Exposure tooth aid eruption					
D7285	E	Biopsy of oral tissue hard					
D7286	E	Biopsy of oral tissue soft					
D7290	E	Repositioning of teeth					
D7291	S	Transseptal fiberotomy	0330	10.97	$558.42		$111.68
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					
D7420	E	Lesion > 1.25 cm					
D7430	E	Exc benign tumor to 1.25 cm					
D7431	E	Benign tumor exc > 1.25 cm					
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					
D7480	E	Partial ostectomy					
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					
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					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	10.97	$558.42		$111.68
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					
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					

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CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D9410	E	Dental house call					
D9420	E	Hospital call					
D9430	E	Office visit during hours					
D9440	E	Office visit after hours					
D9610	E	Dent therapeutic drug inject					
D9630	S	Other drugs/medicaments	0330	10.97	$558.42		$111.68
D9910	E	Dent appl desensitizing med					
D9911	E	Appl desensitizing resin					
D9920	E	Behavior management					
D9930	S	Treatment of complications	0330	10.97	$558.42		$111.68
D9940	S	Dental occlusal guard	0330	10.97	$558.42		$111.68
D9941	E	Fabrication athletic guard					
D9950	S	Occlusion analysis	0330	10.97	$558.42		$111.68
D9951	S	Limited occlusal adjustment	0330	10.97	$558.42		$111.68
D9952	S	Complete occlusal adjustment	0330	10.97	$558.42		$111.68
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					
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					
E0130	A	Walker rigid adjust/fixed ht					
E0135	A	Walker folding adjust/fixed					
E0141	A	Rigid walker wheeled wo seat					
E0142	A	Walker rigid wheeled with se					
E0143	A	Walker folding wheeled w/o s					
E0144	A	Enclosed walker w rear seat					
E0145	A	Walker whled seat/crutch att					
E0146	A	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	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					
E0191	A	Protector heel or elbow					
E0192	A	Pad wheelchr low press/posit					
E0193	A	Powered air flotation bed					
E0194	A	Air fluidized bed					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
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					
*E0231	A	Wound warming device					
*E0232	A	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					
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					
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					
E0298	D	Heavyduty/xtra wide hosp bed					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0442	A	Oxygen contents, liquid					
E0443	A	Portable 02 contents, gas					
E0444	A	Portable 02 contents, liquid					
E0450	A	Volume vent stationary/porta					
E0455	A	Oxygen tent excl croup/ped t					
E0457	A	Chest shell					
E0459	A	Chest wrap					
E0460	A	Neg press vent portabl/statn					
E0462	A	Rocking bed w/ or w/o side r					
E0480	A	Percussor elect/pneum home m					
*E0481	A	Intrpulmnry percuss vent sys					
*E0482	A	Cough stimulating device					
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					
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	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					
E0608	A	Apnea monitor					
E0609	D	Blood gluc mon w/special fea					
E0610	A	Pacemaker monitr audible/vis					
E0615	A	Pacemaker monitr digital/vis					
E0616	N	Cardiac event recorder					
E0617	A	Automatic ext defibrillator					
*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 furn-electr					
E0629	A	Seat lift for pt furn-non-el					
E0630	A	Patient lift hydraulic					
E0635	A	Patient lift electric					
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					
E0690	A	Ultraviolet cabinet					
E0700	E	Safety equipment					
E0710	E	Restraints any type					
E0720	A	Tens two lead					
E0730	A	Tens four lead					
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	E	Neurostimulator electrode					
E0753	D	Neurostimulator electrodes					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
*E0754	A	Pulsegenerator pt programmer					
E0755	E	Electronic salivary reflex s					
E0756	E	Implantable pulse generator					
E0757	E	Implantable RF receiver					
E0758	A	External RF transmitter					
*E0759	A	Replace rdfrquncy transmittr					
E0760	E	Osteogen ultrasound stimltor					
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	E	Non-programble infusion pump					
E0783	E	Programmable infusion pump					
E0784	A	Ext amb infusn pump insulin					
E0785	E	Replacement impl pump cathet					
E0786	E	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	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	Loop tie					
E0953	E	Pneumatic tire					
E0954	E	Wheelchair semi-pneumatic ca					
E0958	A	Whlchr att- conv 1 arm drive					
E0959	E	Amputee adapter					
E0961	E	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	E	Wheelchair head rest extensi					
E0967	E	Wheelchair hand rims					
E0968	A	Wheelchair commode seat					
E0969	E	Wheelchair narrowing device					
E0970	E	Wheelchair no. 2 footplates					
E0971	E	Wheelchair anti-tipping devi					
E0972	A	Transfer board or device					
E0973	E	Wheelchair adjustabl height					
E0974	E	Wheelchair grade-aid					
E0975	E	Wheelchair reinforced seat u					
E0976	E	Wheelchair reinforced back u					
E0977	E	Wheelchair wedge cushion					
E0978	E	Wheelchair belt w/airplane b					
E0979	E	Wheelchair belt with velcro					
E0980	E	Wheelchair safety vest					
E0990	E	Whellchair elevating leg res					
E0991	E	Wheelchair upholstry seat					
E0992	E	Wheelchair solid seat insert					
E0993	E	Wheelchair back upholstery					
E0994	E	Wheelchair arm rest					
E0995	E	Wheelchair calf rest					
E0996	E	Wheelchair tire solid					
E0997	E	Wheelchair caster w/ a fork					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0998	E	Wheelchair caster w/o a fork					
E0999	E	Wheelchr pneumatic tire w/wh					
E1000	E	Wheelchair tire pneumatic ca					
E1001	E	Wheelchair wheel					
E1031	A	Rollabout chair with casters					
E1035	E	Patient transfer system					
E1050	A	Whelchr fxd full length arms					
E1060	A	Wheelchair detachable arms					
E1065	E	Wheelchair power attachment					
E1066	E	Wheelchair battery charger					
E1069	E	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	A	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					
E1150	A	Wheelchair standard w/ leg r					
E1160	A	Wheelchair fixed arms					
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	E	Wheelchair spec sz full-recl					
E1227	E	Wheelchair spec sz spec ht a					
E1228	A	Wheelchair spec sz spec ht b					
E1230	A	Power operated vehicle					
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					
E1399	A	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 for di					
E1530	A	Air bubble detector for dial					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E1540	A	Pressure alarm for dialysis					
E1550	A	Bath conductivity meter					
E1560	A	Blood leak detector for dial					
E1570	A	Adjustable chair for esrd pt					
E1575	A	Transducer protector/fluid b					
E1580	A	Unipuncture control system					
E1590	A	Hemodialysis machine					
E1592	A	Auto interm peritoneal dialy					
E1594	A	Cycler dialysis machine					
E1600	A	Deliv/install equip for dial					
E1610	A	Reverse osmosis water purifi					
E1615	A	Deionizer water purification					
E1620	A	Blood pump for dialysis					
E1625	A	Water softening system					
E1630	A	Reciprocating peritoneal dia					
E1632	A	Wearable artificial kidney					
E1635	A	Compact travel hemodialyzer					
E1636	A	Sorbent cartridges for dialy					
*E1637	A	Hemostats for dialysis, each					
*E1638	A	Peri dialysis heating pad					
*E1639	A	Dialysis scale					
E1640	D	Replacement components for d					
E1699	A	Dialysis equipment unspecifi					
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					
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					
E1900	D	Speech communication 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					
G0001	A	Drawing blood for specimen					
G0002	N	Temporary urinary catheter					
G0004	E	ECG transm phys review & int					
G0005	X	ECG 24 hour recording	0097	0.84	$42.76	$23.51	$8.55
G0006	X	ECG transmission & analysis	0097	0.84	$42.76	$23.51	$8.55
G0007	N	ECG phy review & interpret					
G0008	K	Admin influenza virus vac	0354	0.10	$5.09		
G0009	K	Admin pneumococcal vaccine	0354	0.10	$5.09		
G0010	N	Admin hepatitis b vaccine					
G0015	X	Post symptom ECG tracing	0097	0.84	$42.76	$23.51	$8.55
G0016	D	Post symptom ECG md review					
G0025	N	Collagen skin test kit					
G0026	A	Fecal leukocyte examination					
G0027	A	Semen analysis					
G0030	S	PET imaging prev PET single	0285	18.72	$952.92	$415.21	$190.58
G0031	S	PET imaging prev PET multple	0285	18.72	$952.92	$415.21	$190.58
G0032	S	PET follow SPECT 78464 singl	0285	18.72	$952.92	$415.21	$190.58
G0033	S	PET follow SPECT 78464 mult	0285	18.72	$952.92	$415.21	$190.58
G0034	S	PET follow SPECT 76865 singl	0285	18.72	$952.92	$415.21	$190.58
G0035	S	PET follow SPECT 78465 mult	0285	18.72	$952.92	$415.21	$190.58
G0036	S	PET follow cornry angio sing	0285	18.72	$952.92	$415.21	$190.58
G0037	S	PET follow cornry angio mult	0285	18.72	$952.92	$415.21	$190.58
G0038	S	PET follow myocard perf sing	0285	18.72	$952.92	$415.21	$190.58
G0039	S	PET follow myocard perf mult	0285	18.72	$952.92	$415.21	$190.58
G0040	S	PET follow stress echo singl	0285	18.72	$952.92	$415.21	$190.58
G0041	S	PET follow stress echo mult	0285	18.72	$952.92	$415.21	$190.58
G0042	S	PET follow ventriculogm sing	0285	18.72	$952.92	$415.21	$190.58
G0043	S	PET follow ventriculogm mult	0285	18.72	$952.92	$415.21	$190.58
G0044	S	PET following rest ECG singl	0285	18.72	$952.92	$415.21	$190.58
G0045	S	PET following rest ECG mult	0285	18.72	$952.92	$415.21	$190.58

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CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0046	S	PET follow stress ECG singl	0285	18.72	$952.92	$415.21	$190.58
G0047	S	PET follow stress ECG mult	0285	18.72	$952.92	$415.21	$190.58
G0050	S	Residual urine by ultrasound	0265	0.95	$48.36	$26.59	$9.67
G0101	V	CA screen;pelvic/breast exam	0600	0.86	$43.78		$8.76
G0102	N	Prostate ca screening; dre					
G0103	A	Psa, total screening					
G0104	S	CA screen;flexi sigmoidscope	0159	2.33	$118.61	$29.65	$23.72
G0105	T	Colorectal scrn; hi risk ind	0158	6.55	$333.42	$83.36	$66.68
G0106	S	Colon CA screen;barium enema	0157	1.98	$100.79	$22.19	$20.16
G0107	A	CA screen; fecal blood test					
G0108	A	Diab manage trn per indiv					
G0109	A	Diab manage trn ind/group					
G0110	A	Nett pulm-rehab educ; ind					
G0111	A	Nett pulm-rehab educ; group					
G0112	A	Nett;nutrition guid, initial					
G0113	A	Nett;nutrition guid,subseqnt					
G0114	A	Nett; psychosocial consult					
G0115	A	Nett; psychological testing					
G0116	A	Nett; psychosocial counsel					
*G0117	S	Glaucoma scrn hgh risk direc	0230	0.61	$31.05	$14.28	$6.21
*G0118	S	Glaucoma scrn hgh risk direc	0230	0.61	$31.05	$14.28	$6.21
G0120	S	Colon ca scrn; barium enema	0157	1.98	$100.79	$22.19	$20.16
G0121	T	Colon ca scrn not hi rsk ind	0158	6.55	$333.42	$83.36	$66.68
G0122	E	Colon ca scrn; barium enema					
G0123	A	Screen cerv/vag thin layer					
G0124	A	Screen c/v thin layer by MD					
G0125	T	PET image pulmonary nodule	0976		$875.00		$175.00
G0126	D	Lung image (PET) staging					
G0127	T	Trim nail(s)	0009	0.63	$32.07	$8.34	$6.41
G0128	E	CORF skilled nursing service					
G0129	P	Partial hosp prog service	0033	4.17	$212.27	$48.17	$42.45
G0130	X	Single energy x-ray study	0261	1.21	$61.59	$33.87	$12.32
G0131	S	CT scan, bone density study	0288	1.17	$59.56	$32.75	$11.91
G0132	S	CT scan, bone density study	0288	1.17	$59.56	$32.75	$11.91
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	E	HHCP-serv of pt,ea 15 min					
G0152	E	HHCP-serv of ot,ea 15 min					
G0153	E	HHCP-svs of s/l path,ea 15mn					
G0154	E	HHCP-svs of rn,ea 15 min					
G0155	E	HHCP-svs of csw,ea 15 min					
G0156	E	HHCP-svs of aide,ea 15 min					
G0163	D	Pet for rec of colorectal ca					
G0164	D	Pet for lymphoma staging					
G0165	D	Pet,rec of melanoma/met ca					
G0166	T	Extrnl counterpulse, per tx	0972		$150.00		$30.00
G0167	E	Hyperbaric oz tx;no md reqrd					
G0168	T	Wound closure by adhesive	0970		$25.00		$5.00
G0173	S	Stereo radoisurgery,complete	0721		$5,500.00		$1,100.00
G0174	D	Intensitymodulatedradiation					
G0175	V	OPPS Service,sched team conf	0602	1.38	$70.25		$14.05
G0176	P	OPPS/PHP;activity therapy	0033	4.17	$212.27	$48.17	$42.45
G0177	P	OPPS/PHP; train & educ serv	0033	4.17	$212.27	$48.17	$42.45
G0178	D	Intensitymodulatedradiation					
G0179	E	MD recertification HHA PT					
G0180	E	MD certification HHA patient					
G0181	E	Home health care supervision					
G0182	E	Hospice care supervision					
G0184	D	Ocular photdynamicTx 2nd eye	0235	5.57	$283.54	$78.91	$56.71
G0185	T	Transpuppillary thermotx	0235	5.57	$283.54	$78.91	$56.71
G0186	T	Dstry eye lesn,fdr vssl tech	0235	5.57	$283.54	$78.91	$56.71
G0187	T	Dstry mclr drusen,photocoag	0235	5.57	$283.54	$78.91	$56.71
G0188	D	Xray lwr extrmty-full lngth	0261	1.21	$61.59	$33.87	$12.32
G0190	D	Immunization administration					
G0191	D	Immunization admin,each add					
G0192	N	Immunization oral/intranasal					
G0193	A	Endoscopicstudyswallowfunctn					
G0194	A	Sensorytestingendoscopicstud					
G0195	A	Clinicalevalswallowingfunct					
G0196	A	Evalofswallowingwithradioopa					
G0197	A	Evalofptforprescipspeechdevi					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0198	A	Patientadapation&trainforspe					
G0199	A	Reevaluationofpatientusespec					
G0200	A	Evalofpatientprescipofvoicep					
G0201	A	Modifortraininginusevoicepro					
G0202	A	Screeningmammographydigital					
G0203	D	Screenmammographyfilmdigital					
G0204	S	Diagnosticmammographydigital	0707		$75.00		$15.00
G0205	D	Diagnosticmammographyfilmpro					
G0206	S	Diagnosticmammographydigital	0707		$75.00		$15.00
G0207	D	Diagnostic mammography film					
G0210	S	PET img wholebody dxlung ca	0712		$875.00		$175.00
G0211	S	PET img wholebody init lung	0712		$875.00		$175.00
G0212	S	PET img wholebod restag lung	0712		$875.00		$175.00
G0213	S	PET img wholebody dx colorec	0712		$875.00		$175.00
G0214	S	PET img wholebod init colore	0712		$875.00		$175.00
G0215	S	PETimg wholebod restag colre	0712		$875.00		$175.00
G0216	S	PET img wholebod dx melanoma	0712		$875.00		$175.00
G0217	S	PET img wholebod init melano	0712		$875.00		$175.00
G0218	S	PET img wholebod restag mela	0712		$875.00		$175.00
G0219	S	PET img wholbod melano nonco	0712		$875.00		$175.00
G0220	S	PET img wholebod dx lymphoma	0712		$875.00		$175.00
G0221	S	PET imag wholbod init lympho	0712		$875.00		$175.00
G0222	S	PET imag wholbod resta lymph	0712		$875.00		$175.00
G0223	S	PET imag wholbod reg dx head	0712		$875.00		$175.00
G0224	S	PET imag wholbod reg ini hea	0712		$875.00		$175.00
G0225	S	PET whol restag headneck onl	0712		$875.00		$175.00
G0226	S	PET img wholbody dx esophagl	0712		$875.00		$175.00
G0227	S	PET img wholbod ini esophage	0712		$875.00		$175.00
G0228	S	PET img wholbod restg esopha	0712		$875.00		$175.00
G0229	S	PET img metabolic brain pres	0712		$875.00		$175.00
G0230	S	PET myocard viability post s	0712		$875.00		$175.00
*G0231	S	PET WhBD colorec; gamma cam	0712		$875.00		$175.00
*G0232	S	PET WhBD lymphoma; gamma cam	0712		$875.00		$175.00
*G0233	S	PET WhBD melanoma; gamma cam	0712		$875.00		$175.00
*G0234	S	PET WhBD pulm nod; gamma cam	0712		$875.00		$175.00
*G0236	S	digital film convert diag ma	0706		$25.00		$5.00
*G0237	T	Therapeutic procd strg endur	0970		$25.00		$5.00
*G0238	T	Oth resp proc, indiv	0970		$25.00		$5.00
*G0239	T	Oth resp proc, group	0970		$25.00		$5.00
G0240	A	Critic care by MD transport					
G0241	A	Each additional 30 minutes					
*G0242	S	Multisource photon ster plan	0714		$1,375.00		$275.00
*G0243	S	Multisour photon stereo treat	0721		$5,500.00		$1,100.00
*G0244	X	Observ care by facility topt	0339	6.85	$348.69		$69.74
G9001	E	MCCD, initial rate					
G9002	E	MCCD, maintenance rate					
G9003	E	MCCD, risk adj hi, initial					
G9004	E	MCCD, risk adj lo, initial					
G9005	E	MCCD, risk adj, maintenance					
G9006	E	MCCD, Home monitoring					
G9007	E	MCCD, sch team conf					
G9008	E	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	A	Demo-smoking cessation coun					
H0001	E	Alcohol and/or drug assess					
H0002	E	Alcohol and/or drug screenin					
H0003	E	Alcohol and/or drug screenin					
H0004	E	Alcohol and/or drug services					
H0005	E	Alcohol and/or drug services					
H0006	E	Alcohol and/or drug services					
H0007	E	Alcohol and/or drug services					
H0008	E	Alcohol and/or drug services					
H0009	E	Alcohol and/or drug services					
H0010	E	Alcohol and/or drug services					
H0011	E	Alcohol and/or drug services					
H0012	E	Alcohol and/or drug services					
H0013	E	Alcohol and/or drug services					
H0014	E	Alcohol and/or drug services					
H0015	E	Alcohol and/or drug services					
H0016	E	Alcohol and/or drug services					
H0017	E	Alcohol and/or drug services					
H0018	E	Alcohol and/or drug services					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
H0019	E	Alcohol and/or drug services					
H0020	E	Alcohol and/or drug services					
H0021	E	Alcohol and/or drug training					
H0022	E	Alcohol and/or drug interven					
H0023	E	Alcohol and/or drug outreach					
H0024	E	Alcohol and/or drug preventi					
H0025	E	Alcohol and/or drug preventi					
H0026	E	Alcohol and/or drug preventi					
H0027	E	Alcohol and/or drug preventi					
H0028	E	Alcohol and/or drug preventi					
H0029	E	Alcohol and/or drug preventi					
H0030	E	Alcohol and/or drug hotline					
*H1000	A	Prenatal care atrisk assessm					
*H1001	A	Antepartum management					
*H1002	A	Carecoordination prenatal					
*H1003	A	Prenatal at risk education					
*H1004	A	Follow up home visit/prental					
*H1005	A	Prenatalcare enhanced srv pk					
J0120	N	Tetracyclin injection					
J0130	G	Abciximab injection [10 mg]	1605		$513.02		$73.44
J0150	K	Adenosine, 6 mg	0917	0.34	$17.31		$3.46
J0151	E	Adenosine injection					
J0170	N	Adrenalin epinephrin inject					
J0190	N	Inj biperiden lactate/5 mg					
J0200	N	Alatrofloxacin mesylate					
J0205	G	Alglucerase injection per 10 units	0900		$37.53		$5.37
J0207	G	Amifostine 500 mg	7000		$392.06		$56.13
J0210	N	Methyldopate hcl injection					
J0256	G	Alpha 1 proteinase inhibitor 10 mg	0901		$2.09		$.30
J0270	E	Alprostadil for injection					
J0275	E	Alprostadil urethral suppos					
J0280	N	Aminophyllin 250 MG inj					
J0282	N	Amiodarone HCl					
J0285	N	Amphotericin B					
J0286	G	Amphotericin b lipid complex 50 mg	7001		$109.25		$15.64
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					
J0340	D	Nandrolon phenpropionate inj					
J0350	G	anistreplase per 30 u	1606		$2,693.80		$385.64
J0360	N	Hydralazine hcl injection					
J0380	N	Inj metaraminol bitartrate					
J0390	N	Chloroquine injection					
J0395	N	Arbutamine HCl injection					
J0400	D	Inj trimethaphan camsylate					
J0456	N	Azithromycin					
J0460	N	Atropine sulfate injection					
J0470	N	Dimecaprol injection					
J0475	N	Baclofen 10 MG injection					
J0476	E	Baclofen intrathecal trial					
J0500	N	Dicyclomine injection					
J0510	D	Benzquinamide injection					
J0515	N	Inj benztropine mesylate					
J0520	N	Bethanechol chloride inject					
J0530	N	Penicillin g benzathine inj					
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					
J0585	G	Botulinum toxin A per unit	0902		$4.39		$.63
*J0587	G	Botulinum toxin B, per 100 u	9018		$8.79		$1.26
J0590	D	Ethylnorepinephrine hcl inj					
J0600	N	Edetate calcium disodium inj					
J0610	N	Calcium gluconate injection					
J0620	N	Calcium glycer & lact/10 ML					
J0630	N	Calcitonin salmon injection					
J0635	N	Calcitriol injection					
J0640	G	Leucovorin calcium injection per 50 mg	0725		$4.15		$.38
J0670	N	Inj mepivacaine HCL/10 ml					
J0690	N	Cefazolin sodium injection					
*J0692	N	Cefepime HCl for injection					
J0694	N	Cefoxitin sodium injection					
J0695	D	Cefonocid sodium injection					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	G	Caffeine citrate injection	9011		$3.05		$.44
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					
J0730	D	Chlorpheniramin maleate inj					
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					
J0810	D	Cortisone injection					
J0835	N	Inj cosyntropin per 0.25 MG					
J0850	G	Cytomegalovirus imm IV /vial	0903		$370.50		$47.58
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					
J1050	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					
J1090	D	Testosterone cypionate 50 MG					
J1095	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	G	Dexrazoxane HCL injection per 250 mg	0726		$194.52		$24.98
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, per 10 mg	0917	0.34	$17.31		$3.46
J1250	N	Inj dobutamine HCL/250 mg					
J1260	G	Dolasetron mesylate, per 10 mg	0750		$16.45		$2.11
*J1270	N	Injection, doxercalciferol					
J1320	N	Amitriptyline injection					
J1325	G	Epoprostenol injection 0.5 mg	7003		$12.04		$1.72
J1327	G	Eptifibatide injection, 5 mg	1607		$11.31		$1.45
J1330	N	Ergonovine maleate injection					
J1362	D	Erythromycin glucep / 250 MG					
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	G	Etidronate disodium inj,per 300 mg	0727		$63.65		$9.11
J1438	G	Etanercept injection, 25 mg	1608		$141.01		$20.19
J1440	G	Filgrastim 300 mcg injection	0728		$179.08		$23.00
J1441	G	Filgrastim 480 mcg injection	7049		$285.38		$36.65
J1450	N	Fluconazole					
J1452	N	Intraocular Fomivirsen na					
J1455	N	Foscarnet sodium injection					
J1460	N	Gamma globulin 1 CC inj					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J1470	E	Gamma globulin 2 CC inj					
J1480	E	Gamma globulin 3 CC inj					
J1490	E	Gamma globulin 4 CC inj					
J1500	E	Gamma globulin 5 CC inj					
J1510	E	Gamma globulin 6 CC inj					
J1520	E	Gamma globulin 7 CC inj					
J1530	E	Gamma globulin 8 CC inj					
J1540	E	Gamma globulin 9 CC inj					
J1550	E	Gamma globulin 10 CC inj					
J1560	E	Gamma globulin > 10 CC inj					
J1561	G	Immune globulin 500 mg	0905		$35.63		$3.23
J1563	E	IV immune globulin					
J1565	G	RSV-IVIG 50 mg	0906		$15.51		$1.99
J1570	K	Ganciclovir sodium injection 500 mg	0907	0.42	$21.38		$4.28
J1580	N	Garamycin gentamicin inj					
*J1590	N	Gatifloxacin injection					
J1600	N	Gold sodium thiomaleate inj					
J1610	N	Glucagon hydrochloride/1 MG					
J1620	G	Gonadorelin hydroch/ 100 mcg	7005		$192.37		$27.54
J1626	G	Granisetron HCL injection 100 mcg	0764		$18.54		$2.65
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	E	Inj enoxaparin sodium					
*J1655	N	Tinzaparin sodium injection					
J1670	G	Tetanus immune globulin inj up to 250 units	0908		$102.60		$13.18
J1690	D	Prednisolone tebutate inj					
J1700	N	Hydrocortisone acetate inj					
J1710	N	Hydrocortisone sodium ph inj					
J1720	N	Hydrocortisone sodium succ i					
J1730	N	Diazoxide injection					
J1739	D	Hydroxyprogesterone cap 125					
J1741	D	Hydroxyprogesterone cap 250					
J1742	N	Ibutilide fumarate injection					
J1745	G	Infliximab injection 10 mg	7043		$63.24		$9.05
J1750	N	Iron dextran					
*J1755	N	Iron sucrose injection					
J1785	G	Injection imiglucerase /unit	0916		$3.75		$.54
J1790	N	Droperidol injection					
J1800	N	Propranolol injection					
J1810	E	Droperidol/fentanyl inj, up to 2 ml					
J1820	N	Insulin injection					
J1825	G	Interferon beta-1a; 33 mcg	0909		$225.22		$32.24
J1830	G	Interferon beta-1b / .25 MG	0910		$68.40		$9.79
*J1835	N	Intraconazole 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	Kutapressin injection					
J1930	D	Propiomazine injection					
J1940	N	Furosemide injection					
J1950	G	Leuprolide acetate /3.75 mg	0800		$93.47		$12.00
J1955	E	Inj levocarnitine per 1 gm					
J1956	N	Levofloxacin injection					
J1960	N	Levorphanol tartrate inj					
J1970	D	Methotrimeprazine injection					
J1980	N	Hyoscyamine sulfate inj					
J1990	N	Chlordiazepoxide injection					
J2000	N	Lidocaine injection					
J2010	N	Lincomycin injection					
*J2020	G	Linezolid inj, 200 mg	9001		$24.13		$3.45
J2060	N	Lorazepam injection					
J2150	N	Mannitol injection					
J2175	N	Meperidine hydrochl /100 MG					
J2180	N	Meperidine/promethazine inj					
J2210	N	Methylergonovin maleate inj					
J2240	D	Metocurine iodide injection					
J2250	N	Inj midazolam hydrochloride					
J2260	K	Milrinone lactate / 5 ml	7007	0.44	$22.40		$4.48
J2270	N	Morphine sulfate injection					
J2271	N	Morphine so4 injection 100 mg					
J2275	G	Morphine sulfate injection, per 10 mg	7010		$1.02		$.09

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CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
J2330	D	Thiothixene injection					
J2350	D	Niacinamide/niacin injection					
J2352	G	Octreotide acetate injection	7031		$138.08		$19.77
J2355	G	Oprelvekin injection, 5 mg	7011		$245.81		$35.19
J2360	N	Orphenadrine injection					
J2370	N	Phenylephrine hcl injection					
J2400	N	Chloroprocaine hcl injection					
J2405	G	Ondansetron HCL injection, per 1 mg	0768		$6.09		$.78
J2410	N	Oxymorphone hcl injection					
J2430	G	Pamidronate disodium /30 mg	0730		$265.87		$38.06
J2440	N	Papaverin hcl injection					
J2460	N	Oxytetracycline injection					
J2480	D	Hydrochlorides of opium inj					
J2500	N	Paricalcitol					
J2510	N	Penicillin g procaine inj					
J2512	D	Inj pentagastrin per 2 ML					
J2515	N	Pentobarbital sodium inj					
J2540	N	Penicillin g potassium inj					
J2543	N	Piperacillin/tazobactam					
J2545	A	Pentamidine isethionte/300 mg					
J2550	N	Promethazine hcl injection					
J2560	N	Phenobarbital sodium inj					
J2590	N	Oxytocin injection					
J2597	N	Inj desmopressin acetate					
J2640	D	Prednisolone sodium ph inj					
J2650	N	Prednisolone acetate inj					
J2670	N	Totazoline hcl injection					
J2675	D	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	G	Metoclopramide HCL injection up to 10 mg	0754		$1.17		$.11
J2770	G	Quinupristin/dalfopristin	1024		$102.05		$13.11
J2780	N	Ranitidine hydrochloride inj					
J2790	G	Rho d immune globulin inj [one dose package]	0884		$34.11		$4.38
J2792	G	Rho(d) immune globulin h, sd, 100 I.U.	1609		$20.55		$2.64
J2795	N	Ropivacaine HCl injection					
J2800	N	Methocarbamol injection					
J2810	N	Inj theophylline per 40 MG					
J2820	G	Sargramostim injection, 50 mcg	0731		$29.06		$4.16
J2860	D	Secobarbital sodium inj					
J2910	N	Aurothioglucose injeciton					
J2912	N	Sodium chloride injection					
J2915	N	NA Ferric Gluconate Complex					
J2920	N	Methylprednisolone injection					
J2930	N	Methylprednisolone injection					
*J2940	G	Somatrem injection	7033		$209.48		$29.99
*J2941	G	Somatropin injection	7034		$39.90		$5.12
J2950	N	Promazine hcl injeciton					
J2970	D	Methicillin sodium injection					
J2993	G	Reteplase injection	9005		$1,306.25		$187.00
J2995	K	Inj streptokinase /250000 IU	0911	1.66	$84.50		$16.90
J2997	K	Alteplase recombinant, 1 mg	7048	0.36	$18.33		$3.67
J3000	N	Streptomycin injection					
J3010	G	Fentanyl citrate injeciton	7014		$1.23		$.11
J3030	N	Sumatriptan succinate / 6 MG					
J3070	N	Pentazocine hcl injeciton					
J3080	D	Chlorprothixene injection					
*J3100	G	Tenecteplase, 50 mg/vial	9002		$2,612.50		$374.00
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J3240	E	Thyrotropin injection					
J3245	G	Tirofiban hydrochloride 12.5 mg	7041		$436.41		$62.48
J3250	N	Trimethobenzamide hcl inj					
J3260	N	Tobramycin sulfate injection					
J3265	N	Injection torsemide 10 mg/ml					
J3270	D	Imipramine hcl injection					
J3280	G	Thiethylperazine maleate inj, up to 10 mg	0755		$4.60		$.66
J3301	N	Triamcinolone acetonide inj					
J3302	N	Triamcinolone diacetate inj					
J3303	N	Triamcinolone hexacetonl inj					
J3305	G	Inj trimetrexate glucoronate	7045		$118.75		$17.00
J3310	N	Perphenazine injeciton					
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	6.41	$326.29		$65.26
J3370	N	Vancomycin hcl injeciton					
J3390	D	Methoxamine injection					
*J3395	G	Verteporfin for injection -15 mg	1203		$1,458.25		$208.76
J3400	N	Triflupromazine hcl inj					
J3410	N	Hydroxyzine hcl injeciton					
J3420	N	Vitamin b12 injection					
J3430	N	Vitamin k phytonadione inj					
J3450	D	Mephentermine sulfate inj					
J3470	N	Hyaluronidase injection					
J3475	N	Inj magnesium sulfate					
J3480	N	Inj potassium chloride					
J3485	N	Zidovudine					
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					
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	G	Factor viii, per I.U.	0925		$.87		$.08
J7191	G	Factor VIII (porcine)	0926		$2.09		$.30
J7192	G	Factor viii recombinant, per I.U.	0927		$1.12		$.14
*J7193	G	Factor IX non-recombinant	0931		$26.13		$3.74
J7194	G	Factor IX complex per I.U.	0928		$.48		$.04
*J7195	G	Factor IX recombinant	0932		$1.12		$.16
J7197	G	Antithrombin iii injection per I.U.	0930		$1.05		$.15
J7198	G	Anti-inhibitor, per I.U.	0929		$1.43		$.18
J7199	E	Hemophilia clot factor noc					
J7300	E	Intraut copper contraceptive					
*J7302	E	Levonorgestrel iu contracept					
*J7308	N	Aminolevulinic acid hcl top					
J7310	G	Ganciclovir long act implant, 4.5 mg	0913		$4,750.00		$680.00
J7315	D	Sodium hyaluronate injection	7315		$26.13		$3.74
*J7316	G	Sodium hyaluronate injection	7315		$26.13		$3.74
J7320	G	Hylan g-f 20 injection, 16 mg	1611		$213.87		$27.47
J7330	G	Cultured chondrocytes implnt, 16 mg	1059		$14,250.00		$2,040.00
*J7340	E	Metabolic active D/E tissue					
J7500	G	Azathioprine oral 50 mg	0886		$1.25		$.11
J7501	G	Azathioprine parenteral 100 mg	0887		$1.06		$.10
J7502	G	Cyclosporine oral 100 mg	0888		$5.22		$.67
J7504	G	Lymphocyte immune globulin, 250 mg	0890		$269.06		$38.52
J7505	G	Muromonab CD3, per 5 mg	7038		$269.06		$38.52
J7506	G	Prednisone oral	7050		$.07		$.01
J7507	G	Tacrolimus oral per 1 mg	0891		$2.91		$.42
J7508	E	Tacrolimus oral per 5 MG					
J7509	N	Methylprednisolone oral					
J7510	N	Prednisolone oral per 5 mg					
*J7511	G	Antithymocyte globuln rabbit	9104		$325.09		$46.54
J7513	G	Daclizumab, parenteral 25 mg	1612		$397.29		$56.88

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J7515	N	Cyclosporine oral 25 mg					
J7516	G	Cyclosporin parenteral 250 mg	0889		$25.08		$3.22
J7517	G	Mycophenolate mofetil oral 250 mg	9015		$2.40		$.34
J7520	G	Sirolimus 1 mg/ml	9106		$6.51		$.93
J7525	G	Tacrolimus injection	9006		$113.15		$16.20
J7599	E	Immunosuppressive drug noc					
J7608	A	Acetylcysteine inh sol u d					
J7618	A	Albuterol inh sol con					
J7619	A	Albuterol inh sol u d					
*J7622	A	Beclomethasome inhalatn sol					
*J7624	A	Betamethasome inhalation sol					
*J7626	A	Budesonide inhalation sol					
J7628	A	Bitolterol mes inhal sol con					
J7629	A	Bitolterol mes inh sol u d					
J7631	A	Cromolyn sodium inh sol u d					
J7635	A	Atropine inhal sol con					
J7636	A	Atropine inhal sol unit dose					
J7637	A	Dexamethasone inhal sol con					
J7638	A	Dexamethasone inhal sol u d					
J7639	A	Dornase alpha inhal sol u d					
*J7641	A	Flunisolide, inhalation sol					
J7642	A	Glycopyrrolate inhal sol con					
J7643	A	Glycopyrrolate inhal sol u d					
J7644	A	Ipratropium brom inh sol u d					
J7648	A	Isoetharine hcl inh sol con					
J7649	A	Isoetharine hcl inh sol u d					
J7658	A	Isoproterenolhcl inh sol con					
J7659	A	Isoproterenol hcl inh sol ud					
J7668	A	Metaproterenol inh sol con					
J7669	A	Metaproterenol inh sol u d					
J7680	A	Terbutaline so4 inh sol con					
J7681	A	Terbutaline so4 inh sol u d					
J7682	A	Tobramycin inhalation sol					
J7683	A	Triamcinolone inh sol con					
J7684	A	Triamcinolone inh sol u d					
J7699	A	Inhalation solution for DME					
J7799	A	Non-inhalation drug for DME					
J8499	E	Oral prescrip drug non chemo					
J8510	G	Oral busulfan, 2 mg	7015		$1.91		$.27
J8520	G	Capecitabine, oral, 150 mg	7042		$2.43		$.35
J8521	N	Capecitabine, oral, 500 mg					
J8530	G	Cyclophosphamide oral 25 mg	0801		$2.03		$.18
J8560	G	Etoposide oral 50 mg	0802		$52.43		$6.73
J8600	G	Melphalan oral 2 mg	0803		$2.29		$.33
J8610	G	Methotrexate oral 2.5 mg	0826		$3.45		$.31
J8700	G	Temozolomide, oral 5 mg	1086		$6.05		$.87
J8999	E	Oral prescription drug chemo					
J9000	G	Doxorubicin HCL 10 mg	0847		$37.46		$4.81
J9001	G	Doxorubicin HCL liposome inj, 10 mg	7046		$358.95		$51.39
J9015	G	Aldesleukin/single use vial	0807		$672.60		$96.29
*J9017	G	Arsenic trioxide	9012		$23.75		$3.40
J9020	G	Asparaginase injection 10,000 units	0814		$62.61		$8.96
J9031	G	Bcg live intravesical vac [per installation]	0809		$166.49		$21.38
J9040	G	Bleomycin sulfate injection, 15 units	0857		$289.37		$37.16
J9045	G	Carboplatin injection, 50 mg	0811		$114.46		$16.39
J9050	G	Carmustine, 100 mg	0812		$117.84		$16.87
J9060	G	Cisplatin 10 mg injection	0813		$42.18		$3.82
J9062	E	Cisplatin 50 MG injeciton					
J9065	G	cladribine per 1 mg	0858		$53.39		$4.83
J9070	G	Cyclophosphamide 100 mg inj	0815		$5.82		$.75
J9080	E	Cyclophosphamide 200 MG inj					
J9090	E	Cyclophosphamide 500 MG inj					
J9091	E	Cyclophosphamide 1.0 grm inj					
J9092	E	Cyclophosphamide 2.0 grm inj					
J9093	G	Cyclophosphamide lyophilized, 100 mg	0816		$4.89		$.63
J9094	E	Cyclophosphamide lyophilized					
J9095	E	Cyclophosphamide lyophilized					
J9096	E	Cyclophosphamide lyophilized					
J9097	E	Cyclophosphamide lyophilized					
J9100	G	Cytarabine HCL 100 mg inj	0817		$6.10		$.55
J9110	E	Cytarabine hcl 500 MG inj					
J9120	G	Dactinomycin actinomycin 0.5 mg	0818		$13.87		$1.99
J9130	G	Dacarbazine 100 mg inj	0819		$12.68		$1.15
J9140	E	Dacarbazine 200 MG inj					
J9150	G	Daunorubicin, 10 mg	0820		$76.62		$6.94

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J9151	G	Daunorubicin citrate liposom, 10 mg	0821		$64.60		$9.25
J9160	G	Denileukin diftitox, 300 MCG	1084		$999.88		$143.14
J9165	G	Diethylstilbestrol injection, 250 mg	0822		$14.41		$1.30
J9170	G	Docetaxel, 20 mg	0823		$297.83		$42.64
J9180	E	Epirubicin HCl injection					
J9181	G	Etoposide 10 mg inj	0824		$10.45		$.95
J9182	E	Etoposide 100 MG inj					
J9185	G	Fludarabine phosphate inj 50 mg	0842		$271.82		$38.91
J9190	G	Fluorouracil injection, 500 mg	0859		$2.73		$.25
J9200	G	Floxuridine injection [500 mg]	0827		$129.56		$16.64
J9201	G	Gemcitabine hcl 200 mg	0828		$106.72		$15.28
J9202	G	Goserelin acetate implant, per 3.6 mg	0810		$446.49		$63.92
J9206	G	Irinotecan injection, 20 mg	0830		$134.25		$19.22
J9208	G	Ifosfamide injection, per 1g	0831		$156.64		$22.42
J9209	G	Mesna injection, 200 mg	0732		$36.48		$3.30
J9211	G	Idarubicin HCL injection, 5 mg	0832		$412.21		$59.01
J9212	G	Interferon alfacon-1, 1 mcg	0833		$4.10		$.59
J9213	G	Interferon alfa-2a inj, 3 million units	0834		$34.86		$4.99
J9214	G	Interferon alfa-2b inj, 1 million units	0836		$11.28		$1.45
J9215	G	Interferon alfa-n3 inj, 250, 000 I.U.	0865		$7.86		$1.12
J9216	G	Interferon gamma 1-b inj, 3 million units	0838		$285.65		$40.89
J9217	G	Leuprolide acetate suspnsion, 7.5 mg	9217		$592.60		$84.84
J9218	G	Leuprolide acetate injection, per 1 mg	0861		$69.79		$6.32
J9219	G	Leuprolide acetate implant, 65 mg	7051		$5,399.80		$773.02
J9230	G	Mechlorethamine HCL inj, 10 mg	0839		$12.01		$1.72
J9245	G	melphalan hydrochl 50 mg	0840		$400.74		$57.37
J9250	G	Methotrexate sodium inj, 5 mg	0841		$.45		$.04
J9260	E	Methotrexate sodium inj					
J9265	G	Paclitaxel injection, 30 mg	0863		$173.50		$22.28
J9266	E	Pegaspargase/singl dose vial					
J9268	G	Pentostatin injection, 10 mg	0844		$1,654.14		$236.80
J9270	G	Plicamycin (mithramycin) inj, 2.5 mg	0860		$93.80		$13.43
J9280	G	Mitomycin 5 mg inj	0862		$121.65		$11.01
J9290	E	Mitomycin 20 MG inj					
J9291	E	Mitomycin 40 MG inj					
J9293	G	Mitoxantrone hydrochl per 5 mg	0864		$244.21		$34.96
*J9300	G	Gemtuzumab ozogamicin inj, per 5 mg	9004		$1,929.69		$276.25
J9310	G	Rituximab cancer treatment, 100 mg	0849		$454.55		$65.07
J9320	G	Streptozocin injection, 1 g	0850		$117.64		$16.84
J9340	G	Thiotepa injection, 15 mg	0851		$116.97		$10.59
J9350	G	Topotecan, 4 mg	0852		$664.19		$95.08
J9355	G	Trastuzumab, 10 mg	1613		$52.83		$7.56
J9357	G	Valrubicin, 200 mg	1614		$423.22		$60.59
J9360	G	Vinblastine sulfate inj, 1 mg	0853		$4.11		$.37
J9370	G	Vincristine sulfate 1 mg inj	0854		$30.16		$3.87
J9375	E	Vincristine sulfate 2 MG inj					
J9380	E	Vincristine sulfate 5 MG inj					
J9390	G	Vinorelbine tartrate/10 mg	0855		$88.83		$12.72
J9600	G	Porfimer sodium, 75 mg	0856		$2,603.66		$372.74
J9999	E	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					
K0008	D	Cstm manual wheelchair/base					
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					
K0013	D	Custom power whlchr base					
K0014	A	Other power whlchr base					
K0015	A	Detach non-adjus hght armrst					
K0016	A	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					
K0021	A	Anti-tipping device each					
K0022	A	Reinforced back upholstery					
K0023	A	Planr back insrt foam w/strp					
K0024	A	Plnr back insrt foam w/hrdwr					
K0025	A	Hook-on headrest extension					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0026	A	Back upholst lgtwt whlchr					
K0027	A	Back upholst other whlchr					
K0028	A	Manual fully reclining back					
K0029	A	Reinforced seat upholstery					
K0030	A	Solid plnr seat sngl dnsfoam					
K0031	A	Safety belt/pelvic strap					
K0032	A	Seat uphols lgtwt whlchr					
K0033	A	Seat upholstery other whlchr					
K0034	A	Heel loop each					
K0035	A	Heel loop with ankle strap					
K0036	A	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	Elevate legrest complete					
K0049	A	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	Seat wdth 10–12/15/17/20 wc					
K0055	A	Seat dpth 15/17/18 ltwt wc					
K0056	A	Seat ht <17 or >=21 ltwt wc					
K0057	A	Seat wdth 19/20 hvy dty wc					
K0058	A	Seat dpth 17/18 power wc					
K0059	A	Plastic coated handrim each					
K0060	A	Steel handrim each					
K0061	A	Aluminum handrim each					
K0062	A	Handrim 8–10 vert/obliq proj					
K0063	A	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					
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	Wheel lock extension pair					
K0080	A	Anti-rollback device pair					
K0081	A	Wheel lock assembly complete					
K0082	A	22 nf deep cycl acid battery					
K0083	A	22 nf gel cell battery each					
K0084	A	Grp 24 deep cycl acid battry					
K0085	A	Group 24 gel cell battery					
K0086	A	U–1 lead acid battery each					
K0087	A	U–1 gel cell battery each					
K0088	A	Battry chrgr acid/gel cell					
K0089	A	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	Amputee adapter pair					

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CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0101	A	One-arm drive attachment					
K0102	A	Crutch and cane holder					
K0103	A	Transfer board < 25≧					
K0104	A	Cylinder tank carrier					
K0105	A	Iv hanger					
K0106	A	Arm trough each					
K0107	A	Wheelchair tray					
K0108	A	W/c component-accessory NOS					
K0112	A	Trunk vest supprt innr frame					
K0113	A	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					
K0183	A	Nasal application device					
K0184	A	Nasal pillows/seals pair					
K0185	A	Pos airway pressure headgear					
K0186	A	Pos airway prssure chinstrap					
K0187	A	Pos airway pressure tubing					
K0188	A	Pos airway pressure filter					
K0189	A	Filter nondisposable w PAP					
K0195	A	Elevating whlchair leg rests					
K0268	A	Humidifier nonheated w PAP					
K0415	E	RX antiemetic drg, oral NOS					
K0416	E	Rx antiemetic drg,rectal NOS					
K0452	A	Wheelchair bearings					
K0455	A	Pump uninterrupted infusion					
K0460	A	WC power add-on joystick					
K0461	A	WC power add-on tiller cntrl					
K0462	A	Temporary replacement eqpmnt					
K0531	A	Heated humidifier used w pap					
K0532	A	Noninvasive assist wo backup					
K0533	A	Noninvasive assist w backup					
K0534	A	Invasive assist w backup					
K0538	A	Neg pressure wnd thrpy pump					
K0539	A	Neg pres wnd thrpy dsg set					
K0540	A	Neg pres wnd thrp canister					
K0541	A	Speech generating device					
K0542	A	Speech generating device					
K0543	A	Speech generating device					
K0544	A	Speech generating device					
K0545	A	Speech generating software					
K0546	A	Accessory for sgd,mntng syst					
K0547	A	Accessory for sgd,not clasfd					
K0548	A	Insulin lispro					
K0549	A	Hosp bed hvy dty xtra wide					
K0550	A	Hosp bed xtra hvy dty x wide					
K0551	A	Residual limb support system					
L0100	A	Cerv craniosten helmet mold					
L0110	A	Cerv craniostenosis hel non-					
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					
L0300	A	TLSO flex surgical support					
L0310	A	Tlso flexible custom fabrica					
L0315	A	Tlso flex elas rigid post pa					
L0317	A	Tlso flex hypext elas post p					
L0320	A	Tlso a-p contrl w apron frnt					
*L0321	A	Tlso anti-post-cntrl prefab					
L0330	A	Tlso ant-pos-lateral control					
*L0331	A	Tlso ant-post-lat cntrl prfb					
L0340	A	Tlso a-p-l-rotary with apron					
L0350	A	Tlso flex compress jacket cu					
L0360	A	Tlso flex compress jacket mo					
L0370	A	Tlso a-p-l-rotary hyperexten					
L0380	A	Tlso a-p-l-rot w/ pos extens					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L0390	A	Tlso a-p-l control molded					
*L0391	A	Tlso ant-post-lat-rot cntrl					
L0400	A	Tlso a-p-l w interface mater					
L0410	A	Tlso a-p-l two piece constr					
L0420	A	Tlso a-p-l 2 piece w interfa					
L0430	A	Tlso a-p-l w interface custm					
L0440	A	Tlso a-p-l overlap frnt cust					
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					
L0900	A	Torso/ptosis support					
L0910	A	Torso & ptosis supp custm fa					
L0920	A	Torso/pendulous abd support					
L0930	A	Pendulous abdomen supp custm					
L0940	A	Torso/postsurgical support					
L0950	A	Post surg support custom fab					
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					
*L0986	A	Spinal orth abdm pnl prefab					
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	Furnsh 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					

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CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
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					
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					
L1832	A	KO adj jnt pos rigid support					
L1834	A	Ko w/0 joint rigid molded to					
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	Knee upright w/resistance					
L1900	A	Afo sprng wir drsflx calf bd					
L1902	A	Afo ankle gauntlet					
L1904	A	Afo molded ankle gauntlet					
L1906	A	Afo multiligamentus ankle su					
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					
L1960	A	Afo pos solid ank plastic mo					
L1970	A	Afo plastic molded w/ankle j					
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	A	Afo tibial fx cast plstr mol					
L2104	A	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	A	Kafo fem fx cast plaster mol					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L2124	A	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					
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 upri					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
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	E	Ft insert ucb berkeley shell					
L3001	E	Foot insert remov molded spe					
L3002	E	Foot insert plastazote or eq					
L3003	E	Foot insert silicone gel eac					
L3010	E	Foot longitudinal arch suppo					
L3020	E	Foot longitud/metatarsal sup					
L3030	E	Foot arch support remov prem					
L3040	E	Ft arch suprt premold longit					
L3050	E	Foot arch supp premold metat					
L3060	E	Foot arch supp longitud/meta					
L3070	E	Arch suprt att to sho longit					
L3080	E	Arch supp att to shoe metata					
L3090	E	Arch supp att to shoe long/m					
L3100	E	Hallus-valgus nght dynamic s					
L3140	E	Abduction rotation bar shoe					
L3150	E	Abduct rotation bar w/o shoe					
L3160	E	Shoe styled positioning dev					
L3170	E	Foot plastic heel stabilizer					
L3201	E	Oxford w supinat/pronat inf					
L3202	E	Oxford w/ supinat/pronator c					
L3203	E	Oxford w/ supinator/pronator					
L3204	E	Hightop w/ supp/pronator inf					
L3206	E	Hightop w/ supp/pronator chi					
L3207	E	Hightop w/ supp/pronator jun					
L3208	E	Surgical boot each infant					
L3209	E	Surgical boot each child					
L3211	E	Surgical boot each junior					
L3212	E	Benesch boot pair infant					
L3213	E	Benesch boot pair child					
L3214	E	Benesch boot pair junior					
L3215	E	Orthopedic ftwear ladies oxf					
L3216	E	Orthoped ladies shoes dpth i					
L3217	E	Ladies shoes hightop depth i					
L3218	E	Ladies surgical boot each					
L3219	E	Orthopedic mens shoes oxford					
L3221	E	Orthopedic mens shoes dpth i					
L3222	E	Mens shoes hightop depth inl					
L3223	E	Mens surgical boot each					
L3224	A	Woman's shoe oxford brace					
L3225	A	Man's shoe oxford brace					
L3230	E	Custom shoes depth inlay					
L3250	E	Custom mold shoe remov prost					
L3251	E	Shoe molded to pt silicone s					
L3252	E	Shoe molded plastazote cust					
L3253	E	Shoe molded plastazote cust					
L3254	E	Orth foot non-stndard size/w					
L3255	E	Orth foot non-standard size/					
L3257	E	Orth foot add charge split s					
L3260	E	Ambulatory surgical boot eac					
L3265	E	Plastazote sandal each					
L3300	E	Sho lift taper to metatarsal					
L3310	E	Shoe lift elev heel/sole neo					
L3320	E	Shoe lift elev heel/sole cor					
L3330	E	Lifts elevation metal extens					
L3332	E	Shoe lifts tapered to one-ha					
L3334	E	Shoe lifts elevation heel /i					
L3340	E	Shoe wedge sach					
L3350	E	Shoe heel wedge					
L3360	E	Shoe sole wedge outside sole					
L3370	E	Shoe sole wedge between sole					
L3380	E	Shoe clubfoot wedge					
L3390	E	Shoe outflare wedge					
L3400	E	Shoe metatarsal bar wedge ro					
L3410	E	Shoe metatarsal bar between					
L3420	E	Full sole/heel wedge btween					
L3430	E	Sho heel count plast reinfor					

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CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3440	E	Heel leather reinforced					
L3450	E	Shoe heel sach cushion type					
L3455	E	Shoe heel new leather standa					
L3460	E	Shoe heel new rubber standar					
L3465	E	Shoe heel thomas with wedge					
L3470	E	Shoe heel thomas extend to b					
L3480	E	Shoe heel pad & depress for					
L3485	E	Shoe heel pad removable for					
L3500	E	Ortho shoe add leather insol					
L3510	E	Orthopedic shoe add rub insl					
L3520	E	O shoe add felt w leath insl					
L3530	E	Ortho shoe add half sole					
L3540	E	Ortho shoe add full sole					
L3550	E	O shoe add standard toe tap					
L3560	E	O shoe add horseshoe toe tap					
L3570	E	O shoe add instep extension					
L3580	E	O shoe add instep velcro clo					
L3590	E	O shoe convert to sof counte					
L3595	E	Ortho shoe add march bar					
L3600	E	Trans shoe calip plate exist					
L3610	E	Trans shoe caliper plate new					
L3620	E	Trans shoe solid stirrup exi					
L3630	E	Trans shoe solid stirrup new					
L3640	E	Shoe dennis browne splint bo					
L3649	E	Orthopedic shoe modifica NOS					
L3650	A	Shlder fig 8 abduct restrain					
L3660	A	Abduct restrainer canvas&web					
L3670	A	Acromio/clavicular canvas&we					
L3675	A	Canvas vest SO					
*L3677	A	SO hard plastic stabilizer					
L3700	A	Elbow orthoses elas w stays					
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	E	EO withjoint, Prefabricated					
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	E	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					
L3910	A	Whfo swanson design					
L3912	A	Flex glove w/elastic finger					
L3914	A	WHO wrist extension cock-up					
L3916	A	Whfo wrist extens w/ outrigg					
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					
L3940	A	Dorsal wrist w/ outrigger at					

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CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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 brim 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					
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					
L5300	D	Bk sach soft cover & finish					
*L5301	A	BK mold socket SACH ft endo					
L5310	D	Knee disart sach soft cv/fin					
*L5311	A	Knee disart, SACH ft, endo					
L5320	D	Ak open end sach soft cv/fin					
*L5321	A	AK open end SACH					
L5330	D	Hip canadian sach sft cv/fin					
*L5331	A	Hip disart canadian SACH ft					

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CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5340	D	Hemipelvectomy canad cv/fin					
*L5341	A	Hemipelvectomy canadian SACH					
L5400	A	Postop dress & 1 cast chg bk					
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					
L5660	A	Sock insrt syme silicone gel					
L5661	A	Multi-durometer symes					
L5662	A	Socket insert bk silicone ge					
L5663	A	Sock knee disartic silicone					
L5664	A	Socket insert ak silicone ge					
L5665	A	Multi-durometer below knee					
L5666	A	Below knee cuff suspension					
L5667	D	Socket insert w lock lower					
L5668	A	Socket insert w/o lock lower					
L5669	D	Below knee socket w/o lock					
L5670	A	Bk molded supracondylar susp					
*L5671	A	BK/AK locking mechanism					
L5672	A	Bk removable medial brim sus					
L5674	A	Bk suspension sleeve					
L5675	A	Bk heavy duty susp sleeve					

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CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5676	A	Bk knee joints single axis p					
L5677	A	Bk knee joints polycentric p					
L5678	A	Bk joint covers pair					
L5680	A	Bk thigh lacer non-molded					
L5682	A	Bk thigh lacer glut/ischia m					
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 covr below knee					
L5705	A	Custm shape cover above knee					
L5706	A	Custm shape cvr knee disart					
L5707	A	Custm shape cover 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					
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					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5984	A	Endoskeletal axial rotation					
L5985	A	Lwr ext dynamic prosth pylon					
L5986	A	Multi-axial rotation unit					
L5987	A	Shank ft w vert load pylon					
L5988	A	Vertical shock reducing pylo					
*L5989	A	Pylon w elctrnc force sensor					
*L5990	A	User adjustable heel height					
L5999	A	Lowr extremity prosthes NOS					
L6000	A	Par hand robin-aids thum rem					
L6010	A	Hand robin-aids little/ring					
L6020	A	Part hand robin-aids no fing					
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 splt 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-friction 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					
L6640	A	Shoulder abduction joint pai					
L6641	A	Excursion amplifier pulley t					
L6642	A	Excursion amplifier lever ty					
L6645	A	Shoulder flexion-abduction j					
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					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
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					
L7040	A	Prehensile actuator hosmer s					
L7045	A	Electron hook child michigan					
L7170	A	Electronic elbow hosmer swit					
L7180	A	Electronic elbow utah myoele					

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CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
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	Vacuum erection system					
L8000	A	Mastectomy bra					
*L8001	A	Breast prosthesis bra and 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	E	Compression stocking BK30–40					
L8120	E	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					
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					

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CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
*L8507	A	Trach-esoph voice pros pt in					
*L8509	A	Trach-esoph voice pros md in					
*L8510	A	Voice amplifier					
L8600	N	Implant breast silicone/eq					
L8603	N	Collagen imp urinary 2.5 ml					
L8606	A	Synthetic implnt urinary 1ml					
L8610	N	Ocular implant					
L8612	N	Aqueous shunt prosthesis					
L8613	N	Ossicular implant					
L8614	E	Cochlear device/system					
L8619	A	Replace cochlear processor					
L8630	N	Metacarpophalangeal implant					
L8641	N	Metatarsal joint implant					
L8642	N	Hallux implant					
L8658	N	Interphalangeal joint implnt					
L8670	N	Vascular graft, synthetic					
L8699	N	Prosthetic implant NOS					
L9900	A	O&P supply/accessory/service					
M0064	X	Visit for drug monitoring	0374	0.89	$45.30	$9.97	$9.06
M0075	E	Cellular therapy					
M0076	E	Prolotherapy					
M0100	E	Intragastric hypothermia					
M0300	E	IV chelationtherapy					
M0301	E	Fabric wrapping of aneurysm					
M0302	D	Assessment of cardiac output	0970		$25.00		$5.00
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	E	Screening pap smear by phys					
P7001	E	Culture bacterial urine					
P9010	K	Whole blood for transfusion	0950	1.97	$100.28		$20.06
P9011	E	Blood split unit					
P9012	K	Cryoprecipitate each unit	0952	0.66	$33.60		$6.72
P9016	K	RBC leukocytes reduced	0954	2.67	$135.91		$27.18
P9017	K	One donor fresh frozn plasma	0955	2.13	$108.43		$21.69
P9019	K	Platelets, each unit	0957	0.93	$47.34		$9.47
P9020	K	Plaelet rich plasma unit	0958	1.10	$55.99		$11.20
P9021	K	Red blood cells unit	0959	1.93	$98.24		$19.65
P9022	K	Washed red blood cells unit	0960	3.60	$183.25		$36.65
P9023	K	Frozen plasma, pooled, sd	0949	2.78	$141.51		$28.30
P9031	K	Platelets leukocytes reduced	0954	2.67	$135.91		$27.18
P9032	K	Platelets, irradiated	9500	1.68	$85.52		$17.10
P9033	K	Platelets leukoreduced irrad	0954	2.67	$135.91		$27.18
P9034	K	Platelets, pheresis	9501	9.16	$466.28		$93.26
P9035	K	Platelet pheres leukoreduced	9501	9.16	$466.28		$93.26
P9036	K	Platelet pheresis irradiated	9502	9.94	$505.99		$101.20
P9037	K	Plt, aph/pher, L/R, irrad	1019	9.11	$463.74		$92.75
P9038	K	RBC irradiated	9505	2.44	$124.21		$24.84
P9039	K	RBC deglycerolized	9504	4.11	$209.22		$41.84
P9040	K	RBC leukoreduced irradiated	9504	4.11	$209.22		$41.84
P9041	K	Albumin(human), 5%, 50ml	0961	2.07	$105.37		$21.07
P9042	D	Albumin (human), 25%, 10ml	0962	1.04	$52.94		$10.59
P9043	K	Plasma protein fraction	0956	1.19	$60.58		$12.12
P9044	K	Cryoprecipitatereducedplasma	1009	0.82	$41.74		$8.35
*P9045	K	Albumin (human), 5%, 250 ml	0963	10.35	$526.86		$105.37
*P9046	K	Albumin (human), 25%, 20 ml	0964	2.08	$105.88		$21.18
*P9047	K	Albumin (human), 25%, 50ml	0965	5.20	$264.70		$52.94
*P9048	K	Plasmaprotein fract,5%,250ml	0966	5.95	$302.88		$60.58
*P9050	K	Granulocytes, pheresis unit	9506	27.75	$1,412.59		$282.52
P9603	A	One-way allow prorated miles					
P9604	A	One-way allow prorated trip					
P9612	N	Catheterize for urine spec					
P9615	N	Urine specimen collect mult					
Q0035	X	Cardiokymography	0100	1.47	$74.83	$41.15	$14.97
Q0081	D	Infusion ther other than che	0120	3.08	$156.78	$42.67	$31.36
Q0083	S	Chemo by other than infusion	0116	0.91	$46.32		$9.26
Q0084	S	Chemotherapy by infusion	0117	4.01	$204.13	$52.69	$40.83
Q0085	S	Chemo by both infusion and o	0118	4.20	$213.80	$72.03	$42.76
Q0086	D	Physical therapy evaluation/					
Q0091	T	Obtaining screen pap smear	0191	0.23	$11.71	$3.40	$2.34
Q0092	N	Set up port xray equipment					
Q0111	A	Wet mounts/ w preparations					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q0112	A	Potassium hydroxide preps					
Q0113	A	Pinworm examinations					
Q0114	A	Fern test					
Q0115	A	Post-coital mucous exam					
Q0136	G	Non esrd epoetin alpha inj per 1000 units	0733		$12.26		$1.57
Q0144	D	Azithromycin dihydrate, oral					
Q0160	D	Factor IX non-recombinant	0931		$26.13		$3.74
Q0161	D	Factor IX recombinant	0932		$1.12		$.14
Q0163	G	Diphenhydramine HCL 50 mg	1400		$.23		$.02
Q0164	G	Prochlorperazine maleate 5 mg	1401		$.65		$.06
Q0165	E	Prochlorperazine maleate 10 mg					
Q0166	G	Granisetron HCL 1 mg oral	0765		$44.69		$6.40
Q0167	G	Dronabinol 2.5 mg oral	0762		$3.28		$.42
Q0168	E	Dronabinol 5 mg oral					
Q0169	G	Promethazine HCL 12.5 mg oral	1402		$.01		$.00
Q0170	E	Promethazine HCl 25 mg oral					
Q0171	G	Chlorpromazine HCL 10 mg oral	1403		$.27		$.02
Q0172	E	Chlorpromazine HCl 25 mg oral					
Q0173	G	Trimethobenzamide HCL 250 mg	1404		$.38		$.03
Q0174	G	Thiethylperazine maleate 10 mg	1405		$.56		$.08
Q0175	G	Perphenazine 4 mg oral	1406		$.62		$.06
Q0176	E	Perphenazine 8 mg oral					
Q0177	G	Hydroxyzine pamoate 25 mg	1407		$.28		$.03
Q0178	E	Hydroxyzine pamoate 50 mg					
Q0179	G	Ondansetron HCL 8 mg oral	0769		$26.41		$3.39
Q0180	G	Dolasetron mesylate oral, 100 mg	0763		$69.64		$8.94
Q0181	E	Unspecified oral anti-emetic					
Q0183	N	Nonmetabolic active tissue					
Q0184	N	Metabolically active tissue					
Q0185	D	Metabolic active D/E tissue					
Q0187	G	Factor VIII recombinant, per 1.2 mg	1409		$1,596.00		$228.48
Q1001	E	Ntiol category 1					
Q1002	E	Ntiol category 2					
Q1003	E	Ntiol category 3					
Q1004	E	Ntiol category 4					
Q1005	E	Ntiol category 5					
Q2001	N	Oral cabergoline 0.5 mg					
Q2002	G	Elliotts b solution per ml	7022		$1.43		$.20
Q2003	G	Aprotinin, 10,000 kiu	7019		$2.16		$.31
Q2004	G	Bladder calculi irrig sol	7023		$24.70		$3.54
Q2005	G	Corticorelin ovine triflutat	7024		$368.03		$52.69
Q2006	G	Digoxin immune fab (ovine)	7025		$551.66		$78.97
Q2007	G	Ethanolamine oleate 100 mg	7026		$39.73		$5.69
Q2008	G	Fomepizole, 15 mg	7027		$10.93		$1.56
Q2009	G	Fosphenytoin, 50 mg	7028		$5.73		$.82
Q2010	G	Glatiramer acetate, per dose	7029		$30.07		$4.30
Q2011	G	Hemin, per 1 mg	7030		$.99		$.14
Q2012	G	Pegademase bovine, 25 iu	7039		$139.33		$19.95
Q2013	G	Pentastarch 10% solution	7040		$15.11		$2.16
Q2014	G	Sermorelin acetate, 0.5 mg	7032		$13.60		$1.95
Q2015	D	Somatrem, 5 mg	7033		$209.48		$29.99
Q2016	D	Somatropin, 1 mg	7034		$39.90		$5.12
Q2017	G	Teniposide, 50 mg	7035		$222.80		$31.90
Q2018	G	Urofollitropin, 75 iu	7037		$73.29		$10.49
Q2019	G	Basiliximab 20 mg	1615		$1,437.78		$205.83
Q2020	E	Histrelin acetate, 10 mg					
Q2021	G	Lepirudin	1617		$131.96		$18.89
Q2022	G	VonWillebrandFactrCmplxperIU	1618		$.95		$.14
Q3001	E	Brachytherapy Radioelements					
Q3002	G	Gallium ga 67, per mCi	1619		$25.62		$2.32
Q3003	G	Technetium tc99m bicisate	1620		$403.99		$57.83
Q3004	G	Xenon xe 133	1621		$29.93		$2.71
Q3005	G	Technetium tc99m mertiatide	1622		$137.75		$19.72
Q3006	G	Technetium tc99m glucepatate	1623		$22.61		$3.24
Q3007	G	Sodium phosphate p32	1624		$54.34		$7.78
Q3008	G	Indium 111-in pentetreotide	1625		$935.75		$133.96
Q3009	G	Technetium tc99m oxidronate	1626		$1.47		$.21
Q3010	G	Technetium tc99mlabeledrbcs	1627		$40.90		$5.85
Q3011	G	Chromic phosphate p32	1628		$150.86		$21.60
Q3012	G	Co 57, 0.5 Mci	1089		$81.10		$10.41
Q3013	D	Verteporfin injection					
Q3014	A	Telehealth facility fee					
Q3017	A	Amb srv, ALS assmt, no oth als					
Q4001	A	Cast sup body cast plaster					
Q4002	A	Cast sup body cast fiberglas					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q4003	A	Cast sup shoulder cast plstr					
Q4004	A	Cast sup shoulder cast fbrgl					
Q4005	A	Cast sup long arm adult plst					
Q4006	A	Cast sup long arm adult fbrg					
Q4007	A	Cast sup long arm ped plster					
Q4008	A	Cast sup long arm ped fbrgls					
Q4009	A	Cast sup sht arm adult plstr					
Q4010	A	Cast sup sht arm adult fbrgl					
Q4011	A	Cast sup sht arm ped plaster					
Q4012	A	Cast sup sht arm ped fbrglas					
Q4013	A	Cast sup gauntlet plaster					
Q4014	A	Cast sup gauntlet fiberglass					
Q4015	A	Cast sup gauntlet ped plster					
Q4016	A	Cast sup gauntlet ped fbrgls					
Q4017	A	Cast sup lng arm splint plst					
Q4018	A	Cast sup lng arm splint fbrg					
Q4019	A	Cast sup lng arm splnt ped p					
Q4020	A	Cast sup lng arm splnt ped f					
Q4021	A	Cast sup sht arm splint plst					
Q4022	A	Cast sup sht arm splint fbrg					
Q4023	A	Cast sup sht arm splnt ped p					
Q4024	A	Cast sup sht arm splnt ped f					
Q4025	A	Cast sup hip spica plaster					
Q4026	A	Cast sup hip spica fiberglas					
Q4027	A	Cast sup hip spica ped plstr					
Q4028	A	Cast sup hip spica ped fbrgl					
Q4029	A	Cast sup long leg plaster					
Q4030	A	Cast sup long leg fiberglass					
Q4031	A	Cast sup lng leg ped plaster					
Q4032	A	Cast sup lng leg ped fbrgls					
Q4033	A	Cast sup lng leg cylinder pl					
Q4034	A	Cast sup lng leg cylinder fb					
Q4035	A	Cast sup lngleg cylndr ped p					
Q4036	A	Cast sup lngleg cylndr ped f					
Q4037	A	Cast sup shrt leg plaster					
Q4038	A	Cast sup shrt leg fiberglass					
Q4039	A	Cast sup shrt leg ped plster					
Q4040	A	Cast sup shrt leg ped fbrgls					
Q4041	A	Cast sup lng leg splnt plstr					
Q4042	A	Cast sup lng leg splnt fbrgl					
Q4043	A	Cast sup lng leg splnt ped p					
Q4044	A	Cast sup lng leg splnt ped f					
Q4045	A	Cast sup sht leg splnt plstr					
Q4046	A	Cast sup sht leg splnt fbrgl					
Q4047	A	Cast sup sht leg splnt ped p					
Q4048	A	Cast sup sht leg splnt ped f					
Q4049	A	Finger splint, static					
Q4050	A	Cast supplies unlisted					
Q4051	A	Splint supplies misc					
Q9920	A	Epoetin with hct <= 20					
Q9921	A	Epoetin with hct = 21					
Q9922	A	Epoetin with hct = 22					
Q9923	A	Epoetin with hct = 23					
Q9924	A	Epoetin with hct = 24					
Q9925	A	Epoetin with hct = 25					
Q9926	A	Epoetin with hct = 26					
Q9927	A	Epoetin with hct = 27					
Q9928	A	Epoetin with hct = 28					
Q9929	A	Epoetin with hct = 29					
Q9930	A	Epoetin with hct = 30					
Q9931	A	Epoetin with hct = 31					
Q9932	A	Epoetin with hct = 32					
Q9933	A	Epoetin with hct = 33					
Q9934	A	Epoetin with hct = 34					
Q9935	A	Epoetin with hct = 35					
Q9936	A	Epoetin with hct = 36					
Q9937	A	Epoetin with hct = 37					
Q9938	A	Epoetin with hct = 38					
Q9939	A	Epoetin with hct = 39					
Q9940	A	Epoetin with hct >= 40					
R0070	N	Transport portable x-ray					
R0075	N	Transport port x-ray multipl					
R0076	N	Transport portable EKG					
*T1015	E	Clinic service					
V2020	A	Vision svcs frames purchases					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2002—Continued

CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	Nonaspheric lens bifocal					
V2117	A	Aspheric lens bifocal					
V2118	A	Lens aniseikonic 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	Lens lenticular nonaspheric					
V2217	A	Lens lenticular aspheric bif					
V2218	A	Lens aniseikonic bifocal					
V2219	A	Lens bifocal seg width over					
V2220	A	Lens bifocal add over 3.25d					
V2299	A	Lens bifocal speciality					
V2300	A	Lens sphere trifocal 4.00d					
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	Lens lenticular nonaspheric					
V2317	A	Lens lenticular aspheric tri					
V2318	A	Lens aniseikonic trifocal					
V2319	A	Lens trifocal seg width > 28					
V2320	A	Lens trifocal add over 3.25d					
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					

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CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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	Rose tint plastic					
V2741	A	Non-rose tint plastic					
V2742	A	Rose tint glass					
V2743	A	Non-rose tint glass					
V2744	A	Tint photochromatic lens/es					
V2750	A	Anti-reflective coating					
V2755	A	UV lens/es					
V2760	A	Scratch resistant coating					
V2770	A	Occluder lens/es					
V2780	A	Oversize lens/es					
V2781	E	Progressive lens per lens					
V2785	F	Corneal tissue processing					
V2790	N	Amniotic membrane					
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					
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					

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CPT/ HCPCS	Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
*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					
V5299	E	Hearing service					
V5336	E	Repair communication device					
V5362	A	Speech screening					
V5363	A	Language screening					
V5364	A	Dysphagia screening					

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*Code is new in 2002.

ADDENDUM D.—PAYMENT STATUS INDICATORS FOR THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

Indicator	Service	Status
A	Pulmonary Rehabilitation Clinical Trial	Not Paid Under Outpatient PPS
A	Durable Medical Equipment, Prosthetics and Orthotics	DMEPOS Fee Schedule
A	Physical, Occupational and Speech Therapy	Physician Fee Schedule
A	Ambulance	Ambulance Fee Schedule
A	EPO for ESRD Patients	National Rate
A	Clinical Diagnostic Laboratory Services	Laboratory Fee Schedule
A	Physician Services for ESRD Patients	Physician Fee Schedule
A	Screening Mammography	Lower of Charges or National Rate
C	Inpatient Procedures	Admit Patient
E	Non-Covered Items and Services	Not Paid Under Outpatient PPS
F	Acquisition of Corneal Tissue	Paid at Reasonable Cost
G	Drug/Biological Pass-Through	Additional Payment
H	Device Pass-Through	Additional Payment
K	Non Pass-Through Drug/Biological	Paid Under Outpatient PPS
N	Incidental Services, packaged into APC Rate	Packaged
P	Partial Hospitalization	Paid Per Diem APC
S	Significant Procedure, Not Discounted When Multiple	Paid Under Outpatient PPS
T	Significant Procedure, Multiple Procedure Reduction Applies	Paid Under Outpatient PPS
V	Visit to Clinic or Emergency Department	Paid Under Outpatient PPS
X	Ancillary Service	Paid Under Outpatient PPS

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
*0001T	C	Endovas repr abdo ao aneurys
*0002T	C	Endovas repr abdo ao aneurys
*0005T	C	Perc cath stent/brain cv art
*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
00404	C	Anesth, surgery of breast
00406	C	Anesth, surgery of breast
00452	C	Anesth, surgery of shoulder
00474	C	Anesth, surgery of rib(s)
00524	C	Anesth, chest drainage
00540	C	Anesth, chest surgery
00542	C	Anesth, release of lung
00544	C	Anesth, chest lining removal
00546	C	Anesth, lung,chest wall surg
00560	C	Anesth, open heart surgery
00562	C	Anesth, open heart surgery
00580	C	Anesth heart/lung transplant
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, replacement of hip
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, replacement of knee
01404	C	Anesth, amputation at knee
01442	C	Anesth, knee artery surg
01444	C	Anesth, knee artery repair
01486	C	Anesth, ankle replacement
01502	C	Anesth, lwr leg embolectomy
01632	C	Anesth, surgery of shoulder
01634	C	Anesth, shoulder joint amput

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[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
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, remove 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
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

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
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
21390	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
22100	C	Remove part of neck vertebra
22101	C	Remove part, thorax vertebra
22102	C	Remove part, lumbar vertebra
22103	C	Remove extra spine segment
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

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
22325	C	Treat spine fracture
22326	C	Treat neck spine fracture
22327	C	Treat thorax spine fracture
22328	C	Treat each add spine fx
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	C	Lumbar spine fusion
22614	C	Spine fusion, extra segment
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
23035	C	Drain shoulder bone lesion
23125	C	Removal of collar bone
23195	C	Removal of head of humerus
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
23395	C	Muscle transfer, shoulder/arm
23397	C	Muscle transfers
23400	C	Fixation of shoulder blade
23472	C	Reconstruct shoulder joint
23900	C	Amputation of arm & girdle
23920	C	Amputation at shoulder joint
24149	C	Radical resection of elbow
24150	C	Extensive humerus surgery
24151	C	Extensive humerus surgery
24152	C	Extensive radius surgery
24153	C	Extensive radius surgery
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

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
25170	C	Extensive forearm surgery
25390	C	Shorten radius or ulna
25391	C	Lengthen radius or ulna
25392	C	Shorten radius & ulna
25393	C	Lengthen radius & ulna
25420	C	Repair/graft radius & ulna
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
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
27035	C	Denervation 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 replacement
27132	C	Total hip replacement
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)
27216	C	Treat pelvic ring fracture
27217	C	Treat pelvic ring fracture
27218	C	Treat pelvic ring fracture
27222	C	Treat hip socket fracture

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[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
27226	C	Treat hip wall fracture
27227	C	Treat hip fracture(s)
27228	C	Treat hip fracture(s)
27232	C	Treat thigh fracture
27235	C	Treat thigh fracture
27236	C	Treat thigh fracture
27240	C	Treat thigh fracture
27244	C	Treat thigh fracture
27245	C	Treat thigh fracture
27248	C	Treat thigh fracture
27253	C	Treat hip dislocation
27254	C	Treat hip dislocation
27258	C	Treat hip dislocation
27259	C	Treat hip dislocation
27280	C	Fusion of sacroiliac joint
27282	C	Fusion of pubic bones
27284	C	Fusion of hip joint
27286	C	Fusion of hip joint
27290	C	Amputation of leg at hip
27295	C	Amputation of leg at hip
27303	C	Drainage of bone lesion
27365	C	Extensive leg surgery
27445	C	Revision of knee joint
27447	C	Total knee replacement
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

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[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
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
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
31582	C	Revision of larynx
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
31785	C	Remove windpipe lesion
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
32201	C	Drain, percut, 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

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[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
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
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

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[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
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
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

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

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CPT/ HCPCS	Status Indicator	Description
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

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CPT/ HCPCS	Status Indicator	Description
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
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
34808	C	Endovasc abdo occlud device
34812	C	Xpose for endoprosth, aortic
34813	C	Xpose for endoprosth, femorl
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
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

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CPT/ HCPCS	Status Indicator	Description
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
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
35511	C	Artery bypass graft
35515	C	Artery bypass graft
35516	C	Artery bypass graft
35518	C	Artery bypass graft
35521	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

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CPT/ HCPCS	Status Indicator	Description
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
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
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
37195	C	Thrombolytic therapy, stroke
37616	C	Ligation of chest artery

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CPT/ HCPCS	Status Indicator	Description
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
38700	C	Removal of lymph nodes, neck
38724	C	Removal of lymph nodes, neck
38746	C	Remove thoracic lymph nodes
38747	C	Remove abdominal lymph nodes
38765	C	Remove groin lymph nodes
38770	C	Remove pelvis lymph nodes
38780	C	Remove abdomen lymph nodes
39000	C	Exploration of chest
39010	C	Exploration of chest
39200	C	Removal chest lesion
39220	C	Removal chest lesion
39499	C	Chest procedure
39501	C	Repair diaphragm laceration
39502	C	Repair paraesophageal hernia
39503	C	Repair of diaphragm hernia
39520	C	Repair of diaphragm hernia
39530	C	Repair of diaphragm hernia
39531	C	Repair of diaphragm hernia
39540	C	Repair of diaphragm hernia
39541	C	Repair of diaphragm hernia
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
42842	C	Extensive surgery of throat
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
43030	C	Throat muscle surgery
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	Parital removal of esophagus
43123	C	Partial removal of esophagus

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CPT/ HCPCS	Status Indicator	Description
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 congential
*43314	C	Tracheo-esophagoplasty cong
43320	C	Fuse esophagus & stomach
43324	C	Revise esophagus & stomach
43325	C	Revise esophagus & stomach
43326	C	Revise esophagus & stomach
43330	C	Repair of esophagus
43331	C	Repair of esophagus
43340	C	Fuse esophagus & intestine
43341	C	Fuse esophagus & intestine
43350	C	Surgical opening, esophagus
43351	C	Surgical opening, esophagus
43352	C	Surgical opening, esophagus
43360	C	Gastrointestinal repair
43361	C	Gastrointestinal repair
43400	C	Ligate esophagus veins
43401	C	Esophagus surgery for veins
43405	C	Ligate/staple esophagus
43410	C	Repair esophagus wound
43415	C	Repair esophagus wound
43420	C	Repair esophagus opening
43425	C	Repair esophagus opening
43460	C	Pressure treatment esophagus
43496	C	Free jejunum flap, microvasc
43500	C	Surgical opening of stomach
43501	C	Surgical repair of stomach
43502	C	Surgical repair of stomach
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

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CPT/ HCPCS	Status Indicator	Description
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	Exploration of small bowel
44021	C	Decompress small bowel
44025	C	Incision of large bowel
44050	C	Reduce bowel obstruction
44055	C	Correct malrotation of bowel
44110	C	Excision of bowel 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/taper, cong
*44127	C	Enterectomy w/o 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
44202	C	Laparo, resect intestine
*44203	C	Lap resect s/intestine, addl
*44204	C	Laparo partial colectomy
*44205	C	Lap colectomy part w/ileum
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

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CPT/ HCPCS	Status Indicator	Description
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 reservoir
45540	C	Correct rectal prolapse
45541	C	Correct rectal prolapse
45550	C	Repair rectum/remove sigmoid
45562	C	Exploration/repair of rectum
45563	C	Exploration/repair of rectum
45800	C	Repair rect/bladder fistula
45805	C	Repair fistula w/colostomy
45820	C	Repair rectourethral fistula
45825	C	Repair fistula w/colostomy
46705	C	Repair of anal stricture
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
47001	C	Needle biopsy, liver add-on
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
47134	C	Partial removal, donor liver
47135	C	Transplantation of liver
47136	C	Transplantation of liver
47300	C	Surgery for liver lesion
47350	C	Repair liver wound
47360	C	Repair liver wound
47361	C	Repair liver wound
47362	C	Repair liver wound
*47380	C	Open ablate liver tumor rf
*47381	C	Open ablate liver tumor cryo
47400	C	Incision of liver duct
47420	C	Incision of bile duct
47425	C	Incision of bile duct
47460	C	Incise bile duct sphincter
47480	C	Incision of gallbladder

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CPT/ HCPCS	Status Indicator	Description
47490	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
48020	C	Removal of pancreatic stone
48100	C	Biopsy of pancreas
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 pancreas 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	Removal of abdominal lesion
49215	C	Excise sacral spine tumor
49220	C	Multiple surgery, abdomen
49255	C	Removal of omentum
49425	C	Insert abdomen-venous drain

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
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
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	Removal of kidney
50225	C	Removal of kidney
50230	C	Removal of kidney
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
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

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
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 bowel
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
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	Remv/replc penis pros, comp
*54417	C	Remv/replc penis pros, compl
54430	C	Revision of penis
54535	C	Extensive testis surgery

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
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
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
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
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	Vaginal hysterectomy
58263	C	Vaginal hysterectomy
58267	C	Hysterectomy & vagina repair
58270	C	Hysterectomy & vagina repair
58275	C	Hysterectomy/revise vagina
58280	C	Hysterectomy/revise vagina
58285	C	Extensive hysterectomy
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

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
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
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
61320	C	Open skull for drainage
61321	C	Open skull for drainage
61332	C	Explore/biopsy eye socket

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
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
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
61538	C	Removal of brain tissue
61539	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
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

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[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
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
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
61862	C	Implant neurostimul, subcort
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
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

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[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
62223	C	Establish brain cavity shunt
62256	C	Remove brain cavity shunt
62258	C	Replace brain cavity shunt
62351	C	Implant spinal canal cath
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
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
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

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[Calender Year 2002]

CPT/ HCPCS	Status Indicator	Description
63700	C	Repair of spinal herniation
63702	C	Repair of spinal herniation
63704	C	Repair of spinal herniation
63706	C	Repair of spinal herniation
63707	C	Repair spinal fluid leakage
63709	C	Repair spinal fluid leakage
63710	C	Graft repair of spine defect
63740	C	Install spinal shunt
64752	C	Incision of vagus nerve
64755	C	Incision of stomach nerves
64760	C	Incision of vagus nerve
64763	C	Incise hip/thigh nerve
64766	C	Incise hip/thigh nerve
64802	C	Remove sympathetic nerves
64804	C	Remove sympathetic nerves
64809	C	Remove sympathetic nerves
64818	C	Remove sympathetic nerves
64820	C	Remove sympathetic nerves
64866	C	Fusion of facial/other nerve
64868	C	Fusion of facial/other nerve
65273	C	Repair of eye wound
69150	C	Extensive ear canal surgery
69155	C	Extensive ear/neck surgery
69502	C	Mastoidectomy
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
92970	C	Cardioassist, internal
92971	C	Cardioassist, external
92975	C	Dissolve clot, heart vessel
92986	C	Revision of aortic valve
92987	C	Revision of mitral valve
92990	C	Revision of pulmonary valve
92992	C	Revision of heart chamber
92993	C	Revision of heart chamber
92997	C	Pul art balloon repr, percut
92998	C	Pul art balloon repr, percut
94652	C	Pressure breathing (IPPB)
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
99295	C	Neonatal critical care
99296	C	Neonatal critical care
99297	C	Neonatal critical care
99298	C	Neonatal critical care
99356	C	Prolonged service, inpatient
99357	C	Prolonged service, inpatient
99433	C	Normal newborn care/hospital

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ADDENDUM H.—WAGE INDEX FOR URBAN AREAS

Urban Area (Constituent Counties)	Wage Index
0040 Abilene, TX	0.7983
Taylor, TX	
0060 [2] Aguadilla, PR	0.4832
Aguada, PR	
Aguadilla, PR	
Moca, PR	
0080 Akron, OH	0.9876
Portage, OH	
Summit, OH	
0120 Albany, GA	1.0640
Dougherty, GA	
Lee, GA	
0160 [2] Albany-Schenectady-Troy, NY	0.8547
Albany, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Schoharie, NY	
0200 Albuquerque, NM	0.9750
Bernalillo, NM	
Sandoval, NM	
Valencia, NM	
0220 Alexandria, LA	0.8059
Rapides, LA	
0240 Allentown-Bethlehem-Easton, PA	1.0077
Carbon, PA	
Lehigh, PA	
Northampton, PA	
0280 Altoona, PA	0.9126
Blair, PA	
0320 Amarillo, TX.	
Potter, TX	0.8711
Randall, TX	
0380 Anchorage, AK	1.2696
Anchorage, AK	
0440 Ann Arbor, MI	1.1098
Lenawee, MI	
Livingston, MI	
Washtenaw, MI	
0450 Anniston, AL	0.8276
Calhoun, AL	
0460 Appleton-Oshkosh-Neenah, WI	0.9241
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
0470 [2] Arecibo, PR	0.4832
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
0480 Asheville, NC	0.9200
Buncombe, NC	
Madison, NC	
0500 Athens, GA	0.9842
Clarke, GA	
Madison, GA	
Oconee, GA	
0520 [1] Atlanta, GA	1.0058
Barrow, GA	
Bartow, GA	
Carroll, GA	
Cherokee, GA	
Clayton, GA	
Cobb, GA	
Coweta, GA	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index
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	1.1293
Atlantic, NJ	
Cape May, NJ	
0580 Auburn-Opelika, AL	0.8230
Lee, AL	
0600 Augusta-Aiken, GA-SC	0.9970
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Edgefield, SC	
0640 [1] Austin-San Marcos, TX	0.9597
Bastrop, TX	
Caldwell, TX	
Hays, TX	
Travis, TX	
Williamson, TX	
0680 [2] Bakersfield, CA	0.9659
Kern, CA	
0720 [1] Baltimore, MD	0.9856
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Anne's, MD	
0733 Bangor, ME	0.9593
Penobscot, ME	
0743 Barnstable-Yarmouth, MA	1.3626
Barnstable, MA	
0760 Baton Rouge, LA	0.8149
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
0840 Beaumont-Port Arthur, TX	0.8442
Hardin, TX	
Jefferson, TX	
Orange, TX	
0860 Bellingham, WA	1.1826
Whatcom, WA	
0870 [2] Benton Harbor, MI	0.9000
Berrien, MI	
0875 [1] Bergen-Passaic, NJ	1.1808
Bergen, NJ	
Passaic, NJ	
0880 Billings, MT	0.9352
Yellowstone, MT	
0920 Biloxi-Gulfport-Pascagoula, MS	0.8440
Hancock, MS	
Harrison, MS	
Jackson, MS	
0960 [2] Binghamton, NY	0.8547
Broome, NY	
Tioga, NY	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index
1000 Birmingham, AL	0.8808
Blount, AL	
Jefferson, AL	
St. Clair, AL	
Shelby, AL	
1010 Bismarck, ND	0.7984
Burleigh, ND	
Morton, ND	
1020 Bloomington, IN	0.8842
Monroe, IN	
1040 Bloomington-Normal, IL	0.9038
McLean, IL	
1080 Boise City, ID	0.9050
Ada, ID	
Canyon, ID	
1123 [1,2] Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH (MA Hospitals)	1.1454
Bristol, MA	
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Worcester, MA	
Hillsborough, NH	
Merrimack, NH	
Rockingham, NH	
Strafford, NH	
1123 [1] Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH (NH Hospitals)	1.1293
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	0.9799
Boulder, CO	
1145 Brazoria, TX	0.8209
Brazoria, TX	
1150 Bremerton, WA	1.0758
Kitsap, WA	
1240 Brownsville-Harlingen-San Benito, TX	0.9012
Cameron, TX	
1260 Bryan-College Station, TX	0.9328
Brazos, TX	
1280 [1] Buffalo-Niagara Falls, NY	0.9459
Erie, NY	
Niagara, NY	
1303 Burlington, VT	0.9883
Chittenden, VT	
Franklin, VT	
Grand Isle, VT	
1310 [2] Caguas, PR	0.4832
Caguas, PR	
Cayey, PR	
Cidra, PR	
Gurabo, PR	
San Lorenzo, PR	
1320 Canton-Massillon, OH	0.8956
Carroll, OH	
Stark, OH	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index
1350 Casper, WY	0.9496
Natrona, WY	
1360 Cedar Rapids, IA	0.8699
Linn, IA	
1400 Champaign-Urbana, IL	0.9306
Champaign, IL	
1440 Charleston-North Charleston, SC	0.9206
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
1480 Charleston, WV	0.9264
Kanawha, WV	
Putnam, WV	
1520 [1] Charlotte-Gastonia-Rock Hill, NC-SC	0.9407
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Stanly, NC	
Union, NC	
York, SC	
1540 Charlottesville, VA	1.0566
Albemarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
1560 Chattanooga, TN-GA	0.9369
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
1580 [2] Cheyenne, WY	0.8747
Laramie, WY	
1600 [1] Chicago, IL	1.1046
Cook, IL	
DeKalb, IL	
DuPage, IL	
Grundy, IL	
Kane, IL	
Kendall, IL	
Lake, IL	
McHenry, IL	
Will, IL	
1620 Chico-Paradise, CA	0.9856
Butte, CA	
1640 [1] Cincinnati, OH-KY-IN	0.9473
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	0.8393
Christian, KY	
Montgomery, TN	
1680 [1] Cleveland-Lorain-Elyria, OH	0.9457
Ashtabula, OH	
Cuyahoga, OH	
Geauga, OH	
Lake, OH	
Lorain, OH	
Medina, OH	
1720 Colorado Springs, CO	0.9744
El Paso, CO	
1740 Columbia, MO	0.8686
Boone, MO	
1760 Columbia, SC	0.9492
Lexington, SC	
Richland, SC	
1800 Columbus, GA-AL.	
Russell, AL	0.8440
Chattahoochee, GA	
Harris, GA	
Muscogee, GA	
1840 [1] Columbus, OH	0.9565
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
1880 Corpus Christi, TX	0.8341
Nueces, TX	
San Patricio, TX	
1890 Corvallis, OR	1.1646
Benton, OR	
1900 [2] Cumberland, MD-WV (MD Hospitals)	0.8859
Allegany, MD	
Mineral, WV	
1900 Cumberland, MD-WV (WV Hospital)	0.8306
Allegany, MD	
Mineral, WV	
1920 [1] Dallas, TX	0.9936
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Henderson, TX	
Hunt, TX	
Kaufman, TX	
Rockwall, TX	
1950 Danville, VA	0.8613
Danville City, VA	
Pittsylvania, VA	
1960 Davenport-Moline-Rock Island, IA-IL	0.8638
Scott, IA	
Henry, IL	
Rock Island, IL	
2000 Dayton-Springfield, OH	0.9225
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
2020 Daytona Beach, FL	0.8972
Flagler, FL	
Volusia, FL	
2030 Decatur, AL	0.8775
Lawrence, AL	
Morgan, AL	
2040 [2] Decatur, IL	0.8053
Macon, IL	
2080 [1] Denver, CO	1.0328
Adams, CO	
Arapahoe, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
2120 Des Moines, IA	0.8779
Dallas, IA	
Polk, IA	
Warren, IA	
2160 [1] Detroit, MI	1.0487
Lapeer, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
St. Clair, MI	
Wayne, MI	
2180 Dothan, AL	0.7988
Dale, AL	
Houston, AL	
2190 Dover, DE	1.0296
Kent, DE	
2200 Dubuque, IA	0.8519
Dubuque, IA	
2240 Duluth-Superior, MN-WI	1.0284
St. Louis, MN	
Douglas, WI	
2281 Dutchess County, NY	1.0532
Dutchess, NY	
2290 [2] Eau Claire, WI	0.9068
Chippewa, WI	
Eau Claire, WI	
2320 El Paso, TX	0.9215
El Paso, TX	
2330 Elkhart-Goshen, IN	0.9638
Elkhart, IN	
2335 [2] Elmira, NY	0.8547
Chemung, NY	
2340 Enid, OK	0.8357
Garfield, OK	
2360 Erie, PA	0.8716
Erie, PA	
2400 Eugene-Springfield, OR	1.1471
Lane, OR	
2440 [2] Evansville-Henderson, IN-KY (IN Hospitals)	0.8721
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2440 Evansville-Henderson, IN-KY (KY Hospitals)	0.8514
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2520 Fargo-Moorhead, ND-MN	0.9267
Clay, MN	
Cass, ND	
2560 Fayetteville, NC	0.9027
Cumberland, NC	
2580 Fayetteville-Springdale-Rogers, AR	0.8445
Benton, AR	
Washington, AR	
2620 Flagstaff, AZ-UT	1.0556
Coconino, AZ	
Kane, UT	
2640 Flint, MI	1.0913
Genesee, MI	
2650 Florence, AL	0.7889
Colbert, AL	
Lauderdale, AL	
2655 Florence, SC	0.8722

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index
Florence, SC	
2670 Fort Collins-Loveland, CO	1.0045
Larimer, CO	
2680 [1] Ft. Lauderdale, FL	1.0784
Broward, FL	
2700 Fort Myers-Cape Coral, FL	0.9374
Lee, FL	
2710 Fort Pierce-Port St. Lucie, FL	1.0214
Martin, FL	
St. Lucie, FL	
2720 Fort Smith, AR-OK	0.8053
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
2750 Fort Walton Beach, FL	0.9002
Okaloosa, FL	
2760 Fort Wayne, IN	0.9203
Adams, IN	
Allen, IN	
De Kalb, IN	
Huntington, IN	
Wells, IN	
Whitley, IN	
2800 [1] Forth Worth-Arlington, TX	0.9394
Hood, TX	
Johnson, TX	
Parker, TX	
Tarrant, TX	
2840 Fresno, CA	0.9984
Fresno, CA	
Madera, CA	
2880 Gadsden, AL	0.8792
Etowah, AL	
2900 Gainesville, FL	0.9481
Alachua, FL	
2920 Galveston-Texas City, TX	1.0313
Galveston, TX	
2960 Gary, IN	0.9530
Lake, IN	
Porter, IN	
2975 [2] Glens Falls, NY	0.8547
Warren, NY	
Washington, NY	
2980 Goldsboro, NC	0.8709
Wayne, NC	
2985 Grand Forks, ND-MN	0.9119
Polk, MN	
Grand Forks, ND	
2995 Grand Junction, CO	0.9774
Mesa, CO	
3000 [1] Grand Rapids-Muskegon-Holland, MI	1.0048
Allegan, MI	
Kent, MI	
Muskegon, MI	
Ottawa, MI	
3040 Great Falls, MT	0.9195
Cascade, MT	
3060 Greeley, CO	0.9495
Weld, CO	
3080 Green Bay, WI	0.9357
Brown, WI	
3120 [1] Greensboro-Winston-Salem-High Point, NC	0.9539
Alamance, NC	
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
3150 Greenville, NC	0.9289
Pitt, NC	
3160 Greenville-Spartanburg-Anderson, SC	0.9217
Anderson, SC	
Cherokee, SC	
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
3180 [2] Hagerstown, MD	0.8859
Washington, MD	
3200 Hamilton-Middletown, OH	0.9287
Butler, OH	
3240 Harrisburg-Lebanon-Carlisle, PA	0.9425
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
3283 [1,2] Hartford, CT	1.2077
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
3285 [2] Hattiesburg, MS	0.7528
Forrest, MS	
Lamar, MS	
3290 Hickory-Morganton-Lenoir, NC	0.9367
Alexander, NC	
Burke, NC	
Caldwell, NC	
Catawba, NC	
3320 Honolulu, HI	1.1544
Honolulu, HI	
3350 Houma, LA	0.7975
Lafourche, LA	
Terrebonne, LA	
3360 [1] Houston, TX	0.9631
Chambers, TX	
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
3400 Huntington-Ashland, WV-KY-OH	0.9616
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
3440 Huntsville, AL	0.8883
Limestone, AL	
Madison, AL	
3480 [1] Indianapolis, IN	0.9698
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Madison, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
3500 Iowa City, IA	0.9859
Johnson, IA	
3520 Jackson, MI	0.9257
Jackson, MI	
3560 Jackson, MS	0.8491
Hinds, MS	
Madison, MS	
Rankin, MS	
3580 Jackson, TN	0.9013
Madison, TN	
Chester, TN	
3600 [1] Jacksonville, FL	0.9223
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
3605 [2] Jacksonville, NC	0.8535
Onslow, NC	
3610 [2] Jamestown, NY	0.8547
Chautauqua, NY	
3620 Janesville-Beloit, WI	0.9739
Rock, WI	
3640 Jersey City, NJ	1.1178
Hudson, NJ	
3660 Johnson City-Kingsport-Bristol, TN-VA	0.8617
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3680 Johnstown, PA	0.8723
Cambria, PA	
Somerset, PA	
3700 Jonesboro, AR	0.8425
Craighead, AR	
3710 Joplin, MO	0.8727
Jasper, MO	
Newton, MO	
3720 Kalamazoo-Battlecreek, MI	1.0639
Calhoun, MI	
Kalamazoo, MI	
Van Buren, MI	
3740 Kankakee, IL	0.9889
Kankakee, IL	
3760 [1] Kansas City, KS-MO	0.9536
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	0.9568
Kenosha, WI	
3810 [2] Killeen-Temple, TX	0.7714
Bell, TX	
Coryell, TX	
3840 Knoxville, TN	0.8890
Anderson, TN	
Blount, TN	
Knox, TN	
Loudon, TN	
Sevier, TN	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index
Union, TN	
3850 Kokomo, IN	0.9184
Howard, IN	
Tipton, IN	
3870 La Crosse, WI-MN	0.9250
Houston, MN	
La Crosse, WI	
3880 Lafayette, LA	0.8544
Acadia, LA	
Lafayette, LA	
St. Landry, LA	
St. Martin, LA	
3920 Lafayette, IN	0.9121
Clinton, IN	
Tippecanoe, IN	
3960 Lake Charles, LA	0.7765
Calcasieu, LA	
3980 Lakeland-Winter Haven, FL	0.9067
Polk, FL	
4000 Lancaster, PA	0.9296
Lancaster, PA	
4040 Lansing-East Lansing, MI	0.9653
Clinton, MI	
Eaton, MI	
Ingham, MI	
4080 Laredo, TX	0.7849
Webb, TX	
4100 [2] Las Cruces, NM	0.8676
Dona Ana, NM	
4120 [1] Las Vegas, NV-AZ	1.1182
Mohave, AZ	
Clark, NV	
Nye, NV	
4150 Lawrence, KS	0.7812
Douglas, KS	
4200 Lawton, OK	0.8682
Comanche, OK	
4243 Lewiston-Auburn, ME	0.9287
Androscoggin, ME	
4280 Lexington, KY	0.8791
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Madison, KY	
Scott, KY	
Woodford, KY	
4320 Lima, OH	0.9470
Allen, OH	
Auglaize, OH	
4360 Lincoln, NE	1.0173
Lancaster, NE	
4400 Little Rock-North Little Rock, AR	0.8955
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
4420 Longview-Marshall, TX	0.8571
Gregg, TX	
Harrison, TX	
Upshur, TX	
4480 [1] Los Angeles-Long Beach, CA	1.1961
Los Angeles, CA	
4520 [1] Louisville, KY-IN	0.9529
Clark, IN	
Floyd, IN	
Harrison, IN	
Scott, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
4600 Lubbock, TX	0.8463
Lubbock, TX	
4640 Lynchburg, VA	0.9103
Amherst, VA	
Bedford, VA	
Bedford City, VA	
Campbell, VA	
Lynchburg City, VA	
4680 Macon, GA	0.8971
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Twiggs, GA	
4720 Madison, WI	1.0367
Dane, WI	
4800 Mansfield, OH	0.8726
Crawford, OH	
Richland, OH	
4840 Mayaguez, PR	0.4860
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
Sabana Grande, PR	
San German, PR	
4880 McAllen-Edinburg-Mission, TX	0.8378
Hidalgo, TX	
4890 Medford-Ashland, OR	1.0314
Jackson, OR	
4900 Melbourne-Titusville-Palm Bay, FL	0.9913
Brevard, Fl	
4920 [1] Memphis, TN-AR-MS	0.8978
Crittenden, AR	
DeSoto, MS	
Fayette, TN	
Shelby, TN	
Tipton, TN	
4940 Merced, CA	0.9947
Merced, CA	
5000 [1] Miami, FL	0.9950
Dade, FL	
5015 [1] Middlesex-Somerset-Hunterdon, NJ	1.1469
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
5080 [1] Milwaukee-Waukesha, WI	0.9971
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
5120 [1] Minneapolis-St. Paul, MN-WI	1.0930
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	0.9364
Missoula, MT	
5160 Mobile, AL	0.8084
Baldwin, AL	
Mobile, AL	
5170 Modesto, CA	1.0820
Stanislaus, CA	
5190 [1] Monmouth-Ocean, NJ	1.1257
Monmouth, NJ	
Ocean, NJ	
5200 Monroe, LA	0.8201
Ouachita, LA	
5240 [2] Montgomery, AL	0.7400
Autauga, AL	
Elmore, AL	
Montgomery, AL	
5280 Muncie, IN	0.9939
Delaware, IN	
5330 Myrtle Beach, SC	0.8771
Horry, SC	
5345 Naples, FL	0.9699
Collier, FL	
5360 [1] Nashville, TN	0.9754
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
5380 [1] Nassau-Suffolk, NY	1.3643
Nassau, NY	
Suffolk, NY	
5483 [1] New Haven-Bridgeport-Stamford-Waterbury-	1.2294
Danbury, CT	
Fairfield, CT	
New Haven, CT	
5523 [2] New London-Norwich, CT	1.2077
New London, CT	
5560 [1] New Orleans, LA	0.9036
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	1.4427
Bronx, NY	
Kings, NY	
New York, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
5640 [1] Newark, NJ	1.1622
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Warren, NJ	
5660 Newburgh, NY-PA	1.1113

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index
Orange, NY	
Pike, PA	
5720 [1] Norfolk-Virginia Beach-Newport News, VA-NC	0.8579
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	1.5319
Alameda, CA	
Contra Costa, CA	
5790 Ocala, FL	0.9556
Marion, FL	
5800 Odessa-Midland, TX	1.0104
Ector, TX	
Midland, TX	
5880 [1] Oklahoma City, OK	0.8694
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
5910 Olympia, WA	1.1350
Thurston, WA	
5920 Omaha, NE-IA	0.9712
Pottawattamie, IA	
Cass, NE	
Douglas, NE	
Sarpy, NE	
Washington, NE	
5945 [1] Orange County, CA	1.1246
Orange, CA	
5960 [1] Orlando, FL	0.9642
Lake, FL	
Orange, FL	
Osceola, FL	
Seminole, FL	
5990 Owensboro, KY	0.8334
Daviess, KY	
6015 Panama City, FL	0.9061
Bay, FL	
6020 Parkersburg-Marietta, WV-OH (WV Hospitals)	0.8133
Washington, OH	
Wood, WV	
6020 [2] Parkersburg-Marietta, WV-OH (OH Hospitals)	0.8668
Washington, OH	
Wood, WV	
6080 [2] Pensacola, FL	0.8794
Escambia, FL	
Santa Rosa, FL	
6120 Peoria-Pekin, IL	0.8773
Peoria, IL	
Tazewell, IL	
Woodford, IL	
6160 [1] Philadelphia, PA-NJ	1.0947
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Salem, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
6200 [1] Phoenix-Mesa, AZ	0.9638
Maricopa, AZ	
Pinal, AZ	
6240 Pine Bluff, AR	0.7895
Jefferson, AR	
6280 [1] Pittsburgh, PA	0.9560
Allegheny, PA	
Beaver, PA	
Butler, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
6323 [2] Pittsfield, MA	1.1454
Berkshire, MA	
6340 Pocatello, ID	0.9448
Bannock, ID	
6360 Ponce, PR	0.5218
Guayanilla, PR	
Juana Diaz, PR	
Penuelas, PR	
Ponce, PR	
Villalba, PR	
Yauco, PR	
6403 Portland, ME	0.9427
Cumberland, ME	
Sagadahoc, ME	
York, ME	
6440 [1] Portland-Vancouver, OR-WA	1.1150
Clackamas, OR	
Columbia, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Clark, WA	
6483 [1] Providence-Warwick-Pawtucket, RI	1.0805
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	
6520 Provo-Orem, UT	0.9843
Utah, UT	
6560 [2] Pueblo, CO	0.8811
Pueblo, CO	
6580 Punta Gorda, FL	0.9015
Charlotte, FL	
6600 Racine, WI	0.9333
Racine, WI	
6640 [1] Raleigh-Durham-Chapel Hill, NC	0.9818
Chatham, NC	
Durham, NC	
Franklin, NC	
Johnston, NC	
Orange, NC	
Wake, NC	
6660 Rapid City, SD	0.8869
Pennington, SD	
6680 Reading, PA	0.9583
Berks, PA	
6690 Redding, CA	1.1155
Shasta, CA	
6720 Reno, NV	1.0421
Washoe, NV	
6740 Richland-Kennewick-Pasco, WA	1.0960
Benton, WA	
Franklin, WA	
6760 Richmond-Petersburg, VA	0.9678
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	1.1112
Riverside, CA	
San Bernardino, CA	
6800 Roanoke, VA	0.8371
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
6820 Rochester, MN	1.1462
Olmsted, MN	
6840 [1] Rochester, NY	0.9347
Genesee, NY	
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
6880 Rockford, IL	0.9204
Boone, IL	
Ogle, IL	
Winnebago, IL	
6895 Rocky Mount, NC	0.9109
Edgecombe, NC	
Nash, NC	
6920 [1] Sacramento, CA	1.1831
El Dorado, CA	
Placer, CA	
Sacramento, CA	
6960 Saginaw-Bay City-Midland, MI	0.9590
Bay, MI	
Midland, MI	
Saginaw, MI	
6980 St. Cloud, MN	0.9919
Benton, MN	
Stearns, MN	
7000 St. Joseph, MO	0.7899
Andrew, MO	
Buchanan, MO	
7040 [1] St. Louis, MO-IL	0.8931
Clinton, IL	
Jersey, IL	
Madison, IL	
Monroe, IL	
St. Clair, IL	
Franklin, MO	
Jefferson, MO	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index
Lincoln, MO	
St. Charles, MO	
St. Louis, MO	
St. Louis City, MO	
Warren, MO	
7080 [2] Salem, OR	1.0033
Marion, OR	
Polk, OR	
7120 Salinas, CA	1.4684
Monterey, CA	
7160 [1] Salt Lake City-Ogden, UT	0.9863
Davis, UT	
Salt Lake, UT	
Weber, UT	
7200 San Angelo, TX	0.8193
Tom Green, TX	
7240 [1] San Antonio, TX	0.8584
Bexar, TX	
Comal, TX	
Guadalupe, TX	
Wilson, TX	
7320 [1] San Diego, CA	1.1265
San Diego, CA	
7360 [1] San Francisco, CA	1.4140
Marin, CA	
San Francisco, CA	
San Mateo, CA	
7400 [1] San Jose, CA	1.4193
Santa Clara, CA	
7440 [1,2] San Juan-Bayamon, PR	0.4832
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	
Trujillo Alto, PR	
Vega Alta, PR	
Vega Baja, PR	
Yabucoa, PR	
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.0990
San Luis Obispo, CA	
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0802
Santa Barbara, CA	
7485 Santa Cruz-Watsonville, CA	1.3970
Santa Cruz, CA	
7490 Santa Fe, NM	1.0194
Los Alamos, NM	
Santa Fe, NM	
7500 Santa Rosa, CA	1.3034
Sonoma, CA	
7510 Sarasota-Bradenton, FL	1.0090
Manatee, FL	
Sarasota, FL	
7520 Savannah, GA	0.9243
Bryan, GA	
Chatham, GA	
Effingham, GA	
7560 Scranton--Wilkes-Barre--Hazleton, PA	0.8683
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Wyoming, PA	
7600 [1] Seattle-Bellevue-Everett, WA	1.1361
Island, WA	
King, WA	
Snohomish, WA	
7610 [2] Sharon, PA	0.8607
Mercer, PA	
7620 [2] Sheboygan, WI	0.9068
Sheboygan, WI	
7640 Sherman-Denison, TX	0.9373
Grayson, TX	
7680 Shreveport-Bossier City, LA	0.9050
Bossier, LA	
Caddo, LA	
Webster, LA	
7720 Sioux City, IA-NE	0.8767
Woodbury, IA	
Dakota, NE	
7760 Sioux Falls, SD	0.9139
Lincoln, SD	
Minnehaha, SD	
7800 South Bend, IN	0.9993
St. Joseph, IN	
7840 Spokane, WA	1.0668
Spokane, WA	
7880 Springfield, IL	0.8676
Menard, IL	
Sangamon, IL	
7920 Springfield, MO	0.8567
Christian, MO	
Greene, MO	
Webster, MO	
8003 [2] Springfield, MA	1.1454
Hampden, MA	
Hampshire, MA	
8050 State College, PA	0.9133
Centre, PA	
8080 [2] Steubenville-Weirton, OH-WV (OH Hospitals)	0.8668
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8080 Steubenville-Weirton, OH-WV (WV Hospitals)	0.8637
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8120 Stockton-Lodi, CA	1.0988
San Joaquin, CA	
8140 [2] Sumter, SC	0.8512
Sumter, SC	
8160 Syracuse, NY	0.9621
Cayuga, NY	
Madison, NY	
Onondaga, NY	
Oswego, NY	
8200 Tacoma, WA	1.1616
Pierce, WA	
8240 [2] Tallahassee, FL	0.8794
Gadsden, FL	
Leon, FL	
8280 [1] Tampa-St. Petersburg-Clearwater, FL	0.8925
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
8320 [2] Terre Haute, IN	0.8721
Clay, IN	
Vermillion, IN	
Vigo, IN	
8360 Texarkana,AR-Texarkana, TX	0.8327
Miller, AR	
Bowie, TX	
8400 Toledo, OH	0.9809
Fulton, OH	
Lucas, OH	
Wood, OH	
8440 Topeka, KS	0.8912
Shawnee, KS	
8480 Trenton, NJ	1.0416
Mercer, NJ	
8520 Tucson, AZ	0.8976
Pima, AZ	
8560 Tulsa, OK	0.8902
Creek, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
8600 Tuscaloosa, AL	0.8171
Tuscaloosa, AL	
8640 Tyler, TX	0.9641
Smith, TX	
8680 [2] Utica-Rome, NY	0.8547
Herkimer, NY	
Oneida, NY	
8720 Vallejo-Fairfield-Napa, CA	1.3562
Napa, CA	
Solano, CA	
8735 Ventura, CA	1.0994
Ventura, CA	
8750 Victoria, TX	0.8328
Victoria, TX	
8760 Vineland-Millville-Bridgeton, NJ	1.0441
Cumberland, NJ	
8780 [2] Visalia-Tulare-Porterville, CA	0.9659
Tulare, CA	
8800 Waco, TX	0.8150
McLennan, TX	
8840 [1] Washington, DC-MD-VA-WV	1.0962
District of Columbia, DC	
Calvert, MD	
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	
Alexandria City, VA	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties)	Wage Index
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 Waterloo-Cedar Falls, IA	0.8677
Black Hawk, IA	
8940 Wausau, WI	0.9696
Marathon, WI	
8960 [1] West Palm Beach-Boca Raton, FL	0.9777
Palm Beach, FL	
9000 [2] Wheeling, WV-OH (WV Hospitals)	0.8067
Belmont, OH	
Marshall, WV	
Ohio, WV	
9000 [2] Wheeling, WV-OH (OH Hospitals)	0.8668
Belmont, OH	
Marshall, WV	
Ohio, WV	
9040 Wichita, KS	0.9606
Butler, KS	
Harvey, KS	
Sedgwick, KS	
9080 Wichita Falls, TX	0.7946
Archer, TX	
Wichita, TX	
9140 Williamsport, PA	0.8628
Lycoming, PA	
9160 Wilmington-Newark, DE-MD	1.0877
New Castle, DE	
Cecil, MD	
9200 Wilmington, NC	0.9409
New Hanover, NC	
Brunswick, NC	
9260 Yakima, WA	1.0567
Yakima, WA	
9270 Yolo, CA	0.9701
Yolo, CA	
9280 York, PA	0.9441
York, PA	
9320 Youngstown-Warren, OH	0.9563
Columbiana, OH	
Mahoning, OH	
Trumbull, OH	
9340 Yuba City, CA	1.0359
Sutter, CA	
Yuba, CA	
9360 Yuma, AZ	0.8989
Yuma, AZ	

[1] Large Urban Area

[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2002.

ADDEMDUM I.—WAGE INDEX FOR RURAL AREAS

Nonurban Area	Wage Index
Alabama	0.7400
Alaska	1.1862
Arizona	0.8681
Arkansas	0.7489
California	0.9659
Colorado	0.8811
Connecticut	1.2077
Delaware	0.9589
Florida	0.8794
Georgia	0.8295
Hawaii	1.1112
Idaho	0.8718
Illinois	0.8053
Indiana	0.8721
Iowa	0.8147
Kansas	0.7812
Kentucky	0.7963
Louisiana	0.7692
Maine	0.8721
Maryland	0.8859
Massachusetts	1.1454
Michigan	0.9000
Minnesota	0.9035
Mississippi	0.7528
Missouri	0.7899
Montana	0.8655
Nebraska	0.8142
Nevada	0.9727
New Hampshire	0.9779
New Jersey [1]	.....
New Mexico	0.8676
New York	0.8547
North Carolina	0.8535
North Dakota	0.7879
Ohio	0.8668
Oklahoma	0.7566
Oregon	1.0038
Pennsylvania	0.8607
Puerto Rico	0.4832
Rhode Island [1]	.....
South Carolina	0.8512
South Dakota	0.7861
Tennessee	0.7928
Texas	0.7714
Utah	0.9051
Vermont	0.9608
Virginia	0.8241
Washington	1.0209
West Virginia	0.8067
Wisconsin	0.9068
Wyoming	0.8747

[1] All counties within the State are classified as urban.

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RRECLASSIFIED

Area	Wage Index
Abilene, TX	0.7983
Akron, OH	0.9876
Albany, GA	1.0640
Albuquerque, NM	0.9750
Alexandria, LA	0.8059
Allentown-Bethlehem-Easton, PA	1.0077
Altoona, PA	0.9126
Amarillo, TX	0.8502
Anchorage, AK	1.2696

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RRECLASSIFIED—Continued

Area	Wage Index
Ann Arbor, MI	1.1098
Anniston, AL	0.7841
Asheville, NC	0.9200
Athens, GA	0.9706
Atlanta, GA	1.0058
Augusta-Aiken, GA–SC	0.9970
Austin-San Marcos, TX	0.9597
Barnstable-Yarmouth, MA	1.3423
Baton Rouge, LA	0.8149
Bellingham, WA	1.1296
Benton Harbor, MI	0.9000
Bergen-Passaic, NJ	1.1808
Billings, MT	0.9352
Biloxi-Gulfport-Pascagoula, MS	0.8105
Binghamton, NY	0.8607
Birmingham, AL	0.8808
Bismarck, ND	0.7984
Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	1.1293
Burlington, VT (VT Hospitals)	0.9608
Burlington, VT (NY Hospitals)	0.9606
Caguas, PR	0.4832
Casper, WY	0.9346
Champaign-Urbana, IL	0.9140
Charleston-North Charleston, SC	0.9206
Charleston, WV	0.8902
Charlotte-Gastonia-Rock Hill, NC–SC	0.9407
Chattanooga, TN–GA	0.9181
Chicago, IL	1.0917
Cincinnati, OH–KY–IN	0.9473
Clarksville-Hopkinsville, TN–KY	0.8393
Cleveland-Lorain-Elyria, OH	0.9457
Columbia, MO	0.8686
Columbia, SC	0.9168
Columbus, GA–AL	0.8440
Columbus, OH	0.9565
Corpus Christi, TX	0.8238
Dallas, TX	0.9936
Davenport-Moline-Rock Island, IA–IL	0.8538
Dayton-Springfield, OH	0.9225
Denver, CO	1.0328
Des Moines, IA	0.8779
Dothan, AL	0.7988
Dover, DE	1.0003
Duluth-Superior, MN–WI	1.0284
Eau Claire, WI	0.9068
Elkhart-Goshen, IN	0.9517
Erie, PA	0.8716
Eugene-Springfield, OR	1.1006
Fargo-Moorhead, ND–MN	0.9166
Fayetteville, NC	0.8869
Flagstaff, AZ–UT	1.0105
Flint, MI	1.0810
Florence, AL	0.7889
Florence, SC	0.8722
Fort Collins-Loveland, CO	1.0045
Ft. Lauderdale, FL	1.0784
Fort Pierce-Port St. Lucie, FL	1.0114
Fort Smith, AR–OK	0.7857
Fort Walton Beach, FL	0.8828
Fort Wayne, IN	0.9203
Forth Worth-Arlington, TX	0.9394
Gadsden, AL	0.8386
Gainesville, FL	0.9481
Grand Forks, ND–MN	0.9119
Grand Junction, CO	0.9774

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RRECLASSIFIED—Continued

Area	Wage Index
Grand Rapids-Muskegon-Holland, MI	0.9939
Great Falls, MT	0.9195
Greeley, CO	0.9495
Green Bay, WI	0.9357
Greensboro-Winston-Salem-High Point, NC	0.9395
Greenville, NC	0.9289
Greenville-Spartanburg-Anderson, SC	0.9217
Harrisburg-Lebanon-Carlisle, PA	0.9425
Hartford, CT	1.1571
Hattiesburg, MS	0.7528
Hickory-Morganton-Lenoir, NC	0.9367
Honolulu, HI	1.1544
Houston, TX	0.9631
Huntington-Ashland, WV–KY–OH	0.9238
Huntsville, AL	0.8696
Indianapolis, IN	0.9698
Iowa City, IA	0.9708
Jackson, MS	0.8491
Jackson, TN	0.8843
Jacksonville, FL	0.9223
Johnson City-Kingsport-Bristol, TN–VA	0.8617
Jonesboro, AR	0.8115
Joplin, MO	0.8528
Kalamazoo-Battlecreek, MI	1.0471
Kansas City, KS–MO	0.9536
Knoxville, TN	0.8890
Kokomo, IN	0.9184
Lafayette, LA	0.8395
Lansing-East Lansing, MI	0.9653
Las Vegas, NV–AZ	1.1182
Lawton, OK	0.8281
Lexington, KY	0.8641
Lima, OH	0.9470
Lincoln, NE	0.9843
Little Rock-North Little Rock, AR	0.8800
Longview-Marshall, TX	0.8571
Los Angeles-Long Beach, CA	1.1961
Louisville, KY–IN	0.9416
Lubbock, TX	0.8463
Lynchburg, VA	0.8795
Macon, GA	0.8971
Madison, WI	1.0367
Mansfield, OH	0.8726
Medford-Ashland, OR	1.0033
Memphis, TN–AR–MS	0.8793
Miami, FL	0.9950
Milwaukee-Waukesha, WI	0.9865
Minneapolis-St. Paul, MN–WI	1.0930

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RRECLASSIFIED—Continued

Area	Wage Index
Missoula, MT	0.9177
Mobile, AL	0.8084
Modesto, CA	1.0820
Monmouth-Ocean, NJ	1.1257
Monroe, LA	0.8097
Montgomery, AL	0.7400
Myrtle Beach, SC	0.8577
Nashville, TN	0.9552
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2294
New London-Norwich, CT	1.1526
New Orleans, LA	0.9036
New York, NY	1.4287
Newark, NJ	1.1622
Newburgh, NY–PA	1.0797
Oakland, CA	1.5319
Odessa-Midland, TX	0.9495
Oklahoma City, OK	0.8694
Omaha, NE–IA	0.9712
Orange County, CA	1.1246
Orlando, FL	0.9642
Peoria-Pekin, IL	0.8773
Philadelphia, PA–NJ	1.0947
Pine Bluff, AR	0.7895
Pittsburgh, PA	0.9419
Pittsfield, MA	0.9904
Pocatello, ID	0.9159
Portland, ME	0.9427
Portland-Vancouver, OR–WA	1.1150
Provo-Orem, UT	0.9843
Raleigh-Durham-Chapel Hill, NC	0.9818
Rapid City, SD	0.8869
Reading, PA	0.9216
Redding, CA	1.1155
Reno, NV	1.0421
Richland-Kennewick-Pasco, WA	1.0356
Richmond-Petersburg, VA	0.9678
Roanoke, VA	0.8371
Rochester, MN	1.1462
Rockford, IL	0.9042
Sacramento, CA	1.1831
Saginaw-Bay City-Midland, MI	0.9590
St. Cloud, MN	0.9919
St. Joseph, MO	0.8121
St. Louis, MO–IL	0.8931
Salinas, CA	1.4570
Salt Lake City-Ogden, UT	0.9863
San Diego, CA	1.1265
Santa Fe, NM	0.9765
Santa Rosa, CA	1.2631
Sarasota-Bradenton, FL	1.0090
Savannah, GA	0.9243

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RRECLASSIFIED—Continued

Area	Wage Index
Seattle-Bellevue-Everett, WA	1.1361
Sherman-Denison, TX	0.9003
Shreveport-Bossier City, LA	0.9050
Sioux City, IA–NE	0.8767
Sioux Falls, SD	0.8939
South Bend, IN	0.9993
Spokane, WA	1.0668
Springfield, IL	0.8571
Springfield, MO	0.8357
Stockton-Lodi, CA	1.0988
Syracuse, NY	0.9621
Tampa-St. Petersburg-Clearwater, FL	0.8925
Texarkana,AR-Texarkana, TX	0.8327
Toledo, OH	0.9809
Topeka, KS	0.8749
Tucson, AZ	0.8976
Tulsa, OK	0.8760
Tuscaloosa, AL	0.8171
Tyler, TX	0.9359
Victoria, TX	0.8328
Waco, TX	0.8150
Washington, DC–MD–VA–WV	1.0854
Waterloo-Cedar Falls, IA	0.8677
Wausau, WI	0.9558
West Palm Beach-Boca Raton, FL	0.9777
Wichita, KS	0.9237
Wichita Falls, TX	0.7946
Wilmington-Newark, DE–MD	1.0877
Rural Alabama	0.7528
Rural Florida	0.8794
Rural Illinois (IA Hospitals)	0.8147
Rural Illinois (MO Hospitals)	0.8053
Rural Kentucky	0.7963
Rural Louisiana	0.7692
Rural Minnesota	0.9035
Rural Missouri	0.7899
Rural Montana	0.8655
Rural Nebraska	0.8142
Rural Nevada	0.9161
Rural Oregon	1.0038
Rural Texas	0.7714
Rural Washington	1.0209
Rural Wisconsin	0.9068
Rural Wyoming	0.8747

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Part IV

Department of Housing and Urban Development

24 CFR Part 200

Appraiser Qualifications for Placement on FHA Single Family Appraiser Roster; Proposed Rule

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

24 CFR Part 200

[Docket No. FR–4620–P–01]

RIN 2502–AH59

Appraiser Qualifications for Placement on FHA Single Family Appraiser Roster

AGENCY: Office of the Assistant Secretary for Housing—Federal Housing Commissioner, HUD.

ACTION: Proposed rule.

SUMMARY: This proposed rule would make several regulatory changes designed to strengthen the licensing and certification requirements for placement on the FHA Appraiser Roster. First, the proposed rule would require that appraisers on the Appraiser Roster must have professional credentials that are based on the minimum licensing/certification standards issued by the Appraiser Qualifications Board of the Appraisal Foundation. The proposed rule also clarifies that an appraiser may be removed from the Appraiser Roster if the appraiser loses his or her license or certification in any state due to disciplinary action, even if the appraiser continues to be licensed or certified in another state. Finally, the proposed rule provides that an appraiser who is licensed or certified in a single state and whose license or certification has expired, or has been revoked, suspended or surrendered as a result of a state disciplinary action, will be automatically suspended from the Appraiser Roster until HUD receives evidence demonstrating renewal or that the state imposed sanction has been lifted.

DATES: Comments Due Date: January 29, 2002.

ADDRESSES: Interested persons are invited to submit comments regarding this proposed rule to the Regulations Division, Office of General Counsel, Room 10276, Department of Housing and Urban Development, 451 Seventh Street, SW., Washington, DC 20410–0500. Communications should refer to the above docket number and title. Facsimile (FAX) comments are not acceptable. A copy of each communication submitted will be available for public inspection and copying between 7:30 am and 5:30 pm weekdays at the above address.

FOR FURTHER INFORMATION CONTACT: Vance T. Morris, Director, Office of Single Family Program Development, Room 9266, U.S. Department of Housing and Urban Development, 451 Seventh Street, SW., Washington, DC 20410–8000; telephone (202) 708–2121 (this is not a toll-free number). Hearing- or speech-impaired individuals may access this number via TTY by calling the toll-free Federal Information Relay Service at 1–800–877–8339.

SUPPLEMENTARY INFORMATION:

I. Background

HUD has taken various steps to ensure the integrity of Federal Housing Administration (FHA) appraisals. In August 1999, HUD launched dramatic and comprehensive reforms of the FHA appraisal process through its Homebuyer Protection Plan. The purpose of these reforms is to ensure that homebuyers seeking FHA-insured mortgages receive accurate and complete appraisals of the homes they seek to purchase. As part of the Homebuyer Protection Plan, HUD has established regulatory placement and removal procedures for the FHA Appraiser Roster. These procedures are codified in subpart G of HUD's regulations at 24 CFR part 200 (consisting of §§ 200.200—200.206).

HUD's Appraiser Roster lists those appraisers who are eligible to perform FHA single family appraisals. HUD maintains the Appraiser Roster to provide a means by which HUD can monitor the quality of appraisals performed on single family homes financed through the FHA single family programs and to ensure that appraisers performing FHA appraisals meet high competency standards. The Appraiser Roster is an important part of the FHA Single Family Mortgage Insurance program because accurate appraisals are vital to the success of the program and HUD's ability to protect the FHA Insurance Fund.

This proposed rule would make several regulatory changes that are designed to strengthen the FHA Appraiser Roster licensing and certification requirements. First, the proposed rule would amend § 200.202, which requires that an applicant for placement on the Appraiser Roster must be a state-licensed or state-certified appraiser. The proposed rule would require that the state licensed or certified appraiser have professional credentials that are based on the minimum licensing/certification standards issued by the Appraiser Qualifications Board (AQB) of the Appraisal Foundation. HUD believes that the proposed amendment will help to ensure that appraisers on the Appraiser Roster meet high competency standards, thereby improving the quality and accuracy of their FHA appraisals. For purposes of the rule, an appraiser would not be deemed to have professional credentials based on AQB standards if the state licensing/certification requirements did not conform to AQB criteria at the time the appraiser obtained the license or certification. This is true even if the state has subsequently adopted AQB criteria and has ''grandfathered'' previously licensed or certified appraisers.

The proposed rule would also amend § 200.204, which describes the actions HUD may take against an appraiser on the Appraiser Roster that does not meet HUD's established guidelines for performance, education, competency, and other professional criteria. Specifically, the proposed rule clarifies that an appraiser may be removed from the Appraiser Roster if the appraiser loses his or her license or certification in any state due to disciplinary action, even if the appraiser continues to be licensed or certified in another state. The proposed rule would also provide that an appraiser who is licensed or certified in a single state and whose state license or certification has expired, or has been revoked, suspended or surrendered as a result of a state disciplinary action, will be automatically suspended from the Appraiser Roster and prohibited from conducting FHA appraisals until HUD receives evidence demonstrating renewal or that the state imposed sanction has been lifted.

II. Findings and Certifications

Regulatory Planning and Review

The Office of Management and Budget (OMB) reviewed this rule under Executive Order 12866, *Regulatory Planning and Review.* OMB determined that this proposed rule is a ''significant regulatory action'' as defined in section 3(f) of the Order (although not an economically significant regulatory action under the Order). Any changes made to this rule as a result of that review are identified in the docket file, which is available for public inspection in the office of the Department's Rules Docket Clerk, Room 10276, 451 Seventh Street, SW., Washington, DC 20410–0500.

Public Reporting Burden

The information collection requirements for the FHA Appraiser Roster have been approved by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520) and have been assigned OMB control number 2502–0538. In accordance with the Paperwork Reduction Act, HUD may not

conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection displays a currently valid OMB control number.

Environmental Impact

This proposed rule does not direct, provide for assistance or loan and mortgage insurance for, or otherwise govern or regulate, real property acquisition, disposition, leasing, rehabilitation, alteration, demolition, or new construction, or establish, revise, or provide for standards for construction or construction materials, manufactured housing, or occupancy. Accordingly, under 24 CFR 50.19(c)(1), this proposed rule is categorically excluded from environmental review under the National Environmental Policy Act of 1969 (42 U.S.C. 4321).

Regulatory Flexibility Act

The Secretary has reviewed this proposed rule before publication, and by approving it certifies, in accordance with the Regulatory Flexibility Act (5 U.S.C. 605(b)), that this proposed rule would not have a significant economic impact on a substantial number of small entities. The reasons for HUD's determination are as follows.

The proposed rule would require that appraisers on the Appraiser Roster have professional credentials that are based on the minimum licensing/certification standards issued by the Appraiser Qualifications Board (AQB) of the Appraisal Foundation. An analysis of the FHA Appraiser Roster indicates that of the approximately 22,163 appraisers currently on the Roster, only approximately 330 do not have licensing in conformance with the standards issued by the AQB. In most instances, these appraisers already have some of the hours of education or experience required to meet the AQB criteria, thus further minimizing the impacts of the proposed rule. For example, most appraisers on the Roster have been listed on the Roster for some time, and thus few of these appraisers will have difficulty providing evidence to their state board demonstrating acceptable experience levels. With regards to the education requirements, the AQB standards only require 120 hours of education for certification. Given the few number of appraisers currently on the Roster who do not have a state designation based on AQB criteria and the relative low time and expense that would be required for most of these appraisers to meet AQB criteria, HUD believes that the proposed rule will not have a significant economic impact on small entities.

In addition to the new AQB standards, the proposed rule also clarifies that an appraiser may be removed from the Appraiser Roster if the appraiser loses his or her license or certification in any state due to disciplinary action, even if the appraiser continues to be licensed or certified in another state. The proposed rule would also provide that an appraiser who is licensed or certified in a single state and whose state license or certification has expired, or has been revoked, suspended or surrendered as a result of a state disciplinary action, will be automatically suspended from the Appraiser Roster and prohibited from conducting FHA appraisals until HUD receives evidence demonstrating renewal or that the state imposed sanction has been lifted. To the extent that these changes have an impact on small entities it will be as a result of actions taken by the appraisers themselves—that is, violation of applicable standards resulting in disciplinary action or otherwise failing to maintain their professional state licensing or certification.

Notwithstanding HUD's determination that this rule will not have a significant economic effect on a substantial number of small entities, HUD specifically invites comments regarding any less burdensome alternatives to this rule that will meet HUD's objectives as described in this preamble.

Executive Order 13132, Federalism

Executive Order 13132 (entitled ''Federalism'') prohibits an agency from publishing any rule that has federalism implications if the rule either imposes substantial direct compliance costs on state and local governments and is not required by statute, or the rule preempts state law, unless the agency meets the consultation and funding requirements of section 6 of the Executive Order. This proposed rule would not have federalism implications and would not impose substantial direct compliance costs on state and local governments or preempt state law within the meaning of the Executive Order.

Unfunded Mandates Reform Act

Title II of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) establishes requirements for Federal agencies to assess the effects of their regulatory actions on state, local, and tribal governments, and on the private sector. This proposed rule would not impose any Federal mandates on any state, local, or tribal governments, or on the private sector, within the meaning of the Unfunded Mandates Reform Act of 1995.

List of Subjects in 24 CFR Part 200

Administrative practice and procedure, Claims, Equal employment opportunity, Fair housing, Home improvement, Housing standards, Incorporation by reference, Lead poisoning, Loan programs—housing and community development, Minimum property standards, Mortgage insurance, Organization and functions (Government agencies), Penalties, Reporting and recordkeeping requirements, Social security, Unemployment compensation, Wages.

Accordingly, for the reasons discussed in the preamble, HUD proposes to amend 24 CFR part 200 as follows:

PART 200—INTRODUCTION TO FHA PROGRAMS

1. The authority citation for 24 CFR part 200 continues to read as follows:

Authority: 12 U.S.C. 1701–1715z–18; 42 U.S.C. 3535(d).

Subpart G—Appraiser Roster

2. Revise § 200.202(b)(1) to read as follows:

§ 200.202 How do I apply for placement on the Appraiser Roster?

* * * * *

(b) * * *

(1) You must be a state-licensed or state-certified appraiser with professional credentials based on the minimum licensing/certification criteria issued by the Appraiser Qualifications Board (AQB) of the Appraisal Foundation (for purposes of this section, an appraiser is not deemed to have professional credentials based on AQB standards if the state licensing/certification requirements did not conform to AQB criteria at the time the appraiser obtained the license or certification. This is true even if the state has subsequently adopted AQB criteria and has ''grandfathered'' previously licensed or certified appraisers).

* * * * *

3. Amend § 200.204 as follows:

a. Revise paragraph (a)(1);

b. Redesignate paragraphs (c) and (d) as paragraphs (d) and (e) respectively; and

c. Add new paragraph (c):

§ 200.204 What actions may HUD take against unsatisfactory appraisers on the Appraiser Roster?

* * * * *

(a) * * *

(1) *Cause for removal.* Cause for removal includes, but is not limited to:

(i) Significant deficiencies in appraisals, including non-compliance with Civil Rights requirements regarding appraisals;

(ii) Losing standing as a state-certified or state-licensed appraiser due to disciplinary action in any state in which the appraiser is certified or licensed;

(iii) Prosecution for committing, attempting to commit, or conspiring to commit fraud, misrepresentation, or any other offense that may reflect on the appraiser's character or integrity;

(iv) Failure to perform appraisal functions in accordance with instructions and standards issued by HUD;

(v) Failure to comply with any agreement made between the appraiser and HUD or with any certification made by the appraiser;

(vi) Being issued a final debarment, suspension, or limited denial of participation;

(vii) Failure to maintain eligibility requirements for placement on the Appraiser Roster as set forth under this subpart or any other instructions or standards issued by HUD; or

(viii) Failure to comply with HUD-imposed education requirements under paragraph (d) of this section within the specified period for complying with such education requirements.

* * * * *

(c) *Automatic suspension from Appraiser Roster.* An appraiser who is licensed or certified in a single state and whose state licensing or certification has expired, or has been revoked, suspended or surrendered as a result of a state disciplinary action, is automatically suspended from the Appraiser Roster and prohibited from conducting FHA appraisals until HUD receives evidence demonstrating renewal or that the state imposed sanction has been lifted.

* * * * *

Dated: September 10, 2001.

John C. Weicher,

Assistant Secretary for, Housing-Federal Housing Commissioner.

[FR Doc. 01–29681 Filed 11–29–01; 8:45 am]

BILLING CODE 4210–27–P

Federal Register

Friday,
November 30, 2001

Part V

Department of Housing and Urban Development

24 CFR Parts 5 and 202
Uniform Financial Reporting Standards for HUD Housing Programs, Additional Entity Filing Requirements; Proposed Rule

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

24 CFR Parts 5 and 202

[Docket No. FR–4681–P–01]

RIN 2501–AC80

Uniform Financial Reporting Standards for HUD Housing Programs, Additional Entity Filing Requirements

AGENCY: Office of the Assistant Secretary for Housing—Federal Housing Commissioner, HUD.

ACTION: Proposed rule.

SUMMARY: This proposed rule would amend HUD's regulation on Uniform Financial Reporting Standards by adding HUD Approved Title I and Title II nonsupervised lenders, nonsupervised mortgagees, and loan correspondents to the covered entities required to electronically submit annual financial information to HUD prepared in accordance with generally accepted accounting principles. Under long-standing regulatory and contractual requirements, these entities already submit financial information to HUD on an annual basis.

DATES: *Comment Due Date:* January 29, 2002.

ADDRESSES: Interested persons are invited to submit comments to the Rules Docket Clerk, Office of the General Counsel, Room 10276, Department of Housing and Urban Development, 451 Seventh Street, SW., Washington, DC 20410–0500. Communications should refer to the above docket number and title. Facsimile (FAX) responses are not acceptable. A copy of each response will be available for public inspection and copying during regular business hours (7:30 a.m. to 5:30 p.m. Eastern Time at the above address.)

FOR FURTHER INFORMATION CONTACT: For further information about the entities covered by this proposed rule, Lynn Herbert, the Office of Housing, U.S. Department of Housing and Urban Development, 451 Seventh Street, SW., Washington, DC 20410, telephone 202–708–3976 (this is not a toll-free number). For general information about this proposed rule, Stacey Kniff, Real Estate Assessment Center, U.S. Department of Housing and Urban Development, 1280 Maryland Avenue, SW., Suite 800, Washington, DC 20024; telephone Technical Assistance Center, 1–888–245–4860 (this is a toll free number). Persons with hearing or speech impairments may access that number via TTY by calling the Federal Information Relay Service at (800) 877–8339.

SUPPLEMENTARY INFORMATION: HUD's Uniform Financial Reporting Standards (''UFRS'') regulations, codified at 24 CFR part 5, subpart H establish uniform annual financial reporting standards for the following entities: public housing agencies (''PHAs'') administering traditional public housing; PHAs administering Section 8 project-based housing assistance payments programs and Section 8 project-based certificate programs; owners of housing assisted under any Section 8 project-based program (except for the Moderate Rehabilitation and project-based certificates programs, for which the reporting requirement applies to the administering PHAs); and multifamily housing programs receiving assistance or mortgage insurance from HUD. The regulations provide that the financial information required to be submitted to HUD on an annual basis under these programs generally must be submitted electronically and must be prepared in accordance with GAAP.

The move to uniform financial reporting standards in HUD programs was initiated to bring consistency and efficiency in financial reporting. In addition, the electronic submission of financial reporting standards, as a substitute for paper submissions, is in accordance with the Government Paperwork Elimination Act, 44 U.S.C. 3504.

Since the implementation of the UFRS rule, HUD believes that the transition to electronic reporting of financial information using uniform accounting principles has proceeded well. HUD has worked closely with the entities currently subject to these standards (''covered entities'') to assist them in becoming familiar with GAAP and reporting information electronically. The electronic submission of information results in significant benefits, such as increasing the speed of information preparation and exchange, cost savings from reduced need for storage space, fewer errors than occur with paper submissions, and faster HUD review and analysis.

This proposed rule adds participants under another program to the programs covered under the UFRS rule, 24 CFR part 5, subpart H. The new covered participants are the Title I and Title II nonsupervised lenders, nonsupervised mortgagees, and loan correspondents who are approved by HUD under 24 CFR part 202 to originate, purchase, hold, service and/or sell loans. In addition to revisions to part 5 to add these participants, this rule makes conforming changes to 24 CFR 202.5, 202.7, and 202.8.

HUD believes that the transition from paper to electronic filing for these entities will also proceed well, and will benefit the industry, the Department and taxpayers. This progression to electronic reporting will be further facilitated by the fact that these Title I and Title II nonsupervised lenders, nonsupervised mortgagees, and loan correspondents currently receive all loan authorizations exclusively through the HUD electronic secure on-line Internet system. Accordingly, these entities are familiar with HUD's electronic secure systems.

This rule when issued as a final rule would be effective for the covered Title I and Title II nonsupervised lenders, nonsupervised mortgagees, and loan correspondents after December 31, 2001. Audited financial statements submitted by the covered entities on or after January 1, 2002, must be submitted electronically. Audited financial statements submitted prior to January 1, 2002, may either be submitted in paper or electronically at the lenders' option.

Findings and Certifications

Paperwork Reduction Act

The proposed new information collection requirements contained in this rule have been submitted to the Office of Management and Budget (OMB) for review under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520). Under this Act, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection displays a valid control number.

The public reporting burden for this new collection of information is estimated to include the time for reviewing the instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Information on the estimated public reporting burden is provided in the following table.

Information collection	Number of respondents	Responses per respondent	Total annual responses	Hours per response	Total hours
§ 5.801(c)(3)	7,000	1	7,000	3.0	21,000

In accordance with 5 CFR 1320.8(d)(1), HUD is soliciting comments from members of the public and affected agencies concerning the proposed collection of information to:

(1) Evaluate 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;

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

(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 collection techniques or other forms of information technology, *e.g.*, permitting electronic submission of responses.

Interested persons are invited to submit comments regarding the information collection requirements in this proposal. Comments must be received by January 29, 2002. Comments must refer to the proposal by name and docket number (FR–4552–P–01) and must be sent to: Joseph F. Lackey, Jr., HUD Desk Officer, Office of Management and Budget, New Executive Office Building, Washington, DC 20503 and Rules Docket Clerk, Office of the General Counsel, Room 10276, U.S. Department of Housing and Urban Development, 451 Seventh Street, SW, Washington, DC 20410.

Unfunded Mandates Reform Act

Title II of the Unfunded Mandates Reform Act of 1995 establishes requirements for Federal agencies to assess the effects of their regulatory actions on State, local, and tribal governments and the private sector. This rule will not impose any Federal mandates on any State, local, or tribal governments or the private sector within the meaning of the Unfunded Mandates Reform Act of 1995.

Environmental Impact

This proposed rule does not direct, provide for assistance or loan or mortgage insurance for, or otherwise govern or regulate, real property acquisition, disposition, leasing, rehabilitation, alteration, demolition, or new construction, or establish, revise or provide for standards for construction or construction materials, manufactured housing, or occupancy. Accordingly, under 24 CFR 50.19(c)(1), this proposed rule is categorically excluded from environmental review under the National Environmental Policy Act of 1969 (42 U.S.C. 4321).

Impact on Small Entities

The Secretary, in accordance with the Regulatory Flexibility Act (5 U.S.C. 605(b)), has reviewed this proposed rule before publication and by approving it certifies that this rule is not anticipated to have a significant economic impact on a substantial number of small entities. This rule does not create a new reporting requirement. The annual reporting of certain financial information is a preexisting HUD program requirement. This rule adds HUD approved Title I and Title II nonsupervised lenders, nonsupervised mortgagees, and loan correspondents to the covered entities that must submit financial data electronically. The rule standardizes, to the extent possible, the content of the information and the preparation of the information (in accordance with GAAP). HUD anticipates that these changes will bring consistency, simplicity and reduced administrative burden to the reporting process. With respect to costs, the audit costs paid by Title I and Title II nonsupervised lenders, nonsupervised mortgagees, and loan correspondents are a recognized part of operating and administrative expenses. HUD anticipates no or very little monetary impact. The Federal Housing Commissioner has required GAAP-based accounting for a number of years and the majority of these lenders already adhere to its tenets.

Notwithstanding HUD's determination that this rule does not have a significant economic impact on a substantial number of small entities, HUD specifically invites comment regarding any less burdensome alternatives to this rule that will meet HUD's objectives as described in the preamble.

Federalism

Executive Order 13132 (entitled ''Federalism'') prohibits, to the extent practicable and permitted by law, an agency from promulgating a regulation that has Federalism implications and either imposes substantial direct compliance costs on State and local governments and is not required by statute, or preempts State law, unless the relevant requirements of section 6 of the Executive Order are met. This proposed rule does not have Federalism implications and does not impose substantial direct compliance costs on State and local governments or preempt State law within the meaning of the Executive Order.

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance program numbers applicable to 24 CFR part 202 are: 14.110 Manufactured Home Loan Insurance—Financing Purchase of Manufactured Homes as Principal Residences of Borrowers; 14.142 Structures and Building of New Nonresidential Structures; and 14.162 Mortgage Insurance—Combination and Manufactured Home Lot Loans.

List of Subjects

24 CFR Part 5

Administrative practice and procedure, Aged, Claims, Drug abuse, Drug traffic control, Grant programs—housing and community development, Grant programs—Indians, Individuals with disabilities, Loan programs—housing and community development, Low- and moderate-income housing, Mortgage insurance, Pets, Public housing, Rent subsidies, Reporting and recordkeeping requirements.

24 CFR Part 202

Administrative practice and procedure, Home improvement, Manufactured homes, Mortgage insurance, Reporting and recordkeeping requirements.

Accordingly, for the reasons stated in the preamble, HUD proposes to amend title 24 of the Code of Federal Regulations to read as follows:

PART 5—GENERAL HUD PROGRAM REQUIREMENT; WAIVERS

1. The authority citation for 24 CFR part 5 continues to read as follows:

Authority: 42 U.S.C. 3535(d), unless otherwise noted.

2. Amend § 5.801 by adding paragraphs (a)(5), (c)(3), and (d)(3) to read as follows:

§ 5.801 Uniform financial reporting standards.

(a) * * *

* * * * *

(5) HUD-approved Title I and Title II nonsupervised lenders, nonsupervised mortgagees, and loan correspondents.

* * * * *

(c) * * *

* * * * *

(3) For those entities listed in paragraph (a)(5) of this section, the financial information to be submitted to HUD in accordance with paragraph (b) of this section must be submitted to HUD annually, no later than 90 days after the end of the fiscal year (or within an extended time if an extension is granted at the sole discretion of the Secretary). An extension request must be received no earlier than 45 days and no later than 15 days prior to the submission deadline.

(d) * * *

* * * * *

(3) The requirements of this section will go into effect with respect to those entities listed in paragraph (a)(5) of this section. Audited financial statements submitted before June 1, 2002, may either be submitted in paper or electronically at the lenders' option. Audited financial statements submitted by lenders on and after June 1, 2002, must be submitted electronically.

PART 202—APPROVAL OF LENDING INSTITUTIONS AND MORTGAGEES

3. The authority citation for 24 CFR part 202 continues to read as follows:

Authority: 12 U.S.C. 1703, 1709, and 1715b; 42 U.S.C. 3535(d).

4. In § 202.5, revise paragraph (n)(1) introductory text to read as follows:

§ 202.5 General approval standards.

* * * * *

(n) *Net Worth.* (1) Each supervised or nonsupervised lender or mortgagee approved under §§ 202.6 and 202.7 shall have a net worth of not less than $250,000 in assets acceptable to the Secretary. Each Title II supervised or nonsupervised mortgagee, except a multifamily mortgagee, shall have additional net worth in excess of $250,000 of not less than one percent of the mortgage volume exceeding $25,000,000 in value, but total net worth is not required to exceed $1,000,000. Mortgage volume is calculated as of the end of the fiscal year being audited and equals the sum of:

* * * * *

5. In § 202.7, revise paragraphs (b)(4)(i) introductory text and (b)(4)(i)(A) to read as follows:

§ 202.7 Nonsupervised lenders and mortgagees.

* * * * *

(b) * * *

(4) *Audit report.* (i) A lender or mortgagee must comply with the financial reporting requirements in 24 CFR part 5, subpart H. Audit reports shall be based on audits performed by a certified public accountant, or by an independent public accountant licensed by a regulatory authority of a State or other political subdivision of the United States on or before December 31, 1970 and shall include:

(A) A financial statement in a form acceptable to the Secretary, including a balance sheet and a statement of operations and retained earnings, a statement of cash flows, an analysis of the mortgagee's net worth adjusted to reflect only assets acceptable to the Secretary, and an analysis of escrow funds; and

* * * * *

6. In § 202.8, revise paragraphs (b)(3) introductory text and (b)(3)(i) to read as follows:

§ 202.8 Loan correspondent lenders and mortgagees.

* * * * *

(b) * * *

(3) *Audit report.* A loan correspondent lender or mortgagee must comply with the financial reporting requirements in 24 CFR part 5, subpart H except that a loan correspondent mortgagee meeting the definition of a supervised lender or mortgagee in § 202.6(a) need not file annual audit reports. Audit reports shall be based on audits performed by a certified public accountant, or by an independent public accountant licensed by a regulatory authority of a State or other political subdivision of the United States on or before December 31, 1970 and shall include:

(i) A financial statement in a form acceptable to the Secretary, including a balance sheet, statement of operations and retained earnings, a statement of cash flows, an analysis of the net worth adjusted to reflect only assets acceptable to the Secretary and an analysis of escrow funds; and

* * * * *

Dated: October 30, 2001.

John C. Weicher,

Assistant Secretary for Housing-Federal Housing Commissioner.

[FR Doc. 01–29680 Filed 11–29–01; 8:45 am]

BILLING CODE 4210–27–P

Federal Register

Friday,
November 30, 2001

Part VI

Department of Education

34 CFR Part 75
Direct Grant Programs; Final Rule

DEPARTMENT OF EDUCATION

34 CFR Part 75

RIN 1890–AA02

Direct Grant Programs

AGENCY: Office of the Chief Financial Officer, Department of Education.

ACTION: Final regulations.

SUMMARY: The Secretary amends the Education Department General Administrative Regulations (EDGAR) that govern discretionary grant programs. These amendments will implement new options for our application review process for discretionary grants. These changes will improve the quality of the review process and provide greater opportunities for inexperienced, ''novice applicants'' to receive funding.

DATES: These regulations are effective December 31, 2001.

FOR FURTHER INFORMATION CONTACT: Valerie Sinkovits, U.S. Department of Education, 400 Maryland Avenue, SW., room 3652, ROB–3, Washington, DC 20202–4248. Telephone: (202) 708–7568.

If you use a telecommunications device for the deaf (TDD), you may call the Federal Information Relay Service (FIRS) at 1–800–877–8339.

Individuals with disabilities may obtain this document in an alternative format (*e.g.,* Braille, large print, audiotape, or computer diskette) on request to the contact person listed under **FOR FURTHER INFORMATION CONTACT**.

SUPPLEMENTARY INFORMATION: On April 17, 2000 the Secretary published a notice of proposed rulemaking (NPRM) for this part in the **Federal Register** (65 FR 20698).

In the preamble to the NPRM, the Secretary discussed on pages 20699 through 20702 the major changes proposed in that document to increase the options available for reviewing and selecting discretionary grants. These included the following:

- Amending § 75.217 to include the use of quality bands to evaluate applications and adding a new § 75.223 to describe the procedures used under competitions that use quality bands.
- Adding a new § 75.224 to address the practice that has evolved in some program offices of the Department of Education (Department) involving the use of more than one review of an application, otherwise known as ''multiple tier review.''
- Adding a new § 75.225 to include procedures to use if the Secretary decides to give special consideration to novice applicants.

These final regulations contain one significant difference from the NPRM. As a result of public comments we received, we have decided not to make final the regulations regarding the use of quality bands in this document. We would like to do more work to consider fully the issues raised by commenters and to determine whether to issue final regulations for the quality band procedures. Rather than delay the implementation of the procedures for novice applicants, we have decided to publish as much of the NPRM as possible in final now and to notify the public of our decision regarding the quality band procedures at a later date.

Analysis of Comments and Changes

In response to the Secretary's invitation in the NPRM, sixteen parties submitted comments on the proposed regulations. An analysis of the comments and of the changes in the regulations since publication of the NPRM follows.

We discuss substantive issues under the section of the regulations to which they pertain. Generally, we do not address technical and other minor changes, as well as suggested changes that the law does not authorize the Secretary to make.

A number of commenters supported these regulations while others raised concerns about them. As discussed earlier, the Secretary has decided to proceed with publishing these final regulations without the sections on quality bands. Therefore, these final regulations include only the sections on multiple tier review and novice procedures. All of the comments discussed below concern novice procedures, as none were received on multiple tier review. Before discussing the individual comments, we provide a general response to the comments we received on the novice procedures.

The novice procedures were developed in response to the public perception that the barriers to receiving a grant are highest for those who have never received a grant before. These procedures are an additional option for Department staff—they are not required—and would be used only in those circumstances where they are programmatically appropriate.

When determining the number of bonus points available to novice applicants under a particular program, the Secretary will carefully balance quality concerns with the goal of enabling new applicants to break into the grant award system. The Secretary will not fund projects under these procedures that are of poor quality or do not meet the requirements of the program under which they are funded.

Section 75.225 What Procedures Does the Secretary Use if the Secretary Decides To Give Special Consideration to Novice Applications?

Comments: A number of commenters strongly supported the novice procedures, stating that it would be encouraging to first-time applicants to know that more experienced applicants would not necessarily win out over less experienced, yet highly qualified applicants. These commenters believed that this gave their organizations and their grants' intended beneficiaries a better chance of benefiting from Federal funding despite their inexperience in writing applications and managing grants.

Discussion: These comments affirm the Secretary's intent to broaden the pool of applicants that apply for and ultimately receive funding under the Department's discretionary grant programs.

Changes: None.

Comments: Several commenters questioned the appropriateness of allowing programs to give novice applicants any preference in the selection process, stating that all applicants were novices at one time and were able to get funded by following the application procedures, studying funded applications, and submitting high quality proposals. These commenters were concerned that lower quality applications would be funded under these procedures. One commenter questioned the perception held by some unsuccessful applicants that an organization had to already have a grant to get a grant. Another questioned the need for a separate regulation to make the funding of novices a priority, since programs already have the ability to define priorities for funding.

Discussion: During the Department's reengineering process a significant number of focus group participants from the applicant community voiced the opinion that it was very difficult to break into the grant funding system, particularly for small and inexperienced organizations that lack the resources to hire professional grant writers. Therefore, one of the goals of the reengineered grants process is to broaden the range of grant applicants and recipients who participate in our programs. Instituting special procedures for novice applicants is one way to achieve this goal and to address the perception that our grants process is unfairly weighted toward the larger institutions with greater resources. The

Secretary will not fund poor quality applications or ones that do not address the program's requirements. Although programs may set funding priorities, the funding of novice applicants is generally not addressed in this fashion. In addition, this new procedure standardizes the procedures for programs that choose to open up a competition for novices, ensuring greater fairness in the process.

Changes: None.

Comments: A number of commenters recommended that the proposed definition of novice applicant be changed. One commenter suggested that the five-year period without a Federal discretionary grant be eliminated from the novice applicant definition and that the Secretary be given latitude in the final determination of which applicants qualify as novices. One commenter was concerned that under the proposed definition, a ''novice applicant'' may never have received a grant before simply because it did not have the need that would have made it eligible to apply for a particular grant competition, and not because it lacked the resources or capacity to apply. Another commenter was concerned about how the definition would be applied to groups of applicants, such as consortia and partnerships.

Discussion: The definition was set at five years without a discretionary grant from any Federal program in order to ensure that the applicant was truly an inexperienced novice applicant. If the definition applied only to an applicant that had not received a grant or subgrant under the particular Department of Education program from which it seeks funding, then an applicant with extensive experience in receiving grants from other Federal programs could apply as a novice, which clearly it would not be.

The Secretary recognizes that there is a slight possibility that an organization could qualify as a novice, despite the fact that it had the resources and capacity to apply earlier, but hadn't received a grant from the Federal government in the past five years merely because it hadn't had a legitimate reason to apply. However, the Secretary believes that the likelihood that this would happen is small, and that achieving the goal of broadening the pool of applicants who apply for, and ultimately receive, discretionary grant funding outweighs this concern.

Moreover, the Secretary believes that reserving broad latitude to determine which applicants qualify as novices would not give all potential applicants clear notice of the rules by which the competition will be judged. Finally, the Secretary agrees that clarification is needed in these final regulations regarding how the novice applicant definition would apply to applications submitted by groups, such as partnerships or consortia. The Secretary believes that in order for an application submitted by a group to qualify as a novice application, all members of the group should meet the definition of novice applicant. The Secretary has also amended the novice applicant definition to clarify that any member of a group application that receives a grant under a Department program could not qualify in the future as a novice applicant for that program.

Changes: In order to provide clarification on how the novice application procedures would apply to applications submitted by a group, the Secretary has amended the novice applicant definition in § 75.225(a) to indicate that when a group submits a novice application each member of the group must meet the novice applicant definition. Further, we have amended the definition to preclude members of a group of eligible applicants that receives a grant from being considered as novice applicants under that particular program in the future. Section 75.225 (a) has also been renumbered accordingly.

Comments: Several commenters supported the idea of separate competitions for novice applicants, but did not want standards to be lowered for these competitions; novice applicants should have to meet the same requirements as any other applicant. There was also support for keeping the size of the awards to novices relatively small. Others commented that the winners of novice competitions might require closer monitoring or additional technical support until the novice grantees develop more experience in grants administration. Another commenter thought it would be more prudent to give the additional assistance in advance of the competition, to ensure the submission of high quality proposals.

Discussion: We agree that novice applicants must meet the same requirements as other applicants. As discussed earlier, the purpose of this regulation is to increase the number of competent grantees, not to reward lower quality applications with funding. In addition, it has always been the policy of the Department to nurture successful projects by providing assistance to new grant recipients, particularly first-time or relatively inexperienced grantees. This assistance is given in the form of technical assistance workshops, where training in basic grants administration is provided, as well as regular contact by phone or e-mail between Department staff and grant project staff. We expect that in the case of novice grantees, post-award support will be provided to a greater extent than normal, to help ensure the success of these projects. In fact, the use of special procedures for novice applicants will make it easier for program staff to identify those applicants that may need the most assistance. As we gain experience with novice applicants, the most effective ways of ensuring their success will in all likelihood become more evident.

Changes: None.

Paperwork Reduction Act of 1995

These regulations do not contain any information collection requirements.

Intergovernmental Review

These final regulations are not subject to the requirements of Executive Order 12372 and the regulations in 34 CFR part 79. However, many of the programs that these final regulations would apply to are subject to Executive Order 12372 and the regulations in 34 CFR part 79. The objective of the Executive order is to foster an intergovernmental partnership and a strengthened federalism by relying on processes developed by State and local governments for coordination and review of proposed Federal financial assistance.

In accordance with the order, we intend this document to provide early notification of the Department's specific plans and actions for these programs.

Assessment of Educational Impact

In the NPRM we requested comments on whether the proposed regulations would require transmission of information that any other agency or authority of the United States gathers or makes available.

Based on the response to the NPRM and on our review, we have determined that these final regulations do not require transmission of information that any other agency or authority of the United States gathers or makes available.

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(Catalog of Federal Domestic Assistance Number does not apply)

List of Subjects in 34 CFR Part 75

Administrative practice and procedure, Education Department, Grant programs—education, Grant administration, Performance reports, Reporting and recordkeeping requirements, Unobligated funds.

Dated: November 26, 2001.

Rod Paige,

Secretary of Education.

For the reasons discussed in the preamble, the Secretary amends part 75 of title 34 of the Code of Federal Regulations as follows:

PART 757—DIRECT GRANT PROGRAMS

1. The authority citation for Part 75 continues to read as follows:

Authority: 20 U.S.C. 1221e–3 and 3474, unless otherwise noted.

2. Section 75.223 is added and reserved and new §§ 75.224 and 74.225 are added to subpart D under the undesignated center heading ''Selection Procedures'' to read as follows:

§ 75.223 [Reserved]

§ 75.224 What are the procedures for using a multiple tier review process to evaluate applications?

(a) The Secretary may use a multiple tier review process to evaluate applications.

(b) The Secretary may refuse to review applications in any tier that do not meet a minimum cut-off score established for the prior tier.

(c) The Secretary may establish the minimum cut-off score—

(1) In the application notice published in the **Federal Register**; or

(2) After reviewing the applications to determine the overall range in the quality of applications received.

(d) The Secretary may, in any tier—

(1) Use more than one group of experts to gain different perspectives on an application; and

(2) Refuse to consider an application if the application is rejected under paragraph (b) of this section by any one of the groups used in the prior tier.

(Authority: 20 U.S.C. 1221e–3 and 3474)

§ 75.225 What procedures does the Secretary use if the Secretary decides to give special consideration to novice applications?

(a) As used in this section, ''novice applicant'' means—

(1) Any applicant for a grant from ED that—

(i) Has never received a grant or subgrant under the program from which it seeks funding;

(ii) Has never been a member of a group application, submitted in accordance with §§ 75.127–75.129, that received a grant under the program from which it seeks funding; and

(iii) Has not had an active discretionary grant from the Federal Government in the five years before the deadline date for applications under the program.

(2) In the case of a group application submitted in accordance with §§ 75.127–129, a group that includes only parties that meet the requirements of paragraph (a)(1) of this section.

(b) For the purposes of paragraph (a)(1)(iii) of this section, a grant is active until the end of the grant's project or funding period, including any extensions of those periods that extend the grantee's authority to obligate funds.

(c) If the Secretary determines that special consideration of novice applications is appropriate, the Secretary may either—

(1) Establish a separate competition for novice applicants; or

(2) Give competitive preference to novice applicants under the procedures in 34 CFR 75.105(c)(2).

(d) Before making a grant to a novice applicant, the Secretary imposes special conditions, if necessary, to ensure the grant is managed effectively and project objectives are achieved.

(Authority: 20 U.S.C. 1221e–3 and 3474)

[FR Doc. 01–29726 Filed 11–29–01; 8:45 am]

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H.R. 2924/P.L. 107–78

To provide authority to the Federal Power Marketing Administration to reduce vandalism and destruction of property, and for other purposes. (Nov. 28, 2001; 115 Stat. 808)

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